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 13/09/2005

..DAY 3

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

THE COMMISSION RESUMED AT 10.02 A.M.

COMMISSIONER: Mr Farr?

MR FARR: Thank you, Commissioner, I am just waiting on the witness.

MS McMILLAN: Might I just raise something just before the witness resumes very briefly? I just wanted to check was there a direction or not in relation to when submissions had to be in about the recalling of any witnesses, particularly nurse Hoffman and Dr Gaffield?

COMMISSIONER: No.

MS McMILLAN: No. Thank you.

COMMISSIONER: I made no direction about that at all.

MS McMILLAN: I take it if we wish to do so, the appropriate course would be to put submissions in writing.

COMMISSIONER: About when they should be called?

MS McMILLAN: About if they should be-----

COMMISSIONER: There would be no submissions either way about that, so if you want to make submissions about that, you are welcome to do so.

MS McMILLAN: Thank you.

COMMISSIONER: Yes, Mr Farr?

MR FARR: Thank you, your Honour.

JOHN BEVAN NORTH, CONTINUING CROSS-EXAMINATION:

MR FARR: Doctor, can I take you to page 24 of your report, please?-- You can.

Do you have it in front of you?-- I have it in front of me.

Thank you. The third dot point you say this: that "Health care delivery in the Fraser Coast Health District is budget driven for crisis management because or due to the avoidance of patient transfer to larger institutions where acceptable care would be available." Now, do I take it that what you are suggesting there is that the hospital has some financial benefit in not transferring patients?-- Absolutely correct. Mr Allsop in his interview - and can I say, Commissioner, that

initially when we arranged the interviews, he did not want to be interviewed. He declined to be interviewed. This is the district manager, who we thought was reasonably important in this exercise.

COMMISSIONER: Yes?-- He did, after seeing our planned approach to it all, decide to be interviewed much later in the day, and during that interview he explained to us that should he have to transfer someone from Hervey Bay to PA, then PA would charge him the cost of transport. So if it was a spinally injured patient needed medical air evacuation, then his budget would be charged for that trip.

MR FARR: Can I suggest to you in fact he said to you quite the opposite?-- No, that's not correct, sir, because-----

Did you make any - sorry, did you make any inquiries yourself of what in fact occurs?-- We took each of these people as though they were telling the truth.

So does that mean-----

COMMISSIONER: What inquiry would you make, Mr Farr?

MR FARR: I beg your pardon?

COMMISSIONER: If the administrative head tells you that's the position, what better source could you have?

MR FARR: Well, the previous Commission has heard quite a lot of evidence on how this works.

COMMISSIONER: I understand that, but from Dr North's point of view, what better source could there be?

MR FARR: Well, I am putting to him that was not what he was told.

COMMISSIONER: I know that, and he has denied that, yes.

MR FARR: Do you have any knowledge on this topic yourself other than what you were told?-- No, I accept the patients at my end because they often come to Princess Alexandra Hospital - in fact often without introduction, meaning the helicopter arrives and we end up having to treat the patient without a proper referral or a reasonable introduction on the phone.

All right, so-----?-- But I don't look into the funding of it, the process of funding and, indeed, it seemed a little strange to me that he should have to pay for that patient.

All right, thank you. In the footnote on page 24 of your report you speak of the administration changing the roster title for the district in the first six months of 2004, then "(possibly after hearing that an investigation was to be undertaken, the word 'consultant' was removed from that title)"?-- And medical officer was put in its place.

Yes, that's the consultant list that we have been speaking about yesterday?-- Correct. Correct.

And do I understand from that that the document was in fact corrected prior to any investigation occurring?-- No, each month there might be a document placed - pinned to the wall, and the document of that month that was pinned to the wall had "medical officer on call".

You see-----?-- It wasn't a previous document changed.

No, I understand what you are saying?-- It was the monthly-----

The nature of that type of document which is generated each month-----?-- Uh-huh.

-----went from being - having a column entitled "consultant"?-- It was a page of A4 on its side.

Yes, and that column was changed to something else, to "medical practitioner", or something like that?-- I think it was "medical officer".

Can I suggest to you that the change occurred in October 2003. Does that - do you have any knowledge of that?-- I don't. I didn't investigate it. I saw one of the previous pages of A4 with "consultant" on it from the previous year and I saw the one that was on the wall on that day.

Can I ask you to look at these two documents-----?-- Certainly can.

-----if you wouldn't mind, for me, please. I will just ask you if you recognise those two documents. I don't mean those particular documents, but that style as the style of the document that you have just been speaking of?-- My recollection is not of these - seeing these documents at all. Again, it is quite some time ago.

I understand that?-- But my-----

Let me-----

COMMISSIONER: Let him finish. But?-- I am - I don't have a perfect memory, Commissioner, but my understanding was that clearly the word "consultant" appeared on a piece of A4. It didn't have "plus medical officer on-call roster". And the one that was on the wall, on the day that we actually interviewed Dr Khursandi, Dr Padayachey, and both Mr Hanelt and Mr Allsop in the room where this was pinned to the wall, because our attention was turned to it by those we interviewed, and we were - we compared what we saw on the wall with what we were given by Dr Mullen, and, truthfully, it doesn't - I do not remember seeing either of those items.

MR FARR: Just to be clear, I am not-----?-- Remember I was there in July '04.

That's right?-- Not November, October '03.

And I am not asking whether you saw the particular documents for October or November of '03 but whether the documents that are before you now are samples of the type that you are speaking of?-- In fact, I doubt it. They do not - because, as I said to you before, I almost certainly saw a piece of A4 on its side.

All right. Well, I will have those returned then. You would, I dare say, agree that if the inappropriateness of the term "consultant" had been pointed out to management at the hospital by, for instance, one of the doctors in town and they subsequently changed that, that would be the appropriate course to adopt?-- Would you say that again, please?

If the use of the term "consultant" in a document of the type that you have been speaking of was criticised by one of the private practitioners and that criticism was brought to the attention of hospital management and they subsequently changed that term in subsequent documentation, you would agree that is an appropriate course to adopt?-- If it was criticised by someone, pointed out that the word "consultant" was entirely inappropriate, I would hope they would change it.

Thank you.

COMMISSIONER: It would be more appropriate, perhaps, never to have put it up?-- It would be much more appropriate never to have put it up because it was a plain lie. They were not consultants, although the word's abused at present in every walk of life, but in the medical arena a consultant is equivalent to - by inference or reality is equivalent to specialist.

MR FARR: All right, thank you. Can I ask you to turn to page 27? And you speak at about line - about a third of the way down the page under the heading "patient care", on the third paragraph in that category, starting with "at interview". You can see that paragraph?-- I do.

And you speak there of "nursing initiated X-rays being common in orthopaedic patients because medical officers could not be found or brought to the emergency department"?-- Do you understand what that means?

I understand what that means. Can I suggest to you, however, that nurse initiated X-rays at that hospital had nothing to do with the availability of medical officers?-- I disagree with that because we were told by nurses who were in charge of that department that that was in fact the case, that they often had to do it because they could not raise or find the people that they needed to sign those X-ray forms. And in the normal practice of medicine, one sees the patient first, introduces themselves to the patient, says, "I am Dr North. What's the problem?" So the history comes first - introduction followed by history. Then if they say, "Well, I have fallen on my outstretched hand", then examination comes third. Now, nurses

aren't - they can take a brief history in the emergency department but they are not qualified, by training or experience, to do an examination. And the fourth thing that comes is investigation. So X-ray requesting is requesting an investigation. Now, none of the nurses felt comfortable doing that. In fact, I would suggest it is probably not legal for a nurse to sign an X-ray request form because it certainly doesn't attract the Medicare benefit.

Are you aware of a system that has been adopted, I understand, in a number of hospitals that employ a triage nurse in the emergency department?-- Yes. We have one at PA.

All right. In this particular hospital can I suggest to you that the system in place allowed the triage nurse, if that nurse complied, with a predefined protocol to order certain X-rays?-- I would think that would be an unsafe use of a registered nurse.

Okay. Putting aside that safety issue, were you-----?-- I think the safety issue is very important because it is best-----

I am just dealing with one aspect of your report for the moment?-- Right.

Were you aware of such a system at the time that you conducted your investigation?-- No, we did interview the emergency department nurse unit manager and she did not inform us that that situation was present. If she was concerned about nurses initiating X-ray requests, would have been reasonable for her to talk to us about that, but she didn't, so can we be sure it actually existed at that time? I doubt it.

Did you raise it with others?-- She was the nurse unit manager of the emergency department. It is not appropriate to raise - organise to - or to interrogate the nurse unit manager of the ward about that.

Well, did you raise it with administration?-- I can't remember every question that I asked the administrators but that was a nursing question in the emergency department and we raised it and discussed it with her.

Did you see any documentation regarding that practice?-- You don't need to see any documentation regarding that practice. It is simply a stated practice and if I stood in the emergency department and watched the process, I would see it. It is not a documented practice even at PA.

All right. Can I take you to page 29, under the heading "record keeping" you say in the second sentence, "The investigators were informed that patients would write ward round notes on scraps of paper which never found their way into the files."?-- We were actually told that from time to time patients wrote notes. I - it seemed incredible to me but if you remember there were two of us as investigators there. This is not an individual thing. There were two

investigators. If both investigators heard that statement, we felt it was prudent to raise it. It seems incredible to me and I have not even seen it in the third world, that this would happen, but-----

Were you told - did you seek confirmation from others in that regard?-- We were discussing this with the unit manager, nurse unit manager of the surgical unit.

Who is that? What's that person's name?-- I can't tell you all the names, and I hesitate to use the names, but they are written earlier in the report.

Well, if we go back to page 5 and 6?-- Yes.

That might assist you?-- I don't want to use a name, Commissioner, on the grounds that I haven't seen her for more than half an hour more than a year ago.

COMMISSIONER: All right?-- Page 5? No, page 6 I have.

MR FARR: Yes. Are you able to tell us which of the persons gave you that information?

COMMISSIONER: If you can't remember, don't-----?-- I can't remember. I honestly can't remember. I know think Gail Plint was the surgical unit manager nominee. I know it says it there but I - the surgical unit is the whole unit, is my understanding. I thought we saw the person but I can't - I can't from that list be sure, I am sorry.

MR FARR: All right. Did that information come from just one person or more than one person?-- It came from more than one person.

Do you remember any of the names now?-- When we talked to the doctors about what happened in the emergency department, they agreed that often X-rays would be there when they arrive, which meant-----

I am speaking of patients writing ward notes on scraps of paper?-- Oh, no, no, no-one else. Only one person informed us of that alleged practice.

All right. And, again, did you raise that topic with anyone in administration?-- No, we didn't, recognising that we had a half an hour with Mr Allsop, there were much more important issues to raise, and we went through the issues that we thought were prudent at the time. If we would have had a week to do this, we might have made a long list, had three secretaries to help us, and possibly even some legal support, but there were two investigators there giving up their Thursday, Friday and Saturday to take this on, and we listened to what we were told and accurately recorded it and accurately and meticulously collated it subsequently.

All right. Did you ask to see any files, any patient charts where the input came from the patients themselves?-- Patient

names weren't quoted in that interview, and, as I said to you before, the only dozen or so files that we saw were the ones where we had a name, a UR number and some appropriate X-rays that we took with us to study on the evening of that investigation day.

All right. So insofar as patients writing ward round notes, you aren't and weren't given particular patient names?-- I cannot confirm it. I cannot deny it. It was a comment and we put the comment in there because we thought it was a very relevant comment, and if it in fact did occur, then our instruction to the Director-General was that it should be investigated. We couldn't investigate it on the basis of time or resources available to us. That would have taken months.

All right. The last sentence under the heading "record keeping", "investigators were told that the administration was aware of the poor documentation procedures but had not attempted to address the problem." Were you given times or dates when administrators were given such information?-- No, not at all.

If the information of that nature had been given to the administrators just a couple of weeks prior to your arrival, you have no knowledge of that one way or the other, is that the case?-- I have no knowledge of that.

All right?-- I can tell you from the documentation in the 12 charts that we saw that it was fairly pathetic.

I am talking about here your statement "the investigators were told". It is the telling, the information supplied to the administrators that I am interested in, you see?-- This came from the administrators, so this is a comment by the administrators about the documentation in the files at their hospital.

Right. So who are you speaking of when you speak of the administrators who gave you that information?-- Dr Hanelt and Mr Allsop.

Okay. Was it the case that when they spoke of that, that they also told you that the information of that nature, that complaint, arrived via email two weeks prior to your review?-- I can't say that I do or didn't.

Can I suggest to you - and this might refresh your memory - that it was suggested to you that they thought it best to leave that for the investigation?-- Do you - well, certainly I can't remember them saying that. I can't remember them offering a file or numbers, or UR numbers to check - for us to check on. I would suggest that if they were sincere and honest about that, they would have had a set of files for us to look at that day. The files we had were ones that we offered names and UR numbers and requested X-rays.

But you didn't ask Mr Hanelt for any information prior to that day?-- You mentioned that yesterday. I can't - because I

haven't seen all the information sent by Dr Beh, but a list was compiled of the people we wanted to interview, the information that we wanted, and it is my understanding Dr Beh sent that to Dr Hanelt a couple of weeks before. I can't confirm or deny that. According to your comments yesterday, Dr Hanelt didn't receive anything and you quoted one email from me the day before we came. Just to clarify that, too, it was an offer by him to actually pick us up at - I think the airport initially and at the motel early in the morning to transfer us to the hospital.

All right. Well, look, I will show you this document, if you don't mind. It is a copy of an email, seemed to be from you to Dr Hanelt?-- Correct.

I will just give you an opportunity to read it. It might refresh your memory?-- Could I say, Commissioner, that the dealing was with the central office and I was not the honorary secretary of the central office so I wasn't necessarily party to all the letters, e-mails that went between Hanelt and Beh.

That's understandable?-- In July 2004.

Thank you?-- "Thank you for arranging. It seems fine from this end", meaning the airline is organised, the accommodation is organised, and I requested to see the district manager-----

Yes?-- -----when we arrive on that day.

Just go to the end of that email that you sent?-- Yes.

Firstly, do you recognise it?-- Yes, that's definitely sent by me. No question.

If you look at the - I think it might be the last sentence, or second last sentence where you speak of, "I won't burden you with the documents that we need. We will discuss that tomorrow", or words to that effect, and it speaks of seeing him "in Maryborough tomorrow"?-- That's right.

So clearly it is the document - a document sent the day before your arrival?-- The day before, yes. It is a courtesy document saying, "Thank you, don't meet us at the plane, we will get a taxi." I didn't say that, but we were thankful-----

All right?-- -----that he would meet us at the hotel and I just think that's a courtesy document. We tried to give him a schedule of interviews and there had previously been a previous schedule. You don't have the previous schedule?

All I am interested in is the comment there you indicate to him you are not going to burden him with the documents you need, that you could discuss that upon your arrival?-- The documents were the charts and UR numbers and we gave him a list of those when we arrived and he said, "I will have them for you this afternoon." That was the charts - because we weren't totally sure whether we would have some more numbers -

UR numbers. The list that we had had some names but UR numbers or dates of birth are very useful. Names are very unreliable.

As you told us yesterday, you were, to the best of your recollection, supplied ultimately with all of the documentation that you requested by - from Dr Hanelt?-- As far as I know, yes.

All right. Commissioner, I won't tender that. That's an attachment to Dr Hanelt's statement, rather than have two copies of the one document before this Commission.

COMMISSIONER: Very well, thank you.

MR FARR: But for the record, it will be attachment TH4.

COMMISSIONER: Okay.

MR FARR: And it can be returned.

WITNESS: Can I just comment, Commissioner, there is a sentence on the second page there that says, "The district manager may be available." So it was no confirmation to us when we met Dr Hanelt initially that he was to be available.

MR FARR: Can I take you to page 30, please? And just the very first line, it speaks of "The SMOs and Director of Orthopaedics not undertaking continuing education to maintain and improve surgical skills."?-- I have got that sentence in view.

All right. Now, I am a little confused. I thought one of your criticisms earlier in your report dealing with Dr Naidoo was the amount of study leave or continuing education leave, or whatever the correct term might be, that he undertook? That is a criticism, as I understand it?-- The amount of leave he took, some of it was classified as study.

Right. So-----?-- Whether it was taken as study, he offered no data to support he was actually at a meeting or-----

But how did - do you know that he did not undertake continuing education?-- He did not offer any of those attendance documents.

But that's not what you say in your report. You say, "The SMOs and Director of Orthopaedics at Hervey Bay Hospital do not undertake continuing education to maintain and improve their surgical and medical skills."?-- We asked all three and their continuing professional development activities.

But-----?-- Do you understand continuous professional-----

Yes, do you understand my question?-- I do.

In your report you make what appears on the face of it an assertion of fact?-- Yes.

Well, what evidence do you have to support that fact?-- Asking the three of them directly what continuing professional development they undertook.

Do you specifically recollect asking any of those doctors that?-- Yes, I did, I may not have used the word "CPD".

Mmm?-- We might have said "continuing orthopaedic education" which was a synonym for it and it's possible to actually check that certainly for the Fellow of the College because he's required to do and maintain records of continuing professional development.

In fact, the AOA keeps such records, don't they?-- Absolutely, yes.

Did you check them?-- No, we didn't.

Before making that comment, you didn't check those, your own association's records?-- I can tell you why, at that, at that time approximately 30 per cent of orthopaedic surgeons used a rather antiquated AOA CPD logbook. Our College of Surgeons had a poor but progressing web site for CPD and most people used the College diary which I've referred to before and I pretty much kept them back to the 1980s. It's very easy then to go through a diary like that and if Dr Naidoo had offered it and said, "Well look, there's where I attended the ASM last year, there's where I attended that COE, continuing orthopaedic education activity.", we were there, I've got any diary here today, it's easy to show where I've been, what I've done. Dr Sharma commented that he was going to a industry driven educational activity and, in fact, left on the same plane as we did that day, the day we left, so whatever the day in, whatever the Saturday morning was, he was going to an industry driven educational activity. You just need to be careful that sometimes the industry driven ones are more a market thing than education and-----

COMMISSIONER: By industry driven, do you mean organised by someone who sells things to be used by the medical profession?-- Correct.

MR FARR: I take it you would have assumed, if not checking particularly, that Drs Sharma and Krishna, as part of their employment package, would have study leave entitlements?-- They did.

I take it that you would have assumed that they would, like most persons in that employ, avail themselves of their entitlements?-- I would.

I take it from the evidence you've given, you didn't check their staff file or human resources file, I think they call it these days, or anything of that nature to see what leave they've taken for what purposes when?-- Yes, we have all those files, all those documents are in Sydney.

All right?-- Every page for the five doctors mentioned.

Right, so did you check those documents?-- We did.

And they did show that Dr Sharma and Krishna availed themselves of study leave?-- It did, but it didn't show where they went, if they went, if they had a document to say they went and there was no record that they offered-----

Mmm?-- -----that said they went.

And did you check?-- I assume Dr-----

Did you take those documents to you to Sydney or were they sent to you subsequently?-- No, the address for all documents was sent to a central Sydney-----

But they were sent to you after your early July investigation?-- Yes, that was our request from the HRM person at Maryborough Hospital.

So when you checked those documents, at what stage that might have been, did you subsequently contact either Drs Sharma or Krishna for documentation supporting what the records show?-- No, we didn't.

Why not?-- We could have contacted every person we interviewed 20 times after the investigation.

What, to try and get it right?-- No, to try and get more information. If you want a Commission, you budget for a Commission and you budget for all the costs of that Commission. If you want a simple investigation, you take two people or appoint two people who are thought to be honest, have basic integrity, reasonably sincere about safety and standards in orthopaedics and you send them there. They do have to get on with all of the other things that they have to do during the rest of their life and so there's not unlimited time, there's not unlimited secretarial help and we didn't have all those options available to us. But we spoke to and believed all that we heard. Now, when I met Dr Sharma with Dr Giblin at the airport on our way home, and he's a very

gracious man, and he introduced us to his wife and his two teenage children, we believed him that he was going to the Gold Coast for an industry driven course. Now, should I have disbelieved him and checked up on that? I mean, this is not an exercise in whether they are truthful or not truthful. We believed that all the people we interviewed were truthful. We didn't go to the nursing union and say, "Can we trust this nurse's honesty?" We believed what we heard, even from the administrators, but when we saw "consultant" in one year and "medical officer" in the other year, our investigation didn't confirm what we heard.

All right. Given that you believed, however, the staff that you spoke to, and I take it you include medical practitioners in that category; that's right?-- I've just said that.

Why do you then, having been told by Drs Sharma and Krishna that they would attend on study leave to courses and-----

COMMISSIONER: He didn't say that, he said that they told him that, unless I misheard him.

MR FARR: Sorry, I must have misheard. I understood that he'd been advised and the records confirmed.

COMMISSIONER: No, no, advised by Dr Sharma and Dr Krishna, I thought his evidence was to the contrary, that he asked them about that and they didn't volunteer evidence about it.

MR FARR: No, they didn't volunteer evidence about it but they said that they had gone on to further education, that was my understanding.

COMMISSIONER: All right?-- The only evidence we had that he had attended was that Dr Sharma was at the airport going to the Gold Coast.

MR FARR: No, I understand that. What I'm asking though is if you took them as honest people, you should have records to show that they do attend further education?-- No, I've received records.

Why do you in your report say that they do not undertake continuing education?-- No, I've obviously misinformed you, we received records for - from HRM for the district that said they took study leave for a period. Now, taking study leave for a period may be like taking sick leave for a period, it does not confirm nor is it evidence to say that the patient is sick.

Right. But then you had the option, if you like, after receiving that documentation, of asking from them for some confirmation but you didn't take that option?-- We had a lot of options and not enough time to do all that you desire.

All right.

COMMISSIONER: We've been around that bush about three times,

Mr Farr.

MR FARR: No, that's all. Can I ask you this: did you go to theatre and watch either Drs Sharma or Krishna perform?-- No. We did, however, ask previous surgeons who had taught, supervised and looked after Dr Krishna in another city in Queensland about their estimates, estimation of particular competencies and that was mentioned in fact before Dr Krishna went to Hervey Bay. These are just small pieces of information that were received, not in a written form.

All right. Now, of theatre staff that you interviewed, do I understand, looking at page 6 again, that would be Ms Dale Erwin, Ms Gail Plint and perhaps the fellow-----?-- No, I don't think Gail Plint was in the operating theatre, I think she was the surgical unit.

I see, all right, and the fellow whose name was omitted and I just can't remember off the top of my head that we spoke of yesterday - Stubs?-- Stubs, that's correct, yes.

Was he surgical?-- He was definitely in the operating theatre.

Theatre, thank you?-- There was the nurse unit manager of the operating theatre, as my understanding, and one of the registered nurses in the operating theatre, that's the - Mr Stubs.

Of the nurses that - well, so, does it effectively mean there were two nurses that you interviewed from theatre?-- Yes.

They would have been people that you would have placed some reliance upon?-- Yes.

When receiving information about clinical competence?-- Yes. In fact, we asked them some simple questions about those and we said, "Who would you go to if you needed an orthopaedic surgeon in this area?"

Did you ask - I take it you would have asked Ms Irwin-----

COMMISSIONER: What was their answer to that?-- Dr Mullen.

Mmm.

MR FARR: I take it you would have asked Ms Irwin, for instance, about their or her view about the clinical competence of Dr Krishna?-- Yes, we went through, we went through all her concerns about health care delivery in half an hour that, you know, what was available in a half an hour.

Right. Did you ask her that though?-- Yes, we asked about all of the operators there and that included the Visiting Medical Officers and the Director.

See, can I suggest to you that Ms Irwin, for instance, was in no way critical of the clinical competence of Dr Krishna, it

was quite the opposite, it was quite complementary?-- That's not the message that we received.

You took notes no doubt?-- We did, and they're available if the Commissioner would like them.

All right. But she hasn't seen them?-- We mentioned that yesterday, that we did not show the written answers that we scribed to the questions that we asked. I didn't see her taking notes at the time, Commissioner, so I think that probably our document is a reasonable assessment of what she actually said, what we actually said.

Now, finally, can I take you again to page 21 of your report?-- Twenty?

One?-- The second sentence on the page?-- Under "Nursing Staff"?

Yes, starting with, "Indeed the clear impression."?-- Yes.

Now, is that an impression, I take it, that you gathered from speaking to the various staff members?-- Absolutely.

Did you receive information to the contrary from staff members on that topic?-- No, we had no support for Dr Naidoo's leadership, if we go through these one by one.

COMMISSIONER: Well, I'm not too sure what "to the contrary" means. To the contrary means that the nursing staff weren't any good or that Dr Naidoo's supervision wasn't any good.

MR FARR: No, no, to the contrary meaning that the orthopaedic unit was not kept going by the nursing staff with the help of Dr Mullen, that that was not correct?-- I'm sorry, you've confused the water even more?

Well, for instance, did you speak-----

COMMISSIONER: Well, you have for me also because there seem to be two propositions in that.

MR FARR: No, I'll clarify. Did you speak to Nurse Irwin Jones about what you say in that sentence?-- Irwin Jones?

About your impression-----?-- Irwin is the name that you used - Irwin was the name that we were given.

All right?-- Yeah, we spoke to everybody, we interviewed all the nurses particularly.

And did she give you information that allowed you together with other information to form that impression?-- Every nurse we interviewed commented on leadership and communication and I think I mentioned that in depth yesterday.

Did she say anything to you that was not consistent with the impression that you were gaining?-- Not, not that I remember

and not that we recorded in our collation, but I'd be happy to have those files delivered.

All right. Yes, thank you, that's all I have.

COMMISSIONER: Thank you Mr Farr.

MR ALLEN: Just one topic arising from my learned friend's cross-examination.

COMMISSIONER: Yes.

CROSS-EXAMINATION:

MR ALLEN: John Allen, appearing for the Queensland Nurses Union. You were asked some questions yesterday by Mr Farr in relation to the situation that might confront a regional hospital management in enlisting the assistance of the College for the credentialing and privileging process?-- Yes sir.

And that process would be applicable in relation to a person who was to be employed as a specialist or as a Senior Medical Officer?-- Correct, and it wouldn't matter whether it was Camooweal or Coolangatta or Princess Alexandra, the same process should occur.

And you've already said in response to Mr Harper yesterday the reason why that process is so important?-- It's a safety reason, correct.

You were asked by Mr Farr to consider the situation where the College refuses to cooperate by nominating-----?-- Mmm-hmm.

-----a Fellow to assist in that credentialing and privileging process?-- Mmm-hmm, I firstly find that very hard to believe, that the College would do that, or that the AOA would do that and it's never, that I know happened, but the thought was use a Fellow of the College resident nearby.

Okay, so if the College failed to nominate someone, that would not prevent the Director of Medical Services, for example, approaching a Fellow who's employed in private practice nearby?-- Seems quite reasonable.

Right. Would there be another alternative which would be to go to a Queensland Health hospital outside that district, for example, approach one of the hospitals in Brisbane to see if a staff specialist could assist in that process?-- Yes, or even a visiting specialist, yes.

Or even a visiting specialist?-- And I would say I've responded to that request on many occasions from Nambour to Coolangatta and west.

Okay, so even if the College was not prepared to cooperate in any formal sense by nominating someone?-- Mmm-hmm.

That wouldn't present any impossible situation for a district manager in that case?-- Would never be an impasse. In fact, I think it's pure heresy to say that the College did not-----

COMMISSIONER: No, but you're asked to assume the situation that it may not, there are other avenues?-- Yeah, absolutely.

MR ALLEN: Yes, thank you.

COMMISSIONER: Thank you. Mr Andrews, do you want to ask any questions in re-examination?

MR ANDREWS: Yes.

RE-EXAMINATION:

MR ANDREWS: Would you please put this page up on the screen? I'm putting to you now, Dr North, a document that had been put by Mr Applegarth to you yesterday. It's part of a memorandum to Dr Steve Buckland from Dr Gerry Fitzgerald?-- Yes. 35.

GF 32 I think it was?-- 32, sorry.

And you'll see the first of the dot points that's been identified by highlight, "The Chief Health Officer has provided preliminary advice to the effect that the issues of concern appear to relate to the organisation and management of the service." Now, of course, this is a suggested speaking point for the Director-General when being asked about the report of which you were a co-author. Is it a fair and accurate categorisation of your report that the issues of concern appeared to relate to the organisation and management of the orthopaedic service?-- Beautiful summary.

Are you, for the record, meaning to suggest that that's accurate or inaccurate?-- This is an accurate summary, the issues of concern appear to relate to the organisation and management of the service, absolutely, and in fact, he goes on in that next sentence it says, "Will require a much more detailed audit."

So you do in fact regard that as a satisfactory summary?-- I think the Chief Health - I think the Chief Health Officer - let me read it again - has provided preliminary advice, so his advice was that the concern related to the organisation and management of the service. That was where his concern lay, I think that reflects our concern and that reflected in our recommendations to the Director-General.

COMMISSIONER: But it wasn't just the organisation and management?-- No.

It was the quality of medical care?-- Absolutely.

Yes?-- But that's under the umbrella of organisation and management.

I see?-- Who appoints these people.

How do they get those people?-- How do they get there? Who advertised? Who said they were okay to come?

Mmm, yes?-- Who went out to actually try and find them?

Yes.

MR ANDREWS: If one were to, when speaking of the report, describe it as a report that raised issues of concern about the organisation and management of the service, wouldn't that be to disguise an essential feature of the report, which was that the organisation and management led to an alarming risk to patient safety?-- Correct.

I have no further questions.

COMMISSIONER: Thank you. Does anyone want to object to Dr North being excused from further attendance? Dr North, you're excused from further attendance. Thank you for coming?-- Thank you sir.

WITNESS EXCUSED

COMMISSIONER: Mr Douglas?

MR DOUGLAS: Commissioner, the next witness is Dr Scott.

JOHN GRANT SCOTT, ON AFFIRMATION, EXAMINED:

MR DOUGLAS: Dr Scott, could you give the Commission your full name?-- John Grant Scott.

And do you - you are a duly qualified medical practitioner?-- Yes, I am.

And are you formally the Senior Executive Director, Health Services of Queensland Health?-- Yes, I was.

That position terminated on the 27th of July of this year?-- I think it was actually the 27th of August but I was gardening between the 27th of July and the 28th of August.

And you reside at an address known to the Commission?-- Yes.

Thank you. Dr Scott, at the request of the Commission, you have provided a statement?-- Yes.

Thank you. The original of that statement is with the Commission. Is that statement dated the 9th of September 2005?-- It is.

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

Commissioner, I tender that statement.

COMMISSIONER: That will be Exhibit number 317.

ADMITTED AND MARKED "EXHIBIT 317"

MR DOUGLAS: There's one qualification that's been pointed out to me in relation to that. Dr Scott, on the face of that statement at one point identifies one of the patients otherwise designated as P26. That person's identified by name. It's appropriate that you make an order that that patient not be identified by name in any press or other media.

COMMISSIONER: I so order.

MR DOUGLAS: Thank you.

MS DALTON: Commissioner, could the memorandum that came from the Morris Commission to which that statement responds to go in as either as part of that exhibit or the next exhibit? As I understand it's been done with other witnesses so it's clear.

COMMISSIONER: What, is that the series of questions?

MS DALTON: Yes, so it's clear.

COMMISSIONER: The series of questions are in fact set out in the statement.

MS DALTON: Yes, we've pulled them out.

COMMISSIONER: But they are in the statement?

MS DALTON: Yes.

COMMISSIONER: Why do you want them separately?

MS DALTON: I suppose there's some other paragraphs in that document.

COMMISSIONER: It seems superfluous to me if the questions are all in the statement. We don't want too many documents, Ms Dalton.

MS DALTON: No, I'm happy-----

COMMISSIONER: If there are any other matters that are raised that aren't in the statement, you can do so later.

MS DALTON: Thank you.

MR DOUGLAS: Thank you Commissioner.

Dr Scott, could I invite you first please to look at section 7 of your statement? Section 7 commences at the foot of page 7 of the document?-- Yes.

In broad terms, the question asked of you in which you respond to concerns the issue of credentialing and privileging of employed clinicians at hospitals?-- Yes.

Thank you. Is it correct to say that the policy of credentialing and privileging is concerned, in broad terms, with the assessment of the clinicians' capabilities and then the matching of those capabilities or competence with the hospital where he or she is based?-- Yes, it is.

You now know the essential facts pertaining to the appointment of Dr Patel?-- Yes.

He was appointed as a senior medical officer in April 2003 at Bundaberg?-- Mmm-hmm, yes.

Do you agree?-- Yes.

You may have to make sure you respond for the shorthand writers as well, thank you?-- Yes.

You're also aware now that he was appointed Acting Director of Surgery within a week or so of his appointment as a Senior Medical Officer?-- Yes.

You also know that he was appointed Director of Surgery in a

permanent role in June of 2003?-- Yes.

You also know that he continued in that role, of course, at Bundaberg, until late March or early April 2005?-- Yes.

You identify the Queensland Health policy pertaining to credentialing and privileging in your statement?-- Yes.

You are thoroughly familiar with that policy?-- I wouldn't claim to be thoroughly familiar, I hope I'm familiar, yes.

Is it a policy which fell within your bailiwick of responsibility which you've fulfilled from late 2003 at Queensland Health?-- Yes, it's one of the overarching planks of our practice.

Is it correct to say in your view that having regard to the content of that policy, Dr Patel should not have touched a patient until he was credentialed and privileged?-- It's certainly my view would be that one needs to assess the credentials of someone in determining in the first instance whether you employ them or not and that will obviously be an assessment against the criteria that you've laid down under the position to which you're employing them, and then in the context of that, their privileging in terms of what they're able to do in the context of the facility that they're working in is determined after that, yes.

Thank you. Could I examine with you for the benefit of the Commissioner the - any time-lapse or lead time that might be involved in that process? To start with you identified the process of credentialing being a matter which ought obtain or be examined prior to appointment of a clinician to a Queensland Hospital?-- I'm probably talking, I guess, in the informal sense, if you like, of the appointment process as per an advertisement, an interview, and then a decision about recruiting someone to the position. Formally, after that, there should be a credentialing process which is associated with within their privileging.

Thank you. And again, I led you to it?-- Yes.

In terms of the lead time that might be involved in that process, for the purpose of the Queensland Health policy, is there any prescription or understanding or whatever the case may be, and I'd like you to speak about that, involved between the time of actual appointment and the time of final credentialing and privileging?-- I think the first thing that you'd have to say is that the time should be determined by safety issues, so you would have to satisfy yourself at the very least when you appointed someone to a position they were able to safely discharge the duties of the position that you've appointed them to.

Let's focus on Dr Patel?-- Mmm.

Knowing that he was a surgeon?-- Mmm.

Or at least for the - appointed for the purpose of undertaking surgery, could you ask my following questions through that process please?-- Yes.

In relation to the last question, I understood you to say that there were safety issues which were involved. In that context, what are the safety issues you are seeking to identify to the Commissioner?-- I think you are wanting to know that the person that you are appointing to that position has got the capacity to deliver services of the level that you are looking to have delivered in a safe way in the environment you are actually looking to deliver them.

By reference to the appointment of a candidate to a position as a surgeon at a Queensland hospital, what is specifically involved in that regard, in terms of dealings with the patients?-- Well, obviously surgery, and from that point of view I think that you would expect to have someone on the interview panel who was familiar with surgical practice and who understood how to assess someone's capacity to deliver surgical practice.

When you identify the interview panel, you are speaking of the panel comprising those who would credential and privilege the candidate in question?-- No, what I'm really - this is what I meant about an informal and formal process. I am talking about the group of people who would have been gathered to assess the applicants for the position, and then I'm expecting that after that there would be a formal process, and I think Dr North has referred to that earlier.

Yes?-- Where you may need to say we've found someone who we think is suitable for this position, but we are now going to have to find an expert appear from somewhere else who can assess them formally in terms of their credentials and determine their capacity to practice within this institution.

To be clear about this then, in terms of the Queensland Health policy was the process of credentialing and privileging to take place before or after appointment?-- I would expect after, from the point of view that you have got to decide the person that you are wanting to credential and privilege is someone who is worthwhile appointing from the point of view of what you think is a field of people who often you can immediately discard.

COMMISSIONER: What happens if you have appointed the person already? I think you are saying the credentialing took place after?-- At that point in time you have really got to get a formal assessment. If you are expecting that they are going to be appointable, then you are going to get them formally assessed. I'm saying there's a group of people who might be the medical superintendent, you might want to have a nursing director in there-----

No, I understand the process of credentialing, it is just I thought you are saying it should be after an appointment. I couldn't understand-----?-- No, after you have determined that the person is appointable.

I see. Not after appointment?-- No.

No.

MR DOUGLAS: Do I understand you to be telling the Commissioner that the process of potential appointment of an otherwise apparently suitable candidate might be going on contemporaneously with the credentialing and privileging process?-- It should all be one continuing process, yes.

Is that to preclude any gap in time between the finalisation of the credentialing and privileging process and the formal appointment?-- Yes.

And perhaps in the meantime the candidate might not go elsewhere, take up some other position?-- Yes. That's always an issue you have got to consider, in particularly provincial areas.

Can I come back them to the question I put to you earlier, if Dr Patel, being appointed to a position to undertake surgery, had not been credentialed and privileged at the time of his appointment, then in your view under the Queensland Health policy then existing he ought not have touched a patient?-- I'd certainly be wanting to be confident that peers had assessed him as being capable of touching patients, yes.

When you speak of peers in the context of surgery, you are speaking of other qualified practising surgeons?-- Yes.

COMMISSIONER: That didn't happen in this case?-- In retrospect it doesn't appear to have, no.

Is that why you said that, "No doubt there had been a serious system failure in Bundaberg.", or is it more than that?-- No, I think that in my view, and I have had some experience not with specialist colleges but with the College of GPs, that you really do need to have a very formal process to assess someone's competence to practice.

Is that what you meant when you said, "There's no doubt there's been a serious system failure in Bundaberg."?-- In terms of this process of appointment, yes. I mean, if I may, Mr Douglas, just say as well I suppose I have sympathy going back to Dr North's testimony as well that sometimes it can be difficult to put together the panel to do the credentialing and sometimes you are faced with a decision as to whether someone should start work. My counsel would be we have got to make sure that person is going to operate safely before they start work, but if we're faced with a position where we get - can't get a peer to properly assess someone, then I guess it's a dilemma that has to be decided at the local level.

MR DOUGLAS: When you say "delimma that has to be decided", under Queensland Health policy could that dilemma, in your view, be decided by permitting the surgeon to commence practice as such without some credentialing and privileging being undertaken?-- I think if you had some sort of finite timeframe in which the person was going to be credentialed and if there was pretty much no doubt in terms of the person's

capacity, if they'd just come from Royal Brisbane where they had discharged their duties and had no evidence against their character or their performance, then you might say that, but I think otherwise if you have got someone who is unknown, I think you need to bring your credentialing process in fairly early.

COMMISSIONER: That would be anyone from outside Australia, wouldn't it?-- Well, again, I have alluded to that in my statement, but, yes, because the difficulty that I found from personal experience is that people coming from overseas, it's very difficult to assess their teaching, to assess the institutions in which they worked, and my personal experience was again with the College of GPs where we tried to draw together panels of overseas trained doctors who had worked in Australia who had demonstrated a capacity to deliver high quality services and then we'd use them as a reference point, so we might say, well, these people are trained in a particular location, they have worked in hospitals in that area and we want to refer this person their CV to them for assessment. But I think that's - perhaps you could say counsel of perfection, but I know from the point of view of my experience that if you proceed down a path and you don't map out the route that you are going to take, you will inevitably get caught at some point along that path.

MR DOUGLAS: You mentioned to the Commissioner a moment ago an exception to the credentialing and privileging process, namely where someone, say, worked at a hospital in Brisbane and, as I understood your answer, was almost a sure thing that they would be appointed. That comprehends the exceptions in question?-- Mmm.

You agree?-- Yes.

And there ought be no exception in your view as a matter of Queensland Health policy as it existed in 2003 in the case of an overseas trained doctor, such as Dr Patel, irrespective of what were his apparent qualifications in surgery?-- I think it's very difficult to assess someone sight unseen and again you are relying on referee reports, and if you are not aware of the referees and who they are, then you have got to question the value of those referee reports. So I think the credentialing process is important, absolutely vital in that sort of situation.

So we can make it clear, therefore, your view is under Queensland Health policy Dr Patel should not have commenced undertaking any work as a surgeon until he had been completely credentialed and privileged?-- My view is that he should have been credentialed and privileged, yes. I mean, I have to add the rider to that that the difficulty is then how you in practice make that happen and I'm just talking now about, if you like, the human face of this, and I know it's difficult because there are two human faces, there's a patient's human face and the administrator's human face, if we are allowed to call them human, and I think the difficulty there is that you have got someone who perhaps on the face of it seems to be a

capable performer and you have got people who need operations. So, I'm saying there might have been some pressure to put a person into work fairly quickly, but my view would be if you have got someone who is from an overseas country, from a medical school that you may not be aware of where you can't be absolutely confident in their capacity in terms of their past performance, then I think you have got to credential them as soon as you possibly can.

If a district manager is under some pressure in the area you just identified, then under Queensland Health policy at the time you would expect that district health manager to go to his zone manager or his or her zone manager or in alternative even up to you?-- Yes.

That would be your expectation?-- Yes.

That would be your expectation because to do otherwise would involve a departure from Queensland Health policy?-- Yes. I mean, I just - if you don't mind, Mr Douglas-----

Certainly. If it answers my question, doctor, please go ahead?-- Just to pick up on that point, I would certainly welcome that. I have-----

You would expect that, would you not, not welcome it?-- I would.

You'd expect it?-- Yes. I would have to make the point, though, that some of the difficulty comes in - and again I refer to Dr North's evidence - that I have written to the College of Surgeons asking the College of Surgeons' current chair to support nomination of college representatives for credentialing committees and he's written back and said that he would support fellows making themselves available but didn't see that it was the college's business to do that. And I have got a copy of that letter, if you like that, but I guess my difficulty with that situation is that taking a local fellow, and this is again counsel of perfection, if that local fellow says that they won't accept someone's credentials or won't privilege them to do certain things in a facility, then there's always the potential for that person to be accused of bias, and I'm certainly more comfortable to have someone who is nominated as a college fellow or college representative ahead of someone who has been perhaps chosen in an ad hoc way.

COMMISSIONER: It's better having someone chosen in an ad hoc way than no-one at all?-- Absolutely.

That's why it's essential to have credentialing?-- I guess I am just adding this in if there are directions that are going to come out of the Commission, I'd certainly like to think that the college would be encouraged to participate fully and to nominate representatives for credentialing committees, rather than saying that that's the business-----

There may be problems for defamation so far as the college is concerned?-- I'm sorry, I will leave that to people more

learned than me.

MR DOUGLAS: To take up the commissioner's point, which I was going to raise with you in any event, that defamation, that legal potential is something, for instance, by way of analogy arose in the case of the North Giblin report; isn't that so?-- Yes, yes.

The reason there was some delay, among other things, in respect of that report is because of concern about defamation in the case of an adverse report by investigating surgeons?-- Yes. I mean, if you want me to answer more fully, I understood that along the way steps had been taken to try to address the indemnity concerns. But I'm saying that in some respects this is an issue for all colleges, and again if I go back to my past experience, not awarding someone a fellowship is, in effect, reducing their rate of pay, is affecting their lifestyle and leads colleges inevitably open to some degree of challenge from people. So it's almost a fact of life, I think, in the current environment, that colleges do need to accept responsibility.

Can I suggest to you that credentialing and privileging is a matter which whilst difficult at times has been able to be fulfilled by Queensland Health, say in the last five or 10 years without too much difficulty?-- Yes, and I don't wish to seem to be saying that it's not a very appropriate thing to do, because I think you are right, it's a policy, it's something that we have to address as part of safe practice, and it's something we have to make sure.

You were present here in the hearing room when Dr North gave some evidence about this towards the latter portion of his examination by Mr Farr at the other end of the table?-- Yes, yes.

He said he'd been called upon many times as it appears to engage in that credentialing and privileging process?-- Yes. I am aware of that. I guess my plea is simply if we could ask colleges to involve themselves more fully in this process, I think it would be of great use to everyone.

Dr Scott, I'm not sure how closely you followed the evidence in these proceedings - I am not suggesting you haven't - but there was evidence given by Dr Nydam of the Bundaberg Hospital suggesting that no credentialing of Dr Patel was apt because he was, in effect, a temporary appointment for about 12 months. Do you have any comment about that?-- Well, first of all, I haven't followed the proceedings too closely. But I think that on the basis of what we have said earlier, whether people are temporary appointments or full-time appointments, I think it's important we know they are operating safely.

COMMISSIONER: You can do a lot of damage in four months can't you?-- In one day.

MR DOUGLAS: Thank you. I will just take you back. Dr Patel, once he was appointed Acting Director of Surgery, indeed

Director of Surgery, your expectation would be that he would be appointed to any committee that dealt with surgical complaints; is that so?-- That would be, I think, what one would expect.

If there was a complaint by someone about some surgical misadventure, then your expectation is it would come to a committee meeting by, among other people, Dr Patel?-- As the Director of Surgery

Could I take you to paragraph 7.3 of your statement. Paragraph 7.3, doctor. If I'm going too quickly, tell me?-- No.

Doctor, you say there that at a later point in time one of the issues pertaining to Dr Patel became known to you, that you examined the measured quality documents issued by Bundaberg Hospital. Do you see that?-- Yes.

Just explain again to the Commissioner what these measured quality documents are intended to demonstrate once issued by the hospital?-- This is, I guess, a process in development. It was an attempt to collect most of the performance information that we have on various facilities - or across all facilities in Queensland Health. It addressed the broad range of issues from infections to laundry services. It's really an attempt, if you like, to collect some fairly in-depth vital signs and as the name suggest, it's really an attempt to then measure the quality of the performance of each of those facilities against those parameters to determine whether there are areas where we believe improvement needs to occur, and we talk about outlier reports where we pick up on people who are outside of what are considered to be the normal range and is that some further work is done to lift those areas of performance.

The measured quality documents issued by Bundaberg Hospital which you examined in about mid-2005, they were for the years 2003 and 2004?-- Yes.

Those documents dictated in respect of each year that there was a policy of credentialing and privileging on foot in respect of clinicians at that hospital?-- Yes. There was a question and I think the box was ticked as to whether you had a credentialing process in place or not, and the indication was that there was a credentialing process in place.

There was no caveat or qualification noted in that measured quality report by those who drafted the report in that respect?-- Not from my recollection, but again what I saw was the summary document and not what would have been the original response from the district.

COMMISSIONER: Are you going on to another topic?

MR DOUGLAS: Yes, I was going to.

COMMISSIONER: We will take a short break.

THE COURT ADJOURNED AT 11.17 A.M.

THE COMMISSION RESUMED AT 11.34 A.M.

JOHN GRANT SCOTT, CONTINUING EXAMINATION-IN-CHIEF:

MR DOUGLAS: Sorry, Commissioner.

MS DALTON: I apologise, Commissioner.

COMMISSIONER: That's all right.

WITNESS: It was my fault.

COMMISSIONER: That's okay, doctor. Yes, Mr Douglas?

MR DOUGLAS: Thank you. Dr Scott, could I take you now to section 8 of your statement. It commences at the foot of page 9. You were asked questions there about Queensland Health policy on complaints management which was issued on - in July 2002?-- Mmm-hmm.

Do you agree?-- Yes.

In paragraph 8.5 you say that, "The Sentinal event and serious adverse risk reports from hospitals were to be reported by staff at the hospital to the district manager who should investigate both the specific event or incident and whether there was any pattern of adverse events emerging." That's part-----?-- Yes.

-----of the policy?-- Yes.

Look at paragraph 8.6 of your statement and you say there, and I will quote, "With hindsight this process did not work in relation to Dr Patel's time at Bundaberg Base Hospital." Could you describe to the Commissioner a reference to any particular events or the process and the policy and the interaction between the two, how you say the policy should have worked in relation to Dr Patel, given facts as you know them?-- I think in the first instance someone's going to have to recognise there is an adverse event occurring. So, I would just like to preface what I say by saying that hindsight is a wonderful thing, and we're very clear what's happened in the past now, but whether in the same situation as the people were in we would have seen these issues, I don't know. But the approach that we were developing within Queensland Health was built upon that policy of 2002. It was predicated upon people recognising that a significant event had occurred and

reporting that event and as part of the development of the processes Queensland Health was putting in place an electronic interface as well to allow people to notify sentinal events or adverse events electronically and that was also giving people the capacity to do that anonymously.

Could I ask you to pause for a moment. I don't want to interrupt your train of thought. You have said to the Commissioner that Queensland Health was putting in place - you were speaking about the policy of 2002. Could you please, if you can in terms of point of time, identify what was taking place?-- Yes.

In broad terms when, up to the time of the termination of your position?-- Yeah. I think the problem with adverse event reporting is that it has been shown internationally that unless you are doing it in the context of a no blame culture, the effect will be that people tend to shy away from reporting adverse events or sentinal events. So, the first thing that you need to do is to put in place a process that ensures that people feel that there will not be blame attached to their reporting an adverse event, either if it's being potentially them who's caused it or, alternatively, if there's a person who's identifying this and reporting it as someone who is peripheral to that point.

Was that policy ever put in place to that event?-- That is certainly what were looking to do and, as I say, we put the 2002 policy in place, but just writing down a policy in the context of what we are talking about here is difficult because, as I say, to actually give the policy any capacity to deliver benefits, we have to recognise that we develop a no blame culture. So, writing the policy and then developing the culture in which the policy can work properly were two separate things, and it was the second part, the creating the culture that we'd been working on since the 2002 policy was written.

Are you seeking to identify to the Commissioner that it's one thing to predicate a policy and another thing to implement that policy at the coal face, so to speak?-- Absolutely, and I'm not just talking about Bundaberg or Queensland, this is an international issue, it's recognised internationally, that unless you have a situation where you have created an environment which attaches no blame to reports and it's seen as a positive thing where you can actually improve patient safety or you can improve process and learn from other people, then there's a natural human response which says, "I don't necessarily want to report this incident."

You identified to the Commissioner that there was or there was to be - I wasn't sure which - some electronic recording-----?-- Yes.

-----of events. Was that a policy which was on foot at the time of your termination?-- Yes.

And when did that come on stream?-- It's been developed

through last calendar year and this calendar year and at the time of my termination the electronic database was actually rolling out across the State and training was being provided to people in its use, and feedback was being gathered from the initial sites where it had been rolled out. Obviously with any information technology system it's got people who like it and people who don't like it. There's an element of getting used to using it. But it was certainly rolling out over this calendar year, probably over the last - my guess is six months.

The fact that it's an electronic record, does that facilitate the review of those records by a central body, namely Queensland Health, Charlotte Street?-- It does, and it's, of course, linked in to the development of Innovation and Workforce Reform directorate and the Patient Safety Centre within that directorate. So, I'm probably confusing you here, Mr Douglas.

Not at all?-- I apologise, but the 2002 policy, we need a culture which - in which that's going to work. Electronic reporting is going to assist that to a degree, particularly with the capacity to provide anonymous reports, but at the same time we need to go out and put other parts of the process in place, and that's really to have a Patient Safety Centre which gives us a local - a capacity to support a local response, and that's why we were funding patient safety officers in each district, so that we could start to say if there's an adverse event or a sentinal event in this particular location, people work in a culture where they feel that they can safely report it, there's a person who is identified as the point of contact that they can go to to report it, there is a process which then escalates that. I have identified in my statement that I believe resolution of these issues is best at the local level and certainly from the patient point of view I think it's been demonstrated internationally that the first point and right at the time that it happens is the best time to engage the patient and to help them to understand what's happened, but we were also putting a process in place which was organisational-wide which would give us the capacity to reflect on both things that might come up - one event here would not suggest a systemic problem, but if we had the capacity to recognise that those evens were occurring across the State, we'd recognise systemic problems, and it also gave us the capacity if we saw that there was a problem in one particular location to organisationally go in and so part it's being addressed, either through funding or professional support for people in that area.

Can I raise two things with you deriving from your last few answers. The first is can I suggest to you that evidence before this Commission suggests, perhaps not surprisingly, that those involved in sentinel events may merely as a matter of ego and natural inclination be disinclined to identify such an event or at least delay its identification. You accept that proposition as something which has to be dealt with in the policy?-- I do, but I'd say that that's such a

complicated issue that I think writing it into a policy will never address that sort of complicated issue. I think it's a matter of within the implementation of our policy how are we going to support peoples' egos, how are we going to support their feeling they are not being blamed but they are part of a team who wants to lift its game across the board. So, I guess I'm just making the point you can't just write those sorts of things into policies. It's actually how you create an environment in which that policy can be enacted and where people feel supported, and I think that the literature around this recognises that most of these things will have a group of people who are come on board fairly quickly with the new policy and will sing its praises, there will be another group of people who no matter what you do will never change and they will be dragged along as the last of the people to embrace the new policy, and then there's another group of people who are influential who you need to engage and get to support the policy development, and that's pretty much the process we had to go through.

Can I raise a second issue with you arising out of your answers, and that's this: there is evidence before this Commission that a number of people - rightly or wrongly; doesn't matter - a number of people feel that they were - I hesitate to use the word bullied, but certainly moved or attempted to be persuaded not to raise issues for fear of retribution. Is that at the very least a factor that has to be built into the policy as well?-- Yes, and, look, if we talk about bullying, I guess I am someone who can speak from some experience in terms of that issue. I think that there is a perception thing that goes on which is two-sided, so I think that people may hear someone wanting to raise adverse issues and feel that that's an attack on them. Equally, someone who raises adverse issues will be sensitive to any criticism and they may see that as bullying as well, and I think that my experience would be that we were very much trying to work towards an environment where people wouldn't feel bullied, where people wouldn't take adverse events being raised as criticism, and, to a degree, that requires development of trust between the various parties, which my experience would suggest takes a long period of time and fairly consistent behaviour to develop. So we were in a difficult environment. I accept what you are saying in terms of people feeling that they may have been bullied. I make the point that we hear that in terms of people being bullied by management, but I think equally it was a two-way street and I think that management felt set upon at times, and I think it was not an environment which was going to be conducive to implementing this policy of no blame in a short time-frame. It was something that was going to require us to just model behaviours over a longer period of time.

Can I take you to paragraph 8.9 of your statement? You note there - 8.9 - you note there, as you have already identified, that "the measured quality reports from Bundaberg did not demonstrate a variation of performance over the period of Dr Patel's tenure." You also say that "the policy is a work in progress." I also note you say, "This approach to organisational performance, one thing would be best considered to represent national level best practice." Dr Scott, given the adverse clinical outcomes which occurred at the hands of Dr Patel at Bundaberg, of which you now know, would it be correct to say that Queensland Health's measured quality reporting policy to date in respect of concerning consistently flawed clinical practice at a State hospital, namely at Bundaberg, is devoid of any utility?-- No, sorry. As a work in progress, I think it has got a great deal of utility. I think if people, through the years, had stopped when they didn't feel that they had any utility because they weren't getting positive outcomes, then we would not enjoy a lot of these other scientific and other advances that we've got over the last century. So what I am saying is that we have been working towards refining the process, and we recognise that at this point in time, it is actually an aggregate of performance across a number of practitioners in each location. And I think if we go to the initial report from the Chief Health Officer, when he went and looked at surgical practice in Bundaberg after we became aware that there were issues, he

still could not find any evidence to say that here we have a stand-out surgeon who has got major issues. So I guess I am making the point that if we are serious about trying to get to a stage where we can monitor the performance of health systems, measured quality reports are a significant step in the right direction, but it is just that we have still got a lot of learning to do to get to a point where we can differentiate, and I think that it may be that it comes down to requiring reports on individual practitioners and their performance in each location, and I think that, again, Dr North spoke about continuing professional development, the issue of accreditation, and I think that colleges are recognising that we need to work towards a situation where peers will assess the performance of peers, and I think in the past-----

On an ongoing basis?-- Absolutely, and I think that what we're finding is that it wasn't enough just to sign up to a three-year commitment to professional development. I think we're starting to realise, as we have in general practice - and I apologise for going back to general practice, but it is where I come from - that we now accredit practices and I think the next step in this process is going to be to require individuals to put forward evidence of their performance or to audit their performance, say every three years for two months, or something like that. I think we're getting to the point where we realise that we have to drill down further to actually identify where the problems exist.

Can I pause there and identify a couple of matters you have canvassed in your statement, I have canvassed with you this morning, the process of credentialing and privileging on the cusp of appointment of a clinician to a State hospital. What you are seeking to identify now, as I understand it, is that there needs to be, in your view, an ongoing process of continuing professional development and continuing peer review to ensure that the clinician so appointed in his or her second, third, fourth or fifth year, et cetera, is still properly credentialed and privileged having regard to changes that might occur, his or her age, the hospital's facilities, or the like?-- Yes, and I think you can't make - these are major changes, and I just make the point again they are not major changes just for Queensland Health or in Australia, they are major changes internationally, but if we look at - Jeannette Young gave some evidence before the Commission - she is the Medical Superintendent at PA - that we have a process in place now looking at infection control which is occurring independent of practitioners through Dr Michael Whitby out there. We have put in place a process of medication management because we recognise that infection and medication errors were two significant issues in terms of clinical performance, but I think that once we put those processes in place, there are other quality measures that we're going to have to develop over a period of time, and the challenge is to do them to a level where they are not intrusive, and certainly where they don't require an army of bureaucrats, while at the same time they give us the answers that we believe we need, and I think we're still defining what the indicators are that

we believe are the vital signs, if you like, of a healthy health care system.

Can I maintain your focus or return your focus to the measured quality reporting which you describe in your statement? Can I take you specifically in that regard to paragraph 8.8 of your statement? Paragraph 8.8, Dr Scott?-- Uh-huh.

What is the "feedback to the hospitals" which you are identifying there on the fifth and sixth lines?-- We had developed the measured quality reports in order, as I said, that they would give hospitals the capacity to judge their performance against a group of peers, and the measured quality reports are stratified according to whether they are large tertiary hospitals or intermediate or small facilities. Then across the range of indicators that we collected information on, we were measuring their performance against their peer groups, identifying where they didn't quite fit within that peer group's performance and where there was need for further attention.

Can you give us an example with respect to Bundaberg how it would be peered?-- It would be peered to hospitals, say like Rockhampton or perhaps to Toowoomba, and we would then collect, say, the post myocardial infarction length of stay in hospital, and then we might say, "Well, the average across all of those peer hospitals is 6.2 days. In Bundaberg, it is 15.3." That's a significant difference at the 99.9 per cent competence level, and we would then say, "We need to understand why you are keeping your patients this long. So that's how you would identify - I mean, obviously hospitals vary. For instance, in Prince Charles people may get kept for a much longer period of time because they have had more significant damage to heart muscle, et cetera.

So when you speak of feedback, are you saying this: that in the examples you gave, Bundaberg, Rockhampton, and Toowoomba as part of the peer group would receive collective information pertaining to all three hospitals, so they could compare themselves with another hospital together with the feedback from Queensland Health in the analysis of the information-----?-- That was our intent. My point in that paragraph, I guess, is to say that that was our intent, but the measured quality reports were drawn into cabinet and were, because of cabinet-in-confidence, not only to be made available to the hospitals to complete the process.

Did Queensland Health develop a policy to the effect that there would be such feedback?-- That's certainly - there is not a lot of point collecting the information if we don't provide feedback, yes.

But that never occurred, at least in the 2003 year, because, according to your knowledge, the documentary information canvassed from each of the peer group hospitals was taken to cabinet?-- Yes.

Do you know whether any attempt was made to disgorge that

information from cabinet to enable the policy to be implemented?-- That was before my appointment, so I can't really talk about the 2003 process.

COMMISSIONER: How did it come to be taken to cabinet? Who was responsible for doing that?-- I think that was a decision taken between the then Director-General and the Minister. So I really - I didn't guess what the decision was based on.

MR DOUGLAS: Your appointment was taken up in November of 2003?-- Mmm.

So that process would have occurred for the calendar Year 2002/3, some time prior to your appointment?-- That's right.

But after 30 June 2003?-- Yes. And for the next year, I was able-----

I will deal with that now?-- Sorry.

You also deal with that in paragraph 8.8. So can you tell the Commissioner what occurred in that year, 2004, which was during your tenure?-- We were able to get reports which were provided in hardcopy to district executives to allow them to look at the reports and what the reports were saying in terms of their performance against their peers, and to identify for them where they needed to direct their efforts as regards improvement. But my understanding was that - my recollection, sorry, was that we provided summary comments only and that it was based on limited circulation. And then the requirement was that the reports were taken to cabinet again.

I am sorry, sir, it might be me-----?-- I am sure it is me, I am sorry.

In 2004 you - this policy was implemented under your aegis, under your control, correct?-- Mmm.

Is that so?-- Yes.

Can you tell the Commissioner why the policy wasn't implemented for the calendar Year 2003/4 in the manner in which you have indicated, that is obtaining feedback or providing feedback to peer group hospitals?-- I think what I was trying to do was to push the envelope a little bit. The previous experience would suggest that the 2004 report should have gone to cabinet. I believe that if you are going to collect the information and you can't give some useful feedback, that you have almost got a process which is not worth doing.

Why wasn't the feedback given to the hospitals?-- In 2004?

Correct?-- Well, it was but it was given in an abbreviated summary form.

Why was that?-- Again, because I - I think I was trying to

get as much information as I could to the hospitals without necessarily having that information go too wide.

COMMISSIONER: But who was preventing you from giving the full information?-- Well, I guess this was done before we sought advice on whether the 2004 report should go to cabinet and when we did, the 2004 report went to cabinet.

MR DOUGLAS: It-----

COMMISSIONER: But at the time you sent this information, this abbreviated information back to the district, who prevented you from sending the full information back?-- No-one was preventing me, it is just that-----

Why didn't you?-- If I had wanted to, I would have had to ask the question of should this first go to cabinet as it had done with the previous report.

And you expected the answer would be yes?-- Yes.

So you tried to outflank that by sending an abbreviated version?-- Yes, I did. Again, I just make the point, and I have - after I left general practice, I did some epidemiology studies, and I have a view unless you use information you collect-----

I am not being critical of you of that, quite the contrary?-- So that was what I was trying to do, was at least to get numbered copies to people so they could see where they stood in relation to their performance with their peer group, and my preference would have been to provide the whole report on the basis that that's how we're going to actually get improvement. But, again, it probably comes back to my earlier comment about adverse incident reports, perhaps in the next iteration it will be easier for us to get the full report out to hospitals, perhaps it is just a matter of gaining trust and realising that people aren't going to link these reports.

MR DOUGLAS: What response would you expect generically from hospitals if the full information was provided?-- I would expect that they would find the areas where they were outliers, where they were outside of their peer group. There may be some people who are outliers because they are performing exceptionally well. In that instance, I would welcome there being mentors for their peers. But, of course, for people who are outliers in terms of poor performance, then there would be an expectation, particularly in the environment where we now have the Innovation and Workforce Reform Directorate, we have got the Patient Safety Centre, and we are also doing work around development of collaboratives that we would encourage people to work with their peer group to improve their performance.

COMMISSIONER: Doctor, can I just go back to the point we were talking about before? Was any explanation given to you by the Director-General or by anyone else as to why the full information went to cabinet and why consequently it could not

go out to the district hospitals? Did anyone say to you why that was so?-- I think it was just that it was a decision of government.

Well, you said it was a decision made, you thought, between the Director-General and the Minister?-- Yeah, well, I take that to be a decision of government.

Right?-- Because I would think that - and I would have to let the Director-General speak - or the ex-Director-General speak for himself, but I think he was probably of a similar view to me.

I see.

MR DOUGLAS: Dr Scott, I want to ask you some questions now about waiting lists. At paragraph 10.8 of your statement you say that the concept of an elective surgery waiting list-----

COMMISSIONER: Just while we are a passing through - sorry to interrupt you, but I just noticed what seemed to be a typographical error in the reproduction of question 9 in Dr Scott's statement. In 9B there seems to be an omission of some words after the word "is" in the first line. I presume it is something like "a shortage of".

MR DOUGLAS: I will have that checked, Mr Commissioner.

COMMISSIONER: All right, thank you.

MR DOUGLAS: Thank you. At paragraph 10.8 of your statement, you say that elective surgery, in your opinion, has been elevated in importance by political decision making to a marker of health system performance. What do you mean by that?-- I think that - and this is a national issue as well - that elective surgery is an area that's mandated in terms of collection of performance information, and so a decision has been taken that the capacity of the system to deliver elective surgery for people in need is one which has been considered by the system at the national level to be worthy of collecting performance information on. So that's really been a decision taken through Health Minister's advisory council, which is CEOs of health departments, and subsequently by the Health Minister's council. So it is one piece of performance information which has been chosen to be monitored and I can understand why, particularly as I get older and I probably will need elective surgery myself at some stage - that it is an area that affects a lot of people. But I guess elsewhere in my statement I talk about the importance of potentially having other lists measured as well, because as soon as you measure something, in effect it demands some sort of action to respond to areas of non-performance, and, you know, I just make the point that elective surgery is measured. There are lots of other things that aren't measured.

The term elective surgery is a misnomer in this context, isn't it? It really is a list consisting of persons whom specialists have determined require surgery?-- Yes.

So it is hardly elective, really?-- Yeah, yes. It is just elective versus emergency, so it is really a time-frame in which the people need the surgery.

Anterior to that list, that elective surgery waiting list, there is a body of persons, a body of patients, prospective patients of the public health system who are seeking an appointment on referral from a general practitioner for a specialist within the system. That's correct, isn't it?-- Mmm.

You will have to answer for the record?-- Yes, sorry.

Thank you. Can I tell you that Queensland Health in this Commission has provided to the Commission, at least for the date of 1st July 2004, now exhibit 267, a body of material comprehending all of the hospitals in Queensland as of that date, which prescribes persons who have an appointment and persons on a waiting list for an appointment for each of those hospitals. Have you seen that material?-- No, I haven't.

Thank you. What I will do is put in your hands a portion of it for the - I have no particular reason for selecting this hospital, but for Townsville. One for the Commissioner as well. Tell me once you have had a chance to peruse that. Can I tell you, sir, that exhibit 267 consists of a series of these. There is no computation of the total, but a series of these in the same format for each hospital within the public health system in Queensland. Is that form of document one with which you were familiar on or shortly after, or some time after, even, 1st July 2004?-- No.

Information of this type, would it be collected under your general control?-- Well, my general control included all of the hospitals, and this information would have been stored within those hospitals. So, yes, in that respect, yes.

Throughout the time of your tenure, from late 2003 until the middle of this year, you were no doubt aware that there was this body of people who were awaiting specialist appointment?-- Yes.

You say in your statement that that was a useful body of information for Queensland Health to utilise for the purposes of allocating resources, among other things?-- Yes, yes.

Well, who in Queensland Health, or what body within Queensland Health would address this information for that purpose?-- It wasn't addressed in the context of the compilation of all of those waiting lists. It was addressed in the context of the need for resources that was expressed from facilities and districts. So it wouldn't be provided as raw numbers, but I would expect, on the basis of what we have here, that the district manager in Townsville would have identified that cardiology was an issue that they needed to have addressed, that their diabetes clinic was an area that they needed to do further development on, obviously their orthopaedics and

general surgery were areas that they needed to address. So it wasn't a matter of using these raw numbers, it was a matter of the synthesis of the needs of those districts that came from raw numbers such as these that we would base resourcing decisions on.

These raw numbers, nonetheless, were an essential component of that process?-- Yes.

Indeed, they were the basal component of the process?-- I would expect so.

If you look at the document still?-- Yes.

Would it be correct to say that utilising the headings which appear on the vertical axis of the document, so to speak, starting with cardiology and concluding with psychiatry, of those one could say that from cardiothoracic surgery down to and including, perhaps, gynaecology, were the surgical side of the list?-- Yes.

So I have done an exercise based on section 267 - let me show it to you - and if there is a mathematical error, no doubt someone will point it out to me. Can I tell you about the document first? What it purports to do is list all of the hospitals within the system and the first column is taken from material otherwise provided by Queensland Health as to the elective surgery waiting lists for each of the hospitals in question?-- Yes.

You will see the total - if my numeracy is correct - for the year is 31,478 persons awaiting surgery, that is who are persons entered on the elective surgery waiting list as at the 1st of July 2004?-- Yes.

You can see what the remaining columns are?-- Yes.

D is just a summation of B and C, and I can tell you that the B and C information is taken from the whole of exhibit 267?-- Yes.

Including the item you have before you from Townsville Hospital. So you will see again, numeracy allowed for, that for all hospitals in Queensland, as at the 1st of July 2004, those patients on what I have described as a waiting list with an appointment to see a specialist is 20,415 persons, and without an appointment is 46,637 persons, a total of 67,052 persons. I will just ask you - I am just telling you about the document to start with. I am not asking you to accept the correctness of it for the moment. I am asking you to assume also that for the purpose of this document, the figures that appear in columns B and C, if you look at the Townsville document?-- Uh-huh.

It involves a summation of those items from the items cardiothoracic surgery, down to and including other gynaecology?-- Yes.

Are you with me?-- That's the point I was going to make.

Thank you?-- Yes.

So all the other items on the list, from cardiology down to and including other medicine are excluded?-- Yes.

Can I ask you some questions about the document on those assumptions? It is correct, isn't it, for the purposes of looking at matters in a surgical context, to exclude those items from cardiology down to and including other medicine because whilst they might result in surgery, it is more than likely that they won't. Is that a correct proposition?-- Yeah - I guess - and I am not trying to be difficult - but I just make the point that probably if you went to some of the areas there, like, say, gastroenterology and perhaps even general medicine-----

Yes?-- -----that there may be people waiting there for endoscopies who could have a polyp removed which couldn't require a colectomy later. So I am just talking about what we call elective procedures rather than elective surgery, and just reflected the fact we need to get upstream of a need for surgery, and that we can sometimes cut that short. So there is an interaction between the top part of the list and the bottom part, and I just make that point in passing.

Accepting that point, that would only augment the bottom half of the list; it wouldn't detract from it?-- Probably, yeah. I mean there may be some people on that bottom part of the list that wouldn't be there if they had-----

Exactly, and it's also correct that those who appear on the waiting lists, what I call the anterior waiting lists with or without appointment, ultimately they may not require surgery?-- Yes. If I can just make a point on that too: we have been doing some work or we were doing some work to look at people who are on waiting lists in the context of perhaps lifestyle modifications, so weight loss, physical activity, smoking cessation, where we were saying look, it may well be that with some simple modifications, some weight loss, the person may not need the hip replacement that they thought they needed.

COMMISSIONER: Yes, I think we're concentrating on the existing waiting lists?-- Yes, I absolutely accept what you're saying, I just want to say there's another area of work in that anterior-----

Of course.

MR DOUGLAS: You make the point in your statement that any general practitioner referring patients to public outpatients would know of this anterior list?-- Mmm.

That's the point you make, isn't it?-- Yes.

And you also say or you make the point that any surgeon working within Queensland Health, a Queensland Health hospital would know that there were patients on waiting lists?-- Yes.

I suggest to you that what any general practitioner who was considering referring a patient to public outpatients would not know is the number of persons on that anterior list?-- I absolutely accept that.

And I suggest to you that any surgeon working within a Queensland Health facility also wouldn't know the number of persons on the anterior list?-- Not in total, no, they may know it for their particular clinic.

And can I also suggest to you that as a matter of Queensland Health policy or disposition, up until the time that you ceased several months ago and certainly during your tenure, that no district zonal or other manager in the employ of Queensland Health was at liberty to reveal such anterior list information to any person upon request?-- Well, it wasn't something that I had directed people not to do. It was not a specific policy and I guess I'd make the point and I think I make the point in my statement as well, that the difficulty for us is that we can't do anything about those waiting lists unless we have a capacity to improve the throughput of the theatres and the throughput of the outpatients consequent upon people being able to be referred for surgery. So even if we were able to make that information available, and I am making the point that specifically I don't think people were directed not to talk about waiting lists for waiting lists. Our capacity to address those waiting lists was absolutely determined by our capacity to deliver elective surgery and in tandem with that to improve our throughput in outpatients.

You have mentioned on a number of occasions and in your statement that your background is as a general practitioner?-- Mmm.

Albeit you have also extensive specialist study areas subsequent to that-----?-- Mmm.

-----in epidemiology, but that background would allow you to say, I suggest, that for a referring general practitioner, in particular, the state of what I've described as the anterior list before you, would be useful information?-- Yeah, probably not even the size of the list, but just a timeframe for that person to be booked into and to see a specialist.

COMMISSIONER: But the length of the list determines the timeframe?-- That's right, but I'm just - that's exactly my point.

Yes?-- I don't think there's any value in saying to a GP there are 700 people on the waiting list, but if you told them it's going to take you 12 months to get an outpatients appointment-----

Yes, but it would be important to know that there are really, in effect, twice as many, three times as many people on the waiting list as the first list, if I can call it that, disclosed?-- Yes, I guess, I mean, that would for me be part of a process that would determine the thing that they wanted to know which was the waiting time for their patient.

Mmm.

MR DOUGLAS: You would consider it an important consideration to better inform your patient who needed referal to a specialist?-- Yes, I guess my point again is if I phoned the outpatients and I said, "I want to get an appointment for my patient.", and they said, "It will be 18 months", that would be the thing that I would discuss with my patient and not that there are 632 people ahead of you.

Is that the sort of information that you can get, to your knowledge, if I was a GP 12 months ago in the Bundaberg district or any other district, Toowoomba district, could I ring the local hospital and say, "Well, how long's it going to take my prospective patient here or your prospective patient to gain an appointment on the specialist list?-- Well, I would expect that people could do that.

Do you know whether they could?-- I don't know with regard to Bundaberg, no.

COMMISSIONER: Or any other regional hospital?-- I would expect-----

No, no, do you know, with respect?-- No, I don't know, no.

No.

MR DOUGLAS: If you were advising your patient who needed specialist referral and you knew this information as to the state of the anterior lists, it may lead that patient to decide to travel to a major centre rather than perhaps a smaller centre in which he or she may live in order to seek that specialist treatment?-- It may do, I mean, the paradoxical situation is that often you can get more quickly seen and treated in a small centre than in a large centre.

It varies from place to place?-- Mmm, that's right.

It might also lead that patient to seek private treatment?-- Yes, yes.

A number of the patients even on the category C list, the least of the lists, are persons who perhaps need surgical treatment such as hip treatment or the like and they need to make decisions about their employment and how they can stay in their employment for a period of time, how long they can put up with their symptoms perhaps if they're in more physical employment; isn't that so?-- Yes.

So that information would enable patients who, say, being impaired at work, to better inform themselves and perhaps their employers and those with whom they're dealing commercially in relation to how they should deal with that particular issue?-- Yes. And I just make the point in respect of that, that Queensland Health had been doing work to develop a prioritisation system, but of course, if you're going to develop an operative system, you need to determine what parameters you're going to base that on, and we'd looked at work that had been done in New Zealand and Canada with a view to saying - and this comes back to my earlier point about referral with people with lifestyle issues as well, that we were saying if we had a truck driver with a cataract who's 49 and supporting a family, then they may be someone who is prioritised ahead of someone who is 89 with a cataract who can be managed within their nursing home.

To be fair, Dr Scott, you're dealing with a situation in your last answer with a person who is actually on the elective surgery waiting list?-- Yes.

And there's prioritisation?-- Yes.

I'd like you to address the position in respect of the anterior list or the anterior position, that is, before one gets on to the list, that's what I'm asking you to address at the moment.

COMMISSIONER: Just on that question, Dr Scott, if you were a GP in, say, Bundaberg and you saw that the official waiting list for patients for surgery, there was approximate 600 people, you might refrain from asking how long it would be, whereas if you knew that it was in fact about 2,600 people, you would be much more inclined to ask how long it would be?-- Yes. I mean, we had made some investments over the last two

years in particularly joint replacements and cataract surgery where we had been able to treat relatively large numbers of people, so I'd still want to know, even though the list is that particular size, what's the timeframe.

Yes, I understand that, but you'd be much more inclined to ask the question if you know it was 2,600 than if it was 600 people?-- Yes, yes.

MR DOUGLAS: Mr Commissioner, I tender that document.

COMMISSIONER: Yes. That will be Exhibit number 318.

ADMITTED AND MARKED "EXHIBIT 318"

MR DOUGLAS: You note in paragraph 10.2 of your statement that the decision to publish what I've described as the anterior list is one for the Minister?-- Yes.

Could you please just explain that in terms of what you've just said? Are you speaking about the publishing of it as a list or the disclosing of that information; can you discern between the two in terms of the Minister's fiat in that regard?-- I would say both. Certainly, in terms of disclosing that information and then in terms of the publication of the list as well, and I'd make my earlier comment, that in terms of disclosure, we're talking elective surgery here, but there are a whole range of other areas as your first document identifies in areas like oncology and diabetes management where one could believe that disclosure of lists for treatment would be equally as important as for elective surgery.

You say in paragraph 4.3 of your statement that the then Minister, Mr Nuttall, had a particular interest in, among other things, elective surgery waiting lists; do you recall saying that?-- Yes, yes.

Are you able to say whether Mr Nuttall during-----

COMMISSIONER: What paragraph are you now?

MR DOUGLAS: 4.3.

COMMISSIONER: 4.3?

MR DOUGLAS: 4.3. You also say in that portion of your statement that you attended together with Dr Buckland and some others regular meetings with the Minister?-- Yes.

I think every week?-- Yes.

Are you able to say whether Mr Nuttall, during your tenure as Minister, was given information as to the extent of these

anterior lists?-- No, I don't know.

Were they ever discussed?-- I would expect that they would have been discussed, but my recollection is that they weren't discussed regularly, so it wasn't a matter of discussing what the anterior list was every week, and I just come back to my earlier point, Mr Nuttall was a very strong advocate for extra funding for elective surgery, and I think the record stands in relation to what he achieved around the $110 million that was put into elective surgery over three years, the $20 million worth of extra elective surgery activity that was undertaken last calendar year, and I just make the point again that until we are able to clear the category 3 waiting lists, we have no capacity to move into the anterior lists, and so we put 100 or the Government put $110 million into elective surgery over three years, shortly before I left Queensland Health we'd done some extra work to look at the cost of addressing those category 3 waiting lists and we believed on the basis of our estimates at that point that we needed about an extra $80 million per year in the budget to do away with those category 3 lists and to allow us to start to move into the anterior lists, so ----

COMMISSIONER: Sorry, you keep going?-- So I just really want to make the point that I understand where you're going with the anterior lists, but I'm just saying that unless you're able to clear the block that exists in the system in the theatres and in the outpatients, that list is really not going to be able to be addressed.

MR DOUGLAS: Dr Scott-----

COMMISSIONER: Can I just interrupt, Mr Douglas?

MR DOUGLAS: Sorry, Commissioner.

COMMISSIONER: Can I just suggest, Dr Scott, that you answer the questions that you're being asked and try not to digress too much?-- Yes, certainly.

MR DOUGLAS: I suggest to you, Dr Scott, that you can think of no good reason why, what I've described as the anterior lists, ought not be published for the benefit of patients, their general practitioners who might be referring them and the specialists whom they might consult?-- No.

Do you agree with that?-- I do.

Thank you. I have no further questions, Commissioner.

COMMISSIONER: Thank you.

MR DOUGLAS: Unless there's some issue you'd like to raise?

COMMISSIONER: Not at the moment. Now, Ms Dalton, is there anyone else who wants to examine Dr Scott apart from Ms Dalton?

MR GOTTERSON: Yes, I would have some questions if your Honour pleases.

COMMISSIONER: Ms Dalton, it would be fairer to your client, I think, if I let others examine him first and then you have a right then to examine after that.

MS DALTON: Thank you, Commissioner.

COMMISSIONER: Does that suit?

MS DALTON: It does. Can I just mention while I'm on my feet, the typographical error that you referred to is actually in the - we just cut and paste-----

COMMISSIONER: So it's in the questions?

MS DALTON: It's in the questions itself.

COMMISSIONER: That's all right.

MS DALTON: I'd take responsibilities for the typos in the answers.

MR DOUGLAS: And I for the questions.

COMMISSIONER: Yes, it's all your fault. Yes.

MS GALLAGHER: If the Commission pleases.

COMMISSIONER: Sorry, who are you for?

MS GALLAGHER: AMAQ, my name is Gallagher, initial S.

COMMISSIONER: Yes, Ms Gallagher.

MS GALLAGHER: I will anticipate, Commissioner, that there will be questions of Dr Scott. The difficulty which I face is that which many of my colleagues is the timing of the delivery of the statement yesterday late in the afternoon. Those persons from whom I accept instructions are by and large surgeons or physicians and at this point in time, while the statement has been distributed to them, I haven't been able yet to take instructions from them.

COMMISSIONER: Well, all I can say at the moment is that I'll let you go last.

MS GALLAGHER: Thank you, Commissioner.

COMMISSIONER: With a right to Ms Dalton to ask further questions after you've examined him, but that's not granting you an adjournment.

MS GALLAGHER: I understand, Commissioner, and one wasn't sought.

COMMISSIONER: Thank you.

MS KELLY: Commissioner-----

COMMISSIONER: And who are you for?

MS KELLY: I'm for Dr Aroney-----

COMMISSIONER: Mmm.

MS KELLY: -----and the Queensland Clinicians Scientists. I'm awaiting further instructions over the luncheon adjournment. I expect to be able to proceed straight after lunch if necessary.

COMMISSIONER: All right, okay, that's fine. Mr Gotterson.

MR GOTTERSON: If your Honour pleases.

CROSS-EXAMINATION:

MR GOTTERSON: Dr Scott, you said a little earlier that Mr Nuttall had a very strong interest and advocacy for the elective surgery waiting lists-----?-- Yes.

-----do you recall that? And you also in answer to a question said that you didn't know if Mr Nuttall was given information with respect to what Mr Douglas has called anterior lists-----?-- Yes.

-----do you recall saying that? I take it by that you mean you don't know if he was given totals, raw numbers, I think you used the expression before, on a Statewide basis for anterior lists?-- Yes.

Am I correct?-- Yes.

And you don't know if he was given numbers for individual hospitals?-- No.

For the anterior lists?-- If I were to guess, I would say that the-----

COMMISSIONER: No, don't guess.

MR GOTTERSON: We don't want you to guess?-- I-----

You are not able to-----?-- I can't recollect, I'm sorry.

Now, indeed, a little earlier in your evidence, you were shown a sheet, I wonder if you still have it, it was part of Exhibit 267? Do you still have it there? It's the one that's headed-----?-- Yes.

-----"Numbers of Patients Waiting for Outpatient Appointment

as at the 1st of July 2004"?-- Yes.

Do you have that document there? Am I correct in understanding your evidence too that until this was shown to you this morning, you had not seen it before?-- No.

Are you able to tell from it, and assuming it is a Queensland Health document, where in Queensland Health this was prepared and when it was prepared?-- No, I can't, I'm sorry.

I take it also from your answer, that you don't recall yourself providing this document or similar ones for other hospitals to Mr Nuttall?-- No, I think I can be very clear, I didn't.

You were also shown this morning, and it was tendered Exhibit 318, that's the document, summary document headed "Waiting List, 1st of July 2004"?-- Yes.

And I take it you hadn't seen that document before this morning?-- No.

And it's obviously then not a document that - well, I take it you can't tell me when it was prepared, obviously?-- No, the only comment I'd make is that I had the pleasure of going on long service leave from the 28th of June 2004 to the 4th of October.

I see?-- So whether it's come through when I was away, but I certainly haven't seen these documents before.

All right. And it wasn't a document that you yourself obviously provided to Mr Nuttall?-- Definitely not.

All right. By way of comparison, I'll ask you to look at one document, it's a sample, and it relates to - or is part of Exhibit 311, and it's one that's headed "Waiting List Reduction Strategy". I wonder perhaps rather than having it put on the screen, whether I can hold it up and ask you whether at that distance it's a type of document that you're familiar with?-- Yes.

All right. And perhaps if I could hand you this one just so you can have it before you and can familiarise yourself with it. That, as I've noted, is for the month of November 2002, and are you able to tell the Commission whether it is a document that deals with what Mr Douglas has called anterior waiting lists as well, perhaps, with elective surgery waiting lists?-- That document is similar to the reports, it's from before the time that I was appointed.

Right?-- But we had similar documents and I'm sure that the formatting was the only thing that changed, but it's similar to the documents that we're provided on a regular basis, but it is really in relation to the category 1, 2 and 3 waiting lists and not the anterior waiting lists.

I'm going to suggest to you that preparation of documents in

the form that I've shown you, the one dated November 2002 ceased in January 2003; do you know about that or not?-- No, well, they may have ceased in this form but we certainly had regular reports when I was there which was about reporting the category 1, 2 and 3 waiting times, the numbers and it was broken down to the facility and sub-specialty level.

And these were what, information that was provided to you?-- To me and to the Director-General.

I see?-- To the other senior executive directors and to the Minister.

MR DOUGLAS: Just - I'm reluctant to interrupt Mr Gotterson, and I apologise for doing so: one of the disadvantages this Commission has at the moment, Commissioner, and I was going to let it lie for a while and hope that it would be cleared up this afternoon, is that we are yet to receive, the Commission is yet to receive from Queensland Health an affidavit which deals with these issues, all of the documents that have been produced thus far and the sequence in that respect in terms of when they ceased in a particular form and when they commenced in another form, so to some extent even Mr Gotterson is forced to cross-examine with an arm tied behind his back.

COMMISSIONER: Mmm.

MR DOUGLAS: Because we really don't know in what form these documents are. This witness is left to, with respect, to guess at when it was he received a particular form of document. It's a rather unsatisfactory situation and the sooner it's remedied, with respect to Queensland Health, the better.

COMMISSIONER: When did you first request Queensland Health-----

MR DOUGLAS: It has been requested on a number of occasions. The last request was made this morning.

COMMISSIONER: No, the first?

MR DOUGLAS: The first during the tenure of your Commission was made, I must say, informally on Thursday last week, but it is a document which, with respect, during the period of the Morris Commission was something which, as I understood it, was but a short period of time away. I don't want to complain about it, but it is unfortunate that the Commission has to receive evidence in this fashion.

COMMISSIONER: Mmm.

MR DOUGLAS: Without having that information before it and really, this witness is asked to guess at his recollection of what form documents were at any particular time. Queensland Health are going to have to remedy this, with respect.

COMMISSIONER: Do you want to say something about that?

MS DALTON: I'll complain about it. We first asked for it in correspondence on the 30th August. We wrote again yesterday. We find it very frustrating - yeah, well, to the solicitors acting for Queensland Health.

MR BODDICE: Commissioner, if I can indicate that it was raised towards the end of the Morris Commission.

COMMISSIONER: Mmm.

MR BODDICE: Steps were put in place, of course, when that Commission ended, those steps ceased. I have been speaking to my learned friend about it and I expect that the statement will be provided this afternoon in relation to-----

COMMISSIONER: What, by 2.30?

MR BODDICE: Well, I hope.

COMMISSIONER: I order that it be provided by 2.30 this afternoon.

MR BODDICE: All right, Commissioner, but it is being attended to, it was something that was, it seems to be occurring.

COMMISSIONER: Certainly.

MS DALTON: Could I put on the record, and I did in the previous Commission: I suspect that there's some reluctance because a lot of these documents are Cabinet confidential, and I don't have to tell you the law about that, but the existence of those documents, even if the contents are not made available to us, the existence of them ought to be acknowledged.

COMMISSIONER: Mmm.

MS DALTON: And I put that on the record in the Morris Commission and I'll put it on the record again.

COMMISSIONER: Thank you. Mr Gotterson.

MR GOTTERSON: Your Honour, in view of the confusion that can arise because of uncertainty about what-----

COMMISSIONER: Would you rather have those documents before you cross-examine?

MR GOTTERSON: I think I should, yes, everyone should see what Queensland Health says they prepared.

COMMISSIONER: Well, it's unfair to you. Do you have any other topics on which to cross-examine?

MR GOTTERSON: No, this is the only topic.

COMMISSIONER: Well, I might just leave that for the time

being.

MR GOTTERSON: Thank you.

COMMISSIONER: Ms Dalton, do you have any other topics to cross-examine before we adjourn?

MS DALTON: No, I don't.

MR DOUGLAS: Mr Commissioner, I have had a free exchange with Mr Boddice about that and I don't have any complaint about that in that regard, but if it's going to be that the document is going to be better presented and finalised if it's half past three or half past four as opposed to half past two, so be it, I'm mindful of your direction, but I don't want to be in the same position again at half past two and neither should this Commission.

COMMISSIONER: None of us do, and the Commission can't proceed further at the moment unless that's produced. Mr Boddice, you appreciate that?

MR BODDICE: I understand that and I will ensure that the best endeavours are put in place for it to be here at 2.30.

COMMISSIONER: All right. Well, I think we'll adjourn now until 2.30.

THE COMMISSION ADJOURNED AT 12.41 P.M. TILL 2.30 P.M.

THE COMMISSION RESUMED AT 3.04 P.M.

JOHN GRANT SCOTT, CONTINUING:

MR DOUGLAS: Mr Commissioner, since we adjourned there has been received from Queensland Health a signed statement of one Michael Carlo Zanco without exhibits but the exhibits are coming. I am told by Mr Boddice for Queensland Health that a further statement from the named individual is forthcoming and should be with the Commission together with the exhibits to Mr Zanco's statement very soon.

The document is not a brief document and no doubt those appearing here would like or may like some opportunity to look at the content of that. The appropriate course in the meantime may be to allow this witness to be - or have this witness examined with respect to other matters.

COMMISSIONER: Yes.

MR DOUGLAS: That may well take up the slack and in turn allow those who need to look at these documents to do so during the course of the afternoon, if that's satisfactory to you.

COMMISSIONER: Yes, that's so.

MR DOUGLAS: Thank you.

COMMISSIONER: Does someone else want to examine?

MS KELLY: It may be I'm next, Commissioner.

COMMISSIONER: You are happy to proceed?

MS KELLY: Yes.

CROSS-EXAMINATION:

MS KELLY: Dr Scott, my name is Kelly. I represent Dr Aroney and the Queensland Clinician Scientists Association.
Dr Scott, you refer in your statement to a no surprises rule. Now, can I suggest to you that there were two no surprises rules operating while you were employed in Queensland Health senior bureaucracy, the first being that of the Minister and the second being that of you and Dr Buckland. Is that right?-- No.

Okay. Can you explain then what, if any, no surprises rule existed between you and the Minister?-- The no surprises rule was essentially to ensure that if there were any question that

an issue could arise which the Minister may need to know about or, in fact, any of the members of the senior executive, then it was preferential to advise people of those issues rather than to not advise them. So, essentially issues that people thought might become problematic or which they felt were worthy of attention would be escalated up the chain and would go to certainly to myself and to the Director-General and usually on the basis that it was better to tell the Minister or the Minister's media advisor. They would be advised as well.

All right. Now, was it part of that no surprises rule that the rider was attached that the surprises, if any, be pleasant ones?-- Oh, I think that wasn't other than in a document that we were developing around indicators for the health services directorate and that was thrown in almost as a throw-away line, that if we are going to get surprises let's make them pleasant ones rather than unpleasant ones.

JG3 I think might be the document to which you refer. Have you got your statement in front of you?-- Yes.

Turn to JG3?-- Yes, that's right, yes.

Some perhaps 10 pages in?-- Yes.

"No surprises, except pleasant ones." Is that the one to which you refer?-- Yes. Tthat was very much a throw-away line.

So the throw-away line then, in effect, meant that the Minister didn't wish to be acquainted with any information introduced to him by the media or the public of which he wasn't already aware unless it was pleasant news?-- No.

Is that right?-- No. No, the throw-away line came at the level of myself and my executive and it was purely if we're going to get surprises, let's make them pleasant ones.

What were you to do with unpleasant surprises?-- Make sure that no-one got any unpleasant surprises.

What were you to do with unpleasant news?-- Make sure that the Minister was advised so that he wasn't surprised by the unpleasant news.

Was it part of your task as a senior - I don't like to use the pejorative term, what's become a pejorative term, bureaurocrat, but if you can accept I'm using-----

COMMISSIONER: It's not a pejorative term in the Inquiry.

MS KELLY: Thank you, Commissioner. That's what I wish to have made clear. As a senior bureaurocrat in Queensland Health, was it part of your task to manage those issues which might, quote, "blow-up", unquote, so that there was no need to acquaint the Minister with any such news?-- No. No, it was my job to acquaint the Minister and then to

manage them and if the Minister directed they should be managed in a certain way, then that was the way that we managed them.

Did you then acquaint the Minister with the public - the potential for public disquiet at disclosures being made by Dr Aroney in the course of November 2003 to the cessation of your tenure at Queensland Health?-- Yes, yes, as appropriate.

You did. On what occasions did you brief the Minister on Dr Aroney's disclosures?-- Oh, on numerous occasions and I briefed two ministers when Dr Aroney first raised the issues in, I think, November of 2003 or December. I was briefing the previous - the - at that time - sorry, Minister Edmond.

Yes?-- And then subsequent to that I was briefing Minister Nuttall.

Yes. And did you advise the Minister that essentially Dr Aroney's allegations being publicly made were in essence false?-- I think what we briefed the Minister was that there were issues around what Dr Aroney was claiming, that there were some elements of what he was claiming which were related to shifts in resourcing from Prince Charles to PA, which were part of established policy and had been part of established policy since probably 2002. So there were no cuts going on there. At the same time we also acquainted the Minister with other aspects of what Dr Aroney was saying around people on waiting lists, but at that point in time and subsequently as we have discussed this morning there are waiting lists which will always exist until we get sufficient funding to take them away. So, it's not a matter of these are terrible things that we can address now, but there will be waiting lists that will exist into the future until we have got sufficient funding.

So Dr Scott, were there any matters which you briefed the Minister - any matters raised by Dr Aroney which you briefed the Minister which were in essence false?-- Yes.

What were they specifically?-- I think Dr Aroney spoke about cuts in funding, which I think he referred to in the 2002/2003 financial year, and then he spoke about another two rounds of cuts to funding which were not cuts to funding.

Now, were these briefings committed to writing?-- I am sure that they would have been.

And do you have possession of those writings?-- No, I don't.

Do they remain in the possession of Queensland Health?-- I would expect that they are, yes. They would be on the formal system.

Thank you. Now, you have said that you advised the Minister that the allegation of funding cuts were wrong?-- Yes.

The essence of Dr Aroney's public disclosures, I suggest to you, was to the effect that people were dying and would die if

these limitations in procedures, if I can use that neutral term, were not addressed. Did you advise the Minister that that was true or false?-- We advised the Minister that particularly there were two elements to this. There was one element which was a list of specific cases that Dr Aroney raised, and we subsequently had those investigated and advised the Minister in relation to the substance of those claims, and then there was a broader claim in relation to waiting lists and people dying on waiting lists which we also advised him about. We found in the investigation of the first group that out of the, I think, probably eight or nine cases that were investigated we could only find one or two where perhaps we could have improved the management of those people. But on the broader issue of waiting times for people and people dying on waiting lists, I think that the advice would have been that while there were waiting lists there would be inevitably deaths, particularly in the area of implantable defibrillators, and this is taken up in the Maher Johnson report that was done, where until we - I think the funding estimate was about $60 million to address all of the people who could potentially be waiting and there was a potential for people to die on those waiting lists.

So, is the latter part of that answer you advised the Minister that the allegations of people dying on waiting lists was true?-- There are people who will die on waiting lists simply because - being something which is of a cardiac nature there is no way that you can avoid people waiting unless you put those defibrillators in, for instance, as soon as they come to the attention of the clinicians.

And the response of the Minister, if any? Was there any response of the Minister to acquire the defibrillators and put them in?-- Well, I think this comes back to my - I mean, the answer is yes but in a limited way compared to the $60 million worth of funding that was estimated to be required. But the question really comes back to the discussion that we had this morning around waiting lists, which is - and this is also the essence of the issue we took with Dr Aroney's concerns.

Sorry, Dr Scott, if can I just stop you.

COMMISSIONER: Now, let him finish. Let him finish his answer. Keep going, doctor?-- The difficulty is there will never be enough resources, so if we put resources of the amount of maybe $60 million into implantable defibrillators, I have already said that we probably need about $80 million a year to put in elective surgery waiting lists, and of course there's - Mr Douglas has shown us this morning there are a lot of people who are on waiting lists for oncology services. I have also spoken about some of the early interventions like colonoscopies that will prevent avoidable deaths. We just did not have the resources available, and it comes down to a decision as to where those resources are going to be put. That was the Minister's decision and I think the Minister took advice from the department as well as making his own calls on where those resources would be allocated. So, I'm sorry, but the short answer is some money was put towards addressing

people waiting for defibrillators and other cardiac interventions, but certainly not anywhere near the level that you would need to commit to stop avoidable deaths.

MS KELLY: Yes. Dr Scott, all I was asking you about is what was the Minister's response, not the defence or otherwise of that response?-- I was trying to explain how he'd come to that decision.

Okay. Thank you. So, Dr Scott, was it any part of your duty to make defence of the restrictive budget of Queensland Health and its impact on the provision of clinical services in the media?-- Put that way, no, it wouldn't be.

You appeared in the media on a number of occasions and I will take you to one in particular. On the 15th of October 2004 you made an appearance on Stateline, the ABC program?-- Mmm.

Do you recall that?-- Yes.

It's CA13 to Dr Aroney's statement, the transcript of that interview. Now, did you tell the truth in that interview, Dr Scott?-- I believe I did.

All right. Can I just explain to you the context? I understand you had recently returned from long service leave on the 3rd of October; is that right?-- Thereabouts, yes.

You had previously in January of 2004 met with Dr Aroney and there had been some acrimony over Dr Aroney's disclosures. That's right, isn't it?-- Yes.

You and Dr Buckland attended a Cardiology Society - Cardiac Society-----?-- Cardiac Society.

-----meeting on the 15th of February 2004 where there was more acrimony. That's right, isn't it?-- I think at the start of the meeting. I felt by the end of the meeting that there wasn't a lot of acrimony at all.

All right. And the Cardiac Society then prepared for and presented to you in the middle of 2004 a comprehensive submission, which is CA2 to Dr Aroney's statement, on the planning for and provision of clinical services for cardiology in Queensland. That's right, isn't it?-- I think it might have been to the Minister because I think the Minister responded to Dr Aroney. But-----

You were aware of that submission?-- Yes, definitely-----

It was a comprehensive submission?-- Yes.

Of which Dr Aroney was the principal authority; that's right?-- I certainly recall that but it was - it went to the Minister.

Following that, at the Prince Charles Hospital there was what Dr Aroney has called a third round budget cuts?-- Mmm.

Reducing the number of procedures from some 90 angiographies or some 90, 80 or 90, to 57?-- Mmm.

Over a fixed period?-- Mmm-hmm.

Do you recall that?-- Yes.

And in protest Dr Aroney made public comment about the impact of those cuts or that reduction on the cardiac patients serviced-----?-- Yes.

-----by his zone?-- Yes.

You went on ABC television and said that you don't see that you were - "We are behind" - we, being Queensland - "being behind any other States in Australia in terms of the number of cardiologists per head of population." Is-----?-- Did I say this?

All right. Let me be fair to you. The interviewer said to you, "Dr Con Aroney is predicting a crisis in cardiac care. He says by international standards Queensland has only one third of the number of cardiologists that it should have. Is that true?" Your response was, "We don't believe that it's true to the level that he's describing it." You go on to compare to Australia generally and say, "So we don't see that we are behind any other States in Australia." Now, was that true? Is that - does that truly represent your opinion?-- Yes. I think Dr Aroney - and I'm sorry but I can't recollect - but I think he said that we needed something like an extra 70 cardiologists in Queensland. Maybe I have got that wrong, but it was certainly of a quantum that we had no capacity at all to recruit to Queensland and we would never be in a position - even with very competitive wages we wouldn't be able to recruit the numbers that we were talking about to Queensland.

Dr Scott, if I can just ask you, is it true that Queensland is not behind any other States in Australia in terms of cardiologists per head of population?-- No, I think I was saying not the level that Dr Aroney was talking about.

COMMISSIONER: That's not the way it was read out, Dr Scott.

MS KELLY: Perhaps if I can put it up - ask for it possibly to be put up on the screen.

COMMISSIONER: Yes?-- Sure.

MS KELLY: I have the only copy to hand.

COMMISSIONER: All right.

MS KELLY: And it's marked. The blue highlighted - the first blue highlight, Dr Scott, is what I've read out to you. I have read out all of it to that point?-- Yeah. Well, I think that's certainly what I said.

It's not true, is it?-- Well, I think when - we see that we would certainly be prepared to accept that we have issues to address with staffing, but really that's an issue for Australia generally, and so the question really is are we behind other States. We probably are in terms of numbers per head of population, but I think when we look at the other factors that we confront in terms of decentralised States, I think my point is we would be prepared to accept that we have issues to address with staffing. I think I go on to say, "I suppose we would say that we are behind but we're not putting lives at risk." I mean, essentially what I'm saying there is we are going ahead with further funding and I think if you look at the record we have done that.

COMMISSIONER: You are saying you not behind in the statement, Dr Scott?-- Well, what I'm saying is I said, "We're not behind any other States in Australia." That sentence there - but the sentence prior to that I have said, "We would certainly be prepared to accept that we have issues to address with staffing."

No, I know, but you still say and you seem to want to qualify that now that, "We are not behind other States of Australia." That's what you say?-- Well, in terms of that sentence, I guess, yes, that's a sentence that I would say is not correct.

So you accept that now that that's not true?-- That sentence is not correct. I guess I'm saying I would put it into the context of the two paragraphs that are there around it.

Well, I can't see how the meaning of that sentence changes by reference to what's around it?-- No, well, I will have to accept that. I will have to accept that, Commissioner.

Yes.

MS KELLY: In relation to the second highlighted excerpt, "We really feel that the services we are delivering at the moment are not putting any Queensland lives in jeopardy.", now, that isn't what you really felt because you have told us following evidence you gave this morning that, "The services we", Quendland Health, "are delivering at the moment were, in fact, putting Queensland lives at jeopardy." That's right, isn't it, because people were dying on waiting lists?-- Yes, but again-----

Thank you?-- I would probably stand by what I said about all other States in Australia as well.

COMMISSIONER: No, no, but the point is whether, in fact, the services that Queensland is delivering at the time you made those statements are putting any Queensland lives in jeopardy and you just said here that they were?-- Yep. Okay. Well, look, I will accept again that as a basic sentence taken as it's written it's not correct.

Taken in context it's not correct, in the context of anything

else you have said there is not correct?-- Well, again, I guess I will have to take your view of that, Commissioner.

All right. Well, you don't have to. You can explain to me why I'm wrong?-- Well, as I have said before, I have tried to qualify in terms of the staffing issues and I think without getting into a great level of detail, as I have said, we also have to put this into the context of resources being scarce, allocation of those resources across a whole range of issues.

You don't say that. You just make a royal statement there the services are not putting Queensland lives at risk and that's not correct?-- No, and I accept in the context of the print that's in in front of me that it is not correct, but I'm just saying to you in the context of what I knew I believe that there is a different picture which needs to be presented in the context of scarce resources in the context of decisions around implantable defibrillators that are not being made by any State in Australia as well. So if we are putting lives in jeopardy, then every other State in Australia was putting the lives of all of their populations in jeopardy as well.

MS KELLY: Well, you see, I want to suggest to you, Dr Scott, there was a concerted spin being placed on the lack of procedures or the cut in procedures available to Queenslanders and that was to suggest constantly that this was an Australia-wide problem and if you looked in any other State you will find exactly this same circumstance there, and this is the line that you have produced on Stateline-----?-- Well-----

-----to suggest that Queensland is the same as all the other States?-- Well, again, I would have to say I have said that we have got issues to address with staffing. I have also pointed out that there are other States in Australia where they don't have policies for implantable defibrillators and I have also spoken about resource allocation and scarce resources and they are issues for the other States in Australia as well.

Well-----?-- Perhaps-----

Sorry, I want to suggest to you that they are not issues for the other States to the degree they are in Queensland. Is that true or not?-- They probably aren't, but again I'd have to say we have the most - probably the most decentralised State in Australia. We have a significant proportion of indigenous people in our State who are living in remote communities. We have got some of the highest rates of smoking and obesity in the country and we have been endeavouring to address those. So it's a multi-factorial issue and part of the argument that we were putting was the solution to this is not purely more angiograms and stents.

In fact-----?-- It-----

In fact, the Cardiac Society had told you as early as the 15th of February that Queensland had the worst coronary heart

disease outcomes of all the major States?-- Yes.

And that was attributable in large part to a lack of cardiologists?-- I absolutely disagree with that. I mean, I haev just said to you that it is not attributable in large part - it is attributable in large part, and I go back to the evidence of Dr Keith McNeill, that if-----

Sorry, we may be at cross-purpose?-- -----we were dealing with smoking we would not need to have the Prince Charles Hospital there. I absolutely reject that.

We may be at cross-purposes, Dr Scott. I'm not asking you whether you agree with me what the Cardiac Society told you. I'm asking you that is what they told you in February 2004?-- Again, I'd have to see what they have said because that's such a difficult proposition to put because as I said, Keith McNeill was recognised that the solution is not cardiologists.

All right. Just before we leave, we will come to what you were told in February 2004. Just before we leave this, I want you to look at the last paragraph on the screen - sorry, where it says, "We seem to be accused of cost cutting." Do you see that blue highlight?-- Yes.

Now, what you were asked by the interviewer was, "There are a reduction in the number of cardiology procedures at Prince Charles Hospital"?-- Yes.

And you said, "No"?-- And I still stand by that.

All right. All right, we'll come back to that. You said, "No", and then answered a question about cost cutting?-- Yes.

All right. Which isn't the same as procedure cutting. It's not the same thing, is it?-- No.

And you answered the point by saying, "We're transferring to other hospitals", in effect, and then ended up by saying, "And perhaps that's part of the reason why we're having this debate." Now, I suggest to you that that was clearly to implicate Dr Aroney as being Prince Charles-centric, if I can use that phrase, in protecting his own turf. Is that what you were intending to do when you answered that question?-- No, I think what I was endeavouring to do was to respond to an attack from Dr Aroney.

Yes?-- On me. So I didn't initiate an attack on Dr Aroney. I think what happened was Dr Aroney went out to the media first and took the issues to the media and I was responding to allegations like I was prepared to sit in Corporate Office and didn't care if people were dying. So what I'm saying here is we are not cost cutting. In fact, we have increased the investment that we've made in cardiac services significantly and we are not about cutting costs or cutting funding to Prince Charles; we're about expanding cardiac services across the state. Then when we come down to the issue of reducing cardiac procedures at the Prince Charles Hospital, I'm being accused of cost cutting because I've reduced the procedures, and what I was saying was, "No, the base budget has always been predicated upon 57 procedures." We increased the funding for procedures in 2004 as part of the increases in funding that came for elective procedures but the baseline always remained at 57. I hadn't cut the baseline funding. I hadn't cut the funding to Prince Charles, and in fact across the state, and I've highlighted this in my statement, we had increased services for cardiac care.

Dr Scott, I'm suggesting to you that you were indeed responding to what you perceived to be an attack by Dr Aroney on you?-- Mmm.

And you did that by identifying his concerns as being turf protection type concerns in protecting Prince Charles and at the expense of other districts; is that true?-- I was making the point that I didn't hear Dr Aroney talking about the increases in funding that were going to cardiac services at the PA, at the Gold Coast and Townsville or the increased number of procedures that we were doing across the state. All I heard about was what was happening at Prince Charles.

Dr Scott, nowhere in the interview is it indicated that

Dr Aroney had attacked you. So what is the basis on which you say you were responding to an attack by Dr Aroney on you?-- Well, again, I'm making the point that Dr Aroney has gone to the media and said, "Queensland Health administrators did not care if people died", that we're about protecting budgets, and I think-----

Did you identify that as an attack upon you personally?-- Well, as the person who was responsible for health care services in the health services directorate at that stage, as the person who Dr Aroney earlier in the year had accused of bullying, I thought it was-----

Sorry, can I get you to answer my question. Did you identify that as an attack upon you personally?-- Yes.

All right. Now, if I can come to the interviewer's next question it was a reduction, it was true, was it not, that Prince Charles had put in place a reduction in services from 80 to 57 per week or per fortnight?-- No. No, as I said before, the baseline activity was 57. The baseline activity had always been 57. For a period of time the activity increased with the funding that came in the elective surgery allocation and then - as with the previous round of costs, as Dr Aroney referred to them, people were being asked to come back to their baseline level of funded activity, which was 57 procedures per week.

COMMISSIONER: This is just playing with words, Dr Scott. They were reduced from 80 to 57. You have explained the reasons why they have been reduced from 80 to 57, but they were in fact reduced?-- Well, I guess that's-----

Isn't that right?-- Commissioner, I have got to accept your view of the words-----

No, no, don't accept my interpretation; just answer my question?-- They weren't - they weren't reduced. They had increased and they were coming back. Now, I'm sorry, if I sound like I'm playing with words. I apologise sincerely.

At one point in time there were 80 cardiac procedures performed at Prince Charles Hospital. At a later point of time there were 57?-- Yeah, I mean, without wanting to play with words, I would rather say-----

A lot of them transferred and brought back to baseline, you have said all that?-- For a period of time we increased the procedures that were being done.

Yes, yes, but in the long term, they were reduced from 80 to 57?-- No, in the short-term they were increased from 57 to 80. I apologise.

All right. They were 80 at one point?-- Yes.

All right. They were reduced from that to 57?-- I can't argue with that interpretation but I guess the-----

All right?-- -----interpretation-----

But you say they had already been increased from 80 to 57 and they were brought back to baseline?-- Yes, and the interpretation I was trying to get across to Kieran McKechnie on Stateline was we are not about funding and cutting. We have for a period of time increased-----

But you didn't say that. You didn't say that?-- No, well, I'm sorry, I'm demonstrating today how on the media as well, sometimes I can't say exactly what I would like to say but the intent was very much we have not cut services.

All right.

MS KELLY: Well, I suggest to you, Dr Scott, that your intent was to identify Dr Aroney as the source of false information and the source of unfair criticism. What do you say?-- Well, I don't accept that.

Could the other document be put up, please? It's the document going on to the screen now, is CA8. That is the attachment CA8 to Dr Aroney's statement. Now, these were what passes for minutes of the meeting of the Cardiac Society on the 15th of February 2004 at which you attended with Dr Buckland. Do you recall the meeting?-- Yes.

Do you recall there was - you said initially there was some controversy but by the end it seemed to be rather less controversial; is that right?-- Yes.

I suggest to you that's not right but we'll come back to that. You were advised in the course of a meeting by numerous speakers that Queensland had the worst coronary heart disease outcomes of all the major states?-- Yes, yes.

Yes. And you were advised of inordinately high rates of death in northern and central Queensland centres?-- Yes.

Which have no staff cardiologists?-- Yes.

All right. And so, when you said earlier that you had not been so advised, you were wrong?-- I had not-----

I asked you earlier was it not the case that the Cardiac Society had advised you as early as February that not only did Queensland have the worst outcomes in Australia but that this was attributable to a lack of staff cardiologists?-- No, I - I absolutely reject the interpretation that what that says is that those deaths, inordinately high in northern and central Queensland centres have no staff cardiologists - that the cause of inordinately high deaths in those centres was no staff cardiologists.

COMMISSIONER: I agree with Dr Scott about that. I can't see that you can draw that inference at all.

MS KELLY: Thank you. Thank you, Commissioner. I take you to a further document. I'm going to take the witness to CA2, which is an attachment to Dr Aroney's statement.

COMMISSIONER: Can you put that up on the screen.

MS KELLY: Which is too large to put on the monitor.

COMMISSIONER: Right.

MS KELLY: But, Dr Scott, just let me ask you: do you recall having seen the cardiac submission which, as you mentioned earlier, was addressed to the Minister; it claims to also be addressed to you and to Dr Buckland and to the Premier?-- What was the date again?

29 July 2004?-- Well, as I say, I was on long service leave at that stage.

Oh, okay. So does that mean that as at the 15th of October 2004, when you were on Stateline responding to Dr Aroney's assertions, you hadn't read the Cardiac Society's submission?-- I can't recall. I mean, I don't know whether - I certainly wouldn't have received it when it was delivered because I wasn't there. Whether I read it after that, I don't know. I mean, I was aware of these sorts of interpretations before being told on the 15th of February 2004 but I don't know what that document says.

Have you read it now?-- If you could - oh, I have but not recently. If you would like to tell me what specifically you're referring to.

Well, there is no point me putting to you what it contained and what inference - what knowledge you had arising from it in October if, indeed, you hadn't read it?-- As I say, I may have read it.

MS DALTON: Commissioner, just in fairness, could the witness see that? It is a big document. It is Exhibit 2 to the affidavit which is Exhibit 263 in these proceedings.

MS KELLY: Sure.

COMMISSIONER: Yes. Exhibit what was it?

MS KELLY: CA2.

COMMISSIONER: CA2. What did you want him to see, Ms Dalton, the statement?

MS DALTON: CA2.

COMMISSIONER: Is a statement?

MS DALTON: It's Exhibit 2 to Dr Aroney's statement. Dr Aroney's statement is 263 in these proceedings.

COMMISSIONER: Yes. You want him to see Dr Aroney's statement?

MS DALTON: No, I want him to see the thing that is CA2 to that. That is the second attachment-----

COMMISSIONER: The second attachment. Perhaps - Ms Kelly, can you show him your copy. We don't seem to be able to locate it at the moment.

MS KELLY: Certainly. Mine is marked at the moment but just ignore the marks.

MS DALTON: I have got one with writing all over it too so I don't know-----

COMMISSIONER: No, no, don't worry. Did you want to ask him any questions about that, Ms Kelly?

MS KELLY: No, because he hadn't seen it.

COMMISSIONER: Oh, just leave it to Ms Dalton to ask questions about that. You can hand that back.

MS DALTON: Sorry, I just wasn't sure that he was saying that he hadn't seen it. He was saying-----

COMMISSIONER: No, he doesn't know whether he had seen it or not. He didn't seen it by the time he went on that program or not, he wasn't sure. No, he was uncertain about that.

MS KELLY: Dr Scott, at paragraph 19.15 in your statement you say that you later wrote to Dr Aroney, now this is later, being after the meeting you had with him of the 8th of January referred to in the three preceding paragraphs. So you'd later wrote to Dr Aroney saying, "You would appreciate the Cardiac Society's view on how they believed we should allocate funding in the south-east corner. He did not help us with there. He replied asking for staffing numbers, budgets, numbers of patients." Now, that's not true, is it?-- Yes, it is.

Dr Aroney in fact chaired the meeting of the Cardiac Society on the 15th of February?-- Mmm.

At which you and Dr Buckland attended, which meeting was expressly called for the purpose of gaining consensus amongst the Cardiac Society members as to those issues?-- No. If I can give you my recollection of events?

Yes?-- I wrote twice to Dr Aroney saying, "I'd appreciate the Cardiac Society's view on how they believed we should allocate funding in the south-east corner." Dr Aroney wrote back to me and said that he wanted advice on staffing numbers, budgets and those sorts of things. I then said to Dr Aroney, "We would like to meet with" - this was in a letter, "We would like to meet with either the Cardiac Society executive or the full membership to seek their views on these matters", and then consequent to that letter, Dr Aroney organised the

meeting with the Cardiac Society.

So he did help you with it. He did help you with it by organising the meeting so it could be discussed and the subject of consensus?-- Well, that's your interpretation. My interpretation is he didn't help me and I therefore wrote back to him again and said, "Could you arrange a meeting for us with your executive or with your full membership."

All right?-- So perhaps he helped me at that point in time. He certainly didn't help me with my first request for advice.

This request being after the meeting of the 8th of January and before the 15th of February Cardiac Society meeting?-- Yes.

Okay. Dr Aroney then was the principal author of a document which - to which we have just referred, a lengthy document CA2?-- Yes.

Delivered in July, which you're not sure you read. You can't now recall?-- No, I can't recall-----

If you read it and when you read it?-- That's right.

All right?-- Can I just add though that subsequently Queensland Health has worked at cabinet direction to develop a statewide cardiac services plan and the Cardiac Society's submission was considered in the preparation of the plan for development of the cardiac services plan. Dr Aroney, as representative of the Cardiac Society, was invited to a meeting to develop up that plan in May of this year and will be continuing to be part of the process of developing that plan for delivery to cabinet I think probably in November or December.

Thank you. If we can come back then to the matters that proceeded your first acrimonious meeting with Dr Aroney, you were acting in your senior position from early November?-- Mmm-hmm.

And were confirmed in that appointment late November 2003; is that right?-- No, I was acting from late November - or early November 2003.

All right. But in that capacity, you received from certain persons in cardiology a document CA4 to Dr Aroney's statement, a submission, being a submission to inform about the crisis in cardiac care and funding?-- Mmm.

And seeking additional funding?-- Mmm-hmm.

And that document was dated the 24th of November 2003?-- Mmm-hmm.

Do you recall having seen such a document? It's one you would have-----?-- No, not specifically but I'm sure I have read.

You would have read in preparation of your statement?-- Yes.

All right. And in that submission, the request is made for funding of six to seven - 600 to $700,000 to take up the slack as it were in unmet demand so that an additional 188 procedures could be performed. You agree with that?-- Yes.

Yes. Notwithstanding that - notwithstanding that submission, no additional funding was forthcoming, was it?-- Not at that point in time, no. Additional funding was provided the following calendar year.

In fact, you made no response to this submission, did you?-- I'm sure I would have because I always responded to submissions.

All right. You deny though in your statement - I'm sorry, I'll withdraw that. Dr Aroney was then motivated to write to the Premier in December 2003 and somehow the job was given to you to go meet with Dr Aroney. Who gave you that task?-- I think it was probably a discussion between the Director-General and the Minister.

All right. And what was the nature of your instruction from the Director-General and the Minister?-- To go and meet with Dr Aroney to listen to what his points of view were and to put our points of view.

Was it part of your instruction to see if common ground could be reached?-- I don't think it was explicitly put but obviously if you can reach common ground, then that's a good outcome.

Was it part of your brief to bring back recommendations, if any were necessary, for further funding?-- I don't think that would have been a specific recommendation because obviously our decisions on funding were not going to be predicated upon that one meeting, and they would not be predicated upon a meeting that I had with Dr Aroney. They'd be predicated upon submissions from the Prince Charles Hospital district.

Are you able to say whether you made any response to the CA4 submission of the 24th of November 2003 prior to this meeting?-- Look, I'm not sure but I would imagine that I would have because I wouldn't have liked to have left a submission sitting around unresponded to for that period of time if I could have, but I could have.

We're only talking about a five or six-week period?-- Well, five or six weeks is a long time.

All right?-- And particularly when Christmas intervenes when I would be trying to tidy up my paperwork.

Yes. Dr Aroney's letter to the Premier CA5 was dated 16 December 2003 and in that letter Dr Aroney identified some severe problems and three deaths which he said arose out of those problems; do you recall that?-- Yes.

Now, you didn't speak to the Premier about that. It was only the Minister and Dr Buckland; is that right?-- Yes. The Premier didn't often speak to me.

All right. So when you met with Dr Aroney, you telephoned him and asked him to meet with you. That's right?-- Yes.

And he brought Dr Galbraith?-- Yes.

Your opening words in the meeting - this is the meeting you've told us was to hear Dr Aroney's concerns and express your own - were "your letter to the Premier was offensive to Queensland Health and personally offensive to me". "You made a lot of cheap shots". That's right, isn't it?-- I'll have to take your word for it. I don't recall the exact words that were used.

You said words to that effect and you recall that, don't you?-- I'm certainly happy to say that I - I could have used words like that. I just don't recall using them but I'm happy to accept that I may have said something like that, because as we discussed earlier, I did find it personally offensive that I was being accused of not caring if people died.

Just have a look at the minute of that meeting signed by Doctors Aroney and Galbraith.

MR DOUGLAS: CA6?

MS KELLY: Yes, CA6. Now, ignore the markings, Dr Scott, I apologise for those?-- Mmm-hmm.

Is that an accurate record of the meeting?-- I don't know. I mean, my recollection of it is not as good as Dr Aroney's obviously, unless he's recorded it.

Well, he evidently has recorded it?-- Yes.

This is a minute?-- Well-----

If you would move down to the bottom of the page, you will see Doctors Galbraith and Aroney having initialled it at the bottom. Do you see that?-- Yes.

All right. So you accept then that you said to Dr Aroney, "You come after us and we'll come after you."

COMMISSIONER: He accepted that in his statement.

MS KELLY: Pardon?

COMMISSIONER: That's contained in his statement.

MS KELLY: Yes. Yes. Dr Scott, you say in your statement, where you acknowledge having made that claim, that what you intended to say was that - what you intended by that statement was that Queensland Health would respond in the media should

Dr Aroney continue to make disclosures to the media?-- Mmm-hmm.

Is that what you think that means?-- I think - I may have made the point in here but it was really meant to say, "This is not a simple matter of funding for Prince Charles if we're talking about a comprehensive cardiac plan for Queensland. And if you are going to continue to come after Queensland Health and say that Queensland Health is cutting funding to Prince Charles, then we're left with no choice but to respond, and if you're using the media, we're going to have to respond in the media."

So that's what you mean by saying, "We'll come after you"?-- Well, if - if I've said that one line and then not spoken more with Dr Aroney about what I meant by it, then, yes, that's what I have said. But I'm fairly confident that we had a discussion about my perspective on it which was this is broader than angiograms and stents. This is about prevention of disease. It's about early management of disease. It's about early diagnosis or earlier diagnosis. It's about cardiac rehabilitation. It's about management of heart failure. Cardiac care is not just about coronary arteries at Prince Charles.

Now, you were aware through public controversy at a much later time, weren't you, that Dr Aroney regarded you as having threatened him by saying, "We'll come after you"?-- Well, the day after, yes.

Yes. Now, did you telephone Dr Aroney and assure him that that had not been your intention?-- When someone's just gone to the media to announce that you're a bully, my view is not that phoning them is the best way to go because I would think that then I'll be seeing myself in the media the next day as having continued the threats. Our - our view of the interaction was obviously not a shared view-----

COMMISSIONER: But you'd agree in retrospect that the interpretation which Dr Aroney put on that statement was a reasonable one, "We will come after you"?-- Well, not in terms of what I knew I was saying. I didn't think it was reasonable then to say that I was bullying him.

All right.

MS KELLY: All right. So the 8th of January meeting ends acrimoniously. Dr Aroney doesn't feel persuaded and writes to the Premier on the 25th of January of the same - of the same year?-- Mmm-hmm.

Three weeks later. CA7. In that - in that letter, refers again to people dying on cardiac waiting lists, "Since my earlier letter to you, another three patients have died on cardiac waiting lists." That he exposes to the Premier the assertions you've made to him in the 8th of January meeting. What was your response to that letter?-- To the Premier?

Yes. Did you become aware of this letter to the Prime Minister?-- Yes, I did and I think the Director-General and the Minister gave an undertaking that we would investigate those three deaths.

Right. But you became aware that the Premier had been told at least that you had accused Dr Aroney of cheap shots and that public allegations were made that he had lied?-- I don't know about public allegations-----

Did you respond to those?-- -----were made that he had lied.

Okay?-- But, certainly, I discussed the letter with the Minister at that stage-----

Yes?-- -----Wendy Edmond, and that was when the decision was made to go ahead and make the - to do the investigation.

And the decision on the broader issue, people dying on the waiting lists, there was no decision with respect to that?-- I think I've already explained that we were in the process of developing a comprehensive cardiac plan, that we had moved funding across the PA, that we were expanding services at the Gold Coast, so we believed that we had a process in place to increase our investment and I think for this financial year there has been an increase of some 17 million in cardiac services across the state. But I think you need to realise that it's not a matter of we can turn on services overnight. We had a plan which we were developing which was going to respond to these allegations but, clearly, we couldn't respond as quickly as Dr Aroney wanted us to and, clearly, he wanted funding to go into Prince Charles at the very least.

Now, Dr Scott, forgive me if I've misremembered this but I think I recall you saying this morning that you personally didn't have any reason or believe it to be desirable for any reason to withhold information on waiting lists from the public?-- Mmm.

Is that what you said this morning?-- Yes.

All right. Could the CA6 document be put back on the screen, please. The second page. Sorry, the minute of the 15th February meeting. Now, just to remind you, we've looked at this document, the first page of this document earlier and this is the minute of the Cardiac Society meeting which you and Dr Buckland attended on the 15th of February 2004. Do you recall seeing the first page of that document or do you want to see it again?-- This is the minutes of the Cardiac Society meeting?

Yes, here it is, CA8, the conclusions of the Cardiac Society?-- Yes, yes.

Do you remember this page?-- I do.

The second page of that is what you're looking at now. Dr Aroney, don't you think the public should be aware of the

number of deaths which occur while waiting longer than their waiting list category? It would be appropriate for this information to be available to the public." Your response, "What is your aim in making this information public? I would see death rates as unnecessarily alarmist"?-- Yes.

Now, are you asserting that that's consistent with your information - the evidence you gave this morning?-- We're talking about death rates here. We're not talking about waiting times. And I'm happy to have the discussion about if we're going to publish death rates for cardiac disease, then let's not publish just death rates for people waiting for coronary angiograms, let's publish the deaths of the children who died of rheumatic heart disease in remote indigenous communities, let's publish the people who die from smoking but let's also publish the people who die while waiting for oncology services, who die of their uncontrolled diabetes. I mean, where would you like to start, where would you like to stop? That's the issue for Health.

Dr Scott, we're talking about whether you saw that there was any impediment or there should be any impediment to the publication of waiting lists?-- No, I don't have a problem with waiting lists.

Not people out there who might be dying from smoking, unrelated to any waiting list, we're talking about waiting lists and deaths on waiting lists?-- But you see my point, Ms Kelly.

I'm sorry, can I finish my question?-- Certainly.

In response then to Dr Aroney's assertion at the second last line, "Will you give an undertaking that these can be published?" You say, "If you publish cardiology waiting lists, let's look at them all, let's get methadone treatment." What does that mean? What does that mean, Dr Scott?-- That's exactly the issue that I'm speaking about at the moment. If you want to, let's talk about the people who can't get on to methadone treatment who are dying of their heroin overdoses, let's, as I said, talk about the children who are dying in remote indigenous communities because we aren't improving the sanitation and the water quality and their capacity to have showers in these communities, you know, I think you need to get some balance into this because - and I had this discussion I hope with Mr Douglas this morning, that if we're going to publish waiting list, let's make sure that we don't selectively publish waiting lists that suit particular individuals or specialties, if we're going to get the public to understand waiting lists, let's get them all out.

COMMISSIONER: What about the publication of false waiting lists though?-- False waiting lists?

Mmm?-- As in our discussion this morning?

Yes?-- I don't know that they're false waiting lists, I mean-----

But they are, aren't they?-- Well, they're the people who have been seen and who have been scheduled for surgery.

Yes, a small category, subcategory of people on the real waiting list?-- Yeah.

A very small proportion?-- But I guess again, Commissioner, I made the point this morning that those waiting lists are mandated by the Commonwealth and agreed by the State.

Mmm?-- I'd be very happy to agree some other waiting lists because the area that I come from in terms of my specialist qualifications is public health medicine.

Mmm?-- And we would love to publish-----

No, no, we're really talking about - I was talking about anyway, asking you about the publication of in that document 318, the publication of category A but not category B or C

waiting lists?-- Category 1, 2 or 3.

Yes, category 1, but not 2 or 3?-- Oh, we published 2 and 3.

MS KELLY: No, no.

MS DALTON: You're confusing him. The witness should see 318.

COMMISSIONER: This document here, category A but not category C?-- Oh yes, sorry.

All right, well I think we've been through that anyway. Yes.

MS KELLY: Yes, thank you.

Dr Scott, you were asked initially this morning about the credentialing process - yes, we can shut that down, sorry, thank you. You were asked about the credentialing process. Now, you were aware, were you not, that after Dr Aroney resigned from Queensland Health, he sought to be credentialed by Prince Charles Hospital for the purpose of volunteering his services while other persons were developing skills in procedures which he had devised; are you aware of that?-- I became aware of it after the process was finished, I certainly had no part in it.

What process did you refer to then?-- The process of his application and apparently decision as to whether it would be accepted or not.

And what was that decision?-- I understand that it was decided that they weren't going to accept his offer, but as I say, I only heard about that after the event.

And from whom did you hear it?-- It could have been either the medical superintendent or the district manager at Prince Charles.

Okay, so you spoke to both of those persons about Con Aroney after his resignation, did you?-- No, I spoke to both of those people about a lot of things.

Yes?-- And in one of those conversations I recall being told that he had applied for but that they hadn't granted or credentialed privileging to do those things.

Now, you must have been appalled at the stupidity of that, were you?-- I accept what the manager of - the district manager is doing out there, I think was - I think that over the last probably 12 months great progress has been made in the staff getting focussed in the procedures being done out there, and I think in a sense of harmony developing within the staff at Prince Charles, so in other words, I was quite comfortable to let the district manager make those decisions.

Now, when you say "a sense of harmony" you say that derives from Dr Aroney's absence?-- No, I didn't say that at all.

Oh okay, I was asking you-----?-- No.

-----is that what you're suggesting?-- No.

Dr Aroney is the President of the Cardiac Society, he's the Principal Author of the National Guidelines on the Treatment of Coronary Care?-- Mmm-hmm.

He was the principal author of the lengthy submission and detailed submission which was put to you and the Minister and Dr Buckland-----?-- Mmm-hmm.

-----last July. He had developed new procedures which were groundbreaking and his volunteering of services in order to facilitate other persons learning those procedures. That volunteering was rejected?-- Yes.

By means of this decision?-- Well, that was a decision, as I said, that would have been taken, I would expect, by the district manager in consultation with not just the medical superintendent but the Director of Cardiology.

Now, are you aware that Dr Cleary alone made that decision?-- No, I'm not.

All right. Would it surprise you that that was solely made by - that decision was solely taken by Dr Cleary?-- Yes, it would.

Yes. You were aware that Queensland Health's public reputation was suffering somewhat not only amongst its own staff but amongst the public generally because of media disclosures about Dr Aroney's treatment by Queensland Health, weren't you?-- No.

Had you read about Dr Aroney's treatment in the paper-----?-- No.

-----while you remained a senior bureaucrat?-- I'd have to say I don't read the paper.

Okay. Now, when did you make the decision to resign?-- I didn't make the decision to resign.

All right. Are you aware of a media report, and you may not be, earlier this year after the Commission of Mr Morris to the effect that you had already formulated the intention to resign?-- No, I indicated to a meeting of rural doctors in North Queensland where I was invited to speak on Queensland Health in 2010 - that was the topic of my talk, Queensland Health in 2010 - I indicated to them that that was where I believe Queensland Health would be in 2010. I then indicated to them that I wouldn't be with Queensland Health in 2010 and that it was my intention to leave Queensland Health next year. I didn't say at any point in time that I'm tendering my resignation and, in fact, subsequent to that I advised people that my intention was to see out the Commission process, see out the process of the review by Peter Forster, get the

recommendations of those two processes, see those processes through to implementation and then at that point in time to make my decision about when I was going to go, so certainly my intention was not to leave Queensland Health until probably sometime in the early part of next year.

All right. Now, Dr Scott, you would be disappointed, I suggest, at the disclosures of the dysfunction in Queensland Health that have been made during the course of these two inquiries; is that a fair comment?-- I think "disappointed" is not a word that I would use, I've probably been, I guess, disheartened by some of the disclosures but at the same time heartened by some other aspects of the disclosures in that disclosures that needed to be made have been made, I think the system needs to get some recognition of the areas where it needs more funding, where it needs perhaps some greater focus and this is an issue not just for bureaucrats within Queensland Health but for the Government in whichever persuasion the Government is and also for the people of Queensland.

Is it a fair comment to say that your statement as a whole presents as a problem, Queensland Health has the sort of problems that are solved by throwing buckets of money at it and buckets of money simply have not been thrown at it?-- No, I think my statement is intended to convey the fact that we need to have some sort of comprehensive plan that we can put our services, that we'll never be able to deliver services in a decentralised way unless we have incentives for people to go to the locations where we need to get them to go. We need to have decisions made about how decentralised we make our services. We need to invest in retrieval services if we're not going to put specialists out into rural communities, there are a whole range of things that need to happen and funding is necessary to deliver those, but funding on its own is not going to deliver them.

Do you identify any deficits in your own performance as a senior bureaucrat?-- I'm sure I did, I'm sure we all do.

And what are they?-- I think probably if I look back in retrospect, I would say that I probably was more of an activist for the Government and the Minister than perhaps I should have been. I think that there are issues that need to be addressed which sometimes aren't attractive politically, but I think that in terms of how hard I've worked, how hard I've tried to support people, I don't have any deficits from that point of view that I can see.

You say in your statement that you regularly received briefings from your officers about the staffing difficulties faced by Queensland Health. I'll take you to the paragraph. Sorry, Commissioner, I just can't find it for the moment.

COMMISSIONER: That's okay, take your time.

MS KELLY: Well, I won't take you to it because I can't find it, but you clearly had identified to you over the course of

your tenure a number of items which were thought to contribute to Queensland Health's staffing crisis?-- Mmm-hmm.

Medical staff crisis?-- Mmm.

Did you have any reports during that period over the attrition of medical staff?-- Yes.

They're not mentioned in your statement and so that's why I ask you, what was the effect of those reports?-- I think, well certainly in terms of attrition I took the view when I talked to members of staff that I think that there are probably two components as to whether we retain staff: one of them is their remuneration levels, and I think that that is important whichever way you look at it. A lot of people say the money is not that important, but I recall talking to the junior staff, the junior specialist staff at Prince Charles and they kept saying, "The money's not important" "The money's not important" then they kept saying it and until we said to them, "Well, how much do you think you need to get paid per year?", and they said, "Probably about $400,000." Now, that's consistent with what I'd been told by the anaesthetists at Royal Brisbane as well who said they thought they needed to be paid something between 50 to 100 per cent increase in their salary rates, so I accepted that we needed to pay people more because the capacity to compete with a system which is Medicare funded and which to some degree is open-ended is not there if we don't pay more for people, but I also recognise that there are - and I think these are probably more the emblematic sorts of issues, a range of issues which are important that we address for our staff and they'll vary according to whether you're in a metropolitan or a rural or provincial area, but I think that we've got to look at the professional development allowances, we've got to have a bit more flexibility in terms of how we respond to the needs of people, some people like to teach, some people like research, some people are there just to do the work of clinical service delivery. I think we've got to have flexible packages that allow people to choose a job to excite them in their work and we haven't had that previously. I think we've got to have incentives for people to go to rural areas and not to just think about the individuals, but their families, their children, their spouses. I think we've got to think about bringing people back from rural locations to give them access to professional development because often we don't give them extra travelling time above and beyond what everyone else gets to go to a conference in Brisbane when they might be living in Mount Isa. So I think there's a range of things and we worked through those and identified those, that of components that have gone through the interest-based bargaining process which we have engaged with the unions and the enterprise bargaining process.

And were you ever given statistics on the attrition rates in Queensland medical staff compared to other States?-- I don't specifically remember that, but I certainly remember getting information about comparative analyses of the conditions and incentives under which people worked.

Yes, and you've heard various people give evidence in the course of the previous inquiry to the effect, in essence, that Queensland Health is a dysfunctional and most unsatisfactory employer; have you heard that evidenced?-- I've heard that, I don't agree with it and I think we've certainly been getting, I suppose, the edge of the wedge, if you like, in terms of the views of people. I mean, we've heard from a lot of people who've got a lot to say. I don't think we've heard from the majority of people who haven't sought to come forward, and I think that when we hear people like Keith McNeil, who is a senior member of the clinician environment speaking, I think we've heard from people yes, we have got some problems and I think it was Jeannette Young, the med super at PA who said that we are still a pretty impressive deliverer of clinical services when you consider all of the issues that we have to respond to, and I think in my own area of public health, I think that we certainly stack up as well as anyone else in the country. So we may have heard in the Commission that we're a terrible employer, that we're a terrible health department, but I think that there are a lot of other people out there who could come forward and give evidence that might not say that.

And as soon as you became aware of the assertions that there was widespread bullying within Queensland Health, did you take any steps to actively prevent that from occurring?-- Well, we had processes in place to address bullying in Queensland Health already and I have to make the point, and I'm sure that Queensland Health can deliver the policies and the training modules and so forth that have been provided to people and there is a code of conduct which has been in existence for some years now which would also talk about bullying, but I think the other thing to note is that when we look at investigations of complaints for bullying across departments, that Queensland Health doesn't stand out as any worse for those complaints than any other government department, and I think Peter Forster has also commissioned an independent review of culture within Queensland Health through the University of Southern Queensland which he told me indicated that Queensland Health's prevalence of bullying was no worse than most other public sector organisations. So I'm aware of the allegations. I don't know that the facts necessarily support them.

And you would deny, would you, that you bullied Dr Aroney?-- Well, I have to say that it really depends on the definition that you use of "bullying". I certainly don't believe by my definition that I've bullied Dr Aroney. In fact, I would argue that going out to the media, as I said, and saying that I as someone who's put 15 years into direct one-to-one patient care doesn't care if people dies, I personally find to be bullying, and I personally take that as a major slight on my personality and my personal integrity. So I think if we're going to talk bullying, and he may believe that I bullied him, I believe he bullied me, I think in the overall context of things I don't believe I'm a bully and I think that I've got people who've been prepared to come forward and make statements to that effect: Andrew Galbraith is one of those

people; Ross Cartmill, who's Chair of the Visiting Medical Officers Group has been prepared to say that; and Keith McNeil has been prepared to say that.

So did that - you didn't bully Dr Aroney?-- No, that I'm not a bully.

Right?-- I'm sorry, as I say-----

All right. Dr Scott, I'm almost finished. Did you discuss with either Dr Cleary or Ms Wallace the budget cuts instituted in late 2004 at Prince Charles Hospital prior to them being implemented?-- Well, there weren't any budget cuts.

All right, the reduction in numbers of procedures?-- Yes, I'm sure that I did.

All right. And who was present at those discussions?-- I'm just not sure, I don't know. I mean, I might have talked to them on the phone, if I'd talked to them together, then I would believe that it would have been one or both.

And it was part of your role as their superiors, Wallace and Cleary, to ensure that those reductions went ahead; that's right, isn't it?-- That they maintain budget, yes.

All right. And other areas, other areas such as the transplant area were not similarly cut in terms of the procedures, the numbers of procedures available at the same time, were they?-- Well, again, I know we're playing with words, but I'm not aware that the transplant team were overbudget, and if they were, then I would have taken the same approach, that we expect people to work within their budget and if we know that there are pressures on the budget and we believe they're legitimate pressures, then we would seek to put extra funding into supporting increases and, as I said, we've done that across the State in terms of the money that we've put in $11 plus million last year, $17 plus million for this year and into the future, some of that's gone to the transplant team, some of it's gone to management of cardiac failure, some of it's gone to increases in implant and defibrillators and some of it's gone into increases in angiograms and stents.

You see, you said in answer to a question this morning that you several times or many times made application to your superiors, in effect, I suspect, the Director-General and the Minister, if not the Budget Review Committee, for further funding?-- Mmm.

That's right?-- Yes.

Now, why did you not then regard Dr Aroney's disclosures of the severe shortage in funding as helpful to your cause?-- Well, I think we did see them as helpful to the cause through the channels of submissions to me and to the Director-General. I don't believe that going to the media and talking about death rates in the media is helpful because the only way it

can be helpful is if every other clinician who believes that they have needs in their area is allowed to go to the media as well. So in other words, I'm fine with people putting their requests forward, so long as we get a balance in terms of what's put forward and then we make appropriate investments in terms of the areas that we know are priorities.

And does that principle which you've just articulated apply also to Dr Aroney having written to the Premier which he did before he made any public disclosures?-- Well, again, I think everyone's welcome to write to the Premier, the Premier then manages those letters according to his want and that's up to them.

And it would be absurd to take offence at such a letter to the Premier, wouldn't it?-- Not if the implication is that I as an administrator are happy to let people die just to maintain my budget, it's not absurd.

But finally, Dr Scott, I suggest to you that you bullied Dr Aroney out of his job and out of service to the public patients of Queensland?-- Is that a suggestion or is it a question?

Yes, I suggest that to you, I'm sure you're going to say that's not the case?-- Yes, it's not the case.

And I suggest to you that you were concerned to make an example of Dr Aroney by ensuring that the services with which he was concerned were cut, or reduced if you'd prefer that term, so that other persons would be dissuaded from making public disclosures?-- You're obviously welcome to your point of view. If cutting the servicing means increasing the number of procedures done between PA and Prince Charles, if it means increasing the budget to Prince Charles for cardiac services in that year and subsequent years, then I guess I must be guilty, but I don't see that as cutting. The budget for that year increased, it didn't go down.

Thank you Commissioner.

COMMISSIONER: Okay. Mr Boddice, do we have any further advance on-----

MR BODDICE: I have provided the draft statement.

COMMISSIONER: A statement?

MR BODDICE: No, the two statements have been provided, the one from Mr Zanco we spoke about before.

COMMISSIONER: Yes.

MR BODDICE: And a draft statement from a Mr Walker has been provided to the Commission.

COMMISSIONER: Mr Boddice, I don't know and I assume other counsel who wish to examine on these questions don't know whether, in fact, they answer the general requirement that I imposed on you this morning. So what I propose to do is to make a more specific order which I now do for compliance by 9.30 tomorrow.

MR BODDICE: That I will do. Obviously I will liaise with Counsel Assisting to see if there's anything else they wanted added in to that statement.

COMMISSIONER: Mr Douglas, the documents which were produced to - bundle of documents which were produced and marked QH1, were they produced to this Inquiry?

MR DOUGLAS: They were produced to the previous Inquiry.

COMMISSIONER: But they weren't made exhibits?

MR DOUGLAS: They weren't made exhibits.

COMMISSIONER: That's okay. As long as I can identify them in that way.

MR DOUGLAS: Yes.

COMMISSIONER: All right. Thank you.

I direct that by 9.30 tomorrow the State of Queensland provide written information verified by a servant or agent of the State having direct knowledge of the same as to the origin and distribution within the State's Department of Health to the Minister of Health and to Cabinet of the following documents and as to the cessation of collection and collation of the kind of information contained in the following documents: namely one, Exhibit 267; two, the bundle of documents produced to the Commission of Inquiry constituted by Commission of Inquiry order number 1 of 2005 and marked QH1.

MR DOUGLAS: Can I identify those documents for the record? They consist of the bundle of documents commencing in November - I should say October of 2000 - October 1998 and concluding in January 2003 variously described as Waiting List

Reduction Strategies. They are monthly documents. I believe Mr Boddice knows the documents to be produced.

MR BODDICE: We do.

COMMISSIONER: This should identify them. There are two points I would like to make an order about. The first is, of course, that is subject to any valid claim of privilege, but I would invite you to urge upon those who instruct you to consider whether any claim of privilege is in the public interest and particularly in the interest of the public in now knowing the full truth about waiting lists.

The second point I would like you to urge upon those who instruct you is the consequences of the direction I have made.

MR BODDICE: I will do so Commissioner, in respect of that.

COMMISSIONER: There is nothing usefully I can do?

MR DOUGLAS: I agree. We have to resolve those documents and digest them, but I am still hopeful that those documents - that Mr Boddice and his team will no doubt proceed throughout the balance of the afternoon and evening and give us those documents at the earliest time tomorrow morning.

COMMISSIONER: I am sure he will do his best. None of the criticism implied in making those orders is directed to you personally, Mr Boddice. I know you are doing your best.

MR BODDICE: Thank you.

MR DOUGLAS: With Mr Boddice's permission, in the meantime I would like to be able to give to the other parties the draft second affidavit.

MR BODDICE: I accept that, provided it's understood that it's a draft.

COMMISSIONER: Yes.

MR BODDICE: Which the witness is still looking at.

COMMISSIONER: Certainly.

MR DOUGLAS: I just want to save time tomorrow morning, Commissioner.

COMMISSIONER: Sorry?

MR DOUGLAS: The purpose is to save some time tomorrow morning.

COMMISSIONER: I understand that.

MR BODDICE: We have no objections to that.

COMMISSIONER: All right. Thank you. Dr Scott, I am sorry

that you have to be brought back tomorrow morning. We hoped to finish you this afternoon but you understand why?-- Thank you.

MS DALTON: Commissioner, may I raise a matter?

COMMISSIONER: Sorry.

MS DALTON: I have got another Court professional engagement at 11 o'clock tomorrow morning.

COMMISSIONER: Yes. Well, we will accommodate you the best we can.

MS DALTON: It should only take an hour but it is important, and - I mean, I can cancel it but-----

COMMISSIONER: No, no.

MS DALTON: I very much prefer not to.

COMMISSIONER: 11 tomorrow morning you have that appointment.

MS DALTON: Yes.

COMMISSIONER: You don't mind - well, Mr Douglas might well take up the time between 10 and 11 tomorrow morning. There may be others who wish to cross-examine on those and if not, we will - you will let us know when you are available after 11 o'clock tomorrow morning. We will adjourn whenever Mr Douglas finishes and if you don't turn up by then we will adjourn until you tell us you are available.

MR DOUGLAS: Mr Nuttall is also to give evidence tomorrow.

COMMISSIONER: Yes.

MR DOUGLAS: For the Commissioner's convenience.

COMMISSIONER: I understand that.

MS DALTON: But-----

COMMISSIONER: But?

MS DALTON: If Dr Scott's going to be in the box, whoever's examining, I'd like to be here, that's all.

COMMISSIONER: We can accommodate your absence but I am not sure we can - well, unless Dr Nuttall - Mr Nuttall can be here at 10.

MR GOTTERSON: We will make arrangements for that.

COMMISSIONER: Is that a problem?

MR GOTTERSON: No problem.

COMMISSIONER: All right.

MR GOTTERSON: So long as we have all of this.

COMMISSIONER: I just don't want to waste any more time. All of which material?

MR GOTTERSON: The Queensland Health material.

COMMISSIONER: By 10 a.m.

MR GOTTERSON: Yes. We should have it this afternoon.

COMMISSIONER: We hope. Certainly by 9.30 I hope. Is that suitable?

MR DOUGLAS: It is. We are happy to accommodate Ms Dalton.

COMMISSIONER: Go ahead with Mr Nuttall at 10 o'clock and that should leave you free to lunch time, I imagine.

MS DALTON: I am grateful.

COMMISSIONER: All right. We will now adjourn.

THE COURT ADJOURNED AT 4.32 P.M. TILL 10.00 A.M. THE FOLLOWING DAY