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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

BRISBANE

..DATE 08/08/2005

..DAY 36

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THE COMMISSION RESUMED AT 10.04 A.M.

COMMISSIONER: Mr Atkinson?

MR ATKINSON: The order of witnesses today is to be this: first of all Dr Jason Jenkins, secondly - time permitting - Mr Glen Tathem, and thirdly, from 2 o'clock, Dr Mark Ray. Dr Jenkins and Dr Ray, of course, are the two vascular surgeons. If I might, Commissioner, I propose to call Dr Jenkins.

COMMISSIONER: Thank you, Mr Atkinson.

MR BODDICE: Commissioner, before that happens, could I raise one matter?

COMMISSIONER: Yes.

MR BODDICE: Dr FitzGerald mentioned about the Skills Development Centre and-----

COMMISSIONER: Yes.

MR BODDICE: -----we were wondering whether the Commissioners would find it of some use to have a view of the Skills Development Centre which is at the Royal Brisbane Hospital complex.

COMMISSIONER: Yes, I think that would be a great idea.

MR BODDICE: We'll seek to arrange something for next week for 8.30 or quarter to nine in the morning so it doesn't disrupt sitting times.

COMMISSIONER: Yes.

MR BODDICE: I'll liaise with my learned friend Mr Andrews in relation to what is a time that's convenient for the Commissioners, and go from there.

COMMISSIONER: I think all of us live on the north side of town, so if it were a matter of going straight there, as you say, 8 o'clock in the morning or something like that, it would be particularly convenient. We might ask Mr Andrews to come along too, just to supervise us, make sure we don't do anything improper.

MR ANDREWS: And I'd find it very interesting myself, Commissioner.

COMMISSIONER: Thank you.

MR BODDICE: We'll arrange that and I'll speak to Mr Andrews in relation to a time.

COMMISSIONER: Thank you, Mr Boddice. While you're there, can I ask whether any progress has been made in locating any additional files which should be brought to our attention?

MR BODDICE: I understand in terms of the Toowoomba doctor that material was provided on Friday to the Commission.

COMMISSIONER: Excellent.

MR BODDICE: And I understand in relation to the other files that searches are ongoing in respect of them, and they will be provided if there are any other reports.

COMMISSIONER: Right. And finally - the secretary is unwell today so I haven't been able to check with him, but have we - I'm not sure that we've found out the situation regarding Dr Lennox. You will recall Dr Lennox was going to make some time available to the Inquiry during August and September. Perhaps you could have your instructing solicitors follow up-----

MR BODDICE: We'll certainly find that out. I understood it was just a time that was convenient for the Commission, but I'll find out and liaise again with Mr Andrews.

COMMISSIONER: Thank you, Mr Boddice.

JASON STEPHEN JENKINS, SWORN AND EXAMINED:

COMMISSIONER: Make yourself comfortable, doctor. Do you have any objection to your evidence being filmed or photographed?-- No, I don't.

Thank you.

MR ATKINSON: Witness, would you tell the Commissioners your full name?-- Jason Stephen Jenkins.

You're a-----

MR BODDICE: Could we seek leave to appear for Dr Jenkins?

COMMISSIONER: You have such leave.

MR ATKINSON: You're a vascular surgeon at the Royal Brisbane?-- That's correct.

Doctor, have you prepared a statement for the Commission?-- I have.

And do you have the original of that statement before you now?-- I do.

Commissioner, I tender that statement.

COMMISSIONER: Yes. Dr Jenkins' statement will be Exhibit 254.

ADMITTED AND MARKED "EXHIBIT 254"

MR DIEHM: Commissioner, I had a letter that was tendered late on Friday to Dr Keating from the University of Queensland down as Exhibit 254.

COMMISSIONER: I had that as 253. Just going through Friday's, there was the statement of Dr De Lacey, 252, the letter from - I think it was Dr Burke from the University to Dr Keating, 253, and the statement of Dr Jenkins now will be 254.

MR DIEHM: It seems likely to be my mistake, Commissioner.

COMMISSIONER: I wouldn't count on that. Yes, Mr Atkinson?

MR ATKINSON: Doctor, if I can just step briefly through your qualifications, you did your primary degree at the Sydney University?-- That's correct.

You trained at St Vincent's Hospital in Sydney?-- I trained at St Vincent's until the end of 1989 - 1989, yes.

Came to Queensland and to Brisbane in 1990 and you worked at the Prince Charles?-- I worked at the Prince Charles Hospital for one year, and then following that worked at the Royal Brisbane Hospital and did a general surgery fellowship there.

You gained your general surgical fellowship?-- That's correct.

Then in 1997 you gained your vascular surgical fellowship?-- That's right.

And since then you've worked as a full-time employee - a staff specialist at the Royal Brisbane?-- That's correct.

COMMISSIONER: Doctor, can you just gratify my curiosity for a moment. I understand that a number of medical specialties fall within separate colleges. So, for example, there's a college of orthopaedic surgeons. But as I understand it, vascular surgery is regarded as a subspecialty?-- That's correct.

You're members of the College of Surgeons?-- Yes.

But with a subspecialist interest in vascular surgery, is that right?-- That's correct. I mean, we are classified as a section of the College, but yes, we are all members of the College of Surgeons.

And what - is that the case with other specialist surgeons? Would, say, a neurosurgeon or a colorectal surgeon be subspecialties in a similar way?-- Exactly. All surgeons who are trained in Australia are members of the Royal College of Surgeons, and as part of that there are sections - subspecialties such as neurosurgery, vascular surgery - orthopaedics as well is still a member of that.

Thank you.

MR ATKINSON: And doctor, just to clarify further, do you have to get a general surgical fellowship before you can go further and specialise in, say, vascular surgery?-- When I trained you had to have a general surgery fellowship. Prior to commencing vascular surgery training now you do not need to do that. You can do vascular surgery as a primary fellowship on its own.

COMMISSIONER: And that's been the case with orthopaedics for many years?-- That's right,

MR ATKINSON: Doctor, you mention in your statement that you were the Director of Vascular Surgery at the RBH. It's the case - is this right - the position rotates amongst the senior consultants every two years?-- That's correct.

You've said elsewhere when you are the Director, I understand, that you are still able to spend nine-tenths of your time doing clinical work and maybe one-tenth doing admin work?-- That's right.

I was curious how you're able to run the unit with how little time of the professional staff dedicated to admin?-- The administrative side of our unit is primarily the running of, at varying times, the surgeons in that unit, the number of surgeons that we have. At the moment we have three surgeons. Two have been on sick leave for a number of - a long period of time. So the actual administration of our unit per se doesn't take up a huge amount of time. What I do is - and since I commenced there in 1997 I've done possibly 70 per cent of the vascular surgery at the Royal Brisbane Hospital and 30 per cent has been done by visiting medical officers, and the major administrative section of our unit is possibly carried out by the Division of Surgery which is - has a director, secretaries, who manage that side of it.

Most of your admin work is really about securing more funding?-- Lately it has been. And also the management of our trainees who come through our unit, running education programs, running our audit program to monitor performance of our unit, and also to basically try and improve the function of our unit and its ability to service our region.

D COMMISSIONER EDWARDS: Could I interrupt you? Do you have the right of private practice?-- I do have the right of private practice, yes.

D COMMISSIONER VIDER: What about the on-call roster, doctor?-- The on-call roster is variable depending on how many surgeons we have. Three years ago we had five vascular surgeons at the Royal Brisbane Hospital. Last year we got down to one vascular surgeon, which was myself, for a short period of time, and we were in crisis at that point. We had to go - I was on call for two weeks straight, and I said it was unsafe for me to continue that practice and we actually went on bypass for the first time ever for vascular surgery to the PA Hospital. At the moment we have three vascular surgeons. We are two surgeons down because we've had - two of the senior surgeons have been away on sick leave for almost the whole year. So we do a one-in-three on call at the moment, which is highly taxing. Our workload has increased in the last 12 months. It's gone out of control. When we're on call we're usually in the hospital for a large per cent of the time. Say - on the weekend I spent - all three days I was in the hospital. All Friday night, I was there Saturday, and I was there Sunday. So it's not like some specialties where your registrars actually do the work. When you're on call for vascular surgery, a high percentage of the time you have to do the surgery yourself.

Do VMOs share the roster timetable with you?-- Yes, when we have them.

Thank you.

COMMISSIONER: Do I infer from that that you don't have any at the moment?-- At the moment they're off on sick leave. We have one VMO and we have one other full-time staff at the Royal Brisbane, but the VMO does one night a week and one weekend in three like the rest of us in the unit.

Do you know from your own knowledge whether there are vascular surgeons in private practice in Brisbane who would be available to accept appointments as VMOs if the funding and facilities were available?-- The reality of anyone applying for a job anywhere is that you need to get them at their window of opportunity, and that's when they finish their training. So most people try and get their week as busy as possible as quickly as possible, and if you want to employ a vascular surgeon you need to get them when they finish their training, not advertise jobs six months after they've finished their training, otherwise they're occupied in private and they're not going to come back. We have had, over the last two years, two vascular surgeons who have trained in our unit who were very keen to work in the public system who were not offered jobs because there was no funding available at the time. They've gone to out in the private sector and they've been lost to the public system, which is a shame. It's about funding. It's about funding at the appropriate times and planning for the future. The future of Queensland is that it's growing and our vascular services are growing and we're not planning for that. We're trying to keep everything the same as it has been for the last 10 years, and that's not going to service our community.

Doctor, certainly it's about funding at one level, but we've heard from many sources the suggestion that Queensland Health doesn't encourage VMOs, that there is a preference to have staff surgeons. Have you encountered that?-- I disagree with that. I think if you look at the Royal Brisbane Hospital, the full-time staff surgeon is the minority. The majority of the surgeons who work in most public hospitals will be VMOs.

Yes?-- They bring two things to the hospital. They bring, in a lot of cases, a great amount of experience, but they also bring different ideas from other institutions where they're working. So they actually improve the system because you're getting ideas from a number of hospitals where they may be doing things differently. VMOs certainly will offer their time to the hospital, but they need to be treated in a fashion that they're not just another employee. I mean, they're actually going out of their way to work in this system for limited money, where they could be earning three, four times the amount of money in the private sector. So they want to be treated with some deal of respect. We had a vascular surgeon in our unit who worked there for 30 years, and he resigned this year and did not even get a letter to say, "Thank you for working at the Royal Brisbane Hospital for 30 years." For mine that's a sign of lack of respect, and that's the culture which has developed in the hospital system since medical superintendents left the system, because the medical superintendent was someone who actually stayed in the hospital for a number of years, knew his staff and knew that they'd worked there for 30 years. The district manager now possibly wouldn't know half his staff, wouldn't know how long we've worked there for and treats them as an employee. I think some VMOs expect to be treated more than just an employee, and I think that's not unreasonable.

One of the suggestions that's come through to me from Mr Forster, who is conducting a review of the health system generally, is that whilst the government has recently marginally increased the pay to VMOs, that's not the important thing so far as VMOs are concerned. What's important are things that may seem trivial individually, but things like having a carparking space, having a common room where they can sit with the other specialists and have a coffee and talk about their issues, not having their schedules and rosters interfered with so that when they arrive they can get down to work and get things finished, and as you say, being treated with respect, being given the sort of courtesy that they're used to in the private hospital system. Can you comment on those perceptions?-- I think you've summarised it very nicely. I would venture to say there would be not one VMO working in a public hospital who does it for the money. I do not believe the money is an issue. They do it - the thing the public hospital has which private hospitals don't have is units per se, and that - the unit such as our unit has, on most situations, five surgeons in it. We sit down, we're having regular meetings. It's an educational forum. It's not only camaraderie, but we change - we interchange ideas, ways of doing things. So therefore you actually improve the way you do things. We have an audit system which allows us to

monitor each surgeon's activity and their results, and those things are things which you can't get in the private sector necessarily. Most surgeons don't want to be treated like a school kid, and some of us are treated like school children now. We're berated like school children, we're - you know, and I don't think that's why we work in the system that we work in. I don't work at the Royal Brisbane Hospital full-time because of the money. I work in the full-time system because of what I am doing for patients and the type of patients that I operate on. I stay there at the moment, and sometimes I wonder why. I say to myself, "It's like hard work going to work", and I said when I - when work stopped being enjoyable I'd leave. I love the Royal Brisbane and I love looking after public patients, but at the moment it's becoming more and more difficult. I don't believe we're offering the standard of care - not at the coalface, but I think the standard of care is that our patients are piling up behind us and we can't keep up with it, and standard of care is now - we're treating more acute patients than we've ever treated. These patients should have been picked up earlier. They should have been treated electively, but they're coming through the back door which problems which sometimes aren't treatable. They're losing legs, they're losing their lives, rupturing aneurysms, because they haven't been seen in outpatients, and that's a factor of funding. That's a factor of staff. That's a factor of building a hospital which was too small. They downsized the Royal Brisbane Hospital over the last 15 years from 1,000 beds to 300 - I don't know how many any more. Depends on how many they want to open on the day. But I mean, a 300 bed tertiary referral centre to service from here to Rockhampton is crazy. Every day we get a message on our pagers, "Discharge patients. Beds critical. No admissions without approval." That's what you get every day at the Royal Brisbane Hospital on my pager. It's - it becomes an intolerable place to work because you can't actually work. You're told to stop working because there's no beds. You're told to stop spending money because there's no money, stop putting in the best graft for the patient because we've used up our prosthetics budget. Put in a business case if you want to get something else done. You know? Business cases - we were told the other day that all the business cases just get thrown in a box at Charlotte Street because there's no money to actually deal with them. So we waste our time doing things like that. We want to work, but we're not allowed to work a lot of the time because there's not the money to actually fund this system.

You mentioned a few moments ago that patients are piling up behind you. One of the viewpoints that's been expressed to us is that - it involves two elements. One is that the figures are distorted because published statistics for waiting list times really don't take into account the length of time necessary to get an appointment in outpatients with the specialist before you get on the official waiting list, and also, they don't take into account exploratory or preparatory procedures such as colonoscopies or endoscopies or what-have-you. So that's sort of one element that the figures are distorted, and the second element is if the true figures

were known there would be the political will to put the money in that's necessary to get rid of those waiting lists. Are you able to comment on either of those propositions?-- I can only comment on what happens in my unit.

Yes?-- When I first stated as a full-time specialist in 1997 our waiting time for the public system - and this was - we categorise patients as Category 1 patients which need to be seen within 30 days, Category 2 patients which need to be seen in 90 days, and Category 3 patients which do not require to be seen within 90 days, but still should be seen. Okay? That was 12 weeks for all of those three categories. So if you had varicose veins you get seen at the Royal Brisbane Hospital within three months, four months maybe. Now Category 3 patients never get given an appointment because they will never get seen. We have - I think the waiting time for if you actually gave everyone an appointment for a Category 3 patient would be possibly 10 years. Category 2 patients are now - we've got 195 Category 2 patients on our waiting list. So they actually haven't been given an appointment. So we're seeing about - adding one of those patients to our outpatients a week, so you do the math. I guess that works out, you know, one or two a week, that's 50 weeks, 60 weeks - maybe 100 weeks before they get seen, and then the Category 1 patients, who are patients who need to be seen within 30 days, we manage those fairly well. We get those in in time, but that's basically all we're seeing at the moment is Category 1 patients and the higher risk Category 2 patients who we are unsure, based on their referral letter, whether they should be a one or a two. The reality is we see aneurysms, people whose legs are threatened and likely to lose them within 30 days if they're not seen, people who have carotid disease - and by that I mean people who have narrowing in the main artery going to their brain and having mini strokes who need to be operated on within 30 days. We manage those. So one would say that the figures which we're seeing aren't the real figures, that's correct. We've got these waiting lists waiting to get on to an outpatient appointment. If you don't see patients you don't get them on to operating lists, you don't extend your operating list waiting time. The benchmark in Queensland Health has always been Category 1 and Category 2 operating waiting lists, all right, and if we come in under the mark for Category 1 and Category 2 patients we retain our funding. If we go over the waiting time for Category 2 patients we potentially lose funding. So we actually end up being worse off if we actually don't meet those targets. It's an unusual system where you work as hard as you can, but get penalised because you didn't work hard enough.

It also seems unusual that if the resources you have aren't sufficient to cope with your existing waiting list, the way Queensland Health treats that is to reduce your resources even further?-- Exactly. I mean, how are you meant to keep up with the system? It's an unusual, I guess, system. They call it a business. I've never called healthcare business. I've called healthcare - I do healthcare to give health to people. If someone needs my help I'll be there, all right, but I don't like people telling me you can't do something because there's

no money. "You can't operate on this person because there's not enough money." Two years ago I got told I could do 56 aortic aneurysms in the year. I said, "Okay. So what happens when number 57 comes in", and they said, "Oh, we haven't really thought about that." I said, "Seeing we do about 145 a year at the Royal Brisbane then we've got a big problem, don't we?" They never challenged me on it and I just kept operating, but I mean, they try you out, and that's about funding. They're doing their job. I'm not criticising them. They're doing what they're told to do because they've been told to come in under budget. It's not their fault, but that's - they're doing their job, but I'm trying to do my job, but I find it very hard to do my job if someone says, "You're not allowed to do it." That's the bottom line.

Just going back to the comments you made about VMOs a little earlier, I assume you'd be aware that there is a vascular surgeon practising in Bundaberg, Dr Brian Thiele?-- Brian Thiele, yes.

And are you able to confirm that he is a vascular surgeon in good standing and respected amongst his colleagues?-- I've never met Professor Thiele. I have it on good standing from members of the vascular community who have met him that he is a surgeon of the highest standard, but I could not make any comment one way or the other on his abilities.

Certainly from the evidence we've heard to date it seems, without exaggeration, a crying shame that Bundaberg has a person of that calibre available, but for whatever reason Bundaberg Base Hospital hasn't been able to continue to utilise his services as a VMO?-- It's a shame. I guess one of the problems with being a single provider of a service in a community is that that service will get too much for you, and when Dr Thiele was working at the public hospital there would be patients who, when he wasn't on call, would get transferred to the Royal Brisbane Hospital. You cannot be on call every day of the week. But I do think it's a crying shame that they haven't continued to utilise his services, and maybe that comes back to respect. Maybe that comes back to listening to a senior clinician about his concerns of a system which was in trouble.

D COMMISSIONER VIDER: Can I just ask you, doctor to come back - you said there is 192 patients on the category 2 waiting list?-- That's correct.

And you said the most serious of those does get seen, but what was the average length of time for that category 2 waiting list?-- The average length of time - I think the next available appointment - I can only comment on my clinic - would be about November this year. So what's that work out? Five months. We try and keep spaces for new cases and follow-ups in clinics, okay. The new cases will be primarily filled with category 1 patients. If there is a cancellation from a patient in my clinic and they get - all the patients - run the week of the outpatients, if they are not going to turn up then we will pull someone off that waiting list and see them. I actually got to the point where - it has been policy of Queensland Health to have just category 2 patients. Well, actually ended up having to classify them as category 2A and 2B because the 2B might end up waiting, you know, years before he is seen and his problem will then be a category 1 problem. The GPs get angry at us because we can't see these patients, and send us back letters saying, "My patient's important", and we appreciate their patient's important but we can do nothing about it.

D COMMISSIONER EDWARDS: And this is further complicated then by the waiting list to get into theatre, once you have seen them after five months or whatever it might be?-- That's correct, and I guess that's been amplified this year by the shortage of anaesthetists at the Royal Brisbane Hospital, which has been brought to a head by issues within their department, with monetary issues, workload issues, and the anaesthetic department, different to a lot of other departments in the hospital, is one which is run almost solely - well, not solely but a large percentage of the anaesthetists in the hospital are full-time anaesthetists and, therefore, if you lose two anaesthetists, full-time anaesthetists, you potentially lose 14 - 28 lists a week, which is a lot of lists.

D COMMISSIONER VIDER: Is there a staff association or somewhere where the staff specialists would be able to come and can you meet with the executive or with the Director of Medical Services-----?-- We have-----

-----and air your concerns?-- We have a Medical Staff Association, which is the majority of the full-time staff, junior medical staff at the Royal Brisbane Hospital, and certainly a percentage of the VMO staff are members of, and we have a Chairman of that, Dr Les Nathanson, who is the present Chairman. He has regular meetings with our District Manager and airs some of the hospital's concerns. I guess, not being critical of Les, but Les is a VMO, so maybe sometimes he doesn't have the full understanding of the problems that the full-time staff have, but in the past the medical association Chairman would be a member of the hospital executive. That's no longer the case. And Dr Hodge, who is the former Chairman, used to go to the executive meeting every week, and I had the

pleasure to stand in for Dr Hodge on a couple of occasions at the executive, and I think unless the medical staff have a voice on the hospital executive, then I don't think we have a say in how the hospital runs. The executive now appears to be an administrative executive rather than a clinical executive and, therefore, decisions sometimes are made based on a business sense rather than a clinical sense.

Was there a change in structure that was formally announced whereby the Chairman of the staff association doesn't attend the executive, or is it because the Chairman of the staff association currently is not available to attend the executive?-- I couldn't answer that question. The only thing I can answer is in the past when the Chairman wasn't available, I for some reason was called upon to substitute for him, and I would have thought that that situation would still be available for us.

COMMISSIONER: Doctor, coming into this whole issue from outside as a lawyer, from day 1 it has struck me as surprising, to say the least, that in hospitals the ultimate decision-maker, and the ultimate figurehead isn't a clinician. I can't imagine in my own profession, for example, a firm of solicitors having someone as managing partner or senior partner who isn't legally qualified and a practising lawyer, and I am sure the same would apply to most other professional groups. Do you consider that there would be advantages in having a Chairman or Chief of Staff, or someone of that type who is a practising clinician at the head of the hospital administration?-- I think it would be ideal but I don't think it is practical. I mean, as a clinician I don't think you have the time to run a major teaching hospital such as the Royal Brisbane Hospital, and I think that's been borne out over decades, that clinicians are too busy to actually have the time to deal with those issues. I think the District Manager does not need to be a clinician, he needs to be a man or woman who is - who has an open mind, who talks to his workers, who goes and sees what his workers are doing, talks to them about the problems that they have in their own specific areas, rather than talking to Directors of Surgery, a man who may have - or executive directors, as they are now called. I guess we need to respect our District Manager, and in order to respect your leader you need to know your leader, to see your leader, and you need to admire your leader, and your leader needs to go into battle for you. And at the moment the general consensus in the public hospital system is our leader doesn't go into battle for us. When we ask for help, we get none. The only help we get is when there is a crisis because we don't want it to end up on the front page of The Courier-Mail. And that's something which is - I hate to say it, which has actually been said to me. "Let's not let this out, this will end up in The Courier-Mail. We will fix it now." And, I mean, we're playing politics with health. Health is not politics. Health is people and the problem at the moment is where we're messing with it with politics. We need to look at it, say, "How much money needs to be injected? How do we run it? What levels of administration can be cleared out to actually allow clinicians to do their job?",

and that's what needs doing. They need to speak to clinicians and ask them what needs to be done, not have administrators telling us what clinicians should be doing.

I'm intrigued by the statistics you mention, and we've heard similar sorts of figures that the number of beds at the Royal is less than half what it was when, for example, Sir Llew was Minister for Health. Presumably that would, or is intended to achieve some cost saving, but one would then expect that the cost saving goes back into providing clinical services at a different level. Obviously, from what you say, that hasn't happened?-- I guess one of the issues with cutting the hospital size is that over the years we've actually become more efficient. So in surgery at the Royal Brisbane Hospital, we still do the same - or a similar number of cases that were done when the hospital was a larger size, but we move them through a lot quicker than we ever used to. So it hasn't affected our ability to perform what we do, but it sometimes means that patients are moved through the hospital system possibly more rapidly than would be appropriate in some cases. I think the recent - there was a recent report in The Courier-Mail which showed that we had one of the shortest length of stays in Australia for patients being in hospital. Now, again, length of stay is one of their benchmarks. Now, just because your patient's not in hospital for a long period of time, doesn't mean you have actually treated them well. But that's their classification of a gold standard, is length of stay. I assume their reasoning for that is if they stay in hospital longer, then surely they have had more complications. But that's not necessarily the case. I think we push people out, purely because if we don't push them out, we can't operate the next day. We'll just have to cancel our operating lists because there are no beds.

Doctor, I have been accused recently of using the expression "bureaucrat" as a term of abuse. I don't mean it quite that way, but what is your perception of the level of managerial or administrative staff within a hospital like the Royal, as compared with private hospitals or as compared with the Royal Brisbane 10 or 15 years ago?-- I couldn't comment on private hospitals. As far as the Royal Brisbane Hospital, when I first started there in 1991 the corridor was a very short corridor. Let me say the corridor for the surgery department now is a very long corridor. That would be my only assessment.

Mr Atkinson?

MR ATKINSON: Thank you. Doctor, in terms of models, I understand the model for the vascular unit at the RBH is that there be five vascular surgeons, two staff specialists, two VMOs and one university surgeon, is that right?-- That's correct.

In addition there is two trainees. One is a trainee in vascular surgery and the other's a trainee in general surgery?-- That's correct.

That's how it is supposed to operate, if it is-----?-- That's in the ideal world, yes.

And these two trainees, they are quite senior people, I understand, in that they are in the last three years of their advanced training?-- That is variable. So the vascular trainee can be anywhere from the start of his training to the finish of his training, same with the general surgical trainees. So they could be a year 1 or year 4 trainee. So that changes every six months or every 12 months, depending on their rotation.

Sometimes - for instance, we'll talk later about P26 - and when he arrives on the 1st of January 2005, the Senior Registrar is Dr Mark Ray, and he had just got his fellowship in vascular surgery?-- In that situation, you have got a very senior registrar who, theoretically, within a week or two will be a consultant in a hospital. So, yes, that's - but that's an unusual situation.

Sure. But it is a good resource, in that the senior registrar, whoever that person be, is effectively the point man. Patients come in and that registrar assesses them and then works out the appropriate consultant, normally you, to see them?-- Depending on what day it is. They do a one-in-two roster, so it is the general surgical registrar will be on one day, the vascular registrar will be on the next day of the roster, but they're assessed by the registrar, the registrar will make his decision on treatment, he will ring the consultant on - and depending on the severity or the complexity of the case, the consultant would either come and see the patient or they will agree with the registrar's assessment.

Now, when we talk about the RBH's catchment area, I thought it might be from North Quay to Aspley, but it is actually from North Quay to Townsville, is that right?-- Basically we do cover everything from north of the river to Rockhampton. There have been intermittent periods during that last five years or 10 years that Dr Thiele has worked in Bundaberg Hospital and provided an excellent service there. In Nambour they have had two surgeons who have worked in the public system there who have come and gone. Prior to that they had a general surgeon who was very proficient in vascular surgery who performed vascular surgery, but for the greater percentage of the population, we're it.

So what should happen is that when somebody as far north as Rockhampton has a vascular surgery problem, they should either call you for some advice or, if the situation is an acute one, transfer the patient to Brisbane?-- In an ideal world, that would be correct. I guess sometimes people don't necessarily realise the patient has a vascular problem and that can result in delayed transfer. But on the whole, most hospitals follow that protocol.

Right.

COMMISSIONER: Just if I can examine further that catchment area, do I assume that when you say it goes as far north as Rockhampton, people north of Rockhampton tend to get referred to Townsville rather than-----?-- That's correct. Townsville has a very proficient vascular unit. They have two vascular surgeons there, very high standard vascular surgeons who can cope with any vascular emergency.

And how far west does your catchment area - I assume to the border?-- It basically - we pretty much service the coastline, sort of into Emerald sort of region. North of that tends to go to Townsville.

Yes?-- Going west, Toowoomba is part of PA's catchment area. So Toowoomba - anything west of Toowoomba would normally go to PA, dependent on intensive care beds. If the patient was thought to require an intensive care bed and they didn't have one, then they would come to us.

And I guess that's the other element of your catchment, that whilst you might be the primary service for someone who is coming from Gladstone, for example, if you don't have the beds then they have got to look at PA or Townsville as the only other options?-- Depending on the problem, my philosophy has always been that if the patient needs to come to the Royal Brisbane Hospital for an urgent operation, the patient comes to the Royal Brisbane Hospital for an urgent operation and someone else sorts out the problem afterwards.

Right?-- That's been taken away from us to some degree by new protocols, so we have to go through the ambulance service. But sometimes you can waste two hours trying to organise a transfer of a patient and those two hours could be critical in that patient's life. My response to it is get the patient here, let's operate on the patient and then sort it out. And that's what it should be. For, say, a ruptured aneurism, which is the major artery in your abdomen, if that ruptures you may have some time, you may have five minutes to get to the operating theatre before you die. Now, you shouldn't be worrying yourself about where I can find an intensive care bed. All I should be worrying about is operating on that patient. But the reality is now my registrars can spend three hours trying to find a bed first off, and second off three hours trying to get approval to actually get the patient transferred. And, again, that's not the fault of any hospital, it is just the fact that we don't have enough ICU beds in Brisbane to cope with the number of patients who require intensive care. I regularly get patients cancelled because there is no intensive care beds. And, again, I am not going to operate on them unless I can give them the best possible outcome, and that requires an intensive care bed.

Similarly, I guess it occurs from time to time that you have to take patients that aren't part of your formal catchment area because they can't be accommodated at the PA or other hospitals?-- We do - it is not a common situation but it seems to be more common that they go the other way. But PA seem to cope reasonably well. I think their catchment area

isn't as big as ours.

Yes?-- And they have - the Gold Coast is sort of the equivalent of the Sunshine Coast. The Gold Coast has vascular surgeons but the Sunshine Coast doesn't. So we've picked up sort of 250,000 extra people, which is growing every day, as you know, and the growth that's going to those areas is the older population, and they are the population for me that have vascular problems. So our workload is increasing exponentially with that growth rate in south-east Queensland.

Mr Atkinson?

MR ATKINSON: Doctor, you spoke just before about the fact that one of the biggest access blocks on the system is the availability of ICU beds. Is that a fair summary?-- Well, it is not ICU but I think it is beds full stop. But ICU beds for certain procedures.

For theatre you need-----?-- Well, for certain - not for all procedures, but some of the procedures that I do, ICU beds are an important part of the patient's management, yes.

And when you spoke about the scarcity of those beds, is this right, that you are talking about the scarcity of funded beds rather than physical beds?-- There is an uncommissioned pod of beds at the Royal Brisbane Hospital. I think it is nine beds that were in the original plan were not planned to be commissioned purely based on - they were there for future growth. I think that was the plan. They still have not been commissioned. But Queensland Health have commissioned what we call high dependency beds in the last two years which has certainly improved the throughput of elective surgery at the Royal Brisbane Hospital and I think they have opened - I am not sure of the number but I think it is about six beds. So there has been - there has been improvement. An intensive care bed is the most expensive bed in the hospital to run. I think it is around about $3,000 a day but I might be wrong on that figure. So to open an intensive care bed for a year is a million dollars. So it is not a small amount of money we're talking about. To open nine beds is $9 million. So we haven't got an endless pot of money to go to every time. You are not going to go to the tree and pull off another 9 million because it is just not there. That's what they tell us. If the 9 million is there, we should be opening the beds.

Your concern, I understand, from your exchange with the Commissioner, is that there aren't advocates for the clinicians and the patients like there used to be, within the senior management?-- Yeah, I would tend to agree with that. I think the division of surgery used to always be run by a surgeon. The division of surgery is now run by a very competent intensive care nurse, but I think we're losing our level of people to go to. You know, my go-to man is no longer the number 1 person in surgery, it is the number 2 person in surgery, you know, so he has less power than he had five years ago. And his go-to person is now district manager, who is not really interested in listening to his concerns a lot of the

time because he is not the director of - or the Executive Director of Surgery. So I guess we're being made toothless tigers in a system which is being run by administrators.

D COMMISSIONER EDWARDS: Do you know any other system in the world that has other than a surgeon as the Director of Surgery?-- Not in my experience, but I don't have a huge experience. I think it would be an unusual occurrence, yes, but I couldn't comment on other systems.

MR ATKINSON: Doctor, we were speaking about that transfer. You have this huge provincial catchment area. In terms of people calling in, you know, want to use a lifeline, if you like, to ask a vascular surgery question, or people who have to transfer, are there very clear protocols about how the person from Gin Gin makes a call to discuss a vascular surgery problem?-- The protocols - I guess they are not clear, but they're learnt protocols as you go through your training, and all Queensland-trained doctors, or most Australian-trained doctors have to go through the hospital system. So you learn that protocol as you are going through, as you would have when you did your training. And most people know that if you have got a vascular problem and you ring the Royal Brisbane switchboard, you ask for the vascular registrar and the vascular registrar will discuss the problem with the person calling, whether it be a consultant in another hospital or a registrar, or whatever, in the other hospital. If that's out of their league and they don't know what advice to give to that person, then they will contact the consultant who is on call for the day. For more complex problems, it is not unusual for a consultant in another hospital to ring - if I was on call, me directly and ask me my advice, because he's definitely, you know, in need of vascular opinion and urgently.

Is one of the problems with having overseas-trained doctors in regional areas (1) they are not very well connected, so they are unlikely to have gone to university with Mark Ray or with somebody at a junior level, and, second of all, they have language problems, in that they can't always speak freely to a consultant on a telephone?-- I think there is - we have a culture where we do know other doctors in other centres. I mean Geoff de Lacy on Friday was my resident when I was a registrar. So they - it is just natural you feel more comfortable ringing someone that you know or you have worked with. But I don't think that's an impediment. That's a personality thing. There are some people who have egos who think they know everything, and they are never going to ring anyone. So you can't train that in someone, you can't tell someone they have to do that. They don't have to do it, it just makes sense that if you are unsure of something that you ring and ask someone else for help. At the Royal Brisbane I frequently consult my other colleagues, not because I don't know what to do, but it is always good to get a second opinion, or a different slant on a difficult problem, and that just, to me, is common sense. Overseas doctors, sure they're possibly less familiar with our system. He may not have even known the Royal Brisbane Hospital existed. So that can be an

issue. But I think when they start in a place such as Bundaberg, any doctor, should be made aware of the landscape that we're working, the geography that we deal with, the huge state that we have and the services that are available in other places. You know, the quality of care that you get at a tertiary referral system - tertiary referral hospital in Brisbane I think is as good as anywhere in the world. You know, I questioned - I think it was discussion paper 6. I thought that was a disgraceful bit of penmanship because here we have someone who is making criticisms of full-time staff specialist working in our public health system who he has got no evidence to tell me we're not as good as anywhere else in the world. So I have digressed a little bit there, but as for the speech problems, you know, you can always eventually understand someone if you take the time.

Sure.

COMMISSIONER: Doctor, I am very glad you raised that, as I made the point in Townsville but I would like the opportunity to make it here as well, that the contrast between VMO and staff specialists was in the context of overseas-trained specialists, the situation we see at Bundaberg with Dr Patel as compared with the Australian-trained surgeons who were available but not utilised at the hospital, and if it was interpreted the other way, I would certainly like to apologise for that because it was never intended to carry that implication?-- I think that's an implication which is sometimes the public - the private sector has tried to project that the public sector is inferior.

Yes?-- I would challenge that.

Yes?-- In all areas. There may be instances which we're finding out about where that's not the case, but in major hospitals in Brisbane and in Townsville and Cairns, I think for the majority the standard of care is superb. It is just maybe we're not allowed to do it as much and as often as we'd like.

And don't get paid as much either?-- Again, you know, some people do things for money, other people do things because it challenges them.

Yes?-- I could work in the private sector and do - 70 per cent of my work would be varicose veins, and 30 per cent would be arterial work. In the public system I do 98 per cent arterial work, which is the more challenging of the two and that's why I do it. I do it because I can teach people, I do it because I can help people outside of - you know, who maybe aren't as fortunate, and a lot of us do it for those reasons. Money is not the prime objective of our lives. I make a reasonable living, sure. It is not as good as others but it will do me.

MR ATKINSON: Doctor, we were talking about provincial areas and the catchments, and you mentioned earlier that there was a time last year when the RBH was on bypass. I understand what

that means is that if patients are coming in, they're told, "Look, the RBH is full. You are going to have to keep going. You better go to Annerley or Woolloongabba and go to the Princess Alexandra. Is that what bypass means?-- Bypass means your hospital is no longer able to offer that service. Now, you go - when you don't have an intensive care bed, you are on bypass because there is no intensive care bed to offer that person that option. And the same if you don't have a consultant on call, then theoretically you must go on bypass.

You mentioned earlier often, almost daily on your pager, I understand, you get a message saying, "No more admissions without approval." That's one step down, is it, from the bypass?-- That's just telling you that we should be on bypass but we're not and the patients are piling up in the emergency department, and not in beds but are on trolleys waiting for beds to come up in the hospital.

So certainly it is your view that the funding is inadequate for the catchment area?-- Yeah, I think, you know, the reality is Royal Brisbane Hospital is possibly 100 beds shy of what it should be to cope with what's required in our State. The problem arose, you know, 10 years ago when they decided - or someone decided that decentralising healthcare in Queensland was the way to go. Treat people in provincial centres, build hospitals in Hervey Bay, build hospitals in all these places, and they had the philosophy that if we build these places, people will come, as in the surgeons will come.

This is the policy I think Dr Cooke called reversal of flow?-- Yeah. I mean, it just didn't happen. They built the hospitals, they have got the beds and the communities, but there is no-one there to actually do the surgery who is trained to do it. So they decided that they'd build these hospitals but they would take beds from the Royal Brisbane Hospital, they would take beds from the PA because you are not going to need them because they are all going to be treated in Hervey Bay, Bundaberg, Gladstone and all those places, and now we've got this, you know, amazing hospital, absolutely, you know, one of the best in the world but it is 100 beds shy of what it should be. You know, we, theoretically, in winter potentially are on bypass every day. We don't do it because it is just not feasible. You know, you can't close your doors. The biggest teaching hospital in Queensland can't close its doors, so we keep them open. But the reality is that, you know, the accident/emergency department at the Royal Brisbane Hospital is inundated with patients every day. Putting call centres in is not going to the problem. The majority of the patients that are there are there for a good reason. They need to be in a hospital bed sometimes.

Has the problem been alleviated to some extent by Stephen Rashford's people, the QEMS, the coordination centre, so he, for instance, can be a bit of an ICU bed broker?-- I think they do a great job. You need to have a point man, as I said before, to go to to organise things. You know, organising a patient to be transferred from Rockhampton to Brisbane sounds like a simple thing but it is actually not that simple, and

you need someone who is experienced to organise that all the time and to get it done quickly. The average time - if I get rung up by Rockhampton Hospital to get a patient down here with a ruptured aneurism is eight to 10 hours. Now, that's a long time, seeing it is only a two-hour plane flight, I think, not even that. So it is the organisation in the middle that takes a lot of the time, trying to find beds, trying to do all those things, and eight hours with someone with a ruptured aneurism can be life and death, basically. Fortunately, the Darwinian theory tends to work and the fit survive, and that's been borne out, that it is far better for a patient with a problem such as that to be transferred to a tertiary referral centre because they actually do better than if they are treated by someone who does low volume in a provincial centre. So that's been well documented in Scandinavia and we have figures to bear that out at the Royal Brisbane, that your survival is very good if you come to a teaching hospital.

Doctor, that dovetails nicely into paragraph 7 of your statement. You are speaking about the fact that there are not - it wasn't easy to get specialists when they built the hospitals in the provincial areas. You mention here that things working well it would be nice, I understand you say, for local people to be treated locally, but is it your view that if the specialists aren't there, it would be much safer and efficient even to transfer them to the teaching hospital?-- It is no doubt safer to be treated in an institution that does complex surgery of a vascular nature all the time. I firmly believe that. It's - again, it's not just providing the surgery, it's providing all the infrastructure that goes with the surgery.

The pathology, the radiology?-- Radiology especially in vascular surgery. We worked out that - they wanted to set up a unit in Nambour Hospital and it would cost a million dollars to actually set up an angio suite and have a vascular ultrasound machine, and then you have actually got to find someone to run those things. So, it actually is more cost effectively done with things in a centralised fashion, certainly the super specialities like neurosurgery, vascular surgery, where you require a lot of infrastructure to actually make those run. With general surgery, you don't need as much infrastructure to actually make those specialities run. I'm not saying they are any less complex or difficult, I am just saying you can - a lot of general surgery is based on examination rather than on complex tests that sometimes we arrange. What was the other thing you were asking? I suppose just on that note, I mean, recently Queensland Health have been pushing us as vascular surgeons from the Royal Brisbane Hospital to drive to Nambour to do clinics and to operate up there, and - you know, they will give us funding for the work we're already doing - try and fund us appropriately if we get in our cars and drive up there to do clinics up there, rather than the patients driving down here to see us, which is, what, an hour away. I mean, it's no big deal as far as I can tell, whereas for me it would take me two hours to drive up there and two hours to drive back, so I waste four hours of my day to make it a little bit easier for patients in Nambour. I know it's difficult to come to Brisbane sometimes, but you are wasting your most valuable commodity sending them out for hour when I can actually be doing something else for four hours clinically. To me, this is just illogical. Take a bus up to Nambour and bring them all down on a bus if need be, but don't make your clinicians go and do silly things, you know.

This is another example, I guess, where it's hard to define if Queensland Health is responsive to issues that you have because they are difficult to raise, are they?-- I guess we were given an ultimatum and that was we want to start doing a new procedure at the Royal Brisbane Hospital which will potentially cost 300, $400,000 in the next financial year, and that's what we call carotid stinting, which is to put stints in the carotid artery, and the prosthetic cost for doing that will be about $250,000 for - which would treat 50 patients. We were told you are allowed to do that but we will only allow

you to do that if you go to Nambour, so it's sort of like - it's not blackmail, but it's - it's sort of blackmail, isn't it, really, if they are saying, "You can't" - "If you don't go to Nambour you can't do that." Well, that's stupid, isn't it? The patients need it done, we should be doing it, not telling us go up and get in a car and drive to Nambour and then we will allow you to do it. I mean, that to me is a culture which rather than recognising that this is what needs to be done and give us the money to do it, we have got to go and do something which is not really - that's not why I joined - went to the Royal Brisbane Hospital, was to drive to Nambour once a week.

D COMMISSIONER EDWARDS: Without mentioning names, at what level would that instruction come to you from the Health Department?-- Well, I mean, I don't know where it actually comes from. I mean, I'm sure it comes from an elevated level. I think there is - Nambour is crying out for a vascular surgeon. They have been crying out for vascular surgery for two, three years, since the surgeon up there left, and that - the reality is that vascular surgery will never take off in Nambour unless you have two or three vascular surgeons, purely because you can't be on call every day. You know, there's too much work for one person, there may not be enough for two people. It's going to be very hard to get two surgeons to go there.

COMMISSIONER: Really, having one vascular surgeon in Nambour almost achieves nothing because that person can't be on call 24 hours a day?-- Exactly. So they still - the emergency patients still come down to the Royal Brisbane after hours. So, no, that happen - that used to happen and we used to accept the fact that this person would do X number of nights on call and it was unrealistic to expect him to be on call - you know, seven days a week, so we take the other nights, but it increased our workload up again. So they - and they potentially took funding away from us when that happened. It's all about money, and - you know, it's like - with renal access - which we will get to I have no doubt - but the demand for renal access has just been exponentially flying through the roof in the last - you know, 18 months to two years. Units have all appeared over - up the coast. Rockhampton used to do their own access, Brian Thiele used to do the access in Bundaberg. Nambour used to do their own access. Now it all comes to us and the Royal Brisbane gets no more money, we have to just pick up the work, try and fit it in when we can - a lot of it's done after hours - and we're just told to accept it and just get on and do it, but - you know, you get worked to the - into the ground sometimes and a lot of the times it affects everyone in the unit. Because there's so much work to do a lot of the time I will do it myself rather than let my registrar to do it because can I do it quicker, so I actually get more cases done on the list to try and get through the workload. So, it has a detrimental effect on training. So, we're all sort of under pressure to get it done. But they need - again they are looking at funding.

Yes?-- But it needs - it needs to happen.

MR ATKINSON: Sure.

COMMISSIONER: Mr Atkinson, that might be a convenient time to take a 10 minute break.

MR ATKINSON: Yes, Commissioner.

THE COMMISSION ADJOURNED AT 11.07 A.M.

THE COMMISSION RESUMED AT 11.36 A.M.

JASON STEPHEN JENKINS, CONTINUING EXAMINATION-IN-CHIEF:

COMMISSIONER: Mr Atkinson?

MR ATKINSON: Thank you, your Honour. Doctor, we were just about to turn to the issue of renal access. I understand that's something that occupies a lot of your time?-- That's correct.

You mention in your statement that renal access is something you have to get right the first time if at all possible?-- I guess, to try and explain renal access, there are two different types of - well, there are three types of renal access that are employed. One is a temporary form of catheter which is inserted into a large calibre vein for dialysis while the patient is having either a fistula made, and a fistula is where we join an artery and a vein together and try and get high blood flow through the vein. A fistula - venous fistula is made with a vein. The ideal fistula has lower complications, risk of getting infected and a lower risk of blocking off. Statistically, no matter who does the fistula in the first place, most patients will need 1.1 procedures per year for the fistula to keep working for their lifetime. So if you're 30 years of age you may end up having 30 operations to maintain adequate access for renal dialysis lifelong. So, the greater - that probability of intervening with their fistula increases if the original operation was possibly not the best operation, and there will be dispute on what's the best operation but I guess from experience you work out which is the best vein to use, the best artery and the best limb. You have only got four limbs, which means that you have got four possibly ideal fistulas to create, but the best fistulas are actually in your arms.

Right?-- And a lot of these patients have got multiple medical problems and they have been in hospital for a number of admissions so a lot of their veins have actually been damaged by drips that have been put into their arms so they

may only have one limb which is suitable for fistula formation.

If you got the fistulas wrong-----?-- If you lose that limb, then they may not have any other options for a venous fistula, and then when you have to put in a prosthetic graft into their arm, and they have a significantly higher complication rate - well, not complication, they require more servicing to keep them going. I sort of use the analogy of a fistula is like a car, to my patients. It needs to be serviced regularly to actually keep it functioning, and the prosthetic fistulas require a lot more intervention to maintain their patency than a venus fistula.

Doctor-----?-- So, you know - I mean, I guess it's one of those things that people - you know, I have asked - someone asked me recently, "Oh, if I get you to go up north to a hospital, can you teach them how to do a fistula in a few days?", and I said, "Well, I can teach how to do a fistula in a few days but it doesn't mean you are going to be able to do a fistula or operate on all patients who require a fistula." I mean, I found it just a tad insulting that I have to train for 15 years to learn how to do a fistula and they can train for two days to learn how to do fistula. It's not just about doing the fistula, it's about looking after the fistula, it's about doing the fistula with the appropriate material in the first place, and insulting comments like that to us also make us annoyed and less willing to sort of want to keep working in the system where you are treated like that.

Doctor, in paragraph 9 you speak to the fact that you had a chance prior to the whole P26 issue to observe the quality of Dr Patel's work, at least in the sense of seeing patients who had been transferred?-- I guess I had seen some patients which had been treated in Bundaberg Hospital and by Dr Patel. I guess seeing a small caveat of patients is not necessarily a true reflection on someone's ability and I, as I surgeon, receive a lot of patients transferred from other hospitals which may be secondary to a result of a complication which the patient has had. Dr Patel is not the only patient - doctor to - that's, you know, ever referred a patient to me to manage.

No?-- So I make that clear. I also make it clear that - you know, it's - if you don't see someone operating you are not sure of their abilities. So I can't comment on his abilities. All I can comment on is that fact of one particular case I saw the way that the vein was anastomosed to the artery. Now, again, his registrar might have done the operation. The patient was under high care, but all I can say is that the standard with which it had been done I would not thought of someone who'd had adequate or sufficient training. But, again, he may have been adequately trained but he wasn't very good.

COMMISSIONER: In paragraph 9 you refer to the brachiocephalic fistula. Is there some significance in the particular type of fistula you are talking about here?-- A fistula, we are joining the upper arm vein to the artery at the level of the

elbow. So there are different sites where these fistulas can be made and, I guess, it was that fistula which was transferred after the patient had a complication, and the exact details of the case I cannot remember, but to my recollection I was a little bit unhappy when I saw what I found when the wound was open. But the exact details I wouldn't like to verbalise at this point.

MR ATKINSON: Your recollection is that that wasn't the only example of renal access work you saw coming out of the surgical department in Bundaberg that caused your concern?-- I had had a couple of other patients who had had temporary catheters inserted for dialysis, that is the catheters inserted into the large veins, and two of those patients had catheters inserted into the carotid artery instead of the internal jugular vein. They were transferred for management. Now, who had put the catheters in I'm not aware of, and I know in one case it was not Dr Patel, so I don't know who the surgeon was, and I must admit I didn't explore that any further. But certainly I recognise the complication of inserting a catheter, that it can be inserted into that patient's artery - they're right next to each other and, in fact, the carotid artery and internal jugular vein are very intimately positioned next to each other. So, it can happen, and best practice in a lot of units in the world is - now they are all put in under ultrasound control to actually avoid that complication. But I treated those two patients. There were other patients who I thought the creations of their fistulas were not - I would say optimal in my experience, but again, my experience - what I - my standards may be a lot higher than other people's standards, and I guess I - I get passionate about it because these patients, they are with you for life, I guess, is the way I look at a renal patient. This patient will keep coming back to me, so if I do it badly the first time or do an inappropriate operation the first time, I have got to fix up that complication. Then I've got to say to them in two years time we haven't got any other more access sites to go for, you know, you may not be able to dialyse any more, and if you don't dialyse any more you die. So basically you hold their life in your hand and if you do it properly or if you monitor these patients properly, they certainly do have a better long-term outcome. You know, that's - it is a known fact that longer catheters are left in patients their mortality drops significantly. If they are dialysed through what we call a PermCath for longer periods of time they have an increased risk of infection, septicaemia, and they do have a higher risk of dying. We try and put all patients on to create their fistulas as soon as possible, but that's not always possible, purely due to the sheer numbers of patients we deal with.

Doctor, in paragraph 10 you deal with a patient called P52, and I won't ask you to go into detail about her. Essentially, what you do say in the paragraph, of course, is that there were three issues that concerned you. The first was that when you spoke to P52 she couldn't say to you that she'd been offered a bypass; the second was that she couldn't remember seeing the surgeon after the surgery; and the third was that

the stitches were there six weeks post-operatively. I understand, of course, that you don't know exactly what went on in Bundaberg, all you were seeing was the outcome and the patient's statements; is that right?-- That's correct.

Right. In any case, at paragraph 12 you speak about a conversation you had with Dr Patel?-- That's correct.

Was that before or after the discussion about P52? Sorry, you say you think it was after?-- I believe it was after, but the exact date of the phone call I wouldn't like to say what the date was, because I can't remember.

And you raised your concerns with Dr Patel but he didn't seem to be budging much?-- That's correct, and I guess that's why I subsequently wrote the letter to Dr Miach because I felt that I wasn't speaking to someone who was willing to discuss the outcomes of some of his patients.

COMMISSIONER: For the record, of course, the name of patient P52, Marilyn Daisy, has been released-----

MR ATKINSON: Sorry.

COMMISSIONER: -----from suppression.

MR ATKINSON: The letter, of course, comprises Exhibit 17.

COMMISSIONER: Yes?-- I guess I wasn't aware at the time that - and as has been made aware to me since that letter was written or only recently, in fact, that the patient signed herself out of hospital against medical advice. I mean, that happens. That happens to all of us and that's not a reflection on the surgeon, that's not necessarily a reflection on anything but the patient just doesn't want to be there any more.

MR ATKINSON: Certainly you found Marilyn Daisy to be a cooperative patient?-- Yeah, I did. I mean, again I have had a reasonable amount of experience with indigenous people who have got renal failure and I would have a number of patients who I have treated. I guess you - they needed to be - they need to be managed somewhat differently to other people in terms of their - they don't like staying in hospital and you have got to appreciate that and you have got to work around those things, and that's part of their - part of their cultural needs, I guess. Marilyn's a nice lady. I don't know what the state of her leg was or her general health before she had her leg amputated. My only concern is that if she was suitable for limb salvage, and by that I mean doing a bypass and trying to improve the blood flow to her leg, then that should have been offered to her, and it can't be offered to her if - unless it's being offered by someone who's trained in that area.

All right. Now, can I take you - well, just to finish off with the question of Dr Miach, who you mentioned, is it the case that you learnt through the conversations you had with

Dr Miach on the phone that certainly he told you he wasn't referring his patients to Dr Patel?-- That is how he phrased it to me, yes.

Doctor, can I take you then to paragraph 13 and following where you deal with P26. You first saw P26 on New Year's Day this year?-- That's correct.

He came to you on a patient retrieval exercise from Bundaberg?-- That's right.

When he came to you the leg was clearly ischaemic?-- Yes.

He was tachycardic?-- Yes.

He had a high temperature?-- Yes.

There was dead skin around the sites of the fasciotomies?-- He had some dead skin around the sites of his fasciotomies, but my guess is the area which was where the skin was dead was on his foot, but the fasciotomies were not too bad.

Right. And he needed inotropes?-- I can't remember the - whether he need inotropes at that time, but I - I would need to have a look at his chart.

You took him to surgery and to debride the wounds. But he wasn't in a fit state to do any substantial surgery?-- Well, no. I mean, I guess at that point in time P26 arrived to us - his mother had - mother or father were not with him at the time. It was reasonably obvious that he was going to need an amputation to - at some stage, all right, and I guess I was unwilling to amputate his leg without the consent of his mother or his father and discussing it with him beforehand. They were in transit. P26 was fairly narcotised from painkillers, so we - I explained to him the severity of the problem, and he's an amazing kid and he took it in his stride. I said to him, "Look, you might lose your leg out of all this.", and he - he knew that, and I spoke to our medical superintendent on call, because to take P26 to theatre as a minor and - I couldn't take him to theatre without some approval, not just my own, all right. So I had to get consent and that was the only form of consent we had available. I didn't think it was reasonable to wait any longer to assess the severity of P26's limb. So, I took him to theater and we found that he had pus coming out of his groin wound, where the original entry was a motorbike injury and he had quite massive trauma to his groin. He'd disrupted his femoral artery, his femoral vein. He'd a fractured pelvis, he had huge muscle tears of his adductor muscles in his thigh, and this original surgery done in Bundaberg Hospital was life-saving surgery. He saved - you know, this boy's life.

That-----?-- He did a good job.

The first operation where they do the-----?-- Yep.

-----work to - the femoral work?-- You know, this is a kid

who's come in bleeding to death, all right. He saved his life. He's not a vascular surgeon. He saved his life. He's done a good job. He used a prosthetic material in his groin, which is an artificial graft to fix his artery. Now, I could have an argument with 100 vascular surgeons, 50 might say it was the right thing to do and 50 might say it was the thing to do. The reason why I say it's the wrong thing to do is it's in a bed which has been contaminated because it's - now there's grass and dirt, a lot of bacteria would have contaminated that wound, and I would have used a vein graft instead of a prosthetic graft. But he used a prosthetic graft. The reason I don't use a prosthetic graft is because of infection, and this kid had an infection when he arrived. He had pus pouring out of his wound. The risk is that if we don't fix that, that graft's going to rupture and he will bled to death, so he's back to square 1 again.

You say-----?-- I took the graft out, took some vein from his other leg, replaced that graft with a vein graft, which is risky in itself and some people may say that that, you know, potentially put him at risk of having another bleed from his leg. If I didn't do that he would have ended up losing his - most likely his whole leg, his buttocks, and ended up with a horrific amputation. So, I did that, and I did a muscle flap transfer to place over the repair that I did. So he's having a major surgery, this first operation. You know, I don't know where we got the idea it wasn't major surgery.

Sorry, that-----?-- No, no. I think it was in my statement.

Yes?-- But I think it was misinterpreted by the person who actually took the statement. And I did a muscle flap to cover over that - the graft that I did, and at that time we also looked at the vein and realised that the femoral vein was basically not there, and found that the original injury, the femoral vein had been transected, the proximal part of the vein had actually retracted up into his abdomen and had basically stopped on its own, tamponaded out and thrombosed, and the surgeon who fixed him in Bundaberg Hospital thought that he was actually repairing his femoral vein but in fact he'd repaired the femoral vein on to what's called the profunda vein, which is the deep vein of the thigh. So, in fact, he'd actually ligated the femoral vein, which is - again, the kid's bleeding to death and that was his only option, then's not necessarily an unreasonable thing to do and you may need to do that. Having done that, then if you are in - I would think the sensible thing to do is, "We have just done a really major" - this is in Bundaberg - "We have done a major operation, this child is better served being somewhere else." That would be my assessment.

Right. What I might do then is just take you through chronologically what happened in Bundaberg?-- Yep.

What I want is your assessment of it. There were three operations, you understand, in Bundaberg on 23 December 2004?-- That's correct.

The first operation was the operation to the femoral vein to stop the bleeding. The second operation were the three fasciotomies, and the third operation was the insertion of the gortex to repair - at least work on the femoral - the arterial injury?-- I'm not sure of the exact - not sure that that's the - is that the exact order? I would have to have a look.

COMMISSIONER: I think you can take Mr Atkinson-----?-- Yeah, no, no, I am sure I could. I would have thought that this - just my feeling with the gortex graft was actually earlier in those proceedings, but-----

MR ATKINSON: I think you will find there is a letter where Dr Risson's explaining-----?-- Yeah, that's okay.

It doesn't matter too much the order actually. With the first one, the femoral vein, what you are saying is it was entirely a good thing that he did tie off the femoral vein to stop the bleeding and it saved the boy's life?-- That's right.

Nevertheless, your view is that whoever the surgeon was, he got the anatomy wrong, because the surgeon's report says that he repaired the femoral vein. In fact, he hadn't reconstructed it at all?-- That's correct.

And the result of that is that you have got blood going in through the femoral artery into the limb, but it can't drain away through the common femoral vein; is that right?-- That's right.

And as a result you get a build up of pressure in the leg and that led to swelling?-- I think - and it's even, I guess, amplified by the fact that I thought from my recollection the artery was actually fixed in the original operation. So this child's had an ischaemic limb for a period of time, which actually if you - if you in the first instance rush the flow to the leg right after it's been ischaemic for a period of some time, the leg naturally swells, all right.

That's recalled redefusion?-- That's what we call a redefusion injury, and if someone's been ischaemic for more than four hours it's not unusual for us to have to do fasciotomies on those patients, that's someone who comes in with - we commonly see people come in with what we call a clot sitting in their femoral artery. We clean it out and if it's been going for a long period of time we do what's called fasciotomies. If they are not done appropriately, then the muscle will die, or if they are not done the muscle will die because it's in a fixed compartment, the muscle swells and that pressure actually increases the pressure on the blood getting to the tissues and prevents that, because on top of that you have tied off his vein which on its own will actually cause the leg to swell.

Right?-- All right. So you have got two factors working here.

Muscle swelling anyway?-- Yeah.

And the fact that the common femoral veil-----?-- You have got venous swelling as well. You can get two types of gangrene, arterial gangrene and venous gangrene. Venous gangrene we rarely every see, but you can see it within someone with thrombrosis in the major veins in their legs, and it's almost impossible to discern whether this child's problem was ischaemic or arterial, but I would punt on there being a major venus component to it as well.

I understand there's one artery going in but there's lots of veins coming out?-- There are lots of veins coming out, yes, but the main vein is your common femoral vein and your profunda vein, and at the time when I operated on the boy I opened up those veins and they were full of clot distal to where they'd been tied off. So, clots tends to propagate and propagate which means spreads down the leg if you are not on blood thinning medication, and the result and effect of that is you may, in fact, block off all those other little collateral veins which drain your leg, which-----

Right?-- -----potentially make the problem worse.

So, the initial surgeon's report, at least where it deals with the femoral vein, talks about a repair?-- Yes.

It certainly wasn't a repair because it wasn't reconstructed?-- I mean, I think - again not defending anyone - but in trauma situations anatomy is not always clearly obvious. He's had a major injury to his groin. It's like a gun shot's gone off in his groin and what he did at the time he didn't recognise. It's not an area of anatomy that I would assumed that he would operate on on a regular basis. Therefore, you know, sometimes people do misinterpret what they are seeing and that is potentially possible.

If all that-----

COMMISSIONER: Mr Atkinson mentioned to you the second operation was the fasciotomies?-- Yes.

You accept that they were necessary and appropriate procedures to undertake?-- Absolutely.

And were they competently performed?-- I would say that they could have been a little bit more aggressive with their fasciotomies, but again, the way the fasciotomies were again is - you know, again if I had 50 surgeons in the room, half of them may say very were satisfactory, but I would say they were less than satisfactory.

MR ATKINSON: Just to clarify that, there were three compartments, the anterolateral, the medial and the lateral compartment. They were the subject of the fasciotomies. Your concern is that they should have been opened up so that the whole compartment could swell?-- That's correct.

With the first operation, the femoral vein, if the patient had his femoral vein tied off and then he was transferred, that would have been a great result because a vascular surgeon in Brisbane would have understood the anatomy and fixed the problem. Is that right?-- If he still had an arterial injury, or if his artery hadn't been fixed, it would all depend on time, and the time it would take to get the child from Bundaberg Hospital to the Royal Brisbane Hospital or to PA or wherever he was going. We have a fixed time between when you have an injury to a vessel such as an artery, which is the primary blood supply to the limb. Ideally four hours is your minimum time before you start getting damage to tissue, all right, and after that time the damage increases. So - younger people tend to tolerate injuries better. I've had young people transferred from Rockhampton with injuries to their arteries of their arms and they've gone for eight to 12 hours and had absolutely no damage, long-term side-effects. So every patient is different. But the sooner he gets to a centre where his artery can be fixed and his vein can be fixed the better the chance that he has of surviving.

This boy was a bit special, I understand. He is six foot four, in robust, good health. Apart from his terrible injuries, he was a young, robust kid?-- Any boy 16 years of age is special.

Sorry, I mean in terms of his-----?-- You know what I mean? Every patient is special, and I agree, he is a special kid, and I've actually got to really like him because I think he's got an amazing - he's shown an amazing ability to cope with what's happened, and he is very willing to really go for it and, you know, he's a good basketballer and I've told him the sky is the limit, you know. "You can be at the Olympics, but you don't have to be at the big Olympics. You can be at the disabled Olympics", and you've got to give them something to fight for, a goal. You know, he is special, but every kid is special, and we should give them the best care possible.

COMMISSIONER: I think Mr Atkinson's point was simply that given his state of overall fitness and strength-----?-- I don't think that has - I mean, any child, you know, regardless of their physical attributes, their time - ischaemic time is possibly the same. They're young. They tend to tolerate things better than as we get to our age. We don't tolerate things as well.

MR ATKINSON: They don't have the terrible problems that smokers have with their arteries?-- Sure. They're fit, healthy kids and they do tolerate things better. You can never give anyone guarantees about anything. I'd be a fool to give someone a guarantee, but regardless of whatever happens, his best chance is being in a centre - regardless of whether it's me or he'd gone to PA or wherever, his best chance is being operated on by someone who deals with that problem seven days a week.

Now, the third operation was this one where they repaired the femoral arterial injury with the gortex. I understand what you say is that in your view it's not best practice to use a synthetic substance. A good surgeon - a good vascular surgeon at least - you say would harvest a vein rather than using a synthetic?-- I would believe that 80 per cent of vascular surgeons would use a vein from his other limb, which is what he eventually had done to repair his femoral artery.

COMMISSIONER: But, doctor, the real point in this case is that it wasn't a vascular surgeon making that judgment. When we come to the third operation, surely that's when anyone should have heard the alarm bells ringing that this is a patient who should be in a tertiary referral hospital?-- I would agree with that. I mean, in my statement I said I think even if you - you know, the best of what you do, doesn't matter who you are, if you're getting to three operations maybe you're missing something and you should at least discuss it with someone else, and it's not uncommon for someone who has an arterial injury or arterial surgery for them to go back to theatre for bleeding problems or for a second look operation. But if you're not au fait with those procedures all the time, then I think you should be on a phone saying, "I've got this kid. Is what I've done okay? If not, what do you think I should do?" But that's just common sense. I mean, it doesn't make you a good surgeon or a bad surgeon. It's just a surgeon who doesn't have any common sense that doesn't think to ring up someone.

D COMMISSIONER EDWARDS: You get those kind of calls regularly?-- Every day.

COMMISSIONER: Doctor, we've heard evidence from other people who were present in the operating room - junior doctors and nursing staff and so on, and in fact the fairly clinical version that Mr Atkinson has given you downplays some of what we've heard about junior doctors desperately trying to find a pulse in the foot and being unable to find one and so on. Would those sort of circumstances just add to the obvious

outcome that this is a patient that should have been in a major tertiary hospital?-- If - I mean, I wasn't there, but if that was the situation then that just adds to the situation. Yes, he should have been somewhere else. I think his first operation - there is no doubt he should have had that at Bundaberg Hospital.

Yes?-- There is absolutely no doubt.

I don't think anyone has disagreed with that?-- No.

You do say in your statement that there would have been a significantly higher probability of saving the leg if he'd been in Brisbane. Obviously no-one can give any guarantee on that?-- No.

But by the time he arrived in Brisbane, if you could have saved the leg you would have done so?-- If it was possible. I mean, we would have no doubt taken him back to theatre, assessed what had been done in Bundaberg, and either at that point in time, if his vein was able to be repaired then, repaired his vein - I would have repaired his vein and I would have also revised the gortex graft that was put into his groin. But, you know, I mean, it's just - it would be impossible for me to say that the kid's leg was definitely going to be okay. I can't give you that guarantee, but I'm sure there was possibly a slightly higher chance that he would still have his leg.

Well, if you'd seen him nine days earlier there at least would have been some chance which he didn't have by the time he got to RBH?-- Yes, that's right.

MR ATKINSON: Can we put it higher than that, doctor? I understand from what you said to the CMC that you thought that there was more than a slight prospect if he was in Brisbane that his leg would have been retained?-- As I said, I think there was a higher probability. I mean, we've had not injuries similar to this, but we've had a lot of other arterial injuries, and in our experience the number of patients who lose their legs is low, you know, in this age group, and with - but again we need to get them in a window. We need to get them in a 12 hour window of the injury occurring, and once it's outside that window what we can offer the patient is limited.

So it depends on the detail, but the sooner you could have had a transfer after the initial-----?-- Yes.

-----femoral vein ligation-----?-- Yep, the greater the chance of his leg surviving. It's not just about the surgery with this problem as well. I mean, management of venous congestion in a limb - there are a number of things that don't require operations. We use - elevate the end of the bed to actually improve the drainage from the limb, we use things called sequential compression which actually pump the leg to actually improve the blood flow out of the leg, and all those things may have improved his leg. Again those things are

things that I think about, but someone who doesn't deal with that type of problem doesn't necessarily think about all the time.

COMMISSIONER: Doctor, I realise this statement was prepared some time ago - probably during July, I think - and you say at the end of paragraph 19, "The result is that six months after the operation this 15 year old boy still does not have a prosthesis." Can you bring us up-to-date on what the situation is now?-- At the moment he has still got skin grafts that every time that he puts his prosthesis on they break down, because they're at a point in his legs where his fasciotomies were on his thigh that we take what we call split skin, which is actually very, very thin skin, and put it over those areas, and that usually is strong enough to support a prosthesis. But in his case, every time he puts the prosthesis on it rubs, because he's trying to play sports and do things in it, not like a 60 or 70 year old who basically wants to be able to get to the dining room and back and it works all right for them. We've - I've tried, on occasions, to get some support for him to get a significantly more expensive limb, I think in the vicinity of $70,000 for - it's like a bionic limb, and I think the importance of that for him is that there is a higher probability he will be able to have that - put that on without any further surgery, and it won't have - his skin grafts won't break down, and also it will give him his best chance to get back to play sport. I've met with a number of obstacles along the way since trying to do that, and it's gone to the Premier's office and I think it's been sort of approved, but it has to go via a few legal departments.

I was actually going to ask you about that, because that came to my attention last week as well, and I was simply going to ask you whether there's anything that can or should be done to expedite that process?-- I think it should - I think it has a huge psychological effect on this boy and, you know, he - last time I saw him he said, "Oh, I don't like getting on the school bus because I feel different because I don't have a leg", you know, and I think he's been through enough and we should be, as a community, just expediting this and getting this done, you know, and this has been going on for six to eight weeks trying to get this limb, and I've phoned a number of people, and I guess the worst part about it was that someone actually told him that - told us that it was approved about four weeks ago, so I tell the mother that it's approved, she tells her son it's approved, he gets all excited, and then we have to turn around and say, "Well, it hasn't actually been approved yet", so he gets depressed about it. So I think, you know, let's be - say this is a kid who deserves this limb and let's get it for him.

MR ATKINSON: It certainly is the case-----

COMMISSIONER: Mr Fitzpatrick, I don't know if you can assist with this, but could you pass on to the Department that I am deeply disturbed that this matter has been allowed to drag on for so long. I think on any view of it this is one patient

that needs the support of all of us here, and I'm sure you will do whatever you can to pass those comments on to whoever makes the relevant decisions.

MR FITZPATRICK: I certainly will, Commissioner.

Thank you.

WITNESS: Can I say just in defence of - I think all the people who have been involved have actually gone out of their way do this, and the last advice that I was given was that it was going to be part of some settlement and that was the reason why it was being delayed, and so I think everyone has been trying to get it done, but it's just taking - as with most bureaucracy, it takes too long, and the person who actually needs it is the one who is being damaged by this.

COMMISSIONER: Thank you, doctor. Can I just take this opportunity to remind the press and media that the doctor has used the patient's first name on a few occasions. I make no criticism of that, but we don't want that name repeated outside these proceedings to protect his privacy, and a suppression order is still in place, so that that name must not be used in the press or media or outside this hearing room.

MR ATKINSON: Doctor, just to return to that third operation, you mentioned that some doctors would have used the vein, some would use the synthetic. If you use a synthetic, is this right: it's always a temporary measure because it has this danger of infection?-- Oh, I wouldn't say - a lot of people use prosthetic grafts for elective surgery all the time. So no, that's not the case. It just increases your risk of infection. I guess, you know, what was used at that operation again has no bearing on P26's outcome - sorry, I keep doing it - has no bearing on-----

COMMISSIONER: Don't worry, doctor. The press are very responsible about these things?-- That's all right. It's just I find it hard to call people P26. That was no bearing on his outcome. It has a bearing on what I had to do to him when he came to the Royal Brisbane, and he got what normally does happen in that situation, which was an infection in his groin and an infected graft.

MR ATKINSON: It has a bearing, I imagine, in this sense: given that he did have the synthetic at a dirty site, if you like, and given that he had had three operations in about 12 hours, they are all things that you think should speak loudly to a clinician about transferring the patient?-- Yeah, I guess. I mean, more the three operations in the period of time. I think the use of whatever he used - that's - I'm not going to, you know, say that was a bad thing or not. He was attempting to save this child's leg, but clearly at the end of that third operation he should have been going, "It's out of my league", you know, move on.

Doctor, of course he wasn't transferred straight away. He

stayed there for almost 10 days from the 23rd of December to the 1st of January, and much of that time was in the surgical ward rather than in ICU. Do you think that's an error of judgment on the part of the hospital?-- Not necessarily. No, I don't think so. I think we would manage a patient such as this - after that injury he may have gone to intensive care for immediate stabilisation after his surgery, but that's a patient who would be typically managed in a ward situation in any hospital. So no, I think that was totally appropriate. I guess the problem possibly falls in what day this happened and what week, you know, and it's possible - the worst time to get sick is between Christmas and New Year. I mean, it's like in any profession. It's the least number of people that are around. You can never find anyone. There are people on call, but here's a kid who's possibly in a hospital which is being run by the most junior medical staff doing ward rounds on public holidays, trying to, you know, keep everything at bay, and they may not have recognised the problem, and I guess that would possibly heighten my reason for sending the child to a tertiary referral centre. It's happened just before Christmas. There's going to be very few people around, with a problem that they're not used to managing in that hospital.

Yes?-- I don't think anything that happened after that was particularly anyone's fault. It was possibly their failure to recognise the problem, and they're not trained to recognise the problem because it's outside of their area of their normal daily work.

The real problem you see is that after the first operation, but certainly after the third operation, the boy should have been transferred?-- That's my opinion, and others may disagree with that, but on the basis of the notes, the basis of what I saw when the child arrived at the Royal Brisbane Hospital, that would be the most appropriate thing for this child.

Certainly what you would have expected is that someone would have made a phone call at least to discuss the continuing care of the person - of the young fellow from the 24th?-- I guess my understanding of the situation isn't the - the exact timeline of things I can't be sure of, but I've been made aware that the surgeon who performed the surgery actually left the country two days after he performed the surgery and handed over the care to someone else.

Well, he left on Boxing Day?-- There you go. Boxing Day. So you know, it's difficult to blame the person who is looking after this child who he hasn't operated on to actually be clearly aware of what's going on, and the person who operated on him - if I do an operation, I'm responsible to that patient (1) until his care is completed basically, and that doesn't mean leaving a hospital. That means until they come back to see me in outpatients and I say, "You've had a good outcome", basically, and that's completion of care. I think I have a moral responsibility, if I'm leaving the country, to leave the patient in the hands of someone who is capable or experienced enough to look after that patient.

Right. And if they're not available on campus, you send the patient-----?-- You would have to ring - say if it was Brisbane, I would ring a colleague in another hospital and say, "Do you mind covering this patient", but it is unacceptable to leave a patient without anyone overseeing their care except for a junior doctor.

Doctor, after this all happened, you may be aware that Dr Stephen Rashford made a complaint?-- I am.

And you may be aware that as a result of that complaint the medical super at Bundaberg Base, Dr Keating, provided a report to Mr Bergin, the zonal manager, about the quality of care?-- No, I'm not aware of that report.

Were you ever contacted by Mr Bergin or Dr Keating in the course of January 2005 to discuss what you had seen?-- No.

Were you available in January 2005?-- I would say I was, but I can't - you know, I mean, I was - clearly I was at the Royal Brisbane Hospital on the 1st and 2nd of January. What I was doing on the 4th, I can't tell you, but I'm sure I was at work.

Not every single day, but you weren't on holidays the whole of January?-- No.

Did you take this opportunity to report Dr Patel to anyone?-- I remember it actually quite clearly the day - I mean, I mentioned it to Dr Richard Ashby, who is our Executive Director of Medical Services. I think that's the title we give him these days.

He's the medical super?-- Well, they call them Executive Director of Medical Services. They don't call them medical superintendents any more. It was actually the day Mark Ray, who is coming this afternoon - he was applying for a VMO job at the Royal Brisbane Hospital and I actually mentioned it to Dr Ashby prior to the commencement of that interview. So the exact time we'd be able to find, and at that time Richard said to me that he had referred it to what we call the Trauma Committee, and the Trauma Committee is similar to what Stephen Rashford would be involved in which is the Department of Emergency Medicine at the Royal Brisbane Hospital holds a meeting once a month at which they discuss transfers from provincial centres and how those patients could have been managed better, or things that could have been done, and it went through that committee and he thought that that was the most appropriate forum for it to be discussed in. I guess I raised concerns about the standard of care at Bundaberg Hospital - of this particular surgeon to him at that time, but he said it was best managed through that forum.

Commissioner, on Friday Queensland Health provided us with a report from the Trauma Committee. I haven't had time to provide it to my learned friends, but I might just show it to doctor and tender it in any case.

COMMISSIONER: Certainly.

MR ATKINSON: Doctor, that's a letter from the Trauma Committee - not the first one, of course, but what follows. Have you seen that correspondence before?-- No, I haven't.

I might tender it in any case. I tender that, Commissioner. It will need to be de-identified, of course.

COMMISSIONER: Yes, all right. I'm just a little concerned. Maybe Mr Dwyer or someone from Crown Law can sort this out. I see that there's a fax cover sheet to Matt Wilkinson in Crown Law. I wonder whether that relates to a personal injuries claim rather than something we should know about.

MR FITZPATRICK: Commissioner, I'm not sure what you have in front of you. When it's convenient-----

COMMISSIONER: I'll have this go back to Mr Atkinson, and if you and he can sort it out at lunchtime or whatever is convenient - I just don't want to stray into areas that perhaps we ought not to be ventilating.

MR FITZPATRICK: Thank you, Commissioner.

MR ATKINSON: Doctor, is it very clear - if you have concerns about a peer, another doctor, is it very clear, and has it been made clear to you in any courses, what you should do?-- I guess in - I'll comment on how we deal with it in our own institution. That is, we have what we call an audit system, and we do that on a regular basis, and what we do is as a group we look at all patients that have been operated on in that institution for all procedures. We look at all deaths and all complications and work out ways to improve outcomes. If someone was having problems or doing procedures which we thought were outside of his scope, then it is our responsibility as surgeons within that unit to make that known to that particular surgeon, and also - not just - it's not - it's not meant to be adversarial, but it's actually meant to be offering help to that person.

Support?-- And you may go and support that person when they were doing those procedures that they may have been having difficulty with. We would - within our own unit we have what's called - well, within Royal Brisbane Hospital we have what's called credentialling, which is a very strict forum for determining what procedures people should be and should not be allowed to do, and that is based on their - not only on whether they believe that they can do it, but whether they have been adequately trained to do those procedures. That allows us to have a fairly strict method of control, and then if you had ongoing concerns, you would refer it to the Royal College of Surgeons and they would deal with it and send a representative to interview that person. So if you're outside the Royal College of Surgeons then you're really - you can be a bit of a rogue and you can do what you want because you're not actually answerable to anyone. So the role of what we

call the senior medical officer, who is not a member of our college, allows them to maybe operate under different standards than what we adhere to.

COMMISSIONER: More particularly, if the hospital concerned doesn't have a functioning accreditation system?-- Yes, I think also that you'd find that most of the other surgeons involved in that hospital would be involved in some audit procedure. Otherwise they wouldn't be allowed to continue on and the College of Surgeons - because you have to actually show that you undertake this. Now, they may undertake that in the private sector because they feel that's a more appropriate forum for them. But I guess we're all responsible for everything we do, and if we partake in something and we don't think that the person standing at the other end of the bed giving my anaesthetic - if I'm not happy with that person giving the anaesthetic - not because they're not a good anaesthetist, but they may not be skilled in that area - then it's my responsibility to say that, "I don't think you should be doing this." People should be big enough to take, you know, the responsibility in their own hands and not go blaming other people, you know. We all have a role in whatever we do, and whether you're the scrub nurse, the anaesthetist, you know, and I think you need to stand up and say what you think, and I think too many people in this system - or in the world today are too scared to actually say what they think. Sometimes I think I say too much, and I possibly do, but at least I tell the truth and say how it is.

Doctor, I have that problem as well?-- Yeah, I know. Well, as long as I don't see you at that other Court, all right.

Can I articulate to you what I think is really the heart of all of this: we have an overseas trained doctor who is appointed Director of Surgery at Bundaberg who is not a member of the College, who is not a part of any effective ongoing audit procedure, and who hasn't been put through an operative accreditation process, and that person is the top of the tree as far as that hospital is concerned in relation to any clinical decision about surgery. There is no avenue of appeal. We had, I think I can fairly say, very impressive young medical students and trainees who were around the place, but they weren't in a position to countermand Dr Patel's instructions. At the same time you have an anaesthetist who is also an overseas trained person, no doubt extremely competent, but doesn't have the same sort of connections and the same sort of authority as an Australian trainee would have. In that sort of situation, unless there is a sort of right of appeal to a chief clinician who is part of the Australian medical culture, you've got a man like Dr Patel who is a law unto himself?-- I mean, I can't comment on the process or anything that happened in Bundaberg Hospital. I guess one thing I will make clear - and I think people need to be careful - is we should look at - and I'm not defending anyone here, but you need to be very careful at looking at a very short timespan when you assess someone's performance. Clearly we've looked at his performance over a long period of time, but if he's done 100 oesophagectomies and 97 of them

survive up until this date and we look at his last three, he's got a mortality rate of 3 per cent. If you look at his last three operations he's got a mortality rate of 100 per cent. I think, you know, things can be put in any light that you want to, whether it favours you or not, and I think you'd be careful there. In terms of process, I mean, I don't think - one surgeon in a hospital, there's no process.

Yes?-- I don't know how many surgeons are in Bundaberg Hospital, to be quite frank. I couldn't answer that.

MR ATKINSON: Two.

COMMISSIONER: There were two surgeons, and there were certainly a coterie of apparently very competent private surgeons in the town who could have participated in auditing processes and accreditation processes?-- Sure, and I think that's the only way to monitor situations is to have regular audit, and that should be done, and it should have been done.

MR ATKINSON: Doctor, Dr Woodruff will say that perhaps the system needs to be hubbed and spoked, by which he means there should be a system where the PA marries up with the Toowoomba, maybe the RBH marries up with Bundaberg, and in terms of auditing and peer review and general discussion and networking, they act as one administrative unit. So that you don't just have two surgeons at Bundaberg, they are part of a bigger group like the RBH, and even if they have come in from America or somewhere else, they know the names of Jason Jenkins-----?-- Sure.

-----and maybe Harry Gibbs at the PA, and they know who they can go to. Do you think that hubbing and spoking can work?-- I think it can work. I guess we already have a network of hospitals which we service, and the natural thing is that you actually have more of an educational sort of process which brings them to us and us to them, so to speak. I mean, I have always offered my services. I thought the best way to solve the dialysis access problem in Bundaberg was for them to come down, and someone who is experienced in doing the procedure - this is just for the PermCaths - teach the radiologists how to do it and rather than people - you know, not - obviously not knowing how to do it properly. But, yeah, I think hubbing and spoking - that's an interesting term - could work. I mean, we do a similar thing in Queensland. There is not a lot of vascular surgeons, so we actually have a similar group where we get together three times a year and we actually discuss problems for the State and how we manage it. And I think you have got to do that. When you are a small group of people, you need to all get together to actually cross fertilise, I guess, so long as it is not personal.

Doctor, there was a couple of comments you made in your record of interview with the CMC. Can I take you to one of them? You said that, "There is an underlying current in Queensland Health that if you don't toe the line you will be dealt with." Why do you say that?-- I might have been angry that day. I guess it is just because we have lost much role in the process of how the hospital runs, it is - you know, we get treated like, I don't know, a mechanic. I get treated like a mechanic sometimes. It is just, "Go and do your job. You know, do your 9 to 5 and get out of here and don't make waves. Well, you know, I make waves and they don't like it and sometimes that comes back to hurt you. I mean, I guess - I don't know, it is just the feeling I get sometimes that they are not on our side, which is what I said earlier. You know, I sometimes feel that we're playing for a different team. We're playing for the health team and they are playing for the budget team.

The second comment you made is decisions by Queensland Health to - sorry, I should start earlier: "I also believe that when you are asked to do something by administration, quite frequently if it is against your beliefs and you ask for it in writing, they will say, 'No, we won't put it in writing. We just want you to do it.' So there is no - my feeling is then there is nothing to track you back to them, basically, it was your decision." Is that an experience you have had?-- It is. I mean, there is a reluctance to put anything in writing. It-

certainly at the Royal Brisbane Hospital - I mean, anything of significance into writing it is always, you know, it is a verbal communique which you are to follow. But if you say, "Well, so you will put that in writing and have it on my desk and I will be more than happy to do that?", they say, "No, we won't do that." Well, why don't - if you are not willing to put it in writing, then clearly you are hiding something, you know, or you don't want anyone to know about it, basically. And I won't do anything that I don't think is morally right unless I have got no other alternative and ordered to do it.

The third thing and the last thing I wanted to take you to, doctor, you say, "Decisions by Queensland Health to write letters on behalf of your department stating changing policy but it is not on behalf of Queensland Health, it is on behalf of the department of vascular surgery, making out to the GPs and the patients that it is us that have instituted these changes. And it is not us, we're totally against the changes and they're instituted by Queensland Health but they won't have the ... to stand up and say why they are doing it." I have missed out a bit there?-- Yeah, I think that goes back to the outpatient issues which we discussed earlier, and I guess that was one of the turning points for me in the way we offered care to patients now is that the waiting lists for the waiting list for the waiting list is actually blowing out. I mean, there is a waiting list for everything now and you can't actually get on to it. Patients now - I have got patients who are waiting for surgery who have been waiting - and I have only been working at the Royal Brisbane as a consultant for nine years or eight years, and they have been waiting eight years for their operations, and they are things such as varicose veins. I think, sure, it is a minor problem and it is not a life-threatening condition but people have the right to health care, people have the right to get health care within a reasonable period of time, and 10 years is not a reasonable period of time as far as I'm concerned. It may be a minor problem - and that's - I guess I keep coming back to when I say that's not a criticism of the system. It is a criticism of the system but the system can only deal with a certain amount of work. I mean, you know, health is a huge problem. It is just growing exponentially every day. The baby boomers, we're all out there. We're - you know, we want the best care. People come into me and they want, you know, their aneurism fixed when they are 80 years of age. You know, 15 years ago they weren't offered surgery because that was the system. There wasn't money, they were told, "You are 80 years of age. You have had a good innings." Now everybody wants to be treated if they are suitable. And I don't think that's unreasonable but it is causing a lot - costing a lot of money to do that. You know, the grafts I use to fix aneurisms in the aorta can cost anything up to - I did a graft the other day, cost $30,000 just for one patient for their graft. I spent a million dollars on prosthetics in our department in a year, and that's just me. So there is a lot of money that's required to support this system and there is a limited budget. Now, it is fine to go and build stadiums, you know, for $500 million. That looks good. But the reality is, you know, football stadiums don't save lives. They might make us happy,

but money needs to be put into the right places. It doesn't need to be put into places where no-one is ever going to work. There is no point in having a hospital with no patients, which is what they - you know, they have planned in a number of places in this State. We need hospitals with patients with doctors in the right places.

COMMISSIONER: Doctor, accepting, as we all have to accept, that health budgets are always going to be finite?-- Yep.

It seems to me the priority is to make sure as much of that as possible goes into actual health care?-- Totally agree.

Are you able to make any observations, whether anecdotally or specific instances, or whatever, of money being wasted on things that don't improve patient outcomes?-- I guess there has been a growth of what we call project officers in Queensland Health, and they're people who are actually, you know, paid $X a year to actually work out how to fix the problems, but they - you know, all they need to do is come to the clinicians and say, "This is how you fix the problem." I mean, one of the problems is they don't come to us to ask us how to fix the problems. Half the time they tell us how to fix the problems. A lot of the time that involves actually more administration and less patient care. You know, it is a growth industry. I would love to be an administrator.

That's the evidence-in-chief.

D COMMISSIONER VIDER: Can I just ask a couple of questions? Doctor, do you have any input into the budget preparation of the capital requirements for theatre? For example, do you get an opportunity to say what your likely throughput of patients is likely to be, and how much money you would need approximately for grafts and other surgical accessories?-- No, we get told how much we have got to spend and once we've spent that amount of money, we're not allowed to spend anymore.

You are not asked for your estimation?-- No.

The other thing is you said the credentialing process at RBH is robust. Do I understand that?-- Yeah, I believe it is relatively robust.

To the point you could get down to find an individual practitioner's scope of practice?-- I do the credentialing - or I have been involved in the credentialing of vascular surgery. I won't comment on other specialties because I am not involved in those - but in our specialty, each of us has varying skills. Some of us have what we call endovascular skills which is performing vascular surgery through very small incisions, whereas other people in the unit don't have those skills, therefore they are not credentialed in those areas. Some of us have ultrasound skills, which we carry, others don't. So people get credentialed in specific areas within their units. And then within our unit down the track we tend to manage problems by saying, "Well, this person is the most

experienced person with this problem. Therefore, that referral will go to that person." And therefore we build - we build knowledge by actually, you know, sharing knowledge.

Would you see in the future that could be another opportunity for the application of the hub and spoke principle, whereby maybe some of the places that are isolated and wouldn't necessarily be able to assemble a peer group, may be able to tap into somewhere like the RBH?-- Yep.

For that credentialing function?-- I think that would be a great idea. I do think it is far easier to ring someone at 2 o'clock in the morning if you have actually spoken to them or met them.

Yes?-- You know, I try and always be fairly civil - and I get woken up a lot in the middle of the night - but it is clearly easier if you have actually met the person before and you know they are a sensible person. I think where - communication is something which we can all work on, but clearly for the provincial centres, it would help them and possibly make them feel less isolated, less vulnerable, and, you know, we all have egos and we all sort of feel like we're defeated if we actually ring for help. We need to create a culture where you are ringing for help because "I am here to give it", rather than "I am going to scold you for ringing me up at 2 o'clock in the morning." I mean, that's the same with the junior staff. A lot of junior staff in hospitals, you know, they are scared to ring more senior doctors in the middle of the night for fear they are going to get berated, or the doctor's going to be angry at them. You know, again, that comes back to communication. They've sort of taken that out of the hospitals, they have fractured us, they have moved all the departments all around the hospital. They don't give the doctors a common room because they call that elitism. It is not elitism, it is actually a way that we communicate with other people in our workplace and that's a very important part of what we do, is communication.

Thank you.

COMMISSIONER: Sir Llew? Mr Fitzpatrick?

MR FITZPATRICK: Thank you, Commissioner. Commissioner, I have spoken to Mr Atkinson. We're content, that is both of us, for the review - the Trauma Review material to be tendered in the form in which I now hand it up.

COMMISSIONER: Thank you. Exhibit 255 will be the material - I will just describe it the material from the Trauma Review Committee concerning patient P26.

ADMITTED AND MARKED "EXHIBIT 255"

COMMISSIONER: Please continue.

MR FITZPATRICK: Thank you, Commissioner, I have no questions for Dr Jenkins.

COMMISSIONER: Thank you. Mr Harper?

MR HARPER: Yes, Commissioner.

COMMISSIONER: Doctor, Mr Harper represents the patients group at Bundaberg.

CROSS-EXAMINATION:

MR HARPER: Dr Jenkins, you have given evidence about your steps prior to the treatment of patient P26, about your steps to warn the Bundaberg Hospital management of your concerns about Dr Patel. Could I suggest to you that your concerns were really in two primary areas: the first and major one being the scope of Dr Patel's practice in doing vascular surgery, is that correct?-- Well, no, as I said, I have no - I have no knowledge of what his level of training was, okay. That's the first thing. So, therefore, all I can comment on is what I saw presented to me as patients and my assessment is that, you know, maybe it wasn't the highest quality work. But that's - I can't really comment more on that.

In terms of-----?-- In terms of, you know, informing the Bundaberg Hospital, I mean, I went through the avenues that I thought were appropriate at the time, and that was with respect to the renal patients. The easiest way to stop somebody operating on renal patients is go to the source, which is the renal physician, which is what I did, and if you tell the source not to refer, then the patients really will not go back. You know, they won't get referred to Dr Whoever and therefore they will go somewhere else. So I thought that was appropriate.

I will just go back to your answer earlier about you can't make an assessment necessarily of the quality of the care. It is fair to say, though, isn't it, that you as a vascular surgeon have had years of training?-- Yep.

To get to that point?-- Sure. I mean - well, what I am saying is - I know I didn't say it correctly - is that based on one operation or two operations, my assessment is that, you know, his standard of training in vascular surgery I would say would be limited. But, again I have no knowledge of what his training is so I can't actually make comment on his training. You can have a bad vascular surgeon who is trained in Australia, doesn't mean he is not trained, it just means he is bad. You can have a bad mechanic. Doesn't mean - I mean, just because someone is bad at what they do, doesn't mean they

are not trained, is what I am saying.

COMMISSIONER: But I think it is common ground here at the Commission that Dr Patel was not a vascular surgeon?-- He was not a trained vascular surgeon, no, but he may have trained in vascular, or done some vascular surgery training. We have vascular surgery trainees who come through our unit and some of them might spend up to a year in our unit doing vascular surgery. At the end of it they will be a general surgeon, they won't be a vascular surgeon. The term general surgeon, unfortunately, is an old term which is now becoming increasingly outdated, but general surgeon in the old days meant you did everything; you did orthopaedics, urology, you did vascular surgery, and in provincial centres, in some degree, that still exists because they are the only person so they get to do everything. So the term - to say he is not a vascular surgeon means he doesn't do vascular surgery every day of the week.

Would I be right in thinking - you have seen vascular surgery after the event, of course, but you have seen vascular surgery that has been performed by general surgeons and there are general surgeons who can do it quite competently?-- Absolutely.

But that wasn't the case with Dr Patel?-- From my-----

From the-----?-- From my experiences, no.

MR HARPER: In any event, you made, on my count, four attempts to try and alert people at the hospital to the concerns about Dr Patel doing vascular surgery?-- Not to the hospital. I made one to Dr Miach, I made one to Dr Patel, and I made one to Dr Ashby at my own hospital, but I never made any complaints to a person per se at Bundaberg Hospital except for Dr Miach.

I guess I counted both Dr Miach and Dr Patel as staff of the hospital?-- Yeah, that's fine.

Your first attempt was a discussion you had with Dr Miach you say in the course of 2004 where you expressed concern about Dr Patel's performance on a renal patient?-- Yes.

Was that an unusual step, to discuss that with Dr Miach, do you think?-- No.

Was-----?-- I guess because - because I had - prior to that, Dr Thiele had been doing a large percentage of the renal work in Bundaberg, and all of a sudden I saw a change in what was going on up there, and to me that concerned me, and sort of a knee-jerk reaction, if it is going badly there, it is going to increase the amount of work I have got to do. So I wanted to get to the root of the problem straight away, sort it out as quickly as possible.

Do you know how long before the treatment of Marilyn Daisy that discussion occurred?-- I couldn't tell you.

There was then the referral from Dr Miach of Marilyn Daisy down to be treated by you. Did he have a discussion with you before he referred her down?-- No.

Did you have a discussion with him after you had initially treated her but before you sent the letter to Dr Miach?-- I can't remember whether I rang - you know, I clearly know that - obviously know I wrote the letter. So, yeah.

So at some stage you had a discussion?-- I assume I did but I can't remember it.

Did Dr Miach or anyone else contact you subsequently about the letter in relation to the patient Marilyn Daisy?-- No, they did not.

So you weren't aware that at the time you wrote that letter there was actually an investigation within the hospital going on into Dr Patel's care?-- No, I did not.

Or that part of that investigation was about the scope of the surgery which Dr Patel was performing in other areas?-- No, I did not.

You then subsequently had a discussion with Dr Patel about the possibility of referring him to the Medical Board. That's a fairly unusual step for you to take, though?-- I don't know, I get passionate about things and I clearly thought that this was a situation where if I hadn't rung him previously and received, I guess, an unusual response of someone being aggressive and rude to me on the phone - and at that time I had said to him, "Look, you know, clearly if you keep doing this then there are going to be consequences." And the letter, I guess - Marilyn Daisy - and, you know, Marilyn - I am not allowed to say her name, am I?

COMMISSIONER: Yes, yes, her name-----?-- Sorry. Again, at the time I saw her, I guess I was very upset seeing her amputated leg. But, I mean, I have been made aware of different things since that time about Marilyn, about her signing herself out. So that puts it somewhat in context. I mean, it is very hard to take someone's sutures out if they have actually signed them out of hospital, very hard to give them an outpatient appointment to follow them up, you know, if they leave. And that happens to all surgeons, that's not just Dr Patel or anyone. We get patients who sign themselves out of hospital for varying reasons and it is very hard to track those patients down sometimes. I have a number of patients who don't come back to see me in outpatients, and I go through sometimes exhaustive sources to try and track them down because I feel a responsibility that I should follow these patients up. Now, he amputated her leg, she didn't come back. It is possibly not unreasonable he said, "Well, it is her responsibility to sort the problem out." But in saying that, again, I don't know everything that happened in Bundaberg so I can't comment on that. All I can comment on is what I saw when she came to see me and what she said in terms of the fact

that, "I haven't seen the surgeon since the operation." And that's, I guess, why I wrote that letter with a reasonable amount of what you might say venom attached to it.

MR HARPER: Yes. And that letter made crystal clear, didn't it, your concern that vascular surgery was beyond the scope of the Bundaberg - of Dr Patel and the Bundaberg Hospital?-- Yes, but in saying that also, one must be careful, an amputation of a leg is not necessarily the confines of a vascular surgeon, and if she was septic and dying because of her gangrenous leg and the appropriate treatment may have been an urgent below-knee amputation to save her life - again, I can't comment why the amputation was done because I don't know the goings on in Bundaberg Hospital - but that would be an appropriate thing for a general surgeon, an orthopaedic surgeon to do anywhere in the world - Bundaberg, Proserpine, Thargomindah - if that was going to save a life.

An amputation of that nature, though, it would be fairly common for a vascular surgeon at some stage to become involved?-- Again, if the patient had what we would call stable dry gangrene of their foot, which is the most likely cause why she had her amputation in the first place, if it was not threatening her life, all right, then it would be reasonable to refer her to - be appropriate to refer her to a vascular surgeon for an assessment to see if we could save her leg. If she had what we call wet gangrene, which is infective and toxins get into your bloodstream which actually cause you to die, all right, the appropriate treatment is either urgent revascularisation, which is not an option in Bundaberg Hospital, or amputation. So, again, that would all have to be based on the patient's clinical state prior to the amputation, which I have no knowledge of.

COMMISSIONER: Even if it were a wet gangrene, would it normally be feasible to transfer the patient to Brisbane for a vascular surgeon?-- If the patient was sick and unwell, then - and the patient - and the surgeon was comfortable doing the amputation, I think it would be actually dangerous to transfer the patient to Brisbane. So that would be the wrong management.

Yes.

MR HARPER: Can I move on now to the treatment of patient P26? Is it fair to assume that with an injury of the type which that patient had, that there would be an expectation he would have required specialist treatment at some stage by a vascular surgeon?-- Yes.

You gave evidence earlier, in response to some questions from Mr Atkinson, about that the people at the Bundaberg Hospital may not have been trained in this area, and so in a sense you don't blame them. Is it fair, though, to say that any competent medical practitioner should have recognised the need to engage a vascular surgeon at some stage, given the nature of these injuries?-- I guess it depends on who you are talking about. If you are talking about the junior staff, it

is a bit of a hierarchical sort of situation, and, you know, the intern's not going to go to the consultant, "Hey, you should be ringing a vascular surgeon in Brisbane." That's not going to happen. It is a bit like, you know - I won't make any other analogies. I guess the only person who would have been making that decision should have been the surgeon who either did the surgery or the surgeon who was looking after the patient, and if they were monitoring the patient's condition on a daily basis, then my assessment is the state of the child's leg when he arrived in Brisbane, you know, days prior to that, it would have been appropriate for him not to be in Bundaberg Hospital.

But, indeed, Dr Patel, having performed the emergency surgery of tying off the femoral vein and fixing the femoral artery, at the very least should have known that at some stage it would require some specialist assessment by a vascular surgeon?-- I guess it is a matter of determining whether he believed he had actually fixed the problem at the initial operation. If he thought he'd fixed the problem at the initial operation, the child's recovery was going as planned, then, you know, it would be not unreasonable to send the child to us in two to three weeks' time. Clearly, he fixed the problem as best he thought he could. The problem was he didn't realise that the problem wasn't fixed. And that's where - you know, that's something which, you know, unless you are there examining the child every day - I can't tell you what the kid's leg looked like day 1 post-op or day 2 post-op. You know, all I can say is no-one there recognised the problem, until I think it was an orthopaedic registrar or someone found the patient, you know, nine days post surgery and was acutely concerned and rang the Royal Brisbane.

Can I put it this way: in the context of the concerns which you had previously raised with Dr Miach and Dr Patel?-- Mmm.

Would it be your view that someone like Dr Patel could do this emergency surgery but that it would be a prudent step to then transfer them to Brisbane for specialist assessment by a vascular surgeon?-- Yeah, I guess so. I mean, at the end of the day he saved his life, all right, so if he hadn't operated on him in the first place, the child would have died. In the second instance, he took the child back to theatre for fasciotomies. The second operation was possibly reasonable. Now, I am not sure of the timeline but I think we're getting into night-time now, aren't we?

Yes?-- Now, it possibly would have been reasonable for him to ring us and ask us advice at that point in time. Ringing us at 12 o'clock and trying to arrange a transfer from Bundaberg Hospital to Brisbane at 12 o'clock at night, unless you can give me a dam good reason why you want to transfer a child at 12 o'clock at night who has just had an operation, then it is possibly not the right thing to do. I mean, you know, it is not easy to give you a cut and dry answer on this. He obviously thought the kid's leg was going all right, so you wouldn't have transferred him till the next day anyway. So, you know, and then the damage may well have been done by then

anyway. So it may not have changed the outcome, is all I am saying, but if he'd come earlier it would have. I am not saying it is technically possible to change it.

You mentioned before he may have thought the kid's leg was going all right-----?-- Yes.

-----to use the layman's terms. What would have been some of the clinical indicators that the leg was not going all right?-- I guess things we would consider to be the clinical markers would be if the pain - the leg was painful, pulseless, powerless and had paraesthesia, and also was - when I say pallid or pale, we call the five Ps of ischaemia. If you have those things, he is in a lot of trouble. So, again, I have never seen the Bundaberg charts so I can make no comment on what the limb looked like, all right, but if he had those signs then there was your ongoing problems.

What about if there were a mottled colour. Would that be a pallid sort of look, as you described?-- Mottled colour may be depending on what colour the mottle is, and the distribution of it, but that may be a finding of an ischemic leg but could also be a finding of someone whose arterial circulation is fine but he has venous congestion in his limb. So there can be two different types of mottling in that situation.

You also gave evidence earlier in response to the questions from Mr Atkinson about the importance of when a leg becomes ischaemic getting it treated as quickly as possible?-- Sure.

Is it fair then to say that as soon as there were clinical signs that the leg had become ischaemic, there should have been a heightened awareness of the need to transfer the patient to Brisbane?-- Yeah, I mean, he - what we would say is revascularised the limb when he did the vortex graph. So the leg - in a true sense, there was no ongoing arterial ischaemia at that time. The problem possibly for this child is that he developed what we call a compartment syndrome, and that was possibly the major cause of him losing his leg, and the surgical treatment for that is, you know, aggressive fasciotomies and sometimes even doing that, you fail to save the person's leg. So - but, you know, I have said all along I think the child should be transferred. You know, the timing of the transfer clearly couldn't be before the first operation, possibly could have been after the second operation. Again, you know, I wasn't there.

Could I just show the witness this document, which is the referral letter from Dr Risson?

COMMISSIONER: Do you want it on the screen?

MR HARPER: That probably would be of assistance. You can see there the third paragraph of that letter refers to the initial emergency surgery. Further, two paragraphs down, it says, "At 1700 he returned to theatre for left leg compartment syndrome with a pulseless leg with upper and lower fasciotomies performed." Would those be the sorts of indicators which, as I say, would have again heightened the need for a transfer to Brisbane sooner rather than later?-- I would have to say yes. Where's the bit about the pulseless leg? I missed that bit.

At 1700?-- In the statement - oh, with a pulseless limb. Yeah, I mean, I guess - it also depends on whether he's pulses came - see, you can have pulseless leg after - prior to fasciotomies being done and they can actually return after the fasciotomies been done. I mean, I, not knowing whether the pulses were there after that procedure, I can't comment whether - all I'm saying is if his limb was still pulseless after the fasciotomies, then the kid's got a real problem and he should have been transferred at that point in time. If his pulses came back, it's possibly not unreasonable to do anything further. I would be surprised if his pulses came back, because then they took him back to theatre and actually fixed his artery in the next operation.

Yes?-- So, clearly he wouldn't have had pulses after the 1700 operation. So - you know, they are in trouble and it's still taken them another four hours to actually get him back to theatre again. So he actually possibly shouldn't have left theatre after the fasciotomies and had an angiogram on the table, is what we would have had done in Brisbane to determine what was going on.

And again, you will see further down, two paragraphs down, at 2100 he's returned to theatre with acute left lower external extreme ischaemia?-- Ischaemia.

From your evidence earlier, does it not then become critical that they try and transfer him as quickly as possible?-- Well, no, because he fixed the artery at that operation. So, I mean, he's fixed the problem but the problem is now it's - you know, what was the original injury, 11.45. It's now 9 o'clock at the time, but by the time you finish the repair it's possibly, you know, 11 o'clock at night. So this has been going for a fair while now. One of the reasons why people might say how can he miss that the artery wasn't - you know, the injury to the artery, the original operation, what happens with a sort of massive trauma like this is the actual artery spasms and there's no bleeding. So he wouldn't have actually seen any bleeding at the original operation from the arteries, so he possibly didn't recognise that the artery was injured. It's just one of those things. If you aren't there all the time you don't recognise these problems. If there'd been another vascular surgeon, you know, Dr Woodruff or

someone of that standing, I am sure they would have picked up on that.

Or perhaps Dr Thiele?-- Yeah, Dr Thiele may well have sorted the problem out. But, you know, Dr Thiele's not - is not employed by the public hospital, so he's - you know, he wouldn't have - they wouldn't have even thought to call him about this problem.

COMMISSIONER: I think on the evidence he was overseas at the time?-- Yeah. So I mean, that clearly wasn't - wasn't someone who they could go to.

MR HARPER: In any event-----?-- Yes.

-----as I have said, this is the sort of surgery-----?-- That he may have - may well have been able to deal - he certainly would have been able to deal with it appropriately in Bundaberg.

It's surgery within the scope of practice of a vascular surgeon?-- Yes.

Just one final matter. You referred earlier to the patient's continuing treatment and your continuing to be primarily responsible for his care?-- That is correct.

There was just one matter which I wanted to clarify, and if you go to paragraph 19 of your statement-----?-- Yep.

You mention that in the second and third sentences, "We amputated through the knee to save him and we also did a skin graft from part of his leg. The skin graft still has not healed." I just wanted to clarify the current state of that skin graft, though. Is that - it has now healed?-- It's - the skin graft is in the area where he had his fasciotomies, which is a long lateral incision on his thigh, and one of the problems being - is that that's where his prosthesis socket fits, and it will heal, it breaks down once he gets fitted with the limb, which he's presently being fitted with, so at the moment it - I'm - to my knowledge it's actually - it is not healed, it's broken down again. So that will be an ongoing problem. That problem again can be resolved with the higher tech prosthesis and that appears to have less problems with skin grafts like this and we can fit silicon sockets into them. So, again, that also shows the importance that the sooner this boy gets this limb the better for him, save him having another operation. The only alternative is doing most likely a free flap, which is taking a muscle flap from another part of his body and putting it into that area, based on the fact that the muscle, which is in his thigh, was severely damaged as well, and - you know, I was fairly amazed when we were actually able to save his leg through the knee. Normally we go below knee or above knee. The reason I went through the knee was there's no muscle in your knee, whereas the muscle in his thigh was damaged, and the muscle we - would have actual skin grafted on to has had a reasonable amount of ischaemic damage to it. So, the only other option was for him was a

hindquarter amputation when he arrived. So I opted for the less radical surgery in the hope that we may be able to give him a more functional life, and fortunately he's got away with it.

I have nothing further, Commissioner.

COMMISSIONER: Thank you, Mr Harper. Mr Allen?

CROSS-EXAMINATION:

MR ALLEN: Just briefly. Doctor, my name's John Allen. I'm appearing for the Queensland Nurses Union. You mentioned that there's been a trend I suppose in hospitals nationwide, if not worldwide, towards decreasing the length of stay, and is that something which has been a trend over at least the last 10 years?-- I think it's been a rapidly increasing trend, possibly over the last five years. I mean, in Queensland we're a member of what we call the Health Round Table, which is 10 benchmarking hospitals throughout Australia, and our goal standard for whether we're as good as the other hospitals is our length of stay. So clearly we're all competing with each other to try and get the shortest length of stay, rather than the best. That doesn't mean we're not providing the best health care, but sometimes it may lead to less than optimal care. Now, I find it hard sometimes to admit someone for an operation, major surgery, and I know they might be 80 years of old - 80 years of age, they have got to get up at 4 o'clock in the morning, they have got to get to the hospital by 5.30, sit in a queue for two hours, and then go to an operating theater at 8.30. I mean, these poor old people are coming in sort of, you know, exhausted to have their surgery purely to save a day in hospital. You know, I mean, I think we also have to be humane as well as - providing a service to the community. I mean, there are two standards of care and I always think - I try and treat patients like my relatives, and sometimes I don't think I do because I'm forced to cut corners and get them in and out of hospital quickly.

COMMISSIONER: And doing all of that under a nil by mouth regime and-----?-- Yeah, I mean, poor little old grandma can't even, you know, have a cup of tea. The last cup of tea she had was at 6 o'clock the night before, and they get there and they're exhausted. But we have saved a bed day in hospital. And sometimes it's - the only way we can get patients into hospital is actually bringing them in the day of operation to get it done. It's efficient, it's - you know, people will possibly say there's no difference in outcomes, they will put up all these figure and say, you know, you don't have any greater complication rate because you bring them in day of surgery. It's also about the patient.

Excuse me a moment, Mr Allen. Mr Harper, were you intending to tender that referral letter? I thought it might make sense.

MR HARPER: I am happy to tender that.

COMMISSIONER: I don't think it's in evidence anywhere else at the moment, is it?

MR ATKINSON: It might be actually, Commissioner. This is the letter from Dr Risson?

COMMISSIONER: Yes.

MR ATKINSON: Perhaps we should check that over lunch. I think it is in evidence.

COMMISSIONER: Yes, yes. I will let you do that. Sorry, Mr Allen.

MR ALLEN: So, I suppose, a inevitable consequence of that trend is that although patients are in the hospital for a shorter period of time than they may have been five or 10 years ago, during the period of time that they are in hospital they are actually sicker than a patient would have been five to 10 years ago?-- Yeah, maybe, maybe not. I mean, there are things that - things that we do - things that I do that five or 10 years ago they used to stay in hospital 10 days and now I do it for a minimum invasive technique and - you know, an aneurism stays in for two days and they are significantly better off. So, we make savings with technology but we also, I think - you know, 20 years ago people having a hernia repair would stay in hospital for a week because they thought that if they got them out of bed too quickly they could get a recurrence. Well, that's proven to be rubbish, you know, patients coming in for surgery to have their hernias fixed. So there will be some patients who - you know, clearly technology and improvements result in us keeping them in hospital for shorter periods of time, but there are other patients who we try and push out of hospital quickly. We're forced to try and get patients back to their communities possibly prior to when they would be discharged from us, so we will have to ship them into an ambulance, send them back to Nambour or Bundaberg or Hervey Bay, so - and then they have - the rest of their recuperation is in those hospitals. Now, that's less than ideal because there's no-one in those hospitals who does vascular surgery, but if I don't get them out of the hospital then there are two or three patients I will cancel off my list tomorrow. So, I have got to weigh up - you know, the balance of the needs versus the dangers of what we do, and most of the time, you know, it's safe, but it's pushing the system. It all comes back to beds. It all comes back to, you know, there are 300 and whatever beds in the Royal Brisbane Hospital and it's clearly not enough.

Overall, the trend associated with the decreased length of stay has been a rise in patient acuity for those patients in the hospital at any one time?-- Yeah, I think we - it's clear I do less what we call elective vascular surgery than I did five years ago. Most of the patients I operate on are all category 1 patients who have had multiple major morbidities

and they are sick patients and that's what I do. I don't do varicose veins, I don't do - operate on people with simple claudication any more, because we just don't have time. So the pressure actually flows back on the staff, the nursing staff, the junior medical staff, intensive care, everyone's working on sicker people. You know, I'm commenting on what I do, but in what I - the area I work, we are more stressed than we have ever been and, you know, five years ago when I was on call I used to get called in maybe once in five times. Now when I'm on call I'm in the hospital pretty much every weekend operating, and that's just the nature of what we're faced with. It's no-one's fault.

No. It's not just nursing staff, as you pointed out, but certainly this decreased length of stay, more people going through the beds, higher patient acuity, means that nursing staff are having to work harder than they may have five or 10 years ago?-- Yeah, I have no doubt that they are having to work harder. They are having to grasp, you know, fresh technology at a rapidly growing rate and to understand what we're doing - you know, because we're doing different things differently. Yeah, I think everyone's working harder than they possibly were 10 years ago. So, you know, we, nurses, doctors, administrators, we are all working harder.

Yet with the rise in population in Queensland over the last 10 years there's always been a drop in full time equivalent nursing numbers per hundred thousand of the population in Queensland. That would simply exacerbate the workloads and stressors upon nursing staff, would it not?-- Yep. I have no doubt - you know, sometimes - you know, you have got to advertise jobs to get people to come and work and - you know, you can always say there's shortage of doctors, there's a shortage of nurses. I personally don't believe there's a shortage of anything. You have got to actually put an ad in the paper and pay them an appropriate amount of money and they will come and work there. You know, if you run something down, people will walk away from it because they don't want to work there. If you make it something good, people will come to it. You know, build it and they will come. Well, we have got fantastic hospitals in Queensland. People want to work there but you have got to advertise jobs to actually get them through the door. Until you do that, you are not going to staff the hospitals appropriately.

You have also got to be an attractive employer and Queensland Health certainly is not for nursing staff or medical staff, is it?-- You know, I mean, again it's - the loss of student nurses in hospitals was the - you know, possibly one of the biggest monetary problems that Queensland Health ever had to face. You know, in those days you'd have three or four student nurses who were paid very little and two registered nurses on a ward. Now, you have got seven or eight registered nurses on a ward. The cost of nursing has gone up dramatically and no-one really factored that into their budgets, you know, 10, 15 years ago. Every nurse you employ - and we need them and I'm not saying, you know, we don't need them - but it's cost a lot of money, and -

because all nurses now are registered nurses in the hospital pretty much, aren't they? The student nurses come and go, but they are not a constant in any public hospital.

Well, there's been a trend towards more highly qualified nursing staff to meet the increasing needs of such-----?-- Yeah, I am totally with that and I think that - you know, the more qualifications the better, but sometimes - you know, that costs money as well, and it's all about money. I mean, the whole thing - more nurses costs more money. More doctors costs more money. Doctors want more money. It's about money, you know.

Yes?-- Don't worry about the patients, it's about money.

Thank you.

COMMISSIONER: Mr Devlin?

CROSS-EXAMINATION:

MR DEVLIN: Yes. Doctor, Ralph Devlin. I represent the Medical Board of Queensland. Can I just ask you a few questions? I will be as quick as I can. You said early in your evidence that protocols concerning transfer of patients from provincial centre are learned protocols. What do you mean by that?-- Learned protocols. I guess that the protocol is that if you have a problem you ring the teaching hospital that is in your region or zone, you ask for the appropriate registrar who gives you the appropriate advice, and that's something which you saw when you worked in that hospital and that's how the process was undertaken. There's possibly now slightly more sophisticated protocols of interhospital transfer, but that's different to ringing up and asking for advice. I think - you know, the job that Stephen Rashford does is a program of - there is a definite protocol there for transferring-----

Yes?-- -----of a patient, but that's different to ringing up me and asking me whether I will accept the patient. I might just say, well, you don't need to come, and that's - that's possibly the most important person, is the specialist who's going to ultimately accept the patient.

Does it follow, though, from the observation you made that overseas trained doctors, at least the newly arrived ones, are at something of a disadvantage until they can pick up those nuances of learning of protocols in the general way which you have put it?-- I am sure that's the case, but I think as an employer - it doesn't matter where you work - surely you give someone a reasonable orientation to actually put them in a situation where they understand the system they are working in, the state they are working in, and where they go next if they do have a problem? I mean, that's something which we do

poorly as doctors. I mean, you know, we don't have very good orientation, you know, we - at the start of every year we get new registrars, new residents, and it's day 1, the first time you meet them is usually in an operating theatre and they are straight into it, you know. So, they learn along the way.

At least orientation would help?-- Orientation especially for overseas doctors, I think, would be - I think we should make it mandatory so they understand what is quite a difficult state medically to manage.

Yes. Thank you. Turning now specifically to the patients, the two that have been mentioned here. In relation to Marilyn Daisy, you speak of your sense that nobody had offered her the option of trying to save her leg with a bypass operation. Specifically, what sort of bypass operation did you have in mind?-- I asked her whether anyone had offered her the option to see if her limb could be salvaged. I can't offer her any option. I don't know what her arterial tree looked like prior to her leg being amputated. Unless she had an angiogram or an ultrasound, then - you know, your guess is as good as mine. The majority of these people have a combination of large and small vessel disease, so if they have significant small vessel disease, then the probability is low that she would have had a limb that was salvageable, but - I can only comment on the question I asked her and that was, "Did anyone offer you the option?", and she said no. So, I can't - I can't comment on anything else.

Is it your opinion, then, that general surgeons of good repute would consider that such a consultation should have occurred or is it one of those categories where, as you said in relation to fasciotomies, I could give you half the room of surgeons who might take-----?-- Sure.

-----a view? Which is that? You see the difference?-- I do. I mean, we - I mean, I get a huge number of patients, you know, referred to me with exactly the problem that - this problem happens on a regular basis for our opinion.

Yes?-- No, the only reason not to offer her an option of revascularisation at her age is she was too unwell, okay, she didn't want it, or she had a degree of gangrene on her lower extremity which would not have allowed us to salvage her leg and the ultimate treatment would have been of below knee amputation anyway. So they are the three options. A lot of the times you have got to be careful that if you - he may have actually - the person looking after him may have actually asked the patient whether he wanted any surgery or an opinion from Brisbane and they may have said no. A huge number of patients in provincial centres do not want to come to Brisbane. They are quite happy once they are there, but it's just that initial take them out of their community and they are not 100 per cent happy with that. So, what was verbalised to that patient in Bundaberg Hospital, I can make no comment on, or-----

COMMISSIONER: Doctor, this isn't the 100 Years War. You

don't cut people's legs off, generally speaking, without exploring the other options?-- Unless - unless - if she was septic and, you know, needed her leg operated on, you can - you know, if it needed to be done, it needed to be done then.

Yes?-- Okay. So if someone could bring a charts and tell me her pulse was 140, she had a temperature of - you know, 39.5 and she was confused and unconscious, transferring to Brisbane would have been the wrong thing to do and an amputation in that hospital is exactly what I would have done.

Of course?-- Okay. So-----

But you'd explore those options first, you wouldn't just-----?-- Dependent on the patient's condition.

Yes?-- Yeah, I mean, you know - but if she was that sick then amputation is treatment of choice. No-one would argue with that.

Similarly, whilst you may have a lot of experience of patients reluctant to come to Brisbane, if it's a matter of saving or losing a leg, most patients would make the sacrifice of coming to Brisbane?-- Yeah, I can think of not too many who wouldn't.

Yes.

MR DEVLIN: Thank you. In relation to a review of the initial surgery, within what period of time would you expect a review should have occurred? Assuming for the moment the history she gave you was correct, within what period of time from the surgery would you expect a review to have occurred?-- The morning after.

Thank you. Now you have - in relation to your telephone conversation with Dr Patel in which you mentioned that you would report him to the Medical Board of Queensland, can you assist any further with any further context of that conversation, firstly, was it in this context of Marilyn Daisy? If you are unable to say, then, please?-- I mean, I couldn't give you the exact situation that it was involved with. I mean, I clearly said it and clearly I - well, you can read that I wrote it. So, but I - I never contacted the Medical Board of Queensland.

I understand that?-- Yes.

Can you assist us with any context?-- I can't tell you the exact - the exact - I'm pretty sure it was after the brachiocephalic fistula and I am sure it was a Friday night because I can remember sort of being angry at - they send these patients down to us with complications on Friday night after they shouldn't have been doing the surgery in the first place, and you are sort of stuck in, so it sort of scratches on you a little bit. But that's what we are there for and that's not a problem, but it wasn't because we were on Friday night, it was just, I guess, because it's - there was a trend

occurring that may be needed to be looked at.

Thank you. In relation to the next patient, the child patient, then if his leg was ischaemic for a period such as six hours, do you see that as being a pointer to the leg not being viable in the longer term or would you say that there was nevertheless in your opinion a possibility of saving the leg?-- I guess it's - it's possibly an exponential curve from four hours on that the chances of saving the limb decrease dramatically, all right, but the original surgery was done - if he had his artery repaired at the original operation there is a high probability his leg would have been saved.

Very well?-- As time went on, that probability decreases. But clearly, as Mr Atkinson said, we have collaterals coming out of her leg. We also have collaterals going into our leg of different arteries, and that's possibly why younger people's legs can survive a longer ischaemic time than an older person's legs because those collaterals are undiseased. So to give an absolute, I can give you an absolute time of when this child's leg would no longer have been salvageable, but clearly from four hours onwards the longer it goes the less likely it becomes.

COMMISSIONER: 6 o'clock, six hours is getting a bit on the-----?-- Again-----

-----perimeter?-- No. In a young person that's possibly not - you almost certainly will be able to salvage their limb in six hours. If it was a kidney, no, but a limb, yes.

MR DEVLIN: Turning to the point - only got a few more questions - turning to the point where the first operation was done on the child, is it your opinion that most surgeons of repute would consider the failure to transfer at that point unacceptable or is it more at the point of the third operation?-- It would be the third operation. First operation - I think the first operation - the fact that they didn't recognise the injury is, I guess, understandable.

Yes?-- It's the fact by the third operation we have got a child here with a pulseless leg that's been going on for 10 hours - I can't remember the time line - but it's - you know, it's a considerable period of time, that we're in trouble here and we need help.

Yes. Now, in relation to the failure to consult, is it your opinion that the failure to consult with a specialist after the first operation is something in your opinion that's unacceptable or is it more after the third operation?-- I think after the - after the - well, prior to the third operation. I think after the third operation. I think when you are walking into the theatre for the third time in the 24 hour period and you are clearly not sure what you are doing, then that's the time you should be asking for help, and doing the third operation in Bundaberg is not the wrong thing to do, but maybe just getting on the phone and saying, "Tis is what we have got. Have you got any ideas?", or, "What should

I do?"

Thank you. Now, in relation to the failure you spoke of to arrange cover for the patient of a suitably qualified practitioner once the surgeon went away, again, are you of the opinion that surgeons of good repute would find that to be unacceptable?-- I guess - I don't know who was covering for him when he was away. I have got no idea what his qualifications are and he may well be a surgeon of good repute, and I am sure he is. I guess he was thrown into a situation where it was possibly - he didn't even realise it was out of his league. I think most of us would accept that if we go away for even a weekend - if I go away for a weekend and I've got patients in hospital, I will contact one of the other vascular surgeons who works in our unit and tell them what I have got in hospital and what I'm worried about, more importantly. It's usually the patient - will be one patient in a hospital at one time that we're worried about and that's this specific patient who you will go and focus on the next day. If he said, "Can you look after my patients?", and then say, "I have got a 15 year old boy of - just taken to theatre five times or three times", then it's not the fault of the person looking after the - takes over the care, it's the fault of the person who didn't actually inform him they had a very sick kid sitting in a hospital bed which he may not even have found out about for five days.

Yes?-- You know, so he relies on his registrar. I mean, we all rely on our registrars and on our residents to see patients on weekends, on public holidays-----

Yes?-- -----when we're not on call. So I don't blame the person who was - who got handed over the care. I only blame him if he knew that the patient was as sick as he was, but I assure he possibly did. I am sure he was not well aware of the situation at all.

Following, looking at the period after care and keeping in mind the state of the leg which you found it on New Years Day, when the boy arrived - or very soon after New Years Day - we now know that the central line of antibiotics was taken out a few days previously. From a vascular point of view, can you think of any reason for having done that?-- I think they thought the kid was out of trouble.

That's the way you see it?-- One of the deceptions of the fasciotomies is on the outside of the fasciotomy everything looks okay. Like, it actually looks pink - and I've got photographs to show it looking pink - and I'm sure the poor resident or registrar who is looking at this kid every day saw these pink fasciotomies and said, "The kid's leg looks great. Let's do a skin graft", but little did he know that deep to all that red stuff was dead muscle, and stopping the antibiotics was possibly - that had no effect on the outcome of this boy.

So this is really another area where specialist care was really indicated?-- It would have helped. It would have helped.

Thank you.

COMMISSIONER: Mr Devlin. Mr Diehm?

MR DIEHM: Thank you.

CROSS-EXAMINATION:

MR DIEHM: Doctor, my name is Geoffrey Diehm and I'm for Dr Keating. I just want to ask you a couple of questions, if I could, about your letter of 2 November 2004 to Dr Miach. Do you have a copy of that?-- Yes, I do, thank you.

In your statement in paragraph 10 you detail the concerns that you've had concerning P52's treatment, and you distill it to three aspects, the first of which you mention as being that nobody had offered her the option of trying to save her leg with a bypass operation. Now, please, doctor, don't take my question as quarrelling with your view that she should have been offered that, but are you able to say whether there is - whether that topic is the subject of your letter of 2 November 2004?-- Sorry, I don't understand the question specifically.

COMMISSIONER: Did you mention that concern in your letter?-- That she wasn't offered an operation?

MR DIEHM: Yes, or that she should have been?-- Basically the letter of 2nd of November I was reiterating my conversation which I had with my patient in which she stated she was not offered an option of salvaging her limb, yes, and I put that in the letter.

Now, I'm sorry, can you just direct me to the part of the letter where you deal with that concern?-- Maybe I didn't put it in that letter, sorry.

I just want to be perfectly clear, Dr Jenkins?-- No, that's fine. It's not in that letter.

Thank you?-- Okay?

The other question - and your misunderstanding about what you had included in that letter may explain why you responded to Mr Harper in this way, but Mr Harper, who appears for the Bundaberg patients, a little while ago asked you a question about this letter, and he put the proposition to you words to the effect that it raised as an issue that vascular surgery should not be being done at the Bundaberg Base Hospital, and I think you responded quickly, in getting on with your answer, in an affirmative way that the letter did make that observation. Is it right to say that the letter doesn't actually make that observation?-- "I think if procedures can't be performed" - the spelling is not correct, but - "appropriately within the Bundaberg Hospital, they should not be performed at all." That - I don't know what that means, but to me that says if you can't perform the procedure then you shouldn't be performing it in the hospital. Now, that's not to say that if a vascular surgeon is working in Bundaberg Hospital then it's appropriate for those procedures to be performed there. So if Dr Thiele is on staff at the time then it's totally appropriate for a vascular surgery procedure to be performed in Bundaberg Hospital. Did you get the paragraph I wrote that in?

I'm sorry, if you could just help me?-- Just go to the letter, the second last paragraph.

Yes?-- "I think if procedures can't be performed appropriately within the Bundaberg Hospital, they should not be performed at all."

Thank you?-- That defines everything. That's vascular surgery, you know, taking a toenail off. If the person is not trained to do it then they shouldn't be doing it.

Now, that - what particularly sparked that comment was your concern about - as you understood the history at that time, your concern about the problems in the follow-up of the patient after her surgery?-- Yep.

And in particular that she had been left for so long with these sutures still in the stump?-- Again that's purely based on her discussions with me, and, you know, I was not aware at the time that she signed herself out of hospital. So, you know, again I can't comment on - I'm only commenting on what I know at the time that letter was written, all right?

I understand.

COMMISSIONER: Doctor, was that comment also taking into account your views about the renal access work that you had seen?-- Yes, I think it was discussing the whole thing. We'd had conversations prior to this about renal access, and I guess Marilyn was a renal access patient with another problem which, you know, I just happened to stumble upon. I mean, she came in wanting a fistula. She didn't come for me to look at her below knee amputation. I noticed a bandage on a below

knee amputation stump and I said, "When did you get that done", and she said, "Six weeks ago", and I said, "Do you mind if I have a look at it? Has it not healed yet", and she said, "No, it hasn't healed yet." So I took the bandages down. She had an area of gangrene on her stump, she had sutures left in, and I said, "So have you seen the surgeon since the operation? What's he going to do about this", and she said, "I haven't seen the surgeon since the procedure", and I said, "Did he offer you a chance of saving your leg", and she said, "No, they just said I need my leg off." Now, that's all I'm privy to. Okay? It wasn't my place to take her stump down. The reason I took it down is if I'm doing an operation and she's got gangrene in another part of her body, then it's inappropriate for me to operate on her. So I was assessing the patient in toto so I knew what I was dealing with, and, you know, when I have a conversation with someone, they can tell me their side of the story, and that's the only side I've got at that point in time, then I'll believe that side of the story. Okay? Now I know that the story is somewhat different, but at the time I was responding to the story I was given, which I think was appropriate.

MR DIEHM: Thank you. Thank you, doctor. I don't have anything further.

COMMISSIONER: Thank you, Mr Diehm. Ms Feeney?

MS FEENEY: I have no questions.

COMMISSIONER: Mr Fitzpatrick, any re-examination?

MR FITZPATRICK: Commissioner, just one thing that might be helpful.

RE-EXAMINATION:

MR FITZPATRICK: Do you still have a copy of your letter to Dr Miach in front of you?-- I do.

Could you focus, please, on the second paragraph and the sentence that begins with the words, "I was astounded when I discussed with Marilyn about when did she have her left below knee amputation" - do you have that sentence?-- Yes.

You go on to record an understanding about her condition. Does that - is that a possible explanation as to why-----?-- Sure. I mean, as I've said, if she was unwell and she needed it done then it was - if it was a lifesaving procedure then it's totally reasonable for her to have her leg amputated with no investigation to save her life, and that would be a standard practice by vascular surgeons throughout the world.

I see. Yes, thank you for clearing that up, doctor.

COMMISSIONER: Thank you, Mr Fitzpatrick, for clearing it up. Mr Atkinson?

RE-EXAMINATION:

MR ATKINSON: Thank you, Commissioner. I'll just stick with this letter and nothing else, Dr Jenkins. You sent the letter to the Director of Medicine and you CC'd it to the Director of Surgery?-- Yep.

You used the word "venom". Certainly you're t'd off. I mean, you use the words "mind boggling", and you talk about, "It's strange that a surgeon would do these things", and then effectively you say, on the penultimate paragraph, "If you can't do vascular surgery properly, how about you don't do it at all." You mentioned you didn't receive a response to the letter. Did you receive any feedback about any steps that the hospital had taken, or either director had taken in consequence of your letter?-- Well, I guess it sort of - one director the letter is written about, and one director - the letter is written to the other director, so the question is did either of the directors actually talk to each other, and I don't know the answer to that.

COMMISSIONER: Or did either of them talk to you about it?-- Well, none of them - I mean, I guess I'm not sure whether - the only response - Peter Miach did say - he did do something about it. Okay? He said, "I'm not going to send any more renal patients to Dr Patel." So he clearly took a positive step, okay? And as far as the Bundaberg Hospital and Queensland Health, that's the positive step that needed to be taken in that particular instance. In terms of vascular surgery, you know, he didn't do vascular surgery such as a fem pop bypasses, he didn't do aortic surgery, he didn't do carotid surgery. The appearances are that he did vascular surgery when it was a lifesaving situation for the most part, apart from his renal access surgery. Now, I've no problem with him doing lifesaving surgery as long as he knows when he's done it - if he is still not sure that he's done enough or something more needs to be done, to get on the phone, and I'd expect that of anyone.

Thank you.

MR ATKINSON: In terms of this letter from you, the only response you received was-----?-- The only response I had is verbal from Peter Miach, and that's pretty much it.

Thank you. Nothing further. I might physically tender the statement before it goes.

COMMISSIONER: No, I think we-----

MR ATKINSON: I've tendered it formally, but you don't have it with you.

COMMISSIONER: Yes, all right. Thank you.

MR ANDREWS: It's been worked over. And then if the doctor might be excused, Commissioner.

COMMISSIONER: Yes, indeed. Doctor, can I just say to you, as a mere lawyer I've really been humbled by the calibre of medical evidence we've received at this hearing. It has been a wonderful, although at times very distressing experience to hear the contributions that people like yourself have made. I am, for myself, and for the two Deputy Commissioners, very grateful for your time and for the frankness with which you have expressed your views to us. We appreciate it very deeply, and you're excused from further attendance?-- Thank you.

WITNESS EXCUSED

MR DEVLIN: Commissioner, may copies of Exhibit 255 be made available over lunch?

COMMISSIONER: I'm sure that can be arranged. Mr Atkinson, when is Dr Ray-----

MR ANDREWS: He was scheduled for 2 o'clock, but he's actually made contact with me to say that he's caught in an operation, so he won't be here at two, and I intended to make available instead Mr Tathem.

COMMISSIONER: All right. Shall we resume at 2.30, then if Dr Ray has arrived by then we can continue with him, if not Mr Tathem can see us out.

MR ANDREWS: That's perfect. That suits.

THE COMMISSION ADJOURNED AT 1.41 P.M. TILL 2.30 P.M.

THE COMMISSION RESUMED AT 2.38 P.M.

COMMISSIONER: Mr Morzone?

MR MORZONE: If it please, Commissioners, I call Glenn David Tathem, G-L-E-N-N.

MR FITZPATRICK: If the Commission pleases, I appear for Mr Tathem.

COMMISSIONER: Thank you, Mr Fitzpatrick.

GLENN DAVID TATHEM, SWORN AND EXAMINED:

MR MORZONE: Your full name is Glenn David Tathem?-- That's correct.

You're currently the Acting Manager of the Probity and Investigations Department of the Compliance Section of the Queensland Office of Gaming Regulation. Is that right?-- That's also correct.

You prepared a statement in this matter, and attached to that statement is a copy of your curriculum vitae. Are the facts contained in your statement, including your curriculum vitae, true and correct to the best of your knowledge and belief?-- They are correct.

Is your professional address care of the Fifth Floor, 33C Charlotte Street, Brisbane?-- That's correct.

I tender the statement, if it please, Mr Commissioner.

COMMISSIONER: Yes, Mr Tathem's statement will be Exhibit 256.

ADMITTED AND MARKED "EXHIBIT 256"

MR MORZONE: Mr Tathem, you, on the 4th of June to the 22nd of December 2004, were on secondment to Queensland Health in the position of Principal Internal Auditor Investigations?-- That's correct.

And as Principal Auditor your role was to investigate suspected official misconduct?-- Yes.

And that's involving staff employed by Queensland Health?-- With Queensland Health.

And also in that role you made certain recommendations on whether health service districts were compliant with internal policies and procedures?-- That was all part of the investigation. We'd look at the procedures aspect as well as making a finding against staff members of official misconduct.

You also conducted ethical awareness information sessions throughout Queensland. Is that right?-- That's correct.

Those ethical awareness sessions were held in a number of districts other than Bundaberg. Is that right?-- We actually rolled out the ethical awareness - sorry, the ethical information sessions to most of the districts I'm aware of, and I was responsible for rolling out 13 of those information sessions.

Now, we've heard evidence before that one of the information sessions occurred in Bundaberg in October 2004, and it coincided with other events which occurred at Bundaberg. Can you tell the Commission when it was that the Bundaberg information session was organised?-- The actual session itself took place on 14 October. In terms of the arrangements of the session, I wasn't involved in arranging that particular session or making contact with the district itself, but it would have been some weeks leading up to that.

Okay. Was Bundaberg part of other hospitals that you visited as part of that tour of Queensland, so to speak?-- Yes, that particular week we actually, I believe, delivered five information sessions across the North Burnett, Bundaberg, Gladstone region, and Bundaberg was at the tail end of those sessions.

You state in paragraph 7 and 8 that each information session was presented by one or two people, including yourself?-- That's correct.

And that the sessions were designed to make employees aware of matters involving the reporting of, principally, misconduct. Is that correct?-- Yes, essentially the sessions were designed to provide an overview of the legislation and policy which provide for the ethical framework within Queensland Health for staff to abide. Also with - the information sessions provided staff with an overall view of our role - when I say "our role", the Audit and Operational Review Branch, because there was not a great awareness of that particular branch and the functions of the branch. We also looked at the reporting of official misconduct. We talked about four types of misconduct which were commonly reported to the Office, and we also talked about the protections afforded to whistleblowers.

The basis of the information session was a powerpoint presentation, and you reproduced in your statement the slides that were used for that presentation, is that right?-- That's correct.

In that exhibit which is exhibit GDT4, there is an area of information contained within a box and then some further information underneath it. Is it the boxed area that was presented on the powerpoint presentation or the whole page?-- The actual - the slide is the top part of the page and the presenter's explanatory notes appear at the bottom half and those explanatory notes expand on each of the dot points raised in each of those slides.

I will take you to that a little bit further in a moment, but upon your arrival at the hospital, you have said in paragraph 19 and 20 as a general courtesy you usually call on the manager of the hospital, in this case it was Mr Leck, is that right?-- That's correct.

Do you recall anything that was said to you at that meeting prior to the presentation relating to the particular circumstances at Bundaberg?-- No, nothing at all. The meeting with Mr Leck was, as like any normal meeting we would have with a district manager. It was just more of a meet and greet to say we actually arrived, we were there. We talked about the information session and what we'd actually be discussing. Each district manager is provided with a copy of the slides and we would also ask whether there was any particular issue that may not be addressed in the content of the information which may also be raised during the information session. In this case - the district managers were quite pleased with the issues that we were discussing, in terms of four main types of conduct, that being assault, substance abuse, breach of confidentiality and theft or fraud, sorry.

You mentioned just a moment ago - you used the word managers, in plural?-- Talking about the district. I do 13 districts so I am referring to the 13 district managers.

Now, do you recall whether Mr Leck on the 14th of October told you anything about Dr Patel or any complaints about Dr Patel?-- No, not at all.

Was it the case that you were at any time brought to Bundaberg in response to issues about Dr Patel?-- No, not at all. That was all part of the statewide rollout of the training, of the information sessions.

If you go to your exhibit GDT 4, if we perhaps pick through it very briefly, we see, I think on page 17 of your statement, you explain there or the slide talks about why you are there and why you are talking about ethical awareness?-- Yes.

And then where you are through to-----

COMMISSIONER: Mr Morzone, just while you are on page 17, I

see that in a number of places this slide show talks about the code of conduct, and we've obviously had reference to that in proceedings but I am not sure we actually have a copy of the code of conduct in evidence.

MR MORZONE: No, we don't.

COMMISSIONER: Could we-----

MR FITZPATRICK: We will attend to that, Commissioner.

COMMISSIONER: I appreciate that very much, Mr Fitzpatrick.

MR MORZONE: Can you tell me, perhaps first of all, this: were you party to the preparation of this information or were you involved mainly in the presentation of it?-- I was only involved in the presentation of the session.

So not in the preparation of its content?-- No.

Who prepares the content?-- I believe the content of the presentation was done by Rebecca McMahon, the Acting Manager of Internal Audit and Investigations and that included the explanatory notes as well.

The material, if we go through it again very briefly, I think has an emphasis upon official misconduct or what I might call serious misconduct of, like you said, assaults of a criminal nature, rather than upon necessarily the competency of medical practitioners, or the nursing practitioners, or the like. Would that be a fair statement?-- Yeah, the sessions purely looked at the trauma behaviour which constituted criminal offence, and that's part of the definition of official misconduct, the Crime and Misconduct Act. It either warrants dismissal action or it is a criminal offence.

And-----

COMMISSIONER: To put it another way, you focussed on positive acts of wrongdoing such as assaults, frauds or substance abuse, rather than an absence of skill or an absence of qualifications or something like that?-- That's correct, Commissioner.

Yeah.

MR MORZONE: Okay. And whilst we're on it, I suppose - you tell me if you are not in a position to make these statements generally from your background - but obviously the encouragement of staff who have information about clinical competence or have good reason to believe that doctors or nurses aren't meeting a certain clinical standard, encouragement of that staff in an open forum within the internal organisation would be a good goal to achieve? Would you agree with that or are you unable to comment?-- I probably can't really make a comment on the later statement regarding the competence, but certainly we've reinforced with staff the obligations under the code of conduct and also

legislation to report acts of wrongdoing or maladministration.

Do you know - you refer in your statement, for example at page 22, of the duty to report misconduct. And again you deal with fraud, corruption and there is a reference there to maladministration. But do you know if there is any duty, either in Queensland Health policy or any other policy for that matter, to report clinical incompetence, or don't you know?-- I can't really comment, sorry.

COMMISSIONER: Mr Tathem, the references to IRM, is that the Industrial Relations Manual?-- That's correct, Commissioner. That's actually the Industrial Relations policy which sets out the reporting processes for official misconduct.

Yes.

MR MORZONE: As part of the presentation, you did deal with whistleblowers and the Whistleblowers' Act. That's at page 38 of the attachment?-- That's correct.

And reference is made there to a person making a public interest disclosure not being able to make it to a union or the media, or a member of Parliament?-- That's right.

That's right? Do you - obviously that's something that you would have said during the course of this presentation?-- I actually - I made the statement that in order for a public interest disclosure to be managed and assessed, it needed to be reported to a proper reporting entity.

Uh-huh?-- And that reporting entity would be the Director-General of Health, the Crime and Misconduct Commission, or the Director of Audit or a delegate of his. When I talk about manage and assess, given the implications for a whistleblower person making a public interest disclosure, there is obviously potential ramifications for that person in the workplace and it needs to be managed in regards to potential reprisals and action by a person whom the complaint's been made against. Secondly - the second point to that as well is a person who actually does make a proper public interest disclosure and it is actually assessed in that manner, they're actually protected against reprisals, a person who commits a reprisal action is a criminal offence.

COMMISSIONER: Mr Tathem, my concern is if you look at page 38, as I understand it, what's in the box at the top is the slide that's projected and the audience see what's in that box. Below that is really, in a sense, your script for the presentation you provide?-- Yes, Commissioner.

And when one reads it, on its face it says: "PID", a public interest disclosure, "cannot be made to, for example, a union rep, the media, or a member of Parliament." Do you think it is possible that people were given to understand that it was, therefore, wrong to make such a disclosure to people of that nature; to union representatives, media or parliamentarians?-- The actual statement is made in the explanatory notes, because

if a person does go to an entity outside of that forum - when I say the forum, being the reporting entities - they are not actually protected then against potential reprisal action.

I understand why you might say to your audience, "Look, if you do speak to your union or to the media or a parliamentarian you won't be protected", but that's different from what appears here, which says a, "PID cannot be made to any of those people". That makes it sound as if there is something naughty about speaking to your union?-- Can I just go one step further, too, Commissioner?

Yes?-- In regards to the earlier slide on investigation of official misconduct, I gave an overview of the investigation processes and how we deal with witnesses, complainants and subject officers. Subject officers are those persons complaints are made against.

Yes?-- We made it quite clear that when we're dealing with those group of people, we make it quite clear of the allegation, and natural justice and procedural fairness is tailored around our investigation. So they are advised to contact - they have the option of contacting union representative or seeking legal advice on a matter of official misconduct.

But that's different from the question of when you have got public interest information, it is naughty to tell your union official about that. Let's take a hypothetical example. I am an employee at a Queensland hospital and it comes to my attention that the waiting list statistics are being falsified - purely hypothetical example. I raise that with the manager, nothing is done about it. I raise it with the zone manager and nothing is done about it. Eventually I get frustrated and I speak to my union, or I speak to the newspaper, or I speak to the member of Parliament. Now, there would be nothing wrong in doing that, would there?-- I am not in a position to comment on individual - that particular aspect, given my experience. I am not - I mean, in terms of the seminars, the information seminars, that's what they were, information seminars, and we just provided an overview, I suppose, a paraphrasing, summarising legislation.

Yes?-- I wouldn't be in my position to comment on that particular example you provided then.

All right. But, see, if you look at your page 38, "A PID cannot be made to", those type of people. So it comes across as if you are telling the Queensland Health employees, "If you make this public information disclosure to the union or to a parliamentarian or the media, you are doing something wrong." You see how it comes across like that?-- I understand where you are coming from.

Yes. You accept, with the benefit of hindsight, and having had it pointed out to you that it could have been expressed more clearly to make it obvious that a person is permitted to do those things but won't have protection if he or she does

them?-- I take that on - I take that point.

Yes, thank you.

D COMMISSIONER VIDER: Can I just ask a couple of questions? I notice that the seminar is referred to as "Ethical awareness"?-- That's correct.

Was it an interactive session so people could ask questions or-----?-- It was very much so, Deputy Commissioner. It was actually arranged in such a manner that we tried to invoke discussion and engage in conversation and have staff view their issues or concerns regarding how they view certain things. Because there is a perception in, I suppose, any workplace that a whistleblower is a dobber, and that was one of the myths we tried to dispel by having the information session, to say, "We're not dobbers", and there is protections there for them to come forward. So-----

On page 17 in the explanatory notes that were being used by the presenter, third heading down, "Costs of unethical behaviour to the organisation", "high sick leave rates, high turnover and loss of skilled valued staff." I can understand that that's spoken about as an HR issue and as an attempt to keep valuable staff, they are their most precious asset. But I don't quite know how high sick leave is unethical?-- We were just - that was probably just some examples of the impact of unethical behaviour that can be a result where people don't want to work in an environment where people are doing the wrong thing.

COMMISSIONER: Or, for example, if somebody is involved in substance abuse, that might result in high sick leave rates?-- That's correct, Commissioner.

D COMMISSIONER VIDER: On page 18, you have just got a heading there, "Financial compliance unit", and it says, "Provides the DG with independent appraisal of effectiveness of financial controls in place". In all of the sessions that you participated anywhere, did anybody ever raise with you, from the ethical perspective, the lack of resource allocation?-- Not that I can recall from my sessions, Deputy Commissioner.

I just wondered whether anyone had talked about the fact that they felt that they were - it was difficult to do their job because they didn't have enough resources allocated to them?-- I don't recall that being raised.

You didn't have those sorts of general discussions?-- No.

MR MORZONE: Now, I think - you said to me before that there wasn't a focus on the presentation on the ethical duty to report clinical incompetence of doctors and nurses, but to the extent there is a focus on a duty to report, was the duty to report primarily involving those issues which you said before?-- The four main conduct issues.

The four main conduct issues?-- That's correct.

Okay. Perhaps you can help me in relation to just those, even, as to whether or not you agree with some general propositions. Do you agree that as regards those four individual topics, at least, there ought to be an atmosphere where individuals are encouraged to raise concerns about those things without fears for all sort of things, including reprisals? Is that, again, something that is outside your expertise, so to speak, and you are there really just as a presenter of information?-- I mean, from the presentation viewpoint, it was designed to actually allay fears of staff who may have been aware of those types of issues at the workplace, and for one fear - through not reporting it, we tried to reassure them that there are avenues to have those matters looked at or investigated.

And from your position, as being an auditor, in particular, that deals with complaints of that sort of nature, particularly in the gaming area. Is it a fair statement from your experience and qualifications to say that developing a culture where particular members of the particular organisation feel a sense of being able to complain about those things is a proper aim?-- Yes.

And that obviously includes a culture where there is not a fear of reprisal and the like?-- That's correct.

And it might also go so far as to include a culture where people perceive it as having a duty to report those sorts of things and being rewarded for being brave enough to report the duty?-- That's true.

I have nothing further, thank you, Mr Commissioner.

COMMISSIONER: Thank you. Mr Fitzpatrick.

MR FITZPATRICK: Yes, thank you, Commissioner Morris.

EXAMINATION-IN-CHIEF:

MR FITZPATRICK: Mr Tathem, the Commissioner was asking you about the code of conduct?-- Yes.

As it applies in Queensland Health, and I think you refer to that in paragraph 4 of your statement. Have you any knowledge as to whether there exists, in other public sector units of the Queensland Government, a code of conduct?-- I believe it is under the Public Sector Ethics Act. It is a requirement for most government agencies to have a code of conduct in place for staff to abide.

I see?-- I am not an expert in that field either but it is

just from my - we have one at Queensland Treasury.

Yes. All right. So you have some experience of the code of conduct at the Queensland Treasury?-- I have reviewed it, as all staff should.

Does it - how does it compare with that which applies at Queensland Health? Do you know? Is it the same?-- I think the tone of the document is very much similar. I think there is a general main focus on integrity, and respect for all organisations and persons in government, and that's the general tone throughout the code of conduct.

D COMMISSIONER VIDER: Mr Fitzpatrick, can I just ask a question? The code of conduct then, is that explained to all new employees at their orientation?-- I can't really make a comment, Assistant Commissioner, because I am not in that sort of role. I am unaware. It may happen. It may be an answer that can be best dealt with by someone else at Health.

Thank you.

MR FITZPATRICK: Thank you, Deputy Commissioner. Mr Tathem, you say that in your presentation at Bundaberg, and, as I understood, at the other 13 sessions that you facilitated, you focussed on four main topics?-- That's correct.

Is it the case that you focussed on those topics not only at Bundaberg but at the other 12 locations?-- Yes.

Where you presented-----?-- That exhibit in front of you is basically a generic document which was presented to all districts and the only thing that was changed was the statistical information on the reported incidents of official misconduct.

COMMISSIONER: So the one we have got has some statistics relating to - I think it was the Sunshine Coast?-- That was my - that was my working copy, Commissioner.

Yes. But when you go to Bundaberg you would have one specific to Bundaberg?-- Exactly.

Yes.

MR FITZPATRICK: All right. Now, Mr Tathem, do you know - I think you have said you weren't the author of the powerpoint or indeed the explanatory notes that accompanied it and which accompany it in your affidavit, is that so?-- That's correct.

Do you know why it was that the focus was on those four main topics?-- From - I wasn't involved in the drafting of the document, but just from my experience at the Audit Operational Review Branch, those four issues are the main four matters of official misconduct which are reported to the branch.

So those are the four-----?-- The four.

-----problem areas for Queensland Health so far as this topic goes?-- Four main issues.

I see, all right. Now, you said in answer to a question from Commissioner Morris - I think you said that at some stage of your presentation the - those in attendance were told that they could involve - I think you said a union representative at some stage of the process, is that so?-- Or a solicitor to seek legal advice. That's with regards to the investigation process. When we deal with our witnesses, complainants, subject officers as well that we involve - when we invite them to participate in interviews, we actually advise them of their rights to seek information or advice from a union or legal representative.

I see. And is that part of your presentation? Do we see that reflected at page 37 from the material?-- In the explanatory notes.

Yes. Do you have that there?-- I will just have a quick look at it.

Is it the dot point?-- Yeah, it is actually the - it is the fourth main heading under "Investigation official misconduct". It is the two last dot points.

Yes, I see?-- Reference to the representation.

During the investigation process, union, legal other support?-- That's correct.

Have you had experience of actually conducting investigations into these matters?-- I have had experience doing official misconduct investigations.

Including when you were on secondment to Queensland Health?-- That's correct.

And is it your experience that those involved in being investigated avail themselves of the right to be represented and bring along-----?-- Absolutely.

-----these representatives?-- Yes.

Now, Mr Tathem, some of the witnesses who were in attendance at your presentation in Bundaberg have told the Commission that, you know, they found it upsetting and frightening, and so on. Can you think of any part of your presentation, that is whether in the manner of the presentation or the content, that might cause that response?-- I was very surprised to read those comments. The actual presentation was to allay fears of staff and it was done in a manner in which the questions were - it was interactive. So we tried to get group participation, and staff were advised at the outset that it was an interactive presentation, whereby if someone wanted to challenge an issue or seek further clarification, they could do so at any stage, and we had a couple of icebreakers. When I say icebreakers, given the content is quite bland and quite

boring in regards to the aspect of misconduct, I mean, I did use appropriate use of humour in regards to introducing whistleblower's legislation, and we also actually made a reference to - or introduced in that particular aspect of the seminar, to get what people's thoughts were of whistleblowers, and at the start of the information session I asked people what they thought ethical behaviour was and I felt that the presentation by the feedback forms was quite good, actually. I thought staff actually appreciated and they actually felt quite relaxed.

COMMISSIONER: Mr Tathem, if you approach it from the mindset of someone who has raised public interest concerns with, for example, their union or with a member of Parliament, and then we get up to page 38 and they hear you say, "The public interest disclosure cannot be made to a union or to the media or to a member of Parliament", you can imagine that sort - a person in that mindset would find it very disconcerting to be told that what they have done is something they shouldn't have done?-- I can understand in hindsight, yes.

Yes.

MR FITZPATRICK: You said that you were pleased with the information that you received in the feedback forms?-- That's correct.

Was the seminar that you gave at Bundaberg well attended or-----?-- It was one of the better attendances. It was one of the bigger districts we went to as well, because we actually - that week we went to North Burnett, other smaller hospitals, so we had smaller attendances, but we did have a good attendance at this particular information seminar and there was a lot of interaction as well.

I see. And did you receive some gratification when you read what was in the feedback forms?-- I think across the board the presentations were well received across most of the districts, and I don't think there was any greater feedback at Bundaberg or even worse feedback, but there was some good feedback in regards to the delivery of the presentation and the value of it, as seen by staff.

COMMISSIONER: Mr Tathem, I'm having trouble with the handwriting. If you go to page 66, one of the feedback forms says about, "Disturbing to find out you can" - is it "make complaints" or-----

MR ALLEN: "You can only complain".

COMMISSIONER: "You can only complain", and what's it say after that, "within the"?

MR FITZPATRICK: It looks like "within Queensland Health"?-- I think it might have been "within Q Health", which certainly wasn't the case or the information was conveyed at the session.

COMMISSIONER: But you understand in retrospect that that may be the very view that you conveyed when you said that public interest disclosures can't be made to the union or to the media or to politicians?-- Whilst that was made, made clear in regards to the context of having assessed and managed-----

Yes?-- We certainly made it clear that if people had problems reporting matters to the DG or internally, they had the option of reporting directly to the Crime and Misconduct Commission.

When you got this feedback form and it was obvious that someone had interpreted the presentation the way I have mentioned, they were disturbed to find out they could only complain within Q Health, did you take any steps to review the program?-- I didn't personally, no, Commissioner.

Yes, Mr Fitzpatrick?

MR FITZPATRICK: Yes, thank you, Commissioner. That's all I have.

COMMISSIONER: Mr Allen?

CROSS-EXAMINATION:

MR ALLEN: Thank you, Commissioner. Mr Tathem, John Allen for the Queensland Nurses Union. If I could just ask you about a few things you have mentioned in your statement from paragraph 24 after you express the opinion Ms Hoffman had misinterpreted the information that you provided. Now, in paragraph 25 you say that the presentation discussed the obligation of the staff under section 63, as it then was, now section 62A, of the Health Services Act, not to disclose confidential patient information, and would that part of the discussion occur in relation to the PowerPoint slide at page 21 of your statement?-- Yes.

If you just go to that. In the notes, for your assistance, there's reference to section 63 of the Health Services Act dealing with confidentiality of patient identifying information and stating that breach of that section is a criminal offence?-- That's correct.

And that's been provided in the context of giving an example of official misconduct?-- Sorry, just repeat that - repeat that again?

It's in the context, isn't it, of the slide which is entitled, "What is Official Misconduct."? This is page 21 of the attachments to your statement?-- Page 21.

Yes?-- That's similar - I mean, in regards to breach of confidentiality and performance of section 63, that could constitute - if the person breached issues of confidentiality, it could constitute initial misconduct.

Okay. So what you would have explained to the persons at the seminar is that breach of section 63 of the Act constitutes a criminal offence?-- Yes. There are exemptions, of course.

Yes?-- Yes.

But breach of the section itself constitutes a criminal offence?-- Yes.

And are you saying that that would, therefore, be official misconduct or could be or would likely be official misconduct?-- Nothing was ever - was - it was always conveyed to the audience at the information sessions "may constitute official misconduct". Nothing was ever definite. It's obviously up to a Magistrate to decide that matter, but in terms of issues of confidentiality it was made quite clear that people need to - staff need to be aware of that particular provision because divulging information could possibly be a breach.

All right. It would be a criminal offence, you have indicated to them, and, what, could be official misconduct as well?-- That's correct.

All right. Because you have - the PowerPoint slide which would have been presented apparently indicated that official misconduct would involve conduct serious enough to be a criminal offence or to warrant dismissal?-- That's right.

And do you recall whether the aspect of breach of section 63 of the Act was always discussed in the context of that being serious enough to provide reasonable grounds for dismissal as follows in the information?-- That wasn't really - didn't go to that - that extent actually, we just sort of presented a brief overview of the provision of section 63 and talked about it was maybe a criminal offence if a person did divulge information to - in contravention of that particular section of the Act, and it may be misconduct. So I didn't really sort of expand upon that, unless it was actually asked of, and I can't recall that being the case.

But you wouldn't be surprised at all if the persons who attended the seminar would have left with the impression that disclosing confidential patient information was, firstly, a criminal offence and, secondly, could provide grounds for dismissal?-- Sorry, what are you leading to?

You have been asked about whether you were surprised that people had the impression of that sort of thing. I'm asking you in a similarly - given the context of what was discussed at page 21 of your statement, you would not be surprised that someone may have left the presentation thinking that disclosing confidential patient information in breach of section 63 of the Act could constitute, firstly, a criminal offence and, secondly, provide grounds for dismissal?-- Right. I mean, I can't really comment on how other people are feeling but I understand where you're coming from, but it was just a generalisation, paraphrasing the legislation.

Well, see, you have commented - you have commented that Ms Hoffman is misinterpreting the information and you have also said in answer to Mr Fitzpatrick you were very surprised to think that people would be upset or frightened by the presentation?-- At that particular time on the 14th of October, yes.

All right. But isn't it the case that someone could have left that seminar with the understanding that breaching section 63 would be a criminal offence and could provide grounds for them to lose their jobs?-- Probably.

Okay. Now, in paragraphs 26 and 27 of your statement you deal with the information provided to attendees in relation to the Whistleblower Protection Act?-- That's correct.

And at page 38 of the attachments there was some information that was provided to the attendees in relation to public interest disclosures?-- That's correct.

Now, just in relation to your script down the bottom which you have been asked about already, that a public interest

disclosure cannot be made to a union rep, the media or a member of Parliament, you conveyed that information to the attendees, didn't you?-- That's correct.

And then you conveyed that if someone did disclose information to such bodies they would not be protected under the Act for that disclosure?-- It was reported to a proper reporting entity.

So it wouldn't be protected?-- It would be protected from a reprisal action.

COMMISSIONER: No, no, I think you are misunderstanding Mr Allen's question. You told them that they must not report to the union, the media or to a Member of Parliament?-- That's correct.

All right. And you told them that if they did report to those bodies, to the union, or the media or a member of Parliament, they wouldn't be protected under the Act?-- They wouldn't be protected from reprisal action.

I'm sorry?-- They wouldn't be protected from reprisal action.

Well, but they wouldn't be protected from any of the other consequences, like committing a criminal offence?-- But that - in regards to that particular slide, the explanatory notes relate to the not being protected against reprisal actions.

Well, you may have known that in your mind but did you say that?-- That was actually - that was conveyed at the - at each of the presentations.

See, if you go back to paragraph 26 of your statement, you explain what was said in relation to whistleblowing, "Attendees were informed that under section 10 of the Act a complaint which amounts to a public interest disclosure can only be made to an appropriate entity." Now, that's wrong, isn't it? You can make it to anyone you like, but it's just that you don't have legal protection unless you make it to the appropriate entity?-- That's correct, Commissioner.

It then goes on, "This ensures that public interest disclosures are made to an entity that has the power to make - to take appropriate action and unfair damages are not caused to persons against whom disclosures are made by an inappropriate publication of unsubstantiated disclosures." So, you were really conveying the impression that it's a naughty thing to disclose information to anyone other than someone within Queensland Health?-- Or the CMC.

Or the CMC?-- CMC.

It's a bad thing to go to the press?-- It may give that impression.

Yes, and if you do go to the press you are outside the protection of the Act?-- You may well be.

If you do go to the press, you might be committing a criminal offence or you might be liable to lose your job?-- That's in regards if you breach confidentiality. If you disclose the information which leads to the identity of a patient who's received a health care - that's in regards to - can I just make that point clear as well, actually, that in regards to that particular aspect of that - of the section, we talked about if - disclosing the identity of a person who's actually received a health service treatment.

But again in your paragraph 27 of your statement you make that very clear, "A public interest disclosure cannot be made to the union, media or member of Parliament because they do not fall within the classification of the public sector entity. Such a disclosure may amount to a breach of the confidentiality provisions in the Health Services Act." So you are telling these people you are not allowed to say these things to the union or to a Parliamentarian or to the media, and if you do, you may be breached for committing a criminal offence?-- That's "may".

Yes. You may be committing a criminal offence?-- That could be a potential outcome, but not definite.

Does it still surprise you, then, that Ms Hoffman said the talk scared the living daylights out of her?-- I understand - I understand from her point of view.

Yes.

MR ALLEN: You wouldn't, therefore, be surprised that the impression she was left with was that, "It was impermissible for us to tell our union about what goes on in the hospital or hospital related business"?-- My comment - what?

You wouldn't be surprised she was left with that impression in hindsight?-- In hindsight, it may - no, maybe not.

Okay. And that she was left with the impression that, "We were told that that was illegal and that if we spoke about anything that had happened at the hospital to our union we could go to gaol and lose our jobs."?-- Well, that was never inferred or stated.

Well, would you be surprised she was left with the impression that she could be guilty of a criminal offence and subject to dismissal?

COMMISSIONER: I think Mr Tathem's already answered that.

MR ALLEN: Yes.

COMMISSIONER: And said with the benefit of hindsight or in retrospect he sees her viewpoint.

MR ALLEN: Thank you, Commissioner. Now, my copy at page 38, and I just want - my page 38 of your statement, it concludes

with the words, "under the Act for that disclosure". Is there supposed to be another line under there?-- I believe that's in relation to identifying - releasing information which may identify a person whose received a health service.

So there should be another line underneath that one?-- Sorry?

This is page 38?-- Sorry, that was actually - I think the person who actually makes the public disclosure must make it honestly and not provide false or misleading information.

Do you have another line that I don't have? The last line I have is the fourth dot point, "If you disclosed information in this way you will not be protected under the Act by disclosure"?-- No. That's - my copy's the same as yours.

COMMISSIONER: There is a line missing?-- There is a line missing and that's in relation to the - that it must be made truthfully.

Yes.

MR ALLEN: Right. Okay. Look, there was reference - and we can see this from just turning over the page to page 39 - down the bottom of the page to, "Criminal offence punishable by maximum of two years gaol". But although it's not clear from the actual PowerPoint slides, that was in reference to the reprisal provisions of the Whistleblowers Act?-- That's correct.

So you believe that if someone was left with the impression that they might be looking at two years gaol for disclosing confidential information, that would have been a misinterpretation?-- I think it was made quite clear. In my statement I have made it - I don't refer to gaol term. I can't recall referring to the gaol term. I just said - it was generalised, said it was a criminal offence for a person who takes reprisal action. So I just don't understand why the two year - whilst it's provided for in legislation, I don't recall referring to a two year gaol term.

COMMISSIONER: If you were following the script, what people at the session would see is a slide with the word "Protection" and four dot points, and "Obligations" and two dot points. That's what they'd see. And the second dot point is, "Must disclose to an appropriate entity", and whilst they are looking at that on the screen, someone's saying to them, "There are provisions under this legislation for two years gaol."?-- But I - Commissioner, I can't recall actually referring to the two year gaol term.

All right.

MR ALLEN: You can't?-- No, I can't.

All right. Did you make any reference at all to section 85 of the Criminal Code and the events of disclosing official secrets?-- No.

Certain about that?-- Yeah, I am actually.

Given your experience in relation to investigations, do you have any knowledge as to the provisions of section 85 of the Criminal Code?-- No, I don't.

At all? So it would only be coincidence if someone was left with the impression that if they disclosed confidential information as a Queensland Health employee they could be subject to two years gaol, and it seems that in fact that would be an offence punishable by a maximum of two years gaol under the Criminal Code?-- I'm not too sure where you are going, sorry.

You didn't refer to it?-- No.

I see. Okay. Page 41. The last part, "When faced with an ethical delimma, ask yourself the following questions." One is, "Is the action legal and consistent with departmental policy?" Is that so? I suppose that would include consideration if one was thinking about disclosing information as to whether that might amount to a breach of, say, section 63 of the Health Services Act?-- No, I mean, the whole focus of the ethical awareness information centres were on the four types of conduct, looking at the fraud, substance abuse and also theft and the breach of confidentiality, as you have mentioned.

All right. Breach of confidentiality, the first question is, "Is the action legal and consistent with departmental policy?" The second question, "Is it in line with departmental values and code of conduct?" The third question, "Is it the right thing to do?" Was there any discussion about the situation where it might be the right thing to do but nevertheless was illegal, inconsistent with departmental policy and in breach of the code of conduct?-- Those points there were just - just general, I suppose, things for a - for a staff member to consider if they were having an ethical dilemma.

There wasn't any discussion about the dilemma that might be faced in balancing number 3 against the rest?-- They were just a number of questions that a person could ask themselves.

Thank you.

COMMISSIONER: Thank you, Mr Allen. Mr Devlin?

CROSS-EXAMINATION:

MR DEVLIN: Yes, Mr Tathem. Ralph Devlin, I represent the Medical Board of Queensland. Interested in a couple of aspects to your presentation here. Exhibit 3, GDT3, is your flyer. One of your dot points, among issues, is, "How other government agencies such as the Crime and Misconduct Commission, the Queensland Police Service, the Medical Board of Queensland and the Queensland Nursing Council could affect your workplace." You are familiar with that?-- I'm aware of the flyer, Mr Devlin. However, I wasn't involved in the drafting of that flyer.

No, that's fine. What I'm interested in is did you as one of the presenters see the Medical Board and the Queensland Nursing Council as appropriate reporting entities?-- Probably not in a position to actually answer that question. Probably best to direct that to the Acting Manager of Investigations.

No, that's okay. I'm interested in just your state of mind?-- I'm probably not - well, given my six months secondment to Queensland Health, probably not in the position to answer that question fairly.

Right.

COMMISSIONER: Mr Tathem, if I can assist, if you go to page 19 you talk about liaison with the Crime and Misconduct Commission. This is in the typescript section?-- Yes.

And it says, "Liaison with the Commission" - "CMC and constantly communicating with other government agencies, such as the Medical Board and the Nursing Council." Was that the only context in which you considered the Medical Board relevant?-- Just from a general investigation's viewpoint, we provided a brief overview to say that in regards to investigations into nursing staff and practitioners we would adopt a liaison role and provide the Medical Board or the Queensland Nursing Council with an update as to what was happening.

MR DEVLIN: Yes, I see. So, I'm not being critical here, but the presentation didn't specifically address that those bodies, the Medical Board and the Queensland Nursing Council, dealt with medical misconduct or nursing misconduct?-- No, not the presentation.

But simply there was reference to those bodies in passing as being somebody who might receive a briefing from the CMC?-- That's correct.

Thank you.

COMMISSIONER: And perhaps just to make that complete, on page 30 you made the point that if there's substance abuse -

that is the last dot point on the page - that may amount to "unprofessional conduct leading to cancellation of registration as a nurse or medical officer"?-- That's correct, Commissioner.

Yes.

MR DEVLIN: Thank you. And my last matter is this. Are you able to estimate how many people did attend the session in Bundaberg on the 14th of October?-- I think it was around 27.

Okay. It's interesting, you have got feedback forms numbering almost that. Did you get a feedback form from everyone?-- I'm not too sure, to be honest, to be totally honest.

You have got about 25 forms there, so it seems like almost everybody did respond?-- Yes.

And in every case the ticks are in the boxes where they, for the most part, agree or strongly agree that they, for example, had their knowledge increased and so on?-- That's correct.

So you felt yourself entitled to interpret the feedback as being largely very positive?-- That's correct, Mr Devlin.

At least by way of ticking boxes, if not comments?-- The majority of people are just in a hurry when they are filling those forms out, so they will tick the boxes, but there were a couple of comments and the Commissioner has raised the other one.

Yes.

COMMISSIONER: Thank you. Thank you, Mr Devlin.

MR DIEHM: I have no questions.

COMMISSIONER: Thank you, Mr Diehm. Ms Feeney?

MS FEENEY: No.

COMMISSIONER: Any re-examination, Mr Fitzpatrick?

MR FITZPATRICK: No, thank you.

COMMISSIONER: MR Morzone?

MR MORZONE: No, thank you, your Honour, if it please.

COMMISSIONER: Mr Tathem, you are excused from further attendance, but before you go, can I express to you on behalf of the three of us here on the Bench our appreciation for your time and your assistance, and particularly the very frank and candid and helpful way in which you have answered all of the questions asked of you, and also I convey to you our apologies that you were messed around. I think you were due to come here on a previous date or possibly two previous days. It's over now anyway?-- I'm here. I got here anyway.

Yes?-- Thank you. Thank you, Commissioner. Thank you, Deputy Commissioners.

WITNESS EXCUSED

MR HARPER: One housekeeping matter. You asked me earlier regarding the letter from Dr Risson-----

COMMISSIONER: Yes.

MR HARPER: -----regarding patient P26. Mr Atkinson has kindly advised me that it is in evidence and is Exhibit 208.

COMMISSIONER: 208. Thank you for that, you and Mr Atkinson.

MR FARR: Commissioner, we are just discussing the remaining witness for the day. That was to be Dr Ray, who's been caught up in surgery most of today. He can be here at around 4 o'clock hopefully. However, Dr Younis, who was to be the first witness tomorrow morning, has arrived this afternoon from up north. He's outside. I don't know if the parties are in a position to proceed with him, but he's more than willing to give evidence this afternoon if it can be done.

COMMISSIONER: Why don't we at least start with him and - is that convenient to you, Mr Morzone?

MR MORZONE: Yes, certainly, Mr Commissioner. I know at least one party has expressed the view that they are not ready to cross-examine, but we can separate - we can do perhaps evidence-in-chief this afternoon or at least start him.

COMMISSIONER: We might just have a five minute break and then at least get his evidence-in-chief underway.

THE COURT ADJOURNED AT 3.39 P.M.

THE COMMISSION RESUMED AT 3.49 P.M.

MR ATKINSON: Commissioners, by a happy coincidence, whilst you were out Dr Ray arrived, but that means that the Queensland Health staff are speaking to him now in an effort to have him finally sign his statement and prepare him for giving evidence, so that's why nobody is in Court except me.

D COMMISSIONER VIDER: Dr Ray?

MR ATKINSON: Dr Ray.

COMMISSIONER: We've got his statement, but is it unsigned?

MR ATKINSON: It's unsigned.

COMMISSIONER: We're happy to wait.

MR ATKINSON: Thank you.

COMMISSIONER: You haven't missed anything, Mr Fitzpatrick.

MR FITZPATRICK: I'm relieved about that.

COMMISSIONER: We couldn't possibly start without you.

MR FITZPATRICK: Commissioner, Dr Ray is here. He's just checking his statement with Mr Farr and he will be here directly.

COMMISSIONER: Of course. Thank you. While Dr Ray is coming, I wonder whether I can invite people to start thinking about timetables for submissions. As presently anticipated we will have two more weeks of evidence after this one, so three weeks including this week. Following that we're allowing ourselves essentially the whole of the month of September to write our report.

Obviously it would be useful for us to have peoples submissions sooner rather than later, but I realise that that involves a lot of work for each of the counsel at the Bar table, and what I'd like you to think about is whether it would be feasible, for example, to have submissions in writing, say two weeks after the close of evidence, and then the following week if anyone wishes to speak to the submissions, we could afford the opportunity to do that, although expecting that people won't need to elaborate their submissions in great detail orally. It will all be in writing and we can proceed on that.

Anyway, I just ask you to think about that, and obviously before the evidence finishes we'll canvas that again to see what everyone regards as feasible.

That also reminds me, Mr Atkinson, are we still considering it may be necessary to go back to Bundaberg for a day or two?

MR ATKINSON: We are, but I had some informal discussions with Ms Feeney - I'm not sure if they're on the record or not.

MS FEENEY: Commissioner, I've had some discussions with Mr Ashton.

COMMISSIONER: Yes.

MS FEENEY: We would prefer to cross-examine in person if that's possible, but we don't want to be responsible for everyone having to return to Bundaberg for one witness. If there are other witnesses that might be a different issue, and I understood that Mr Ashton was going to attempt to speak to Mr Andrews about that today.

COMMISSIONER: Look, I'd appreciate that, but can I say I don't want - particularly in light of things that are happening elsewhere, I don't want there to be any scope for concern that your client hasn't been given the opportunity to challenge evidence that may be relevant to the possibility of adverse findings, and so I think we're proceeding on the assumption that if we were to go to Bundaberg to hear the evidence of Mr Chase, we could probably usefully make advantage of the time by also hearing evidence from at least Dr De Lacey, and possibly one or two other witnesses.

MR ATKINSON: Yes, your suggestion, Commissioner, was that it would be not this Friday, but the one after, and if that was to happen, of course, Dr De Lacey said every Friday is a Patel day for him, and if we were in Bundaberg we could hear evidence from him.

COMMISSIONER: Yes. If that were to happen I would like to make sure that it's done as efficiently and inexpensively as possible. For example, we'd probably use the small courtroom in the Natural Resources Department building instead of going out to the TAFE campus again, and certainly so far as the Commission of Inquiry is concerned, we wouldn't need to take our entire team, and I imagine, for example, Queensland Health would have just one of its team rather than all three going up, but we could try and minimise the expense as much as possible.

MR ATKINSON: I must say there is still some attraction from our point of view in having telephone evidence, if it's acceptable to Mr Ashton, because certainly it would be - it would involve Mr Devlin, I expect, going up there, certainly Mr Diehm, and perhaps other people if we were going up to cross-examine Dr De Lacey.

COMMISSIONER: Yes.

MR ATKINSON: So there's some attraction in having Mr Chase by phone, and we could fly Dr De Lacey down, or even possibly-----

COMMISSIONER: Certainly all of the economies are in favour of doing it here if that's possible, but so far as Ms Feeney is concerned, I don't - I wouldn't want your client to feel under any pressure to agree to do it by telephone. If his advice is that his interests require cross-examination in person, then that's what will have to happen.

MS FEENEY: Thank you, Commissioner. I'll discuss the matter further with Mr Ashton and with my client, and we'll liaise with counsel assisting.

COMMISSIONER: Thank you.

MR ATKINSON: Commissioner, if I might, I call Mark Jonathan Ray.

COMMISSIONER: Certainly.

MARK JONATHAN RAY, ON AFFIRMATION, EXAMINED:

COMMISSIONER: Doctor, please make yourself comfortable. Do you have any objection to your evidence being filmed or photographed?-- No, that's fine.

MR ATKINSON: Your name is Mark Jonathan Ray?-- That's right.

And you're a vascular surgeon?-- That's right.

You gained your fellowship, I think, in December 2004?-- That's right, completed my training in 2004.

At that time you were on secondment, I understand, from the PA to the RBH?-- Not exactly. I was actually employed in the last six months of my training at the Royal Brisbane Hospital.

That's part of the training program?-- Part of the training program. So I wasn't seconded. I was an employee at Royal Brisbane Hospital.

Doctor, would you have a look at this statement? Is that a statement that you provided to the Commission?-- Yes, it is.

And it's a statement of your evidence in relation to the matters touching upon P26?-- That's correct.

The facts contained in that statement are true - are still true and correct to the best of your knowledge?-- Yes, they are.

Commissioner, I tender that statement.

COMMISSIONER: Yes, the statement of Dr Mark Jonathan Ray will be Exhibit 257.

ADMITTED AND MARKED "EXHIBIT 257"

MR ATKINSON: Dr Ray, I might step briefly through that statement. As you're aware, we heard from Dr Jenkins this morning?-- Mmm.

But I'll ask you some of the questions that maybe we haven't touched upon?-- Sure.

You set out in paragraph 3 that you worked at the Royal Brisbane, and of course now you've returned to the Princess Alexandra Hospital?-- In a consultant capacity as a visiting medical officer, so yes.

As a VMO?-- As a VMO.

Both the RBH and the PA, I understand, service discrete provincial areas?-- That's right.

So the RBH goes north and the PA goes west?-- So it drains Bundaberg as well.

And at the PA you drain from Toowoomba out to Windorah, I guess?-- That's right.

Is there any protocol at either hospital as far as you understand in terms of how doctors in the outskirts, in the provinces, might approach the central hospitals?-- I'm not aware what - if there are strict protocols in place, but certainly the first port of call from Bundaberg would be to the Royal Brisbane Hospital.

How do people know that?-- I think it's just generally acknowledged where the drainage areas are, where the tertiary referral hospitals are.

In paragraph 4, doctor, you speak about receiving a phone call on New Year's Day. I understand what happens is that you receive a call from a doctor In Bundaberg explaining the situation?-- That's correct.

And it seems so amazing to you, I understand, that you think it might be a practical joke?-- Yes, I do. I remember the call quite vividly. It was around 10 or 11 a.m., and I just remember hearing the story unfold over the phone, and much to my amazement, and it just did cross my mind for a fleeting moment that it may have been just a practical joke, but it soon became evident that it wasn't.

What did you find amazing about the story?-- Just the series of disasters, I guess. Just the way in which it was - it was handled.

Do you remember who called you?-- I don't remember his name, but I remember it was one of the orthopaedic PHOs, principal house officers.

We've heard evidence from a doctor called David Risson. Do you know whether it was him?-- Yes, I think it was David Risson.

And when you say a series of "disasters", at that stage you heard a story, I understand from Dr Risson, about a boy who had been in hospital since 23 December?-- That's right.

So the length of stay by itself, I guess, was something you found startling?-- Yes. What he was describing over the phone was a boy who was profoundly ill, and just a series of events, how it had transpired. It just crossed my mind that maybe someone was playing a joke on me, but-----

You make a similar point in paragraph 10, where you say you searched your memory because you were sure that if something had arisen and it had been going on for nine to 10 days in Bundaberg, I understand-----?-- That's right.

-----you would have expected that you would have received a call?-- Exactly. So - and I did the calculation at the time and realised I was on call that night when he came in to hospital, and I certainly hadn't received any calls at all. I hadn't heard about the boy until that time.

And in a sense, doctor, is this right: the senior registrar is the linchpin of the unit. You're the first - you're the person who assesses people and then you-----?-- I am. I wasn't on call every night. I was on call in a one-in-two, but certainly I assumed that it - had the other registrar - the junior registrar received a call about someone with such a profound injury, that we would have just got him down anyway. He would have been under our care. There's no question about that. But - because we just had a very low threshold to bring people down.

If you had heard - if anyone had approached the unit, you would have heard about it?-- I would have heard about it.

Because the other registrar was training in general surgery?-- He would have talked to me about it.

A question that that raises for me, doctor, is you seem so surprised that you hadn't received a phone call, and yet there don't seem to be any clear protocols about when or how regional areas approach the RBH?-- I think it's just common sense. As a practitioner, essentially you know when to ask for help - or should do, as a clinician - as an experienced clinician. It certainly seemed to be a case in point.

You hear sometimes about trauma surgeons, doctors who are specifically trained with the idea that they work to manage the initial trauma and then they send the person to a tertiary hospital, but that isn't something that's commonplace in

Australia yet, is it?-- No, no, it's not, but the same principles can apply. You can certainly salvage a situation, save someone's life, and undergo - damage control really is the term, and send someone on to an appropriate tertiary referral centre. That's what normally happens.

And can you tell us about that, the extent to which your practice, either as a VMO at the PA or as an advanced trainee at the RBH has involved taking phone calls from provincial areas, from outlying areas or arranging transfers?-- Well, for example, at the Royal Brisbane Hospital, because it's such a huge drainage area, we received multiple calls every day. It was just part of our job, really just triaging calls over the phone, and essentially we have a very low threshold to bring people down. Admittedly you can't really make an assessment over the phone, so we're very conscious of that fact. Even if it was something seemingly benign such as a diabetic toe, we get the patient down promptly so that we could at least make an assessment, and certainly anything as significant as a trauma would come down promptly.

That's at the Royal Brisbane?-- Well, it applies to the PA as well. The Royal Brisbane Hospital has a particularly large drainage area, so it seems that we're receiving more calls than we do at the PA.

Now, in paragraph 11 you talk about the arrival of P11 - P26 at the hospital?-- Yes.

Can you tell us something about his condition when you saw him?-- Yes, I just remember he was a very sick boy, and I've indicated here that I could literally smell him when I entered the Emergency Department, and that's not sounding emotive, but it's true. I could - it was very malodorous. He was in the resuscitation bay and he was lying on a trolley and was just really unable to converse with me effectively because he was profoundly sick, in a lot of pain, and very septic, and he had fairly - he was fairly floridly septic. He had a pulse that was racing and a temperature that was very high, and he was very pale and very sweaty and looked - and looked like he had septic shock.

COMMISSIONER: Doctor, I suppose a 15 year old boy - and we've heard some description of his physical condition, that he was six foot tall and a sportsman and so on?-- Yes.

I guess that would be regarded virtually as the peak of good health and fitness?-- Exactly. Exactly.

If he had been in a poorer condition to start with, is it likely that the trauma that he would have been through would have killed him?-- Well, very possibly it may have. I think the thing about this is that it took eight days for him to manifest as profoundly sick, whereas if it had been in someone older, I think that that would have taken place a lot earlier, and I think I made the point that these are life-threatening injuries and people can die. Even when you're young you can become that sick and die, and that's quite a scary

proposition. But he's young, he's fit, and it took him a week to really decompensate to the point where he was - where he became inotrope dependent and he started to have the systemic manifestation of the sepsis and needed intensive care.

MR ATKINSON: Doctor, two things flow from that. The first is this: can you explain why it is medically that it was necessary to amputate the leg?-- The leg was not salvageable, clearly not salvageable, and I took photographs and submitted it for pathological examination to corroborate that. But he had fixed mottling of the forefoot, so that certainly wasn't salvageable, but he had fairly flagrant necrosis and infected necrosis involving the whole compartments of the leg below the knee, and some patchy necrosis above that. So he - the end result was a through-knee amputation, and I think much to the credit of Dr Jenkins, in actual fact, because I thought that on - my initial impression was that he would not only require an above-knee amputation, but that it may have been a fairly high above-knee amputation, but we managed to salvage the thigh.

And if you'd left the leg there, the problem, I understand, is that the toxins spreading from the infection could damage the kidney, the liver-----?-- They already were beginning to do that.

-----and then the heart and the brain?-- And the heart and liver and the brain, and all organs. People develop multi organ failure, and he had some manifestations of that already affecting his kidney function and his clotting ability.

That was the risk to his life?-- Clearly I made the point to the parents that - because I couldn't really force the issue with him, but it was life or limb, clearly.

D COMMISSIONER VIDER: Can I just ask you, the malodorous nature of that leg that you said you could smell from the other side of the Emergency Department?-- Yes.

Would you have presumed that that would have been malodorous in the last few days that he was in Bundaberg?-- Yes. I mean, that's why I was a bit upset with what I saw and - because this was a boy who was sitting on an orthopaedic ward or a surgical ward up until that morning, a fever having been ascribed to a central line, to line sepsis, and subsequently taken out and antibiotics stopped. This was a boy who came down initially without any intravenous fluids until I had to ring them back and make absolutely certain that he was adequately resuscitated. This was a boy who was sitting on an orthopaedic ward in a provincial hospital. It was upsetting.

COMMISSIONER: Doctor, apart from the loss of his leg - the great tragedy that is - you mention that it was starting to have impact on his other organs, kidney, liver and so on?-- Yes.

Will that have any ongoing effects on his health?-- I don't believe so, but I haven't - my experience with this young man

ended in mid-January.

Of course?-- I haven't followed him up to see whether his renal function, kidney function returned to normal and what-not. I mean, the expectation would be certainly that there would be no longlasting sequelae.

MR ATKINSON: When the patient came down, he came down, I understand, with a letter of referral from Dr David Risson?-- From memory, yes, he did.

Perhaps the witness could see Exhibit 208, Commissioner. That's the one that my learned friend Mr Harper-----

COMMISSIONER: You might use Mr Harper's copy.

MR ATKINSON: Doctor, does that jog your memory in terms of the letter of referral that you received?-- It does.

Right. It sets out a chronology there, of course, doesn't it, of three operations?-- Uh-huh.

Over about 12 hours, femoral vein repair, then the fasciotomies and then the insertion of the gortex?-- Uh-huh.

You have expressed some concern about the length of time that he was sitting in the hospital in an outlying area. The surgery as well caused you some concern?-- The - yes, it did. I mean, I would like to make a point that the initial surgery saved his life. There is no question about that. I mean, he was a young man who had a major injury, clearly lost a lot of blood at the scene and nearly died, from what I can understand, and had he - and had his life saved with the initial operation. But then, yes, there were issues with the subsequent two operations.

The first one - not so much the first one where the femoral vein was clipped off?-- Well, I wasn't entirely sure what had taken place. The operative note had indicated in the first operation that the femoral vein had been repaired.

Yes?-- Yet it was clearly obvious, and I have photos of that, that the vein was ligated at either end with a segment of about five centimetres missing. So that's the common femoral vein, which is the vein that really drains all the blood from the leg. So it is important to try and restore its continuity. So I think "repaired" must have meant ligated.

And that would be okay as a temporary measure but it means someone has to reconstruct?-- Yes.

The common femoral vein?-- Yes, fairly - in a fairly timely fashion.

COMMISSIONER: When you say fairly timely, within 24 hours?-- I think so, yes, within 24 hours.

MR ATKINSON: Then the second operation, your view, I understand, is that the fasciotomies weren't long enough?-- It wasn't just that, it was just the fact that from reading the notes, his leg was still pale and pulseless and there has to be a reason for that. Now, it may be that the compartment pressures are so high, but if someone's pulseless, then you have to address the problem. And, sure, fasciotomies sounded appropriate, but if you didn't have pulses at the end of the procedure, he needed to have his groin re-explored and have the problem fixed. The fasciotomies themselves were inadequate in length.

Right. And then the third operation was when they did go back and explore?-- Later that evening they went back a third time when things clearly weren't right and the leg remained pulseless and a thrombo-femoral artery was found and that was

repaired.

Was there a time when in your view a reasonably competent general surgeon would have transferred the boy?-- I mean, I just think - I - the expectation that I would have as a trainee or a surgeon here, acknowledging that it can be very difficult in provincial areas, but, you know, it is all about communication. So, yes, I would expect someone to get on the phone fairly early and just to say, "Look, this is what's happened. Do you want him? I would like to send him down?", or, "What do you think?", or, "Look, he is not right now. I would like to send him down", or, "Can you give me some advice or something?"

That's really the stunning thing, from your point of view, is you are faced with a major femoral vein bleed, an arterial injury and no-one is talking to the experts?-- Clearly something was wrong if someone has to go back three times in the night. It was a very significant injury and it would be a very difficult injury to manage in a tertiary centre, there is no question about that, but, yes, picking up a phone is what it is all about.

Doctor, it was all done, and Dr Jenkins did a very good job, you have explained, in at least reducing it to a through-knee operation?-- Yes.

Amputation. Did you consider afterwards making some complaint about perhaps somebody in Bundaberg acting outside their expertise or alternatively about making sure the patients were transferred earlier?-- Yes, I did. Certainly did.

Those two things were of concern to you, I understand?-- Yes, they were of concern to me.

Almost separate issues?-- Yes. It was something that was - it was something that was broached. My tenure at the Royal Brisbane Hospital ended, I think, about 10 days later, and so at which time P26 was still an inpatient at the hospital. I felt that it should be broached, or it should be raised at a unit level rather than - rather than me as a trainee, as a loan voice making a formal complaint, I thought that that was inappropriate, but it was discussed and I had assumed that in due course, when he was further along in his convalescence, that a formal complaint would be lodged.

On the 4th of January 2005, the medical superintendent at the Bundaberg Base Hospital prepared a report about the circumstances of P26's injury and transfer. Were you contacted at any time?-- No.

To explain what you had seen in the course of surgery?-- No.

So you have never had a chance to explain to anyone whether or not the surgery was adequate and how it might have been done differently?-- No, haven't spoken to anybody.

Doctor, I wonder if you could have a look at this document?

It is a limb observation chart. I really want to show it to you to assist in this question: when you see the boy on the 1st of January 2005, he is in a very bad state, tachycardic, he has got spike temperatures I think of about 39 degrees?-- Yes.

And across a range of indicators he is in a bad way. Is that something that happens gradually or it can happen in a sudden turn of events?-- I mean, there is no hard and fast rule but I think what you often find in someone of this age, who is young and fit, is that someone who is 15 can compensate for sepsis and, you know, when he does decompensate, he will decompensate very quickly. So that's why I made the point before that it took eight days, and although there may have been some signs, in retrospect, with white cell counts being elevated, and temperatures not being quite right, he clearly deteriorated around the time of transfer. I don't know, really, exactly when.

I am just wondering, looking at that limb observation chart, you will see it starts on 27 December?-- I can see that his - I mean, certainly the foot is purple and motley from that stage and-----

Doesn't seem to get any better, does it?-- Clearly - I knew when I saw the leg that he had fixed mottling, he had fairly fixed gangrene of his forefoot, so that had been going on clearly for a number of days at the least.

And that reinforces your view that he could have been transferred earlier?-- He should have been transferred earlier.

He should have been transferred earlier. Doctor, I have another question and it is this: I understand that any person, if their leg is ischaemic for up to six hours, there is a good chance that they will lose that leg?-- If it is - yeah, if it is frankly ischaemic, then irreversible changes can occur at six hours. If it is total ischaemia, and that's more of a problem in someone who is young who doesn't have what we call chronic ischaemia where alternative pathways or collateral blood vessels can develop and can keep legs on, in someone young, they don't have those collateral pathways.

The collateral-----?-- If the - if the arterial continuity is lost, then the leg will usually be frankly ischaemic, and I think that that was part of the mechanism here. It was partly arterial injury or arterial inflow injury, in combination with a reperfusion injury, which I talked about in my statement, in conjunction with fairly profound venous outflow problems as well because the femoral vein was not in continuity.

Right?-- All of which led to very high compartment pressures and subsequent tissue necrosis and death, which subsequently became infected.

And that raises this issue, though, I guess, given that the accident happened, as we know, around about 10 a.m. and the

first operation was around about 11.50, that's the vein repair or the vein ligation, the fasciotomies happen about 6 that night and then the arterial repair, the gortex job, happens still later. If we start with 10 a.m., if he is transferred any time after 4 p.m. or even earlier, allowing for transit, there is a good chance he might have lost his leg anyway?-- He may have. If you are assuming that the arterial injury was manifest originally - I don't know at the first operation whether the artery was patent or not. There was no mention of it being thrombosed, who knows. Certainly if it were thrombosed at that particular point in time, it should have been recognised and dealt with appropriately, and either way - I mean, either way, with the maths, he clearly had a significant period of ischaemia and then a reperfusion injury as part of that early picture. There is no question about that.

But if he was transferred-----?-- But he - well, it depends, really, to answer your question, whether the artery was in continuity or not at that initial operation, I guess, as to whether or not if he'd come, for example, to the tertiary institution, whether it would have been a different outcome, I don't know. It would have been very difficult to manage and, yes, he may have still lost his leg. That may have been - that may have been a result in best hands with a significant injury like that. I think it is unlikely but I think it is certainly a possibility.

COMMISSIONER: Sorry, just to understand that, you think it is unlikely he would have lost his leg?-- I think it is unlikely but, you know, clearly - I mean, if he had arrived at our doorstep, I would be telling the parents and him that it is a life threatening - that it is a limb and life-threatening injury. Clearly it is when there is a major venous and arterial injury, and even in the best of hands, things can go wrong and people can lose legs, and so that's clearly a possibility. I think it is unlikely that he would have lost his leg if that had been the case, but that's the context.

D COMMISSIONER EDWARDS: Can I - I am not quite sure. You said it is unlikely he may not lose his leg. Is that - are you indicating if the treatment would have been undertaken earlier?-- Yes. Say, for example-----

If he would have been in Brisbane?-- If he had been transferred promptly, or if he turned up with an injury like this, turned up on our doorstep, for example, then I guess what I am saying is in the best of care, in a tertiary referral centre with vascular expertise, he could still lose his leg, but I just think that that's unlikely that he would have.

Would it be fair to say that such an outcome would be not as likely in regional or centres outside of the Brisbane and major capital cities - major cities of Queensland?-- That an optimum-----

For example, if it happened in Longreach or something like

this, wouldn't this kind of injury be a very serious injury?-- Clearly it is.

At that level?-- It is.

It is fair to say - I am not justifying an out - there will be some more questions - this was a very significant injury?-- It was a very significant injury. Just to reiterate, even if he arrived on our doorstep, there is still a chance of limb loss and life loss. There is no question about that. What I am saying is I think, you know, it would have been less likely, but with a tyranny of distance, we rely on - I guess on damage control, as I say, and prompt referral.

MR ATKINSON: When he-----

D COMMISSIONER EDWARDS: Could I just ask another question, sorry, on that point? Did I hear you correctly to say that he was transferred without an intravenous line?-- No, he was transferred with an intravenous line but I had to dictate the resuscitation over the phone, that's all.

COMMISSIONER: He was initially going to be transferred without one and you stipulated-----?-- I can't remember whether he was going to be without fluids - I think they were just inadequate. The rate was frankly inadequate.

MR ATKINSON: What you understood, doctor, perhaps to answer Sir Llew's question, is that on the day you received the phone call from David Risson, the doctor?-- Yes.

The consultant in Bundaberg had taken the boy off the central line?-- Yes. I mean, that angered me because I just didn't realise how that could take place, that here was a boy who was clearly very sick, had a temperature up to 39.5, clearly septic, and that was ascribed to central line sepsis and the line had been removed and he had - and he had his antibiotics stopped at that stage, so.

Just to go back to this timing thing, the maths, as you say, he has the first operation, starts at 11.50 and might finish as late as 3 o'clock by the time he is transferred to ICU. Very clear from what you say that the first operation was absolutely necessary?-- Yes, definitely.

Right. The second operation, the fasciotomies, that seemed to be necessary, too, you say, because he doesn't have a pulse after the first operation?-- I think he got - I think he may have got the wrong operation at that stage. I think that if he had - I think, in retrospect, he had arterial injury that wasn't recognised at that stage. So I think that should have been dealt with. In addition, fasciotomies probably would have been appropriate at that stage anyway. If we're talking a number of hours of ischaemia, then he should have had adequate fasciotomies, but in addition to fixing the primary problem.

My question, I guess, is this: you have got a general surgeon

in Bundaberg trying to deal with a traumatic situation?-- Yes.

And he has to stabilise it before he can even think about transferring?-- Yep, that's true.

When do you think that a general surgeon should have started to make arrangements to transfer? After the first operation or the second or the third?-- I think probably after the first operation, I think. Somewhere around that. I think any major arterial injury in a young person - having said that, it was recognised as a major venous injury at that stage, and it all becomes hypothetical because, there again, I mean, it was clearly ligated. So if the knowledge was that it was ligated, it was a major injury, I think he should be referred, you know. Young person who is going to get significant venous hypertension should be referred.

Because if you do the venous ligation you are going to have the drainage block?-- Absolutely yes.

That means you must expect some swelling?-- Absolutely.

Even independent of the-----?-- Absolutely.

So that has-----?-- Even the soft tissue is clearly difficult to manage. The soft tissue injury was clearly difficult to manage, but I think after the first operation, let's say, for example, he didn't have an arterial injury or wasn't recognised, I would expect people to at least get on the phone and say look - I mean, we receive phone calls quite appropriately for fairly minor things.

Yep?-- What could be perceived as fairly minor. And we always just got people down fairly promptly. So, you know, you certainly expect with major vascular trauma, it would come down. Certainly after the second operation.

Do you need to get that, doctor?-- No, I don't.

COMMISSIONER: Doctor, tell me if I am wrong, but the impression I got, really, from hearing Dr Jenkins' evidence this morning, your evidence and some evidence we have heard before, is that at the very latest, before Dr Patel picked up the knife and started doing the fasciotomies, he should have been on the phone to someone like yourself asking for advice, and the advice almost certainly would have been either do the fasciotomies and get the patient on the plane to Brisbane-----?-- Exactly.

-----or just get the patient on the plane to Brisbane?-- Exactly, yes, definitely.

Had that happened, as you said earlier, there is at least an increased possibility and, indeed, you would go so far as to say probability that the leg could have been saved?-- I think at that stage it would have been - he - he may have lost some toes or forefoot, I don't know, but there is a good chance he

would have kept his leg if he'd come down - if he'd come down earlier, yes. I mean, when he came down, the arterial flow was repaired with a prosthetic graft, so he actually had arterial flow restored, but, no, I think if he'd come down earlier, I think he would have probably kept his leg.

MR ATKINSON: And I understand what you are saying is the sooner he was transferred, the more likely it was that we would have been successful in revascularising him?-- Oh, definitely.

All right. When it comes the time when you have lost that chance altogether, how many hours do you have?-- It is hard to say, but, I mean, all I can say is that certainly at about 12 hours or so of frank ischaemia, then you may still salvage a leg, but it can be a fairly useless leg at that stage. So earlier the better.

COMMISSIONER: You would have muscle death or something?-- Muscle and nerve death.

Yes.

MR ATKINSON: That's the evidence-in-chief, Commissioner.

COMMISSIONER: Thank you, Mr Atkinson.

MR FARR: I should indicate, Commissioner, that I appear on behalf of Dr Ray. At this stage I have no questions.

MR ANDREWS: May I interrupt for a moment, Commissioner? I have just been alerted by one of the representatives of the media that during the day there was an announcement from the Premier's Department with respect to the patient P26. As I understand it, an offer of a prosthesis may have been made, but during the announcement the patient's name was revealed, and I thought you may care to take the opportunity to exhort the representatives of the media not to reveal that name when publicising the Premier's announcement or the Premier's Department.

COMMISSIONER: Thank you for that, Mr Andrews. What I am about to say is directed to the press and media. Obviously, I can't sensor anything which the Premier says, and that's entirely a matter for Mr Beattie, but from the evidence I have heard in these proceedings, it strikes me as self-evident that this young man has suffered enough without also suffering from the trauma and anxiety of having his name bandied about in the newspapers and on television. So if I could urge, as a matter of common humanity, that his privacy be protected, I would certainly appreciate the media support in that regard. That's all I can say. I can't tell you what to do, I can only urge you to consider it that way, and I don't know whether in fact Dr Ray would like to say anything in support of that?-- Certainly would agree with those sentiments.

Thank you for that, doctor. Do you have any questions?

MR FITZPATRICK: No, I don't have any questions.

COMMISSIONER: Mr Allen?

MR ALLEN: No, thank you, Commissioner.

MR DEVLIN: Nothing, Commissioner.

MR DIEHM: Nor I.

COMMISSIONER: Ms Feeney?

MS FEENEY: No, thank you, Commissioner.

COMMISSIONER: There can't be any re-examination then. I said to Dr Jenkins when he was here this morning how frankly humbled I feel to have the benefit of expert testimony from the likes of himself and now yourself. The extraordinarily difficult task which we have in this Commission of Inquiry would be totally impossible if it wasn't for the input we have had from people like you. We realise how desperately busy you are and how you had to tear yourself away from an operation to get here this afternoon, and we have heard your mobile phone ringing while you have been here. It plainly is an imposition on people like you to have to give up your time. We do appreciate it very much indeed and we're very grateful for your evidence. You are formally excused from further attendance?-- Thank you very much.

WITNESS EXCUSED

MR ATKINSON: We have no further witnesses this afternoon.

COMMISSIONER: Thank you. 9.30 tomorrow or 10? What's planned?

MR FARR: We have arranged Dr Younis for a 9.30 start, so we're happy to do that.

COMMISSIONER: That's fine. 9.30 it is then.

THE COMMISSION ADJOURNED AT 4.38 P.M. TILL 9.30 A.M. THE FOLLOWING DAY