Transcript of Proceedings

MR A J MORRIS QC, Commissioner

SIR LLEW EDWARDS, Deputy Commissioner

MS MARGARET VIDER, Deputy Commissioner

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

IN THE MATTER OF THE COMMISSIONS OF INQUIRY ACT 1950

BUNDABERG HOSPITAL COMMISSION OF INQUIRY

COMMISSIONS OF INQUIRY (No. 1) 2005

BUNDABERG

..DATE 07/07/2005

..DAY 20

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

THE COMMISSION RESUMED AT 9.35 A.M.

MR D JACKSON QC (instructed by Hunt & Hunt) appeared with Mr R Ashton for Mr Leck

COMMISSIONER: Mr MacSporran, I appreciate that yesterday when you were not here, there was a witness that you wished to cross-examine, Mr Martin, is that right?

MR MACSPORRAN: Yes, I think there was Mr Martin and Miss Hunter who was called in my absence.

COMMISSIONER: Yes.

MR MACSPORRAN: I've seen the transcript of their evidence from yesterday and subject to things that might arise during Mr Gaddes' evidence today, I don't think I need Mr Martin or Ms Hunter recalled.

COMMISSIONER: Good, I appreciate that very much, but if you feel it's a necessity, please feel free to recall them.

MR MACSPORRAN: Yes, thank you.

COMMISSIONER: Mr Andrews?

MR ANDREWS: Commissioner, the first witness today is Mr Gaddes.

COMMISSIONER: Yes.

MR ANDREWS: Commissioner, I see that Mr Jackson is here and on his feet. I apprehend that he has something to bring to your attention.

COMMISSIONER: Good morning Mr Jackson.

MR JACKSON: Good morning Commissioners, I seek leave to appear with Mr Ashton for Mr Peter Leck.

COMMISSIONER: Yes, thank you. Sorry, do you have an application or something?

MR JACKSON: I wish to raise whether the matter that you raised on Tuesday was to be dealt with?

COMMISSIONER: Oh right, well Mr Gaddes might take a seat for the moment.

MR JACKSON: I think you may recall Mr Commissioner, that on Tuesday you adjourned until 9.30 this morning issues which you raised that morning, specifically, what the Commission might do while awaiting for Mr Leck to bring an application that had been foreshadowed.

COMMISSIONER: The situation was that on Monday we received a letter from your instructing solicitors that your application was to be held yesterday and your instructing solicitor made a submission that we should not hear evidence pending the filing of that application. I sought clarification of the situation yesterday afternoon with the instructing solicitor and I was informed that the application had not been filed and she could not say whether it would be filed or when it would be filed, so that the issue doesn't seem to arise. Is that the situation still?

MR JACKSON: The application has not been filed.

COMMISSIONER: And will it be filed?

MR JACKSON: I can't give an undertaking as to the future indefinitely, but it won't be filed at the moment.

COMMISSIONER: All right. Well, there's nothing to raise, is there?

MR JACKSON: Unless you wish to deal with the matters that were raised by you, no.

COMMISSIONER: Well, it's a matter for you. If you have an application for me to disqualify myself or an application that we cease hearing evidence or something like that, I'll hear whatever you have to say, but it doesn't sound as if there's anything pending either in the Supreme Court or here that needs me to deal with it.

MR JACKSON: If you don't wish to deal with it, yes.

COMMISSIONER: All right. You say if I don't wish to deal with it. Is there something to deal with?

MR JACKSON: Well, no, in terms of an application, quite.

COMMISSIONER: All right. Well, you say no, in terms of an application. Is there something other than an application?

MR JACKSON: Well, you adjourned any consideration of other matters to be dealt with today. I don't know if there was any other application, I thought there was.

COMMISSIONER: Mr Deihm, is there?

MR DIEHM: Well, Commissioner, the position with respect to Dr Keating remains as I said yesterday afternoon, it is intended for an application to be filed in the Supreme Court-----

COMMISSIONER: Yes.

MR DIEHM: -----today. I don't have the application that I made to you but the application is expected to be filed early this afternoon.

COMMISSIONER: Yes, well, as matters stand, the record will show that neither your client nor Mr Jackson's client has either applied to me to disqualify myself or apply - well, I shouldn't say you haven't applied, you have indicated clearly that you don't ask me to stop hearing evidence in the meantime.

MR DIEHM: Yes.

COMMISSIONER: Is that still your position?

MR DIEHM: Yes.

COMMISSIONER: Thank you. And you have no application, Mr Jackson?

MR JACKSON: No, Mr Commissioner. I'm here to explain the circumstances if that were required by the Commission. If it's not, then I need not say anything.

COMMISSIONER: No. Yes, Mr Gaddes, would you kindly come forward?

DAMIEN PAUL GADDES, SWORN AND EXAMINED:

COMMISSIONER: Good morning Mr Gaddes. May I inquire whether you have any objection to your evidence being photographed or video recorded?-- None at all.

Thank you. Mr Morzone?

MR MORZONE: If it please, Commissioner. Your full name is Damien Paul Bonderenko, spelt B-O-N-D-E-R-E-N-K-O, but you've been known through your childhood by your surname Gaddes; is that correct?-- That's correct.

You've prepared two statements in this matter, including a supplementary statement recently which relates to a further patient; is that correct?-- That's correct.

Do you have copies of those statements in front of you?-- Yes, I do.

Does the Commission have copies of the statements?

D COMMISSIONER VIDER: I'm not sure, I've got a statement but-----

COMMISSIONER: I think we've got the principal statement but not the supplementary one.

MR MORZONE: I'll hand up to the Commission three copies of the supplementary one.

COMMISSIONER: And have counsel for all of the parties represented have copies of the supplementary statement?

MR MORZONE: They have, Commissioner.

COMMISSIONER: Thank you.

MR MORZONE: Could I mention the supplementary one refers to a patient's name. The patient's code on our patient key is P31 and so could I merely note that when the matter is finally put on the internet, P31 should be in that statement and that's being attended to.

COMMISSIONER: Thank you.

MR MORZONE: Mr Gaddes, are the facts that are contained in both statements true and correct to the best of your knowledge and belief?-- I believe they are, yes.

Are there any changes that you wish to make to any of the statements?-- No.

I'd ask that the statements and supplementary statement be admitted.

COMMISSIONER: Yes. Exhibit 146 will be the statement of Mr Gaddes together with the supplementary statement.

ADMITTED AND MARKED "EXHIBIT 146"

MR MORZONE: Thank you. Mr Gaddes, you were registered as a nurse in 1992, and since that time you've had various nursing positions in the perioperative environment; is that correct?-- Yes.

And that includes as the theatre nurse at the Bundaberg Mater Hospital and at the Bundaberg Base Hospital?-- Yes, and the Rockhampton Mater as well.

In your statement, you state in paragraph 7 that you felt complaints from nurses about doctors would be treated differently to complaints about other persons within the hospital and you've set out an example in paragraphs 3 through to 7 which you have used for that purpose; is that correct?-- That's correct.

Can I note there, Commissioners, too, that the copies of the statements that have been provided to the relevant parties have the doctor's proper identity in it.

COMMISSIONER: Yes.

MR MORZONE: For the purposes of the original, that identity has been changed to merely refer to Dr B.

COMMISSIONER: Yes, I should mention for the record, Mr Andrews raised this matter with me, it seems that the doctor referred to here as Dr B, do I understand correctly had a problem with drug addiction, can I put it that way?

MR MORZONE: Yes.

COMMISSIONER: And the matter was fully and exhaustively dealt with by the Medical Board of Queensland consistently with their policy of assisting the doctor towards rehabilitation rather than at what had been a punitive approach, this is all about 12 or 13 years ago it occurred and my preliminary view was that it was in no-one's interest to reopen the very old wound involving a doctor who went through an extremely unfortunate situation some years ago and seems to have come out the other side. So unless anyone at the Bar table wishes to raise anything, my indication to Mr Andrews was that the doctor's name should be suppressed. Does anyone have a different view? All right, well, I will direct under the Commission's Inquiry Act that the name of that doctor not be published or broadcast, and for the purpose of this proceeding will be referred to as Dr B.

MR MORZONE: Thank you.

COMMISSIONER: Thank you.

MR MORZONE: Mr Gaddes, you raised that merely as an example for the statement that you ultimately make at paragraph 7. How do you say nurses or complaints about nurses and other persons were treated differently from that particular instance?-- I felt that any misconduct on a nurse's behalf was dealt with immediately and disciplinary action was somewhat more immediate than with Dr B. I probably would have been suspended straight away pending an investigation and I felt that that that's contrasted.

It might be suggested to you that it's an appropriate course of action for the Director of Nursing to ask you not to mention the matter further to other nurses pending an investigation; is your complaint about that statement or is it more about the suspension of the person concerned?-- My complaint was probably more of the bullying culture, they said that if I had breathed a word to anyone, it would be instant dismissal on my behalf. I was merely just reporting an incident as a patient advocate and safe practice and I felt that I didn't need to be treated that way.

COMMISSIONER: Mr Gaddes, would I take it that you accept and support the policy of the medical board as I understand it that in cases of doctors with drug addictions and the like, an attempt is made to resolve the matter for the benefit of everyone concerned rather than take the punitive action; do you accept that that's an appropriate way to deal with that sort of case?-- Yes.

And is part of your complaint that maybe nurses aren't given

the same degree of leniency in that regard as medical practitioners?-- I would have felt that, yes.

MR MORZONE: If we can move on then to the time when Dr Patel was there. At paragraph 10 you state that your impression was that he appeared to have the appropriate skills in relation to routine surgery but that his ability in major surgery was a matter of concern to you; could you expand upon what you refer to as routine surgery?-- Operations basically along the lines of hernia repairs, laparoscopic cholecystectomies, that type of surgery. Major surgery as I define it would be things like bowel resections, gastroesophagectomies, that sort of thing.

And what was the concerns that you had in relation to in relation to major surgery?-- I found that Dr Patel's approach to major surgery with bowel resections, his aseptic technique was somewhat more casual than I had experienced in the past with other surgeons.

Can you expand on that?-- When you resect the bowel or you cut the end off the tube or the end of the intestine, it is considered contaminated and that every effort is made to possibly hold it outside the abdominal cavity or swab it with Aquacel Betadine to minimise potential contamination. Often I would see Dr Patel just leave the end of it freely clamped and flopping around inside the abdominal cavity and to me that is a potential factor of infection.

COMMISSIONER: Have you seen that happen with other surgeons?-- Yes, I have, but they have tried to remedy the situation by extending antibiotic cover and washing thoroughly out the peritoneal cavity.

Right.

MR MORZONE: Did you ever raise your concerns with Dr Patel?-- Not with Dr Patel directly, no.

Were there other concerns that you had in addition to the matter you just mentioned, the aseptic techniques?-- Gowning and gloving technique is very important in the theatre environment, infection and control is about controlling the numbers of the potential pathogens that could come on to a patient. Dr Patel had extensive, it looked like dermatitis with small sores all up and down his arms, and in his gowning and gloving technique I found that he did often contaminate himself by - you have a closed glove technique when you put the surgical glove on over the gown without having any skin contact so that the hands and the gown are to be as clean as possible, and I would find that his fingers or skin would touch those areas.

And were there post-operative complications that you were aware of such as wound dehiscence?-- Occasionally I would hear about wound dehiscence but the situation is when the patient's outside of theatre I tend to lose track of their care. I'm primarily involved in doing just the theatre cases. I had been involved - I think that I was involved with a wound

dehiscence and that was when Dr Patel complained about suture material.

And you mentioned before that you did make complaints to other persons other than Dr Patel; who were they?-- My nurse unit manager at the time, Jenny White.

What was her response to your complaints?-- Well, she said that she's just a nurse so what can she do about it, you know, I can't tell a surgeon what to do.

And you state in paragraph 11 that you believed such comments were reflective of the culture that you've mentioned before; is that correct?-- Yes.

Now, can I ask you to turn then to the part of your statement where you address the operation on Mr Kemps?

COMMISSIONER: Before we come to Mr Kemps, just on the subject of surgical technique, we've heard some other criticisms of Dr Patel and I just wonder if you can assist us with any comments you can make on those criticisms. One related to what's been described as fairly rough handling of internal organs once he's opened the abdomen of the chest, a degree of roughness that some witnesses say seemed different from other surgeons. Did you make any observations of that nature?-- I could collaborate roughness, yes, a lot of other surgeons - well, typically, all surgeons would use techniques of blunt dissection with their fingers where Dr Patel would use other techniques with sharp dissection with scissors to get into the bloodless plains of between tissues, and great care was taken to ensure that haemostasis was maintained. I found Dr Patel favoured more the blunt dissection approach and there were lots of bleeders, I mean, arteries were attended to where the venous bleeders probably weren't so much attended to.

D COMMISSIONER VIDER: We've had comment as well that he wasn't all that gentle when he was using retractors to get protected tissue?-- Yes, I would agree with that. Often surgeons, or typical practice would be to place a sponge behind large retractors where there was going to be significant force applied to have a surgical view. He would just place the retractors there and have the junior medical staff pull on them, yes.

Can I just take you back to the comment you made about the gowning and gloving technique which is a fairly basic first step in maintaining an aseptic technique?-- Yes.

When Jenny White's comments to you, "What do you expect me to do, I'm a nurse", we've also had evidence that Dr Patel's manner was not necessarily engaging or easygoing, would it have been difficult to have a discussion with Dr Patel about his aseptic technique?-- Yes, I felt it would have been very difficult to approach him.

For example, if you were assisting - if you were a scrub nurse at a procedure being undertaken by Dr Patel and you were both

at the scrub sink, would you have felt comfortable saying to him, "You've contaminated yourself in what you've just done with that gown and glove."?-- No, I wouldn't have.

He wouldn't have said to you, "Thanks very much for pointing that out the me."?-- No, he wouldn't.

So it might have been that perhaps Jenny White had raised the matter and it hadn't brought forth any change in practice?-- No. In the theatre environment, it's a team approach to asepsis-----

That's right?-- -----and to the patient, and peer review is one of the most constructive things that we have for maintaining the standard, and if that channel of communication is somewhat difficult, then there is a breakdown in the standard.

And certainly the culture in an operating theatre between doctors and nurses is an old well established one, and I'm not suggesting that every surgeon says to a nurse who points something out to them, "Thanks very much, I'm so pleased you're here to tell me that.", but generally speaking, commonsense prevails and those principals of surgery like maintaining an aseptic technique is maintained?-- Yes.

So it is a problem if you've got that; did you see that breaking of the aseptic barrier more than once with Dr Patel?-- Yes, often.

Often?-- Often.

COMMISSIONER: Mr Gaddes, another of the suggestions that's been made about Dr Patel's surgical technique is that he failed to establish a clear field of vision for the particular organs that he was working on, so if he was going to perform, let's say, for example, a splenectomy, he didn't ensure that the other organs were pulled up to the side and that he had a clear view of the organ that he was operating on; do you have any comments on that suggestion?-- Sometimes I felt that his incisions were small which wouldn't allow you to have adequate exposure of the area that you need to be operating on, so in that instance, greater force would be needed to pull upon the retractors to give you the necessary exposure that you needed, and in doing so potentially you could cause more damage to surrounding organs.

If I can ask you also about another aspect of Dr Patel's practice. We've again heard suggestions from a number of sources that Dr Patel showed a degree of favouritism towards female staff. As the first operating theatre male nurse that we've heard evidence from, I'm wondering if you're able to comment on whether you felt any sort of favouritism or defavouritism of that nature?-- Being a male nurse in a female dominated profession is sometimes can be a difficult thing. It was something that happened on a day-to-day basis and I really just kind of ignored any sort of favouritism, I just went about my job basically. I can't say for certain

that he was more favoured to females than males to be honest.

Right. And do I get the impression that from the way that you answered that question, that if Dr Patel was guilty of that, he's not the only doctor in the history of the medical profession?-- That would be a fair assumption of it.

Yes. Thank you, Mr Morzone.

MR MORZONE: Thank you Commissioner. Another matter that we've heard some evidence of, and I think we'll hear some more evidence of is the risk of cross-contamination between patients, that Dr Patel would look at or do procedures on more than one patient at a time or successively without proper clinical practices in between; do you have any comment about that or did that occur in-----?-- Do you have an example as per se? Because in a theatre environment you wash your hands before each procedure on one patient, so he wouldn't be able to be involved with more than one patient at any one time, so I'm not sure what you're trying to say.

In an operating theatre, it's never a case that he would operate on more than one patient at one time?-- Not that I recall.

And outside an operating theatre do I understand from what you're saying, you wouldn't have witnessed him?-- No, that would probably be in a ward situation. In a theatre environment we do one person at a time.

All right. Can I ask you then about Mr Kemps and the operation that occurred on the 20th of December? You state in paragraph 13 that you commenced your shift at about 7.30 in the morning and you started early to organise the necessary equipment for theatre; is that correct?-- Yes.

And you conversed with ICU staff about the readiness of the staff to accept Mr Kemps post-operatively; is that correct?-- Yes, I did.

And you were informed that ICU did not have the staff for another ventilated patient because they already had two patients on ventilators and you relayed that or you told Dr Berens that you would relay that to Dr Patel; is that correct?-- That's correct.

What did you say to Dr Patel when you referred that to him?-- I informed him of the information that we just spoke about and said that ICU had two ventilated patients there and at the present point there was no bed available for Mr Kemps post-operatively. Dr Patel became very angry and he felt that ICU staff were trying to interfere with his planned case for the day.

COMMISSIONER: Mr Gaddes, I know it's very difficult to ask you to do this but your impression as to what he felt or how angry he was and so on, whilst that may be helpful to us, what would be more helpful is if you could recall what gave you that impression, whether it was the words he used or the tone of his voice or anything else?-- Practically speaking, I think that he was - he had raised his voice to the point of almost yelling and he was very angry and he seemed upset in his tone.

Yes, and what did he say specifically about the ICU, the staff or the situation with the beds in ICU?-- He basically said that, "That brain dead patient should have been switched off last night", and he had relayed information to people to clear that bed for - I presume for Mr Kemps and that the other patient that was ventilated had private cover and could have been shipped out to Brisbane. And then I went on to say - I cut him off, basically, and said that I wasn't going to open any expensive equipment and prepare a theatre if there was a potential chance that we weren't going to proceed with this case and he said, "I know", and, "Thank you", and hung up.

D COMMISSIONER VIDER: So there were two ventilated patients in the intensive care unit?-- That's right.

One, in Dr Patel's terms, was brain dead?-- Yes.

And the second one had private cover and could have been shipped out?-- To Brisbane, yes.

So he was going to deal with both patients on the ventilator?-- Well, either or.

MR MORZONE: Did Dr Patel also make some mention about ICU interfering with his surgical list?-- As I said before, he thought that the ventilated patient should have been have - the brain dead person that he referred to should have been switched off and the patient removed from the ICU so that there was a bed free for him, and he felt that - can I say other doctors' names?

COMMISSIONER: Yes, by all means?-- Yes, Dr Jon Joyner and the ICU staff were interfering with that by keeping the patients there ventilated.

I think we've heard Dr Joyner's name mentioned before. Would you remind us what specialisation he had?-- He's an anaesthetist.

Right?-- And he does on-call.

So, he would have been working under Dr Carter in the ICU area?-- Yes.

D COMMISSIONER EDWARDS: And they would have been following the protocols relevant to brain dead?-- Yes, I would assume that to be so.

MR MORZONE: You continued to prepare the theatre suite to the extent that you could without wasting materials; is that correct?-- Yes.

And you were subsequently then informed of something; is that correct?-- Yes, that there's - that a bed had become available and we would start with the case.

You were then the anaesthetic nurse for the purposes of the surgical procedure that occurred on Mr Kemps; is that right?-- Yes, it is.

And that commenced, you say in your statement at paragraph 16, at 9 a.m.?-- Yes.

Or the anaesthetic commenced then and the procedure commenced at 9.52 I think, over the page?-- That's correct.

It concluded then at 13:12, some nearly three and a half hours later; is that correct?-- That's correct.

Now, in paragraph 18 you refer to approximately half an hour into surgery noticing that the bellovac drain was half full without vacuum and that blood was freely draining into the bellovac. Can you explain further on that?-- I didn't define half an hour into the surgery. It was half an hour into the thoracotomy part of the surgery. So the drain, the bellovac drain from the laparotomy side of it - I think we've discussed previously what this procedure entails.

Mmm-hmm?-- Had no vacuum on it, and a vacuum drain is to - to remove blood under - under a vacuum. But this had no vacuum so it was equal to atmospheric pressure and blood was freely flowing into this drain.

COMMISSIONER: I'm sorry, Mr Morezone, I'm going to interrupt again because I want to make sure I've got this picture absolutely clear in my mind. During the laparotomy part of the operation, that was the opening of the abdomen, in effect, in what position was the patient?-- The laparotomy?

Yes?-- The term supinal, lying on his back.

Lying on his back, all right. In the course of that procedure a drain was inserted to drain the fluid from the abdomen?-- At the end of the procedure, just before they closed the abdomen, a drain is inserted routinely for such major cases.

And whilst the laparotomy phase of the operation was taking place, did you notice any blood or other fluids escaping from

the body or was there evidence of bleeding?-- It's quite normal for there to be bleeding because you are cause - you are being invasive, but nothing that drew my attention to being abnormal, no.

And-----?-- At that point.

-----given that the operation started at just before 10 o'clock, how long did the laparotomy phase of the operation take?-- I'd only be guessing. Oh, somewhere round an hour.

Okay?-- Or so. Probably a little more.

So something like a third of the way through the entire operation?-- Something, yeah.

All right. Then the patient's abdomen was actually sewn up, was it?-- That's correct, and then the position changed to a lateral position.

Which means on his side?-- Yes, sorry.

Yes. And then the thoracotomy commenced, which was the opening of the chest cavity?-- Yes.

All right. And is that the time at which you noticed the blood draining from the drain that had been placed in the abdomen?-- Yes, yes.

Okay.

MR MORZONE: And you mention in paragraph 18 that by that time you'd given the patient at least three units of packed cell blood products?-- We had started giving him that during the thoracotomy stage of it, yes.

Were there other matters indicative of what the potential was at that time?-- The patient's heart rate climbing steadily and the blood pressure was low.

Did you say something to Dr Patel?-- I - I conversed with Dr Berens about the matter and he - his suspicions were that perhaps the patient might be haemorrhaging. I made a statement to Dr Patel indicating that the drain had no vacuum on it and the blood was freely flowing into it. It was approximately half full.

D COMMISSIONER VIDER: How much blood was ordered for this patient prior to the surgery commencing, can you remember?-- I can't recall exactly but I think it was about six units.

Yes?-- Somewhere around there.

Which would have been what you would have expected to have?-- Well, yes. Yep.

COMMISSIONER: Presumably you allow some margin for error. If four units was the average, you'd order six units so that

there was-----?-- That's more of a medical arena decision.

MR MORZONE: What was Dr Patel's response to what you'd said?-- He said, "That's what's drains are for, Damien", and just continued on with the surgery.

What occurred after that?-- We emptied the drain a couple of times. I believe Dieter Berens had spoken to Dr Patel that he suspected the patient was haemorrhaging before we closed up the thoracotomy. Dr Patel closed the major part of the incision into the thoracotomy and left the junior staff-----

D COMMISSIONER VIDER: The capacity of the bellovac drain is a litre?-- I think 500 mls, somewhere around-----

500 mls, yes. All right?-- And then he left the theatre, so left the juniors to close the skin incision.

MR MORZONE: Sorry, who did he leave to-----?-- The - Sanji and Anthony I think.

That's Dr Athanasiov?-- Yeah. I have trouble pronouncing-----

And Sanji. Even I have trouble pronouncing----- ?-- Kariyawasam.

COMMISSIONER: At the time when Dr Patel left surgery, the patient was still bleeding, was he?-- That was our impression, yes.

All right. Was blood still flowing from the drain?-- Yes, it was and the monitor was showing a low blood pressure and tachycardia, which is indicative of hyperbilirubinemia for whatever reason.

D COMMISSIONER EDWARDS: Was that the stage, as Dr Patel left the theatre, that Dr Berens said the patient will be back to theatre, at about that time?-- Yes, somewhere around that time.

MR MORZONE: Did Dr Patel give any explanation why he wanted to close the patient while this was occurring?-- I'd ask Dr Sanji to go and get Dr Patel to review the patient before taking him off the table and discharging him to ICU because Dr Berens and the rest of the staff there felt that this patient was haemorrhaging and, to be sort of proactive, we thought we best have a review now while he's on the table and we could have the equipment ready.

D COMMISSIONER VIDER: Just let me interrupt you there, Dr Patel actually did the sewing up here; he didn't leave that to the junior staff?-- The juniors just did the skin layer.

So he had left the theatre before the skin closure was completed?-- That's correct.

COMMISSIONER: What were the clinical indicators that suggested to you that there was a problem, apart from seeing

blood coming through the drain?-- We had an arterial line in which is a very accurate measure of measuring the blood pressure.

Yes?-- And his blood pressure was low and his pulse rate was up and the pulse rate generally goes up when the blood pressure is low to compensate.

Yes.

MR MORZONE: Were those matters made known to Dr Patel?-- Dr Sanji was aware of the situation and I had assumed that he indicated that information to Dr Patel.

What about during the procedure, before Dr Patel left? Was he aware of those indicators or should he have been aware of those indicators?-- I believe Dr Berens had spoken to him of his concerns and that was where I made comment in my statement that he gave no response.

You mentioned that you believe Dr Berens made Dr Patel aware of that. Are you able to tell us whether you heard that occurred or what makes you believe that?-- Dr Berens had - as I said in the statement, had indicated during surgery of his suspicions.

Okay. And before Dr Patel had left, do you recall how many times the bellovac drain had been emptied before he'd left?-- Twice that I recall.

And would he have been aware of that?-- I can't recall to be honest. I had another nurse assisting me at the time and we were busy attending to fluids and document - documenting things as such.

COMMISSIONER: Someone has also mentioned that a very large number of sponges were used. Are you able to comment on that?-- Yes, I think there were a large number of sponges used but, as I say, I had - I was very busy attending to anaesthetic matters.

I'm sorry, I don't have the transcript reference with me but I think we were told a figure of something like 70 sponges.

D COMMISSIONER VIDER: Seventy-five.

COMMISSIONER: Seventy-five. Would that be an unusually large number?-- Given that I haven't been involved in such major surgery of that nature, I can't honestly be objective about that.

MR MORZONE: When Dr Patel had left the theatre, do you recall where he had gone?-- No.

Okay. Did Dr Sanji return to inform you of some instructions from Dr Patel?-- To discharge the patient to the ICU.

And what was your reaction and the reaction of other staff in

the theatre?-- Absolute disbelief. Disbelief that he wouldn't even consider or entertain our feelings. This is a team approach to the patient's wellbeing and the best outcomes. So, even if he knew or felt that we - we might have been over reacting, he still should have come and reviewed the patient in my view. That's my opinion.

Was there any further discussion amongst staff about taking some other form of action or involving some other consultant?-- I was instructed to go to my lunch break whilst the patient was on the table, so I can't recall or wasn't present for any further discussions about the patient at that point.

You make mention in your statement of Dr Berens having made a statement to the effect that the patient would be back in theatre tonight; is that correct?-- Yes, that's correct.

Was that the extent of what Dr Berens said; could you elaborate on that?-- I'm sorry, I can't recall him saying anything else but that is something that sort of stuck in my mind.

I think you may have told us in your statement earlier but in case you didn't, during the course of that first operation, who was present in the operating theatre besides yourself? Dr Berens we've heard of, Dr Sanji; is that correct?-- Yes.

Dr Patel?-- Yes.

Who other-----?-- Janelle Law, Marie Goatham and I think Katrina Zwolak, I think.

Were there any other junior doctors besides Dr Sanji and Dr Berens, do you recall?

COMMISSIONER: Was Dr Athanasiov there?-- I think he was.

MR MORZONE: In paragraph 21 you refer then to beginning your shift the following day and being told that the patient had died; is that correct?-- Yes.

You weren't involved further with that patient after you'd left to go on your break?-- No, I returned to the theatre just to clean up and prepare for the next case.

In paragraph 22 you make reference to a day or so later, yourself and two other theatre nurses meeting with Ms Mulligan in her office ?-- That's correct.

Did you outline concerns to Ms Mulligan at that time?-- Basically, I had informed her of the things that we've discussed and outlined in my statement.

And what was the response of Ms Mulligan to that?-- She seemed supportive at the time and she indicated that we write out a formal statement and that would be forwarded to Director of Medical Services and the situation would be investigated.

Did you do that?-- Yes.

Can I ask you then to pass to patient P26, the 15-year-old boy that you refer to in paragraph 25 onwards of your statement. In paragraph 26 you refer to the first procedure which occurred and you refer to the vein, the femoral vein, having been repaired. On this occasion, what was your role in the theatre?-- I was the scrub nurse, which is the person that directly assists the surgeon.

Are you able to tell us, did you have vision of how the vein was repaired?-- I believe he repaired it with a prolene suture 60, or something of that nature. I can't be certain but, basically, it's like sewing up a sock if you want to think of it in simple terms.

Did you notice anything unusual about how the vein was repaired or are you unable to comment on that?-- Unable to comment.

That first procedure ended approximately an hour after - it was approximately an hour long?-- About that, yes.

And you state in paragraph 27 that later in the shift you were informed the patient would be returned to theatre?-- That's correct.

For what purpose was that, do you recall?-- Apparently the circulation of the leg had become compromised and the patient developed what was said to be compartment syndrome, so the patient was scheduled for fasciotomies, which is to release the constricted muscles within the sheaths and to restore blood flow.

Prior to that occasion, that return to the theatre, had there been any conversation that you heard relating to the transfer of the patient to Brisbane?-- Not at that stage, not that I can recall accurately, no.

In paragraph 28 you refer to asking Dr Patel what would cause the compartment syndrome; is that correct?-- Yes.

Where and when did you ask him that?-- Probably about halfway through the procedure. We'd done the fasciotomy in the thigh section or the femur section and moved down to the calf, or the lower leg, and I had asked him what would cause this compartment syndrome.

What was his response?-- Bleeding into the muscle or a clot.

Did you ask Dr Patel then if the patient was bleeding?-- Yes.

And what was his response to that?-- He said, no, he was happy with the anatomy and what he had done. I then went on to question him if the femur had been broken and possibly could contribute to that.

You state then it was suggested that you do a table angiogram or a portable X-ray. For what purpose did you suggest that?-- If we did an on-table X-ray and the femur was found to be - found to be broken, seeing that the vascular supply was compromised, we could have had immediate attention from the orthopaedic side of things to fix the broken leg and restore vascularity to the leg, and the angiogram side of it is injecting dye, which is visible on the X-ray, and it can show you the flow of blood or any disruptions to the vascularity from the arterial side.

COMMISSIONER: Was the equipment readily available to perform either of those procedures?-- It would e have taken 10 minutes for the radiographer to come up.

Yes?-- Ten or 15 minutes, and in that time I would have had the equipment ready, I would have asked my scout to prepare it for me.

Obviously the X-ray would have been entirely uninvasive. Would the angiogram have been in any way potentially invasive or harmful to the patient?-- When you inject anything into a patient there is always that chance of a side effect.

Yes?-- Or something happening. But given the situation, I didn't think so. I didn't feel that way.

And in any event, Dr Patel didn't suggest to you that the reason for not having the angiogram was because of potential side effects?-- No, he said he was happy with the anatomy and what he did in the previous surgery.

We have also heard that someone present might have suggested an ultra sound. Do you recall whether that suggestion was raised?-- Dr Patel asked Anthony-----

Yes?-- -----whether the X-ray has been taken of the leg and towards the end of the case he suggested that an ultra sound be done at some time.

Who suggested that?-- Dr Patel did.

And again, that's an entirely uninvasive process?-- It is indeed but the equipment is in the X-ray department, it is not exactly portable.

It is not exactly portable. So the patient would have to be moved down to the X-ray department?-- That's right.

I see.

MR MORZONE: At the beginning of paragraph 29 you refer to Dr Patel attempting to palpate for a pulse in the foot. Do you recall when that occurred in sequence? Was that before or after you suggested the angiogram and portable X-ray, or can't you recall?-- I think that was after.

What about before or after the suggestion about there being a

scan?-- The ultra sound?

Yes, the ultra sound?-- I think - chronologically, I can't remember that exactly but I think it was - it was around the time before or after he tried to palpate the pulse in the foot.

Was a pulse found, do you know? Did Dr Patel give you any indication about whether he'd found a pulse or do any actions that suggested he didn't?-- I don't think - I can't recall exactly but I don't think that he'd felt a pulse and he sort of made mention that the pulses would return after the swelling of the muscle had gone down.

You suggested that you set up a Doppler and Dr Patel agreed?-- Yes.

And were pulses found with a Doppler?-- No.

COMMISSIONER: Doppler, I take it, is just an electronic device which tests for a pulse?-- That's right. It's an electronic ear basically.

Yes.

MR MORZONE: Who was involved in the operation of the Doppler during this time?-- It's a device that I had to put a sterile sleeve over so I was involved in that initially and my scout nurse. So, we had to dress it if you will and then we got some sterile gel and put it on the usual places that you'd find a pulse in a foot, and we couldn't find anything at that time.

How is the pulse recognised? Does it show up on a speaker or can-----?-- It's an audible thing on a speaker and, yeah, like you hear on the television, that sort of swishing sort of sound.

Could there have been any doubt that Dr Patel wouldn't have recognised that there was no pulse? Did you convey that to him or should he have heard the beeping?-- Well, he didn't hear anything. I certainly didn't hear anything, so one would assume that he would not have heard a pulse.

Was there any comment made about there being no pulse by anybody at that time?-- No-one was saying anything at that point.

Did you notice other features about the leg which gave you concern?-- The leg was mottled in appearance and dusky pink, which would indicate there being a lack of circulation to the leg.

And was that apparent to Dr Patel?-- Yes, it was.

Did Dr Patel then leave the room, or before he left the room did he make some further comment about whether or not the pulse would return?-- He said after the swelling went down,

he believed that the pulses would return.

Was there any comment made by any person about that after he said that?-- Not that I recall, no.

Once Dr Patel left the room, you yourself then tried to palpate a pulse in the patient's foot; is that correct?-- Yes.

And you found no discernible pulse?-- Not that I could recognise, no.

Was there a reason why you did that before the patient returned to ICU?-- I was concerned for the patient's leg. The longer a leg is without - or a limb is without circulation, the longer or the more chance, the probability that he could lose his leg or lose proper function of his leg. So, time is of the essence with circulation problems.

D COMMISSIONER EDWARDS: And was that your being unable to feel the pulse at approximately, I think, 5 p.m., if I remember rightly, recorded in your notes?-- Yes.

MR MORZONE: The patient was then discharged to ICU; is that correct?-- Yes.

And you then expressed concerns to Dr Risson?-- Yes, that's correct.

What-----

COMMISSIONER: Could you remind - I'm sorry, Mr Morzone. Could you remind me what Dr Risson's role was in the theatre?-- I think he was the doctor on call for the evening, so he was staffing casualty and organising surgical patients.

So was he a doctor who ordinarily worked in surgery or in emergency?-- Yes, he was. He was on orthopaedic rotation at that point.

Right. Again, a relatively junior doctor?-- Relatively.

Yes?

MR MORZONE: You expressed concerns to Dr Risson?-- That's correct.

What did you say to him; do you remember?-- Basically, I believe that he was there towards the end of the operation. We just, basically, exchanged clinical indicators and felt that if there was no pulse there now that, perhaps, we could get consultation from someone else in the best interests of the patient.

And you state that he said he would contact Dr Roberts?-- That's correct.

You then completed your duties and the theatre was shut down; is that correct?-- That's correct.

Okay. And you then entered the ward?-- That's correct.

And you saw a conversation occurring between Dr Patel, Dr Robinson, Dr Risson and Dr Athanasiov; is that correct?-- That's correct.

Did you hear that conversation?-- No, no, I hadn't paid much attention to the detail.

At that time or shortly after that time did you have another conversation with Dr Risson?-- Yes, I did.

And what was that?-- It was asking if the pulse had returned to the patient's leg, and his response was that it had not.

Now, up until this time had you heard any conversation or mention again of the patient being transferred to Brisbane?--

Dr Anthony said that they would be - likelihood of transferring him to Brisbane after that second procedure, yes.

When did he say that; do you recall?-- Well, that was while I was in the ICU.

In the ICU?-- So I had spoken to Dr Risson and then Dr Anthony.

COMMISSIONER: Sorry, Mr Morzone. Just looking at your statement, the top of page 12, you attribute there to Dr Athanasiov the words "we will get him to Brisbane". That might come across as rather boastful or something like that, but as you've just related in the witness-box, it didn't - it wasn't in that way at all, it was more-----?-- No, no, it wasn't.

-----"he will need to go to Brisbane"?-- Basically, yeah. I think Anthony was just talking from a team approach, "We will get him to Brisbane".

Yes?

MR MORZONE: Was that a conversation which Dr Athanasiov had with you with others, as well?-- I think Dr Risson was within hearing range, but-----

What about Dr Patel?-- No, no, not at all.

Was there any mention made to you by Dr Patel at that time that the patient would be referred to Brisbane?-- No.

Was there any mention of the contrary by Dr Patel?-- Not that I was aware of, no.

You then returned home and while you were at home you received another phone call in relation to the patient and the patient needing to return to theatre?-- That's correct.

How long was this now, after the patient had first arrived in the hospital, approximately; do you remember?-- When the patient arrived at the hospital?

Yes?-- From the helicopter?

Yes?-- It would be - that would be eight hours.

You returned to theatre - you returned to the hospital and to theatre; is that right?-- For the third time, yes.

And on this occasion what did you understand the purpose of the operation to be for?-- We had to explore the wound and investigate the lack of pulses in the patient's leg.

D COMMISSIONER EDWARDS: You were on call for the-----?-- Yes. Sorry, yes, I was on call for that.

MR MORZONE: What happened during that operation?-- We

reopened the wound, Dr Patel had said that he noted that the femoral artery was damaged. He suspected there might have been an embolus or blood clot in the arteries, so we obtained an embolectomy catheter and passed that down to what we believe was past the clot, inflated the balloon and pulled out the clot, and because he felt that that part of the artery was so damaged he removed that part of the artery and replaced it with a gortex graft, which is a synthetic product that can be used for - substituted for arteries and veins.

Did you notice anything further about the leg?-- No change. It was still mottled, and I forgot to mention it was extremely stiff still, so you couldn't put it through its usual range of motion.

The operation ended and the patient was, again, transferred back to ICU; is that correct?-- That is correct.

During the course of the operation, again, was there any mention at that time of the patient being transferred to Brisbane?-- Not that I recall, for the reason being that Dr Patel was quite upset with everything. I had staff that weren't as experienced on call with me and didn't know the location or name of some products that were required for the operation, and Dr Patel was quite upset about that. So it was more about retrieving articles that was necessary for the operation than patient care.

I don't think in your statement you refer to those persons who were involved in the third operation other than yourself, obviously, and Dr Patel. Who else was involved in that third operation?-- During the second operation those people there, they were on call with me, those nursing staff.

So they all returned; that's those that you referred in paragraph 27?-- Yes.

Including the medical staff, did they return?-- I can't recall the anaesthetic side, to be honest.

COMMISSIONER: Dr Zia was an anaesthetist?-- Yes, he was.

Junior to Dr Berens?-- Yes, that's correct.

You don't recall whether he returned, as well?-- No, I can't remember. I was extremely focussed on what was going on at that point.

Of course.

MR MORZONE: During the course of the third operation was there some determination reached by Dr Patel or any of the other medical staff as to why the pulse hadn't returned?-- Not that I recall exactly, just sketchy details, to be honest.

Do you recall after or during the third operation whether or not Dr Patel thought that the pulse would return after the operation?-- Yes, I think he did make mention of that then.

And what did you think he said; do you remember?-- No, I don't, sorry. We just talked about the subject matter, what was actually said.

Did the operation end with the view that matters had been repaired or fixed up or did it end without knowledge of whether or not the trouble that had been experienced was going to continue?-- Sorry, could you repeat that, please?

Yes. When the operations ended, was the view that the condition of the patient had been rectified or did it end not knowing whether or not the patient's condition was-----?-- Whose view are you wanting to know, mine or Dr Patel?

The view expressed by, particularly, Dr Patel and the other medical staff, if they expressed one?-- He - he said that he felt a good palpable post-tibial pulse at that point, so I would assume that he thought that that final surgery had rectified the problem.

Do you recall him feeling for that pulse?-- Yes.

And how did that occur? Does that-----?-- Towards the end - at the end of the operation before we were putting the dressings on he felt for a post-tibial pulse, which is on the high part of that ankle on the inside. He felt that he could feel a pulse.

Did anyone else feel for the pulse?-- Oh, when he left the room I felt for it again, and I couldn't feel anything.

The following day was Christmas day, and you stated in your statement that you came on shift - I beg your pardon, it was Christmas Eve?-- It was Christmas Eve.

You came on shift and you had another conversation with Dr Risson about the patient, and he told you that the patient then still had no pulse in his leg; is that correct?-- Yes.

Do you recall what was said about that?-- I think I asked him the question had the pulses returned yet and, basically, it was just a basic no.

And at that time was there discussion that you were a party of about transferring the patient to Brisbane?-- I think that he was talking in the interests of the patient, going to do what we could to get the patient to Brisbane.

To whom was he talking when he said that, to you or to others?-- To just myself.

And he asked Dr Risson to keep you informed about the patient's progress, and then after that you had time off for Christmas holidays; is that correct?-- That's correct.

When you returned the patient had already been returned to Brisbane on the 29th of December; is that correct?--

Apparently not. I was briefed by counsel the other day that he had been transferred to the medical ward. I had assumed that because he was not in ICU - Dr Risson was also on leave - I assumed that he had been sent to Brisbane.

COMMISSIONER: In any event, it's very hard for any of us to remember precisely because of the amount of days, but you recall learning at some stage that the patient had gone to Brisbane, and learning that he had an amputation?-- That's correct. Dr Risson had informed me about that.

I see we're getting onto a part of your statement where you talk about dealing with complaints and discussions you had with Dr Risson about that. I'd like to understand whether at this time - we're going back to Christmas/New Year of 2004/2005 - whether you were aware of other grumblings from other parts of the hospital about Dr Patel?-- Apart from experiencing things first hand in theatre, the way that he spoke to staff, I heard that Toni Hoffman and Dr Patel had a personality conflict between the two of them, and there were along the grapevine things of wound dehiscence, increased wound infections, patients dying, complications occurring outside the Bundaberg community where they had their initial surgery in Bundaberg. I felt that these sort of things were subjective because I couldn't prove or see them for myself, so I treated it as gossip at that point.

You weren't aware, for example, of any concerns raised by Dr Miach regarding having his patients treated by Dr Patel?-- I felt concerned when I heard that Dr Miach had refused Dr Patel to treat any of his patients for any procedures at all, and felt concerned why wasn't that being investigated.

When did you first learn about that?-- Possibly August last year, somewhere around there. I can't be certain, to be honest.

You mentioned that you heard on the grapevine a version attributing Toni Hoffman's interest in all of this just to, sort of, personality issues. I don't want to cause you or anyone else any embarrassment by trying to track down the source of that, but are you able to recall who told you it was a personality problem?-- Dr Patel, himself. I had heard it during conversation with his junior staff. So if I was the scrub nurse or scout nurse, you could hear him quite clearly speaking about the personality differences.

Are you able to recall any of the detail of those conversations?-- Not particularly. I remember him being derogatory towards Toni Hoffman, but as to the issues of the conflicts, I couldn't say.

Yes. Thank you, Mr Morzone.

MR MORZONE: After you learnt of the outcome of the patient P26 and that the patient's leg had been amputated through or above the knee, you decided to make a complaint; is that correct?-- Yes.

And you set out a conversation which you had with Dr Risson about whether or not he had been prepared to support you in paragraph 36, and you also spoke to Dave Levings; is that correct?-- That's correct.

And did you make a complaint in relation to the treatment of P26?-- I - Dave Levings informed me that there would be an impending inquiry and that I would have room to make a complaint then. So I had waited until then to make a formal statement.

COMMISSIONER: Sorry, can you just remind me who is Dave Levings?-- He was the Acting Nursing Unit Manager at that point.

Nursing Unit Manager for theatre?-- For theatre, yes.

MR MORZONE: And when he referred to there going to be an inquiry, was he talking about this specific case or generally?-- Generally, I think.

Generally. About Dr Patel?-- About Dr Patel, yes.

In paragraph 39 you refer to Dr Patel after that time having a conversation with you which you set out and state that you felt intimidated by the comments, and you said that you knew Dr Patel had threatened other nurses previously with them losing their jobs or being transferred from the theatre. How did you know that?-- I had been conversing with those staff about some of the things that he had said. One of the staff members, whom I have a good rapport with, told me that Dr Patel would give her the sack if she couldn't find a particular suture that he knows that he ordered, but we knew that wasn't in stock at that point in time. He also made reference to our techniques being third world and of not up to the measure of the United States.

D COMMISSIONER VIDER: When Dr Patel would make statements that he would give somebody the sack, I mean, in reality did you think Dr Patel could give anybody the sack?-- No, no, but I think that he would make life difficult for them.

Nursing staff as well as medical staff?-- Yes.

This might be a bit out of sequence, but I'm just conscious of the fact that these two events that we're talking about, the 20th of December-----?-- Yes.

-----Mr Kemps, and the 23rd of December, the 15 year old boy, are difficult situations where you have outcomes that the theatre staff experienced with these. Did you have an opportunity to do any debriefing, and I'm wondering whether the Director of Nursing came to the operating theatre at any stage and said, "You've had a difficult couple of days"?-- I certainly don't recall anything like that, no.

Does that ever happen?-- It has happened in the past, yes,

but not something that I would call to be often.

Well, how do you debrief because these situations are difficult to deal with?-- Indeed. Generally, the theatre team or theatre environment have a good rapport with one another, and we debrief amongst each other. Social workers and that are made available if we wish to speak to them, if we wish to take the issues further and then try and deal with the - the emotional aspects of it, yes.

But unless you actually go to the Director of Nursing you are not aware of the Director of Nursing coming to the department-----?-- No.

-----to comment on how you all might be coping-----?-- No.

-----emotionally with what the work load is producing for you, clinically?-- I think the time that she was being supportive was when I had the interview regarding Mr Kemps and-----

But you went to her office for that?-- Yes.

She did not come to the operating theatre?-- No.

COMMISSIONER: You said in answer to a question from Deputy Commissioner Vider that you had experienced that sort of interaction with executive management on some previous occasions. Was that with different Directors of Nursing or in different hospitals or different circumstances?-- Probably in different hospitals and sometimes different circumstances, yes.

Mr Morzone, is that a convenient time to take the morning break?

MR MORZONE: Certainly, Commissioner.

COMMISSIONER: We will be adjourned for 15 minutes.

THE COMMISSION ADJOURNED AT 10.51 A.M.

THE COMMISSION RESUMED AT 11.15 A.M.

DAMIEN PAUL GADDES, CONTINUING EXAMINATION-IN-CHIEF:

COMMISSIONER: Yes, Mr Morzone?

MR MORZONE: Thank you, Commissioner. Mr Gaddes, you recall before the break we were referring to when - you were making mention again of your meeting with Ms Mulligan?-- Yes.

During the occasion of that meeting, did you also mention to Ms Mulligan the occurrence of other oesophagectomies that you were aware of?-- Yes, I did.

Do you recall what she said about-----?-- The subject was just pertaining to all the previous patients that had had oesophagectomies. Dr Patel had 100 per cent complication strike rate, whether it be death or major complications, and I was concerned at how the administration - it hadn't been flagged to their attention, and Ms Mullins informed me then that sometimes these things fall outside the criteria of the system to be seen.

COMMISSIONER: You said Ms Mullins. You meant Mulligan?-- Yes, sorry.

D COMMISSIONER VIDLER: What would she have meant by that comment "fall outside the system"?-- I-----

Was that discussed?-- No, no, I just assumed that she meant that it wasn't specific data that drew to her attention. Pigeon holing of information, I guess, might be a better way of describing it. It didn't fit the bill.

One would have thought it would have come up in - you know, one of the clinical indicators would have indicated the complication rate?-- Well, I would have thought so, yes.

That sort of surgery?-- Yes.

MR MORZONE: You state in your statement that Ms Mulligan had indicated that she hadn't been aware of those earlier, is that correct?-- Yes.

Okay. The other matter that I want to take you to then is patient 31, which is in your supplementary statement, and that patient underwent a procedure which was a mini laparotomy, is that correct?-- Yes.

What was the purpose of that procedure?-- That we were to give the patient a pericardial window and take a biopsy of the pericardium.

That was performed on the 17th of August 2003, and you were reminded of that through some evidence that you heard Dr Miach give earlier in the sittings?-- I had been watching the news, like most other nurses have been, and I recognised the patient that he was talking about.

And did you learn back in August 2003, this particular patient was to undergo that procedure under a local anaesthetic, is that correct?-- Local with sedation, yes.

And did that cause you some concern?-- Yes, it did.

Why is that?-- It is an extremely invasive procedure and any chance that the patient could move whilst the surgeon was trying to achieve his goal could have catastrophic outcomes. I mean, we're right there on the heart, for one. We have got the descending aorta which is within and the inferior venacava. If you were to prang something like that, you would you have got moments to get things ready to counteract the problems.

You said that it was invasive surgery. For those of us like me who aren't familiar with it, can you describe what happens during that surgery?-- Basically we made an incision where your ribs meet up together and then we went through into the patient's - through the diaphragm into the mediastina, which is the area around the lungs, around the heart where the lungs go around, and we went in there and pushed the tissues aside to reveal the heart and we - there is a sac that surrounds the heart called the pericardium and we took a small piece of the pericardium out.

In paragraph 5 of your supplementary statement you refer to having spoken to Dr Carter before the case about the procedure and its risks under local anaesthetic, is that right?-- Yes.

And Dr Carter told you that the patient was a high risk for general anaesthetic?-- That's correct.

In those instances where there is a high risk for general anaesthetic, what are the alternatives for sedation or anaesthetic?-- It becomes a situation where risk versus benefit. If the benefit is going to be of a greater outcome for - or a more optimal outcome for the patient, then it is discussed as a team to evaluate the risks and take them as necessary. I felt that these procedures - being so invasive as they are, a general anaesthetic would have alleviated a lot of the risks - potential risks for this patient.

COMMISSIONER: Were there other options, though, such as local anaesthetic or sedation?-- We did use local anaesthetic and sedation, as I stated earlier. You know, I can't think of any other options other than perhaps the patient could have gone to Brisbane where there is more specialists available who undertake these sort of things on a daily basis.

MR MORZONE: In the event, the decision was made by persons other than yourself to undergo the operation-----?-- Yes.

-----with the risks that were involved, and you state in paragraph 7 that during the procedure, the patient was moving and reacting to the pain from the surgery, is that correct?-- That is correct.

Can you describe that in further detail?-- When we were dissecting or cutting, when we were placing retractors in, basically just about everything we did inside the patient he did feel. We tried to - Dr Patel tried to rectify that with appropriate amounts of local anaesthetic, and Dr Carter was supplying the sedation side of things and it just - it didn't seem to have much effect on the patient.

Did Dr Patel cease the procedure when that was occurring or-----?-- He did stop at times to allow the anaesthetic to work or for the sedation to catch up and take effect, yes.

You state that you thought that the procedure nevertheless was dangerous as it occurred, is that right?-- Yes, I did.

Is that for the reasons that you have mentioned?-- Yes, it is.

And from the fact that the patient was moving, as you have described?-- Yes, that's true, but also I had outlined to Dr Patel, "What extra equipment would you like for me to have available in the event of plan B, C, D?", and I suggested that we have a thoracotomy tray available and have the - which is a tray of instruments used to open the chest, and an arterial tray, which has instruments of a vascular nature to attend to vascular needs, and he said that they weren't necessary to have available, and I found that to be unsafe practice.

That's the evidence-in-chief, if it please the Commission.

COMMISSIONER: Thank you, Mr Morzone. Mr Allen?

MR ALLEN: Yes, I appear for Mr Gaddes, if the Commission pleases.

EXAMINATION-IN-CHIEF:

MR ALLEN: Mr Gaddes, just briefly in relation to patient P26, at no time during the events of the 23rd of December last year were you, or apparently anyone else, able to locate a pulse in the leg?-- I believe that to be correct, yes.

And even after Dr Patel claimed to have found a good palpable post-tibial pulse after the third procedure, you in fact were unable to palpate any pulse?-- That's correct.

And the last information you received in relation to the patient came from Dr Risson on Christmas eve?-- Yes.

When he indicated that there was still no pulse?-- That's correct.

Do you recall about what time it would have been on Christmas eve?-- I think somewhere around lunchtime. Somewhere around lunchtime.

Would it be fair to say that if anyone was examining the records of the patient and reading any notes made by Dr Patel regarding there being a presence of a pulse, one would have to regard that with some skepticism?-- I would think so.

Now, in answer to a question from Deputy Commissioner Vider, you agreed that Dr Patel couldn't actually sack nursing staff as he might have threatened on occasions?-- Yes.

Apart from making your working life difficult or unpleasant in his interactions with you, what sort of threats to your career could he in fact carry out?-- I believe that if you were to work with him, he would discredit your techniques and credibility to a point where the nursing hierarchy would have to investigate your actions, and possibly with an unfavourable outcome. Dr Patel has said things in the past to the nature that he doesn't want certain staff working with him because he believes them to be incompetent, and that really disseminates through the whole team. And, really, it is not very good for morale, that sort of thing. A team is as good as its weakest link so that team should be fostering those people, not pushing them aside.

D COMMISSIONER VIDLER: Were bells starting to ring with staff? You get somebody that starts a pattern where you can say, "Well, he doesn't want to work with this one, he doesn't get on with that one, and he is having problems with somebody else." What were the consequences of that around the hospital? Were you aware of any of those, if you became aware of them?-- Speaking from the grapevine point of view-----

Yes?-- -----I found it unbelievable that people like Dr Miach refused to have anything done, Toni Hoffman had so called personality conflicts with him. The fact that from both sides of the stream, medical and nursing, had issues with Dr Patel and nothing seemed to be forthcoming from that, I - it was cause for concern.

COMMISSIONER: Just following on from a question you were asked a moment ago about him threatening your career, I guess without actually being in a position to sack members of the nursing staff, Dr Patel's influence would have made it difficult, for example, for members of the nursing staff to act in a position, when an acting position became available, that sort of situation?-- It could be read that way, yes. He certainly would say, if he was on call for that evening and that person was a level 2 nurse, that he would say, "I don't want that person on call with me because I believe them to be incompetent", or whatever.

And no doubt there are opportunities from time to time where if you were a member of the theatre nursing staff, there is an opportunity to act as Nurse Unit Manager in that area of the hospital, maybe if you were a nurse unit manager there is an opportunity to act as Director of Nursing or Deputy Director of Nursing, there are always those opportunities to act in a higher position temporarily?-- Yes, yes.

Does that depend on how good your reputation is around the hospital?-- That is an influencing factor, but we do have competency evaluation systems in place where basically it is a peer review structure from a nursing point of view, and that also could be influenced from medical opinion as well.

Yes.

D COMMISSIONER VIDLER: Can I just take you back to the example you have just given, if a level 2 nurse was on call and Dr Patel said, "I don't want that person on call", did that happen?-- Not that I recall, no, but it was just a potential situation.

I was going to go on and say if the person that Dr Patel said he did not want to work with was regarded as clinically competent, was Dr Patel then told that that person would be on call, they were clinically competent and were quite able to do call and Dr Patel would have to go and find some other solution? Because you can't end up with having an on-call roster that's just got a selection of people that Dr Patel wishes to work with?-- That instance probably would never have arisen because I don't believe anyone would have had the courage to present that to him in such a way.

So it didn't actually happen. You don't know whether there ever was a discussion between the manager of theatre and Dr Patel regarding the competence of staff, or with the Director of Nursing-----?-- Not that I recall.

-----and Dr Patel?-- It was a perceived threat.

All right.

MR ALLEN: Did the perceived threat extend to fears of being transferred out of theatre to another unit if one was to criticise Dr Patel?-- Nursing staff had come to me and said - quoted words to that effect, that they would be transferred out of the theatre, yes.

And did you consider that these types of threats and intimidation from Patel were either designed to or had the effect of stifling criticism of his surgical techniques?-- It could be suggested that, yes.

D COMMISSIONER VIDLER: Whilst we're talking about perception then, following on from that, would the nursing staff have had the perception that Dr Patel would have been able to get them transferred out of the operating theatre?-- I think people firmly believed that he possibly could, yes.

So they would not have expected, in going through a normal hierarchical approach to authority, that the Director of Nursing would have said to Dr Patel, "That nurse isn't going anywhere." That wasn't the perception? I know you haven't got actual experience, but the perception of the theatre staff-----?-- It was a feeling that we never really had support from the corporate or administrative side of nursing.

It was a feeling?-- And there was much cynicism and probably negative feedback from administration, from the nursing sector. We seemed to be spoken to only, from the corporate side, when we'd done something wrong. Rarely did we receive much praise.

So you weren't reassured?-- There was no reassurance whatsoever.

You could get on with doing what you were doing. You were employed as a competent nurse in the operating theatre, or wherever, and the expectation was you met those competencies according to position description?-- That's correct.

And support wasn't given to you to tell you that you were quite secure in what you were doing?-- That's true.

COMMISSIONER: What is needed to address that sort of situation? Do you need to have the Director of Nursing or other executive people visiting the wards and the theatres regularly and speaking to the staff?-- I believe that certainly is the case, you need to have that hands-on approach and get the real feel for how people are coping in their situations, in their environments.

And particularly after crises and the Deputy Commissioner Vider has made this point, that here your staff within two or three days before Christmas have dealt with two quite major catastrophes one after the other; what would you have liked to see happen in that situation?-- I - perhaps the Director of Nursing or someone of - in the administration come to us and see how that we're coping, offer debriefing and some form of counselling, yes.

Is that important to the nursing staff at the frontline?-- Absolutely, absolutely.

Yes, Mr Allen.

D COMMISSIONER VIDER: Mr Allen, can I interrupt again?

MR ALLEN: Yes, please.

D COMMISSIONER VIDER: I just want to go back to the supplementary statement-----?-- Yes.

-----that you've got here where you refer to the patient that had that procedure done with local anaesthetic and sedation. Is there a surgical services review committee or an operating theatre committee where you could have taken a case like that and discussed the case?-- Not from my position I don't believe.

Not from the nursing position?-- No.

So sometimes if there is a difficult case that people - staff might have various opinions about, what could have been done, what should have been, what might have been done, that wasn't a forum at the Bundaberg Base Hospital where you could have gone down and did a case review, if you like?-- What you're talking of I believe to be reflective practice, it was something that wasn't done often and I think that in order to maintain standards and for staff moral, reflective practice or encompassing peer review is essential.

Do you have such a committee in Bundaberg in the operating theatre?-- Not one that we frequent or one that I'm aware of to be honest.

No.

MR ALLEN: Mr Gaddes, you've been at pains to point out in your statement that you have no axe to grind with doctors generally or indeed with overseas-trained doctors generally?-- That's correct.

Indeed, do you have some opinions as to the value to our hospital system of overseas-trained doctors?-- I admire people that come from another country and bring their families here, that takes a lot of courage and I think that these people are just equally compassionate and competent individuals within the Queensland Health sector.

Yes, thank you.

COMMISSIONER: Thank you Mr Allen. Mr Mullins?

MR MULLINS: Thank you Commissioner.

CROSS-EXAMINATION:

MR MULLINS: Mr Gaddes, my name is Mullins, I appear on behalf of the patients. Just a few questions. Prior to December of 2004, what did you understand to be the formal complaints procedure that you could follow in the event of an adverse event occurring?-- Firstly, probably would discuss it with your nurse unit manager or a senior individual acting in that position, filling out the appropriate adverse event forms and, depending on the outcomes of that, that was forwarded on to the administrative side of things and then that was reflected back to you and the outcomes of that was discussed.

Prior to December 2004, had you completed an adverse events form at any stage?-- No, no.

You mentioned that you had seen Dr Patel's aseptic technique during the course of theatre; had you seen it outside the theatre at all?-- No, as I - like I said, I worked within the theatre environment so really I didn't see anything in the ward situation.

Thank you. Nothing further.

COMMISSIONER: Thank you. Sorry, Mr Devlin.

MR DEVLIN: No, thank you, Commissioner.

COMMISSIONER: Mr Deihm.

MR DIEHM: Thank you, Commissioner.

CROSS-EXAMINATION:

MR DIEHM: Just briefly. Mr Gaddes, my name is Diehm and I appear for Dr Keating. In paragraph 42 of your statement, you

- and this is your main statement - you mention a meeting with Ms Mulligan regarding P21 and you say that at that meeting you told Ms Mulligan that Dr Patel had had five patients die after oesophagectomies?-- Yes.

Can you tell me what the source of your information was?-- I had understood that to be the case from discussions with other clinical staff.

That wasn't based on your own experience with having been involved with five separate patients?-- No, Mr Kemps is the only one that I recall definitely.

And would it be fair to say that the source of your information that made up this understanding of yours, that there were five such patients who'd died, came from a variety of people?-- Yes.

All right. Thank you.

D COMMISSIONER VIDER: That would have been available to you though from the theatre register, would it not?-- Absolutely.

So it's not a difficult thing to check?-- No, it's available on the theatre register and I can't precisely remember the data collection forms, but each form was filled out for a patient, their details, the time they were in the theatres and the procedure that was done.

MR DIEHM: Did you check any of those sources of information?-- No, I did not follow them up.

I just remind you, Commissioner, that there is a document in evidence that would suggest that there were two out of five patients who died. I'm not challenging the witness of his belief which has been communicated.

COMMISSIONER: No, the evidence is very clear, Mr Gaddes has simply passed on to Mrs Mulligan the evidence he'd gleaned around the theatre, he doesn't claim to be able to verify that information.

MR DIEHM: Thank you Commissioner.

COMMISSIONER: Thank you Mr Deihm. Mr Jackson?

MR JACKSON: No, thank you Commissioner.

COMMISSIONER: Thank you, Mr MacSporran.

MR MACSPORRAN: Thank you.

CROSS-EXAMINATION:

MR MACSPORRAN: Mr Gaddes, I appear for Ms Mulligan, my name is Allan MacSporran. The area you deal with in respect of two patients in particular, P21 and P26 all occurred over the holiday period in late last year; is that so?-- Correct.

You indicate that you had been told by the Acting Nurse Unit Manager theatre, David Levings, that he'd spoken to Ms Mulligan during that period?-- That's correct.

You don't know whether he had in fact done that?-- No, but it was reflected by that I had a meeting with Ms Mulligan so I assumed that he had spoken to her about this situation, yes.

And you assumed he had because she ultimately met with you and two other nurses?-- That's correct.

But can I suggest this to you and you may not know this, but she was on leave, that is, Ms Mulligan was on leave from the 21st of December 2004 through until the 4th of January 2005?-- Perhaps it was the next day, I can't - I wasn't certain, but perhaps it was the next day.

Which day is that you're referring to?-- The 21st of would have been.

Well, that's her first day of leave, I'm suggesting to you she wasn't there at the hospital on the 21st and didn't come back until the 4th of January. In any event, your information about her being told about this during that period was from someone else-----?-- That's correct.

-----relayed to you, you had no personal knowledge?-- No.

Okay. You do say, of course, that once you had heard that from Mr Levings, you met with Ms Mulligan a couple of days later?-- Yes.

Could it have been in January you met with her?-- Quite possibly, yes.

Okay. In fact, I'm suggesting it was the 7th of January?-- Okay.

Now, at that meeting, she spent some time with you and the other two nurses, didn't she?-- Correct.

How long, do you recall?-- I think I was there for about half an hour and I left before the other two.

Okay. Did you fully inform her of what your concerns were?-- Yes.

You went into some detail?-- Yes, I did.

As did the other two nurses who were present?-- I believe so, yes.

And did you notice Ms Mulligan taking notes of what you were saying to her?-- I don't recall her taking notes, no, but that's not to say she didn't.

She appeared to be, at least by her manner, receptive to what you were telling her?-- Receptive and concerned, yes.

And supportive?-- Yes.

I want to show you a document that she compiled, I'm suggesting is a file note after the meeting with you and the two others on the 7th of January to see if you recognise the issues that she's noted.

COMMISSIONER: Do you want that put on the screen, Mr MacSporran?

MR MACSPORRAN: Yes please.

COMMISSIONER: Thank you.

MR MACSPORRAN: While that's coming up, Mr Gaddes, the other nurses, for the record, were Katrina Zolak?-- Zolak, yes.

Zolak, and Janelle Law?-- That's correct.

Now, can I just direct you to one thing. Firstly, you'll see a date on the top left-hand margin there, "7 December 2004". Now, clearly, it can't have been the 7th of December when you met with Ms Mulligan, can it?-- I would have thought not, no.

If we proceed on the basis it's a typo, it should be 7th January 2005?-- That's plausible.

Okay. Now, can I just ask you to look at the contents of that file note that Ms Mulligan made at the meeting and tell me whether it properly reflects the discussion you had with her.

COMMISSIONER: On the first sentence it talks about the three of you making an appointment to see Mrs Mulligan. Your evidence is that you didn't make the appointment, that that was done by your Nurse Unit Manager?-- Acting, yes.

MR MACSPORRAN: You went through your chain of command-----?-- Chain of command.

-----and you assume that she made it on your behalf and then you met?-- The "Alleging of falsifying of documents by Dr Patel, and threatening/intimidation of other medical staff to keep quiet about certain patient outcomes.", that was some of the information circulating around the hospital and I just wanted to draw her attention to it, if she was aware of anything of that nature.

Absolutely. The point I'm trying to make with you, I suppose,

Mr Gaddes, is that what you had relayed to Ms Mulligan on the 7th of January, this meeting, she faithfully, it appeared, recorded in this file note?-- Yes.

All of these issues were the ones that you and the other nurses raised with her?-- That's correct.

She treated them seriously and was supportive of your stance?-- Just at that interview, yes.

Yes. And one of the concerns you - I'm sorry.

D COMMISSIONER VIDER: Mrs Mulligan - in one of the statements in this file note, the second dot point, "and believes that patients are having poor outcomes including unnecessary deaths as a result." Mrs Mulligan didn't indicate that this was the first she was hearing of that though?-- She said that she had been aware of some things and they were pending an investigation at this point or words to that effect.

Because unnecessary deaths, I would have imagined that wouldn't have been used to Mrs Mulligan, that would have been coming through-----?-- From the nursing.

-----in many ways?-- Mmm.

MR MACSPORRAN: Mr Gaddes, you may be aware that there had been a report, the first time to Ms Mulligan on the 20th of October 2004 when Ms Hoffman, about the clinical competence of Dr Patel and the causation of death as a result; were you aware of that?-- I had heard sketchy details about it from the grapevine, but exact details, no.

Anyway, nowhere in the discussion on the 7th of January was Ms Mulligan telling you that these were the first occasions she'd heard these difficulties?-- No, I guess so.

She was indicating to you that your concerns in particular about retribution would be taken seriously and appropriately addressed?-- That's correct.

COMMISSIONER: Mr MacSporran, I certainly won't cut you short if you wish to pursue this. My own feeling is that nothing in this witness' evidence could be regarded as critical of Mrs Mulligan regarding her handling of this complaint either at the meeting or subsequently.

MR MACSPORRAN: Yes.

COMMISSIONER: If you feel that there is some issue in your client's interests that you wish to pursue, you're very welcome to do so.

MR MACSPORRAN: Thank you.

COMMISSIONER: But if you feel that the intimation I've made is sufficient, that's a matter for you.

MR MACSPORRAN: Certainly, Mr Commissioner. I'd be content to have a number of documents tendered for the record that deal with the position of Miss Hunter from yesterday.

COMMISSIONER: Yes.

MR MACSPORRAN: This witness today and the witness Law who is to come.

COMMISSIONER: Perhaps, Mr MacSporran, if you don't mind, I can put it this way: Mr Gaddes, do you make any criticism at all of Mrs Mulligan's handling of the matter when you went to see her?-- No, no, not at all, not at that point in time. Perhaps the only criticism I could make was following it up personally perhaps, but other than that, she did everything that her job description entails, I feel.

And would you agree with the suggestion that in terms of her presence in the operating theatre and in the wards and so on, that's very much a matter of management style and you've experienced Directors of Nursing who handle things the way Mrs Mulligan does, you've experienced Directors of Nursing who are more hands-on?-- That's correct.

Different people have different styles; is that a fair summary?-- I think that's a fair assumption.

Does that help your position?

MR MACSPORRAN: It certainly helps my position, thank you, Commissioner.

COMMISSIONER: Very well.

MR MACSPORRAN: Just a couple more matters, Mr Gaddes. One of your concerns was that there wasn't personal feedback to you having a complaint made to her on the 7th of January to you in person, you got no direct feedback from her?-- Not directly, no.

But in fact, you got feedback from your next in line of command, the Acting Nurse Unit Manager, Gail Doherty?-- Yes.

And what Miss Doherty told you was that she had raised your concerns with Miss Mulligan and Miss Mulligan had responded to her, she was aware of them and they were being treated seriously and there was an investigation proceeding?-- Yes.

So you knew in fact what had been done about your complaint?-- Yes.

But not from the Director of Nursing herself?-- No.

You understand, no doubt, how busy her role was?-- Yes.

Would you still have liked to have some personal contact with her about these things, would you?-- I've experienced other Directors of Nursings to have the same workloads and busy

issues as Mrs Mulligan's has and still manage to be personal.

Management style again?-- It's plausible.

But you were left in no doubt from a number of sources that your complaints had been taken seriously?-- Yes.

All right. Could I tender that file note, Mr Commissioner?

COMMISSIONER: Yes, the file note of Mrs Mulligan.

MR MACSPORRAN: It's dated the 7th of December 2004 but that's clearly, it seems, an error.

COMMISSIONER: Yes. The way I'll record it, if this is appropriate, is the file note of Mrs Mulligan dated 7/12/04 relating to a meeting on 7/1/05. Yes, that's Exhibit 147.

ADMITTED AND MARKED "EXHIBIT 147"

MR MACSPORRAN: Thank you. Could I also tender this document which is a e-mail from Ms Mulligan to Mr Leck of 7th of January referring to the meeting with theatre staff including Mr Gaddes. I don't require that on the screen but I'd like to have that on the record at this stage if that's convenient, Mr Commissioner?

COMMISSIONER: This is from Mrs Mulligan to Mr Leck, e-mail of 1 - look before that comes in as an exhibit, I'd like that shown to Mr Jackson in case he has an objection to it.

MR MACSPORRAN: Certainly.

MR JACKSON: I have no objection.

COMMISSIONER: Thank you. Exhibit 148 will be e-mail from Mrs Mulligan to Mr Leck of 7/1/05, and do you wish to include the handwritten note as part of the tender?

MR MACSPORRAN: Yes, thank you, yes.

COMMISSIONER: Yes, with handwritten note of 14/1/05. Yes, that's Exhibit 148.

ADMITTED AND MARKED "EXHIBIT 148"

MR MACSPORRAN: Mr Gaddes, just in respect of that matter, after you had the meeting of the 7th, you undertook to supply documentation to Ms Mulligan, did you, by way of a statement?-- Yes.

You did that after the meeting?-- I had already done a draft copy prior to that and formally completed one after that, yes.

And the other two nurses, Zolak and Law did the same to your knowledge?-- Oh, they can speak for themselves, I think.

And your statement went to Miss Doherty; is that so?-- Yes.

And you expected that would be forwarded on to Ms Mulligan-----?-- Correct.

-----as she'd requested. All right. Could I tender the next file note which is a file note of Ms Mulligan dated the 14th of January 2005 referring to a subsequent meeting with the nurse unit managers?

COMMISSIONER: File note of Ms Mulligan dated the 14th of January 2005 will be Exhibit 149.

ADMITTED AND MARKED "EXHIBIT 149"

COMMISSIONER: Do you mind just pausing for a moment as I think the Deputy Commissioners - or would you have spare copies for the Deputy Commissioners?

MR MACSPORRAN: I have one copy.

COMMISSIONER: Well, that will allow Sir Llew to read it simultaneously.

MR MACSPORRAN: Yes. Mr Gaddes, just to make clear what we're doing, you would expect that Ms Mulligan would have ongoing direct contact with the nurse unit managers about these issues?-- Yes.

And as you've told us, you'd hear from them or from your direct nurse unit manager, in this case, Gail Doherty, what was going on?-- That would be the line of communication.

Thank you. I've covered that with you but I'll just show you another e-mail, it's between Ms Mulligan and your then Nurse Unit Manager, Gail Doherty of 14 January. If you know how to read those things, you'll see that it's a response from Ms Mulligan to Miss Doherty in respect of an e-mail from Miss Doherty to Miss Mulligan indicating that you've been kept informed of what's happening?-- It says here there's just with a meeting with you on Thursday, that could be about any subject matter.

Okay, but just carry on, what's it refer to there?-- "Staff involved and they understand what is happening.

And that's around the time that you had submitted your

statement about the event that had occurred in December the previous year, isn't it?-- Well, I assume so.

And that's about the time that you had received feedback from Miss Doherty about what Ms Mulligan was doing about your complaint?-- Yes.

Thank you. I tender that e-mail dated 14 January 2005.

COMMISSIONER: Mr Gaddes, you'll understand this isn't like a criminal trial where everything has to be proved beyond reasonable doubt?-- Mmm.

You'd agree it's a pretty fair inference that this is flowing from your meeting with Mrs Mulligan?-- Oh, I'm just assuming, yes.

Yes. Exhibit 150 will be the e-mail from Mrs Mulligan to Gail Doherty of the 14th of January 2005.

ADMITTED AND MARKED "EXHIBIT 150"

MR MACSPORRAN: Your Honour, I next tender an e-mail that relates to the Michelle Hunter issue if it's convenient at this stage. The e-mail from Mr Leck to Miss Mulligan of the 5th of January relating to a letter from Michelle Hunter.

COMMISSIONER: Again, has Mr Jackson seen this?

MR JACKSON: I have no objection.

COMMISSIONER: Thank you.

MR MacSPORRAN: Together with a handwritten notation, please, Mr Commissioner.

COMMISSIONER: Exhibit 151 will be the e-mail from Mr Leck to Ms Mulligan dated the 5th of January 2005 together with the handwritten note of the 6th of January 2005.

ADMITTED AND MARKED "EXHIBIT 151"

COMMISSIONER: I'll just mention that that e-mail contains the name of a patient which is the subject of a suppression order, patient P26.

MR MacSPORRAN: Yes.

COMMISSIONER: So that version will be doctored before it is made public.

MR MacSPORRAN: Thank you. The next is effectively an e-mail in response from Ms Mulligan to Mr Leck of the 5th of January 2005 with some handwritten notes. Again it relates to the Hunter issue.

COMMISSIONER: Yes. The e-mail of the 5th of January 2005 from Mrs Mulligan to Mr Leck together with the handwritten note of the 6th of January 2005 and a further handwritten note of the 10th of January 2005 will be Exhibit 152.

ADMITTED AND MARKED "EXHIBIT 152"

MR MacSPORRAN: Thank you. The next is a memorandum to Michelle Hunter from Linda Mulligan dated 5 January '05 referring to a complaint lodged by Ms Hunter. That was referred to by Ms Hunter yesterday in evidence I understand, Mr Commissioner.

COMMISSIONER: Yes, Exhibit 153 will be the memorandum from Mrs Mulligan to Nurse Hunter dated the 5th of January 2005.

ADMITTED AND MARKED "EXHIBIT 153"

COMMISSIONER: That's 153.

MR MacSPORRAN: Just in terms of who was acting in position of

Nurse Unit Manager Theatre during that December/January period, do you recall there being two nurses acting month on, month about?-- The role was interchanged between Dave Levings and Gail Doherty.

Dave Levings was there in December '04 and Gail Doherty was the Acting Nurse Unit Manager Theatre in January '05?-- That might be right, yes.

Now, could I take you just finally to para 42 of your statement on page 14?-- Yes.

You mentioned this towards - right towards the end of your evidence-in-chief. You were clear that Ms Mulligan told you she wasn't aware of the five deaths that you referred to?-- Yes.

But you go on to say she made some comment about them not filling the criteria for reporting or something like that?-- Yes.

That's why she wasn't aware?-- Mmm.

Right. I suggest she didn't make that comment to you at all. She simply said she hadn't been aware of the five deaths you referred to?-- I later on said, "How could this not come to your attention?", and it didn't fall within criteria that would flag her attention.

Okay. So that's your summary of what she was trying to convey to you about how she could not be aware of those deaths?-- Mmm.

Is that right?-- That's plausible, yes.

So was the effect of what she was saying that absent an incident report highlighting the death, she wouldn't otherwise have found about it? Is that the effect of?-- An incidence report isn't just to flag people's deaths.

No, I understand that, but what other records that she would be given would reveal those five deaths in your opinion?-- I understand that the Director of Nursing do receive a basic summary of the goings on in the hospital as far as patients are concerned.

Well, mention has been made of the theatre register?-- Mmm-hmm.

That wouldn't record outcomes, would it?-- Not always, no.

It would most often record procedures being undertaken but not the outcome?-- That's correct.

Other records might refer to a patient being returned to theatre without going into the detail of what happened?-- That can be possible, yes.

Anyway, whatever the situation was, she was telling you that she wasn't aware of the deaths and had seen no documentation that alerted her to those deaths?-- That's right.

COMMISSIONER: And you had no reason to doubt what she was saying to you?-- No, no, not at all.

MR MacSPORRAN: Excuse me. Just to be clear about one thing, Mr Gaddes, you don't know how the situation arose that Ms Mulligan found out about your concerns, do you? We've covered that to some extent. You think that Mr Levings told her in December?-- Well, I spoke to David Levings and it was followed up by Linda Mulligan then. I assumed that that would be how it got there, that's all I know.

That's all - you don't know the mechanics of it. You know that you were told - she'd been told and that she then had a meeting with you?-- That's correct.

We do know the meeting that she had with you was in fact on the 7th of January, it seems?-- Mmm-hmm.

And that she was on leave until the 4th?-- Yes.

Okay. Now, you've assumed that all along that your concerns were passed to her by your then Acting Nurse Unit Manager Mr Levings in December?-- Yes.

As opposed to some other mechanism in January?-- I guess so, yes.

Either way, she became aware of it and dealt with it by meeting you personally?-- Yes.

Thank you.

COMMISSIONER: Mr MacSporran, before you sit down, when Mr Morrison was here, I think two weeks ago it was now.

MR MacSPORRAN: Yes.

COMMISSIONER: I raised with him a possibility, because I'm concerned, quite candidly, that your presence and that of Mr Morrison are obviously premised on the assumption that Mrs Mulligan needs to be protected against any possible adverse conclusions. So far as I'm aware from the evidence so far, there really is no basis for any adverse findings against Mrs Mulligan beyond general matters as we've talked about, managerial styles and that sort of thing, which wouldn't be the subject of the criticism beyond potentially, and I'm only guessing at this stage, suggesting in our ultimate report that that style of management is less desirable than other styles of management, not in a sense as criticism of her but as encouragement to Queensland Health to-----

MR MacSPORRAN: Change the system.

COMMISSIONER: To change the system.

MR MacSPORRAN: Yes.

COMMISSIONER: I'd ask that you give some thought to raising with senior counsel assisting Mr Andrews the possibility, for example, of a letter of comfort that would allow Mrs Mulligan in - Mrs Mulligan's mind to be put at rest and also to save some money by her not needing to continue to be represented when it may be we're just starting at shadows.

MR MacSPORRAN: Yes, I'd be grateful for that course to be adopted, Commissioner.

COMMISSIONER: Yes, yes.

MR MacSPORRAN: The only reason we are here, as you've said, is to protect her interests and on the evidence that's before the inquiry thus far, there would seem to be no basis to make any adverse finding against her, as you've said.

COMMISSIONER: And I can well understand the concern that she was, I believe, stood down pending the resolution of these issues.

MR MacSPORRAN: Yes.

COMMISSIONER: And it's only natural that someone in that position would wish to fully defend her position. But at the moment, it doesn't seem that there is anything at all to defend herself against.

MR MacSPORRAN: No. And perhaps more particularly though, in the ordinary course Ms Mulligan will give evidence to this inquiry.

COMMISSIONER: Yes.

MR MacSPORRAN: She is in the process of compiling what is a very detailed but appropriately detailed statement about all of the issues that have arisen. She deals in that statement comprehensively with these issues and it might be a case where if that's provided reasonably quickly to senior counsel assisting, that might facilitate the process of providing that letter of comfort that you've mentioned. A lot of these issues that have arisen can be explained by her completely but she won't have the opportunity for some time yet.

COMMISSIONER: And it's regularly come up that - and Mr Gaddes is a good example of it, he only saw the tip of the iceberg and he knew that a complaint was made to her but didn't know how that complaint was dealt with and how she passed it on to other people within the executive and so on. So what might initially have appeared as a criticism of Mrs Mulligan, you don't have to scrape very far below the surface to realise that you're just not getting the entire story.

MR MacSPORRAN: That's exactly correct. She has a wealth of documentation which paints that very picture. She has

documented all of these contacts, these e-mails, these file notes. They will all be annexed to her statement and paint a very clear picture that she did everything she could and appropriately.

COMMISSIONER: Yes.

MR MacSPORRAN: And that should be noted for the record.

COMMISSIONER: My other concern is, particularly in the context of things that have been said within the last 72 hours, that by providing your client with a letter of comfort, that might be suggested that we're somehow focussing the blame more on other individuals. But so far as I'm concerned, if there is no evidence to found any allegation against your client, that fact should be recognised as soon as possible, and if there are others who have to remain in the proceedings, that's a matter for them.

MR MacSPORRAN: Yes. The only - the only submission I'd make, Mr Commissioner, in addition to what I've said already is that even if there was a letter of comfort given, firstly, it would depend upon the terms of that.

COMMISSIONER: Of course.

MR MacSPORRAN: Secondly, there would be possibly some residual concern that evidence might be led that might in some way make adverse comment about Ms Mulligan's position.

COMMISSIONER: Yes.

MR MacSPORRAN: I would expect in those circumstances Ms Mulligan would be given advance warning of that and have the option to deal with those issues if that they were to arise.

COMMISSIONER: Yes. I also want to make it clear that I have appreciated both Mr Morrison's and your assistance because your cross-examination has brought out matters that might not otherwise have come to our attention. So the last thing I want to do is deprive ourselves of the benefit of your assistance but it sounds like it would save significant amounts of money and, more importantly, put Mrs Mulligan's mind at rest if we could arrive at some sort of outcome like that. In any event, I will leave that as something you can take up with Mr Andrews and we will deal with that as promptly as we can if we receive such a submission.

MR MacSPORRAN: Yes. And, of course, I will need to get specific instructions.

COMMISSIONER: Of course, yes. That's understood.

MR MacSPORRAN: Thank you.

COMMISSIONER: Mr Farr.

MR FARR: Thank you, Commissioner.

CROSS-EXAMINATION:

MR FARR: Mr Gaddes, my name is Brad Farr. I'm appearing on behalf of Queensland Health and you'll be pleased to know I only have a few questions to ask of you. You have spoken in your evidence and you have at least inferentially stated in your statement that there is a perception of a culture of intimidation or reprisal amongst some of the staff at least if they are to make a complaint or are contemplating making a complaint of some kind. I take it that you have in the course of giving your evidence and preparing a statement been very careful in the choice of the words that you've used and that perception is the considered choice that you've taken?-- Yes.

And do I understand by the word "perception" in the context that you've been using it, that you mean by that a fear or worry that if I was to complain, that it might backfire on me in some way in the future?-- I think it is probably more along the lines of a general concern amongst the individuals that I work with. That's how it comes across.

Right. Okay. Do I understand your evidence correctly that one of your hopes for the rectification of whatever needs to be fixed is that not only will there not be a culture of retribution or retaliation but also that whatever the system changes might be, it will remove even the perception of such things?-- If you removed the perception or the tyranny or fear factor of things, constructive criticism can flow either way and we can keep the standard and increase it.

So I take it that you have - well, I'll take it back just one step. In so far as the issues relating to Dr Patel are concerned, do I understand that there was a particular concern of the potential for retribution because of Dr Patel's behaviour and comments over the time that he was working at the Bundaberg Hospital?-- Yes.

For instance, you have heard him or heard of him being critical of staff, threatening to resign or threatening to get someone dismissed?-- Mmm.

I dare say, knowing the personality of the person with which you were concerned, that would have done nothing other than heighten the concern that it somehow could backfire if a complaint is made?-- I suppose so, yes.

You would also recognise, I take it, that in any given system, a lot depends upon the personality of the person concerned as to what steps they take once they have decided that they have a complaint or a problem of some description?-- That can be one of the factors.

I'm not suggesting it's the only factor but it is certainly a factor, is it not?-- Yes.

And I think, in fact, you really, to be fair to you, have given us an example if you like in the course of your own statement where you have, on separate occasions, been to two different Nurse Unit Managers of theatre. I think one was an acting-----?-- They were both acting.

Both acting?-- Yes.

Thank you. And got quite different responses if you like, both of whom nevertheless were working under the same system?-- Yes, that's true.

All right. And so, you would agree with me I take it that when one is endeavouring to improve the system, one will need to take into account very carefully, I suppose, human nature to try and do whatever one can to overcome the reticence of even a shy personality if you like?-- That could be a factor definitely.

Could I also ask you just a couple of questions in relation to the issue you raised in your addendum statement, which I think is in relation to patient P31 if I remember correctly. You have noted in that statement that you had a discussion with Dr Carter before the surgery or before the procedure occurred regarding the nature of the anaesthetic to be used. That's correct?-- The nature of the anaesthetic and the rationale for procedure, yes.

Yes. As I understand your statement, the issue was raised as to why, for instance, a general anaesthetic would not be preferred over a local anaesthetic?-- Mmm-hmm.

And you were advised by Dr Carter that he was concerned that the patient was a high risk if a general anaesthetic was used?-- That's correct.

Your statement, effectively, on that conversation ends there. Do I take it from that that Dr Carter then did not go through with you the rationale behind the opinion that he held in relation to that matter?-- Basically, just discussed that giving the gentleman a general anaesthetic would be - could have drastic outcomes basically.

All right. So it would seem from your understanding of this that the nature of anaesthetic was certainly something that appeared to have been well considered by the anaesthetist involved prior to the procedure itself?-- It was well considered, yes, I-----

Okay. Now, I notice that you have voiced in the course of your evidence here today some concerns as to whether in fact a general anaesthetic might have been the better option as opposed to the local anaesthetic, but do I understand your evidence to be that you were doing no more than raising an issue that might be relevant for some consideration? You're

not, for instance, saying that your opinion is right and Dr Carter's is wrong?-- I'm not saying my opinion is right.

Okay. Thank you. Yes, that's all, I have, thank you.

COMMISSIONER: Thanks, Mr Farr. Any re-examination?

MR ALLEN: Not from me, thank you, Commissioner.

MR MORZONE: Nor me, thank you, Commissioner.

COMMISSIONER: Mr Gaddes, thank you for coming along and giving evidence. We appreciate the frank and forthright way in which you have given it and your helpful answers to all of the questions that have been asked, and you're excused from further attendance?-- Thank you.

WITNESS EXCUSED

COMMISSIONER: Mr Farr, at a convenient time, there's something you might help us with. The two Deputy Commissioners and I thought it was appropriate that while we're in Bundaberg we should take the opportunity to view the hospital, principally to get a sense of the relationship between the various parts of the hospital which have been the subject of evidence, the theatre, ICU, surgical ward, medical offices and so on. We realise that it is a busy practising hospital. We don't want to interfere in any way with the treatment of patients and medical and nursing and other staff going about their ordinary business. I wonder if you could make inquiries through Queensland Health with the hospital management as to when would be the most convenient time to do that so as to create the least disruption.

MR FARR: I'll certainly do that. Can I ask if there is a preferable time so far as the Commissioners are concerned?

COMMISSIONER: Really, any time while we're in Bundaberg. It would be pointless coming back just to do that. I should indicate to everyone here that whilst we wouldn't discourage counsel or solicitors from coming along, obviously the bigger the crowd, the more disruption there is going to be. We are not going to be speaking to anyone or really doing any evidence gathering, more getting a sense of what the venue is like, so I don't see any need for all the lawyers to come along. And it may be, Mr Farr, that you can find someone who is entirely noncontroversial so far as these proceedings are concerned-----

MR FARR: Yes.

COMMISSIONER: -----who can show us around.

MR FARR: Certainly.

COMMISSIONER: For example, I know Dr O'Rourke is filling in for the time being. He is not in any way involved in the Patel matters. He happens to have been involved in training Sir Llew many years ago, so he might a sort of non-controversial source.

MR FARR: I am sure we can organise a tour.

COMMISSIONER: Thank you. Mr Morezone.

MR MORZONE: Yes. I call Martin Brennan.

COMMISSIONER: Thank you.

MARTIN JOHN BRENNAN, SWORN AND EXAMINED:

COMMISSIONER: Do you have any objection to your evidence being videoed filmed or photographed?-- No, Commissioner.

Thank you.

MR MORZONE: Your full name is Martin John Brennan?-- That's correct.

You're a registered nurse and have been so since 1982?-- That's correct. I trained in the UK from '79 to '82 and I started work in intensive care there and I've worked in intensive care for the last 23 years.

COMMISSIONER: Could I ask, I'm sorry, to keep your voice up a bit because we all need to hear what you're saying?-- Sorry. I'm what you'd call an overseas trained nurse I suppose.

Yes?-- I trained in Belfast in 1979 to 1982. I started work in intensive care for - just shortly before my training finished. I've worked in intensive care in the UK, Northern Ireland, Middle East and in a number of hospitals in Australia over the last 23 years.

MR MORZONE: You're presently employed as a clinical nurse in the Intensive Care Unit at the Bundaberg Hospital?-- That's correct.

And you have worked in that position since about 1991; is that right?-- 1990 actually.

You were involved in the care in that unit of both Mr Kemps and also patient P26?-- Could I ask one thing? Beforehand, normally you've been asking if the statement I have is correct or if there is any changes. There was a - one issue or one section that I wanted to correct. On page 5 paragraph 20, when I made the statement I mentioned that the average hours of ventilation were around 100 hours a month. Subsequent to

making the statement, I've gone back and checked the records and the figures are actually around the 200 mark, which I think there's been two months in the last two, three years where it's reached 300. That is prior to Dr Patel coming.

COMMISSIONER: Sorry, so how should the paragraph now read?-- Sorry, the figure should just be around 200. Between 200 and 300 hours per month was the average prior to Dr Patel coming to Bundaberg.

MR MORZONE: So in the fourth line of paragraph 20, the 100 hours is changed to two to 300?-- The two to 300 hours, with occasionally 300.

COMMISSIONER: I think we have seen detailed statistics of that.

MR MORZONE: We have, yes.

COMMISSIONER: But there was something like a doubling or a bit over a doubling in the average?-- Sorry, I wasn't aware of that. I just wanted to correct that in my statement.

No, no, we appreciate the accuracy.

MR MORZONE: Are the facts otherwise contained in your statement true and correct to the best to your knowledge and belief?-- They are.

I tender the statement, may it please, Commissioner.

COMMISSIONER: Yes, the statement of Martin John Brennan dated the 18th of May 2005 will be Exhibit 154.

ADMITTED AND MARKED "EXHIBIT 154"

COMMISSIONER: Mr Brennan, as I mentioned before, you were involved in the care in the ICU of both patient P26 and Mr Kemps?-- That's correct.

You deal with patient P26 first in your statement, so we'll follow that order. The main issue that I wanted to ask you beyond your statement related to the source of your belief for the second paragraph in paragraph numbered 4 that Dr Athanasiov was in the process of contacting Brisbane for the transfer of that patient. This is after the patient returned from theatre for the first time?-- Mmm-hmm.

Is that correct?-- That's correct.

Were you present when you heard that or what's the source of that belief?-- I was present there. When patient 26 returned from theatre, on examination I checked and found that there was no pulse in his left leg. I contacted Dr Athanasiov, as

he was the surgical or assistant that had been involved in the operation. He came, he examined the leg and I suggested to him that the patient needed to go to Brisbane. He agreed with me. I was of the belief he'd gone over to the desk in the intensive care unit to make arrangements or to look at transferring the patient to Brisbane. A short while later he came back to the patient's side and said, you know, he'd spoke with Dr Patel and the patient wasn't going back to Brisbane - wasn't going to Brisbane. Dr Patel was - preferred to take the patient back to theatre in Bundaberg.

Okay. Can I ask you to go then to the treatment with Mr Kemps and, again, you set out in your statement in some detail your involvement there. But can I ask you in particular about, first of all, Dr Patel coming in on the morning of the 20th of December and noticing that there was no ventilated beds available. You refer to that in paragraph 9 of your statement?-- Right.

Do you recall that incident?-- I do. I probably need to go back a little bit further to explain Dr Patel's apparent reaction. I was on night duty, starting at 7 o'clock on the Sunday night the 19th. When we took handover from the day staff. We had a patient on a ventilator, patient P44. This lady had had a large cerebral bleed. The neurosurgeons at Royal Brisbane had contacted us in relation to it. We had received information that they felt there was nothing surgical available for her and that prognosis was poor. We were told at handover from the day staff that Dr Patel had instructed that the patient's ventilator be turned off at around 10 o'clock that night when some family members had had time to arrive and see the patient.

I was - at that time I was a bit concerned about it. One, there had been no brain death test done, which is not normal. I was also concerned Dr Patel was making this decision as patients on ventilators, on life support, are normally looked after by the anaesthetist, and the anaesthetist or intensivist was not available.

D COMMISSIONER VIDER: Was Dr Patel this patient's doctor?-- Dr Patel was there when the patient came in with a cerebral bleed that could be potentially operable. He was involved in the initial assessment and management of it, but a patient on life support is normally looked after by the anaesthetist and in terms of withdrawing the ventilators that is normally the intensivist that makes that decision.

But the person as principal medical officer under whom this woman had been admitted was Dr Patel?-- I can't be sure of that. Sometimes if they're admitted directly into emergency - they would be admitted to ICU and Dr Patel would be a consult. The intensivist - I'm not sure from an administrative point of view who he went in under.

I was just trying to determine what Dr Patel's relationship was with P44?-- Right. Because the lady had had a cerebral bleed, which potentially could require surgery, he would have been called in to see and look at the surgery side of things, if surgery was available, or whether it should be done. As I said, Brisbane - neurosurgical people in Brisbane had been contacted and the advice that I had been given - was passed on to me was that nothing surgically would be available, and that the patient's prognosis was very poor. I was also concerned, as well - I'm sure Dr Patel was making the decision by turning off the ventilator - I was concerned with the haste with which it was being done. The patient had only arrived in the unit, I think, that morning. It's not normal to make these decisions in terms of turning off life support without further tests and without, also, looking at other issues.

MR MORZONE: You are speaking there of the morning of the 19th, that is, the morning of the night before when Dr Patel first raised the matter the night before; is that correct?-- Yes. He apparently had given instructions during the day that the ventilator was to be turned off when the family members had had time to arrive, which was to occur on my shift at 10 or 11 o'clock in the evening. I was also aware at this time Dr Patel had a patient booked to come to ICU the next morning after an oesophagectomy, and I was aware the unit was full at this time and that there were - there would, therefore, be no beds and it would be impossible or it would be wrong to start the surgery in this circumstance on the Monday morning.

COMMISSIONER: So may I summarise your concerns as, really, three fold; one, the decision was being made by the wrong person, that is, Dr Patel rather than the intensivist?-- Mmm.

Secondly, it was being made without the appropriate clinical indicators having been obtained?-- Correct.

And, thirdly, it appeared to you it was being made for the wrong reason, that is, to free up a bed in ICU for another patient rather than-----?-- That was a suspicion I had.

Yes?-- I wasn't certain of it. I just had this feeling that this could be about Dr Patel's mind.

D COMMISSIONER VIDER: And your other concern was the fact the patient had only been admitted relatively less than 24 hours earlier?-- Normal circumstances would be to ventilate the patient, keep them on life support, do brain death criteria, which would establish if there was brain stem death. There are occasions where patients don't meet brain death criteria, but may not be compatible - the brain injury may not be compatible with life, in which case in the past we have had to use an ethics committee regarding the issue of withdrawing ventilators.

COMMISSIONER: Was there a functioning ethics committee at Bundaberg?-- Not at this time. There had been in the past. I know Dr Thiele was setting one up, but at this stage there was none functioning as far as I was aware of.

MR MORZONE: When Dr Patel came into the unit the following morning and saw that patient 44 was still there, what did he say to you?-- He got quite angry and demanded to know why the patient's ventilator had not been turned off as he had - why the patient's ventilator hadn't been turned off as he had instructed. I explained to him that the required tests, et cetera, had not been done; also, that we had contacted Dr Jon Joyner who was the anaesthetist on call on the Sunday night, overnight, and explained to him the situation. He said that he was completely unhappy to turn the ventilator off without the further tests having been done, and Dr Joyner, being the anaesthetist, to my mind had the, sort of, deciding choice. It was technically his patient, in normal circumstances.

What was Dr Patel's response to that?-- He got angry at the time I told him that the patient's ventilator hadn't been switched off and the reasons. He said, "I have a theatre case to do." I'd suggested to him that he would not be able to start his theatre case at this time because there was no beds available in the unit, and he stated that he had to do the theatre case that day because he was due to go on holidays in some days time and needed to be there to manage the patient postoperatively. This was fairly early in the morning. Dr Patel had a habit of coming into the unit quite early, sort of, 6.30 in the morning. We felt it was to avoid seeing the other specialists during ward rounds in intensive care. They weren't done, normally, until 8 o'clock. It was Dr Patel's practice to come in an hour, an hour and a half before that. When I explained to Dr Patel we hadn't turned the ventilator off, and the reason behind it, he explained he needed to do the theatre case that day, and he stormed off into theatre, which is next door to intensive care.

You returned to duty then that evening?-- That's correct.

And you found at that time that P44's ventilator had been turned off?-- That's correct.

And you spoke to Dr Carter?-- I'm not sure if it was that evening, but I did speak to Dr Carter within the next day or so and expressed my concerns, one, that the patient hadn't had brain death tests performed and, secondly, that the haste that this - with which this had been done - I mean, I'm - I'm not suggesting this patient would have survived the bleed, et cetera, but without tests nobody really knows for sure, and I felt this had been done with indecent haste, purely to provide Dr Patel with a bed for his patient.

D COMMISSIONER VIDER: When you have a situation where you are going to turn off the life support system, is it normal practice in the intensive care unit to have a case discussion with all the staff, medical and nursing?-- Not necessarily. The nurse who is the primary care giver and is trying to look after the patient will obviously be involved with talking with the doctors and, possibly, with the family. The situation has to be discussed with the family.

So whatever was the primary care nurse's opinion, obviously, that was not involved here?-- I wasn't on at this stage. The primary care nurse on the night duty while I was there was offered the same opinion as myself, that the ventilator should not be turned off, which is why we contacted the doctors, and then Dr Joyner to discuss it with him. On his instructions we didn't withdraw the ventilator.

And Dr Carter was the director of the intensive care unit?-- He came on the next morning as director of intensive care.

D COMMISSIONER EDWARDS: Your decision was on the protocols that existed?-- That's correct. It's normal practice to do these brain death tests. We were unhappy they hadn't been done. We contacted the consultant on all - overnight, and he agreed with us that we shouldn't turn the ventilator off until the tests, et cetera, had been done.

D COMMISSIONER VIDER: What was the patient's family told?-- The patient's family had been told by Dr Patel, apparently before I come on duty on the Sunday, that the patient - I was simply told the patient was brain dead and "we switched the ventilator off when the remaining family members arrived". Dr Patel was not there, actually, during the night when - after I come on at 7 o'clock in the evening. I didn't see Dr Patel until the next morning.

COMMISSIONER: I understand very much the points you made earlier about the indecent haste and Dr Patel's apparent desire to clear a bed in ICU so that you could use it for another patient and so on. I'm concerned, though, that some of the things you've been saying may be thought to reflect also on Dr Carter's decision. Now, if that's - that's what you're intending to convey, then that's fine, but-----?-- No, what I'm saying is that on the shift that I worked I was not happy that the patient should be switched off. I felt it was

being done too soon, the required tests hadn't been done, and that it was being done for the wrong reasons.

Yes?-- I'm - I was not there when Dr Carter came in, and I wasn't there when the ventilator was removed. I'm not really commenting on that part of it. That was a clinical decision for Dr Carter.

And I just want to make clear that there - because people can read things into this evidence that may not be intended, I want to make clear that you have no reason to doubt or suspect that Dr Carter failed to apply the appropriate clinical considerations in arriving at the decision?-- I don't think so. I - when I spoke to Dr Carter afterwards he said he was happy with the patient's clinical condition and that his actions were correct. I - I can't really argue with that. That's a clinical decision made by a consultant.

Would it be fair to say, from your dealings with Dr Carter over the years, he didn't strike you as the sort of man who would allow Dr Patel to twist his arm and force him into turning off a patient's ventilator unless he, Dr Carter, considered that was the right thing to do?-- I think that's the case. I can't remember specific examples, but I had the feeling occasionally Dr Carter would go along with Dr Patel on other issues because - not that he was intimidated by him, but because it was an easier course of action, not in any serious issues. It was minor issues they were discussing, very minor things.

Not in life and death matters?-- No, I don't think Dr Carter would - he would have felt he was doing the right thing.

MR MORZONE: That same night that you are speaking of when you returned to your shift and you spoke to Dr Carter, Mr Kemps was in ICU, had had an oesophagectomy performed earlier that day; is that correct?-- When I come on duty at 7 o'clock Mr Kemps had returned to theatre for the second operation.

Okay. About an hour afterwards you received a call to get Mr Kemps' family to come to the hospital; is that correct?-- That's correct. The theatre staff rang us and asked us to contact the family to come up, that Dr Patel wanted to talk to them.

And were you present when Dr Patel did speak to the family?-- That's correct. I took a patient - I took the family into the outside area of theatre and Dr Patel came out from theatre in his scrub suits and spoke to the family.

Do you recall what he said to the family?-- Yes. He - he explained that he had reopened his initial surgery, and that he had found the patient was bleeding heavily. He had checked his original surgery and that it - he felt it was perfect, there were no problems. He said he - he said this on a number of occasions, that his surgery was fine, that there was nothing wrong with it. He checked it. He went on to say that he was obviously bleeding, "I don't know where it's coming

from", and he gave them the impression that if it's the case there was a continuing bleed the patient would not survive.

The patient returned to ICU and continued to bleed heavily, as you have said in your statement, and earlier the next - or the next morning passed away; is that correct?-- That's correct.

Okay. That next morning you also had a further conversation or heard Dr Patel have a conversation about whether or not a coroner should be called; is that correct?-- Dr Patel come into the unit as normal, fairly early in the morning, and he - I'm not sure whether he directed it to the nursing staff or to one of the doctors that was there, but he said that he was quite happy, that he was - and he was aware of what the patient would die from, and that he would be quite happy to issue a death certificate, there would be no need to contact a coroner, it would not be a coroner's case.

Mr Commissioner, could I note that paragraph 13 the patient's name, P44, appears again and that should be corrected, obviously, and-----

COMMISSIONER: Yes.

MR MORZONE: -----others might note that.

COMMISSIONER: I noticed the same thing in paragraph five at the bottom of the first page, the 15 year old.

MR MORZONE: Thank you.

COMMISSIONER: Mr Brennan, we would normally take lunch about now. I just wanted to make sure that we're not going to cause you any inconvenience. I suspect, even if we went for another 15 minutes or half an hour, we wouldn't be able to set you free, so-----?-- I would doubt it.

-----would it be convenient for you to come back at 2 o'clock then?-- That's fine, Commissioner.

Thank you. We will adjourn until 2 p.m.

THE COMMISSION ADJOURNED AT 12.46 P.M. TILL 2.00 P.M.

THE COMMISSION RESUMED AT 2.07 P.M.

COMMISSIONER: Mr Brennan, if you don't mind coming back to the witness-box. Mr Morzone?

MARTIN JOHN BRENNAN, CONTINUING EXAMINATION-IN-CHIEF:

MR FARR: Commissioner, just before the evidence commences, just in response to the issue you raised earlier about having a walk around the hospital, I'm instructed that next - I'm instructed that next Wednesday morning would be a suitable time for hospital staff in that regard.

COMMISSIONER: Yes.

MR FARR: 8.45 has been a time suggested which might mean that we would start here, perhaps, at 10 o'clock rather than 9.30, if that's suitable to the Commission.

COMMISSIONER: Wednesday could be a problem for various reasons. I should have thought of that sooner. Wednesday might be a problem.

MR FARR: If that's a difficulty we can make alternative arrangements.

COMMISSIONER: Any other day, and that time of morning would be perfect.

MR FARR: All right.

COMMISSIONER: Thank you, Mr Farr. Mr Morzone?

MR MORZONE: Mr Brennan, before lunch we had finished discussing the case of Mr Kemps and we were moving onto a new topic which commences at paragraph 14 of your statement and, in particular, could I ask you about paragraph 14 where you refer to one of the junior doctors in ICU having told - referred to us, which I presumed means to nurses in ICU; is that correct?-- That's correct.

That Dr Patel had instructed junior doctors not to record complications. Now, were you personally involved in that conversation, yourself?-- I wasn't personally involved in the conversation. I don't specifically remember the junior doctor involved. However, I do remember it was confirmed by another junior doctor. We had a very large turnover of junior doctors through the unit at that time. I don't remember which specific ones actually said this, but certainly it came from two separate doctors.

Two separate doctors?-- Mmm.

Are you able to give us any details of their appearance or description of them or-----?-- They were both male doctors. I really don't know. As I say, we were having junior doctors coming in, working for a week at a time, two weeks at a time in the unit, and moving onto another - we had no permanent doctors based in the unit at that time. Also, other junior doctors would come in and discuss matters; it may have been a specific intensive care matters.

You stated in paragraph 16 you noticed many patients came to ICU from theatre with complications intraoperatively. Can you be more specific about those cases?-- I don't remember the specific patients. It was a pattern - I've been thinking about this to try and work out how many patients were actually involved. It could be - may be, perhaps, a dozen over a year, a year and a bit. There was a pattern that patients who would have surgery would go to recovery and would then come through to intensive care for postop management, and at the handover we were given from the recovery or theatre nurses - on a number of occasions they would say, oh, this happened in theatre or the bowel was nicked or a spleen was nicked or artery got nicked, and when we get patients sorted out you would start checking through the records. There was nothing actually written on the operation notes to that effect. I haven't specific examples. It's impossible to find them because, as I said, there's nothing written in the operation notes to identify those patients any more.

COMMISSIONER: Would it then be your practice to write anything in the progress notes within ICU?-- Not usually, no.

What-----?-- Looking back into time I probably should have. Sometimes - I mean, I may have been looking after the patients. Sometimes it could have been other nurse's patients. When a patient comes back from theatre the whole team, sort of, gather around to get a patient sorted out on the monitors, et cetera. So it may not have been specifically my patients.

D COMMISSIONER VIDER: Would it be an indication, though, if a patient was booked for a procedure, let's say a lap choly, and ended up with a complication, like they had their spleen removed-----?-- Mmm.

-----you wouldn't expect the patient to be coming to the intensive care unit following a lap choly, but if there was a complication that brought the patient to the intensive care unit, how would you be able to explain that, if it wasn't written in the notes?-- They were often - from recollection, most patients were probably not the ones who have gone - there were patients who have gone for, perhaps, bowel surgery, anyway, an event occurred during theatre that required some action, perhaps, you know, a larger amount of bowel being resected, et cetera.

So that mostly these were patients who were-----?-- Who were probably coming to intensive care, anyway. Without looking back and checking the charts, having nothing in them, it's very difficult to remember.

In your statement you talk about nothing being written on the patient's discharge summary, but you're now saying that there was nothing written in the record?-- There were gaps in the patient's operation record. We were being told events had occurred or certain instances happened in theatre, and when you look at the operation notes written by the surgeon or,

perhaps, the deputy these events were not recorded.

So then in this situation that would have meant that that patient's progress or that patient's disease episode would have been incorrectly coded?-- Correctly, yeah. The operation record is not where the coding comes from. My understanding is it comes from the discharge summaries.

It's one of the areas where it comes from, would be my understanding, because a code can look at the whole record, but if the whole record is subject to audit, and there are gaps throughout the record-----?-- Yes, then it's not going to show up.

-----that's a problem.

COMMISSIONER: And, also, the person who prepares the discharge summary, that person may in turn rely on what's in the theatre notes to-----?-- That's correct, Commissioner.

This is actually a major concern to us, Mr Brennan, because as you've probably read in the newspapers a report has been prepared and - by four medical people from Queensland Health which involves an analysis of the clinical records relating to patients and an attempt to identify those where deaths or adverse outcomes have been caused by Dr Patel's negligence. I'm sure you're familiar with that-----?-- Yes.

-----from the press. One of our concerns is that in many cases an analysis of the clinical records would not be definitive because those clinical records are merely Dr Patels's version of what happened rather than, necessarily, a complete and accurate version; is that a-----?-- That's correct. The staff - we felt that, ourselves, for a while. It would be very difficult to substantiate a lot of the events that may have occurred because there's nothing recorded.

Toni Hoffman and others have said to us that really to do any detailed clinical analysis, it would be necessary to, as it were, scrutinise every stage of the documentary records, from admission notes to theatre notes, to progress notes, to discharge summaries, and everything else along the way?-- Uh-huh.

But from what you are telling us, even that may not necessarily pick up things-----?-- I think certain cases would be missed, you know. It would be impossible to pick up these events.

Yes.

MR MORZONE: You mentioned before that you were disinclined yourself to make a note of those matters on the records, and in the next paragraph you refer to retrospectively that you could have persisted with the complaint mechanism but did not because of the culture. Can you extend upon that culture? In particular, you say that previously you had the experience that complaints had been ignored?-- Yes, the - my feelings - I did speak to Dr Carter on a number of occasions and also kept Toni Hoffman sort of informed of things occurring. More formal complaints - how do I put it - there was a general feeling in the hospital that administration didn't want to know about problems. I don't think that's to say sort of local level, I think also that filters down from corporate level as well. I mean, a good example of that is the last couple of days you have talked about the incidents of adverse reporting forms. Now, a few years ago these forms would normally - an incident form, for example where a patient fell, or received the wrong drug, or a nurse hurt themselves, or just basically incidents that had happened in a unit, these forms used to be kept in the patient's notes, the charts. However, this policy changed and these reports are now kept by DQDSU as part of a quality management process. I am not a real expert, but at a conference I was speaking to a barrister who dealt with health issues, and her comment on that was, "Well, this was part of Queensland Health's risk management strategy, because patients' notes are accessible under Freedom of Information", whereas quality management documents are not. And this would prevent patients finding out about incidents that occurred during a hospital stay. I was aware of this as other staff were aware. I was aware of a lot of incidences in the hospital where things had not been handled or reported - not specifically patient outcomes, but, I mean, there was a - the incident with Dr Qureshi, for example, where patients made allegations of serious criminal matters, nothing basically was done about that. I mean, the doctor continued working, was not suspended. There was no apparent investigation to us. You get the feeling, well, if I am complaining about maybe incompetence or negligence, and they are prepared not to do anything about serious criminal matters, what's the point in me complaining about minor - what to them would be minor issues.

COMMISSIONER: Mr Brennan, just following on from those

comments you have made, obviously one of the things we have to consider is whether these issues are the result of neglect, if that's the right word, by individuals or a system which is intrinsically neglectful. I take it you are not in a position to give us any indication of whether particular individuals within the hierarchy were responsible for suppressing these matters?-- Not really. I wasn't involved - I was aware of the incidents, for example, in relation to Dr Qureshi, but the action taken - I was aware he continued to work, he was still around the hospital despite, I think, three separate allegations being made against him. You have actually - earlier you were talking to Mr Gaddes and you mentioned the difference between how nurses and doctors were treated, and if a patient made an allegation of sexual misconduct against me or another nurse, we would be suspended, and quite rightly so, until it was investigated. In the case you were a doctor and these allegations were made, he continues working. In fact, there was an attempt even made to put him into intensive care to work, which Dr Carter sort of knocked on the head. But when you have this sort of an attitude, there is just a feeling, "What is the point complaining? What is the point in doing anything? It is not going to achieve anything."

I suppose what I was driving at, though, is, to take one example of your line superior of Mrs Mulligan, so far as you know, when complaints went to her she dealt with them in accordance with the system - and you might criticise the system but you are not in a position to say that that was her fault?-- I am not attaching any blame to Ms Mulligan or any of the other-----

Or, for that matter, Mr Leck or Dr Keating?-- No, no, because I wasn't involved in dealing with complaints. I know these incidents happened and staff in the hospital could see that nothing has been done about them, which I think led to a general feeling in the hospital that, okay, the processes are there to complain but nothing gets done about it, so what is the point.

On that subject we passed over paragraph 15 of your statement where you refer to claims made by Dr Patel to the effect that, "I can get what I want from Darren", which presumably means Dr Keating, "as I have just made this hospital $500,000."?-- That's correct. He has made that statement in my hearing.

He said that to you. You have no way of knowing whether that was true?-- No, but it created a feeling amongst staff that Dr Patel had a lot of influence that could achieve - this is the idea he gave staff, anyway.

Yes?-- Staff felt he was continually making statements to that effect, that he was indispensable to the hospital and he was untouchable.

I guess what I am asking again is you don't know Dr Keating's side of that story?-- I accept that.

Yes.

D COMMISSIONER EDWARDS: Traditionally, nursing notes have been very detailed in the progress of patients during hospital care?-- Uh-huh.

Do I get a view in your evidence that you were discouraged to produce those details in nursing notes?-- Not really. In relation to the - for example, the patients coming to us from theatre, I would have expected this would be documented by the nurses in theatre who were there when this event occurred. We were not in theatre when these events actually happened, we were going on what we have been told by - basically we were getting hearsay from theatre nurses as to what had happened in theatre, which makes it difficult as to how you write that, where you would write it.

MR MORZONE: Mr Brennan, in paragraph 20 you have made reference to noticing an increase in the number of patients being ventilated and you made the correction at the beginning of your evidence that we have heard about. You have attached to the back of your statement a document which you've said in paragraph 21 is a table of statistics kept by you?-- Uh-huh.

Do you see that?-- That's correct.

Can I ask you to have a look at exhibit 23 - I beg your pardon, Exhibit 93 as well? I notice your exhibit MB1 is part of that exhibit?-- That's correct.

The balance of the exhibit includes figures for earlier years?-- That's right.

Are those earlier years also statistics that were kept by you?-- That's correct.

By you personally or other staff?-- By me personally.

And does that also assist you in your statement that you make in paragraph 20 about the number of patients who were being ventilated increasing over the period Dr Patel was there?-- Yes, looking at the figures for ventilated and intubated hours for 2002/2003, as I corrected my statement the figures are in 200s, occasionally 300 up to about May/June 2003, which was around the time shortly after Dr Patel came. As you can see the figures there, there were 400, 600s, and many months in fact leading to 2004 there were around 7, 800 ventilator hours. Not all these patients obviously were surgery - we do ventilate patients other than that - but a large proportion of them were patients coming to us from theatre, often after minor surgery problems, problems like lap cholies, for example. We had a large proportion of patients who developed infections or wound breakdowns from microscopic cholecystectomies and would have to attend to theatre for laparotomy, and the condition often was such that they would come back to intensive care.

Since Dr Patel has left in April 2005, have you noticed a change in the figures again?-- The figures have dropped quite

a bit. Figures always fluctuate. I am aware over the last three or four weeks we have had a lot of ventilated patients, trauma, things like that, but as a general pattern, the figures have dropped. I think I commented in my statement that around October/November 2004, Dr Patel was away on leave, less surgery was being done and the ventilator hours dropped to 85 from 600 the previous month, which is a substantial change.

Thank you, Mr Brennan, that's the evidence-in-chief.

COMMISSIONER: Thank you.

MR ALLEN: Thank you, Commissioner. I do appear for Mr Brennan.

COMMISSIONER: Yes.

EXAMINATION-IN-CHIEF:

MR ALLEN: Mr Brennan, you were giving some evidence only a short time ago in relation to paragraph 17 of your statement regarding factors which impacted upon your willingness to take more formal steps by way of making complaints?-- Uh-huh.

And you were asked some questions about the fact that you yourself really can't speak as to what happened with complaints after they were passed up?-- That's correct.

All right. And I suppose one of the reasons for that would be that they were passed up through your line manager and that wouldn't be, for example, Ms Mulligan; it would go to your nursing unit manager?-- It would go to Toni Hoffman.

And passed up by her?-- That's right.

Did you ever act as a nursing unit manager for the ICU?-- Occasionally. I think there were five of the two in intensive care, and we would take it in turns relieving when a unit manager is on annual leave, et cetera.

Okay. Well, in the instances where you are acting in a normal position or acting other than nurse unit manager did you have any occasions to have contact with Ms Mulligan?-- No, Ms Mulligan was - basically was never seen around the hospital on clinical areas. I first saw her for the first time nine months or so after she had actually come to the hospital. That was only at a meeting where I was acting in a position. I actually never saw her in intensive care or I didn't see her until that time.

I see, all right.

MR MacSPORRAN: Can I just raise a point at this stage?

COMMISSIONER: Yes.

MR MacSPORRAN: This is the very reason that we are still here representing Ms Mulligan, because this hasn't appeared in any statement we have been given. It is perhaps said to be collateral to the issues, and yet it is being pursued. If I am to deal with this-----

COMMISSIONER: I understand.

MR MacSPORRAN: -----I want some notice.

COMMISSIONER: I understand entirely, Mr MacSporran. Mr Allen, the statement of Mr Brennan was prepared by the Nurses' Union, wasn't it?

MR ALLEN: That's so.

COMMISSIONER: It doesn't raise these issues.

MR ALLEN: It doesn't raise them directly, no.

COMMISSIONER: Well, you appreciate Mr MacSporran's point. It is rather unfair to take him by surprise with this sort of point? What does this go to?

MR ALLEN: Well, it goes to the factors which impacted upon this nurse and, one would expect by analogy, other nurses' willingness to advance and pursue complaints.

COMMISSIONER: But in a systemic sense, or by way of criticism of particular individuals?

MR ALLEN: Well, that's not a matter for this witness, it is a matter for submission, ultimately, by others.

COMMISSIONER: What's your objective? Are you setting out to criticise the individual or the system?

MR ALLEN: Well, at this stage I expect that there would be room for argument as to criticism of both.

COMMISSIONER: Well, my view is that if you and those you represent wish to mount a case critical of Mrs Mulligan in particular or anyone else, Dr Keating or Mr Leck, or any other individual, it really is a matter of fairness that you give them advanced notice of your intention in that regard.

MR ALLEN: These matters should come as no surprise. They have been voiced by other witnesses, in particular Ms Hoffman at the commencement of the hearing of this Commission.

COMMISSIONER: Why isn't it in the statement then?

MR ALLEN: Well, I didn't take the statement. It is often the case that witnesses - and we have seen many instances of them throughout this Commission - perhaps don't put everything they

can say to assist this Commission in a formal statement.

COMMISSIONER: But the point here is that the legal representatives - not you personally, but the legal representatives of the Nurses' Union prepared this statement. If they want to run a witch-hunt on Ms Mulligan, I will consider whether or not that's within the Terms of Reference, but I simply don't want something like that done by stealth.

MR ALLEN: My client is not running a witch-hunt against Ms Mulligan and I resent that implication. It is an unfair characterisation of the questioning of this witness.

COMMISSIONER: Well, I asked you what your purpose was now in pursuing this line of questions and you told me that it may be used at some stage to support submissions critical of Ms Mulligan.

MR ALLEN: Yes, and that's not fairly characterised as a witch-hunt.

COMMISSIONER: I see. All right. Well, I am not going to allow cross-examination on issues like this without fair notice to those who are likely to be adversely affected by it. How would you like to handle this, Mr MacSporran? Shall we ask Mr Allen to give an opening of what the case is he wants to present on behalf of the Nurses' Union?

MR MacSPORRAN: Yes, that would be helpful. I simply would like to know in advance of any suggestion that's going to be made that my client has failed to do her duty in any respect.

COMMISSIONER: I think that's fair enough. Does anyone else at the Bar table wish to contribute to this discussion? Mr Devlin, as always I value your submissions or-----

MR DEVLIN: Well, this appears in context, because the witness has also made observations from his own perceptions that nothing happened to Dr Qureshi, but this Commission has heard a lot of evidence of what did happen to Dr Qureshi.

COMMISSIONER: Exactly.

MR DEVLIN: It is very, very difficult to pin down gossip.

COMMISSIONER: Yes, I agree entirely.

MR DEVLIN: And everything is against the background of rumour and innuendo, which is rife amongst the staff. I intend to ask this witness about what he knew about what happened to Dr Qureshi. He obviously worked on impressions completely opposite to what did happen.

COMMISSIONER: I wouldn't like that to be understood as critical of Mr Brennan. He comes here to give evidence of what he knows, and one of the things he knows is that the staff, rightly or wrongly, had a perception that these things weren't being dealt with properly. Now, he is not in a

position to tell us whether that perception was valid or invalid; he is simply telling us that was the feeling amongst the staff.

MR DEVLIN: So it is no more than a communication issue. That's all it demonstrates, if that.

COMMISSIONER: And that's why I think it is very important that if, for example, Mr Allen wants to take these things further and say not merely that there was an impression, or a perception, or a belief, or a sense amongst the staff that Mrs Mulligan was letting them down, but to advance a positive case that she was in fact letting them down, of which I have not seen a whit of evidence to this moment, then that should be put very clearly so that Mr MacSporran knows the case he has to answer.

MR DEVLIN: Yes. It is probably not - probably doesn't go to any point in particular that a member of staff didn't see much of a senior member of staff. I mean, that could be said about almost any organisation at any given time.

COMMISSIONER: Yes.

MR DEVLIN: Probably doesn't go to any particular point.

COMMISSIONER: Yes. I mean, I have said a number of times - and I will only say very briefly again - partly it is a matter of management style, over the Coles Myer management style where the executives are on the top floor and no-one sees them, or McDonald's management style where the executive is part of the client service team who are visible to the public and dealing with public on a day-to-day basis.

At the end of this hearing, the members of the Commission may have views as to which style of management is more desirable and effective and we might make recommendations about that, but that's no reason to criticise an individual who is simply working in accordance with a system as it exists. If there is a problem, let's fix the system and not attack the individual. Mr Allen, I am inclined to let you take some time to get instructions about these things.

MR ALLEN: I don't need to, Commissioner.

COMMISSIONER: Yes.

MR ALLEN: I have taken the question as far as I intend to, but can I say that I am not here in the role of a prosecutor of anyone.

COMMISSIONER: No, no.

MR ALLEN: There is no need for me to particularise a case against any person, and it would be not only premature but unfair for me to formulate some type of case against Ms Mulligan when we haven't even had the benefit of a statement from her, and I don't propose to formulate any case

against her.

COMMISSIONER: Fairness is something that goes both ways. I mean, these Commissions of Inquiry are very different from Court cases where you have pleadings or formal charges or something like that. It is exploratory. I don't want to say more about that because it may be a question that arises in another proceeding in another place. But Commissions of Inquiry are exploratory. That's what it is all about. But if you, as the representative of one party, given leave to appear, wish to explore issues with a view to supporting accusations or allegations against someone else, whether or not that party has been given leave to appear, fairness requires that person be given advance notice. That's, I think, all Mr MacSporran is saying.

MR MacSPORRAN: That's so. I mean, I am quite content to let the questioning go ahead. If I know what's coming, I can deal with it. My client can give me instructions. But she is entitled, in fairness, to know what is going to be said. If it affects her reputation, which is everything to her, she values it, she wants to know what's going to be said.

COMMISSIONER: Yes.

MR ALLEN: As I said, I haven't finished my questioning.

COMMISSIONER: But that's not the point, Mr Allen. You have sprung this on Mr - I don't mean this as criticism of you either; you are doing, if you will forgive me for saying so, a particularly good job on behalf of your client and I am sure Queensland Nursing Union is appreciative of the work you have put into this and the efficient way you are running the case, but fairness goes both ways. I believe I have been very fair to you and your client and given you every opportunity to raise the issues they wish to raise. But when it conflicts with the rights of another party, then fairness also requires that party be given a reasonable opportunity to answer issues.

So I would encourage you, if you consider this sort of matter is going to arise again, to give appropriate warning to Mr MacSporran, or those instructing him, and if you don't do so, the consequence will be delay and inconvenience, or alternatively my preventing you from asking those questions.

MR ALLEN: Yes, that's understood.

COMMISSIONER: Thank you, Mr Allen.

MR ALLEN: Thank you.

COMMISSIONER: Mr Devlin? I am sorry, Mr Mullins, did you have anything?

MR MULLINS: No questions.

COMMISSIONER: Thank you. Mr Devlin?

CROSS-EXAMINATION:

MR DEVLIN: Ralph Devlin. I represent the Medical Board of Queensland. I take it you did not know that hospital management called the police about Dr Qureshi?-- I heard about that later on, yes

Well, you did say that you didn't think much happened about him?-- I did say that, but the doctor was continuing to work, he was still seen around the wards. I feel strongly that that would not have happened in my case and there is a difference in treatment-----

I take your point on that and we will explore that in a moment, but you did know, did you, that police-----?-- At a later stage. I didn't - it was quite a while later.

You did know, as a result of police interest, he had fled the country?-- That's correct. I had heard about that.

You did know the Medical Board was advised by hospital management?-- Not until I read it in the transcripts of this Commission.

All right. Is your point really this: that - sorry, there is one other element to this: you did know that Dr Qureshi, on the direction of management, had to have a chaperone when near female clients - patients?-- Yes, I have heard that.

Well, there are a number of areas in which activity occurred to your knowledge?-- The point I am trying to make is he was still allowed - there was a difference in the way he was handled. This was, to me, very serious allegations, and I am quite certain if it was made against me or any other nurse, for example, I would not have been working the next day.

All right?-- I wouldn't be working the same shift.

The systemic point you make is a doctor like Qureshi might have been allowed to work, but with a chaperone, whereas a nurse would have been suspended, and that's really the point you are making?-- I am pointing out it gave no-----

Is that the point you are making?-- I am trying to point out more that the way this seemed to be handled by the staff in hospital gave us no confidence that management would deal with problems appropriately.

Well, if you are making the bigger question, then I must pursue it again, just briefly. You knew that the police had been called?-- Not at that stage, at the immediate stage. It was much later on when I realised - I discovered the police had been involved.

Well, you do not know whether the police were called or

involved as soon as matters involving allegations involving Dr Qureshi came to light, you just do not know the timing of that?-- No, I don't.

Thank you. You do not know the timing of hospital management involving the Medical Board in an investigation of Dr Qureshi's alleged actions, do you?-- No, I don't.

Thank you. You do not know the timing of hospital management requiring Dr Qureshi to be chaperoned?-- I don't know - well, I heard about it some days later, that he was to be chaperoned when he was dealing with female patients.

Right. So I thought the point you were making was that nursing staff are more likely, in that circumstance, facing those sorts of allegations, to be suspended than a doctor? Is that the point you are making?-- In part, yes.

Well, how do you make the point that hospital management appears to have been beset with inactivity on the question of Dr Qureshi when you do not know how soon after the allegations arose that the police were involved and the Medical Board were involved? How can you say that?

COMMISSIONER: Mr Brennan, don't answer that question at the moment. Mr Devlin, I don't think Mr Brennan has said the management was beset with inactivity. What he said was that there was the perception amongst the staff that management was beset with inactivity because they saw nothing happening. It doesn't go beyond that, does it?-- No.

MR DEVLIN: I will pursue that then. Is there something to be said for determining whether the allegations are true before staff, all and sundry, are told that the police have been summoned? Can you see any value in that, that management just get about their business and see if the allegations have any substance?-- I can see that's necessary, yes.

Thank you.

COMMISSIONER: Would you agree that as a nurse you would also prefer to have people investigate the substance of things before all and sundry had to learn about it?-- Yes, but I would still expect at the same time that direct action would be taken to remove me from an area where these allegations have been made to prevent that. I mean, I would not have expected somebody with serious criminal allegations would be allowed to continue working in the ward.

The point you make are two-fold really: one is that you think that there is in fact a difference in treatment between medical staff and nursing staff, as illustrated by the situation with Dr Qureshi?-- Mmm.

And the second point is that, rightly or wrongly, members of the nursing staff and other people within the system felt reluctant to make complaints because when serious complaints were made, like those concerning Dr Qureshi, you were left

with the impression that nothing was happening?-- That's correct.

Mr Devlin, do you wish to take that any further?

MR DEVLIN: No, thank you.

COMMISSIONER: Thank you. Mr Diehm?

MR DIEHM: Yes, Commissioner.

CROSS-EXAMINATION:

MR DIEHM: My name is Geoff Diehm. I am counsel for Dr Keating. Could I ask you some questions about the final topic in your statement, Mr Brennan, concerning the ventilated patients? Now, a couple of propositions. Firstly, is it right to say that the number of ventilated patients in ICU or, indeed, perhaps putting it another way, the number of ventilated patient hours in ICU have typically involved a split between patients who are surgical patients and patients who are from the CCU?-- No, generally CCU patients would not be ventilated. Patients on ventilators would be intensive care patients, they would be patients post-operative, or patients who come through part of emergency medicine, following trauma, et cetera. But as a general rule, very few cardiac patients would end up on life support.

Thank you. The split between surgical patients verses other patients-----?-- Mmm-hmm.

-----on ventilators, is it the case that it is normally such that the number of surgical patients is less than the number of other patients, so in other words, that it's less than 50/50 in favour of surgical patients?-- Do you mean specifically patients on life support or-----

Ventilated patients?-- -----ventilated patients?

Ventilated patients?-- It's very very difficult to say. It varies, I don't - the figures we've done on the statistics I keep are mainly to look at unit activity, Toni has to prepare a report each month based on the costs centre budget, she has to analyse that and prepare reasons as to certain areas and previous months and these figures are collated to provide us with data as to the unit activity. I don't - and this data here on that spreadsheet differentiates between patients ventilated for surgical reasons or for other reasons.

Yes, all right?-- From recollection though, generally, it could say be 50/50, however, I think I said in my statement, when Patel came there was a noticeable increase noted by all the staff in the unit, that the number of surgical patients we were ventilating had increased and for markedly longer periods.

There was an increase though at the same time, wasn't there, in the number of patients and/or the number of patient hours on ventilation for non-surgical patients?-- I can't differentiate that from this, no.

Mr Brennan, another proposition that I will put to you to see if you have any comment on it is that in the two year period or thereabouts that Dr Patel was at the Bundaberg Hospital, that he - of his patients, there were 24 who were ventilated for more than 24 hours?-- I can't comment on that, I don't know the figures.

No-one would be surprised that you couldn't comment on the precise figure, but is that sort of figure your impression or would you have - was your impression that it would have been many more?-- My impression was that it would have been higher.

And when you say "higher" are you saying in small degrees or large degrees?-- The total number of patients ventilated is possibly higher, the total number of hours ventilated would be substantially higher. The patients receiving post-operative were often patients who'd been back to theatre one, two or three times and were requiring long term ventilatory management, sometimes more than one to two hours which is why the hours were so markedly increased. The actual number of patients was not a precise problem, it was the length of time that they would require ventilation because of problems with infection, septic shock, et cetera, as a result of surgical problems.

Thank you. Now, I just want to look then at this table that you've referred to in paragraph 21. You say in there you make the point about the November figures for ventilated patients and ventilated hours being down markedly. You say that that coincided with Dr Patel taking a period of leave. Is it your recollection that he was away at that time?-- He was away around that time, I don't precisely know when he was away, I do remember he was away for a period and there was a lot less surgery being done in his absence.

Now-----

COMMISSIONER: Are you suggesting it might have been not so much or not only while he was away but in the lead-up to his going on holidays?-- Possibly in the lead-up and also the fact that a lot of the patients were where problems occurred down the track from the initial surgery, he may not do the surgery - he may do the surgery one day and the problems may occur a few weeks later and we'd find them in intensive care, so it's difficult to correlate the exact month of November that when Dr Patel would have been away.

MR DIEHM: If I can ask that this document be put on the screen please? Now, there are three pages to this document and what it - that what they each demonstrate is the periods of leave that Dr Patel had of different types. Now, we can see from that document that Dr Patel finished a period of leave on the 2nd of July 2004 and that he commenced his next period of leave on the 27th of December 2004?-- That's correct.

Now, if that is the true position with respect to his leave, then that tends to demonstrate, does it not, the assumption for the drop in the hours that you have made is not right, and if I could take that a little further Mr Brennan, because not only was he not on leave in November, but he wasn't on leave, for instance, in September or October with the flow-on effect that you mentioned and didn't go on leave until very late in December, in which case he was unlikely to be winding down surgical patients leading up to taking that leave?-- I can't explain that. I was under the impression, talking to medical staff, that Dr Patel was not around in November when we were looking at these figures.

Yes, all right. Don't be concerned, Mr Brennan, I'm not about to launch an attack upon you for what is apparently a mistake, but the point being in short, there must be some other explanation for the fluctuation of the hours in November?-- As I said earlier, the hours do vary substantially or they vary from month to month. I cannot give you any explanation for November.

All right, and just to make sure that I'm being completely fair to you, I said this is a three-page document?-- That's correct.

If we go to the second page please, Mr Assistant? And it

deals with different types of leave, I just want to make sure that I'm not missing something. This deals with study leave and with special leave, standdown time and so on?-- Mmm.

Now, you tell me if you think there's any period of leave there that needs an explanation for the assumption that you had made in paragraph 21?-- No, it isn't.

Okay, and if we can go to the final page please?-- Again-----

There's nothing on that, nothing relevant?-- No.

Thank you. If that document can be tendered please, Commissioner?

COMMISSIONER: Yes, Exhibit 155 will comprise - may I describe it as records relating to Dr Patel's leave?

MR DIEHM: Yes, thank you.

ADMITTED AND MARKED "EXHIBIT 155"

MR DIEHM: Mr Brennan, do I understand from an answer you gave a few moments ago that your assumption about Dr Patel being on leave in November 2004 was not based on your own recollection but rather on information that you had found out from somewhere else - from somebody else?-- I, when I was looking at this data, I spoke to a number of staff in the unit and met with staff and they were all also of the impression that Dr Patel was away at that period.

There was a discussion in one group and did you move to another group?-- I think there was two separate people.

Thank you. Thank you.

COMMISSIONER: Thank you Mr Deihm. Ms Feeney, you've been left alone again?

MS FEENEY: I have indeed Commissioner.

COMMISSIONER: Yes.

MS FEENEY: I have no questions.

COMMISSIONER: Thank you. Mr MacSporran?

MR MACSPORRAN: I have nothing.

COMMISSIONER: Thank you Mr Fitzpatrick.

CROSS-EXAMINATION:

MR FITZPATRICK: Nurse Brennan, I'm Chris Fitzpatrick and I act for Queensland Health. I just wanted to ask you some questions if I could concerning those parts of your statement that deal with the death of P44. You deal with that topic in paragraphs 7 to 10 of your statement; do you have those available to you?-- I do, yes.

All right. Now, do we take it from some of your answers to some questions put to you by Commissioner Morris that you know that it was your head of the unit, Dr Carter, who arranged for the ventilator to be turned off in P44's case?-- I wasn't aware at that time but I was aware that it was Dr Carter.

You're aware, and I think you also said in answer to a question from Commissioner Morris that you thought it was unlikely that Dr Carter, in arranging for the ventilator to be turned off, that he wouldn't have been acting under dictation from Dr Patel, in other words, that it was Dr Carter's own decision to have the ventilator turned off; is that your evidence?-- I would assume that, yes, I'm saying that, yes.

Well, you've - I think you say in your statement that you worked in your unit at the base hospital for 14 years; is that so?-- That's correct.

And for how long have you worked there under Dr Carter?-- I'm not sure how long Dr Carter's actually been there, it is a number of years.

So you know him-----?-- I know him very well.

-----very well and you trust him?-- Yes.

You trust his judgment?-- Yes.

Well, can I ask you this: could you look at paragraphs 7 to 10 of your statement?-- Mmm.

And tell us whether in those paragraphs you make any criticism of anyone other than Dr Patel?

COMMISSIONER: Mr Fitzpatrick, if you don't mind me offering a suggestion, I wonder whether it would be easier to put the question to the witness in these terms, as to whether you have any criticism of anyone other than Dr Patel relating to the handling of patient P44?

MR FITZPATRICK: Yes, thank you, Commissioner, I'm grateful to adopt that question?-- I - my probably only criticism with Dr Carter would be that in, as I spoke to him afterwards, was the way of speed with which the process was done gave the impression that it was being done to facilitate a bed for Dr Patel. I'm not saying that Dr Carter did it for that reason,

but I did say to him it was done and the staffing unit felt it was being done with indecent haste, "indecent haste" was the exact words, it gave the impression that it was being done to provide a bed for Dr Patel's patient.

So-----?-- I'm not questioning his clinical judgment in turning the ventilator off.

All right, so you do say that in addition to the feeling of the staff, that you too felt that the ventilator in P44's case had been turned off - to adopt your language in paragraph 10 of your statement - with indecent haste to clear a bed for Dr Patel's patient?-- That was my feelings.

Well, is that your feeling at this time as well?-- I still feel that, yes.

All right. Now, at paragraph 13 of your statement, you detail how you sought to refer to the charts in P44's case for some purpose, but that you weren't able to access them, they being with the executive; is that the case?-- Yes, there was no criticism intended there, I just wanted to refresh my mind and wasn't able to access the chart.

Have you looked at the charts in P44's case?-- No, not in any detail.

If the Commission pleases, could I ask for parts of the charts to be put up on the screen?

COMMISSIONER: Yes, certainly, or what's more efficient? Would it be easier for you to show the witness through the parts of the chart or let him look through the parts that are of interest and then put up any that's significant?

MR FITZPATRICK: Commissioner, it might be, if I could hand to the assistant perhaps one page, I've copied the chart.

COMMISSIONER: Yes.

MR FITZPATRICK: And perhaps one page at a time and I've highlighted them.

COMMISSIONER: Yes, certainly.

MR FITZPATRICK: Thank you.

COMMISSIONER: Just with our previous experience has been that when you put these things up on the chart, often indistinct handwriting becomes more illegible.

MR FITZPATRICK: Commissioner, the actual mechanics of the handwriting in this case are fairly clear.

COMMISSIONER: Excellent.

MR FITZPATRICK: Although some of the language used is a little difficult to interpret.

COMMISSIONER: Yes.

MR FITZPATRICK: But perhaps with the assistance of the witness, we'll see how we go.

COMMISSIONER: So you want this one on the projector?

MR FITZPATRICK: If possible please, Commissioner. Now, Nurse Brennan, can I suggest to you that this is part, in fact, the opening part of the in-patient progress notes at the base hospital relating to P44; does that seem right to you?-- That looks correct.

All right. And with your help perhaps we can interpret those parts that I've highlighted in highlighter pen. Do we see that on the 18th of December 2004, the surgical principal house officer noted of P44 that she was admitted following a fall in a bath that day in which she had slipped on a bath mat and hit her head?-- That's correct.

That seems right?-- Mmm.

And if we could just trawl down the page a little to the next highlighted section please Court officer?

BAILIFF: There's no more highlighter.

COMMISSIONER: Just while that was up though, does that suggest the patient was admitted on the 18th of December, Mr Brennan, so you were under the impression?-- I was under the impression that the patient came in earlier on, the early period of the 19th.

Yes, it's not quite clear from that whether the patient came straight into ICU or perhaps we'll come to that.

MR FITZPATRICK: Commissioner, I think that that becomes clearer from the next page.

COMMISSIONER: Good.

MR FITZPATRICK: Which I'll hand to the Court officer now. Nurse Brennan, if you just look please at the first entry on that page. Am I right to interpret that it reads that the patient was intubated and ventilated in the Department of Emergency Medicine; does that seem right?-- That's correct.

That there were observations taken of her pupils and so on, and that in the second paragraph it is recorded that a CAT scan of her head was administered?-- Mmm.

Does that seem right?-- Correct.

A CT head?-- Yes, CT head, large right-sided subdural haematoma.

All right. Which is a brain injury; is that so?-- That's

correct.

And its dimensions were taken?-- That's correct.

And do we see in the next paragraph that there was a discussion with a Dr Bryant who is said to be a neurosurgeon at the Royal Brisbane Hospital; does that seem right?-- That's correct, I mentioned that in my evidence earlier.

Thank you. And Dr Bryant was of the view that the patient was not for transfer to his - do we interpret to the Royal, to his hospital?-- Yeah, I don't remember seeing this particularly, but I - at handover, I was told that the neurosurgeons in Royal Brisbane had been contacted, they felt that there was nothing surgical they could provide for the patient and that her prognosis was poor.

And that her, I'm sorry?-- Her prognosis was poor.

Yes, and that's evidenced, I think, by the next note, "Poor Prognosis"; is that so?-- That's correct.

And then the matter of interest to Commissioner Morris, that there was a plan that the patient should be transferred to the intensive care unit; is that so?-- That's correct.

So that indicates that the patient was not at that time in that unit?-- No, the patient would have come through the Department of Emergency Medicine and had the CT scan and then would have come to intensive care.

All right. And then two lines down, do we interpret that there then occurred a discussion with the patient's family and son?-- That's correct.

And it was decided that there should be a repeat CT scan of the patient's head in 24 hours; is that so?-- 24 hours, yes.

All right. Yes, thank you Mr Court officer. Can I just ask you whether the notes that we've reviewed together so far assist you in deciding whether the patient was admitted on the 18th or the 19th? I take it you'd agree that P44 was in fact admitted to some part of the hospital on the 18th?-- That's correct.

All right. Now, on the note that's on the screen, do we see that on the 19th of December, the next day, the CT was repeated?-- That is correct.

And that Dr Patel, the surgeon, was of the view that the patient had got a cerebral herniation; is that so?-- That's correct.

And that the next note, "So only supportive measures continuing till family decision"; does that seem to be-----?-- That's correct, that's what it says.

And can you help us please? Is "supportive measures" a term

of art in nursing which indicates that the patient should be continued on ventilation because there was no surgical option available for her or-----?-- Supportive measures, you take - you're basically taking measures to keep the status quo rather than active measures to try and treat something.

Yes.

COMMISSIONER: Are you able to identify from the handwriting or the signature who made that note?-- I'm not sure. It could be Dr Zia, I'm not - I couldn't say with any confidence.

D COMMISSIONER VIDER: Mr Fitzpatrick, could I just ask whether - where it says there Dr Patel surgery is of the view that something has got cerebral herniation; was that the official report in the CT scan from the radiologist?-- I couldn't be sure, it's possible there may not have been a formal report from the radiologist.

I know we've been told that radiology services are outserviced?-- That's correct.

But I would imagine in these sorts of situations you would be able to get a rapid response?-- I would assume so, I don't remember seeing a CT report in a formal report.

So you're not sure whether that's the official reading of the report?-- No.

MR FITZPATRICK: Thank you, Deputy Commissioner. Nurse Brennan, can you help us please with the next two words as used as they are in the context of the words "supportive measures"; can you tell us what sort of "family decision" was in contemplation or would that be just speculation?-- It would be conjecture, I wasn't there.

COMMISSIONER: But Mr Brennan, it would not be unlikely that in these circumstances the family would be consulted as to whether or not to keep the patient on life support when there was no prospect of recovery?-- I think that's probably what would have been discussed.

As you say, it's only a matter of conjecture but it's the most obvious conjecture, isn't it?-- Yes.

MR FITZPATRICK: Thank you, Commissioner Morris. Could that sheet be returned and this put up in its place? I think we now have a note taken at 7 o'clock in the morning; does that seem right, on the 18th of December last year?-- Have we gone backwards? The previous note was the 19th.

I see, it does seem to be out of sequence-----?-- Out of sequence.

-----as we'll see, but on its face, it is a note, is it not, taken at that time and on that date?-- Yes.

Yes. And we see that-----

MR ALLEN: Is the original record here so that the witness could have it in front of him? Obviously, if it's a question of sequence, it would assist if the whole document is there so that the witness can interpret it.

COMMISSIONER: I suspect it's not a matter of any confusion. I had the impression, Mr Fitzpatrick, we'd been looking at the notes initially from the emergency department and that is a note from the ICU.

MR FITZPATRICK: Quite so, Commissioner.

MR ALLEN: But if one looks at the-----

COMMISSIONER: Mr Brennan, if you feel any confusion or any need to look at the original file, I understand that Mr Fitzpatrick has it available and you let us know if you need to look at it?-- I feel that this obviously is out of sequence here, that the sheet we looked at last or prior to this is the sheet that should be in the chart after this particular chart.

What we'll do, Mr Brennan, is we'll take a 10 minute break, I'll ask Mr Fitzpatrick to flag the pages that are relevant so that you can just make sure that anything that you're shown you understand its context and sequence so that you're not in any way disadvantaged or confused?-- Thank you.

Is that satisfactory?-- That's fine, thank you.

All right, we'll adjourn for 10 minutes.

THE COMMISSION ADJOURNED AT 3.13 P.M.

THE COMMISSION RESUMED AT 3.31 P.M.

MARTIN JOHN BRENNAN, CONTINUING CROSS-EXAMINATION:

COMMISSIONER: How did we go, Mr Fitzpatrick.

MR FITZPATRICK: Commissioner, I understand Mr Diehm wishes to make a submission.

MR DIEHM: Commissioner, I just wanted to inform yourself and the other legal representatives here about the state of my client's application.

COMMISSIONER: Yes.

MR DIEHM: It's been filed.

COMMISSIONER: Yes.

MR DIEHM: In Court a little while ago and a time has been arranged for 10 o'clock on Monday morning for a directions hearing.

COMMISSIONER: Yes.

MR DIEHM: The Crown solicitor has been notified of that. I mention it, Commissioner, simply from the point of view of it being considered about what the parties and the Commission wants to do on Monday, as to whether or not - enough of the lawyers here say they personally want to be at the directions hearing and ask the Commission to take that into account.

COMMISSIONER: I see.

MR DIEHM: I'm not seeking to draw anybody to respond immediately.

COMMISSIONER: Yes. Yes.

MR DIEHM: I'm only informing-----

COMMISSIONER: I certainly don't want to put your client or anyone else to the expense of having to retain different people to be in two places at once. Yes, all right. Well, I'll leave everybody to that position and maybe, for example, Mr Farr, if everybody is going to be in the Supreme Court in Brisbane on Monday morning, we might take opportunity to have a look at the hospital or otherwise find a way to put the time to good use.

MR DIEHM: Thank you, Commissioner.

COMMISSIONER: Again, you have no application otherwise that the hearing not proceed or that-----

MR DIEHM: No, I'm not making any application, Commissioner.

COMMISSIONER: No. Thank you. Thanks, Mr Fitzpatrick.

MR FITZPATRICK: Yes, thank you, Commissioner. Nurse Brennan, have you had an opportunity to look at the original charts and resolve any question about the dates?-- It's very difficult from the chart. I mean, the dates appear to be wrong. There are - the dates are in the wrong number, the 18th followed by the 19th, back to the 18th, then the 19th again. It is confusing. Before we go on, could I just answer one question that Deputy Commissioner Vider asked me in relation to the CT report? We've checked through the chart and there is no proper - formal CT report from a radiologist in relation to this patient.

D COMMISSIONER VIDER: So it would be assumed that that's Dr Patel's reading?-- That's Dr Patel's reading of the CT-----

That would be the assumption?-- Yes.

MR FITZPATRICK: Nurse Brennan, having looked in the chart, in the original chart, are you content to hand back the original chart to me to work off so that the copies can be put up on the screen?-- Yes, I just feel that with the sequence, it is difficult to follow the order in which things happened.

All right. Well, apart - I will withdraw that, Commissioner. I think, Nurse Brennan, we were focussing on the entry there for the 19th of December 2004, which appears at the bottom of the screen. It appears to be an entry by the surgeon called principal house officer?-- That's correct.

Do you have that? And it reveals that the patient's situation was neurologically unchanged overnight. Does that seem to be right?-- That's correct.

And there was a plan made that it would be - the results of a repeat CT scan this morning would be awaited and then there would be a discussion with the family after that; is that so?-- That's correct, that's correct.

All right.

COMMISSIONER: Can you interpret the letters and hieroglyphics at the right-hand end of the second line after "surgical PHO"?-- I'm not sure what they mean actually.

No. Thank you?-- I'm sorry, I can't help.

MR FITZPATRICK: Can that page be handed back, Commissioners, and this one substituted. Nurse Brennan, do we see then that according to that entry the patient was examined at 1.35 p.m. on the 19th of December last year?-- That's correct.

And a CT was reviewed at that time?-- Yes.

In the second line?-- That's correct. Although, it doesn't actually say who reviewed it.

No. And there ensued a discussion with a Dr Zia; is that so?-- Yes.

Do you know who that is?-- Dr Zia, who is an anaesthetist who would have been on during the day over the weekend.

All right. It seems that there was an assessment made by someone that the patient had suffered or was suffering an acute right subdural - does it look like "haematoma"?-- Haematoma.

That there was right-sided brain oedema. Is that swelling?-- That's swelling of the brain.

And it says, so far as I can tell, "and complete obliteration of the right ventricles." Does that seem right?-- That would be correct.

All right. And in addition there was marked left - it's impossible for me to say-----?-- Oh, shift.

Shift and brain stem herniation; is that so?-- That makes sense.

Does that term "brain stem herniation" imply that some part of the brain was leaking into-----?-- Basically, when you get severe bleeding or oedema in the brain, that part of the brain can push down into the upper part of the spinal cord and the brain stem.

Thank you?-- It herniates downwards.

All right. In the next paragraph it's noted that there was no spontaneous breathing and in the next paragraph it's noted that there was a long discussion with the family about prognosis. Discussion about not to resuscitate. The next word I can't decipher, can you?-- States.

MS HOFFMAN: Status.

WITNESS: Oh, status.

MR FITZPATRICK: Status. "Status hold"?-- No, discussion about not for resuscitation "status held".

"Status held"?-- That there was a discussion about the status of the patient, whether or not resuscitation was confirmed.

I see. Do we interpret from that note that it was confirmed, somebody's decision not to resuscitate the patient was confirmed in that discussion?-- It doesn't actually say not to resuscitate. It says - it says that a discussion about whether to resuscitate the patient or not, this discussion was held and the family does not wish to - does not want for them to stay on prolonged ventilatory support.

Yes, I see. So do we interpret that the family was not wanting the patient to be - to remain on ventilation for a long period?-- For a long period, yes.

But it's the case with this patient, at least on reading on the notes, that there was no other alternative to - well, to maintain life other than that she be ventilated; is that so?-- Normal practice would be to ventilate a patient for a period of time. Cerebral oedema decreases after a period of time and patients sometimes make very good recoveries. It's a process that you normally wait for a few days to see if there is any improvement unless you do, for example, brain death criteria testing in which case you would establish that the patient is actually brain dead. In the absence of those you can't really say whether a patient is going to make any recovery or not. I'm not saying the patient is going to make a recovery. Her injuries are very, you know, severe. But in the absence of a brain stem death test, you - you don't know the patient's status.

All right. Well, there seems to be some regard to those tests in the next paragraph of the note. Can you help me there?-- It says, "Patient will not qualify for brain death criteria for organ donation."

"As there will be"?-- "As there will be significant cortical activity from left hemisphere." I'm not quite sure what they're getting at there. The first part, the first couple of sentences, are implying that she wouldn't be a suitable candidate for organ donation. Brain death has to be a requirement if you're looking at the patient to be a potential organ donor.

They're a mandatory requirement?-- They're a mandatory requirement for organ donations, yes.

All right. In the absence of organ donation, what is the-----?-- It is normal procedure to do the brain death tests anyway.

I see. All right. Well, in the next paragraph it says, "Family will decide soon regarding timing of withdrawing the support", does it not?-- Regarding, yes, timing of withdrawing the support, yes.

That note is signed by Dr Patel, is it not?-- That's correct.

All right. Now, Commissioners, we're almost done and if this page could be substituted. Nurse Brennan, it's recorded, is it not, that at 2.30 p.m. on - do we take it the 19th of December 2004?-- 2.30 p.m., yes.

There were more discussions with the family. "They will notify us when they decide to withdraw ventilatory support." Is that what the note says?-- That's what it says.

And it's also recorded, "Also", something-----?-- "Also asked

to get NFR form signed."

What's that?-- There is a form when a patient's condition is decided that they're not for resuscitation, it's discussed with the family. Their views are taken into consideration and they then sign that the patient is not for resuscitation in the event of a cardiac or respiratory arrest.

Those notes are signed as well by Dr Patel, are they?-- That's signed by Dr Patel, yes.

Now, a little - two paragraphs down we move to the next date, the 20th of December 2004, where at 8.35 in the morning; is that right?-- Yes.

Looks like Dr Carter-----?-- Dr Carter's handwriting.

-----has recorded, "In view of the dreadful prognosis this lady has and following discussion with family, ventilator support is to be withdrawn"?-- Yes.

And then at 8.55 on that same date Dr Carter has made a note that the ventilator was turned off?-- That's correct.

All right. Now, there are - Commissioners, if I could have that last page handed to me.

COMMISSIONER: Yes.

MR FITZPATRICK: I propose to tender those progress notes.

COMMISSIONER: Exhibit 156 will be the bundle of progress notes relating to patient P44.

ADMITTED AND MARKED "EXHIBIT 156"

COMMISSIONER: Deputy Commissioner Vider reminds me that the patient's name appears in these documents. I see no need why her name should be released from suppression, particularly given the evidence suggesting that her death was not suspicious in a sense. Unless anyone at the Bar table feels otherwise, the suppression will remain in place and the name will be obliterated on the copies that are made available to the public.

MR FITZPATRICK: Thank you, Commissioner.

COMMISSIONER: Is that in order? Thank you, that's Exhibit 156.

MR FITZPATRICK: Nurse Brennan, I also have seen in the original charts, and I apologise, Commissioners, for not having a copy at this stage, that in the - in a set of notes called the progressive nursing notes?-- Mmm-hmm.

Does that mean anything to you?-- Patients on life support in intensive care, we use a large flow sheet, and I think you've got one of them there, in which we record all observations, drugs, fluid input and output and neurological observations and also events that happen during the shift. The nurses don't generally write in the general progress notes chart. They're notes that are recorded in the flow chart.

But you're aware of a class of documents called progressive nursing notes?-- Yes, at the back of the flow chart.

Are those documents filled in by the nurse?-- They're filled in by the nurse on each shift who is the primary carer for the patient.

And the doctors don't write in them?-- The doctors don't write on them, no.

I see. There is an entry that's on the 20th of December 2004, and I will hand it to you in a moment, that at 0800 hours there was some observations taken - I'm sorry, at 0830 hours Dr Carter, Dr Patel and Dr Sanji, "Doctors spoke with relatives. Relatives wished to have treatment withdrawn. 0900 ventilation ceased. Family in attendance." Would you like to look at that?-- Oh, I'm sure that's what it says. It's what I understand happened.

All right. Commissioners, I'll undertake - I'd like to tender this at an appropriate time.

COMMISSIONER: Yes. Well, I will reserve for it Exhibit number 157.

ADMITTED AND MARKED "EXHIBIT 157

COMMISSIONER: Can you give me an appropriate description.

MR FITZPATRICK: Thank you, Commissioner. Commissioner, I suggest that it be entitled an extract from the progressive nursing notes for P44 on the 20th of December 2004 at 0830 hours and 0900 hours.

COMMISSIONER: Just give me those times again.

MR FITZPATRICK: 0830 hours and 0900 hours.

COMMISSIONER: Yes. That document will be Exhibit 157 and you will make a copy available in due course to go into the record.

MR FITZPATRICK: I will, Commissioner.

COMMISSIONER: Thank you.

MR FITZPATRICK: Nurse Brennan, aside from the issue about the date sequence that we identified before the afternoon break, have you any reason to doubt the veracity of the entries in the notes that you and I have been reviewing this afternoon?-- Veracity in what - in-----

Well, the truthfulness?-- Yeah, that what was done was what is recorded there.

Accurately records-----?-- That's correct.

You accept them?-- I accept that what's written there is what happened, yes.

All right. Do you, having reviewed the notes and accepted them as genuine, maintain your objection that the ventilation in P44's case was peremptorily terminated?-- Yes, I do.

You do?-- Can I make some comments on the notes? In Dr Patel's entry, he states that he discussed with the family and he was awaiting the family's decision to turn the ventilator off. It's not - the family's wishes are taken into consideration in these cases. The family does not make the decision to turn the ventilator off. That's normally a decision made by the intensivist looking after the patient.

Well-----?-- I'm not saying this patient wasn't brain dead. However, I'm saying that the correct procedures were not followed. Procedure is to follow brain death criteria. Dr Joyner, who is a senior anaesthetist in the hospital, was not prepared to turn the ventilator off because the tests had not been done, and I concur with his opinion. I see no other reason why this was done at 8 o'clock in the morning shortly after Dr Patel came into the unit and wanted to know why the patient had not been turned off so that he could operate.

I can see no reason why brain death tests were not done. They do take time and it would have prevented Dr Patel from starting his surgery on the morning of the 20th. Brain death tests you have to stop drugs, et cetera, that the patient are on, wait a period of time. You need two senior specialists to do the tests. What I'm suggesting - I'm not saying the patient wouldn't have met the brain death criteria, we don't know, but the proxy to it-----

It was suggested at one point in the notes the patient wouldn't meet the criteria?-- Without doing the tests you don't know.

Well, you remember-----?-- These tests have been put into place to establish brain death. You can't establish brain death without doing the tests.

So you do make a criticism of Dr Carter?-- I'm criticising the haste in which it was done.

I see.

COMMISSIONER: I think the witness did make it very clear earlier that he wasn't criticising the doctor's clinical judgment. The criticism related to the way in which it was done rather than the conclusion that he had arrived at.

MR FITZPATRICK: Yes.

COMMISSIONER: Is that a fair summary?-- That's correct. I'm not saying - I feel the patient probably would not have met - would not have put - it sounds - she would have passed the brain death test, in other words, be declared brain dead, but in absence of doing the test you can't be sure. I have seen cases where patients, perhaps, fail part of the test and while their brain injury may be incompatible with living without a ventilator - you can't just switch people off without knowing. Without doing the tests you don't know. I'm not saying that - how do you put it? I'm not criticising Dr Carter in his judgment that the patient would have met the criteria. In the absence of doing the tests as is policy you don't know. I cannot see any reason why the tests were not done other than. They take time and time appeared to be of the essence for Dr Patel.

MR FITZPATRICK: All right. Do you accept, though, that it was within the prerogative of Dr Carter to do as he did in ordering that the ventilator be turned off?-- It's within his prerogative, but it's not normal procedure or policy.

Yes. Thank you, Commissioners. That's all I have.

COMMISSIONER: Mr Allen?

MR ALLEN: Nothing arising out of that.

COMMISSIONER: Thank you, Mr Allen. I should say during the break I had some reflection and it became apparent to me,

which it wasn't at the time, that my use of the expression witch-hunt could convey connotations that I certainly didn't intend. I withdraw and apologise for that expression. I was simply focussing on the situation where the purpose of cross-examination was to raise issues of allegations regarding individuals rather than the system. I'm sure you understood it that way, but I will apologise for the use of that inappropriate expression.

MR ALLEN: That is appreciated, Commissioner.

COMMISSIONER: Thank you. Mr Morzone?

MR MORZONE: No re-examination, Commissioner.

COMMISSIONER: Thank you. Thank you so much for coming to give us your evidence and the frank and forthright way in which you have given it. We do appreciate your time and your contribution for these difficult proceedings. You are excused from further attendance?-- Thank you.

WITNESS EXCUSED

COMMISSIONER: Before we move to the next witness, there are some documents that I would like to place on the record of the inquiry. They are publicly available, but not in a way that is likely to be readily accessible by anyone. They are documents that - it may be that some people will wish to refer to in submissions or for other purposes at some stage of proceedings.

They're both reports of previous Royal Commissions, one is a Commonwealth Royal Commission which was set in Bundaberg in the late 1920s concerning a medical emergency here relating to the inoculation of children in respect of diptheria resulting in the deaths of 12 out of 21 children who were inoculated. It is not merely of historical interest, but of direct practical interest that as long ago as 1928 people were wrestling with the same sort of issues as we have to consider regarding the provision of the highest possible standard of medical care in a remote but - not remote, but in a provincial location like Bundaberg. The other is, perhaps, more directly relevant.

The Commonwealth report will be Exhibit 158.

ADMITTED AND MARKED "EXHIBIT 158"

COMMISSIONER: I should formally identify it as the report of the Royal Commission into the Medical Emergency at Bundaberg

dated 11 June 1928 by Commissioners Charles Kellaway, Pete MacCallum and A H Tebbutt.

The second Royal Commission report I want to put on the record is, again, quite an old one from 1930, but it was a Royal Commission conducted in relation to, as it's described, a General Administration and Control of Public Hospitals in the State and, again, it's quite fascinating to see that the members of that Royal Commission were considering and struggling with many of the issues that we've canvassed in these proceedings.

It's a pity, in one sense, that Mr Jackson QC has left us because I understand that he was related to one of the three Commissioners. The Commission comprised Mr W Harris Police Magistrate, Dr Sandford Jackson, and the Deputy Auditor General Mr Glassey. The report of that Royal Commission on Public Hospitals dated 13 June - I'm sorry, it doesn't seem to be dated. Anyway, the 1930 report of the Royal Commission on Public Hospitals will be Exhibit 159.

ADMITTED AND MARKED "EXHIBIT 159"

COMMISSIONER: Yes, Mr Morzone?

MR MORZONE: If it please the Commission I call Jenelle Joy Law, J-E-N-E-L-L-E.

JENELLE JOY LAW, SWORN AND EXAMINED:

MR MORZONE: Is your full name Jenelle Joy Law?-- It is.

You are an enrolled nurse and you have been a nurse for 28 years; is that correct?-- I have been, yes.

You are employed by Queensland Health in the operating theatre at the Bundaberg Hospital?-- I am.

And you have worked at Bundaberg Hospital for over four years?-- That's true.

COMMISSIONER: I should have asked Ms Law do you have any objection to your evidence being filmed or photographed?-- That's fine.

Thank you.

MR MORZONE: You prepared a statement in these proceedings. Do you have a copy of that statement with you?-- Yes, I do.

Are the facts contained in the statement true and correct to the best of your knowledge and belief?-- They are.

I tender the statement, if it please.

COMMISSIONER: That statement will be Exhibit Number 160.

ADMITTED AND MARKED "EXHIBIT 160"

MR MORZONE: Ms Law, you were involved in the - in theatre during the operation of Mr Kemps. In paragraph 10 you refer to having been rostered on as the scout nurse during that operation; is that correct?-- That is correct.

You've made mention in paragraph 11 of concerns, to your knowledge, being raised at the end of the operation and earlier in paragraph 10 you state that you don't recall or have any knowledge of anything having gone wrong during the operation; is that correct?-- That's right.

Is it the case that there may have been concern during the operation expressed or in the mind of other practitioners, but that you were simply not aware of it?-- Sorry, what was that?

I will repeat that, yes. Is it the case that there may have been concern or comments made during the course of the operation about the operation, but that you were not, personally, a party to it?-- I didn't hear any comments or concerns during the surgery.

In particular, could I ask you, you have heard evidence earlier today that nurse Gaddes had said to Dr Patel during the course of the operation that the bellovac drain was over half full with no vacuum and it seemed to drain freely, and Dr Patel said, "That's what drains are for Damien"?-- I didn't hear it, no.

That could have occurred, though?-- It could have occurred, yes.

You state in your statement that you first became aware of concerns related to the operation at the end of the operation, but before the patient had left theatre; is that right?-- Yes.

And it was then - it then came to your attention that the bellovac drain was filling quickly with blood; is that right?-- Everybody that was in the theatre at that time did know that. We just saw it because we were about to transfer Mr Kemps off the table.

Can you relay, in your own words, what you recall happening at that time?-- I wasn't there for very long once it was noted. I remember Dr Dieter Berens asking that Dr Patel come back and

review the patient before he was transferred off the operating table. Then I was asked to go to lunch. So that was all I was there for for that case.

The patient then returned to theatre later on?-- That's correct.

And you made a note in paragraph 12 that that was at 1730 hours?-- It would have been roughly about that time, yes.

And that was after your normal shift had ended and you were continuing on call; is that correct?-- I was on call, yes.

And you state in paragraph 13 that Dr Patel performed a laparotomy, splenectomy and thoracotomy; is that right?-- That's correct.

And, again, you were scout nurse for that operation?-- Yes, I was.

Within a short time you say you noticed such a unit fill very quickly again?-- That's the role of the scout nurse. We hook up all the tubing that's hooked up for the scrub nurse. I did know I had to empty that one very quickly, that one bag, and replace it with another one.

Are you able to tell us or recall how much fluid the relevant drain held at that time?-- The bellovac or the suction?

Both?-- The bellovac was in the other case, the first case, but the suction unit - there's two on each of the units that we use and there's two litres in each. So there's about 2.3 litres of blood within a very short period of time once the second procedure was started.

What about in the case of the bellovac drain? There was a question asked earlier and the earlier witness didn't know; do you remember?-- You are confusing me with the bellovac drain. Is that to do with the second one you were asking before?

The second operation?-- I didn't have much with the bellovac. It was noticed it was filling, and people noticed it was filling very quickly. As I said, I had to go to lunch after that.

Do you recall in paragraph 14 during that second operation there was 75 large sponges used and 15 raytec; is that correct?-- That's correct, yes.

Did you, was it your responsibility to count those?-- As we're taking them out we count them out. Myself and the scrub nurse count them off, and we count-----

You will have to speak a little slowly-----?-- Oh, I'm nervous.

-----so that the reporters can take it down. So you - you had great knowledge of the number that was used?-- I had exact

knowledge of the amount which was used, yes.

And you describe in that paragraph that as the procedure progressed there was blood on the floor and everywhere; is that correct?-- It was everywhere. It was as people were coming and going - as I was having to leave the theatre to get more sponges or equipment that was needed there was just a trail going out of the theatre into the adjoining room where I had to get my equipment that I needed to get.

And what did Dr Patel say about the condition of the patient and what was causing the bleeding?-- Dr Patel was saying, "This isn't my fault. This has nothing to do with my surgery." He was quite agitated as he was saying it. He was just shaking his head saying, "This is not my fault. It's got nothing to do with what I have done."

And at one point you refer to, in paragraph 15, Dr Patel stating that the patient was going to die?-- He did. He said that a couple of times, "This patient's going to die."

And was that - and at - he was yelling to you, to get the family?-- He was stating that there's - also yelling, "Get the family. Get the family." So David Levings, who was the anaesthetist for this case, was running through the intensive care unit to see if the family could be located.

When Dr Patel was stating the number of times that you mentioned that it had nothing to do with his surgery, what prompted him to make those statements? Was someone making accusations to him?-- Not that I recall, no. He seemed very agitated when he was saying it, but I don't remember whether anybody was saying anything. I remember Dieter Berens - I can't remember if it was the first case or this case, but I remember seeing Dieter shaking his head, questioning, why is this patient bleeding, but I don't know what prompted Dr Patel to be saying what he was saying.

The paragraph 16, you refer to being present when Dr Patel spoke to the family; is that correct?-- I wasn't present. I opened the door because Dr Patel was still scrubbed in his gown and gloves. So I opened the door, let him out of the theatre, took him to where the family was waiting and then I left. So I wasn't present.

And did he return to the theatre after that occasion?-- He did. He come back.

Did he rescrub and change his gloves?-- No, he didn't.

Did he still have his gloves on?-- He did.

And did the rest of the procedure continue after he returned to theatre?-- It did.

What was his attitude like on the remainder of the procedure?-- Basically the same, I think. He seemed quite agitated and - I was just really busy, just getting stuff.

D COMMISSIONER VIDER: Can I ask you about the statement in paragraph 14? You make reference to the fact that there was blood and blood clots on the floor?-- That's correct.

Was that blood overflowing from suction bottles or-----?-- No, it was not overflowing. The blood that goes into the suction bottle is contained in a sterile suction tube. It goes into its own receptacle.

Where was the blood coming from that was on the floor?-- The sponges that he was using as he was trying to mop up the blood I'm assuming. I wasn't close enough because, being the scout, I wasn't right near the patient or anything. As he was handing - being handed sponges, as they were filling with blood, as he was mopping them up handing them back to the scrub nurse, they were getting handed back to the scrub nurse, so they were either so full of blood at the time of being handed back or just in his haste trying to mop up the blood, so he could see what he was doing, that's where the blood was coming from.

Thank you.

MR MORZONE: You are stating that Dr Patel, during the remainder of the procedure, remained agitated?-- Mmm.

And I think you also say in paragraph 17 that he was very defensive. Can you be a bit more explicit about how he manifested that in his actions or what he said?-- He just kept saying, "This isn't my fault. This isn't my fault." It was like someone was questioning him, what have you done wrong, without anything being said. He was just saying, "This isn't my fault. It has nothing to do with my surgery."

Do I take it from what you have just said that, again, no-one prompted those comments from him?-- Not that I heard, no.

At the end of that paragraph you refer to the patient's incisions then being closed. When the patient's incisions were closed was it clear from what you heard or saw of the - of Dr Patel or any of the other medical consultants there whether or not the bleeding had been stopped?-- I visibly saw that the bleeding hadn't been stopped because the dressings that we initially applied were quite thick combines. I have described it here. They're like a big sanitary pad because they absorb a lot of blood. We had to, in the short amount of time, reapply more combines over the initial ones to soak up excessive bleeding.

Was anything said by anybody as to why the patient would be closed in those circumstances, when he was continuing to bleed?-- Not that I heard, no.

Was it the case then that the patient was transferred back to ICU still bleeding?-- Yes.

You became very distressed about the incident; is that

correct?-- That's correct, yes.

And subsequently prepared a statement in early January 2005 which you have attached to your statement?-- Yes.

The contents in that statement, do they remain true and correct to the best of your knowledge and belief?-- They do, yes.

Paragraph 23 of your statement you refer to finding Dr Patel to be a very arrogant man and you have given some examples of incidents which occurred involving Dr Patel's behaviour in paragraphs 20 to 22. Are there other incidents or other events that you want to relay to explain how you found him to be a very arrogant man other than those?-- Basically the two instances I have put here in my statement were pertaining to myself. That did upset me at the time, but there has been other instances with myself also and other staff members. He's just really made fun of - belittled you in front of other staff members. It was just an ongoing thing with him. He just - if he had an opportunity to say something to put someone down he did, he took the opportunity. I haven't written everything down because you just, sort of, take it in your stride. That was my job and that was him, so I just, sort of, accepted it.

In paragraph 24 you state at the beginning of March 2005 Dr Patel was skiting about his extension of the contract. Do you recall what he said about that in his words now or-----?-- He was - we were doing an endoscopy list together. I was assisting him and he was saying that he's no longer leaving at the end of March, his contract has been extended for another three months and he said, "They're going to pay me as much for those three months as what I get in a year", and he was just bragging about it and saying that he was going to get all this money for a short period of time being there.

That's the evidence-in-chief of the witness, may it please the Commissioner.

COMMISSIONER: Thank you. Mr Allen?

MR ALLEN: I do appear for Ms Law, and I have one matter.

CROSS-EXAMINATION:

MR ALLEN: Ms Law, in paragraph 18 of your statement, you refer to the distress that you felt as a result of the procedure involving Mr Kemps?-- Yes.

And writing a statement, which you have referred to. You say, "It took me quite a while to work up the courage to hand it in after I had written it as I feared for my job."?-- That's correct.

What fears did you hold?-- Dr Patel was saying that he could have people removed. I am only new to theatre, I have only been in theatre two years, so I wasn't aware, up until the day, that he couldn't have me sacked. But he was always just saying that, you know, "If I am not happy, or something is not making me happy", he will get rid of us, whatever is causing him concern, and I wrote this statement a few days after Mr Kemps's case, and I kept it on my computer at home. And then initially I handed it in when the two other staff members. I just felt I had to do - I couldn't not do it, so - but I was scared of my job because of how he always portrayed himself that he was such an important person.

And towards the end of your statement you say that even as late as April you held fears about your job to the extent that you were very distressed, and counselling was offered?-- That's right. I got distressed a lot over this issue. Once the inquiry started, and we always - the media publications, you know, and they were saying that the nurses weren't doing what they should have been doing, they were backing him up, and all this, and for me, that wasn't the case. They were saying we used to go out to dinner with him and that. I know you can read what you want out of that, but that did really distress me because I felt I was really being picked on and put into a basket that we supported this man, and I didn't support him. All the intention all the time - and in our workplace, it was getting a bit picky between our staff members because of all the stress that was going on, and the work situation, and it just got too much and I just broke down.

I understand what you are referring to then?-- Thank you.

Thank you.

D COMMISSIONER VIDLER: Ms Law, did this issue with Dr Patel in the operating theatre, did it become divisive among the staff?-- Sorry?

Did Dr Patel's behaviour in the operating theatre become divisive among the staff?-- You mean did it divide us?

Yes?-- I don't think so. I think a lot of us were of the same opinion, that he was not a very-----

I am following on from your comment that you said there were reports that some nurses had gone out to dinner with him?-- They went out as a group. They went out when he was leaving as a group. I don't think we were dividing greatly in such a fact, it was you went or you didn't go, sort of thing. You didn't hold it against that nurse if they went out with him for dinner, or whatever.

No, no. My other comment is noting the fact that you have been an enrolled nurse for 28 years?-- Uh-huh.

But you have only been working in theatre since May 2003?-- That's right. I am new to theatre but I have worked in different hospitals. I have worked in community nursing for the Blue Nurses, I have worked in nursing homes, plus raised three children as well, so.

It is a wonderful record. Your theatre experience then - and this case with Mr Kemps would have been very traumatic, I am sure, the experience for you, and you have said that you have had counselling. You have also outlined here that you did have a significant emotional response to this?-- Uh-huh.

You have also talked about the fact, though, that you had the opportunity for some debriefing within the theatre complex?-- Yes.

Do you feel that the counselling and the support that you have been getting has helped you work your way through this experience?-- Yes, I am getting better now, yeah. It has.

Yeah. Thank you.

D COMMISSIONER EDWARDS: You bring to our information details of this one particular case, but you had obviously heard of a lot of other cases, or have you not, that Dr Patel was involved and concerned the staff in that theatre?-- I hadn't really been involved myself with any major cases other than this one. Is that what you wanted to know?

I was asking had you heard of other concerns within the theatre staff of other cases other than this one to which-----?-- I had heard of them, but because I wasn't involved, because I am new to theatre, I don't understand a lot of the cases and what goes on. So I don't know.

COMMISSIONER: Anyone else?

MR MULLINS: I have no questions.

COMMISSIONER: Mr Devlin?

MR DEVLIN: I have nothing, thank you.

COMMISSIONER: Mr Diehm?

MR DIEHM: I will go before Mr MacSporran.

COMMISSIONER: If you insist.

MR DIEHM: I'll be relatively uncontroversial and brief, I am sure.

CROSS-EXAMINATION:

MR DIEHM: My name is Geoff Diehm. I am counsel for Dr Keating. I only wanted to ask you about a matter you mentioned just a few minutes ago. I appreciate, from what you have said, that you weren't there, but is it your understanding that when Dr Patel finished up employment at the hospital, that there was a group of staff that went out to dinner with him to see him off?-- To my belief, yes, there was.

And again, appreciating that you weren't there, do you have any idea as to whether it was a large group or a small group?-- I really couldn't tell you.

Did it include doctors and nurses?-- I don't know.

Thank you. Thank you, Commissioner.

COMMISSIONER: Thank you, Mr Diehm. Mr MacSporran?

MR MacSPORRAN: Thank you.

CROSS-EXAMINATION:

MR MacSPORRAN: Ms Law, I appear for Ms Mulligan. Alan MacSporran is my name. You said you were traumatised by the experience in the theatre on that occasion?-- Yes.

And you were ultimately encouraged to make a complaint by Gail Doherty?-- No, I wrote the statement myself off my own bat. I spoke to Gail acting as unit manager.

Yes?-- She said it was my decision if I wanted to take it further. I just said I felt I had to take it further.

Yes?-- So she arranged a meeting with Linda Mulligan for me.

Gail Doherty, though, was supportive of you?-- She was supportive, yes.

In you making your complaint?-- She said it was my decision. She supported me either way.

Okay. All right. And apparently she arranged the meeting for you with Ms Mulligan?-- That's correct.

And that occurred on the 7th of January this year?-- It is probably about that date, yes.

And is it a fair summary of that meeting that Ms Mulligan spent some time with yourself and the other two?-- That's correct.

Gaddes and Ms Zolak?-- That's correct.

And she was supportive of your concerns?-- Yes, she appeared to be.

And can I show you just briefly a filenote that she made after that meeting to document your concerns?-- Uh-huh.

Could the witness see exhibit 147, please, Mr Commissioner?

COMMISSIONER: 147?

MR MacSPORRAN: 147, I think it is. Could I just ask you to look through that, if you would, and just tell us whether you agree with what is written there as being the issues that were raised by yourself and others with Ms Mulligan on that day.

COMMISSIONER: Before you do so, I should point out that document is dated the 7th of December 2004 but it seems to be accepted by everyone that that date can't possibly be right?-- Okay.

The most likely date is the 7th of January 2005?-- Okay.

Does that fit in with your recollection?-- That does, yes.

Are you asking me are all these correct, what was said at that meeting?

MR MacSPORRAN: Yes?-- I believe they are.

Yes. In particular, you see the last paragraph there?-- Yes.

"Staff were encouraged to document their concerns immediately and were reassured they would be dealt with as they expressed fear of retribution or no action occurring". That's a fair summary of her approach to you and the others in that meeting, that she understood your concerns about your fears of retribution?-- She did.

She took them seriously?-- She did.

And wanted you to document your position immediately so she could forward those concerns up the line?-- She encouraged us to submit our statements so she could pass them along, yes.

And I think one of the concerns you have had since then, since that meeting, is that you had no feedback directly from Linda Mulligan about what was happening with your complaint?-- No, I hadn't heard anything, only from what Gail Doherty had said to us, yes.

From Gail?-- Yes.

Gail, of course, was your line manager?-- Our acting line manager. Still is.

Still is?-- Yes.

She was acting in January this year, whereas David Levings had been acting in December last year?-- I can't remember. They sort of swapped and changed so often, you just don't know who - two weeks on, maybe one month on you lose track of who has been acting when.

But those two were sharing the acting role?-- That's correct.

David Levings and Gail Doherty-----?-- That's correct.

-----at the time of this meeting, which was January this year?-- Uh-huh.

Gail Doherty was acting?-- That's right.

And, in fact, you received feedback from Gail Doherty about what was happening to your complaint?-- Yes, we did.

You would presume, wouldn't you, that that feedback came from Linda Mulligan to Gail?-- Well, yes.

And that's the way it should have come, shouldn't it, down the line?-- Well, I suppose so, yes.

You wouldn't seriously expect, would you, the District

Director of Nursing to be approaching you personally with the feedback?-- I think I was hoping that she would approach us personally because we had gone through a really hard time.

All right. In an ideal world, if she had the time, she may have approached you personally?-- Well, maybe, yes.

But you would concede, wouldn't you, that Linda Mulligan in that role was a very busy woman?-- I appreciate that, yes.

All right. Thank you.

COMMISSIONER: Mr MacSporran. Ms Feeney?

MS FEENEY: No, thank you, Commissioner.

COMMISSIONER: Mr Fitzpatrick?

MR FITZPATRICK: Thank you, Commissioner.

CROSS-EXAMINATION:

MR FITZPATRICK: Ms Law, I am Chris Fitzpatrick and I act for Queensland Health?-- Uh-huh.

Can I just ask you, please, about those parts of your statement where you have told the Commission that at various times you have been concerned you might lose your job?-- Mmm.

It is the case, I take it, that no-one other than Dr Patel suggested to you that your job was in jeopardy over matters that you have canvassed in your statement?-- Only from him, yes.

And you refer, in the last paragraph of your statement, to the fact that counsellors were obtained. It is the case they were obtained by your employer, Queensland Health?-- Uh-huh.

And they have been made available to you?-- That's correct.

And was it them who reversed your impression that Dr Patel had some power of dismissal over you in your employment?-- Well, Dr Patel was gone at this stage when I was having counselling, so he was no longer a threat to me, so.

I see. Well, you said in your evidence that you learned that what Dr Patel had said to you about having the power of dismissal over you or having influence-----?-- Uh-huh.

-----in that regard was false. You found out that he couldn't?-- I found out today, yes. I mean, sorry, can I retract that? When I was making - talking to the solicitors making this statement, I asked them - I said, "Can I lose my job?", and they said no.

Yes. And so far as the counsellors go, have you found them helpful?-- I did, yeah.

And they have settled your feelings of upset?-- I still get upset. It is just going to be a matter of time, I think. You know, it was pretty traumatic. You feel like you are involved in this case, and these nice people die and that, and it did really upset me. It still upsets me. But I am getting on with my job, I am getting on with my life, and I know I will get better as time goes by.

Yes. Thank you, Ms Law. That's all I have, Commissioners.

COMMISSIONER: Thank you, Mr Fitzpatrick. Mr Allen, any re-examination?

MR ALLEN: No, thank you, Commissioner.

COMMISSIONER: Mr Morzone?

MR MORZONE: No re-examination, if it please.

COMMISSIONER: Ms Law, thank you for your time, coming in and giving evidence?-- Thank you.

Contributing to the work of this inquiry. We appreciate your frank and open way in which you have spoken up about these matters and we do appreciate your evidence?-- Thank you.

You are excused from further attendance.

WITNESS EXCUSED

COMMISSIONER: Anyone else this evening?

MR MORZONE: There is a witness who is available, but it is a longer witness so we could start her tomorrow.

COMMISSIONER: Who is that?

MR ANDREWS: That's Ms Raven, Commissioner.

COMMISSIONER: She will be quite - well, simply from reading her statement, which is very large, I assume she will be a longer witness.

MR ANDREWS: I expect so. Tomorrow morning, to meet the convenience of - I think it is Dr Kelly, I anticipate that he needs to be called at 9.30.

COMMISSIONER: Right. Okay. So we will adjourn until 9.30. Is that your proposal?

MR ANDREWS: Yes. Thank you, Commissioner.

COMMISSIONER: Before we adjourn, I just record I have been handed copies of the originating application by Darren William Keating against myself, Sir Llew and Ms Vider, and the supporting affidavit of David John Herbert Watt, covering letter from Flower & Hart Solicitors to the Crown Solicitor. Is it appropriate, is it, Mr Andrews, we make those an exhibit?

MR ANDREWS: Yes, Commissioner.

COMMISSIONER: So everyone knows what's going on. So those three documents will be exhibit 161.

ADMITTED AND MARKED "EXHIBIT 161"

COMMISSIONER: Mr Diehm, apropos the matter you raised a little while ago about the hearing continuing on Monday, from reading through the affidavit, I can't identify anything that's relied on that's occurred since the 10th of June that is raised on your client's behalf. In those circumstances, it is not immediately apparent to me why this inquiry should interrupt its proceedings simply to accommodate the fact that your client has chosen to issue proceedings in the Supreme Court at this time rather than at any time in the last month.

MR DIEHM: Commissioner-----

COMMISSIONER: Perhaps you could think about that overnight.

MR DIEHM: I could say that it does raise matters that have occurred since the 10th of June. In fact, the last matter that it raises is something that occurred last Wednesday.

COMMISSIONER: What's that?

MR DIEHM: Concerning the cross-examination of Dr Miach.

COMMISSIONER: I didn't pick that out from the affidavit, but I will take your word that's-----

MR DIEHM: I have not seen the final version of it, Commissioner, but it certainly ought to be in there and I would expect it is.

COMMISSIONER: I see. There are references to transcript pages, and that presumably includes Dr Miach's evidence last week.

MR DIEHM: It should do, Commissioner.

COMMISSIONER: Yes.

MR DIEHM: Commissioner, I didn't need to be so presumptuous, and I was trying not to be, when I raised my point to merely meet my convenience or my client's convenience in terms of that. I was actually contemplating - because I have already spoken to my instructing solicitor about the fact the Commission may well sit on Monday and it may be necessary for some arrangement on my client's behalf to be made, either representation here or in the Court. What I had in mind, then, was other interested persons who are represented here before the Commission who may have sought to appear on the hearing of those - and they, too, have other people appear - but they may have said that they wanted to appear, with their knowledge of matters, to articulate their point of view with respect to directions. So it is not that I am urging the Commission not to sit on Monday.

COMMISSIONER: All right. Well, does anyone wish to have the proceedings on Monday adjourned?

MS FEENEY: My client's in a position where we would want to appear at the Supreme Court directions hearing on Monday.

COMMISSIONER: Well, but do you want these proceedings adjourned?

MS FEENEY: It would make it easier for me to arrange representation for my client if it were, but it is a matter for you, Commissioner.

COMMISSIONER: Why is that? Your client hasn't had counsel here all week, apart from Mr Jackson and Mr Ashton appearing this morning and them not asking any questions. Why would it make any difference?

MS FEENEY: Arrangements would need to be made, Commissioner. I am sure I could manage that.

COMMISSIONER: If you want the proceeding to adjourn on Monday, I will entertain that, but I want to know what the basis is. Just to say that arrangements have to be made isn't very helpful.

MS FEENEY: I am in your hands.

COMMISSIONER: When the situation - well, I am actually in yours. If you want an adjournment, you will have to tell me why.

MS FEENEY: My client would like to appear in the proceedings in the Supreme Court.

COMMISSIONER: Yes. Well, your client hasn't been here for three weeks. So it is not a matter of him appearing.

MS FEENEY: Well-----

COMMISSIONER: Your counsel-----

MS FEENEY: -----counsel appear on his behalf.

COMMISSIONER: All right. Well, your counsel haven't been here all this week, apart from Mr Jackson and Mr Ashton being present this morning and not asking any questions. So is there some difficulty or inconvenience, or something that needs to be arranged that necessitates the cost of adjourning these proceedings?

MS FEENEY: I am not - I won't press the application.

COMMISSIONER: Well, if you wish to, as I say, if there is some basis for adjourning the proceedings, I will deal with that.

MS FEENEY: I am not pressing the adjournment.

COMMISSIONER: Thank you. Does anyone else wish to raise that? Mr Devlin? Mr MacSporran? Mr Farr? Mr Mullins?

MR MULLINS: My clients' specific instructions is to proceed with the inquiry.

COMMISSIONER: Thank you.

MR ANDREWS: Commissioner, I am curious if you're having - if you and the Deputy Commissioners are going to the hospital for a view, I am curious as to what time on Monday counsel will be required here.

COMMISSIONER: I don't know that a time has been fixed, has it, Mr Farr?

MR FARR: It is not, because I was going to ask if Thursday is available, until you made the mention of Monday.

COMMISSIONER: Thursday would suit us perfectly, I am sure.

MR FARR: What we had tentatively arranged was 8.45 on Thursday morning.

COMMISSIONER: 8.45 on Thursday morning. Subject to any further application that may be made, Mr Andrews, I imagine Monday 10 a.m. to allow people to come in on the earlier flight, if they choose not to come up the night before.

MR ANDREWS: Thank you, Commissioner.

MR FARR: Just so there is advance notice of this issue, the hospital administration has asked that cameras not be involved in the walkaround of the hospital.

COMMISSIONER: Absolutely not, and, indeed, I was contacted by the press about that, and the indication I gave was that they could film us in public if they chose to film us arriving at the hospital, but what goes on in the hospital grounds is a matter for the hospital management, not for us. And I certainly don't have either the authority or the inclination

to put patients to the inconvenience of having to put TV cameras-----

MR FARR: I must say, I had anticipated that response and I advised them that's what I expected to be the case.

COMMISSIONER: Thank you for that, Mr Farr. Anything else?

MR DIEHM: Perhaps I can just tell everyone in this public forum with respect to those documents you have made exhibits, my instructing solicitor's intention was to cause copies of them to be emailed to the legal representatives of each person appearing.

COMMISSIONER: We have saved you that trouble.

MR DIEHM: Thank you, Commissioner.

COMMISSIONER: Thank you. 9.30 tomorrow.

THE COMMISSION ADJOURNED AT 4.38 P.M. TILL 9.30 A.M. THE FOLLOWING DAY