Transcript of Proceedings

THE HONOURABLE G DAVIES AO, Commissioner

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

IN THE MATTER OF THE COMMISSIONS OF INQUIRY ACT 1950

COMMISSIONS OF INQUIRY ORDER (No. 2) 2005

QUEENSLAND PUBLIC HOSPITALS COMMISSION OF INQUIRY

BRISBANE

..DATE 12/09/2005

..DAY 2

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

THE COMMISSION RESUMED AT 10.00 A.M.

COMMISSIONER: The first matter I propose to deal with is the letter from Clewett Corser & Drummond. Ms Dalton, is there any reason why that shouldn't be made an exhibit?

MS DALTON: No, Commissioner.

COMMISSIONER: But I think it is probably one of those exhibits which may have a limited life.

MS DALTON: I agree with that.

COMMISSIONER: So I will mark it exhibit - is it C? Exhibit C.

MARKED "C" FOR IDENTIFICATION

MS DALTON: In one respect my position has changed from what is recorded in that letter, and that is that if you determine that the evidence of Dr Aroney is within your Terms of Reference, we no longer submit that you should consider if there is a useful purpose to cross-examining him. If it is in, I want to cross-examine him.

COMMISSIONER: Sorry?

MS DALTON: If you decide his evidence is in, then I do want to cross-examine him. That's a change from what's recorded in that letter.

COMMISSIONER: Do you want to say anything further about your submission about the Terms of Reference?

MS DALTON: No.

COMMISSIONER: I noted what you say about the evidence from the Morris Commission and about how other evidence may be affected by bias, and I will bear your comments into account when I consider the matter.

MS DALTON: Thank you, Commissioner.

COMMISSIONER: You don't want me to do anything more than that now?

MS DALTON: No.

COMMISSIONER: Thank you. So far as the evidence of Dr Aroney is concerned, it seems to me it may well follow from my

decision on the Terms of Reference.

MS DALTON: Yes.

COMMISSIONER: Do you want to say anything further about Dr Aroney?

MS DALTON: No, I think it is probably the same construction point that we've raised in the Terms of Reference.

COMMISSIONER: I do, too. Dr Kane, it is my present - I should say at the outset that Dr Kane's statement has never been admitted into evidence.

MS DALTON: Thank you, Commissioner.

COMMISSIONER: And at the moment I am inclined not to admit it into evidence. Really because I don't think that this Commission will be able to explore Rockhampton, and certainly not in the way that it explored Bundaberg. If we were to do that, we would be here this time next year.

MS DALTON: Yes.

COMMISSIONER: So we're certainly not going to do that, or even the way we have explored Hervey Bay. So at the moment I think you can assume that Dr Kane's evidence will not be admitted-----

MS DALTON: Thank you.

COMMISSIONER: -----into this Commission. If that changes, then of course Dr Scott will be given leave to answer those.

MS DALTON: Well, thank you, and I think, with respect to Dr Kane, I would want - if Dr Kane comes in and Dr Scott responds, which we can do quickly because it is already a written response, I think there will really be a question then as to whether there would ever be any point in cross-examining him about it because it is just so peripheral.

COMMISSIONER: Yes, I agree with that. Do you want to say anything further about the further conduct of the inquiry?

MS DALTON: Yes and it is this: I appreciate that you may not be in a position to determine the point about the Terms of Reference at the moment and I am particularly conscious about the Thursday deadline you have given to Mr Couper and Mr Applegarth.

COMMISSIONER: That wasn't with respect to Terms of Reference.

MS DALTON: I am sorry.

COMMISSIONER: I intended to determine that question now.

MS DALTON: All right. At the moment there is nothing else I want to say.

COMMISSIONER: All right, thank you. There are no other written submissions apart from those?

MR APPLEGARTH: Excuse me, sir, we put in a very brief one.

COMMISSIONER: I didn't see it.

MR APPLEGARTH: Well-----

COMMISSIONER: It missed me.

MR APPLEGARTH: I think I can read the relevant part. It is only a few sentences.

COMMISSIONER: All right.

MR APPLEGARTH: And it relates to your invitation to make submissions that was made at pages 5103, 5104.

COMMISSIONER: Written submission by 10 o'clock this morning.

MR APPLEGARTH: Yes, I am instructed that I sent - I had hoped to have multiple copies here.

MR ANDREWS: I can hand up what I suspect to be - if it is a letter from Minter Ellison of 12 September 2005?

COMMISSIONER: That's only one sentence.

MR APPLEGARTH: Yes. I think my learned friend has highlighted the sentence I was going to read.

COMMISSIONER: Don't do that. I did see that, I am sorry.

MR APPLEGARTH: Thank you.

COMMISSIONER: That's hardly a submission; it is an agreement.

MR APPLEGARTH: Very brief submission.

COMMISSIONER: It is an agreement with Ms Dalton's submission.

MR APPLEGARTH: I am sorry, I haven't seen Ms Dalton's submission so I can't comment.

COMMISSIONER: All right, thank you. Ms Dalton for Dr Scott and Mr Applegarth for Dr Buckland have made submissions to this Court that waiting lists are not within the terms of paragraph 2C of the Terms of Reference. Ms Dalton's submission in short is this:

> "Waiting lists are not within the scope of the Terms of Reference of this Commission. The natural meaning of paragraph 2C of the current terms is an inquiry as to complaints about clinical procedures conducted by medical practitioners."

I disagree with that submission. It is not an inquiry into

complaints and concerns, and it is not, more importantly, about clinical procedures but relating to clinical procedures, and it has been held on many occasions by Courts that the words "relating to" are a phrase of very wide meaning.

Ms Dalton's submission goes on:

> "Queensland Health has practices and procedures about waiting lists. They are not clinical practices and procedures."

But the question is not whether they are clinical practices and procedures, but whether the waiting lists relate to clinical practices and procedures.

In my opinion they clearly do and I so rule. It follows that waiting lists are, in my opinion, within paragraph 2C of the Terms of Reference. I should add, however, that it may well be that I will ask the government to add a term of reference which states that more clearly so that no members of the public will be under any illusions as to that question. It will be necessary, as I indicated last week, to ask the government to add a term of reference which seems to have been omitted. That's the one which was raised in another letter last week, so it may be at the same time I will do that.

Ms Dalton said that the natural meaning of the Terms of Reference of this Commission did not include systemic and funding issues. I agree with that proposition generally but I would phrase it in this way: that the Terms of Reference don't include matters which are solely systemic and funding issues, and there will inevitably be an overlap between issues relating to acts or omissions by persons which are within the Terms of Reference of this Commission and solely funding issues which are not.

So it seems to me that whilst issues solely related to funding are not within the terms of this inquiry, there may be issues which are related to funding which are within the terms of this inquiry because they relate also to acts or omissions of persons. It follows, in my opinion, from the construction which I have reached, that Dr Aroney's evidence is within the Terms of Reference of this Commission. The doctor, as I understand his evidence, was unable to perform clinical practices and procedures that he thought essential. That is a concern relating to clinical practices. It may be ultimately that the reason for the underfunding of those clinical practices is not within the terms of this Commission but that won't be ascertained until the Commission knows the reasons why the funding was not made available.

I have already indicated that Dr Aroney will probably not be called, and with respect to future conduct of the inquiry, I would certainly give leave to Ms Dalton to file further statements from other witnesses as to allegations of bullying and threats by Dr Aroney.

Nothing else you want me to deal with, Ms Dalton?

MS DALTON: No, Commissioner. As we said in that letter, we accept your ruling.

COMMISSIONER: I understand that, thank you.

MS DALTON: And we're anxious just to proceed then, if it can be managed this week. And can I suggest to counsel assisting that the copies of the statements they have perhaps be altered just by covering that part which relates to Dr Kane, and, otherwise, Dr Scott's available any time this week, and the sooner the better.

COMMISSIONER: All right, thank you very much.

MR ANDREWS: Commissioner, it is anticipated that Dr Scott would be called tomorrow.

COMMISSIONER: That suitable?

MS DALTON: That's suitable, yes. Would that be at 10 o'clock?

MR ANDREWS: Yes.

COMMISSIONER: All right.

MS DALTON: We're grateful, thank you.

COMMISSIONER: It is proposed this morning, I understand, to call Dr North but there are some objections to this, is that correct?

MR BODDICE: That's so, Commissioner.

MR ANDREWS: Before dealing with that matter, Commissioner, there was one other submission with respect to Terms of Reference that was received before the bell at 10 and that's from the AMA.

MR TAIT: Good morning, Commissioner. The submission of the AMA essentially is that the statements which have previously been prepared by Dr Cartmill, the head of the VMO organisation, and Dr Buckmaster, the head of the salaried doctors organisation, which had been circulated but not tendered, are still sufficiently relevant to be within the Terms of Reference in that they explain the system of VMOs and staff specialists. I have written submissions. I misunderstood the procedure and I apologise for that. Mr Andrews has had copies of the statements of those witnesses for some time.

COMMISSIONER: No need to apologise, Mr Tait, because I don't understand what you are talking about, because I haven't read the statements of those witnesses and I can't deal with that matter this morning.

MR TAIT: Very well.

COMMISSIONER: So we will deal with it at some - it is not urgent from your point of view, is it?

MR TAIT: No, it is not.

COMMISSIONER: All right. We will deal with it at some convenient time.

MR TAIT: Thank you.

COMMISSIONER: Other than this morning.

MR TAIT: Certainly, thank you, Commissioner.

COMMISSIONER: Thank you.

MR TAIT: There is one other matter could I mention, please? The AMA are either the only party or one of the few parties receiving no funding from the government, and Commissioner Morris had permitted us to come and go if witnesses did not affect the AMA's position.

COMMISSIONER: You can certainly do that. I think I had a request from someone else to do that, and so far as I am concerned, if matters don't affect your client, then I certainly don't expect you to be here.

MR TAIT: Thank you, Commissioner.

COMMISSIONER: It was proposed to call Dr North this morning, but there are some objections. Mr Boddice, you are one of them?

MR BODDICE: Yes.

COMMISSIONER: Who else? Was there someone else who wants to take a similar course to Mr Boddice and that is to object to Dr North being called this morning?

MR APPLEGARTH: Commissioner, I didn't so much object. We wrote on Friday foreshadowing a difficulty, and it is really for, I think, Mr Boddice, who will have the main cross-examination. I don't think that, if his cross-examination proceeds, I will have any cross-examination of Dr North. If any, it would be very limited. We have a copy of a letter that we wrote, if it helps to explain.

COMMISSIONER: No, that's all right. If you don't want to add any further submissions, that's fine.

MR APPLEGARTH: Perhaps I could add whatever needs to be added after Mr Boddice has his say.

COMMISSIONER: Okay. Yes, Mr Boddice?

MR BODDICE: Your Honour, the position that we wrote about was that we, of course, are not in a position to cross-examine

Dr North today with the short notice.

COMMISSIONER: Why not? You have had his report for how long?

MR BODDICE: It was given just after lunch on Friday.

COMMISSIONER: The report.

MR BODDICE: No, the report's been given some time ago but his statement was given-----

COMMISSIONER: The statement only relates to the furnishing of a report. That's a peripheral matter.

MR BODDICE: With respect, it doesn't. It deals with issues pertaining to why the report was delayed.

COMMISSIONER: Yes.

MR BODDICE: And there are a number of people who need to be spoken to in relation to that.

COMMISSIONER: That's a peripheral matter, Mr Boddice. I can't see how that affects the findings of this inquiry or the recommendations that I will make very much at all, why the report was delayed. I hope we're not going to delay too much time to cover that point.

MR BODDICE: Except that if the statement simply said, "Here is my report", but the statement didn't. The statement in fact doesn't even annex the report. It deals with all of these issues, which your Honour refers to as peripheral issues.

COMMISSIONER: If you don't think it is relevant, don't cross-examine on it.

MR BODDICE: Of course, the difficulty is, your Honour, that's a risk. If a statement goes in and I don't cross-examine on it and you wait until the end to make submissions it is not relevant, it can, of course, then be said, "Well, you let it go in without being cross-examined."

COMMISSIONER: I will leave you to cross-examine last, Mr Boddice.

MR BODDICE: Your Honour, what we were proposing was we weren't objecting to Dr North giving his evidence-in-chief, but we were asking our cross-examination be stood down. I spoke to counsel assisting on Friday indicating we would be in a position on Wednesday to be able to deal with it.

COMMISSIONER: No, I am not going to do that.

MR BODDICE: I can't take it any further.

COMMISSIONER: You can cross-examine at the end. I will allow you to do that.

MR BODDICE: Thank you, your Honour.

COMMISSIONER: Do you want to say anything further?

MR APPLEGARTH: Can I provide to you the letter that we wrote on Friday which outlines-----

COMMISSIONER: I did see that.

MR APPLEGARTH: -----our position? Our only interest is in what you have described as peripheral matters, so it is a matter of whether it makes sense and it is convenient to the Commission for us to, as it were, cross-examine on peripheral matters before Queensland Health has their cross-examination. We're in your hands. We would rather prefer to get our-----

COMMISSIONER: I will make Mr Boddice second last and you last, if you would prefer.

MR APPLEGARTH: That seems sensible. If you are not going to cross-examine on matters Mr Boddice cross examines on, you are only going to supplement his cross-examination.

MR APPLEGARTH: I think so.

COMMISSIONER: If that's so, then I will-----

MR APPLEGARTH: I mean, just in terms of the coming and goings, I don't want to be here for two hours hearing Mr Boddice cross-examine because I have got to attend to matters for my client. We're trying to get his statement finalised. So can we come back to the matter when the evidence-in-chief of Dr North is finished? We may have an idea of who wants to cross-examine. My preference would be to leave my peripheral cross-examination until after Queensland Health, but can we revisit that after the evidence-in-chief?

COMMISSIONER: Yes, yes.

MR BODDICE: Commissioner, could we at this stage just raise a matter about the witnesses?

COMMISSIONER: Yes.

MR BODDICE: We understand that there is a need to act timely in relation to this Commission, and certainly from our point of view we're keen for it - for the evidence to be completed as well, but one of the difficulties is that, for example, this statement is something the Commission has had or counsel assisting has had since May, it would appear by it, and it hasn't been distributed. It may be-----

COMMISSIONER: Partly because it didn't have much to do with the essential elements of the inquiry.

MR BODDICE: That may be-----

COMMISSIONER: I don't see what it has got to do with anything, frankly.

MR BODDICE: That may be so, but from our point of view we deal with matters as they come along, obviously.

COMMISSIONER: Such things that you deem relevant.

MR BODDICE: One of the suggestions we would make is even if it means losing a day or two before we start, the opportunity for statements to be distributed in a timely fashion would mean that it would occur in a more orderly fashion, in our respectful submission, thereafter the evidence-----

COMMISSIONER: I am sure that will happen more as the Commission gets going, but you appreciate it has only just started, and the urgency of starting and hearing evidence was very important.

MR BODDICE: Anyway, we wish that to be taken on board wherever possible by counsel assisting, Commissioner.

COMMISSIONER: I am sure it will. Thank you. Mr Andrews? Before Mr Andrews starts, I should tell you that I intend to take a short break at 11.15, or thereabouts, depending on the state of the evidence. Yes?

MR ANDREWS: I call John Bevan North.

JOHN BEVAN NORTH, SWORN AND EXAMINED:

MR ANDREWS: Doctor, is your full name John Bevan North?-- It is.

Have you prepared a statement dated the 12th of September 2005?-- I have.

Would you have a look at this signed version, please? Is that your statement? While Dr North is looking at that I will ask him in a moment to identify Exhibit 38. I wonder if a copy of it can be obtained?

WITNESS: It is.

MR ANDREWS: And the facts recited in it, Dr North, are they true to the best of your knowledge?-- To the best of my knowledge.

I tender it.

COMMISSIONER: Yes. Exhibit number - I don't know.

MR ANDREWS: Would you look please at Exhibit 38? And while you are doing that, the secretary might be able to tell the

Commissioner what the exhibit number is of the last document. Dr North, is Exhibit 38 a 39 page report - 39 pages including two appendices, and is it a document co-authored by you?-- It is.

Are the opinions expressed in it opinions honestly held by you?-- And by my co-investigator.

The facts recited in it, are they true to the best of your knowledge?-- They are.

With respect to your report, Exhibit 38-----

COMMISSIONER: That's 312, Mr Andrews, and others who are interested.

ADMITTED AND MARKED "EXHIBIT 312"

MR ANDREWS: Thank you, Commissioner. You were advised, it seems, from the preamble, that is the Australian Orthopaedic Association was advised, that there were concerns with the delivery and quality of orthopaedic care at Hervey Bay Hospital?-- Correct.

What is the liberty of the Australian Orthopaedic Association to make a preemptive investigation? Do they have any liberty to do so or must they be invited?-- No, they would have to be invited. Although the orthopaedic association wants to uphold safety and standards in orthopaedic surgery, one can't just march into the hospital and say, "We're going to do an audit." I mean, the local practitioners should be running an audit process in any case, but as an association we would support the local audit process completely, but we can't just run in there and say, "Hello, I am here from the Federal AOA."

The Federal AOA, is it a group below the Royal Australian College of Surgeons and part of that group?-- We shall be - we probably should be careful using the word below.

I do beg your pardon, yes?-- If I could explain that a bit more fully, the Royal Australasian College of Surgeons is a college that gives a diploma, that is regarded in Australasia as a basis for specialist registration. In training orthopaedic surgeons to sit that diploma, receive that diploma and become registered specialists, the AOA is designated as the training body and arranges, supervises, organises, supports both the training of and the continuing professional development of orthopaedic surgeons and orthopaedic trainees in Australia. The College is Australasian, the Australian Orthopaedic Association is Australian, and the NZOA performs the same - the same role in New Zealand as the AOA does in Australia.

You are a senior examiner in orthopaedics to the Royal

Australasian College of Surgeons?-- Yes, I was until May last year. My successor - we usually have two or three year terms, and my successor is John Batten, a Launceston orthopaedic surgeon.

You were - you and Dr Peter Giblin were appointed by the Director-General of Queensland Health at the time as investigators pursuant to Division 1, Part VI of the Health Services Act?-- Correct.

Do you understand that that appointment obliged you, pursuant to that statute, to keep confidential the names of any patients?-- That was our understanding.

And within your report, do you avoid using any patients' names and, indeed, do you make it difficult to identify any patient?-- We do. We have.

And that's in part because of the obligation of confidentiality that's imposed upon investigators by the statute?-- Our understanding was that under section 56 we could request information, including charts and X-rays, we could request information not regarding patients but regarding their care, and that this was our right, to request and receive. And so we did do that and received a lot of paperwork as a consequence of that. But that was kept confidential.

Now, your appointment was made on the 8th of June 2004, about six or seven months after the Chairman of the Queensland Branch of the AOA received the expression of concern. Did that seven month delay have to do with - well, in part negotiating an indemnity to protect you and your co-author against the kinds of defamation that you might be obliged to commit to paper if you did a thorough report?-- Correct.

Is it the case that medical practitioners who report on the competence of other practitioners are still subject to the prejudice that they might be sued for defamation if they report adversely on another practitioner?-- Yes, there are certain circumstances where that maybe won't occur. If you are part of a recognised clinical privileges committee for a particular hospital or district, then you may be exempt from that, but apart from that, my understanding is we are open to.

Now, at page 2 of the report you observe that the review was "to investigate matters relating to the management, administration and delivery of public sector health services and was to include advice to assist the district in defining guidelines for the senior medical officers in relation to certain things."?-- Correct.

Senior medical officers, is that a term of art referring to a particular classification of medical person in the public hospital system?-- It is.

Am I right in thinking that in the public hospital system, there might be a hierarchy among medical officers, one might

have a junior house officer?-- Uh-huh, correct.

And above that station might be principal house officer?-- Correct.

Above that, Senior Medical Officer?-- Correct.

And a Senior Medical Officer undertaking training in a hospital that offers it might be classified as a registrar?-- Yes, if we use the terms very loosely.

Right?-- It's a little vague and it's really a pay classification that's grown p with history rather than clearly defined-----

Do you mean registrar is a pay classification?-- No, Senior Medical Officer.

Senior Medical Officer is a pay classification. In some hospitals might a person be engaged as a Senior Medical Officer even though they hold fellowship of the Royal Australasian College of Surgeons?-- It's possible but unlikely.

In general parlance, the next step above Senior Medical Officer is either the consultant or - who is a-----?-- Specialist.

A member of a specialist college?-- Mmm-hmm.

And that specialist might either be employed full-time on staff or visit as a VMO or a Visiting Medical Officer?-- Correct.

So within this report where you speak of VMOs and SMOs, for instance on page 3-----?-- Mmm-hmm.

-----By SMOs you mean Senior Medical Officers?-- Correct.

And VMOs, you mean the specialists who are Visiting Medical Officers?-- Correct.

When discussing the term, "Senior Medical Officer", you say that that is a pay classification. The Inquiry's received evidence in respect, in fact, of Dr Patel?-- Mmm-hmm.

That shows that when he received registration Dr Patel was registered by the Medical Board under an area of need as an SMO Surgery. Now, can you say when a person is registered as an SMO, does it connote that there will be any level of supervision which is going to be required by the SMO in surgery or in orthopaedics-----?-- It assumes a serious level of supervision, I would think.

Well, in particular, if one is an SMO in orthopaedics, does it assume a serious level of supervision?-- It certainly does.

And do you mean by that supervision by a Fellow of the Royal Australasian College of Surgeons or a member of the Australian Orthopaedic Association?-- Correct.

Now, your assumption that it requires a serious level of supervision, is this something that ought to be well-known

outside your association and, I mean in particular ought it to be well-known by, for instance, hospital administrators that a Senior Medical Officer in orthopaedics requires a serious level of supervision?-- Correct.

When looking at page 2 of your report, you were, among other things, to give guidelines for the Senior Medical Officers in relation to, and you will see seven matters then seem to be set out?-- Correct.

Am I right in categorising - well, grouping 1, 2 and 3 in that section as a suggestion that you give an opinion on guidelines to the Senior Medical Officers about what the Senior Medical Officers should and should not be permitted to do-----?-- Correct.

-----without supervision?-- And I think we were fairly clear in the recommendations about that.

Is it the position that even with serious supervision, as I think you called it, there are some things that a Senior Medical Officer in orthopaedics can do without a specialist looking over his or her shoulder and some things that they should not do?-- Yes. If by virtue of his training and experience I have seen that he is able to do that particular procedure, I may be happy to say, look, I need to know about it, and I will be in the tea room, at home, but I'm happy for you to progress. But there's some subtleties in assessment there. You are assuming you know this person to be competent in the assessment of that particular injury, and competent in practising the right management for that particular injury. So, there are a number of issues in competence of assessment as well as competence of carrying out the procedure itself.

And is it the usual case that when one has an unknown quantity arriving at a hospital, for instance taking - a person taking up employment for the first time, for instance, a Senior Medical Officer that - is there a process called credentialing and privileging which takes place?-- There should be.

Pursuant to that process are there some persons who consider the training of the new employee, the equipment and staffing levels at the hospital, the amount of supervision that's available to that new employee, and taking all of those matters into account there will be a list of procedures outlined to the employee which he or she can follow with supervision and without?-- That's expected.

And so when one has a hypothetical Senior Medical Officer in orthopaedics, the list of procedures that that person can undertake might expand if there is supervision and contract if there isn't?-- If there's clear competence in those areas it might expand. Sometimes as you watch the operator operate you might reduce the list, not expand it, depending on competence.

When it comes to competence, quite apart from training and

technical expertise, is there a matter of insight by practitioners that's also considered a significant feature?-- Absolutely. It may be more important than the technical competence.

And by insight, do you mean that a technically adept orthopaedic practitioner with proper insight will know that there are certain procedures he or she ought not to do without assistance, while one lacking insight might dive in and-----?-- Correct.

-----proceed unassisted endangering the-----?-- Life and limb.

Life and limb of the patient. You were also, among the seven items on page 2, to look at the level of direct and indirect supervision required from the consultants. Now, that would be dependent upon the level of skill of the two SMOs, wouldn't it?-- Correct.

And the serious supervision that's required for senior medical officers, can it sometimes be remote supervision by a specialist who's not actually within the operating theatre?-- Can be, as long as that person is completely certain that the practitioner is adequate for that procedure.

And it can even be supervision from a person who's not even within the hospital grounds at the time?-- Perhaps. As long as the same - the previous category applies, yes.

And so a hospital administrator, who's for instance, being told by the Director of Orthopaedics that a Senior Medical Officer is adequately supervised and being told by a Visiting Medical Officer that the Senior Medical Officer is not being adequately supervised, might be confused?-- Might be confused, agreed. With respect to insight, we usually look carefully for that in examining trainees at the end of their training process, and we use the words "advanced clinical reasoning", so that we want to see that they - with all the information available to them they do have this insight, if you want to use that word, or this reasoning process that says yes, this is a prudent thing to do, or not a prudent thing to do, I will balance the risks against the benefits and using my evidence-based surgical experience proceed to operate sometimes and perhaps not operate at other times.

COMMISSIONER: I wonder whether Mr Andrews might be using "insight" in a slightly wider way, to include also the capacity of the person to know what he or she was capable of doing or to think that he or she could do something which perhaps they couldn't?-- And I'd agree that's another dimension completely, and we can't examine for that but in this circumstance I think that's applicable.

But you can observe that?-- Absolutely.

From-----?-- And we did observe it.

You did?-- Mmm.

MR ANDREWS: Indeed, within your report do you say of one of the SMOs that it was your opinion that that doctor-----

COMMISSIONER: Krishna.

MR ANDREWS: Dr Krishna was lacking that essential insight?-- We did.

In the sense that Dr Krishna felt that he was, because of his qualifications in obtained in Fiji and his training obtained in Australia and elsewhere, capable of performing most orthopaedic procedures unsupervised?-- That was his stated position.

Now, still on page 2, I see the next item in the list of seven was, "Clinical Audit/Quality Assurance Recommendations." By, "Clinical Audit ", do you mean meetings between medical practitioners and nursing staff at which there's a frank discussion of the outcomes of prior procedures with a view to identifying areas for improvement?-- Yeah, correct. If I can - may I expand a little bit?

You can, of course?-- It varies again according to your particular situation but, for instance, at 7.30 this morning we had a clinical audit at Princess Alexandra Hospital for orthopaedics. So, my weekend admissions were audited this morning - or Friday, Saturday, Sunday, were all audited, X-rays on screen, description of mechanism of injury, description of what we had done, should do or may do, and physiotherapists, nurses, all the junior medical staff, most of the consultants were all there taking part in this audit and looking for best outcome for that particular situation. So, it's a clinical meeting that audits the patients admitted over a certain period. Now, every two months, however, we had a more formal one in our hospital where - and this should occur in most hospitals - where the two months of patients are audited more critically. So, if someone who came in this weekend has thrombosis or a heart attack or dies or has to return to theatre, all those things are brought out in a clinical audit, which is much more comprehensive and obviously only occurs every couple of months, and that might be called a morbidity and mortality audit or-----

Are you looking at the two monthly audit for patterns?-- Patterns of particular complications, particular consequences of a particular operation, possibly even some dubious insight problems may arise, possibly some questionable technical difficulties might arise.

Does it occasionally happen that a practitioner who's been competent and well regarded for years might suddenly have more adverse outcomes than he or she statistically would ever have had before and these audits can pick-----?-- Absolutely.

-----changing practices up?-- Absolutely. In fact, I have

been asked recently to take part in a clinical privileges committee in my AOA role where that, in fact, did arise. We became - not this the State - but we became part of a clinical privileges committee and two orthopaedic colleagues from a different State went to another State to look critically at this process, look at the patient, look at all the files, look at all the X-rays, quite a job when it's all done pro bono, and then meet with the person, the clinical privileges committee group, and prepare a report as a consequence of that, not quite as lengthy as this, Mr Andrews, but quite a lengthy report. So that happens quite frequently.

And clinical auditing is a universal feature-----?-- Absolutely.

-----in all hospitals?-- Should be.

Although the degree of - the quality of clinical audit will vary from place to place?-- Clearly.

You were to look at quality assurance recommendations. Are they to do with the analysis of systemic matters in the hope of improving system?-- That's a hazy difference between clinical audit and quality assurance. It's very hard to sort of draw a line between them, but a quality assurance might say, does this particular internal fixation device fit that particular fracture pattern, and so once we've looked retrospectively at, say, 50, we might say inefficient device, needs either remedy or a renewed attempt to find what is the best device for that particular fracture pattern.

Item 6, you were to look at requirements for registrar training accreditation. This wasn't a training-----?-- It wasn't, no.

-----facility, was it, for orthopaedics?-- No.

But you were looking to see what would need to be introduced if the SMOs in this hospital were to be allowed the option of training for a speciality?-- Could I just take "these SMOs" out of that sentence, please?

Yes. SMOs in general?-- That's right, yes. If there were to be a training post at that hospital, and certainly several of the - or the VMOs saw that as a natural consequence of a number of years hard work there, then that training post would have to fit within fairly significant criteria, and those are laid down in one of the appendices, I think, whether a particular hospital needs to have a training post. Those training posts are then inspected and have to fulfil the requirements that are stated, and those requirements - in fact, that was the easiest part of the report because basically we simply took from the Orthopaedic Association database the requirements and passed them on to the Director-General.

And the fact that this wasn't a training hospital wasn't a criticism of the hospital, was it? Not all efficient

facilities have sufficient numbers of specialists to allow them to be training hospitals?-- Correct. I mean, we have two trainees at Townsville Hospital at present that will be removed at the end of this month, simply because the criteria for a training post have now lapsed and unfortunately the trainees will be removed.

At page 4 of your report you discuss the timing of the inspection. The original date for submission of a report was set for the 30th of June 2004, but you in fact didn't commence your inspection until the 2nd of July, did you?-- Correct.

And that was all to do or primarily to do with obtaining the indemnity-----?-- It was, exactly.

-----you needed. An extension was granted to the 31st of October 2004?-- Correct.

Is it fair to conclude that would have been granted to you by about the 1st or 2nd of July 2004?-- Probably. Probably.

Now, I see that initially, of course, Queensland Health had intended that you'd report by the 30th of June, they extended the time for four months?-- Yes.

But as you observe, material for the report was still being received by 31 October and you weren't able to meet the deadline. You say you sought an extension of time for the submission of the report but it wasn't granted. Can you recall when you sought an extension beyond 31 October?-- Can I just go back a little bit and explain that we were constantly concerned by the fact that the words "unconditional indemnity of the investigations" was never apparent on any document from Q-Health.

Did that lead you to believe that if you didn't comply precisely with the Terms of Reference, which were to report by a particular time, that you might lose your indemnity?-- Indeed.

Is that your fear?-- Exactly our fear.

And would that be why you would have been very keen to get extensions?-- Absolutely.

And not to report after the deadline?-- Correct.

Doctor, can you say when it was you asked for an extension beyond 31 October?-- I can't exactly. I mean, I think we were at that point getting so frustrated with paperwork not coming in as requested and the fact that it didn't seem as though we were getting support for this in a realistic fashion and the words "unconditional"-----

COMMISSIONER: From whom? From whom?-- Q-Health. There were many messages between the AOA central office and the Director-General's office about this indemnity issue, and we were simple - we are simplistic in the sense of indemnity,

Commissioner, but we weren't comfortable knowing what we had as evidence from the July visit and what we'd collected already in the few weeks, months after the July visit, if we put that on paper we felt even more uncomfortable about presenting a report unless we saw "unconditional indemnity" written somewhere.

Yes.

MR ANDREWS: Well, then, I gather you're not able to say from whom the extension was requested or who declined to give it?-- No. It may be in the hands of our CEO in Sydney, Helen Beh, but I don't have that data with me, sorry.

Thank you. You interviewed people on the 2nd of July?-- Correct.

You perused files and X-rays, you say, of cases of concern?-- Correct.

Can you say who alerted you as to the cases that you ought to concern yourself with?-- Yes. A number of people that had been seen by the two VMOS in the Fraser Coast District alerted us to cases that - and suggested we ask for files and X-rays of those cases that we could see. A number of cases had been referred to colleagues in Brisbane and we were alerted by those colleagues to consider looking at those files and X-rays.

So-----?-- And we did.

That would have been specialists in Brisbane?-- Correct.

And two in the Fraser Coast region-----?-- Correct.

-----who would have pointed you towards certain files?-- Correct.

About how many files did you explore?-- About a dozen. I can't remember exactly. The problem was we were not sent there as an audit exercise, we were sent there as investigators of health care delivery and, you know, we couldn't ask for every file relating to Dr A, Dr B, Dr C, Dr D, it would have taken us six months and a slightly higher budget.

You would have had different instructions?-- Absolutely.

And you say you had telephone meetings over the ensuing weeks in addition to your day of interviews? I'm looking at page 5?-- Yes. No.

About .6 of the way down the page?-- Yes.

The paragraph that begins, "The process of collation"?-- Sure. Now, that was between Dr Giblin and myself, you know, as we discussed it and talked about it. In fact, I went to Sydney one day and we collated that a little more face to

face, but effectively most of this was done - again for cost reasons - was done over the phone or drafts or partial drafts sent between offices.

At page 9 of your report there's a description of the duties of Dr Naidoo. Dr Naidoo, while he may have had training overseas, is in fact registered as an orthopaedic specialist and is a Fellow of the Royal Australasian College of Surgeons?-- Mmm-hmm.

So he's also an Australian trained specialist?-- Absolutely, yes. No, he has a specialist qualification, yes.

Now, he's a full-time staff specialist with on-call commitment. That means that at least at the time you were reporting Dr Naidoo was a full-time employee and he had obligations to make himself available. When you say "on-call", that means after hours?-- Absolutely.

He had to make himself available to return to the hospital if required?-- Absolutely. So, I was on-call at the Princess Alexandra from 8 a.m. Saturday to 8 p.m. this morning. That was my on-call commitment, two 24 hour sets. So, I need to be within a certain distance or reasonable time from those patients.

COMMISSIONER: What sort of time and distance would you have to be?-- Well, we searched Q-Health policy. We are not sure of that. I try to say certainly not outside an hour but within half an hour. But I can't see it written anywhere in Q-Health policy and this may be one of the deficiencies.

Were not three and a half hours?-- Absolutely not. No, I feel very uncomfortable, we live 10 minutes from Princess Alexandra, I feel very uncomfortable with being more than 30 minutes away and yet I had a very senior registrar on duty yesterday and I still spent six and a half hours with him, maybe the Prince Alexandra cohort of patients is very different to other hospitals, but I think if we are an on-call specialist, we have a responsibility for safety to be there and help if necessary, support if necessary, make decisions always, so any patient that comes into that hospital on my day on-call, I get a phone call about, I speak about, I sometimes go in, sometimes there might be an e-mail X-ray, but that's the only way to run a safe practise.

While I'm interrupting, Dr Naidoo apparently had a limited right of practise within the Fraser Coast district. How was that limited?-- Some full timers, some full time specialists in public hospital service are allowed a private practice.

I understand that. How is it limited in his case or don't you know?-- I don't exactly know. There are two options, I'm not sure which option he was actually on.

What are the two options?-- Option A and Option B.

Well, what are they?-- Sorry, one is that he receives the money directly and the other is that Q-Health receives his money and has - gives him an increase in salary at the end of the year.

But neither of them specifies a limit, the number of hours you can spend in private practice?-- Look, I think they do specify.

But if you don't know, don't speculate?-- But I've never been involved in either of them so I can't answer it.

All right, thank you.

MR ANDREWS: You mentioned your own on-call experience?-- Mmm-hmm.

And that you were there for six hours at the hospital despite having a very senior registrar?-- That's correct.

By that, you mean that the person who called you in is likely to have been that very senior registrar?-- Mmm-hmm.

And the description "very senior registrar" means a person probably of status - I beg your pardon - a pay scale likely to be Senior Medical Officer but the person's described as a registrar because they're on a orthopaedic training program?-- Correct.

And they're very senior because they are very experienced?-- Correct.

In their training?-- Correct.

And I suppose the more experienced the senior medical officer, the more comfortable the consultant or specialist might be about leaving that person unsupervised and about being away from - or 30 minutes or more from the hospital?-- Absolutely.

Dr Mullen's description as visiting medical officer, attending the hospital three sessions per week with an on-call commitment, does that mean that Dr Mullen would have had three specified periods per week when he was expected to be at the hospital operating or attending to orthopaedic patients in any event?-- Correct.

And he would have been obliged to attend if required some other period, usually after hours?-- Correct. So if I am on-call a weekday, then my on-call hours are from 6 p.m. to 8 a.m., so we have a one hour - this is a Q-Health directed pay program, so the VMO becomes on-call or 14 hours and a full timer is expected to cover the trauma during the day or the crises during the day.

Now, Dr Krishna is the next. As a senior medical officer orthopaedics, you say he'd been granted periods of Special Purpose Registration. Do you understand that to mean that pursuant to Section 135 of the Medical Practitioners Registration Act of 2001, a determination had been made by a delegate of the Minister for Health at the Hervey Bay Hospital, because of the inability to find an Australian-trained Senior Medical Officer, there was an Area of Need for a senior medical officer that could be filled by an overseas-trained person and that Dr Krishna was registered by the medical board to fill that Area of Need as a Senior Medical Officer, Orthopaedics?-- I understand what happened, but I'm not sure I understand the legislation that leads to it happening. I'm sorry, that's a confusing answer, I think it's very vague, the whole Area of Need situation is very vague.

COMMISSIONER: Well, it doesn't matter really.

MR ANDREWS: The fact that one is a senior medical officer, orthopaedics, you've said requires serious supervision?-- Correct.

What do you mean by "serious supervision"; what degree of supervision is required by a specialist in orthopaedics?-- For the particular doctor do you think or in general?

In general, because I'm interested to know what the administrators at the hospital ought generally to have expected from their consultant - from their specialists by way of supervision and then you can say whether or not for Dr Krishna that general supervision was enough or whether more was required?-- It's very difficult to answer that without a long dissertation, but simply, the man - the particular doctor had been trained overseas, and certainly for the first year of any service in any centre anywhere in Queensland, I would have thought it would have been prudent for his supervisor to have been present in the operating theatre at all times to judge

whether he really could do what was demanded of him in a Queensland medical safety or under a Queensland medical safety umbrella. Now, if you say is that what the administrator would expect of him? I don't think the administrator is sure what to expect of him. If I give you a simple analogy from our hospital, we have a vastly experienced trauma surgeon who is an overseas-trained doctor, he has done enormous volumes of research, enormous volumes of trauma surgery in his 42 years, far more than I've done in my almost 60 years, and yet, he will still have a period of supervision for more than a year and so I will be his on-site supervisor and another person will be his on-site supervisor for at for more - for at least a year and he was granted a year on a sort of semi-compassionate basis because he was so experienced. Now, we're talking about here a senior overseas-trained incredibly well respected, incredibly well written and incredibly technically competent surgeon who will still be supervised, you know, at the command of the College of Surgeons for one year.

COMMISSIONER: And how would you compare him with Dr Krishna?-- Uncomparable, not able to be compared.

Well, why not?-- This man is a specialist.

Mmm?-- Who is able to do very complex and complicated surgery safely and, for instance, to put two screws up between the first and second cervical vertebrae to fuse them together, Dr Krishna probably has never seen that operation, he has probably not heard of that operation because that's not what anybody would expect anybody in Figi could or should do. Just doing ordinary spinal fusions, this man has done many many and is obviously very competent at it. Dr Krishna would perhaps have seen none in his pre-Australian experience and probably hasn't seen any during his stay in Australia. So we're talking about a very different person with a very different level of training and a very different level of experience.

Well, what sort of surgery would - should he have been permitted to undertaken unsupervised, if any?-- Simple cuts and haematomas and relatively simple surgery that could be done by a seriously experienced general practitioner in regional Queensland.

Right?-- He may have been able to manipulate closed fractures as opposed to compound or open fractures, so manipulate forearm bones or possibly ankles, relocate dislocated fractures, fracture dislocations, but serious open surgery should not have been or should not be without supervision.

All right?-- Serious internal fixation should not be without supervision-----

That means any open surgery; any, is that right?-- -----I would think reasonable.

Any open bone surgery?-- Any open bone surgery I think is unreasonable, yes, without supervision.

Sorry to interrupt, Mr Andrews.

MR ANDREWS: I have a clinical privileges document which when evidence is obtained from Dr Krishna, will be tendered, and it has a number of procedures listed upon it. The document's in two parts: one speaks of orthopaedic trauma and the other, elective orthopaedic surgery. Would you look please at this document, perhaps page by page, and tell me whether this privileging is appropriate for Dr Krishna. Can I see the very top of the page so that "Orthopaedic Surgical Services, Dr Krishna's Scope of Practice", is the - a commonplace style of privileging document?-- Never seen one in my life before, sir. It looks quite reasonable though, it looks quite reasonable in the sense of its architecture.

Now, you'll see the left-hand columns containing ticks?-- Yes.

Is headed "Perform Independently"?-- Yes.

That would mean without supervision, wouldn't it?-- I assume so.

And well, looking down that list, can you say whether they are procedures that are or were appropriate for Dr Krishna to perform without supervision?-- Can I go through them one by one?

Yes?-- Closed fracture dislocations I think is tick; compound fracture dislocations, would depend on the gravity of it. Say it was a small finger or a toe, open wound, with a dislocation, I would think that would be quite acceptable but I would still ask my registrar at Princess Alexander to call me and tell me he was doing it, so I would need to know that this was happening. I may not go in and deal with it, but fractured clavicle, ORIF, Commissioner, is open reduction and internal fixation.

COMMISSIONER: Yes?-- A fractured clavicle has some very large vessels lying underneath it and some very important nerves lying underneath it, and open reduction and internal fixation of the clavicle is not a simple fracture. It might be a simple bone and some of us here might have broken them in football and things like that, but open reduction and internal fixation of a fractured clavicle is not without its major consequences, and if they are to occur, they can be very major and very fatal very quickly, so I would not put a tick against that. AC is the acromioclavicular joint dislocation, that's the sort of typical rugby injury out on the outside of the shoulder. Again, not something that I believe Dr Krishna should be allowed to do. Fortunately, they got the very end of the clavicle correct and he's - again, if I perform that operation, I always have a vascular surgeon or a thoracic surgeon handy because there are even bigger vessels under the inner end of the clavicle and can be damaged and I'm not competent by training and experience to deal with those if there is a crisis. So fractures of the proximal humerus, it's

a very complex area and Dr Krishna is not by - is not able to deal with that. So I would not - this is I'm talking as a clinician here that deals with broken patients all the time, so excuse me if I have a different opinion to the ticks. Fractured shaft of humerus, again, I heard just this morning in our audit a comment by an upper limb surgeon, so he only does upper limp, he said, "The humerus is not a happy bone", meaning surgical interference with the humerus is often not the best treatment for the patient, and I think if I had a shaft of humerus fracture like we saw on our screen this morning, I would be very happy to have a splint on one side, a splint on the other side, a sling for the six or eight weeks that it took to unite and no surgical consequences like division of the radial nerve, very common potential for open reduction. Now, remember, if you're not well versed in surgical anatomy, these things are likely to be damaged.

MR ANDREWS: What I might do, Dr North, it was intended that there be an adjournment at about this time.

COMMISSIONER: Well, I'm in your hands.

MR ANDREWS: I might hand this document to you during the adjournment and allow you to perhaps circle all of the ticks that you think ought to be removed from the independent column.

COMMISSIONER: And should be in the other column. Yes. All right. Well, you go ahead and do that and we'll adjourn now for 15 minutes or so.

THE COMMISSION ADJOURNED AT 11.17 A.M.

THE COMMISSIONER RESUMED AT 11.31 A.M.

JOHN BEVAN NORTH, CONTINUING EXAMINATION-IN-CHIEF:

COMMISSIONER: Yes, Mr Andrews.

MR ANDREWS: Commissioner, we seem to be short-staffed just at the moment, so instead of putting the document on the screen.

COMMISSIONER: Mmm-hmm.

MR ANDREWS: To begin with, you've identified, Dr North, on the list in the "Perform Independently Column", a number of matters by using a pink highlighter on the tick that had been in that column. Should I interpret from those 20 to 30 items, that they were matters that should not have been performed independently by Dr Krishna but ought to have been performed

under supervision?-- Correct.

You've identified a number of other items with writing and there seems to be some kind of mathematical symbol and the word "complexity"?-- Proportional to complexity.

Meaning if they were very simple, perhaps he could perform them unsupervised but if they were more complex, it ought to have been with supervision?-- Correct.

With some others you've got the proportional sign and the word "age"; is that self-explanatory? Depends on the particular age of the patient as to whether-----?-- Absolutely, and that needs to be taken into account, especially in fractures around the elbow and the knee with growth plates in little ones, it's very difficult to get accurate reduction sometimes with particular fractures around the elbow, and some of these actually rotate through more than 90 degrees, and it's very difficult to recognise them, so they are not something that an unsupervised person can do easily and especially if by training and experience people are not used to doing it, they need help.

There was another, acetabulum?-- Acetabulum.

Acetabulum, A-C-E-T-A-B-U-L-U-M?-- Correct.

"Fracture simple" and you've got the word "Ridiculous" next to it?-- Well, that's the hip socket, Commissioner.

COMMISSIONER: Right?-- The hip socket is the acetabulum, the femoral head sits in it so if you imagine-----

You don't say it's a simple one, is that what you're saying?-- Yes, exactly right, and any fracture of the acetabulum I would ask my colleagues of who specialises in pelvis fractures, "What should we do with this Laurie?", and I'd be advised.

Well, we don't need to bring that up.

MR ANDREWS: To-----

COMMISSIONER: It's been explained. Do you want to tender it?

MR ANDREWS: Yes, I tender that list.

COMMISSIONER: Now, I think we got the last exhibit number wrong so I won't give this one a number but I'll accept it as an exhibit bearing the next number.

MR ANDREWS: Thank you, your Honour.

When speaking of Dr Naidoo, you say that there was virtually no communication between the SMOs and Dr Naidoo. Are you speaking about the fact that Dr Naidoo was resident in Brisbane or the level of communication when Dr Naidoo was present at the hospital?-- Both. Both Dr Naidoo and Dr Sharma confirmed that there was poor communication between

them and the director and that was confirmed by numerous other parties whom we interviewed that day. It was a well known fact that communication skills and communication generally was not adequate, let alone reasonable.

All right. At page 15 of your report, you speak of the availability of Dr Naidoo for various reasons: study leave, conference leave, sick leave, it seems that there were times when Dr Naidoo was absent; what does that mean for the practice of orthopaedics at a hospital where the Director of Orthopaedics is absent and there are no other orthopaedic specialists supervising or if the supervision is limited perhaps to Dr Sean Mullen's occasional visits to the hospital?-- It doesn't speak very highly of the level of service or, in fact, the safety of service. In fact, it says it's dramatically unsafe.

COMMISSIONER: Could I just ask a question arising out of that? Given that Dr Naidoo lived in Brisbane and it's a three or perhaps more realistic, three and a half hours to Hervey Bay from where he lived, were you able to judge how much time he actually spent in Hervey Bay?-- We weren't.

Sorry?-- We were not.

Did you have any indication from staff there as to what that was?-- He was - we constantly got the sentence, "He is very hard to find".

Mmm?-- And whether it came from medical practitioners or nursing staff, this added to the communication crisis, I would call it, to suggest that on many occasions patients were taken to the operating theatre without any communication between - possibly on the basis of that document, although I've never seen that document before and we asked for some indication as to what was thought reasonable.

Mmm?-- Many patients went to the operating theatre without a specialist being contacted and the one VMO in town could not possibly cover seven days a week, 24 hours a day.

That's Dr Mullen?-- Mmm.

In addition to the fact that he lived in Brisbane, there was a complaint apparently about the amount of leave he took?-- Yep.

Were you able to ascertain how much leave he took in any particular period?-- Yeah, we actually looked through that and there was a substantial amount of leave taken by him and we asked him about this. He did confirm that he had a medical condition but we did not ask for medical certificates to confirm that condition.

Mmm?-- On one occasion I - or we received documentation that he was on sick leave and that in fact he was in hospital, but the hospital had no record of that, sometimes that happens with doctors, especially specialists, you know, the hospital

won't put you through to someone who's in hospital and maybe that happens for judges as well, I'm not sure, but there were grave questions that we could not answer with respect to his leave and the leave activities in the past couple of years.

But were you able to ascertain, for example, how much leave he had actually taken in, say, the last 12 months prior to your inspection?-- Yeah, we had all the documents there, they're available in Sydney.

Oh-----?-- How-----

-----that's a long long way away too?-- Yes, I'm sorry.

MR ANDREWS: Do you recall, Dr North, whether it was days or weeks or something else?-- Oh, weeks.

COMMISSIONER: Or months?-- And in places months.

Months?-- Yes, I know exactly what - a visiting medical officer has five weeks recreational leave per year and three weeks conference leave per year officially, not that you'd take that all the time, plus a sick component as well, but this seemed to be much more than that and he was a full timer, not a visiting medical officer.

MR ANDREWS: Well, when, if, for instance, one has five weeks recreation, three weeks conference, say two weeks sick, that's 10 weeks a year. What is supposed to happen when the specialist, that is, the Director of Orthopaedics at a hospital where there is only one full time orthopaedic specialist and one visiting medical officer, what is supposed to happen?-- Well, I think our recommendation in IM2 says, "Arrange, transfer and referral of all elective and trauma patients to a mentor hospital of sufficient size and complexity to handle such referrals." That's why we made the recommendation.

So if you have a facility that's operating so short-staffed, for specialists, that is?-- Mmm-hmm.

If one goes on holiday during that holiday period, patients who require procedures of the kind that you've marked in pink on Dr Krishna's credentials list?-- Fractured acetabulum.

Fractured acetabulum, ought to be referred to another hospital?-- Absolutely.

COMMISSIONER: Was that being done?-- I can't absolute - we can't absolutely tell you there because we only spent a short period there.

Did you see any evidence that it had been done?-- No, we saw some evidence that it hadn't been done on occasions.

Right?-- And from the Brisbane end we saw evidence that it had been done very late after crises had occurred.

Mmm.

MR ANDREWS: Can you explain that?-- Yeah.

The Brisbane end, I understand you looked at only about a dozen cases?-- Sure, that's right. Can I explain one?

Yes?-- One case that we saw records on, an angle grinder entered a workman's left wrist and cut from side to side, not severing the whole wrist and leaving one artery so that it was still a viable wrist. The patient was taken to the operating theatre, we hope assessed before being taken to the operating theatre, as assessed because it would be very easy to decide whether the two major nerves and the two major arteries had been severed and all the tendons as well, so proper assessment is really key and then marrying that to insight should determine whether you pick up the phone and call the person on-call or whether you pick up the phone and call the Royal Brisbane and say, "Could I have the hand surgeon on-call?" Now, sadly in this circumstance the patient was taken to the operating theatre up there, some attempts at discovering what the degree of problem was were undertaken by one of the two SMOs and it was discovered that it was clearly beyond his help after he'd made several very inappropriate surgical expanding incisions, and so the patient was then referred to Brisbane so he's had one anaesthetic, one set of inappropriate surgical approaches and then had to wake up, then be transferred and then the experts, specialist hand surgeons, upper limb surgeons, microsurgeons at this end were able to demonstrate or saw that despite all those tendons and nerves being divided, that the skin that had been intact - sorry, that had been potentially acceptable with careful surgery and delicate approaches was now no longer available and a large skin loss over the very place where you needed to repair all those nerves and tendons was lost.

COMMISSIONER: Who was the VMO involved in that - the SMO, sorry, involved in that?-- That was Dr Krishna.

Was that work done by him performed with supervision or without?-- Without.

Thank you.

MR ANDREWS: That work, is that work which you think a competent SMO ought to have recognised as being work that required either supervision or, if no supervision was available, at least consultation with a hand surgeon in Brisbane?-- Consultation and referral to a hand surgeon in Brisbane.

You did make the comment in the report that there were no registrars attached to the orthopaedics department. That's significant because it means that there were - there was nobody to assist doctors - the two SMOs who was a person in advanced training for a specialty?-- I don't want to detract from that, what you said, but really these SMOs were working as junior grade registrars, and very junior grade registrars. Despite the pay classification, the fact they had a car, the fact they had other benefits, they were still working in the capacity of very junior grade registrars.

Thank you. You say the outpatient orthopaedic and fracture clinics were not always supervised by a registered orthopaedic specialist. Were the clinics, as opposed to the operating theatre - were the clinics supposed to be supervised by a specialist?-- It would be ideal. I mean, there is a lot of decision making that happens in the clinic.

There is a difference between ideal and acceptable?-- It is not.

We have had no evidence as to whether an orthopaedic specialist would normally be obliged to supervise an SMO in an outpatient or fracture clinic?-- Can I say at Princess Alexandra, for instance, we have some fracture clinics that are not supervised by specialists. However, the registrar who is doing that fracture clinic has easy access to and rapid response from a specialist, and two of them should be in the hospital, at least one of them should be in the hospital at all times, so that it is very easy to facilitate quick communication and decision making about complex issues.

And is it something that ought to have been understood by the administrators at the hospital that the orthopaedic and fracture clinics ought to have either been supervised or there ought to have been a specialist nearby and on call?-- Stop me if I am wrong, but I think the administrators have no understanding of how to develop safety in the process of clinic or operating theatre process. It is like you and I trying to develop safety in the 767 cockpit.

So an administrator ought not to be criticised for failing to understand that there should have been more attention by

specialists to the matter of orthopaedic and fracture clinics?-- A specialist who owns that patient needs to understand that he or she has a responsibility to deliver safe health care to that person. The administrator needs to understand that he or she has a responsibility to facilitate that health care delivery within the limits of certain budgetary restraints. So whether that be supervision or the right internal fixation device, I see myself as a carer of the patient, a servant of the patient.

Dr North, you are speaking about what you understand to be the duties of the specialist?-- Uh-huh.

I wonder whether you are in a position to assess what should have been understood by the administrators as necessary. You may not know what an administrator ought or ought not to know. If so, please don't speculate. Are you in a position to say whether the administrators, for instance the district manager, or the Director of Medical Services at this hospital, ought to have known that, for instance, the outpatient services were unsafe if there was no specialist available to supervise?-- I don't think they would have known, no.

Thank you. You say that "the on-call component at the hospital was impossibly heavy with only two registered orthopaedic specialists." Does the Australian Orthopaedic Association produce a guideline for the minimum requirements for orthopaedic practice which appears as appendix A to the report?-- It does.

And at page 36, that is the second page of the appendix, does it say that there should be the potential for three specialist orthopaedic surgeons sharing on-call workload, including a registrar training"?-- Correct.

And the problem where you have only two registered orthopaedic specialists available for on call is that it means every second night they are capable of having their sleep disturbed and deprived, and it leads to unsafe health professional health services?-- Absolutely. Absolutely.

COMMISSIONER: When you said, "A minimum four registered specialist orthopaedic surgeons required in the Fraser district generally, five would be necessary if continuing professional development was to be undertaken", did you mean full-time or part-time?-- Could be a mixture. Say you had one full-time-----

Yes?-- -----and three or four part-time, that would be complementary. If one wants to go to continuing professional development, or two even want to go, that would be bearable for a week.

Right, thank you.

MR ANDREWS: Is it common enough for a visiting medical officer who might just have, for instance, one or two sessions at a hospital, to nevertheless also be on call for instance

one night a week?-- We have many more specialists at PA but I am still on call one night a week. In that circumstance it is much heavier than that.

Yes. Your observation was that - I see from page 11 - audit meetings were held only occasionally. You say, "They were poorly structured, poorly documented and poorly attended." Is that something you were able to tell by looking at the documents, or from your interviews?-- From the interviews.

And those audit meetings are the kind of meetings you described earlier, an opportunity for assessment and improvement? The non-contactability of Dr Naidoo is discussed at page 15. Whether he - whether Dr Naidoo was enjoying his contractual entitlements or whether he was genuinely sick and unable to attend, the fact of the matter is it was unsafe if he was absent?-- Correct.

Because the two SMOs needed supervision?-- Absolutely.

Dr Sharma, while you say on the one hand that he needed supervision, you have a recommendation that he be placed in the advanced surgical training program in orthopaedics and if his application is unsuccessful, that he be employed as a career medical officer or senior medical officer in orthopaedics?-- Just to change your wording a little bit, that he apply for or seek an application for. We didn't say he should be placed in, we said he may be placed in if by open competition he achieved that placement. And we recommended that may be an appropriate course for him to take. In fact, he did apply, but in open competition he did not achieve entrance to - it is a national selection process - and he did not achieve that goal. But as a secondary goal and following our interview with him, we felt that he may still be suited to this career medical - sorry, career medical officer type position. And if I can explain, there are a number of such positions in Queensland in orthopaedics that have worked reasonably well. For instance, a couple of regional centres have gentlemen that have been assessed over a long period of time, can do basic orthopaedic procedures and are very suited to that. They can deal with patients which have fractured hips and do those procedures without supervision. They can deal with fractured wrists without supervision, they can do fracture clinics without supervision. And I can think of three cities in Queensland where that has worked very well. Now, one of them is nearing his 65th birthday and it may be a bit difficult to find a replacement for him, but Dr Sharma in that circumstance, where there are four VMOs and one full-time orthopaedic surgeon, that would work very well. It is not Hervey Bay.

Yes, because there is inadequate supervision?-- Yep.

Or there was at the time?-- Correct.

Dr Krishna, in your opinion, seemed to, from an interview, lack some insight but he, too, I assume, had a level of competence which with supervision would make him a useful

member of staff at a hospital?-- Perhaps.

But he didn't have that supervision at this hospital?-- Certainly didn't.

Which meant that he left unsupervised was, in your opinion, putting patients - some patients at risk?-- Absolutely.

You put a number of clinical scenarios to him and you say he was unable to respond appropriately. Are these scenarios that are used by you as an examiner?-- Correct.

Were they scenarios that only a specialist ought sensibly to be able to answer?-- No, remember the first person that sees this patient is not usually a specialist, it might be an ambulance officer, and an ambulance officer should be able to look at the nature of the trauma, take a pulse, ask about sensation, gauge generally the nature of the patient's injuries, and then look for priorities, deal with them appropriately. It really did not seem, on one of these scenarios, that - Dr Krishna certainly didn't think about a pulse, which is a pretty basic limb threatening examination component, and it doesn't matter how well you fix the fracture, if you have lost the limb it is pointless.

Were you able to discount the possibility that the gentleman was nervous at being interrogated by the two specialists from town?-- I wouldn't call it interrogation. I think that's a little bit harsh. We called it interview, we wrote down "interview". Yes, he may have felt - and I can't answer for him - he may have felt a little intimidated, but it certainly wasn't interrogation.

COMMISSIONER: How did his manner appear to you?-- He was able to speak clearly and easily, and understandably.

Confidently?-- Perhaps too confidently. There was no communication lack from language or the medical side of things and we kept it pretty simple and straightforward. I mean, in the examination role, these examination candidates are much more adrenalin soaked than Dr Krishna would have been at this interview. You know, these guys have been working for four years to get there. You know, they have been waiting outside for an hour and they have been preparing for this for the last week, and they have been told they will never - it is a really adrenalin soaked 35 minutes by two on one particular day, you know, with a real patient with a real problem. It was nothing even vaguely like that in this circumstance.

MR ANDREWS: In the event it led you to conclude that Dr Krishna ought to be closely supervised in his clinical work and shouldn't undertake any surgical treatment unsupervised?-- On the pink highlighted sheet, I have given a couple of little maybes with training, but if I was a consultant in charge or I was a VMO at Hervey Bay, that would be a very limited list.

But that's the sort of recommendation you would make for trainees in Brisbane-----?-- Absolutely.

-----in any event?-- Absolutely. My senior registrar, so he will sit his exam next May and by the end of next year be a registered specialist in the State of Queensland, still rang me about every case that came in from 8 a.m. Saturday to 8 a.m. Monday and we went through every one of them this morning, apart from my six plus hours in the hospital yesterday.

You observe on page 19 that Dr Krishna stated he did not believe he needed further training in orthopaedics and suggested that he should receive specialist registration because of the work he was doing and the training he had undertaken in Fiji. What did that tell you about him?-- A lot.

You will have to explain?-- I mean, that was one of the reasons that we were really concerned about insight and clinical competence as well. You know, the fool who knows not he is a fool - this is not applied to Dr Krishna, it is applied generally - it is not my proverb - the fool who knows not he is a fool, shun him, I think was the quote, and if there is no insight into your level of training or ability, then you need to carefully rethink your occupational corridor. I mean, there were certain orthopaedic conditions that came in on the weekend - we received one of those cases from that nasty crash in Bundaberg a couple of days ago. I am certainly not adequate to treat the wrist fracture that she suffered when she was ejected from the bus. I have asked the specialist hand surgeon to look at it, take it over, deal with it as he thinks appropriate so that she gets the best outcome in the whole - I mean, I realise I have certain limitations and you cannot be expert in every arena, and when you have some extra help at the end of the phone or in the same institution, you use it.

And you'd say a person with limited skills in the setting at Hervey Bay is a more useful member of staff if they do less work and refer more than if they do it all?-- Absolutely.

At page 22 you say, "The structure of the orthopaedic unit at Hervey Bay Hospital is inherently unsafe in terms of patient care and safety. Leadership of the unit is absent or grossly dysfunctional." That leadership, do you mean by the Director of Orthopaedics-----?-- Correct.

-----because of the absences of Dr Naidoo and the difficulty in reaching him?-- And general communication skills. If the commander doesn't call charge, then obviously the battle isn't begun.

At page 23 you say that "Dr Mullen offered to do a one-in-two on call with Dr Naidoo." Does that mean - what does that mean?-- It means that every second night he would be available to supervise, be present at and be responsible for the patients that came in under his care. An almost impossible task if you consider the people you are supervising were not very experienced.

Easier if they were very experienced registrars?-- Yes.

Less easy-----?-- Yes.

-----if they have got fewer skills?-- Yes.

And-----?-- That's every second weekend as well, so every second night and every second weekend you would be on call.

That's much more than on call in accordance with your minimum standards-----?-- Absolutely.

-----of the AOA?-- You could not do it and survive.

And Dr Mullen, you understand, offered to do this for free?-- That's what he - he spoke to us about that and I hope he will be able to confirm it if you speak to him. I think he had a genuine desire to serve the people of that community, and this was a way to keep the hospital services open and safe.

And you understand that his offer to do this for free was rejected?-- That's my understanding.

There is something about credentialing and privileging I would like you to clarify for me. The inquiry has heard evidence about the credentialing and privileging of surgeons as opposed to orthopaedic surgeons, and as opposed to SMOs in orthopaedics. And as I understand it, for a specialist in surgery, credentialing and privileging will be done by a small committee of that person's peers?-- Plus or minus an administrator or - yep, someone similar.

What about the credentialing and privileging of SMOs in orthopaedics at Hervey Bay? Who ought to be the credentialer; a single person or a committee?-- Oh, committee. Without doubt. And I am not sure we should say of their peers. I mean, I think it should be of those who understand the gravity of the orthopaedic health care delivery.

Now, for instance, the Director of Orthopaedics?-- One.

Dr Naidoo would be an appropriate person?-- Correct.

Assisted by?-- Possibly Dr Mullen, possibly Dr Khursandi. Dr Khursandi knew the Fraser Coast District, the Maryborough District had a great overview of all the orthopaedic needs of the community, the community changes. He has been there almost three decades. He should be able to mentally encompass the needs and he would be a very sensible person to have on that - senior person. And then maybe a human resource - human resource manager type person to see whether qualifications were acceptable, appropriate and fitted into the needs of the particular district. I mean, that's a non-administrator's view of credentialing, but it is in essence to see if they are safe and appropriate for that particular procedure process.

And can you - is it within your expertise to advise us whether

the Director of Medical Services at the Hervey Bay Hospital ought to have known that credentialing of the two SMOs by someone other than the individual, Dr Naidoo, was required?-- He ought to have known that that was required, yes.

Indeed, if it appears that the credentialing was done by Dr Naidoo and another orthopaedic specialist, the Director of Medical Services ought to have been satisfied that it had been appropriately done?-- Ought to have been, yes.

On page 24 you observe your concern that the two SMOs were placed on a consultant register - roster, rather, for the Fraser Coast District. It will be observed by one or other of them in evidence that - and Dr Sharma, that this form of rostering also occurs in Rockhampton where SMOs are placed on an on-call roster under the heading "consultant". Are you aware of-----?-- We saw the piece of paper that said "consultant roster".

Yes.

COMMISSIONER: It doesn't help much that Rockhampton might be following the same bad path, does it?

MR ANDREWS: No, well-----

COMMISSIONER: You think it is quite inappropriate to do that?-- Totally inappropriate.

Right?-- It suggests that the consultant is a specialist.

Yes?-- So, effectively, without using the specialist word, it is saying specialist roster in orthopaedics, dit-dit-dit-dit.

Is a consultant roster a public document?-- It was on the noticeboard in the easily accessible room of the Maryborough Hospital and-----

Open to the public?-- To the public - no, I suppose the public wouldn't wander into that room, but certainly one of the SMOs was referred to as a consultant in print media.

Yes, I saw that.

MR ANDREWS: But where on the consultant roster under the consultant's column you have got an SMO, it means you haven't got a specialist?-- Absolutely correct.

And it in effect means that they are being unsupervised?-- Absolutely.

And had the consultant roster for each day under the consultant column also included a specialist so that it was obvious that doctors Sharma and Krishna were to be supervised by someone on call, that would have been less of a concern, I gather?-- Correct.

But what you saw suggested that there was no-one to supervise

them, that they were given point position?-- Correct.

You speak of media releases initiated by the administration. Did you yourself see that?-- I have some relatives in Hervey Bay, who I trust won't be maligned by all of this, but kept their ears and eyes open and I remember seeing one that went something like this - but couldn't find it when I asked the administration to supply it - "Little Richard will now have his operation earlier.", and there's a picture of little Richard. I have no idea if it was little Richard, I've no idea who it was, but - and it talked about the new consultant at the Hervey Bay Hospital and the way in which his presence would reduce - Commissioner, am I allowed to use the word "waiting list"?

COMMISSIONER: Yes?-- It will reduce the waiting list at Hervey Bay Hospital and that was a print media Hervey Bay special.

Was that attributed to someone? I think everyone concerned accepts that it is, that it was - doesn't he - Mr Leck?

MR ANDREWS: Mr Hanelt.

COMMISSIONER: Mr Hanelt, sorry, Dr Hanelt. I didn't think-----

MR ANDREWS: I can't recall, Commissioner.

COMMISSIONER: All right. We will leave it.

MR ANDREWS: You speak of a budget driven for crisis management. There's a certain degree of interpretation in that opinion, isn't there, but-----?-- There is, yes.

If I were an administrator, should I necessarily be offended if somebody said that I had a budget driven for crisis management?-- As long as your priority is patient safety, no. If your priority is budgetary restraint for performance contract - sorry, performance encouragement process, then that's not for patient safety.

No. And you haven't expressed an opinion about what the driver was in this case?-- We have no idea what the driver was.

But the effect is you have got nonspecialists on consultant rosters and you have got patients being treated in Hervey Bay who should have been transferred?-- Correct.

You recommended in the report that, "The Director-General take steps to ensure that all orthopaedic surgical health care cease immediately." That was something I see at page 31?-- I have it.

That will be because it was health care unsupervised?-- Correct.

Had there been supervisors, Doctors Sharma and Krishna might otherwise have been recommended to be allowed to continue?--

Absolutely.

Let me go back to something. Would you look, please, at this newspaper article from January 2003. It does deal with a patient called Richard. Can we see the first column of the article which is on-----

COMMISSIONER: Mr Allsop is the man I was thinking of.

MR ANDREWS: Yes?-- Yes, he was the district manager, Commissioner. Yes, Richard, I think - Richard was a name I remembered and I think you will see by that that, "An orthopaedic surgeon has been recruited and another was due to start next month, so waiting lists should start to shrink", is it?

COMMISSIONER: They could only have been Dr Sharma and Dr Krishna?-- Correct. Now, when my nine 90 year old uncle in Hervey Bay is ringing me up saying, "I have just fractured my hip, what should I do?"

Come to Brisbane straight away?-- Thank you.

MR ANDREWS: I tender that.

COMMISSIONER: Yes. This will be Exhibit number - we will leave it unnumbered. Thanks. Number 314.

ADMITTED AND MARKED "EXHIBIT 314"

MR ANDREWS: Since supplying the report in May 2005, has the orthopaedic service at Hervey Bay not been discontinued?-- Not completely. I mean, I haven't been to Hervey Bay since. I have heard no personal communications from Mr Allsop, some indirect ones from Dr Hanelt, none from Dr Naidoo, and some phone communication with Dr Mullen, but I understand a number of people have gone from Brisbane to try and sort out some problems with the waiting list and possibly with patients that have had difficulties or complications. But I have no direct knowledge of those. Remember, we were not sent there to do an audit of patients, we were sent to investigate health care delivery and what we were - one of our recommendations was to stop the program, facilitate transfer, try telemedicine triage - doesn't seem to have moved - and rearrange an infrastructure that dealt with the problem safely.

And it seems to some extent item 4 in your recommendations seems to have been implemented in that people from Brisbane have been attending when previously they had not?-- Yep, in a very limited way, is my understanding.

You at 13 recommended an investigation into the specialist care provided by Dr Naidoo. Do you know whether that took place?-- No idea, sir.

Generally the concerns with specialists and other orthopaedic care offered at the Fraser Coast, were you aware that they were matters that might be referred to the Medical Board for investigation?-- We were aware that they could be referred to the Medical Board but we felt that it was not our place to refer them to the Medical Board, if that helps. I mean, this was a confidential report effectively to the Director-General advising him, we thought - two specialists advising him as to some ways of improving safe health care delivery in the Fraser Coast, and when it became a public document or public exhibit, then things seemed to change a little.

Now, your report was prepared some time after the 31st of October, so it was after the deadline that you'd had to complete it?-- As the paper rolled in, and I must say we were still receiving some paperwork up until-----

December, as I notice?-- Absolutely. That's true, absolutely true. I was called about some of that paper work and said, "It's here to pick up.", and, in fact, I picked it up on Christmas Eve. So we digested that along the way and made notes and put together - but we couldn't really start preparing a draft until October. That was a very piecemeal draft which put together all our interview questions and answers together with the paperwork that came back after those questions and answers.

Well, any delay on Queensland Health's part in requesting from you your final version, is it explicable by the fact that you hadn't completed your report, even before December?-- Nothing to do with completion. Our concern was that we would have liked to have seen unconditional indemnity, those two words.

Was your association making it clear that your report wouldn't be handed over without unconditional indemnity?-- Very clear.

And are you in a position to say what Queensland Health's response was, or should we speak with-----?-- I think you should speak with them.

-----somebody from your association?-- I'm happy for both, but most of the communication was between Dr Helen Beh, she is our CEO, and the Queensland Health administrators. I'm not sure exactly all of the people she spoke to, but it was - it was clear that there was a lot of hedging and shuffling and twisting going on until a certain eruption occurred in Queensland.

The Commission - the last Commission of Inquiry was called. You recall a legal advisor from Queensland Health requested your report?-- Mmm-hmm.

And a short time later, after discussions regarding the indemnity, the report was posted to the Director-General's office on about the 5th or 6th of May?-- Correct. And on that day I rang Dr Gerry FitzGerald, who's the now deputy - Acting Deputy Director-General, who knows me and whom I had

approached in October 2003 about safety concerns, and I rang him as a matter of courtesy to say, "Gerry, the document's been posted. It will be on the DG's table tomorrow.", and I rang him to say one other thing, that, "If there's any print media comment the next day it will have come from Q-Health", and I reiterated to him our meticulous confidentiality process, and we did that as a commitment to the people that gave us answers to questions and we had been absolutely meticulous.

Dr FitzGerald as chief health officer for Queensland Health was a person who himself would be called upon in the course of his duties to do reports?-- Correct.

You received a facsimile from the Director-General the day the report was delivered?-- Correct.

And in it he indicated, and you quote, that, "There appears to be no hard evidence to support your recommendations." You found that unbelievable, you say?-- I did. If I can just read the couple of sentences, it was only brief, "Dear Dr Giblin, Dr North, I acknowledge receipt of your report. I know that there appears to be no hard evidence to support your recommendations. Given the significance of your recommendations, I seek an urgent meeting to understand the basis upon which you have made them. I would also like to personally sight the documentation that was used to prepare your report and upon which you based your recommendations. As this is a matter of patient safety, I request that you expedite the opportunity to meet with me.".

Would you put this on the screen? Is that a copy of the document from which you are reading?-- Yes, just slide up - slide down the bottom so we can see the date, please.

6th of May 2005. That seems to be under the signature of-----?-- Yes, that's it. Correct.

And is that your handwriting to the right?-- It is. As it was late in the afternoon, I tried to contact Peter Giblin, my co-investigator, couldn't contact him, so I decided simply to print on this and refax it back to the fax from whence it came, assuming that to be Steve Buckland's personal assistant or private secretary, "Acknowledge receipt of your fax. Note request/need for urgent meeting." I didn't agree to it, as you can see. "Reiterate that all recommendations are directly related to patient safety in Fraser Coast Health Services district. Regards, JN."

So the failure to have an urgent meeting was as a result of your failure to agree to one; is that correct?-- I consulted the President and the CEO of the AOA and my co-investigator and we felt - they felt and corporately we felt that the investigators had done their duty in presenting a report, doing investigation, presenting a report, presenting recommendations. The Federal AOA felt it was more prudent for the State Orthopaedic Association Committee to meet with the Director-General, and this subsequently did happen.

So there was a meeting with the Director-General, was there?-- Yes. Yes, there was. It occurred in the rooms of Dr Chris Blenkin, and Gerry Fitzgerald was at that meeting also. I had said - this is outside the investigation. It was an attempt by the State committee of the AOA and all these concerned orthopaedic surgeons to see safety promoted, and I had spoken Gerry FitzGerald, rang me at home, and said, "Oh, don't you think we could meet?", and I said, "Well, not unless the State - the people who are involved in trying to get safety" - and that was the State committee effectively, "Not unless those people can see the report.", and Gerry FitzGerald said to me, "I don't think that will be possible, it's too hot", or, "It's too - it's too hot", or, "It's too" - it was too hot. Now, of course what happened in the next 24 hours is history and everybody knew what the report said by Friday afternoon, or maybe after.

Was there a meeting between the State committee of the Australian Orthopaedic Association and the Director-General after Exhibit 38 appeared on-----?-- Correct.

-----the Commission of Inquiry's website?-- Correct. Sean Mullen was present at that meeting, I wasn't, but he can attest to what they talked about.

You say at paragraph 19 of your short statement tendered this morning that your - looking at the last page, page 6, you say, "It was more related to the deceit and deception that we discovered relating to many facets of the process of the health care delivery."?-- I have got page 5, number 19.

All right. Perhaps I am looking-----

COMMISSIONER: That's true. But it goes on to page 6. It is the sentence on page 6 you are being referred to. And page 6 starts, "It was not a matter"?-- I'm sorry, I have got - page 5 is the last page.

MR ANDREW: I see the numbering on the bottom of-----

COMMISSIONER: Take mine.

MR ANDREW: In the signed version does show that paragraph 19 is on page 5. You are correct?-- Thank you.

The last sentence of paragraph 19?-- I have it.

Whose deceit and deception are you referring to, if anyone's?-- Little Richard was deceived.

So you are speaking generally about the misleading effect of having the two SMOs on rosters as consultants, working unsupervised and being held out in the newspaper on at least that one occasion as orthopaedic specialists?-- I think it's fair to call that deceit and deception, isn't it?

I'm simply-----?-- Yes, yes.

Don't ask me to comment. I am trying to identify what deceit and deception you had in mind. Is that it?-- That was one of them. The lack of - the lack of presence of full-time employees of Q-Health at his place of work was deceit and deception.

COMMISSIONER: Mr Naidoo, you are talking about?-- I believe so, yes. The lack of being at close proximity to the hospital when you are on call is deceit and deception. The lack of having specialist registration is deceit and deception. There were so many little facets of this that had big question marks beside them and umbrella that spelt deceit was all you could use to cover the whole situation.

MR ANDREWS: Well, would it be fair to say that was a case where two overseas trained doctors were placed into an area of need and were working as and seem to have been described as specialist orthopaedic surgeons when they were not?-- Absolutely true.

Dr North, I have no further questions for you, but some others may have some cross-examination?-- Thank you.

COMMISSIONER: Before that happens-----

MR ANDREWS: May I tender-----

COMMISSIONER: Sorry.

MR ANDREWS: -----that letter to - from Dr Buckland to you with your large note.

COMMISSIONER: Thank you. That is Exhibit number 315.

ADMITTED AND MARKED "EXHIBIT 315"

COMMISSIONER: Thank you. Dr North, I have a couple of questions arising out of what appears on page 16 of your report. Under, "Clinical Performance", that is Clinical performance of Dr Naidoo, you say in the second paragraph, "It was also claimed by interviewees that Dr Naidoo engaged in a substantial amount of photocopying of patients' notes and no legitimate explanation for this activity could be suggested.", that's suggested by them. One perhaps illegitimate explanation which might have occurred to you might have been that it was for the purpose of treating those patients privately?-- That's possible, but he didn't confirm that when we asked him about it.

Can you think of any other explanation, legitimate or illegitimate?-- I can.

What's that?-- It's possible that he was doing medico-legal reports or WorkCover examination reports on public patients and charging for them. It's possible that he was doing some other sort of reporting duty that we don't know about.

Which would not have been legitimate?-- Absolutely. I can tell you at my Princess Alexandra Hospital where I practice four sessions a week, I can't remember doing any photocopying in the last week, not one page.

Yes?-- And there was no explanation for it.

Well, no legitimate one?-- No tendered one.

He gave none?-- He gave none.

Did he-----?-- We asked him about it.

Did he admit do doing it?-- He admitted to doing it but he gave no reason for it.

All right. In the following paragraph you say that it was reported - I should read the whole of it, "Of concern to the investigator were several allegations about Dr Naidoo's involvement with the Link company, manufacturers of total joint prosthetises. It was reported that on a number of occasions Dr Naidoo and a representative of the company had been overheard discussing activities which suggested a conflict of interest situation." What were the activities that was overheard discussing?-- Conference attendance, trips.

Trips at the expense of the company, you mean?-- Mmm-hmm.

Yes?-- These are nonmedical people-----

Yes?-- -----giving this information, but they are bright, sensible.

These are nursing-----?-- Nursing people.

Nursing people?-- Yes.

Yes. All right. Thank you. I have nothing further. Now, who wants to cross-examine, other than Mr Farr, I presume?

MR FARR: Yes, your Honour.

COMMISSIONER: Or Mr Applegarth.

MR HARPER: I have some on behalf of the Bundaberg Patient Group.

COMMISSIONER: Yes, certainly. You go ahead.

CROSS-EXAMINATION:

MR HARPER: My name is Justin Harper. I appear on behalf of the Bundaberg Patient Support Group. I have some questions for you generally about the systems you have identified for credentialing and privileging and auditing. Is it fair to say that the processes you have identified are the essential elements of the whole system which is designed to ensure the provision of the quality health care?-- Could you just ask that again, please?

Is it fair to say those key elements, the credentialing and privileging and the subsequent auditing process, are three key elements of a system to provide quality health care?-- Absolutely essential.

Can I take you firstly to the credentialing and privileging system. As I understand your evidence, the primary purpose of that is to assess, firstly, the clinical competence of the person?-- Well, are the credentials correct.

Yes?-- Okay. Does the paper on which this man's credentials are based, does the paper he presents, are they correct?

Yes?-- So that's the credentialing. Is he by means of training and experience what he purports to be?

Okay. And that then feeds into identifying the appropriate scope of the practice-----?-- Yes.

-----that he can perform?-- Yes.

And the need for - specifically the need for supervision?-- Correct.

You then identify two different processes for auditing within a hospital?-- Mmm-hmm.

The first you described as ongoing and regular clinical audits?-- Correct.

You gave the example this morning - of one you did this morning at the PA Hospital?-- Sure. Yep.

Now, in your experience, all relevant staff are involved in that auditing process?-- Yes. Now, we didn't have every consultant there present this morning, but our normal - major audit meeting would usually be on Friday morning, for instance, and 95 per cent of staff would be there most times, yes.

So that includes nursing staff?-- Not 95 per cent of nursing staff. There would be the Nursing Unit Manager and possibly three or four other nursing - senior nursing staff.

Okay?-- Physiotherapists, senior physiotherapists, possibly

an occupational therapist if there was some hand issues or hand therapy issues involved.

Okay?-- All the residents, all registrars, and most of the consultant staff.

And the idea of those is that there can be an open discussion?-- Yes, yes. I mean, we saw a clear example of a person that morning who's psychotic, on psychotic drugs, and in their late 50s who had a particular sort of implant but has very weak bone. The implant's clearly cut out of the bone. It's a relatively poor prognosis. It's an impossible scenario, but everybody could freely discuss it and whoever owns the patient will take on board all those possible options, and it's not a solvable problem, this one, but every option has to be put on the table and, "Oh, that's a good idea. If I use that and I didn't do this". In fact, we use this as a teaching exercise as well, so the man who's sitting in his exam next May and needs to be grilled a little bit harder becomes the target for our key questions.

COMMISSIONER: Now, in the case of let's say Hervey Bay Hospital for the moment, who should have been responsible for the calling and scheduling of those meetings?-- Director of Orthopaedics.

Thank you.

MR MULLINS: You've identified there then, might I say, two separate types of requirements, the first is it's about assisting with the treatment of individual patients?-- Correct.

But then secondly, improving overall the systems and quality of patient care?-- Sure, and that's where that quality assurance comes in. Say we review 100 cases of this particular sort of nail, that's a quality assurance exercise and we look at the overview and say this nail is indicated in these five fracture types, but not indicated in these three fracture types.

Mmm?-- So that's a quality assurance assessment and it's a research tool that we use to assure that we go down the best corridor.

That's a good example, isn't it, of the need for those meetings to be able to firstly identify the appropriate data which should be collected?-- Mmm-hmm.

And to secondly, make sure that that data is collected?-- Yes.

So is it fair to say then that those meetings would, as they start to see a trend, perhaps direct that further data be obtained about overall patient outcomes?-- Mmm, absolutely, all the time. You know, if you see your bank balance going into the red, you do something to modify that and that's exactly the same course. We stopped using a particular implant because we saw that it was failing more frequently in the very thin boned group, so we said well, maybe although the marketing says it's a reasonable implant to use, the practice as opposed to the marketing says we don't, it doesn't support that.

You spoke then about the morbidity and mortality meetings?-- Mmm.

How often are they conducted? When at - generally at the PA Hospital?-- At the PA we would do this very in-depth audit every two months.

Mmm-hmm?-- So that's generally because the residents come for 10 weeks, so at the end of that resident term or just before they depart for the next - these are junior doctors.

Yes?-- Before they depart for the next term, they've got all the information really at their fingertips, they fill in all their forms, anybody that's passed away, anybody that's had a thrombosis, anybody that's had a return to theatre, anybody

that's had a serious complication, you know, chest infection, bleeding, wound problem, all that is then summarised for each unit.

Mmm-hmm?-- So my Resident would summarise all our unplanned returns to theatres, unplanned re-admissions, unplanned departures.

Mmm-hmm?-- All of those would be summarised in this morbidity and mortality meeting and it's a much more formal way of looking at a two month segment.

COMMISSIONER: And again, the responsibility for those meetings would be the Director of Orthopaedics in those cases?-- Absolutely, absolutely.

MR MULLINS: And again, the purpose of those though tends to be more about systemic issues rather than individual patient care?-- We do look at individual patient care in those, because we might say was that an unexpected death?

Mmm-hmm?-- And I mean, I filled in a sheet of paper on this this morning, this man was 94, very frail, multiple other medical conditions, you know, chest, heart, stroke, poor circulation, needed to have a pin in his hip. Made it through the operation and a few days post-op but then the chest got worse, the heart got worse and discussions with relatives et cetera and finally there was a peaceful parting, you know, within a week of the operation. Now, that's to be expected in certain people that have other morbidities apart from the one they came in to have treated. So we might look at individual cases, you know, why did that man - why did he-----

Pass away?-- Deceased.

Mmm-hmm?-- And just go through, to be sure that we're not dealing with something that has been missed by all other parties, it's just a very open and transparent way of putting every complication on the table. I mean, if we find a lot of thromboses occurred because - but despite the fact that we're using antithrombotic treatment, we're starting to say well, maybe that - the marketing of that drug isn't matched by the-----

Performance?-- Exactly.

When you talk there about those sorts of investigations about individual cases, would there be discussion at that meeting where appropriate about referral to other agencies?-- Meaning?

By that I mean, for example, if there is an unexpected death?-- Yes.

Would there be a discussion at that sort of meeting about whether it should be referred to the Coroner?-- Yes. That probably comes before that meeting even.

Yep?-- But we would discuss it at that meeting anyway. The paper I filled in this morning had a - "Is this expected?", or "Should this be referred?", or "Did they have an autopsy?", or - so I'm asked all those questions-----

Yes?-- -----as a treating practitioner.

Mmm?-- Now, if I think it needs to go to the Coroner, I'll be ringing up the Coroner, you know, before the death certificate's signed, but when sometimes a death certificate is signed, there's still a double-check to say, "Do you think it should have been autopsied? Referred to the Coroner?", so there are probably three other checks before it gets to mortality and morbidity committee.

Which is going through them then, when the death certificate is signed?-- Yep.

And after that?-- A sheet of paper that comes to each consultant saying answer these 20 questions.

Right?-- "Do you think?" "Do you think?" "Do you think?" "Do you think?" "Was this unexpected?" "Unrelated?" "Was this Related?" "Expected?" "Was this unrelated?" "Unexpected?" You know, and you answer the 20 questions. That would then go back to whichever corridor you choose, you know, "Do you think this should be reviewed by a peer review committee?" Tick, goes back to the peer review committee, so other surgeons or that committee would be formed and they would look at the chronology and decide if this needed to be investigated further.

Is that standard practice within the PA Hospital?-- Absolutely.

And in your experience, is that standard practice around other hospitals?-- It should be if it isn't.

You're aware of the policy on reporting of adverse events?-- Mmm-hmm.

Those adverse event forms, do they go to one of those audit meetings for discussion?-- Yes, some of them do, sometimes some of them go to the Human Research Ethics Committee if it's involved in a research process, and many of those are - so there's a couple of ways in which they can be corridored or looked at.

And you're aware of the reporting of what are known as sentinel events?-- Not so much in orthopaedics, no, it's not something I-----

You haven't had the necessity?-- I haven't had the joy or - no, I'm not.

Okay. Can I ask: is there any process for the review of complaints by patients in any of those meetings?-- There may be, but generally we don't get input from the patient liaison

service in those meetings.

Right?-- They're generally handled in another way. A letter is received by the hospital, it's sent to patient liaison. I mean, if you're ever on-call waiting at the PA, you'll find quite a lot of "If you have a complaint, please contact the"-----

Patient liaison service?-- That complaint - complainant is then offered the opportunity to send a letter, that letter's checked and if it's thought appropriate, passed on to a medicolegal medical administrator.

Mmm-hmm?-- And then that's fed back through the Director to the consultant in charge for comment.

Right?-- Those things are usually dealt with outside mortality and morbidity committees.

Right?-- But if there were some serious patient relative concern, that would come up in the Monday morning meeting.

Mmm-hmm?-- You know, or "The relative's said this" or "The relative's very unhappy about that" or-----

So those less formal complaints?-- They're much less formal. I mean, these might be simply spoken by the Registrar who said, you know, "They were very unhappy they had to wait so many hours" or, Mmm, that's the whole thing.

So again, then, those meetings are a forum through which concerns about performance generally of the hospital or of individuals in particular can be brought to light?-- Absolutely, Mmm.

If they're operating appropriately?-- Yes, correct.

I'd like to just ask you a couple of questions about - for your comment generally about the process to which this came to light, the Hervey Bay problems. As I understand it, Dr Mullen reported the matter to Dr Blenkin who was the head of the Orthopaedics Association in Queensland?-- Mmm-hmm.

In your experience, is that a common thing for a medical practitioner to do where there are concerns about medical practice?-- In surgical practice, surgical practice particularly and I'm not totally sure about medical practice generally but in surgical practice particularly there's a mentoring process. Sadly, it's quietly dying as a social exercise, but you know, if Sean Mullen was my Registrar many years ago, he would feel free to pick up the phone and say, "Look, I've got a heck of a problem here" and discuss it with me. Not only Sean, I mean, people do that regularly, not necessarily because they want you to take the patient over but because they want an ear to talk to, an older colleague to discuss it with and especially in regional situations maybe someone who has a broader experience in that area to comment on.

Or perhaps where they think that there is such a service problem?-- Yes.

Which needs to be investigated?-- Yes. I mean, can I give you - may I give you an example that applies to Hervey Bay?

Yes?-- I did get a call from Dr Mullen one night saying, "Look, you know, there's a heck of a problem." I said, "What's the problem?" He said, "Oh, the Resident just called me to go and have a look at this old lady who had a spiral fracture of the humerus.", and a spiral fracture usually means there's a sharp pointed piece of bone at one end and the other end. The sharp pointed bit of bone had actually come through the skin, albeit in a very small way, and that's a compound fracture then, not a closed fracture, it's a compound fracture. Now, the problem was that this had occurred several weeks before and belonged not to Dr Mullen as a patient who owned her, but to Dr Naidoo who'd given some phone advice, which Dr Giblin and I believe was entirely inadequate, and a simple wash and a piece of dressing over it was applied and the patient was placed in a sling. When the aroma became more than the relatives could manage, they return the patient to hospital and unfortunately the owner of the patient, surgical owner of the patient was not available and so the Resident, recognising there could be some serious problems here, rang Dr Mullen, reasonably approachable, very good communicator, and he actually went up and saw the patient and realised that there was now a large area of dead tissue, gangrenous tissue and that this had a life-threatening if not a limb threatening potential but it wasn't his patient. What do you do? Well, I mean, I have a rule in my circumstance where if I need to do an amputation or I'm thinking of doing an amputation, I take one of my colleagues and I say, "Come and see the patient, talk to this patient, talk to the relatives, I believe they need an amputation but I would like you to give a second opinion". It's simple, it reassures every relative and it's sometimes the best and quickest way to deal with the patient's potentially life-threatening disease process. Now, I believe Dr Mullen felt that this was one of those circumstances where it would be good to have someone else walk in, look at the patient, talk to the relatives and say, "Look, this might be better, in fact, in the long term." Dr Mullen tried to save the limb but failed and the patient subsequently had an amputation. Does that answer that question?

In a roundabout way, yes. Can I ask something further though: is it fair to say again that part of the necessary requirements for overall clinical practice is that medical staff or other staff in a position like Dr Mullen was that an important thing for them to have - be able to do is where they identify concerns about clinical practice, they take action and report it, say, to the head of the college?-- Mmm, and that's why he rang me that night saying, "What should I do?" You know, he wants to remain professional so there needs to be an inter-colleague working professional relationship but he wants to remain safe and now we've got a - you know, like a cover-up mentality and you think well, where do I stand?

Which road do I walk? You know, this is the sort of slather of despair or despond, whichever way you want to look at it. It's a very difficult situation if you're by yourself.

Mmm?-- And that's one that I've experienced, I'm sure Dr Blenkin spoke to him on other occasions as well for the very same reasons, what is the best corridor for me to take in this circumstance, and that's why he resigned on the first occasion and my understanding why he resigned on the second occasion.

Okay, thank you doctor. I've got nothing further.

COMMISSIONER: All right, I see it's a little after 1 o'clock. We'll adjourn and resume at 2.30.

THE COMMISSION ADJOURNED AT 1.02 P.M. TILL 2.30 P.M.

THE COMMISSION RESUMED AT 2.32 P.M.

JOHN BEVAN NORTH, CONTINUING:

COMMISSIONER: Is there someone other than Mr Farr and Mr Applegarth who wants to cross-examine Dr North?

MR ALLEN: I understand Mr Applegarth may wish to go first.

MR APPLEGARTH: Counsel assisting is happy for me to go next as is Mr Farr, unless, Commissioner, you had any contrary view. My questions would be rather short and if I could then leave. We're only dealing with a rather limited area.

COMMISSIONER: All right. Yes.

CROSS-EXAMINATION:

MR APPLEGARTH: Dr North, my name's Applegarth and I appear for Dr Buckland. I just wanted to ask you some questions about the timing of events and the indemnity issue. I don't intend to ask you questions about the substance of your report or much of the evidence that you've given this morning. I'll leave that to others?-- Thank you.

Can I deal first with your appointment. Now, is it the case that negotiations took place in late 2003 and early 2004 between the AOA on your behalf and Queensland Health?-- Correct, yes, in fact, I presented my concerns to Dr Buckland in a letter, a copy of which I'll show you if you wish, but may already been tabled, I'm not sure, in October-----

Okay?-- -----2003 and met with him shortly after.

Thank you, in terms of progressing matters, Dr Beh, I think?-- Ellen Beh, yes.

I'm not mispronouncing it?-- No, Beh is correct, B-E-H.

She's given us a statement that produces different items of correspondence?-- Yes, that's where it will be.

Hopefully that will act as a record. If we look at that correspondence, it seems that the discussions took place in trying to negotiate what sort of investigation it could be and those discussions were really between the AOA on your behalf and largely Dr Hanelt, H-A-N-E-L-T, who was the Director of Medical Services at Fraser Coast?-- Correct.

And you may know that by early - sorry, by early 2004, there

were a couple of different options being canvassed as to the type of investigation that would be undertaken?-- Correct.

One was that you would form a quality assurance committee as one option?-- That wasn't put to me but it may have been partied with the State AOA committee, I'm not sure.

And another was that there would be a contract entered into for the investigation to take place?-- Mmm.

And the third option and the one that was taken up, was that you and Dr Giblin would be appointed as investigators under the Health Services Act?

COMMISSIONER: Do you know about either of those options?-- Never heard of the contract.

It's in Dr Beh's statement so I don't need to take it any further.

COMMISSIONER: Mmm.

MR APPLEGARTH: Now, I've given you a copy of your Instrument of Appointment that was signed on the 6th of May 2004; you've seen that document before?-- I have, I have it here.

And there would have been one in identical terms for Dr Giblin?-- There was, correct.

May I tender that?

COMMISSIONER: Yes, certainly. That will be Exhibit 316.

ADMITTED AND MARKED "EXHIBIT 316"

WITNESS: It is in our report, Commissioner.

COMMISSIONER: Oh, is it? All right, well it's in evidence already.

MR ANDREWS: Not so far as I recall.

COMMISSIONER: It's not?

MR ANDREWS: No.

COMMISSIONER: Okay. 316.

MR APPLEGARTH: I'm happy for you to look at it again if you need to, Dr North, but you'll see that that Instrument of Appointment has as the second clause, and you can look it up on the overhead, if you need to look at it here's a spare copy of it if you need it?-- Thank you.

That you on the appointment "will be indemnified against any claims made against the appointee arising out of the performance of the appointee of his functions under this instrument."; do you see that condition number 2?-- I see that.

And in terms of your appointment, Condition 1 was that, "The appointment commences on the date of this instrument and will end on delivery of the required report."; do you see that?-- I do.

Now, the person with authority to make this appointment under the Act was the acting Director-General, Dr Buckland, it seems to have to go up to him for formal appointment; that was your understanding of the process?-- That was my understanding, yes.

So just to clarify paragraph 3 of your witness statement, when you say, "After a number of months of suggestions from the AOA, the Director-General of Queensland Health" and so on, the fuller account of that is that there were processes of negotiations between the AOA and different people within Queensland Health?-- Correct.

And the upshot was Dr Buckland accepted a recommendation for Queensland Health that you and Dr Giblin be appointed as investigators?-- Correct.

And you didn't deal with Dr Buckland directly during the course of your investigations?-- Not at all.

In terms of administrative arrangements, in terms of when you'd go to Hervey Bay and what you'd expect and other arrangements, were they largely dealt with with Dr Hanelt?-- Dr Beh and Dr Hanelt, yes.

Now, you mentioned Dr Fitzgerald earlier; he was then the Chief Health Officer?-- Correct.

And you knew him personally?-- He had known me many years ago and it was him that I first approached about safety issues at Hervey Bay in October 2003.

And you would have appreciated that Dr FitzGerald, as the Chief Health Officer, had responsibilities of his own and had as part of his duties undertaken investigations as required?-- Mmm-hmm.

That he could undertake investigations of his own motion?-- Absolutely, that's why I visited him.

Yes?-- To ask would he consider that.

Yes, and you respected his professional experience in those sorts of matters and to undertake investigations?-- That's why I wrote to him and went to him.

Now, so in terms of matters progressing, you visited the

hospital or the hospitals, I'm not sure, which was it? The one hospital?-- Both hospitals.

Both, in early July 2004?-- Yes.

And you conducted a series of interviews with staff?-- Correct.

And although, correct me if I am wrong, you didn't observe any procedures being conducted by the orthopaedic staff, you had a number of concerns as a result of your interviews with staff?-- Correct, Mmm.

Is that a fair summary?-- Correct.

Now, do I take it that as a result of your interviews with staff, that by early July or mid July perhaps, that you had concerns about the lack of supervision of the two SMOs?-- Yes, we did have concern.

And for the reason that you've elaborated upon in your final report and in your evidence today, you thought that there were serious deficiencies in Dr Naidoo's performance and in his supervision of the SMOs?-- Correct.

Now, you tell us at page 5 of your report that the process of collation and preparation of the report commenced within several days of the inspection itself. I think that's-----?-- Correct.

-----that's on page 5. You were still awaiting certain documents at the stage?-- Yes, yes, as I said, it took up until the 24th of December to get all the documents.

But getting back to, say, the time period of July/August 2004, even without those documents that you were awaiting, you still had those concerns about the supervision of the SMOs and the possibility that without supervision, they were acting outside their level of competence?-- Correct.

The documents that you requested, and I'm not sure what they were, you needed to complete your report in some fashion or other?-- Can I explain those documents?

If you - if it helps, perhaps a general description, but I don't want to dwell on it, but you tell us what was expected?-- Each interviewee was given a letter and a set of questions was constructed for each of them, so the medical questions might have been a little different to the nursing questions, and we discussed their concerns about the orthopaedic health care delivery in the coast, Fraser Coast and then based on the responses to those questions, we then re-examined the issues and questioned them again at the same sittings, so each person that was interviewed had approximately half an hour and, in fact, Dr Naidoo was asked to come back and Dr Hanelt was asked to come back later in the day so we actually had two episodes with both of those people. Each of them was given a list of data that we felt we should

see and they signed to say they understood that they'd seen the Instrument of Appointment, they'd seen the Terms of Reference, they'd seen a photostat copy of Section 56 of the 1991 Health Services Act and that they understood they were indemnified in giving this data to us, and we gave them the Sydney address as our primary address so that all the documents would be sent to one area and collated in one area, and it was those documents that to which you're referring, I think.

Right. And in just to round that off, in page 5 of your main report, I think you say about middle of the page, "Not all requests had been met at the time of the submission of this report, although most had been received by the end of September."?-- Correct.

So you had a large volume of documents by the end of September?-- I certainly did, Mmm.

But even before that, you probably had a report in a early draft form?-- Absolutely, yes.

Which would have highlighted the key issues that you'd identified?-- Yes.

And perhaps in a draft form contained a number of recommendations?-- Yes, we started putting data on tape on the night - on the evening of the day we were there, so we came back from the hospitals, we looked at charts and X-rays, we put data on a tape and that data formed part of the substance of the first draft.

And, Dr North, I don't suppose you would still have - or Dr Giblin or anyone else would still have a copy of that early draft?-- It wasn't a draft, it was notes on a tape. Yes, Dr Giblin would have them in a locked-----

But then at a certain point did you start to draft the report?-- Yes, I mean-----

In about the August period - August/September period?-- Yeah, it was a constant process.

Thank you?-- Every week we would - almost every week we would talk again about it and go a little further, depending on what we had received.

Okay. And that late batch of documents that you picked up on Christmas eve, that didn't affect the substance of your report? Tell me if it did; I just wonder?-- Only in small ways.

I don't need to pursue that unless you think it will help the Commissioner?-- Okay. Well, it clarified our concerns about the Q Health policy on full-timers, full-time specialists, for instance.

Could you try and tell us in outline what the bundle was, just by general description of what the documents were that came-----?-- The last set of documents were a response to 10 questions by a district manager who I felt was neutral in the circumstance, and so I had asked her would it be possible for her to clarify these 10 points. They were listed and she was approached on the 26th of August 2004 for - to present those questions to her. 26 - no, sorry, the 25th of August 2004, and I have diarised it in this diary, and they were the documents that we received on the 24th of December.

Thank you. Now, going back in point of time, I take it then by August 2004, if not earlier, you had in mind the first recommendation that you eventually came to make, namely that all orthopaedic surgical health care activity in the Fraser Coast Health Service district cease?-- We probably had assumed that on the first night-----

Okay?-- -----following our interviews.

Right. Now, the concerns that you have identified, the concerns that we see in your final report and that kind of recommendation, they weren't communicated to Queensland Health, say at the August period?-- No, we were asked to present a report.

Right?-- We were told after the report was presented we were no longer indemnified.

Right. Just - I think you have probably answered this but just for the purpose of clarity, it is clear you didn't issue an interim report?-- No, we were not asked to, nor did we.

And the concerns and provisional recommendations you had in mind, they weren't communicated to Dr FitzGerald or Dr Buckland?-- They were not.

Formally or informally?-- Because we did not see the words "unconditional indemnity" on any document, including the one you gave me just before.

Okay, I will come back to that. Well, moving forward, in 2005 - May 2005 you produced the report, and, from what you have just said, that was the first notice that Queensland Health had of its contents?-- I think - could I say we delivered the report.

Yes?-- Not produced.

I am sorry. I should have said provided to Queensland Health?-- Right, thank you.

My error. Now, when the document was provided, did you know that a few months before - and I think it was in January, that a Dr Kwon, who was an Australian trained orthopaedic surgeon from Sydney, and a member of the AOA, had commenced work at the Hervey Bay Hospital as Director of Surgery?-- Yes, I did. He was, dare I say, recruited as a recently graduated, now registered person. Up until December or probably the second week of January that year he was what we call a registrar affiliate, meaning he was just through his registrar training program, he was awaiting a fellowship, which is a higher training program in Boston, I understand, and he was recruited by Dr Hanelt, I understand, to come and do many joint replacements.

And you understood in May 2005, when your report was produced, that Dr Kwon had been working as an orthopaedic surgeon at Hervey Bay for a few months?-- I do.

That didn't find its way - and I am sure you will tell me why - into your report?-- The report was effectively finished long before Dr Kwon ever finished his training-----

Well before he started?-- -----program.

Before he started at Hervey Bay?-- Certainly before he started at Hervey Bay.

And I take it that you didn't think that that warranted mention in the final report that Dr Kwon was now on the scene?-- It bore no relationship to what we had investigated and drafted and processed-----

Did you-----?-- -----up to that point.

I am sorry, did you go back and make further inquiries as to how Dr Kwon was addressing, if at all, the concerns you had had earlier?-- We made some low-grade inquiries. This was not included in our Terms of Reference, this was a recruiting

exercise made outside our knowledge, and I only found out about it simply because one of my relatives again heard there was another orthopaedic surgeon appointed as a locum at the Hervey Bay Hospital.

Well, leaving aside low-grade inquiries, did you contact Dr Kwon to find out what he was doing or had been doing?-- No, I didn't, but the State Chairman of Orthopaedic Association in the State did.

When did they do that?-- Can't tell you. No idea.

You don't think it was important to just find out what Dr Kwon had been doing since his appointment in January 2005 to try and address, if he had at all, the concerns that you had about the matter?-- My understanding was that he was appointed as a locum director, and forgive me if I am wrong, my understanding was he was appointed as a locum Director of Orthopaedics at that hospital in place of Dr Naidoo, and, as investigators, we weren't consulted with respect to that in any way, shape or form. At that time it appeared that there was no visiting medical officer at the hospital, so that meant effectively that Dr Kwon would have been on for 100 per cent of the time, on call for 100 per cent of the time, and supervising 100 per cent of the time. And if that in fact was the case, it was even worse than we'd thought might have been present when we saw the July 2 situation.

Dr North, I can't tell you whether those things were the case, whether he was on 100 per cent and so on, and I take it you can't either?-- Well, there was nobody else appointed to that hospital at that time, so I would say I can guarantee that it was a one-in-one roster.

Okay. But-----

COMMISSIONER: If he wasn't, there was no-one supervising?-- Exactly.

MR APPLEGARTH: When - you probably dealt with different Director-Generals over the years, Director-Generals of Health?-- I try and keep away from them, Mr Applegarth. I get on treating the patient and try and let them sort of support me in promoting that as much as I can.

You will be pleased to know then, Dr North, my client is back treating patients and he started work today doing-----?-- I heard that.

He is hoping not to have to deal too much with these matters as well?-- That's right.

But in terms of your understanding of the Director-General and the role the Director-General had, you would have expected him to seek advice from, amongst others, the Chief Health Officer when he received your report?-- Well, that's why I rang. As a matter of courtesy I rang Gerry FitzGerald when the report was posted and said exactly what I presented earlier this

morning, "A report is on its way and because we have been meticulous in our confidentiality arrangements, any press release that occurs in tomorrow's paper, or Friday's paper will be a consequence of"-----

Someone else?-- -----"someone else", exactly. And he knew exactly who we were talking about and we giggled a bit over it.

Well-----?-- There it was on Friday morning.

I am not going to ask about journalist and their sources. I will be shot by someone, I think, from the back of the hall?-- It is all right, he is smiling.

In the course of preparing your statement, your witness statement, or in giving your evidence here today, have you been shown this document - and it will go up on the overhead. It is GF32. And perhaps I can hand up a document just so you can follow it perhaps a little - and one for the Commissioner, if it helps. Dr FitzGerald apparently gave evidence in the former Commission some time ago. He gave a witness statement that was dated 2 June 2005, and this is an exhibit to GF32. Have you seen that before?-- No.

You see there that Dr FitzGerald is advising Dr Buckland about your methodology, and the second paragraph he is talking about the interview and focus group approach. And he says, of you and your colleague, "They have not sought or been in a position to validate any of the concerns, and ordinarily such concerns would require a more formalised investigation in which evidence is collected and responded to." Now, Dr North, I am not trying to open up the division here, but it seems that Dr FitzGerald had a view that that type of investigation was warranted. I don't think he is necessarily being critical of you, but there was perhaps a difference of emphasis that he was pointing out, that you hadn't done the type of investigation that might have been done perhaps with more time, more resources and the like?

COMMISSIONER: He doesn't - I can't see anything there which indicates he favours a more thorough approach. He just said what hasn't been done, and that validation would require more formalised investigation.

MR APPLEGARTH: Yes.

COMMISSIONER: That's what he says.

MR APPLEGARTH: Yes, I will go on and perhaps deal with a few other matters.

COMMISSIONER: All right.

WITNESS: Can I just respond to that statement of yours?

MR APPLEGARTH: Yes?-- I mean, if we look at the recommendations, the recommendations are all addressed to the

Director-General, and if we look at the verbs - "take steps", "arrange transfer", "facilitate", "arrange appropriate", "provide rehabilitation", "immediately take whatever steps are possible", "immediately initiate an investigation" - I am - that's exactly what we're telling the Director-General to do and that's exactly what Gerry FitzGerald appears to be in this GF32 telling the Director-General to do.

You see there - we're not at cross-purposes-----?-- Exactly right.

-----I am sure, and you will see there down towards the bottom of the page, "I therefore recommend that you take a number of actions to address the issues of concern."?-- Correct.

"First, the performance of Director of Orthopaedics should be reviewed and detailed", and so on?-- Yes, Dr FitzGerald actually rang me a couple of nights later and before the subpoena of our document and said could we arrange a meeting. This was after the fax that I presented this morning, and I said, "Look, I am sure the State members would be happy but the Federal members felt the investigators had done their job. The State members were happy to meet but not without them receiving the report." Gerry said, "It is too hot."

Now-----?-- Full stop.

I am not acting for him?-- No, I understand.

But in terms of too hot, that could have been referring to defamation problems?-- He explained that exactly. The word defamation was used.

And you thought it was a bit hot, too, because you were worried about the same problem?-- Absolutely. Well, it appears from the first statement you gave me that "the appointee will be indemnified against any claims up to the end - the delivery of the required report". Now, what happens after?

Good question. You should ask a lawyer?-- Well, we chose not to because we were doing this of our own volition, and the AOA had even sought legal opinion and been told not to put the AOA letterhead on the front of the document.

Okay, we'll come back to that, and I will try and wrap it up quickly, but you will be pleased to know that Dr Beh has given us all the bits of paperwork in relation to that?-- Very kind of her.

Now, Dr FitzGerald is pointing out that the process that you went through, which depended on interviewing the like, was one that - wasn't one that, to use his words, "had validated any of the concerns, and ordinarily such concerns would require a more formalised investigation at which evidence is collected and responded to". You understood that was his position?-- Absolutely. Well, I hadn't seen it till today but it sounds reasonable.

And so please take the time if you need to read it. Another thing that Dr FitzGerald is advising Dr Buckland about is the recommendation that the services at Hervey Bay Hospital be, as it were, shut down. You will see about two thirds of the way down that document he says, "As you would be aware, this recommendation has significant clinical, legal, industrial and community implications", and so on?-- Yes. "It would, in my view, not be wise to take such dramatic action without first recourse to attempts to seek alternative solutions to the issues of concerns identified in the report".

So putting yourself in Dr Buckland's position at the time, he had your report recommending to shut down the service and he had a recommendation from the Chief Health Officer that some alternatives to shutting down warranted consideration, correct?-- With respect, Dr Giblin and I were both specialists, you know, albeit older ones, and Dr Gerry FitzGerald is a specialist in emergency medicine, but he doesn't hold a registrable qualification in orthopaedic surgery.

COMMISSIONER: Well, an appropriate alternative might have been the appointment of four orthopaedic surgeons or three to Hervey Bay?-- Yes, exactly.

Then they wouldn't have to shut down the service?-- Exactly.

MR APPLEGARTH: Just to round this matter off, the final recommendation from Dr FitzGerald is that Dr Buckland meet urgently with the AOA and you to seek your assistance in identification of methods by which clinical orthopaedic services may be ensured. And-----?-- And they did but only after the document became public.

Right. But you could understand the good sense of that recommendation; that you had been there, you had had the store of knowledge and it would be useful, if there wasn't any legal complications, for you to meet with Queensland Health representatives to progress matters if you could?-- Let's not use the personal "you" there, and let's use the orthopaedic association representatives in Queensland, might be better.

And if there weren't any legal problems in terms of legal exposure for you and your fellow investigator, that of all the people who could assist, you two ideally should be included because you had been there and you had done the report?-- Yes, except - except - I mean, armed with the report, the State committee would have been more than adequate.

Okay?-- But when we received the "no, that's not going to be possible", we were a little depressed and possibly even a little bit more concerned about our indemnity.

Okay. Can I just round off on these indemnity questions, because I promised at the start I would ask you some questions about them. There was a delay on the indemnity issue and one major aspect of it was that the Australian Orthopaedic

Association wanted its own indemnity, that it wanted an indemnity in addition to the indemnity that you and Dr Giblin had been given. Did you understand that to be the case?-- If we back up a little bit, the original request was to the national body, the Australian Orthopaedic Association. We felt that that - we, meaning the members of the association generally, and particularly in Queensland, felt that that was a fair and reasonable way to have an independent investigation at Hervey Bay without inappropriate bias by someone that came from Rockhampton or someone that came from somewhere else in Queensland, you know, who might be biased against Dr Buckland.

Okay?-- So the AOA federally, through its Federal President, therefore chose to appoint two people, one with a College of Surgeons hat at that point and that was the senior examiner, myself, and one with a Federal AOA executive hat, Honorary Secretary Peter Giblin, who is an orthopaedic surgeon himself. So two practising orthopaedic surgeons, you know, with some experience in assessment processes were appointed by the Federal President.

Cutting to the chase, you two eminent doctors prepare a report and then an issue arises as to whether it should go out, as it were, on AOA letterhead, is that right?-- Mmm.

And did you become aware of legal advice that the AOA obtained in September 2004 about that course?-- I was, yes.

If you just look at this - and the gentleman with the overheads can put it up if it helps everyone. Have you seen that advice before?-- Yes, now I have.

If you go to the fourth page, it concludes - and I am summarising here - that the advice is that a way forward is for AOA letterhead not to be used, and so on, and you see that it includes if that course of action was taken, the AOA's lawyers told it that they didn't believe that there was any legal liability would attach to the AOA for the report?-- And what about us?

Well, please-----?-- Well, Commissioner asked me to ask a lawyer before, so I am asking a lawyer.

COMMISSIONER: No, you did?-- I am sorry, sir.

MR APPLEGARTH: Please be assured I am leaving you till last, Dr North, but I haven't forgotten your indemnity?-- Thank you.

But you saw that advice at the time?-- We saw that advice and we felt a little bit deserted. Is that a reasonable word?

It all depends on your indemnity, I suppose?-- No, we both did it under a Federal AOA umbrella.

Okay?-- We were doing it as representatives of that - not as individuals, as representatives of a national body absolutely committed to safety and standards.

Okay?-- Full stop.

Well, in any event, the AOA get their advice. Turning, as I have promised, to your indemnity, we saw at the start when I showed you your letter of appointment there was an indemnity there?-- Yes.

Now, that didn't change, did it? You didn't get a better indemnity, a different indemnity, one with any more bells and whistles on it?-- Would you like me to go through a short chronology of that?

Well, I think-----?-- Very short.

Well-----?-- Incredibly short.

If you will be short, sure, go ahead, but I just suggest to you as a conclusion that the indemnity that you put forward at the end - sorry, the indemnity that you had at the end was the indemnity that you had at the start, that one I showed you at the start?-- There was a very different attitude towards the process once the Patel issue had arisen, and it was very clear from all that was happening with the Commission - previous Commission, should I say?

COMMISSIONER: Yes?-- That there were possibly two and maybe more reports that had been requested by Dr Buckland or his department that had either not been brought to public knowledge or certainly weren't in Q Health's hands, so they couldn't possibly be acted upon.

MR APPLEGARTH: Well-----?-- It - sorry.

If I can just deal with those matters, in terms of your indemnity and any concern that you had that the indemnity might have run out in October 2004, those were matters that were addressed between the AOA on your behalf and the legal section of Queensland Health, I suggest to you?-- No, we still believe we are indemnified at that point because we hadn't passed the report to Q Health. That's what it says and I think that's what it means by what it says.

Yes, I think we all agree that means what it says and that was the advice that was given in writing from the Legal Administrative Law Unit to the AOA, so I think there is no dispute about that?-- Sure. But there was a number - there were a number of phone calls between - I understand Peter Croft is his name - I don't know him - and Helen Beh.

And Dr Beh?-- Yes, which changed the umbrella attitude without any - the essence was, "We want the report and we want it very quickly."

Yes?-- "We will do anything to get the report."

Just final clarification, when you said the umbrella attitude, was that doing the report under the umbrella of the AOA or

some other umbrella? You just used the expression "umbrella"?-- No, the umbrella attitude - sorry, when this came out, we looked at that and we said, "I can't see the words 'unconditional indemnity'", so we were still concerned - not being legal people, okay, but both of us being responsible husbands, fathers and grandfathers, we both thought, "That seems to me to be too loose."

So you could have, and perhaps you did, seek some legal advice from the AOA?-- And when the AOA legal advice said, "Don't put your - don't put it on your letterhead and don't put your Coat of Arms on it", we were even more convinced that this was deficient.

Okay. But at the end, you were sufficiently satisfied, from whatever advice you got from whoever, that this was in fact the unconditional indemnity that you had always wanted?-- We were still concerned but we believed that the discussions between Peter Croft, Q Health solicitor, and Helen Beh were - there had been sufficient negotiation there to support our putting in the report.

And that you had the benefit of unconditional indemnity?-- No, never saw that but we hope that.

Okay. I have no further questions. Thank you very much, Dr North.

COMMISSIONER: Thank you. Mr Farr?

MR FARR: Thank you, your Honour.

CROSS-EXAMINATION:

MR FARR: Dr North, my name is Brad Farr. I am appearing for Queensland Health?-- Could I just ask your surname again, please?

Farr, F-A-R-R?-- Thank you.

The report that you have prepared, I understand from your evidence, was finalised some considerable time prior to its presentation?-- Correct.

But had that delay, for the reasons you have just been discussing with my learned friend. From your evidence a little while ago, I understand that the report was finalised, it would seem, some time before, for instance, Dr Kwon started his work at the Hervey Bay Hospital?-- Correct.

Now, I understand - you may not know the answer to this, and if so please say so, but I understand he started perhaps late December '04, early January '05?-- Probably was mid-January '05 because it would be very difficult to have him

registered as a specialist in December.

Right?-- This is just technical details of training, moving to registration.

All right?-- So I would think mid-January.

Mid-January, all right. The report that you did provide, however, speaks in the present tense, doesn't it? It was written in the present tense when it was written?-- Uh-huh.

And then, as I understand it, and you tell me if I am wrong, but on my reading of it it is then presented as a present tense document?-- Yes, I think it was still present tense applicable.

Notwithstanding the apparent tense of the document, however, it had been, by the time of its presentation, some, what, 11 months or so since you had been out to the Hervey Bay Hospital and had that, I think, a day and a half or so of speaking to people?-- One whole day.

Right?-- And one evening going through charts and X-rays. Two hospitals.

All right. So it is about 11 month period of time as a delay, and in that 11 month period of time you had been the recipient of documents over a number of months, it would seem; that's correct?-- Correct.

And I take it that the last of the documents that you received was the Christmas eve documents that you have spoken of?-- Correct, uh-huh.

Okay. You had some - how do I call it - some second-hand information of Dr Kwon having started at the hospital through a family member having some knowledge of the situation, but you did not embark upon any further investigation, or discussions, or interviews as an update, as it were?-- What would you have expected I would investigate?

COMMISSIONER: Mr Farr, I don't want to cut you short but this is ground Mr Applegarth has already gone over.

MR FARR: Yes, it is, but I want to take it a little bit further, if I can.

COMMISSIONER: Perhaps you can, but I would be grateful if you don't repeat cross-examination or examination that other counsel-----

MR FARR: I will endeavour to be brief on all the points that I raise. The effect of it all, however, is, can I suggest this to you, that by the time the report is presented, that the current situation which then existed in May of 2005, the Fraser Coast Health District, might not have been necessarily anything like what existed back in June the previous year?-- It is very possible. We weren't asked to investigate in May

2005, we were asked to investigate in July 2004.

All right?-- A witness can only respond to what he sees, hears and feels.

Yes?-- At the time he sees, hears and feels it.

All right. Well, that's understandable.

MR APPLEGARTH: Excuse me, Commissioner, may I seek your leave to depart? I don't wish to be rude.

COMMISSIONER: Of course. You are not being rude, you are welcome to go.

MR FARR: The position as at May of 2005, however, may well have been - and I understand that you really-----?-- I can't help you at May.

-----are in no position to comment, which is really what I am after?-- That's right.

Your acceptance-----?-- I can comment, but I have only the basis of hearsay on which to comment.

All right?-- There was one registered orthopaedic surgeon there doing a locum for the director and no VMOs attending the hospital, that is a one in one roster, specialist supervision, one in one, on call, one in one.

All right?-- I couldn't manage.

I put it to you this way: the Commission's going to hear evidence from a number of people associated with the Fraser Coast district, some of whom worked there during that period of time and continue to do so. Would you accept that those people would have a much greater knowledge of the more recent events, if you like, for the last six months than you would?-- Naturally.

All right. And your report is not in any way purporting to contradict anything that's occurred over the last six months, for instance?-- I think it probably summarises the yet undeclared or uninvestigated or unseen problems that - or undefined problems that were there when we wrote those 19 recommendations.

All right. And if evidence were to be produced, for example, indicating that at the time of Dr Kwon's appointment as the locum director of orthopaedics there were also two VMO orthopaedic specialists, you are in no position to challenge that?-- No, but I would be very interested to know who they were, sir.

All right. Okay. Now, you have - you have a copy of your report in front of you, I take it?-- I do.

You speak at page 3 of your report and the inspection documentation of not receiving documentation seven days prior to the inspection date, despite receiving undertakings that you would in fact do so. See the paragraph that I speak of?-- Yes.

Did you send out letters or your co-investigator send out letters or requests for documentation prior to your arrival at the health district on the day of the inspection?-- We instructed the federal office of the AMA - sorry, of the AOA to pass to Dr Hanelt things that we wanted to see.

Right. Do you know if that was done in writing?-- I can't answer that question. It might be in Dr Beh's documents, I'm not sure.

I see?-- We assumed it was. Much of that went from my PC to Dr Beh's PC and would have come via central office. Because it was a request of central office, we felt that all those requests should come from central office.

I understand. It in fact is the case also, as I understand it, that you at the time of your presentation at the hospital

itself spoke to people and indicated to them then what documents you might require from individuals?-- Mmm-hmm.

And that's that questionnaire, I think, you spoke of earlier in your evidence?-- The questionnaire wasn't a standard questionnaire for every person, it was a sheet of paper that allowed us to write questions down-----

Right?-- -----and then confirm with the recipient paperwork that we would like to receive. So we had a copy, photocopied it for them, they went away with a signed copy to say they understood 56 - section 56, they understood they had to get these documents, they understood they'd post them to that address.

Dr Hanelt, you spoke to him I think on a couple of occasions-----?-- We did.

-----whilst you were up there. And is it the case that during your conversations with him you identified, if you like, documents that you might need from him?-- We certainly did.

Had, in fact, you prior to meeting him at the place indicated to him that you would discuss what documents you would require when you were there? Can I put it to you this way-----?-- Just clarify the question a bit.

Did you say to him on the day before, that was the 1st of July 2004, "I won't burden you with what documents we need just yet, but talk more about that tomorrow."?-- Was it a conversation?

In an e-mail?-- I sent quite a lot of e-mails. If it's in an e-mail I would have communicated it to him, but-----

All right. I don't want to bombard the Inquiry with documents?-- I don't remember every e-mail I have sent but-----

No, that's fine. But that would be consistent with the approach that you adopted, I take it?-- No. If I looked at my e-mail, I think I could show you a document that went to Helen Beh requesting a number of levels of information from Fraser Coast admin that we might look at before we actually appeared.

All right?-- And I mean, I don't remember seeing that, and some particular material we asked for we didn't ever receive. I think - was that part of your question was well? I mean, simple things like referees' letters for appointments for directors of orthopaedics, referees' letters for appointments of SMOs, the investigators felt it was important to see those referees' references but, as I said, we never saw them.

Right. The on-site review was the 2nd of July. That's correct?-- I will-----

I understand that-----?-- -----go back to my diary. I think

it was the 2nd of July or 3rd. I can look at it easily. We went up - we flew up on the 1st of July, stayed overnight, Dr Hanelt picked us up on the 2nd of July, so we spent all day Friday at Hervey Bay Hospital and Maryborough Hospital, so we saw both campuses. We returned to our motel at about 6 p.m. with charts and X-rays, went through them over a number of hours and returned to Brisbane and Sydney respectively on Saturday the 3rd.

And did you subsequently receive from Dr Hanelt all of the information, the documentation that you requested from him?-- Except references with respect to the people I mentioned before.

Right?-- Now, there may have other materials we didn't receive, but they are the ones that stand out in my mind as not being received.

Okay. In the course of your report you refer to the people to whom you interviewed. Have you included all persons in that regard?-- As far as I know, yes.

By name?-- Yes.

COMMISSIONER: Plainly not.

MR FARR: Sorry. Have you referred to or made reference to what you were - the information you were given by all the people that you interviewed or have you selected parts of what you were told?-- I have not - the - remember I mentioned that in August I requested some identification of Q-Health policy on certain issues?

Yes?-- 10 issues. They were to clarify whether or not we were right in accepting what had been said by someone in the interviews. I mean, that probably could have been accessed by me by going to a Q-Health policy website. However, I'm not that computer literate that I can do that.

All right?-- So I asked my district manager would it be appropriate, and she agreed, albeit taking a long time to respond.

Did the situation arise during the course of these interviews with various people where you may have been given inconsistent information on the one point from two or more different people? Did that situation arise?-- It did. We had nurses - we had nurses from one area of the hospital saying there was a lot of photocopying went on, and we had doctors who were alleged to have been doing this photocopying saying-----

COMMISSIONER: A doctor. A doctor?-- A doctor, yes, apparently not doing a lot of photocopying.

MR FARR: What about in examples such as the clinical competence of a particular person? Did you receive information, for instance, from some quarters being critical and others being complimentary?-- There wasn't a lot of

complimentary comment put forward with respect to full-time doctors.

Right?-- And quite a lot of complimentary comments put forward with respect to visiting medical doctors.

Did you include, for instance, on any occasion where you did receive such inconsistent material, did you include the details of that in the report or did you try and make an assessment of what you were given and include what you thought was the most correct?

COMMISSIONER: Mr Farr, that assumes that he received inferences in the material. I don't think he said he had.

MR FARR: Well, the doctor might need to clarify that. I understood his answer to be that he didn't receive a lot of-----

COMMISSIONER: That may generally be some sort of general statement. I think you should clarify that.

MR FARR: I will clarify that.

COMMISSIONER: Please do.

MR FARR: Your answer was you didn't receive a lot of. Does that mean there was no or some?-- There was - I'm a person that says never say never and always, because I can never guarantee that this operation will go well and I can never say I will always guarantee that operation will go well. So you have got to be very careful trying to be black and white there.

COMMISSIONER: But can you remember any comment?-- I can't remember any conflicting comments about the full-time doctors in the orthopaedic department there and it was only when we were - we had supportive evidence or supportive comment - I shouldn't say supportive evidence, I should say supportive comment - that we pursued something.

MR FARR: Right?-- So when we included the word "lazy", I think in one description there, lazy and - anyway, there were three words in inverted commas.

COMMISSIONER: You talking about Dr Krishna?-- Yes. I mean, they came from multiple areas, not just from one area. Communication, almost every nurse in the hospital that we interviewed - no, I'm sorry, every nurse in the hospital we interviewed commented on the lack of or failure of leadership and communication.

MR FARR: All right?-- In fact, I think Dr Hanelt himself supported that. So conflicting wasn't the word. There was so much supportive evidence that we went away that evening virtually with the essence of the recommendations weighing heavily on our minds.

At the bottom of page 5 and then going-----?-- Is this our document?

Yes. Bottom of page 5 going over on to page 6 of your report?-- "Medical Staff."?

And you will see - yes, "Interviews.", "Investigators interviewed the following people as part of the review process." Then you list a number of people in the different work categories?-- Yes, they are the medical people on page 5 and others on page 6.

Is that a comprehensive list of the people that you interviewed or is that just a sample of some?-- No, no, as far as I can remember that is - as far as I can remember, that is all. It's possible there was one other theatre person-----

I might be able to assist you in that regard?-- -----not mentioned there. Yes, I just-----

There is a name of registered nurse from the operating theatre that I have been provided, a Mr Rod Stubbs?-- That's right, exactly. And I don't see it on that page.

So he's a name that's just been omitted?-- Apparently - yes. I'm sorry, it doesn't appear on that page at all, yep. Can I suggest he was a late admission to the interview process.

Right?-- And again was taken through the same process, signed the same forms, sent some post-interview paperwork to us, but for some reason his name's been omitted from page 6.

On page 6, about the fourth line, you speak of a Ms Theresa Winston?-- Winston.

Who was asked to attend the interview but was unavailable and no reason was provided for her absence. See that there?-- I do.

Do you recall a Gail Plint being offered as replacement for Ms Winston?-- Yes, I have noted that there, "Nominated for Hervey Bay Surgical Unit Nurse Manager."

And do you recall being advised that Ms Plint was unfortunately otherwise engaged and not able to attend?-- No, we saw Ms Plint.

Sorry, I should have said Ms Winston. Ms Winston was otherwise engaged?-- Yes.

Was unable to attend at the interview?-- Yep. We were advised that.

And that Ms Plint would be available to assist you in whatever way-----?-- Yep. We understood that exactly. We didn't have a reason, however, for her "otherwise engaged".

Did you subsequently speak to Ms Winston via telephone?-- I'm

not sure. We certainly received a lot of paperwork from her subsequent to that.

All right. Well, could I suggest this to you, and this might assist your memory, that you spoke to - you personally spoke to her on the telephone on the 7th of July?-- I can't remember. I make 20, maybe sometimes more than that, phone calls a day. I can't help you.

Do you recall sending to her, as I understand it, a list of questions?-- Yeah, we sent a lot of questions. I think we - we may have sent them to her or we may have given them to Ms Plint to pass on to her.

And did you receive a response from Ms Winston to those questions?-- We certainly - we received quite a lot of - a lot of material from her, yes.

All right. So she, that is Ms Winston, provided a response to-----?-- Yes, correct.

-----your inquiry?-- Correct.

You didn't meet her face to face as you did with-----?-- No.

-----any other people?-- Correct.

But ultimately you were able to obtain from her the information that you sought?-- Correct. Well, she was an important part. The Nurse Unit Manager of the Surgical Unit we felt was an important person to interview, if possible.

I understand. You don't, however, refer to that, as I have read the report, and I might have missed something somewhere, but of that interaction with Ms Winston at all?-- There's lots of interactions we haven't referred to, but her data was placed in the common pool and used to support or change our recommendations.

COMMISSIONER: I don't think any of the nursing staff were referred to by name, Mr Farr.

MR FARR: Yes, they were.

COMMISSIONER: Were they?

MR FARR: On page 6, the Nurse Unit Managers.

COMMISSIONER: No, no, I mean in the interview process. Are they? Where?

MR FARR: I am referring to page 6 of the report.

COMMISSIONER: Yes. But I'm saying that none of the nursing staff are referred to by name in the interviewing process.

MR FARR: That might be the case, yes. I am referring to the report itself.

COMMISSIONER: Yes, I am talking about the report, the interviewing part of the report where people said this or people said that.

MR FARR: No, I'm not suggesting that.

COMMISSIONER: No nurse was referred to by name.

MR FARR: No, I'm not suggesting that. But the next question I was going to ask you is this: did the information upon which the report was based come from additional people beyond those mentioned on pages 5 and 6?-- No, only insofar as that extra ten questions on Q-Health policy was important to us in understanding what the lawful - sorry, what the Q-Health policy was in a certain circumstance.

All right. So the sources - the various sources of whatever information you obtained from individuals came from the people identified in pages 5 and 6 and the two extra people that we have just be speaking of, Mr Stubbs?-- Mr Stubbs.

And Ms Winston?-- Yes.

And that would be the comprehensive list of the relevant-----?-- That's my understanding, yes.

Thank you. All right. Now, in the course of your investigation did you inform yourself as to the history of the difficulties that district has in attracting specialists to the public hospital system?-- In 1990 I was the secretary of the Queensland branch of the Australian Orthopaedic Association. There were difficulties in attracting orthopaedic surgeons to the regions in those days and as secretary in those days I wrote to every district manager. They may have gone by a different name in those days. Every district manager of a hospital could have supported one orthopaedic surgeon in Queensland and I offered the services of the State branch of the AOA in recruiting orthopaedic surgeons to peripheral or regional areas. You know how many responses I received from that letter?

No, I don't?-- None. So, I have been involved in trying to recruit and, indeed, went to a - went to several regional centres myself as a practising orthopaedic surgeon. For instance, I have been going to Caloundra for almost 11 years. You have say, well, that's not a regional centre, but the answer is nobody wanted to work at the public hospital there 10 years ago and I was asked would I help to set up some instruments and a day surgery service there for the locals and I did, and here I'm still going there 11 years later. I went to Beaudesert, but not to the hospital, for the 22 years. The hospital didn't want an orthopaedic surgeon, except when they needed one, so I was happy to call in at the hospital on the way home, inverted commas, just to check up if there were any - just to respond to any requests to check patients at that regional hospital.

I take it-----?-- So I understand the regions and the crises of recruiting to regions.

And from evidence that we have heard via the previous Commission of Inquiry, which is now before this Inquiry, it would seem that that difficulty has simply exacerbated in the years since 1990?-- Absolutely.

And it would seem particularly so perhaps in the last five years or so?-- Absolutely.

Would you agree with that?-- I think there's very little difference between 1990 and 2005.

All right. The effect of that, of course, is that the regions have to provide the services that they are able to obtain appropriate people for and identify what they can and what they can't do. You'd agree with that?-- Yes, exactly.

They have - regional hospital services have quite, in some respects, a unique set of problems confronting them as compared to, for instance, the PA district or the Royal Brisbane Women's Hospital?-- Mmm-hmm.

You'd agree with that also?-- Absolutely.

Okay. One of the functions, if you like, of your investigation, as I understand it, was to critique the system that was in place insofar as the orthopaedic practitioners were concerned at the Fraser Coast district and to offer advice or recommendations as to how to improve things. You'd agree with that?-- Well, that's what the Terms of Reference say.

Right?-- "Advise to assist the Fraser"-----

COMMISSIONER: You don't need to read them out. We have them before us?-- Mmm.

MR FARR: That's all right. And my understanding, and again if you weren't privy to this please say so, but my understanding is that ultimately - well, at the beginning of all of this process it was Dr Hanelt who sought the involvement of an independent person or persons to come in to conduct this process in an attempt to improve the system in that region. Is that your understanding?-- My understanding is that when a crises arose because of the Area of Need practitioners, alerts regarding safety were raised and the orthopaedic association became aware of those concerns and communicated them to Q-Health and various of its officers.

COMMISSIONER: Aware of its concerns from whom?-- Well, the local orthopaedic surgeons first were concerned about it.

Dr Mullen in particular?-- And Dr Khursandi.

Right?-- Dr Khursandi been there far 28 years, so he understood the crisis.

Yes?-- And other practitioners were receiving poorly managed patients, so they raised concerns as well.

Right?-- So if you mix that together, that's what originally stimulated the AOA to become more involved in the process.

And do you understand that Dr Hanelt sought from the AOA personnel that might be able to assist in that process?-- I think there was some communication between him and the State committee, the State AOA committee, yes.

Would you agree with this, when it's not possible to recruit an adequate number of specialists to provide a continuous specialist service, other models of service delivery must be utilised or considered?-- And we actually suggested that, I think, on the fourth of our recommendations, "Use the telemedicine processes that are presently available in Q-Health hospitals throughout the State."

Certainly. And one of the reasons for the review was to assist in the development of a framework of clinical governance to ensure that alternative models were complied with for the patient safety obligation?-- Where does it say in the Terms of Reference?

I am asking whether you had that as a condition in the course of making your recommendations?-- I don't think we were - unless you put that under the last dot point, it doesn't fall in any others.

All right. I take it from your answer that you hadn't taken that factor into account?-- No, no, we thought governance was very important, in fact incredibly important.

Right. Well, did you do that?-- Did we take it into account?

Can I ask - I will ask you again, did you in formulating your recommendations take into account the development of a framework of clinical governance to ensure an alternative model was compliant with patient safety obligations?-- We couldn't ensure it but we could recommend it.

All right?-- Mmm. The answer is we did take that into account. We recognised probably this investigation more than the other one how regional Queensland is somewhat dysfunctional from a health care services point of view and we did take that into account. I would be very happy to practice at Hervey Bay but only if there were four or five people available for on call, for instance.

All right?-- Now, the governance then - the governance process is, as I have mentioned before, I serve the patient and expect the administration and, indeed, everybody up to the Minister to facilitate my patient care activity, within a certain budgetary restraint, but unless we have that philosophy we will end up with 20 per cent clinicians and 80 per cent administrators. Now, I would like to see at least

90 cents in the dollar get to the patient, but remember I'm a person that still treats patients, and when you are a patient you will probably expect that too. And again if you come in on my on-call weekend as a consequence - and we trust it doesn't happen - of a motor vehicle accident, you will pray that I'm there supervising the senior registrar and not someone else or no-one else.

Can I take you to - forward to page 12 of your report?-- My report?

Yes, please?-- Our report, sorry.

Just a matter that I wanted to perhaps correct if there is a factual matter. Just under the heading of "General Hospital Facilities", you are speaking in the first paragraph of the Maryborough Hospital. You say, "The hospital does not have an Accident and Emergency Department and cases are taken to Hervey Bay."?-- That's what Dr Hanelt informed us of and that's what that Dr Khursandi informed us of.

Right. If I - well, can I put this to you, that the Accident and Emergency Department of the Maryborough Hospital exists, did exist at the time and operated on a 24 hour a day, seven day a week basis?-- Is it similar to the QEII Accident and Emergency Department?

I can't answer your questions, I am afraid?-- Somebody needs to answer that, Commissioner, because the Accident and Emergency Department may be a name but not a functioning entity.

COMMISSIONER: What do you mean by the QEII?-- Well, there may be one resident on call in a front room and the ambulance may arrive, but they have to be transferred to Princess Alexandra because they have no facilities to deal with that process-----

I see. All right?-- -----activity, accurately or appropriately.

MR FARR: Well, perhaps this might fall in what you were saying. I suggested to you that there are no after hours operating theatres availability at Maryborough for emergency theatre cases, and they are transferred to Hervey Bay?-- Mmm-hmm. Dr Hanelt clearly said to us that there was no Accident and Emergency Department at Hervey Bay.

Well-----

COMMISSIONER: At Maryborough?-- Sorry, Maryborough. I apologise. In fact, that was one of the reasons why Dr Khursandi clearly stated to us that he did not go to Hervey Bay. He did not want to be part of an emergency service because he was getting older, a little over 60, I think, and felt that he was less able to service after hour calls for that reason. And he lived on the other side of Maryborough, was my other understanding.

All right. Now, if we can just move on. Now, you appreciate that I'm not appearing for Dr Naidoo?-- I do.

You do speak at page 15 of his leave, I think generous study leave arrangements. Did you make any inquiries though to look at the actual documentation regarding his terms of contract?-- Yeah, no, we only saw the pay sheets - to, sorry, I missed the last part of that sentence, I think.

Did you have to actually look at any of the documentation relating to his terms of employment or the contract of his employment?-- No, we were given three - the employment with the Fraser Coast District appeared to fall into three time periods.

Well, the time period when you were there dealing with that?-- When we were there, we understood that he was a full time director and he didn't clearly answer about what his private practice process was, nor did he give us any documentation with respect to that.

All right. Well, as I say, I'm not acting for him, but are you in a position to be able to comment upon whether his conditions of employment in so far as leave entitlements were concerned, were in any way different to other persons holding similar positions in Queensland Health elsewhere or is that something that you are unable to comment upon?-- I can't comment on that.

All right, thank you. Again, just still on the subject of Dr Naidoo, just over the page at page 16, you speak in the third paragraph of a particular matter, you say, "A case was described to the investigators."; do you see that sentence halfway in the third paragraph?-- Is this dot point under "Investigations, Recommendation, Comment"?

No, page 16 under "Surgical Performance".

COMMISSIONER: Second paragraph under that heading?-- Apologies, yes, I've got it.

MR FARR: And about the third line of that paragraph, "A case was"-----?-- Yes.

It speaks of taking five hours to undertake a total hip replacement?-- Yes.

Now, just using that by way of an example, the information that was supplied to you in relation to that matter, what was actually given to you?-- That statement would have been given to us, that particular time was taken to perform a particular operation.

Did you, as a consequence of receiving that information, then conduct any clinical audit, if you like, of that particular case, look at the patient files, the charts that type of thing?-- We weren't given that patient's name, UR number or file or X-rays.

Did you ask for it?-- We asked the person that gave us the information could he find out who it was and we never received anything to support or that supported that.

Did you ask anyone else in a position of authority in relation to that matter? Dr Hanelt, for instance?-- No, we didn't.

COMMISSIONER: How were you able to conclude from the information you were given that it was a surgical incompetence just from the length of the operation?-- Yes, yes. That would be a fairly serious time for that sort of operation, very serious time for that operation. I mean, if I was assisting my Registrar doing that operation and he took more than two hours, I'd be worried.

Right?-- So - this is a reasonable assistant with a training Registrar.

Right?-- More than two hours I'd be worried.

Yes?-- Five hours, I'd be petrified.

Right.

MR FARR: What if the operation was what's called a revision arthroplasty?-- If it took five hours it probably shouldn't have been done on that site.

Do you know what is the standard time for a procedure referred to as a revision arthroplasty?-- I do, I actually do revision arthroplasty it might surprise you to know, but again, let me say we've done a revision arthroplasty in the last six weeks, again, my Registrar-in-training was the primary operator with me as the assistant, seriously involved assistant.

Right?-- And it still took less than two hours.

And is a - can I give you this term, a revision of a previous hemiarthroplasty to a total hip replacement; is that correctly described as a revision arthroplasty?-- Correct.

All right. Do you know of any studies that indicate that the standard time for an operation of that nature is about four and a half hours?-- It varies tremendously on the nature of the bone loss, the nature of any fracture around it, the nature of the implants that were put in on the first time, the nature of how many previous revisions, there are so many qualifications to that, that you couldn't, you couldn't trust any particular data that tried to put a time scale-----

I see?-- -----on a particular single-----

I take it it's the same as any other type of surgical procedure, some cases present complications, others do not, some take much longer than others for the same type of procedure depending upon the patient's condition, circumstances?-- If it took five hours, I would think there

were probably one or more serious intra-operative incidents that needed to be dealt with.

COMMISSIONER: Is "incident" a euphemism for errors?-- Yes, yes, it might be an unfortunate error.

Mmm?-- But soft bone.

Mmm?-- Fractures below the stem, can't get the cement out, little bit of bleeding, errors not in a negligent way, errors in a mistake way.

Mmm?-- If there's a difference.

Mmm, possibly.

MR FARR: Would it be fair to say, however, given that all you've really received in relation to this matter is a bit of verbal information from a person, that you are in no position to be able to make any finding in so far as that particular matter is concerned?-- The data came from a theatre nurse, the theatre nurse logs the patient in, logs the patient out, logs the operation start time in, logs the operation start time out, those times are recorded.

Did you get those recordings?-- No, we didn't, but we asked but didn't receive, but that could have been forgotten or it could have been a little hot to handle, I don't know, but the registered nurse in the operating theatre would have a very good idea of how long I'd take to do a revision arthroplasty and would be a good witness to that.

Would you agree with me, however, that to properly investigate that - just that matter by way of an example, you would ordinarily and ideally like to see the patient charts, the theatre notes, interview the surgeon concerned and any assistant that might have been present at the time?-- If we were asked to do an audit of that case or a audit of a number of cases, then a totally different pattern would have been arranged.

Certainly?-- A clinical privileges and credentialing committee would have been the appropriate way to do it.

All right. And you have in the course of the conduct of this investigation relied, it would seem, quite heavily on information that's been supplied to you by individuals?-- Absolutely.

I take it from the nature of what you've said and what you've contained - what you've put into your report, that you didn't simply - simply didn't have the opportunity or the time to go through all of the documentation and the patient notes and whatever other documents might have been of relevance in each and every point, what you have done is attempted to identify issues that have been identified to you and put forward the concerns that were - which are said to exist?-- I'm sure we would have been very happy to do that had Mr Buckland asked -

Dr Buckland asked us to do just that, but he didn't in fact ask us that.

No, but that's my reading of it and please tell me if I'm wrong but that's effectively what you've done?-- Just let me back up a little and tell you about this recent interstate one that I had to do. I received two large containers filled with documents. They were photocopies of patients' charts from numerous hospitals, there were only 12 patients involved and I went through each one of those charts, I went through all the summaries and we went through the X-rays, the X-rays came on discs, and two of us then joined together having read the documentation, looked at the charts, looked at the consequences and came to a common view. We then produced a short report to clarify the situation and that's an entirely different thing to what we were asked to do here.

Certainly. At the end of the process that you've just described?-- Mmm-hmm.

I take it that you would be able to form a conclusion upon which you would place a healthy degree of confidence that your findings are correct?-- Correct, yes.

Dealing with the process that you've undertaken in this matter, you have attempted to identify the potential issues, and if such issues exist, recommend areas where they might be overcome but allowed the actual investigation of that to others?-- We've recommended the investigation be done by the Director-General.

I appreciate that, but that's the methodology, if you like?-- The essence of the methodology was define the problem, make a recommendation to the Director-General that he investigate the problem and if the AOA can help at the end of that investigation, there was a willingness to do that.

Certainly. And my understanding - again, please tell me if I'm wrong - but when you have received, for instance, verbal information from people, from either doctors or nurses, you have summarised it as best you are able, and in the course of the report, identifying if a problem in fact is correct, these are the causes or the reasons for it as best we've been able to discern, these are the things that you might need to do in relation to attempting to correct it?-- Nurses are very good historians. In fact, if you hear comments from nurses, we - we didn't cross-examine them, we simply tried to make it clear in our mind what their concerns were. You know, nurses are an incredibly good assessor of communication skills by a doctor, and I mean, if you were to ask any of the nurses in the room to assess their general practitioner's communication skills, I'm sure we'd get a quick paragraph, but that's one of the reasons why we use the nurses' information as very useful information. I can't guarantee that any comments were absolutely correct.

All right?-- But there's no way we can do that. We have to take what we're given just as from a patient I have to take

what I'm given as acceptable. Now, if I see a needle track mark up the forearm and somebody says, "No, I've never been an IV user", I take little credence in the history and much more credence with the examination.

All right. If I can take you to the next page, page 17, you speak of, in that page - I'm just trying to find the passage, Dr Mullen withdrawing his services; he was a VMO, I understand?-- Correct.

Withdrawing his services the previous year when he felt that patient care and safety had been compromised or was being compromised in the third - second paragraph under Dr Sean Mullen starting with both Dr Hanelt; do you see that paragraph?-- Yes, correct.

About half way through that paragraph. That information, I take it, came to you from Dr Mullen?-- Correct.

Dr Mullen - well, did you make - again, just by way of an example - but did you make any inquiries as to any paperwork that might have been produced?-- Yes.

At the time that Dr Mullen resigned?-- Yes, we asked for the resignation letter.

And did you receive it?-- Didn't receive it.

I see, all right. Who did you ask?-- Dr Hanelt.

Dr Hanelt. And was that something that you did not receive from Dr Hanelt?-- My - I can't remember seeing it at all, so I assume we didn't receive it.

You said to me earlier that you thought that you had received all of the documentation that you had requested from Dr Hanelt I think by sometime in October you said; might that be something that you had overlooked as well?-- It's possible.

All right?-- That's almost a year ago and I can't remember every-----

No, I appreciate that?-- I was hoping I could have deleted some of this from my memory banks before today, sir.

Very well. And this report, the details of it were not released either physically or-----?-- Verbally or-----

-----or even speaking of it in any way, shape or form prior to its actual presentation?-- "Meticulous confidentiality" was the words I used to Dr FitzGerald and they were words I'd used again, "Meticulous confidentiality".

Thank you. Can I turn now to Drs Sharma and Krishna. Your investigation would have identified no doubt those orthopaedic specialists with whom they worked during the period of time that they were at the Fraser Coast district, whether it be Dr Mullen or Dr Naidoo or another VMO?-- No, they are the only

two that they worked with.

No?-- There was no other VMO that worked with - unless they went to Maryborough Hospital for part of the time, but my understanding was Dr Padayachey worked at Maryborough Hospital and Dr Sharma and Krishna worked only at Hervey Bay Hospital.

All right?-- So there were no other VMOs, there were no other specialists with which they worked, Naidoo and Mullen were the only two.

In producing your report, on the topic of these two men, you have again relied upon information provided to you by staff?-- Correct.

You have, I take it, seen some documentation that might be relevant to either Dr Sharma or Dr Krishna perhaps in relation to their appointment or that type of thing?-- Mmm-hmm.

But I understand that you did not go so far as, for instance, to go through patient charts in relation to individual patients or all of their patients, you may have seen a couple perhaps?-- No, no, we saw about a dozen charts and their X-rays.

Right?-- But only ones that we had been alerted to and there was no essence of audit in the Terms of Reference.

No, no, I can understand that, I'm not being critical of you in that regard, please understand that?-- Mmm.

But were you given, for instance, any estimation to number of procedures these doctors might have performed?-- Not at all.

So if, for instance, you were referred to a dozen cases, do you not know what proportion of the entire number of procedures that would constitute for each individual?-- Can't help you, we're not asked to go through and find out or do a mortality and morbidity audit on all the cases of the orthopaedic department.

All right?-- I mean, that would take a year. My understanding is that Q-Health commissioned - no, not commissioned, sent a number of people including a number of orthopaedic surgeons up there in recent days with a dozen or so supposed clinical investigators who spent a number of weeks there to try and sort out who were the advantaged or disadvantaged persons in this group. Now, I don't know what they did, how they did it, I can't however believe that a physiotherapist would be able to figure out whether that orthopaedic procedure was reasonable, senseless, inappropriate, I can't believe that somebody working as a, you know, Q-Health bureaucrat could figure out what was appropriate or inappropriate in those circumstances. Now, the orthopaedic surgeons could have if they were sent there for that reason, but my understanding was they were sent up there to try and sort out the waiting list more than audit the cases either numerically or according to merit, I don't know, that's

never been advertised. I've seen - I only caught a glimpse of a document late last week that was produced by this supposed group, but I've had no input or seen no figures on that audit.

All right. Did you ask Dr Naidoo of his opinion of Dr Sharma's clinical abilities?-- Both Dr Sharma and Dr Krishna.

Did you ask Dr Mullen?-- Yes.

In relation to each of those men also?-- We did.

All right, thank you?-- And we asked all the nurses as well.

Would you just excuse me for just a moment if you will?

COMMISSIONER: Yes.

MR FARR: On page 21 - excuse me again - I don't need to take you to that. Yes, yes, I'm sorry. Yes, at page 21 down at the footnote, I was overlooking the footnote - you'll see down there again the issue of the nurse unit manager for the surgical unit, Ms Theresa Winstone, you again refer to her being unavailable for interview, "No reason was offered for her unavailability. The investigators were concerned that some coercive behaviour may have occurred that led to her decision. The culture of the unit clearly delineated in many interviews (would strongly support that possibility)." Now, it would have been the case, would it not, Dr North, that by the time that was written, you would have had contact with Ms Winstone via telephone and via the documentation that exchanged between you?-- No, that we came to that, we talked about that at the end of the Plint interview and in fact, after all the nurses had been interviewed including Mr Stubs, that we-----

But we-----

COMMISSIONER: Just let him finish.

MR FARR: I'm sorry.

COMMISSIONER: Yes, keep going?-- We felt that there may have been some albeit subtle obstruction to this lady presenting on that day. It was only - we only mentioned that because we felt that that could be the case and I'm happy to go into it further if you wish.

MR FARR: But what I'm interested in that you in fact by the time this was written, which I understand was months later, had in fact had contact with that woman and had received all of the information that you required from her?-- Nothing that that woman said confirmed what we thought, but let me give you a quick analogy: in the lunch break I had to ring up Princess Alexandra Hospital and inform my Registrar I wouldn't be - I would be unable to assist him doing the total knee replacement this afternoon that we had planned to do for a number of weeks. I gave him a clear reason why I would not be available this afternoon. He accepted that reason and I asked him to

translate that reason to the patient so that he understood why we could not do it this afternoon. Now, it may be that Miss Winstone was going to the doctor and didn't want us to know about it, but there was no reason offered as to why she could not present for interview.

Did you ask her if she had been coerced or not?-- No, we didn't.

Did you ask her subsequently-----?-- No, we didn't.

-----in writing? So there is no evidence upon which you make that statement other than for the fact that she wasn't available to be interviewed personally?-- There was no evidence and there was no reason given for her not presenting.

COMMISSIONER: You also say in that footnote that, "The culture of the unit clearly delineated in many interviews (which strongly support this possibility)." What did you mean by that?-- It was clear that the district manager was seriously involved with the nurse unit manager in a partnership and the nurse unit manager of the operating theatre was another person who was interviewed. As we've seen-----

Sorry, who's the nurse unit manager?-- Beg your pardon?

Who was the nurse unit manger?-- The nurse unit manager of the operating theatre there.

Yeah?-- Was the girlfriend, can I say, partner of the district manager.

And what was her name? If you don't know - was she one of the people you interviewed?-- Yes.

Oh, okay?-- And subsequently events have suggested that inappropriate pressures had been placed on certain persons.

Yes?-- To make it difficult for them to be open on the day in question.

Right.

MR FARR: Yes, thank you.

COMMISSIONER: You can take it up further if you want, Mr Farr?

MR FARR: No, I won't take that any further, I think that's as far. Just again remaining on page 21, the last paragraph of the body of the report, you say in the second sentence, "It was clear to the investigators that the nursing staff had concerns about the performance of some medical staff and some of the processes in place at these hospitals that they had expressed these concerns to those who were in a position to address the problems but that their complaints usually fell on deaf ears." Do you see that passage?-- No. Page 21?

Page 21, the last paragraph?-- Under "Investigators Recommendations"?

Yes, and the second sentence, "It was clear"?-- Yes, right, yep, we actually received some of those e-mails that were documented to confirm that nursing staff had taken their concerns higher.

Do you remember when they were dated?-- I couldn't possibly.

Do you have any idea where those e-mails are now?-- Yes.

Where are they?-- They're with Dr Giblin in his locked cupboard.

So are they able to be produced?-- I would think so. In fact, I think the nurses would be happy to produce them again.

Do you have this recollection, that they were shortly before your investigation commenced?-- I couldn't possibly tell you.

You don't know?-- I couldn't possibly tell you.

All right?-- That documentation's available if the Commissioner wishes, sir.

COMMISSIONER: Thank you.

MR FARR: Thank you. Okay, now, page 22 you speak in the fourth paragraph down under "Administration of the Orthopaedic Department", "From time to time RMOs from the Royal Brisbane Hospital attended"?-- So these first, second, or third year doctors from the Royal Brisbane.

Do you remember where that information came from?-- Yes, Dr Sharma, Dr Krishna, Dr Naidoo, in fact, I think Dr Hanelt told us all of those things and some of the nurses as well.

The rosters therefore for the medical staff should show the RMOs from the Royal Brisbane Hospital being allocated to that unit?-- Should.

If they're being maintained correctly?-- Should do. It's a common regional - common practice of sending metropolitan residents to the regions for a country term so-called and-----

Did you - I'm sorry?-- And that was part of it, Mmm-hmm.

Did you see any of that documentation, the rosters et cetera?-- No, we didn't, we just accepted that that is a normal pattern.

All right. Once again, you've accepted that information that was given to you by someone else?-- That's correct. My resident when she leaves next week might be transferred to Cunnamulla for five weeks. That's a common practice.

All right. Can I take you over the page, page 23. And you speak in that page about two thirds of the way down the paragraph starting, "Dr Hanelt also expressed the view that credentialing and re-accreditation procedures."; if you can see where I'm referring to?-- Absolutely, yes.

He described them as a joke?-- That's his quote.

All right. Can I suggest this to you: the district had been attempting to get the Royal Australasian College of Surgeons nominate a representative on the credentialing and clinical privileges committee for some time at that stage. Do you have knowledge of that?-- I don't have knowledge of that.

All right. The Australian Orthopaedic Association had also been requested for a nominee in July of 2003 but had made no response. Do you have any knowledge of that?-- I have no knowledge of that.

If a college or an association fails to nominate a representative, then it just becomes impossible to follow the gold letter standard, isn't it, for a regional hospital?-- If that did occur, yes, it would be, but having been the Secretary of the State Branch of the AOA, I think it would be very unlikely that someone wouldn't accept such a request, and having been on the State committee of the Royal Australasian College of Surgeons for nine years in the past, I can't ever remember a request for a regional nominee to come through the State committee.

All right. But if in fact that was the position, then a district, a regional district, what alternatives would they have to determine clinical competencies, would you suggest?-- Use a local specialist surgeon and approach him directly.

What about - I understand that. What about the use of - in the orthopaedics field, the use of the Director of Orthopaedics, if that person, for instance, was a Fellow of the college?-- I think he would be regarded as biased.

Right. So you would think that's not the ideal situation?-- Totally biased. I would think it is not a situation that you would regard as transparent.

I see?-- I mean, I have been asked to fill in forms about two recredential in the last six months. I do two sessions, so one whole day a fortnight at Logan Hospital, so I had to present all the information to them for their credentialing process. Now, I am not sure who sits on that credentialing committee, but I am not part of it, because I would clearly be biased. I filled in all the data, sent an abridged CV and answered all the questions appropriately, gave the names I think of three referees. Now, I have had to do that for the Princess Alexandra Hospital as well, and for the Sunshine Coast district for my Caloundra activity, but neither of those - well, none of those three have suggested there was any problem with getting a credentialing committee together.

All right. Can I ask you this question: would you agree that for the credentialing and privileging process to work at its best, it requires the cooperation of both the individual, the employer, the colleges and associations?-- Absolutely.

All right. Are you aware that since the release of your report, that the AOA had - that the Queensland chairperson of the AOA has provided a representative to participate in that process at the Fraser coast region?-- I am not aware of that. I am not on the State committee, so I can't be understanding of all their decisions.

That's all right. You speak as well on that topic of Dr Hanelt having no understanding of the processes in place regarding to credentialing and privileging?-- Which paragraph?

Again, same page.

COMMISSIONER: Last sentence on the same paragraph.

MR FARR: Yes, thank you?-- Same paragraph?

Yes.

COMMISSIONER: Last sentence.

MR FARR: See that sentence?-- Yes, yes.

Did you ask Dr Hanelt of his actual experience in this process?-- We did.

Or experiences he has had in the past?-- We did, and how about after that?

Were you provided with such information? You asked, did he give you answers?-- Yes - no, not that were satisfactory, not that confirmed to us that he understood honest credentialing.

Were you aware that he was the author of the district policy in relation to the process of clinical privileging assessment?-- No.

Did you know that he had served on the clinical privileges committees for local districts, for that district at times and also others?-- I know he had been in Roma before that, but we knew that district credentialing committee wasn't working so we assumed that anybody serving on that committee was not acting in good faith, let alone by good process - or in good process.

When you spoke to the people that you spoke to in July at the hospital, how did you record what you were told?-- We wrote it down, right there and then.

And did those people get a copy of that?-- They did.

So you provided each person that you interviewed with a copy?-- No, we didn't provide them with the answer to their questions, we provided them with a written record of the data we wanted to receive from them. The answers to their questions were for the investigators, that's obvious.

Mmm, so it wasn't tape recorded?-- No, no, no, we used our pens.

All right?-- And a prepared sheet which we then-----

COMMISSIONER: Mr - sorry, keep going?-- We wrote out a question, we wrote their answer; our question, their answer.

MR FARR: But did the people that you interviewed have the opportunity of seeing the answer that you recorded-----?-- No.

-----as having been made by them?-- No we didn't think that was appropriate.

COMMISSIONER: Can I just go back to Mr Farr's earlier question about your conclusion that Dr Hanelt had no understanding of the processes in place, and had made no attempt to ask for advice prior to the lead-up to the investigation. Can you recall now what caused you to reach that conclusion?-- Probably a number of things. But most of it was - and would be better, probably, documented by the present State Chairman, Chris Blenkin is his name, and when he had spoken to Dr Hanelt on many occasions, there was no really constructive or productive support to make concerns - sorry, to deal with concerns that the AOA had. That's my understanding. And that's probably what led to the State committee saying, "Why don't you refer this to the Federal committee, have them appoint two independent unbiased investigators, indemnify them and send them up."

All right, thank you. Yes, Mr Farr.

MR FARR: Thank you, your Honour. If I can take you - still on page 23-----?-- Can I make one just further comment to sort of explain or answer your question, Dr Hanelt's understanding of the process?

Mmm?-- Again, not placing the document, Commissioner, but come to my knowledge, because of my honorary secretary Federal hat, was Dr Hanelt's recruiting process after this and in fact after Dr Kwon. It had been brought to my notice that Dr Hanelt - and I am saying this with due respect - was trying to recruit an Australian-trained orthopaedic surgeon from Sydney who had on three occasions, to my knowledge, been deregistered in New South Wales. Would you like me to say that again?

COMMISSIONER: No, I think we all heard you.

MR FARR: I understand. Commissioner-----

WITNESS: That supported our original - this is subsequent information, but that supported our view that he did not have insight, if we go back to a word previously mentioned by Mr Andrews, he did not have insight to realise what he was actually trying to recruit.

COMMISSIONER: Yes.

MR FARR: Commissioner, that's a matter that-----

WITNESS: Now, that applied to his understanding of - I think you have got to be a brave man to say the college credentialing committee is a joke when you are not a member of that royal college.

COMMISSIONER: Yes.

MR FARR: I don't have instructions on that point. Can I adopt this approach: that if necessary, a short addendum statement can be taken from Dr Hanelt on that point.

COMMISSIONER: Yes, of course.

MR FARR: I dare say I won't need to cross-examine at any other stage.

COMMISSIONER: All right.

MR FARR: Thank you. Can I take you down to page - still on page 23, second last paragraph starts with, "Reports from medical staff indicated that the lack of respect showed to them by the administrators was returned in full measure." Do you see that sentence?-- I see that sentence.

Now, the medical staff that you speak of, I take it, would be some of those you identified on page 5 of this report?-- Yes.

There are, on my instructions, about 75 doctors employed within the district. Is that something about which you have any knowledge?-- No idea.

Do you have knowledge that the doctors that you did speak to and the nurses that you spoke to, represent a small proportion of the overall staff in the district?-- I understand they only represent a small proportion, yes.

I take it that sentence should be read in the context of the small proportion of people that you spoke to, this is the flavour that came across?-- Entirely fair.

All right, thank you. The - you were questioned earlier about the document referred to as the consultant roster?-- Correct.

And can I suggest to you that that was a document not for publication amongst the general public?-- It still said something very important.

I understand what you are saying, but do you know-----

COMMISSIONER: I think he accepted it wasn't something for the general public to see.

MR FARR: All right, thank you. If - would you accept this: if it is not for the general public to see, it could not be

described as advertising?-- I don't think I ever said it was advertising.

All right?-- I think Little Richard's story in the Chronicle was advertising.

All right?-- Or, no, that's gracious, that was misadvertising.

Whilst you are on that topic, upon seeing that story in the paper, did you make any attempts to obtain the media release upon which it was based?-- No, I spoke to the State Chairman of the orthopaedic association and said, "This is serious."

But my question is we can see the newspaper article?-- No, I didn't.

The newspaper article-----

COMMISSIONER: He said no.

MR FARR: All right.

WITNESS: No.

MR FARR: So we don't know if the article was in fact accurate or not?-- It quotes Mr Allsop as saying two orthopaedic surgeons were coming.

But we don't know if, in fact, it is an accurate quote or not?-- It was supported by a piece of paper that was in the staffroom that said "consultant roster".

You accept, don't you, that we don't know whether it was accurately reported or not?-- I saw the consultant roster.

COMMISSIONER: That's self-evident, Mr Farr. You don't have to-----

MR FARR: Thank you, I won't take it further. On page 24, four dot points, you speak in the first of those dot points that, "Health care delivery in the Fraser Coast Health District is budget driven for crisis management, manifested in this way the appointment of persons who, by virtue of the nature of their training and the level of expertise, costs less to employ but were clearly unsafe in terms of their level of medical practice." Were you provided with any documentation to show that that was the purpose or the sole reason for their appointment? Was there some documentation that you saw that evidenced that?

COMMISSIONER: I don't think the dot point says that that was the reason for appointment, just that it happened.

MR FARR: Well, can I ask this question: do you intend to infer from that comment in your report that that was the reason for the appointment of the people about whom you speak?-- That's a reasonable inference, I think. I think it

says it fairly clearly.

Did you or were you provided with documentation to support that?-- It wasn't for us to chase all that documentation as to how much they cost or don't cost. By virtue of their training and experience, they were there purporting to be specialists, not paid as specialists, clearly with some perks that went to specialists normally, but while - even if you believe they weren't truly called specialists, they were not safe in their medical practice.

COMMISSIONER: Mr Farr, I see it is 4.30. How much longer do you think you are going to be so we can organise-----

MR FARR: Probably half an hour.

COMMISSIONER: All right. Perhaps consideration overnight might shorten the matter.

MR FARR: It could be, yes. It might do.

COMMISSIONER: I hope so. We will adjourn till 10 o'clock tomorrow.

THE COMMISSION ADJOURNED AT 4.32 P.M. TILL 10.00 A.M. THE FOLLOWING DAY