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Transcript of Proceedings

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IN THE MATTER OF THE COMMISSIONS OF INQUIRY ACT 1950

BUNDABERG HOSPITAL COMMISSION OF INQUIRY

COMMISSIONS OF INQUIRY (No. 1) 2005

BUNDABERG

..DATE 06/07/2005

..DAY 19

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

THE COMMISSION RESUMED AT 9.38 A.M.

COMMISSIONER: Mr Atkinson, before we resume the testimony, there are a couple of documentary exhibits we should get clear. I think I indicated yesterday that Dr Smalberger's statement would be exhibit 133. I hope that accords with everyone else's notes. Exhibit 134 was progress notes relating to patient P51, and exhibit 135 was progress notes relating to Mr Kemps, and again they were going to be photocopied from the file.

MR BODDICE: I understand that happened after Court yesterday.

COMMISSIONER: Apart from those, there are a couple of other documents that I thought should be put into evidence, as long as everyone is agreeable. Mr Devlin, on the 22nd of June, your instructing solicitors sent to us the new forms adopted by the Medical Board for the purposes of special purpose applications.

MR DEVLIN: Yes.

COMMISSIONER: It did seem to me desirable they should be put into evidence so that if anyone does have any comments, they are on the record for that purpose. Is that acceptable?

MR DEVLIN: Yes, thank you.

COMMISSIONER: Should your solicitor's covering letter be included with that? That really explains the form. I don't think there is anything confidential in that letter.

MR DEVLIN: I agree, thank you.

COMMISSIONER: The letter from Gilshenan & Luton to the Commission dated the 22nd of June 2005, together with the new forms adopted by the Medical Board, will be exhibit 136.

ADMITTED AND MARKED "EXHIBIT 136"

MR DEVLIN: Thank you.

COMMISSIONER: Might I say two things about that, Mr Devlin: one is, as always, we appreciate the Board's assistance in bringing that to our attention and we are, as always, gratified to see the very proactive way in which the Board is handling these difficult matters.

The other thing I was going to say is that senior counsel assisting, Mr Andrews, has reviewed the forms and he has some comments. I don't think there is any point dealing with those now, but it may be that at some stage those comments can be

made available to you and we can debate them if necessary. Does that-----

MR ANDREWS: That's convenient, Commissioner.

COMMISSIONER: Thank you, Mr Andrews. The other document which we have received - and, Mr Boddice, this relates to your client - we have been given a copy of a letter from Queensland Health signed by Dr Buckland addressed to the Commissioner of Police dealing with the proposed fraud charges against Dr Patel. In one sense, I feel it is important that the fax be out in public, but on the other hand I don't want to do anything that might prejudice any criminal prosecution. I am not sure if you are familiar with the letter.

MR BODDICE: I am not, to be honest.

COMMISSIONER: Perhaps I will make that available to you and you can let us know later in the day whether that should be kept off the record for the time being.

MR BODDICE: Yes. We will obtain some instructions and come back to you, Commissioner.

COMMISSIONER: Thank you. I appreciate that Mr Boddice. Mr Atkinson?

MR ATKINSON: Good morning, Commissioners. Commissioners, there has been some changes in the sequence of witnesses, for two reasons: one is that the various counsel have attempted to accommodate Mr MacSporran, who would like to be here to cross-examine the nurses but has trouble doing that today. The second, of course, is that some of the witnesses will be called out of sequence because many of them will find it more convenient to give evidence in the Brisbane sittings.

COMMISSIONER: Yes.

MR ATKINSON: Having said that, I should say this: the sequence envisaged for today is first of all that the mother of P26 will give evidence. Second of all, that the nurse Patrick Martin will give evidence, and, thirdly, that a nurse called Michelle Hunter will give evidence.

COMMISSIONER: Right.

MR ATKINSON: Commissioners, yesterday we were dealing with the matter of P21, Mr Kemps. There are a number of witnesses still to be called in that matter. One is a doctor called Anthony Athanasiov. He is expected to be called this afternoon. The second is a man many call Dr Sanji. His surname is Kariyawasam.

COMMISSIONER: You have been rehearsing that for a long time.

MR ATKINSON: He works at the Gold Coast and he will be called in Brisbane.

COMMISSIONER: Certainly.

MR ATKINSON: Athanasiov and Kariyawasam were doctors involved with Dr Risson in the operation of Mr Kemps. Dr Risson will also be called, again in Brisbane. He now works in Dalby. Dr Fitzgerald will be called, Commissioners. He, of course, is the Chief Health Officer of Queensland Health but we seek to call him. He is a specialist in emergency medicine. He has reviewed the file and he will be called just to give a short explanation of why the operation was inappropriate.

Also called will be Dr Carter. You will recall he is the Director of Anaesthetics. He will be called on a related issue, in particular of P44. You might recall that-----

COMMISSIONER: Yes.

MR ATKINSON: -----the ventilator is turned off. And to be fair to Dr Carter, I can indicate at this stage his evidence will be that despite the concerns of the nurses, he made an independent decision to turn off the ventilator and only after he had assured himself that there was no prospect of the patient rehabilitating.

COMMISSIONER: My impression - and perhaps I will have to go back to the transcript and look at this - is that particularly Ms Hoffman, when giving evidence about that subject, wasn't critical of Dr Carter for what he did. Her criticism was that Dr Patel was trying to get Dr Carter to turn off the ventilator without going through the appropriate steps. So it was directed at Dr Patel rather than Dr Carter.

MR ATKINSON: Yes. And I just want to make clear that Dr Carter, his evidence will be he made an independent choice and he wasn't coerced, if you like, by Dr Patel at any point.

I turn then to the matter of - the last doctor to be called in that matter of Kemps will be a Dr Joyner and he will be called on Friday, and his evidence will simply be that he was asked to turn off the ventilator for P44 but he declined to do so. He is a GP anaesthetist and a visiting medical officer at the Bundaberg Base Hospital.

COMMISSIONER: Right.

MR ATKINSON: In the matter of P26, that's the 15 year old boy, I thought what I would do, given that witnesses will be called out of sequence, is give a short opening just to explain not so much what every witness will say but to explain how things unfolded.

COMMISSIONER: I appreciate that, and I will take the opportunity to remind the press again that the suppression order in relation to this patient's name remains on foot. And the reasons for that are obvious, that he is only 15 or 16, and he has been through enough tragedy already without causing any embarrassment amongst school friends and the community generally. So that name is not to be published, or, of

course, the details of the incident will be on the record.

MR ATKINSON: On that basis, perhaps I will use his name then.

COMMISSIONER: Well, why don't you confine yourself to using his Christian name when giving the explanation. I just have in mind these things are being recorded and it makes it very difficult for the news broadcasters to edit the footage if the name is in there, and diligently trying to keep the name off the airwaves.

MR ATKINSON: I will do that, Commissioner. That reminds me, Commissioner, the mother of P26 has asked that would it be possible while she is giving evidence that she not be filmed.

COMMISSIONER: Yes, that's certainly-----

MR ATKINSON: The radio journalists have asked if they can nevertheless take sound recordings of her voice.

COMMISSIONER: What's her view about that?

MR ATKINSON: She doesn't object to that.

COMMISSIONER: It would therefore be in order for the video camera to continue operating but not to - not to capture her, so that the cameraman could take video of you asking the questions, or any other counsel asking questions, or the Bench, or proceedings generally, but not the witness.

MR ATKINSON: Thank you, Commissioner. Commissioners, the name of P26 - Christian name is . He was born on 16 July 1989, so that in December 2004 he was 15 years old. He was six foot four even then and he was a gifted basketballer.

On 23 December 2004 he was staying over with friends at Woodgate just outside Bundaberg. His friends had motor bikes and they took P26 with them riding the motorbikes. There was an accident during the morning and in consequence P26's femoral vein was lacerated so that he was - had very steady bleeding to the left groin. One of the other boys went on his motorbike for assistance and in the event the Queensland Emergency Medical System Coordination Centre in Brisbane was contacted. I should say and should interpolate that the QCC is an organisation set up by Queensland Health and the Queensland Ambulance Service and it is in charge of making sure that the right patients get to the right aircraft and the right hospitals, so coordinates, makes sure appropriate transfer arrangements are made.

The Director of the QCC is an emergency medicine specialist called Stephen Rashford. He became aware of the call and the QCC made a decision to transfer the boy from Woodgate to the Bundaberg Base Hospital. That, they will say, was a very appropriate choice because the boy was bleeding profusely and he may not have made it to another hospital.

The transfer occurs by helicopter. When the boy reaches the

hospital, Dr Patel is there waiting for him with Dr Athanasiov. He is taken immediately to surgery. In the course of the next 12 to 14 hours, three operations are carried out to the boy, and I should say that they're operations clearly within the specialty of vascular surgery and they are reasonably complicated operations.

In the first operation there is a repair to the femoral vein, and effectively what Dr Patel does is stops the bleeding to that vein. And again I should say there is no doubt that that first operation saved the boy's life. But for the stopping of the bleeding, the boy would have died. So in the first operation the bleeding stopped from the femoral vein.

After that happens, Dr Athanasiov will say that he notices that the calf and the thigh are still very tense. What is then decided is that a second operation will occur. It is what's called a fasciotomy, and the medical evidence will be that a fasciotomy is a procedure where incisions are made along the leg so that - into the skin and into the fascia so that the leg can swell up without causing damage where there are problems.

After the fasciotomy there was still a problem and it was this: that Dr Athanasiov and others had noticed, even since the first operation and ever after, that there was no pulse to the foot of the left leg.

Dr Athanasiov persuaded Dr Patel to do an ultrasound. Again they noticed that there was no pulse. They found that there was an injury to the femoral artery. The boy was taken back to theatre a third time, and in this operation a repair was made to the femoral artery. What a vascular surgeon might do is harvest the vein and use it to assist the artery. What Dr Patel did - and it is not outside the range of appropriate practice in some cases, the medical evidence will be - Dr Patel used a synthetic substance called gortex to make a conduit for the femoral artery.

There are a number of criticisms that will be made later on by the doctors in Brisbane of the surgery of those three procedures. The first is this: that when the femoral vein was repaired, in fact what happened was that it was stitched across. It was ligated, so that, of course, what's supposed to happen is that the artery is taking blood into the limb and the vein is allowing the blood to drain away. With the vein being ligated like that, the boy wasn't going to be able to get blood into his limb, it would become ischaemic, and effectively from that moment the blood couldn't make its way in and out.

The second problem was that with the second procedure, the fasciotomy, the incisions weren't made longitudinally far enough, so that effectively the leg couldn't swell up as much as it should swell without damage occurring. And the third problem was that with the femoral artery, gortex is a substance one might use in a clean wound, but when you have a motorcycle accident it is likely that the area - the site is

infected. Gortex can be used, if you are not skilled enough in vascular surgery, as a holding position, but there is a high likelihood that the site will become infected and he needs to be transferred to an area where a vascular surgeon can do the vein harvesting as soon as possible.

There is a fourth problem that the doctors in Brisbane subsequently identified. The doctors in Bundaberg - Dr Patel realised that there was some kind of fracture to the pelvis and the hip but they thought it was a mild fracture. In fact, it was quite a serious fracture and the boy would have been in exquisite pain whilst he was in Bundaberg with the fracture. Dr Athanasiov will say that after these procedures of the 23rd of December 2004, there was discussion between him and Dr Patel about a transfer of the patient, and that while Dr Patel considered that course, rather than being dismissive, he eventually decided that he wouldn't go through with the transfer. Dr Athanasiov will say that he stayed on duty for another day.

On the 26th of December Dr Patel went on holidays himself. When he did that, the boy, of course, was still in hospital. It was still the case, it seems, that no-one had found a pulse in the foot. Dr Patel took the view that the boy would get better in due course and that the pulse would reemerge, and consultant surgeon Dr Gaffield was left to care for the patient.

Dr Gaffield, it should be said, will give evidence that he was told by Dr Patel, "The boy will improve. When he does improve, he will need some skin grafts done to the sites of the fasciotomies and you, Dr Gaffield, with a specialty, with a particular interest, at least, in plastic surgery, you might do those fasciotomies in due course, do that skin graft." So it was certainly made clear to Dr Gaffield, it seems, that the boy was to remain at the Base Hospital.

As will be appreciated, the mother of the boy arrived in the hospital very soon after the helicopter flight. She was there from about midday on that first day, the 23rd of December. She stayed by the boy's side for most of that time.

And I should interpolate here that the boy stayed in the Bundaberg Hospital without this blood getting through from 23rd of December until New Year's Day this year, so a total of almost nine days.

The mother was by his side and, as will be appreciated, she was very distressed over that time. The injuries to the boy's leg, particularly after the fasciotomies, were so horrific that she couldn't stand by the boy's side while the dressings were being changed. She was conscious that the boy was in constant pain and needed very high levels of painkillers. She had spoken to friends who had explained that this was really a job for a vascular surgeon, and she said to the staff - at least she explained to a doctor, who was a junior doctor, Dr Boyd, she will say, that she was very keen for the boy, if there was any doubt whatsoever, to be transferred to Brisbane.

And here again I should interpolate that the family had private health cover and certainly the evidence of the mother will be that money was no issue whatsoever in a case of this severity.

COMMISSIONER: There was a vascular surgeon here in Bundaberg.

MR ATKINSON: I should say, to be fair, that Dr Thiele gave evidence - and the significance of it may not have appeared to the Commissioners - but he gave evidence that he was on holidays-----

COMMISSIONER: That's true, yes.

MR ATKINSON: -----in America over this period. She will say that she was very concerned that the boy was having temperatures as high as 41 degrees. She was assured, when she asked questions, that the boy was fine. Indeed, her evidence will be that at one stage nurse Jenkin upgraded her and said that she really needed - she wasn't going to be allowed to ask questions and pull up her doctors on her ward.

The boy remained at the hospital. One of the things that really struck the doctors in Brisbane was that he wasn't in the intensive care unit, he was just kept in the general surgical unit. As I say, he was there for nine days.

On the last day, the 1st of January 2005, something a little bit different happened, as I understand it. The consulting surgeon saw that the boy seemed to be infected. He reached the view that maybe the infection was coming from the central line and he took the central line off the boy so the boy wasn't on antibiotics. The doctors in Brisbane again will say - well, one of them in particular, Dr Ray, a vascular surgeon, will say that that course takes his breath away.

In any case, a junior doctor, Dr Risson, who I mentioned earlier today, came back from holidays at or about that time. He was very concerned by the boy's state and he did something that the surgeons in Brisbane will say should have been done much earlier. He rang the vascular unit at the Royal Brisbane Hospital and he explained what he was seeing in front of him.

The Senior Registrar at the vascular unit at the RBH is a doctor called Mark Ray. He has a general Fellowship in Surgery and he has a Fellowship in Vascular Surgery as well. He will say that initially he thought the call was a joke and he will say that was for this reason: he couldn't believe something so serious had been going on for nine days in Bundaberg and that he hadn't been called. He was told the condition of the boy, temperatures, infection, pus, a very strong odour, and he immediately set about trying to make sure that the boy was retrieved from Bundaberg. He will say that he called Dr Rashford at the QCC and said there needed to be an arrangement that day for the boy to be flown to Brisbane. He will say that he spoke to the head of the vascular unit, Dr Jason Jenkins, who, of course, is a specialist from whom

you have heard in - at least you have seen the correspondence in relation to the matter of P52. He called Dr Jenkins to explain the scope of the problem and to ask Dr Jenkins to come in.

Dr Rashford will say that it is not unusual to receive a call from the referring hospital. It is very unusual to receive a call from the recipient hospital, and he realised, even from that alone, that it was a very serious incident. He arranged for a helicopter to fly from Bundaberg to Brisbane and that takes about an hour and three quarters. He himself then went across from the QCC's offices in Brisbane across to the Royal Brisbane, and he will say that he was shocked by what he saw. The leg, the foot was obviously mottled. There was obviously a lot of trouble with the leg with any blood getting through. The boy was in so much pain he couldn't smile and he could barely talk.

Dr Ray will say that his staff were concerned at that stage that the boy was likely to die. He and Dr Jenkins reached a view that they couldn't operate on the boy that day, the 1st of January 2005, because the boy was unlikely to survive the surgery. They took him to theatre, they debrided the wound and then they let him rest overnight so that they could consider what to do.

In the morning they had discussions with the mother, I should say, and explained that there was a real prospect that her boy might die. In the morning they had to consider what to do and they reached the view that unless they were to amputate the leg, there was a very real prospect the boy would die. In the event, what they did was a through-knee amputation. Initially there was some concern they might need to do more than that but they reached the view a through-knee amputation was required. They did that and Dr Rashford will say in his view it was a very good result from when they started, and the boy might well have died or had a more extensive amputation.

Doctor Rashford will say in particular that he is very critical of the management of the patient for a number of reasons: he will say that it is often difficult for doctors in regional hospitals to seek help from teaching hospitals, from the central hospitals, but it is an everyday procedure. And what can happen is that - what usually happens, doctors call in from regional areas, they have to go through switch, they have to find out which doctor can help them. Sometimes that doctor might be in theatre, sometimes they are away, but, albeit it seems a rather clumsy process, it works, he will say, and doctors in the regional areas do get good advice.

More importantly, he will say this is complicated vascular surgery and as soon as that boy was stable, that is after the first operation, he should have been transferred to Brisbane. Dr Ray and Dr Jenkins will say that if the boy had been transferred when he should have been transferred, he would still have his leg.

They will make the point that I made earlier and I should reiterate that point that Dr Patel by that first operation did save the boy's life.

In terms of aftermath, Dr Rashford will say that after the operation, he was very very distressed. He will say that sometimes a patient wants to come to Brisbane and they might have to ring seven or eight intensive care units until they can find a bed for them, but his evidence will be that when you have a very severe injury to a very young person, he would have moved heaven and earth and he would have made sure that that boy found a bed straight away.

His evidence will be that he thought about this problem for a day, thought about his distress, but after a day he wasn't any less angry and he wrote an e-mail on the 4th of January 2005 to Dr Keating, Mr Leck and Dan Bergin, the zonal manager, and explained his concerns. Commissioners, I won't take you through the evidence, but when one looks at the statement, the draft statement of Dr Rashford, which I have provided to the Commissioners, you will see that there is a chain of correspondence, e-mail correspondence.

On the 4th of January, there's this complaint. On the 5th of January, there's a complete, what purports to be a complete answer, a report that sets out what happened and what needs to be done. You will find amongst those e-mails a note suggesting that in the circumstances, no external review is required. You'll also find that the upshot of this tragedy is that a decision was made that there should be discussions between the RBH and the Bundaberg Base Hospital about transfers. Nothing more formal seems to have been done so far as the e-mails show.

The evidence of one of the nurses involved in the care, Michelle Hunter, will be that she also gave some - or she also had very considerable distress about the management of this boy and in the event she herself made a complaint through the nurses stream about his care, and as I mentioned earlier today, you'll hear from her in the course of the morning.

Commissioners, if I might then, I propose to call the mother.

COMMISSIONER: Well, before you do that, does anyone else expect that they will wish to cross-examine the mother on any issue?

MR DIEHM: Not me, Commissioner.

COMMISSIONER: Thank you Mr Deihm.

MR FITZPATRICK: Not us, thank you Commissioner.

MR DEVLIN: No thank you.

MS FEENEY: No Commissioner.

MR ALLEN: Nothing.

MR MULLINS: There may be one or two matters.

COMMISSIONER: I'm thinking in many ways that - and I shouldn't express any personal views - but I find this probably the most distressing of the cases that we've had to deal with and I just can't begin to imagine how distressing it is for the mother. If anyone seriously thinks that there's a need for her to come into the witness box and give evidence, then that will have to happen, but I would be perfectly comfortable in having her statement tendered as an exhibit and sparing her unpleasantness.

MR ATKINSON: Commissioner, can I say in that regard that there are a couple of things that the mother would like to say. I did propose just to put her statement to her.

COMMISSIONER: Yes.

MR ATKINSON: But there are a couple of things that the mother would like to get off her chest.

COMMISSIONER: By all means. Yes. Can the lady come forward?

MR MULLINS: I should point out, Commissioner, that I have instructions from the solicitors who act-----

COMMISSIONER: Oh Mr Mullins, I understand your position and I didn't mean the slightest criticism of you, you're acting in her interests, not contrary to her interests. Now, as already mentioned, this evidence is not to be filmed or photographed.

R1, SWORN AND EXAMINED:

MR ATKINSON: Witness, is your name R1?-- Yes.

May I show you this document, R1; is that a statement you've made to the Commission?-- Yes, it is.

And is that your signature at the base of the statement?-- Yes, it is.

Are the contents of that document true and correct to the best of your knowledge?-- Yes.

Commissioners, I tender that document.

COMMISSIONER: Yes. The statement of this witness will be Exhibit 137.

ADMITTED AND MARKED "EXHIBIT 137"

MR ATKINSON: R1, the Commissioners now have your statement and they will peruse it very carefully, but independent of what's in that document, is there anything that you'd like to say to the Commission?-- The time that my son was at Bundaberg Base Hospital, my instincts were telling me that, you know, all was not right, but with the culture of the whole Bundaberg Base Hospital when the medical team, the doctors and the nurses backing them up are all telling you, "He's fine", "He's fine", you start to doubt your own instincts, and I think the doctors certainly deprived my son of any chance of the vascular surgeons in Brisbane saving his leg. I mean, he's 15 years old and he lives for his sports and they've taken that away from him. I can't understand how a team of doctors and a ward of nurses could stand by silently while he was dying and that's exactly what was happening to him and I just I will never understand it. I know the staff were under pressure not to complain and not to say anything, but their job is caring for people. I just can't comprehend how none of them did anything sooner. I just can't understand it. That's all I wanted to say.

COMMISSIONER: Thank you for saying that.

MR ATKINSON: Just a couple of questions, R1?-- Yep.

Could you tell the Commissioners something about the care that your boy will require-----?-- In the future?

-----in the future?-- Because of the skin graphs to his thigh area from the fasciotomies, he requires further surgery, they won't stand up to the friction from the prosthetic limb so he'll require - they have to replace it with muscle which they'll take from his back. He has to have continual graphs on his femoral artery and checks with the vascular surgeons. It's just going to be ongoing. He still has - I still have to do dressings daily on his whole thigh area and all his care's ongoing. We travel to Brisbane constantly for the amputee clinic and to see the vascular surgeons and that also will continue, so - and it's just things for the rest of his life, you know, everywhere he lives, it has to be altered, bathrooms have to be altered, it's just, there is going to be - it's an unending stream of things that he'll have to deal with for the rest of his life.

D COMMISSIONER VIDER: Is it anticipated that they will be able to replace the lost muscle to the point where a prosthetic limb will be able to be fitted?-- Yes, if they actually replace the skin graph with like a full thickness graph, it will toughen that area up and then they're quite confident, Dr Jason Jenkins is quite confident that that's what's going to happen.

Have they been able to give your son any timeframe which would give him some hope of reality where he can see an end to this so far as he'll be mobile again?-- Yes. Actually, Dr Jenkins has decided that rather than wait for the surgery, we will try

with another prosthetic leg and even if he can only wear it for an hour a day initially until he undergoes further surgery, as you can understand, my son's not keen to go back to hospital.

No?-- And Dr Jenkins, as he said, he's already undergone 13 operations, you know, it won't hurt to put this one off for a little while anyway, just a few months.

Mmm. What's your son's psychological state like at the moment?-- He seems okay. He's very closed with his emotions, it's very hard to tell what he's thinking, actually, and I think he puts on a brave front a lot of the time for my sake, yeah, so it's hard to tell.

MR ATKINSON: R1, have you received any advice about the likely cost of prosthetics?-- The prosthetic limb we're looking at which will allow him to actually run and continue in some of his sports is between 70 and $75,000.

And how often will that require replacement?-- That comes with a five year warranty on the computer components, computer maintenance, as he grows it will need adjustment and only 15 he's probably got a lot of growing to do, so each time he grows that will have to be adjusted and I'm not sure what sort of life is in a prosthetic limb, I don't know.

Is there anything else at all that you'd like to tell the Commission?-- No, I don't think so.

That's the evidence-in-chief, Commissioner.

COMMISSIONER: Mr Mullins?

MR MULLINS: Thank you.

CROSS-EXAMINATION:

MR MULLINS: My name is Mullins, I appear on behalf of the patients. Just a couple of brief questions: in paragraph 23 of your statement, you say that very soon after the first surgery, you wanted your son to go to Brisbane?-- Yes.

You knew as early as then that that's what you wanted for him; that's correct?-- Well, yes.

And it's the case, isn't it, that you told hospital staff that you wanted him transferred to Brisbane at that time?-- I told the doctors, yes.

Yes. All right. And no-one made the offer to you or even discussed the transfer to Brisbane until 1 January 2005?-- No, that's correct.

Thank you Commissioner.

COMMISSIONER: Thank you. I can't imagine how painful it's been for you to come here and give this evidence. We are all very grateful for you coming forward. If these problems are going to be solved, there's nothing we can do for your son?-- Mmm.

I wish there were, but if this sort of situation is going to be prevented from happening to other people's sons?-- Mmm.

Your courage in coming here to give evidence will be a significant part of that and thank you from the bottom of our hearts?-- Thank you.

We do really appreciate it?-- Thank you.

And you're excused from further attendance.

WITNESS EXCUSED

COMMISSIONER: We might take a 10 minute break, Mr Atkinson.

THE COMMISSION ADJOURNED AT 10.17 A.M.

THE COMMISSION RESUMED AT 10.25 A.M.

MR ANDREWS: I propose for the next witness to call Patrick Damien Martin. As I see no-one striding towards the witness box, I'll ask that he be searched for.

COMMISSIONER: That's all right.

PATRICK DAMIEN MARTIN, SWORN AND EXAMINED:

MR ANDREWS: Good morning, Mr Martin?-- Good morning.

My name is Andrews. I'm assisting the Commissioners. Would you tell the Court your full name, please?-- Patrick Damien Martin.

Mr Martin, I have copy of one of two statements that have been prepared and signed by you. Would you look, please, at this document.

COMMISSIONER: Is that the one we have?

MR ANDREWS: Yes, Commissioner.

COMMISSIONER: Okay.

MR ANDREWS: Do you recognise that as the document you've read and signed?-- Yes, I have.

Mr Martin, the facts in that statement, are they true to the best of your knowledge?-- To the best of my knowledge, yes.

And the opinions in it, are they honestly held by you?-- Yes, they are.

Do you have a copy of it with you?-- Yes.

I tender that original.

COMMISSIONER: Thank you. The original statement of Mr Martin will be Exhibit 138.

ADMITTED AND MARKED "EXHIBIT 138"

MR ANDREWS: Mr Martin, you finished your nursing training in 1986 and you've worked in various hospitals, including the Princess Alexandra Hospital in Brisbane and the Holy Spirit Hospital?-- That's correct.

You've worked at the Royal Prince Alfred Hospital and St Vincent's Hospital in Sydney?-- Yes.

And at Bundaberg, I see at paragraph 6 of your statement you advised that you have an advocacy role to assist Queensland Health staff with certain things, including submissions, health promotions?-- That's correct.

Have you had that role since 2001 or is that something that you only currently hold?-- I've had that role since 2001 and prior to that in the acting role.

Now, in February 2004 you held an acting position, didn't you?-- Yes, I did.

Was that as an Acting Director of Nursing?-- That's correct.

While holding that role two nurses from the renal unit came to see you, Robyn Pollock, the Nurse Unit Manager, and Lindsay Druce. Do you remember that?-- Yes, I do.

And they had some concerns. Can you tell us, please, about their concerns?-- They - as I say in my statement, the nurses raised concerns in relation to some of the procedures that were being undertaken specifically by Dr Patel at that time. These were in relation to the insertion of Tenckhoff catheters. Also, they mentioned another case that had an adverse outcome in relation to the cutting of a - of a subvenacava during insertion of a PermCath patient, which is a separate issue.

Was that separate issue also in respect of Dr Patel?-- No, that was - to my understanding, that was in relation to Dr Patel as well.

Now, with respect to the Tenckhoff catheters, they made you aware, did they, that there were more than one-----?-- Yes.

-----that had been, well, the subject of improper placement by Dr Patel?-- That's correct.

You were concerned?-- Yes, I was.

Did it happen often that nurses came to complain about the clinical competence of a Director of Surgery?-- In my experience, no.

You reassured them that you'd speak with Dr Keating?-- I did.

And you went to see Dr Keating immediately?-- I did.

Now, can you tell us what it was that Dr Keating told you when you went to see him?-- I - Dr Keating told me - I - I broached the issue with Dr Keating and Dr Keating listened to my concerns on behalf of the nurses and he - basically, he said that, "If the nurses have these sorts of concerns, I need to have further evidence. I need to have evidence before I

can take it to a senior surgeon such as Dr Patel. I can't, basically, go to him, you know, with nothing to back me. So the nurses need to bring on this evidence. They need to provide me with the evidence if they" - basically, "if they want to play with the big boys." By that, I guess he meant the senior staff, senior surgeons.

Sixteen months has passed since the nurses came to see you. Can you remember what it is that you told Dr Keating?-- It's very difficult to remember the specifics of that conversation. I think that I probably - I had my notes with me and I think there's a copy here of the notes that I took while the nurses were with me and I basically related that to Dr Keating.

I've not seen the notes-----?-- Oh, sure.

-----that you speak of. Can you tell us what that - may I have a look at them?-- Certainly. Oh, I'm sorry, they're in another statement that I did.

Oh. Perhaps - that might be - that might be available within the courtroom.

MR FARR: I have a copy here, Commissioner. I can indicate that we had been asked to take a statement from Mr Martin a couple of weeks ago, commenced to do so and then discovered that the Commission staff have taken a statement, which is now the exhibit before the Court. The statement that we had commenced taking we have finished and I understand is being photocopied as we speak and the attachments to it, and it simply expands upon the issues that have been raised in the statement which is before the Court.

COMMISSIONER: Do you have a copy of these notes that the witness is referring to?

MR FARR: I can give my learned friend my copy of that.

COMMISSIONER: Why don't we give them to the witness so he can answer the question.

MR FARR: Certainly. But I understand a copy of everything the Commission has is being photocopied because we haven't got the facility.

COMMISSIONER: Yes, I understand.

MR ANDREWS: Mr Martin, these are notes that you made at the time that you were in the company of Robyn Pollock and Lindsay Druce or shortly after they left?-- This was at the time. I was taking the notes while they were speaking to me.

Are the notes brief enough for you to conveniently read to us?-- Yes, certainly. I've got down here - we were discussing peritoneal dialysis numbers as well but in relation to the Tenckhoff catheter insertions, I've got here, "Six recent post-op infections. Four have had to be repositioned", and I'm talking about the Tenckhoff catheters there, and I've got

written here, "Patient died as a result of perforation of subvenacava during a subvena insertion." And that's basically - oh, and down further I've got, "Catheters moving in situ. They're flicking under the liver", I've got in parenthesis, and, "Marking op sites was ignored." The nurses marked the op sites where they wanted the catheters placed but according to the nurses, this was not always being done.

Now, at the time that you took those notes, I noticed that you made no mention of the name "Patel", but you were in no state of confusion that it was all in respect of Dr Patel that these incidents were raised?-- That's my understanding, yes.

Well, when you went to see Dr Keating, did you have your notes with you?-- Yes, I'm pretty sure I did.

And is it likely that you read and reconstructed those notes for Dr Keating's benefit?-- I don't know if I actually read them out as I just did. I probably paraphrased them and said that there were concerns and that a number of patients - I may have mentioned the exact numbers but I can't recall the number of patients that had complications in relation to the insertion of their Tenckhoff catheters.

COMMISSIONER: Is this when Dr Keating said to you, "If the nurses want to play with the big boys, then they need to get their facts straight"?-- It was during that conversation, yes.

And "the big boys" obviously meant doctors?-- Yes, that was my understanding.

So the effect of it was if the nurses want to take on the doctors, they've got to get their facts straight?-- If they - if they want to - if they want to basically bring these issues up, bring them forward, and they're dealing with senior staff, this was my understanding, then they needed to have their facts straight, they needed to provide evidence to back that.

Well, who could the big boys be other than the doctors like Patel?-- Yes, the senior surgeons and senior doctors.

Was there any question about the accuracy of the facts that you'd provided?-- I had no reason to disbelieve them, no.

Did Dr Keating raise any concern about the accuracy of the facts?-- He didn't to my recollection, no.

Well, what facts did anyone need to get straight?-- I think that from my understanding, was that - from the conversation, was that if further investigation needed to be done, there needed to be - I think Dr Keating required more evidence because there was the issue from - with the PermCath insertion as well.

Is that what he told you, that he needed more information?-- He requested that, you know, more evidence be forthcoming.

What evidence did he ask you for?-- Well, data in relation to Dr Patel's complication rate as opposed to his successful outcomes basically.

MR ANDREWS: All right. Mr Martin, as well as you can remember the effect of Dr Keating's words relating to that last issue, I'd like you to tell us his words, not what you thought he was intending but what Dr Keating may have said when requesting more evidence?-- Basically, it's more or less as I recall as I just said, that he requested further data, further information, because he - I guess he needed to get an understanding of the ratio between Dr Patel's successful outcomes, you know, all the procedures that he's done that have been successful, as opposed to the ones that have been non-successful or unsuccessful.

I see. Now, did Dr Keating make it clear whether he was speaking of Tenckhoff catheter procedures or procedures generally?-- My understanding was that it was procedures generally, that it was - the Tenckhoff obviously was the big issue here but I'd also mentioned the insertion of the PermCath as well. So it was my impression that, you know - in relation to Dr Patel, that - and I guess specifically because the renal nurses had been to see me, that it was in relation to renal issues, renal procedures.

Is it - did you leave the renal nurses after your first meeting with them with the understanding that Dr Patel had placed six Tenckhoff catheters and that all six had led to post-operative complications?-- I think there were six and that four had to be repositioned, that six - I guess, yes, there had been infections, I think was the word that was used.

But the nurses, had they left you with the clear impression that that was - that they were the only six Tenckhoff catheters that Dr Patel placed?-- They were the only ones that we were talking about at the time. I mean, I just assumed that there may have been other catheters that Dr Patel had placed as well, but he was talking about these specific ones.

I'm thinking of Tenckhoff catheters. Did you leave with the assumption that Dr Patel may have placed more than six Tenckhoff catheters or only six Tenckhoff catheters?-- I assumed that Dr Patel had been doing these procedures for - for quite some time, I don't know how long, but this was just in relation to this particular six. So I assumed that there had been other placements undertaken.

Now, when you saw Dr Keating and he advised you as to what the nurses ought to do, how specific was he about the evidence that he recommended be obtained?-- He didn't go into specifics at all, really, from my recollection. It was basically, as I said earlier, that he wanted an idea of Dr Patel's - I guess he was trying to get a picture. I mean, I don't want to speak for Dr Keating at all-----

COMMISSIONER: And it is better not to guess?-- Yes.

Just do your best to recall exactly what he did say?-- Yes.

No-one expects you to remember the precise words?-- Sure.

But rather than your impressions or your feelings or whatever, tell us as best you can what he actually said to you?-- It was in relation to getting an idea, the ratio of successful procedures as opposed to unsuccessful or procedures with adverse outcomes. He wanted that sort of information.

You might not be the right person for me to ask this to but why would a Director of Medical Services ask you to provide that information? Shouldn't he have access it to himself?-- I guess it was because it was raised by the nursing staff, they raised their concerns; that he was requesting the nurses bring further information, so.

MR ANDREWS: And where would a person at the hospital who was interested in such statistical matters, go to gather that information? I assume that the nurses in the renal unit would be able to or had some ready access to renal unit information but not in respect of all surgical procedures, so where would they go if they sought to gather this evidence?-- The clinical coders could provide that sort of information.

Is that DQDSU?-- No, that's a separate department. DQDSU - I mean, they could possibly get that information there as well, I couldn't be sure, but the clinical coders might be able to give them that information.

So if, for instance, Dr Keating had said, "Mr Martin, I want you to get me all these figures", you'd have gone first, what, to the clinical coders, would you?-- I honestly can't say. At the time I probably - I would have sought further advice as to where I should go to this get this information.

Who would you have asked?-- The Quality Support Unit possibly. Yeah, that's the sort of area I would have gone to I think initially to investigate.

All right. The Quality Support Unit, is that the DQDSU?-- Yes.

Who's the person there to whom you'd turn if you wanted these statistical data?-- Probably Jenny Cooper I would have gone to.

Thank you. As a result of your meeting with Dr Keating, you recounted some of the conversation to the nurses. To whom did you speak, Robyn Pollock and Lindsay Druce?-- I e-mailed Robyn and Lindsay straight after that meeting and advised them of the outcome of that and Dr Keating's request.

Would you have a look, please, at this copy e-mail from Paddy Martin to Robyn Pollock on the 2nd of October 2004 which-----

COMMISSIONER: Is that the one that's already in evidence as RP5?

MR ANDREWS: RP5, yes, Commissioner?-- That was the 10th of February 2004.

Oh, of course?-- It is not American.

It is not 2nd of October. Yes, I'm reading it in the Australian way. So it's the 10th of February 2004. That is an e-mail that you sent to Robyn Pollock?-- Yes, it is.

For some reason, at the bottom in handwriting there appear the letters of the words "CC/D" to Darren Keating at the time?-- Yes.

Do you recognise the handwriting?-- Yes, that's my handwriting.

Does it indicate that you also sent a copy of this to the Director of Medical Services?-- Yes, I did.

Did you also speak with Mr Leck about this matter as the e-mail suggests?-- I know I did - that was suggested. I can't recall actually speaking to Peter Leck about it.

Would you have considered speaking with Mr Leck because it was such a serious matter that had been raised or for some other administrative reason?-- I would have because it was a serious issue. As I say, I can't recall actually speaking to Mr Leck about this particular issue.

The nurses from the renal unit didn't ever come back to you with figures, did they?-- No.

You then left the position of Acting Director of Nursing four weeks later?-- Approximately, yes.

Thereafter, this was - it was no longer your duty to be concerned with these matters; is that the position?-- At that time, yes, I went on holidays.

Well, when you returned, you didn't return as-----?-- No.

-----Acting Director of Nursing. Mr Martin, I'm wondering why it is that you didn't follow up with the nurses to pursue them for this. I assume it was because it was no longer your duty. Is it that you forgot?-- It was no longer my duty, it was no longer my responsibility, I'd handed over to my successor. So, I assumed that a process had been put in train and that it would continue at that level.

You assumed, what, that Lindsay Druce and nurse Robyn Pollock would be on - on to that process in train?-- That was my recollection, yes.

But when you did your handover to the next Director of

Nursing, did you think to mention this matter?-- I'm pretty sure I did, yes, she did know.

Which Director of Nursing was that?-- That was Toni, Toni Hoffman.

Now, as the - as time passed, after the 10th of February, you gathered an impression that the nurses had misunderstood some aspect of your message relayed from Dr Keating to them; is that the case?-- Which message was this?

Oh-----

COMMISSIONER: Does it matter, Mr Andrews? We've now got the words from the horse's mouth as to what was said.

MR ANDREWS: Only to this extent: Mr Martin, did you get the clear impression that some nurses felt that Dr Keating had been deliberately unhelpful or obstructive; that he'd suggested an aggressive message to the nurses that if they want to play with the big boys, they should bring it on?-- Bring on their evidence, yes. I don't believe that it was necessarily aggressive.

Yes, but did you understand that the nurses had some kind of misunderstanding?-- Yes.

Why did you not clear it up with them?-- At the time, I didn't think that it was going to be an issue or even at the time I didn't think that it was an issue.

So, am I right in thinking that on the one hand you believed Dr Keating had simply been asking for data; on the other hand, that you believed that the nurses had misinterpreted his request as an aggressive challenge, "If they want to play with the big boys, bring it on"? Am I correct, that that they're the two opposing thoughts, one in Dr Keating's mind and one in the nurses' minds?-- I couldn't - I couldn't say what the perceptions of the nurses were to be quite honest with you. My impression was, I suppose, that they had misinterpreted the comment. I did nothing at the time to correct it but Dr Keating had requested further information and I was of the impression that that was forthcoming.

I have no further questions, Commissioner.

COMMISSIONER: Mr Andrews. Anyone else have any questions? Mr Farr?

MR FARR: Commissioner, there is only the issue of that second statement. I believe the original is now in the possession of counsel assisting. It should perhaps be tendered as part of the exhibit and it can just be an addendum statement if you like.

MR ANDREWS: I have just been handed four statements of Patrick Martin.

COMMISSIONER: Why don't you have a look through that while the cross-examination continues and, unless there is any objection, it can be added to the existing 138.

MR ANDREWS: Thank you, Commissioner.

COMMISSIONER: Thank you.

MR FARR: And I just have one question.

COMMISSIONER: Yes. Yes, Mr Farr.

EXAMINATION-IN-CHIEF:

MR FARR: Mr Martin, just on the last point that you were asked questions about, do you remember when you may have first learned that the nurses may have misinterpreted that comment?-- When this - when this issue with Dr Patel became such as it is now, probably at the beginning of the year, that's when it became an issue then for me that I thought I needed to address it.

Oh, I see. Thank you, that's all I have.

COMMISSIONER: Thank you.

MR DIEHM: Commissioner, I have some questions but I have not had a chance yet to read this further statement and I don't know whether there is anything in that I might need to-----

COMMISSIONER: I wouldn't want you to be at a disadvantage. Do you want five or 10 minutes to do that?

MR DIEHM: Yes, thank you, Commissioner.

COMMISSIONER: Just before we rise, I was going to ask a question which I don't think it necessarily impacts on your position, Mr Diehm, but you will be able to follow that up if you feel appropriate.

MR DIEHM: Yes.

COMMISSIONER: Mr Martin, in paragraph 6 of your statement you describe your job as having an advocacy role to assist Queensland Health staff with business cases, submissions, health promotions, program planning and policy development. What does all that mean?-- That - because I've got zonal responsibilities, I look after or my job takes me across a number of zones, I do health promotion, I - I help identify areas of concern in various districts, I work with the teams on the ground there to develop programs, strategies and so forth. Policy development, I again identify gaps where there may be lack of policy for specific areas and work to develop those sorts of things.

Well, you talk about business cases. What's a business case for Queensland Health?-- Business case is, for example, when we first opened the unit, the Sexual Health Unit here in Bundaberg, I was requested to put forward a business case which outlines the budget requirements, the staffing requirements, what the service gaps already were, what risks there were in setting the unit up and so forth.

And who was Queensland Health going to be doing business with?-- With - from our perspective, it was a new service that was opening in Bundaberg and we were working with the general practitioners, with other stakeholders in the community as well. So we did a consult - consultation process during the establishment of the clinic.

I'm sorry, I misunderstand. What is a business case? I mean, I can understand a company thinking of putting out a new product and they do a business case to see whether supermarkets will stock it and whether people will buy it and so on, but what's a Queensland Health business case? I thought that their function was to provide health services. What business activities are we talking about?-- It's in relation - as I say, you know, it's - my understanding of it is that when you actually get the document, there's a number of headings and you address the headings. It's so that - I guess that everything is above board, that there's a process in place for the establishment of the clinic, that people are advised where we're going to with this so it is not all just in my head, that other people have read the document, that they've had a chance to comment on it, and that it's appropriate to service the needs of the target groups.

D COMMISSIONER EDWARDS: There would be a different doctrine, possibly, in other regions of the state - any difference amongst the regions?-- I'm sorry?

There would be a different doctrine, possibly, in other regions of the state - any difference amongst the regions?-- I'm pretty sure that most districts would have the same template for a business case, and that they use it for similar reasons.

COMMISSIONER: Yes, Mr Mullins?

MR MULLINS: Commissioner, I have some brief questions-----

COMMISSIONER: Go ahead.

MR MULLINS: -----that might relate to Dr Keating and Mr Diehm.

CROSS-EXAMINATION:

MR MULLINS: Mr Martin, I appear on behalf of the patient. My name is Mullins. I just have some questions about the meeting of 10 February 2004, and I haven't had the opportunity to read all the statement, but I'm sure you can tell us or give us an answer to a few questions. I understand PM2 is the note of your meeting?-- Yes.

That's correct. Now, at the time that you had this meeting with the nurses from the renal unit it's the case, isn't it, that Dr Miach had gone on leave?-- I can't recall, to be quite honest with you, where Dr Miach was at the time.

Other evidence tells us that Dr Miach went on leave between 29 January 2004 and mid April 2004 and had left instructions with the renal unit, and I stand to be corrected on this, had left instructions with the renal unit that Dr Patel wasn't to operate on his patients. Now, was that raised during the meeting you had around 10 February 2004?-- Not to my memory, no.

Did you have any independent knowledge of that?-- No, I didn't.

So you had no idea that Dr Miach left these particular instructions when you had your discussion with the nurses?-- No, I didn't.

COMMISSIONER: Didn't you just ask that, Mr Mullins?

MR MULLINS: Sorry?

COMMISSIONER: Didn't you just ask that question?

MR MULLINS: Yes, I apologise.

COMMISSIONER: Why ask it again?

MR MULLINS: I just wanted to clarify it.

COMMISSIONER: I don't think there's any other way to clarify it. He said he didn't recall whether that was raised. Anything else?

MR MULLINS: When you met with Dr Keating, did he indicate to you that he would carry out any investigations on his own behalf, for example, contacting any other surgeons or any other persons within the hospital who might have concerns?--No.

Thank you, Commissioner.

COMMISSIONER: All right, Mr Mullins. Mr Allen, did you have any questions?

MR ALLEN: No, thank you, Commissioner.

COMMISSIONER: Mr Diehm, are you ready?

MR DIEHM: No, I'm not, Commissioner. I would like to take-----

COMMISSIONER: I will give you five minutes then. Is five minutes enough, or ten?

MR DIEHM: I think it would be ten. It's a reasonably long document.

COMMISSIONER: Perhaps you can let us know when you are ready.

MR DIEHM: Yes, thank you.

THE COMMISSION ADJOURNED AT 11.01 A.M.

THE COMMISSION RESUMED AT 11.16 A.M.

PATRICK DAVID MARTIN, CONTINUING:

COMMISSIONER: Mr Diehm?

MR DIEHM: Commissioner, thank you for the time. In light of what's in the further statement of Mr Martin, I have no further cross-examination of him.

COMMISSIONER: Thank you, Mr Diehm. Mr Andrews, have you had a chance to review the further statement?

MR ANDREWS: I have, thank you, Commissioner.

COMMISSIONER: Should that then be added to form part of Exhibit 138?

MR ANDREWS: It should. I will identify the original and ask Mr Martin to identify it. Yes, please look at this document. Is that another statement signed by you, Mr Martin?-- Yes, it is.

And the facts in it are true to the best of your knowledge?-- That's correct.

The opinions in it are honestly held by you?-- Yes.

I tender it.

COMMISSIONER: I think, actually, to avoid confusion in the record we will give that a separate number and make that Exhibit 139.

ADMITTED AND MARKED "EXHIBIT 139"

MR ANDREWS: That statement you have just tendered - you've just tendered Exhibit 139 - is it a statement prepared by you with the assistance of solicitors for the Health Department?-- Yes, that's correct.

COMMISSIONER: Yes, Mr Devlin?

CROSS-EXAMINATION:

MR DEVLIN: Mr Martin, my name is Ralph Devlin. I represent the Medical Board of Queensland. In your second statement under "Patient Complaints" and "Nursing Complaints" you outline your - in general terms your knowledge of those systems. Were you ever in a position as Acting Director of Nursing long enough to form a - a view about the effectiveness of the complaint system? Have you enough experience, generally, in the hospital system to give us the benefit of your view as to whether those systems operated effectively from your point of view or whether there could be ways to improve them?-- I think that I agree, I think there could be improvements.

In what respects?-- I can't really give you specifics. I just believe that, you know, it's an ongoing process,

improving documentation and so forth.

Is there room for thinking, in your experience, that there are - there is a range of matters of complaint that might well be resolved internally and relatively informally, but there are some matters that go beyond that to be of a much more serious type?-- That's my understanding, yes.

And is there a need, in your experience, for more transparency in dealing with the latter more serious type of complaint?-- I think that its transparencies are, yeah, excellent, should be a key - key part of it.

Because from the nursing perspective the concluding comments in your second statement point to a growing sense that some concerns of nursing staff didn't appear to be acted on; is that - do I understand that correctly, just a growing general sense among staff? I will take you to the last paragraph?-- Yes.

Perhaps you might explain what you meant in 62, "I generally recall over time, commencing many years ago and well before the current administration, that a feeling amongst staff began to develop that their concerns were generally not being asked and that there was a growing sense that complaining or raising issues was a futile exercise as the perception was that nothing ever changed." What - do you want to expand on that at all?-- Yes. What I'm trying to get at there is that this - it seems to be more of a culture that existed that you'd - even in my experience when I was working as a registered nurse that, you know, complaints or issues that I may have raised might not have been dealt with adequately from my perspective and, also, just talking to staff over years that there seemed to be, yeah, just this whole business that complaints probably - it was almost - sometimes like beating a head against a wall.

My questions aren't directed at the current management?-- Sure.

I don't expect you to interpret them this way, but is part of the culture, as you've experienced it over the years, a determination to deal with things in-house no matter how serious rather than expose the serious issues to a more transparent view by some means?-- I honestly couldn't comment on that.

All right. But, to summarise, you feel the need for some change in the way complaints are handled, but you can't really articulate for yourself, or for us how, those changes should occur?-- Not off the top of my head, no.

I certainly asked the question at point blank range. In any event, the resolution of serious clinical concerns you would say, from your experience as a nurse, calls for a different response, anyway, to the one that's been-----?-- I think that in light of what's happened-----

-----encountered?-- -----ongoing improvement and these sorts of processes would be a valuable thing.

One of the matters canvassed in the Brisbane sittings was the model or the idea of a - an independent clearing house where matters are classified and sent to the right places to be dealt with; does that appeal as being one of those sort of steps that could increase transparency in the appropriate cases?-- Possibly. Really, it's a decision that I wouldn't really have any impact on.

All right. Thank you. Thank you, Commissioner.

COMMISSIONER: Thank you, Mr Devlin. Anyone else at all? Any re-examination, Mr Andrews?

MR ANDREWS: One short topic.

RE-EXAMINATION:

MR ANDREWS: Mr Martin, your relationship with the Director of Medical Board Services is both a working relationship - but Dr Keating is a friend of yours; is he not?-- Dr Keating is an acquaintance. What - I'd classify that I have about three or four really good friends. I wouldn't say that - I don't socialise with Dr Keating or anything like that. I've got a good, friendly working relationship with Dr Keating.

I have nothing further, Commissioner.

COMMISSIONER: Thank you, Mr Andrews. You are excused from further attendance.

WITNESS EXCUSED

COMMISSIONER: Mr Andrews, I see Mr Atkinson there. During his opening of the evidence relating to the first witness this morning he did refer to a number of e-mails, and so on, which form part of the statement of Dr Rashford. I think now that that evidence is open it is only fair that those e-mails and correspondence be in the record. So I would suggest that Mr Rashford's - sorry, Dr Rashford's statement be tendered at this stage, be given an exhibit number subject, of course, to his being called and making any admissions or clarifications that may be necessary in due course.

MR ANDREWS: Certainly, Commissioner. Commissioner, currently I have the attachments that are to form part of Dr Rashford's statement.

COMMISSIONER: That should be satisfactory. I just don't think it's appropriate to refer to those documents in an opening without putting them in evidence, so that everyone can scrutinise them.

MR ANDREWS: In the circumstances, I tender as a single bundle attachments SJR1, SJR2, and SJR3 proposed to be attachments to the statement of Dr Stephen Rashford. I have a - an unsigned draft of the statement of Dr Rashford that's been opened today.

COMMISSIONER: I think just the bundles then that you have described SJR1, 2 and 3 can go in and be marked Exhibit 140.

MR ANDREWS: I am instructed that the draft statement has been adopted by Dr Rashford.

COMMISSIONER: What's your preference; should they go in now?

MR ANDREWS: I'm content to have them all go in together as one exhibit, Commissioner.

COMMISSIONER: All right. The statement of Dr Rashford together with the attachments to that statement will together form Exhibit 140.

ADMITTED AND MARKED "EXHIBIT 140"

MR ANDREWS: Thank you, Commissioner.

COMMISSIONER: Thank you, Mr Andrews. Mr Mullins?

MR MULLINS: Commissioner, yesterday you adjourned a proposed application until 9.30 a.m. on Thursday.

COMMISSIONER: Yes.

MR MULLINS: It's recorded at transcript 1911 the issues that the Commission adjourned. So that I'm in a position to adequately prepare both legally and the facts upon which the application is based at least to make some contribution, can I request that there be some particularisation of exactly what the application is or is proposed and what the material is likely to be, even by way of more outline, so that I can approach the relevant issues and respond. I understand, of course, that the application is something of a moving feast, but if I can have some outline of what the feast is it would assist me in my preparation. I don't require that immediately, but if something can be laid out, maybe after lunch and adjourned, to give the parties some idea what it is we have to meet in the morning.

COMMISSIONER: Thank you, Mr Mullins. I'm not going to make any direction. It's entirely a matter for any individual or

individual's legal representatives if and when they make an application and provide proper grounds for it. In the case of Mr Leck, for example, back on the 26th of May his counsel said, and I quote from the transcript page 389 lines 21 to 24, "We do not for a moment complain about - certainly don't dissent for a moment about your authority and power to require him to give evidence today and we don't complain about your decision to do so." It was on the 26th of May.

More than a week later on the 3rd of June that counsel suddenly changed his mind and in the transcript, page 866 line 39 he was stated saying "things were unfair, unnecessary and unexplained". You are right, Mr Mullins, it is a moving feast. Those people can decide if they make applications and when they make them and on what basis they make them.

All I want to make clear is that having heard this morning's evidence, so far as I'm concerned anyone in the bureaucracy who thinks this is about them should sit back and think it's not about them, it's about the evidence we heard this morning about the son. That's what it's about.

If they want to bring applications before me or before the Supreme Court, or wherever else they want to go, then we will deal with that as it arises, but for the moment I'd prefer to get on and deal with the - what I see to be the important issues here, which is an impact on the patients.

So unless you want to take that any further, I will invite Mr Andrews to call his next witness.

MR MULLINS: Thank you, Commissioner.

COMMISSIONER: Oh, Mr Morzone, I beg your pardon.

MR MORZONE: If it please the Commission I call Michelle Hunter.

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

COMMISSIONER: Thank you.

MR FARR: Commissioner, if it hadn't been announced for the last witness we appeared for Mr Martin.

COMMISSIONER: I don't think it was, but it is now.

MR FARR: Thank you.

COMMISSIONER: Thank you.

MICHELLE DE-ANN HUNTER, SWORN AND EXAMINED:

MR MORZONE: Is your full name Michelle De-Ann, D-E hyphen A-N-N, Hunter?-- Yes.

You are a registered nurse, and you have been a registered nurse since 1994?-- Yes.

You hold a Bachelor of Nursing degree?-- Yes.

You've been employed by Queensland Health in the surgical ward of the Bundaberg Hospital for some time now; is that correct?-- Yes, on and off.

And on and off you have also been Acting Clinical Nurse in the surgical ward for Bundaberg Base Hospital?-- That's correct.

And from time to time you have acted as Nurse Unit Manager-----?-- That's correct.

-----while the permanent Nurse Unit Manager is away. You've prepared a statement in this matter which you have signed. Is there a correction which you wish to make to paragraph 12 of the statement?-- Yes.

What is that correction, or have you prepared a little supplementary statement?-- Yes, yes, that's correct.

Okay. Can I ask you to look at this document?-- Yes, that's it. Do you want me to read it out?

No, no. Is your statement, which you've signed as now supplemented by that supplementary statement, true and correct to the best of your knowledge and belief?-- Yes.

I will tender the statement, if it please the Commission, with the supplementary statement.

COMMISSIONER: The statement and supplementary statement of the current witness will together form Exhibit 141.

ADMITTED AND MARKED "EXHIBIT 141"

MR MORZONE: You refer in your statement to having, on the 30th of December 2004, during the evening shift looked after a patient by the name of P36, a 15 year old boy?-- I have got P26 in my statement.

P26, I beg your pardon, yes?-- Yes, that's correct.

Was that the first occasion that you were caring for the - for P26?-- Yes, it was.

And you mention in paragraph 7 from the chart and hand notes you learnt about the patient and what had occurred; is that correct?-- That's correct.

And you then made an assessment of the patient; is that correct?-- Yes.

What was your assessment of them?-- My assessment of the patient was that just from the physical look of the patient that he was extremely unwell, just - his foot, left leg was grossly swollen and it was oozing very large amounts of ooze. His foot was purple and mottled to the ankle. I did Doppler pulses on his leg. He had a posterior tibial pulse, but no dorsalis pedis pulse. He was unable to move his leg. It was cold from the ankle down, and he had patchy sensation in the foot. He was also tachycardic and febrile up to, I think, about 39 or 40 degrees at the time.

Can you explain - I think you are, perhaps, the first witness who, medically, has referred to the Doppler pulse. Can you explain-----?-- It's a machine that allows you to hear the pulses on limbs better than, like, feeling them or listening with a stethoscope.

Okay. Was the patient in pain?-- He was in extreme pain. He had a PCA with Morphine, and I can't quite recall, I think he had Ketamine in it, as well.

Did you become concerned about the patient having seen him?-- Yes, I did.

What did you do?-- I went straight to his doctor, which was the intern that was there that afternoon, and I don't recall what the intern's name was, and I gave her my assessment of the patient and told her that I felt he was extremely unwell, and that I had never seen a boy in this kind of state before.

You refer to the leg having been grossly swollen. How swollen was it; do you remember?-- It was about three or four times the size of his right leg.

Three or four times the size of his other leg?-- Yep.

And what was the response when you raised your concerns with an intern?-- I - I'd asked her if they thought about changing the antibiotics because he had been on IV cephalin for a number of days and he was still febrile and she said, "Not at this stage", and she told me that Dr Patel was away on holidays and that he had done his original surgery and that Dr Gaffield was covering, and that they knew what his condition was like.

Did you relay your concerns on to Dr Gaffield?-- No, I very rarely see Dr Gaffield.

COMMISSIONER: You were on nightshift at this time, were you?-- I was on the evening shift.

Right. And Dr Gaffield wasn't around at that time?-- No.

MR MORZONE: You finished your shift and when you returned on the 2nd of January you heard that the patient had been transferred to Brisbane, is that correct?-- I looked after him on the Thursday, and then on the Friday I was on an evening shift again and he was looked after by another nurse. And then on Saturday I came to work in the afternoon, which is the 2nd, I believe - no, the 1st, and I heard that he had been transferred out first thing on Saturday morning.

Did you subsequently hear through Dr Risson what had occurred in Brisbane?-- No, I heard through the nursing staff, I recall, that he was in a very unstable condition and he was in ICU and that he may die, and that they may have to do a hind quarter, and that when they did do these operations eventually, that they - I don't recall who it was, someone from the nursing staff said that they had tied his femoral vein off.

How did that make you feel?-- I was angry and upset because I believe that if this boy had have been transferred out after his original stabilising surgery, he may not have lost his leg.

What did you do then?-- On - because it was New Year's Eve, I think Monday was a holiday, public holiday, so my nurse unit manager wasn't there and there weren't any executives there, so I was determined that I was going to make a complaint. I didn't really know how I was going to go about that and I did some - I knew that I could make a complaint to the Health Rights Commission, and I did a bit of research on the internet to see whether I could do that or not. On the Tuesday when I came back to work, I asked my nurse unit manager, Di Jenkin, that - I told her that I was upset about this patient and that I was going to make a complaint to the Health Rights Commission, and I went and spoke to Toni Hoffman from ICU about how she went about the process of making a serious complaint like this.

COMMISSIONER: Was it known to you at this stage that Toni Hoffman had already had a clash involving Dr Patel?-- Yes.

D COMMISSIONER VIDER: Can I just ask you a question? I notice in your background that you had 14 months' experience in a vascular unit in Bath in the UK?-- That's correct.

Were you the most experienced vascular nurse on the ward at Bundaberg Base Hospital?-- I don't know.

Did other nurses have vascular nursing experience-----?-- We - Dr Thiele used to work in Bundaberg, so a lot of the nurses

that have worked there for many years do have vascular experience, but I don't know about anyone else.

And your particular concerns about the nursing management or the clinical management of P26, was that shared by other nurses? In other words, was the concern raised at hand over report time?-- The first day I looked after him, they had said most of what I found in my assessment, but I hadn't - I had - that's - I had been on days off prior to that for about five days or something, so I hadn't - this is the first dealings I had ever had with him, and then Kylie Johnson, who looked after him on the Friday, had my concerns as well.

So there was some other staff members that shared your concerns?-- Yes.

MR MORZONE: You were saying that you were determined to make complaint about the management of the patient. What particularly concerned you about the management?-- The fact that he was still febrile and they weren't considering changing his antibiotics, the fact that his foot was ischaemic, and he was a 15 year old boy, and he had these massive open wounds, and he was in severe pain. It wasn't - it just didn't look right.

Okay. You were saying that you raised your concerns and your intention to make a complaint to the Health Rights Commission with Ms Jenkins?-- I - yeah, I told her that I was concerned and that I was going to make a formal complaint. And then I think I went and spoke to Toni Hoffman, how she went about it, and she told me that - that she had thought about that as well but was advised to go through the hospital channels, and I rang the Queensland Nurses' Union and asked them what I should do and they advised me to write a formal letter to the Director of Nursing, which is what I did in the end, and I believe Di Jenkin - Linda Mulligan had come to the ward that day and Di had raised my concern with her and said that I was - that - I don't think she mentioned my name to Linda but she did say that I was going to make a complaint to the Health Rights Commission and Di told me that Linda said, "That's not the right way to go about it", and that, "She needs to write a letter to me."

Okay. Now, the letter that you did end up writing on the 4th of January 2005 to Ms Mulligan is exhibited to your statement, is that correct?-- That's correct.

And you - did you forward that to Ms Mulligan or did you give it to her personally?-- I forwarded it to her, yes.

Did you speak to Ms Mulligan at all? Did she come and ask you-----?-- No, I received a letter back from her in that same week, I think - I don't have a copy of that letter - and she said that my letter had been sent on to the executives.

Did you - did anyone else from the executive speak to you about your complaint?-- No, but in February, I think it was the 14th or something like that, there was a review team and I

was - one of the executive secretaries rang me up and said, "There is a review team here and your name has been put on the list. Can you come at this time?" And I said, "What is it about?", and they said they didn't know. So I presumed it was about P26 and my complaint. So I went to the review - that was the only other time that I spoke about it, was at the meeting with Sue Jenkins, I think her name is.

Can I take it from that that in addition to not being further interviewed about it, you never received any feedback about the outcome of your complaint?-- No.

In paragraph 22 of your statement, you refer to ERROMED meetings which started in July 2004 and you were the chairperson of those meetings?-- That's correct.

Can you explain how that group came to be established?-- I presume that Di Jenkin had a directive from executives that we had to form these ERROMED meetings on a local level, and she informed me that we were going to start them and that she would like myself and Kylie Johnston to be on this committee, and that also Dr Patel would be on this meeting as well.

You have set out that the purpose of the meetings was to look at the adverse events that had occurred in the surgical ward during the previous month and to ensure that those issues were dealt with so that risk management strategies could be put in place, is that correct?-- That's correct.

And how was it intended for that to occur?-- Di would divide up the previous month's adverse events into different categories, and each of us would take them before the meeting and come back with a report as to how many and what type and think of some strategies to try and prevent further recurrence.

Do you remember the different categories now and who was responsible for what?-- I think I was responsible for falls - no, I was responsible for pressure areas. Kylie did the falls. Di did any of the staffing issues or miscellaneous issues, and Dr Patel did the medication incidents.

And was it intended that at these ERROMED meetings you receive information from other persons, or was it simply an information gathering exercise by the relevant members of the meeting?-- I don't understand that question.

Were there other persons able to come to you with their concerns, for example about surgical issues?-- No, they were purely actual documented adverse event forms.

D COMMISSIONER VIDER: This was actually an internal review team that was going to look at incidents on adverse events that had been put forward in the internal hospital channel?-- It was only our surgical ward adverse events.

Okay?-- Yep.

MR MORZONE: I understand. So the adverse event forms which had been lodged through the hospital with DQDSU, is that correct-----?-- Yes.

-----were referred back to you so that some review could occur of them?-- We kept a photocopy of all of the adverse events. The NUM - that's the NUM's job, to photocopy all the adverse events before we send them to DQDSU so that we could then use them for our meeting.

D COMMISSIONER VIDER: Can I just ask, included in the indicators that you would have looked at, was the infection rate included in those? Did someone look at the infections?-- No, that was dealt with on the infection control committee.

I just thought you might have had it in the ward-based criteria as well?-- No, no.

MR MORZONE: Other than you keeping, or the surgical ward keeping copies of the adverse event forms, were adverse event forms or adverse events generally referred back to you at any time by the DQDSU, or any other part of the hospital that you can recall?-- I am not sure. I mean, it is the staff - if there is an incident happens, we fill out the forms and then the nurse unit manager has to do a costs centre report on how the issue has been dealt with and referring it to anyone else, and then it is sent on to DQDSU, and then I don't know what happens after that.

Do you recall there ever being an occasion where an adverse event form was completed and subsequently, as part of the investigation of that form, you were approached by DQDSU or some other person about that event?-- Not that I recall.

So the ERROMED meetings that you were talking about before were meetings established internally within the surgical ward relating to adverse events which had been forwarded by the ward to DQDSU?-- That's correct.

And did they meet independently of, without communication to the DQDSU?-- I am not aware of how they came about. All I was told from my nurse unit manager is that we were going to start them and that they were going to be a monthly thing, and then I don't know whether she went back and reported to some other meeting. I am not sure.

Now, you mentioned that at these meetings Dr Patel was to handle all doctor related incidents?-- That's correct.

How did Dr Patel perform in that role?-- I recall one meeting when - I think I must have been acting nurse unit manager, and I had approached him the day before the meeting and said, "Are you still coming to the meeting tomorrow?", and I said, "Here are your group of adverse events. Can you take them away and come back with a report for the next day?" The next day we had the meeting. It was obvious that he hadn't looked at them at all because he was shuffling through them as we were having the meeting. And if an incident came up relating to the

doctors, he said that he would take it back to a meeting with the doctors and discuss it with them.

You state in paragraph 23 that the meetings were supposed to occur monthly after July 2004. Did that occur?-- I think we only had three in total for two reasons: Kylie and I worked shift work and obviously Di and Dr Patel only worked Monday to Friday. And the other thing was that you couldn't always get Dr Patel to come to these meetings.

D COMMISSIONER VIDER: Can I just ask you another question? Can you give me an example of what was the scope of things that were handed to Dr Patel in his bundle?-- They were-----

Is it medication errors?-- Medication errors which related to either not giving a drug or patient getting a drug that they were allergic to. Documentation issues, where the doctors actually writing orders was a huge amount of the adverse events, and that's why he was basically on the meeting.

Did you have an indicator that would have said from the ward "unplanned return to the operating theatre", or any of those sorts of things?-- I didn't see any adverse events of such.

MR MORZONE: Did you ever see any adverse events which related to surgical error or-----?-- No.

-----operation error?-- No.

Was it your understanding that those sorts of forms ought to have been completed for that purpose, or not?-- I would presume that that - if the event - whoever was there when the event happened, that they would complete an adverse events. That's what I am used to doing. If something happens, we fill out an adverse event.

Paragraph 24 you refer to wound dehiscence and to records having been kept about wound dehiscence. Were you personally involved in that, or do you have knowledge about that, or should we ask others?-- I was very concerned about it because I had seen a number of dehiscences in the ward and I had never worked anywhere else where I had come across so many dehiscences ever, and I spoke to my nurse unit manager about this some time last year and she said they were starting to collect figures on the amount of dehiscences there were. And I do recall once - I think I must have been acting in her position - and I did flag some for her for when she came back, and she also said that she had been to one - an aspect meeting, I think it might have been, where they discussed the dehiscences, and she told me that Dr Patel had argued the definition of a dehiscence and that the figures that we collected, he didn't agree that they were dehiscences. And, basically, that's kind of where it got left.

Were the experiences that you had of wound dehiscence having occurred in the ward, were they Dr Patel's patients?-- I recall a majority of them were, yes.

At paragraph 25 you state that-----

D COMMISSIONER VIDER: Just before we move on to that.

MR MORZONE: Sorry.

D COMMISSIONER VIDER: In paragraph 24 you say that the mortality and morbidity committee was going to be chaired by Dr Patel?-- Yes, I did ask - because I was concerned about, you know, that small things, like a day surgery lap choly or a hernia, things were going wrong, and I said to Di, you know, "Is anyone looking at what's going on here?", and she said that Dr Patel chaired his own mortality and morbidity - some type of mortality and morbidity committee and that's where those things were brought up, apparently, but I understand there was never ever a mortality and morbidity committee as far as what people have said to me.

It would have been hard to gather some information from the charts, given previous evidence we've heard that Dr Patel wasn't the best notetaker, so you wouldn't have necessarily picked a lot of that up, but it would have also been interesting to have Dr Patel doing an assessment on the morbidity-----?-- Of his own patients.

-----of his own patients.

COMMISSIONER: What's the usual practice in other hospitals where you have worked?-- I am not sure. I mean, I have not been in a management position before, so I am not aware of what goes on at that level. I presume that they have a mortality and morbidity committee.

But you would expect on any such committee the person reviewing incidences of mortality or morbidity would be someone other than the surgeon who performed the relevant surgery?-- You would think so.

Just stands to reason, doesn't it?-- Yes.

MR MORZONE: Do you remember now who the other members of the committee were?-- On which - mortality morbidity?

Yes?-- No.

D COMMISSIONER VIDER: Do I understand-----?-- I think it was some kind of doctor forum. That's what I am led to believe now.

Did it ever meet?-- I don't know.

MR MORZONE: In paragraph 25 you state that some time in the middle of 2004, after a number of disasters involving Dr Patel, that you did a Google search?-- That's correct.

Before I ask you about your Google search, what particular disasters are you referring to there?-- Just all of the wound dehiscences and, you know, some of the lap cholies got quite

sick and, you know, they - just things didn't seem right. I can't pick out a specific incident that I thought - you know, it has been more than a year now, but at the time I just felt that things weren't right.

Did you have concerns about Dr Patel's competence?-- Yes.

You did a Google search and what did you do?-- He had told us about all of his qualifications, said that he trained in America and that he'd lived in Oregon, so I am aware that you can look up doctors' or dentists' qualifications to make sure they actually registered in their State. So I went to the Oregon Medical Board site, and it has got a facility there where you can search for doctors' names, and I did, and it brought up a number of doctors with that name. I think one was a paediatrician. And then I eventually found - I don't know how I found it - but I found that there was negligence cases against a doctor with that name and that he - it said then that he wasn't to perform certain types of surgery because of those cases.

You say in your statement you were shocked to learn this?-- Very.

And did you tell-----?-- But I didn't know whether that was him. I didn't - I wasn't sure because there was a number of doctors with that name on the site.

All right. You state that you told your colleagues. Who did you tell?-- Just the nursing staff in the ward, that I said I looked up his name on the Oregon Medical Board site and that there were cases with his name against them but that I wasn't sure whether that was actually him or not.

And did you tell your nurse unit manager, do you remember?-- I think she would have probably heard. I don't recall speaking to her directly about it. I could have, I don't remember.

And did you raise it with anyone else other than nurses?-- No, it is not my job to say whether a surgeon is competent or not. I was - you know, that's the job of whoever registers him and management, I would assume.

All right. You state in paragraph 27 that when you spoke to Ms Hoffman about P26 on the 4th of January 2005 some time after your Google search, you mentioned the results of your Google search to her?-- That's correct.

Do you recall whether that was the first time you'd raised it with Ms Hoffman?-- Yes, it was.

In paragraphs 28 through to 30 you raised particular instances concerning Dr Patel's behaviour. Those largely speak for themselves, but in paragraph 30 you refer to Dr Patel not complying with practices - sorry, policies and procedures or disregarding basic policies and procedures at the hospital. What particularly are you referring to there?-- His hand

washing. He would go - from the first time I ever did rounds with him I was appalled. He went from - took down a patient's dressing, went to the next one, went to the next one, didn't wash his hands, and I actually pulled him up and said, "I want you to go and wash your hands before you go to the next patient", which he complied with. Whenever I did rounds with him, I would always make him go and do that, but when I wasn't doing rounds with him, I saw him not do it. And also he - the policy about theatre attire, he - the doctors would always be in the ward in their theatre attire, or outside of other places not in theatre, and I know that they had actual photos of what they were supposed to do in the theatres, and everyone knew they weren't to wear their theatre gear out, and that he was blatantly ignoring that policy, and that as far as I know that he - the doctors kind of followed him, whatever he said was gold standard, basically.

That is the evidence-in-chief if it please the Commission.

COMMISSIONER: Thank you Mr Morzone. Should the order be Mr Mullins?

MR MULLINS: I only have just some brief questions.

COMMISSIONER: Thank you.

CROSS-EXAMINATION:

MR MULLINS: Miss Hunter, my name is Mullins, I appear on behalf of the patients. I'm interested in paragraphs 7 and 12 of your statement. This is in respect of patient P26, and in paragraph 7 you say that you viewed the chart and the theatre notes of patient P26 when you first became involved; that's correct? And you say that the notes stated that at this time the femoral artery and nerve were intact. Now, at paragraph 12 you say that after the patient P26 had been transferred to Brisbane, you subsequently discovered that the femoral vein had been tied off?-- I don't know whether that is actually fact, that's what I heard.

All right. Well, let's just assume for the moment that's fact. Was there anything in the notes that you reviewed to tell you that the femoral vein had been tied off?-- I only got to see - he went to theatre and when he first came in, he went to theatre three times and when I actually wrote my letter of complaint, I was actually, the day that I wanted to write the letter I needed to have a chart to write the letter and I was at lunch and I was aware - a nurse, Hazel Evans, called me in the lunch room and said that, "The executives want the chart and that do you want me to photocopy anything out of it for you so you can write your letter?", and I said yes, I did and she only managed to photocopy the first theatre notes and the letter written by David Risson to the Brisbane doctors and that's where I gained all of that information.

Right, but I'm just taking you back to 30 December; can you recollect whether there was anything in the notes to let you know that the femoral vein had been tied off?-- No, so far as I know, he had a one centimetre laceration in his femoral vein and that they repaired that.

Had that information, that is, the femoral vein had been tied off been in the notes, would your treatment of his circumstances been any different?-- I imagine that the doctors mustn't have realised that that was the case, if that was an actual fact and that they would have treated him differently, I guess, I don't know, I'm not a surgeon.

Thank you Commissioner.

COMMISSIONER: Thank you Mr Mullins. Mr Allen?

MR ALLEN: No thank you, Commissioner.

COMMISSIONER: Anyone else? Mr Devlin, you'll have some questions, I imagine.

MR DEVLIN: Yes, thank you.

CROSS-EXAMINATION:

MR DEVLIN: I'm Ralph Devlin, I represent the Medical Board of Queensland. Just a couple of questions about the wound dehiscence issue. We have the benefit of the minutes of the meeting for the ASPIC clinical forum which is Exhibit TH11, and on the 14th of April of 2004, a strategy was devised whereby persons discovering wound dehiscence would fill in an adverse event form. You were generally aware of an increase in wound dehiscences?-- Yes.

Did you also become aware of that general requirement to record them?-- No, I didn't know that.

Mmm?-- I was - I would tell my nurse unit manager if there was a dehiscence and if it happened on a weekend, I would leave a note for her to say that we'd had a dehiscence that if the patient had have been discharged so that she can keep those figures.

On the face of it, that kind of initiative to create an incident report would have, if that had been generally known and followed from April 2004 onwards, that in itself would have had the potential to create a good database, wouldn't it?-- Yes.

Apart from just the informal inquiries that obviously somebody was trying to achieve. That initiative, if it had been well broadcast, might have helped to deal with the matter in a more organised way perhaps?-- It would have had the - made the figures-----

D COMMISSIONER VIDER: Could I just clarify? If you didn't write a specific adverse event form about a wound dehiscence as well as leaving a note for the nurse unit manager if it occurred at the weekend, would an entry have been made in the progress notes?-- Well, I don't know whether the doctors would have but the nursing staff certainly would have written "wound dehisced".

Do you know that nursing staff did make those sorts of entries in the progress notes?-- I can't speak for anyone else but myself but I definitely would have.

MR DEVLIN: So that was the other way that at least it could be recorded, by putting it in the progress notes?-- Yes.

And that's what you did for your part?-- Yes.

Thank you. Now, just on your Google search, did you spend some time keying in different words to-----?-- No, I just put in "Jayant Patel".

So you didn't put in any words like "disciplinary" or any touch words like that? Once you got the information that it could be him, did it - and I'm not being critical in the way I ask this question, I'm just interested in your state of mind - did it cross your mind that the registering authority could be contacted and let know?-- I presume they must know about it.

Yeah. Well, of course, if he was practicing here but had problems elsewhere, it's a question of whether he revealed them to those who let him in?-- But I found it quite easily so I presumed that anyone else could have as well.

Mmm. Anyway, it didn't cross your mind to take it further in a formal way because that wasn't your - you didn't see that as your place to?-- That's not my role.

No, and if it wasn't the right person, it might have created more problems than it was worth for you; did that occur to you, that you said you weren't sure whether it was him or not?-- No, I didn't know whether it was him but I presumed that people must have known about it because it was so easy to find.

Okay. Thank you.

COMMISSIONER: Thank you Mr Devlin. Mr Deihm?

MR DIEHM: I have no questions.

COMMISSIONER: Thank you Mr Deihm. Mr Fitzpatrick?

MR FITZPATRICK: Thank you Commissioner.

CROSS-EXAMINATION:

MR FITZPATRICK: Ms Hunter, my name's Chris Fitzpatrick and I act for the Health Department. Can I ask you this: you said in your statement and I think your evidence as well that it was about New Years Day this year that you resolved to make a complaint about the treatment of P26 in the Bundaberg Base Hospital; do you remember giving that evidence?-- Yes.

And you said, I think, that you were unsure about what to do?-- Yes.

And that you consulted or you researched on the internet?-- Yes.

Was the internet facility that you searched the Queensland Health intranet which is-----?-- No, I did it at home.

You did it at home?-- Yep.

Are you aware that at the Bundaberg Base Hospital there is access to the Queensland Health intranet?-- Yes.

And are you aware that part of the web pages there displayed include guidance as to how to go about making a complaint?-- No.

You've not yourself looked at it?-- I've not seen that, I might have looked at it but I haven't actually seen it.

All right, thank you. Yes, thank you Commissioners, I have nothing further.

COMMISSIONER: Any re-examination?

MR MORZONE: No, thank you, if it please the Commission.

COMMISSIONER: Thank you Mr Morzone, and thank you so much for coming to give evidence today in the frank and helpful way in which you gave your evidence which we appreciate a great deal and you're excused from further attendance?-- Thank you.

WITNESS EXCUSED

COMMISSIONER: Mr Andrews?

MR ANDREWS: Commissioner, for the convenience of I might say another party, will you be prepared to take an early lunch so that we can call Dr Athanasiov upon resumption?

COMMISSIONER: You have no other witnesses ready to go?

MR ANDREWS: No, no other short witnesses.

COMMISSIONER: Yes, well then, we have little option but. We'll resume at, would 1.30 be suitable?

MR ANDREWS: Yes, thank you, Commissioner.

COMMISSIONER: All right. We'll resume at 1.30.

THE COMMISSION ADJOURNED AT 12.12 P.M. TILL 1.30 P.M.

THE COMMISSION RESUMED AT 1.33 P.M.

COMMISSIONER: Over lunch we have been told by Dr Athanasiov he does not wish to be filmed or photographed. Do we know if he has any objection to a sound recording?

MR FARR: I don't know but I can certainly ask in that regard.

COMMISSIONER: Yes, thank you. Mr Atkinson.

MR ATKINSON: Commissioner, I call to the stand Anthony Ray Athanasiov.

ANTHONY RAY ATHANASIOV, SWORN AND EXAMINED:

COMMISSIONER: Doctor, I understand you prefer not to be filmed or photographed?-- Yeah, that's correct, if possible.

Perfectly in order. Do you have any objection to your evidence being sound recorded?-- No, I don't.

The same condition applies as before.

MR ATKINSON: Witness, your name is Anthony Ray Athanasiov?-- That's correct.

How do you pronounce your surname?-- Athanasiov.

Athanasiov?-- Yes.

Now, you provided a statement to the Commission?-- That's correct.

Could the witness see a copy of his statement. Dr Athanasiov, is that your name and signature?-- Yes, it is.

Are the contents of that statement true and correct to the best of your knowledge?-- They appear to be.

If you don't mind, I'll just take you through that statement slowly?-- Sure.

You're currently a principal house officer with Bundaberg base hospital?-- That's correct.

I understand, Doctor, that you graduated from Toowoomba Grammar in 1996?-- That's correct.

And you went into university at - in Adelaide and you graduated at the end of 2002?-- Yes, that's right. So you were an intern in 2003?-- Yes.

You started at Bundaberg Base Hospital in 2004?-- Yes.

So, as you know, most of this concerns your period working under Dr Patel from November 2004 to January 2005. At that time, I understand, you were a second-year doctor?-- That's correct.

And it was your first year at Bundaberg Base?-- That's also correct.

You speak in your statement about working as a junior house officer. Can I ask you this to start with, Doctor: can you tell the Commissioner the kind of hours that you worked once you started at Bundaberg Base?-- The hours varied depending on the rotation that you're doing. Last year I did emergency rotations and surgical rotations and in emergency it was shift work, which was a set number of hours.

Was this right, that you would often work up to 100 hours per week?-- Yes, that's correct.

And you would work those hours for four weeks running?-- On occasions we did that, yes.

And you would have a weekend off at the end of those four weeks?-- That's right, yes.

And then you would go back to working four weeks?-- That happened two months in a row towards the end of last year.

And is it also the case that in addition to working at Bundaberg Base, you would be required to relieve from time to time at Childers and Gin Gin?-- Yes, that's correct.

And you'd be on-call at least one night a week?-- That's right, yes.

You worked under Dr Patel and that was in the surgical department?-- That's right, yes.

But you were rotated - also, you worked in the emergency department?-- Yes, that's correct.

We heard evidence from Dr Berens I think it was about registrars and I understand that a registrar is someone who is a training and specialist - sorry, a specialist in training?-- That's right, yes.

But when you were working at surgery, it wasn't because you were training to be a surgeon; it was part of a rotation?-- It's both. I'm doing basic surgical training but I'm not classified as a registrar. That's when you're doing advanced training.

COMMISSIONER: Is it your hope or ambition to become a surgeon?-- Yes, that's correct.

So this may lead to getting a registrarship in surgery?-- Yes,

that's my hope, yes.

Yes.

MR ATKINSON: I note, Doctor, just while we're on that point, you say in your curriculum vitae your ambition is to work in a regional centre rather than in a city?-- I do like working in regional centres, that's correct.

You also mentioned that you're on a Queensland Health Rural Fellowship-----?-- Scholarship.

A fellowship. Can you explain how that works?-- It's a sponsorship where Queensland Health provide you with some financial assistance whilst studying at university and then you're required to work for them for a period after you graduate in areas that they appoint you to.

How long are you required to work in the designated areas?-- My service time is four years.

So you have to work for Queensland Health from 2003 to 2007?-- That's correct.

Right. Now-----

COMMISSIONER: Doctor, we've heard a lot of evidence about how difficult it is to attract medical practitioners to rural and regional areas. I think you're the first Australian-trained doctor we've heard evidence from who has expressed a keenness to work outside the metropolitan area. Are you originally from the country or is there some particular reason?-- Yes, I'm from the area around Toowoomba.

Right?-- Mmm-hmm.

What are the other attractions? Is it lifestyle?-- Yeah, I like the lifestyle and the space.

Yes?-- Yes. I'm happy working anywhere but I do enjoy regional centres.

Is it also the variety of work you get in the country is more attractive than being in one of the metropolitan hospitals which seem to be a bit like department stores; once you get into one department, you're doing just that sort of work and nothing else?-- I think that's correct, yeah, they seem to be a lot more subspecialised in the bigger centres, and so you are able to do a broader range of things, I guess, in a regional place.

Thank you.

MR ATKINSON: Doctor, I asked you earlier about the kind of hours you would work at Bundaberg Base. Many of us are aware that young doctors are asked to work very long hours. Can you say by comparison with your peers or with your other jobs, whether working up to 100 hours per week is normal?-- I think

it's probably a bit above normal. It seemed - from talking to other people who work in other places, it seems to be more than what they are doing at the same - the same level.

When you worked in departments like emergency-----?-- Mmm-hmm.

-----or surgical, did you have consultants cover?-- In emergency there's usually - or often there's not consultant cover. In surgery there was always consultant cover on-call and we did get reasonably good cover.

So in emergency, on those times when there wasn't consultants cover-----?-- Mmm.

-----does that mean that you were the senior doctor in charge or there was a PHO above you all the time?-- There's always a PHO and a JHO rostered on and then there's - I guess there's help, you know, on-call if need be.

Could you tell the Commission something about the induction you went through when you started at Bundaberg Base?-- I think we had two mornings of introductory sessions where we were in a seminar room just being told about how the hospital runs and what services they provide and some general details about the area. I don't remember too many details about that.

Can you say whether or not you were told about adverse events, sentinel events and the complaints procedure within the hospital?-- I don't recall being told about that.

Could you tell the Commission something about the resources at the hospital in terms of equipment, consumables, that kind of thing?-- I think for the most part we have almost everything we need, though at times stock is - perhaps you run out of simple things, like, you run out of gloves at times and just getting basic things, sometimes you run out of them, and I think that's more a stocking issue rather than a supply issue. But I haven't really come across any major problems with getting equipment that was needed.

Can I take you then more specifically, Doctor, to your statement. In paragraphs 8 to 16 you talk about working as a junior house officer. Effectively, for the year 2004 you had two rotations, is that right, emergency and surgical?-- That's correct.

And you chopped and changed a little bit between the two but it was effectively six months in each?-- It was slightly less than six months in emergency and slightly more in surgery. I think it was 7-5.

In surgery, you work both under Dr Gaffield?-- Yes.

And under Dr Patel?-- That's correct.

I might just ask you there. When you worked under Dr Gaffield, were you aware that where Dr Miach was the

physician involved, his patients would never be sent to Dr Patel but they would be sent to Dr Gaffield?-- Yes, I was aware of that.

How did you become aware of that?-- I guess I became aware when the medical team started calling our team for consults for Dr Patel's patients.

So the people from internal medicine-----?-- From Dr Miach's team, yes.

Even if it was to be - looked like it should have been a Dr Patel patient, they would talk to Dr Gaffield and his team?-- That's correct.

Now, you started working with Dr Patel from November 2004 and you recall, you say in paragraph 12, assisting him with a range of operations?-- That's right.

Can I ask you this on a general level: were you aware of a high incidence of infection during 2004 at the Bundaberg Base Hospital?-- I can't say that I was aware of a high incidence because I didn't see any data of the number of infections that there were. I guess we did note that there were infections and we looked at ways that we could try and reduce the number of infections but I'm not sure of any specific data about how many infections there were or if that was higher than anywhere else.

What about the wound dehiscence?-- I don't recall anything higher than - well, I haven't worked in another general surgical unit and, so, I didn't recall - I don't recall thinking that it was an abnormally high number.

Can I ask you another question generally about paragraph 12. Can you say whether or not it was the case that in your experience Dr Patel would accurately record the activities during an operation in the surgical chart?-- I have no - no recollection of him not recording things in the chart. Often the note would be written by the PHO.

Now, you speak in paragraph 13 of a perception amongst some staff that Dr Patel was cranky?-- Yes.

Did you find that to be an issue?-- Only on occasion. Most of the time he was quite nice to us, and I did know that other staff had problems with him on occasion.

You found him, I understand, a little bit hypocritical sometimes?-- I think sometimes, you know, it was difficult to know whether to call him or not to call him and you could get into trouble either way if you did call or didn't call, so in that sense he was a little hypocritical at times.

And sometimes he would tell you to call if the patient had a problem but then he would be cross when you called?-- That - I think that occurred once or twice. I don't think it was a huge problem but it sort of made us feel like we had to

tread a bit carefully.

In paragraph 14, Doctor, you make a point that Dr Patel was hard to miss?-- Mmm.

He was loud and he was always telling stories?-- That's correct.

Was it also your experience that he tended to stick his nose into other areas like radiology or into wards that weren't surgical?-- No, I didn't have any experience with that.

And in paragraph 15, it's a little hard for me to make sense of that, you say that, "If Dr Patel disagreed with something, he would give the reason why he did not agree and then he would proceed with his course of action"?-- What I was trying to say there was that I was of the impression that he would listen to any concerns that we had and would provide us with a response before he went ahead with his plan of action.

Was it ever the case that in your experience, that in the course of discussions with other clinicians he might change his course?-- Yes, he did do that.

In paragraph 16 you talk about some of the support that Dr Patel would give. I understand a point that you make, Dr Athanasiov, is that he was quite generous with his time and his learning with junior staff?-- Mmm-hmm.

Can you explain that to the Commission?-- He did put in a lot of effort with teaching, both informal teaching and formal teaching, and he always made himself available to provide assistance and advice. When he was on-call, you could call him at any time of day or night and he was always prepared to come in and help if you were out of your depth. And even if he wasn't on-call and the other consultants felt like they needed help, then he would come in and help. So in that sense he was a good assistance to the junior staff just by being constantly present and providing us with assistance.

Could you tell the Commission a little more about the teaching work that Dr Patel did?-- He did informal teaching on ward rounds and on a case to case sort of basis where he would talk about what the problem with the patient was and management plan and the general principles around the issues relating to the patient. He also took tutorials where he taught general surgical principles and he also had formal tutorials with the medical students as I understand.

So it was your experience that he had a high presence, if you like, in the hospital?-- That's correct.

And he was quite supportive of the junior staff?-- That's correct.

In paragraph 17, Doctor, you talk about the executive and you say that your experience was that you received very little support from the executive?-- Yes.

Can you just explain what you mean by that?-- That's just a general feeling that I had, that it was difficult to get to see the executive. It usually required an appointment one or two weeks in advance and it was just a general feeling that we got good support from our immediate supervisors but beyond that, we didn't have a great deal of support.

Well, you knew that the hospital manager was Mr Leck and that the Director of Medical Services was Dr Keating?-- That's correct?-- Yes.

Would you see them day-to-day in the hospital?-- Not day-to-day.

When would you see them?-- I would see them if I had to go to their office or sometimes at meetings, and that's about it.

But did you see them at all in the wards?-- Maybe once in a while. I can't recall how many times but it was not very often.

Now, in terms of going to their office, if you had an issue to raise such as rostering or resources or some concern, what was the process for approaching the people in the executive offices?-- We just had to call the secretary and make an appointment to go and see them if we wanted to discuss those issues.

I imagine with rostering, sometimes a person might feel that they had been hard done by; was that the case?-- I imagine with rostering that that could be the case, yes.

Did you ever try to raise issues about rostering?-- I think I brought it up at a meeting with Dr Keating but I can't recall the specifics of any concerns that I raised with him.

If you wanted to raise it with Dr Keating at his office, the process was simply make an appointment with his secretary?-- Yes.

And then you'd see him the next day?-- I don't recall ever seeing him the next day. It was usually in about a week's time or something like that.

Did you find that he had an open-door policy?-- No.

In what sense?-- If I ever went to the office to see him, I would be told to make an appointment and come back at another time.

When you made the appointment, I understand that you would have to sit outside and wait?-- That's correct, yes.

And then you'd be ushered in?-- That's right, yes.

In paragraph 18 you talk about the nursing staff and I understand that generally you found the nursing staff good to

deal with and proficient?-- In general they're good, yes.

I glean from paragraph 18 that you found them inflexible in certain protocols?-- I did find that to be the case on certain occasions, yes.

Can you just elaborate upon that, explain what you mean by that?-- There were a couple of instances where I found it difficult to do certain things on the ward. On one incident where there was a patient who arrested on the ward and we wanted to give them a particular medication, it was the protocol that stipulates you can't give that medication unless the patient is on a monitor, and we have a monitor on the arrest trolley in the ward which we were able to use to give that medication but the nurse insisted that we needed that trolley in case someone else on the ward arrested, and that we weren't allowed to give this medication on the ward because we needed to be in a monitored bed. The ICU was full, there is no other monitored beds anywhere in the hospital and so we were basically left in a situation of not being able to give the medication or, according to her, we were told we weren't allowed to give the medication. And that - that's the sort of inflexibility that I found concerning.

Now, you speak in paragraph 21 of assessments. It's the case, is it, that after your rotation into the surgical department, the surgical ward, you would be assessed by the doctor who supervised you?-- That's correct.

During the time with Dr Gaffield, you'd be assessed by him?-- That's correct.

And then with Dr Patel, you would be assessed by him?-- Yes.

Did the fact of that assessment put some pressure on you to comply with the things that Dr Patel told you to do?-- No, I don't think it put a great deal of pressure on me in that sense, no.

Now, Doctor, in January 2005 you make clear in paragraph 22 that you were told by Dr Patel that he was being stood down and you and some other junior doctors felt that he made a positive contribution; you were distressed by that, were you?-- He told us that he was being stood down on the basis of some complaints from ICU staff and about the treatment of a particular patient and it seemed to us, from the way that he described it, that he was being treated unfairly and he was distressed by the way he'd been treated and so we thought that we should point out some of the contributions - the positive contributions that he'd made in his time there, in particular the support that he gave to junior staff, just to prompt further thinking about how the issue was being dealt with.

COMMISSIONER: Mr Atkinson, I notice that in the statement the name of the patient is mentioned in the second line of paragraph 22. Of course, that name is the subject of a suppression order and we should make sure that before that statement is distributed to people outside this room, that's

non-inquiry staff, that the reference to that patient be replaced with "patient 26".

MR ATKINSON: Yes, I will attend to that, Commissioner.

COMMISSIONER: Thank you.

MR ATKINSON: The letter that you wrote appears as ARA4. Do you have that before you?-- Yes.

It's dated the 14th of January 2005 and I note in the third paragraph you say, "Dr Patel's approach to his work is nothing short of admirable." Now, is that a reference essentially to the things you've already discussed: the level of teaching, the level of support to junior doctors?-- That's correct. We were - we weren't making any comment about his surgical ability or his decision making or any of that sort of thing. We were just providing our opinion from our point of view about the support he gave to us and the enthusiasm that he seemed to show towards his work.

COMMISSIONER: Doctor, if it's of any assistance, let me say clearly there is no need to feel any defensiveness or embarrassment about this. Obviously a lot has come to light in the last six months that you weren't to know and couldn't have known at the time when you wrote that letter?-- No, that's right.

And I'm sure no-one here will be criticising you for defending a man who on the version of events that have been given to you appeared to be receiving a hard time?-- Yes.

MR ATKINSON: Doctor, was that a letter that was prompted by you or was it prompted by somebody else?-- It was prompted by, I think, the group of us. We all felt that he deserved our support at that time, based on what we knew.

And you make the point in paragraph 25 that perhaps now you wouldn't write a similar letter?-- Obviously with - in light of some of the allegations that have come out, you would - I probably would not write that letter again.

D COMMISSIONER EDWARDS: Dr Patel did not ask you or other residents to sign such a letter or send a letter of support?-- No, he did not.

Thank you.

MR ATKINSON: Doctor, at ARA5 there is another exhibit. Do you see there a response from Dr Keating? The letter is dated 19 January 2005 and I notice in the second paragraph there's a sentence that reads, "Your letter confirms previous reports of Dr Patel's very positive approach to patient care whilst he has been employed by Bundaberg Health Service District." Were there any discussions with Dr Keating at the time of the letter?-- I had no discussion with Dr Keating at the time, no. All I received was this letter back.

Now, in your time under Dr Patel there's two particular patients that had negative outcomes, if you like, in quick succession. The first, of course, was Mr Kemps who died on 21 December 2004, and the second was the patient that we call P26, and he's the patient who had the amputation. Can I take you through them in turn? The second patient, of course, happened two days after Mr Kemps' death. He came in on the 23rd of December. Mr Kemps - can I ask you, first, generally about oesophagectomies. You had never done one before, had you?-- That's correct.

You haven't done one since?-- That's correct.

You weren't involved in any decision making in the operation?-- No, that's right.

Effectively, you were a third pair of hands?-- That's correct.

Dr Sanji was the PHO?-- That's right, yes.

And, I think, Dr Risson was there, too?-- No.

Sorry and, yes, effectively you were there as the third pair of hands?-- Yes, that's right.

And is this right, that in that role your job is, basically, to do not much else than hold the retractors?-- We just needed to keep the surgical field in view of the surgeon and cut, stitches and that sort of thing; provide that sort of assistance.

You hadn't read text books on oesophagectomies prior to the operation?-- I hadn't read text books. Dr Patel took us through what to expect and what to do.

You weren't in any position to exercise any critical judgment about how the operation was going or whether it was appropriate?-- No, that's right.

COMMISSIONER: I will quickly admit to you that I had never heard of an oesophagectomy before it came up in this matter. Is it something that is covered in your university medical training? Is it a common enough operation that you, sort of, know about it?-- No, it's not a very common operation. If it is covered in medical school teaching, it's more that you learn about its existence rather than the details of how to do it.

Right.

MR ATKINSON: Doctor, were you aware prior to this operation whether there was any controversy within the hospital about whether Dr Patel should be doing oesophagectomies?-- I wasn't aware of any controversy at the time, no.

Is this right, that at the end of this operation, and we will go through it, but at the end of this operation Dr Patel

turned to you and said, "Maybe they're right. Maybe we shouldn't be doing oesophagectomies"?-- Yes, that's what he said. He obviously had comments made to him.

But you are not aware of the background to that comment?-- No, I don't recall being aware of anything at the time, no. No-one had said anything to me.

Now, Mr Kemps became known to you on or about 20 December 2004?-- That's correct, yes.

There wasn't any discussion in your presence about alternative courses besides an oesophagectomy?-- No, I wasn't present when Dr Patel first examined Mr Kemps. That was done, I think, a week or so beforehand, and I wasn't present for that. The first time I met him was the day he came from his surgery.

And there wasn't any discussion in your presence about stating - working out how advanced the cancer was?-- No, there wasn't.

Now, you say in paragraph 31, "The operation commenced at 9.30 a.m.", and that, "the operation appeared to go well as Dr Patel did not indicate otherwise"?-- That's correct.

And do we read into that last phrase, if you like, that as I said earlier you weren't in a position to know whether it was going well or not?-- The operation went as he explained it would and he didn't point out that anything adverse had come of it, and I certainly didn't see anything that looked to be abnormal at the time to make me think that something had gone wrong.

You mention in paragraph 33 that after the surgery Mr Kemps was sent to the ICU for monitoring and that that had always been envisaged, even prior to the operation?-- Yes.

You mention over the page in paragraphs 34 through to 37 that there was a drain in the abdomen in the course of surgery, but that seemed to be normal?-- Yes.

You talk about a bleeding and in paragraph 35, in particular, you say that after surgery the drain kept filling with blood. Doctor, there's been some evidence that - can you tell me whether it is your recollection that the bleeding commenced in the course of the surgery?-- There was some bleeding at the - in the surgery, a little bit of ooze from blood vessels around the stomach and, initially, after the operation when there was some blood in the drain. Dr Patel explained it was likely to have come from those small blood vessels around the stomach, and it just appeared to be a small amount of ooze which he expected would stop fairly soon.

Can I put this to you: that early in the operation there was some loss of blood, but that wasn't considered by anyone there to be out of the ordinary for an oesophagectomy; do you recall that?-- I don't specifically recall it, no.

And that later in the operation, but prior to the end of the first operation, there was discussion from Dr Berens, the anaesthetist, and from Damien Gaddes amongst others, one of the nurses, that there was clearly a bleeder?-- I don't recall that discussion.

And the bleeder was - seemed to be coming from the abdomen?-- Like I say, the only signs of bleeding that I remember are the small blood vessels around the stomach where part of the stomach was removed, and I don't remember any discussion from those people at the time.

COMMISSIONER: I would just like to clarify that. I think you told us earlier you saw some bleeding, and Dr Patel was the one who claimed that that came from the small blood vessels around the stomach. Did you, yourself, actually see that that was where the blood was coming from or are you just basing that on what Dr Patel said?-- At the time I saw there was ooze from the area where he indicated. He did show that to us at the time.

Do you recall the patient had to be turned at some stage during the process, there was initially the abdominal part of the surgery and then later on the chest part, and he needed to be manipulated on the table?-- Yes, that's right.

To your observation was there any change in the amount of blood within the cavity at the time of that turn?-- When we turned the patient his stomach had been closed up completely.

Right?-- So I can't comment on whether there was any more blood in the abdomen at the time when we turned him onto his side.

Right?-- Because we couldn't see then.

And then at the end of the chest surgery he was turned back on - turned onto his back again?-- As I recall it, that was the end of the operation when he was turned onto his back, and his chest had been closed up.

And at that stage were there exposed drains from where the blood could flow out, the same drains that were later observed in ICU?-- There was the one drain in the abdomen, as I recall.

And was that producing blood at the time when he was turned onto his back again?-- I think it had about five or 600 mils of blood in it at that time, and that was when Dr Patel explained that that was likely due to the bleeding around the stomach that we had seen at the time.

That's the point at which he gave that explanation?-- That's correct, yes.

And you weren't in a position to judge whether that was right or wrong, you just accepted the surgeon's assessment that that was the problem?-- That's right. I remember the issue being

raised at the time, and I don't remember specifically who pointed out the amount that was in the drain, but I do remember that being raised and Dr Patel explained that that was likely from the oozing around the stomach.

You have been described as the third pair of hands. Without, in any sense, wishing to downplay the significance of your role. You were about the least senior doctor in the room?-- Yes, that's right.

Is that a fair thing to say?-- Yes.

Dr Berens, you knew, to be an experienced anaesthetist?-- Yes.

And Dr Sanji, as he's called, was senior to you?-- That's correct, yes.

D COMMISSIONER EDWARDS: I take it there were two drains at the end of the operation, one was an intercostal into the thorax and the other in the abdominal?-- Yes, I think we put in a chest tube, as well.

MR ATKINSON: Is it possible at the point where the thoracotomy was finished and it was closed a nurse called Damien turned to Dr Patel and said, "Dr Patel, the bellovac drain is over half full and is still draining freely"?-- As I pointed out that was pointed out during the operation and we had the discussion where that may have come from.

Dr Patel may have said these words, do you agree, "That's what drains are for, Damien"?-- I don't recall that.

Can you recall whether or not Dr Berens at the end of the operation said words to the effect of, "This patient will be back to theatre tonight"?-- I can't recall that.

In any case, the patient Mr Kemps was taken to the ICU?-- Yes.

And Dr Patel, for his part, moved on to do another operation?-- That's correct.

In a different theatre?-- It was in the same theatre, as I remember.

Did you continue to monitor Mr Kemps in the ICU?-- Yes.

And you would get word back to Dr Patel about his progress?-- That's right.

And it's a case, is it doctor, that the signs coming from Mr Kemps, they were bad signs?-- As the afternoon progressed they certainly were bad signs, yes, that's right.

Can you explain to the Commission what signs there were and what they suggested to you?-- He continued to have more blood into that drain that we talked about earlier. He was getting

more blood transfusions. His blood pressure remained low. His heart rate remind high, indicating that he was having ongoing bleeding, and so that - when that failed to settle it indicated that he needed to go back to theatre to have a look at where the blood loss was coming from.

Is this right, doctor, he was having very large quantities of blood products given to him, Mr Kemps, in the ICU?-- Yes, that's correct.

Maybe something like 27 units of blood?-- That could be correct. I'm not sure.

And very large quantities of Gelofusine?-- Yes, that was given to try and maintain his blood pressure.

So how did it come about that he was taken back to surgery?-- I think by that point it was reasonably obvious that he had ongoing blood loss and needed to return to theatre, and so Dr Patel prepared to take him back to theatre.

Now, when he went back you accompanied him?-- Yes, that's correct.

With Dr Sanji?-- Yes.

And, again, you assisted by holding the retractors?-- That's right.

Is this right, you talk about it in paragraphs 39 and 40 - is the effect of your evidence this, doctor: that it was clear that there was very heavy bleeding?-- Yes.

One of the nurses has suggested, and you tell me if this is your recollection, that 75 sponges were used?-- I have no idea how many sponges were used, I'm sorry.

But he was bleeding profusely?-- That's right. There was a lot of blood in the abdomen, and in the chest.

Dr Patel set about trying to work out where the blood was coming from?-- That's right.

But he couldn't?-- That's correct. He - yes, he couldn't find exactly where it was bleeding from.

He eventually suggested that it was coming from the thoracic aorta?-- Yes.

But your understanding is this, right, that is by a process of exclusion?-- That's right.

He didn't know where it was coming from and so he assumed that it must be the aorta?-- What he based that on or what he told us that he based that on was where the blood appeared to be coming from. It was underneath tissue layers that we hadn't gone through. It was very bright blood, and it was bleeding at a rate which he explained could only be coming from a large

artery, such as the aorta. And he also palpated the aorta and he felt that there was a blood clot or haematoma around it which extended from the chest down into the tummy, and on the basis of those findings he concluded that it was coming from the aorta.

Is this right: there was some doubt in his mind he didn't know exactly where the blood was coming from?-- I can't - I can't say whether there was any doubt in his mind. That's what he explained to us.

And the thoracic aorta, you were saying that that was involved with tissue that hadn't been the subject of the operation?-- That's correct.

So if it was the thoracic aorta Dr Patel was saying, was he - that couldn't be the result of the surgery?-- That's what he was saying, it was bleeding from there. He didn't give any explanation as to why.

Did he say at any point to your recollection in the operation, "This isn't from my surgery"?-- I don't recall whether he said that or not.

Can you say whether Dr Sanji ever agreed that the aorta was the source of the bleeding?-- I can't recall whether he agreed or not.

D COMMISSIONER VIDER: Dr Athanasiov, you say in paragraph 40 that Dr Patel checked the spleen?-- Yes.

What else did he do? Did he remove the spleen?-- As I recall he did, yes. He thought that, perhaps, that's where the bleeding was coming from, the back of the spleen because that did get moved around at the time of the initial surgery, and he thought if we could stop the bleeding by removing the spleen that would be a reasonable course of action, so he did that and it didn't stop the bleeding.

So he's got a large haematoma around the aorta?-- Yes, we found that after the spleen had been removed, as I recall.

And what was happening with that haematoma, that large gathering of blood around the aorta?-- Sorry, can you-----

Was that - if you observed a large pool of blood around the aorta and you've got here that you have got the retroperitoneal space with a lot of blood in it, was that investigated to see if you could locate the site of bleeding in the aorta?-- We didn't expose the thoracic aorta, no.

At all?-- No, no.

And the patient continued to bleed?-- Yes.

During the surgery?-- Yes.

So you still had drains that were filling up with blood?--

Suction tubes that we were using, yes.

COMMISSIONER: Doctor, it's been suggested to us that one of the fundamentals of any internal surgery is to create a clear space, a clear line of view, so that you can see the organ that you are working with?-- Yes.

And the suggestion has been made that Dr Patel's practice was not consistently good in that regard, that it wasn't his practice to give himself a clear line of sight. Are you able to comment on that?-- I didn't have that experience. That's what we were there for, was to try and provide clear line of sight for him, and as far as I knew he had clear line of sight.

Again, it's been suggested that he was somewhat rough in his handling of the internal organs when he was undertaking surgery, both abdominal and thoracic, that he treated organs like the spleen and even the heart and lungs more brusquely than one would expect a careful surgeon to do. Again, are you able to comment on that?-- I think I'm too junior to make any reasonable comment on that. My level of experience was not huge, and a lot of the operations that we did I hadn't done before, so I had nothing really to compare it to.

Right.

D COMMISSIONER VIDER: Once Dr Patel was able to make an assessment that he thought it was the thoracic aorta that was leaking, do you remember him suggesting that another surgeon might be able to be found to be brought in to assist him?-- I don't remember him suggesting that.

MR ATKINSON: To go back to the question asked by Commissioner Morris, can you tell the Commission anything about your observations about Dr Patel's dexterity or his eyesight or his manual skills?-- The only comment that I have made in my statement was that sometimes he appeared a bit rushed with what he was doing, and on two occasions I recall I thought he was having trouble seeing the stitch. That was on two occasions only.

And when you say "he was rushed", I understand you are not talking specifically about the Kemps operation?-- No, I'm not talking about that case specifically.

Your experience was that he tended to put too much on his plate, as I understand it?-- He tried to get through a lot each day, yes.

How did that affect the surgery, or was that something you are too junior to say?-- I'm not sure if that affected his surgery or not. That was what I noted about the way he worked, was a reasonably rushed manner.

I guess from your point of view the Kemps operation is a good example because he's doing the first operation, there are complications, but it's hard to get to him because he's doing

a second operation?-- I'm not sure if that's an example of him being rushed, but that's what happened, yes.

I meant it as an example of him having too much on his plate?-- He had two operations on the day, and I guess it's up to him to decide whether he's able to do that in one day or not.

D COMMISSIONER VIDER: Was it a normal part of your roster for that day to go with Mr Kemps from the operating theatre to intensive care? I understand from your statement you stayed with Mr Kemps in intensive care?-- I was in and out, actually.

In and out?-- Yes, and I ended up needing to assist in that second operation, as well.

COMMISSIONER: Doctor, one other thing that arises from your statement, I see that you - it was your job to speak to Mrs Kemps and get her to sign the consent form for the second operation?-- Yes.

Again, please understand, I mean this totally sincerely, none of these questions are intended as criticism or anything of that sort, but with the benefit of hindsight, do you feel that it would have been better for someone who was more familiar with the operation and the issues involved to speak to Mrs Kemps?-- Certainly for the first operation it needed to be someone familiar with the operation.

Yes?-- With the second one it was, sort of, emergency surgery, essentially.

Yes?-- And, I guess, it was definitely higher risk surgery and it - if available Dr Patel probably would have been better to speak to her.

I guess the situation then, though, was without the surgery he was certainly going to die, and with the surgery there was a chance, possibly, he was going to survive?-- Yes, I think that's what Dr Patel explained to Mrs Kemps at the time.

Yes.

MR ATKINSON: Dr Athanasiov, if I can take you back to a question asked by Commissioner Vider; Dr Patel felt that the thoracic aorta was bleeding?-- Yes, that's right.

That was the source of the bleeding?-- That's what he felt, yes.

Could he have - was there available another surgeon who could have been called and who could have come to theatre?-- I don't know if there was anyone available on that day.

You can't say whether Dr Gaffield was at the hospital or close by?-- No, I can't recall whether he was or not, I'm sorry.

And were there any other surgeons on the staff?-- Not in the hospital. I know Dr Thiele visits occasionally, but I don't know whether he was available or what his situation was at the time in-----

D COMMISSIONER EDWARDS: But to bring in another surgeon would be a decision of Dr Patel, not you, as already-----?-- Oh, yes, that's correct, I don't have any input into that decision at all.

MR ATKINSON: What had Dr Patel told you about the experience with oesophagectomies?-- He explained to us that he had done a number of oesophagectomies and had a number of very good outcomes from them. He seemed very confident that he was able to do them, and he normally got good results from them.

I guess it was after the discussion with the Kemps, was it, that Dr Patel said to you, "Maybe they are right, maybe we shouldn't be doing oesophagectomies"?-- It was during the second operation when he said that.

And was there any further discussion about what he meant by that?-- No, I didn't talk to him any further about that.

Now, you're aware now, I understand, that after this operation Dr Berens and Dr Carter went to see Dr Keating?-- I became aware of that recently, yes. I had heard that at the time that they had done that, but I didn't know if that was true or not.

Were you ever asked to tell Dr Keating about what you had observed during the operation?-- No, I wasn't.

Were you ever approached by anybody about the operation?-- No.

I understand, doctor, that you subsequently approached the coroner's office?-- I phoned them, yes.

What made you do that?-- I just wanted to clarify the - because I was told that the new ruling stated that if the cause of death was known or if it was an expected outcome of surgery, then no coroner's inquest was required, and I wanted to clarify that with the office, so I telephoned them.

And when you telephoned them your recollection of the advice you received was that there was no need for an autopsy if either the death was an expected outcome of the operation, but that wasn't your view about this operation; is that right?-- Can you just ask that again, I'm sorry?

Sorry. Your recollection of the advice you received from the coroner's office was that an autopsy was not required in two circumstances: one, where the death was an expected outcome of the operation; is that right?-- Yes.

And, two, where the cause of death was known?-- That's correct, yes.

And the first limb didn't apply to your understanding?-- It wasn't expected, no.

Your reason, if you like, for not pressing the matter further, I understand, and you tell me if I'm wrong, is that the cause of death was known?-- That's what I discussed with Dr Patel, and that's what he said, that we knew what the cause of death was, and so therefore we didn't need a coroner's inquest.

D COMMISSIONER VIDER: But the death of the patient was not the expected outcome of the surgery?-- No, it was because he explained he knew that we knew what the cause of death was, and that was the reason he gave in the end.

COMMISSIONER: But, really, to your understanding the cause of death was more speculation than anything else; you hadn't actually seen the aorta that was supposed to have been bleeding?-- Yes, that's right.

MR ATKINSON: And it's worse than that, isn't it, doctor, in that the thoracic aorta bleed, if that's what it was according to Dr Patel, it wasn't caused by the surgery?-- I don't recall him saying specifically that it wasn't caused by the surgery. He just said that that's what the patient had died from, and because we knew the cause of death we didn't need to do-----

Sorry, I should be more precise. He suggested the thoracic aorta was the cause of the bleed?-- Yes.

And that was an area that you hadn't touched?-- Yes.

So it would mean that by, if you like, a coincidence the thoracic aorta had started bleeding in this 78 year old man at the very same time as you were operating on a separate part of his body?-- What he said at the time was because Mr Kemps had previously had problems with his aorta, he had previously had an abdominal aortic aneurysm repaired, he stated that the aneurysm must have started bleeding higher up in the lower thorax area.

Doctor, there's - there will be a suggestion in evidence that at one stage Dr Patel turned to a junior doctor and said, "Keep tight lipped about this, and don't discuss this with anyone"?-- That was not me.

And you didn't hear those words?-- No, I did not.

Before this operation had you ever heard of the words "refractory shock"?-- Yes, I have.

In what context?-- I don't recall the number of contexts, but I heard about that before. It's just a term that is used.

And you are familiar with the term and what it meant?-- Yes.

Can I ask you to turn to ARA7? That's the cause of death

certificate. I guess the first question I have is why have you filled out this document when, as the Commissioner said, you seemed to be the least senior doctor in the theatre?-- It always seems to be that the most junior doctor on the team does the death certificates, and it didn't seem out of the ordinary that I was asked to fill out this one.

I guess the issue that I'm struggling with is: it's hard for you to know exactly what happened in the operation, it's your first oesophagectomy?-- Yes.

You are not doing much more than holding the retractor?-- Yes.

You are not making the clinical decisions; how do you arrive at a decision as to the cause of death?-- Well, that's what I discussed with Dr Patel, and I arrived at that decision after discussion with him.

So he told you what to put here?-- He told me what the cause of death was, and then I filled in the gaps.

And I understand the form should be read from 1D up to 1A. What it should be saying is - what it does say is that there was a resection of oesophageal cancer, and then that caused the aortic bleeding, and then that caused the refractory shock?-- Yes.

D COMMISSIONER VIDER: But the actual cause of death is actual blood loss from the aorta?-- Yeah, or bleeding - I guess the cause of death is inadequate blood supply to the tissues.

Which can be called refractory shock?-- Yes.

But, in effect, we've heard evidence that Mr Kemps' life expectancy might have been a further six to 12 months. Mr Kemps was not expected to die as a result of this surgery in December?-- No, that's correct.

When you fill in a death certificate like that, do you show it to Dr Nydam or to someone else in management?-- We just submit the death certificate into - we just put it into the chart, and then it's my understanding that they get reviewed, and it's been my experience that they have been reviewed by Dr Nydam. He's called me if there's been issues with them in the past.

And there's a booklet, I understand, that you have reference to in deciding how to complete-----?-- Yes, that's correct.

-----the death certificate?-- They provide a guide book, yes.

COMMISSIONER: Doctor, I suppose, again with the benefit of hindsight, it would be obvious to you that if you yourself are unable to form a judgment as to the cause of death, then you are not the appropriate person to be signing a death certificate on the footing that the cause of death is known. If someone senior to you such as Dr Patel believes that he knows what the cause of death is, then he should take the responsibility for signing the death certificate?-- Yeah, that would have been better, yes.

Okay.

MR ATKINSON: Did you consult with Dr Sanji in completing the death certificate?-- He was involved in the process, yes. He had - he was there when I discussed with Dr Patel, as I recall.

D COMMISSIONER EDWARDS: Could I just follow up the Commissioner's question? Isn't that, however, the policy within hospitals in Queensland, that either the resident or the registrar signs the death certificates rather than the consultant because the resident has the day-to-day care, and that death certificate may be signed in consultation with the consultant?-- I am not sure if a policy exists but that's certainly what happens in practice, yes.

And do you think in retrospect, and now you are more experienced, as it were, better that the person doing the operation be responsible for a death certificate should such an unfortunate incident occur?-- I think that would be reasonable, given the problems with this particular case, yes.

COMMISSIONER: Well, everything else aside, it is unfair to ask you, as the most junior person in the room, to take the legal responsibility for certifying an autopsy is not required?-- Yes.

Mr Atkinson, were you about to move on to patient P26?

MR ATKINSON: I was.

COMMISSIONER: We might take a five minute break.

THE COMMISSION ADJOURNED AT 2.31 P.M.

THE COMMISSION RESUMED AT 2.50 P.M.

ANTHONY RAY ATHANASIOV, CONTINUING EXAMINATION-IN-CHIEF:

COMMISSIONER: Mr Atkinson?

MR ATKINSON: Thank you, Commissioner. Dr Athanasiov, can I take you to that form at the back of your statement, the cause of death certificate? You will see down towards the bottom there is a box "non-coronial autopsy consented by next of kin." You made clear there isn't to be - above that you say it is not a reportable death and then you state that an autopsy is not to be carried out. Do you see those boxes ticked?-- Yes.

Is the sequence of events this: that you called the Coroner's office to find out the criteria for having a coronial inquest, if you like, or an autopsy, that you then spoke to Dr Patel and that you then completed the certificate?-- Yes, that's correct.

Was there a stage when you did say to a nurse - I think it was a nurse called Vivian Tapiolas - that Mr Kemps should be treated as if he was a coroner's case?-- I can't recall that, but perhaps while I was looking into whether we needed to or not, I would have said that, I think, but I don't recall saying that because I wasn't there when he died. So I can't recall if I said that or not.

Can we turn then to the case of P26.
Can you explain your involvement - and just talk us through, if you will, from paragraph 50 - just explain how you became involved in the case and what you saw?-- I became involved in that case because I was on call the day that he came into the hospital and a trauma call was issued, and so I was there when the helicopter came in and they called me out to the tarmac where the helicopter lands because his condition was so unstable, and the paramedic was putting pressure on P26's left groin to try and stop the bleeding from there, and we then took him straight to theatre, straight through the emergency and up to theatre.

And the first thing you did, I understand, was to try to repair the femoral vein?-- We had to stop the bleeding, so we inspected the wound, found that it was bleeding from a tear in the femoral vein, which Dr Patel repaired by stitching that tear closed.

Also present in the operation was Dr Risson?-- Yes.

And in the course of the operation Dr Robinson-----?-- Yes.

-----came in, too?-- That's correct.

Now, that operation was completed, but after that operation you noted, I understand, that there was tension in the left leg?-- That was a couple of hours later, yes.

Did you ever feel a pulse or detect a pulse in the left leg after that first operation?-- No, we couldn't find a pulse, no.

So after the first operation and some hours later, you noted tension in the left calf and the left thigh?-- Yes.

And you notified Dr Patel?-- That's correct.

COMMISSIONER: Sorry, I would like to understand the situation with the pulse. There was a pulse in the artery?-- No, at the groin. There was a palpable pulse in the femoral artery.

But not in the vein or not below the repaired-----?-- Not below the groin, that's right. There was no pulse that we could find in the foot.

You said that Dr Patel stitched the femoral vein to repair it?-- Mmm.

Did he stitch it in the sense of reconnecting it or simply stitching it off?-- It wasn't completely severed. It had a tear which involved part of the circumference of the vein and he stitched that tear closed with the intention of repairing the vein, not to occlude it.

Right.

MR ATKINSON: You say in paragraph 55, "At the time of the operation, the femoral artery had a good pulse but you couldn't find a pulse in the foot."?-- That's correct, yes.

And you couldn't work out how that could be?-- Yes.

In retrospect, would you agree that it is consistent with the operation having had this effect: that it ligated the vein so that the blood couldn't get down?-- It is not consistent with that at all, no.

COMMISSIONER: Because if there had been ligation, there would be no pulse in either direction, as it were?-- No, it is - ligation of the vein wouldn't affect the pulse. It is two totally different systems.

Right?-- The artery bringing the blood down and the vein carrying the blood back up, a ligation of the vein would stop the blood from flowing back up. There should still be a pulse present. So even if the vein was completely ligated, you can still expect to feel a pulse.

MR ATKINSON: But if the blood can't drain through the vein wouldn't the effect be that it can't drain, so there is a back-up and so it stops going in because it can't get out?-- Certainly there would be a back-up but you should still have a

understanding that the ultrasound showed that there was an obstruction to the blood flow in the artery and it suggested that there was a tear in the wall of the artery which was blocking the blood at the level of the groin.

So what happened after that?-- That's when P26 went back to theatre for the third time and they bypassed that obstruction by putting in a graft.

Can I ask you this, doctor: I appreciate you have limited experience, but when you are operating on a patient three times in the course of some 14 hours, is it fair to say that's an indication to a surgeon or to a practitioner that perhaps they're out of their depth?-- I don't know if that's an indication of that. Those - all three of those surgeries I think were necessary at the time and it is up to the individual surgeon to decide whether they're out of their depth or not.

And I appreciate it is not your choice, it is not your decision-----?-- No.

-----but it is an unusual thing in a hospital, would you agree, for three operations to one patient to occur in such a short space?-- I don't think it is unusual in the setting of, you know, this particular patient. Those surgeries were necessary. I don't think there was any way to avoid them.

With the fasciotomies - had you ever carried out a fasciotomy before yourself?-- I have never done one myself.

It has been suggested - it will be suggested by some of the specialists in Brisbane that the fasciotomy could have been longer. You don't have a view on what the appropriate length of a fasciotomy is?-- It was my impression that the fasciotomies were sufficiently long at the time.

And with the third operation where the femoral artery was repaired-----?-- Yes.

-----there is a view that will be expressed by the specialist surgeons in Brisbane that gortex wasn't the appropriate substance to use because in a dirty site, if you like, it might lead to an infection later?-- I'm definitely not qualified to comment on that.

Now, you took your leave the day before Christmas. That's the next day, the 24th of December?-- Yes, that's correct.

Did you visit the boy before you took your holidays?-- I called in but I wasn't involved in his care at that time. He was being looked after by some of the other junior doctors and Dr Patel.

From your knowledge, from the time you first saw him coming off the helicopter until the time that you left, there was no pulse in the left foot?-- No, I believe there was a pulse present after the third surgery.

But nevertheless Dr Patel didn't agree to do an ultrasound at that stage?-- His explanation was that the - due to the severity of the injury that P26 had had to his leg, that it was likely that the artery had just gone into spasm and he felt that that was going to resolve over the next couple of hours, and he said that the blood supply to the tissue still looked to be okay.

Now, at that stage I understand again you raised with Dr Patel the idea of the good sense in transferring the young boy to Brisbane?-- I talked to him a couple of times about it over the afternoon. I don't recall specifically when.

If I take you to paragraph 60 of your statement, I understand the point you are making in the last sentence is that when you canvassed that idea with Dr Patel, he wasn't immediately dismissive?-- That's right, yes.

But he took the view that it wasn't necessary?-- He considered P26's situation and at the time he couldn't think of any reason that he needed to be transferred. He - his comment was, "What more could they do? At the moment there is nothing else that needs to be done." So that was his reason for not wanting to transfer at that time.

D COMMISSIONER VIDER: Given that you still had no pulse in the foot some hours after the surgery and Dr Patel's explanation this might have been due to spasming in the artery, did you think that was a bit long for a spasm to be going on?-- I felt it was a bit long.

Mmm?-- My experience was obviously less, so I took his advice but I still put forward the idea of further imaging.

MR ATKINSON: Were you aware of the vascular unit at the RBH in Brisbane?-- Yes, I am aware of that.

And did it - was there any discussion by you or between you and Dr Patel about the possibility of ringing one of the vascular surgeons at the RBH to discuss the best way forward?-- We didn't discuss calling the vascular unit specifically, no.

Was that something that happened sometimes in your experience at the Bundaberg Base Hospital, that you ring one of the larger hospitals and speak to a neurosurgeon or an oncologist, for instance, about ways forward?-- If you consider that you need advice, then you certainly do that, yes.

Did you ever see Dr Patel do that?-- I didn't see him do that personally, no.

Well, after the second operation, Dr Patel agrees to do an ultrasound?-- Yes.

Can you tell the Commission about the results from that ultrasound?-- I wasn't present for the results but it is my

understanding that the ultrasound showed that there was an obstruction to the blood flow in the artery and it suggested that there was a tear in the wall of the artery which was blocking the blood at the level of the groin.

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And I appreciate it is not your choice, it is not your decision-----?-- No.

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Did you visit the boy before you took your holidays?-- I called in but I wasn't involved in his care at that time. He was being looked after by some of the other junior doctors and Dr Patel.

From your knowledge, from the time you first saw him coming off the helicopter until the time that you left, there was no pulse in the left foot?-- No, I believe there was a pulse present after the third surgery.

How do you know that?-- That's what I gleaned from the records, as I recall. That's what they say, at the end of the third surgery there were pulses present in the foot.

You mention in paragraph 63 that you telephoned to inquire about the boy's progress?-- Yes.

And you were told then that he may lose a toe?-- Yeah, what I was told was that he was progressing quite well and that it looked like there was some - that he had some damage to the peripheral tissue and he may lose a toe and some skin on his foot, but it looked like he was progressing well at the time that I called up.

Your understanding is that Dr Patel took a holiday on the 26th of January, on Boxing Day?-- Yes, that's my understanding.

And then that Dr Gaffield became the treating surgeon?-- Yes.

And you note that P26 was transferred to Brisbane on 1st of January 2005?-- That's my understanding, yes.

Are you aware that in relation to this patient that there was a complaint by a nurse Michelle Hunter?-- I am not aware of that, no.

Are you aware that there was an expression of concern by the head of the QCC in Brisbane, Dr Stephen Rashford?-- Yes, I am aware of that.

When did you become aware of that?-- When I came back from my leave, and I believe that was one of the complaints that related to the ER, Dr Patel's told he wasn't going to have his contract renewed, I think that was the complaint they were talking about.

When did you return from leave?-- I think it was the 4th of January.

There is evidence before the Commission that a request was made of Dr Keating on the afternoon of the 4th of January to report on this case of the boy P26 and that on the day of the 5th, the next day, he provided a report. Were you ever asked to give your observations on what you saw?-- No, I wasn't.

Do you know when Dr Patel returned from his holidays?-- I think it was around the 10th of January.

So at the time of Dr Keating's report, Dr Patel - well, at least he wasn't available in person to Dr Keating?-- From what you have told me that sounds right, yes.

Commissioners, that's the evidence-in-chief.

COMMISSIONER: Mr Mullins?

MR MULLINS: Thank you, Commissioner.

COMMISSIONER: Sorry, Mr Farr.

MR FARR: I should indicate that we act on behalf of Dr Athanasiov.

COMMISSIONER: Yes.

MR FARR: I just have a couple of questions, if I can ask him at this stage.

COMMISSIONER: Yes. I am sorry, Mr Mullins.

EXAMINATION-IN-CHIEF:

MR FARR: Doctor, can we just in fact work in reverse, if you like, dealing with the patient P21 you have just been speaking of, you were asked some questions about telephoning-----

COMMISSIONER: P26.

MR FARR: P26, I am sorry, the vascular surgeon at the Royal Brisbane Hospital. Did you make any calls to the Royal Brisbane Hospital in relation to that patient?-- I did call the Emergency Registrar on call just to have a chat with him about the case.

Do you remember when, in the order of things, that occurred?-- I am not sure of the exact time. It was either just before the second surgery or just after the second surgery.

And do you recall what advice you received at that stage?-- Basically, I explained to him what the situation was and he said it seemed we had done everything that was reasonable and the only other things to do was to get some imaging studies with an ultrasound or an angiogram.

I see. Is that where the idea of doing imaging came from?-- I asked those things specifically from him to see whether he thought that was what we should do.

Had you contacted the Emergency Registrar of your own volition or had you been requested to do so?-- No, it was my own choice to do that.

And did you pass on the information that you had received?-- I believe I discussed that with Dr Patel, yes.

All right. Now, can I take you back in your statement to paragraph 46, which is one of the paragraphs in which you speak of completing the death certificate in relation to Mr Kemps. You speak in that paragraph of there being a book in the ICU which is the guide to completing cause of death

certificates?-- Yes.

And that you have reference to that book before completing that particular document, that is correct?-- Yes, that is correct.

And would you have a look at this, this is a photocopy of the book - booklet I suppose it might best be called, and can you just confirm that that is a photocopy of the booklet that you referred to?-- Yes, that's correct.

All right. Perhaps we could just briefly put two of the pages up on the screen, the first one being the first yellow tag which it is opened to? Whilst that's warming up, the book is - and on the front cover indicates it's from the Australian Bureau of Statistics. Could you have a look? Could we just go to the top of the page so we can see the actual heading on the top of the page please? Now, did you have reference to that particular page?-- Yes, I did.

And I take it that you had reference to that page because of that heading "Should The Death Be Referred To The Coroner?"?-- Yes, that's correct.

Which was the question that you were attempting to determine at the time?-- That's right, yes.

And did you then have reference to the graph that appears at the bottom of the screen at the moment?-- Yes.

And if we look at that graph, we can see the very first entry is "Patient Deceased", then a little arrow, then "Coroner's Case", and if one looks in each direction "Yes" or "No"?-- Yes, that's correct.

Did that graph help you with your query at all?-- No, well that's the - that very first step is the one that causes the problem.

The little arrow between "deceased" and "Coroner's Case" is actually the error that you wanted to have resolved?-- Yes, that's right.

And then once you had the resolution to that, you could then go "Yes" or "No"?-- Yes.

I see. All right. Did you continue to read on, however, in that book and did it indicate that it was an Australia wide publication because it spoke of the varying legislations throughout the States?-- Yes.

And on the next page, and I don't think we need to see it, but does it supply the telephone numbers for the head chief office of each Coroner's office in each State?-- Yes.

And does it indicate that if there are doubts, then one should ring the Coroner's office?-- Yes, that's what it indicates, yes.

And that's what you did?-- Yes, that's correct, because I was uncertain.

Thank you. Now, could we just go to the second highlighted page and just go to the top again just so we can see the

heading thanks? You can see it's headed "List of Terms Inadequate for Coding Causes of Death" and you would know that that category then goes on for about four pages or so?-- Yes, that's correct.

And did you have reference to the terms under this heading to determine what is not appropriate to put on to a death certificate?-- Yes, I looked through those, yes.

And as a consequence of studying those pages, did that assist you in reaching the opinion that for instance refractory shock was an appropriate entry because it doesn't appear in all of the entries on that - in that booklet?-- That's right, it's not written there as something that would inadequately explain the cause of death, so-----

All right. Could that - I'll tender that booklet, Commissioner.

COMMISSIONER: Thank you. I'm not sure that I've noted before that Dr Athanasiov's statement was given Exhibit number 142.

ADMITTED AND MARKED "EXHIBIT 142"

COMMISSIONER: Exhibit 143 will be the booklet entitled "Cause of Death Certification Australia".

ADMITTED AND MARKED "EXHIBIT 143"

MR FARR: Thank you, Commissioner. And if we could have the machine on again, perhaps we can put this on the screen, ARA7 is the document that's attached to your statement which has been referred to. If we just put a copy on the screen but you can refer to the copy in front of you and I'd just like to be sure that we read the document correctly and that's this passage that was there. Could we just move it up just a fraction? That's it, thank you, just there. And is the way that one reads this correctly as it's written by yourself that the disease or condition directly leading to death is as follows: "Refractory shock due to or as a consequence of aortic bleeding post-operatively due to or as a consequence of" and then one goes down to the bottom entry "resection of oesophageal cancer due to or as a consequence of primary oesophageal cancer."?-- Yes, that's correct.

And do we see two little arrows in the left-hand side of those bottom two entries to indicate that you have put them down in the wrong order?-- Yes, that's right, yes.

So we should read them the other way around to the way they

appear on the page?-- Yes, that's correct.

Yes, all right, yes, thank you, that can be returned. Can I ask you as well, you spoke of the death certificates being placed in the records and that Dr Needham to the best of your belief would subsequently examine those certificates. Did you have an understanding as to when that might occur in relation to any given certificate?-- Usually it occurs either later the same day or the next day that they've been reviewed.

I see, all right. And finally, can I just clarify in case there is any degree of ambiguity about something you said about wound dehiscences. Is your evidence that you don't recall thinking at any stage that wound dehiscences at the hospital were unusually high but that you were unable to make any comparison because you had not worked in the other surgical unit?-- Yes, that's right.

All right, thank you. That's all I have.

COMMISSIONER: Thank you Mr Farr. Mr Mullins?

MR MULLINS: Thank you.

CROSS-EXAMINATION:

MR MULLINS: Doctor, my name is Mullins, I appear on behalf of the patients. Just some brief questions. Mr Farr asked you some questions about the review by Dr Needham of the death certificate. Is it the case that he reviews it before or after it's submitted?-- It's my understanding that he reviews it before.

All right. Secondly, you do mention in your statement that you were asked to complete the cause of death certificate. Who asked you?-- I was asked by the nursing staff in the ICU.

Thank you. Thank you.

COMMISSIONER: Thank you Mr Mullins. Mr, who else? Anyone else?

MR ALLEN: I have a few questions, thank you, Commissioner.

COMMISSIONER: Thank you Mr Allen.

CROSS-EXAMINATION:

MR ALLEN: Doctor, I'm appearing for the Queensland Nurses Union, I just want to ask you if you recall some matters which

will be given in evidence, and if I could deal firstly with Mr Kemps and the first operation. You mentioned in your evidence that you recall during that operation there was a bellovac drain which had about five or 600 mls in it?-- Yes.

Okay, and are you able to say how much those drains actually hold, what their full capacity is?-- They're usually about a litre.

About a litre?-- Yeah, the bag holds about a litre.

Okay. Can I suggest to you that during the first operation, the bellovac drain was emptied twice before the surgery was complete?-- I'm not sure about that, I wasn't told about that.

Okay. And were you present at the time Dr Patel left the operating theatre after the first operation?-- That I can't remember.

It seems that he left some substantial time before the patient actually left the theatre. Had you yourself left the theatre before the patient left the theatre?-- That's possible, I can't recall, I'm sorry.

Okay. Do you recall at any stage Dr Sanji going off to speak to Dr Patel about the condition of Mr Kemps because of the concerns about him haemorrhaging?-- I know that we did talk to Dr Patel at the time about the amount of blood loss and being brought up by the nurses, I only recall as I say that the amount of five or 600 mls in the bag and I'm not sure whether they emptied it before or not but Sanji and myself both talked to Dr Patel about that.

And was that at a time when the patient was still in the theatre after the first operation?-- Yes.

And was the - was that discussion with Dr Patel to inform him about concerns about the bleeding at that time?-- Yes.

And was there discussion then as to whether or not the patient should undergo further surgery or should be transferred to the ICU?-- I didn't have that specific discussion with him but we told him of what the situation was and it was for him to make the appropriate decision that we should do.

And what did he tell you to do?-- I don't recall him specifically telling me to do anything but what I recall is that he explained the bleeding as being from the blood vessels near the stomach and he said that that should settle down and that then the patient was transferred to the ICU.

All right. Now, in relation to the passage of events after Mr Kemps was transferred to the ICU, can I just suggest a few matters to see if you can comment one way or the other as to whether you recall, don't recall or agree or disagree?-- Mmm-hmm.

I suggest that Mr Kemps arrived in the ICU at about 2.30 p.m.?-- Yes, that's my understanding.

And that you at times attended the ICU to review him?-- Yes.

Can I suggest that at about 3 p.m. the - Mr Kemps was hyperthermic, that is, he had a temperature of over 35 degrees; would that be consistent with your recollection?-- Did you say hyper or hypo?

Hypothermic, sorry?-- And it was over 35 or under 35?

Yes, over 35?-- I'm not sure that I understand your question? You said he was hypothermic?

Yes?-- And his temperature was over 35?

This doesn't make sense, my question?-- No.

I see. Would it be hyperthermic?-- If his temperature was high, over 38 or something it would be hyperthermic and if it was low, same, under 34, something like that, then he'd be hypothermic.

Okay?-- If it's above 35, unless it's a lot above it, then it's probably normal.

All right. Does it accord with your recollection at that time, 3 p.m., he was hypotensive?-- Yes, that's correct.

Tachycardic?-- Yes.

And he was obviously therefore showing some signs of blood loss?-- Yes.

A had a heart rate of around 110 to 120?-- I can't recall specifically, but that could be correct.

Do you recall being advised over the phone by someone from ICU of those symptoms?-- Yes, that call was from the theatre resident as I recall but I did talk to people.

And did you actually attend the theatre to review the patient?-- The ICU?

Yes?-- Yes.

And were you requested by a registered nurse to give permission for some blood to be taken from the bellovac drain to be compared with the arterial blood sample?-- Yes, I recall that we did do that on the afternoon.

And were you then informed that the samples in fact had the same results which therefore indicated that there was an arterial bleed between the patient's abdomen?-- Yes, that's my recollection.

And you said that you'd talk to Dr Patel about that?-- Which

I did, yes.

And I suggest that that occurred some four hours before the patient actually left the ICU for a second round of surgery?-- I'm not sure what time that was, I can't comment on that, I'm sorry.

You can't comment? That's fine. But in any event, ICU nursing staff contacted you subsequently to tell you several times about the patient's condition?-- I relayed all of those concerns to Dr Patel.

Yes?-- And we were at that time involved in another case in the theatre.

And eventually he did go back to surgery because of those concerns?-- Yes.

Now, just briefly, in relation to patient P26, can I suggest that during the first surgery, that one of the anaesthetic nurses queried - oh, excuse me, that during the second operation, the fasciotomy, one of the nurses queried what could have caused the compartment syndrome?-- Yes, that was a question that we were all contemplating.

And raised the question as to whether or not the patient's femur could be fractured?-- We did consider that that might be a possibility.

And Dr Patel asked you if the X-rays had verified such?-- I can't recall that.

And do you recall one of the nurses and do you know the nurse Damien Gaddes?-- Yes, I know him.

Do you recall Damien Gaddes suggesting that you could do a table angiogram or a portable X-ray?-- I don't remember, I don't recall him suggesting that.

So that's while the patient is still on the table, so to speak, that there could be a portable angiogram or X-ray done at that time to see if there was a fracture?-- I can't recall having that discussion.

COMMISSIONER: Doctor, can you say if either of those things would have been feasible?-- I've never seen an angiogram in the theatre here, we could certainly get an X-ray done.

Yes?-- We could possibly get - I'm not sure whether we can do an angiogram in the theatre or not.

And am I right in guessing, because it's only a guess, that any question about a broken bone would only be because that would give you a hint that maybe there was a broken artery as well?-- I think it's just because if there is a broken bone in the leg, that can cause a lot of swelling.

Yes?-- And can cause the compartment syndrome, so we're just

running through what the causes for it might have been.

Yes?-- And talking about the appropriate further investigations.

So the portable X-ray would have either established or excluded one of the possible causes of compartmentalisation?-- Yes, that's right.

But you'd actually previously suggested, hadn't you, the ultrasound?-- Yes, that's correct.

And presumably if Dr Patel wasn't going to take up that suggestion, something rather more complex wasn't going to take his interest either?-- I can't remember his comment to that being raised, but-----

MR ALLEN: Just in case it jogs your memory, I suggest that the response from Dr Patel was to the effect of, "No, it's not necessary to do it now, I'm happy with my anatomy, we have hemostatis?-- He - yes, I can't recall him specifically saying that but he may have said that.

If I suggested to you that during this occasion of surgery, Dr Patel told you to order an ultrasound at some stage-----?-- No.

-----do you agree or disagree?-- No, I disagree with that.

When did he first agree to an ultrasound occurring?-- 6.30 that night.

And can I suggest that that surgery finished at about 5 p.m. and that sometime after that there was an occasion when Dr Patel, Dr Robinson, Dr Risson and yourself were standing about the patient's bed considering the patient's condition?-- Yes.

And I suggest that you spoke to Damien Gaddes at that stage out of the hearing of Dr Patel and told him words to the effect of, "We will get him to Brisbane"?-- It was my hope that he would go to Brisbane but I don't recall having that conversation with Damien, and the conversation with the four of us I remember as being in the ICU.

Yes, that's correct, I suggest that Damien Gaddes also attended the ICU?-- Okay.

And went to the patient's bed?-- I can't recall that, sorry.

Could you have indicated to Damien Gaddes that you would get him to Brisbane?-- I may have indicated to him that I wanted him to go to Brisbane which I did raise with Dr Patel. Unfortunately, that's not my decision though.

No, of course not. What do you say to the suggestion that you may have indicated that you were taking steps to get the patient transferred but that that was countermanded by Dr Patel?-- The steps that I took were to discuss it with Dr

Patel. I didn't go behind his back to try and arrange something without his knowledge and he didn't try and foil any attempts on my behalf to arrange it, but he felt that the patient didn't need to be transferred at that stage.

COMMISSIONER: Doctor, we've heard from the patient's mother that in a sense money was no object, that they wanted the best treatment for their son and if it was necessary for him to go to Brisbane for the best vascular surgery, the cost would not be an objection to it; did anyone ever pass that on to you?-- I recall speaking to P26's father and who said that similar sort of message.

Right?-- Which I relayed on to Dr Patel as well.

Mmm?-- And again, I discussed it with Dr Patel and Dr Robinson and they might have felt that there was nothing more that needed to be done at the time.

Was that before or after the arterial problem was discovered?-- Before.

All right. So, it's starting to sound as if had you been listened to in terms of firstly having the ultrasound when it was initially suggested and the patient being transferred to Brisbane, he might have two legs?-- That's a tough thing to speculate on. That was - that would have been my - my preference, for him to go to Brisbane.

Yes. Thank you, Doctor.

MR ALLEN: Just finally in relation to that patient, do you know a registered nurse who was there in ICU named Karen Fox?-- Yes.

Can I suggest that she asked you why you didn't transfer - that is, while the patient is in ICU and in light of the absence of a pulse, why you didn't transfer the patient to Brisbane. Do you recall her querying it?-- I do recall talking to I think it was Karen about that, yes.

I suggest that you said that you couldn't do anything without Dr Patel's instructions?-- Yes, we're not allowed to transfer without the approval of the treating consultant.

And that you couldn't do anything without losing your job?-- I don't recall making that specific statement.

This was in the context of not being able to do anything without Dr Patel's instructions?-- Yes, I did say to her that we couldn't transfer with - you know, if Dr Patel wouldn't approve the transfer, but I don't recall saying that I would lose my job.

Finally, one matter that you've mentioned in your statement and your evidence, some apparent inflexibility on the part of nursing staff regarding observance of protocols. Do I understand your evidence to be that you've encountered a couple of instances where you've asked for something to be done and the nursing staff have indicated that the protocols don't permit that?-- Yes. Yes, that's correct.

And you understand these protocols are some type of binding directions upon the nursing staff as to the procedures that must be undertaken by them?-- I'm not sure what the binding of them is but I understand that there are protocols there to follow.

So the concern you have was that in a couple of instances some concerns were met with a response that the protocol didn't allow you to do that?-- Yes, that's my concern.

Thank you, Doctor.

COMMISSIONER: Mr Devlin?

MR DEVLIN: I have no questions, thank you.

COMMISSIONER: Thank you. Ms Feeney?

MS FEENEY: No, thank you, Commissioner.

COMMISSIONER: Mr Diehm.

MR DIEHM: Commissioner.

CROSS-EXAMINATION:

MR DIEHM: My name is Geoff Diehm, Doctor, and I appear for Dr Keating. I just have a couple of questions about your evidence concerning meetings or the process for arranging meetings with Dr Keating. Could I suggest to you that what the process that was in place for meetings with Dr Keating for a junior medical officer such as yourself was for you to phone his or contact his secretary and in the event that the meeting was not urgent, you arrange an appointment at the convenience of yourself and Dr Keating?-- Yes, that's correct.

And if it was to take a week or so for that meeting to take place, that might be because of problems with Dr Keating's availability but also problems with your availability?-- I never had any problems with my availability.

All right. In any event, was it the practice of Dr Keating's secretary to try and arrange a meeting at a time that met with your convenience as well as Dr Keating's?-- Obviously we had to find a time mutually suitable.

Thank you. Now, if, however, a doctor in your position, a junior doctor, within a hospital needed to see Dr Keating on an urgent basis, it was open to you to say so and a meeting could be arranged more urgently than that?-- Yes, I never had any need for an urgent meeting.

But did you understand that if you needed to see Dr Keating on an urgent basis then you could say so and you could get to meet with him quickly?-- Yes, I know that you can talk to him over the phone if urgent matters. I don't recall anyone needing to speak with him in person urgently so I don't recall that.

I have nothing further, Commissioner?

COMMISSIONER: Yes.

D COMMISSIONER VIDER: I just have one comment, Commissioner. You, during 2004, were a junior house officer and this is your first time out of the metropolitan area?-- Yes.

It would appear to me that these two cases that have been before us this afternoon would have been very difficult?--

Yes, they were.

Memorable might be a word that one could say for your first year out-----?-- Yes.

-----as a junior house officer. Were there any opportunities for you to debrief at the end of last year after these cases? How did you unburden your own particular feelings for these - for the involvement with these cases? Were there opportunities or processes available to you?-- We normally have informal - more informal debriefing, things just talking to colleagues I think.

Yes?-- I'm not aware of any formal sessions that were available.

Were you able to do that?-- To-----

To debrief with your own colleagues informally or-----?-- Yes, I think so.

Because it would be very burdensome to be carrying this burden-----?-- They were stressful cases, yes.

-----into your professional career-----?-- Mmm.

-----with you forever. You will carry them forever but one would hope that it wouldn't be burdensome.

COMMISSIONER: Any re-examination?

MR ATKINSON: A couple of questions, Commissioner.

RE-EXAMINATION:

MR ATKINSON: Just to pick up on the question asked, Doctor, by Commissioner Vider, did you speak about this incident with Dr Fitzgerald when he did his audit in February of 2005?-- Which incident, sorry?

Well, either; the oesophagectomy or the vascular work?-- I think I did, yes.

You did?-- I think so.

And did you describe these incidents in any detail?-- I can't recall, unfortunately, how much detail I went into.

And did you discuss these incidents with the medical review team headed by Dr Mattiussi?-- That I can't recall.

Did you meet with Dr Mattiussi?-- I don't remember that.

Right. He has been working with a team of four:

Dr Wakefield, Associate Professor Hobbs and Dr Woodruff?-- I don't recall a meeting with him, no.

Or any of those other clinicians or practitioners?-- No.

You were asked questions by my learned friend Mr Diehm over here about the meetings with Dr Keating or the accessibility, if you like, of Dr Keating. Was it the case that your relationship for the most part was with Dr Keating's secretary, Judith Woods?-- Yes, that's correct.

If Dr Keating wanted to get a message to you, you would get a phone call from Ms Woods?-- Yes, that's correct.

And if you wanted to approach Dr Keating, you would have to approach Ms Woods?-- Yes.

If there was information about rostering, you would learn that through I think her name is Sue Hutchins?-- Or Judith, yes. Mostly from Judith.

Sorry, I should have asked you in evidence-in-chief but in that second operation with Dr - with Mr Kemps, I understand that Dr Risson visited for that operation?-- The second operation with Mr Kemps?

Yes, that's right?-- I don't recall him being there. He may have been but I can't recall that.

Nothing further, Commissioner.

COMMISSIONER: Thank you, Mr Atkinson. Doctor, thank you for your time today and for coming in to give evidence?-- Thank you.

I would like to echo what Deputy Commissioner Vider has said to you. You have obviously been through a baptism of fire in your professional career. We certainly hope that it's not going to harm what is obviously a very promising career and look forward to hearing in the near future about your surgical registrarship and admission to the college. Thank you again for your time?-- Thanks very much. Thank you.

WITNESS EXCUSED

COMMISSIONER: Mr Atkinson.

MR ATKINSON: Commissioner, we have two witnesses available. One is Ms Hoffman, who has been made available, of course, for Mr Devlin.

COMMISSIONER: Yes.

MR ATKINSON: And the other is a patient called P170,

who is in the Court - in the premises. I'm in the Commission's hands as to which - what sequence we take.

COMMISSIONER: Mr Devlin, does it suit your convenience to deal with Ms Hoffman's cross-examination?

MR DEVLIN: Certainly. I'd be about 20 minutes, perhaps 30 minutes.

COMMISSIONER: All right. We might take an afternoon break and resume in about 10 minutes or so with Mr Devlin.

THE COMMISSION ADJOURNED AT 3.39 P.M.

THE COMMISSION RESUMED AT 3.53 P.M.

COMMISSIONER: Ms Hoffman, can you return to the witness box.

MR MULLINS: Commissioner, briefly before we resume, can I clarify a matter in respect of Mr Flemming?

COMMISSIONER: Yes.

MR MULLINS: He has asked that, subject to any objection from the Bar table, there be a correction of an oversight on his part. It is in respect of the tendering of a photograph. The relevant passage of the transcript is page is 1870 and he was asked the question after being shown some photographs, "Is that the correct state of your belly at the current time?" and he replies, "Yes, it is." In fact, the photograph wasn't correct. The photograph was taken before 6 June 2005 this year when he'd had further surgery. So it was the correct state of his belly before 6 June 2005 and he's asked me to correct that evidence, and there is no objection from the Bar table and there is a further photograph, if required to tender, of the current state of his belly.

COMMISSIONER: I don't think we need a further photograph. In fact, at the time of the question Deputy Commissioner Vider questioned whether that was strictly correct and now that it's been clarified, we understand the position perfectly.

MR MULLINS: Thank you.

COMMISSIONER: Thank you, Mr Mullins.

TONI ELLEN HOFFMAN, CONTINUING:

COMMISSIONER: Ms Hoffman, you of course remain under oath. Mr Devlin, on behalf of the Medical Board, has some questions for you.

CROSS-EXAMINATION:

MR DEVLIN: Ms Hoffman, Ralph Devlin. I'm just interested to tease out some of the detail of some of the procedures that you've referred to in your evidence. I'm sorry to be raising it with you so long after you've given evidence but we'll just go through it as carefully as we can. In relation to P34, who's James Phillips, you said that you thought that doctors in Brisbane had refused previously to operate on Mr Phillips?-- Yes

Is that the state of your knowledge?-- Yes.

From what source did you gain that knowledge?-- I can't remember now whether it was in a general conversation or if someone specifically told me, or even if the family told me. I can't remember now.

All right. It is just that we have the benefit of the chart now and at page 83 of that we see a gastroscopy report by Dr Mark Appleyard, visiting grastroenterologist, and that's dated the 23rd of April 2003. It just says this: "I am concerned about the appearances of the oesophageal nodule. If the biopsies are negative, he should be put on a double strength Proton pump inhibitor and be rebooked for an endoscopy in six weeks' time. If the biopsies are positive, he will need surgical assessment and consideration for oesophagectomy", and the follow-up was with "Dr Miach in approximately 10 days' time." Does that - any of that jog your memory?-- No, no, sorry, it doesn't.

So you just can't help us with the source of your knowledge?-- No, I can't.

All right then. Now, the next one we go to is P18. You spoke of two episodes of wound dehiscence. Was this - this was a person that you had overall responsibility for his care in the ICU; correct?-- Do you mean, like, I was his primary nurse?

No, but he was in your ward?-- He was in my unit, yes.

In your unit, sorry. Do you know whether a cause was ever determined for the wound dehiscence - that is, infection as opposed to inferior suturing or-----?-- No.

Is a patient having been a smoker an indicator for a higher likelihood or a higher exposure to wound dehiscence? Do you know that of your own-----?-- I don't know if I'm the right person to ask.

All right?-- Maybe in terms of general - you know how a smoker is generally poorer in health. Other than that, I'm - I couldn't - I'm not one - I shouldn't answer that.

Okay. In terms of Dr Patel, you said you believed he refused to speak to a surgeon in Brisbane about this case; is that right? Do you remember giving that evidence?-- I'm just trying to remember-----

Yes?-- -----about that particular patient. I would have to rely on my own notes to remind me of that. I can't recollect it myself. I have just - from - it would be the e-mail that I sent to Darren and Mrs Goodman.

Right. And you haven't got a copy of your statement in front of you now?-- I have a copy of my statement in front of me now.

Right. Is the e-mail there?-- Yes, I've got-----

Please feel free to go to it. TH3, isn't it?-- Yeah, I just can't find it at the moment. Sorry. Yes, that's what I recall. Is that one of the issues with Dr Patel, he didn't want to transfer this patient out and whilst the intensivists had found a bed for him or the anaesthetist actually is an intensivist, had found a bed for him in Brisbane at that particular time, they needed Dr Patel to talk to a surgeon there and from what I can recall, he refused to and that's when he went up to Dr Keating and they decided to keep the patient for a longer period of time.

Are you looking at TH3?-- Yeah, yep.

From where do you refresh your memory about those details?-- Oh, just from where I said - where I say, "I'm worried that the patient's care has been compromised by not sending him to Brisbane on Tuesday."

Right. So, it's that description that refreshes your memory about an incident-----?-- Yeah.

-----that you say happened with Dr Patel refusing to, what, presumably go to the phone or some such?-- Refused to talk to - surgeon to surgeon, yeah.

And were you present for that incident or was that simply related to you by someone else?-- Well, I would have been present in the unit but, like, I may not have actually - I'm aware of the situation and what - what occurred but I may not have - I didn't hear any phone calls or anything like that that I can recall.

Yes, all right then. And so, as for who it might have been

was on the other end of the phone, you can't help us with that?-- No, no.

Do you know-----?-- I know that we spoke to - later we spoke to or they spoke to several different hospitals.

Yes. Do you know what became of P18 in the longer term now? --I believe he may have survived for around six months, if I'm correct about that.

Okay. Can we look at what you say on page 11 of your statement about wound dehiscence. You said, when dealing with this in your evidence-in-chief so long ago, that you began to develop a concern that Dr Patel might have been writing incorrect records?-- Yes.

You went so far as to make the strong claim that you thought there was falsification of records?-- Yes.

You've told us about Gail Aylmer's exercise in collecting data about wound dehiscence and you suggested that one of the things that might have been happening was a misdescription of wound dehiscence as something else?-- Yes.

Did you give some thought to how you could go about discovering whether what you suspected was true, some method for determining whether what you suspected was actually happening, that is misdescription of incidents?-- I started to keep some records, like, little things in our admission book if I noticed - if I noticed that there was some sort of discrepancy. Some of the things I did not notice until I went back and actually went through the charts myself and I made a note of them, and a lot of it, as I said before, was based on the fact of what we would be told on handover from patients coming from theatre to the nursing staff but it would be in the chart. So, like, you know, about things that had happened intra-operatively and then it wouldn't be recorded as such in the notes.

But at the time, to deal with that, did you not simply arrange for your staff to enter up the chart correctly?-- No, we're not allowed to do that.

Right?-- We're not allowed to correct a chart that someone else has written - no. No, that-----

Right?-- Because - because I don't know that-----

I just meant by the next entry, recording what was given to you on handover, that's not the way charts are entered?-- The nursing staff should - should have written down, if it was pertinent, you know, like that - what - what they were told at handover by the other nursing staff but-----

That's what I'm getting at?-- Yeah.

Would you agree that if there was misdescription going on in the records-----?-- Mmm-hmm.

-----the time to deal with it was then and there when the misdescription was discovered?-- Yes.

On handover?-- Well, yes, I - yes, it should have been, yes.

Mmm. And would not the staff have been advised to make a particular note in the chart if a misdescription was identified or suspected?-- Yes, they should - well, they should have been or they could have been, yes.

Because it's very difficult, isn't it, working backwards after lapse of time-----?-- Yes, it is.

-----to identify a misdescription positively?-- Yes.

And the person who made the notation in the first instance might well want to argue about it but by then there's too much time gone by perhaps?-- Mmm, yes, that's true.

In the same connection we see from your TH11, which is the ASPIC meeting of the 14th of April 2004 which you and the secretary, I believe quite a large number of NUMs or acting NUMs turned up - have you got that exhibit?-- No, I haven't.

I probably only need to read it to you anyway, but it was the meeting of the ASPIC Clinical Forum attended by Martin Carter, yourself, Darren Keating, Gail Aylmer, Gwenda McDermid, Jenny White, Margie Mears, Di Jenkins, Karen Smith and Joan Dooley as a guest speaker. The item I have in mine is the one dealing with wound dehiscence and it read this way: "The concern was raised by members of the group about where the numbers of wound dehiscences are being captured." Later on it says - sorry, I'll read the full entry: "If it is not identified in discharge summaries or picked up by coders, it could be missed as some patients are experiencing wound dehiscence in the ward, some at home, et cetera. Staff feel there has been an increase in wound dehiscence but we have no stats at the moment. It was agreed that all areas would let Di know, as a central person, if a wound dehiscence has occurred and we will look at how we are going to capture this data. The first action is to fill in an adverse event form and send to DQDSU. A definition of wound dehiscence was also requested." Now, that action was said to apply to all members, so we have this situation that back in July of 2003, as a result of an exchange of concerns between yourself and Gail Aylmer, this problem was identified, but still - by the meeting of the April of '04, you were still trying to devise a means to capture the information. Are you with me so far?-- Yes - yeah, we were, because - I mean, it was supposed to have been having been captured but we were still not convinced that it was being captured and Gail had done that other audit herself, which she's spoken about previously.

Yes?-- So we were just concerned that because of the different areas where they may occur some may be missed.

Yes?-- That's why we decided to do that.

Well, we now have the benefit of a statement from a Ms Raven, who went through then and searched all the records for the incident reports. There is but one report that deals with wound dehiscence after the 14th of April. Do you know why it was systemically or in context that these fairly strong concerns about getting stats and doing the paperwork didn't result in more paperwork, if indeed the concern was there?-- It seemed that there were more - a lot more wound dehiscence at the beginning of Dr Patel's time than at the end.

I see?-- So I don't have, actually, any statistics on that except that that would bear that out.

Did the initiative of the ASPIC committee - was it taken seriously, do you think, by the staff? Was it actively pursued to have these incident reports reflect these incidents for statistical purposes?-- It-----

Or did it drift into disuse, do you know? Can you help us there?-- No, it would have been taken, like, seriously because we were all trying to, you know - to try - we were all trying to do the right thing by finding out what was causing these wound dehiscence. So - I would just suggest that, perhaps, after that period of time, perhaps, there wasn't as many wound dehiscence as what we had observed earlier for whatever reason, I don't know.

So can we take a reasonably reliable view that if Ms Raven has searched the records, and there's not much there about it, that that accords with your general recollection that the incidences of wound dehiscence did decline?-- I think, from memory, after we decided that we would make Di Jenkin the central point. I think I called her with, perhaps, two - two wound dehiscence, from my memory. Whether they actually happened in ICU or whether they were in ICU as a result of it or came back to ICU post surgery or what, I can't remember, but I think I actually made two phone calls to her about that.

Yes. In fact, you give an account in your statement of a wound dehiscence that you considered a reality in the case of P14 at paragraphs 56 and 57 of your statement?-- Mmm.

And that incident is recorded by you as being on the 8th of April 2004. P14, paragraph 57, "On the 11th of April 2004 P14 wound fell apart"?-- Yes.

Is that one that you are most likely to have reported?-- I don't believe that actually happened in ICU, I believe it happened elsewhere.

So you are acting on what you have been told there, are you?-- She came to ICU after having - after going to theatre for repair. So that's - that's - I would have been aware of that,

but-----

But it didn't-----?-- I don't think it actually - it didn't actually occur in ICU, from my knowledge.

Okay?-- She had left ICU at that time from my memory.

What strikes me is that the 11th of April is but three days before this meeting, the ASPIC meeting. So did you become aware of it at the time, around the 11th of April?-- I can't remember.

Something else I wanted to ask you about that. Your own reports to Di Jenkin, were they more of an informal nature, not the filling out of an incident report?-- No, they were verbal. That's what we agreed we would do, we would call her and let her know, and she would investigate it.

Was that up to this - up to this ASPIC meeting?-- No, that's what we wanted to do as a group. We wanted to capture wound dehiscence globally before it affected the hospital.

I have read to you the provision in the minutes. It does appear what was discussed was a formal way of doing that?-- To fill in a form?

Yeah?-- That's right.

Is there any reason you can think of why that didn't happen?-- For this-----

The filling in of forms? I don't mean in this specific case?-- No, no, other than what I - no, other than what I said, I think that the wound dehiscence actually probably - the - the occurrence of it probably lessened.

All right. And P41, over the next page, 58, there's another episode of wound dehiscence which you mention there. Was that in your unit or somewhere else or simply a hearsay description of what occurred?-- There is Wason. She - she spent, from what I can recall, quite a long period of time in ICU and her wound - I'm not quite sure where her wound dehiscence happened.

Okay?-- From memory she was admitted several times to ICU. That's - that's from memory.

All right. Now, in relation to P1 I want to make reference to that paragraph 59 - oh, that's one you just described without any personal recollection of it. What grounds did you have for believing that Dr Patel was engaged in surgery on P1; can you remember?-- I think from the chart, from the patient's chart.

Okay. Well, the-----?-- I think - is this the one we had, the confusion with the name, though?

Oh, right?-- I just need to check that P1 is the same P1.

That might have been while I wasn't here. We won't pursue that. That may be the case?-- The P1 I have is not that P1.

That explains it, thank you. Now, in relation to paragraph 61, P17, do you know who did write the death certificate in that matter? You say you subsequently saw the death certificate?-- No, I can't remember that, no.

Okay. And that matter is with the coroner; do you know?-- I don't think - he might be with the coroner now. I don't think at the time he was a coroner's case. He actually died in the radiology department.

Okay?-- And I think he had actually been - he had actually been transferred out to the surgical ward. He was no longer a patient in intensive care at the time of his death. It was his - it was his death certificate which - which I was concerned about, what was written on that.

Okay. Paragraph 68, there is P12. Are you able to say what happened to P12 after his transfer to Brisbane? You just say he was ventilated-----?-- Sorry, I'm having trouble finding where it is.

Sorry, 68?-- From subsequent discussions with other staff I think he actually - he actually survived, that patient, and actually did quite well, I think, from what I can remember.

Now, P11, Mr Bramich, you need to go to pages 31 and onwards of your statement. Just a couple of details on that list you need to assist us with. You probably need to go to your - to a couple of attachments, TH19 and 20, which are reports on the incidents surrounding Mr Bramich. I just wanted to point out a couple of things to you. In P20, which you noted as being Martin Carter's statement concerning the matter, at the end Dr Carter says that the areas of concern were the delay in the arrival of the retrieval team and he put it this way: "Request logged at 1620, dispatched at 1930 and arrived at 2300." So that's the first aspect of it. Then over on - anyway, what I'm getting to is this - TH29, I'm sorry, Ms Cree's statement. She says this, "Also during this time frame Dr Patel, Director of Surgery, came into the unit and overruled the transfer at one point. He and Dr Gaffield were standing behind me." She describes a loud conversation. She asked them to move away. What I'm getting to is this: do you have any information that the RFDS retrieval was stopped at any point? You see, Dr Carter doesn't say that in his report. There's just an unexplained delay, at least on the face of the document, between the request being logged at 1620, the dispatch at 7.30 p.m. and the arrival at 11 p.m.?-- Mmm.

Do you have any information to suggest positively that the aircraft was stopped or turned around or turned back?-- I don't - it was never turned around or turned back, but the surgeon - once again, the surgeon in Brisbane wanted to speak to the surgeon here and - and before - before that plane left, and my recollection of that event is that the bed was obtained

much earlier than that at the PA and the delay was because Dr Patel came in and said that the patient did not need to go to Brisbane, that he wasn't ill enough at that point and, therefore - and the surgeon wanted to speak to the surgeon before the retrieval team was activated.

Dr Carter, in his report, says as the factor number four as an area of concern was lack of radiological support, CT's not reported until the 30th of August' 04. Was there any requirement that before the patient travelled by air that a CT scan ought to be performed?-- They - they wanted one.

Yes?-- I don't - I don't know whether it was a - a direct request from the surgeon in Brisbane or even the RFDS doctor, but the - but Dr Gaffield - that was one of the delays, was that Dr Gaffield or Dr Patel, I can't remember which, wanted a CT done before the patient left.

That's what I was just getting at?-- Yep.

In terms of the general system at Bundaberg, are delays sometimes encountered in the obtaining of a CT scan as a matter of generality?-- In an emergency?

Well, in an emergency can you get your CT scan when you require it; when you request it, generally?-- To my knowledge, yes, I think so.

Okay. Do you have any information as to why there was a delay in the obtaining of this CT scan?-- I can't - I can't remember what was actually going on prior. The patient needed to be stabilised.

Yes?-- And one of the anaesthetists was stabilising the patient. So - and then they decided that they wanted the CT scan and at that point he was intubated, and so I - and it was getting close to time for the doctors to leave, and so Dr Patel, I think - I mean, I will be repeating myself here, but Dr Patel had gone in and done a colonoscopy and perforated someone's bowel and came in and wanted an anaesthetist to go in and anaesthetise that patient. We only had two anaesthetists, one who was trying to resuscitate Mr Bramich and who intubated him and Dr Patel came in and said - I can remember what he said was - was that a - an emergency surgery to repair this colon - perforated bowel overruled a routine CT. He was referring to it as, like, a routine CT. So he - he wanted the anaesthetist. So that was the delay. There was a delay in getting an anaesthetist wanting to go down with Mr Bramich for the CT and one because he was required back in theatre.

I see?-- So I actually called Dr Carter, myself. Dr Carter was wanting to go home. He was going off to give a lecture somewhere and asked him to please go down with Mr Bramich, so that we could get this retrieval going.

Well, are you able to quantify the delay that was actually occasioned in the obtaining of a CT scan? Are you able to say

how much time was lost in that process?-- No, I can't.

Right?-- No.

Okay. Dr Carter gives a fairly bland account of that particular part of the transaction, I will just read it to you, "The Director of Anaesthetics was called to review and advise of further management of the patient. His decision was to arrange for the patient to be transferred to a tertiary centre in Brisbane where the capacity to provide thoracic surgery, long-term ventilatory support and a blood bank with the capacity to provide product for massive transfusion were collocated. The flight coordinator was contacted at 1620 to arrange a retrieval flight. In the interim a further abdomino thoracic CT was performed to explore an intraabdominal catastrophe." So certainly in his account he doesn't - he doesn't speak of delay at that point, although in completeness I should read this, "Despite fluid resuscitation he says the patient remained hypertensive and was commenced on a vasopressin agent. The Director of Surgery reviewed the patient and decided to ultrasound, guide pericardiocentesis despite the evidence of the CT." So that seems to be the whole - but you can't assist us with - with how and why there was any delays over the CT which, in turn, delayed the aircraft?-- Only with getting the anaesthetist.

Yep?-- And getting the patient stable enough to go down there.

I understand, thank you. I have heard you give that evidence before?-- Yeah, and then also, I think, Dr Carter does refer to - doesn't he refer to - that that lasted - about the delay in CT, as well.

Well, he talks about lack of radiology support, CT's not reported until the 30th of August 2004?-- Mmm.

That's not about the obtaining of a CT scan. That's why I wanted to point it out to you. In any event, that's how you remember the delay in the taking of the CT-----?-- Yeah.

-----scan?-- That's how I remember. Dr Carter also wasn't present in the unit the whole time. It was Dr Younis who was doing resuscitation. Dr Carter was only coming in and out and only came in to accompany Mr Bramich to CT on my request, and I was actually with - with the doctor. The doctor who was arranging for transfer with the clinical coordinator actually wasn't familiar with the procedures of arranging the transfer, so I was actually trying to help him at the desk.

Righto. What seems to remain unexplained about the late arrival of the aircraft is that according to Dr Carter's report the aircraft was requested at 1620, dispatched at 1930, but didn't get there until 2300. So we're - we still don't know why that was?-- No.

You are certain it didn't turn around?-- No, no.

All right?-- And I would dispute those times even because I'm sure that - the times that I have said in the charts. They were on site - I thought they were on site until 10 o'clock. I left at 7.30 and the plane was on its way.

The RFDS records should assist, as well, I think?-- Yes.

At page 48 of your statement you list a number of patients and give a short description of the matters of concern. Can we take it that you identified these possible cases of mismanagement by looking at the patient files and charts; is that right?-- Yes.

Can we take it that you don't have any direct knowledge the individual cases?-- I will have to cross reference them. When you say - can you just repeat the question?

It was just whether you were directly involved in these particular patients' care and directly involved in any direct contact with Dr Patel over any particular patient or whether these were just ones that you came up with as a result of looking in the charts?-- Because some of these patients were in the unit I was directly involved because I would have seen them - been there and talked - you know, seen the patients and talked to the nurses and that sort of thing, but other than what I've already said, I didn't - I wasn't their primary caregiver or anything like that.

Okay. Thank you. At paragraph 7 - sorry, number 7 on page 48 there's a discussion of P26 that's taken a lot of our attention today?-- Yes.

In some other material it is suggested that the young fellow wasn't in the ICU. Was he in the ICU?-- Yes he was in ICU.

Okay. So he wasn't in a general ward?-- Went to a general ward after ICU, yes, he did.

At what point - oh, I suppose his chart will tell us that?-- Yeah.

What does your memory, your general memory tell you if I tell you the incident occurred just before Christmas?-- Yeah, I can remember it well.

Okay. When did he go to the general ward then?-- I don't remember what date he went to the general ward. That would have - you would have to look - because I, myself, went on holiday.

When did you go on holiday?-- I can't remember.

Okay?-- It was a few days, probably a couple days before Christmas or just, maybe, even Christmas holidays. I can't remember. I remember when he came in, and I remember spending a lot of time with his mum.

Okay?-- Mostly with his mum, and that - trying to organise

things like that.

And that's the period for which he was in the ICU; is that right? You had dealings with mum during the period that the lad was in the ICU?-- When he first came in - when he first came into the ICU, yes.

Thank you?-- Other than that I don't remember much more after that than what-----

But the charts will tell us when he went to a general ward?-- Yes, will tell you.

Yes, I have finished cross-examination.

COMMISSIONER: Thank you. Mr Andrews, do you have any re-examination?

MR ANDREWS: I do not, Commissioner.

D COMMISSIONER VIDER: Can I ask Ms Hoffman a question?

COMMISSIONER: Yes.

D COMMISSIONER VIDER: I think in your earlier evidence you have stated that in your experience the findings, the clinical findings from Dr Patel's patients were not always documented by Dr Patel in the record. For example, if the patient returned to theatre the specific reason why they were returning to theatre for a reanastomosis or whatever wasn't the reason why - as the reason for going to theatre; is that correct?-- That's - that's what I - that's what - yes, that's my opinion.

My question now, a few more weeks on into the inquiry, is if one wants to do a chart audit, unless one is specifically directed to go to particular records and look for particular things, you won't pick up irregularities?-- No, they are not going to be picked up. Every single - every single piece of paper probably that exists in Bundaberg Hospital, including - from admission notes to what's written in the ICU book, to what's written in the chart, to what's written in the theatre book, is all going to have to be really scrutinised, and, as I said before, like each little bit has to be married up with every bit of paper because it is not going to give an accurate-----

So you would have to have assistance to say which records are deficient?-- Yes, and even then we mightn't know. I mean, a lot of it we will know because we know now because the patients are coming back with not having the surgery that they were said to have had. I mean, there is several occasions now we know that, that they haven't had what they said they were having. So - so it still - even now we're finding out things that we didn't know then.

So it is not going to be easy?-- No, it is not going to be easy.

No, thank you.

COMMISSIONER: Thank you, Ms Hoffman. I think you have come to the end of the road. So we again express our gratitude to you and you are excused from further attendance?-- Thanks.

WITNESS EXCUSED

MR MORZONE: If it please-----

MR BODDICE: Just before we start, could I just address that letter this morning that you asked me about?

COMMISSIONER: Yes, yes.

MR BODDICE: If I might hand it back to you. I notice it has some writing on the bottom of it. Commissioner, I have sought instructions, and in view of the letter I specifically asked that the Police Commissioner also be contacted to see whether he had views about whether it should be tendered, and I have received instructions that the Director-General spoke with the Police Commissioner and that the Police Commissioner's view is that, as the letter forms part of an active investigation, he would prefer that it not be published at this time.

COMMISSIONER: Well, I don't know why it was sent to me then, but all right.

MR BODDICE: I think it was to keep you informed on what had happened.

COMMISSIONER: Yes.

MR BODDICE: But as I understand it, because it is part of an active investigation, that's the preferred view. I don't think that means that - necessarily if you feel that it should be published, it can, but I understand that's the preferred view.

COMMISSIONER: As most of us here know, I don't like keeping things secret. These things work much better if it is all out in the open. If the Police Commissioner feels there is some operational reason for not making it public, I won't do so.

MR BODDICE: Thank you.

COMMISSIONER: On the subject - you were also going to follow up yesterday, find out whether there were any more of these secret reports kept in the closet, whether Mr Thomas has found the last of them.

MR BODDICE: I have requested that searches be conducted and I will - when I get the results of those searches I will come back to you, Commissioner.

COMMISSIONER: Thank you for that. I also wanted to ask Ms Feeney, your letter yesterday talked about proceedings being filed today - sorry, your letter on Monday talked about proceedings being filed today. I think the Registry is closed. Do we know if anything has been filed?

MS FEENEY: Not today, Commissioner, no.

COMMISSIONER: When is it going to be filed?

MS FEENEY: I am unable to say that at the moment, Commissioner.

COMMISSIONER: Is something going to be filed?

MS FEENEY: I am unable to say that at the moment, Commissioner.

MR DIEHM: I am expecting there will be an application filed by my client tomorrow, Commissioner. There have been some things happened today that have caused some interference and delayed those matters but the matter is progressing as far as my client is concerned.

COMMISSIONER: I indicated yesterday that I would hear argument about the progress of these things tomorrow morning because I assumed, based on - not directed to you, Mr Diehm, but based on Ms Feeney's correspondence and proceeding on the assumption we would have the papers today and, therefore, we would know what was happening. Now that's not happening and Ms Feeney can't tell us anything about it. There is not much

point in having a discussion tomorrow at 9.30 about something that's still as mysterious as it was when we had the discussion yesterday morning.

MR DIEHM: Yes.

MS FEENEY: Might I be able to say, Commissioner, that we should be in a position tomorrow morning to be able to assist you.

COMMISSIONER: But no-one else will understand what's in your secret bag of tricks.

MS FEENEY: No, Commissioner.

COMMISSIONER: Well, as I said earlier today, anyone who wants to make any application at any time, that I disqualify myself, I will entertain at the appropriate time, but I am not going to put people like Mr Mullins, for example, who raised this very point earlier today, and others at the disadvantage of having to answer things on the fly. So if and when something is forthcoming, we will deal with it.

MS FEENEY: Thank you, Commissioner.

COMMISSIONER: Thank you, Mr Morzone.

MR MORZONE: If it please, Commissioner, there are two witnesses available. One is a Mr B, who is a patient. He would like the protection of the umbrella of your earlier ruling and ask that he not be photographed or that there be any still photography of him.

COMMISSIONER: Certainly. Again, is there any objection to his voice being recorded?

MR MORZONE: No, Commissioner. He will be very brief and then my learned friend Mr Andrews also has another witness who has come to Court particularly, a Mr Cronin, who is from Jetset Sunstate, and he is also present. Mr B would be quite quick.

COMMISSIONER: All right. Let's hear Mr B's evidence first, if Mr Cronin doesn't mind waiting for a little while. Mr B, come through to the witness-box, please.

MR B, SWORN AND EXAMINED:

COMMISSIONER: Please make yourself comfortable and I will direct you not be photographed, either by video or still photography, whilst giving your evidence or within this room. But that's not to stop any sound recording of what's going on in these proceedings?-- Thank you.

MR MULLINS: If the Commission pleases, I appear on behalf of

Mr B.

COMMISSIONER: Thank you.

MR MULLINS: Just in terms of the radio or the audio recording, if he could be allotted a number or use of his second name, for example, so he is not identified by virtue of that recording either. He is not allocated a patient number at this point in time.

COMMISSIONER: No, and, as I said I think last week, I really don't like the idea of anonymous witnesses. You sort of get into Gestapo Stasi type things when you have witnesses whose names aren't out in the public arena, so unless there are compelling reasons, I would be quite disinclined to allocate a patient number at this stage.

MR MULLINS: Thank you.

COMMISSIONER: I mean, it is quite different if it was a matter where the witness has strong reasons, personal or health or professional or something else, then I will entertain anything you have to say, but just because an individual doesn't like the publicity, I think that's not enough reasoning, in an inquiry like this one, to keep the truth concealed.

MR MULLINS: It is more a question of personal embarrassment. Has the Commission had the opportunity to read the statement?

COMMISSIONER: No, I haven't.

MR MULLINS: Some of the surgery relates to impact upon sexual organs.

COMMISSIONER: I see, yes. Well, look, I understand. Mr Andrews, do you have any view?

MR ANDREWS: Commissioner, in the exceptional circumstance, because of the particular embarrassment for this particular witness, I submit it would be appropriate if he were to be addressed as Mr B.

COMMISSIONER: Yes. Does that suit everyone? Does anyone have any objection to that course? No, all right. Witness, you will be known henceforth as Mr B, if that's all right?--Yep.

Thank you.

MR MORZONE: Commissioners, I can inform you also that Mr B is a person who is referred to in the Woodruff report as having had an adverse outcome caused by Dr Patel.

COMMISSIONER: Yes.

MR MORZONE: For the record. Can I hand to the Commission a copy of Mr B's statement and also ask the witness to see a

further copy which he can prove. Does your full name appear at the top of that statement?-- Yes, it does.

You are 32 years of age having been born on 5th of February 1973. You are a fisherman working on a spanner crab boat, is that correct?-- That's correct.

Are the facts contained in your statement true and correct to the best of your knowledge and belief?-- Yes, they are.

I tender that statement.

COMMISSIONER: The statement of the witness known as Mr B will be exhibit 144.

ADMITTED AND MARKED "EXHIBIT 144"

MR MORZONE: I am instructed, too, Commissioner, that the patient has a number P170 in the Woodruff report, for the record.

COMMISSIONER: P170 in the Woodruff report, okay.

MR MORZONE: Mr B, in early October you had a painful attack from a hernia you had pre-existing at that time, is that correct?-- Yes, that's correct.

And you attended at the emergency section of the Bundaberg Hospital. Is that correct?-- Yes, that's correct.

You were seen by a Croatian doctor, whose name you don't recall, and he asked you to obtain a referral and return the next day?-- Yes, that's correct.

You returned the next day and you saw another doctor?-- Yes, a lady doctor.

And you refer in your statement that she said that you should have been admitted straight away?-- That's correct.

In any event, you saw Dr Patel on the same day and he booked you in for surgery?-- That's correct.

Did Dr Patel advise you of the risks or any risks which would be associated with your surgery?-- I don't recall. He just assured me that it was a simple operation and that most people would return to work within two weeks.

And the operation was for the repair of the hernia?-- Yes.

You underwent an operation and that involved an overnight stay?-- That's correct.

And the following morning Dr Patel informed you that an

accident had occurred in surgery?-- He informed me of the accident when I woke up from the surgery, that I had a severed right vas.

What are the consequences of that, shortly?-- Short - in the short, that the chances of having children are reduced fifty-fifty.

Subsequently you went home and over the course of the following days you experienced pain and swelling, is that correct?-- That's correct.

And you returned again to surgery on the 3rd of December?-- That's correct.

What was that for?-- The surgery was for a haematoma, a blood clot.

Okay. And you were discharged from that surgery on the same day?-- Same day, yes.

Did you subsequently return to surgery again?-- Uh-huh.

Was that on the 9th of December 2004?-- 9th of December, yes.

What was the purpose of that surgery, briefly?-- It was for an infection.

Okay. And then you remained in hospital between the 9th of December and the 17th of December 2004?-- That's correct, 10 days.

From the time when you have had your first operation in - on the 11th of October 2004, how long did you remain absent from work?-- Roughly about four months.

Subsequently after the third surgery did you continue to experience swelling and pain?-- Yes, swelling, pain, discomfort.

And, briefly, what was the nature of that swelling and pain?-- Well, it turns out that the mesh was placed incorrectly down the track from when I went to see the other surgeon at the Mater Hospital.

And you saw that surgeon in April 2005?-- Yep.

And underwent further surgery yet again in May 2005?-- The fourth operation, yep.

What was the nature of the surgery that you underwent in 2005?-- It was to replace the mesh that Dr Patel had put in. It was supposed to be two separate surgeries but he was able to do both in the same day, take one out and put a new one in.

Did that involve further time off work?-- Another month off work.

Is there anything further you wish to add that's not already contained in your statement?-- No.

That's the evidence-in-chief.

COMMISSIONER: Thank you.

MR MULLINS: I have no questions of the witness.

COMMISSIONER: Anyone else at the Bar table have any questions? Thank you. Mr B, I know I would not wish to come along and talk in public about matters as private. I admire your courage tremendously. Thank you for coming to give your evidence. We appreciate your time very much indeed?-- Thank you.

You are excused from further attendance.

WITNESS EXCUSED

COMMISSIONER: Mr Andrews, we might take a five minute break.

MR ANDREWS: Very convenient, Commissioner.

THE COMMISSION ADJOURNED AT 4.50 P.M.

THE COMMISSION RESUMED AT 4.55 P.M.

COMMISSIONER: Yes, Mr Andrews?

MR ANDREWS: Commissioner, I call Peter David Cronin.

PETER DAVID CRONIN, SWORN AND EXAMINED:

COMMISSIONER: Mr Cronin, please make yourself comfortable. Do you have any objection to your evidence being filmed or photographed?-- No, that's fine.

MR ANDREWS: Mr Cronin, would you look, please, at this statement of yours? While you are doing so, you're Peter David Cronin of Jetset Sunstate, Bundaberg?-- That's correct.

Mr Cronin, did you provide a statement to Mr King on the 21st of June 2005?-- That's correct, yep.

And are you looking at the original of that statement bearing your signature?-- Yes.

Are the facts that are recited in that statement true and correct?-- That's to the best of my knowledge, yes.

And are the opinions in that statement your honest ones?-- Yes.

I tender it.

COMMISSIONER: I am not sure that we have a spare copy amongst the Commissioners.

MR DIEHM: I have one extra.

MR ANDREWS: I have spare copies, Commissioner.

COMMISSIONER: Thank you. The statement of Peter David Cronin, dated the 21st of June 2005, will be exhibit 145.

ADMITTED AND MARKED "EXHIBIT 145"

MR ANDREWS: Thank you, Commissioner. Mr Cronin, Dr Patel called at your business on the 26th of March 2005 to arrange travel from Bundaberg to Portland in the United States of America?-- That's right

You had conversation with him on that day?-- Yes.

And he told you that he was traveling one way and the effect of the conversation was that he didn't need the hassles that were going on for him at that time?-- That's correct.

By that stage, Mr Messenger had spoken in Parliament and the local newspaper had reported matters relating to his speech. Do you recall that?-- That's right. At that stage, I suppose, you know, as an individual, we didn't really know much about it except that there was controversy there and what

was behind it was only to come.

And on the 26th of March, Dr Patel booked, through your business, a flight to depart Bundaberg on the 2nd of April 2005 with an overnight stay in Brisbane to fly out from Brisbane to the United States on the 3rd of April?-- That would be correct, yes.

Now, on the 31st of March, did Dr Patel come in and pay money to you?-- I will just check the receipt. That's right, on 31 March he would have came in and paid $3,500, of which at that time it should have been 3,547.

But $3,500 was all he had on him at the time?-- That's correct.

Did he offer to return the next day with the balance of $47?-- That's right, come in at that time to pick up his documents, his tickets and pay the balance.

All right. But something happened. You couldn't arrange accommodation for him in Brisbane?-- Yeah, because of the closeness of the payment and departure date, we weren't able to prepay the accommodation in Brisbane for that night. So we had to refund that amount to him on his return, which would have been the 1st of April.

Now, annexed to your statement we see a receipt for $3,500?-- Yes.

Dated 31st of March 2005. Would that be a copy of a document that you would have handed to Dr Patel on the 31st of March?-- Yes.

When he paid you?-- Yes.

Now, it was proposed, wasn't it, that the total sum that he would pay you would be $3,547?-- That's right.

That was at the time when you expected that you would be arranging his accommodation in Brisbane?-- Correct.

And in those circumstances, did you issue him with a tax invoice?-- Yes, we issued a tax invoice which was basically ready for him when he came in to pay the amount with the expected travel plans, which would have been for 3,547, I think.

I am going to have put up on the monitor a tax invoice dated the 1st of April 2005 which is - appears as an annexure to a document from a statement of Terrence Allen Fleming who is proposed to be called tomorrow or the day after.

When you - you'll see it on the monitor shortly, Mr Cronin, I'd ask you to tell me whether you recognise it?-- Yeah, that would certainly appear to be the one we would have issued, yes.

I see it's dated the 1st of April. Is it likely that you gave it to Dr Patel on that date or on the 31st of March?-- I think then we must have - we would have issued it on the day we done - that it's there so it must have been given to him on the 1st of April in that instance.

I see. Now, once you determined that you couldn't arrange accommodation for Dr Patel in Brisbane?-- Mmm-hmm.

What did you do?-- Well, normally what we would do, okay, we would say we can't do that for some reason, we'll give you those funds back and you can arrange that accommodation yourself. I think from memory we actually arranged it but he would have to pay for it himself as opposed to us prepaying it.

Did you hand him back some money?-- Yes, for that, yes.

$100?-- That's right, yes.

Does that mean that the total that Dr Patel paid to you was $3,400?-- That's correct.

Being the $3,500 he'd initially given you with a deduction from that sum when you returned $100 to him?-- That's right, yes.

But you armed him with a receipt for $3,500?-- Yes.

And a tax invoice for $3,547?-- Well, normally of course we would have re-issued that tax invoice but I suppose it just didn't happen at that time because he was due to leave and, you know, it was a rush job, we would have normally just re-issued it and put it on the file but we didn't have anywhere else to send it to be honest, sort of, he was gone and we didn't have anywhere to dispatch a new tax invoice to.

COMMISSIONER: And Mr Cronin, would I be right in thinking that this document that we see on the screen at the moment was probably typed up in advance of Dr Patel coming in to pick up his tickets?-- That's correct, yes.

And so where it says "Paid in Full", that was because you were expecting him to bring in the extra $47?-- That's right. I mean, it's just a procedure to have that ready so that the person doesn't have to wait around while we do the actual typing, and unfortunately, that you know, that should have been re-issued, that's all that comes down to.

The unfortunate outcome was that then he was armed with a document that he could and apparently did take to Queensland Health and get reimbursed for the full amount of $3,547, $147 more than he'd actually been paid?-- That would seem to be

the case, but of course, we didn't actually know that he was going to be reimbursed for those funds.

Of course?-- Yeah.

MR ANDREWS: And you had no contact with the hospital or anyone from it aside from Dr Patel at on either the 1st of April or in the week prior to it?-- No, not at all.

I have no further questions for Mr Cronin.

COMMISSIONER: Thank you. Mr Cronin, I just have one question. We have heard suggestions that what occurred here was quite unusual and perhaps irregular in that for official travel by staff of Queensland Health, arrangements are made through what's referred to as their corporate travel office. Have you any experience of other doctors or other staff of Queensland Health organising official travel through your office rather than, for example, personal holidays or things like that?-- Well, Queensland Health has a service provider, a travel service provider which isn't actually our office.

Yes?-- So if they have reason to travel on official business, I don't know who they're booked with but it isn't us, probably is the way to answer that.

Yes?-- But we do certainly have business or do business for other doctors in the hospital or other people but they're on a private basis, but, yeah.

Yes. Any questions at all from the Bar table?

MR BODDICE: No thank you.

MR DEVLIN: No thank you.

MR DIEHM: No Commissioner.

MS FEENEY: No.

COMMISSIONER: Mr Cronin, thank you for coming in this afternoon for your evidence and you're excused from further attendance?-- Thank you.

WITNESS EXCUSED

COMMISSIONER: Yes, Mr Andrews.

MR ANDREWS: Commissioner, the witnesses proposed for tomorrow are in this order: Gaddes, Brennan, Law and thereafter witnesses Kirby and Raven from the hospital, although the order in respect of those two witnesses is yet to be determined.

COMMISSIONER: All right. And it sounds like there's not going to be any legal argument about other issues at 9.30 but we'll see what develops as the week goes on. All right, well, we'll now adjourn until 9.30 a.m. tomorrow.

THE COMMISSION ADJOURNED AT 5.07 P.M. TILL 9.30 A.M. THE FOLLOWING DAY