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Transcript of Proceedings

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IN THE MATTER OF THE COMMISSIONS OF INQUIRY ACT 1950

BUNDABERG HOSPITAL COMMISSION OF INQUIRY

COMMISSIONS OF INQUIRY (No. 1) 2005

BUNDABERG

..DATE 03/08/2005

..DAY 33

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THE COMMISSION RESUMED AT 9.34 A.M.

COMMISSIONER: Yes, Mr Andrews?

MR ANDREWS: Good morning, Commissioner. Today it is proposed to call firstly Dr Eric Peter Guazzo. To follow Dr Guazzo, Dr Reno George Rossato, then Dr John Alexander Allan, and the witness carried over from yesterday, Mr Jon Gallagher. I call Dr Guazzo.

ERIC PETER GUAZZO, SWORN AND EXAMINED:

COMMISSIONER: Dr Guazzo, please make yourself comfortable. Do you have any objection to your evidence being filmed or photographed?-- No, Mr Commissioner.

Thank you.

MS GALLAGHER: If the Commission pleases, I seek leave to appear for Dr Guazzo.

COMMISSIONER: Such leave is granted, thank you, Ms Gallagher.

MS GALLAGHER: Thank you.

MR ANDREWS: Doctor, you are Eric Peter Guazzo?-- I am.

Doctor, I have a copy of your statement which was taken by one of the inquiry staff and it appears to have been taken on the 13th of July 2005, and with it is a large bundle of correspondence, some of which is referred to within your statement. Is the statement where it contains facts, containing facts that are true to the best of your knowledge?-- It is.

And where it contains your opinions, are they opinions honestly held by you?-- Yes.

I tender that statement.

COMMISSIONER: Dr Guazzo's statement will be exhibit 242.

ADMITTED AND MARKED "EXHIBIT 242"

MR ANDREWS: I had intended also, Commissioner, with it to tender the bundle of correspondence.

COMMISSIONER: Yes, that will form part of the exhibit.

MR ANDREWS: That correspondence also contains your curriculum vitae. Doctor, you are the Vice President of the Neurosurgery Society of Australasia, and you are on the Board of Neurosurgery of the Royal Australasian College of Surgeons. What do those roles involve?-- The Neurosurgery Society of Australasia is the representative society for practising neurosurgeons in Australia and New Zealand. The society began in the 1940s. It has an executive which is an elected executive by its membership. Its function is to represent neurosurgeons as a group, both in practice and politically. I have been a member of that executive since 1996 when I was elected to the general executive. Since then I have held other positions, such as the Treasurer of the society, the Secretary of the society, and last year I was elected as the Vice President of that society.

COMMISSIONER: Mr Andrews, in light of comments that have been made about apprehension of bias and so on, it is perhaps worth mentioning that the father of one of counsel assisting has been active I think in both of those organisations. I am referring to Mr Damien Atkinson whose father is a neurosurgeon?-- Regarding the Board of Neurosurgery, the Board of Neurosurgery is a Board of the Royal Australasian College of Surgeons. Board of Neurosurgery consists of a chairperson, who is currently Dr Michael Weidmann, and a member of that Board from each State of Queensland - each State of Australia and a representative of New Zealand. The Board is charged with the conduct of training neurosurgeons in Australia and New Zealand and ensuring the standard of training is adequate. It involves inspecting the training hospitals and ensuring candidates are prepared for and sit for the examination. A member of the board is a senior examiner in neurosurgery. I have been a member of that board for about three years, I think my memory recollects.

MR ANDREWS: Doctor, I understand that it can be difficult to encourage neurosurgeons to come to North Queensland; that's correct?-- Yes, it is correct.

I wonder how it is that someone so well regarded comes to be practising in Townsville?-- I was born and grew up in Ingham, which the Commission will know is only 100 kilometres north of here. I was educated in Ingham until the 10th grade, when the school that I went to no longer - didn't go any higher. So I went to boarding school in Brisbane and then I did my university at University of Queensland Medical School, and then I practised here as a junior doctor for three years before going on to neurosurgery and training in Brisbane and Melbourne, and subsequent postgraduate and further neurosurgery experience in the University of Cambridge in England. After being there for some years in England, my wife and I, for a number of family reasons primarily, decided that we would prefer to live in Australia, and we then considered where we might best practise and live, from a social and professional point of view, and we felt that this offered the best opportunity for us. And there are family reasons, as I

have explained to the Commission, plus I thought professionally it also offered challenges and would be a very broad scope of practice that I would enjoy and I have enjoyed.

I accept that you have enjoyed it, but as I understand it there are only two neurosurgeons practising in Townsville and to the north?-- Yes, when I joined, Dr Rossato, my professional colleague, he had been here since 1979 as a solo practitioner and I began practice on the first of October 1994 in a mixed public/private practice, spending around about half of my working normal day and night hours at the public hospital and half in private practice as well as being on call.

Doctor, the inquiry has heard that to be on call every second night takes a terrible toll on practitioners. It sounds as if there are only two of you, so there will have been many occasions where you have been on call at that rate?-- The way we organise the on-call roster was that we would do a week on call at a time. So we would alternate one week each, beginning Monday morning at 8 o'clock and finishing the following Monday at 8 o'clock, and the variability of on call meant sometimes it was busier than others. But we field many, many phone calls because we deal with and provide advice on neurosurgical matters to all practitioners from the Torres Strait, down to Sarina, out to Mt Isa, and all the hospitals in between.

Does that mean that there are people providing neurosurgical care who ring you for advice?-- By choice, and hopefully very rarely to the exception, all neurosurgical procedures are done in Townsville at the Townsville Hospital or the Mater Private Hospital, all major elective trauma cases and urgent cases are directed to the Townsville Hospital because we have the zonal retrieval service and it would be inappropriate for those patients to go to the Mater. So whether the patients have insurance or not, they are transferred there for urgent care. We have a better infrastructure for acute care but, yes, occasionally medical emergency neurosurgery outside of Townsville where acute surgery has needed to be performed but often - and we encourage the practitioners to ring, speak to us, we advise, and we take and share the responsibility of managing that patient and make a decision on how that patient should be managed, how acutely they should be transferred in, and we collaborate with our accident emergency colleagues who organise the actual physical retrieval and liaise with us about that. Just occasionally, if my memory serves me correctly, I have flown to Cairns with the Royal Flying Doctors in the middle of the night to do a procedure in Cairns when unfortunately there wasn't a bed available at the Townsville Hospital, and we needed to do an emergency procedure there and we went there and did it and then came home.

Doctor, that punishing schedule leads me then to paragraph 5 of your statement, in 1999 you began to make formal approaches to the hospital administration regarding the planning required for the initiative to attract a third neurosurgeon to North

Queensland. And yet, as I understand it, no third neurosurgeon was approached until late 2004, is that the case?-- As best I understand that is the case. It may be there may be information that I am not aware of.

In any event, the hospital somehow found the funds to allow for an approach to a third neurosurgeon in 2004?-- That's correct.

In late 2004 you had - you were, and had been for a number of years, a VMO practising at the Townsville Hospital but for a short period you resigned that position, is that the case?-- Yes.

As I understand it, during the period of your resignation there was consideration of the candidates who were applying or showing interest in the position of neurosurgeon for Townsville?-- I understand that to be correct.

COMMISSIONER: Doctor, do I understand that apart from being the only two neurosurgeons working at Townsville Hospital, either as staff surgeons or VMOs, you are also the only two neurosurgeons in Townsville generally? There is no other private neurosurgeon?-- Yes. If I could just expand on that a little, Mr Commissioner?

Yes?-- There are two of us neurosurgeons, Dr Reno Rossato and myself. We were both originally in mixed public/private practice, meaning that we both dealt with patients insured or uninsured in private practice. There are no other neurosurgeons practising in North Queensland. There was a neurosurgeon practising in Rockhampton, Dr John Baker, but for a number of reasons he left his practice and has gone to Brisbane. So we're the only neurosurgeons north of the Royal Brisbane. We endeavour to provide high class service and I think we do. We also conduct outreach clinics which are outpatient clinics. There is a clinic every week at Cairns Base Hospital. I was, until last year, every 12 weeks visiting Mt Isa and providing an outreach clinic there as well. We are in constant contact with our colleagues at the bigger hospitals in our zones, such as Mackay and Mt Isa and Cairns, and of recent times we have been able to establish a system where they can send the images to us so we can interpret them. For instance, someone has a traumatic injury of the head, they can image them in Cairns and send it to us, and we can view it and provide advice as to where treatment should be given, how urgent it should be given, what steps should be taken. It might sound that we do a lot of after-hours surgery but we don't do a lot of after-hours surgery. I guess it is a lot, but the major aspect of it is phone calls from people who aren't certain, and particularly I think, as more and more hospitals have more and more junior staff to give advice to these people, it is important.

And my impression - please correct me if I am wrong - is that to draw a contrast, for example, with vascular surgery, if vascular surgery is needed, the patient will bleed to death within hours, whereas neurosurgery can often be put off for

six or 12 or 24 hours, even in a fairly drastic situation?-- Oh, can I differ with you a little?

No, please, I ask these things only to find out?-- Yes. There are - the scope of our practice varies, as you would imagine. We do elective work which involved primarily conditions of the spine, elective conditions of the head, which may be brain tumours or elective abnormalities with blood vessels that need to be prepared, peripheral nerve surgery involves routine work and that often doesn't require urgent surgery, it requires management. But a portion of our work is trauma work and that's where most of our acute surgery is performed and that type of surgery can be life-threatening and emergent, meaning it can need to be done within an hour or less, if possible, and just rarely we have to instruct practitioners at other hospitals to do emergency neurosurgery under our supervision, that is, for instance, to remove a blood clot from the head which is life-threatening and the patient can't wait to be transferred, won't survive the trip to Townsville. We have recently instituted a rapid transfer service, and with the help of particularly our accident emergency colleagues who facilitate that, we have endeavoured to ensure that all patients who do need urgent neurosurgery can be at this hospital, that is the Townsville Hospital, as quickly as possible. So there are some life-threatening emergencies in neurosurgery, and we're often called in the evenings/weekends to do that life-threatening work, and I guess when we look at the emergency work we do at the Townsville Hospital, it would reflect that.

Doctor, I am not sure of the precise demographics but I would guess the catchment area or the drainage area for your services from Torres Strait down to Sarina and west, essentially to the Northern Territory border, would probably amount to several hundreds of thousands of people?-- My understanding is, Mr Commissioner it is about 660,000.

It strikes me as extraordinary that if one imagines a city of 660,000 people, that city would only have two neurosurgeons, and even that's not a fair comparison, because if you had two neurosurgeons in one city, at least they wouldn't have to spend their time travelling and on the phone to remote locations and so on. Am I right in thinking that is a gross undersupply of neurosurgery?-- Yes. Do I need to lean forward?

Perhaps you can turn - actually you will find it works best if it is under your chin because then you are not breathing into it?-- Yes, you are correct. There have been investigations and assessments of what would be considered optimum supply of neurosurgeons, I think probably might be the right way of looking at it, and most recent of which - I have a copy here, if you like - is the Australian Medical Workforce Study of 2000 - the year 2000, which has recommended that there be one neurosurgeon for 175,000 population, and that's about the current recommendation, although we are a society, of which I am the vice president, we are currently engaged with the relevant bodies again at looking at that requirement to see if

it still is adequate for current practice today, 2005. So looking at that study, we would at least need three neurosurgeons in this region to provide adequate neurosurgical cover, and I would argue, because of the requirements of our practice, that perhaps may not be enough, and that was one of the reasons I took that information with me when I started approaching the hospital in 1999 and subsequently in 2000 when it was available.

If you had the luxury of, say, four neurosurgeons for North Queensland, would you see them all concentrated in Townsville or would there be an argument of having one at Cairns or one at Mt Isa?-- It is a difficult balance. Recent assessment, which we put forward to the workforce study, which is being undertaken, and this was conducted by Mr Len McCullough who is our immediate President, he said it costs around about $8 million to establish a neurosurgery unit with all the equipment required. That doesn't account for the personnel and staffing as well. You will understand it is appropriate and reasonable to have staff who are experienced in neurosurgical procedures and practice as well as yourself to ensure you have a high level - high standard of care. I would argue that it would be better to have the practitioners concentrated in Townsville but we would improve our outreach services, and we would continue to improve the manner in which we bring emergency patients into our hospital, and that can be done, and I know with the assistance of our accident and emergency colleagues, we're working towards that, but there are some impediments. I think it is better for practitioners to be in a group, for professional reasons, of continuing standards of care, collaborating with one another, ensuring that the best service is given. I think it is difficult to be - very difficult for a neurosurgeon to practise in isolation by themselves, and the neurosurgery society has a general policy that we feel that wouldn't be best for practice. But we recognise the requirements of people around the country, and I recognise that more than anyone else, having grown up in the country, my family all live in the country, but I do think we can provide a level of service that is adequate - not adequate, that is as good as any other service, concentrating the service in the major regional centre with all the additional services we rely on and need to provide that level of service without fracturing to provide lesser levels of service.

Doctor, how many neurosurgeons are there in the State, do you know off the top of your head?-- There are around about - I can tell you the figures because of the study - there are around about 120 or so practising neurosurgeons in Australia and New Zealand. There are around about 20 practising in Queensland and the population ratio is around about 1 per 170,000. I know that because I have just reviewed the figures last week. So they are disproportionately in the south-east corner. There are four practising at the Gold Coast, and the remainder are primarily practising in Brisbane and providing outreach services to, for instance, Toowoomba, but I am not sure if they go to Bundaberg - Dr Baker still visits Rockhampton and provides an outreach service there.

It occurs to me, doctor - and I certainly don't want to take money out of your pocket, but it occurs to me when you talk about providing telephone advice to Cairns or Mt Isa or more remote localities, that is something that could be done as well from Brisbane as from Townsville whilst you are in the situation of not having enough neurosurgeons here. Obviously, the desirable thing is to address the problem and have enough neurosurgeons but whilst you and your colleague are under such heavy pressure, I should have thought part of that pressure could be taken away by offloading work that is done by telecommunication to others in the south?-- Yes, it doesn't hurt when we can't provide call for whatever reason. You would understand that living and working here, our professional relationships, we know most of the other practitioners who refer patients and there are emergencies where transfer to Brisbane takes additional numbers of hours and that compromises patients' care. So wherever possible we try to provide that service so that one of us is available to do that at all times. Yes, they could field the phone calls, they could take that advice. We give that advice very competently, as you would be aware, and there would be a potential system of fielding the phone calls but it wouldn't take away from the restrictions of the on-call basis on your life, that is working life and social life. When you have to be available, you want to be available for the emergency that needs your care as an immediate issue. Whereas if your patient needs to be transferred to Brisbane, and I have to defer to my colleagues who actually do all the transfers to Brisbane, it takes many more hours to arrange that and that could compromise their care.

Doctor, I am not suggesting this for a moment as a solution to the problems, but I have heard it suggested that the ability of specialists in Townsville to provide advice and assistance to outlying hospitals could at least be enhanced by having a stable, high quality videolink so that you could, for example, observe an operation taking place in another hospital?-- I would agree with you 100 per cent. I didn't mention that before I left for Townsville Hospital I did used to conduct video outpatient sessions with Mackay with Dr Michael Williams, who is a paediatrician, and rather than the patients all traveling to Townsville to have, for example, an assessment of their ventricular parietal shunt, which is a device to drain fluid from the brain. Dr Williams would arrange the outpatient session in advance, he would in fact fax me the names and details of the patients and then I would sit in the video room in Townsville and he would be in Mackay, and the patients and their parents would come in, we would discuss - we would manage them. That way works very well. It was an example of excellent use of video conferencing outpatient sessions and I think that with - I think there is no doubt with the infrastructure we could use that more often, we wouldn't have to travel, we could see people examining patients.

Doctor, I was reading in your statement about the review of surgical services in 2003 which resulted in Dr Rossato

becoming a staff specialist rather than a VMO, so one infers there was a recommendation that neurological services at the hospital needed to be increased. But it strikes me that that really isn't a solution at all because if there were only two neurosurgeons in town and one becomes full-time in the hospital, that that just means that the other one has to do all the private work and also try and help out at the public hospital as well?-- That's correct.

You'd been pushing I think at that stage for four or five years to increase the number of neurosurgeons in Townsville and no-one consulted you about that alternative as it were?-- No.

Doctor, on a slightly different but possibly related point, we have heard from various sources criticism that the various specialists colleges operate as cartels to lock out aspiring members of that specialisation to ensure that the spoils are there for the limited number who are already members of the college. On the other hand we have heard very strong defence of the college system, even from people largely outside the system who say, you know, that for every training position that exists in the state, colleges will support a traineeship. What strikes me about your evidence is that you and Dr Rossato have the ultimate duopoly like Qantas and Ansett sewn up between yourselves and yet you are pushing to spread the work and, in effect, give up a third of your practice to someone else?-- I didn't see it that way. I saw the practice of neurosurgery in North Queensland needed to be developed. The best way to develop it and to provide a better service was to provide additional personnel. You need to plan for that. It is difficult enough to get high quality practitioners of any sort to come outside of south-east Queensland. You just can't put an ad in the newspaper and expect a competent neurosurgeon to apply and turn up the next day. It requires years of careful planning and identification of suitable people, and that's what I thought. There is more than enough practice in North Queensland for three or four neurosurgeons. What happens is, as you've probably heard from other practitioners, an example would be the development of oncology in North Queensland, is what you think is needed is far below what is required.

Yes?-- If we had more practitioners, we would meet the demand better. We wouldn't be under-employed; we would be better employed and we'd provide a better service. So I didn't see it as a personal threat to me professionally. I don't see it as a personal financial threat to me in any circumstances. It is on the record and is well known to people that I have tried for a long time for us to attract at least one other neurosurgeon and I would like that person to be working in private practice because I think the model of health care that works in regional Australia is to have high quality practitioners contributing to public and private practice, not to separate them out, because we cannot have the large volumes or numbers of people that are available in capital cities. So we need people who are willing to contribute to both sectors to ensure that the standard of care is equal across the sectors.

Doctor, I hope you'll forgive my ignorance of your profession but is neurosurgery regarded as a specialisation in itself or is it a subspecialisation of surgery?-- I can perhaps identify that or answer that best by saying that neurosurgery is one of the nine fellowships offered by the Royal Australasian College of Surgeons. So, it sits alongside specialities such as plastic and reconstructive surgery,

general surgery and orthopaedics. Our training program - people enter our training program at the same time they enter the others. So when people are competing for our training program, they are at the same stage in their career as people who are competing to enter orthopaedics or cardiovascular surgery or what have you. To go back to the points you made about the cartel, in neurosurgery we have been very proactive in increasing our training numbers and we have more than met the requirements that have been stipulated by various investigations of our speciality. We have now over 50 trainees in neurosurgery and we have 123 active practitioners. It's a five-year training program. So you can see that we have many people coming through the system who are of high quality. We would like to think that we are an open, competitive practice but we also would like to think that we ensure that the public have practitioners who are trained to a high standard. Speciality

Just on that question of subspecialities, I have the impression, and I'll be candid that I haven't looked into this and I don't pretend to understand it, but there are some specialists surgeons, I think vascular surgeons may be one group, colorectal surgeons may be another who don't have a separate fellowship for their subspeciality. They are regarded officially as general surgeons even though that they have an interest or practise exclusively in one area. But neurosurgery is different; you are a fellowship unto yourself?-- We are a fellowship to ourselves but we also have subspeciality interest groups within our society such as - or within our fellowship, for example paediatric neurosurgery, vascular neurosurgery. There are some of our practitioners who are concentrating their expertise in those areas and wherever we can and wherever appropriate, we transfer patients to those specialists. I can give you an example of recently in my practice a patient was admitted to the Townsville hospital as a public patient with a complex abnormality of blood vessels of the brain. There was really only one neurosurgeon in Australia who has the expertise to manage that, it's well outside of my expertise and that patient was transferred to Sydney for that specialist's treatment. That was done within the public hospital system. That is available and is appropriate for that young person to get that treatment. So we have subspeciality practitioners whom we know and we refer where appropriate.

And within the training system, do you have a training position or a registrarship for neurosurgery in Townsville?-- Over the years and before we had a position designated as a neurosurgical registrar, which was not a training position but would have been best described as a service position or a Principal House Officer position, and it often was filled with people who are interested in neurosurgery and considering that as a career and many of the people who fill that position have gone on to train in neurosurgery and graduated from neurosurgery, and in my time at the hospital I can think of four people who filled that position who have now completed neurosurgery or are now in a training program and it's anticipated they will. About two and a half years ago, after

a series of discussions and particularly as I was now on the Board of Neurosurgery, there is a position in neuro - for training in neurosurgery called an affiliated hospital which means not a really large hospital but one that would provide training adequate for neurosurgery.

Yes?-- And we - so we affiliated with the Princess Alexandra Hospital and specifically with Dr Adrian Winski. So we established after board approval - the board came and visited the Townsville Hospital. We established an affiliated position in neurosurgery training and initially for the first year, which was year 2003, we had two trainees visit for a six-month rotation from the Princess Alexandra Hospital and then last year, the year 2004, we had one trainee visit for the period of 12 months from the Princess Alexandra Hospital. Those trainees provided positive reports regarding their experience at the Townsville Hospital. That position no longer - is currently - is not currently filled because of the uncertainty regarding my resignation from the hospital and the uncertainty regarding the supervision that trainees would have and whether they would have enough training at the hospital but it is to be reviewed once the workforce at the hospital stabilises and the board can review that position to see whether it fulfils the criteria again as an affiliated hospital.

I suppose, Doctor, and please forgive me, I'm really thinking aloud, but I would guess that in many areas of general surgery there are fairly minor procedures which can be left to a Registrar with some confidence. I wouldn't care to define what those are but I'm sure there are such procedures. But I suspect neurosurgery is the sort of area of practice where you're either competent to do it or you're not and there are obvious risks in leaving it to a trainee or to a Registrar?-- I think neurosurgery perhaps is no different to other specialists' surgical training, that we have a scope to practise that involves what we consider less technically challenging procedures and some that are very technically challenging just as other surgical specialists. So if I was to use, for example, the experience of a surgical specialist training registrar at the Princess Alexandra Hospital that, you know - it's a five-year training program, four of those are in clinical practice, one is in research. We would expect during that five-year program that the advanced surgical training would progressively increase the degree of unsupervised surgical operating they did as their competency improved. So in the first year, we would expect that they would do very little, if any, unsupervised surgery. They would then begin to do more unsupervised surgery. The last part of our practice that neurosurgical registrars are exposed to early on is the management of trauma and that can be complex or it can be straightforward. It may just be a very simple fracture that requires minor surgery or it may be a very complicated neurosurgical procedure. So to answer your question, yes, neurosurgical registrars do operate unsupervised on occasion. It is a matter of judgment as to that level of competency and it's usually in a progressive manner as they go through the program and become more

competent. We at the Townsville Hospital had training Registrars in their first year initially, so they did some but very little unsupervised training. The Registrar in the year 2004 was very experienced, had worked in Melbourne for two years and one of those years was at the major trauma hospital. He was able to do significantly more complex surgery unsupervised or limited supervision, he was extremely competent, and you make that judgment as you would expect by observing and watching and listening to what your colleagues had said about him previously.

Doctor, I acknowledge we are in the presence here today of the Dean of the local medical school, which we do acknowledge and for which we're very, very honoured. How do you see traineeships in specialisations including your own as graduates from the local university come on-stream over the next few years?-- The - I know Professor Hayes knows my position, that I'm an extremely strong supporter of the development of the medical school at the James Cook University and I hope I have been able to contribute in a very positive way to that. I think it's a very important development for the provision of medical practitioners in our part of Australia and in other regional parts. From what I have seen of the graduating class of this year, I think they'll compete very admirably with trainees from other universities. I see no problem in they competing for advanced training programs. By the nature of advanced training programs, most are based in major hospitals in southern Queensland or elsewhere but there are some training programs I understand, because it is not my speciality, but based in Townsville, for instance the Northern Australia General Surgical Training Program where trainees are rotated between Townsville, Cairns and I think Mount Isa - sorry, I think Darwin. They do go down to Brisbane as part of that. I can't in the immediate future see a program being based in Townsville for a training program. We just don't provide the breath and scope and I think it is very important for a trainee to be exposed to a number of different institutions to ensure they get the widest exposure. I don't see that there'd be any problem at all with a graduate from the James Cook University leaving the school, completing their residency and competing very well against other people who are training in neurosurgery.

It does concern me that whilst it undoubtedly would be a wonderful thing for North Queensland to have its own homegrown locally educated medical practitioners, some of that advantage is going to be lost if local hospitals aren't in a position to provide the specialists training or even the GP training needed for those graduates when they come through?-- My view, and it certainly's held by the Board of Neurosurgery and by the neurosurgery society general consensus view, is that it's very important wherever possible that we expose our trainees to the broadest scope of practice. That includes giving them experience in more regional and provincial hospitals wherever possible. So we have trained - we had a position here in Townsville. We have positions in smaller centres such as Canberra, Nepean, Wollongong - sorry, Newcastle and we hope that fostering those relationships with neurosurgeons in those

areas will allow some of those trainees to see that there is a very good, very enjoyable practice in neurosurgery outside those capital cities. But you're right, unless we can attract enough specialists of all specialists to work in regional Australia, it will be difficult to eventually courage those students to come back and work here and see the positive aspects of a career in medicine outside of a capital city.

D COMMISSIONER EDWARDS: Doctor, would you like to tell the Commission a little bit about the support services needed for a successful neurosurgical practice such as anaesthetics and intensive care, just a brief reference so that we can be up-to-date on the latest requirements to neurosurgical practice?-- We are very reliant on the services particularly of accident/emergency because of our close relationship with those practitioners. We are probably most reliant on our anaesthetic colleagues. One of the significant advances in neurosurgery and our improved outcomes has been because of the conditions provided to us by our anaesthetic colleagues. While - and that then carries through to the intensive care. The management of conditions such as traumatic brain injury has changed significantly over the last 15 years and it requires an environment where we can institute high level intensive care practice which I won't go into the technical details of. It would be impossible to practise neurosurgery without those three critical specialities. In addition, we require oncology liaison, a very well-equipped and staffed radiology practice because we're so reliant on imaging for our practice. As well as that, we rely on a lot of other colleagues in the operating theatre and elsewhere. We need technical equipment for modern image guided theatre and so forth in the operating theatres and we need staff who are working with us regularly so we can form close professional relationships with them so they know the procedures we're doing. They contribute to those procedures and make sure we get the best outcome. It requires, as I've mentioned, an infrastructure that costs about $8 million to establish. It requires many people committed to the service and involved and enjoying the practice for it to provide a high outcome or a good outcome.

COMMISSIONER: Thank you, Mr Andrews.

MR ANDREWS: Doctor, your statement advises us that towards the end of 2004 you resigned for a short time from your position as visiting medical officer to the Townsville Hospital. Reading between the lines, it seems that now reached a level of frustration with both your relationship with the administration and with what you saw to be the standards of neurological care offered at the hospital and those two things caused you to resign?-- Yes.

The administration over the next couple of months lured you back to the hospital; is that correct? Or did the best that they could to lure you back and you return?-- Yes.

COMMISSIONER: Was it that the hospital succeeded in luring you or that your commitment to the patients drove you?-- I

enjoy working in the Townsville Hospital and I envisaged that it would be part of my practising life for a time. I was disappointed to resign and I thought it was reasonable to return to practise to see whether the environment would change and I would continue to enjoy the work and feel it was worthwhile.

MR ANDREWS: You are disappointed that in the period you were away from the hospital you were not consulted about the persons who had responded to advertisements for a neurosurgeon?-- Yes, I was, and there were two reasons for that or maybe three. One was I thought that perhaps a person who was involved in the processes of neurosurgery, that being the neurosurgery society, the Board of Neurosurgery, would have something to offer to the appointment of another neurosurgeon, in his selection that is, and I also had had discussions with Mr Ken Whelan, the District Manager, who indicated to me that irrespective of whether I was in private or public practice at the hospital or not, that I would have some role. And I also felt that as that person would be joining neurosurgery practice in north Queensland, I would have a very close working relationship with them and that it would be reasonable for me, as one of the only other neurosurgeons here, to have some role.

And Mr Whelan seemed to agreed with your proposition?-- My understanding was he agreed, yes.

I see in the bundle of correspondence annexed to your statement a letter of the 1st of December signed by both Dr Whelan and Dr Johnson in which they advise you that, "The recruitment process is currently underway for a third neurosurgeon. A number of applications have been received, the most promising from a neurosurgeon currently working in Auckland. If you choose to remain with QH, we would welcome your input into the interview and appointment process." Is it your opinion that in the circumstances in Townsville, where there are only two neurosurgeons, that whether one of them is employed by Queensland Health or not employed by Queensland Health, it's appropriate that that neurosurgeon should be consulted?-- Yes.

Your statement speaks for itself in raising some of the other frustrations but I see at paragraph 17 there are some matters which may relate to patient safety that perhaps you should elaborate about. It seems that when you made this statement you were concerned that there had been no regular audit. Has that situation been remedied?-- About two weeks ago there was a neurosurgical audit for the period till - for a five-month period till the end of May.

How regularly do you think it is practical-----?-- I should - perhaps I - that's the only audit I understand has been conducted.

How regularly do you think it is practical to conduct a neurosurgical audit, bearing in mind the number of neurosurgeons here?-- I think the practice of having an audit

once per month is more than acceptable and that's how it should be done.

The correspondence does show that there were a couple of meetings that were intended to be attended by both you and Dr Rossato and you've observed in your correspondence that Dr Rossato didn't attend. As a reader, I infer that there seems to be some tension in the relationship between you and Dr Rossato at the moment?-- I proposed to Mr Whelan that to ensure proper professional association and sharing of information about management and conduct of practice of neurosurgery of which I was intimately involved, that we needed to have more meetings because it was my opinion that I hadn't been properly consulted in the past about matters that were very important to my practice to which I thought I had have had a very positive contribution to make. My understanding, in my discussions with Mr Whelan, part of the arrangement we had come to is that we would have a monthly business meeting which was to be attended by both neurosurgeons and the Operations Director of the Institute of Surgery plus the business manager where appropriate to discuss financial issues, so that there will be a forum that will allow us to properly share information that was appropriate.

And if there is any person to blame for the breakdown in this procedure, is it Dr Rossato for failing to attend?-- I don't know if I can answer that question accurately as I'm not sure of what information he had regarding those meetings and how he understood them to proceed and perhaps it will be a question better addressed to him.

Thank you. You at paragraph 18 seem to be speaking of a situation that you'd observed prior to your initial resignation and certainly before your return as a VMO. Have those situations improved?-- Yes.

Within the correspondence attached to your statement I see that there are two letters - I won't take you to them - each of the 5th of May 2005, which you call grievance letters. Have those matters been - are you satisfied that the administration is aware of them and attempting to address them?-- Yes, those letters as you see were addressed to Dr Andrew Johnson, the Director of Medical Services, at the Townsville Hospital. He has acknowledged those letters and my understanding is that he has put in process procedures that are established in Queensland Health. My understanding is that he is waiting on further information and the - and then we can attempt to resolve issues around those letters.

Now, your exclusion from the process of considering appropriate applicants for the advertised position of neurosurgeon meant that you were unable to give your strong advice that Dr Myers seemed to have had too little practice over the last few years in the Virgin Islands to warrant practising at Townsville unsupervised?-- Before answering that question I would like to draw the Commission's attention to the statements I've made regarding my - Dr Myers. In no way am I inferring that Dr Myers is not a neurosurgeon and nor

professionally qualified as such. It's not meant in any way as to carry any inference regarding his professional capability as a neurosurgeon. My objections were to the process by which this occurred and in my discussions with Dr Myers, he and I both have discussed the fact that his recent practice has been limited and that to deal with potential complexities of a general neurosurgical practice in North Queensland requires competencies across a whole broad range of neurosurgery, which I'm sure Dr Myers has been trained in but of recent times has not practised in and would require further experience - further re-experience in that area. So to answer your question, I think it's important that the Commission recognises this, I - my grievance with the process was that, as in the example that I used before, that the process was flawed, that a person was going to be appointed who may be extremely capable but no-one had really ensured that that was the case and I believed that the people employing this person had an obligation that that be the case before that person was able and allowed to practise independently in a geographical location like our own.

And is it your opinion that it's crucial in the process to consider the degree of experience that a person has to make a determination about whether they are sufficiently current to be able to practise unsupervised?-- Yes.

COMMISSIONER: Are you satisfied with the arrangements now in place involving supervision of Dr Myers' work before he starts performing neurosurgery on his own account?-- You will be aware, I assume, in your discussions with Dr Johnson yesterday, that I assured Dr Johnson that I would behave in the most appropriate manner as a colleague and professionally to Dr Myers, and I believe I have done that, and I have worked with Dr Myers and he has worked with me and we've operated together on numbers of cases. He has observed and assisted me at the private hospital as well to ensure that he has a broader overview of what practice is like in Townsville. I believe that he had been really left in a situation that's untenable, because I don't believe that the administration have really treated him professionally. At times he's left not really sure of what his responsibilities are. I find him very professionally honest, and we've met personally outside of work and I would hope, as I've said in my statement, that if due processes were involved and that Dr Myers was accredited by the College of Surgeons, and despite all of this he wished to work and practise in Townsville, I would certainly go out of my way to welcome him to Townsville. I've said that to him and I've said it in my statement. To answer your question, I think that from my point of view I have attempted to help Dr Myers as best I can and to help him understand the practice of neurosurgery in North Queensland. Yes, I believe his level of supervision currently is adequate.

Doctor, I feel I should ask you this, because you've said some things which - both in your statement and here this morning that are critical of the hospital management. I take it you would accept that the hospital management are under a lot of pressure from a lot of directions, from central administration in Brisbane and from having to deal with not only neurosurgery, but every other area of specialisation within the hospital. Are you prepared to concede that your personal enthusiasm for ensuring that the highest level of neurosurgery is available to the people of Townsville might colour your view when considering the fact that the hospital administration has to deal with all the other areas of hospital management as well, that they've got priorities that may not accord with yours?-- I concede that that may be the case. However, I have an obligation, and my obligation is to the patients. I'm not an administrator and I don't understand the pressures that they may be under to ensure the services, but I do have an obligation to ensure that when patients come into the Townsville Hospital for neurosurgery, that they're going to get what I think is reasonable and safe neurosurgery. That's my obligation, and that's why I've, over the years, tried to encourage the hospital administration to put in place a plan so that we wouldn't get in a crisis situation that was foreseeable, if you just even didn't know the basics of neurosurgery, that we just couldn't go on with two neurosurgeons of differing ages when one of us may become

unwell, one of us may retire. But more importantly, we needed to establish a service that proceeded longevity and succession, not just react to a crisis when someone resigns. I can understand what you're saying, but I also have an obligation for what I saw was something that was not correct, and I don't think that anyone would accept that we lower the bar to fill the post.

I guess what I'm really asking you is this, doctor: your evidence indicates - and you've really presented to us a very compelling case - that the people of North Queensland have been let down in the area of neurosurgery. The question, which I think is still an open one, is whether the blame for that lies with the individuals who are in charge of the hospital here, or whether the blame lies with the system that doesn't allow those individuals to address your concerns, and I take it from what you've just said that you're not pointing the finger of blame at individuals, you're simply saying the system has broken down, and whoever is at fault, it needs to be fixed?-- I think that summarises my opinion as I see it. I've mentioned that I feel that Dr Myers has been put in a very difficult position, and I feel extremely embarrassed that he's been put in that position, and I think the system has let him down. I don't know why it did, but it was obvious that the system was going to let him down, and it was also letting down the planning of services. It was the system that was the problem, and I don't know why that goes on. If they have the same goals as I do, which is patient care, I can't see why it should happen.

Doctor, I'm also going to ask you a question, but I'll preface it in this way: not all of us have complete self-awareness. I've discovered over the last 24 hours, as a result of being reliably informed, that I'm angry and cruel and aggressive and offensive and all sorts of other things?-- Can I reassure you that each of those apply to me at times as well.

That's what I was going to say. Is there scope for a suspicion that you haven't been the easiest person for the Townsville Hospital to manage at times, and that again your passion for providing neurosurgical services to the people of Townsville has perhaps caused you to be a bit ill-tempered with people that you see to be obstacles to achieving that?-- I accept that some people may form that view, but I don't think - of course it's from my point of view - that that's the case, and I would suggest that the evidence is quite to the contrary. I think I am held in high regard in neurosurgery across Australia and New Zealand, and I'm proud of that. I think the evidence that you have shows that I'm held in high regard by clinicians with whom I work around North Queensland and with staff whom I work with who are not in the medical field. I don't think I'm a difficult person to get on with at work, and I never have any difficulty having people work with me in the operating theatres or elsewhere. I expect that other people maintain the same standards that I do, and I expect a certain level of professional conduct when I provide a certain level of professional service. I believe I have provided a high level of service to the Townsville Hospital,

and I don't know why they have excluded me from certain decisions about neurosurgery, or perhaps ignored what I said. Now, they may have very good reasons, but they've never indicated those to me. So yes, I accept that that may be the case, but I don't believe that's a big issue. I don't think that I'm a difficult person to get on with at work, but I do set certain standards, and I'm not sorry or making excuses for that.

Thank you. Sir Llew?

D COMMISSIONER EDWARDS: No.

D COMMISSIONER VIDER: I have no questions.

COMMISSIONER: Mr Andrews?

MR ANDREWS: Doctor, was there a time when you saw the rosters - the on-call rosters for Dr Myers and saw that initially the plan appeared that Dr Myers would be on call unsupervised?-- Yes.

And the danger in such a thing is that there could have been procedures that he'd not been accustomed to performing because of his years in the quieter life in the Virgin Islands?-- Yes, because of his recency in practice.

The hospital seems to have - you certainly made your opinion known to the hospital that it was inappropriate that this should be permitted?-- Yes.

And the hospital has not permitted it?-- No.

For Dr Myers to get up to speed and to get sufficient practise, is it necessary for him to be assisting in surgery as he has with you?-- I think it's important to recognise that neurosurgery has a scope of practice, as you recognise - as I'm sure you recognise. There are many areas of neurosurgery where Dr Myers is extremely competent currently because of his scope of practice, but there are some areas, because of the type of practice he's been in recently, that he needs to re-acquaint himself with those surgical procedures and to become once again accustomed to those procedures, and I might add that some of those procedures he has - many of the procedures he has performed very competently in the past.

From what I hear you say, do you mean that even now it would be appropriate to give to Dr Myers certain privileges as an SMO for surgery?-- I'm not fully acquainted with the processes of SMO and privileges, so I don't know if I can answer that question correctly - or accurately.

COMMISSIONER: But if your advice was sought by the hospital, would it be practical to work out a schedule of procedures which Dr Myers could - at his present stage of being up-to-date with his skills - be left to do without supervision with the possibility of increasing the list of procedures in due course?-- Yes.

MR ANDREWS: And you'd be willing to assist in the process of identifying for the hospital which procedures, in your opinion, Dr Myers might satisfactorily perform without supervision?-- Yes, I've made it very clear to the hospital and to Dr Myers that I'm prepared to help in any way as a colleague to ensure that he settles into practice in the hope that he will stay indefinitely.

I have nothing further, Commissioner.

COMMISSIONER: Thank you. Ms Gallagher?

EXAMINATION-IN-CHIEF:

MS GALLAGHER: Can I just pick up, doctor, where Mr Andrews has left off. The schedule of procedures to which Mr Andrews has referred would be, I understand from what your evidence is, an elective list?-- Yes.

Because from what I've understood you to say, it's still the position though, notwithstanding that the hospital has undertaken to secure you a neurosurgeon, that the world hasn't changed in terms of on call for you or Dr Rossato?-- That would be the case.

Can I ask you one other thing, please, about recency of practice and competency assessment? I understand from your statement that you are off to Cambridge again to practise for some period of months there?-- Yes.

And, from your CV, that you have undertaken training there historically?-- Yes.

What have you had to do to assure Cambridge, for example, that you are both registered to practise and have sufficient recency of practice to be able to undertake surgery at that hospital?-- As my curriculum vitae indicates, I was practising as a consultant neurosurgeon at the Addenbrooke's Hospital in Cambridge with an honorary appointment to the University of Cambridge for three and a half years from 1991 to 1994. I have - I did have general Medical Council registration and specialty registration in the United Kingdom which I electively removed from the roster, which you can do, mainly to avoid having to pay the fees every year, and you can then just write to them, which I have done, supplying them with a certificate - or a letter, I think it is, of good standing from the Queensland Medical Board, a copy of my recent certificate from the College of Surgeons showing my maintenance of standards and continuing professional development, a copy of my certificate from the Townsville Hospital outlining my accreditation, and I have provided them with an overview of the scope of my practice for the last two to three years. In addition, you would understand that I have

continuing professional contacts with people in the Neurosurgery Department there, in particular Professor of Neurosurgery, Professor John Picard, who I have formed a professional relationship with over the years. So I'm well known to them, and they also know my professional colleagues in Australia very well, in particular two of my senior colleagues, and he remains in close contact with them. So he is aware of my practice, he is aware of my continuing practice, and he is aware of my involvement in the Society at high levels and the fact that I remain in good standing not only with the Medical Board, but with my peers generally.

When you arrive in Cambridge. Do you expect that you will be placed on the on-call roster?-- I expect that I'll be on the on-call roster. It is a little less demanding than Townsville. It's a one in 10 roster. I don't expect that I'll be on the first night, and I don't expect that I'll be on the on-call roster for some weeks until I've re-acquainted myself - that's the anticipation, that I re-acquaint myself with the system of care at the hospital and that I begin to do some elective surgery, and I guess to ensure that they see that I am the person they have employed.

COMMISSIONER: I imagine there'd be a slightly more compact geographical area than you're drawing patients from in Cambridge?-- Yes. Addenbrooke's Hospital in Cambridge provides neurosurgery for the East Anglia region, which is Norfolk, Suffolk, Cambridgeshire and Huntingshire and areas north of London. About 4 million people, Mr Morris. It's a large neurosurgery service of 10 neurosurgeons operating in a separate facility within a large hospital.

But you could drive from one end of it to another in half an hour?-- It's a bit larger than that. We do clinics in Norwich, which you will know is much larger than Cambridge, but it's provided with neurosurgery. That's the furtherest clinic, and in US terms that's a long way, 60 miles, and patients used to come down to Cambridge and wonder why they had to travel such a distance for their surgery. Many of them had never been to Cambridge, because you might know East Anglia - some people live out and don't move around too much, but it's a very enjoyable practice and a very large practice, and professionally I'm looking forward to it enormously.

MS GALLAGHER: Notwithstanding you've trained with these people, these people know you, they've reviewed, effectively, a log book of what you've done in the last 10 years-----?-- They've asked me to provide them with a summary of what I've done.

Is it your expectation you will conduct any unsupervised surgery when you first arrive?-- I don't expect to conduct unsupervised surgery for some weeks.

Thank you. I have nothing further.

COMMISSIONER: Mr Devlin?

MR DEVLIN: I have nothing, thank you.

COMMISSIONER: Mr Fitzpatrick?

MR FITZPATRICK: Thank you, Commissioner.

CROSS-EXAMINATION:

MR FITZPATRICK: Doctor, I'm Chris Fitzpatrick and I act for Queensland Health. Doctor, I was concerned to see that your statement was sworn only recently - I think about the middle of July - and that in it you say this concerning the proposed appointment of Dr Myers to the staff of the Townsville Hospital. This is in paragraph 21. You say, "My concern is the process that was adopted in his appointment and the blatant lack of accountability by the hospital administration to ensure the competence of this surgeon." Now, some would say that those are strong words, strong criticism of my client and the Townsville Hospital, yet listening to you give evidence and answering the Commission's questions, one has the impression that perhaps since you've returned to the hospital, some of the concerns of which you speak have been allayed. Is that so, or is that false?-- I'm a little unclear on the question. Are you asking me about the hospital processes since I've returned to the hospital or are you asking me about the process of Dr Myers' appointment?

Well, I suppose, doctor - and I'm sorry if it's unclear. I'm in the process of losing my voice, I think. But I was wondering really whether you stand by that statement. That is, whether you remain of the view that there was, on the part of my client, a blatant lack of accountability by the hospital administration to ensure Dr Myers' clinical competence?-- Yes, sir.

You do.

COMMISSIONER: Doctor, just so I understand that, you stand by that as your view of the system which had taken place up to the 15th of July - or whatever the date of your statement was. Since then things, of course, have moved on, and I think you've already told us that you're not dissatisfied with the steps that have now been taken to ensure that Dr Myers brings his skills up-to-date and so on?-- I think if I could just read the first sentence of that as well to make my position clear.

Yes?-- "The comments I am about to make are not a personal reflection on the person concerned or his professional ability." I just want to make that clear. I think, yes, it was - my concerns were about the process, that we are appointing someone, and to my mind steps were not appropriately taken to ensure that person was capable of providing the level of service that was required.

And it's one of those rare situations where the wrong process has nonetheless produced the right result?-- Well-----

In the sense that Townsville now has someone who has all the promise of making a big contribution to neurosurgery in this part of Australia?-- Yes.

MR FITZPATRICK: And doctor, please understand I haven't come up from Brisbane to make trouble for you in your professional practice or create rifts between you-----?-- I fully understand that.

Yes, thank you. But I'm just interested to find out what it is about the process that's been adopted with Dr Myers that concerned you. Can we go back to basics? I think that we are all agreed - you have agreed with the Commissioner that because of the situation of Townsville, and indeed much of regional Queensland, it is difficult to attract any sort of candidate to practise in neurosurgery here. Is that so?-- Yes.

So the hospital has a limited pool of applicants from whom to choose at any given time?-- I'd imagine so. I never saw the pool of applicants for this position.

Well, Mr Andrews read out to you a letter that was written, I think to you, in which the hospital said that of the available candidates, the most promising was someone from New Zealand, I think?-- I think it was a South African who applied to go to Auckland, yes.

That's so. Evidence will be given, I think, that because of the income which that candidate was able to derive from staying - or going to New Zealand, that he dropped out of the race and what the hospital was left with was Dr Myers. You may not know whether that's so or not?-- I accept that's the case, yes.

So the Townsville Hospital has Dr Myers as its candidate. Dr Rossato has said in his statement - and will give evidence, I expect - that when he reviewed Dr Myers' CV, he discerned that if it had any weakness at all, if I can use that term advisedly, it was because of his recency of practice and the fact that because he practises in the Virgin Islands, which has a very limited, as I understand it, neurosurgical facility, that there was some weakness there, and what seems to have resulted from that is that he was put on as a locum. He was - it was made clear to him at the time of engagement that he was to be supervised, that he's not been given any right of unrestricted clinical practice, that he practises at all times under the supervision of you or Dr Rossato - that seems to be borne out in fact - that he's been put up, I think, to the College, and that it's expected that he will be credentialled, and that Dr Rossato or you will be involved in that credentialling process.

What is it about that process that concerns you and causes you to say that it reflects a lack of accountability on the part of the hospital administration?-- The information that I had sought from Dr Johnson, from Miss Jackie Hanson, was about how was level of competency determined, and no-one was able to give me that information. I said, "Would it be possible for me to review the surgical log book? Would it be possible for me to see a copy of the curriculum vitae?" I got a copy of the curriculum vitae that contained every second page. I've yet to receive a full document.

I see?-- I received an on-call roster which had his name in it. I have a copy of an e-mail which says that Dr Andrew Johnson expected him to be able to do independent on call from the 23rd of June. I think all those things raised significant concerns. It's not meant as an attack on Dr Myers' credibility, and I've said that.

Yes?-- I find him a very professional person. It's the process. It's the process that was - and I don't think that's accountability. I think that - I've subsequently received an on-call roster, that's completely revised, that has his name completely removed from it. It arrived last Friday. Dr Myers arrived at the hospital when I was the only person here. Who was going to supervise him when no-one had approached me about the situation to say, "Are you going to supervise Dr Myers?" I was informed by the theatre sister that I was going to do it.

Yes, I see?-- So I think that raised significant concerns in my view.

Yes?-- And I've mentioned why I was concerned so I think that that's not professional.

Yes.

COMMISSIONER: Mr Fitzpatrick, I'm certainly not going to stop you from pursuing this matter if you think that the interests of Queensland Health require an exploration of that. I'm sure I speak on behalf of the Deputy Commissioners, having heard Dr Johnson's and Dr Myers' evidence and now the present witness's evidence we have no expectation that we'll be able to resolve what's plainly a difference of opinion as to how matters should be handled. Certainly I've seen nothing that reflects adversely on the way that the local administration has handled the situation within the constraints under which they operate. That's not for a moment to down-play the significance of the present witness's concerns which are very genuine concerns and very responsible concerns, but I don't see that as a reflection on the management of Townsville Hospital that has to operate within a system and operate under the constraints of a difficulty which everyone acknowledges in attracting top level specialists to come to Townsville. So you make your own judgment, but I don't think it's useful for us to pursue it any further.

MR FITZPATRICK: Thank you, Commissioner, and in view of the doctor's helpful comments I think there now is better understanding from this part of the room. Thank you, doctor.

COMMISSIONER: Thank you.

MR ALLEN: No questions, thank you.

COMMISSIONER: Any re-examination, Ms Gallagher?

MS GALLAGHER: No, thank you, Commissioner.

COMMISSIONER: Mr Andrews?

MR ANDREWS: No, thank you, Commissioner.

COMMISSIONER: Doctor, one of the astounding things about the experience I've had of being on this Commission of Inquiry is having the opportunity to hear evidence from people who are obviously very highly skilled in their profession, but also obviously very compassionate about providing service to the community. The fact that we have torn you away from your patients even for a couple of hours is, in one sense, regrettable, but we are really very grateful for your time, for your coming along and sharing your views with us and we hope that at the end of the day we'll be able to produce a report which hands down recommendations that repays in some small way the great level of assistance that we have had from individual members of the profession like yourself?-- Thank you very much.

You're excused from further attendance.

D COMMISSIONER VIDER: And I would like to say before you go you will be in Cambridge in a year that is not warm and sunny so you might be able to recruite some neurosurgeons to Townsville?-- If I take enough holidays shots I might be. Perhaps the environment that attracts people to Cambridge is not the weather and it is a long way from here to there and the professional environment is very different, but I'll try.

COMMISSIONER: Thank you, doctor.

WITNESS EXCUSED

COMMISSIONER: We'll now take a 15 minute break.

THE COMMISSION ADJOURNED AT 11.03 A.M.

THE COMMISSION RESUMED AT 11.26 A.M.

COMMISSIONER: Mr Andrews?

MR ANDREWS: Commissioner, I call Dr Rossato.

RENO GEORGE ROSSATO, SWORN AND EXAMINED:

COMMISSIONER: Dr Rossato, good morning?-- Good morning.

Please try to make yourself as comfortable as possible and can I ask whether you have any objection to your evidence being video recorded or photographed?-- Not at all, sir.

Thank you.

MR ANDREWS: Doctor, you are Dr Reno George Rossato?-- I am, sir.

You have for inquiry staff prepared a statement dated the 29th of July 2005?-- That is correct, sir.

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

And the opinions you express in it are they your honest ones?-- They're my firmly held honest opinion.

Thank you, doctor.

COMMISSIONER: The statement of Dr Rossato will be Exhibit 243.

ADMITTED AND MARKED "EXHIBIT 243"

MR ANDREWS: You became a Fellow of the Royal College of Surgeons in 1973 and of the Royal Australian College of Surgeons in 1975?-- Correct, sir.

You're a Fellow of the American College of Surgeons?-- Yes.

And have been since 1980?-- Yes.

You've been a neurosurgeon practising in Townsville since 1979?-- That is correct, sir.

And until 1994 you must have been extremely tired because you were the only neurosurgeon in Townsville?-- Both statements

are correct, sir.

Since then Dr Guazzo has been practising in Townsville?-- Yes.

You and Dr Guazzo for much of that period have shared the on-call time?-- That is correct, sir.

Until 2003 you were a visiting medical officer at the Townsville Hospital?-- Correct.

But then you became a full-time staff specialist?-- Yes, I did, sir.

Can you explain why?-- It was always my intention with the - in early 2003 not to proceed with private practice principally because of the confusion regarding indemnity and where the need for malpractice was heading. I had an interest in surgical affairs. I had already been appointed by the previous administration as the Chairman of the Institute of Surgery and I really needed to, with the institute's reorganisation, to increase my available hours to do both jobs properly and I applied to convert my status from VMO to staff specialist and this has been done before within the institution and was agreed to on this occasion.

As clinical director of the Institute of Surgery at the hospital how much of your time is taken up with administrative duties?-- I am getting very close to half of it.

Now, you are involved in the planning and recruitment needs of your institute, I suppose?-- I must confess I - I recognise clinical deficiencies and try to make the argument that they should be filled. The actual - the actual process tends to be initiated by HR. I've always thought the place has gone downhill since we started talking about human beings as human resources.

So you identify a need. HR goes about trying to fill it by advertising?-- Yes.

And HR, no doubt, does so firstly by trying to comply with Queensland Health policies as to the method of advertising?-- Absolutely, sir.

And do you have any opinions about whether that method is a practical one when trying to seek specialists to fill needs of the hospital?-- I think it's been glaringly ineffective, sir.

Does the adherence to the Queensland Health protocol for advertising slow down the process?-- Yes, it does.

And does that slowing down sometimes jeopardise patient health and safety?-- I think if there was an obvious need that wasn't being met then theoretically patient safety could suffer as a result of it. One would hope that a deficiency would be recognised before it reached that crisis point however.

There's been evidence, for instance, that there was a deficiency that led to a need for an ear, nose and throat specialist and eventually that position, it seems, hasn't yet been filled?-- That's quite correct, sir.

And it took quite some time in attempting to fill that position?-- Yes, and that - those attempts eventually led to a lot of dissatisfaction from our visiting medical officers in ear, nose and throat surgery.

COMMISSIONER: What in broad terms was the source of their dissatisfaction?-- I think they thought, Commissioner, that a process was in place to appoint somebody who wasn't qualified or fill the shoes that he was being asked to do. Now, that's - having said that, the people who actually carried out the interview was one of the people, Dr Andrew Swanston, who was an FRACS and who was the Director of the Ear, Nose and Throat surgery at the time, so it seemed a little strange to me because I wasn't involved, but it seems strange to me that it actually got past that barrier. I'm not quite too sure I understand how that happened.

I guess so much like these things it is a matter of perception that if there isn't a transparency in the process then rumours and scuttle bugs start to get around?-- And incredibly powerful they are too, sir.

Yes. Doctor, you did mention the inefficiencies in the recruitment process. One of the things that struck me, both from your evidence already and the evidence of Dr Myers yesterday, and the evidence of some very, very senior specialists that we've heard elsewhere, is that one of the things that really does attract people who work for Queensland Health is the professional indemnity medical malpractice issue. When particularly I heard the evidence from Dr Myers yesterday, I hadn't been conscious that that issue we've experienced in Australia in the earlier part of this decade was also a major issue in the United States, and it seems to me to be at least one selling point that Queensland Health hasn't fully capitalised on?-- I think that's a fair comment, Commissioner, yes.

We can't at the moment offer people salaries that are comparable even with other parts of Australia, let alone North America or Europe, but we can offer them the guarantee that they are not going to have to reach into their own back pocket to pay for malpractice claims?-- I think it is also a little under the table, Commissioner, to have the indemnity value rolled up in the so-called package.

Yes. There has been a suggestion - I just put this to you as a devil's advocate - that the fact that Queensland Health is self-insured has in some ways contributed to a certain laxness in clinical standards because private hospitals, as we're all aware, operate under fairly strict scrutiny, not only from Government, but also from their own insurers, and Queensland Health doesn't have that check in the system of an independent body with significant financial interest in making sure the highest possible clinical standards are maintained. Do you have a view about that?-- I do, Commissioner, I think one of the references I have so far is the arm's length authority, if you like, that does scrutinise practice in public hospitals, that concept I think has an awful lot of merit, I also think, being a self-insurer. We've all seen examples of it in the finance industry, really leads to some malpractices.

Thank you, Mr Andrews.

MR ANDREWS: There has been difficulty attracting a third neurosurgeon to Townsville and you attribute, firstly, the disparity in pay that can be offered in Queensland when compared with the pay that can be offered in other Australian States?-- All other jurisdictions pay significantly better than we are paid in Queensland.

Secondly, you speak of the amount of on-call time. Now, sharing 640,000 - or the needs of potentially 640,000 members of the population between two neurosurgeons, how does that contrast with the amount of on-call time you would expect in other hospitals offering neurosurgery?-- The two major centres for public neurosurgery, of course, are Royal Brisbane and PA and the Royal Children's Hospital. My understanding is that - not quite a new revolt, but there was a fair amount of disgruntlement when it was suggested a 1-in-4 roster could be

applied. I think it is currently 1 in 6.

That must seem like retirement?-- It has certainly got a nice aura about it.

Now, you have mentioned that Townsville serves a population of approximately 640,000 and you have said that ideally you would like to see three neurosurgeons here. We have heard evidence this morning that there are some published figures, now slightly out of date, that suggest that there should be one neurosurgeon for each 175,000 people?-- I - I concur that those figures are certainly out of date. And I suspect a more realistic figure would go down rather than go up and that they would anticipate - I would anticipate that figure coming down to 1 per 150,000.

Well, ideally you would want four to five neurosurgeons for Townsville?-- Four, yes.

COMMISSIONER: Doctor, when you talk about that figure going down rather than up, is there a greater need for neurosurgery in our society, or is neurosurgery more time consuming? What has caused this situation where the need for neurosurgeons on a per capita basis has increased?-- There are several things have contributed to that, Commissioner. I think one is that our retrieval services are infinitely better than they have ever been, and our health care services are better than they have ever been, which essentially means that people, because of time factors, that might otherwise have died from their trauma are now more quickly retrieved. So that our trauma treatment has increased because there is more of it that arise at the hospitals in this State. Secondly I think that the public expectation has been generated by - well, by politicians generated by media expectation, that this sort of care would be available to all and sundry, all Queenslanders. And that also drives the demand for neurosurgical outpatient services. The bar has come down, in effect.

I guess part of that - the implication of the second point is that a lot of cases or conditions, which historically wouldn't have been treated by a specialist neurosurgeon, now there is an expectation amongst the public that they will receive that specialist treatment?-- That's the expectation, Commissioner, and, of course, there are conditions that in the past would have been considered untreatable neurosurgically that are now being assessed and attacked.

And patients also that historically simply wouldn't have been able to get to the hospital in time to-----?-- Certainly.

-----receive treatment-----?-- Yes.

-----are now being successfully treated?-- Yes.

MR ANDREWS: Doctor, late last year the hospital found funds to allow for advertisements to attract a third neurosurgeon?-- Yes, they did.

After HR had advertised, there were how many candidates?-- From that round zero.

So what did you do after HR had failed to attract candidates?-- Well, we put a message on the ACS website and the RCNS website, Neurosurgery of Australasia website.

Wouldn't that be free?-- Yeah, but I don't think we're supposed to have done it. That also attracted no response, Mr Andrews. The thing about advertising, of course, is all of the medical agencies - it is almost like sticking the flag above the parapets. They see these ads in QH advertisements and they immediately have their antennae raised and they start looking around and that's how you usually get applicants.

How did you obtain applicants for the position? What was the successful strategy?-- I think it was various - various agencies actually forwarded to us some names and would we like to see their CVs.

How many were you offered?-- Four all up, two were South Africans in South Africa, one was a South African working in New Zealand, who I knew personally, and one was Donald Myers.

How many of the four were interested in the position?-- Initially all of them expressed interest but they all eventually fell over, for one reason or another, financially one case. And, secondly, two South Africans had actually taken new jobs in South Africa.

The one who fell over financially, are you referring to the neurosurgeon practising in New Zealand?-- I am.

Was that practitioner earning more than you could offer at Townsville?-- His description of his conditions of service sounded like some sort of dream after an illegal substance.

COMMISSIONER: Mr Andrews, if you are going to move on to the details of Dr Myers' appointment, I am presently inclined to think there is no point. You know, we've heard really quite unanimous and unequivocal evidence that the people of Townsville have been extraordinarily fortunate to attract a neurosurgeon of Dr Myers' eminence. Dr Guazzo has outlined to us his concerns about the transparency of the procedure but my inclination is at the moment to feel, those concerns were appropriately answered in Dr Johnson's evidence yesterday. For the moment I don't see it is going to progress things by exploring these things in any further detail. Unless, of course, do you wish to say anything more on it?-- No, I have nothing further to add, Commissioner.

I take it you agree with what we've heard from all other sources, that it is an almost biblical blessing that Townsville has been able to attract Dr Myers?-- I think that's a fair comment, yes.

Mr Andrews?

MR ANDREWS: I have nothing further in the circumstances, Commissioner.

COMMISSIONER: Thank you. Ms Gallagher?

MS GALLAGHER: No, I believe-----

COMMISSIONER: Mr Devlin?

MR DEVLIN: I have nothing, thank you.

COMMISSIONER: Mr Fitzpatrick?

MR FITZPATRICK: No questions, thank you, Commissioner.

COMMISSIONER: Mr Allen?

MR ALLEN: No, thank you, Commissioner.

COMMISSIONER: Sorry, doctor, you don't seem to have any customers today?-- Delighted, sir.

Thank you so much for coming along. We appreciate your time and your evidence?-- Commissioner, can I just say I think it is a fine thing that you are doing.

Thank you, doctor.

WITNESS EXCUSED

MR ANDREWS: Commissioner, the next witness, Dr John Alexander Allan, would, by his calling now, cause inconvenience to at least one counsel at the Bar table.

COMMISSIONER: Yes.

MR ANDREWS: It was proposed to call him after lunch.

COMMISSIONER: I have no difficulty with that at all. I will leave it to you, Mr Andrews, to confer with whichever counsel that is and see whether there is any scope to start a little earlier, say 1.30 or something like that, so we don't lose too much time.

MR ANDREWS: I am sure that's ample time.

COMMISSIONER: Yes. Is Dr Allan the only remaining witness proposed for today?

MR ANDREWS: Mr Gallagher. And may I just inquire as to his availability? Available at 4 o'clock.

COMMISSIONER: Well, how long do you think Dr Allan will be?

MR ANDREWS: Not as long as two hours.

COMMISSIONER: So it sounds that if we resume at 2 o'clock we will comfortably finish Dr Allan's evidence and be able to start Mr Gallagher as soon as he is available?

MR ANDREWS: Yes, I believe so.

COMMISSIONER: Does that suit everyone's convenience? Does anyone disagree with those time estimates? That being the case we will adjourn then till 2 p.m.

THE COMMISSION ADJOURNED AT 11.49 A.M. TILL 2.00 P.M.

THE COMMISSION RESUMED AT 2.01 P.M.

COMMISSIONER: Mr Andrews.

MR ANDREWS: Commissioner, before calling Dr Allan, I have to hand a report of Dr D Fraenkel, F-R-A-E-N-K-E-L, and a Dr C Anstey, A-N-S-T-E-Y, dated March 30, 2000. That report has been received by the Inquiry within the last week and upon review it does appear to be relevant to the Bundaberg Base Hospital ICU. It contains recommendations that any patients likely to be ventilated for more than 24 hours in the ICU at the Bundaberg Base Hospital should be retrieved to a higher level facility. It also recommends that junior staffing rosters be re-examined to allow the immediate availability of a suitably skilled doctor to the unit at any time after-hours and to ensure that the daytime senior health officer remains available every weekday.

COMMISSIONER: Sorry, this is dated in 2000?

MR ANDREWS: Yes, Commissioner.

COMMISSIONER: What did it say about the ICU?

MR ANDREWS: That any patients likely to be ventilated for more than 24 hours should be retrieved to a higher level facility. It also says that, "There is a wish to develop the service with relevant expertise and infrastructure to provide increasingly sophisticated levels of care and organ systems support. However, such aspirations are neither in keeping with the patient case load nor the infrastructure and other services provided by the hospital. The existing and projected case load would not justify the major additional investment to operate the ICU as a Level 2 unit. Patients' safety and clinical requirements dictate that the care of patients with multisystem organ failure or prolonged ventilation should be practised in a secondary or tertiary referral centre. Occasional experience with higher acuity patients is not an appropriate way of maintaining clinical expertise or justifying the retention of these patients." I submit, Commissioner, that this may be of some relevance.

COMMISSIONER: How did we come by this report?

MR ANDREWS: It was appended to a submission received from Dr Fraenkel on the 28th of July.

COMMISSIONER: I'll ask the inquiry staff to treat that submission as a submission and put it on the website with our other submissions. The report itself will be Exhibit 244.

ADMITTED AND MARKED "EXHIBIT 244"

COMMISSIONER: I would ask Commission staff as well, Mr Fitzpatrick, as those who instruct you to make inquiries as to when and how this came to the attention of Queensland Health and why again it's something that-----

MR ANDREWS: Commissioner, those inquiries have been made.

COMMISSIONER: Yes.

MR ANDREWS: Dr Fraenkel has instructed that the report was delivered to Mr Lindsay Pyne, P-Y-N-E, then the Central Zonal Manager, and that later it made up part of a presentation to the then Director-General.

COMMISSIONER: Dr Stable.

MR ANDREWS: Dr Stable. And to Mr Pyne at the Prince Charles Hospital in about May of 2000.

COMMISSIONER: Thank you for that. Yes, well, that report will be Exhibit Number 244.

MR ANDREWS: Thank you, Commissioner.

COMMISSIONER: Yes.

MR DEVLIN: Commissioner, may I produce the Board's file in relation to Vincent Berg.

COMMISSIONER: Certainly.

MR DEVLIN: I think the number 238 was reserved for it.

COMMISSIONER: Yes. Medical Board of Queensland file relating to Berg will be Exhibit 238.

ADMITTED AND MARKED "EXHIBIT 238"

MR DEVLIN: Can I indicate that I'll expect to be able to tender into the record tomorrow an affidavit of Mr Demy-Geroe which deals with the salient features of the file.

COMMISSIONER: Certainly. I again appreciate your assistance, Mr Devlin.

MR DEVLIN: Thank you.

MR ALLEN: Excuse me, Commissioner, I was just wondering if my learned friend counsel assisting is able to clarify whether that report first came to the Commission as a result of that submission and wasn't earlier supplied by Queensland Health.

COMMISSIONER: I understand from what Mr Andrews said we only

became aware of it as a result of the submission of one of the auditors.

MR ANDREWS: That's so, Commissioner.

MR ALLEN: Thank you.

COMMISSIONER: I think, Mr Andrews, you said we received it within the last week or so?

MR ANDREWS: Yes, it was received on 29 July.

COMMISSIONER: Thank you.

MR ANDREWS: I call Dr John Alexander Allan.

JOHN ALEXANDER ALLAN, SWORN AND EXAMINED:

COMMISSIONER: Doctor, please make yourself comfortable. Do you have any objection to your evidence being video recorded or photographed?-- No.

Thank you.

MR ANDREWS: Doctor, your full name is John Alexander Allan?-- It is.

Doctor, did you provide to Inquiry staff a statement sworn on the 29th of July 2005?-- I did.

Are the facts recited in that statement true to the best of your knowledge?-- To the best of my knowledge, yes.

And the opinions you expressed in that statement, are they your honest opinions?-- Yes, they are.

I tender that statement.

COMMISSIONER: Yes, the statement of Dr Allan will be Exhibit 245.

ADMITTED AND MARKED "EXHIBIT 245"

MR ANDREWS: Doctor, do you have a copy of it with you?-- I do, yes.

You're the Director of Integrated Mental Health Service for the Townsville Health Services District?-- Yes, I am.

You've been a consultant psychiatrist since 1987?-- Yes.

You are on the examination committee of the Royal Australian and New Zealand College of Psychiatrists?-- Yes, I am.

As a Director of the Integrated Mental Health Service, do you practise predominantly in adult psychiatry?-- Yes, I do.

You have a significant administrative case load?-- I do, yes.

And about 60 per cent of your time is involved in administrative work?-- Around that, around that amount. In a general sense, yes.

Vincent Berg came to be employed at the Townsville Hospital?-- Yes.

His prior employment had been at the Gold Coast?-- He'd been - he was an observer at the Gold Coast Hospital.

He'd performed about 12 weeks of unpaid work there?-- That's my understanding, yes.

He came with favourable references from those who'd encountered him at that hospital?-- Yes, he had three referees, who gave him favourable accounts.

And before he was offered a position at the Townsville Hospital, you spoke with two of those referees?-- Yes, I did.

Dr Hamilton and Professor Morris?-- Yes, I did.

And I gather they spoke-----?-- They spoke favourably of him. They said that it was thought that he was appropriate to be employed in a general position.

His written references were quite complimentary?-- They were very complimentary.

You, naturally, didn't take any steps to contact a university in the former United Soviet Socialist Republic to determine his qualifications?-- No, I did not, no.

You relied upon-----?-- I relied upon what was given to the Medical Board.

Thank you. When he arrived at the Townsville Hospital, how soon after his arrival were idiosyncrasies with his practice observed?-- I think that there were some issues that arose within the first few weeks. I had expected that would be the case in that he had been out of practice for a long time and he'd come from another country and that from my discussions with him, I thought that his practice of psychiatry would be significantly different to ours. But I thought that those things would be able to be sorted through but there were some significant - there were some issues that began in the first few weeks.

And what were they?-- I think that they were really that he

had - he gave the impression of a person who'd done a lot of reading and he certainly presented himself as a person who was very knowledgeable about psychiatry and that he felt he had a very good knowledge of psychological and psychodynamic issues and he had a lot of knowledge about medications, their use and their side-effects and so on. What I think was of issue was that he appeared not to have practised for some time and that he wasn't particularly systematic about his application of that knowledge, and I would think that in medicine or psychiatry in particular, that a systematic application, being able to make judgments about the way that those treatments or ideas should be applied, would be very important and I thought that some of the things that he - some of the decisions, not all of the decisions but some of those decisions certainly didn't show he had that kind of clinical judgment that people would think about in a person who is normally practising in psychiatry.

You comment in your statement at paragraph 25 of a tendency to over analyse clinical issues and to come up with complicated diagnoses for uncomplicated conditions?-- Yes.

It suggests, Doctor, that you had regular audits or you were regularly-----?-- Regularly supervising his work.

-----supervising?-- And checking with his work. At that point I was his supervisor and so we would have regular meetings to discuss his patients and I guess I'm commenting on that, that my view of what he told me about the patients and his view about what was wrong with them and what should be done had detail and depth that wasn't really there in my opinion.

Now, he began in January 2000?-- Yes.

As that calendar year progressed, I imagine you observed more and more?-- There were more and more concerns about his performance. There were - he was working three different areas at the time. One was in a community based clinic where I was his direct supervisor, one was in a rehabilitation unit, the Kirwan Rehabilitation Unit at Townsville, and another was visiting at the Charters Towers rehabilitation, both of those two are longer stay psychiatric hospitals if you can think of it in that way, and I was supervising there. And staff at all of those areas, and from my observations, raised concerns about particular points of practice. I think that, as would be the case with anybody, we addressed those in a supervision way and through discussion but it eventually reached the point where there were written concerns given to him about his practice and he answered those concerns and the outcomes were that we would more closely supervise him. One of the outcomes was that we actually stopped him going to Charters Towers because that was 100 kilometres away or 130 kilometres away and it wasn't possible for me to go every day with him to Charters Towers so that I felt it was actually better not to have him go than have him go on his own. And he had a disagreement with a consultant at - with Dr Boyes, who was working at the Kirwan Rehabilitation Unit, and they agreed not to work together anymore as a result of problems that she had

had with him.

It seemed that he was a person prepared to ignore supervisors' instructions?-- That seemed to be the case. There were a number of instances, and those, again, were recorded in the records, that he had not done things that consultants had asked him to do, preferring his own opinion. That, of course, came up through the course of supervision or discussion with the staff and he would give a complicated explanation as to why the person, why the consultant was wrong about that. There's always points of view and you can always argue your case but there also comes a time when you can't - when you've just got to get on with it and do the treatment. So, that certainly happened.

Now, Mr Berg wanted his Russian training recognised by the Royal Australian and New Zealand College of Psychiatrists but you couldn't support that application?-- No. He'd come to us originally via the registrar training scheme and made an application to join as a training psychiatrist and he'd been rejected from that because of a lack of recent experience, and that was not uncommon, and I suggested that he start in a general position where his value could be assessed and then his true level or his true ability could be assessed so we could support whatever applications he made. Based on the work that he had done with our service, I felt that there - he was very far - a long way from functioning independently as a psychiatrist and I told him that. He had the belief that his Russian qualifications should be recognised and he spoke to me often about that, probably after the first month that he came was, "Well, have you seen enough now? Are you going to write the letter to the College of Psychiatrists to say I'm ready?" and I'd say, "Well, actually, there's concerns, I'm not certain. It's too soon to do that." I think that reached about the middle of the year, I think about May or June, reached a crescendo for him in that he had to get an application into the exemptions committee of the college which looked at whether or not the person should be considered as a psychiatrist and I had told him I wouldn't support that and he became very angry with me about that, and I did actually write to the college about some other issues for him but didn't support him and he became upset about that.

Did you have an alternative recommendation for him?-- I - they didn't actually ask me for any particular recommendation. My recommendation at that time was that I was doubting whether or not he was suitable for a registrar training program and that that - that crescendo reached the point where I told him that I thought he was unsuitable to work for us and that I wouldn't be recommending for him the lower level down, the registrar training level either for the next year. That led to some very heated argument - discussion between he and I with him accusing me of not understanding his position, and that was of course - it's quite difficult in that time.

In your statement you say felt - you thought that he should undergo the AMC exams?-- Yes. The reason for that was that as I - excuse me. I was concerned about his practice in

psychiatry but I was also concerned about his practice in general medicine. I thought that he wasn't a very competent general doctor because he - he was unskilled in physical examination of patients. He certainly made many physical diagnoses, some, not many of them, not as well supported as they should be and, again, I thought that his examination technique and his physical findings were not systematic in the way that I would expect doctors to be systematic. I have had a number of discussions with colleagues about this and we - we - and with him, and put it down to the way that doctors were trained in Russia. I was aware that in many European countries there was not a lot of hands-on experience in medical training as there would be in Australia and that, really, those doctors learn on the job and that he was Russian and that needed to be explored. So I felt that it would be better for him to go back to a more solid grounding in general medicine and in psychiatry, to really start his training again. I thought that would be a better way for him to be a safe practising doctor.

By August of 2000 you sent him a letter setting out about 10 concerns?-- Yes.

Commissioner, the letter has not been de-identified. There are a number of patients' names within it and they may - some of them may be residents of Townsville easily identified and for that - to begin with, it obviously is an exhibit that needs to be de-identified before it's put on any website but it also means it's inappropriate for me to put it on the monitor at the moment.

COMMISSIONER: Yes. Will you be ultimately wanting to tender it in as a de-identified statement?

MR ANDREWS: Yes.

COMMISSIONER: I will attribute to the letter at the bottom of the exhibit Number 246-----

MR ANDREWS: Oh, the letter is part of Dr Allan's statement.

COMMISSIONER: Statement, I see. Well, all of the lawyers here and members of the Commission have copies to which they can refer. I should mention, while there's an interruption, a couple of things. Firstly, we have some numbering wrong and I'm not quite sure how but the Fraenkel/Anstey report will be Exhibit 244. I think I said 234.

MR ANDREWS: Thank you.

COMMISSIONER: Similarly, Dr Allan's statement will be 245. Also while there's slight interruption to proceedings, Mr Devlin, can I raise something with you? I've just been flicking through the Berg file.

MR DEVLIN: Yes.

COMMISSIONER: And I have a few concerns about it. One is

that Dr Berg made some very serious allegations against another psychiatrist in Townsville.

MR DEVLIN: Yes.

COMMISSIONER: Those allegations seem to have been fully refuted by Dr Allan but I'm reluctant to put into the public arena-----

MR DEVLIN: Absolutely.

COMMISSIONER: -----allegations concerning an individual where they are not the subject of our investigation and fall outside our Terms of Reference and the individual concerned doesn't have an opportunity to answer those matters.

MR DEVLIN: Yes.

COMMISSIONER: What I was going to propose therefore is that the references to that doctor be de-identified before the file becomes publicly available.

MR DEVLIN: Yes, I'm entirely in accord with that.

COMMISSIONER: Do you agree with that?

MR DEVLIN: Yes, thank you. It was wasn't the Board's intention to ventilate that matter.

COMMISSIONER: The other thing you might help me with or the second thing you might help me with is this: going through the file, you might recall yesterday the evidence was that the Crime and Misconduct Commission looked at the matter, referred it back to Queensland Health and, ultimately, the decision was made that there's no point pursuing police investigations because Dr Berg or Mr Berg, however we should call him, had left Queensland and wasn't worth pursuing.

MR DEVLIN: Yes.

COMMISSIONER: What I noticed from the Board's file though is that the Board was still corresponding with Berg at an address at Palm Beach in Queensland as recently as April 28th, 2003. I wonder whether you might have inquiries made as to whether that was, as it were, the last known address for Berg and, more importantly, whether anyone from Queensland Health checked with the Medical Board concerning Berg's last known address before making the decision that he shouldn't be pursued because he'd left the state.

MR DEVLIN: Yes, I'll have those matters addressed in Mr Demy-Geroe's affidavit.

COMMISSIONER: Thank you. The third thing is, again, I see from the file that Berg had apparently made applications for registration both in the Northern Territory and in Western Australia.

MR DEVLIN: Yes.

COMMISSIONER: The outcome of the Western Australia application, appears from the file, is that the Western Australian authorities got in touch with the Medical Board here and as a result of that the application in Western Australia for registration was withdrawn, but there's nothing to indicate what happened regarding the application for registration in the Northern Territory. So maybe the Medical Board grapevine can find out whether that went anywhere.

MR DEVLIN: Yes, but the file so far seems to reveal that following his termination in Townsville, he then attempted to obtain registration not only in Western Australia and Northern Territory but in New Zealand. There's a reference to that on the file too.

COMMISSIONER: I hadn't picked that up yet because, again, the evidence suggested yesterday that the Medical Board had put steps in place to make sure that there was a - in effect, an international alert I think, that was the implication anyway, and I haven't encountered that within the file but it would be interesting to see what processes were taken to make sure that this apparent fraudster wasn't allowed to get registered anywhere else.

MR DEVLIN: Yes. The file seems to reveal that at least up to a certain point the Board took the view that his qualifications were unable to be substantiated.

COMMISSIONER: Yes.

MR DEVLIN: Then, as we discovered yesterday, the terms of its last letter appears to have shown a shift in attitude in that Dr Toft's letter picks up the allegation from Townsville that he was not qualified, which is a much more black and white proposition than the one which is shown in the earlier part of the file.

COMMISSIONER: Yes.

MR DEVLIN: I'm endeavouring to discover what, if anything, caused that shift other than a straight acknowledgment that Townsville's concerns were justified.

COMMISSIONER: There is also a cryptic reference to information passed over the telephone from Western Australia back to the Board in Queensland, which hints that there may be some more information that was communicated verbally but doesn't appear on the file. So no doubt Mr Demy-Geroe will be able to fill in those blanks.

MR DEVLIN: I'll see if I can do that.

COMMISSIONER: Thank you. Thank you, Mr Andrews.

MR ANDREWS: Your letter, doctor, dated 8 August, is Exhibit JAA1 to your statement, and within it you number 10 paragraphs of concerns that you asked Vincent Berg to respond to?-- Yes.

In the second paragraph, if I can paraphrase, it seems that Dr Berg changed a prescription of some medication from a 2 milligram Respiridone tablet to half a 4 milligram tablet, and it led to some confusion for the patient who began taking the whole 4 milligram tablet rather than a half daily, and that-----?-- Yes.

-----caused appropriate physical symptoms of anxiety-----?-- Yes.

-----and agitation. Now, it seems that even after advising Dr Berg that there was no financial saving involved for the patient, he still refused to prescribe the Respiridone in 2 milligram doses?-- Yes.

And you say that his reaction was irrational and seemed to be based upon a perception of himself as always correct?-- I think I was actually quoting from the e-mail I received. That was the e-mail from the team leader, his reaction about Dr Berg.

I see. Had you yourself ever observed Dr Berg to behave in such a way as to lead you to a similar conclusion?-- Yes, I had, in refusal to change his mind or consider other alternatives to things suggested.

I notice among the different paragraphs there are few that - many contain other persons' descriptions of Dr Berg rather than your own?-- Yes.

Was that-----?-- That was - I probably should explain to you we had a discussion about de-identifying in the letter. In a previous letter to Dr Berg I'd written to him about removing names, and he'd written back to me saying, "If you don't tell me the names, I won't answer you." So that's why the names are from it. You need to understand that. Secondly, it was because by this stage he had decided that it was a personal vendetta of mine against him to do that, and it was really like, "You're not fit to be a supervising psychiatrist", and I really wanted to show there was a very broad range of opinion that supported my argument that things were - there were problems. That's why I've quoted so many other people. This is really a synthesis of a very large amount of informing that I was given about particular problems. I guess I tried to not always identify those people in some ways.

Now, paragraph 4 there's a description of a patient well known to the acute inpatient unit who was admitted for seven months in 1999. After extensive work-up there seemed no doubt that she had schizophrenia and she'd been stabilised on - is it Clozapine?-- Yes, Clozapine.

It seem that Dr Berg disagreed with that diagnosis, felt that the problem mainly was anxiety, and took her off that medication?-- Yes.

Now, is that something that a person of his seniority can do when-----?-- I don't think that he can do that without consultation.

It seems that he had-----?-- That he had done that, and that had led to a considerable degree of conflict between he and Dr Boyes, as I mentioned there as well. That was really the basis of the problem, I guess.

Now, he proclaimed, when he was discovered, "I'll prove you wrong. Let me treat her my way and I'll get her better in two months." Was that kind of explanation typical of Dr Berg?-- That was probably the extreme of it rather than typical, but certainly it's what he said.

At paragraph 5 there's reference to another patient whose medication was stopped by Dr Berg without discussion, and it seems that patient suffered a relapse?-- Yes.

Now, that patient had a long history of schizophrenia, intellectual impairment, a murder charge, a family assault, and it seems that he was acquitted of the murder charge on the grounds of mental illness?-- Yes.

I don't recognise the medication, all I can tell is that Dr Berg seems to have stopped it. Does that seem a radical thing for him to-----?-- That would have been a very radical thing to have done, and again the issue was that he didn't inform that he had made that decision, so it went along, and it wasn't until there was a review of the patient because of a concern about the patient's condition, that the supervising doctor realised what had actually happened and then restored the medication and the patient was appropriately treated. But given the history of that patient, one would think that a proper discussion around such decision should be made. Well, that was obvious to me.

Now, you gave that letter to Dr Berg for response. What did he do?-- He asked for more time. I don't think that I ever received a written response. He came and spoke to me about the matters and I said that we'd actually reached the point where I required a written response. It turned out that I went on some leave at that time, and during that time he went off sick. He went off sick for a few days, and then he later took an extended sick period during which time he took a WorkCover claim for stress and harassment, citing myself as the cause of that.

You informed him at about the time you gave him this letter that you wouldn't be renewing his contract from January 2001?-- I did, yes.

He returned for - he stayed away from work, I gather-----?-- Stayed away from work for some time, and he returned for three

or four days at the beginning of January 2001. I gave him some restricted duties. I asked him to write some summaries of patients that he'd seen, and didn't let him see any more patients.

He left employment, no doubt, at the end of December 2001-----?-- I think the first week of January.

End of December-----?-- First week of January, I think. Maybe the 7th, or something like that.

And it wasn't until later - probably 10 months later, November 2001 - that you discovered that perhaps you'd not had a psychiatrist at all?-- That's correct. I had a conversation with a colleague in Melbourne at a College of Psychiatrists' committee meeting. It was a casual conversation in which he said, "Whatever became of that doctor who wasn't a doctor?" It turned out that we quickly identified it was Dr Berg he was speaking about, and that the College of Psychiatrists, as part of the exemptions process I mentioned before, had written to the Russian university, who I was told had then written back to the College saying that he wasn't - he didn't have that qualification, and further, that it was told to me that they at the College of Psychiatrists had written to the Medical Board much earlier - in January or February of that year - informing the Medical Board of that, but I hadn't known about that until that conversation.

If you had known in January or February of 2001, was there anything of clinical advantage to the patients that you'd have done?-- I think - there was. When he was - it's a complicated answer. When he was a problematic doctor and under supervision, I tried very hard, as you can see from these letters, to find out all the things I could find out about his practice. There were obviously some things that seemed quite reasonable. I don't want to say that everything was bad. Some patients were very happy with him, but I felt two things about that. One was that if there were problems that had gone on with patients which related to him not having a medical qualification, that (1) the patients needed to know that, and (2) that there may have been other decisions that he'd been hiding from me - because there was now not just plain intransigence and difficulty in dealing with him, but he was actually lying to me about various things - that he may have lied to me about other things about the patients, and I felt it would be important to contact those patients and find out exactly what had happened and make sure that they were okay. So from my point of view, had I known that back at that time, I would have started that audit process that I undertook much earlier. So I lost 10 months in doing that, and as a result, some of the patients that I wanted to follow up I was unable to find by the time I did get to contact them.

Now, you identified 259 patients?-- Yes.

Do I understand from the audit report, which is part of JAA2, that it's possible that there were more than 259 patients?-- It's possible. I did everything that I could to be very

thorough about finding the patients. I looked through the patient lists of all the appointments that he'd had in that year, and even when other doctors were sick, to see if he'd seen any of their patients when they were away. I looked through the inpatient lists of the Charters Towers and Kirwan units. I looked through the on-call records and looked at every night that he was on call. I looked at his pay sheet. There was a requirement to write down the UR numbers of all patients that doctors saw on call, and they wouldn't get paid unless they did that. I think he was quite diligent about writing that down. So - and I checked the casualty attendance records to see if there were patients there. I looked as thoroughly as I could, but I could not guarantee that there were not patients that for some reason weren't identified by that. So I didn't think there would be many, but I was unable to say for sure that that was every patient.

You recommended, did you, that the media be contacted so that you could assure yourself that if there were more than 259 patients, you were more likely to find those you'd missed?-- Yes, I thought that would be one way of finding those people we'd missed.

Within either your audit or your brief to the Minister, I see that you suggested that the patients should be told, but it isn't obvious to me as a reader whether the reason for that was because it seemed the right thing to do or because it might have some clinical advantage for the patient?-- I looked at that - this is a little complicated to read that, I admit. When I started out the audit, which was in the beginning of December, I wanted to see whether there had been anybody who had been clinically disadvantaged by decisions that had been made, and whether or not there was some decision that had been made which was so obviously wrong or dangerous to a person that I needed to contact those persons immediately and do something about their treatment, and then there were people who I thought their contact with him may have been difficult but it hadn't had a particular effect on their treatment, and there were some people whom I thought that there was really little consequence on their clinical treatment by contact with him. Of the 259 people, I identified that there were 10 people who I really wanted to find - actually turned out to be 15 when I looked at it further, but there were a group of people I really wanted to find because I wasn't sure what had become of them. There were about 40 people who there could have been something that - about his practice that, from a clinical point of view they needed to be told, and then there were another 200 something people who I couldn't be convinced from what I had read that his clinical practice had made a particular difference to them. I was particularly looking at whether or not they'd actually had proper reviews from other doctors and whether any deficiencies in treatment had been fixed up. But I wasn't sure, because the notes don't contain the entire story. If he had behaved in the way that he often behaved with me towards those people, he wouldn't write that down. So I couldn't be sure about that. So I think there was a mixture of both of those things. I was mainly concerned that there were clinical

things that people needed to know, and I needed to know as a director to make sure that my patients were all right, and secondly, I also thought that there was an ethical issue, that they had seen a doctor who wasn't a doctor, and that they had a right to know that. There were both sets of circumstances.

COMMISSIONER: I inferred from reading the material, doctor, that there was a third possible reason for wishing to go public, and it was simply this: if, for example, there were letters sent out to psychiatric patients mentioning some doubt about the qualifications of one of the psychiatric staff at Townsville, that could have the potential to undermine patient confidence in all of the rest of the psychiatric staff. So there was also a need to protect the reputation of the rest of the staff?-- Yes, I think that's true. I think it was important to make sure that it was he who was identified as the problem, not everybody. That's certainly true.

Mr Andrews?

MR ANDREWS: Doctor, within the audit you observed that 10 of the 259 patients resulted in Dr Berg signing Mental Health Act documents which we have been advised remain valid as he was a registered medical practitioner at the time?-- Yes.

What's the significance of that?-- Well, the Mental Health Act has particular status in the sense that it's a legal document. It's about compulsory treatment of patients or about detaining patients in a particular place against their will, a range of things like that. Obviously for that to happen there have to be valid clinical decisions, there have to be appropriate reviews about that. The person who signs those papers would be considered to be what's called an authorised doctor, meaning that they would, by virtue of their training and qualification, be able to make legal orders that pertain to compulsory treatment or compulsory detention of people. So I was particularly concerned that if patients had had treatment under those orders, then if he wasn't a qualified doctor, then that would be an invalid order and we may be operating under - we may be restricting peoples rights under things that were invalid. So I was concerned to have a look at those and see what he'd actually done.

COMMISSIONER: And no doubt you were concerned to review those which he had signed to make sure that they had been appropriately-----?-- Yes, and I think of all those I identified one where he had actually discharged an order that - it was hard to say whether that was appropriate or not. Nine of them were things that had happened - were orders that he had signed and other people had reviewed.

Yes?-- And they were inconsequential in that sense, and there was one where he had discharged a patient from an order, which may have been a perfectly appropriate thing to do, but he was the person that made that decision.

Yes.

MR ANDREWS: You identified approximately 50 high priority patients?-- Yes.

How quickly were you able to reach those patients and monitor them?-- Once I had actually identified that group, I then put in place a strategy of ringing those people up. I rang many of them. That took me - all up that took around two weeks. I started with the high priorities, trying to get in contact with them. Those people that I could not ring, sometimes I sent people around to their house to find them. There were some - for example, there was an indigenous woman who was of no fixed abode, but I knew someone who would know where she was, so I sent someone to find her. After about two weeks I had contacted as many of those people, I'd spoken with those people and invited them to come and talk to me or talked to them on the phone as I could. I then sent letters to the remainder and again used some contacts to find various people because I knew they'd be around somewhere, and I got a response from a lot - not all of those people, so there were some that I'd never found.

And you believed that you had no authority to disclose to these patients that Dr Berg may not have had any medical qualifications?-- I had wanted to do that, but I was under instructions not to do that, so I approached it from saying that there had been an audit of Dr Berg's practice and there were concerns about the person's treatment from Dr Berg's practice and it was my task as the director to find out how they were and to talk to them about that, about those issues.

COMMISSIONER: Doctor, I guess that as an employee of Queensland Health you're bound by the lawful directions of your superiors, but as a member of the medical profession and as a specialist psychiatrist you're also bound by your own ethical considerations. How - please understand there is no criticism implicit in this question, but how do you reconcile to yourself your duty to obey orders with what you considered to be an ethical obligation to advise patients?-- I thought it was very difficult. I was actually very unhappy about what I'd been asked to do. My self-solace was that I was doing everything that I could within what was happening to make sure that the patients were okay. I felt that I told the patients as much as I could possibly tell them about their own treatment without saying that particular fact, and I felt I made it fairly clear to them that I was very unhappy about the treatment they had received, and that I would be doing anything that I could to help them address issues in their treatment that I could. A couple of people actually said to me, "Well, why are you doing this? Why don't you do this about all the doctors? Why don't you ring up about every doctor that we don't like", and a couple actually said to me, "Well, maybe he wasn't qualified", and I said, "Well, you'd have to ask the Medical Board about that." It was just - it was a kind of very difficult position. It also came that - when I was ringing people and talking to them about it, it became clear to me that if I wasn't going to tell them that he wasn't registered, it was actually a bit difficult to know what I was to say about it, to have a reason why. So I did

feel compromised in that way. My solace was that I felt I had to check on the patients.

Yes?-- That's the limits I had to do it in.

MR ANDREWS: Do you recall who instructed you that you weren't to advise the patients that it was - that Dr Berg wasn't registered?-- Well, I had a lot of conversations with people around that time, and one recollection of that was that in discussion with Andrew Johnson, the Director of Medical Services, and Ken Whelan, the District Manager, we discussed the fact that we'd been instructed not to do that. I'm also now reminded of a teleconference that I was present at where Ken Whelan, Andrew Johnson and myself and Karen Voland, who was the media officer, talked with various people in Brisbane, and it was made quite clear to us that we weren't to go to the press about this, or to tell - because the argument was that he was a registered doctor, that the issue about the qualifications was unresolved, and we couldn't say anything.

Do you happen to recall who it was who gave you those instructions from Brisbane?-- Well, I think it was Dr Buckland, and there were other people at the other end of the conference who I can't recall, or they didn't mean anything to me as to who they were.

Thank you. Aside from the 50 you contacted within the first fortnight, the balance 209 odd patients, how soon after did you follow them up?-- I didn't personally follow them up in the sense that I contacted - did not contact those people, because I was really under the instruction that I had nothing to say to them, so that I did not follow through my original intention to write to them and inform them about Dr Berg's lack of qualifications. What I did do was satisfy myself that they had all been properly reviewed by a psychiatrist in that meantime, that their treatment was appropriate, or they had been discharged to their general practitioner and their treatment was appropriate. There were some of those 209 that he hadn't actually seen at all, but he had seen a lot of them, and there were some patients who also died as well. I also ascertained that I did not think that he was involved in their death.

You were disappointed about the decision that prevented you from alerting the media so that the matter would receive sufficient publicity to alert any other potential patients?-- Yes, I was.

And do you recall at the time that Dr Buckland - in the teleconference - discussed the reasons why you shouldn't alert the media, was it already plain at that stage that the College had determined that Mr Berg was not Dr Berg?-- I felt that that was the case. I had felt that - the person who told me from the College, Dr Peter Burnett, is a person I have known for a very long time and is a very thorough person. I felt that if that's what the College had determined, and there was those letters that suggested that, I was of the belief that that was the position. That's what I firmly believed.

And am I right in thinking that it wasn't for you to argue with Dr Buckland?-- I just - I thought it was pretty clear that that was the position and there wasn't anything that I could do to change that.

COMMISSIONER: From your viewpoint as a practising clinician, was there any good clinical reason for not going public with this information? I mean, it occurred to me possibly that there may be a concern that at risk psychiatric patients would be disadvantaged by public discussion of that nature?-- Psychiatry gets in the newspapers quite a lot.

Yes?-- And patients are vocal in coming forward. There is certainly an argument that you could cause public alarm and loss of confidence in the system. The counter argument is that if you can demonstrate that you know what the issue is in the system and do something about it, it might increase public confidence. So I'm not entirely sure that the not causing alarm argument is particularly persuasive.

I just raise it because I wonder whether there is any possible justification for saying, "We should keep this out of the press."?-- I thought that at the time - I mean, I was involved in helping to write the proposed media statements, and we prepared a media statement, we prepared an information sheet that we would give to people about the facts, so that when people contacted us they could have a clear statement of facts rather than what might be distorted in reports. I thought that was the best thing to do overall about what to do. I thought like - it was always seen as a short-term plan, because if we get up and say, "This has happened", there will always be somebody who will be alarmed about that. But on the other hand, I just felt it had to happen.

MR ANDREWS: In 2001 you received a call from a colleague on the West Australian Medical Board about Dr Berg?-- I received a call from the Registrar of the Medical Board who had been asked to ring - who had suggested that I be rung by a colleague of mine in the medical ward, Dr Geoff Reilly. The reason - she said to me that Dr Berg had gone to Western Australia, obtained a job - I think in Fremantle, but I could be wrong there - and had worked for them for a couple of weeks. There were concerns from Fremantle Hospital about his performance, and the temporary registration that he had was coming up - had come up to the Medical Board meeting for ratification and there'd been an issue with the Certificate of Good Standing that he had because it had noted that documents had not been verified. They were alarmed that they had registered a person - or to give a temporary registration to a person on that basis, because they felt that maybe they hadn't seen that appropriately or had missed that qualification, and it was discussed. Geoff Reilly is a professor of psychiatry in Western Australia who I know from the College, and from work we've done together, and he thought the best thing to do would be to ring me up and ask me about Dr Berg. I duly told the registrar all - many of the things that I've told you today about Dr Berg's performance, and the registrar of the

Medical Board was very unhappy about what she heard about him.

You say that the registrar told you the Medical Board had issued a Certificate of Good Standing for Mr Berg with the qualification that the Medical Board of Queensland had not checked his documents?-- Yes, that's the conversation. I didn't see any of the documents.

D COMMISSIONER EDWARDS: Do you recall what period in 2001 that was happening?-- To be honest with you I cannot recall that.

Early in the year, late in the year?-- I searched my memory but I do not know. I guess - I assume the minutes of the Australian Medical Board would have a record of that, but what I remember, the telephone call came - I spoke to them-----

COMMISSIONER: Dr Allan, I might be able to assist. I have with me the Queensland Medical Board file which is now Exhibit 238 and that includes a fax from the Western Australian Board dated 13th of March 2002 which relevantly says: "I advise the Medical Board of Western Australia received an application for registration from Dr Vincent V Berg on 29 January 2002 for conditional registration (Unmet Area of Need). Dr Berg was provisionally registered pursuant to" - the first relevant provision of the legislation. "The Board subsequently became aware (via enquiries undertaken by the RANZCP regarding an application for specialist assessment) that the university from which Dr Berg obtained his medical qualifications advised that they did not issue the qualifications stated by Dr Berg in relation to his application for registration. Dr Berg's provisional registration was cancelled by the Board on 28 February 2002." I would infer from that that your communications with Western Australia occurred in that period between January and February of 2002?-- That must have been the time. There's only one time.

Yes.

D COMMISSIONER EDWARDS: Thank you.

MR ANDREWS: Let me see if I can shake your confidence in that conclusion?-- Yes.

At the time that you spoke with the Registrar from Western Australia as I read your statement-----?-- Yes.

-----it suggests to me that you had not then been involved by your colleague at the conference in Melbourne-----?-- Yes.

-----but that Dr Berg was suspect and that his-----?-- It does. I honestly can't recall. I have to say that I don't remember all the bits of the conversation because it was really on the fly. It was a telephone call that just happened so I - I'd have to admit to being hazy - to not having a full recollection.

You didn't refer Dr Berg's conduct to the Queensland Police Service nor to the CMC because?-- Well, I did refer - I did actually talk to Ken Whelan about Dr Berg's conduct to the press and I was present at a - I went and talked to him about two things. One was that I was concerned that when we went to the press - when things became public that Dr Berg and I had such a bad relationship that I was concerned for my own safety. I had a discussion with Mr Whelan about that and we

decided the appropriate thing to do was to ring - was to inform the police so he - he made inquiries with the police on my behalf. One, to find out where Dr Berg was and, two, to talk about what would happen when all this became public and also - there was also the issue of the misdemeanour or whatever, but I didn't personally contact the policeman, but Mr Whelan did on my behalf. The CMC I did not contact.

I have no further questions for Dr Allan.

COMMISSIONER: Thank you, Mr Andrews. Before we proceed I've just been handed a letter from the Premier of Queensland, Mr Beattie, with a series of attachments. Mr Beattie makes it clear that he is extremely anxious that this Commission of Inquiry should have full information about the instant involving Dr Berg and has provided copies of the briefing notes and other material provided to the Minister at the time, Wendy Edmond, and other relevant Government documents and he has invited and encouraged us to make those an exhibit in this proceeding. I am inclined to accede to that suggestion from the Premier unless anyone has any view to the contrary. If not, the letter of the 3rd of August 2005 from the Premier together with attachments will be Exhibit 246.

ADMITTED AND MARKED "EXHIBIT 246"

COMMISSIONER: And what I was going to then suggest, Mr Andrews, is that we take the afternoon break a little early so you might have the opportunity to look through that and see whether there's anything further you wish to raise with Dr Allan whilst he's here. Before we do rise though there are a couple of questions I wanted to raise. Doctor, for many years it's been a staple of Hollywood filmmakers to create an image of the persons who pass themselves off as a medical practitioner without being properly qualified, but I would suspect in real life it is not easy to do so. Was it your suspicion that Berg had at least some training in either psychology or psychiatry that allowed him to talk the talk-----?-- Yes.

-----to be a psychiatrist?-- Yes. I mean, he had - he had a document that he purported to be his PhD thesis for his doctorate in medicine. It was a translation from the Russian and then he had reworked it as a thesis for Australia about suicide. It was overly long and complicated and overreferenced and dense and obscure, but I had the impression that he probably had a degree in psychology.

Yes?-- And that he probably worked around psychiatric hospitals or psychiatric services for some time and had in the - and had picked up quite a lot - sorry, he had that kind of psychological knowledge and that in the time he had in Australia before he actually came to us he had probably done a lot of medical study and certainly learnt a lot about

medications and their use.

That perhaps leads me to another question. I've read his resumé which came into evidence yesterday which tells a rather colourful story about, I think, his - not only his history claiming to be a psychiatrist, but also his history as a deacon and then a priest and then a Bishop in the orthodox church, his persecution by the KGB and how following his persecution he couldn't get proper employment in his field of study and since then I've also seen from the Medical Board file that even after he had become an Australian citizen he continued to, at least, claim that the KGB were still after him and that if inquiries were made with authorities in what is now the Russian Federation that might tip off the KGB to his present whereabouts and lead to them coming to Australia to pursue him and so on. From as much of that story, as you knew at the time, did you find it farfetched or was it convincing?-- I thought that story was a bit far fetched and I actually took the opportunity on a number of occasions to talk to him about that. What was interesting about it was that he actually down-played many of the - many of those features. He - when I asked him about religion, what his current interest in religion was, I said, "How come you were a Bishop and now you're not? What does that mean?", he had a very plausible answer about losing faith and all the things that did happen. He didn't pursue that line. The KGB story, he maintained that story for some considerable time and he said - and one would have to think retrospectively what an interesting story, but he said, really, the KGB is not gone. There are still serious elements in Russia who are against me and they're now the Mafia, but he wasn't particularly paranoid or - I suppose to a lot of people about KGB stories, about being chased - and it wasn't the psychiatric flavour with this, if that is one of your questions, no.

Well, I suppose one of the thoughts that did cross my mind was whether his knowledge of the psychiatric system was necessarily the result of being a clinician or in some other capacity?-- Well, that's possible - that's certainly possible. I just think it was probably a general knowledge of - prestige of general knowledge about a whole range of things. I mean, he was a very - at times he was a very personable and engaging sort of person despite - it was only when he got into it, that was the problem.

I would think, doctor, and I'll confess I'm really only speaking from general knowledge and things that I read in the general media, but my impression is that psychiatry and particularly pharmacology in the use of medications has leap frogged in the last decade or so, particularly within your range of serotonins, of suppressants and those sorts of drugs. Did he come across as having up-to-date knowledge of psychiatric treatment?-- That's a very interesting point. He had a very good knowledge of old fashioned psychiatric treatments and because, by his claim, he had been out of practice since '91 or '92 - I just can't recall those dates - there had been a revolution of psychiatric treatment in pharmacological treatments and none of the drugs that - none

of the medications that we would be using in 2000 when he was there would have been the same as they would have been in the late 80s when he - if he had been practising he would have practised with, so what he had was a knowledge that he gained from reading about those medications and - but he hadn't - I had the opinion that he never applied or used those medications. It is somewhat similar to psychiatrists who come to us from Africa or the third world. They know about the old fashioned drugs and they read the journals about the new stuff, but they never had an opportunity to use them. They are usually those kind of doctors that work it out over a couple of months, they understand the principles and they work out what to do and that's the position where he started at, but over those first couple of months he didn't work it out. He wasn't able to assimilate that knowledge on to the backbone of what should have been a medical and psychiatric training which is - earlier I talked about how that - how then my opinions about him changed because things did not work out in the way that I would expect a doctor to be able to understand those things. As I said, at that time I thought it was a cultural issue, the Russian practice, or what I increasingly thought was his arrogance about accepting other people's advice.

Doctor, you recall that I raised with Mr Devlin, the barrister representing the Medical Board, an issue that appears from the Medical Board's file by way of a candid attack on Berg by one of your colleagues. I was hoping you could put that matter to rest. If I ask you, are you familiar with allegations Berg made regarding the use of a drug called clozapine and the connection between that and some of the fatalities?-- Yes, I am. There was an issue after Dr Berg left - I'm sorry, I need to check the dates properly because he wasn't practising with us - where three patients who were treated with clozapine - it has been well covered in the media - last died within a few days of each other during a period of very hot weather and the conclusions about those deaths were that the - the drug had two effects: one was that it affected the body temperature regulation; and, secondly, there was a possibility of cardiac arrhythmias related to this medication and it was probably a combination of extreme - of heatwave conditions, people locked up in their houses over Christmas and then - and then it lead to the deaths of two or three people. Dr Berg wrote a letter at the time to the Townsville Bulletin saying the doctors treating these people were incompetent and had misprescribed and so on. That is not the case. I mean, it was a very unfortunate set of events which were again thoroughly investigated and, really, it was probably due to the - to patient problems, the hot weather and these complications, but there was no inappropriate prescribing or treatment practices.

All of the occasions where the medication was prescribed were consistent with the manufacturer's recommendations?-- Everything was very consistent. The monitoring of the patients was actually very good and I - as you can imagine I've actually looked at that very thoroughly. I've actually prepared a paper for the College of Psychiatrists, a journal, about that. We have gone to many reviews, everything to find

out about that because it was such an unusual occurrence.

Are you able then to confirm to this Commission of Inquiry that there is no substance or basis for the concern in relation to Berg's allegations against any of your colleagues over the years of that medication?-- Yes, I will. I would confirm that.

D COMMISSIONER EDWARDS: Were these cases referred to the coroner?-- Yes, they were all then looked at and they were subject to the coroner's investigation.

COMMISSIONER: Is it your recollection that the timing of those complaints by Berg may have corresponded with, and may have been retaliation for, the examination of his clinical practice?-- Well, I recall that those things occurred that Christmas time of - I - I have to - I hadn't thought about this issue. I cannot recall at which Christmas it was. I can't recall which one of those it was, I'm sorry. I just need to go back.

Again, if it assists, I have a copy here of the complaint, not to the newspaper, but a complaint to the College of Psychiatrists to Dr Stable and to other bodies and organisations and that's actually dated January 2002?-- Okay. Well then, that would have happened at the Christmas time of 2001 which would have been a year after he'd left our employ.

Yes?-- At that time I would have been investigating what I found out doing the audit, but I - and that would have been the time or - that we're discussing now, around this decision to go public or not, but I don't have any records of this matter.

The final matter I wanted to put to you is this: we heard evidence yesterday from Dr Johnson about his knowledge of an involvement in the issues concerning Berg and it came as a surprise to Dr Johnson to learn that the matter had been referred initially to - from the audit branch within Queensland Health to the Crime and Misconduct Commission and came back to the Queensland Health. Were you ever informed of those investigations either by the audit office within Queensland Health or by the Crime and Misconduct Commission?-- No, no. First time I ever heard of those was yesterday as well.

Would it be right to assume that you could have and would have been willing to provide information and assistance to those bodies?-- Yes, I would have been. I would have been very happy to.

Is there anything arising out of that, Mr Andrews, that you would like-----

MR ANDREWS: No, thank you, Commissioner.

COMMISSIONER: We might break now for 15 minutes and give everyone an opportunity to look at what is now Exhibit 246. I

might ask the secretary to - can we get photocopies done? Yes, we can.

THE COMMISSION ADJOURNED AT 3.18 P.M.

THE COMMISSION RESUMED AT 3.40 P.M.

JOHN ALEXANDER ALLAN, CONTINUING:

COMMISSIONER: Please be seated. Mr Andrews, having had only a brief opportunity myself to read that material, it strikes me that the most significant thing, so far as this inquiry is concerned, is the revelation that there was an incident similar to that involving Dr Berg in Townsville. I was wondering - obviously not today or while we're in Townsville-----

MR ANDREWS: In Toowoomba, I think you mean.

COMMISSIONER: In Toowoomba, yes. I was wondering whether I could invite both Mr Devlin and Mr Fitzpatrick in due course to see if either the Medical Board or Queensland Health can provide us with any additional information relating to the Berg-like case in Toowoomba.

MR DEVLIN: I will make inquiries with the Board as to whether there was an incident of a named doctor in Toowoomba. My instructing solicitor has no knowledge of it, but that's not to say the Board didn't have some contact with some allegation about that.

COMMISSIONER: Certainly when we're back in Brisbane on Friday would be quite early enough, Mr Devlin. Likewise Mr Fitzpatrick.

MR FITZPATRICK: Thank you, Commissioner.

COMMISSIONER: Mr Andrews, is there anything else you wish to canvass with Dr Allan?

MR ANDREWS: No, Commissioner. Well, subject to this one matter: at the end of the very last document in the bundle there is some handwriting and that last document is in fact a briefing to the Minister. The handwriting is identified by the Premier's letter as being the handwriting of Dr Buckland, and on the last page of the briefing, the last typed paragraph of a briefing, which I understand may have been prepared by Dr Allan - the last typed paragraph reads:

> "Many clinical staff maintain that there exists an ethical obligation on Queensland Health to inform patients that they have been receiving care from a person whose qualifications to provide that care have been found to be invalid. This raises serious concerns about the potential for adverse public comment. Direction is sought from GMHS as to whether any of the patients subject to this audit are to be informed of the validity of Vincent Berg's claimed qualifications."

After that paragraph there is a heading "Draft Media Release", and then the letters underneath it "N/A", for "not applicable", and then there appears the handwritten passage which reads:

> "I have had this discussion on at least four separate occasions with medical and management staff including Doctors Allan and Johnson. My instructions have been clear and have not altered. The process is appropriate, ethical and clinically sound. Given that the client base have a mental illness, any at-risk patients have been identified and managed."

And then there appears a signature attributed to Dr Buckland and a date 31 January - it looks like '00, but I suspect that the briefing note to the Minister is January '03, so that probably is more likely to be the date.

COMMISSIONER: Thank you. Dr Allan, were you the author of the typewritten part of that document that Mr Andrews-----?-- I don't think I was of that last part that was read out. You will have to show me the e-mails but I don't believe I wrote that bit.

COMMISSIONER: In any event, what do you say to the handwritten suggestion that Dr Buckland raised - canvassed with you the ethical issues?-- Well, certainly there was a lot of discussion around that, and I really stand by what I said earlier, that I was referring to my desire to inform the public about that and his wish that we not do that.

To your knowledge does Dr Buckland have any background or qualifications in psychiatry?-- I am not aware of that.

As a psychiatrist yourself, what are your views regarding the validity of Dr Buckland's assertion there are clinical issues for the benefit of patients?-- If I understand the question that you are asking me, whether telling a person with a psychiatric illness something like this would have an adverse effect on their health?

Yes?-- As a group, no, but there may be individuals where that could be an issue. That's similar to the Freedom of Information application, and so on, where finding out something might have an adverse effect on someone's health, but those cases are rare rather than usual. So in general, psychiatric illness or not, people should be told things that affect them.

Yes?-- I am not sure if that answers your question.

It does, thank you. Mr Andrews?

MR ANDREWS: I have nothing further for Dr Allan.

COMMISSIONER: Mr Devlin?

MR DEVLIN: Yes, thank you.

CROSS-EXAMINATION:

MR DEVLIN: Ralph Devlin. I represent the Medical Board of Queensland, Dr Allan. A couple of things: in the break you had an opportunity to see a letter from your college back to the executive officer of the AMC, dated the 16th of October 2001 which made reference to the allegation of forgeries coming from Russia?-- Yes.

You had already given evidence that the first you knew of the doctor, who wasn't a doctor, as it was put to you by Mr Burnett-----?-- Dr Burnett.

Dr Peter Burnett was in a meeting of a committee of the college in November 2001?-- Yes, I thought it was the 8th of November, I think is in my statement.

So having seen those documents - and you saw one from - I showed you one apparently coming from a university in Russia, dated September 2001, alleging forgery?-- It was a Russian letter with that date on it, yes.

Right. So are you prepared to accept as a general proposition that it would appear on that material that the college had come into possession of that allegation in about September/October?-- Yes, that would appear to be so.

Which would correct your general recollection it was earlier in the year?-- Yes, it would. I had said I think February, and that was my recollection of the conversation, but that's obviously the more correct interpretation.

Thanks for your fairness on that. Look, there is another document I omitted to show you, but it is probably one that won't take much recognising. On the Medical Board's file is a document signed by you as Director of the Townsville District Integrated Mental Health Services, dated 20 September '99. So that's before the employment of Berg-----?-- Yes.

-----to use a neutral term. And it is headed "Referees report from Dr Petchkovski for Dr Vincent Berg". Do you remember doing that or would you like to see it?-- I would like to see that because I can't recall that.

It is not a perfect - it is not a perfect replication of it. It is a little bit faulty in the copy, but really my question was going to be whether you remembered whether you actually made contact with Dr Petchkovski who gave a reference for Berg on the Gold Coast. I will show you the document?-- I would have to look at it. As I said, I can't recall that I rang him. I recall speaking to the other two. I thought that when I tried to ring him he wasn't there.

Yes, okay?-- I haven't seen this document before.

Look at that. I am sorry I didn't show it to you in the break. And I am sorry about the quality of the copy. It is on the Board's file towards the end, Commissioner?-- Obviously I wrote that, and until you showed that to me I could not recall having done so. It wasn't in my records about Dr Berg.

Yeah?-- But obviously I did do that.

But you have got a general recollection of speaking to two others. Were they from the Gold Coast?-- I remember speaking to Diana Hamilton, who was a supervisor of his. I remember that was a telephone conversation, and I thought around that time. And I remember speaking to Professor Phillip Morris, who was the director of that unit, and I remember that being in person either at a meeting of the training committee or some other meeting in Brisbane that he and I both attended.

So in the lead-up to the appointment of Berg by Townsville, would it be fair to say that you had direct contact with two people speaking on behalf of Berg from the Gold Coast and possibly with Dr Petchkovski?-- Yes, that's true.

The document you are looking at doesn't clearly indicate that you actually spoke to Petchkovski, does it?-- It doesn't say that, but if I look at my style, it said "he's described as a very typical European psychiatrist", so - it says, "We discussed the previous referee's concerns."

So would it be fair to glean from that that there were three professionals on the Gold Coast prepared to give at least a positive reference-----?-- Yes.

-----for Berg at that point?-- Yes, I always thought that Dr Petchkovski had given a very positive view of Vincent Berg and-----

What about the other two practitioners?-- Obviously when I spoke to Diana Hamilton, she had raised some concerns about dealing with practical everyday issues with psychiatry, pace of work and things that were required, but that's an issue for everybody who is returning to practice in their 40s. So I felt that that was something to address, which is why we had this period of supervision and checking out.

Yes. And then, of course - I don't know whether you were here yesterday for Dr Johnson's evidence but - were you here yesterday for that?-- No, no, I was in Charters Towers.

Right, thanks. There is evidence of references which Berg obtained subsequently during 2000-----?-- Yes.

-----in other words during the period of his employment, which were quite complimentary of him?-- Yes.

From Doctors Vorster and Brian Boettcher?-- Yes.

What's your view - firstly, were you made aware of those?-- I was aware that they were two psychiatrists - I was aware that Dr Boettcher and Dr Vorster, who were two psychiatrists in our services, were supporting Dr Berg and felt that my assessments of him was incorrect. I can only say that I thought they were wrong. I subsequently - I had problems with Dr Vorster's work and he also left and Dr Boettcher resigned not long after that.

Okay. So you were not inclined to put much weight on the opinions of those two professionals from the local area?-- No, I wasn't. I mean, I certainly listened to what they had to say on the subject but I had 20 or 30 others telling me something else.

Yes, thank you. And in relation to the supervision issue then, the matter unfolded over about eight months?-- Yes.

There is no implied criticism in this at all, I am just trying to discover the dynamics of it. Unfolded over about eight months to the point where a direct step was taken to ask Dr Berg to show cause, with your letter of the 8th of August 2000?-- Yes.

Correct? Over that time, can you describe the level of one-on-one supervision that you were able to afford Dr Berg?-- Personally we had weekly meetings.

Yes?-- Some of those were cancelled due to busyness on either part but later rescheduled. Generally we had those weekly meetings. I also asked other doctors to supervise him. I particularly asked Dr Boyes, who I mentioned, who was supervising his practice at Kirwan, and I asked another doctor, Dr Satish - his full name is Dr Satish Karunakaran but he goes by Dr Satish. He is another psychiatrist who had come from overseas and who had gone through the AMC, and who had requalified through the AMC and through the college, and I actually felt he would be a very helpful supervisor to Dr Berg because he had been through that process and could help him in that. So he also had supervision from those people. When I was away, Dr Vorster supervised him. I asked him to directly supervise him, and towards the end of that time, when Dr Berg and I became estranged from each other, Dr Vorster did the primary supervision because it just was not working out between Dr Berg and myself.

Right. So would you say that the supervision you were able to afford Berg, from the start of that year to whenever the other practitioner took over, was typical of the kind of supervision you would afford anybody in Berg's position?-- I tried very hard to do that, yes.

Yes?-- Some of that was actually quite long. We would drive to Charters Towers and discuss cases in the car for a couple of hours in the car, for example, so there was more than just that.

Yes. So the discussion of cases, did that involve a discussion of patients whom you knew something about so that you could evaluate the professional judgments that Berg was making?-- Both. There were new cases and there were cases that I knew about.

Yes, I see. And to come back to that question then, was that a typical period of supervision like any other person in his position would have received?-- It was intended to be so but it was a difficult period of supervision because I felt that he avoided the issues in the supervision.

But necessarily in that period then, it follows from the fact that you wanted to do a review of all these patients that supervision is not to be understood as some kind of standing there whilst the treatment's directed to a patient?-- The usual method of supervision in psychiatry is patients are not always that happy to have the supervisor sitting in the room all the time and it is not possible to do that.

No?-- But there is a requirement to observe the person in action at times, but mainly supervision is about discussion of what's occurred.

Yes, thank you. Once you got unsatisfactory responses to your 8th of August requirements - and I missed your evidence there, but I assume what you got back, if anything, was unsatisfactory to you?-- I didn't get back what I wanted, no.

Sorry?-- No, it was unsatisfactory.

Just again, no implied criticism here, but trying to understand the position that you found yourself in, apart from not renewing his contract, which we know occurred-----?-- Yes.

-----in the start of the next year, were there any other options open to you?-- The option open to me was then to make - to give him a formal warning, and I discussed the possibility of doing that with Andrew Johnson, and we were going to proceed to that but Dr Berg went away sick.

Right?-- So that that opportunity was lost. And then when it became clear he was not going to come back for some time, we really just followed through the notion of terminating the contract.

Very well. Just for your information, Dr Johnson and I had a discussion yesterday about he seeing his role sometimes as or often as reporting concerns then about clinical competence informally or even in writing to the Medical Board. Did you in your position contemplate that as a course you might take, or would that be something more appropriate to Dr Johnson's position?-- Usually we would discuss those matters and one or other of us would write such a report, but I would usually write it through him. He would be aware of something like that.

Do you have any recollection of having such discussions about Berg, that is a report to the Medical Board, or was that somewhat - was that possible course somewhat interfered with by the developments with Berg after August - about sick leave and so on - and then the decision to terminate or not-----?-- I think that we - I have to be honest, I cannot give you a full recollection of that.

I don't want you to speculate so-----?-- And I don't - I don't recall what we discussed about the Medical Board. I know we discussed the Russian doctor registration thing on a number of occasions, but I don't know that we - I don't recall what we discussed about reporting to the Board, and it would be fair to say that that whole disciplinary and reporting process was interfered with by Dr Berg going sick.

Yes. To sum up then, would if be fair to say that in Berg's case you confronted a somewhat unusual set of circumstances?-- Correct.

You had a fellow that showed some medical knowledge, is that right?-- Yes.

Some psychology based knowledge-----?-- Yes.

-----at times.

COMMISSIONER: Or psychiatry?-- Something or other.

Yes.

MR DEVLIN: Quite personable at times?-- Yes.

Claiming to have been persecuted by nefarious unknown people in his country of origin?-- Yes.

Even claiming to have been a clergyman at some point?-- Yep.

Is that right? And another one that - were you aware of this - that on coming to Australia he changed his name?-- Yes, I was aware of that. That was part of the persecution story.

Yes. So he volunteered that to you?-- Well, his documents were in a different name. He had various documents from the Department of Immigration showing this claim and he said that that was their advice.

Yes. He, it appears, did get refugee status with Australian authorities?-- Yes, that's true.

Did he speak to you about claims based on international law that as a refugee he was entitled to have his qualifications looked at afresh rather than the authorities going back to the country of origin because of alleged persecution? Did he ever raise that with you?-- That's what he told me about contact with Russia.

So it was an incredible grab bag of issues that this man

presented with?-- Yes.

And unique in your experience, one would hope?-- I would hope not to meet it again.

But unique in your experience?-- Yes.

And, therefore, even as an experienced clinician, very difficult to unravel?-- Yes, it was. It was very difficult to unravel.

Thank you.

COMMISSIONER: Doctor, I did want to go back again to that passage that Mr Andrews read out. Mr Andrews, you made a great fist of trying to work out the handwriting. I wonder if I could get you to read out again the final sentence of the handwritten passage attributed to Dr Buckland? Is it "any at risk patients"?

MR ANDREWS: "Any at risk patients have been identified and managed."

COMMISSIONER: "Identified and managed." Doctor, I was of the understanding from reading the material that came to us yesterday through Dr Johnson's evidence that there were 259 identified patients but no-one could say how many other patients Berg may have seen in outpatients clinics?-- I felt very confident that that was the vast majority of the figures. I was really talking about someone he might have seen in the middle of the night and not recorded that on a time sheet or a person who may have shown up at a clinic without an appointment that was seen as an emergency and somehow didn't make the registers, so I thought that there were odd occurrences rather than many occurrences.

I do recall seeing a note somewhere along the lines that, "If we haven't caught all of them or if we haven't identified all of them, we'd expect that there'd be a maximum of maybe 10 others"?-- That was a guesstimate from me.

Okay. And it is, however, not literally true to say that all at risk patients had been identified and managed?-- No, I made that clear.

I guess that some people would feel that when we contrast the Berg case with the Patel case in Bundaberg, which is the reason we're here after all, people would say it's a much more serious matter with a surgeon because an incompetent surgeon kills patients or can do so. On the other hand, there are suggestions about that incompetent psychiatric management can have fatal consequences as well, whether it is a matter of suicide or a matter of the giving of medication which causes dizziness and causes a person to fall over?-- That certainly - that certainly would be an issue for me. Certainly that's true, yes.

I was also going to ask, following up on something that Mr Devlin was saying about supervision, again speaking from a position of being unfamiliar with modern psychiatric practice apart from what one reads in the general media, I understand that what perhaps was once called talking cure isn't perhaps a central part of psychiatry as it may have been?-- It certainly wouldn't be the only therapeutic endeavour but the ability to talk properly with patients is central to psychiatry.

And that makes we wonder how you can effectively supervise someone in Berg's position when the one-on-one communication between patient and psychiatrist is so central to the treatment process?-- Yes. Well, I think that is - supervision is a matter of observing that interaction. When I observed interactions with - between Vincent Berg and the patients, he was as sweet as pie of course. But one has to rely upon reports from the psychiatrist about that and one relies on the general training that people have had for that to be - to be effective.

Mr Fitzpatrick.

MR FITZPATRICK: Thank you, Commissioner. Commissioner.

COMMISSIONER: Yes.

MR FITZPATRICK: I act on behalf of Dr Allan and I should have sought leave to appear for him.

COMMISSIONER: Don't worry, Mr Fitzpatrick, you have such leave.

MR FITZPATRICK: Thank you, Commissioner.

COMMISSIONER: I should have given you the opportunity then to examine before Mr Devlin.

MR FITZPATRICK: Commissioner, a more substantive issue though and one in which I could clearly see Commissioners interested arises from a matter that you raised I think yesterday with my leader; that is, as to whether we represented Dr Buckland. Commissioner, can I indicate that I've been actively, throughout today, seeking those instructions and although I understand the matter is being looked at in Brisbane and explored, I haven't got any substantive instructions. Certainly, I have no substantive instructions from Dr Buckland as to whether the apparent differences of approach between him and my witness, what the situation there is. So that is as far as I can take it and I would grant that that is - it is of very limited assistance.

COMMISSIONER: Mr Fitzpatrick, I personally sympathise very much with your position and that of the other counsel with whom you appear and I realise that changes at a high political level can happen without people necessarily thinking through the consequences. I have absolute confidence in you and the rest of the team, Mr Boddice and Mr Farr, to resolve those matters as quickly and as appropriately as possible and I simply draw to your attention one potential difficulty that the further we go, the greater likelihood that there will be some form of conflict between the instructions that you may get from one source and the instructions you may get from another and, for example, over the last two days representing Dr Allan and representing Dr Johnson yesterday may create difficulties in also representing, in relation to the same issues, Dr Buckland. So I will trust entirely to the wisdom and the sagacity of you and your two colleagues to sort those things out and hopefully come up with a solution that is workable for everyone.

MR FITZPATRICK: Thank you, Commissioner. And, Commissioner, I have no questions for the doctor.

COMMISSIONER: Thank you for that, Mr Fitzpatrick. Mr Allen.

MR ALLEN: I have no questions, thank you, Commissioner.

COMMISSIONER: No relation I take it.

MR ALLEN: No relation.

COMMISSIONER: Mr Andrews, any re-examination?

MR ANDREWS: No, Commissioner.

COMMISSIONER: Doctor, thank you so much for your time. I have said a couple of times already since we've come to Townsville but I would like to say again how humbling it is for me at least, and I'm sure my two colleagues, that we have received the benefit of such a high calibre of medical specialists who have come along to give us the benefit of their testimony in these proceedings here in Townsville. We are particularly grateful to you for making the time available to do so and for your contribution to these proceedings. You are excused from further attendance?-- Thank you very much.

Thank you.

WITNESS EXCUSED

COMMISSIONER: Mr Andrews?

MR ANDREWS: Commissioner, I call Mr Jon Gallagher.

JON GALLAGHER, SWORN AND EXAMINED:

COMMISSIONER: Mr Gallagher, please make yourself comfortable. Do you have any objection to your evidence being video recorded or photographed?-- No, no.

Thank you.

MR ANDREWS: Mr Gallagher, your name is John Gallagher, spelt J-O-N?-- That's correct.

You're currently employed by Queensland Nickel as a health adviser on-site for that company?-- That is correct.

Mr Gallagher, I'm holding a signed statement dated the 2nd of August 2005 and three copies of it, one for each of the Commissioners. Would you have a look at the signed version and tell me whether you recognise it as your statement.

COMMISSIONER: Mr Andrews, does this differ from the ones that are provided in our briefs?

MR ANDREWS: I hope not, Commissioner.

COMMISSIONER: Good. So do I?-- That's - that's the one, yes.

MR ANDREWS: Did you change that statement in any way from the draft?-- I was sent a draft statement to me, oh, approximately a week or so ago and I made a couple of amendments to it and returned that back to the person who sent it to me and this is - this statement has those amendments in it.

Thank you. I expect, Commissioner, it is identical with the ones you hold.

COMMISSIONER: Thank you. In any event, the statement of Mr Gallagher will be Exhibit 247.

ADMITTED AND MARKED "EXHIBIT 247"

MR ANDREWS: Mr Gallagher, the facts recited in that statement are true to the best of your knowledge?-- To the best of my knowledge, yes.

And the opinions within it are honestly held by you?-- Yes.

You worked for Queensland Health for 10 years until 2005?-- On and off during the period of over about 10 - 10 years, yes.

You've been a Level 2 intensive care nurse and a relief

after-hours nurse manager at the Townsville Hospital?-- Yes, that's correct.

But for the three years from 2002 to 2005 you were the Patient Safety Project Manager and then the Patient Safety Officer at the hospital?-- That's correct.

And is it correct that those positions were created for you by the administration at the hospital?-- Yes, as far as I'm aware, yes.

They didn't fit necessarily with a Queensland Health stereotype?-- No. In fact, I was one of only three people that I knew of in the state that held that sort of position.

And your job as Patient Safety Project Manager was to implement a system that would identify patient safety issues and develop tools and procedures to manage them?-- That's correct, yes.

And one key system you implemented, of which you seem to be justly proud, was the root cause analysis process?-- Yeah - yes, that was a major part of my job.

And it's your evidence that the funding for your position came as a result of some creative accounting by the executive at Townsville?-- Yeah, the executive at Townsville put an application through the clinician development program to have - to develop a patient safety framework in a 12-month period.

COMMISSIONER: I'm a little concerned, Mr Andrews, the expression "creative accounting" can sometimes have a pejorative implication in the Enron sense. You're obviously not implying anything of that nature.

MR ANDREWS: Not at all, Commissioner.

COMMISSIONER: Really, it was a fact that funds that perhaps Queensland Health didn't expect to be used for your job were made available by the hospital management?-- Yes, that would be the intent, yes.

Yes.

MR ANDREWS: After the initial funds ran out, did Dr Johnson and Mr Whelan fund your position out of the hospital's budget?-- Yes, that's correct.

Now, you express the opinion that the Townsville Hospital is at the leading edge of patient safety in Queensland. Is that an opinion you can express by comparing Townsville with other hospitals?-- The systems that we had - we were developing and have in place at the Townsville Hospital were outside of the south-east corner comparable to no other. We had systems in place that were much more advanced than any other hospital outside the south-east Queensland and, indeed, I think they were comparable to the biggest hospitals in south-east

Queensland.

One of your disappointments, I read, with continuing in employment with Queensland Health is that you did not get to have training opportunities. I wonder whether you travelled or were given the opportunity to travel to south-east Queensland to-----?-- I did get to travel to south-east Queensland, to go down to Corporate Office to be involved in some of the patient safety programs and activities that they were developing at the time, yes.

Once a root cause analysis has been performed are the findings and recommendations then presented to a patient safety committee?-- That's correct, yes.

And while you were employed at the hospital, that committee was made up of the 10 or so persons I see listed in paragraph 18?-- If that's taken from my statement, that's correct, yes.

It seems a number of other committees also reported to the Patient Safety Committee, including the Infection Control Committee, the Mortality and Morbidity Committee?-- There were mortality and morbidity committees across all the institutes within the hospital, so there was a number of committees.

And incident review committees?-- Yes.

Was there an Incident Review Committee in each of the hospital institutes?-- All bar one institute, yes, and that was one of my aims as part of the patient safety program, is to develop those sorts of committees.

As patient safety co-ordinator were you also responsible for reviewing adverse events at the hospital?-- Yes, that was a - probably the most important part of my job.

And when you received notice of an adverse event, would you do a preliminary investigation?-- Yes, to substantiate the initial facts that we had received and sort of evaluate what sort of issues were involved.

When you did a root cause analysis, I gather you would inform all the individuals who were involved in the incident?-- That's correct, yep.

But was it different if there'd been an adverse event?-- It was significantly different. There was little in the way of structured processes for any other events that weren't of a serious or critical nature. Sorry.

Does that mean that persons who reported an adverse event might be left wondering?-- Yes, that - that's probably the biggest complaint that you would receive about incident - adverse incidents and incidents reporting, is that there is little in the way of feedback or knowledge of what occurred. It seemed to go in a big black hole.

You had the nursing informatics - I-N-F-O-R-M-A-T-I-C-S - manager put together a database to keep track of all recommendations?-- Yes, at that stage we didn't have any - any sort of database or software suitable to use for that purpose and, in fact, he developed an access database which wasn't supported by the Corporate Office, he did that off his own bat for us. That was about the only thing that I could rely on.

Mr Gallagher, did you create these processes yourself?-- I - how - how the processes or how the system worked within the hospital, yes. Well, I developed them and in consultation with all the relevant executive and key members of the hospital to get them approved, yes. And that was based on the root cause analysis procedure, which was adopted from the United States.

At paragraph 33 you express your understanding that the position of Patient Safety Manager was not considered by Queensland Health to be an essential role. Do you mean that Queensland Health considered it and determined that it wasn't essential or do you mean that Queensland Health had not at that stage created a protocol for establishing around the state a Patient Safety Manager?-- They left it up to individual districts who had the capability or saw it as important enough to employ someone like that and, as I said before, I was one of only three in the state and most places I went and told people of what my role was, they were very interested to know how that funding was able to be obtained and how they could go about setting up something very, very similar and we had lots of requests about that.

Is it your understanding that for about a year Queensland Health has developed a Patient Safety Centre and is developing policies that are intended to be implemented throughout the state?-- Yeah, they have been working on that for - they have been working on that for a - yeah, a while. I can't tell you exactly how long they've been working on it for but the plans for that were - I saw some initial development - some initial plans for those and they were repeatedly, the time frames and the details - the time frames were repeatedly extended out and minor sort of adjustments made to the funding and the positions that were originally described.

Your statement tends to imply that it's been over about the last 12 months that Corporate Office of Queensland Health has been developing - that it's about 12 months ago that it created the Patient Safety Centre. Is that about-----?-- That's about correct, yeah. That was a - I guess, after they saw some of the successful districts such as Townsville in the use of patient safety position.

And you imply that the policies have been developed during that last 12 months?-- Well, developed, drafted. I don't think they're completed yet but they're certainly beginning to trying to implement them.

And it's a matter of pride for you that Townsville Hospital

has been a couple of years ahead of Corporate Office in this respect?-- Oh, yeah, very much so. In fact, I find it amazing that the health service has not sort of - has not considered putting in place this sort of position and all these sort of systems given the safety critical nature of the business that we're in and the consequences of making errors.

While you were employed at the Townsville Hospital you had to deal with Corporate Office in Brisbane from time to time?-- That's correct.

And can you give us the benefit of your experience to tell us how efficient it was for you when dealing with Corporate Office?-- Well, efficient is probably not the word that I would use right from the word go. I found it fairly frustrating both in terms of trying to get something done and trying to work out who was responsible for the tasks that I was trying to develop or implement.

Was this, during your time, associated with patient safety or in your prior roles?-- Mostly during my roles as - with patient safety. I had limited contact with Corporate Office in my previous roles.

Well, I expect that the individuals in Corporate Office would have been as helpful as they could?-- Yeah, in general, yeah. Once you worked out who it was that you were trying to find and what they were - you know, once you worked out where to go and got someone that could actually help you, they were as helpful as they possibly could be, but that was quite a difficult task.

Is that because at Corporate Office people were grouped into different silo like organisations?-- There appeared to be - there appeared to be little effective communication between the different divisions or different areas responsible for different projects and some of them virtually didn't talk at all and whilst I was in the position of patient safety manager, there were a number of restructures within Corporate Office such that when you were trying to get something done it was basically put on hold because it was subject to the restructure, and that was both before the restructure happened and then after the restructure had occurred. Nothing happened in that - during that period and that occurred on a number of occasions during the time that I was in patient safety.

Do you mean that when you tried contacting people in Brisbane to liaise with them about some initiative you had in mind, you would, after you identified the appropriate person to talk with, occasionally be told that you couldn't have an answer yet because there was a restructure?-- That was fairly common.

Well, you're suggesting that it happened on more than one time?-- There was a period there, and I can't recall the exact period, there was a period there where there were a number of restructures and people that I would normally network with and liaise with to try and get tasks done simply

didn't know who their boss was going to be in the future or where they were going to be placed or what work they were going to be doing.

COMMISSIONER: Mr Gallagher, can I ask you a question; if you think it is an unfair question, please say so and I won't press you to answer it. But having recently moved from the public sector to working for a private company, how have you found the change of environment from working with the bureaucratic system you've just described to working for what is I'm sure everyone knows a major public company?-- BHP is probably just as big if not bigger than Queensland Health. It has its own bureaucracy problems but the stark contrast I find between Queensland Health and this company is that if you're given a task to do something, you're appropriately resourced and given the tools that you're required to do it and you can usually find someone who can help you out with what you need and give you the things that you need to do your job.

MR ANDREWS: Speaking of being appropriately tasked to do things, I see at paragraph 42 you speak of what seemed to be about nine programs that were created by Corporate Office. By their titles, they all look as if they are sensible and as if their creators have good intentions. Were you appropriately resourced to implement those programs?-- In my opinion, no. That was one of my biggest concerns, was that Corporate Office was very good at identifying - developing packages but the way in which they rolled them out and the standard routine for rolling them out was to have some project officer in Corporate Office develop the package and usually only in conjunction with the south-east corner people and not much outside of there.

Was that in itself a problem?-- Oh, that's a huge problem. It appears that Queensland Health only exists in the south-east corner and everything else outside of there just has to do the best they can.

But is that based on practical matters or your disappointment that you're not consulted as well?-- I think I was probably consulted more than the average person outside of the south-east corner. In fact because of my networking and connections, I think I was privileged almost. I don't know what their agenda is with that, but there is very little consultation outside the south-east corner with programs-----

COMMISSIONER: I think what Mr Andrews was driving at though is this: let's take any one of these programs - the pressure ulcer prevention program. If Queensland Health developed that program in consultation with hospitals, say at Southport and Nambour and Gympie and out to Toowoomba or something like that in the south-east corner, what difference would it make if they consulted more widely throughout the state?-- Well, for a start, the south-east corner hospitals, in particular Princess Alexandra, Royal Brisbane, and to a certain extent Prince Charles, appear to be significantly better resourced to implement programs. All these programs that are mentioned in my statement largely fall on the same one or two people, and in Townsville we're quite likely - we're a reasonable sized organisation, and we can kind of deal with those sorts of things, but some of the smaller districts that only have one person that has numerous roles, wearing numerous caps, it's virtually impossible for them to try and complete one effectively, let alone to try and complete all of them.

MR ANDREWS: Mr Gallagher, as I understand your answer, you were alluding to the problem that if these eight programs are supplied to Townsville, one or two people at Townsville are supposed to go around the hospital, make sure that all the staff are informed that there's a new program, and try to explain it to them so as to educate them, and that that's a very time-consuming activity. Is that what you meant by your answer?-- Yeah, that's what I meant, and-----

There'd been another topic that you'd been discussing shortly before that, and it was that you were disappointed that all these programs were created in South-east Queensland, and I wondered whether the place where they were created made some of the programs impractical.

COMMISSIONER: Mr Andrews, Mr Gallagher will correct me if I am wrong, but I think he made two points. One is that they may have been appropriate for hospitals with the funding and resources of, for example, the PA and the RBH, but not for less well funded regional hospitals-----?-- I think these programs are very appropriate for hospitals, but the way in which they roll them out and expect them to be taken up in the districts was my biggest concern, and there didn't appear to be any coordination of the way in which they were rolled out. It just seemed to be lots of different areas developing things and, "Here you go, here you go, here you go", and they all end

up in the same peoples laps out in the districts or trying to get these programs rolled out to the people at the coalface.

You were also making a second point that whilst PA and RBH may have staff to deal with these things, and perhaps in Townsville you were lucky enough to have enough resources to deal with them, if you go to Babinda Hospital there's no-one to deal with it?-- That's exactly right. For instance, I know that out in Charters Towers district, there's a lady out there who coordinates equality and patient safety, and is rolling out all these programs in addition to her normal jobs she has to do. It's setting itself up to fail, really.

Yes.

MR ANDREWS: There were eight programs on that list?-- That's just that I know of and have had some sort of involvement in.

Do you recall after they were conveyed to Townsville, whether anyone at Corporate Office in Brisbane ever followed up to determine how they'd been received and whether the training had been successful and how they were being used and-----?-- To be fair, I think the only one out of those was probably the medication safety program, and that seemed to be by far and away the best planned and funded program that I'd seen in a long time, but the rest of them there was little follow-up if any on those programs that I've referenced there.

And you make the practical observation that when a program arrives in Townsville, even if it's sensible, the staff don't have the time to attend the education courses?-- Yeah, that's a significant problem within Queensland Health, access to training.

D COMMISSIONER VIDER: Mr Andrews, can I just ask a question? It would seem to me there's a bit of a shift going on here in the continuum of evaluation with this program in that we're moving along from something that's overtly termed "quality" to something that's got "patient safety" in its title. What was it like for you introducing this program? Was it easy to get buy-in from clinical staff and those that had to participate in it with you?-- There were - the majority of staff there, if you can demonstrate the value of the programs and what you're trying to achieve, they're more than willing and will do their best to try and take up those programs and make the necessary changes.

That's not unreasonable, though, is it?-- No. They're incredibly overstretched, so they've got to be very careful what they commit to. But one of the problems is the culture within Health has never been - not used to having safety systems in there, and there's - changing the culture within Queensland Health and having transparent systems and policies and procedures everybody must adhere to, and not just, "I'm a professional. I've had my tertiary training. I know what to do", there is an incredible variance amongst practitioners.

Are you referring there to the culture within the Townsville clinical community or are you talking about corporate Queensland Health?-- No, I was actually talking about - "the culture" was reference to the clinical community, and they're not used to having to follow procedures. They're used to, "I've been trained. I do it from my head. I'll follow what I think is appropriate" sort of thing, and in a safety critical industry you must have standardised systems to follow where everyone follows the exact same system, and I think some areas of the health profession have very big problems with adjusting to that.

What about sentinel events? In the time that you were involved with this project, can you, off the top of your head, remember how many sentinel events you would have put through?-- It would be somewhere in the vicinity of half a dozen at the Townsville Hospital.

In that period of time?-- In that period of time, sentinel events there. As for root cause analysis, I conducted approximately 35 to 40 of those in that time.

Thank you.

COMMISSIONER: Mr Gallagher, a lot of what you've said is really backing up what we've heard in other evidence about other places, but one of the things I find disturbing and frustrating is we keep getting told that in each regional hospital resources are stretched out like a violin string, and yet there seems to be a lot of money to spend on developing programs where no-one has thought through, "Well, when we get to the end of development, is there going to be money to implement it? Are there going to be the staff available? Are we wasting our time preparing this package because no-one may be able to use it?"?-- I think that's a very valid observation. It's one of the biggest problems. That's what I mean when I said before we set ourselves up to fail. Sure they provide money to develop these flash packages with their CDs and CD ROMs and do a train the trainer day, but in the end how effective that is taken up by the coalface and whether or not it actually achieves what it set out to do is never really evaluated. There's - or tested for compliance.

I also really start to wonder whether the development of a patient safety program in a highrise in Charlotte Street - you had the patient safety program up and running here in Townsville. Surely rather than spending two or three years developing a new program in Charlotte Street, your model could have been adapted to hospitals around the state as one that was already in operation?-- I have to be fair and say that the person in charge of the patient safety centre in Brisbane at the moment was at the forefront of developing that at Princess Alexandra Hospital.

Yes?-- But as to how systems get implemented out in the districts, I - I don't believe there's been a great deal of consultation there. Also to be fair, it was - prior to my - just as I left, it was just starting to get rolling on. So I

don't know what sort of things have happened in that time since I have left.

And as you've already commented to Mr Andrews - and I certainly wasn't implying anything to the contrary - you have no trouble with the individuals who you were dealing with and who were working towards these programs. It was the structure of the system?-- Yes, that's what - yeah. All the individuals involved, generally once they could see the value in the system, bent over backwards to try and get it implemented as best and as effectively as they possibly could.

Yes?-- As I said before, it was set up to fail a lot of the time.

Thank you.

MR ANDREWS: Mr Gallagher, you obviously admired Dr Johnson, Mr Whelan and the Executive Director of Nursing, Val Tuckett. I see you mention each of them-----?-- Yeah, I had admiration for the job that they were doing and the conditions under which they had to do it and trying to balance everyone's interests to try and provide health service to the Townsville community.

And yet you resigned from the Townsville Hospital in June this year. Can you tell us your reasons?-- Well, my resignation, for a start off, was quite a difficult decision, and one which I made reluctantly, but in addition to my position not being made permanent or any sort of - I had been promised for quite some time this was coming, and I was on a temporary permanent job and had taken a reduction in pay of two - from AO8 to AO6 and which - I wasn't really in the job for the money. If I was in it for the money I would have left ages ago. So in addition to my job not being sort of - the job that I was trying to do being sort of guaranteed funding and whatnot, my job relied on getting people out at the coalface to be able to try and implement the actions that I was trying to get implemented basically, and they were just doing the best they could, but were just behind the eight ball all the time, strictly resources stretched to the limit.

Do you mean you didn't have the staff made available for you to implement your patient safety program?-- That would be - that's a reasonable way of putting it, yeah.

And that would have been simply because there wasn't enough money?-- Well, unable to plan - there was restrictions with how many casual staff we can employ or agency staff and things like that. We weren't allowed to book them in advance, so trying to get people away from the floor to come and attend training was extremely problematic.

So if you had training that you had in mind, the problem was if you wanted to have the hospital staff come to training, then it would have been necessary to hire agency staff to take their places while they came to attend your training?-- Yeah. They can't just leave the floor - nobody would be left on the

floor - to come and sit down in training for a couple of hours. Somebody has to be looking after the patients.

COMMISSIONER: And it would be unreasonable to expect them to do it in their own time?-- Well, some of the training that I conducted, staff members did sacrifice their lunch breaks and ate lunch while I was delivering training.

Yes.

MR ANDREWS: You haven't left for financial reasons. Your salary is much the same?-- Much the same.

And you say you were disillusioned with the lack of training opportunities. I assume that's for yourself?-- Well, I actually consider that I was fairly privileged, given the support that I received from the Townsville executive and the way I was included from Corporate Office. I think I was extremely privileged, although the opportunities for training were limited and very, very hard to come by. For people out on the floor it's almost impossible to get any training, especially any external training.

You say there's no recognition of any significance of the effort put in by staff from Queensland Health?-- That's correct, yeah. Staff feel just used and abused. There's no recognition for them doing extra shifts when - at the expense of their family life, no recognition of the double shifts that they might do, work 16 hours straight, sort of thing, no recognition of middle management staying and doing 50, sometimes 60 hour weeks when they're only paid for 38 or 40 or whatever the case may be. There's little in the way of any sort of recognition for that.

COMMISSIONER: And Mr Gallagher, do I take it those comments again aren't aimed at Dr Johnson or Mr Whelan or anyone in particular, it's a systemic problem?-- No, it's a systemic problem. One of the reasons why I wanted to come and talk about this was because I feel the districts are forced into making decisions that they would not normally make. The system is failing them.

MR ANDREWS: Thanks, Mr Gallagher. I have no further questions for you.

COMMISSIONER: I just have one, Mr Gallagher. I don't know how closely you have followed the course of this Inquiry in the press or you've read about the Patel saga in Bundaberg, but I wonder if you can give us the benefit of your comments as to how a patient safety system like the one you have in Townsville might have assisted the clinical staff in Bundaberg and the patients in Bundaberg to deal with that situation?-- Well, anything of any real significance - I guess one of my jobs was to be fairly impartial, and be sort of able to talk to the coalface people as well as to have - and to talk to management as well. So I had to have - people would routinely come to me from the floor and, say, let me know, and that was one of the only ways that I found out about numerous

incidents, was via the grapevine, and people having the confidence to come to speak to me and know that I would try and investigate it and do the best I can, and that it was not so much a blame-free culture, but a just culture. If you had nothing to fear and hadn't done anything deliberately or purposefully unsafe then you had nothing to fear from this process we were trying to go through to try and work out what the problems were and create some corrective actions, and the people that were involved in it were people from those areas, and they had some sort of control and input into what happened.

Right. Mr Devlin?

MR DEVLIN: No, thank you, Commissioner.

COMMISSIONER: Mr Fitzpatrick?

MR FITZPATRICK: Just a couple of things, Commissioner.

CROSS-EXAMINATION:

MR FITZPATRICK: Mr Gallagher, I'm Chris Fitzpatrick, and I act for Queensland Health. In your statement in a number of paragraphs you express your opinion that whilst you worked at the Townsville Hospital, which I think was as recently as June this year, it was at the leading edge of patient safety in Queensland. On looking at your statement, am I right in understanding that your reasons behind that opinion include the fact that Townsville at least had a dedicated patient safety officer - yourself - whereas other districts to your knowledge didn't have that advantage?-- Sorry, what's your-----

Is that - I'm asking you, if you could, to identify the features of the Townsville system which put it at the leading edge in Queensland?-- Well, yeah, first off I guess it would not have been possible without a dedicated resource to do the job.

Yes?-- Even though my responsibilities expanded over a period of time to be greater than what I could personally achieve just by myself. We were at the leading edge because we had a dedicated resource that could go off and research, look at what could work and implement those - try and do the best we can with implementing those systems, and many districts, as I said before, were inquiring as to how to get this sort of system in place and get the resources to do this job.

Yes. I think you've said that when you endeavoured to speak to Corporate Office about it, there was some difficulty in finding precisely who to talk to. Was that so?-- About the patient safety position or about-----

Yes, yes?-- Well, I never made any inquiries - I knew - I was kept up to speed with my - with the executive group, Dr Johnson and Ken Whelan, about how the patient safety program or the plans for funding were going on. What I said before was about when I was trying to develop individual policies, processes, systems, that sort of stuff, that was the problem, to try and find out who was responsible for it and what their plans were.

I understand. Were those policies that you were seeking to develop not related to patient safety?-- No, they were. That's my job, patient safety. So I was dealing with patient safety.

I understand. Was another feature of the Townsville system the fact that you had, and had implemented, a root cause analysis program?-- That was definitely one of the features of it, because it was a structured process that had been proven in the field in the United States to work, so that was a definite feature, and Princess Alexandra also had that process, and that was - that's why they had so much success with it as well.

Yes, I see. Also the fact that Townsville had a sentinel event policy which was well entrenched and understood - accepted, I think you say?-- Well, we already - the sentinel events policy was developed by Corporate Office. They developed that list of events that they wanted to have the root cause analysis procedure conducted on. Prior to that we had identified many other events that we thought had - put them through a risk assessment process and conducted the root cause analysis procedure. We did conduct a root cause analysis on many other things beside sentinel events. Sentinel events was only a small part of our work.

I see. I've been given instructions that the policies which are currently being - and have been in the development phase by Corporate Office and by the Patient Safety Centre are in fact closely modelled on those which have been in place in Townsville and at the Princess Alexandra Hospital?-- That's correct, yes.

You know that?-- Yes. Those events, by the way, are a nationally listed - they're a group of nationally known events, and largely adopted from the United States and modified to suit Australia. So they're not an unknown list of events.

Yes. Obviously the Commission will receive detailed - and will be interested to receive, no doubt, detailed information about what's being done in that regard, but can you help - in the Patient Safety Centre, which it seems has the responsibility for coordinating the roll out of these policies throughout the state, we have a dedicated body to whom other centres can - from whom they can get direction and so on. Do you see that as an advantage?-- I think the Patient Safety Centre is a very good step in the right direction.

All right?-- Provided it's adequately resourced.

Yes, I understand?-- Not in Brisbane. I mean how it's implemented out in the districts.

COMMISSIONER: Yes.

MR FITZPATRICK: Yes, I understand. And it also seems that from the instructions I've been given, that there have been created 26 permanent safety officer positions who are to be-----?-- I'd like to - that's planned.

Planned?-- And that was one of my - one of the questions that I was asked before. That's been on the drawing board for - it must be close to 18 months or more now at least, despite numerous people from many districts requesting funding for those sorts of positions.

Yes. But assuming - I mean, assuming the funding comes through and - you see that as an advantage, that there are finally 26 equivalents of you - or your former life?-- Well, you know, anything is better than nothing at the moment, but having, for instance, 26 positions when you have - how many districts are there? Thirty-seven? And creating half positions in certain districts and things like that and only one position in, say, Townsville Health Service District which has almost as many staff as, say, the Princess Alexandra - as almost equivalent size of the Princess Alexandra Hospital - I'm not talking about the hospital, but the size of the district and how many people it services, how many staff, whatnot, I think they've, once again, started to set themselves up to fail by not adequately resourcing it.

COMMISSIONER: But from three to 26 is a step in the right direction?-- Oh, as I said, it's a step in the right direction, that's right.

MR FITZPATRICK: Thank you, Mr Gallagher.

COMMISSIONER: Mr Allen?

MR ALLEN: Thank you, Commissioner.

CROSS-EXAMINATION:

MR ALLEN: Mr Gallagher, you-----

COMMISSIONER: Mr Gallagher, John Allen represents the Queensland Nurses' Union.

MR ALLEN: Mr Gallagher, did you become registered as a nurse in 1995?-- No.

Okay. It was subsequent to that?-- Yes.

Did you commence your nursing studies?-- I did my nursing studies in Victoria at Monash University and was registered in 1992 in Queensland.

All right?-- Commenced my graduate year at Princess Alexandra Hospital.

So you completed a Bachelor of Nursing?-- At that stage it was a Diploma of Applied Science before it came - before it came a Bachelor of Nursing.

But it would have taken some considerable effort, I suppose, and time to gain that qualification?-- Standard three years of tertiary education.

Three years?-- Yeah.

And you became registered in 1992?-- In Queensland, yes. I was registered in Victoria prior to that.

So in Queensland you would have worked as a registered nurse for some 10 years even before becoming the patient safety officer?-- Yes.

And did that involve any type of further education towards, say, intensive care qualifications or any other specialties?-- I actually resigned from Queensland Health in 1994 because they wouldn't sponsor me to go and continue to do a post-graduate diploma in critical care. So I went and worked for a private hospital for 12 months to - so I could do the university degree.

So you could actually gain that further qualification?-- Yes.

And then why did you go back to the public health system?-- That's a pretty good question, isn't it. I actually - I came up to Townsville to study a marine biology/environmental science degree, and that was a way - I continued to work for Queensland Health part-time as well as study full-time. That's why I stayed with - that's why I joined Queensland Health again.

It would be fair to say that you don't join a system and then rejoin and stay in it for over 10 years without having some type of commitment to the idea of public health?-- Oh, obviously that's my career that I've chosen, is to work in health. That's - I'm still involved in health and - but I did leave - I have left now twice because of disillusionment about not being able to solve the problems that are faced before everybody.

So your career aspirations were to continue with Queensland Health, but it was that disillusionment you've explained in some detail which caused you to make the change?-- Yes. That's why I left to go and work out in the mining environment. I was doing the Acting Nurse Manager role, and to be - to - it is just chaos, crisis management every day.

Same problems every day, and I couldn't see any way of resolving them.

COMMISSIONER: What sort of problems? Shortage of beds?-- Shortage of beds, shortage of staffing, asking people to do double shifts all the time - yeah, just all - never having any money to get anything done.

D COMMISSIONER VIDER: So if we came back to resource allocation again, if the resource allocation had been different, BHP may not have their employee sitting before us now?-- I think that's definitely the case. I wouldn't have left. I think I demonstrated my commitment to Queensland Health by taking a pay cut of about $15,000 a year or something like that and still having my roles expanded. I saw my family less in that role than I did when I was working out in the mining environment.

MR ALLEN: Have you, in your experience, seen other committed, experienced and capable nurses reach burn-out in Queensland Health so that they just give up?-- Anybody that displays any sort of go-get-'em, motivated, can-do attitude will be exploited in the end until such time as they start looking after themselves, and that's what I guess you see nowadays with the shortage of nurses that are available - or willing to work full-time or part-time and prefer to go on a casual or agency - in an agency bank so they can determine when they are going to get flogged.

And when you talk about individuals being exploited, is it more general than that too, in that the ultimate employer, Queensland Health, can really count upon the fact that nurses generally don't want to leave their co-employees in the lurch, they don't want to leave their patients without care, and so they're willing to undertake the double shifts or the extra shifts?-- Look, to say that Queensland Health as a corporate body or whatever actually prey on that, I'm not prepared to say that, but I will say that nurses and all health professionals - they're dealing with people, and they can see if they leave, the people they're trying to look after won't get the care that's necessary. So if they can do it, they'll go the extra mile to try and ensure that people get looked after.

And in your experience is that extra mile recognised by their employers? Is that appreciated?-- Not really.

You say in your statement that there's no recognition of any significance of that effort. What were you meaning there?-- Well, for instance, in private industry you have a performance appraisal where they sit down and you work out what sort of things you want to achieve with your role. They - where you want to go to, and they try and give you the tools that you need to go there because they know it's going to benefit them in the end, and that's in addition to monetary rewards, access to training to allow you to do a better job and improve the company's performance.

COMMISSIONER: Mr Gallagher, may I ask - it might be a leading question, but how does it feel to you when you read in The Courier-Mail about senior bureaucrats - I don't mean within Queensland Health specifically, but senior bureaucrats in any branch of government getting what are referred to as performance bonuses?-- I don't know if I've got anything constructive to say on that one.

Leave it at that.

MR ALLEN: Access to training is obviously a very important issue. It was so important to you that you, in fact, resigned in the what - I think, first half of the 90s so as to improve your skills, then came back to Queensland Health and it was one of the main reasons, as I understand it, that you ultimately resigned this year?-- Yes, that's correct.

And that's not simply because you took some path which led to patients' safety. Training is an important element in relation to all nurses and clinical practitioners generally?-- Well, it's what motivates you and makes you want to go further and push that extra little bit further and try and implement - well, try and improve your practice and the practice of others and knowledge is a good thing, isn't it?

Yes. Well, it's good for the patients too, isn't it?-- It's nice for the patient to have the confidence in the person that's trying to save your life in knowing they know what they're doing.

But if any of these programs or desires for training are to have any practical benefit at all then rosters of nurses have to actually allow some time for the training or also - as in your experience they simply won't get it?-- Yes. They can't - if they are required to leave the floor then someone has to replace them because there are people there that are depending on them.

When you mentioned 50 to 60 hour weeks being worked by middle management would that include persons such as nurse unit managers?-- Yeah.

What else would middle management encompass?-- I guess I would be classified as middle management. You get nursing directors, if you like, in charge of institutes and things like that. Let me see, other sort of - other allied health professionals, you know, in a middle management sort of role overseeing physio departments or occupational therapy departments. You have doctors that are involved in some sort of administrating role. They have to-----

So when you are using it in the nursing context it would really extend from, say, Director of Nursing down to perhaps the Nurse Unit Manager and the perhaps position immediately underneath that?-- Yeah, that's - that would be fair to say. The only time you really got to get any sort of - get a chance to speak to these people was after about 5 o'clock.

Can I-----?-- Or on the weekends.

All right. Look, apart from some things that you mentioned already which is allowing time for training and actually appreciating that nurses use that how else do you feel that Queensland Health can provide that recognition for the effort that's coming from nursing staff?-- I think that would be in consultation with the individual staff member, what is important to that staff member and how can Queensland Health help them to achieve those objectives so that they can, in

turn, help the performance of Queensland Health because that's what they're all about.

So listening to the staff is an important thing and then responding appropriately?-- Yeah.

All right. During that period of time that you were involved in nursing in Queensland from 1992 onwards would it be fair to say that trends in health such as decreased length of stay and increased patient acuity have meant that nurses have been working harder?-- I'd say it is a lot more technical and a lot more specialised these days, yeah. There's been efforts to try and minimise the manual labour element of it, but in terms of the technical responsibility and the supervisory responsibilities, that's pretty difficult.

Could I ask it this way, that situation that you described in the first half of 2005 of some people basically going that extra mile, working in conditions such that they reach burnout and want to give up, is it worse now than it was 10 years ago?-- Well, perhaps I wasn't as aware of it 10 years ago because I just entered the - entered the profession and was pretty green, really, just happy to have a job and doing what I wanted to do, but burnout is a significant issue these days and I feel it's always unhappy people back then and there seems to be more and more unhappy people these days.

So the situation just seems to be getting worse?-- It does, yes.

Yes, thank you, Mr Gallagher.

COMMISSIONER: Mr Gallagher, I did want to ask you, for a position as a patient safety officer do you feel with your experience that training as a clinical nurse is the best form of training for that sort of position?-- I think that you have to have some form of well rounded clinical experience. I don't know that just your general nursing experience would cut it because you generally get focused on just sort of one area or it can be a little - on my background obviously I described before is pretty good care where you were exposed to an array of conditions, and in my role as patient safety officer I had to visit a vast array of clinical conditions and I don't feel that anybody who is not a clinician and hasn't had broad experience could do the job.

Sir Llew?

D COMMISSIONER EDWARDS: No.

COMMISSIONER: Mr Andrews, any re-examination?

MR ANDREWS: No, Commissioner.

COMMISSIONER: Mr Gallagher, I think you're about the 60th witness we have heard in these proceedings and I'd have to say personally I found your evidence to be amongst the most inspirational that we have heard and whatever else comes out

of this inquiry I hope we can do something towards giving to people like you in the position you held as patient safety officer the recognition and support that it needs because as my colleague Deputy Commissioner Vider has repeatedly said this should all be about the patients?-- I think you should try and address some of these things to allow the people to implement the changes that we are trying to put forward to them so they can actually be implemented and improve the system.

Thank you very much, Mr Gallagher. You are excused from further attendance.

WITNESS EXCUSED

COMMISSIONER: Mr Andrews, that is it for today?

MR ANDREWS: Yes, it is.

COMMISSIONER: I wanted to check what the prognosis is because I imagine everybody would be wanting to get on planes tomorrow afternoon.

MR ANDREWS: It is anticipated that there will be only two witnesses, Mr Whelan and Mr Drummond.

COMMISSIONER: We were also given in our bundles a statement from a Mr Symmons or Symmons.

MR ANDREWS: Yes, Commissioner. Mr Symmons was able to give some evidence relating to access block.

COMMISSIONER: Oh, yes. I suspect Dr Johnson's already covered that adequately for our purposes.

MR ANDREWS: I was disinclined to lead that evidence because it did seem to be covering familiar territory.

COMMISSIONER: Well, I will be guided by you on this and if anybody else at the Bar table wants to say anything else about that, but otherwise I assume if we start at 9.30 we won't expect there to be any trouble finishing tomorrow.

MR ANDREWS: I expect that the incentive to be aboard everyone's booked flight will make us all very brief.

COMMISSIONER: Are you saying we should start at 11.30?

MR ANDREWS: 9.30, thank you.

COMMISSIONER: 9.30.

MR DEVLIN: Can I clear up one housekeeping matter, Commissioner?

COMMISSIONER: Of course.

MR DEVLIN: I asked for the Board's file in Berg's case to be reserved as a number yesterday.

COMMISSIONER: Yes.

MR DEVLIN: I think you have given it a fresh number so perhaps we can clear it up.

COMMISSIONER: No, I gave it the same number. 238 was the number reserved for it.

MR DEVLIN: Thank you. I thought you gave it a number in the 240s.

COMMISSIONER: 238. Anything else, gentlemen? Thank you. Adjourn till tomorrow.

THE COMMISSION ADJOURNED AT 5.09 P.M. TILL 9.30 A.M. THE FOLLOWING DAY