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 15/09/2005

..DAY 5

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

THE COMMISSION RESUMED AT 9.58 A.M.

MR ANDREWS: Good morning, Commissioner. The witnesses scheduled for today are firstly Dale Erwin-Jones. To follow Ms Jones will be Dr Sean Mullen and, if necessary, it is proposed that a Dr Mattiuissi would be available to be called any time after 2.30.

COMMISSIONER: Thank you.

MR ANDREWS: I call Dale Erwin-Jones.

MR FARR: I seek leave to appear on behalf of Ms Erwin-Jones.

DALE FRANCES ERWIN-JONES, SWORN AND EXAMINED:

MR ANDREWS: Good morning. Do you have a copy with you of a statement that was signed by you on the 15th of August 2005?-- I do.

Is your full name Dale Frances Erwin-Jones?-- That's correct.

Ms Erwin-Jones, the facts recited in your statement, are they true and correct to the best of your knowledge?-- Yes, they are.

And you express a number of opinions in the statement. Are they honestly held by you?-- Yes, they are.

I tender that statement.

COMMISSIONER: I should say, before accepting that statement, that I have read it. It contains a good deal of argumentative material, it contains some speculation, and some of it is expressed in intemperate language. Those matters may affect the extent to which I accept that statement, but certainly, as far as I am concerned, doesn't affect its admissibility. So I will admit that as Exhibit 329.

ADMITTED AND MARKED "EXHIBIT 329"

MR ANDREWS: Thank you, Commissioner.

COMMISSIONER: Yes.

MR ANDREWS: Ms Erwin-Jones, you've, for 20 years of your career, been involved in the operating theatre?-- That's correct.

You sit on the Queensland Health Peer Review Committee for Operating Theatres. Can you explain what the significance of that-----?-- It is a forum for if they need to review specific hospitals, there is numerous people from various departments that they can select from. So if a particular operating theatre somewhere was asked to have a review undertaken, they may nominate me as being one of the review team. I was nominated to that group some time ago. I have never actually had - been asked to go and review.

You have been the nurse unit manager of the operating theatres at the Maryborough Hospital since May 2002?-- That's correct.

What's your role at the Hervey Bay Hospital?-- Currently I am classified as the nurse officer level 4 for the Fraser Coast District operating theatres where I have strategic management over both sites, Hervey Bay and Maryborough.

Now, what is your - I am concerned in particular with a period from July 2002. As I understand it, Dr Krishna became employed as an SMO at the Hervey Bay Hospital from about the 20th of July 2002, and Dr Sharma from about March 2003. Is that approximately correct?-- I couldn't give definite dates but thereabouts, yes, and my understanding would be that they were district employees, not strictly assigned to Hervey Bay Hospital.

Did they work predominantly at the Hervey Bay operating theatre?-- Initially, Dr Krishna did work in Maryborough doing minor orthopaedic surgery. We had a review in terms of orthopaedic provision at Maryborough - I can't remember specific dates - where Dr Morgan Naidoo had been doing some surgery, had ceased doing surgery in Maryborough, came back to do surgery. We were looking at whether it would be best practice for us to do orthopaedics - major orthopaedics, particularly joint surgery, only at Hervey Bay because of the infrastructure.

The point of my question is to determine whether Dr Krishna and Dr Sharma operated predominantly at one hospital or the other, or whether they divided their time equally?-- No, I would have to say predominantly at Hervey Bay.

Thank you. Where, for instance from July 2002, did you predominantly base yourself?-- From July 2002-----

Yes?-- -----through until December 2003, I was still in my substantive position Nurse Unit Manager Maryborough operating theatres. From January 2004 until today I predominantly work out of the Hervey Bay operating theatres.

Thank you. As a nurse unit manager of operating theatres, do you participate during the operations or do you organise the other nursing staff who will be in the operating theatres during surgery?-- I predominantly organise sessions and staffing, budgets, targets, all of those things. I do occasionally work in the operating theatres if there is staff shortages, to keep up clinical skills.

Now, I notice within your statement you make the observation that as a member of nursing staff, there are some limits to the judgment that you can make about a surgeon - an orthopaedic surgeon's technical skills - and I thank you for that observation - but is it the case that you will not have had very much opportunity, because you have been nurse unit manager, not very much opportunity to assess the performances within the theatre of Doctors Sharma, Krishna, and Naidoo?-- I couldn't give you specific time on that. I have observed all of them in their clinical practice in various clinical circumstances, from minor to major, to joints surgery, to trauma. I - I take advice from my staff, so if my staff had any level of concern about the competence or clinical capabilities of any surgeon, or anaesthetist, or any member of the medical staff, they would firstly bring it to me. One of the first things that I would choose to do is then spend some time in an operating theatre making the observation for myself. I was never asked or given any concerns by the staff.

Part of your role, I see described in paragraph 8 of your statement, has to do with rostering, coordinating elective - or working, rather, with the elective surgery coordinator for selecting theatre cases?-- That's correct.

And, so, where later in your statement you have some observations to make about a particular patient, Dr Sean Mullen was trying to organise for surgery on a Saturday, it would be part of your role to consider the propriety of rostering staff on for a Saturday?-- That's correct.

Or seeking to postpone the surgery to a Monday?-- That's correct.

For normal rostering?-- That's correct.

At paragraph 21 of your statement, you observe that the Terms of Reference given to Doctors North and Giblin in preparing their report are the direct responsibility of the Director of Medical Services through his management of the Director of Orthopaedics, and those two persons should be the only two under scrutiny under the Terms of Reference?-- In the Terms of Reference 1 through to 7, the issues pertaining to those I felt were only relevant to both the Director of Medical Services and the Director of Orthopaedics.

And by those persons, you mean Dr Hanelt as the Director of Medical Services, and Dr Morgan Naidoo as the Director of Orthopaedics?-- That's correct.

At paragraph 25, you speak of "a bitter agenda driven voice of a Dr Sean Mullen." The expression suggests to me two things about Dr Mullen; (1) that you hold the opinion that Dr Mullen is for some - or was for some reason bitter, and the second is that you thought that he had a particular agenda. It is the bitterness I would like to explore to begin with. Is it your opinion that at the time that the investigators visited the hospital, that Dr Mullen was bitter for some reason against

some persons?-- It is my personal view, not an organisational view, that Dr Mullen had been unhappy with how he had been treated and managed by the organisation, and his access to operating theatres in his own time, and the reasons for carrying out - or taking the action that he did I felt were not driven out of real concern for the public safety. I personally felt it was more driven from what his personal needs or wants were.

Well, that bitterness - I just want to exclude some possibilities. It is not a bitterness against either Drs Sharma, Krishna or Naidoo you are speaking of, but a bitterness against what the administrators - perhaps the Director of Medical Services or the District Manager?-- The administration generally and - and Dr Naidoo.

But not-----?-- Not to Sharma and Krishna, no.

And you speak also of your opinion that Dr Mullen had an agenda. Now, of course, one agenda might be a concern for the services offered by the hospital. Are you suggesting that he had another agenda?-- Personally I felt that there may have been underlying reasons for it. Dr Mullins had been an employee of the district previously and I know that there had been some issues prior to the - in the first years that he was employed, and I am not confident that when he returned to the service that he was happy to be there, and that he was there just to provide services as a VMO for the benefit of the community.

Now, Ms Erwin-Jones, I need the benefit of your opinion so that when Dr Mullen comes to give evidence, I will be in a position to put your opinion to him, to test the veracity of the things he has to say. It is for that reason that I am asking you about this. Is it your opinion that Dr Mullen has some other agenda? If it is, I need to understand it?-- In terms of agenda, I believe that Sean's initial position on reporting this through to the AOA was in regard to his issues with Dr Morgan Naidoo, and I think that the majority of people involved in the review were happy that there would be a review, albeit we weren't overly happy about the way it was reported in the news.

Let me bring you back then to what you regard as Dr Mullen's issues. Am I right in thinking that your opinion is his issues for seeking a review were issues with Dr Morgan Naidoo?-- Yes.

Now, what do you regard as - what do you think his issues were with Dr Morgan Naidoo; lack of attendance at the hospital and supervision of the SMOs?-- Yes.

Or something else?-- No, mainly - mainly to do with the lack of supervision.

Thank you. At paragraph 26, you mention that many comments made by you were not in the report of Drs North and Giblin. Are you able to identify which important areas of the

information you provided to those doctors you saw as missing from the report?-- I was asked by the review team of my opinion of the clinical capabilities of Dr Sharma, Dr Krishna, Dr Naidoo. My advice to the review team was that I felt that both Dr Sharma and Krishna tried to work within their scope of practice, they knew what their limitations were. They unfortunately sometimes got into a position of not being able to control that, because once you get into the operating theatre, the surgery was more complex than they first understood it to be, that there was no supervision for them. In terms of Dr Naidoo, I was asked what I felt of his clinical competence and I advised that I thought his arthroplasties, which is joint replacement surgery, was absolutely fine. That didn't come across in the review. In fact, I think in the review it makes comment to that it is in Dr Morgan Naidoo's own mind that he is good at arthroplasty. I did state that I felt that trauma was a concern with Dr Naidoo but because of his availability. They also asked me what my opinion of clinical practice for Dr Khursandi and Dr Padayachey, which I gave them, and that was not in the review. They did ask me - I can't recall whether they actually asked me about Sean's clinical competence or anything about Sean, really. I don't think they went into detail. I did note that Mr North stated that he asked me where I would go if I needed orthopaedic surgery and he stated that I - my statement was I would go to Dr Mullen. My recall of that day was that I actually said I would return to the Illawarra, where I originated from.

Well, on that topic, do you mean that it was your opinion in July of 2004 that if you needed orthopaedic surgery, you wouldn't have it done at the Fraser Coast?-- It would be very dependent on what the surgery was. If it was elective surgery, then I would have an option. I have private health insurance. I know a number of orthopaedic surgeons from where I have worked previously, I know the anaesthetic team. My level of confidence, having worked with those people for 20 years, may have bearing on my decision where I would go. If I was in a trauma case where I had a car accident and needed surgery, I wouldn't have any hesitation to have Sharma or Krishna or Dr Mullins perform the surgery if it was required.

But for elective surgery, you'd have - there would be many kinds that you wouldn't have done at the Fraser Coast?-- Well, I would have to consider what it was. If I was having a joint replacement, certainly I would go elsewhere.

At paragraph 28 you mention "elective surgery business rules". Were the business rules a particular protocol that was to be applied at the hospitals in the Fraser Coast?-- One of the concerns in relation to supervision is that often there was limited staff in specialties, and this didn't just apply to orthopaedics-----

But may I interrupt for a moment? It is just that your statement uses upper case for "business rules" as if it is - as if they were a document. Is it correct there were particular rules?-- They - there were particulars - it is a particular document. When I first arrived on Fraser Coast,

one of my concerns was that there didn't seem to be good management of the medical staff in terms of leave. As a member of the surgical management advisory group, I suggested that we adopt business rules. I then wrote the business rules and sent them out for comment, and they were eventually ratified through the surgical management advisory group. Those rules state one staff member out of any specialty only to be on leave at any one given time. Those rules were continually broken.

When were those rules implemented?-- I would have to say they were probably ratified early 2003, from memory.

COMMISSIONER: You say in the same paragraph that "Dr Naidoo took inordinate amount of leave." Could you estimate how much in any one period of 12 months Dr Naidoo would have taken leave?-- I have to say in the time that I have been there, probably at least two to three months a year. Some of that was sick leave, some study leave, some annual leave.

MR ANDREWS: Well, if I ask you about that in the context of the business rules, that only one member of staff from orthopaedics should be granted leave at any one time, does that suggest that while Dr Naidoo was taking his leave, that there was another member of staff also on leave at those times?-- That had been known to happen, yes.

And if there are more than one member of staff on leave, is the problem that the on-call roster is too demanding for those who are left behind?-- Absolutely.

That they have to work tired, and-----?-- And with lack of supervision.

And with lack of supervision, I see. When it comes to supervision, I am going to ask you whether you are in a position to give us an expert opinion about something. Now, of course, if it were a topic to deal with nursing, that would certainly be within your area of expertise. I am a lawyer. You can tell me whether this question is about something you understand sufficiently: the position of senior medical officer in orthopaedics, is it the case that it is accepted in Queensland that when one is a senior medical officer in orthopaedics and one doesn't have Australian specialist qualifications, that it means one is supposed to be supervised by a consultant?-- My understanding was, up until the Bundaberg inquiry, that there was no definition to what level of supervision an SMO would have. Certainly since that time, we have been directed that there will be specific levels of supervision. I did ask verbally, when Dr Sharma and Krishna had been with the service a little while, what were their limitations to the surgery they could perform, and was advised only verbally that they could perform any type of surgery excluding joint replacement surgery.

Well, who gave you that advice?-- Dr Hanelt.

COMMISSIONER: Were you concerned that some level of

supervision was necessary or desirable?-- No, it was always my practice in the Illawarra to try and endeavour to get what level someone was allowed to practise at when they came to the operating theatre. In Queensland Health we have PHOs and we need to know whether they can operate independently, whether they need to be directly supervised. Certainly since the inquiry, we have still requested to have a clear definition on that; do they need direct supervision in the operating theatre, do they need supervision within the hospital, do they need supervision within 30 minutes? I have not seen a document out of Queensland Health that states what level of supervision there is for any member of staff under consultant.

Thank you.

MR ANDREWS: Now, in answering my question, you first referred me to definitions. I was more interested to know whether in your long experience in Illawarra and in Queensland it is the - it is the practice in orthopaedics for a senior medical officer who doesn't hold Australian qualifications to be supervised by a consultant?-- It is my understanding that there is no degree of that they must be supervised.

Right?-- And certainly Sharma and Krishna did work independently and that was known by Dr Naidoo and Dr Hanelt.

When it comes to supervision by, for instance, a consultant of a Senior Medical Officer, there are different levels of supervision, aren't there? I mean, one can be supervised by having a consultant looking at the operating procedure, or one can be supervised by a consultant who is at the other end of the telephone or at least available?-- I would find that - it should be an acceptable practice but there should be some clear definition around that if there are concerns.

And you mentioned 30 minutes in answer to a prior question. Did you mean to suggest that it is - there is some acceptance of a principle that a supervisor ought to be within 30 minutes of a hospital?-- No, I probably used that time-frame because on the Fraser Coast we have two acute sites and that surgery occurs at both centres, and that the consultant may be operating in Maryborough Hospital and an SMO operating in Hervey Bay Hospital. So they're available should - or doing a clinic, say, in Maryborough, they are 30 minutes away if they needed to be contacted or come and directly supervise.

You observe that Dr Naidoo's inordinate amount of leave left holes in the roster, particularly on call. Do you mean by that that there were many periods where the workload given to the two SMOs was unsafe?-- Well, it was certainly untenable. You would have seen the roster that was submitted by Sean that clearly had Sharma and Krishna for Hervey Bay Hospital alternate nights, so a one-in-two on-call, and Dr Padayachey from Maryborough on a one-in-one on-call, and they were doing alternate weekends. So their call ratio was far too high for any practitioners.

Well, that takes a toll on the practitioner. Is it also

unsafe from a patient's point of view?-- It could be. It depends on the callout. If they have four nights in a row where they haven't had a call, then there is nothing wrong with their fatigue levels, but if they are being called to a multitrauma in the middle of the night and they have been up all night, and they have got an elective session the next day and they operate on that session, then they could be qualified to be unsafe, they may then be required to stay on overtime on that shift and be caught up and be on call the next night.

Well, in thinking generally, does it put an unacceptable risk into the system if you have got that high call rate?-- Absolutely.

You also mention that this consistently left inadequate supervision for the SMOs. By the SMOs you mean Drs Sharma and Krishna, don't you?-- Yes.

There was a level of supervision that they should have been provided by the hospital, wasn't there?-- As I say, I am not aware of any written document that says what that level should be, but from a professional clinical point of view, I would understand that they should have the availability of someone certainly within the district that should they get into a complex case, could come and assist. And that did occur on many occasions, where either Sharma or Krishna were performing surgery that again became more complex, and they did try to contact Dr Naidoo and on occasion Dr Mullins and were unable to contact them by phone, either they were unavailable in the district or they weren't willing to attend. There were various reasons. I can't give you specific dates, although a number of my staff could give you very clear examples.

When you say that there should have been someone in the district available, do you mean someone who was rostered to be on call to assist them if they needed help?-- Yes.

And so when Drs Sharma or Krishna, or both of them, were operating, do you mean that there ought always to have been a consultant at least on roster to be able to respond if they needed help?-- Yes. I believe that would have been safe practice.

And is it the case that very often there was no consultant rostered to be available to assist them if they needed help?-- I would have to say always. The roster system doesn't allow for an SMO on call and a consultant on call. The consultant may have been in the district. Dr Morgan was - Naidoo was there, you know, Monday to half day Friday regularly. So, he may have been available, he may have been in the district, but whether he'd actually come and attend was a different matter. He wasn't actually on call, paid to be on call.

Within your statement you spoke of occasions where help was required by Drs Sharma or Krishna - I forget which - and there was no response from either Dr Naidoo or Dr Mullen?-- Mmm-hmm.

Is it fair to say that if Dr Mullen or Dr Naidoo were unresponsive, you could blame them if it was their duty to respond, but you would be less critical if they weren't rostered to respond?-- I think that from the professional point of view - that morally if they were in the district they should be available to help their staff. It's like the situation on the Saturday when Dr Mullens wanted to perform the surgery.

But that would effectively make them on call seven days a week, wouldn't it?-- Yes, absolutely.

So put to one side the fact that morally they might be obliged to be on call seven days a week. From an employment point of view, they're only to be rostered on call about what, one night in four?-- One in four, yes. But my point was that as the Nurse Unit Manager I am available to my staff at any time other than when I'm on annual leave, and do get contacted by the staff, as I did on that Saturday, for advice and I don't get paid an on call allowance and I'm quite happy to do that because as a manager that's what you do to support your staff, and for the district to function well, certainly we need much more than one consultant and a very, very part-time VMO and a part-time VMO that only works in one site to manage that secondary on call. You certainly would need at least two full-time consultants and three or four VMOs.

Now, I am going to ask you to explain the difference between the practices when there was on call and the practices for the other variety of surgery. If somebody was on call, for instance, one of the SMOs, do I understand correctly your evidence that if they were on call then a consultant was never put on call at the same time?-- That's my understanding.

Now, on call is generally after hours, isn't it?-- Yes.

Well, during hospital - regular hospital hours, was it ever

the case that Drs Sharma and Krishna would be on duty and there would be no specialist in the district available to supervise them?-- Yes, regularly.

That's far from ideal, isn't it?-- It is.

Now, it's not the fault of Dr Sharma or Krishna, is it, as I understand your statement?-- No. No.

That would be either the fault of the Director of Orthopaedics or the District Manager - or the-----?-- Director of Medical Service.

Director of Medical Services. That is either the fault of Dr Naidoo or Dr Hanelt?-- That's my opinion.

And the failure to have a consultant, that is a specialist, available in the district to assist either of those SMOs, puts at risk the patients who are being treated by the SMOs?-- Potentially, yes. I have to say that it's very difficult to attract any medical specialist out of the metropolitan. There may have been times when the Director of Medical Services tried to recruit a greater mass of orthopaedic specialists - I'm not particularly aware of whether that occurred or not - but I wouldn't be surprised if we had tried to attract other VMOs or consultants but had not been successful in that. It's very difficult, as I say, outside the metropolitan to attract specialists of any kind.

That seems to be accepted. Miss Erwin-Jones, when Dr Naidoo was employed at the hospital, I understand he was employed as a full-time staff specialist, Director of Orthopaedics. Does that mean that his employment was five days a week?-- I don't know the ins and outs of the medical award, but, you know, my understanding would be that they had set hours, either a 40 hour or 46 hour week. What accountability they have under the banner of being director, I'm not au fait with, no.

And when Dr Naidoo wasn't on leave, was he attending at the hospital or remaining within the district for hours such as those you have speculated about?-- When he wasn't on leave?

Yes?-- I would have to say that he was often unavailable even in normal office hours, Monday to Friday.

COMMISSIONER: He was living in Brisbane, wasn't he?-- He lives - his permanent residence is in Brisbane. He did have - I'm not sure of how his accommodation worked, whether he had a specific arrangement through the hospital of where he stayed Monday to Friday, but if he wasn't on call then it would be common practice that he would leave the district on the Friday mid-afternoon and not return till Monday lunchtime on a regular basis. The consultant - the roster that was touted to be the consultant roster that Dr Mullens put forward, which I have to say nobody in the district saw as a consultant roster and I don't believe that the district - either the District Manager or the Director of Medical Services or Dr Sharma or Krishna held themselves out to be consultants on

that roster, it was just the term "consultant".

I think you are straying from the point I asked you?-- But Dr Naidoo, if you look at that document, he's on - actually on call five times out of - I think it's 32 days and they are always a Tuesday or a Wednesday, never a weekend. But nor is Dr Mullens on that roster.

Thank you.

MR ANDREWS: At paragraph 31 you observe that you advised the investigators that Dr Krishna worked within the scope of practice or his scope of practice. Is his scope of practice a document that sets out a number of operations that he can perform independently and a number of operations he must perform with supervision?-- One would like to have that available. It was never made available. My understanding of his scope of practice is that he knew what his limitations were. We would never book in for joint replacement surgery, but anything up to, and when you performing trauma surgery, it can be often much more complex than joint replacement. He - we were advised that his capabilities and that of Sharma's could meet that need, and we did not see any evidence to show that he wasn't competent in performing.

COMMISSIONER: You didn't - don't say "we", you didn't?-- Sorry.

You didn't?-- Myself, nor my staff.

Well, the other staff can speak for themselves, if necessary. I'm really asking you?-- Yep. No, I - and I have observed both Sharma and Krishna at work in trauma and elective.

MR ANDREWS: But you weren't given a list of the procedures that they - either was entitled to perform-----?-- No.

-----without supervision?-- No.

You say at paragraph 31 that, "If Dr Krishna got into trouble during a case, he always tried to get the assistance required."?-- Mmm-hmm.

On how many occasions do you recall Dr Krishna to have got into trouble and to have tried to get assistance?-- At least three or more.

But you say, "That assistance was rarely forthcoming." Do you mean on those three or four occasions?-- Mmm.

You remember that Dr Krishna was left-----?-- On his own.

-----on his own. Are you able to recall whether there was a consultant whose - not whose moral duty, but whose rostering duty was to be available to supervise?-- At least on two of those occasions Dr Naidoo was in normal working hours within the district. Whether he was in the hospital is anybody's guess, because we are ringing a mobile phone, and - you know,

you have got a scrub team who can't pick up the telephone so you have got a nurse holding the phone to Dr Krishna's ear so he can talk to Dr Naidoo, explaining the scenario, and asking for assistance, and clearly being advised that - you know, "You will have to get on with it. I can't get there." On one occasion he did actually show up at the end of the operation, but by that time - you know, we completed the procedure.

And on either of those two occasions did Dr Naidoo explain why he couldn't make it?-- No.

You say at the end of paragraph 31 that, "It's a well-known fact that over the years that Dr Naidoo worked for the district, he often did on call from Brisbane." Is that a conclusion that you were able to draw yourself or is it something you have been told by others?-- That was advice from staff prior to my working in Hervey Bay when I was primarily in Maryborough and prior to my employment on the Fraser Coast, that that sort of occurrence happened regularly.

When you say he worked - he did on call from Brisbane, wouldn't that mean that when he was on duty to be available for emergencies after hours that he'd be three hours from attending?-- Yes.

And are you able to say whether that's inappropriate?-- That's absolutely inappropriate.

You say of Dr Sharma that, "If he required assistance he would try to get it." Do you have any particular recollections of occasions when Dr Sharma asked for assistance?-- I don't personally. However, that was the advice - you know, staff had given me over the time.

You say, "This was always refused or unavailable." I gather that's something you have been told by other staff?-- Yes, the same scenario as what I actually am aware of with Dr Krishna.

This reputation - your experience with Dr Krishna's asking for help and not getting it and the stories you have heard from other staff of Dr Sharma's asking for help and not getting it, are these things that you thought to bring to the attention of Dr Naidoo's line manager, the Director of Medical Services?-- I have on several occasions spoken to Dr Hanelt in regard to the lack of support and supervision for Drs Sharma and Krishna. I didn't ever put anything in writing because, to my knowledge, there was never any negative outcome from those events. It was - the surgery was completed. From an operating theatre perspective, we do the surgery, we recover the patient, we send them to the ward. We very rarely find out what happens to the patient post-operatively, so I'm unaware of whether those occasions led to complications for those particular patients. So there was no real reason for me to put in an incident report specifically related to that. My understanding was that the issues that I verbalised to both the District Manager and to the Director of Medical Services was that they were looking at ways to manage Dr Naidoo. I'm

not privy to what those each avenues were, but I certainly believe that the request to have the review undertaken was supported by them for that very reason, so it may help them manage Dr Naidoo.

COMMISSIONER: Can you remember when these oral complaints were?-- Sorry?

Can you remember when these oral complaints were?-- Well, it would have to be between January 2004 when I went down to Hervey Bay up until the review in July 2004. So in those six months.

Thank you.

MR ANDREWS: Am I right in thinking that as soon as you got to Hervey Bay this became obvious to you, that Dr Sharma and Krishna weren't being supported by their Director of Orthopaedics, and you complained to Dr Hanelt and Mr Allsop?-- I would have to say not immediately. When I first went down to Hervey Bay I was there to review the theaters and the staffing and just the general management of the operating theatre, so my direction was to look at nursing issues in particular. So, it would probably be further down the track, around the March or April, that it became obvious that these SMOs were not being supported. I think I make a comment in my statement in regard to the comments in the review where - that Sharma and Krishna were not good at communicating and were hard to find. We never had a problem with them attending the operating theatre in a timely fashion or communicating with us, but you could see a general disheartening between them the longer they were there. There were occasions where Dr Naidoo belittled them in the theatre and I think over time that their heart was not in the job because of the way they were treated. I think that they believed that they needed further support, but I don't believe that they understood the system well enough to know what they could do about it. I certainly believed it is their responsibility to act for themselves as well, but that I'm not sure that they knew where to go with that.

The only places they could go, according to the system, the first port of call for them would be to their Director of Orthopaedics who happened to be the-----?-- Problem.

The problem?-- Mmm.

And their next port of call would be to the Director of Medical Services, Mr Hanelt?-- Yes.

And you brought to Mr Hanelt your own opinion that they were being left unsupervised too often?-- Mmm-hmm.

And above Mr Hanelt, I suppose, it's Mr Allsop, and he seemed to be - you say he was a person to whom you'd brought this situation?-- My concerns with Dr Naidoo and his attendance at the hospital.

You say at paragraph 35 that, "Teaching and learning opportunities are the responsibility of the Director of Orthopaedics." Were you in any position to assess whether or not Drs Sharma and Krishna were or were not given sufficient opportunity for teaching?-- I certainly think that when Dr Naidoo was available and in the theatre that there were some teaching practices going on in terms of we had a trauma case on the table that he would teach as he worked, and I am aware that there were occasions where they were given support to attend specific things. I know that in July - 2004, early 2004, Dr Naidoo assisted both one of the SMOs, I think it was Dr Krishna, and one of my senior orthopaedic nurses through a company to go and do a trauma course in Sydney. So, I do believe that he tried to support external education to a fashion, but what you need is on-site education all the time and I don't think that that was available to them in the capacity it should have been.

You were the chairperson of the Theatre Review Committee?-- That's correct.

And quality and safety are standing agenda items?-- That's correct.

Bearing in mind that you were stationed until, I think, 2004 primarily at Maryborough-----?-- Mmm-hmm.

-----I gather that you weren't in a position to hold committees dealing with quality and safety at Hervey Bay, were you?-- In 2003 the Queensland Health Operating Theatre Review recommendations were released and I think there are 14 recommendations. We already had a Theatre Review Committee, albeit not very functional, and out of that review one of the recommendations is to have a Theatre Review Committee. So we reconvened the committee with each of the directors of each of the specialities and the two Nurse Unit Managers, myself and the Nurse Unit Manager of Hervey Bay, the elective surgery coordinator. At first committee meeting we had to determine the terms of reference and elect chair, and I was elected as chair. I was - the positions of who managed elective and who managed trauma were divided so that the theatre manager of Hervey Bay became the trauma emergency manager and I became the elective surgery manager, and it was under those guidelines that the committee sat. We worked through the recommendations that Queensland Health had offered that all hospitals should take up.

May I interrupt? Is this committee, is its function to do clinical audits?-- One of the recommendations from that review was to undertake quality activities and I think I place in my statement that when we got to a recommendation, which I think from memory is recommendation 4 or 5, I requested of each of the directors that they table at this committee their quality activities, so if they carried out audits or any sort of review - the anaesthetic department does morbidity and mortality report - that it should be tabled there to sit under the management advisory group.

So there isn't - this committee wasn't the clinical audit - the primary committee for doing clinical audits, it would oversee the clinical audits done at other levels?-- Well, the idea was that they would bring their clinical audits to this committee so that we could then determine whether there were specific areas that need to be addressed. However, I was unable and unsuccessful in ever getting the directors of any of the departments to submit anything under the quality banner.

Now, you said that mortality and morbidity meetings were done, did you say, by the department of anaesthetics?-- I believe that they do. I'm not involved in that.

But obviously not by - well, did you ask - did you find from Dr Naidoo, the Director of Orthopaedics, a reason why he was unavailable to submit to you the outcome of his department's clinical audits?-- At the theatre review meeting where I requested that they table them through this committee because that was normal protocol and the staff clinical governance, I was advised by all of the directors it would be impossible because they didn't have administrative support to actually collate that data to bring it, that they actually carried out various things but that they didn't have time to put it together. As the chairperson, I wrote to the District Manager requesting support for them, which - I have a copy of that letter, and they were then allocated some administrative support. So, we're talking July - somewhere 2000 - early 2004 perhaps, and to this date I still have not had anything tabled from any of the specialities.

Well, that in itself is a matter for concern because am I right in thinking that such a committee can perform a useful function towards improving clinical services in the hospital by performing risk analysis, by seeing trends and identifying methods for improving patient services?-- Absolutely. I have to say, and I think I have put that in my statement, that clinical governance on the Fraser Coast or in Queensland Health generally is very much in its infancy, and as much as having the background from a different State where things are done a lot differently, trying to push that was very difficult, particularly when you are a nurse trying to get doctors to be involved and be open, have open disclosure about their complications.

You are not in a position, are you, to say whether or not in the orthopaedics department there was an adequate clinical audit process going on?-- Dr Naidoo advised that they did do audits, that he was having trouble collating that data, that he requested a software program and it's my understanding that that was approved by the District Manager. But I have still not seen any of those audits.

You at paragraph 37 seem to be alluding to some extent the - this lack of management by the directors as being partly also the responsibility of the Director of Medical Services?-- I have to say that the directors have a - in the majority a

large clinical workload. The issues that need to be addressed in terms of quality and safety and complaints handling, you have to allow them some nonclinical time, again referring back to the fact that it's very difficult for areas to recruit out of the metropolitan, that when you are - your staffing is limited in your speciality and you are the director, then your clinical workload is always going to take precedence over what they classify bureaucratic paperwork.

And so is it correct for me to assume from paragraph 37 that if the Director of Orthopaedics, Dr Naidoo, was not participating adequately with the Theatre Review Committee, the fault isn't entirely with him, but it's also partly with Mr Hanelt for not managing Dr Naidoo adequately?-- If I could give you a scenario, as a Nurse Unit Manager my line manager is my Director of Nursing. If I don't manage my staff appropriately or my budget or my targets or any of the other items that fall in my position description, I am answerable to my Director of Nursing, and she will ask me questions and she will performance mange me, and so my understanding is that it should work like that in medicine and that if Dr Naidoo wasn't being accountable to this provision, then the Director of Medical Services should have been performance managing him.

You say that Dr Naidoo - this is at paragraph 38 - is on leave yet again; does Dr Naidoo remain on leave at the moment?-- I don't actually know what his status is at the moment.

Is he absent from the hospital currently?-- I have seen him there on a couple of occasions since the release of the AOA report when it was first released he was on signed off leave on some annual leave and then he had some - he returned for a week and then went on some study leave and then he returned to work but because of the closure of orthopaedic services he can't do any clinical practice and I have seen him there on a couple of occasions but I don't know what work he's performing.

You mention at paragraph 41 that, "The failure of Drs North and Giblin in their report to address the clinical ability of Dr Khursandi and Dr Padayachey maligns Drs Sharma and Krishna". Should I infer from that that you mean there were some negative things that ought to have been brought out about the performance of Drs Khursandi and Dr Padayachey?-- My concern is that in the review document, it doesn't actually state anything about Dr Khursandi or Padayachey's clinical skills but it does talk about more-----

COMMISSIONER: But is there something negative that should have been said about the clinical skills of either of them?-- I did not give a positive response to the reviewers and it was not in the document.

What do you mean by that? You gave a negative response about their clinical skills?-- I would have to say that I wasn't overly confident about a measure - if you wanted to measure Paddy or Khursandi against a senior orthopaedic specialist, then I don't believe that that was the - it was fair to the others who were being measured against the AOA standard when neither Khursandi or Padayachey were.

You don't seem to be answering my question. Did you say negative things about Khursandi and Padayachey?-- Yes, I did.

Well, perhaps you should tell us now what you said about either of them; did you give any specific examples?-- No, I didn't give specifics, they just asked me whether I felt that their clinical capabilities were-----

Adequate?-- -----I can't remember the terminology that was used, but I certainly said that I wouldn't - I wouldn't have either of them as my surgeon.

All right.

MR ANDREWS: You advised the investigators that there were major issues with Dr Naidoo's supervision of the SMOs due to his availability I see too from paragraph 42?-- Mmm-hmm.

Major, by that I assume you mean serious matters for concern?-- His unavailability.

And that that was a major issue?-- I saw it as a major concern because both Sharma and Krishna needed the support not just from an educational point of view but from being on-call one in two and when you get a complex trauma case, you often need more than one orthopaedic surgeon.

And indeed, you might need an orthopaedic specialist?-- That's correct.

Would you have brought the - to the attention of the Director of Medical Services that it was a major issue in your opinion?-- I don't recall whether I used the word major, but certainly I had voiced my concerns as I said previously.

And did the Director of Medical Services appear to agree with you that it was a major issue?-- Yes.

You speak of, "Another major issue with Dr Naidoo being his ability to be the Director of Orthopaedics; he didn't manage his department, you say, and didn't support his staff, the executive, the nursing staff or the organisation as a whole."; is that something you informed the Director of Medical Services about?-- I probably certainly advised Dr Hanelt that I thought that Dr Naidoo wasn't suitable to be a Director, but then my opinion of any Director in the medical service is that, in small areas like ours, they don't actually have any training in being a Director, they don't have administrative skills and they don't - perhaps don't have an understanding of what's required of that position prior to taking it on. The demands on them, as I said earlier, clinical verses non-clinical, they're always going to take clinical over non-clinical work, I have to say doctors are like that, they prefer to operate or see patients than to do paperwork, and although Dr Naidoo has been a surgeon for a very long time, and I'm not quite aware of what his status was at his previous employment, but how can I say it - he - Dr Naidoo could talk the talk, you know, he - in meetings he was very good of coming across as a professional Director, but he actually didn't produce anything as a Director.

I've just remembered some evidence you gave earlier about occasions when one of the senior medical officers had asked for help to perform surgery and Dr Naidoo for some reason was unavailable or turned up at the very end, and you've told the Inquiry that you informed Mr Hanelt of this verbally but didn't put in an incident report because you were not in a position to judge whether there was an adverse outcome?-- Mmm, that's correct.

Isn't it the case that if there is a risk created in surgery that shouldn't have been created, that that too can be an opportunity for filling in an adverse incident report?-- It certainly can be, you have to judge each situation individually, and depending on the scenario of the time, on that particular occasion it wasn't new to anybody that Dr Naidoo wasn't available, I was still in the position of looking at services of the operating theatre, I wasn't there to evaluate the medical staff, so it probably wasn't foremost

in my mind to be sorting out what the medical directors do or don't do in terms of supervision, and I'd never been given particular advice on what the level of supervision was. I have to say to this day I have asked for a definition on the supervision now after the Inquiry commenced and the brakes have been put on literally, I've requested can I have a clear definition of what a PHO can do, what SMO can do, what level of supervision is required in the hospital, in the district, and I haven't received those.

Who did you request that information from?-- As most recently as the chair review, the Acting District Manager.

And who's that person?-- Kerry Winsor. We haven't had a meeting since that letter has gone forward so I have to say I may get a response before the next meeting.

"Dr Naidoo" - you say at paragraph 42 - "did not have a private operating session between January 2004 and July 2004". What's the significance of that observation?-- In the review they talk about Dr Naidoo's private work, that he somehow skims the system on private work, but to my knowledge whilst I was there he didn't actually undertake private operating theatre sessions. He has the right of Option A, and I am also a member of the finance committee and my understanding is he actually didn't generate any dollars for his Option A. So my understanding there is he wasn't actually doing any private work for the Fraser Coast.

Now, if he had been, would he have performed surgery at the - either the hospital in Maryborough or in Hervey Bay?-- Or potentially St Stephen's, the private hospital.

And had he performed at St Stephen's, how is it that you would have known of it?-- I may have known just because of my connection through an external group called the Perioperative Nurses Group of Wide Bay where we meet and, you know, we discuss different things, so I may have heard it from that, but also in the finance report, it was where it was discussed in terms of the doctors who had Option A and how much they generated for that Option A and my memory for that year was that Dr Naidoo generated very little, you know, under probably $100.

Now, remind me of what Option A is? Is that where someone performs private work and generates funds for the public system?-- They perform work on privately insured patients or patients who are willing to pay. They don't actually bill the patient or get the private facility fees that come in the private sector, they are paid in addition to their salary a certain amount of money to be Option A and I think the idea in Queensland Health is that they generate enough money to compensate for the money that they're given, but certainly that didn't occur with Dr Naidoo in that previous 12, 12 months, I believe when he first came to the district he generated a lot of private work.

COMMISSIONER: But if Dr Naidoo was doing this private

operative work, and I'm not suggesting he was, but if he was, there's no reason you would have known of that?-- In the private sector, no.

No.

MR ANDREWS: At paragraph 44, you refer to something from the investigator's report, a quote that, "Nursing staff from the operating theatre referred to a procedure called cancelectomy as being Dr Naidoo's specialty." You don't say whether you dispute that there was among the nurses in the operating theatre this irreverent joke about Dr Naidoo?-- No, I think it was absolutely true that that's what the nurses referred to Dr Naidoo. It's not something I told a review team.

At paragraph 49, you mention a particular case and a weekend in which you had concerns about Dr Mullen's desire to schedule a patient for surgery on a Saturday?-- That's correct.

Now, was it your duty, because of your involvement with rosters, to be concerned with whether it was appropriate to schedule surgery for a Saturday?-- On the Fraser Coast we don't run a 24/7 operating theatre, the staff work on the weekend but are on-call from Saturday morning through to Monday morning. The nursing staff that were on duty on that particular day, of which two were extremely experienced orthopaedic nurses, contacted me because they'd been requested by Dr Mullens to book a case.

Did both of them contact you or only one?-- No, the most senior, the one that was in charge of the shift and the concern - she raised the concern because she has worked for the Fraser Coast - for Hervey Bay Hospital since it opened, she was well versed with Dr Mullens and knew of his activity when he had previously worked for Fraser Coast, in abusing-----

What was the concern about this surgery that she raised with you?-- The first concern was that he asked to book the case using specific prosthetic equipment that we don't have, that it had to be brought down from St Stephen's Private Hospital, so it would have to be done at a additional cost to what we would routinely do. The second concern was that the anaesthetist had already advised that we shouldn't perform the case because the patient had a chest infection and he believed that the patient should be treated for that chest infection and booked scheduled for Monday.

COMMISSIONER: Who was that anaesthetist?-- Dr Surendra Bhutra.

Mmm-hmm.

MR ANDREWS: Is that B-H-U-T-R-A?-- Yes. So the staff had concerns about the way Dr Mullens was pushing to get this case done and the use of the expensive equipment, and then all of a sudden the patient was, I don't know, I wasn't there, but the advice I was given was that the patient was requested that if

he went private we could certainly get this done and the family then conceded that they would pay.

Who passed all this on to you, somebody else?-- The senior nurse. She asked my advice, "What should we do?" I said, "Look, I think given that I know that the District Manager and the Director of Medical Services want to keep Sean on board, we don't want to upset him too badly but we don't want him to be abusing the system either. I will need to talk to the Director of Medical Services, I'll get back to you.", which I then tried to contact Terry and was unable to, I then tried to contact the District Manager and was unable to. I then decided to make a decision myself and advised the staff to advise him that we would not perform the surgery, that he could book the case for Monday.

Was your concern that he wanted to work at the weekend because that was an opportunity for him to earn additional income?-- I wasn't particularly interested in whether it was a financial thing, it just - it suited him to do the case then, the patient had been in hospital for some time and the fracture was, I believe, at least two weeks old.

Was your concern-----?-- My concern is that the team that would be tied up doing this surgery meant that there wasn't a team for real life and death emergencies. So we have an emergency block that's staffed Monday to Friday when we have additional staff around so that if we've tied up the emergency theatre, we can still pull a team together. On the weekend there's only that team there. If they get tied up in that emergency and other emergencies then backlog, then they're on overtime, they're also on-call, we have a high call-out rate for Cesarean sections so their fatigue levels are going to be high. This was not a life - to me was not a life or limb threatening operation and the anaesthetist certainly didn't see it as that. Dr Mullens overrode that decision by the anaesthetist by calling his private anaesthetist and asking him to perform the anaesthetic.

COMMISSIONER: Did you speak to this staff anaesthetist?-- Did I.

Mmm?-- No, I did not.

I thought what you said so far was that he refused to anaesthetise because of the chest infection?-- That's what the senior nurse on duty advised me.

Did she tell you anything else that the staff anaesthetist had said?-- No, not that I can recall.

All right, thank you?-- Dr Mullens was unhappy with that and made-----

MR ANDREWS: Do you understand he made contact with the Director of Medical Services?-- No, no, no. He was advised by the nursing staff that I had advised that the case should not go ahead. He then made some disparaging remarks about me

and said he would get in touch with the DMS himself. I don't believe he could contact the DMS either. He then managed to get hold of the District Manager and they had a conversation along the lines of, "If Sister Erwin has said that, you know, she can't staff it or it's inappropriate, then I have to take her opinion into consideration." They - the decision was then made that he could do the surgery the next morning which would allow us time to get a contingency plan for a separate core team so the surgery went ahead the next day.

Had there been a decision to cooperate with Dr Mullen, could the surgery have proceeded on the Saturday?-- Probably if his negotiation skills were a little bit better, we - the staff on duty may not have got to the point that they were unsure what to do, that they then felt that they needed to contact me. I don't like for my staff to be abused by medical officers and so if they get into a situation, I always say, "Please feel free to contact me at home and I'll talk to them".

COMMISSIONER: So it was very much a personality clash?-- Not between Dr Mullens and myself.

No, no, between Dr Mullen - as reported to you Dr Mullen and the theatre staff?-- I think so, yes.

All right. Is this a convenient time?

MR ANDREWS: Yes, Commissioner.

COMMISSIONER: All right, we'll adjourn for 15 minutes.

THE COMMISSION ADJOURNED AT 11.19 A.M.

THE COMMISSION RESUMED AT 11.38 A.M.

DALE FRANCES ERWIN-JONES, CONTINUING EXAMINATION-IN-CHIEF:

COMMISSIONER: Yes, Mr Andrews.

MR ANDREWS: Thank you, Commissioner.

At paragraph 65 of your statement, you mention that you'd taken your concerns regarding the management of the orthopaedic department to both the DMS and the DM verbally and you say you were happy that they were working towards putting processes in place to manage Dr Naidoo. What made you believe they were putting processes in place to manage him?-- They both agreed that there were concerns and that there had been efforts made in the past to try and address some of the issues in relation particularly to leave. They didn't outline to me

how they were going to deal with him or what they were going to do in regard to the issue, but as I said earlier, as I've not seen any major clinical poor outcomes on either himself or the two SMOs, I didn't have - I didn't feel I had significant evidence to give to them to say, you know, you must act on this. It's - to me, it was a general issue about his management of that department more than it was about patient safety, and when they advised that they would be, you know, looking at ways in order to manage Dr Naidoo, I accepted that.

I have no further questions, Commissioner.

COMMISSIONER: Well, just on that point: did anything appear to change after that?-- As I say, that would have been mid 2004, about April, around April/May and then the review, then I was advised that the review would take place and it did take place in the July.

Mmm?-- So there wasn't really a big time for that to happen.

But did anything change?-- After the review?

What review are we talking about now?-- The orthopaedic review by North and Giblin.

But that wasn't published?-- No, no, when they come to do the interviews in July 2004-----

Right, yes?-- They attended interviews there, it was only a couple of months prior to that that I raised my concerns.

Yes?-- After the review was undertaken, then there were some improvements in the servicing - Dr Naidoo's approach to education and the audits, you know, it was then he requested the software package to develop the audit too because I believe that he, he understood that there would be some recommendations out of that report and he then tried to put some of those things in place. He then again had further leave and then it was organised for a locum to come early 2005. When the locum arrived, he actually put in place all of the recommendations out of the report and the service was running very efficiently and effectively until we were shut down.

But the report wasn't published until after that?-- Yes, it wasn't published until April 2005.

So nothing occurred between April 2004 and that date in 2005?-- I think that, as I say, there were some things that Dr Naidoo put in place, he requested the audit tool-----

But you didn't see any results from that?-- No, I didn't, as I say, but that's a difficulty with all medical specialties trying to get them to actually produce the evidence of their quality activities.

Mmm?-- I don't think that Fraser Coast is any different than most.

Well, did you see any change apart from Dr Naidoo requesting a software package but nothing emerging from it?-- I think that his approach to Dr Sharma and Krishna improved a little bit in that time.

I see?-- And his dealings with them in trying to provide in-house education. He - his leave didn't - his leave patterns didn't change.

All right, thank you.

MR ANDREWS: Do you mean he continued in the second half of 2004 to take more leave than you considered appropriate for Drs Sharma and Krishna?-- For them to be left on their own.

Yes?-- Yes.

And you say that when the locum arrived in 2005, that person immediately attended to all the things that were ultimately recommended-----?-- Yes.

-----by the North/Giblin report?-- Yes.

Do you mean that the locum was always available within the district to supervise the two SMOs when they were in surgery?-- Yes, he was.

And was that entirely different from the situation that had existed before the locum's arrival?-- That's correct.

And what was that locum's name?-- Dr Ming Kwon.

Could you say it again for me?-- Dr Ming Kwon.

Thank you. I have nothing further, Commissioner.

COMMISSIONER: Mr Farr, if you would prefer that, I'll leave you until last.

MR FARR: Yes, I'm happy to go last.

COMMISSIONER: All right. Who else wants to examine this witness?

MR DEVLIN: I've got a couple of questions, Commissioner.

COMMISSIONER: Very well. Sorry. Two people, okay, you go first then. Thank you.

CROSS-EXAMINATION:

MR DEVLIN: Thank you. I represent the Medical Board. Ralph Devlin is my name, Sister. You have had the benefit, have you, of reading Dr Mullen's statement?-- I have.

And in that statement, Dr Mullen gives seven different accounts of seven surgical procedures, if you like, or the handling of seven patients. You have had the opportunity as recently as at the break at my request to turn your mind back to those seven incidents that he speaks of?-- I did.

Apart from the last of those in his statement, which is the one that you have spoken about, about the weekend booking of the theatre?-- Uh-huh.

Do any of the other six - do you recall any of the circumstances of the other six matters that he relates?-- Not personally, no, I don't.

Thank you. That's all I have.

COMMISSIONER: Thank you. Yes.

MS GALLAGHER: Thank you, Commissioner.

CROSS-EXAMINATION:

MS GALLAGHER: Good morning, my name is Gallagher and I appear for the AMA and some of its members. I might actually start where Mr Devlin left off. In respect of those persons that are referred to in Dr Mullen's report as persons with clinical - adverse, perhaps, clinical outcomes, were there any incident reports generated that you can recall?-- No, none.

If there were in fact incident reports created out of intraoperative events, would they come to your attention ordinarily?-- They would have come - if they were coming from the nursing staff, they would have come to me in the first instance. If they were coming from the medical staff, they may give them to me but theoretically they would go to their line manager or further up the chain, Director of Medical Services.

Perhaps, then, if we move from there across to the theatre review committee and the surgical management advisory group, is it likely such incident reports would come to that group?-- Any incident that demonstrated some negative outcome or poor clinical practice, in terms of clinical governance, that's where it should have started. As I said earlier, the request to have quality as an agenda item on that committee was to allow them to bring issues of concern to that group so we

could consider whether further investigations of a particular case or whether there was a pattern developing that we would then need to follow through on, that would be the place that you would bring it to initially. There was never anything brought to that committee in terms of orthopaedic care of the patients.

Those particular patients?-- Of any of those I am aware of, no.

Thank you. Is at least part of the function of that committee, when you are talking about quality data, to look at things that don't normally fall within the norm - I suspect things like unplanned return to OT?-- Yes, they are part of the standing agenda items as key performance indicators, unplanned returns, cancellations, that sort of thing, targets.

And the incident, for example, of the closed fracture that became a compound fracture that was returned to the OT wasn't one that came before the committee?-- No, from the dates on that, it was prior to my time as the manager of the operating theatre in Hervey Bay. I had reason to go back through the incident report books recently on another matter that were held in the department and there was nothing in any of those books related to any negative clinical activity in orthopaedics over the period 2001 to 2005.

Who actually constituted that committee during your time? I am not asking you to speak of matters before your time?-- As I said, it was a recommendation out of the Queensland Health operating theatre review-----

Sorry, I have confused you. Who employed by the district were the persons who constituted the committee?-- Oh, sorry, the director of each department, so the Director of Obstetrics and Gynaecology, the Director of Anaesthetics, the Director of Orthopaedics, the Director of General Surgery, the nurse unit manager of operating theatres Hervey Bay, the nurse unit manager operating theatres Maryborough and the elective surgery coordinator.

Did that committee have the responsibility or power to issue directives in respect to the supervision of surgeons?-- It would be the committee's role to report to the executive any level of concerns. So would write to the executive and say our concerns related to something specific, could you address this, could we have a memo, could we have a policy, you know.

So you make a recommendation and it would go to the person - for example, if we're talking about supervising surgeons, to the Director of Medical Services to give such directive?-- All correspondence went directly to the district manager for dissemination. Because he may not be able to answer the question, it may have to go to a different department, so Director of Medical Services, Director of Nursing, infection control coordinator but the response would come back from him.

So, in essence, I suppose to distil that down, it is a

committee that had the power to make recommendations?-- Certainly.

Thank you. You spoke also in respect - changing topics - about on call, and the ability or the responsiveness of persons to come on call when contacted by staff. Was that something that you would expect, if not on it, if one of your members made a phone call for on call assistance and it wasn't answered, that would find its way to an incident report?-- If the person was on call, rostered to be on call and was uncontactable or didn't appear, yes, it would generate an incident. However, the assistance required by the SMOs was from a more senior orthopaedic surgeon but no-one was actually on call beyond the SMOs.

Okay. So that-----

COMMISSIONER: Let me clarify that. You say that there should be an incident report, not that there necessarily would be?-- If, for instance, Dr Naidoo was on call and he didn't arrive when we requested him, that would generate an incident report.

Well, it should?-- Should, yes.

Not necessarily would?-- Well, no, but nurses are fairly proactive in doing incidents.

They may or may not be. Yes, all right.

MS GALLAGHER: Thank you. You have said in your evidence that Dr Mullen didn't respond to on call on occasion?-- No, to request for assistance.

I beg your pardon. So that you don't assert there has been ever an occasion where Dr Mullen has been on call and not come when on call?-- No.

Are you aware what - sorry, are you aware of the nature of Dr Mullen's contractual relationship with the district?-- Only insofar as he is a part-time visiting medical officer.

Do you know how many sessions per week he is contracted to provide?-- He no longer works for Fraser Coast but prior to his resignation my understanding was that he would give a session per week.

And how many hours is a session per week?-- 3.5.

May you not be aware he also had perhaps an outpatient session for another one session per week?-- My understanding was that he would do an outpatient session one week and an operating theatre session - sorry, I stand corrected. It was two sessions initially, that he would provide two sessions per week, one of those being an outpatients clinic followed by an operating theatre session. However, that didn't occur and his sessions were more one session per week. He worked - he approached the elective surgery coordinator to request that his surgery be one week and his outpatients be the following

week, so he reduced down to one session per week. Then he supplied dates when he would be available for surgery. So it didn't actually work out to be one session of operating per week or per fortnight. Sometimes he would operate once every four weeks. It would be in relation to what his availability against his private practice was.

Can I ask you how often you had opportunity to observe the surgeons performing surgery?-- It would be hard to put a time on it, but all of them - all of the surgeons I have observed, I have probably seen much more of Dr Khursandi and Dr Padayachey's work because I was substantively the nurse unit manager of Maryborough theatres for almost two years before I went to Hervey Bay. In terms of, say, sessions, I would have seen Dr Naidoo operate doing arthroplasties three or four sessions, Dr Sharma and Krishna do elective work probably a handful and emergency trauma work a handful each. Dr Mullen, maybe two or three times.

Two or three surgeries, two or three sessions?-- Sessions.

So how many surgeries would that be, roughly?-- Generally only one case. I did actually spend some time with Dr Mullen's theatre because I was - I had previously been a scrub nurse and done orthopaedics in Illawarra, but it had been a number of years, and I suggested to him that I would like to polish up my skills and that I will take the opportunity to work with him. It didn't actually ever occur because he left before that could happen, but I did scout in the theatre a couple of occasion.

May I ask then, if we're talking about two surgical interventions having been observed by you, how it comes to be then that you can determine that he is of limited ability - and I am referring specifically to paragraph 59 of your statement?-- Dr Mullen?

Mmm?-- I will have to refer to it. 59 did you say?

Yes, that's right it is actually on page 17. It is the second last sentence at the top of the page, in the paragraph at the top of the page. I beg your pardon, I will take all of that back. I withdraw all of that, I beg your pardon?-- Sorry, that's what I thought. I don't think I ever made that comment about Dr Mullen.

In respect of the matters that you raise in paragraphs 47 to 53, starting particularly with the expression - sorry, the last phrase in the - in paragraph numbered 47, "his desire to manipulate the district to suit his own needs", can you explain how it can be that surgery performed by Dr Mullen on the weekend, and one may only assume he is on call then, serves his personal need?-- I can't - I can't actually say that it was a personal need, you know, or - no, I am not insinuating it was for any financial gain, but it suited him to operate at specific times that may not have been suitable for the organisation. I give an example in my statement about a Saturday morning where he requested the on-call team be

called in to do a fractured ankle, I think it was, and the nurse manager requested of him that we delay it, the call-in, until the staff arrive at 10 a.m. He refused to do this and demanded that the call team be called, so they were, which, as I spoke of earlier, the call team - the staff that are on on the weekend are then on call, so they have been called in early, it is a eight-hour shift, there is a high possibility that they will do over time at the end of that shift and get called out that evening. So he has brought them in earlier, so they are now on at least a 10 hour shift, and if it was - if it was a critical life or death scenario, then no-one would request that. If the limb was threatened, no-one would question that. The - part of my role is to ensure that the theatres are used efficiently and effectively within budget constraints, okay, so one of my positions is that we should question the surgeons about the need to call the call team in (1) from the dollar value, (2) the fatigue issue, and (3) that my nursing staff actually have lives outside of work, children they have to feed and bath and care for, and, you know, not to appear sexist, but most of my staff are girls and they don't have people to go home and their dinners cooked and their kids are bathed, they have to go home and do all that, come back the next day. Predominantly doctors don't have to do this. This day and age it probably happens a bit more. So on that particular occasion they were called in early and then the scrub nurse overheard Dr Mullen discussing with the anaesthetist the real reason behind the need to call the call team in and get it done early was because he had an appointment with his mother for morning tea at 10.30.

COMMISSIONER: What did he say? Why do you say that's the real reason?-- Well, that was the comment made to the anaesthetist, "We better move this along because I need to get out of here, I have got an appointment with my mother for morning tea at 10.30."

How do you draw the inference from that that was the real reason he booked the surgery then?-- Well, it wasn't a life or limb-threatening surgery.

All right.

MS GALLAGHER: But you would agree, wouldn't you, that if Dr Mullen made a clinical determination that patient's care was best served - the patient's needs were best served by surgery that morning, that surgery should be performed that morning, operating within the constraints as you can?-- Absolutely. I mean, it is not our role to say they can or can't do things, it is our role to determine what the overall needs are, the big picture sort of stuff, you know. Any surgeon who is on call and so is linked to the hospital for a period of time, and having worked with surgeons for 20 odd years, their preference is actually to work. So if they have to be bound to the hospital, particularly if they live in Brisbane, then they'd rather actually work than sit around watching TV or doing nothing. So when I first took over the position in Hervey Bay, one of the things I had to do was set some boundaries about what constituted emergency surgery and

have a category system for category 1 emergency, 2 and 3, because there was abuse of the system - not just by Dr Mullen, by many people, calling the call team in to do, you know, an abscess at 2 o'clock in the morning, you know, which is not-----

COMMISSIONER: We're talking about other things now. But did you ever seek to speak to Dr Mullen about his view as to whether that surgery was urgent?-- No, I don't recall.

Why not?-- Well, I very rarely saw Dr Mullen, as I say-----

No, no, no, why didn't you seek to speak to him?-- Well, I didn't have any reason. The call had occurred, the patient had had its operation. He was a VMO-----

No, the patient hadn't had the operation. As to whether the patient should have the operation?-- No, I wasn't on duty on that day, so I didn't see him, the patient went ahead and had that surgery on that day.

I thought you said the surgery was postponed until the Sunday?-- No - that was-----

MR FARR: I think it is two different cases.

WITNESS: That's a separate case.

COMMISSIONER: Okay, what about the one the surgery was postponed to the Sunday, did you speak to Dr Mullen about that?-- No, I did generate an incident report about it.

Why didn't you speak to Dr Mullen to see what his opinion was about the urgency of that surgery?-- Well, again, I don't think that I actually saw him in any close time-frame, and-----

No, no, why didn't you?-- I had some difficulty with Dr Mullen because he is very argumentative.

If you had some doubt about the urgency of the surgery, didn't you think it would have been prudent to ask Dr Mullen, the surgeon concerned, his opinion about the urgency of that surgery?-- Well, I knew what his opinion was. His opinion was that the surgery needed to be done that day, that best practice states a fractured neck or femur needs to be performed within 72 hours of the fracture. But on that particular case - I then reviewed the charts - that patient had had the fracture for two weeks, there were issues around that particular patient, his overriding of the staff anaesthetist, the director of anaesthetics had reason for concern as well, he took it to the Director of Medical Services.

We're just straying from the point there. Why didn't you discuss your concerns with Dr Mullen?-- Probably because I felt that it would just end in an argument between Dr Mullen and myself.

Right, okay, thank you.

MS GALLAGHER: Thank you. I think the patient the Commissioner has been speaking of is that you refer to in paragraph 49.

COMMISSIONER: Yes, it is.

MS GALLAGHER: Thank you, Commissioner. You don't disagree with the proposition, though, that if a doctor, as a consultant orthopaedic surgeon, made a determination the clinical need of patient paragraph 49 was best served by having the surgery that day, that that course was anything other than appropriate, do you?-- No, we - if the doctor says it is in his clinical judgment to do the surgery, he normally says, "It is in my judgment and I will make the decision. This is what we're going to do."

And might that not have been exactly what he did say on that day, given that you did not speak to him, as I understand it?-- The record of events from the nurse that was in charge of the shift was that he approached her earlier in the day requesting that it be done at 8 p.m. At 8 p.m. my staff would have been off duty for two hours already, so they would be a recall. It then blocks that theatre for real life and death emergencies, had cost implications to the district and fatigue implications. That's why their concern took them to contact me in regard to the matter. I - certainly if Dr Mullen's had turned around to the theatre staff and said, you know, "I don't care what she says and I don't care what the district manager says, we're going to do it", they would have done it. I mean, we would never stop a doctor operating if he said it needs to be done.

I suppose what follows from that is if he determined that the $5,000 prosthetic would better serve that patient than the cheaper prosthetic, the same would apply?-- There was never a debate about whether he could or couldn't use it. That was just part of my incident reporting, that I saw that as questionable that he chose a more expensive prosthetic, given the whole scenario of that particular patient over the patient that followed that surgery, the next day. When he did that case, he actually followed it with another identical case and used the cheaper version. So in the context of the two cases, I couldn't understand why two patients with exactly the same fracture, where one gets a five and a half thousand dollar prosthetic, one gets a $550 prosthetic, one is able mind and bodied, and one is slightly demented and lives in care.

But all of that added together still didn't give rise to you speaking to him about, say, the differential in prosthetic cost or the need for surgery or any other relevant clinical issue prior to you formulating an adverse incident report?-- No, as I said, he is a difficult man to deal with at the best of times and so I chose to take it to his line manager, the DMS, as not - I didn't write an incident report - Queensland Health incident report, I wrote a statement with evidence to

say to the Director of Medical Services, "Please investigate, you consider it", you know, because Dr Mullen, when he had worked for the health service previously, was well-known to utilise the emergency block because he couldn't utilise the Monday to Friday block because his time was taken up with private practice. So a lot of cases would get held over and put on the weekend, which led to a lot of fatigue leave, a lot of cost, and a lot of unhappiness with the nursing staff. So it was part of my role to try and ensure that we didn't get back to that same path with Dr Mullen, okay, so-----

I understand?-- It is quite difficult to be a nurse and try and direct the traffic with a medical officer, and we had come to blows over a previous incident where I requested him to fill out a consent form for a patient, because the one that was in the patient chart was not valid because it was out of date, and, you know, we got into a large argument over it because he said it was just rubbish and he wasn't going to do it. I am there to ensure that we meet processes, policies and practices within the realms of Queensland Health and Fraser Coast, and he wasn't willing to participate. You know, so already we had a difficult relationship in terms of being able to sit down and have a logical discussion about what was right and what was wrong.

So if hearing what you are saying correctly, he is difficult to communicate with, don't communicate with him at all. If you have trouble with him, report him to his line manager?-- Well, to take it to his line manager for discussion with me on how I should deal with it, okay, so that I would - what I am requesting - I have the letter I wrote to the DMS here, if you wanted to review it - I am requesting advice on the situation. I didn't actually receive any advice on what to do about it and no action, to my knowledge, was ever taken over it.

I want to ask you one more question before we move off this patient, and I have to say I am not, unfortunately, entirely sure it is the same patient, but could it be the case that the anaesthetist who did not want to anaesthetise this patient, given a chest condition, made a clinical determination that this administration of that anaesthetic was, in that particular person's view, not something he wished to undertake?-- It was in his clinical judgment that it - the patient safety would have been at risk to do the anaesthetic on that day, that they would be better off commencing conservative treatment for the chest infection and booking her for the Monday.

Might it be the case that a more experienced anaesthetist would be happy to deliver an anaesthetic to somebody with chronic chest conditions?-- I suppose that's a possibility but one would hope then that the more senior anaesthetist actually came and examined the patient before making that determination.

Indeed, but you are not sure, are you, or you have no way of knowing if that did in fact occur?-- In the patient's charts there is a notation by Dr Mullen that the patient was seen by

Dr Myer, but it is in Dr Mullen' handwriting, not in Dr Myer's handwriting, and there was no indication in the chart preoperatively that the anaesthetist had seen the patient.

COMMISSIONER: So you draw from that an inference that Dr Myer did not see the patient?-- Yes.

All right, yes.

MS GALLAGHER: Quite easily could be the case that the matter had been discussed with Dr Myer or Dr Myer had his hands full at the time, couldn't it?-- I suppose they could have discussed it on the phone but Dr Bhutra is a highly skilled anaesthetist and I wouldn't question his judgment.

I don't purport to assert anything other than there may have been somebody more experienced who may have suggested that they were happy to deliver the anaesthetic?-- Maybe. I would have to say that it doesn't matter how highly experienced or many years you might have in some specialty, some doctors will take greater risks than others.

You say at paragraph 15 of your statement that Dr Mullen - "issues with respect to orthopaedic surgical outcomes ought properly have been first referred to theatre review committee and surgical management advisory group." If I was to suggest to you that Dr Mullen had raised his concerns about issues like clinical competence and lack of supervision with the Director of Medical Services on several occasions prior to his taking the step of going to the Orthopaedics Association, would that be a route, given his role of reporting requirements that was appropriate for raising such issue?-- Certainly you have that avenue. As I said before, in line with clinical governance it is opportune that you take your issues through the correct channels. And, as I said, until Dr Mullen's complaint to the AOA, no-one, not Dr Mullen, not Dr Naidoo, not Dr Hanelt, not any of the nursing staff had ever brought to my attention any concern about the capabilities of Dr Sharma or Dr Krishna. So if Dr Mullen had had those concerns, then - then one would have hoped that he would use normal channels, and that would be through theatre review - not that he wasn't a member, but he could take that to the Director, and if they had been doing their clinical audits as they should have, perhaps it would have been picked up there if there was some poor clinical outcomes. But, as I say, nothing was ever flagged. There was never a red flag that went up.

COMMISSIONER: Not to you?-- And said there was a problem-----

Not to you?-- Not with me, no. I am not disputing that he may have taken this up with Dr Hanelt. I don't know that.

MS GALLAGHER: Indeed, given the hierarchical nature of both medicine and nursing, that Hanelt was in fact his line reporting manager?-- I am not sure that Dr Naidoo would be the first port of call.

I beg your pardon?-- But then Dr Hanelt, yes.

That's where the problem arose, then it was perhaps the next person to discuss the matter with, short of going to the District Manager, would in fact be the Director of Medical Services?-- Yes, yes.

Has Dr Mullen ever sworn at you?-- Not at me personally, no.

Has he ever cursed you?-- Not to my face.

Can I just ask you to have a look at paragraph 34, please, of your statement?-- Uh-huh.

A consultant within the medical - to use the term "consultant" within the medical sphere is to use a term of art, isn't it?-- To use a term of art?

It means a specialist, doesn't it?-- Consultant?

If I say to you, "I am going to see a consultant today.", do you think I'm going to see, for example, a training registrar?-- No.

Do you think I am going to see an nontraining registrar?-- No.

So, isn't it the case that "consultant" means, within the industry, specialist?-- Yeah, probably. I think the terminology in different States is different, so-----

I am only asking you about in Queensland, I'm sorry?-- Yes. Yeah. A specialist is a consultant, I suppose. You can classify them as - together.

But there was nobody who was not a specialist that is an consultant either, is there?-- Well, a VMO is not classified as a consultant, he's classified as a VMO.

Indeed. But he too was a specialist or she too was a specialist?-- Yeah, but we don't call them specialists, we call them VMOs and we call consultants consultants. The term "specialist", isn't - I don't think is one that's routinely used.

So, sorry, now I am confused. So who can be a consultant that does not hold specialist qualifications registered with the Medical Board?-- No, I suppose - yeah.

There was nobody, is there?

COMMISSIONER: You agree with that, don't you?-- That a specialist is a consultant-----

No, no, no?-- -----or a VMO?

There is no consultant who isn't a specialist?-- No, I suppose not.

Right. Thank you.

MS GALLAGHER: It is fair to say you don't like Mr Mullens?-- No, that's not fair to say. I don't know Mr Mullens particularly well, not on a personal level, and our professional relationship has never had an opportunity to go anywhere really.

COMMISSIONER: You believe you don't get on well with him?-- He's difficult to get along with.

No, you believe you don't get on well with him?-- No, I believe-----

Whether he's difficult or because you are difficult, you have that belief, don't you?-- I believe that he doesn't like me particularly.

You don't like him particularly?-- I don't like his attitude, no.

All right.

MS GALLAGHER: Thank you, Commissioner. I have nothing further.

COMMISSIONER: Thank you. Mr Farr?

CROSS-EXAMINATION:

MR FARR: Ms Erwin-Jones, can I take you back to the patient you referred to in paragraph 49, that's the Saturday/Sunday operation involving Dr Mullen?-- Mmm-hmm.

Can I just summarise it so I understand the situation. You were presented with a position by one of your staff whereby you had been informed that the surgeon wished to conduct the operation. Another specialist, the anaesthetist, had expressed a view that he wasn't prepared to do so for safety concerns for the patient. That's correct?-- Mmm-hmm.

You were unable to contact the two line managers that might normally be involved in a decision of that nature, that's the DMS or the District Manager?-- Yes.

I understand - please correct me if I'm wrong - that you knew something of this matter or looked at the charts for this patient?-- After the event.

After the event. So you were given the information that you required, I take it, by the nurse to whom you were speaking?-- Yes.

I see. And you were, as I understand it, again advised that the Dr Mullen was intending to try and contact either the DMS or the District Manager after you'd made your decision?-- Yes.

You didn't interfere in any way in him doing that?-- No.

And as we understood it, he was able to contact the District Manager, Mr Allsop?-- Yes, that's correct.

And is it your understanding that as a consequence of that contact, the opinion of another anaesthetist was sought in relation to this matter? Do you understand that to be the case, or don't you know?-- I'm not sure at what point the

other anaesthetist was contacted, whether it was prior to contacting the District Manager or after contacting the District Manager.

I see?-- I believe that he advised the District Manager that he would use a private anaesthetist if one concern was re tying up the public anaesthetist, which is of one concern, but the other concern is the nursing staff are also tied up, and that was my concern.

And a particular concern, as I understand, that you had was that this was on the face of it is not an emergency that required to be worked on that weekend. Secondly, there was some health and safety issues that had been brought to your attention if it were to proceed and, thirdly, that if your staff are tied up with that procedure and another or an emergency does occur, then you have got real staffing problems in looking after the subsequent patient?-- That's correct.

All right. You spoke a little while ago of Dr Ming Kwon, who I think worked as the Director of Orthopaedics?-- Acting Director.

Acting Director of Orthopaedics. And we understand that was from approximately mid-January 2005 till about mid-May 2005?-- Yes, that's correct.

He, as I understand it, left soon after the report, the North Giblin report was published?-- When the-----

I'm not after his reason?-- Yes.

But that was the timing?-- Yes. He didn't just up and leave, he stopped clinical work and proceeded to review the patients that he had operated on, see all the patients that we had planned to operate on and explained to them the scenario.

All right?-- He was still available to give some level of support to Sharma and Krishna during that period.

Okay?-- I think his finishing date was in June.

For the majority of the time that he was there, though, it would seem that he was in that position prior to the publishing of the report?-- Yes.

Notwithstanding that he was there prior to it becoming public, do I understand your evidence to be that he initiated or assisted in a number of changes to the system where there was some problems identified?-- Yes. I will have to say all of the recommendations that came out of the review were addressed by Ming Kwon. I don't know that he did that purely on his own direction, perhaps Dr Naidoo gave him direction, I don't know that, or whether it's just his own professional skill and clinical abilities that he could see the holes and decided to act upon it, I couldn't qualify that.

That's all right. That was the bit that I wanted to try and

clarify. When you say that he had acted upon the recommendations, I take it what you are saying is that he had prior to the recommendations either himself or with the assistance of others acted in such a way that when the recommendations came out they were in areas that had already been corrected?-- That's correct.

COMMISSIONER: Can you identify those areas in which he acted and what he did?-- Well, the supervision had improved dramatically. He was always available.

His supervision, yes?-- Yes. Of the SMOs. The education pathways, the planning, one of the recommendations was about planning cases. He worked through that.

Just say what he did in terms of recommendations. Yes?-- Introduction of clinical pathways. I just can't remember all of the recommendations out of the report.

Not so much the recommendations, what he did. Just identify what he did?-- Well, he-----

One of the recommendations was to close the orthopaedic area down in Hervey Bay. That wasn't - he didn't implement that. I just want to know what he did?-- Well, he improved the overall performance of the department.

Yes. In what respect?-- By - by introducing better education processes-----

Yes, you have said that?-- -----for SMOs, education processes for the nurses.

Yes?-- We looked at different ways to manage the sessions in terms of doing joint replacements. We were given the opportunity to perform quite a large number of joint replacements during that period because of his skill and then to facilitate that outside of having never being able to achieve more than one or two joints on a session, we went from two joints a session in Hervey Bay and three joints a session in Maryborough because of his efficiencies and his ability to pull a team together.

Did he do all those joint replacements?-- Yes.

In both Maryborough and Hervey Bay?-- Yes. The introduction to the clinical pathway.

Yes, you mentioned that?-- We had been - the nursing staff had tabled that through the Surgical Advisory Group years before and had never been able to progress it because Morgan was resistant, Dr Mullens was resistant, Dr Khursandi was resistant. We'd given them - at least Dr Morgan - a copy before.

I just want you to identify the respects in which he, you say, implemented the report. You mention clinical pathways. Can you mention any other respects that you haven't mentioned so

far?-- Morale in the orthopaedic department. He treated both Sharma and Krishna as human beings and-----

Right?-- -----people that needed respect and guidance and - which they hadn't had before.

Yes?-- His team approach with everybody, the nursing staff, the anaesthetic department, the ward, the physio and allied health people, he - the audits, he - if Dr Naidoo hadn't already commenced the audits, he took on the audit control. I don't - again, none of that documentation came through to Theatre Review Committee.

Do you didn't ever see it?-- No. But we had limited meetings during the time that Dr Ming Kwon was there because he didn't actually want to sit as the director in that chair, he didn't want to be on that committee in an acting position, so-----

All right. This was-----?-- He only attended one meeting.

But you did never see them. What else?-- Just general patient care, the way he managed patients.

All right. Thank you. Right. Yes?

MR FARR: Thank you, Commissioner. The effect of all of that, was the orthopaedic department in May of '05 in any way similar to the orthopaedic department as it existed in July '04?-- Only in terms of we still did not have enough staff to have an appropriate on call system. As I said earlier, to manage that in a fair and equitable fashion we need at least two consultants per hospital, plus VMO coverage of - you know, probably somewhere between four and six, along with your SMOs. Dr Kwon did an inordinate amount of on call while he was there to support Sharma and Krishna. I don't think that it was his intention to have to do that but he was happy to do it while he was there.

Can I ask you as well, the Maryborough Hospital, does it have an emergency department?-- It does. Well, it has the - at the time of the review we had a functioning emergency department. Today we have a primary level care emergency department, since the release of the report.

COMMISSIONER: What did you mean by "functioning emergency department", doing what?-- Assessing, triaging and treating, resuscitating and managing all the patients that come through the front door.

Right?-- At primary level care we now basically only receive patients that require minimal medical intervention. Most patients are transported directly to Hervey Bay and-----

But any patients who require surgery were transferred to Hervey Bay?-- If it was known that they required surgery prior to the ambulance taking them somewhere, yes, they go to Hervey Bay, because we don't have a 24 hour operating theatre in Hervey Bay or an on call system - oh, in Maryborough,

sorry - or an on call system.

MR FARR: You have mentioned in your evidence that you have spoken to Dr Hanelt on occasions regarding the issue of poor supervision by Dr Naidoo of the SMOs?-- Mmm-hmm.

And I understand your evidence to be that those conversations occurred on - some time between January '04 and July '04?-- Yes.

I take it that these issues came to your attention when you commenced in your position at Hervey Bay and that you then subsequently drew them to his attention?-- Yes.

When did you first learn that there was to be a review or an investigation - I'm not quite sure what term might be best used - but there was to be some sort of investigation conducted at Hervey Bay?-- I can't - I couldn't give you a specific date but it would have to be somewhere between probably May and June of '04. I knew about it prior to it occurring, but how much in advance, I can't recall.

Were you aware when you did learn of its - that it was to be conducted, were you aware that one of the issues that was being sought, the guidance, was an issue of supervision?-- Yes.

Including issues such as assistance with management practices and recommendations for appropriate levels? Are you aware of that?-- Well, the detail of that, the terms of reference weren't ever given out prior to the review.

All right?-- And not on the day of the review.

If you didn't know about that then I won't take it further?-- Yeah.

Thank you. There is one matter that you might be able to comment upon. You have spoken and been asked questions about availability of doctors and your administrators, I suppose, but we know the Fraser Coast district there are two primary hospitals, if you like, there's Maryborough and Hervey Bay. Does having the two hospitals within that one district in itself cause any difficulties? For instance, can it be the case that a person can be in surgery at Maryborough when they might also be required in Hervey Bay? Does that sort of thing arise?-- One of the items for the Theatre Review Committee was to align the session arrangements so that didn't occur, so there was always the availability of a surgeon in orthopaedics, in general surgery, and in obstetrics available for emergencies, so they weren't tied up in an operating theatre at either site or in a clinic, so they were on a nonclinical activity day so that they would be available for any emergencies that came through. It is difficult to manage two hospitals under one umbrella because of the amount of medical staff we have. It's not difficult to do in terms of organisational structure - it happens quite commonly across the country - but we have always struggled with recruiting

medical staff to adequate numbers to facilitate both hospitals.

All right. Can I take you to paragraph 42 of your statement, please. You have been asked some questions about the topics that you raise in that paragraph and there is just one matter I am a little confused about from your evidence-wise. You were asked if you voiced your concerns of it being - of having a major concern to the DMS and I think you are referring to the term "major" in that paragraph. My understanding of your answer was that you might not have used the term "major" when you spoke to Dr Hanelt. Did I understand you correctly?-- Yes, I may not have said, "I have major concerns."

All right?-- I may have just said I have some concerns in relation to supervision or leave or the activities in the orthopaedic department.

All right. The bit that confused me, and I just ask you if you could to clarify it, is that Mr Andrews asked you after you gave that answer if Dr Hanelt agreed that it was a major concern, and you indicated yes, and that's where my confusion arose. Did he speak of it being major or-----?-- No. He just agreed with me that there were concerns within the department.

I see. Do you recall when it was that you voiced those concerns?-- Not down to a specific date.

Oh, no?-- But it would have-----

A period of time?-- -----to be somewhere between April and when the review was undertaken in July. I say that because when I first went down there in the January, my focus was to address the nursing issues within that department, so I didn't get heavily involved in the medical performances or what was going on in terms of medical activity until - when I had to address the fatigue leave and the overtime, it became apparent that the emergency block was being abused or - okay, misused in terms of causing the fatigue and the overtime. It was probably at that point I thought, well, why is this happening, that-----

All right?-- -----so much work is being pushed out of hours.

Okay?-- That's why I say it would have to be between April and July.

All right. Now, you also said in reference to Dr Naidoo that he could talk the talk, as a orthopaedic surgeon. I understand you to make that reference, but often didn't produce. What did you mean by that?-- Well, as a director, he's the manager of that department and on committee meetings, you know, he could often - you know, espouse about, you know, the best practice and how we are going to manage this and what we will do with the audits and - but you never actually saw any evidence of any of these things that he believed to be best practice or believed that they were doing in the

department.

I see. Yes, thank you. That's all I have.

COMMISSIONER: Thank you, Mr Farr. Mr Andrews, any re-examination?

MR ANDREWS: I have no further questions, thank you, Commissioner.

COMMISSIONER: Ms Erwin-Jones, you are excused from further attendance. Thank you for coming?-- Thank you.

WITNESS EXCUSED

COMMISSIONER: Mr Andrews?

MR ANDREWS: I call Dr Sean Mullen. I am not certain that he's here.

COMMISSIONER: Do you want to say something?

MR DEVLIN: Yes, Commissioner. It was about the calling of Dr Mullen.

COMMISSIONER: Yes.

MR DEVLIN: There are a number of specific surgical procedures referred to in Dr Mullen's statement without any further elucidation. I note that Dr Mullen's statement is dated the 7th of June.

COMMISSIONER: Yes.

MR DEVLIN: Conscious of the Terms of Reference, in relation to surgical procedures in which my client has an interest in, to assist the Commission, soliciting those as closely as possible, having in mind the issues about charges Dr Mullen makes about Dr Naidoo's level of supervision of some of these specific procedures, conscious also that the subsequent statements of Drs Krishna and Sharma address the general terms of the North Giblin review report but don't address any of these specific incidents which are alleged to have involved them-----

COMMISSIONER: Yes.

MR DEVLIN: My submission is that it will be difficult if not impossible to adequately assist the Commission to explore these specific procedures with Dr Mullen without access to the patient charts and, indeed, we don't at this stage even have patient names.

This difficulty has arisen in the previous Inquiry as well where a number of witnesses were examined early in the piece without any of the parties having access to specific patient charts, and the focus of some of the more prominent matters has shifted dramatically once the charts became available.

I did raise my concerns with Mr Andrews last evening and my instructing solicitors did write a letter to him raising these concerns and I express them now.

COMMISSIONER: You want that letter as an exhibit?

MR DEVLIN: Yes, I do. I'd tender that.

COMMISSIONER: All right. Thank you. That will be Exhibit 330. No, I think it may be - I will put it on the exhibit letter numbers, I think. It remains a public document. It will be Exhibit letter something or other, the next one, whatever that is.

MR DEVLIN: I would also like to make available to you, perhaps after lunch, a letter that was written at a very early stage, alerting-----

COMMISSIONER: D, Exhibit D. Sorry.

MARKED FOR IDENTIFICATION "D"

MR DEVLIN: Thank you. Yes. A letter written at a very early stage in the previous Inquiry alerting Commission staff to this difficulty.

COMMISSIONER: Yes.

MR DEVLIN: That without patient charts the discharge of the - or the attempts by my client to assist the Commission in discharging its responsibilities under the terms of reference in relation to specific concerns, allegations or complaints about specific surgical procedures is significantly limited and, in fairness to Drs Krishna and Sharma in particular, and I don't know whether there is a statement of Dr Naidoo in existence at this stage - I am not aware of one - but in fairness to those gentlemen, who in other material appear to be described as very good at what they did, it is impossible, in my respectful submission, to adequately test the recollections of Dr Mullen in relation to these specific procedures of which there are about six that would fall into the category of which I speak where the criticism is either insufficient supervision by Dr Naidoo of other doctors and/or insufficient skills possessed by those doctors in relation to specific procedures. That's the difficulty I wish to point out to the Commission at this stage.

COMMISSIONER: Thank you. Anyone else want to say anything

about this?

MR FARR: Yes, I do, thank you, Commissioner. I expect to be appearing on behalf of both Drs Krishna and Sharma and my - I will adopt the submission of my learned friend rather than repeat any of it. But can I say that in relation to those two men, the concern is far more direct. The statement in the evidence of Dr Mullens as anticipated is quite critical and he makes reference to specific patient procedures. We have not been provided with the names of those patients. We are, therefore, unable to gather those charts and make assessments and have a look at things for ourselves. His evidence on the topic for each of those patients simply can't be tested, and I do point out that the statement of Dr Mullen is dated the 7th of June 2005. It's been in existence for quite some time. It was only delivered to us three days ago.

COMMISSIONER: Yes.

MR FARR: My instructing solicitors also, I think, e-mailed yesterday requesting the names. I don't know I have that e-mail with me, but we were advised to raise this matter before we gave evidence today.

COMMISSIONER: Right. Thank you.

MR FARR: I have got the difficulty I simply can't cross-examine him properly - in fact, I can't cross-examine him at all on those topics without having the material.

COMMISSIONER: All right. Thank you. Ms Gallagher, you want to say something?

MS GALLAGHER: Thank you, Commissioner. I will be seeking leave to appear on behalf of Dr Mullen. As the Commissioner's aware, I spoke with Mr Andrew last evening when he raised with me the difficulty that were going to be faced by certain parties in the absence of medical records and assured Mr Andrews that I would seek from my own client instructions to accept the summons that would allow him to release patient confidential names. Unfortunately, despite attempts made by - that I have made and Commission staff have made, we haven't been able to speak to him this morning.

COMMISSIONER: Speak to Dr Mullen?

MS GALLAGHER: Yes. We understand from the Commission staff he was flying down due to arrive at 11 - after 11 o'clock.

COMMISSIONER: Nothing much we can do about that at the moment.

MS GALLAGHER: No. What I would have in mind doing, if in fact the patient records can be made available, and I assume that they are at Hervey Bay Hospital and they could be obtained within the next day or so, is to permit him to give his evidence-in-chief on the basis of the cross-examination would follow as soon as the records are made available to

those who want to see them.

COMMISSIONER: Do you know any more about that, Mr Andrews?

MR ANDREWS: No. It's a surprise to Ms Gallagher and to me, Commissioner, that Dr Mullen is not here.

COMMISSIONER: Right.

MR ANDREWS: An appointment was made for him to give evidence today during the course of the last Inquiry and I think it was made some weeks ago for Dr Mullen to be here to be called at 11.30 a.m.

COMMISSIONER: Yes. All right. There is nothing useful we can do at the moment. Mr Farr?

MR FARR: Can I just raise one point from the matter you just spoke of?

COMMISSIONER: Yes.

MR FARR: I have a concern in that the giving of evidence-in-chief without immediate cross-examination following has had the result previously of allowing the media to publish the evidence-in-chief.

COMMISSIONER: Yes. I see the problem.

MR FARR: Some attention which on points have been changed and subsequently proved to be incorrect in cross-examination without similar attention processes occurring.

COMMISSIONER: I can understand your concern. Yes. What is your solution?

MR FARR: Well, I wonder if he 's to give evidence-in-chief, whether those particular matters where he's referring to patient procedures could be delayed - he give the remainder of his evidence-in-chief today on those issues - until once we are in a position to cross-examine properly, so that when that evidence is given there will be cross-examination following immediately.

COMMISSIONER: Yes. I am inclined to adopt your submission in that respect, Mr Farr. It may be as a consequence of that that we sit tomorrow. I don't want to take up too much time on this. I really wanted to move on with this Inquiry as quickly as possible. So if there's some possibility of getting those medical records this afternoon or by early tomorrow morning, I would be inclined to perhaps call Mr Mullen, assuming he turns up this afternoon, on other issues, delay his evidence-in-chief and cross-examination on the specific issues you talked about until tomorrow, and hear his evidence on that basis - examination-in-chief and cross-examination now.

MR FARR: I will follow whatever ruling your Honour makes. I

am not available tomorrow because of another commitment I made when we thought we weren't sitting Fridays. But we have others in our team of course that can-----

COMMISSIONER: I, as you know, try very hard to accommodate counsel, Mr Farr, but the urgency of the matter proceeding quickly in the limited time would require me to sit tomorrow if in fact those records are available.

MR FARR: Can I just flag another concern that I have. A lot will depend upon the size of these records.

COMMISSIONER: Yes.

MR FARR: And the interpretation of medical records is not something that, through experience, one does quickly.

COMMISSIONER: No.

MR FARR: We will endeavour to have someone assist us in that regard but I am just merely flagging potential concerns.

COMMISSIONER: I understand that. But I think that it probably will be you have to do your best.

All right. We will adjourn until 2.30 or perhaps even before then if Dr Mullens arrives.

MR ANDREWS: For the sake of the parties, your Honour, may I ask that a fixed time of 2.30 be arranged? Otherwise I need to canvas all the counsel in the room and have them return at some-----

COMMISSIONER: Okay. 2.30.

MR ANDREWS: I warn the parties that if Dr Mullen doesn't attend it would be proposed to call Dr Mattiuissi.

COMMISSIONER: Okay.

THE COMMISSION ADJOURNED AT 12.45 P.M. TILL 2.30 P.M.

THE COMMISSION RESUMED AT 2.32 P.M.

COMMISSIONER: Yes, Mr Andrews.

MR ANDREWS: Good afternoon, Commissioner. Commissioner, Dr Mullen has been kind enough to provide us with the names of some patients referred to in a statement he'll soon identify. I understand that the charts with respect to those patients at least with respect to one of them is likely to be very bulky.

The result of that means that though I've not yet learned whether they can be scanned or whether they have to be manually photocopied and transported to Brisbane, but it seems to me unlikely that the parties would be able to digest them this afternoon. Dr Mullen is available on Friday of next week to complete evidence that begins today.

COMMISSIONER: All right.

MR ANDREWS: As to his availability tomorrow.

COMMISSIONER: It doesn't like too realistic, does it, to ask him to come back tomorrow because I don't think he'll be cross-examined then by the sound of it.

MR ANDREWS: That does sound to be a risk, that he still wouldn't be - the parties wouldn't be able to cross-examine.

COMMISSIONER: Well, I wouldn't want to bring him back if he can't complete his evidence.

MR ANDREWS: No.

COMMISSIONER: I suppose that will mean at this stage we will exclude even from his statement the evidence dealing with those six or seven cases and I suppose I could do that by accepting as an exhibit the affidavit but deleting from the admission into evidence at the stage of certain paragraphs; are you happy with that, Mr Farr?

MR FARR: Yes, Commissioner, that's fine.

COMMISSIONER: Yes. Can you identify the paragraphs?

MR FARR: Yes, I can. Paragraphs 6 to 14 concern one patient.

COMMISSIONER: Well, these are 6 is-----

MR FARR: Perhaps 6-----

COMMISSIONER: Six is Dr Naidoo, you're not appearing for him?

MR FARR: No, I'm not.

COMMISSIONER: And his solicitors have a copy of the statement, they've been told that Dr Mullen was giving

evidence today and they haven't decided to come, so.

MR FARR: I won't take that any further, I'm just identifying what paragraphs.

COMMISSIONER: No, would you mind just then identifying the paragraphs which deal with Drs Krishna and Sharma.

MR FARR: Yes, if I could then move on to paragraph 24?

COMMISSIONER: 24?

MR FARR: 24.

COMMISSIONER: 24.

MR FARR: It goes 24, 25 and 26.

COMMISSIONER: Yes.

MR FARR: Probably actually from 23 to 26 in fact and then the final paragraphs are paragraphs 31, 32, 33 and 34 and then - sorry, they were the penultimate paragraphs, then one goes to paragraph 37.

COMMISSIONER: Yes.

MR FARR: 37, 38.

COMMISSIONER: Sorry, what's that got to do with it, 37 and 38?

MR FARR: That's the final patient that's referred to in the course of the evidence of this witness.

COMMISSIONER: Yes, but that's not to do with Dr Sharma or Dr Krishna, is it?

MR FARR: No, I'm just reminding myself again now. This is the matter about which you've heard-----

COMMISSIONER: Exactly.

MR FARR: -----some evidence so to - so there's no difficulty about that at all.

COMMISSIONER: Okay. What's the objection to 23 to 26 at this stage? Oh, I see, I see, all right. Yes, all right. So 23 to 26 and 31 to 24?

MR FARR: Yes.

COMMISSIONER: All right. Yes, Mr Andrews.

MR DEVLIN: Commissioner, is it possible to have the patient names linked to those particular paragraphs for all the assistance of the board?

COMMISSIONER: I don't know, is it?

MR ANDREWS: It is now.

COMMISSIONER: Right. Well, we can do that but I'm not going to disclose the patients' names in public here.

MR DEVLIN: No, I'm simply asking for some information at some point.

COMMISSIONER: The answer I'm told is yes.

MR DEVLIN: Thank you.

MR ANDREWS: Commissioner, I submit it's appropriate for me to tender a list that reveals those patients' names and for you to order that they not be published for the moment. There is a running list of patients on an exhibit referred to as a patient key which has something in the order of 300 patient names on it currently and the media have responded to orders and intimations that they ought not publish confidential names on that list.

COMMISSIONER: All right. Well, the first I suppose I should, if you want to tender - well, we haven't even sworn the witness yet.

MR ANDREWS: Correct.

COMMISSIONER: Make sure you better go and do that.

SEAN ANDREW MULLEN, SWORN AND EXAMINED:

MR ANDREWS: Dr Mullen, what's your full name please?-- Sean Andrew Mullen.

Doctor, you've prepared a statement, an affidavit sworn on the 7th of June?-- That is correct.

Of 49 paragraphs?-- Yes.

Are the facts set out in that affidavit true to the best of your knowledge?-- They are.

Are the opinions you give honestly held by you?-- Absolutely.

I tender that statement.

COMMISSIONER: I admit into evidence that statement minus paragraphs 23 to 26 and 31 to 34 which for the moment I would exclude from evidence and that statement minus those paragraphs will be Exhibit 330.

ADMITTED AND MARKED "EXHIBIT 330"

COMMISSIONER: Yes.

MR ANDREWS: Dr Mullen, please look at this short statement of yours? Is that your statement setting out the names so far as you know them of the patients referred to in various paragraphs in your statement?-- Yes, it is.

And the patient referred to in paragraph 32 of your statement is still unknown to you?-- Yes.

Do you expect that you'll be able to identify that patient?-- I think I should be able to do that, yes, that's underway.

COMMISSIONER: Why do you want to tender that at all?

MR ANDREWS: As a record of their names.

COMMISSIONER: But won't I do that after I admit paragraphs 23 to 26 and 31 to 34? Is that a convenient time to do it?

MR ANDREWS: It is a convenient time.

COMMISSIONER: Is there any other reason why you want it in at this stage?

MR ANDREWS: So that the parties need to act upon - need to prepare for these matters can know the names of the statements, names of the particular patients as they relate to particular paragraphs.

COMMISSIONER: But you can just give a copy of that document to them at that stage, can't you?

MR ANDREWS: I can.

COMMISSIONER: All right, well perhaps we won't admit that into evidence at this stage, that's the safest way of doing it. Yes, very well.

MR ANDREWS: Dr Mullen, you're an orthopaedic surgeon?-- Yes, that's correct.

And you moved to Hervey Bay in about 2000?-- That's right.

At that time, the Director of Medical Services was Dr Hanelt?-- That's right, yeah.

The immediate superior of Dr Hanelt at the time, would that have been the District Manager?-- Yeah, that would have been just then the new district manager was Dr - Mr Michael Allsop and we'd just had a new change of district manager when I arrived.

And at the time you arrived, Dr Morgan Naidoo was the Director of Orthopaedics?-- That's right.

You took a VMO session or two at the Hervey Bay Hospital shortly after your arrival?-- That's correct, I had two sessions at Hervey Bay Hospital, a morning and an afternoon session when I first arrived once a week.

Did that make you subject to the direction of Dr Naidoo as the Director of Orthopaedics?-- Yeah, my understanding was that I was - that I was involved in, you know, reporting things to Dr Naidoo because he was my immediate superior at that time which is my understanding of the system.

In 2002, there was an incident when you were doing a ward round and you refer to it at paragraph 6?-- That's right, yes.

That involved an elderly lady who'd been admitted about 10 days previously?-- Correct.

With a fractured arm?-- Yes.

How often would you be visiting the hospital in 2002?-- At this time I was visiting once a week and every Wednesday morning was the morning I did my ward round, so I would go and see my patients on the Wednesday morning prior to my clinic starting and so that would have been the time at which I was doing a weekly ward round of my patients and seeing people on the ward.

The nursing sister in charge asked you to see an elderly lady who was one of Dr Naidoo's patients?-- That's correct.

Do you recall the circumstances relating to her?-- I do, vividly. I was doing my ward round as usual and Sister Winton who was the Charge Sister at that time of the ward contacted me and showed me a photograph which of course is an instant Polaroid photograph that we often take for the recording of wounds et cetera, and showed me this large wound that was present on this lady's arm, and she really asked me if I could see this lady because there was concerns from the junior medical staff and the nursing staff that this lady had a problem which was not being managed in their opinion to the best of the ability and they were concerned about her health.

Now, what's the normal protocol? For the surgeon who has performed surgery to manage the patient following surgery?-- Normally that's the case, yes.

And that would have been Dr Naidoo?-- That's correct, yes.

Why is it that - well, where was Dr Naidoo?-- Well, that wasn't very clear at the time and because, because of my position as a visiting medical officer, I'm not really aware of the administrative goings on of the presence of certain people, so it's hard for me to assess where he was at that time, but he wasn't available at that time to be able to see

that patient which was the concern, and by the information I was given, and certainly saw later in the notes, that he hadn't been really available for several days to see that patient which is why I was asked to see the patient at that time.

COMMISSIONER: Do you know if he was scheduled to be on duty at that time?-- Well again, the information that I have is that as a full time orthopaedic surgeon he should have been there from certain hours during that time. I wasn't aware of him being away on scheduled leave and the information I got was that several of the junior staff had contacted Dr Naidoo by telephone about this lady in the preceding days and that Dr Naidoo had given some advice on the telephone but hadn't actually attended to the patient.

Mmm?-- And that was the information I got from the chart and from talking to other people.

Yes.

MR ANDREWS: That lady's name was P430?-- That's correct.

And did - do you have some notes that allow you to determine at what date P430 was seen by you?-- Yes, I do.

Do you have a copy of them with you?-- Yes, I do, indeed.

So this will have been a Wednesday?-- This was a Wednesday and the date was the 2nd of August 2000 - 2000.

Within your statement at paragraph 6 you speak of the incident as being in 2002?-- Oh, well that's incorrect, that was 2000, yeah.

Okay?-- My impression was that it was later than that.

But the notes show you that it-----?-- The note shows 2000. It's difficult with these dates because this has been going on over a four year period and the dates become difficult but 2000 is the one.

When you say this has been going on over a four year period, do you mean your time at the hospital has been going on for four years or do you mean something else?-- Yeah, I guess what I'm trying to say is that the issues that we've been trying to address with supervision have been a problem for that period of time and I think that these issues have been going on, obviously as you can see, from year 2000, not 2002.

And what is it about the fact that the patient had a, according to the notes, had been taken back to theatre when the bone had protruded so that a dressing could be placed on it and that it was to be put in a new plaster that concerns you?-- Yes. My concern about the management of these types of fractures is that once a fracture has become open or has breached the skin, then that fracture has a much higher risk

of infection and the usual process of dealing with these fractures is to widely open the wound and to stabilise the fracture in a way that would prevent the bone from continuing to move. That's the way that we would deal with these in a usual fashion, so there was - that raised my concerns as that would not be the way that I would personally manage that patient in that situation.

Was it a way that other orthopaedic specialists might legitimately choose?-- In my practice, no, and certainly in my involvement in teaching of students in the management of these fractures, the contemporary teaching is that those fractures should all be managed in the same fashion, stabilisation and debridement of wound.

COMMISSIONER: You describe that practice as unacceptable?-- Of what was done, yes.

Yes. Do you describe it as negligent?-- I understand the question. When it comes to the management of that sort of fracture that way, I would have to say in my opinion it would be negligent practice and I would consider it to be negligent practice.

Thank you.

MR ANDREWS: Your criticisms of Dr Naidoo throughout the rest of the statement have all been to do with the fact that his absences have meant that there have been unsupervised senior medical officers. This is the only instance, as I understand it from looking at your statement, where you criticise Dr Naidoo's level of care?-- Yeah. That's correct. The whole way through the situation, I feel very strongly that the problem is not about clinical acumen but about lack of supervision, and the two things in my humble opinion are completely different issues. Clinical acumen, as far as I'm aware, is not a problem, and again, Dr Naidoo is a contemporary orthopaedic surgeon whose clinical skills are certainly contemporary, the problem is that the supervision problem has allowed situations to occur that have been unsatisfactory and that's my big issue, yeah.

And indeed, the supervision problem you're talking about is the supervision of Drs Krishna and Sharma?-- Yes.

And of those two doctors, you do say at paragraph 44, "They're not the ones to blame for what has occurred". You regard it as an administration failure?-- I do, yes.

For allowing two-----?-- Yes.

----- doctors who haven't fully developed their skills to practice unsupervised?-- Yeah, I do feel that is the big problem, yes.

COMMISSIONER: Before you go on to that, the patient that you are talking about in the end needed an amputation?-- Yeah, that's correct.

Of her arm?-- Yes, yes.

And you attribute that to neglect and delay in treatment by Dr Naidoo?-- Yes I do, and the reason I believe that is because it is in my practice, in my experience and those of many of my colleagues, I have never seen a closed, that is, non-open fracture of the humerus in a low velocity situation in an old patient end up with amputation. I cannot find a case study in the literature to support that information. So it seems to me that the long term outcome was determined by the lack of intervention early-----

Thank you?-- -----is my opinion.

MR ANDREWS: Doctor, have you retained some notes relating to that patient?-- I have, yes.

Have you recently, that is, within the last 20 minutes or so provided a bundle of patient notes-----?-- Yes I have.

-----you have retained?-- Yes I have.

But in respect of each of the patients, all but one?-- All but one, and I think one of the patients who was only treated entirely at Hervey Bay Hospital who was not my patient who I was asked to see, those patient notes remain at the hospital and I haven't seen those notes at any stage.

And the selection of notes that you retained, have you selected them because they tend to illustrate what you regard as some relevant features of the care of the patients referred to in these notes?-- Yeah, I think the reason I've retained these notes is that they really reflect to me situations which I believe developed mostly out of a lack of supervision rather than the usual complications that we would see after surgery, every single surgeon has a list of complications that routinely occur and we accept that and we deal with them in the best way we can, but supervision of junior unqualified or underqualified doctors leads to decision-making which often results in outcomes which are not due to routine complications which we expect but are due to complications that are due from poor decision-making or just not knowing what to do next and that's why I've retained these notes to illustrate that.

Can you identify this and tell me whether it's a copy of the notes you've retained?-- Yes, that appears to be right, that's correct.

Commissioner, I'll tender those with a view to getting them copied so that I can circulate the parties.

COMMISSIONER: But before you - before I accept those, don't they also relate to the matters dealt with in paragraphs 23 to 26 and 31 to 34?

MR ANDREWS: They do.

COMMISSIONER: Well, I shouldn't admit them into evidence at this stage.

MR ANDREWS: You can admit them into evidence with an order that the names within them not be published.

COMMISSIONER: Except with what I've done with respect to the evidence which the witness covers in the statement, the relevant part of Dr Mullen's statement. What's the advantage of admitting them at all at this stage?

MR ANDREWS: So that they will remain on the record and-----

COMMISSIONER: I can take them into my custody if that's appropriate rather than-----

MR ANDREWS: That's equally satisfactory, yes.

COMMISSIONER: Yes, okay, I'll take them into custody, I won't make them an exhibit at this stage and that will depend upon any objections to the statements contained in paragraphs 23 to 26 and 31 to 34 of Dr Mullen's affidavit.

MR ANDREWS: Thank you.

Did you speak with Dr Naidoo about this particular case?-- Yeah, I did. I contacted him initially when I saw the patient. I discussed the situation with the family and the nursing staff and it was obvious that she needed fairly urgent attention because she was becoming sick from infection, and I - although it was an ethical issue for me to take over the care of another doctor's patient in that way without discussion, I felt that it was going to be necessary to do that, so I tried to contact Dr Naidoo but was unable to contact him at that time. I then contacted my next superior who was Dr Terry Hanelt and explained the situation to him and he indicated that I should take the patient to theatre. Later that morning before theatre, which was scheduled for 1 o'clock I believe, I then was able to contact Dr Naidoo and he wasn't available on the hospital grounds and he indicated to me that I should take over the care of the patient and operate on that patient but wasn't available to do that himself. So I subsequently took the patient to theatre and did the appropriate emergent care that I thought was necessary at that time and that was probably the sum of my discussions with Dr Naidoo at that time.

You stabilised the situation?-- Correct.

What does that mean?-- Well, it was quite a difficult situation. I had to remove a large amount of the arm muscle because it was dead and infected, the radial nerve which is the nerve that supplies the wrist was also damaged and not viable and I then had to apply a frame, an external fixated frame which is a large frame to stabilise the fracture from externally so that the fracture could be more easily managed on the ward.

Over what period of time are you able to estimate had the muscle been dead?-- You know, for muscle to develop that appearance it's usually over a several day period, it has some gas in the wound which indicates that there is a gas forming organism which does appear in dead muscle, so that the period of time was probably several days that it had been developing. The wound was large enough as you can see from the photographs, was about two by three centimetres and so it had been going on for some time and the notes indicated the junior staff had been trying to do something about the situation for the several days to stabilise the situation.

I see. For a - is it the case that the surgeon, Dr Naidoo, ought to have been at least capable of being contacted by the junior staff?-- I think that's a situation - I think that - there is no doubt that when something develops which is extraordinary, you need to have the ability to at least discuss the situation and expect, rightly so, that the doctor in charge would actually attend and deal with the problem.

And is this a situation that was extraordinary?-- I think it was extraordinary, as I say, yeah.

And do the notes show you that attempts were made to contact Dr Naidoo that were unsuccessful?-- That's what I have seen from the notes. There is an area where one of the resident doctors, who felt very strongly about the problem, did a summary of the admission because she felt very uneasy about what had occurred, and she then did a summary of the dates, clearly how they developed, and this, of course, is something I couldn't have been able to do because I wasn't involved till very late in the process. But she has applied a fairly clear chronological sequence of events, and there was a period I can see of about six days where Dr Naidoo was contacted about this but was unable to attend to deal with the problem. And, so, that was what - I believe that the delay there would have led to the outcome of amputation because of the delay in care at the time.

Now, being the surgeon who had performed a procedure on this patient, does it mean that Dr Naidoo had to be any more than contactable during that six day period?-- Absolutely. I think that - most importantly with these sorts of situations is proximity, and that is that none of us expect that we will be present 24 hours a day all the time. It is not possible. But if there is a problem which needs dealing with, then the proximity has to be such that you can attend in a fairly prompt period of time to deal with the problem.

In the year 2000 when this occurred, do you know whether there was a protocol at the hospital for filling out forms that notified of adverse or unexpected outcomes like this one?-- At the time that this happened, I wasn't aware of any such information. Later on in the piece there was a form that was developed by Dr Naidoo that was placed for patients or for resident staff to fill in information about abnormal outcome. But unfortunately there was no audit process done per se in terms of a peer audit. So that information - I am not sure how it was dealt with but I never attended an audit session with that information until very late in the piece. Probably the first of those meetings I attended and the last was last year, 2004. So up until then there were no regular audit meetings of that information that I was attending or had seen.

Do you mean by that that there may have been audit meetings-----?-- Well. What I mean-----

-----instituted that you were never told of?-- Well, there certainly were meetings that occurred that I wasn't attending because I wasn't notified, but an audit requires two or three

peer review of the situation. You can't audit your information with one person. It is not an audit. So those meetings, if they occurred - again, I am not sure whether they did; I can't tell you that - but if there were meetings that occurred that I wasn't at, they weren't peer review audits, that's for sure.

Making them less acceptable?-- Unacceptable. An audit by definition requires peer review.

Back to the patient whose arm was amputated, you raised your concerns about this whole issue you say with Dr Hanelt and assumed he'd investigate the matter?-- That's right. At the time I - when I talked to Dr Hanelt, I explained to him at the time that I was very unhappy about having to deal with this and I felt it was inappropriate, and that I felt that this was something that needed to be looked into further, and I then made the assumption that the information would then be taken on hand and dealt with appropriately through the system.

Now, Dr Mullen, at paragraph 15, the evidence that you give in it is probably coloured by the misconception you had that the patient whose arm was amputated was dealt with in 2002?-- Yeah, correct, that's right. Correct I thought - this is the event occurred in 2002, I didn't realise 2000 - that's actually the first thing I was doing my visiting medical work and I assumed it was later in the period, from recollection.

Can you say aside from the incident you describe relating to the lady who is an amputee, when was the next occasion you became aware that Dr Naidoo was unsatisfactorily absent from Hervey Bay? Would it have been as late as 2002 or was it earlier than that?-- It was - it was at the time when the new Fijian doctors arrived at Hervey Bay, which I believe - as I said in my report, I think it was either late in 2002 or early 2003 when they arrived.

Well, I expect that there will be evidence that Dr Krishna began employment on about the 20th of July 2002?-- Yes.

And that Dr Sharma began in about March 2003?-- Well, that could be right, and that's what I have said, either late 2002 or early 2003, that's correct.

Do you mean that from 2000 until late 2002, a period of about two years, you were no longer concerned that Dr Naidoo was taking unsatisfactory absences?-- No, that's not true. I think the situation was that there was not another clinical situation that arose that became - that I had to be involved in that was due to lack of presence, but there was always a problem with supervision the whole way along, in terms of being available for supervision of junior staff at that time. When I was working at the hospital, because of my concerns about supervision, I did all my own outpatient clinics myself, all my own theatre sessions myself, and I didn't allow anyone to do any surgery without me. So I attended everything because of my concerns at that time. And there were issues with availability, but there was not another clinical problem

that I can recall that I had to be directly involved in in that two year period.

How did you become aware of the issues relating to availability?-- It usually came by with talking to nursing staff or talking to patients. Often I would see private patients privately who had been seen publicly and who had issues about being managed and contacted - being able to contact the person who did their surgery. There were issues with rostering, where when I got my rosters as my on-call roster, Dr Naidoo would not appear for a period of a month at a time. And so it was a very big problem with his availability to do these things. And so I guess the issue at that time was more a feeling that there was not a person who was regularly attending as their job as a full-time director, which of course is a salaried full-time position.

Well, at paragraph 15 you speak of the situation at the hospital becoming untenable for you as a professional in your relationship with Dr Naidoo. You say you were fearful of supervision conditions at that stage?-- Uh-huh.

Are you able to date that?-- It is difficult - I can actually date it because it was around the time my second child was born, which is about 2003, and at that time it was getting very difficult because I was the only private orthopaedic surgeon providing private cover for patients, and I was doing my visiting sessions, I was being - constantly felt that I was having to supervise at a higher level than I would normally be expected to do. I did have phone calls at times from staff - junior staff about patients that they wanted advice on because they couldn't get advice from the director. And I felt at that time that it was becoming very difficult to do the job 100 per cent the way I feel it should be done in terms of-----

When you say, though, couldn't get advice from the director, do you mean the Director of Orthopaedics?-- The Director of Orthopaedics at that time, yes.

Did you discuss these things with Dr Naidoo?-- I discussed it with him several times. However, the-----

What did he say?-- Well, it was a very non-committal situation. Normally he had a reason why the situation occurred and would explain it away and would guarantee me that the situation was being attended to. So you have the impression that the situation was under hand. And, really, at that time, because the Fijian doctors were not present, it was something which wasn't becoming very acutely aware to me because, of course, they weren't - there wasn't a group of doctors who were being allowed to autonomously operate unsupervised in the same way that's developed with the two new doctors. So at that time I was more aware of the fact that there was a lack of ability to give appropriate guidance and information, rather than a lack of specific supervision of the surgical procedures which were going on. But this was something which changed, as I say, once the Fijian doctors arrived because of the situation there.

Perhaps before I proceed to their arrival, did you by any chance discuss with Dr Naidoo why he had not dealt with his own patient who became an amputee, or his method of dealing with the patient when she was first treated?-- At the time, I must admit I didn't realise till much later than an amputation had been performed on that lady because she wasn't my patient, so that patient - she was treated by Dr Naidoo when he returned, once I'd done the emergent surgery, so I didn't really have the information at hand about that lady until much later, until I actually, out of interest, when I thought about this lady, went looking for reasons why what actually went on long-term in terms of her recovery and found out she had had an amputation at that time, some weeks subsequently.

When you learned that there were two Fijian doctors - bearing in mind they seem to have arrived about eight months apart-----?-- That's correct.

-----did you - were you away from the hospital for the tenure of the first of them?-- That's correct, that's right. I think I returned to do elective work. I never actually left doing on-call emergency work, I continued to do that the whole time because I felt I needed to offer some sort of after-hours service, because we have a fairly small number of surgeons providing services in the area, and so I never removed myself from the on-call roster.

Well, that's a charitable act on your part, isn't it?-- Well, the thing is the whole point about this is that - for me, anyway - that I live in the community. We're only a small community and we're trying to develop something that's going to be sustainable long-term. And, you know, for me to take away my services on call was going to be a very big problem, because on call was going to have to then be covered by either junior staff or patients going away to another area. That actually became a problem, too, because there was concerns from the administration about how those on-call patients could be managed long-term, given the fact that I wasn't doing elective sessions. So they did raise a lot of problems, which they saw as problems.

I am curious, you say that if you didn't do on call, it would either be done by junior staff or the patients would be referred away?-- Well-----

What about the staff specialist in orthopaedics, the Director of Orthopaedics?-- Well, that was one of the big problems, was - if you look at the rosters, particularly some of the rosters coming out at the time of 2003 and 2002 when the new Fijian doctors were present, Dr Naidoo was very rarely on call as the full-time orthopaedic surgeon.

As a matter of practice, is there a reason to be concerned if you have SMOs who are on call and no specialist orthopaedic surgeon also on call?-- Well, I think that's what - that's probably the issue that I raised very early on when the Fijian doctors arrived, was the fact that they are on call, their

on-call process that was organised was to me completely unacceptable professionally because - and there is one roster that I have here from early on in 2003, July, that has them on call as the consultant orthopaedic surgeon and I am on call in a conterminous way with them, in other words they follow my weekend. So they were basically being treated as specialist orthopaedic surgeons and they were autonomously operating, and there is a period of time where Dr Naidoo was absent on leave and they continued to do on call as the orthopaedic surgeon on call. There was no-one supervising their surgery.

Is that inappropriate?-- I think it is, yes.

COMMISSIONER: Even dangerous?-- I think it is dangerous.

MR ANDREWS: Would you have a look, please, at this July 2003 roster? I will put it on the screen. Is that a roster that you collected from-----?-- That's the roster, and this is one of the rosters probably that first started my concerns about the situation, was the way it was released, and it was done at the same time that a news report was released from the hospital indicating that two new orthopaedic surgeons have begun practice in the region at the public hospital, and I indicated at the time to the Director of Medical Services that I thought that this was inappropriate, not just from an ethical point of view and a safety issue, but also from a medical registration point issue, where they weren't registered as specialists in Queensland at that time. And, again, I didn't get much satisfaction as to the problem.

So you pointed out to Dr Hanelt that this even was a registration issue?-- I said to him I felt - I felt in my opinion it was a registration issue.

Did you look at their registration or is this something that you were able to-----?-- Well, I had discussed this with - this situation with various colleagues who are involved in medical registration issues who indicated to me that they felt from their experience that this was an unacceptable situation, from a registration - I am certainly not an expert in medical registration but to me that seemed to be inappropriate, yes.

Now, what is it about the - well, let's, for instance, take the first group of sessions that concerns you?-- Well, if you look at the roster, if you look at where it says "medical officer on call", "district orthopaedic consultant" and "district surgical consultant", the word "consultant" indicates to both layperson and doctor that that person is the specialist consulting surgeon for the region who is providing both experienced advice and treatment for these patients.

COMMISSIONER: Was that roster made public, though, doctor?-- This roster?

Yes?-- Only to the medical staff. Patients - the only way patients would have access to that roster would be if - if they were relatives of a doctor working in the hospital.

MR ANDREWS: Indeed, is the distribution list at the bottom of the page - can you raise it so we can see the last paragraph - does it show the persons to whom this roster would be distributed?-- Yes, it does, yes, who are the medical practitioners appearing on the roster. And, of course, administrative people as well.

Now, can we go back to the top of the page? For instance, for Sunday the 29th of June, I see there is a medical officer Majid?-- Correct.

The consultant is said to be Krishna?-- Yes.

And the surgical consultant Diaz?-- That's right. Majid would be the very junior medical officer who would be basically involved in dealing with the patients on the ward, inserting cannulas for drips, writing up drug orders, and seeing patients in casualty on a small basis. Dr Krishna would be the person expected to do the surgery on any emergency case that attended the hospital that weekend, and that could include any type of complex surgical procedure, particularly as we have a helicopter pad there which brings in cases from other areas. And Dr Diaz is the surgeon, as in the general surgeon who is also expected to be on call to cover general surgical problems which, you know, obviously are different specialty area.

Now, if this roster were to be satisfactory from a patient safety point of view, for Sunday the 29th ought there be an orthopaedic specialist's name?-- Correct. The way it should read would be medical officer, senior medical officer, orthopaedic surgeon.

And if there was an extra column showing senior medical officer-----?-- Yes.

-----and then a column for the orthopaedic surgeon?-- Yes.

That surgeon would either be, what, you or Dr Naidoo?-- Myself or Dr Naidoo.

And would, in theory, the principle be that the senior medical officer would attend to any after hours emergencies and would call the specialist who is on call to seek advice-----?-- Correct.

-----and advise about emergency situations so the specialist could make a judgment about whether to attend in person?-- That's the normal process. That's the process that we used at Princess Alexandra Hospital when I was doing my full-time job as a full-time orthopaedic surgeon there, and we had a roster that worked that way and there would be - and, of course, the level of supervision that you provided for the doctor depends on their level of expertise. And, of course, we dealt with a whole range of expertise at the Princess Alexandra where you had junior staff who had to be supervised with every operation, very senior doctors who could be supervised from a further distance. But those people were put through a process

that took sometimes up to four to six years to work out who was suitable to be left alone and who wasn't. And my problem at this situation was that I didn't know these two men, in terms of their surgical ability, and I wouldn't have been happy to leave them unattended for an extended period of time until they were assessed, and that's why when they first arrived at 2003, as you can see they are on the roster as orthopaedic surgeons, several months after they - in fact, in fact, one month after they arrive in the area and start working. So that was my concern at that time. That's what really - that was what really drove me to talk to the administration about this more seriously because I felt that this was misrepresenting what these doctors were capable of doing, and unfair on them as well to be doing this.

Are you aware of whether they underwent an appropriate privileging and credentialing process?-- Well, again, that's an area which I have very little knowledge about in terms of what they actually have to do. My understanding, from an orthopaedic surgical point of view, the Australian Orthopaedic Association has some recommendations for credentialing of orthopaedic surgeons and, of course, the College of Surgeons has an appropriate level of credentialing which needs to be done to allow people to work in an autonomous fashion. The only way they could be credentialed to do consultant work unsupervised would be if they were looked at for a period of time by, in my humble opinion, very experienced orthopaedic surgeons in a large area of excellence, such as one of the larger Brisbane hospitals where they could be supervised more closely. And then they could be credentialed and then they could be passed to the area in a way which was safe for all of them.

There is a document from the Hervey Bay Hospital, a form called Orthopaedic Surgical Services Scope of Service?-- Right.

Are you familiar with such a document?-- I have no idea what that document is.

If there were to be credentialing, for instance, of Dr Sharma who arrived in, as I understand it, about March 2003-----?-- Yes.

-----would it be appropriate if he were credentialed by Dr Naidoo alone?-- Not at all. And that's - that's something which, again, when it comes to assessing people for their individual surgical abilities, the mentoring process requires multiple opinions from multiple surgeons over a period of time, because personality conflicts can occur and they are not an objective way of dealing with someone's ability. So you need to be looking at people with multiple inputs over periods of time.

I suppose it is conceivable that he may have been credentialed by Dr Naidoo, Dr Padayachey?-- No, Dr Padayachey was a senior medical officer as well. He was actually also under supervision by Dr Khursandi in Maryborough and he was

supervised, on my understanding, in Maryborough.

Is that why you wouldn't have complained about the situation-----?-- Correct.

-----in Maryborough?-- Correct because the situation there was different. Dr Khursandi was supervising him and did supervise him and had been doing so, on my understanding, for 30 years, and that was a completely different situation to this one.

I tender the July 2003 roster.

COMMISSIONER: Yes. Thank you. That will be Exhibit 331.

ADMITTED AND MARKED "EXHIBIT 331"

MR ANDREWS: Have you been able to form an opinion about an appropriate scope of practice for, for instance, either Dr Krishna or Dr Sharma?-- Well, my - one of my big problems that I have had here is that because of the way that they have been used by the public hospital locally, they were never given to me in a way that I could supervise them. In other words, I was never on call with them after hours because they worked in a fashion where they worked on weekends that were unsupervised, so I never got to work with them, and, of course, they were then doing clinics, et cetera, which were unsupervised whilst I was operating. So the only person I had any experience with was Dr Sharma, because he would, of his own volition, come to some of my operating sessions, and I personally did find him to have a degree of insight into what he was doing, he was concerned about his level of supervision personally, and I felt that with appropriate care he could actually become a very good orthopaedic surgeon and I was willing to be a referee for him for his recent interviews, which I did, willingly, because I felt that he had been treated in an inappropriate fashion by the way he was supervised. So that's what I was trying to say about the fact that these individual doctors didn't, at any time that I was aware of, go out of their way to be harmful to anyone, but with lack of supervision they were put in situations which were untenable for themselves.

When you raised with - to Hanelt your concerns about the lack of supervision and the fact that it might even have consequences with respect to their medical registration, what did he say?-- He assured me that they had it all in hand, and that it had been appropriately cleared, and that there was no issues with their working in this fashion, and that was why I felt that - I found that hard to believe, that that could be the case. It is very difficult when you are told by the Director of Medical Services of the hospital that this is an appropriate thing, to argue the fact because it is not my area of expertise, and so I accepted the fact that it must have

been appropriate. But I did question it further and I did contact the Australian Orthopaedic Association at that time to get advice because I felt that I had a responsibility to at least take this a little further to try and work out whether there was a problem, and I felt that not to act then would be inappropriate on my behalf, which is why I contacted the AOA then at that time.

By the 16th of January 2004, did you have a meeting with Dr Hanelt, Dr Naidoo, as well?-- Yeah.

And this isn't, so far as I can see, part of your statement?-- No, not at all.

And as a result of that meeting, receive a draft summary of the meeting held in the administration conference room at the Hervey Bay Hospital?-- Yes, I did, and I do have that document. I have read that document. I didn't sign it, if you notice, at the bottom of the document to say that the minutes were accurate and correct because-----

I will put it up on the screen so that others in the room who don't have the advantage of it can follow this conversation?-- Yes.

Is that the document you are referring to?-- Indeed, that is. It was at that time, and it was only at this time after - and if you remember at that time there was a lot of information that came out in the press about the situation at Hervey Bay and the Australian Orthopaedic Association raised their concerns publicly, and it wasn't until then that there was these talks that were undertaken, which I was present at that time, about teaching and morbidity and mortality sessions, and this is the meeting we had at that time, and at that meeting these things were agreed. One of the things that was discussed, which you will see later on is mentioned that consensus was not achieved on, was the level of supervision of the doctors.

Perhaps one thing at a time. It seems that there was an agreement that there should be morbidity and mortality meetings?-- Yes.

To commence?-- Yes.

Does that mean they hadn't?-- No, they hadn't been having regular morbidity and mortality meeting, and that's the audit process I was talking about earlier. For us to remain College of Surgeon credentialed, we have to perform our own - an audit process regularly, every six months, and that audit process in most cases, for public hospital doctors, is the morbidity and mortality meeting, which is provided by the hospital, and all the hospitals.

How often are they held?-- Mostly monthly. Most hospitals every month.

And should I understand from this draft document that the

consensus seemed to be that they hadn't been held at all?-- They weren't held at all. They were - and again, as I said, whether - if meetings were occurring, I wasn't invited to them.

Who was the draftsperson of this document? Would it have been Dr Hanelt?-- I assumed it was Dr Hanelt, yes.

Did Dr Hanelt supply you a copy of this document for you to sign?-- Yes, he did.

Is there anything else on that page you should direct our attention to?-- I don't think on that page.

Could I see the second page?-- If you see the first part of that second page, we were discussing the problem with me doing after hours work and dealing with my patients, because one of the big problems that the administration had with me as a visiting specialist was that because they didn't have any other visiting specialists, they didn't understand the need for me to have the ability for someone to deal with my patients on an emergent basis whilst I was working elsewhere. So if I'm working and doing a case at a private hospital, I can't attend that patient instantly. So there has to be a system in place whereby the person who is the full-time surgeon can at least deal with that patient on a short term basis and then contact me and then I can attend once I'm finished that case. That's a safe practice. Otherwise, I can't be there because I'm in two places at once, and of course as a visiting medical officer, that's the way we assume - and, in fact, of course having been a full-time orthopaedic surgeon, the way I manage dealing with visiting medical officers at the Princess Alexandra Hospital. So we discussed this and I think we tried to work out some sort of contemporary arrangement at that time. That was the first part of it. Certainly, there was the issue that I had, was that the Senior Medical Officers were seeing new patients at elective outpatient clinics.

Is this the first of the bold paragraphs beginning, "Whether the Senior Medical Officer should have ambulatory clinics"?-- Correct. That was something on which there was disagreement. I felt that in an untested situation, seeing patients for the first time and making clinical decisions on them requires a large amount of experience and communication skills and decision-making skills, and probably the outpatients area is just as important as the operating theatre in getting things right, because once those patients are placed on an operating list they are not seen again until they have their surgery.

There was obviously a disagreement between the parties. Did you, what, suggest that at the ambulatory clinics there should be a consultant available?-- Yeah, that's right. My approach was going to be if I was doing a clinic then the Senior Medical Officer would do a clinic next to me.

Do you mean in the same room?-- Rooms next to each other and then he would discuss the case with me at the end of every consultation and we would then discuss the case. I would see the patient and discuss it briefly, ensure that they are on the right track, and this is the way it is done in the teaching hospitals and in most big large area hospitals for many years, and it ensures that the Senior Medical Officer learns the skills but has a level of checking to make sure that we are making right decisions.

So this isn't just for the education of the SMO, it's also for the safety of the patient?-- It's the safety of the patient.

And what was Dr Naidoo's opinion?-- He felt they were - they were suitable to do clinics unsupervised. If he was operating they could do a clinic when he wasn't operating unsupervised, and again I disagreed because I don't see how that decision was made, given that some of these people had only been supervised and looked at for a period of less than six months, and I don't see how you could possibly see whether someone is suitable to do a clinic in the training program.

Do you mean you felt that the two SMOs hadn't been observed by Dr Naidoo-----?-- Yes.

-----for sufficiently long for him to make the judgment-----?-- Correct.

-----that they had sufficient skill to operate-----?-- Correct.

-----autonomously?-- Correct. That's exactly right, yes.

Now, the next item seems to be the issue of the availability-----?-- Yes.

-----of a consultant at all times?-- Yes, and then there is the issue - I don't know again whether you have this document, I have a document that was sent to the Australian Orthopaedic Association by Dr Hanelt very early in the process when the Orthopaedic Association was asked to or was involved in this, and he says in his document that he feels that, "There is no reason why procedural GPs can't do obstetric cases. Therefore, we shouldn't have to accept the goal standard of care in the provincial areas because of the lack of specialists available.", and this ties in with the same attitude, was that because we didn't have enough numbers we should accept a lower rate of - we should accept a lower standard at that time, and I didn't agree with that. I felt that - and at that time when this was mentioned I offered to do a second on call situation for the Fijian doctors to be available when they were on call, to call me in, and I was happy for a one in two arrangement with Dr Naidoo. Now, for my personal private life that was going to be a disaster, but I felt that that was a short term solution to some supervision and that was - that was - that request was not accepted and then there was a mention of costs, and I was willing to do that for free if it was going to involve covering these chaps as a second on call arrangement if they needed some supervision, and the feeling I got at the time was that there was an obstinence to accept the fact that these doctors couldn't work autonomously. They wouldn't see that.

You offered your time?-- Yes.

Was it going to be at a cost to the hospital?-- Well, at the time they said to me that costs were an issue and I agreed and I said I was willing to offer that free of charge.

Now, who was present for that conversation?-- Dr Naidoo and Dr Hanelt. That was the same meeting. This is where we discussed this and I said to them that that would be something I would be willing to do, and I explained that it's not a sustainable solution, but I felt strongly enough that-----

Well, did they accept your offer?-- No.

Was there an explanation why?-- No. I felt again that it was to do with the fact that there was a degree of conflict between the idea that people need to be credentialed to an appropriate level and between the concept that was being used in Hervey Bay where it was acceptable to have a lower standard of care because we were working in provincial area.

Now, explain to me, if you held one view that unsupervised SMOs were unacceptable-----?-- Yes.

-----and you wanted instead supervision-----?-- Yes.

-----do you mean it was your view that if the SMOs could not be supervised then the orthopaedic service should not be offered?-- Yes, indeed. I felt that-----

Is that not worse for the patient care in the area?-- I don't believe that. I think that when it comes to safety issues - safety issues always are a paramount thing. If I can explain it a different way, if I see a patient who has a problem that I can't deal with locally, I will refer that patient on to another orthopaedic surgeon in the City area for further care. I do that on a routine basis in my private practice. I don't think that second referral system is a bad problem at all. I think it's actually safe practice which we all use in our private practices, and I don't see why it couldn't happen in the public system.

And so on occasions when there could not be supervision-----?-- Yes.

-----would it have been your advice that a patient arriving for treatment ought to have been referred to another hospital at which there could be supervised orthopaedic care?-- Correct, yes.

Were there any in sufficient proximity to make that advice practical?-- Well, I think there was. I think that patients could be sent to the Nambour Hospital, which is available not that far away and, indeed, we have a helicopter service, helicopter pad just outside the hospital area. There's no reason why the helicopter cannot be used to transfer most orthopaedic patients, except the very sick, to another area, and it's used routinely in a lot of other provincial areas to move patients around.

Was Dr Hanelt in a position to adjudicate between the view you held and the view that the - the contrary view that Dr Naidoo held?-- Well, my impression from the meeting was that

Dr Hanelt agreed with Dr Naidoo's opinion. In fact, at that meeting again Dr Hanelt was fairly clear about the fact that he felt the specialist colleges were actually preventing doctors from working in the provincial areas and they were actually making - in a word sabotaging the process. So, I felt that his opinion was very similar to Dr Naidoo's at that time, and they formed a very similar opinion about how the system should work.

Now, why wouldn't you sign that draft? What was it about it you-----?-- Well, I didn't feel that it fully represented what went on in that meeting and of course, as I said to you, there was not information given about the fact that I'd offered to do second on call arrangements, which were not taken up, and I felt that that didn't fully reflect the - my attitude in that meeting, what I was available to do. And, you know, to me it's a situation which - you know, probably required further discussion about the ability of the medical officers to have supervision, and that wasn't made open to me that we could discuss that. Essentially it was made very clear that nothing would happen until the AOA investigation was completed, which of course was going to be done, and of course, as you know, the recommendations only just came out just recently.

Yes. Doctor, so far as the draft contains things, are the things in it accurate so far as they go?-- Absolutely. All of the other things we discussed seem to be the things we discussed at that meeting, yes.

I tender it.

COMMISSIONER: That will be Exhibit 332.

ADMITTED AND MARKED "EXHIBIT 332"

MR ANDREWS: May the witness be shown Exhibit 314 which is the newspaper article tendered a couple of days ago. You speak of large amounts of leave that Dr Naidoo was taking, often four to six weeks at a time?-- Yes.

Did you discuss those with Dr Hanelt?-- I did mention to Dr Hanelt about that, that - and he assured me that the leave was appropriately signed leave and, therefore, there was nothing he could do about that, and the reason I was concerned about the leave wasn't because Dr Naidoo wasn't entitled to it - I mean, everybody is entitled to their leave - but there was no arrangements made while he was on leave to supervise the junior staff, and I would have felt that that should have occurred, that there should have been some supervision put in place.

Ought there have been locum engaged?-- A locum or patients

moved to another location at that time, and that was my understanding of the best process.

At paragraph 21 you speak about an article in the local paper inserted by Queensland Health. Is that the article, Exhibit 314?-- That's correct.

That can be handed back. Did you speak to Mr Allsop about the article which does appear to suggest that Mr Allsop referred to persons as orthopaedic surgeons?-- At that time I had given up talking to the local administrators about these problems. I actually referred the issue on to the Australian Orthopaedic Association because once this occurred I felt that my ability to change anything locally was very limited and I - that's when I got the - our association involved on a higher level.

Why had you given up on Mr Allsop?-- Because my dealings with Mr Allsop are - were generally awkward because my impression was always that the decision was made before - before the discussion occurred and that I didn't feel I was going to get a fair hearing, and I felt more comfortable at this time getting some further support because I felt very isolated.

I'm interested to know whether there were any specific instances of conversations with Mr Allsop that led you to conclude you wouldn't get a fair hearing?-- That is a very hard question. I don't believe I can recall a conversation that I had where he indicated to me directly that I wouldn't be listened to. I guess it's more of a perception of conversations that were had, and it would be unfair of me to say that he didn't indicate - that he indicated at any time that he wasn't going to listen to me, it was more the fact - the impression I got from discussions that the information that was fed in the papers and subsequently was very clearly indicating that the Australian Orthopaedic Association at that time was leveling unfair - ungrounded criticism to the hospital. So, I felt at that time it was very difficult for me to be involved in any discussions about this further.

At paragraph 28 you talk about your unhappiness causing animosity towards you from management, both Dr Hanelt and Michael Allsop?-- Yeah.

Is that being unfair to-----?-- No.

-----Michael Allsop?-- No. The reason I included that in my statement was because of the incident that occurred that I believe has - the insert with the patient, and I don't know whether we were discussing it today, the patient with the fractured neck and femur that was cancelled?

COMMISSIONER: I think we are not going to discuss that today. We will leave that till next time?-- Yeah. That was one of the-----

MR ANDREWS: With respect to Dr Hanelt, what animosity did he show towards you, any?-- Mostly a level of - and again I

haven't - make it very clear on a personal level I have no personal feelings towards either these gentlemen. I don't know them socially, I don't deal with them on a personnel level. It's more about the way that he dealt with my professional concerns and took away my ability to have clinical governance of patients in an aggressive way by not allowing me to show my opinion about what was going on and to act on it in some fashion. There wasn't really any action taken with my concerns until we had the AOA and the media that surrounded the AOA and then action was taken at that time. But there was a long period of time when no action was taken.

Doctor, I suppose I'm searching to see whether or not your concerns with Dr Hanelt was that he held a contrary opinion that you regarded as unsafe. I can understand that-----?-- Yes.

-----seems to have emerged well in your statement?-- Yes.

Or whether there was something more, that he was aggressive towards you in another way?-- Yeah. He certainly would deal with my complaints in a way which left me in no doubt that he didn't believe what I was saying to be true. So, instead of dealing with them in a professional way, it was dealt with more in a dismissive way.

He did ultimately, though, agree to the engagement of the Australian Orthopaedic Association?-- Yeah, he did and I think - I think again that was brought to bear - the pressure was brought in bear in the public arena. Prior to the - as I say, prior to the media attention, there was no indication that anything would happen.

At paragraph 36 you say that your offer to perform services free of cost, that is to be point of contact to the doctors and to cover and supervise difficult cases-----?-- Correct.

-----was rejected and you say by Dr Hanelt and Mr Allsop?-- Yes.

Now, as I understand your evidence, there was a meeting between you, Dr Hanelt and Dr Naidoo?-- Oh, yeah.

Is it fair to say that Mr Allsop also rejected the offer?-- Yeah. I understand the question. Mr Allsop wasn't at the meeting. I made the assumption that Dr Hanelt would have discussed this with Mr Allsop because he was his supervisor and I assumed that the offer would have been discussed, and then I made the assumption that obviously it was rejected by both members. It may not have been. I may be incorrect there, but that was my assumption.

COMMISSIONER: When you made the offer to Dr Hanelt, did he reject it out of hand straight away or did he come back to you later and reject it?-- No, he just rejected it at the time, at the meeting, Commissioner, yeah.

I see.

MR ANDREWS: At paragraph 37 you deal with some difficulty you had in scheduling a procedure for an elderly woman?-- Mmm.

Who needed work done on a fractured hip?-- Yes.

Do you recall - had there been an anaesthetist aside from Dr Myer who'd looked at the patient-----?-- Indeed there was.

-----previously?-- Yes, there was. The situation was such that there was a Senior Medical Officer who was on call for that weekend who was still not credentialed as a specialist anaesthetist who saw the patient - that was under my understanding - who saw the patient and who indicated he felt she had a chest infection and I felt that that was not necessarily the case because she had a chronic chest condition, and I asked the medical physician on call to see the patient, and the medical physician saw the patient and indicated he didn't believe she had a chest infection and, therefore, I felt that she should proceed to surgery, and I discussed the case with one of the senior anaesthetists who was a full-time - I think - no, he was a full-time anaesthetist at that time at the hospital who wasn't on call for the weekend, but who was more senior and said to him, I think, "Would you be available to do this case because this lady needs surgery and I'm concerned about her waiting.", and he was happy to do that. Initially there was - and I think initially he saw the lady in the casualty department because at one stage she was talking about having private medicine and private care, and I think he saw her as a private patient and then the lady was not - didn't have any private insurance so she went on to be a public patient. I was on call that weekend anyway and I do public and private patients together in the same hospital. So, Dr Myers had seen her already. So, I said to him, "Look, would you be able to do this case because you have seen this lady and the public hospital anaesthetist feels that she shouldn't have surgery." I felt that it warranted me discussing this with a more senior person, given the seriousness of the case, and he was quite content that surgery would be a reasonable option for her, given the advice from the medical people who saw her.

Was there any urgency to the case?-- Well, in my opinion, yes, and the thing about the situation was the lady is 90, she had a chronic chest condition, which leads to chest infections very easily. She had a fractured hip which makes her bedbound and the evidence based medicine shows us if you operate on these people under 48 hours they have a much better outcome in terms of reduced morbidity and mortality. So, I felt that she needed to have the surgery early, being aware that this is a Saturday, I don't want to be operating on a Saturday, I want to be with my children, but my issue is with her safety. So, I felt that she should have the surgery and that the surgery should be done that day.

Now, might she have been 85?-- She may well have been 85. I thought she was 90, but again that's my recollection.

Do you have it in your-----?-- Sorry, I will-----

-----patient-----?-- I do. She's 87. 87. Yes. 87.

COMMISSIONER: When did she have the fracture though? She had the fracture some days before that?-- Well, no, that was the - that was the - the issue - that was an issue that had been raised but the answer is not really. What had happened was she had had some pain for several weeks, and we see in those older patients stress fractures which develop slowly over a period of time, and then the day of admission she'd fallen suddenly at the nursing home and had sustained a complete fracture of the hip.

I see?-- So really the information that was tendered on that is in inaccurate in that she was getting symptoms for two weeks but the acute fracture happened the day of admission. The nursing home admitted her because she couldn't mobilise any more.

Right. Was that on the Friday?-- That was on the Friday.

Right.

MR ANDREWS: And is it a best practice to treat such persons within 72 hours of the fracture?-- 48 - certainly - 48 hours in most of the recent evidence based medicine, 48 hours seems to be the ideal situation, provided there's not a really good contraindication. As I say, we looked at that issue and found there wasn't a contraindication.

Now, at paragraph 40 you speak of feeling bullied and harassed by the administrators Hanelt and Allsop. Have you discussed the only occasions where they dealt with you in ways you found inappropriate?-- This occasion was certainly with Mr Allsop. I felt this was very inappropriate and I felt - I'd never, ever been in a situation where the hospital administrator cancelled the case without notifying me.

The administrator holds no medical qualifications?-- None, and when I asked about the reason for cancellation, I was told that he had discussed it with a senior nursing member and subsequently the senior nursing member was not someone who was present or had seen the patient at any stage. So this discussion was going on at a distance about a patient. The only person that had seen the patient was myself, the anaesthetist and a medical doctor on the ward. So, I would have thought that we were the people to make the decision at that time. That was my opinion.

Eventually, though, Mr Allsop must have listened to your concerns and scheduled - allowed the procedure to be scheduled for the Sunday?-- Well, at that time he - before this happened he asked me about why I was using a particular prosthesis for this case because of the cost of this particular prosthesis, and I outlined to him and in my notes the reasons why I wanted to use this more expensive prosthesis on this lady, because of the situation that arose, and again

in my clinical judgment this was the best prosthesis for this problem. So we discussed that for an extended period of time, and then he wished to talk to the anaesthetist who was the consultant anaesthetist who had seen the patient to discuss it with him first before he was comfortable taking more advice.

You mean Dr Myer?-- Dr Myer. So at that time he wouldn't give me an answer. Then he rang me back and told me I could proceed with the case, the following day. Can I add something at that time? One of the things that was difficult, just on a personal level here, is that I had talked to the patient's relatives and explained to them at length why I wanted to operate on this lady quickly and why it was important to get the operation done, and then I had to explain to the patient's relatives why the patient was cancelled that evening, it was not going to be done the next day, and it's very hard from a clinical governance point of view to maintain any rapport with the family when your decision has changed suddenly, and I was told by Dr - Mr Allsop not to tell the family it was due to financial constraints, because I felt myself that financial constraints were a big reason why this case was cancelled. So, it was awkward and I think that's probably - I felt harassed in that situation by the administration because of that involvement. I guess that answers the question about harassment.

Paragraph 43, you speak about patients being left with permanent disabilities because of inexperienced, unsupervised surgery. Were you speaking hypothetically or do you - or do the permanent disabilities reflect actual cases?-- No, I'm talking about specific cases. I think that - again my experience personally with several cases which I have provided were the - were the - the evidence that I've got in my - in my possession that indicates to me there was a problem with supervision, because I was directly involved in - I wasn't - this wasn't hearsay, and several of those patients, in my opinion, have a permanent disability, again not because of an attempt to harm the patient or even negligent care, but a problem with supervision and decision-making during the procession of caring for the patient, and those patients, several of them are looked after privately, and the reason I came across them was because they were - they referred themselves privately to my private practice because of concerns with their care in the public system.

Dr Mullen, are those patients among the six who are referred to in your statement?-- Correct, they are.

And there are none outside those - that group of six?-- There are none that I was personally involved in. I am aware that there may be other cases but they are not cases that I was involved in and I have no experience or knowledge about them and I feel uncomfortable commenting on them because I wasn't involved directly.

I have nothing further, Commissioner.

COMMISSIONER: Who wants to examine this witness, other than

Mr Farr? Does anyone? On those points so far.

MR DEVLIN: Commissioner, I only needed one bit of clarification but my interest will be in the other procedures once more material-----

COMMISSIONER: All right. This is your last chance to examine on this aspect.

MR DEVLIN: Well, there is only one clarification for when the doctor comes back and it's in relation to the patient key. If I can just ask him about that?

COMMISSIONER: Yes, certainly.

CROSS-EXAMINATION:

MR DEVLIN: Thank you. Doctor, I am Ralph Devlin. I am for the Medical Board of Queensland?-- Yes.

You provided a patient key which in relation to paragraph 34 you included the lady's name there, paragraph 34 and 37, which is the weekend issue that you just spoken about?-- I'm sorry. 34 is-----

A male person?-- I have got the name for that patient. You are right.

Can you produce that on a piece of paper?-- I can. I can do it on a piece of paper for you. Yes, absolutely.

COMMISSIONER: Nothing else? Mr Farr?

MR FARR: Commissioner, I don't suspect that I would finish the other parts of my cross-examination this afternoon, and there's an issue that has arisen in the course of this evidence that just causes me a little concern as to obtaining some instructions. I wonder if you might-----

COMMISSIONER: From Dr Sharma or Dr Krishna?

MR FARR: No, from Queensland Health in relation to others employed within the department.

COMMISSIONER: I see.

MR FARR: And I would like to take those instructions because it might be that I shouldn't be questioning on certain issues, that others might have to-----

COMMISSIONER: All right. I suppose I will have to let you - it's unfortunate we will be wasting time. Can we call another witness at this stage? Is that possible?

MR ANDREWS: No. But I can ask another useful question.

COMMISSIONER: That won't take up much time will it?

MR ANDREWS: It won't.

COMMISSIONER: I will let you do that.

MR FARR: Thank you.

COMMISSIONER: Yes.

EXAMINATION-IN-CHIEF CONTINUING:

MR ANDREWS: Would you look at the monitor please, I'm going to show you a scope of service document relating to Dr Krishna. Were you in a position to assess, in respect of Dr Krishna, his capacity to perform independently the procedures shown in the left-hand column or would you have needed more time?-- Certainly some of these procedures, certainly things like sterno - where are we, fractures of the proximal humerus, for example, that fracture these days is often inordinately difficult and very often is undertaken by a specialist shoulder surgeon rather than even a general orthopaedic surgeon because of the level of complexity that we find in these fractures. Now, so I wouldn't have been happy with that. In fact, you'd need several years to assess the ability to undertake some of those complex humeral fractures, the decision-making of fractures sometimes changes during the operation because of what you find. Certainly again, compound fractures, I would have said that they should all be supervised initially because they can often be very complicated and sometimes limb threatening. Supracondylar fracture. Supracondylar fractures of the humerus in children are one of the most complicated children's orthopaedic fractures and, you know, in terms of - I must admit myself, I still feel very uncomfortable and I'd spent six to 12 months at a children's hospital doing these cases over a long period of time and I feel very uncomfortable about that fracture because of the small potential risk of loss of limb and in loss of blood supply, so that fracture is a complicated fracture and before - it's a large amount of supervision before it's undertaken unsupervised.

Well, if you can accept from me that the ticks in the middle column suggest that these are procedures that can be done unsupervised by Dr Krishna, do they suggest to you that he is - that he would have to be an experienced orthopaedic specialist?-- Yes. See, in my experience, and I would say as well that in the experience of my colleagues who deal with these, that we wouldn't be happy letting anyone other than an advanced orthopaedic trainee at the time of their examination process and perhaps after their final examination process doing all of these cases necessarily unsupervised, but certainly it is something that requires a huge amount of clinical acumen and they're difficult cases some of these with significant complications, and I mean, again, I wouldn't be comfortable assessing people for these sorts of injuries unless I had quite an extended period of time with the person looking at their ability, years.

Did you say "years"?-- Years. I'd - and again, it wouldn't just be me, it would be a number of orthopaedic surgeons over a period of time.

I have no further questions, Commissioner.

COMMISSIONER: Anyone else want to-----

MR DEVLIN: I do have some that arise out of the evidence that's been given this afternoon, Commissioner.

COMMISSIONER: Oh, you have?

MR DEVLIN: Yes, do I, thank you.

COMMISSIONER: You want to go beyond that last question, do you?

MR DEVLIN: No, no, in relation to the procedure which was discussed that occurred in 2000, the lady with the damage to the arm.

COMMISSIONER: Oh, I see, but you want to go beyond the list there? I did ask you before but you're welcome to do it now.

MR DEVLIN: Yes, thank you, yes, I apologise I overlooked it.

FURTHER CROSS-EXAMINATION:

MR DEVLIN: Paragraph 6 onwards of your statement, doctor, in relation to the lady of advanced age with the difficulties with her arm?-- Yes.

You in paragraph 8 express the strong opinion that the lady was subject to unacceptable care and you agree or you were asked by the Commissioner whether you believed you were of the view that it amounted to negligent practice?-- Yes.

And you said you did?-- Yes.

Given that this occurred in 2000 and you were out by a couple of years in your recollection?-- Yes.

And I'm not being critical of you about that, but do you recall what steps you took to raise any concerns about that particular event?-- Yeah. At the time, my concerns I raised with Terry Hanelt personally, on a personal level and again, as I said previously, I felt that that was the port of call, given that this was a full time public hospital employee, I felt that the first port of call was the Director of Medical Services who was responsible for that issue.

Yes?-- And I assumed that that was going to be undertaken, of course, in the light of what we've seen and I've seen recent since that time, you know, then I wish I had perhaps taken it further at that time, but I assumed that I would be supported by the Director of Medical Services that when I explained this to him, that the matter would be properly investigated and I left it in his hands.

But you contented yourself with an oral report to Dr Hanelt;

is that right?-- Yeah, absolutely, and that's something as well, there's - there is certainly since the time of this first incidence, I've become aware of the need to document some of these things more clearly, but at the time I'd worked at a place at Princess Alexandra where it was enough to pass on that information to a colleague or a superior and expect that that information would be acted upon. I wasn't aware that there was a form I could use or a thing I could do and Dr Hanelt at the time did not indicate to me that I needed to put this in writing, he didn't say to me that, "If you wish to take this further, please progress this way, use this form, do this thing", I just assumed by the fact that he didn't discuss it with me any further, that he had taken the matter on hand and was going to deal with it in the appropriate fashion and that was my understanding.

Can you take in hand the bundle of notes that you do have, the one that's got the coloured binders; have you got that there?-- Yeah, yes.

And turn to the bundle of documents relating to that patient which starts with those three photographs?-- Yes.

Can you take us through or point to the entries which were of significance to you? For example, from that roster that was produced earlier, we know that Dr Naidoo was at least listed on the roster about the 29th of July?-- Mmm-hmm.

We don't see in these documents any notation of Dr Naidoo attending to the patient on that date?-- No, not that I can see.

And you mentioned a junior practitioner who took a, I gather, an interest in the matter?-- Yes.

Such as to make detailed notes?-- Yes.

Is that a reference to Dr Taylor Robinson?-- Correct, yes.

And where is she now?-- I'm not sure I must admit - that I know that she was an English doctor, I think at the time I think she was out from - on a 12 month period of stay, so I'm not sure where she works now. From my memory, again, this is five years ago, but from my memory of the event, she discussed this with me and she was very upset about it and I said to her that at the time that she should make sure that she has a proper summary in the notes because of the concerns, and again, I thought that that would aid in any further investigation of the issue if it came to hand.

COMMISSIONER: Dr Naidoo's mentioned on the 8th of August when you-----?-- That's right, he - 8th of August is when he obviously took the patient back to theatre because the wound required further treatment because of further infection after the debridement.

Mmm.

MR DEVLIN: Now, on the 28th of July 2000, we see a note by the English doctor about five pages in. Can you point to any notes made by staff members indicating their concern about the state of the patient given that you were asked to take over the patient on the 2nd of August, we can see that from the notes?-- Yeah, that's right. I must admit I have - I can't see any from the nursing staff mentioning that they had any concerns. Normally they discuss things with the clinical nurse consultant of the ward.

Mmm?-- And I assume again this is just assumptions, but I assume that they must have discussed it with her and that's why she approached me that morning, they must have had enough concerns at that time to raise it.

Who was the sister?-- Sister Theresa Winton.

Winsor?-- Winton, W-I-N-T-O-N.

The page that started with the date 28th of July, have you got that?-- Yeah, I'll just have a look.

It's the fairly neat handwriting of Kate TR?-- Oh yeah, this is the summary or-----

In "Patient Progress Notes" is what's in my bundle.

COMMISSIONER: It's on the 5th page.

MR DEVLIN: Fifth page in?-- Yeah, I see it, yes.

Can I just ask you to comment on a couple of things?-- Yes.

I've got nursing notes on the 29th of July?-- Yes.

Bearing in mind we're still three or four days short of you being approached?-- Mmm-hmm.

We've got a note apparently by a Principal House Officer-----?-- Yes.

-----on the 29th of July; do you recognise that handwriting by any chance?-- The surgical-----

No, the one that starts "Patient now in dementia"?-- Yes, "Known dementia".

"Known dementia, been fiddling with the"-----?-- Back slab, yeah, I don't recognise that person, no.

Right. But there seems to be a big gap then in terms of any notes?-- Yeah, there is, isn't there, yes.

Although on the page ahead of that, we see a nursing note on the 29th of July, "Noticed bleeding coming from inside top of arm"?-- Yes.

"Notified doctor", et cetera?-- Yes.

How did you come to retain this particular selection of notes?-- Oh, I at the time of the - the concerns that were raised I felt that, that I should retain some copies of the notes because of my concerns with the patient and I kept notes that I felt represented the situation, and I must admit, I raised this issue about this patient with the AOA as well when the supervision problem remained on hand and I thought that those notes would probably most represent the problems that had occurred prior to me being asked to see the patient at that time.

Yes?-- But I'm not sure, again, I think there may be more notes than this in the patient file.

I'm sure there will be?-- Yeah.

But these are the ones you chose to retain?-- These are the ones I chose to retain, yeah.

And how long ago did you obtain just these sheets?-- I can't remember that, I don't know.

Now, in the mistaken belief that those events - and again, I'm still not being critical - in the mistaken belief that those events occurred in 2002?-- Yes.

Counsel Assisting took you to paragraph 15 where your memory told you as you did the statement that it was as a result of inaction over that incident?-- Mmm.

That you took time off away?-- Mmm.

Now, that's really not right, is it?-- It was probably many incidences, I guess that's the one that sticks in mind the most because it's the most prominent so I guess I used that when I was doing the statement, I was trying to recall the chronology of events.

Yes?-- And it's very hard over five years to work out how they fit in.

I understand that?-- And so this event was probably the most outstanding in my mind at that time.

Yes?-- And I guess there were other events of course that occurred at the same time that were also a problem.

Was it late in 2002 that you downscaled your public sessions?-- Correct, yes.

Can you have a - may I assist to have this go up on the screen then? This is a letter dated the 4th of September?-- Yes.

To Dr Hanelt?-- Yes.

You agree that you only cited family reasons?-- Yeah, I did at that time and I think at the time the reason the family

reasons was such an issue was because we were having a new baby and I felt the stress on my time at the public hospital was - was becoming a big family stressor as well, so that was the reason I had to take the time off, I just felt I couldn't give my family the same time I needed to give them as well as my private practice as well as dealing with these problems.

Mmm?-- I did explain that to Terry, I didn't write them down in the letter I must admit, but obviously family was not the only reason, the family issue was the break - the straw that broke the camel's back.

But doctor, patient safety was a big issue in your mind?-- Absolutely at the time, yes.

What was the disincentive to going on the record when it came to a matter as critical as patient safety that one of the major operative factors on you reducing your public sessions was or were mounting concerns about issues of patient safety?-- I think at that time I had been, for want of a better word, banging my head against a brick wall for such a long period of time about this issue, it had been something I had been bringing up, it hadn't been addressed and I felt that there was absolutely no value in trying to discuss the issues of safety again which I have previously brought up many times, so when I was putting in this letter, the family issue at that time was foremost in my mind because of the - our new child and I wrote that down on the letter for that reason, but I can tell you that that is not the only reason why I withdrew my services at that time.

In relation to the cases that we will get to this to discuss next time?-- Yes.

That are set out at paragraphs 31 to 34 of your statement?-- Yes.

And summarised in brief?-- Yes.

Are the timings of those cases prior to your letter of September 2002 or were they cases which occurred after you came back into the public sessions after a break of some nine months?-- Yeah, that's difficult because I haven't looked at all the times of all those things. I think that a lot of them, and maybe the majority of them occurred after that time because the majority of them occurred whilst the new Fijian doctors were in the hospital, so it looks like that they arrived in 2002 and 2003, so it must have been either at the time or just after that those patients - those problems occurred.

And then it was in the early part of 2004 that you raised your concerns with the AOA; is that correct?-- No, 2003.

Late part of 2003?-- Middle part of 2003 with Chris Blenkin at the AOA, he was the President at that time. Because I had - I had gone back to the administration and said, "Look, I want to come back and try to offer more service for you.", I

was reassured that the problems were being solved, so I went back and there was not an improvement in the servicing in the supervision, so that's when I contacted the AOA at that time. The time that I withdrew my time from the hospital was, as I say, really driven by my previous experiences and the birth of my new child and those two things drove me to take my service again, as I say, not remove them all together, I offered an on-call service because I felt I had to.

Mmm?-- Yeah.

All right. Yes, that's all I have for the moment, thank you Commissioner. If I could have that document back, it's actually an exhibit to Dr Hanelt's statement.

COMMISSIONER: All right. Well, we'll adjourn until Monday, but not with the witness. I presume we'll try to get sometime that accommodates you as best we can, doctor, and we haven't arranged that time yet.

MR ANDREWS: I understand that it would be least inconvenient for Dr Mullen to return on Friday of next week.

COMMISSIONER: All right.

MR ANDREWS: And on Monday the schedule is for Dr Buckland to give evidence and it's anticipated his evidence may even run into Tuesday, and on Tuesday I understand that Mr Kerslake, the Health Rights Commissioner is scheduled to give evidence. The parties have a statement from Mr Kerslake which was supplied to the last Commission of Inquiry and relating to its Terms of Reference. I understand that Mr Kerslake's revised statement will be to abbreviate the original by excising some of its paragraphs to leave it relating only to the Terms of Reference for your Inquiry, Commissioner.

COMMISSIONER: All right.

MR DEVLIN: Commissioner, in relation to that, is it known when that will be available? Mr Kerslake's abridged statement?

MR ANDREWS: I regret I'm in the hands of Mr Kerslake's solicitors, but I assume that it ought to be tomorrow.

COMMISSIONER: Well, you're hardly going to be disadvantaged though, are you, if it's just having paragraphs deleted?

MR DEVLIN: Yes, it's just a question of which ones to deal with, that's all.

COMMISSIONER: All right.

MR ANDREWS: There is also booked for Monday a Dr Jayasekera for 2.30 in the afternoon, but as I understand it, Mr Buckland's evidence or Dr Buckland's evidence is scheduled to run for more than one day.

COMMISSIONER: Mmm.

MR ANDREWS: In the circumstances, Commissioner, perhaps out of fairness to Dr Jayasekera, I ought to reschedule him. He's used to it.

COMMISSIONER: All right, we'll try not to do it to him again. All right, thank you doctor.

WITNESS STOOD DOWN

COMMISSIONER: We'll adjourn until Monday.

THE COMMISSION ADJOURNED AT 4.19 P.M. TILL MONDAY, 19 SEPTEMBER 2005 AT 10.00 A.M.