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Transcript of Proceedings

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SIR LLEW EDWARDS, Deputy Commissioner

MS MARGARET VIDER, Deputy Commissioner

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IN THE MATTER OF THE COMMISSIONS OF INQUIRY ACT 1950

BUNDABERG HOSPITAL COMMISSION OF INQUIRY

COMMISSIONS OF INQUIRY (No. 1) 2005

BUNDABERG

..DATE 08/07/2005

..DAY 21

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THE COMMISSION RESUMED AT 9.35 A.M.

MR ALLEN: Excuse me, Commissioner, could I raise one preliminary matter?

COMMISSIONER: Yes, of course.

MR ALLEN: Commissioner, the media reporting of this matter has been for the large part both responsible, accurate and at times even insightful.

COMMISSIONER: Yes.

MR ALLEN: However, I'm concerned with reports in the local ABC Radio news this morning to the effect that Ms Mulligan has been given a clean bill of health, that the Commissioner has stated that she has been cleared of any suggestions of wrongdoing based upon the fact that there is no evidence to support such. It would seem to me that that is in fact not quite an accurate representation of what transpired yesterday.

COMMISSIONER: Yes. I'm not aware of those particular reports but if they are to the effect you've indicated, then that is an overstatement of the situation. What I did make clear to Mr MacSporran yesterday is that, given the current state of the evidence, we would consider issuing a letter of comfort. No decision has been made about that and I think Mr MacSporran understands that entirely. Needless to say, we would need to discuss that with him and ensure that there is not likely to be any further evidence forthcoming. My comments were based entirely on the evidence as it currently stands.

But, at the same time, I don't mind restating that in my view, as the evidence currently stands - perhaps I should explain it this way. Under our Terms of Reference there are issues relating to Dr Patel which are obviously individual to him. At the other end, we're invited to make recommendations as to whether anyone should be the subject of criminal charges, official misconduct proceedings or disciplinary proceedings. My comments were really directed to that third category; that there does not appear to be anything that could suggest that Mrs Mulligan is in line for any recommendation of that category.

In between those first and last Terms of Reference there are matters going to systemic issues within Queensland Health. Inevitably, when we examine systemic issues, individual cases will be looked at not by way of criticism of the individuals involved but by way of analysis of how the system operates. Unfortunately that will have the effect that some people, including, possibly, Mrs Mulligan, will feel some embarrassment and some awkwardness because their conduct will be under examination, but not with a view to making specific recommendations relevant to them; rather, with a view to making recommendations relevant to the future of Queensland Health.

What I was attempting to convey is that on the evidence as it stands, Mrs Mulligan certainly is not in line for any criminal official misconduct or disciplinary recommendations, although things like her management practices and systems in which she operates will still be relevant for an examination of the efficiency of the system as a whole. Mr MacSporran, that's roughly as you understand the situation.

MR MacSPORRAN: Yes, certainly, Mr Commissioner, that's as I understood it. And in that context, Ms Mulligan is more than prepared to give evidence and answer any suggestions that might be made about her practices.

COMMISSIONER: Thank you. I hope that also answers your concern.

MR ALLEN: Yes. My only concern was that there not be an inaccurate perception that the Commissioner prejudged matters before the evidence was heard, and you have clarified that, thank you, Commissioner.

COMMISSIONER: Thank you, indeed.

MR ALLEN: Commissioner, I understand that there will be some legal argument before the next witness is to be called. I would wish to be heard on that but I understand my learned friend Mr Farr may wish to make some submissions first.

COMMISSIONER: This concerns the evidence of Mr Kelly?

MR ALLEN: It does.

COMMISSIONER: Mr Farr, what's the situation there?

MR FARR: Commissioner, we were provided with Dr Kelly's statement made yesterday afternoon. I don't know whether you have had a chance to read it or not but he is concerned with the emergency department of the Rockhampton Base Hospital. He makes allegations concerning a number of different people in the course of his statement. Yesterday afternoon was the first we were aware of these allegations. We have endeavoured overnight to take some instructions from these people. I have had some phone conferences with some people but it is the situation that I am not in a position where I would feel comfortable, with my instructions in the state that they presently are, to conduct a proper cross-examination of Dr Kelly. It's a matter where we will necessarily have to take statements from quite number of people.

I understand that the intention was for him to give evidence via telephone linkup.

COMMISSIONER: Yes.

MR FARR: Which is another matter which I might wish to address but - and I understand also that he's indicated he is flying out to the States some time soon I believe.

COMMISSIONER: I understand he is leaving Australia on Sunday. Is that right, Mr Atkinson?

MR ATKINSON: I understand that it is, Commissioner.

MR FARR: That being the case, if the intention was for it to be telephone evidence, then in my submission there could be no reason why he couldn't give it from the States for instance other than it would be more expensive. But it is a situation in my submission where we should be given the opportunity of taking full instructions from a number of different people in quite detailed matters.

There also is the issue which after taking those instructions might result in submissions being made as to whether parts of his statement are of any relevance to the Terms of Reference for the Commission of Inquiry. On the face of it, there would seem to be quite some difficulty in some of those areas but, once again, it would be I think rather pre-emptive of me to make submissions without really obtaining the full particulars of the instructions that I feel that I need to properly address the issues that he raises.

COMMISSIONER: Mr Farr, I am of course entirely sympathetic with your position individually. I have to say I'm not so sympathetic with the position of Queensland Health. This matter comes to light at this stage only because those who give you instructions chose, for whatever reason, to keep Exhibit 129, the report relating to the Rockhampton emergency department, not only out of the public eye but also away from this Commission of Inquiry. Quite on the contrary we received an initial written submission from Queensland Health containing lavish assertions as to how effective and reliable the systems within Queensland Health were to address problems relating to overseas trained doctors and it comes as a matter of disappointment and surprise that we learn about this report only because Hedley Thomas was able to get a copy off the back of a truck. In those circumstances, I don't feel that your client is in a position to ask for any particular indulges or latitude beyond those which are strictly necessary to ensure that your client has an opportunity to make any proper objections or to properly defend itself by way of cross-examination.

What I am minded to do, subject to any further submissions, is to take the evidence-in-chief from Mr Kelly now and if it is your wish to take time to take instructions to conduct your cross-examination, then we can arrange another telephone call with Dr Kelly after he returns to the United States. Would that be satisfactory to you, Mr Atkinson?

MR ATKINSON: It is, Commissioner. I imagine the other thing you might consider in order to address questions of fairness is whether or not the practitioners' names in the statement of the evidence from Dr Kelly are the subject of a suppression order?

COMMISSIONER: Yes, that would be a fair course. How would that suit you, Mr Farr?

MR FARR: Well, it would be preferable; it would allow me to take proper instructions. But can I just raise this issue, and I appreciate the comments that you've made in relation to Queensland Health as an organisation, but we also act for a number of individuals of course.

COMMISSIONER: Yes.

MR FARR: Some of those individuals are people that are referred to in the course of Dr Kelly's evidence. There is no blame attributed to them in the provision of a report of any description.

COMMISSIONER: Of course.

MR FARR: And specifically in relation to the individuals that may concern, I take it you would have had the opportunity to have read the report from June last year that's been provided this week which addresses and identifies a number of problems with the emergency department of Rockhampton Base Hospital.

COMMISSIONER: Yes.

MR FARR: Dr Kelly speaks of some of those areas in common with that report and it's not my intention to be cross-examining on any of those issues at all. So there's no dispute about those important matters if you like.

COMMISSIONER: Yes.

MR FARR: My bigger concern however is in relation to allegations of individual behaviour, if you like, regarding the management styles, the interaction with individuals. I have certain instructions which I would necessarily have to put to Dr Kelly, if in fact he gives evidence-in-chief today, that ultimately I would be hoping the Commission would not even need to go into.

What I was proposing was that his evidence be simply postponed to a later date. We can take instructions from any relevant people, provide counsel assisting with those statements and then when all of that material is gathered, a decision be made as to whether in fact it is necessary to tender the statement and call him or whether even, in fact, an edited version just in relation to important systemic problems that he speaks of in certain paragraphs might be all that is in fact required, which would reduce the time considerably in evidence for the witness, the time for the Commission and also some cross-examination that does not necessarily have to occur.

So what I was suggesting was really a course which cannot take up any more of the Commission time. It just means more work for certain of those people instructing me, but I'm hopeful

that in fact it will reduce the sitting time for the Commission so far as that witness is concerned.

COMMISSIONER: Another option would be to give you time to get instructions and take - Mr Kelly doesn't go back to the States until Sunday?

MR ATKINSON: I think that's right. He's left his job in Rockhampton obviously. He's staying in a hotel with four of his children in Sydney. I think they're having a five-day vacation there and my understanding is that he returns to Pennsylvania on Sunday.

COMMISSIONER: We might be able to deal with it tomorrow then, Mr Farr.

MR FARR: I don't know that it will be possible to get the instructions and the statements that I need from all of the people. We'll have to physically, of course, arrange with Rockhampton and one Brisbane person and identify some people. I understand as well at the moment, but I only have very scant details of this, that one person is unwell.

COMMISSIONER: Yes. Well, Mr Farr, can you take me through the statement and identify those paragraphs that would cause you concern.

MR FARR: Certainly. Well, can I, in a shorter, quicker exercise, identify for you the paragraphs that I was not intending touching upon in cross-examination, or touching on only in a certain respect. If I can take you to 9.

COMMISSIONER: Yes.

MR FARR: Paragraph 9(a) speaks of the standard of the junior doctors employed at that emergency room. I think the Commissioner would have seen in the report that was prepared the identification of some criticism of standards of the doctors employed at that place. So there was not the intention to cross-examine on that topic other than perhaps for a clarification of the term "horrendous".

COMMISSIONER: Yes.

MR FARR: It might be that I would certainly need to take him to that term. And I think it's not giving evidence from the Bar table that the report identified, if I remember correctly, that what was required for that emergency department to run properly was a total of four specialist emergency doctors.

COMMISSIONER: Yes.

MR FARR: Which they were endeavouring to obtain.

The absence of radiologists is not disputed but there would be some cross-examination about the arrangements that have been put in place with a private radiologist service utilising the local specialists population for that purpose, but I'm still

awaiting the full details of that.

I won't touch upon paragraph (c). I think Mr Allen has some submissions in relation to that but I do have some issue that I can take with some of the things that are said there.

If I then move on to paragraph 11 and-----

COMMISSIONER: Mr Farr, I'd be more interested in knowing which paragraphs give you a problem rather than those in which you feel you're able to deal with.

MR FARR: All right. Sorry. If one goes to paragraph 13.

COMMISSIONER: Yes.

MR FARR: You will see there is evidence proposed to be given of an approach that was made to him regarding being appointed the Director of Emergency Medicine, that approach being rescinded after some period of time.

COMMISSIONER: Yes.

MR FARR: There will be some cross-examination on that and on discussions that were held, the reasons that were given. There is in paragraph 14 an allegation that the witness was told that the report was secretive, as you will see at the very bottom of that paragraph.

COMMISSIONER: Well, it was, wasn't it?

MR FARR: My instructions are that it wasn't and that it had been distributed but I don't have instructions as to where and to whom it had been distributed. That's one of the-----

COMMISSIONER: Well, it wasn't a public document?

MR FARR: I can't answer that.

COMMISSIONER: No.

MR FARR: If I could, I would. Paragraph 15, as I understand my instructions that was not the reason given to Dr Kelly that he speaks of.

In paragraph 16 and through to 20 he speaks of a particular case which resulted, ultimately, in a complaint of clinical competence being made against him and an investigation occurring and ultimately clearing him of any wrongdoing. My instructions are quite different in many respects to the information he's provided on that topic.

In relation to paragraph 21, there is a difficulty in that it is thought that he is comparing wage rates between different categories of doctor. Additionally, my understanding is that because of the nature of the recruitment agency involved in this case, he was in fact not an employee, a paid employee of Queensland Health but, rather, he was paid by the recruitment

agency and placed in a position for Queensland Health, and I understand this agency has a somewhat different practice to most others.

You will see in paragraph 22 he speaks of having a lengthy telephone conversation with NP12. You see the length he alleges of that conversation. NP12 has a very different recollection of that conversation.

COMMISSIONER: You will have no difficulty getting instructions from NP12, will you?

MR FARR: No. In fact, I have spoken to him over the telephone. I just haven't had time - because it is such a lengthy conversation, certain instructions haven't been obtained in the way that I would normally approach this matter.

COMMISSIONER: Yes, yes.

MR FARR: There were then the cross-examination as to the nature of Dr Kelly's behaviour in respect of his work commitment following that conversation and the subsequent termination of employment and a number of matters arising from that.

The issue, given the matters that he's raised in this document, is that credit will become an issue. What I was hoping is that upon receipt of material that I can in fact provide to counsel assisting, it may be that none of this is necessary.

COMMISSIONER: Well, I think it's highly necessary if credit - if you're telling me that you have instructions to put Dr Kelly's credit in issue, then it would be very difficult to take evidence by telephone and we may have to follow to the United States to take his evidence. I think it is tremendously important evidence, but if NP12 or someone else wants to put his credit on the line against Dr Kelly's, then we'll have to play that out in the proper way.

MR FARR: Yes. I might say that on the instructions that I have received, there are many differences and a telephone cross-examination of that nature, of course I will do, if you so order, but I was going to say that it will be necessarily a very difficult to exercise.

COMMISSIONER: Mr Atkinson, what do you say?

MR ATKINSON: Commissioner, I understand my learned friend's concerns. I would have thought those concerns can be addressed in two ways: One, by deferring the cross-examination and the second, by suppressing the names of practitioners until the evidence can be tested. The other thing that comes to my mind is that if this doctor is allowed to give his evidence under those circumstances, then my friend in some sense is assisted because he will then have the full sense of the evidence and the cross-examination can proceed

better prepared.

Commissioner, as you say, the problem for counsel assisting is that we only became aware of this doctor and the problem at Rockhampton Base after learning of it through The Courier-Mail. I spoke to the doctor, personally, yesterday and took a statement from him, typed it up, and once he explained that that did represent his evidence, I provided it to the other parties. It hasn't been tested and I certainly understand my friend's concerns for that reason, but the doctor has gone to some trouble to make himself available. He is in a hotel room with four children; one of them has Down's syndrome I understand. His wife in any case is rather unhappy with him and the situation because they've come to Australia and they're going back. I'm very keen to get his evidence out while he's available and, as I say, under the conditions, under the circumstances that I suggested at the outset.

COMMISSIONER: My major difficulty is that Mr Farr has flagged very clearly that at the end of the day he will be asking us to decide whether Dr Kelly's telling the truth or NP12 is telling the truth because they're going to give conflicting versions of things. Fairness would require that if we have to make a decision as to which of those two, either the emergency specialist or the bureaucratic, is telling the truth, then it's difficult to do that without having seen the witness in person giving his evidence.

MR ATKINSON: Mr Andrews says he could make himself available to a trip to Pennsylvania.

COMMISSIONER: And please convey to Mr Andrews I'm grateful for his willingness to put himself out in that way. There must be a sensible way that you can resolve this. He is very reluctant, I understand it, to come to Bundaberg and break his holiday in Sydney?

MR ATKINSON: He is. He is very reluctant to face his wife actually.

COMMISSIONER: Something I can definitely sympathise with.

MR ATKINSON: I mean, the key issues aren't the personality ones that are sought to be elicited. The key issue is as to how overseas trained doctors find the conditions in Australia, how they are treated generally and, also, whether this report was available as widely as might be suggested. They're issues that don't need to involve the practitioners to some extent and, certainly, their names will be suppressed without any harm to the cogency of the evidence.

COMMISSIONER: Well, Mr Atkinson, my inclination is to see whether you and Mr Farr can whittle back the statement on those things on the one hand you regard as critically important and on the other hand won't create any problems of that nature for Mr Farr. If your main is concern is the systemic issues rather than the personalities and, candidly, that's how we on the bench see it, we're much more interested in the systems failures rather than who said what to whom, if you and Mr Farr can work out some common ground as to what - what can be dealt with without causing Mr Farr any inconvenience, that would seem to be the perfect solution. Do you think that is possible, Mr Farr?

MR FARR: I'm certainly poignant to have a go at that, yes.

COMMISSIONER: I'm aware, of course, that Mr Allen wanted to say something about this, of course, as well.

MR FARR: Yes.

COMMISSIONER: Mr Allen, would I be right in anticipating that the sort of solution that I would be anticipating, that you would have something to say in terms of what should be included or excluded?

MR ALLEN: My only difficulty was one which may be able to be resolved through that process.

COMMISSIONER: Yes.

MR ALLEN: If counsel assisting doesn't intend to lead the contents of paragraph 9(c) I have nothing further to say.

COMMISSIONER: Does anyone else at the Bar table have anything to say about this? It wouldn't interest you, Mr Diehm, would it? Mr Devlin?

MR DEVLIN: There is an issue concerning the alleged standing of overseas doctors. This is a matter which seems to require a much wider range of inquiry and a presentation of both sides of the story at the same time rather than let a set of allegations hang in the air for some indefinite time until the matter can be brought back on. I have in mind from the Medical Board's point of view that the Medical Board will probably be interested to know what - about what doctors Dr Kelley makes an allegation of substandard practice, then to go to their files and see how they presented to the system and what CV they presented and what scrutiny they were subject to before they started to practice as overseas trained doctors in Rockhampton; that would take quite some time so that a balanced cross-examination or presentation of Dr Kelley's evidence could occur.

COMMISSIONER: How do you propose we do that?

MR DEVLIN: Well, to postpone the taking of his evidence until all of the issues can be teased out, and a proper presentation of a package of evidence.

COMMISSIONER: And if he's back in Pennsylvania?

MR DEVLIN: If he has to fly back to Australia on important matters-----

COMMISSIONER: I understand once he's back in Pennsylvania, this is what I'm told, he has no interest of returning to Australia and telling us his evidence.

MR ATKINSON: That's correct, Commissioner.

MR DEVLIN: The timing with which this has been presented leaves a number of parties grasping at how to be properly briefed to cross-examine him.

COMMISSIONER: Well, whose fault is that?

MR DEVLIN: Well, it's certainly not my party's fault.

COMMISSIONER: It certainly isn't, Mr Devlin.

MR DEVLIN: And it's not the fault of the Queensland Nursing Union.

COMMISSIONER: No, it's not.

MR DEVLIN: It's not the fault of the individuals working within Health.

COMMISSIONER: What about NP12, is he going to tell us he knew nothing about this report? He's the one that says he can't answer these allegations. Is he going to come here and give evidence, "I didn't know this report existed, even though I'm deputy Director General. The first time I heard about it was in Mr Hedley Thomas' column in The Courier-Mail."

MR DEVLIN: With respect, all the matters Dr Kelley raises, rather than merely being a paragraph here and a paragraph there, would require us to tease out the various matters of criticism.

COMMISSIONER: You are perfectly right, the need to make full and proper inquiry is frustrated by the fact that someone at Queensland Health has chosen to conceal this report from us. What I'm trying to do is to work out the best way forward, given that we only found out about this a week before the man leaves the country.

MR DEVLIN: Well, I'm asking for his evidence to be postponed.

COMMISSIONER: Until when?

MR DEVLIN: Until proper inquiry can be made about all of the aspects that he raises.

COMMISSIONER: How long is that going to take, Mr Devlin?

MR DEVLIN: Hopefully it won't take too long. Hopefully it can occur in the lifetime of this Commission.

COMMISSIONER: So you want him to come back on the 29th of September?

MR DEVLIN: No, I would be happy to tease out the details of what Dr Kelley is trying to say and then be in a position to examine those matters in the public interest.

COMMISSIONER: How do we tease that out without hearing from him?

MR DEVLIN: The - well, it needs more examination of the hospital records, for example, to find out what staff were working in the Emergency Department at the relevant time. He's not going to know every - the name and classification of every doctor he worked with, for example, or every nurse.

COMMISSIONER: Mr Devlin, I'm looking for your help, not your complaints. I mean, if I listened to you on Tuesday we would have shut down the entire inquiry because of a letter from solicitors threatening an application that never happened. You know, what I would really like from you is assistance as to how we overcome this problem that has not been created, as you say, by your client or by Mr Allen's client or by the AMA or by the counsel assisting the inquiry, but is a problem we still have to deal with.

MR DEVLIN: Commissioner, you have frequently resorted to me as somebody who has had considerable experience in public inquiries dating back to the Fitzgerald Inquiry.

COMMISSIONER: That's why I appreciate your assistance.

MR DEVLIN: I don't every time get to my feet and complain. I am complaining now because of the breadth of what he says about the functioning of an Emergency Department in a large provincial hospital. It demands larger attention than three pages of rampant criticism by Dr Kelley. It simply needs more careful attention before the public is drawn to the concerns that Dr Kelley raises as being genuine concerns and, perhaps, destructive of reputations, unnecessarily, until a balanced picture can be drawn of the situation Dr Kelley confronted.

COMMISSIONER: So, Mr Devlin, how do you suggest we deal with it?

MR DEVLIN: To postpone his evidence until these matters can be more thoroughly investigated.

COMMISSIONER: With the result that he goes back to the United States and we lose any opportunity to hear what he has to say?

MR DEVLIN: I don't understand that the opportunity of taking evidence from him is lost entirely at all.

COMMISSIONER: Well, Mr Atkinson, whilst you are trying to sort out matters with Mr Farr and Mr Allen, will you also make contact with Dr Kelley and ascertain his willingness either to return to Australia to give evidence or to give evidence in the United States, if that arrangement becomes necessary due to the complaints we've heard, or if he is able to give evidence from the United States by telephone or video link after he returns because it seems based on the complaints of Mr Devlin we're driven to one or other of those options.

MR ATKINSON: I will do that. I will just make this comment, Commissioner: I understand the concerns about a particular practitioner, and I hope that can be helped by suppressing names. In terms of what Mr Devlin calls the rampant criticism, it's not different to what's contained in the report. The report, itself, contains very damning criticisms of the level of hospital staffing and a suggestion that the Emergency Department was used just to put undertrained doctors where they couldn't be used elsewhere, a suggestion that all the overseas doctors tended to be put in the Emergency Department, and it's those generic issues rather than raising particular, untested allegations against particular practitioners that I sought to ventilate.

COMMISSIONER: I understand that, Mr Atkinson. Mr Devlin has put that in the wind now. So we will see what practical solutions we can work out than argumentative ones.

MR FARR: Can I just flag the suppression of names probably doesn't have much of an effect because when positions are identified the local populations, of course, know the people involved.

COMMISSIONER: Mr Farr, I think you know where I'm going and, candidly, the individuals concerned are not a matter of interest to us.

MR FARR: I appreciate that.

COMMISSIONER: What's of interest to us are the comments that Dr Kelley makes about the systemic flaws and the way in which staff are recruited and used, particularly with respect to putting underqualified people in emergency medicine positions. That's what we think is important.

MR FARR: Yes.

COMMISSIONER: Now, Mr Devlin may want to pursue other matters and he will be given that opportunity, but so far as I'm concerned those are the issues. As I say, if-----

MR FARR: I will speak to Mr Atinkinson.

COMMISSIONER: -----you and Mr Alan and Mr Atkinson can whittle things down to what's interesting to us, and Mr Devlin will have his opportunity if he wants to pursue other matters that are of interest to him.

MR FARR: Thank you.

COMMISSIONER: We will adjourn.

MR MacSPORRAN: Commissioner, can I make a very brief submission?

COMMISSIONER: Yes.

MR MacSPORRAN: Firstly, I support Mr Devlin's submissions for the reasons he's given and you seem to accept the tenor of that submission. Secondly, and for my client, I support Mr Allen's submission in respect of paragraph 9(c) of Mr Kelley's statement on the basis that the matters raised there are clearly, it would seem, just general nonspecific complaints about individuals.

COMMISSIONER: And that's precisely what I've been saying for several weeks, that we're really not interested in things about people feeling that other people have incorrect management styles, and that sort of thing.

MR MacSPORRAN: Yes.

COMMISSIONER: I agree entirely, Mr MacSporran.

MR MacSPORRAN: Perhaps Mr Allen and his client would take a similar view in respect of matters that seem to be coming in through statements from his client in respect of Ms Mulligan. It's a very similar style of complaint.

COMMISSIONER: Yes.

MR MacSPORRAN: Nonspecific, very difficult to deal with, and not, I would have thought, properly the subject of this Commission of Inquiry.

COMMISSIONER: Mr MacSporran, I hope you will agree that I have done all that I could reasonably do without being accused of bias to protect your client from inappropriate comments of that nature.

MR MacSPORRAN: Yes, I'm grateful, Commissioner.

COMMISSIONER: And I will do the same to protect other members of the Queensland Nursing Union represented by Mr Allen or, indeed, members of the medical profession or, indeed, bureaucrats from unsubstantiated vague assertions of that nature rather than specific allegations of systemic problems.

MR MacSPORRAN: Yes. I simply raise it at this stage again because there are other statements that are in the pipeline, as it were-----

COMMISSIONER: Yes.

MR MacSPORRAN: -----and there may need to be some editing of those before they come before the Commission.

COMMISSIONER: Yes. I think that's a very valid point and if any of those slips through the sieve I trust I can count on you to bring that to the attention of counsel assisting, so it doesn't get into the public arena until it's properly whittled back to things that are appropriate.

MR MacSPORRAN: Yes, thank you.

COMMISSIONER: And, Mr Allen, I'm sure you would agree with that, as well, the sort of general assertions contained in 9(c) are, really, quite unhelpful to anyone.

MR ALLEN: They are. They're not even within the terms of reference

COMMISSIONER: I don't know about that, but you would agree about the generality of those assertions and what's sauce for the goose is sauce for the gander; general assertions shouldn't be made about other people, as well.

MR ALLEN: I don't agree they're analogous to the matters my learned friend complains of.

COMMISSIONER: Okay. 15 minutes, gentlemen?

MR ATKINSON: Thank you, Commissioner.

COMMISSIONER: Thank you.

THE COMMISSION ADJOURNED AT 10.12 A.M.

THE COMMISSION RESUMED AT 10.35 A.M.

COMMISSIONER: Yes, Mr Atkinson?

MR ATKINSON: Mr Allen, Mr Farr, and I have had discussions and we have come to an agreement. The agreement - do you need to hear the agreement, Commissioner?

COMMISSIONER: Just the broad outline.

MR ATKINSON: A broad outline is this: that I intend to elicit evidence, with my learned friend's consent, from Dr Kelley as to how he came to be in Australia and whether or not that report was widely available, at least to him, and also I intend to elicit evidence about whether or not that report in June 2004 portrays the conditions in 2005. But apart from that, I won't be seeking to elicit evidence about specific people or even about a particular conflict that happens at the end of the trip - at the end of the stay.

COMMISSIONER: Yes.

MR ATKINSON: I had spoken to Dr Kelley about whether or not he might be prepared to give further evidence by telephone once he has returned to the States. He said that he is prepared to do that. As to whether or not he might fly back, he would certainly consider that but he says it would cause him considerable personal and professional hardship and he may not be able to do that.

COMMISSIONER: Yes.

MR FARR: Commissioner, can I just indicate for the record that if Dr Kelley's evidence is, for instance, that the recommendations identified in that June report had not been implemented by the time he started, and then I receive contrary instructions that some of those things have, we will prepare a statement that can be provided to the Commission and the witness can give evidence if necessary, but it might be the case that I need to cross-examine him in future, if the matters haven't been resolved-----

COMMISSIONER: Certainly, Mr Farr. You have made your position, as usual, very, very clear, and there will be no suggestion of any Browne v. Dunn problem or anything like that, if matters come into evidence now that you are not in a position properly to address in cross-examination.

MR FARR: Thank you.

MR ATKINSON: Can I say this, from counsel assisting's point: there is some possibility we will seek to press the balance of the statement at a later time, but obviously we will consider that position with Mr Farr and reach a decision and give him good notice of that.

COMMISSIONER: Yes.

MR ATKINSON: May I call then the witness.

COMMISSIONER: Thank you, yes.

MR ATKINSON: Dr Kelley, can you hear me?-- Very well.

WILLIAM THOMAS KELLEY, SWORN AND EXAMINED VIA TELEPHONE LINK:

MR ATKINSON: Dr Kelley, it is Damien Atkinson again. Your full name is William Thomas Kelley?-- Correct.

And you spell Kelley K-E-L-L-E-Y?-- Correct.

You were born on 10 March 1951?-- Correct.

You are presently staying temporarily in Sydney and then you are returning to the United States?-- Correct.

You are a citizen of the United States?-- Correct.

You are a specialist in emergency medicine?-- Correct.

You have about 25 years' experience in that field?-- 25 plus.

Right. You trained at the John Hopkins Medical Centre in Baltimore?-- Correct.

That's a very well regarded emergency medicine centre?-- I would say one of the top three in the world.

When you finished your training there, you were offered a teaching position?-- Correct.

Instead, though, you worked at a large trauma centre in the Lehigh Valley?-- That's correct.

That's about 90 minutes from New York?-- That's correct.

Whilst you were there, you had a wide range of duties, including supervising others?-- Continuously.

After that you worked 15 years as the Director of Emergency Medicine in a rural hospital in Pennsylvania?-- That's what I currently do, that's correct.

And you were supervising three board-certified doctors?-- That's correct.

The position, is this right, in the United States, or at least in Pennsylvania, is that every 10 years an emergency medicine specialist needs to undertake exams again to show that they have appropriate skills and qualifications for emergency

medicine?-- Yes, that's a national requirement, and I've done it twice. As recently as last year I completed the last exam.

In 2003, or was it 2004 you first learnt of Queensland and Queensland Health?-- It was November 2004.

Can you tell the Commission how that came about?-- A friend of mine who took up a position had attended a conference, and at the conference there was a kiosk with a company by the name of Global Medical Services, and they were advertising positions available in Australia. So I - he came back from the conference, told me about it. I called Global Medical and it went from there.

Okay. Now, don't go into the specifics of how you came to have your job, but effectively I understand you were offered a position at the Rockhampton Base Hospital and you took that job?-- Correct.

And you moved across from Pennsylvania to Rockhampton with your wife and four of your children?-- Correct.

Now, you started work in Rockhampton in March 2005?-- Thereabouts.

And you put your wife - sorry, you put your children into school at Yeppoon?-- Correct.

Now, in the course of your time in the Emergency Department, or the emergency room as you call it, at Rockhampton, you noticed some problems, is that right?-- Absolutely.

And they were problems of a clinical nature?-- Clinical nature, administrative nature, management nature, yes. Problems all over the place.

And in the event, there came a time when you suggested to management - and we won't go into specific people at this stage - you suggested to management that the conditions were so dangerous that the Emergency Department should be closed down?

MR FARR: With respect-----

WITNESS: Yes, it should be closed down, not only that was because of the danger but because I thought that would be a way of political statement that would allow the public to realise how bad the situation was and hopefully to move forward.

MR ATKINSON: If you can wait for a moment, Dr Kelley. One of the other barristers is taking an objection.

MR FARR: Commissioner, we just might be getting a little bit away from what we had anticipated the evidence was going to be at this stage.

COMMISSIONER: Yes.

MR FARR: So I have no objection to my learned friend leading the witness through the evidence that he is intending to take.

COMMISSIONER: I think that might be the best course, Mr Farr. Obviously, none of us can control a witness who is keen to give evidence of things as he sees them, but, Mr Atkinson, if you can try to stick to the script as much as possible?

MR ATKINSON: I will. I will. Dr Kelley, when you raised concerns, whatever they were, with management, is it the case that management told you that similar concerns had been raised in a report dated June 2004?-- Correct.

Now, when you raised those concerns, can you remember roughly what month it was?-- Oh, it was within two weeks of my starting there.

Can you say whether prior to that time you were provided with a copy of the report?-- Not prior to that time. I attended a meeting in which I basically at that meeting said the place was dangerous. It was dangerous.

Well, that causes some sensitivity at the bar. You attended the meeting and you explained that you thought the place was dangerous and you have elaborated upon that?-- And I also said that I would be willing to take my whole time to try and find the senior doctors to come and tab the place to help out.

You were presented with this report?-- Yeah, and he said to me, "There has been this report that was done a year ago.", and I said, "I would like to see it." And I also asked them what did the public have to say about this report.

All right. And you were told that the report hadn't been made available to the public?-- Not only that it had not been made available to the public, the public would have to - the report was secret and it was under no circumstances to be exposed to the public, to which I objected. I pointed out as far as I could tell it was a report that had been paid for by public taxes and the public had every right to know what was in that report.

Prior to that meeting had anybody within the hospital spoken of or discussed with you the report?-- No.

Have you got the report in front of you, doctor?-- I do.

It is a report called "The Emergency Department Review - Rockhampton Hospital, Final Report June 2004"?-- Correct.

What I want to do, doctor, is take you to parts of the report. And I want you then to explain whether or not the conditions identified in June 2004 prevailed in March, April, May, June 2005?-- Well, I can just tell you summarily-----

No, I don't think I am allowed to - I think what I have agreed with my learned friend from Queensland Health is that I will

go to particular issues?-- Whatever you like.

MR FARR: I have got no objection - if the doctor's evidence is that the problems identified in the report were still evident at the time he commenced work, then I have got no difficulty.

COMMISSIONER: Mr Atkinson, let's hear the summary first and then, if necessary, go to the specifics.

MR ATKINSON: Dr Kelley, I cut you off. You were saying you could tell me summarily that?-- I was just saying that summarily the conditions present in Rockhampton were present - were present when I started and are present as we speak.

What you say is there was no change from March 2005 to the time when you left?-- I think it got worse.

I have an unrelated question which is this: whether the conditions were just as bad as are identified in the report?-- Worse.

Can I take you then to some specific issues?-- Yes, go ahead.

Would you turn to page 6 of the report? It has got Chapter 3 at the top. Can I take you down to the last heading, that is "Poor utilisation of existing IT resources"?-- Correct.

Can you say whether or not that was a problem in the Emergency Department?-- There was no use of IT resources in the Emergency Department.

Can you elaborate on that for me, doctor?-- Well, the - I actually attended a two-hour course on how to use the system that they had in place, called the HBICS system which they originally said they wanted - they wanted data entered by me about patients, about flow of patients, the time they checked in, et cetera, et cetera. I looked at them at the end of the two-hour course and I said, "This is clerical work. This is nothing to do with me and I don't know why you have just taken two hours of my time to show me this.", and on top of which, it is all in DOS, which means you can't - it is not even - you can't use a mouse with it, you have to - it is 25 years old. 20 years old. It is absolutely a cumbersome and inefficient system that, really, I had no interest in at all. I think that the information - the data that they were attempting to collect is not unimportant by any stretch of the imagination, but it is so far down the list in terms of the problems that exist there that I had little interest in it. Beyond that, what I was interested in in terms of IT was internet access, and I found that when I got here that in order to get internet access I had to fill out a four-page form and have it signed by the district manager, which did happen, but the whole process took about, oh, a good day in order for that to happy. I turned out, from the meeting, the only doctor in the emergency room who did have internet access. And I might even point out that this internet access required a user name and password, and when the initial screen came up there was a

message on there that should I access any pornographic site, that I would be summarily dismissed.

The other doctors didn't have IT access, is that right?-- They didn't have internet access because they didn't fill out the form and they - it was their decision but, you know, I can't imagine practising medicine without it.

Can you just tell us very briefly why internet access assists in the work of an emergency medicine specialist?-- Oh, absolutely. It is - you know, people come in with - oftentimes with medications that I am not familiar with, less frequently with medical conditions that I am not familiar with, and I just do a Google search and I can come up with the names of the medication that's used in the English system versus the American system, and I can read about conditions - let's just put it this way: I use it all the time. It is just, you know - I mean, certainly not as important as my stethoscope, but it certainly should be easily available on any doctor practising emergency medicine at any place at all.

There is reference in the report of 2004 into a system called EDIS that seemed to being implemented. Does that assist clinicians?-- Well, actually, that again is a data collection system that allows people to track how long patients wait in the emergency room before being seen, how long they spend in the emergency room and how long it takes patients to go from the emergency room to a hospital bed once admitted. All that information is important. However, it is nowhere near as important as proper patient charting, and I tried to introduce a system that we use in the united States called a T-system, which is a template charting system that allows you to chart very efficiently, using check marks on a piece of paper, the patient's history, past history and relevant family history, and as well as physical complaints on exam and have that information available for training purposes or for other doctors in the hospital who subsequently see a patient seen in the emergency room. So I would say that using that system is clinically much more relevant than the EDIS system and attempting to introduce that system, I was told there was no money for that, and I tried to tell them that this was critically important as a tool in emergency medicine and that once this tool was implemented, not only would you have a better teaching system but the whole issue of how long patients are waiting to be seen and to be moved through the emergency room would solve itself because the amount of information is collected quickly and efficiently using this system.

And if you have, I understand, a slick emergency room, then there are flow-on effects for efficiency in other parts of the hospital?-- It all starts in the emergency room.

The emergency room is the first point of contact. It is like the point man and then you can distribute the patients to the proper wards if they're-----?-- I say - I am not sure of the number of patients that are admitted in the emergency room in Rockhampton, but I can tell you that 65 per cent at home.

If I can ask you to go then to page 7 of the report? On that page there is reference to the medical emergency team. Can I just dumb that down for myself, doctor: medical emergency teams are floaters, I understand? They are groups of specialists or well-trained staff who assist throughout the hospital where emergencies arise?-- That's correct.

Right. If I ask you then to turn to page 8. That's the next page?-- That's correct.

You will see there that the second paragraph starts: "The Rockhampton Hospital has implemented a MET team and this is to be commended." It then goes on to say, "It was worrying in the extreme that the Emergency Department actually needs to call on the services of the MET for its own patients."?-- That's correct.

Have you read that paragraph before?-- Absolutely.

Do you share the concerns spelt out-----?-- Absolutely.

Can you explain it in your own words what the concern is? It seems okay to have the MET team come into the Emergency Department?-- It is not MET teams can't come into the Emergency Department-----

We just have to speak very slowly, I think, doctor?-- Okay.

It is not that they can't come into the Emergency Department, what is the problem?-- The problem is that in a well run Emergency Department, the emergencies are handled by the doctors in the emergency room. In Rockhampton, the talents of the people who are present are so lacking that the emergency room has depended on having doctors come from other parts of the hospital when an emergency happened. I will give you the context: in my hospital at home when there is an emergency - any emergency that comes into the emergency room I personally handle. If there are emergencies in other parts of the hospital, they call me. I am the specialist in emergency medicine.

Right?-- In Rockhampton, not only do they not have specialists in the emergency room, but they rely on doctors in other parts of the hospital to respond to critical care of the cases.

Can I take you then, doctor, to paragraph - page 12 of the report?-- I am there.

Now, that talks about medical staffing. It seems to be a little bottom heavy, is that right?-- You mean shy on talent, is that-----

No, no, I didn't mean that, so much as that there are many junior doctors. There seem to be-----?-- Oh, yes, absolutely.

Now, at the foot of the page you will see a chapter - a paragraph that starts, "Queensland Health role delineation for Rockhampton Hospital is that of a major regional facility." Then it talks about how, "This level of cover, however, is unsustainable at current staffing levels."?-- Correct.

Would that be your experience?-- That's the hardest matter. I mean, if you recall what I said two weeks after arriving at this meeting, I said - maybe you didn't understand it - but I said that I was going to spend my entire time there on the phone to England, South Africa, New Zealand, United States, any place I could get a hold of senior doctors. Now, what I mean by that is I told them I wouldn't see patients until this was accomplished.

Right, okay. And that offer wasn't accepted?-- Absolutely not.

Right. Doctor, can I ask you to turn then to page 13? At the bottom of that page there is particularly-----?-- Actually, I want to just mention to you, in fact, when I called the company in the United States, they said to me they had two candidates available right now, and when I presented that to the management at Queensland Health, I got an email saying that Queensland Health had decided to review its contract with Global Medical, and at this point in time there would be no further doctors coming from or through Global Medical.

Now, at page 13, at the base of that page there's a paragraph headed "Skill Mix"?-- Right.

And it suggests that the skill mix is very bad within the Emergency Department so that sometimes, for instance, junior people have to supervise people who are formally more senior to them; do you see that paragraph?-- The junior people are what?

Well, one sentence reads, "In fact, the situation often arises where staff on the lower pay scales are rostered to supervise staff on higher pay scales." It suggests, in essence, that paragraph, that the skill mix is very poor; was that your experience?-- Oh, well, let me just put it this way: I felt like a glorified baby-sitter.

And why do you say that?-- Because I had nobody at my level to talk to and I was bombarded day-long by people who were clearly in need of help clinically and who I - when I say baby-sit, I couldn't trust them and so it - I couldn't answer their questions until I personally went and did the history and the physical.

Can I ask you to turn over the page? The last two sentences of the first paragraph read like this. "Given the fact that many of the non-intern RMOs are recruited from oversees, it means that oversees doctors are concentrated in the Emergency Department"?-- Yeah, okay.

How many? Were there a lot of overseas-trained doctors in the Emergency Department?-- Well, let me put it to you this way: there was no Australian doctors in the Emergency room while I was there, except for occasional RFDF, the flying doctors would sometimes come in but on a temporary basis, but the core group was all non-Australian.

Then doctor, can I take you to the bottom of the page, a paragraph headed "Hospital Perceptions". There's a stunning paragraph there that reads, "There is a perception that the department is a dumping ground for underperforming doctors."?-- Yes.

And that the senior medical staff are not regarded as specialist or senior colleagues?-- Yes, myself included.

I'm picking up that your view is that the Emergency Department is precisely where you need the best trained doctors?-- Absolutely. That's where the creme de la creme is put.

Now, in paragraph-----?-- Actually, I'll tell you that one of my recommendations to management was to take the money that they were spending on, I think 12 or 13 junior doctors, if you look at the original roster line-up, and I said, "Take that money, dump all these people and find good doctors in here, at the point where you find good doctors, you can then establish a core of highly trained people and at that point you can introduce junior doctors for trained purposes".

Doctor, if you go to page 15 of the report, headed "Solution", somebody else seems to have had or the author of the report seems to have had a similar idea. You'll see the first sentence reads, "The main solution to the chronic medical staffing issues is to create a specialist workforce in the ED."?-- Yes.

Can you say whether there was any evidence when you attended the hospital of that being implemented?-- Well, I think to the extent that they got me to come there I would say that that was their attempt at implementation, however, as soon as my - I opened my mouth to tell them where to go from there and how to implement this report, I was a marked man.

Can I take you to page 17? And there's a heading there, "Other Issues"?-- Right.

This seems a little surprising. "The ED Director is the only medical director within the division of surgery who is not a member of the Divisional Management Committee."?-- Well, let's just talk about this. At home we - the Divisional Management Committee at home, there's a committee called the Medical Executive Committee on which I sit. The Medical Executive Committee is a committee of all heads of all departments. The hospital is run by this committee, they are all doctors. In Rockhampton, there is no such committee at all. There is nobody to talk to.

What's this Divisional Management Committee that's spoken of?-- Well, I never attended it and so I'm assuming it's the - when I asked, "Well, where is the Medical Executive Committee?", they said, "We don't have one because we couldn't get a forum.", and so I'm assuming the translation is the Divisional Management Committee.

The paragraph goes on to say, "Given that there's no ED director on that committee, it's difficult to imagine how issues concerning the ED are discussed and how the ED is involved in the broader clinical and management issues within the hospital." You were the most senior doctor in the Emergency Department?-- Correct.

Were you involved in management issues or decisions during your term?-- Well, only to the extent that I spoke to the District Manager and the Medical Director, the Divisional Medical Director.

All right. On page 18-----?-- I guess the answer to that is was there a group of doctors who were heads of department that I spoke to? No, because there was no such committee existing in the hospital at all and there was no radiologist present in the hospital at all.

Can you tell us why the presence of a radiologist is to your mind something that's important either for training or for diagnosis?-- Yes, because a radiologist is - a radiologist is the basis - is the authoritative voice on what is going on with X-ray, and for myself after spending 25 years reading

those, I almost always read my own but there is always a radiologist that I can go and speak with at home.

Why can't he just write you a letter telling you how he interprets the radiology?-- Well, because there are two reasons: and not that the letter is not important, the report is important, but if you are going to improve your own skills clinically, then you've got to be able to take the film themselves, the X-rays themselves and show them and show them to the radiologist and learn from the experience of his eye and that is not happening at any level in that hospital because there is no radiologist.

And is it-----?-- Furthermore, in that hospital, the radiologist, there are four of them down the street at the Mater Hospital which is about two minutes away and I was told that before my coming, that there was a discord between the Director, the Managing Director of Rockhampton Hospital and radiologist and they all packed up and left and so I tried to point out to them that the emergency room was the place where even radiologists' families are treated and if anything is to be improved in this hospital, one of the things that had to happen is that a radiologist needs to be present for all of the doctors in the hospital, not just the emergency room.

We spoke about one specific issue earlier, doctor, but was there any evidence to your mind that there was some progress in implementing this report whilst you were there?-- Zero. It got worse. I think it got worse because, I mean, they managed to, you know, to get me to come there and I'm not there anymore, so I mean, at the moment there are two people that are functioning at SMOs in the emergency room, two. There should be five.

Doctor, can you tell us why you chose to come to Australia?-- Oh, because I thought it would be a great adventure and, you know, I don't want you all as Australians to think that this whole thing has been a negative experience, there is many positive things about it, I think you have a beautiful country and I thought that I could be of help and I found it that the more I talked, the less people wanted to listen to me, and then there were events that occurred that really I thought were quite ugly and I thought even some illegal.

And it to your mind, you didn't just identify problems but you also identified solutions?-- Absolutely.

That's the evidence-in-chief, Commissioners. Should I - will Dr Kelley be cross-examined?

COMMISSIONER: Does anyone wish to conduct any cross-examination now or simply leave it all until-----

MR FARR: I'd prefer to leave it until a subsequent time, your Honour, it can be done if necessary one way or the other.

COMMISSIONER: It's entirely in order. Mr Mullins, you wouldn't have anything?

MR MULLINS: No, thank you.

MR ALLEN: No, thank you.

COMMISSIONER: Mr Devlin?

MR DEVLIN: No, thank you.

COMMISSIONER: Mr MacSporran?

MR MACSPORRAN: No, Commissioner.

COMMISSIONER: Ms Feeney?

MS FEENEY: No Commissioner.

MR ATKINSON: No Commissioner.

COMMISSIONER: All right. Well, I'm not sure that Dr Kelley can hear me from here but perhaps you can pass on that we appreciate him giving evidence and he may be required at a later time.

MR ATKINSON: Dr Kelley, thanks for your time?-- Okay.

You're excused, have a safe journey. Bye-bye?-- Okay, will we speak later then?

We will doctor, and thank you for your time?-- Thank you. Bye-bye.

WITNESS EXCUSED

COMMISSIONER: Mr Andrews?

MR ANDREWS: Commissioner, I call Leonie Raven.

COMMISSIONER: Mr Atkinson, I was not intending that Dr Kelley's statement should be an exhibit at this stage; is that the understanding?

MR FARR: That's so. In fact, it's not even signed at this stage so it can't be. Can I indicate I appear on behalf of Ms Raven.

COMMISSIONER: Oh, thank you, yes.

LEONIE THERESE RAVEN, SWORN AND EXAMINED:

COMMISSIONER: Ms Raven, do you have any objection to your evidence being photographed or filmed?-- No, not at all. One thing I would ask though that if anything that I say here today makes the news tonight, that it will be reported in the context that it's given and not misquoted please.

Well, we feel that's one of the advantages of having it filmed, that at least that way it's your own words that get reported rather than words that someone else wants to put into your mouth.

MR ANDREWS: Miss Raven?-- Hello.

Hello. What's your full name please?-- Leonie Therese Raven.

Do you have with you a copy of a statement that you have signed?-- I do.

And is it dated the 17th of June 2005, a statement of 11 pages with numerous attachments?-- It is. The statement was actually prepared on the 16th or 17th of June. It was the 24th before I signed it, so we've just changed, like, just crossed out the 16th and put the 24th on this signed copy that I have.

Thank you. Miss Raven, are the facts recited in that statement true to the best of your knowledge?-- They are.

And are any of the opinions you express in that statement honest opinions of yours?-- They are.

I tender that statement.

COMMISSIONER: The statement of Leonie Therese Raven will be Exhibit 162.

ADMITTED AND MARKED "EXHIBIT 162"

MR ANDREWS: For the time being, Miss Raven, you can retain that document so that you can look at it, but I'd like you to leave it when you finish your evidence so that it can be tendered as an exhibit?-- Sure, no problem.

Commissioner, I'm not entirely sure how many copies of Miss Raven's statement the Commissioners have. Mr Groth has just provided me with a copy that he retained for himself.

COMMISSIONER: Well, actually, an extra would be useful just because Deputy Commissioner Vider left her copy in Brisbane,

so-----

MR ANDREWS: Thank you. The Queensland Health has been thoughtful enough to provide two further copies.

COMMISSIONER: How kind of them.

MR ANDREWS: Miss Raven, you're the Quality Coordinator, District Quality and Decision Support Unit?-- That's right.

I see from your position description, which is LTR1, that you have a very long list of duties?-- I do.

Among them was a duty to provide expert direction, support and training in the implementation of risk management processes across the district?-- That's right.

You were also, I see, to manage the complaints system?-- Yes.

You were to report trends twice a month to the District Manager?-- In my original position description it was - it's supposed to read "second monthly". At some point after that we went to third monthly because a lot of, you know, like a lot of other reports are provided quarterly so it became a quarterly report.

I see, bi-monthly is every two months?-- Every second month.

And you were to monitor and evaluate performance and provide feedback to quality improvement teams and committees?-- That's right.

Now, I see that your prior experience is set out within your statement; you have a Certificate of Nursing?-- Yes.

A Bachelor of Health Science Nursing?-- Yes.

And a Graduate Certificate in Critical Care Nursing?-- That's right.

Do any of those qualifications particularly make you an appropriate candidate for those responsibilities that are within the job description - or position description?-- Not directly. The qualifications that I have were probably more useful when I was employed as a nurse. I spent a couple of years working in the Intensive Care Unit at the Base - at the hospital. In terms of qualifications relevant to my current position, I've actually probably acquired those more since I've been into the position of the quality coordinator.

Like on-the-job training?-- That's right.

Now, among the other duties that you've had as a quality coordinator, I see you were responsible for preparing the hospital for the Australian Council for Health Care Standards Accreditation?-- That's right.

Now, that was first achieved in May 2000?-- That's right,

and - but the preparation for that first organisation was the survey was done by the person in the position prior to me and I took over the position of the quality coordinator in July 2000.

Now, that first accreditation that the hospital achieved?-- Yep.

Was it for two years?-- It was for a period of 18 months. At that time, because it was our first accreditation, we were only ever, like, we were on a three - your first accreditation goes through a three year cycle, it's since changed under the new equivalent to become a four year cycle, so our first accreditation, there were some recommendations, including some high priority recommendations, so we were given a period of 18 months.

Do I deduce accurately you were given 18 months to implement a number of high priority things so that you could maintain your accreditation?-- That's right, and they came back at 18 months, did a periodic review it's called.

And what happens if the hospital loses its accreditation? Is it a significant thing?-- It's significant, depending on which, you know, health care organisation it is. Obviously, some of the private health care organisations, their funding is attached to ongoing accreditation. For Bundaberg and for the Queensland Health districts, it's not linked to any funding at this stage, but certainly it is part of our service agreement with corporate office that we will be accredited, it's a requirement under that service agreement that the district remains accredited, so there is, you know, significant adverse outcomes, if you like, if we were to fail.

And am I correct in deducing that it was your job to make sure that those outcomes were achieved?-- That's right.

And you were - that was your primary responsibility until what, sometime in mid 2003?-- Pretty much so. In the first 18 months, after I took over the quality role, as I said, it was our first accreditation, we had about 56 recommendations, three of those were high priority, so the bulk of my time was spent addressing those recommendations and making sure that the organisation or the hospital was, you know, putting in place the things that had been recommended to us.

D COMMISSIONER VIDER: Miss Raven, what were the three high priority recommendations in 2000?-- There was a recommendation about the - we had a renal unit, or we still have a renal unit and it was in a fairly small location and simply because of the type of work that they do - try to do in the renal unit, the survey, and quite rightly, felt that it was too small an area.

So that was to do with the physical environment of the service?-- Yes. There was a recommendation about relocating, that there was a recommendation about implementing or improving our preventative maintenance program.

Did you have a preventative maintenance program?-- I would have to say not a terribly good preventative maintenance program, it was much more a reactive maintenance program, but within that 18 months, we did implement the third priority recommendation and that was related to the Gin Gin Hospital and some priorities for aged care people up there.

MR ANDREWS: I see from your statement you were also to maintain an adverse events register?-- That's right.

And a complaints register?-- Yes.

They're two separate registers, aren't they?-- Yeah, and I think-----

You were also to maintain a central risk register?-- That's right.

That's a third-----?-- Third register. It's important to clarify, I think, particularly for the Commissioners, there is some, I perceive, some confusion about incidents and complaints. They are quite separate. Like, complaints, the complaints register that I maintain is related to patients who have made a complaint about some aspect of their time in hospital. The adverse event register is quite different. It relates to an accident or a, you know, a fall or a pressure area or whatever.

COMMISSIONER: What about if one of the staff wishes to make a complaint?-- That's not really governed by my unit at this stage. I know typically if a staff member wanted to make a complaint, that would be done through the HR department, and I know that in just recent times the HRM or the Human Resource Management Committee have been looking at improving the process of how we capture and deal with staff complaints, but very much so the complaint register that I maintain is patient complaints.

Well, I can understand why staff complaints about employment conditions and circumstances would go to HR, but am I right in thinking that there was no standard procedure or system for staff to make formal complaints about clinical issues through your unit?-- It just depends on how, like in what-----

Well, let's take the examples we have here; Miss Hoffman's complaint about Dr Patel?-- Mmm-hmm.

That was not something for which there was a system or a procedure by which a documented complaint could be sent to your unit?-- It certainly could have been reported as an adverse event.

Yes?-- Our adverse events outline quite clearly that, for instance, if an organ's damaged during surgery or - it should be reported as an adverse event. If that had been reported, and it clearly wasn't, something would have been done about it, that didn't need to be coming through as a complaint as

such.

D COMMISSIONER EDWARDS: And is it specific as to who makes that complaint?-- Who reports the adverse event?

The surgeon or the theatre nurse or-----?-- Anybody who is aware of an accident or an adverse event having occurred can report it. I know there's been, you know, ongoing bickering amongst the witnesses about, you know, I didn't see it so I can't report it and somebody else should have reported it, anybody, anybody at all who becomes aware of an adverse event can report it.

It goes direct to you?-- That's right.

Not through the system?-- Well, I am my unit.

But not through management first?-- What they do - that's right, all adverse events come to our unit to be registered and then we direct them on to the appropriate management team to look after them. The other thing that's really, that the clinicians are aware of is, and I know that there's been concern about reprisal or retribution if people reported incidents, there is always an opportunity or always the option to report anonymously, there was no requirement that they had to put their name on a form. If I had received a form that said, "Dr Patel was killing patients" with no name on it, I would have still acted on it quite definitely.

D COMMISSIONER VIDER: You'd need a bit more specific information than that though?-- I would - actually, I don't think so. If somebody was so passionate and concerned that they wanted to tell somebody, if they had put on a form, you know, "Dr Patel is killing patients.", I wouldn't have filed it in the bottom drawer, I would have taken it straight to Peter Leck or to Darren Keating and said, "What should we do about this?" They didn't have to put their name on it.

MR ANDREWS: I suppose if someone identified poor clinical skills in another and filled in an adverse event form without including a name, it would be fairly easy to determine who it was who is likely to have witnessed the event?-- It potentially could have been easy to identify who it was, however, with the new system that we put in place, it was not about apportioning blame or, you know-----

No, it was about problem solving, not blame?-- If we had a problem reported to us about Jay Patel, we would have reported it, regardless about who reported it.

Let's move to the systems that you helped to create-----

COMMISSIONER: Just before you do, Mr Andrews, you mentioned that there was some bickering and I'm not sure whether that's entirely fair, but if you go to your-----?-- Well, perhaps "bickering" was the wrong word, I'm sorry.

If you go to attachment LTR4?-- I don't have all of the

attachments with me, I've only just got my statement.

Well, we've got a spare volume here.

MR ANDREWS: Yes, that volume probably has legible attachments.

COMMISSIONER: All right, I think it's useful if the witness has all of her attachments really available. If you can look at LTR4, am I right in thinking that's the policy regarding adverse event reporting?-- That's right.

All right. And what we were - we had drawn to our attention previously on page 3 - item 2 on page 3 stating that the staff member who was involved or discovered the adverse event completes the relevant section of the event report form. That obviously gave the impression to people that if they weren't directly involved or if they weren't the person that made the discovery, then they were not the appropriate person to fill in the form?-- Well, I guess it's what your interpretation of "discovery" is. I think if somebody had come into the Intensive Care Unit and said that this person's accidently had his spleen removed, then that's discovering that that had happened. Anybody could have, like, if that's, you know, a misinterpretation by the clinicians, then that's unfortunate, however, discovering that something has happened can be interpreted many ways.

Yes, the same thing can be discovered by different people on different occasions?-- And whoever discovers it should have - could have reported it.

Yes?-- Our intention was to make sure or to try and encourage clinicians and anybody indeed in the hospital to report openly and to report as many like, you know - we certainly said we'd rather receive hundreds of adverse events than not receive any at all. You know, even if you're not sure whether there is an adverse event, please report it so we can start looking at where our problems are.

Well, in any event, we should read item 2 on page 3 that at least the intention behind it as being that any staff member who becomes aware of an adverse event may complete the relevant section?-- That's right.

Yes.

D COMMISSIONER VIDER: This adverse event form came into - it's dated the 1st of June 2004?-- I can't really explain why it's dated the 1st of June 2004. The system was actually introduced in February 2004 and this is a policy that I wrote prior to going on sick leave which I went on sick leave in March 2004. Why there's been a discrepancy in the day, you know, or when it actually got up or published on to G drive, but I can assure you that this system was in place in February 2004.

My question was this was the introduction, the first adverse event reporting mechanism as an adverse event reporting mechanism?-- No. There's always been reporting of patient incidents-----

But that was incidents?-- -----whatever they're called, over a number of years. When we first developed this policy based on some information that I'd gained from attending workshops with Queensland Health, they were starting to use the terminology of adverse event, and an adverse event is exactly the same thing as an incident. We changed to incident towards the end of 2004 because by that time Queensland Health has introduced or released their policy and their name for their policy was incident management. So for consistency of terminology we changed our policy to incident management as well but it is in essence the same thing.

You mention that it's acceptable for people to record an adverse event anonymously?-- Yep.

Do you get many anonymously presented forms?-- Not terribly many, the odd one or two, but, you know, not - not usually. Most people are prepared to put their name on who's actually reporting.

Because it is hard to follow up an anonymous event?-- It is. But it would be better to have some information than no information, if the thing - if the reason that a person was not prepared to record was the fact that they didn't want to put their name on it.

D COMMISSIONER EDWARDS: Ms Raven, can I ask you, it is a fairly complicated form, say, for a very elderly person. Do you assist them in filling it out if necessary or are there facilities by which they can have assistance to fill out these forms?-- When we introduced the form there was comprehensive training, like, quite regularly provided to all clinicians. In addition to the form and the policy, I released adverse event reporting guidelines which stepped them through the form. Certainly, there's - occasionally I will get a phone call from one of the staff members in the wards-----

I meant patients?-- No, the patients don't fill out the adverse event form. The staff member fills out the adverse event form.

Patients don't have any input into that at all?-- Not in filling out the form, no, because they're recording something that's happened to a patient but, no - no, this is very much a form that a staff member would be required to fill out.

MR ANDREWS: So that I understand the evolution, before you created the adverse event form and a complaints register, adverse event reporting and complaints management was dealt with by nurse unit managers?-- Again, they're two separate things. I actually took over or developed the complaints register, patient complaints, back in 2002. Prior to me or our unit taking over adverse event reporting in February 2004,

there were a number of forms and this was one of the reasons that the new system was introduced. When we were starting to look at whether we were capturing good information about the adverse events that were occurring in the hospital, we discovered that there were about five or six different forms that went to five or six different areas, which I think for any clinician is confusing. So based on - I presented that at a heads of department meeting, which is a meeting where all the, you know, nurse unit managers and cost centre managers attend, and ask them, you know, what were the problems with the system we currently had and what would they like - you know, what would a new system need to do. So, based on that feedback, we created a single form and created a single point of reporting.

And prior to that time, you observe at paragraph 9 of your statement that adverse event reporting historically had been managed in a fairly ad hoc way-----?-- Yes.

-----depending on the nature of the event, and it would be referred on to different individuals to action but there was no central point for management of the information?-- That's right. And that's what I was saying. There was a falls report form - so if a patient felt, you know - a number of different forms depending on the type of adverse event that they were reporting. That then went to a variety of different places and, certainly, it was Peter Leck who was one of the first people who started to be concerned about not having a central point of where we could collect information and monitor what was truly going on in the hospital.

And you were the creator and author of LTR2, which is the policy and procedure manual for the complaints management system?-- That's right.

And that's a manual relating to complaints if patients wished to make them?-- That's right.

And you did that in about May 2002?-- I did. Again, I attended a workshop - not to be overly critical of corporate office or Queensland Health, but they do tend to take quite a bit of time to actually develop things. So, I attended a workshop where they gave us information about what - I should just say, at that point they were looking at developing a complaints management system that they would implement across the state.

But it hadn't happened, so you developed your own?-- That's right, based on their information that-----

In May 2002 you also began a risk management course?-- That's right.

Now, that's something different from patient complaints, isn't it, risk management?-- It is. Integrated risk management - it also - it encompasses complaints and incident reports but it's also - it's a separate register again where we look at risks for the district and, you know, how we're going to

manage those risks.

And I suppose, if you're going to be concerned with risk management, then an accurate patient complaints register and an accurate adverse event register would be useful tools?-- Absolutely.

You attended a week-long risk management course?-- Yes.

And you tell us at paragraph 12 that up until May 2002, risk management was a new concept for the hospital?-- It was.

Because you attended the course, it suddenly became one of your responsibilities?-- Responsibilities.

And I see that it's included in your position description?-- That's right.

From 2002?-- That's right.

Now, from January to August of 2003?-- Yes.

The majority of your time was taken up in preparing the hospital for accreditation?-- That's right.

That meant you were able to devote less time than you'd have wanted to some of your other duties such as risk management, management-----?-- Absolutely.

-----of complaints?-- Absolutely. Because in - as of the 1st of January 2003 the ACHS, or the Australian Council for Health Care Standards, implemented or introduced EQuIP Third Edition, which were a new set of standards much more rigorous than the previous standards. So a lot of our time, a lot of my time was spent ensuring that the hospital was prepared for survey, which was happening in August that year.

Indeed, you wanted more resources for your own department because you were at the time being well overworked?-- Absolutely.

In fact, in about March of 2003 you expressed the view to Mr Leck that if you were to do all of the duties that were yours under your job description, you'd have to work 306 hours a month instead of 152?-- That's right.

Which were your allotted hours?-- That's right.

Were you able to get more staff?-- I believe that - I believe Peter tried but it was, at the end of the day, no.

That makes it hard on you with all of your duties-----?-- It does.

-----to perform them all competently?-- Absolutely.

Now, in September of 2003?-- Yes.

You tell us at paragraph 19 of your statement, "The ACHS provided a draft report and that in it there was a recommendation in relation to adverse event or incident monitoring and sentinel event monitoring"?-- That's right.

I think you may be too modest. I suggest this was something, a concept that you yourself had thought of some months earlier and-----?-- That's right.

-----I'd like you to have a look at this e-mail. I'll put it on the monitor if I can to refresh your memory. I can't be sure of the dates. It says 3/06. I'm not entirely sure whether that means the 3rd of June or the 6th of March?-- I couldn't be quite sure either to be quite honest with you. I know I have since changed the date on my e-mail to Australian date format but I'm not sure that I did back then.

But in any event, at that time in 2003 it seems that you were concerned that there was a need for action?-- Mmm-hmm, I do recall this e-mail actually.

About incident monitoring?-- That's right.

Now, can you explain: does this mean that there had been numerous incidents that appear in Gin Gin to have-----?-- That's right.

-----been reported and, yet, they weren't getting to the central office in Bundaberg?-- I do remember this particular incident. Yeah, there was one particular chap in Gin Gin who kept falling over all the time and-----

Do you know why Bundaberg wasn't hearing about it?-- Well, that was I guess - Lear Langley , that was her point. She was filling in incident report forms and they were coming down to Bundaberg. At that time they were being reported to the Assistant Director of Nursing and their concern, and mine was as well, was that if you had 30 to 50 incidents reported, somebody should have been - like, yeah, somebody should have had alarm bells ringing. And under the previous system, where the Assistant Director of Nursing received all the patient accident reports, it was generally perceived that, you know, they fell into a black hole and nobody ever did anything about them.

And that wasn't just the perception at Gin Gin, was it?-- No.

There would be incident reports created and-----?-- Nothing-----

-----there was a lack of feedback. Whether the incidents were acted upon or not, no-one would have known?-- That's exactly right, and certainly one of Peter's passions was in getting something where we could have a better understanding of the incidents that were occurring round the hospital.

It does seem that your e-mail to Mr Leck suggesting that you get to work on this-----?-- Yep.

-----he gratefully accepted on the same day?-- As he always would. Yes, he was very proactive in trying to get better systems in place so we could monitor the quality and the safety of the care we were providing.

COMMISSIONER: Mr Andrews, do you want to have that marked as an exhibit?

MR ANDREWS: I do, please.

COMMISSIONER: Because it is not referred to in the statements as far as I'm aware.

MR ANDREWS: It's not.

COMMISSIONER: Exhibit 163 will be e-mail from Ms Raven to Mr Leck and I'll just record the date as it appears here of 3/06/2003.

ADMITTED AND MARKED "EXHIBIT 163"

COMMISSIONER: We are all mystified as to what that meant. Would that be a convenient time, Mr Andrews, for a morning break?

MR ANDREWS: Yes, Commissioner.

COMMISSIONER: We will just have a 10-minute break as we were a bit interrupted this morning.

THE COMMISSION ADJOURNED AT 11.43 A.M.

THE COMMISSION RESUMED AT 11.58 A.M.

LEONIE THERESE RAVEN, CONTINUING EXAMINATION-IN-CHIEF:

MR ANDREWS: Now, Ms Raven, DQDSU can only in performing its tasks in relation to complaints management and data collection, it can only be as efficient as are the people who report to it?-- That's right.

In 2003 it was obvious that there was a problem with the kind of data that you were receiving from different people because people would send you - they'd describe things in different ways from the ways they'd be described by ourselves?-- That's

right.

All right. Incident data would be routinely provided to DQDSU, even if it wasn't by way of adverse incident forms?-- In 2003?

Yes. Have a look at this e-mail. You can probably sort it out for me. I will put it on the monitor?-- Okay.

It's an e-mail from Jennifer Kirby, who worked at DQDSU, to you and others about incident monitoring?-- Yes. Yep.

Do you recall it?-- I do actually. Carolyn Kennedy is the assistant Director of Nursing who-----

She was at the time?-- Yes, she - and she still is.

I see?-- At that time, incidents went to Carolyn Kennedy and I believe-----

What do you mean by "incidents"?-- The same as - this was basically the paper based system prior to us introducing this new system of adverse events reporting in February 2004.

Now, so that I can understand the paper based system, do you mean somebody would fill in an adverse event form and hand it to Carolyn Kennedy?-- That's right.

And she'd no doubt store them somewhere?-- Yes, she did.

And-----?-- In the black hole.

-----would either those documents or data collected from those documents routinely be given to DQDSU?-- I believe back in - at this time, when Carolyn was receiving and collating incident data, she would send up to the DQDSU a summary that - that was included in various reports that Jenny Kirby would have prepared. I do have vague recollections of this because there was information sent up that didn't seem to add up. Certainly Jenny Kirby would have a better recollection of the exact circumstances around this.

Well, are you able to explain where Jenny writes, "Allan's made every effort to try and understand the difference and correct accordingly, but basically it's a complete mess." Now, that was about the information coming from Carolyn Kennedy?-- That's right. There was some inconsistencies, from what I can recall, related to certain incidents being classified as one type of incident when in fact, that they were another. That's as best as I recall. I just know that it was around the time that we were getting quite concerned that the information Carolyn was collecting and collating was not accurate and couldn't be relied on.

And would that have been talking about the severity of the incidents or other descriptions of it?-- Probably more about the number of incidents that we were - that were occurring and certainly the type of incidents.

Well, she's unlikely to be over reporting. Do you mean she would have been under reporting the number of incidents?-- I believe at that time there was a gross under reporting of incidents. You know, for example, since we've introduced the new reporting system in February 2004, we have had around 900 incidents reported to the DQDSU. The records that Carolyn has given me, which relate to 2002 and 2003, those entire two years there would have probably been less than three or 400 incidents reported. And certainly - and that was our aim, to increase the reporting so that we were capturing good data.

And whose responsibility was it, say, in mid-2003 to report back to those who reported an incident? Was it DQDSU?-- No, it was Carolyn Kennedy's responsibility.

Well, it seems by that stage there became apparent a need to improve the management of incident monitoring?-- That's right.

You created the adverse events management policy. Are you still responsible for its terms? That's LTR4, a document to which you were taken a little earlier. Are you in a position to improve that document if you see a need for it?-- Yes.

Now, for instance, on page 3 at item 2, you will recall there was some discussion about how some people might read that differently from the way you read it?-- That's right.

You're in a position to have the wording of that form changed, are you?-- I am, yes.

Now, you developed the adverse events management policy?-- Mmm-hmm.

Which was to be implemented in February 2004?-- That's right.

And in the normal course, you'd have been the one overseeing its implementation?-- That's right.

But you went on sick leave?-- I did.

It was a WorkCover related sick leave?-- No.

Now, with respect to adverse events, there was a responsibility to risk rate them?-- That's right.

And because you were the risk management expert at the hospital-----?-- Yes.

-----or the only one who had done the course, in any event-----?-- That's right.

-----that fell to you?-- It did.

Does that mean for that six months they were - there was no risk rating of the adverse events?-- No, I believe when I first went on sick leave Jenny Kirby and at times Dr Keating would risk rate them up until the time that Jane Truscott was seconded to fill in my position, and then she took over the risk rating of them.

I tender that document on the monitor.

COMMISSIONER: Exhibit 164 will be the e-mail from Jennifer Kirby to Peter Heath and others dated the 17th of the 7th 2003.

ADMITTED AND MARKED "EXHIBIT 164"

MR ANDREWS: Among your numerous duties-----?-- Yes.

D COMMISSIONER VIDER: Mr Andrews, could I just interrupt for a moment?

MR ANDREWS: Of course.

D COMMISSIONER VIDER: This adverse events policy statement, that's LTR4?-- Yes.

Is that used, generally, by Queensland Health?-- I honestly couldn't tell you whether it's exact - that exact wording. Certainly I developed that policy statement based on information that I had gathered during various workshops and meetings with other people. So - and it also, you know - certainly Queensland Health would have a very similar policy statement, but whether it's exact - that exact wording.

It was based on the generic statement from Queensland Health?-- Although, like, in terms of the time line of this policy, because Peter Leck and the executive at the Bundaberg Hospital were very anxious to make sure that we were capturing good information, we put this out in February 2004. Queensland Health didn't, actually, distribute their policy until June 2004, and that's - that's fairly - fairly - what's the word I'm looking for, consistent with the way the executive approached management at the Bundaberg Hospital. They were trying very desperately to be proactive in terms of

improving the systems that we were working within.

COMMISSIONER: Getting back to the point I raised earlier, whilst we have that document in front of us about who should be filling in the forms, you made the suggestion when I gave the example of Nurse Hoffman's complaints that she could actually have formulated those complaints as adverse events?-- That's right.

Even though a substantial part of the information wasn't things that she had observed, herself, it was simply information she had gathered from other staff?-- That's right.

In exactly the same way then she passes that information on to, say, Mr Leck, would it then be expected that he would prepare an adverse events form?-- No.

Why not?-- Because the adverse events reporting system is a system to be used by the clinical staff. Mr Leck isn't employed as a clinician, he's employed as a manager. It's the same as I wouldn't fill out an adverse event form. I'm employed as an administrator. The clinical - the adverse events that we were trying to detect relate to problems within patient care, and the clinicians are the people who have that knowledge.

I see. So it's not anyone who becomes aware of an adverse event, it's just someone below the executive level that becomes aware of an adverse event?-- If you want to be pedantic about it, but you know-----

No, I want to work out how it's supposed to operate?-- I would imagine if Toni Hoffman had gone to Peter Leck and said this has happened, he would have suggested to her to please put an adverse report in, and we would have got it sorted.

I see. That's how it should have happened?-- Yes. Well, it certainly was one of the systems that they had available to them to raise their concerns.

All right. Well, let me take another example then. Dr Miach raised the issue of the failures in relation to the Tenckhoff catheters, the six out of six failure rate. Is that something that should be an adverse event?-- Absolutely, it should have been reported as an adverse event.

I see. So instead of doing that he simply takes it to Dr Keating, but it's not Dr Keating's responsibility to fill in an adverse event form?-- No, I wouldn't have thought so.

Mr Andrews?

MR ANDREWS: Thank you, Commissioner. Now, one of the duties within your position description was to monitor and evaluate performance and provide feedback to quality improvement teams and committees?-- Yes.

One of those committees would have been the Surgical Anaesthetic, Preadmission, Intensive Care Clinical Service Forum?-- That's right.

Sometimes called ASPIC?-- ASPIC.

A-S-P-I-C. And, indeed, I have the terms of reference for ASPIC, and I see that the district quality coordinator ex officio is one of the members?-- That's right.

As to is the - and that would be you?-- That's me.

And, also, there is the DQDSU manager ex officio, another member, and that would be Jennifer Kirby?-- Jennifer Kirby.

And the terms of reference that I have, one says reviewed October 2003, next review date October 2004, and the next is developed 28 April 2005, review date July 2003. I can't explain that either?-- No.

But each of them has you as an ex officio member or a member?-- That's right.

And as part of your position description and duties it would be to a group such as that that you might provide - I will turn up that position description again-----?-- Yep.

-----feedback after you've monitored and evaluated performance?-- That's right.

Now, that Surgical Anaesthetic Preadmission Intensive Care Clinical Service Forum would be one that would be typically interested in things such as adverse incidents?-- That's right.

And, indeed, adverse incidents are one of the standing agenda items for its meetings?-- Yes.

And so to are complaints?-- That's right.

And you are particularly interested in complaints, as well?-- In terms of being able to provide them information on how many complaints were, you know, reported related to their various units.

Now, there was a system breakdown between the DQDSU staff and the - and some of the persons attending the ASPIC meetings in late - mid to late 2003, wasn't there?-- There was. What you need to realise is the ASPIC group, for most of its existence has been quite dysfunctional in terms of there were personality conflicts with the members of that meeting and a lot of their time was spent arguing and fighting with each other rather than getting on and looking at information and improving it.

And DQDSU's two standing members on the committee stopped attending after August 2003?-- At the request of the group.

Well, would you look, please, at this e-mail?-- Yep.

From - which appears to be from Mr Keating - from Dr Keating to Mr Leck, Jennifer Kirby, with a copy to you?-- Okay.

Oh, indeed, I have misread it. It's a - it seems to be a pair of e-mails?-- Right.

The one at the top of the page is the one from Dr Keating, but further down there seems to be an e-mail-----?-- Yep.

-----from Jennifer Kirby and if one sees the back of the - or the next page one sees there's a copy of it sent to you. Now, that's the e-mail I'm interested to have you explain for me?-- Yes.

Now, this will have been for a - presumably a meeting which was shortly prior to the 27th of August in 2003?-- Yep.

And it suggests that there must have been a heated meeting if minutes had been toned down?-- Yes. Most of their - attendance at the ASPIC committee meeting was always very traumatic for myself and for Jennifer Kirby.

Now, it seems that people were sometimes derogatory towards you and Jennifer?-- Extremely derogatory.

What were their complaints? Would it have been to do with the data that you were providing?-- A lot of the time because some of the data that we were trying to show them was not what they wanted to see. It's a common strategy, I guess, with a lot of clinicians that we have to work with, to just discredit the data rather than accept it, that this is what it's telling us.

Should I deduce from that that it was a regular complaint at the ASPIC meetings when you would - you or Jennifer Kirby would produce data that it wasn't showing what the clinicians expected to see?-- That's right.

From your point of view did they regard it as, what, inaccurate or unhelpful?-- I guess a lot of the information what Jenny could provide out of the transition database they tried to discredit as inaccurate. In terms of the way they - they treated me, as a quality coordinator, it was what - just with pure contempt because you are trying to get clinicians to improve their practice, but-----

Are you able to give me an example, so that I can understand it?-- With particular reference to the ASPIC committee or?

ASPIC, yes, please?-- I guess in relation to the Press Ganey Report, that's another one of the things that I do, is coordinate the Press Ganey patient satisfaction survey report once a year for the district. Press Ganey is an international company that's widely recognised as experts in the field of monitoring and measuring patient satisfaction. Because there were certain elements in the Press Ganey Report that suggested

that pain management could have been improved Martin Carter, whose patient was about pain management, chose to try to discredit the report rather than accept that patients perceive that their pain is not managed well in hospital. So that then became like, you know, he would just ridicule you because he didn't want to accept that that was the data that was available to us.

All right-----

D COMMISSIONER VIDER: Can I just take that a little bit further?

MR ANDREWS: Of course.

D COMMISSIONER VIDER: So you have an issue coming before you out of a patient satisfaction survey?-- Yes.

That would indicate from the patient's point of view that pain management for them was a problem?-- Yes.

And the clinician is differing-----?-- Yes.

-----with those findings. Is the ASPIC committee then the forum where that's discussed?-- It is because they're the areas that are covering - that committee covers the areas where - I mean, you have to put it in context that the information given to the ASPIC committee would have been the parts of the Press Ganey Report that were pertinent to them. So, you know, because you can - you can individualise the report or the results that you get, and so you can look at what the results were for the surgical unit and then inside that surgical unit the patients are saying their pain is not managed well, so it's - it's very definitely a place, you know, that - something that the ASPIC committee should have been trying to address.

And that discussion sometimes can be very fulsome-----?-- Very what, sorry?

Very fulsome, in that you often will get disagreements because perception is involved with that?-- That's right.

The patient perceives that their pain management-----?-- But what they were trying to discredit was that Press Ganey didn't, you know - the - and this came up again and again in a number of different forums. What Press Ganey say is that - and this is through years and years of testing, that once you have 30 patient responses, then the trend will be the same. So whether you have got - once you have 30 responses they consider that a valid report. So whether you then have 30 or whether you end up getting 3,000, the information that's coming out of that will start to be the same, but because the clinicians didn't necessarily like - and, yes, they are dealing with patient's perceptions but, you know, patients are the most important people, but it wasn't a problem that they were dealing with patient's perceptions, they tried to focus on the fact that, oh, we only had 37 responses so, therefore,

it can't be right, like, it's not valid. They didn't want to accept that Press Ganey had explained to them that once you have 30 responses you have a valid report.

Well, moving beyond the statistical relevance of Press Ganey's ideas of 30 being adequate, was there opportunities then in that forum to even look at the individual's and then review it case by case?-- The individual patients?

Patients?-- No, because the - the Press Ganey surveys, they - they get distributed from the Press Ganey organisation in the Gold Coast. We do get some patient information if a patient has on the back of their survey form, you know, ticked "yes" to, you know, being - consented to being contacted about their responses, but in terms of when you are measuring patient satisfaction it's really broad issues that you are trying to look at rather than, you know, drilling down to a specific person's.

It can be or you can nominate particular areas that you want to look for satisfaction in your particular organisation, but they're very common, usually the ones that you would go to look at?-- Yeah.

Well then, how did you resolve or what steps did you do to resolve the difficulties that you were having in the committee?-- They were continuing - I mean, I don't know that anything, necessarily, has been resolved. A lot of the time that that committee met for the last few months were - was spent with Martin Carter - or Dr Carter and Dr Patel trying to disband the committee because they didn't want to have to meet together.

As you say, though, the most important focus in this activity is the patient?-- That's right.

So if you're getting reports in that would indicate dissatisfaction in a particular area of clinical management-----?-- Yep.

-----you need to be able to address that?-- That's right.

Because ACHS is interested in the patient's outcomes?-- That's right.

They won't be interested in the fact that the committee had a problem?-- That's right.

They will want to know what the committee did to resolve their problem, so they could address the patient satisfaction because, otherwise, it can be seen - you have identified that pain is a management problem?-- Yep.

Or pain management is a problem; what's happened, what have you done about it?-- Some of the strategies that were implemented, Dr Keating and Peter Leck started attending those meetings to try and stop the appalling misbehaviour of some of the clinicians that were attending. The other avenue that we

had was that it would be discussed at executive Council where all the members of the executive were members along with each of the medical directors. We probably hadn't made a lot of progress, but it wasn't through lack of trying to get these clinicians to start doing something about the problems that had been identified.

So have you repeated the survey, the patient satisfaction survey, and have you got any follow-up results or not yet?-- We've had - we've conducted three surveys so far. They're usually conducted July to August every year. So, you know - whether it's started with the current environment, I'm not really sure, but certainly - it wasn't all bad. Like, the surgical services did actually improve in some areas from, you know, 2002 to - 2003 to 2004 but, you know, the executive were passionate about, okay, you have improved let's not sit back and allow laurels and say, okay, you have improved, let's see what areas we can continue to improve our performance, but it was just difficult to get, particularly, the ASPIC committee to take on board any of the information that - or, you know, to take the responsibility for, you know, implementing those improvements.

COMMISSIONER: Did I understand you rightly to say that according to the statistical data the performance in surgery actually improved from between 2003 and 2004?-- It did.

I did a presentation for the heads of department meeting after I got the 2004 Press Ganey results, and certainly the surgical ward, was one of the best improving - an area that was identified as one who had made the most improvements in terms of their level of satisfaction.

If that was the statistical data, is it any wonder clinicians were ridiculing that data, from what we've heard here over the last six weeks?-- Can you just repeat that?

Yes. If the statistical data showed an improvement in surgery between 2003 and 2004, in light of what we've heard here over the last six weeks is it any wonder clinicians were ridiculing that data?-- I think you have to be very cautious about what you have heard over the last six weeks.

I see?-- A lot - a lot of it is based on rumour and innuendo.

Okay-----?-- You know-----

-----Mrs Kemps didn't lose her husband, a 15 year old boy didn't lose his leg. It is all just rumour and innuendo?-- No-one is denying that there have been some bad patient outcomes. What I am telling you is that if Toni Hoffman had have said anything to anybody, some of these patients would not be sitting here now. This would have been prevented. This is about a nurse who got a bee in her bonnet about one particular incident and then retrospectively went about finding damaging evidence related to Jayant Patel. If she was seriously concerned about what was going on in May 2003, if she had said something to somebody, I can assure you that the executive would have done something about it. No member of this executive would have sat back and ignored those complaints. I can guarantee you that. I have reported to Peter Leck for five years. He is an extremely ethical man. The executive were extremely adamant and proactive in trying to improve the safety of our organisation. The fact that Toni Hoffman and the likes of her chose not to tell anybody is why that group of patients are sitting there now.

So when did you first learn of the 100 per cent failure rate with the Tenckhoff catheters?-- Just since all of this has gone to the media.

Right, right. So it wasn't brought to your attention when it was brought to Dr Keating's attention in June of 2004?-- No, it wouldn't have been because I was on sick leave at that time. So it wouldn't have been directly brought to my attention. I can't say whether it was brought-----

And the DQDSU?-- I couldn't tell you because I was on sick leave.

I see. But your evidence is that you feel that Toni Hoffman is to blame for all of that?-- I don't think I said that. What I did say is that if Toni Hoffman would have raised her concerns when she first claims that she had concerns, then something would have been done about it. She has been saying

that she has been telling people for two years, that she has been screaming it from the rooftop, but nothing is being reported. These people are being persecuted for not acting on information they did not have.

All right. We hear what you say.

MR ANDREWS: Ms Raven, back to the ASPIC meetings?-- Yes.

Did I understand you to say that Dr Carter and Dr Patel did not want to meet with each other?-- It was primarily Dr Carter who didn't want to meet - didn't want that meeting to continue. The last meeting that-----

Now, you did say, though, earlier that Dr Carter and Dr Patel didn't want to meet. Is it the case that there was any kind of dysfunctional relationship between them?-- It was very obvious throughout the organisation that they hated each other's guts.

Thank you. Now, I have here what seems to be a record of an ASPIC Clinical Services Forum and the minutes say they are the minutes of a forum of 13th of August 2003?-- Uh-huh.

I will put them up on the monitor. It is just that from the - that from your - the email we have been looking at of the 27th of August, that you had a copy of, the email gives the impression that Jennifer Kirby and you were at the August ASPIC meeting. But these minutes show you to have given apologies?-- Yes. I believe what was discussed at that meeting was whether the - from what I recall-----

Were you there, or have you been told what was discussed?-- I don't think I was there.

So you didn't attend that August meeting, and it seems that by August it was very unpleasant for you attending these meetings?-- Yes.

And Jennifer Kirby's email - can that be placed back on the monitor? Is it correct that it is the staff - DQDSU who agreed they were no longer prepared to attend?-- That's right. I think what actually happened is Kay Ferrar may have been at that meeting. Kay Ferrar was working in our unit for a short time and she may have come back and explained what had happened at that meeting.

Now, there is another group that met regularly. I think it was - and Dr Miach was a participant in it?-- That's right, the Medical Clinical Services Forum.

And you initially had been attending that?-- That's right.

And discontinued?-- That's right.

Why did you discontinue attending that forum?-- Because Dr Miach said that he would not have that woman at his meeting, referring to me.

Are you able to tell us what led to that?-- In one of the very first meetings - again with the performance monitoring and the clinical indicators that the ACHS produce, I went along to the meeting and tried to get Dr Miach and the people who attended that meeting to identify which clinical indicators they would like me to assist them to collect. Peter Miach's response to that was basically to again discredit the ACHS, to-----

That's not you?-- No, it is not but it is what I do.

Are you able to tell us what it was that led to his antagonism towards you?-- A lot of the medical officers are antagonistic towards me because a lot of them don't support the accreditation process. They think it is a waste of time. Particularly with Dr Miach - I can't really tell you - I think he took a personal dislike to me. I don't know, you would have to tell him - or ask him, at least.

Thank you. Well, was it-----?-- It was certainly-----

Is it possible that it was he was dissatisfied with the data that DQDSU would produce to his meetings?-- At that stage we hadn't really - certainly in terms of clinical indicators, we hadn't provided him any data. So for him to be dissatisfied would be an untested theory, because particularly in relation to clinical indicators, it was very difficult to get any of the medical units to engage in collecting indicators.

All right. May I have the email back on the monitor? Now, what's the point of the complaint that "the unit is not a secretarial service"?-- Several of the Clinical Services Forums that meet, and certainly when they were all established, there is paediatrics, family unit, ASPIC, and medical, Peter wanted Jenny and I to attend to support the clinicians, in terms of doing the grunt work for them, if you like, in gathering data, pulling charts that they might need to look at, doing the background work of obtaining information that may be useful for them to look at. However, a lot of - a lot of the forums chose to view our role as just there to take their minutes. And so that's, I guess, you know - and I know we quite often got very agitated about - about the idea that we should just be there to take their minutes. That stemmed from the idea, that a lot of clinicians have, that I sit in my office doing nothing drinking coffee, waiting for somebody to ring me with something to do. So therefore I would have lots of time to type up minutes. The clinical services forums were one way of trying to get the clinicians actively engaged in looking at their own performance, and, therefore, taking the minutes could have fallen to anybody. It shouldn't have automatically been assumed we should do it.

In your opinion you'd have been of much more service bringing data rather than doing the minutes?-- That's right.

Now, if, indeed, someone wanted - we have heard evidence that with the placement of peritoneal dialysis Tenckhoff catheters

- now, in your - back in your nursing life, you understand what they were?-- Yes.

That there were a number of complications with respect to catheters placed by Dr Patel?-- Yes.

And there was a request made so that - the significance of those failures could be compared with other statistics relating to Dr Patel's surgical work?-- Right.

Where would a person seeking to gather those statistics go in the hospital? Would they come to DDQSU?-- DQDSU, they certainly would. That's information that can be pulled out of a transition database, and Jenny or Allan, who works in DQDSU, could do that for him.

Now, you didn't have, did you, statistics with respect to individual doctors, though, did you?-- I - that's - I can't really answer that. That's certainly-----

Jennifer Kirby?-- Jennifer Kirby's area of expertise.

Now, with respect to that email, at the bottom of the page, just off screen at the moment, it seems that "J", I assume to be Dr Patel, "has had a lot of conversations with staff about disbanding the ASPIC"?-- Uh-huh.

Did you personally hear Dr Patel discuss the disbanding of ASPIC?-- Not personally, not Jayant Patel. I certainly have heard Dr Carter talking about wanting to disband it, but not Dr Patel, from - as best as I can recall, I don't recall having him say that to me.

Thank you. I tender that email.

COMMISSIONER: The third last paragraph, it refers to "it was unprofessional" - it is not on the screen at the moment.

MR ANDREWS: Yes.

COMMISSIONER: "It was time that these unprofessional individuals were advised their behaviour is not acceptable." Who are the unprofessional individuals"?-- Dr Carter, Toni Hoffman, Dr Patel at times, Di Jenkin. Basically the people who attended that particular meeting.

MR ANDREWS: Now, Dr Carter-----

COMMISSIONER: Sorry, Mr Andrews, the email of the 28th of August 2003 - it is from Jennifer Kirby, is it, to Mr Leck and Dr Keating?

MR ANDREWS: Dr Keating with a copy to Leonie Raven.

COMMISSIONER: That will be exhibit 165.

ADMITTED AND MARKED "EXHIBIT 165"

MR ANDREWS: I understand from your evidence that Dr Carter had problems with the Press Ganey report?-- That's right.

And it was a continuing problem in the relationship between you and Dr Carter?-- Yes.

But for the others who attended, Toni Hoffman, and I think you said Di Jenkin, what is it about their - what complaints did they make that caused you distress or - and caused Jennifer Kirby to describe them as unprofessional?-- It was just their behaviour. Di Jenkin, you know, is well-known for snarling and snapping at people. It was generally in relation to-----

So her demeanour?-- Yeah.

What about Toni Hoffman, was it anything about the data that you brought or was it a personality problem?-- Mainly a personality problem.

I won't ask you to describe it?-- Certainly not a personality issue that I had with her. It is just her personality could be described as unprofessional behaviour during a meeting.

COMMISSIONER: I am sorry, if you make that allegation you will have to explain what you mean by it. What was unprofessional about her behaviour?-- Toni Hoffman was well known to-----

No, not what she was well known about. What did she do at the meeting that was unprofessional?-- She would - it's very difficult to give you a specific example off the top of my head but-----

All right. Well, we will have to see that after lunch. We will adjourn for an hour and a quarter. 2 o'clock Mr Andrews?

MR ANDREWS: Yes, if that's convenient, Commissioner.

THE COMMISSION ADJOURNED AT 12.45 P.M. TILL 2.00 P.M.

THE COMMISSION RESUMED AT 2.04 P.M.

LEONIE THERESE RAVEN, CONTINUING EXAMINATION-IN-CHIEF:

MR ANDREWS: Ms Raven?-- Yes.

Shortly before lunch we were discussing an email that had been sent by Jennifer Kirby to Mr Leck, Dr Keating and a copy to you?-- Yep.

Which spoke of unprofessional conduct by persons at ASPIC meetings?-- Yes.

And you had suggested that Toni Hoffman had demonstrated unprofessional conduct?-- Unprofessional behaviour.

Unprofessional behaviour. Now, I wonder if you can give us an example of it. But before you do, during the lunch hour I have taken the advantage of looking at some of the ASPIC minutes and I see that prior to that email of the 27th of August 2003, during 2003 it seems that you and Ms Hoffman had been together at an ASPIC meeting only one time?-- Uh-huh.

And that had been four and a half months before?-- Okay.

Three and a half months on the 14th of May?-- Okay.

It seems that's the only meeting during 2003 that you each attended?-- Yep.

Now, do you recall whether the unprofessional conduct had occurred at that meeting?-- My recollection is that - what I would term or would believe to be unprofessional behaviour occurs at most meetings of the ASPIC committee.

But you and Ms Hoffman had only attended one prior to this-----?-- Yep.

-----email?-- But this is Jennifer's email.

Yes?-- The unprofessional behaviour is not only ever directed at me, it is the type of behaviour that occurs continuously during that meeting.

Well, I will have the opportunity to speak with Ms Kirby?-- Uh-huh.

What unprofessional behaviour do you remember that was demonstrated by Ms Hoffman at an ASPIC meeting?-- Primarily - you have to understand that the ASPIC group are quite a large group. They have to cover a number of critical areas in the

hospital, and invariably they have a big agenda to get through. All meetings are tried - or they try to restrict meetings to an hour. The unprofessional behaviour that I have witnessed is when I have been talking to an agenda item or trying to raise issues with the committee, or, you know, basically trying to - particularly in relation to preparation for survey, Toni Hoffman would be chatting to the person next to her and not actually focussing on what - you know, what she was there for. And that's a behaviour that I - you know, that a lot of people who attended that particular group, there was this ongoing banter and chitchat and not actually focussing on the purpose of us being there at a meeting. And I consider that to be unprofessional.

Now, was there anyone else that you - did you mention Di Jenkin as a person whose behaviour at these meetings was unprofessional?-- Yes, one particular incident - but this would be after that email was sent - Di Jenkin would often try to talk over the top of you, so you would be trying to explain something that you were doing, or, you know, where a particular policy was up to, or what progress you had made of something that was on the agenda. Di Jenkin would just talk over the top of you and berate you because it hadn't been done yet. That certainly has occurred to me.

Well, now, I understand now the problem with respect to Ms Hoffman prior to August of 2003-----?-- Uh-huh.

-----and the problem with respect to Di Jenkin after August 2003, but I don't understand why - the fact that Ms Hoffman would annoyingly chat to the person near her, why you would refuse to attend ASPIC meetings because of your special interest in complaints and adverse events?-- Personally, the reason that I wouldn't, or chose not to, or would have preferred not to attend ASPIC was the way Martin Carter would treat me during those meetings.

Right?-- Things like, you know, he would-----

On my reading of the minutes of the ASPIC meetings of 2003, for instance, I see that you attended one in - I think it was May and another in December 2003?-- Yep.

Is it only Martin Carter's behaviour that kept you away from what seems to be about 10 meetings during 2003?-- No, during 2003, the reason for my absence primarily from the ASPIC committee during that period was the fact we were preparing for survey. Because there was an enormous amount of work to be done, I - I did not attend a lot of meetings. But certainly, as a member of the committee, I got the minutes, so, you know, you keep up with what the committee is doing through the minutes.

Now, if a person wanted particular data relating to the clinical performance of Dr Patel, for argument's sake-----?-- Yep.

-----would a person such as you be the person to whom they'd

turn for such data?-- No, that would be Jennifer Kirby.

All right. And was Jenny Kirby's relationship with Di Jenkin, Toni Hoffman as unsatisfactory as your own?-- I couldn't comment on that. You would have to ask her.

It does seem that way from that email, doesn't it?-- Absolutely, and I have witnessed Jenny being subject to the same sort of behaviour, but whether that affected her in the same way it affected me, you would have to ask her.

Well, you and she worked together, didn't you?-- We do.

You began examining-----

COMMISSIONER: I think, Mr Andrews, it was also suggested that Dr Carter behaved unprofessionally.

MR ANDREWS: Indeed it was. Perhaps you should explain that so that I can ask Dr Carter about it when he gives evidence?-- At one particular meeting, again I think it was during a time when we were discussing patient satisfaction results, Martin Carter - and there were other people at the meeting who said to me afterwards, "I don't know how you sat there and tolerated that." Just generally, like, niggling and baiting, and in the end he said to me, "I'm just throwing out a hook and winding you in." So that was the type of behaviour that I was repetitively subject to by Martin Carter and I considered that to be unprofessional behaviour as well.

Would you encounter Dr Carter in meetings other than this ASPIC forum?-- The only other meeting I believe that I attended with Dr Carter was the executive council.

And would it be right to say that over a period of, say, a couple of - say, 2003, 2004, you would have attended about four ASPIC meetings?-- Possibly about - yeah, it wouldn't be terribly - too many more than that because I was away for a number of months during 2004.

COMMISSIONER: To what do you attribute the level of negativity that you have referred to?-- Sorry, could you repeat that?

To what do you attribute the level of negativity that you have referred to?-- Again, only my opinion.

Yeah?-- There is a degree of resistance to the ACHS accreditation process, medical officers and, you know, nursing officers. Staff in general - some of them; I am not saying everybody - feel that it is a waste of money and that, you know, they're being asked to do things simply because we have to meet a set of standards. It takes a long time to change a culture of an organisation where they can actually embrace those standards because they're recognised to - if you can achieve these standards, and, you know, you can be confident that you are providing quality and safe care, but there is a resistance to have an external surveyor come in and scrutinise

what we're doing. I think that's primarily the negativity that I am exposed to.

And for example, the niggling and baiting that you mention with Dr Carter?-- Mmm.

Is that all down to the accreditation process?-- That and, you know, just generally a number of the roles that I perform in terms of like, you know, preparing their results from the press gaining survey, the patient satisfaction survey, yes, and quite obviously the preparation for survey for ACHS survey, just, you know, generally the roles that I have to undertake.

D COMMISSIONER VIDER: It's not uncommon for organisations to react when new processes get introduced, and certainly I understand that it's in relatively recent times that Bundaberg Base Hospital has gone through the ACHS process - gone into the ACHS process; do you think that things like clinical indicators and the quality cycle are now part of the national scene in Australia?-- Certainly.

Do you think that with some better understanding of the quality cycle, which is really focussed on outcomes?-- Yep.

And ACHS has been going on long enough to meet outcomes, they've moved from the structure and process to focus on outcomes?-- Yep.

Do you think that once people get a better understanding of that, that that may improve?-- Oh, absolutely.

By that, I'm saying the clinical indicators are usually resistant because it means time for people?-- Mmm, yes.

And very often clinicians at the workplace, at the cold face, they know some of the things that are going on, to have to actually collect the data and have it presented, trended?-- Yep.

Whatever, they see as an additional burden, but the ACHS process has moved through now to that point where it is on outcomes, it's on clinical outcomes?-- Yes.

And safe practice and therefore really, whether we like it or we don't like it, that's an obligation on every health professional-----?-- I agree.

-----to engage in that process. But we have to engage ourselves and be engaged to get to that stage of valuing the outcomes?-- Yes.

That comes with it. And would you see that that's one of the challenges of your role?-- It's very definitely one of the biggest challenges of my role. I mean, I wholeheartedly support the ACHS framework and believe that it can lead an organisation to ensuring good outcomes for patients.

Yes?-- It's infecting other people with that same commitment to it.

Yes?-- It's definitely a challenge.

And sometimes it means also that the data that's collected and presented as the clinical indicators of standards that have been attained has to be presented in such a way that they see that it's useful?-- Yes.

So that where there are problems, they've been addressed so that the outcomes can then be seen to have improved patient care?-- That's right.

And that's a challenge too, isn't it?-- It is.

Yes?-- There are certainly examples where we have used the clinical indicator data to improve patient outcomes.

Yes?-- And those areas that have been able to achieve improvements based on the use of indicator data are more likely to engage in the process of collecting that information on an ongoing basis.

Mmm. Just one other comment: who chairs the ASPIC committee?-- Dr Carter.

Because I was going to then say well, the chair of the committee should be able to bring the committee to order so that it is focussed on the agenda before it?-- That's right, and that's been one of the problems, is that it hasn't had a chairperson who could bring it into order because he would sometimes be participating in the, you know, the banter and, you know, niggling and generally distracting sort of behaviour.

And is part of your role to help staff understand the EQuIP process-----?-- Yes.

-----better?-- It is.

So you can get around perhaps and do that through some of the committee processes as well?-- I do, absolutely.

Yes?-- And I also like, you know, I introduce it to all new staff through my orientation presentation, they're led through what the EQuIP process is.

Mmm. Thank you Mr Andrews.

MR ANDREWS: The adverse events management policy was developed by you in January 2004?-- Yep.

It no doubt needed some kind of training to be done?-- That's right.

That lot fell to somebody else because you took-----?-- Went on sick leave.

-----sick leave. When you returned, did you - you had some concerns that the training could have been more effectively

done?-- No, I don't believe so.

All right?-- By the time I returned, what had happened was that Queensland Health had introduced their incident monitoring policy and we therefore had to update our own to reflect the changes in, you know, or to, you know, reflect the information contained in the Queensland Health policy. I know that Dr Keating and Jennifer Kirby did extensive training with all clinicians on the adverse event monitoring system that was introduced in February 2004 and I have no reason to believe that that wasn't effective training.

I'll ask that this e-mail of yours of the 14th of September 2004 be put up on the screen?-- Mmm-hmm.

It runs for several pages and only some of them seem to be relevant. I'll ask that this page be put up first. Perhaps you should indeed, perhaps the first page should be put up first so that Miss Raven has some context and may recognise the document. Now, you'll see that the top of the page is a reply of yours to Mr Leck, Mr Leck's e-mail is in the middle of the page?-- Yep.

And then your - a long e-mail of yours starts at the bottom of the page; it seems to be dated the 14th of September 2004?-- Yep.

Now, about three pages into the e-mail, there are some topics discussed that seem to be relevant to incident management?-- Yep.

Now, you regarded there it as an urgent issue to discuss the incident monitoring and integrated risk management?-- That's right.

Now, incident monitoring, the monitoring of adverse incidents and events?-- Yes.

And integrated risk management is a slightly different topic but it relies upon-----?-- That's right.

----- credible reporting of incidents, doesn't it?-- That's right.

Now-----?-- Do you want me to explain what this e-mail is? Or sorry, go on.

Not really - well, you may if you wish but I'd like you first to come to the points that I've highlighted?-- Yes.

You seem to be speaking about slides?-- Yep.

I assume that they are to do with the education of staff about the Queensland Health incident management policy?-- That's right.

And you are concerned that Gwenda's slides-----?-- This is in no way in relation to the training that Darren Keating and

Jennifer Kirby provided. During my absence, I was away for several months, Peter Leck was concerned that the processes that I had started would fall over, so five people from our district were sent to integrated risk management training to be - they were sent to train the trainer training - if that's not too many trainers - and those five people were to come back to the district and to continue the ongoing training of people within the district in terms of incident monitoring and integrated risk management, because by that time Queensland Health had developed a training package. So they were sent away, they brought the package back and my concerns that I was trying to raise with Peter Leck here was that Gwenda McDermid, who was one of the people trained as a trainer, was starting to deliver education about incident monitoring and risk management. The slides that I refer to there are the ones that Gwenda showed me which are basically straight from the Queensland Health package. My concern was that at no time during that training was she telling staff, "This is the form we use in Bundaberg", you know, "This is how it gets processed" and so on, it was - and I certainly at some point, you know, in the weeks after this, sat through the four hour training course myself and that was my concern, that they weren't - they were just simply delivering the corporate package, which is all very well and good, but they weren't localising it so that the clinicians who were going through their training were having an idea of what form they were to use and where they were to go and so on.

Am I right in thinking that in September 2004 there was still doctors and nurses being given training on incident monitoring?-- The training, we tried to make sure that the training is ongoing, particularly with risk management, it's a very difficult concept to grasp for some people, so the view of the district, I believe, was to provide the training on an ongoing basis, you know, for the clinicians who had come or had been on leave when Darren and Jenny did their training and so on.

And it does seem you had some constructive comments to make about improving the training package?-- That's right, but that was the training package that Gwenda and the trainer trainers had delivered. I believe the training that was delivered while I was on leave, that was delivered by Darren and Jenny, was much more based around how our system was working.

Miss Raven, were people - were doctors and nurses still being given training on the adverse incident reporting system in September 2004?-- Yes.

And still being trained on risk management systems?-- That's right.

Could we move to the next page please? Now, what was the discontent about the risk rating of incidents?-- This had been - there was discontent about this ever since the system was introduced. The nurse unit managers and the clinicians who were filling out incident forms felt, and perhaps quite

rightly, that they should have been the people risk rating the incident, like, determining what, you know, the factor of consequence.

They rather than somebody at the DQDSU?-- Well, when the system was introduced, somebody in the DQDSU, generally me, risk rated all incidents.

And was there some resistance from the nurse unit managers, that they felt that they should be risk rating the-----?-- That's right, but the initial decision to not have them risk rate their own incidents was primarily because there was recognition that there hadn't been enough training on the use of the risk matrix, you know, provided to clinicians. That's why in December when we changed the policy, by that stage there had been more training provided by Gwenda and her crew and they believe that, you know, the nurse unit managers would have a better understanding of how to use the risk matrix and could start risk rating their own.

And did that result in some antagonism between the nurse unit managers and DQDSU?-- When we changed it or in the initial instance?

When you took over the risk rating?-- Well, I risk rated, I always risk rated the incidents from the time that we introduced the new system.

Okay?-- Yes, there was quite a degree of angst amongst the nurse unit managers because of that.

And I see from what looks to be about the second sentence there's a reference to - well, a Linda; I'm assuming that's Linda Mulligan?-- Mmm-hmm.

And there seems to have been a dispute between you and Ms Mulligan about how incidents should be rated?-- That's right.

Can you explain what the difference of opinion was between you?-- It was again based on, I believe, Linda supporting her nurse unit managers in saying that they should be risk rating their own incidents.

Why did you not rate anything above medium? What was your concern about rating things higher than medium?-- Things had been rated - things that are rated high, very high or extreme have to go over to one of the executive directors for follow-up, and one of the comments that had been made to me was that they were getting all these high incidents that shouldn't have been sent across to them, so that was me just being cranky and saying, "Fine, I won't send anything across", but-----

Which executive directors were concerned that things were rated too high?-- From memory, I think primarily Linda because Linda did get a lot of the incidents sent across. The other thing that is - like, risk rating an incident-----

But why have you said you're not prepared to send anything to either Linda or Darren while there's this unresolved question?-- Because Linda - if you have a look at where incidents go, primarily they go to those two people, either Linda or Darren, there's very rarely a - I mean, I'm not saying never, but it's more rarely would an incident go across to, you know, the Director of Corporate Services or the Director of Community and Allied Health.

COMMISSIONER: What is meant by, "The poorly disguised assault by Linda"?-- I honestly, I don't know, I can't remember what it is that I was referring to there.

MR ANDREWS: You certainly weren't referring to a physical assault, were you?-- No, no.

Surely you must have meant that it was criticism from Ms Mulligan?-- There was, again, like, generally concern that as a non-clinician, I didn't have the required knowledge to risk rate an incident that had happened in the clinical area.

But you'd been a clinician and you were the only one that had done the risk rating course?-- That's right, but I can only imagine that because there were a lot of nurse unit managers who were disgruntled about the fact that the DQDSU was risk rating incidents, that that would have been passed on to Linda and Linda was just raising their concerns with me.

Now-----

COMMISSIONER: If she was just raising concerns, you wouldn't describe it as a poorly disguised assault, would you?-- Oh, I might do. I can be quite verbose when I get going on an e-mail sometimes, but as I said, I can't recall what the particular comment was that led me to write that.

MR ANDREWS: When it came to incident management, further down in the e-mail?-- Mmm-hmm.

You refer to "Pockets of activity related to incident management all over the place"?-- Yep.

"With no-one emerging as the coordinator."?-- That's right.

And you feared that the process was starting to spin out of control. Do you - is it right to infer from that that you feared that there were incidents that weren't reaching DQDSU for recording?-- No, no, that's not what I meant at all. Because there had been five other people trained as train the trainers and, you know, Gwenda McDermid was leading that group, it was simple things like she would sign e-mails as the integrated risk management coordinator and, you know, whereas I had understood that that was certainly my role and there was that. What I was getting at there was that there were all sorts of people putting their two cents worth into the risk management process and no one person recognised as a coordinator of that process.

As a risk manager, are you supposed to look for patterns and seek to resolve emerging trends?-- Certainly, that was one of - one of the roles that I undertook. Obviously, you know, as per the policy of if an incident was rated high or above, it went to the relevant director for follow-up.

Speaking of risk rating?-- Mmm-hmm.

There's a complaints register that runs for a couple of years?-- Yep.

And the copy of it which I have begins, "Complaint, Date Received, 1st of July 2002"; that would be about the time that the register began?-- That's right.

And I see that to begin with there's some risk rating?-- That's right.

I assume you will have been the person doing it; is that correct?-- We didn't ever risk rate complaints, that particular register. The history is, I went to a workshop where Queensland Health said that they were going to build us a complaints database.

May I show you the first page of this-----?-- Mmm.

-----because it seems that - well, there seems to be a column with "Risk Rating" and it seems to be filled in for quite a long period of time?-- Right.

Now, do you have open before you the page that shows "Complaints Received"?-- Yep.

The top one being the 1st of July 2002?-- Yep.

Over towards the right-hand side of that page, fifth column from the left?-- Yep.

"Level of Risk"?-- Yes.

E, H, M and L; what do those letters stand for?-- Extreme, high, medium, low.

And I see that column is filled in?-- Mmm.

From the complaint received on the 1st of July?-- That's right.

To the complaint received on the 13th of December on that page?-- Yep.

Were you risk rating those complaints?-- Yes. The form didn't have - they, like, the form that we were using at that time didn't have any fields for the person registering the complaint to identify what the level of risk was, so - and I did for a while try to fill that in, but it was purely just speculation on my part, and as you can see, as we go further

on, I just stopped doing it because-----

You stopped in January 2003?-- Mmm-hmm, yep.

Well, if the second page is accurate?-- That sounds about right.

And looking at the complaints register, no risk rating of patients' complaints has occurred since then?-- That's right.

Does the patient complaint - would it be a useful thing for there to be some fields included in the patient complaints form that might allow you to risk rate?-- Yes, I think absolutely, and certainly my understanding of the database that Queensland Health said that they would build when they gave us this spreadsheet as an interim, which they're still building, will have a field where you can risk rate every complaint.

Now, you do risk rate the adverse incidents register, don't you?-- We do.

Well, you once were rating the incidents and then, as I understand it, nurse unit managers and perhaps costs centre managers?-- Costs centre managers, more or less the same thing, not every costs centre manager was a nurse unit manager, but generally nurse unit managers are costs centre managers, it's just the term, the costs centre that they're looking after.

Now, for instance, in - did Dr Patel have a unit? Was he a costs centre manager or was there someone who was his costs centre manager?-- I don't know that I could answer that with any authority.

Who risk rates the incidents, for instance, that arose out of surgery?-- In those first few months when the policy was introduced, it was myself and then Jane Truscott, when she took over my position. From December onwards Di Jenkin would have risk rated the incidents that arose out of the surgical unit.

COMMISSIONER: Miss Raven, I see in your statement, attachment LTR5 is the document described as "Risk Matrix"?-- Yep.

This is a Queensland Health document rather than your own creation?-- Yes, that's right.

But this is the document that is currently used to risk rate?-- That's right.

All right, and has been in use for how long?-- Since the adverse event reporting system was put in place in Bundaberg.

Right. I just want to understand and make sure that I understand how it works as a matrix?-- Mmm-hmm.

Down the left-hand column you have various types of events,

"Clinical Incidents", "Litigation", "Security", "Staff Morale" and so on?-- That's right.

And for each type and there are what, two, four, six, eight, 10, 12 types?-- Yep.

The types of the consequences that might flow from that are categorised between negligible and extreme?-- That's right.

But then the next step is after you've determined what the consequences are, you then look at whether that's something likely to occur, only exceptionally or occasionally or regular or almost certain to repeat, and that gives you another filter as to the risk status?-- That's right.

Okay. In the first process of examining the consequences and the seriousness of the consequences, to take the first line, you've got "Adverse Clinical Incident"?-- Mmm-hmm.

And it's regarded as a major consequence if there's a loss of life?-- Yep.

And it's only regarded as extreme if there are multiple deaths?-- That's right.

Similarly, if you go down about halfway down, it's a workplace health and safety incident if there's a fatality that's deemed to be major, but if there are multiple fatalities, it's deemed to be extreme?-- Mmm-hmm.

If you look at the second row, described as "Outrage or Damage to Reputation"?-- Mmm-hmm.

I see that the extreme column has in it "QH Reputation Significantly Damaged"?-- Yep.

That's Queensland Health, is it?-- That's right.

So according to the Queensland Health risk rating matrix in place, significant damage to QH's own reputation is regarded as something an order of magnitude worse than a mere loss of life; is that a correct understanding of it? Loss of life is just a major consequence, whereas harm to QH's reputation becomes extreme?-- But that, you see, what that particular type of adverse or, you know, type of consequence, if you're reading "Outrage and Damage to Reputation".

Yes?-- They're the degrees of consequence.

Yes?-- But it's quite separate to adverse clinical incidents.

Yes, I realise it's a quite separate thing, but one loss of life under any category never becomes extreme, one loss of life is only major, whatever category it's in?-- Well, you'll have to argue with Queensland Health who developed this matrix, I can't-----

Well, you use it, don't you?-- I do, but like, if I'm

categorising an incident, it's generally the adverse clinical incident is the type of consequence that I'm using.

But am I reading it correctly when I suggest that that's what it says?-- I don't know that you can really compare across the types of consequence.

Well, I'm inclined to agree that it would seem quite inappropriate to compare loss of life with damage to QH's reputation, but that's how it operates, isn't it?-- Primarily.

Yes.

MR ANDREWS: While you have that bulky complaints register in front of you?-- Yep.

So that I can follow it, the first of the two bundles, being the one that commences in 2002?-- Yep.

About two pages from the back, it refers to a patient about whom we've heard considerable evidence, Desmond Bramich?-- Yep.

And I see the entry with respect to Mr Bramich four lines from the bottom?-- I'm not sure that I'm on the right page. Whereabouts are you looking at this?

Well-----?-- Second page from the back?

Second page from the back?-- Right.

Let me see if you've got the right page. The last entry on the page would be September '04?-- Yep, I haven't got the right page, I've got April '05 is the last.

Yes, I have two bundles here. I assume that yours are bundled similarly. One is a bundle of four pages and the other one has many more?-- I've just got one big bundle. A different bundle over there I think - so what's the last entry on the page, September '04?

Yes?-- Okay.

Do you have it?-- Yes, I do.

Now, the fourth entry from the bottom seems to be Desmond Bramich?-- Yes.

There are a number of things in this Excel spreadsheet?-- Mmm-hmm.

But I see, for instance, in the seriousness category for Mr Bramich, it's still left blank?-- Mmm.

Is that-----?-- By this time the DQDSU was only receiving the complaint registration form. That's a form that's filled in by either the person who's managing the complaint or their support officer. What we enter into the register is purely just the information that's contained on those registration forms.

So who gets the adverse incident form?-- But this is a complaint, not an adverse event.

I see. So the patient complaint form isn't the form you'd receive. You'd receive something else?-- What we get - if a patient for instance, you know - well, let me see. This complaint was received as a written complaint, so that would go to the relevant director to look into. They would correspond to the person who is complaining and, you know, attempt to resolve that complaint. At the end of that process a complaint registration form is filled.

By the patient or-----?-- No, no, by the person who was managing the complaint. And that form includes information such as what the complainant wanted, usually.

I notice that in none of the columns is there a seriousness category. Does the form that's filled in have a space for seriousness category?-- It does, but it's - it's not - it's not always completed.

Well, if I look at this page, it wasn't completed for any of those patients in the period June to September '04?-- Yep.

Is it the case that the forms that are filled in by the director who sends a form to you almost never fill in the space for seriousness?-- It would appear so, yep.

Right.

D COMMISSIONER VIDER: Could I just ask, what proportion of patients complain in a form of a letter, not filling out a

form?-- Well, a patient can come in and there's a - there's a notification of complaint form that if they want to, you know, write something down and complain, but that would still be categorised as a written complaint. We do get most of our complaints by written complaints.

I'm talking about somebody who just goes home from hospital, decides they want to. So, they would just sit down and write a letter?-- Yeah, I can't remember off the top of my head but the bulk of our complaints would be received in writing.

That free hand letter?-- Yes, yes.

Do you leave it as a free hand letter or then - does that come to you?-- No, that goes to the relevant executive director who is looking after that complaint.

And they then follow that through?-- That's right.

Do you get a report on that at some stage?-- No, we get the complaint registration form with just basic information which we enter into here. So it's about, you know, what the - what they were complaining about, what they would like to have done to resolve that complaint, what was actually done to resolve the complaint, how long it took us to resolve the complaint and they're the sorts of things that go into the complaint trend report.

Oh, okay.

COMMISSIONER: Where the relevant director happens to be the person who is the subject of the complaint, for example, in the case of Bramich and Dr Patel was the relevant director in surgery, is it still referred to him?-- No - well, it's one of the executive directors, so either the District Manager, the Director of Medical Services, the Director of Nursing, Director of Community and Allied Health, Director of Corporate Services or Director of Integrated Mental Health.

When you use the position director, you mean executive director rather than director of an operational unit?-- Yes.

Yes?-- But certainly if there was a complaint, I'd suspect if there was a complaint made about a director of - you know, that person has a right to know that there's been a complaint made about them and the executive director follows that process up.

I was obviously under the mistaken impression that when you were referring to director, you mean director of the operational unit?-- Sorry. No-----

And I wondered whether there was a situation where Dr Patel was being asked to investigate the complaint into Dr Patel?-- No.

That's not the situation?-- That would never happen.

No?-- Almost invariably the letters of complaint come addressed to the District Manager, so Peter Leck would then get one of his executive directors, whichever one was the relevant one, to follow it up.

Yes.

D COMMISSIONER EDWARDS: Could I ask you: would it be the same in a big hospital in Queensland the way in which registration complaints are made?-- As I was saying, when they started to try and develop a database that could be used across the state so we could actually start comparing data, this spreadsheet was made available to all districts, but it was entirely up to the district whether they, you know, implement it or not. Because we had, at that stage, no other way of registering complaints, we chose to use it.

MR ANDREWS: As one continues to look at the entries relating to Desmond Bramich, one sees the senior actioning officer is DMS. That would be Director of Medical Services?-- That's right.

Does that mean that it was Dr Keating who would have filled in the form that was sent to you with these details?-- Oh, whether he personally filled it in; it may have been his executive support officer.

Thank you. There's a column that is headed "Detail"?-- Mmm-hmm.

And for Mr Bramich the detail reads, "Treatment following admission to hospital for accident in which he received a fractured sternum. Patient subsequently passed away"?-- That's right.

Will that be a verbatim item detail that will have been extracted by someone in your department-----?-- Generally-----

-----from the form that's come from the Director of Medical Services?-- That's right.

And for the columns-----?-- I mean, I should just clarify. If it's - you know, if it's - if the description is, like, you know, three paragraphs long, sometimes the - yes, my AO or my administrative support officer will precis what's written. But for the purposes of why we monitor complaints, you know, a great long passage of information is not that relevant because we're looking at trends and-----

So you look for the significant detail that might show what kind of incident it was-----?-- Mmm, complaint.

-----that would affect risk for this particular patient?-- Yes.

And looking at Mr Bramich's entry for instance, there is nothing about the detail section that would alert the reader to any untoward conduct by clinical staff?-- Not in this

register, no.

So it isn't much of a guide, this particular register entry, for a risk manager such as yourself to extrapolate and use in a trend?-- No, it is quite useful because, as I was saying before, what I report in the trend report is things like where our complaints are coming from, you know whether they're from the Minister's office or whether they're from patients or whether they're from, you know, a relative of a patient, how they're received, what they're about, and things like our three top complaints or the topic of - the three top topics of our complaints are treatment, access and communication. So based on that, we try to look at how we can improve access to the organisation, how we can improve communication and so on. So it is useful in trending what people are complaining about.

You do have a column that says "Issue/Narrative", and in that column it says "Treatment"?-- ?-- "Issue"-----

About halfway across the page?-- Yes. And that's - those - that's actually selected from a predetermined list.

Yes?-- There's nine categories, as I understand it, by the Health Rights Commission and we put it into one of those categories as to what people are complaining about.

And for the "Department/Service" area-----?-- Mmm-hmm.

-----you have "ICU". Does that show that this was a treatment problem that arose in ICU?-- That's right.

Now, there are three columns that contain no entries. There's the level of risk column we've discussed before?-- Mmm-hmm.

No entries were ever included for that after the first few months of the patients' complaint register but there's a likelihood of recurrence list. Who's to fill that in, the person who fills in the form or someone at DQDSU?-- If they were column - like, basically somebody in DQDSU, but it was not something that we ever really fully went down the path of risk rating complaints.

And "Consequence of Issue 1-5", is that something to do with the risk management?-- That - that would basically be the same sort of risk matrix as-----

Nothing filled in for it either?-- No.

Now, in an ideal world, would those columns be better filled in from a risk manager's point of view?-- Oh, they would be, absolutely.

And when it comes to the Resolution/Outcomes" column?-- Mmm-hmm.

For Mr Bramich it reads "Concern registered"?-- Yep.

Does that mean that the organisation's aware that someone was

concerned to complain about Mr Bramich?-- It would probably have come from what the complainant has requested to have happened. I can't be absolutely sure but one of the important elements of managing a complaint is to find out from the complainant what it is that they want us to do to help them resolve that complaint, and often times it is people just want the hospital to know that this has happened to them.

For the next column, "Complainant Outcome"?-- Mmm.

What's that column suppose to be indicating?-- It's a column - and it is certainly something we were trying to work out how we could capture but it's trying - you're supposed to - hang on, let me start again. The idea of that particular column is to register whether the complainant was happy with - and like, because we don't have at this stage a way of capturing that. But some of the other things that you could potentially see in there - you won't see it in our register because we don't capture it - is "partially satisfied", "completely satisfied", "proceeding to legal action" and, you know, so on.

On the page that Mr Bramich and 30 other complainants appear?-- Mmm-hmm.

I see that column has "Unknown" for complainant outcome?-- Mmm.

Does that mean that you didn't capture that data?-- We can't - that's right. We were certainly, as an organisation, trying to work out a simple way of determining whether the complainant was satisfied with the outcome they received. I think you'll find a lot of districts have difficulty gathering that information.

Well, it would require someone to actually speak to the complainant?-- Ring them or-----

And give that complainant feedback and see what that complainant-----?-- Whether they were happy or not.

What their response was?-- Mmm.

I gather that DQDSU wasn't given that information?-- No.

Would it be that someone would have that information?-- No, that's - that's what I'm saying. Like, Bundaberg at that stage or in I think it's - you know, it will obviously be changing now but we didn't have a way of - that was set in place-----

Do you mean the complainants weren't followed up to see whether they were satisfied with the process?-- Once - that's right. Once they've had their correspondence and you know - it's certainly always put at the bottom of the letter, you know, "If you have any further concerns", and so on. But we didn't have like a structured process whereby we could determine whether a complainant was satisfied or not.

Within the same document, on the last page there is another patient about whom we've heard some evidence, Linda Parsons. You see an entry for Linda Parsons about-----?-- I do.

-----seven or eight from the top?-- Yes.

And it seems that the consumer was the source of the complaint?-- That's right.

The consumer complained about treatment in the DEM/surgical ward. The senior actioning officer was the DMS. Seriousness category blank?-- Hang on, I don't know that I'm reading - I've got the Linda Parsons.

I'm looking at-----?-- April '05, is that?

Ms Parsons may have twice been a complainant. I'm looking at the page after Mr Bramich's page?-- Right.

Which has entries from August '04 to December '04?-- Yep, I'm with you now.

Eight entries from the top?-- Yes.

Commissioner, this won't fit on the monitor, that's why we're having this laborious process.

COMMISSIONER: By the way, were you going to tender the document that is on the monitor or are you coming back to that?

MR ANDREWS: I'll come back to that.

COMMISSIONER: Yes.

MR ANDREWS: Ms Parsons - I beg your pardon, Ms Raven, you see Ms Parsons' entry?-- I do, yes.

Now, the detail, "Not happy with treatment in DEM and surgery ward"?-- Yep.

Will that have been the most crucial part of the detail in the form that will have been filled in by a staff member and sent to your section?-- Generally, yes.

And the resolution outcome is, "Apology given"?-- Yes.

"Complainant Outcome", "Unknown"?-- Mmm-hmm.

And the complaint was resolved on the 8th of October-----?-- Yes.

-----2004?-- Yep.

And there's a column that shows the number of days taken to resolve Ms Parsons' complaint?-- Yes.

How long did it take?-- Four days. That's one of the performance indicators that we look at in terms of how long it takes us to resolve complaints. It's a benchmark set by Queensland Health, and certainly over the last 18 months we can show that the time it takes us to resolve complaints has actually been decreasing.

COMMISSIONER: Certainly decreasing if you regard Ms Parsons' complaint as resolved. Should we have an afternoon break?

MR ANDREWS: Yes, thank you.

COMMISSIONER: Just a short one. Five minutes.

THE COMMISSION ADJOURNED AT 3.03 P.M.

THE COMMISSION RESUMED AT 3.12

LEONIE THERESE RAVEN, CONTINUING EXAMINATION-IN-CHIEF:

COMMISSIONER: Mr Andrews.

MR ANDREWS: The same document that's before you, does it, on the previous page where we were discussing Mr Bramich, show that the complaint in respect of Mr Bramich took 10 days to resolve?-- That's right.

Now, would you turn the page, please, on that e-mail on the monitor.

COMMISSIONER: The next page.

MR ANDREWS: Commissioner, for the benefit of others who may be wishing to cross-examine about the complaints register, I'll tender it.

COMMISSIONER: Yes.

MR ANDREWS: Ms Raven, you have before you a complaints register in two volumes. I'd like that to be given to the Commissioners so that it can be marked as an exhibit.

COMMISSIONER: Sorry, just before it comes back, you said that the Bramich complaint was resolved in 10 days.

MR ANDREWS: That's correct.

COMMISSIONER: Does it indicate how it was resolved?

MR ANDREWS: No. There may - well-----?-- "Concerned

registered", I think is the resolution listed.

Yes, you could be right, Ms Raven. I'll look at that. "Resolution Outcome", "Concern registered". "Complainant outcome", "Unknown."

MR ALLEN: I understand that what the witness may have just handed over is the complaints register but also the adverse incident register.

COMMISSIONER: Is that both registers?-- Yeah, the one underneath is the adverse event register.

Well, Exhibit 166 will be the complaints register.

ADMITTED AND MARKED "EXHIBIT 166"

COMMISSIONER: And Exhibit 167 will be the adverse events register.

ADMITTED AND MARKED "EXHIBIT 167"

MR ANDREWS: Commissioner, I will have to correct those things shortly because I know that the complaints register ought to be in two sections.

COMMISSIONER: All right. Well, I'll reserve those exhibit numbers and, Mr Andrews, I'll leave it to you to sort out with the acting secretary the exhibit.

MR ANDREWS: Thank you, Commissioner. I anticipate that the page on the monitor has some highlighting towards the bottom. Now, the first few lines of highlighting, Ms Raven, is it correct to infer from that you were - that Dr Keating in fact did something appropriately but you got no feedback and you found that frustrating?-- Yes.

And the next paragraph shows that at that time you didn't know what your role was going to be in respect of complaints management?-- That's right.

This is in September 2004?-- That's right.

Commissioner, I seek to tender only the first but not the second and all subsequent pages in that e-mail. The second simply may contain matters irrelevant to the inquiry and of considerable embarrassment to the witness.

COMMISSIONER: Yes, the second page relates to the period of sick leave, or something like that.

MR ANDREWS: Yes.

COMMISSIONER: Well, we don't want to go into any personal or private matters. So what you have given me here is the pages that you wish to tender.

MR ANDREWS: Yes.

COMMISSIONER: Is that all right with you, Ms Raven?-- I think on the very top of that first page there's a reference there that I would like to have removed.

Yes?-- It says something along the lines of "I would have hoped that people would stop looking at me", blah, blah, blah. That - do you want me to show you?

Look, if I can have it handed back and you might fold it at the point where you want it not included as part of the exhibit, so that we will know from the fold down it forms part of the exhibit.

MR ANDREWS: Actually, Commissioner, as I review the second page it isn't the source of embarrassment. I was confusing it with a different e-mail. The second page seems to be one that won't embarrass Ms Raven. I have kept out of the chronology the e-mail that with which she was most concerned.

COMMISSIONER: Ms Raven, I would like you to take a moment to check through the e-mail to make sure there's nothing irrelevant to this inquiry which should be excluded.

MR ANDREWS: Ms Raven, would you look, please, to paragraph 32 of your statement?

COMMISSIONER: Exhibit 168 will be the e-mail from Ms Raven to Mr Leck dated the 14th of September 2004, excluding those parts behind the fold on the first page, so that when that's copied and made available on the Inquiry web site and elsewhere the part behind the fold is not to be included.

ADMITTED AND MARKED "EXHIBIT 168"

COMMISSIONER: Is that the intention?-- Yes, thank you.

MR ANDREWS: Thank you. At paragraph 32-----?-- Yes.

-----you observe that there is often a file held in the executive office in relation to a complaint?-- Yep.

By whom?-- The executive officers keep extensive information about the complaints that they have managed. In those files

would be the letter - the original letter of the complaint, the - you know, the response to that, and so forth. So all of that - the documentation that's related to a particular complaint is kept on the file in the executive's offices.

So the original complaint-----?-- That's right.

-----you would expect it to be there?-- That's right.

What about adverse incident forms, are they kept there too?-- No adverse incident forms are kept by us in DQDSU.

Now, with respect to Mr Bramich's adverse incident and sentinel forms-----?-- Yes.

-----why is it that the sentinel event form was not registered?-- From as far as I can tell what's happened is that on-----

Did you inquire of the person who - who was in charge on the occasion when the sentinel event form was received?-- Jane Truscott was acting in my position.

And have you worked these things out by asking people or have you tried to deduce it without asking?-- I have worked it out by looking at the - at the original forms that have come in.

COMMISSIONER: And have you established that the sentinel event form was, in fact, not registered?-- It wasn't registered. It certainly was forwarded on to Darren Keating who followed it up.

Yes?-- But what has happened is that there's two sentinel - there's two reports come into the unit on the same day related to Mr Bramich and because of some of the stickers and so on that have been - had been attached to them the AO2 in the unit who registers them into the register has stapled them together and assumed they have been the same incident.

MR ANDREWS: The AO2, what was that person's name?-- Marilyn Driver.

Have you spoken to Marilyn about this?-- I did ask her whether she recalls, but if you can understand Marilyn purely is - her role is just to take information and type it into a spread sheet, so she doesn't really try to marry up all the information that she's - so she doesn't actually recall, you know, other than stapling them together thinking that they were the same report.

Yes. Marilyn Driver you say?-- That's right.

And did Marilyn tell you something?-- No, I've - I asked her once - in the last few weeks as all of this has been unfolding I've gone back and had a look at the original forms, and it wasn't until just a few weeks ago, myself, where I've got the Desmond Bramich incident out, the one on the top, as you look at the register - like, as we - like, as I look at

the paper based forms, the one on the top relates to a lack of water in the underwater sealed drainage unit that was rated as very high, and forwarded on. The one underneath that is the sentinel event about Mr Bramich's treatment in the ICU and his ultimate demise. What I believe has happened is those two incidents, because they were received into the unit on the same day, they related to the same person, when Marilyn was, you know, after - after the event just entering information into the register she's stapled them together and believed they were the same one.

Did she tell you that or have you deduced it from what you have seen?-- I've asked her since I've looked at those forms and - and, you know, thought that that's potentially what has happened.

What did she tell you?-- She can't specifically recall, but she does recall, you know, stapling them together thinking they were - because they were the same person it was just the one event.

Would you look at Exhibit LTR9-----?-- Mmm.

-----at the sentinel event form where I see in the corner a post-it note appears?-- Yep.

I will have it put on the monitor. Already forwarded to DM, DMS, DON, "Can you make sure they get a form for AE follow-up?" What does "AE" stand for?-- Adverse event.

Whose signature appears?-- That's Jane Truscott, because Jane helped Tony fill out this particular form, and I believe that she has taken it straight over to Darren, herself, and that's why that stick-it on the top there has been attached to it, because Jane is saying to Marilyn she's already forwarded it to the DM, DMS and DON.

In August 2004 was there any protocol that required Dr Keating to notify the head office or anyone else about this sentinel event?-- We were in the process of changing our policy. It should be made quite clear that Toni Hoffman's understanding that a sentinel event report would go directly to corporate office and they would investigate it is entirely incorrect.

Ms Raven, that's why I asked was there a protocol at the time that sentinel events should be forwarded to head office?-- It does say in the policy that was in existence at that time that the - the central zone management unit or corporate office should be notified that a sentinel event had occurred, but the management of that sentinel event still remains within the district.

And was the central zone management notified?-- I couldn't tell you that. I'm not sure. That would be - either Peter or Darren would have done that, but it's simply just for their information to collect data about how many sentinel events are occurring within Queensland Health.

Thank you.

D COMMISSIONER VIDER: Just that last statement again; who is just going to collect data?-- In terms of notifying corporate office that we've had a sentinel event, it was never that they were going to come and investigate it for you, it was just so that they could, as an organisation, keep as a record how many sentinel events were occurring across the state.

I would have thought for a sentinel event they would want to know that the outcome, whatever that was, was satisfactory?-- They do but, like, the - the investigation into that sentinel event still is the responsibility of the district.

Oh, yes, yes. Can I just ask for my own clarification for a sentinel event - I understand your description of how these two things might have become stapled together. Would a sentinel event as well as an adverse event come to your office?-- Yes.

First?-- They technically should - if you have a sentinel event occur the policy actually states that the district manager, the DMS and the DON had to be notified verbally within 12 hours. So there should have been a phone call made on the 28th, but - so - and that is to ensure that the process of investigating and working out what's gone wrong starts immediately, but the form would come into our unit to be registered and then forwarded on.

Because a sentinel event, you know, is a sentinel event?-- That's right. The policy at the time said to notify the district manager verbally within 12 hours and a written report must follow within 48 hours of the event.

When these forms then come into your office, what's the role of the clerical person?-- That's - the role of the clerical person is after the event. Like, these - the adverse events and sentinel events are all dealt with, forwarded onto the executive member, you know, on the day that they're received. Marilyn, in terms of entering information into the register, does that after the event. Like, it's just putting information in. If she gets a sentinel event, if we get a sentinel event or an event that's, you know, of high risk, she certainly puts a note in the way she keeps her paperwork together to say that's been forwarded on, but often times-----

I suppose I'm asking when do you see these reports?-- As soon as they come up to our unit from the clinical area who are reporting them.

Because it would be - I imagine it would need to be seen by them before they go anywhere; to any clerical person for assessment?-- What happens, they come into the unit via the internal mail system. Generally Marilyn puts them inside a purple folder that I have got just for adverse events as she - and she, like, walks in and out all day. As soon as she comes in, she brings them in, I have a look at them, determine where they need to be sent to and so on. They're dealt with on an

ongoing basis. She may wait until the end of the week to data enter all the information, but it's certainly been dealt with then and there.

And given, I presume, from this incident she now knows to look not only at the patient's name, but at the heading of the event form, as well?-- Mmm.

MR ANDREWS: There's a complaint registration form which I see at LTR8 that relates to a patient. It's the second of the forms in LTR8 I would like you to have a look at?-- Yes.

It's patient P53, according to a register of patients, and I see that the patient's initials are AW?-- Yes.

Now, that patient, the narrative is that a catheter had been inserted into her carotid artery, she had been flown to Brisbane to have it repaired?-- Yes.

Now, that form will have been filled in by someone outside your department, won't it?-- That's right.

Do we see the author of the form?-- No. It would probably have - given that the person handling the complaint was the district manager, it would probably have been his executive support officer.

And am I right to - in deducing that the recommended action taken was no action?-- That's basically if there was going to be some, you know, other change to - to policy or, you know, education or whatever.

Well, the reason I ask is that in the recommended actions section there are tick boxes, they're all blank, but one of the sections seems to have been covered as if with a dark highlighter?-- That's just the way - this is a form that's-----

Is that a word processing mark?-- Yes.

Oh?-- The various support officers in the executive services have ways of filling these out. Some will put an electronic tick in the box, others just highlight the field that they're referring to. So that's just them, in word, highlighting that that's the - that's the relevant section for that field.

With the new adverse events management policy you were creating it in part because there was a sense that complaints were going into a black hole back in-----?-- Adverse events.

Yes, back in 2003?-- Yep.

Of course, you had no doubt the ambition that there would be feedback to those who followed the new system?-- Absolutely.

It didn't happen to begin with because I see at paragraph 25 you say that there were resourcing issues?-- That's right.

That means - does that mean there weren't enough staff to give feedback to those who put in the complaints?-- Primarily, when we first introduced the adverse events reporting system we started off by sending a letter of acknowledgment to every person who'd reported an adverse event saying thank you very much for reporting this, you know, it's been rated as whatever risk rating it received. This is what we're doing with it. But in the first month, you know, we got over 90 incidents reported and it became very obvious quite quickly that that just was not going to be sustainable. So then we looked at trying to develop some sort of report that we could provide back to each of the clinical areas saying these are the incidents you have reported, and we - our aim was to give that back to them on a monthly basis. However, the project officer who was helping us do that got a better job at another district and, unfortunately, we were not able to replace her. So, certainly, in terms of providing feedback to the clinicians we didn't - we weren't able to achieve what we had hoped we would be able to achieve.

And you would agree in an ideal system you would give that feedback otherwise the clinicians will stop reporting adverse incidents?-- That's right.

Have things improved since, now that it's 2005 and you've got so - all this publicity? Are adverse incidents now getting prompt feedback?-- Peter and I had been - Peter Leck and myself had been looking at recruiting a patient safety officer. Corporate office were going to provide patient safety officers. There's been some agreement that there be 25 patient safety officers across the state.

Does that mean it's in the pipeline, but it hasn't happened yet?-- On the very day that Mr Messenger, you know, tabled his letter in Parliament Peter and I had finalised a position description to recruit a patient safety officer to help us in the role of, you know - but Mr Messenger has short-circuited that process.

Has it happened yet?-- There is - well, Bundaberg at the moment, if you can understand, is in a complete state of chaos.

COMMISSIONER: Is the answer it hasn't happened yet?-- I couldn't really tell you that. It certainly - the acting district management would have to explain to you-----

To your knowledge it hasn't happened?-- Not to my knowledge.

Thank you. Mr Andrews?

MR ANDREWS: Thank you. At paragraph 38 you observed that you spoke with Dr Keating and asked him whether he was aware of the sentinel event form in relation to Mr Bramich?-- That's right.

You believed from your discussion Dr Keating was going to report back to the clinicians involved in Mr Bramich's care?--

That's right.

Why did you - what made you think that Dr Keating, by October 2004, had not reported back to them?-- Well, as far as I'm aware the - he had asked - or Dr Keating had asked Dr Carter to do an investigation of the incident. I imagine from what Darren told me was that he would be following up as to whether that investigation had, in fact, been completed and whether a copy of the report was given back to the people who reported it.

Now, you have to be careful when recalling what other people have said and, particularly, so far as Dr Keating is concerned. Are you saying that Dr Keating told you in October that he was waiting for Dr Carter to finish a report?-- No, he didn't tell me that. He said something to the effect of, yeah, that's all right, I'll follow that up with him.

With whom?-- With the person who was doing the investigation of the incident.

And do you know who was doing the investigation of the incident?-- Dr Carter.

All right. Thank you. And so far as you learned from your October 2004 conversation with Dr Keating there'd at that stage been no follow-up to any of the clinicians involved in the Bramich case and, certainly, none to Toni Hoffman?-- I can't answer that. I'm not sure what the status of it was. Certainly Toni at some point received a copy of the report that Dr Carter put together, but whether she had got it by that stage I'm not sure.

Well, certainly from paragraph 37 are you not saying that Toni Hoffman contacted you in around October wondering what had happened to the sentinel event?-- That's right.

So she plainly had had no feedback at that stage?-- She may not have, but she also was under the impression that corporate office would be coming in to do their own investigation and that was not the case.

Now, can you explain to me-----

COMMISSIONER: In the last - sorry, Mr Andrews. In the last sentence on page 5 you say that you informed registered nurse Hoffman that you would make some further inquiries and get back to her. Did you do that?-- I don't believe I did, because Darren said that he was going to follow that up.

But wasn't she complaining to you that she had lodged a sentinel event form and it didn't appear anywhere in the relevant records?-- That's right.

All right. And that's something you would follow up, isn't it, rather than Dr Keating?-- Well, I just asked whether he had - was aware of the sentinel event that had been reported, and he said that he was.

Right. So it's - in paragraph 39 you say that you've got an understanding that Hoffman has given evidence to the effect that there's a belief that the sentinel event was downgraded; that's incorrect?-- That's right.

Any misunderstanding on her part was as a result of the fact that she came to you, asked you what the facts were, you told her that you had investigate it and get back to her, and you never did?-- Not immediately. Certainly-----

No, not at all?-- No, that's not right.

When did you get back to her?-- The day Peter Leck was stood down I was asked to go and speak to Toni about the sentinel event form and the Desmond Bramich incident, which I did.

Who asked you to do that?-- Gail Aylmer asked me to come over and speak to Toni about Mr Bramich's incident. I went to ICU and I said to Toni, "This incident was not downgraded. You realise that Darren did do an investigation." Her words to me were, "Yes, I do note that that was never downgraded. It's a bit of a shame about Darren, because I quite like Darren, but we have to make sure that Peter Leck never gets back."

I see.

MR ANDREWS: You were asked by Dr Keating at some stage to advise what adverse incident reports there had been in respect of Dr Patel's surgery?-- That request, I think, actually came from Peter Leck.

Thank you. I stand corrected. When you sought to respond to that request you were able to find only a few of the adverse incident reports; that's the case, isn't it?-- That's right.

Is that because of the method under which these adverse incidents were record at DQDSU?-- No, not at all. The 900-odd incidents that have been reported in the last 12 months to DQDSU, I physically read through every one of them just to make sure that there wasn't a data entry error. So I have physically read 900 reports, and these are the only ones that are reported about Dr Patel.

But isn't it the case that in the adverse incidents register you generally don't know the name of the surgeon?-- You generally don't, that's right.

That would be why you were only able to find only four?-- No, that's what I'm saying to you, when Peter Leck first asked me to have a look at what adverse events had been related to or reported in relation to Jayant Patel I did a quick search through the register, looking at the surgical ward primarily, but since - since that time and not wanting to miss anything I have got the 900 pieces of paper out and read individually every one of them to be sure that I haven't missed a single event that was reported in relation to Jayant Patel. So I can honestly sit here and tell you that if - the incidents that I

have provided are the only ones that have been reported in relation to Jayant Patel since we have been monitoring incidents.

Now, when you reported to Mr Leck you were able to find only four-----?-- Yeah, that's right, four originally.

-----and you've been able to find a number-----?-- Two more.

-----further since then-----?-- That's right, yep.

-----is that something - your ability to not find more than four initially, is it something to do with the fact that you don't record the surgeon's name on the adverse incidents register?-- Potentially.

COMMISSIONER: I think all Mr Andrews is asking you is this: if you had the surgeon's name listed on the adverse incidents register you could have found six out of six immediately?-- Perhaps.

But - well, no, definitely. If you had Jayant Patel in the register you could have found six out of six immediately, but because you didn't have that sort of system you've had to go through the process you have described of physically checking 900 different forms in order to find-----?-- But, also, remember, we were trying to introduce a blame free-----

Is that the situation? Is that why you could only find four initially and you had to go through 900 pieces of paper to find the other two?-- That's right.

Thank you.

D COMMISSIONER VIDER: Could I just ask you, I understand you were away - was it during last winter?-- That's right.

For a period of time. We have heard some evidence that whilst there might have been deficiencies in four reporting of incidences with Dr Patel, we have also heard that Dr Patel wasn't the best record keeper and it would appear that he didn't document all of the clinical complications that he obviously experienced at times. So you won't find those in a record?-- Right.

I am just wondering when you came back to work at the end of last year, were you aware that there did seem to be some problems about Dr Patel's clinical competence?-- Only the - you know, the corridor gossip that was going on.

Well, the corridor gossip. If you then believe that you have got a culture that's got some resistance to reporting, and we've talked about that earlier, where you introduce a new system, and ACHS is a framework for such a system and there is some resistance to it. Given that you recognise there was some resistance to the reporting mechanism that you were trying to introduce, is it then part of your activity to go around to the different clinical departments and gather verbal information yourself?-- No.

That you can then start to use as a database to report some of this?-- No, I wouldn't - that's not really part of my role.

It could be though, could it not, because your role predominantly is to-----?-- It certainly would be the role of a patient safety officer.

But it could be the role of a quality person as well?-- It could be.

Because you need to be able to gather information by whatever means?-- Yep.

So that you can record adverse events, clinical or otherwise?-- Sure.

With hindsight, is that something you would consider doing?-- Oh, absolutely. It is a very busy position, though, that - I am defending myself, but you don't always have a lot of time to do, you know, extra activities such as walking around the wards.

I accept that. But I think also that we have to be able to explore alternative ways of achieving our ends?-- Yep.

And that might be that you decide to drop something off and do it another way to get the information you need, to get the outcome that you require?-- Sure.

MR ANDREWS: Ms Raven, I am going to ask you to look at LTR6. I will put the first two pages on the monitor. Now, do I see from the first page that that policy relating to sentinel events was effective from 1st of June 2004?-- Again, it is - it is a date error that I cannot explain but this was a policy written by me prior to going on leave in March 2004. So it was introduced at the same time as the adverse event reporting system.

Now, could I see the second page on the screen, please? Would you lift it a little higher? That's the section, yes. The last part in highlighting?-- Uh-huh.

"Liaison and notification of CZMU and corporate office Queensland Health will be required"?-- Yep, Central Zone Management Unit, as I was saying before.

Oh. Now, that's not Central Zone Management Unit or corporate office Queensland; it is both, isn't it?-- That's right, yes.

And so when the central - sentinel event with respect to Mr Bramich was delivered, whoever received it ought to have notified corporate office, Queensland Health?-- That's right.

If complying with that policy?-- That's right.

COMMISSIONER: And what seems to be contemplated there is not merely that they would be notified. You told us earlier it was a matter of record keeping?-- Mmm.

It seems to be contemplated that there is not just notification, but also liaison, which would suggest to me that CZMU and corporate office Queensland Health will actually be consulted in relation to the investigation process?-- What normally happens is once the investigation process is completed, a copy of that report - periodically Queensland Health will or corporate office will request, "These are the sentinel events that have been reported from your district. Could we have a copy of the report of the investigation?"

So the expression "liaison" here, if you were to interpret that as meaning they will be consulted, that's wrong. That simply means telling them there is a complaint and ultimately telling them it is resolved?-- I guess liaison would be, you know, that in the process of notifying them there might be some indication as to what we're going to do, how the investigation is going to take place, and who is going to be investigating it, and so on.

D COMMISSIONER EDWARDS: Who would make the decision if legal advice is sought?-- It would be the district manager, I would have thought.

MR ANDREWS: I have no further questions, Commissioner.

COMMISSIONER: Thank you. Mr Farr?

MR FARR: I have nothing, thank you, Commissioner.

COMMISSIONER: Who is next? Mr Allen?

MR ALLEN: Thank you, Commissioner.

COMMISSIONER: Sorry, Mr Mullins?

MR MULLINS: What time do you intend to rise?

COMMISSIONER: Well, I know that some people are on the late flight tonight. I was therefore planning to rise at 4.15, make sure that you don't miss your flight. Is that convenient?

MR MULLINS: Would you excuse me for one moment? I won't be here on Monday because I will be in Brisbane.

COMMISSIONER: You think you might be able to finish your cross-examination?

MR MULLINS: I won't, but I might be able to tag team with Mr Harper so that he could finish.

COMMISSIONER: Is that because you want to be involved in the Supreme Court proceedings on Monday?

MR MULLINS: That's correct.

COMMISSIONER: Mr Diehm raised yesterday the possibility that some latitude might be allowed for any of the party representatives here who wish to be in Brisbane, which was a quite sensible suggestion from Mr Diehm. Are you expecting to be away all day on Monday?

MR MULLINS: Yes, I will be away for the majority of next week.

COMMISSIONER: All right. So it is not just for that reason you are-----

MR MULLINS: No, it is not just for that reason. Well, it is on Monday.

COMMISSIONER: Yes.

MR MULLINS: But I don't know whether Ms Raven - whether the Commission was intending for her to return on Monday.

COMMISSIONER: Well, I was going to ask that. Ms Raven, we normally try and finish a witness in one day, even if that means sitting on late just so the person is not inconvenienced. Obviously that's not possible today because a number of the counsel here have to catch the late flight out of Bundaberg. Does it suit you to come back on Monday, or is

there another day of next week that would suit you better?-- No, Monday would be preferable to me. I would like to get this over with as quickly as I can.

Well, you have your answer, Mr Mullins. Perhaps if you start now and I will allow Mr Harper to conclude your cross-examination on Monday if necessary. Does that suit you?

MR MULLINS: It certainly suits me. I thought you were asking Mr Allen.

COMMISSIONER: I wondered, actually, Mr Allen, is that all right with you?

MR ALLEN: Excuse me, Commissioner.

MR FARR: Commissioner, just to ensure that perhaps this witness is finished on Monday, I think she is being very modest. I understood she was intending on going away this weekend for three weeks.

COMMISSIONER: I see.

MR FARR: Obviously would like, if she is able, on the Monday, but I am sure she is keen to ensure she finishes on Monday, that's all.

COMMISSIONER: Yes, yes.

MR MULLINS: Mr Allen, there is some matters that he wanted to cover this afternoon if possible. So I better let him.

COMMISSIONER: Fine. Mr Andrews, will we be able to make sure Ms Raven is scheduled as the first witness on Monday and not interrupted? There are no other pressing witnesses who need-----

MR ANDREWS: That's correct, no other pressing witnesses.

COMMISSIONER: All right.

MR DIEHM: Can I just raise a matter? Yes, Mr Diehm?

MR DIEHM: My instructions for myself on Monday are to appear in the Supreme Court application, and at this stage I am booked on a plane that leaves Brisbane at one o'clock. Hopefully I will be able to make that, having completed the appearance there. I had previously discussed with Mr Andrews the likely order of witnesses on Monday until this difficulty, which I well understand and appreciate. The intention was that there were going to be witnesses called who I was unlikely to have any questions for. Now, I might say with Ms Raven, I strongly suspect by the time it gets to my turn after others have cross-examined, that I may well not have had anything of significance for her.

COMMISSIONER: Yes.

MR DIEHM: My only proposition is this: that if in the event that there is something that arises that I do need to cross-examine her about, that at some stage within the life of this inquiry, even if it were by telephone evidence, that it might be arranged that I can take up those matters with her.

COMMISSIONER: Can I ask, Mr Diehm, if you were to start now how long you would expect to be?

MR DIEHM: At the moment I don't think I would have anything Commissioner.

COMMISSIONER: I see.

MR DIEHM: I am really thinking something might arise out of other questions that are raised, that's all.

COMMISSIONER: I am reluctant to give you any promises which depend on the convenience of others. For example, Ms Raven, I understand you have got three weeks' holiday and we're certainly not going to interrupt that if we possibly can. But, Mr Diehm, barring any exigencies that we can't overcome, I am happy to allow you to have the opportunity to ask Ms Raven questions by telephone at a later stage if you consider that necessary.

MR DIEHM: Thank you, Commissioner.

COMMISSIONER: But with any luck you will be back from Brisbane on Monday afternoon and-----

MR DIEHM: That's so, yes.

COMMISSIONER: Mr MacSporran?

MR MacSPORRAN: Can I raise a similar practical difficulty? I have discovered today I am not booked on a flight until 10.30 that leaves Brisbane, so I won't be here when you start on Monday but I will be here as soon as I can. I suppose it will be quarter to 12.

COMMISSIONER: I think Mr Allen can probably keep us amused for an hour or so.

MR MacSPORRAN: Yes, I think so.

COMMISSIONER: Mr Allen?

MR ALLEN: Thank you, Commissioner.

CROSS-EXAMINATION:

MR ALLEN: Ms Raven, my name is John Allen and I am appearing for Queensland Nurses' Union?-- Yep.

And certain of its members, including Toni Hoffman?-- Yep.

If I could just deal very briefly with one matter towards the end of your evidence. You have alleged that on the day that Peter Leck was stood down-----?-- Uh-huh.

You went to the ICU and told Toni Hoffman that a Bramich sentinel event form had never been downgraded?-- That's right. It may have been the day after. I am not sure whether it was the day he was stood down or the day after.

You allege that Ms Hoffman acknowledged that she knew that?-- That's right.

That, I put to you, is a complete fabrication?-- Well, I put to you that it is not. She did say that.

You said that she said words to the effect that, "It was a shame about Darren", but that "we had to make sure that Peter never got back."?-- That's right. They were her exact words.

That, I put to you, is a lie?-- It is not a lie.

On your part?-- It is not a lie.

Now, if we could go to some evidence you gave just before lunchtime.

COMMISSIONER: Excuse me a moment, Mr Allen. Where do you say this conversation took place?-- It took place in the ICU tearoom. Gail Aylmer was with me and certainly Gail heard her say that as well. There was also another member of the nursing staff, who I am not really familiar, I don't know who he was, but was sitting in the room as well.

All right, thank you.

MR ALLEN: You can't give us the name of that person?-- I don't know who he is. He is a male nurse, obviously must have been employed in the ICU, but certainly Gail Aylmer. And Gail Aylmer has-----

She would be able to speak as to this conversation, would she?-- That's right.

We will hear from her?-- Yeah, and she has admitted to me she recalls the conversation.

COMMISSIONER: No, she can tell us about it, can she?-- Okay.

All right. The male person, was it an older man, a younger

man?-- About middle age, I think. Not really - just not that familiar to me. I didn't really take a lot of notice of him. Sandy coloured hair, I think. That's about as much as I can tell you. I wouldn't have thought there would have been that many male nurses working in the ICU. Certainly some of the male nurses I do know but it wasn't one of them.

MR ALLEN: Who can we eliminate? It wasn't Damien Gaddes?-- It wasn't Martin Brennan, it wasn't Gerard Smith, it wasn't Damien Gaddes. As I say, it is a person that I am not familiar with.

All right. If I could just take you back to some evidence you gave before the lunch break?-- Uh-huh.

Now, my note of it is that you claim that if Toni Hoffman had been seriously concerned about what was going on in relation to Dr Patel-----?-- Uh-huh.

-----and had said something in May 2003, then the executive would have done something?-- That's right.

Okay. And you say that Toni Hoffman's failure to raise concerns when she first had concerns led to the situation which we now confront?-- That's what I believe, yes.

Okay. Now, if I could just clarify: do you blame Toni Hoffman for the fact that you are now giving evidence before this Commission?-- I don't blame Toni. Why would I?

Do you blame Toni Hoffman for the fact that patients had adverse outcomes including deaths?-- No. Had she said something, however, we may have been able to prevent some of the bad outcomes that patients have endured.

So Toni Hoffman's failure, as alleged by you-----?-- Uh-huh.

-----caused adverse outcomes, is that your evidence?-- No, I think you are playing with words there. Like, Dr Patel was the cause of the bad patient outcomes. What I am saying is had there been more information provided, or if she had told somebody something, the executive would have been able to do something about it. There were no alarm bells ringing.

"If she had told somebody something"; now, "somebody" being the executive?-- The executive.

"Something" being her concerns about Dr Patel's clinical practice?-- I would imagine so.

Because you gave evidence that "Toni Hoffman and the likes of her" chose not to tell anyone?-- They certainly haven't provided the information as they claim they have. I don't believe that Toni Hoffman has been shouting it from the rooftops with nobody listening to her for two years.

COMMISSIONER: Well, we have heard no evidence that she has been shouting it from the rooftops. She has given quite

specific evidence as to what she said to whom on what occasional.

MR ALLEN: Can I just understand who you refer to in your evidence before lunch when you refer to "Toni Hoffman and the likes of her"?-- Well, the people who are now complaining about - Gail Aylmer had specific issues about Dr Patel.

So she is also liable because she failed to take appropriate action?-- I am not saying that they are liable. I am just saying that this could have been prevented had these people had information to act on.

So Gail Aylmer, you allege, failed to voice concerns to the executive?-- I don't know what Gail Aylmer told who.

Well, why do you say that Gail Aylmer fits into the category of "Toni Hoffman and the likes of her" who are criticised by you for failing to take appropriate action?-- Because there was - I don't have any information - from the information that they could have reported to me, there is nothing to suggest that they had the concerns that they are now saying that they did.

COMMISSIONER: Well, may I take a specific example, rather than to break into - I don't think we're getting anywhere. Let's take, for example, Mr Kemps, who died just before Christmas 2004. How do you suggest that that death could have been prevented?-- Well, if they were concerned about Dr Patel's performance-----

And if, for example, they'd gone to Mr Leck and told him about their concerns in, should we say, October in 2004, you think he would have done something about that?-- He did do something about that.

Well, Mr Kemps still died?-- But, as I said to you, there is - nobody is denying there have been bad patient outcomes.

You want to blame Toni Hoffman for this?-- I am not blaming-----

You have said several times, "If she had done something about it some of these problems wouldn't have happened"?-- That's right.

And I just want to know on what basis you say that, for example, the life of Mr Kemps could have been saved?-- If they had have been - if Toni Hoffman had been more adamant about what her concerns were back in 2003 as she now claims, something would have been done.

So the problem was that she didn't - she wasn't adamant enough?-- I don't believe that she was reporting.

You know she made reports to Mr Leck in October?-- In October 2004, that's right.

Yes. You know they were pretty adamant reports?-- That's right. And on that very same day he started to take action on it.

Yes. And you know that despite that, Dr Patel continued operating through to December?-- That's right.

Right. Well, what are you saying Toni Hoffman could have done to prevent the death of Mr Kemps or the loss of the leg by the 15 year old boy? I mean, if you are going to make that criticism, you have every right to, but I would like to understand why you say-----?-- Because-----

-----any fault belongs to her?-- That what, sorry?

Any of the fault belongs to Toni Hoffman?-- Because there had been no reports prior to that.

Prior to October.

MR ALLEN: Can I take that up, Commissioner?

COMMISSIONER: Yes, thank you.

MR ALLEN: Do you claim that you are unaware, given your role as the quality coordinator, that in May and June 2003 Ms Hoffman met on two occasions with Darren Keating, on one occasion accompanied by the then Director of Nursing, Glennis Goodman, on the other by Dr Joyner, and voiced serious concerns about Dr Patel's practice?-- That's got nothing to do with me. I would not have been informed of that.

COMMISSIONER: Is your evidence-----?-- Of that particular meeting.

Is your evidence that you are unaware of those meetings? The question was are you unaware of them?-- I am not unaware of them now. I know about them now.

What's the next question?

MR ALLEN: Given you were aware of that when you gave evidence this morning, do you seriously maintain that Toni Hoffman took no action until October 2004?-- Yes, I do. That's my belief.

COMMISSIONER: What's the basis of that belief?-- Because it was - it was the Mr Bramich incident that really upset Toni and she has discussed this with me. It was the Desmond Bramich incident that really got her fired up. A lot of the other adverse outcomes that have been detected since then had to be detected retrospectively.

Yes?-- She was extremely upset. Not so much - she has even said to me, "It is not so much that Mr Bramich died, he may have died anyway", but she became extremely upset with the way Jayant Patel spoke to his wife. And if Jayant Patel has spoken to Mrs Bramich derogatively, I profusely apologise for that, as well as, I am sure, all of Queensland Health would,

but it was that incident that got Toni really fired up.

Mr Allen?

MR ALLEN: Ms Raven, do you accept that in the first half of 2003 Toni Hoffman met with Dr Keating twice and voiced to him concerns, including the fact that Dr Patel was undertaking oesophagectomies which was beyond the scope of practice of the hospital and his apparent abilities?-- I believe, from what I have heard in evidence, that that meeting took place.

Now, how would you possibly suggest that the adverse outcome for Mr Kemps can somehow be sheeted home to Toni Hoffman given that she voiced those concerns some 18 months before his death?-- I am not familiar with when Mr Kemps died. Which one - like, which case is that?

He died shortly before Christmas?-- Uh-huh.

2004, some 18 months after Toni Hoffman had voiced concerns to the Director of Medical Services regarding Dr Patel carrying out such operations?-- Well, I think we have heard in evidence, you know, toing and froing, that that particular procedure had already been performed at Bundaberg and quite successfully.

Do you still maintain your allegation - your scurrilous allegation against Toni Hoffman that she failed to take appropriate action from the time she first had concerns in May 2003?-- That is my belief, yes.

You still maintain that on oath?-- On oath, yes. That is my belief.

Can you assist us, just in the little time we have got left, as to your views as to whether there is a shoot-the-messenger culture in Queensland Health?-- I don't think so.

Do you understand the concept; the shoot-the-messenger culture?-- Maybe you should interpret what your belief is, what you are trying to ask me.

Well, the idea seems to be that people who are willing to stick their neck out and raise concerns about patients' safety where such concerns might reflect upon Queensland Health-----?-- Uh-huh.

-----are attacked by management?-- I do not agree with that at all.

You do not agree?-- No.

You do not see yourself as a symptom of that very problem?-- No, I don't.

You don't see your evidence as being coloured by a personal dislike for Toni Hoffman?-- I don't dislike Toni Hoffman.

You don't see your evidence as being discoloured by your loyalty to Mr Leck?-- No, it is not coloured by loyalty to Mr Leck. I know what the executive of this hospital were trying to do.

If I took you through-----

COMMISSIONER: Sorry, Mr Allen. What were they trying to do? You say you know. This isn't just another opinion; you know what they were trying to do. What were they trying to do after Toni Hoffman went and raised her complaints about the oesophagectomies?-- By that I mean in terms of trying to improve systems and processes, they were.

What were they trying to do after 18 months before Mr-----?-- That's not what that comment was relating to.

Okay?-- I know they were trying to - like, the executive of this organisation were committed to trying to improve the services that we provide.

And how is it consistent with that commitment, as you describe it, to get the complaint that Mr Allen has raised with you, and, so far as we have heard so far, do nothing about it?-- Which complaint are we talking about?

The complaints 18 months before the death of Mr Kemps?-- I don't - I don't know that there was nothing done about it. That's certainly something you will have to ask Darren.

I see. But you know that they were committed to doing something?-- My understanding and knowledge of the behaviour and performance of this executive, I can honestly say to you that I believe that they act on any information that they are given. They are committed to improving the services.

Mr Allen?

MR ALLEN: So if I took you through a series of written communications to members of the executive, e-mails from Toni Hoffman throughout 2003 and 2004 up to October 2004, voicing concerns about Dr Patel and particular patients?-- Uh-huh.

That wouldn't change your opinion that Toni Hoffman failed to take appropriate action?-- But I have heard Toni in this chair herself say she didn't actually want anything done. On one particular occasion-----

COMMISSIONER: Will you answer the question please?-- -----she was raising-----

MR ALLEN: I can take you to the details of emails and letters-----?-- Uh-huh.

-----to members of the executive?-- Could you repeat the question?

Referring to particular patients and concerns about their

outcomes?-- Could you repeat the question?

About Dr Patel's practice?-- I have been asked to answer the question. Can you just repeat the question?

Is there any point doing that? Are you going to change your opinion-----?-- No.

-----or are we just wasting the Commission's time?-- I am not going to change my opinion.

You are not going to change it? All right, we won't bother doing that then. By the way, you were contacted by Dr Keating, were you not, after the sentinel event form regarding Mr Bramich was received?-- I was contacted - no. I spoke to him after Toni rang me.

Were you contacted by Peter Leck about it?-- No, not that I can recall.

All right. If we just look at LTR21 to your statement. Do you have that? That's an email from-----?-- That's right.

-----Peter Leck to yourself?-- Yep.

Is that right?-- That's right.

And it seems a reply from you. He has asked you to find any adverse events concerning Dr Jayant Patel?-- That's right.

And your response is, "Hi Peter, there was never a report put in for this perforated bowel incident."?-- Yep.

"Found a great long letter that Toni wrote about ventilated patients"-----?-- Yep.

-----"and one incident about a wound breakdown but the doctor involved is not named."?-- Yep.

"That's about all we have."?-- That's right.

Now, the great long letter you're talking about, is that the document which is included as part of LTR9 to your statement?-- Yes, it is.

I see. Okay. So as at the time of your search on the 21st of October 2004, that's all you could find in relation to adverse incidents regarding Dr Patel?-- This was a very very quick search done because Peter was extremely concerned that these issues had been raised and he needed me to find out whether there was like a wealth of adverse events being reported about Jay Patel, so in the minutes that during these transactions it was just a very quick look at the register that I was able to find these two incidents.

COMMISSIONER: Is the answer to Mr Allen's question is that, that is all you could find?-- At that time.

Thank you.

MR ALLEN: And we've already seen what you could then find after an exhaustive examination?-- That's right.

But you weren't able to turn up any documents such as e-mails from Toni Hoffman to the Director of Nursing or Darren Keating or anyone else-----?-- But I wasn't asked.

-----regarding medical services?-- But I wasn't asked to look for e-mails, I was asked to look for adverse event reports related to Jay Patel.

I see. Did you receive communications from the Director of Nursing or Director of Medical Services prior to that time as to information and complaints they'd received from Toni Hoffman?-- No.

There wasn't a system in place whereby if a nurse unit manager raised with the Director of Medical Services or the District Manager serious concerns regarding a doctor's clinical practice?-- Mmm-hmm.

That you would be advised of them?-- No.

So as far as what you can tell us-----?-- Because that's confidential information and it's got nothing to do with me in terms of what Toni Hoffman is alleging about his clinical practice.

I thought you were the quality coordinator?-- I am the quality coordinator.

What does the quality coordinator do except concern themselves with matters such as the clinical competence of a surgeon?-- I do lots of other things. In terms of the clinical competence of a surgeon, I'm not a surgeon, I can't comment on his clinical competence.

Can we just get this clear then: you didn't see it as part of your job description to track and consider complaints of

clinical competence regarding Dr Patel?-- But that's what I'm saying, I didn't get any so how can I track them if they didn't come?

COMMISSIONER: No, please answer counsel's question. He's asking you whether it was part of your function to track and consider such matters?-- It was.

But to track and consider them, you needed to be told about them?-- That's right.

And when those complaints went to, for example, the nurse - the Director of Nursing or the Director of Medical Services, you weren't told about them, therefore you couldn't track them?-- That's right.

Thank you.

MR ALLEN: And now you must be surely aware that there was a body of serious matters voiced to those persons which was never communicated to you?-- That's right.

And-----

COMMISSIONER: Mr Allen, I think we're going to have the stop there or people will miss their planes.

MR ALLEN: Yes, thank you Commissioner.

COMMISSIONER: Thank you. Miss Raven, I'm sorry we have to inconvenience you to come back on Monday?-- No problem.

But we'll resume, if it suits everyone's convenience, at 10 o'clock which will get those coming in on the first flight to be here hopefully; does that suit you, Miss Raven?-- What time are we starting?

10 o'clock on Monday?-- Thank you.

THE COMMISSION ADJOURNED AT 4.18 P.M. TILL 10.00 A.M. ON MONDAY, 11 JULY 2005