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 20/09/2005

..DAY 7

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

THE COMMISSION RESUMED AT 10.01 A.M.

STEVEN MICHAEL BUCKLAND, CONTINUING CROSS-EXAMINATION:

COMMISSIONER: Before you continue, Ms Dalton, I want to make public an exchange of letters between the Leader of the Opposition and me and the Premier and me. It starts with a letter dated 12 September from the Leader of the Opposition, mentioning the fact that he, on a number of occasions, had private discussions with Mr Morris, who was then the Commissioner under the terminated Commission of Inquiry, and said he looked forward to similar meetings with me. I then wrote a letter in response to him and a letter to the Premier on 15 September in which I said that had I been starting afresh, I'd have had doubt about whether it was appropriate or even proper to have such meetings during the course of the Inquiry, but I was also conscious that there might be a public expectation that I would do so, and with some reservation, I said I would do so. Then yesterday I wrote a letter to them again saying that I had given further consideration to the concern which I had expressed in that earlier letter about the appropriateness and propriety of speaking to them and how to balance that concern against the possible public expectation that I would do so, because Mr Morris did, and I expressed the view that I thought the public interest would best be served if, during the term of the inquiry, I spoke to each of them only in the presence of the other. I will make that bundle of letters one exhibit, and they will together be Exhibit 351.

ADMITTED AND MARKED "EXHIBIT 351"

COMMISSIONER: Yes, Ms Dalton?

MS DALTON: Thank you, Commissioner. Dr Buckland, we got to tab 25 - annexure 25 to Mr Walker's statement?-- Yes.

And do you have there an attachment to the Cabinet Information Submission with something called, "Table 3: Out-patients Departments' Numbers - Waiting"?-- I do.

And does that show the total across the state as at 1 March 2000 and 1 March 2001 for all out-patients waiting, including surgical out-patients?-- That does, yes.

It shows whether or not those patients have been allocated an appointment?-- That's correct.

It shows whether or not they were waiting for a medical appointment, an obstetric appointment, paediatric appointment,

psychiatric appointment or surgical appointment?-- That's correct, yes.

It shows that at 1 March 2000, there were 50,000-odd people waiting, and at 1 March 2001 there were 52-odd - or 52,000-odd people waiting?-- That's correct, yes.

Were you involved in the process of putting that table together? Do you know how it came to be collated?-- No, I wasn't directly involved at all at that stage with the Surgical Access Team. I can only speculate that it was - culminated as a result of collections that were manually sent in to the Surgical Access Team.

That's a collation, if you like, of the material that was being collected every month?-- That would be my interpretation of it, yes.

And that sort of collation could happen during your time, at least, upon request from the Minister or upon request from any of the senior officers in the Department?-- That's correct, yes.

I will get you now to have a look at the second folder you have got there, and I will get you to have a look at tab 30. Have you got that?-- Yes.

You see that's a Cabinet decision and submission for the 13th of October 2003?-- Yes.

Were you acting Director-General then?-- No.

Have a look then at the next one in the bundle, which is 31, and you see that that's a Cabinet decision and information submission of 2 August 2004?-- Yes.

Now, by that stage you were acting - or were you formally appointed Director-General?-- Sorry?

By that stage you were formally appointed Director-General?-- 2 August 2004, yes.

Do you know why there - see every quarter, quite regularly, from the time Ms Edmond took up the portfolio-----?-- Yes.

-----until the thing which is annexure 30, in October 2003, every quarter a document pretty similar to this went to Cabinet?-- Yes.

And then there seems to be a gap and the next one takes up at 2 August 2004. Do you know why there is that gap?-- In this particular document - this is document 4, Innisfail - no, I don't know, but I can - if you are asking me do I know about the collation, I can talk about that.

No, what I'm asking you - what I'm asking you - see the two Cabinet decisions with the information submissions attached, just like we have been looking at?-- Yes.

And from the time that Ms Edmond took up the health portfolio, one of those went to Cabinet - the information submissions went to Cabinet every quarter - every three months?-- That's correct, yes.

But the last of those seems to be this one on 13 October 2003-----?-- Yes.

Which is number 30 - tab 30?-- Yes.

See that?-- Yes.

And then the next one is at tab 31, almost a year later. So, you see the pattern is broken? There's not one going in every quarter, and I'm asking you-----?-- Tabled submission.

Yes?-- I misunderstood.

The information submissions are not going up to Cabinet anymore, and I'm asking you whether you know why?-- No, I don't - I don't think - no. Can I just comment as well, that second one is one just for Innisfail.

Well, the Cabinet was meeting at Innisfail?-- Sorry. It is the location.

It is reporting where the Cabinet meets?-- Sorry, thank you. Okay.

So, you are not aware of any direction that came from Government that this information was not to be provided to Cabinet on a quarterly basis?-- I don't recollect that.

Well, was there any direction within the Department that it wasn't to go to Cabinet?-- No, I don't recollect that either.

COMMISSIONER: And if there had been, you would have recollected it?-- I would think so, Commissioner, yes.

MS DALTON: Now, I take you to - if you look at this one in August 2004?-- Yes.

See page 9?-- Yes.

There's a heading, "Public Presentation". Now, in all these documents of similar type that have gone to Cabinet since Minister Edmond took up the portfolio, there's something pretty similar to the heading "Public Presentation" and words to the effect "not proposed", and so forth?-- Yes.

Was that ever discussed with you at any time as Director-General why there wasn't - you know, why there was no proposal to publish?-- No.

All right. Have a look at the next document, which is 32. Looking at the second page, you will see it seems to be a document which went forward under your hand?-- Yes, that's the policy framework for specialist out-patient services, so I

signed the form, yes.

Yesterday we looked at one Dr Stable had done in 1999?-- That's correct.

And I asked you some questions about people on the anterior list being categorised 1, 2 and 3 under that policy?-- Yes.

And did you in, what, early 2004 oversee the updating and amendment of that policy?-- That policy was already under - being amended and being reviewed at the time that I was General Manager Health Services to be completely revamped, yes, and obviously culminated when I was Director-General-----

In this document that we are looking at?-- Yes.

And again, if you go to page 5 of that document-----?-- Yes.

-----again we have got this idea that once the referral - the piece of paper gets to the hospital, someone in the hospital will categorise the patient category 1, 2 or 3?-- That's correct, yes.

So, it's - it is the same category numbers as under Dr Stable's document back in 1999?-- Yes.

And do you know whether that happened after this new policy that you oversaw or you brought to fruition? Do you know if that happened for the people on the anterior waiting list?-- This categorisation? I don't have any formal knowledge, but I - my assumption is that it did happen and there was an implementation plan to go with it. This was overseen by a project - this part of it was overseen by a project person who developed it, as far as I can understand.

Have a look at document 33?-- Yes.

Is that what you are talking about? Is that the implementation of this new policy for out-patient lists?-- Yes. That appears to be it.

That it was to be implemented. That document is dated 5 October 2004. Did that implementation happen, do you know?-- To the best of my knowledge, it did. Which one?

I beg your pardon?-- 5 April.

I said "October". 5 April 2004?-- Yes, that's all right.

Do you know that that happened?-- I don't know firsthand that it happened, but my belief is that it happened, yes.

Thank you, Commissioner. I have no further questions.

COMMISSIONER: Thank you. Who's next?

MR DIEHM: I'm happy to go next, Commissioner.

COMMISSIONER: Yes.

CROSS-EXAMINATION:

MR DIEHM: Dr Buckland, I'm Geoffrey Diehm, counsel for Dr Keating, and I have a couple of questions for you. The first one relates to credentialling and privileging. The policy that you have referred to in your statement that deals with this topic that was implemented in 2002, during - or as part of, as I understand it, one of your responsibilities at that time was a policy that contained within it an expectation, did it not, that for specialists, such as surgeons, there would be a member of the relevant college participating as a committee member on the credentialling and privileging committee considering the specialist's application?-- That's correct, yes.

And, indeed, the policy itself provided for the intended practice for the colleges to provide nominees to those committees from time to time?-- Yes, as requested by - yes, that's right.

So, the intention was the district or the hospital would approach the college and ask the college for a nominee to come on to its committee for the purpose of dealing with a particular practitioner or group of practitioners?-- Yes, that's correct.

Now, is it the case that you learned subsequently that the colleges were not always providing those nominees as had been the expectation in the policy?-- I certainly had been aware that there were, in some places, problems with colleges - I don't recall the certain specifics of it, but I do recall in some places the colleges had difficulty providing nominees, yes.

All right. We have-----?-- I think - sorry, I think it emanated out of the indemnity debate.

Yes. There was a concern amongst some of the colleges, at least, that their members - or, indeed, perhaps, the colleges themselves - might be exposed to a liability for participating in those committees and were looking to be indemnified by Queensland Health with respect to their participation in those committees; is that right?-- I think that's correct, yes.

We have a letter that was annexed - certainly to Dr Scott's statement - it may also be amongst the many annexures to yours - but a letter that you wrote to Dr Stitz on the 14th of June 2005; do you recall the correspondence I'm speaking about?-- No, I would have to have a look at it.

Perhaps if this could be put on the visualiser, Commissioner? I have highlighted there the relevant section of the letter,

but please look at the introductory part and familiarise yourself with the document?-- Okay.

If that can be scrolled just so we can see all of it?-- Yes, okay.

Now, doctor, would it be fair to infer from particularly the highlighted part of that letter that what you had become aware of was that there was a problem with respect to obtaining participation from the College of Surgeons in these credentialling and privileging committees that extended beyond Bundaberg?-- Yes, that's true.

And it extended beyond the Fraser Coast District as well?-- That's my understanding, yes.

When did you become aware of that?-- I'd have to try to recall, but I think some time earlier I had had a meeting or a conversation with the previous chair of the state college, but I can't actually give you a time frame when that was, off the top of my head, but I was aware there were problems, particularly after the indemnity issues started to surface. We had a view that the indemnity issues were not issues of relevance that the college was expressing concern about, but we believe they would have been indemnified in the process.

Indemnified by Queensland Health?-- Yes, it was a Queensland Health committee.

COMMISSIONER: You had assured them of that - that you would indemnify them?-- Commissioner, I did have a conversation with the previous - I'm just trying to remember his name-----

There was nothing in writing from you?-- No, sir.

MR DIEHM: And I appreciate that you struggle, off the top of your head, to put a time on your learning of these problems, but are we talking about something that happened in 2003 or 2004?-----

COMMISSIONER: Or 2005 when this letter was written?-- No, I think it was-----

This was June 2005?-- This one's 2005. I would be hazarding a guess, but I think it was probably late 2003/'04. I'm just trying to place the indemnity debate.

COMMISSIONER: Late 2003?-- Or '04, I think. Something like that.

MR DIEHM: Thank you. Now, doctor, at the time the policy was implemented in 2002, had there been any communication with the colleges - or any of them - by Queensland Health with respect to coming to an understanding between the bodies that the colleges would, in fact, participate as the policy contemplated?-- Yes.

So, the chronology of it would seem to be that at the time the

policy was implemented in around the mid-part of 2002, there was an expectation, based on information that Queensland Health had, that the colleges would participate, as the policy contemplated?-- That's correct, yes.

But that by around late 2003, early 2004, that cooperation, to the knowledge of Queensland Health, was no longer forthcoming?-- No, I think it was in various places. I don't think it was a comprehensive lack of participation. My understanding certainly was that it was still happening significantly, but in some places there were difficulties.

As a result of those difficulties, it was known that the policy was not able to be complied with in those places?-- Yeah, that's a possibility. That's true.

Now, was anything done by yourself or anybody else within Queensland Health to your knowledge to overcome the problem of the colleges' reluctance to participate?-- The overseeing of the policy rested with the zones and my understanding at the time was that the zones were co-ordinating or attempting to coordinate amalgamating committees, if they had to, to be able to get appropriate privileging, yes.

You don't know of anything in particular that was done, say, in the central zone to affect that?-- Specifically I don't. I'm trying to recall. I think there was some amalgamation of committees, but I'm only just speculating.

There was certainly, to your knowledge, no relaxation of Queensland Health's policy?-- No.

No modification of it?-- Not that I can recall, no.

So, the expectation remained that the policy would be complied with?-- Yes.

Doctor, I now want to ask you some questions concerning your conversation with Dr Keating on the 7th of April 2005?-- Yes, sir.

Relating to what he had discovered concerning Dr Patel. Now, the conversation, as you have said in your evidence, I suggest, was one that occurred after your meeting with the staff on that day, and is it right to say that it was a conversation that was rather brief?-- It was brief, yes.

Because the circumstances and the timing didn't allow for an elaborate conversation-----

COMMISSIONER: Is that document already an exhibit?

MR DIEHM: Sorry, Commissioner, it is JGS6 to the statement of Dr Scott.

COMMISSIONER: Thank you.

MR DIEHM: Doctor, in the conversation, can I suggest to you

that Dr Keating told you that he had learned from a Google search he had done the night before that Dr Patel had problems with respect to his registration in New York and Oregon?-- That's correct, yes. The only thing I'm not sure of is whether he said "the night before", but that's the conversation.

Sorry?-- Whether he said it was the night before I'm uncertain of, but certainly that content's right.

All right. I suggest that he told you that the problems related to, in part, at least, Dr Patel having problems concerning the performance of procedures such as liver resections, pancreatic resections and ileoanal anastomoses?-- I don't specifically recall the procedures he talked about, but I - that's probably correct.

So, do you recall him speaking about some specific procedures?-- I remember him talking about the types of procedures, but I can't recall the specifics of it.

Do you recall him mentioning to you that there was a reference to Dr Patel being guilty of gross negligence?-- I don't remember the use of those terms, to be honest, but again I wouldn't say that he didn't say that. I just don't remember that.

I suggest to you that Dr Keating told you that Dr Patel must have lied to the Medical Board in advising it that he had no restrictions on his right to practice in the United States?-- Again, I don't recall the specifics, but we did talk about his registration, yes. The actual specifics of the conversation, I don't recall, but certainly he did talk about his registration in Queensland, yes.

Do you think, as best you can recall it, that that was in the context of him saying that there must be some difficulty with his registration in Queensland?-- Yes.

Thank you. Now, you have said in two of your statements that Dr Keating told you - and I'll use your words - that he did not want to be identified as the source of this information?-- That's correct, yes.

So, what you are telling us is that Dr Keating advised you that he wished his name not to be mentioned as the person providing this information to you?-- That was my understanding, yes.

Did you honour that?-- I did, until we knew what we were dealing with, yes.

When was it that you knew what you were dealing with?-- Well, obviously, as I said, that night I went home to confirm what Dr Keating had told me. I did not reveal the name to the Minister - that was the initial trip home. I probably - you know, I'm hazarding - you know, I probably relayed the name to the Chief Health Officer when I rang him that night.

Yes. Doctor, I put it to you that Dr Keating didn't ask that his name be kept confidential?-- I would reject that absolutely. It is the reason I never spoke to the Minister on the plane. Quite specifically he said, "I don't want to be identified as the source."

Well, why then did you tell Dr FitzGerald that Dr Keating was the source of your information?-- I guess I was impressing upon Dr FitzGerald that it had been discovered in Bundaberg. Dr FitzGerald had been in Bundaberg and he knew Dr Keating.

Did you contact Dr Keating before speaking to Dr FitzGerald to tell him you were intending to breach the confidence you say Dr Keating-----?-- No, I didn't.

Did you maintain that confidence, aside from telling Dr FitzGerald it was Dr Keating, in disclosing the information to anybody else?-- I don't recall using Dr Keating's name anywhere else but I wouldn't equally say that I didn't.

Doctor, when Dr Keating provided this information to you, did he tell you that he was providing it to you because he thought that it was sufficiently and obviously important enough that it needed to be related to a person in a high position of authority for it to be dealt with appropriately?-- That was my impression of why it was given to me, yes.

Thank you, doctor. I have nothing further.

COMMISSIONER: Thank you. Mr Applegarth - sorry-----

MR BODDICE: I don't have any questions, thank you, Commissioner.

COMMISSIONER: Thank you.

CROSS-EXAMINATION:

MR APPLEGARTH: Dr Buckland, the first thing is really in the nature of possible transcript correction. Yesterday you were asked by my learned friend Mr Douglas about the measured quality program and you said you weren't sure whether it was under the IWR. You mentioned a doctor's name. The transcript at page 5527 records you as saying Dr Ward, but I think you may have said Dr Waters?-- That's correct, yes.

Secondly, yesterday afternoon you were asked some questions about waiting lists, and at page 5540 line 58 you said, "I would also add that clinically it is the length of time that's critical, not the raw numbers because it depends on capacity." Now, I would like you to explain, if you can, what you mean by capacity, and perhaps I can give you a concrete example that

will help you explain it. Let's assume that you are my GP. I come to see you, Dr Buckland, because it looks like I have got cataracts and I may need surgery. Hospital A has a waiting list with 20 people on it to see the eye specialists in the outpatients clinic. Hospital B has 50 people waiting for an appointment. What is the capacity issue that determines whether I am better off having you, as my GP, send me to the list on hospital A or the list at hospital B?-- Clearly, the issue is one around the availability of specialists' time. I mean, if you are in the first list of 20 people, say, and the eye specialist only does an outpatients once a month and then a surgery once a month, versus if you were referred to a service where, say, potentially, you know, you might only see four new patients or two new patients, depending on the list, versus somewhere if you had 50 but you may have five specialists seeing outpatients or two specialists seeing more frequently on a weekly basis. So I guess the point I was trying to make yesterday around capacity really is it is about time. It is not just about the raw numbers, as I said yesterday, and I firmly believe of themselves are not the only indicator. You actually need to know how quickly you can move through the system.

COMMISSIONER: But if the GP in that hypothetical example was given the raw numbers, he would probably know how many eye specialists there were at the hospital A and hospital B and how often they came, or he could find that out fairly quickly?-- Commissioner, I think that statement is true in terms of regional Queensland. I think it is less so in the major metropolitan-----

We're talking about regional Queensland mainly?-- That's right, yes.

MR APPLEGARTH: Do you understand if there is inhibition on a GP contacting hospital A and hospital B and finding out the raw numbers and the other information they need?-- Not at all. In fact, that happens quite frequently, particularly in regional Queensland GPs. They have a close liaison with the specialists at the hospital so they tend to know what they are waiting for.

Next, yesterday afternoon you were asked some questions about funding for elective surgery and at page 5543 line 40 you spoke about the "withdrawal of funding and turning taps on and off", and you said that that had a negative impact, and you said that's the reason you changed it. Just to clarify the decision that was made to change things and when it was made, can you look at your second statement, if you still have it there? If you turn to paragraph 194, I am not suggesting this is the decision but I just want to clarify it, if I can?-- Sorry, paragraph?

194 of your second statement?-- Yes.

Is that the decision that you are talking about?-- Yes, that's right, that's correct.

That was, in essence, to put elective surgery as part of the recurrent base funding for the hospital so they could decide what to do with the money rather than having someone at the surgical access team letting the money out in dribs and drabs and earmarked?-- Basically, yes, and basically what would happen on an annual basis, which makes it very difficult, I think, for hospitals and clinicians and services to run, if it was an annual allocation, a non-recurrent, and it could be adjusted. So if you are planning your work and building up your doctors and your throughput, you can't just keep turning it off and on on an annual basis, and there was a lot of disquiet - in fact, increasing disquiet that the system as it stood was becoming more and more bureaucratic and more and more about numbers and less and less about patients. So we took the decision at that stage then to say, "Look, this needs to be mainstream. Elective surgery is part of our core business. It can't continue to be dealt with this way, it needs to be mainstream and we will allocate the budget so the district has some certainty in its funding", which up until that point of time it didn't.

Yesterday at page 5542 you were asked about the policy that emphasised the policy that you said was around when you entered the senior levels, the policy that emphasised elective surgery targets, and at line 40 on page 5542 you said that "I changed it in 2004/5 for the reasons I just said. It was a perverse driver."?-- Yes.

Now, the term "perverse driver" appears at page 195 of your second statement, which I think we have got up on the overhead?-- Okay.

Just have a look at the overhead or look at the document itself. Is that to what you are alluding when you mentioned perverse driver yesterday? Tell me if I am wrong?-- No, it is part of what I am alluding to, yes.

And you give us an example of a perverse driver that leads to poor clinical practice?-- Yes.

That in a political health district, giving priority for elective surgery might mean that funding is given for a hernia operation when a hernia is not life threatening but that priority may be to the detriment of another patient not requiring surgery but a medical intervention."?-- Yes.

And you go on to say that that was the reason why in April 2005 the distinction was disbanded?-- Yes, that's correct.

Was there - sorry, you continue if it is responsive?-- The rationale behind that - I will give you a very quick example - when this program first started, for example, a lot of cardiac work was done with major interventions and therefore was a surgical procedure. As time has gone on, with the advent of stents and other interventions, they are now done by cardiologists and even though they are procedural under the pure definition of what's elective - of surgery, they were outside of the program. Now, clearly what you don't want to

happen is people to say, "Well, to get funding I will go and do an operation", when in fact there is much better clinical procedures available. So the decision was taken through last year and implemented to say we will broaden the program away from elective surgery as entitled to elective procedures. So it picks up a lot of the concerns that people have had saying, "Well, you are only focussing on surgery but these are very important issues and if you keep funding here you will miss opportunity over there."

Finally, in paragraph 196 you say that you think funding should be directed to elective procedures which hopefully avoid the need for surgery, for example if someone has a stent or a defibrillator, they may not suffer the heart attack"?-- Yes.

And you go on to say that funding should also be directed towards preventative health strategies?-- Yes.

Just finally you address the issue of preventative issues elsewhere at some length in your second statement?-- I do.

Thank you.

COMMISSIONER: Five minutes, Mr Applegarth.

MR APPLEGARTH: The two minutes was yesterday when we were hoping to finish in half an hour.

COMMISSIONER: All right. Mr Douglas?

MR DOUGLAS: Yes, I have no re-examination. Commissioner, what I do propose to do - and I had proposed to do it when Dr Buckland concluded giving his answer to my question yesterday, in light of the publicity in this morning's Courier-Mail in relation to managed quality, there is a document which is being produced to counsel assisting - although it doesn't presently appear in Mr Justin Collins' statement, the gentleman who runs measured quality - in the statement he provided yesterday, that is the public report that was publicised by Queensland Health in June 2003 under the hand of Dr Stable in relation to the issue of managed health - in light of publicity this morning, notwithstanding that I will be canvassing that matter with Mr Collins when he gives evidence on Monday, I thought it apt that that should be tendered now. Again, it is not a matter that I need to detain Dr Buckland about. That's being copied at the present time.

COMMISSIONER: All right.

MR DOUGLAS: Can I tender that and that can be considered by the parties at the Bar table in due course. I would ask, though, that those who are reading that document - again it is dated June 2003, it is headed, when the parties receive it, "Queensland Hospitals - the 21st Century Leading The Way", on page 18 of that document the following appears under the heading "Summary of indicator results":

> "The variations listed below have been identified in the context of a Statewide public health system. The variations in patient outcomes identified between hospital groups and between private and public hospitals will be the focus of ongoing improvement activities with the clinical workforce at the facility, district, zonal and Statewide level. This work aims to both identify contributing factors and reduce variation.
>
> This benchmarking and quality improvement process has occurred within the context of a Queensland-wide health system which provides network services of varying size and complexity. Therefore, quality improvement activities will occur within a system's context through initiatives such as the Integrating Services and Priorities Program, as well as the further development and use of clinical pathways, integrated risk management, the revision of infection control guidelines, tele-health, discharge planning workshops, facilitating community of care, service integration, and other important initiatives detailed in pages 37, 38 and 49 and 56."

I am sorry to read that at length. What I am attempting to exercise, Commissioner, is this: as I anticipate the evidence will be, that this document, this public document was just that, it was publicised, but when it comes to the individual details in respect of any particular hospital, whether in comparison - either whether in itself per se or by way of comparison within the peer group, that information was not published. That's what I apprehend the evidence will be.

COMMISSIONER: All right, that will be Exhibit 352.

ADMITTED AND MARKED "EXHIBIT 352"

MR DOUGLAS: Thank you.

COMMISSIONER: No-one wishes to keep Dr Buckland here, I take it? Thank you, Dr Buckland, you are excused from further attendance?-- Thank you, Commissioner.

WITNESS EXCUSED

COMMISSIONER: Mr Andrews?

MR BODDICE: Commissioner the next witness is Dr Mattiussi.

COMMISSIONER: Sorry?

MR BODDICE: The next witness is Dr Mattiussi and we will be seeking leave to appear on behalf of Dr Mattiussi. I wonder if I could have five minutes? He has only just arrived and I haven't had a chance to speak to him, but I won't need more than five minutes.

COMMISSIONER: All right, five minutes. I will adjourn for five minutes.

THE COMMISSION ADJOURNED AT 10.44 A.M.

THE COMMISSION RESUMED AT 10.56 A.M.

COMMISSIONER: Can I just say for the benefit of counsel, having had that adjournment I won't take my usual mid-morning break.

MR ANDREWS: Thank you, Commissioner. I call Dr Mark Mattiussi.

MR BODDICE: As indicated, Commissioner, we seek leave to appear on behalf of Dr Mattiussi.

COMMISSIONER: Thank you.

MARK PETER MATTIUSSI, SWORN AND EXAMINED:

MR ANDREWS: Doctor, are you Mark Peter Mattiussi?-- That's correct.

And you are District Manager and district Director of Medical Services at the Logan Beaudesert Health Service District? When you answer, if you can do it orally as opposed to with a nod, it can be recorded?-- Yes.

And that means you work at the Logan Hospital?-- I work in the Logan Health Service district. My office is located at Logan Hospital.

Dr Mattiussi, you were one of four persons who collaborated to prepare, in relation to the Bundaberg Base Hospital, a review of clinical services in a confidential review report. Is that correct?-- That's correct.

That - would you look, please, at the part of exhibit 102 which is the report. Mr Groth, that part of exhibit 102-----

WITNESS: I have got my own copy.

MR ANDREWS: Doctor, can you identify that as a copy of the report prepared by you, Dr Wakefield, Professor Hobbs, and Dr Woodruff?-- That's correct.

You were the team leader for the preparation of that document?-- Yes, I was.

I noticed on reviewing it that there was in one place a suggestion that there was an opinion held by Dr Woodruff, but aside from that one, which I saw generally, the opinions expressed in the report appear not to identify any particular reporter. That's generally correct, isn't it?-- Yeah, the reports are generally written as a team. Peter Woodruff was on the team to look at clinical aspects of Dr Patel's care predominantly, but he also participated in the other parts of the review.

The report expresses a number of allegations which the reporters heard from various persons at the Bundaberg Hospital. That is, it sets out what the reporters were told. Do you agree?-- It sets out what we were told as well as our opinion of how that all fitted together.

Where it sets out what you were told, does the report accurately set out the things that you were told?-- In our view, yes.

Well, it is your view that I am interested in?-- Okay.

In your opinion, does it accurately set out the things that you were told?-- Yes.

And where there are opinions expressed in that report, save for the ones identified as being Dr Woodruff's opinion-----?-- Mmm.

-----are they opinions that you honestly hold?-- They're opinions that are formed from team discussions and they were the consensus view. So there are some aspects where Dr Woodruff would have formed an opinion and he would have been the expert, we would have relied on that information in formulating the report. There are other aspects where other members of the team were the expert and again the team relied on that. So I would then view that, yes, we would think that those were the opinions and they were accurate.

Thank you. Have you prepared, doctor, a statement of 17 paragraphs signed on the 18th of July 2005?-- I have got a copy of a different version of that, I think. Can I have a look?

Perhaps you should look at the copy which I hold?-- Yes, I did.

Are the facts recited in it correct to the best of your knowledge?-- Yes, that's correct.

And the opinions you express in it, honestly held by you?-- Yes.

I tender that statement. May I look at that version, just to be sure it has none of my notes in it?

COMMISSIONER: That will be Exhibit 353.

ADMITTED AND MARKED "EXHIBIT 353"

MR ANDREWS: Doctor, I am going to ask you some questions with respect to the joint report, which is part of exhibit 102. You have a copy of it with you, don't you?-- This one.

What, doctor, are your qualifications?-- I have a Bachelor of Medicine Bachelor of Surgery with the University of Queensland, a graduate certificate in management as a consortium between Queensland Health, QUT and USQ, Masters of Business Administration and I hold a Fellowship to the Royal Australasian College of Medical Administrators.

Thank you. At page 20 of your report at the second paragraph, there is an ambiguity I would like you to clear up. Do you see the second paragraph beginning with the words, "This review is purported to have revealed four broad issues of concern."?-- Yep.

You were speaking there, were you not, of the review of Dr Gerry FitzGerald?-- That's correct.

I would like you to turn now to page 31 where a discussion begins at 3.1.2-----?-- Uh-huh.

-----about Dr Patel, credentials and clinical privileges?-- Uh-huh.

It is the case, is it not, that by April of 2003 there was within Queensland Health a Queensland Health policy statement concerning the issue of credentials and clinical privileges. I would ask you to look at a document at the witness-box, exhibit 279?-- You have provided me with a document of a July, I think, 2002 update of the credentials and privileging framework. That was I think initially administered out in the 1990s. So it has been updated recently, so in 2002 that was produced. So April 2003, you said?

April-----?-- This document would have been in effect.

Thank you. As I look at the - my copy of exhibit 279, I see what appears to be a four-page typed covering document which covers a more attractively presented document called "Credentials and Clinical Privileges, guidelines for medical practitioners - July 2002". Do you see those two different sections of exhibit 279?-- Yes, I do.

Can you tell me what the genesis is of the four page covering document?-- Sorry, I'm not quite sure what you're asking me.

Why does the four page document exist in addition to the 25 page, attractively presented document?-- I can't answer that for you. I don't know. You need to talk to the author of the document.

Well, in any event, do you accept that this is a document that the administrators of the Bundaberg Base Hospital ought to have received prior to April 2003?-- The July 2002 document was certainly in circulation.

Now, the one that you refer to is the one headed with - that has a covering page reading, "Credentials and Clinical Privileges - Guidelines for Medical Practitioners - July 2002", and it bears the logo of the Queensland Government at the bottom of the page?-- Mmm.

Is that correct? Could you speak your answer?-- That's this document here, yes.

The joint report, Exhibit 102, reveals that there was no evidence that on appointment Dr Patel was granted specific clinical privileges. You say, "consistent with his credentials and the clinical service capability of Bundaberg Hospital". Do you see that?-- Yes, I do.

COMMISSIONER: Sorry, where are you now?

MR ANDREWS: I'm at page 31, Commissioner.

COMMISSIONER: Yes.

MR ANDREWS: Of Exhibit-----

COMMISSIONER: Yes, I have that.

MR ANDREWS: Immediately under the heading, "Dr Patel - Credentials and Clinical Privileges."

COMMISSIONER: Yes, I have that. Sorry.

MR ANDREWS: The first sentence suggests that specific clinical privileges might be granted consistent with two things. One, credentials, and two, the clinical service capability of the hospital?-- That's correct.

Thank you. So the privileges, I infer, would be determined upon Dr Patel's credentials, but also would be determined against the background of the hospital's facilities?-- In general terms that's correct.

Two sentences further on you observe, "Dr Nydam reported that short-term locums were usually not formally credentialled and allocated privileges." That would be inconsistent with the Queensland Health policy, wouldn't it?-- Yes-----

For even short-term locums ought to be dealt with and given credentials and privileges?-- Yes, that's correct.

A person at the hospital on a one year contract is not a short-term locum, you'd agree?-- Depends on your definition of "short-term".

Well, indeed. I'm asking you whether you'd agree that it's not a short-term locum to be employed for a year?-- I would, on occasions, employ locums for 12 months. Whether you define them as short-term-----

COMMISSIONER: But how would you define them? Would you define them as short-term if they're there for a year? That's what you're being asked, not how someone else might?-- Okay. This is speculation-----

No, well, how would you - that's not speculation, just asking for your opinion?-- I can say to you if you define someone as three months is it short-term? Absolutely. Twelve months - we employ junior doctors on 12 month contracts, don't necessarily call them short-term locums. So you could say that using that logic - and I'm thinking on my feet - that 12 months is a longer term appointment rather than a short-term locum.

MR ANDREWS: The important thing about making a distinction between one category of medical practitioner and another when determining how to credential and privilege them is the duration of their term, not whether they're called a locum or not called a locum. I see that my question is untidy. The reason there would be special rules for short-term locums would be because they're short-term, not because they're locums. Do you agree?-- Yeah, the reason why you have different rules for short-term locums is that your clinical privileges committees don't normally meet more frequently than once a month, sometimes once a quarter, and therefore you need a separate process to allocate privileges so that when people start you can actually allocate privileges to them before they're finished.

Thank you. And so if a person were engaged for a year there would be no reason for excusing that person from submitting to a credentialling and privileging process?-- That's correct. At some time during the tenure you would have run them through the committee.

COMMISSIONER: Or excusing the hospital from not having that process applied to that doctor?-- Yeah, that's correct.

MR ANDREWS: The committee that you speak of which meets monthly or three monthly, that's the credentials and privileges committee?-- That's correct.

And it is and was Queensland Health policy in April 2003 that a hospital such as Bundaberg Base Hospital would have a committee?-- Either that or be linked into a committee with another health service potentially.

Your report doesn't say whether there was such a committee. There wasn't, was there, at the time?-- John Wakefield specifically looked into the risk management framework. From what I understand his findings were that no, there wasn't a committee that was functioning at that time.

Well, that would be a breach of Queensland Health policy?-- You would think so, yes.

And the responsibility for creating such a committee or for appointing it or for ensuring that it is maintained is the responsibility of a District Manager?-- Yes. Sometimes that is subdelegated down to the Director of Medical Services, but it sits underneath the District Manager primarily.

And was there any indication that the District Manager had subdelegated the responsibility for maintaining such a committee to the District Manager at Bundaberg?-- Sorry, your question was the District Manager subdelegating to the District Manager?

Thank you. Was there any evidence that the District Manager had subdelegated to the Director of Medical Services?-- It's hard for me to answer that definitively. I mean, it doesn't appear that there's information either way on that except that the Director of Medical Services was trying, from the information we have, to organise some credentialling and privileging for staff because there are letters in some of the P files that indicate that.

You mean you found no evidence to suggest that Mr Leck had asked Dr Keating to take over Mr Leck's responsibility as District Manager for this committee?-- The direct answer to your question is no, I didn't, but we didn't specifically look either.

On page 31 you observe that, "Dr Keating wrote to Dr Patel advising the colleges have been unable to provide appropriate nominations and this has significantly slowed down the process of formal approval of clinical privileges."?-- That's correct.

Now, it is correct, isn't it, that a privileges committee doesn't - isn't obliged to contain a nominee of a college. It's a recommendation that it does, but there is no obligation?-- That's correct, but usually the colleges are used as assistance in that process.

And in fact there's no reason why, for a surgeon - or someone who is appointed as senior medical officer in surgery, that there couldn't be a privileges committee of local peers?-- Do you include local peers as local surgeons?

I do?-- Usually we try to get the colleges to provide a nomination in that regard so that at least it has some standing within the college, and that gives us the ability also to use the college - and you can do this via letter, not

necessarily a person sitting on a committee - to advise whether the applicant, if they are a specialist or Fellow of the college, whether they're up-to-date with their continuing medical education, or CPD points.

Well, for someone who is an overseas trained doctor and obviously not a member of the college, that's not quite as important, is it, to, that is, have the college involved? What's more important is to have a committee of the peers consider the person's credentials and determine-----

COMMISSIONER: Not necessarily peers in the sense that people not qualified, as Dr Patel wasn't, to be an orthopaedic specialist, but peers who may even be orthopaedic specialists, people who might be better qualified than, say, Dr Patel. He wasn't a qualified orthopaedic specialist.

MR ANDREWS: Commissioner, you're using the expression "orthopaedic specialist". In fact Dr Patel didn't hold himself out as an orthopaedic specialist.

COMMISSIONER: I understand that.

MR ANDREWS: Simply as a specialist surgeon.

COMMISSIONER: Sorry, surgeon. Yes, right.

MR ANDREWS: I beg your pardon. There's no evidence that Dr Patel held himself out as a specialist in the sense of having Australian qualifications, but it's surgery which is the area of expertise as opposed to orthopaedic surgery.

COMMISSIONER: Yes.

WITNESS: Sorry, now I've lost the question.

COMMISSIONER: I confused you, I think.

MR ANDREWS: The Commissioner's question was it wasn't necessary that you should find peers for Dr Patel in the sense of persons not holding specialist qualifications. You could find peers in the sense - and should have found peers at Bundaberg in the sense of holding qualifications in surgery?-- I'd agree that a committee needs to have peers who hold qualifications in surgery if you're assessing the privileges of a surgeon.

And if you're assessing the privileges of a Director of Surgery?-- Again I go back to what I said before, and that is it's preferable to have-----

COMMISSIONER: We're not talking about what's preferable, Dr Mattiussi. Let's assume you can't get someone from the college. What's acceptable in terms of a privileging committee?-- You'd have to then go back and ask the question about why you're not getting someone from the college.

No, no. Forget about why you're not getting someone from the college. Let's assume you can't get someone from the college?-- So the assumption is the colleges don't wish to be involved?

Don't mind why. Forget about why. They're not involved?-- Right.

You have to have a privileges and credentialling committee?-- Right. Well, the only other alternative is another surgeon as a peer, but I'm not advocating that that's the optimal way to manage it.

It mightn't be optimum, but it's better than none, isn't it?-- Yes, it would be better than none.

MR ANDREWS: At the bottom of page 31, under the heading, "Opportunity for intervention", there's the opinion expressed that it's usual practice for a District Manager or their delegate to determine clinical privileges for temporary medical staff. If staff are not temporary in the sense that they're going to be there for a year, it's usual practice for the committee to determine the clinical privileges?-- The committee provides a recommendation. The District Manager is the one who always determines the final privileges under the policy. So they're the person that writes to the doctor.

Thank you, yes?-- Regardless, sorry, of whether they're temporary or permanent employees.

The opinion is expressed at the bottom of page 31, "Typically privileges would have been general surgery, which would not exclude complex surgical procedures such as oesophagectomy which have raised concerns in this case." Now, the word "typically", is that used with reference to short-term, as in one, two or three month appointments, or is that intended to refer to privileges which would be granted to an SMO in surgery?-- The word "typically" is used in the context of this report in that for credentials and clinical privileges committees, if you have a general surgeon, the privileges that are - I hate to use the word again - typically allocated are in general surgery. They don't go down to the specifics of saying, "You can do procedure X or procedure Y", or, "You can't do procedure X or Y", unless there's a specific reason why you would see that in a particular case, usually around the service profile of a hospital. But even in a place like Bundaberg, history would say that clinical privileges are allocated in general surgery rather than general surgery excluding any procedures. It's very complex to do that, and not typically - sorry to use the word again - done in Queensland.

Well, if there were a committee that had one or more surgeons from Bundaberg sitting upon it, would there not be an excellent opportunity to consider whether Dr Patel ought to be privileged for one kind of surgery but not another?-- The idea of the privileges committee is exactly that, but the way privileges committees have operated traditionally in

Queensland - and this is part of the reason why it's highlighted in the report - is that allocation of privileges has been around general surgery rather than the specifics.

Well-----?-- And not just at Bundaberg.

Let me put up on to the screen - you will see on your monitor shortly - page 9 of the credentials and clinical privileges policy document of Queensland Health. Do you see section 6, "Guidelines for credentials and clinical privileges committees"?-- Yes, I do.

The first dot point is that, "Applicants for positions within a facility will have their clinical privileges defined before the completion of the section/appointment process."?-- Yes, I see that.

Was there any reason why Dr Patel's privileges could not have been defined before the completion of the process selecting him for employment?-- He was employed over - from overseas. They would have reviewed his credentials as part of the appointment process. So there's no reason why they could not have been defined. In any event, as outlined in the report, they would likely have been defined - because that's typical - as general surgery.

Would you look, please, to the bottom of the page to a dot point with the figure 8 beside it?-- Yes.

You will see in that dot point there's a suggestion that in some circumstances privileges can be granted subject to an applicant undertaking a period of supervised practice or training?-- That's correct. I see that.

A period of supervised practice or training would be ideal, would it not, where a person does not have Australian qualifications and where a hospital has no past experience by which to judge the new employee's competence?-- That's correct.

It goes on to suggest that, "For example, a surgeon may be granted general privileges", but not endoscopic privileges without evidence of satisfactory training?-- Yes.

Were there some complaints that you were aware of about particular procedures that Dr Patel performed?-- There were concerns raised about a number of the procedures that Dr Patel performed.

Laparascopic procedures? Were they among them?-- No. There were concerns primarily raised about complex surgery. There were some concerns raised in relation to his technique.

Well, with respect to complex surgery, would it not have been within the province of a committee to confine Dr Patel's privileges by reason of the facilities at Bundaberg? For instance, the fact that there was a Level 1 ICU as opposed to a Level 3 ICU?-- As we detailed before, the allocation of

privileges are in relation to their credentials as well as the capability of the health service. So the process is around allocating privileges based on that particular basis.

And so would I be right in thinking that a privileges committee, knowing that there was a Level 1 ICU at Bundaberg, ought to have deduced that that would mean Bundaberg was unsuitable for the kinds of surgery which would routinely result in a patient requiring more than two days on a ventilator in an ICU?-- This is where the complexity begins, because part of our report also looked at the service capability framework within Queensland Health.

And that's what a committee ought to be looking at?-- And the committee can use that framework in order to allocate privileges.

And should, shouldn't it?-- And should.

And if a committee had used that framework, is it not likely that the committee would have considered whether complex surgical procedures such as oesophagectomy would have been appropriate privileges for Dr Patel at Bundaberg?-- The reason why I raised the service capability framework is if you look within that document - and this is highlighted within the report, and I'm sure you've read that section - the allocation of privileges based on the service's capability framework would be quite complex, because complex surgery has a very broad application from abdohysterectomies to oesophagectomies listed as being homogenous procedures.

Yes, and so do you agree that a privileges committee might well have determined that for Bundaberg, surgical procedures such as an oesophagectomy ought not to have been included among the privileges for Dr Patel?-- Prior to Dr Patel commencing duties at Bundaberg, oesophagectomies were performed in that health service, so there was a general acceptance within the health service that those complex procedures could be undertaken. I can't-----

Dr Mattiussi, the fact that they'd been performed before, you conclude from that that there was a general acceptance. Isn't it equally possible to conclude that there was a general abdication of responsibility to set up a privileges committee and that nobody concerned themselves with the issue of whether it was inappropriate? Isn't that an equally possible conclusion to draw?-- The difficulty is that if you have a privileges committee and it's generally accepted amongst the medical community in that health service that these procedures can be undertaken in that hospital, as would appear was the culture or the status quo at the time that Patel was employed, and we take the second point that was raised about putting on a peer surgeon from within that culture/community, you could also have reasonably expected that a credentialling and privileging committee made up in that way with that mindset may have generally accepted that those services were provided in that hospital and allocated privileges accordingly.

And the proper thing to do would have been to have set up such a committee so that they could consider that issue; is that correct?-- There's no doubt that there should be a credentialling and privileging process in the hospital.

COMMISSIONER: Dr Mattiussi, it would be helpful if you listened to the question and answered the question rather than talk about something that isn't necessarily responsive. I'm not being critical-----?-- I'm trying to ensure that the message that I'm getting across is clear.

Forget about messages, just answer the question, if you wouldn't mind?-- Sure. Okay.

MR ANDREWS: It is the case, isn't it, that a committee would feel it appropriate to make contact with the referees of a new employee in the district?-- It's usual when you are employing someone to have a look at their referees, yes, and - the selection committee - and they can then be used as part of the credentialling and privileging process.

And that would be the case, even if those referees are in a foreign country. They are able to be contacted by telephone or Internet, E-mail?-- Yes.

It would be - I suggest it is quite conceivable that a properly functioning privileges and credentials committee in April 2003, considering Dr Patel and the clinical service capability of the Bundaberg Hospital, might have excluded the complex surgical procedure of oesophagectomy when allocating privileges?-- It is my view the privileges that would have been allocated would have been for general surgery at Bundaberg.

COMMISSIONER: What do you mean would have been? What you are being asked, see, Dr Mattiussi, is not what would have been, but what should have been?-- Under - under-----

See, we are asking your opinion. You are an expert doctor?-- See, under Queensland Health's processes at the time and understanding the complexity of the clinical privileging allocation process, what would have been allocated-----

No, what should have been. Should have been?-- There is a difference between should have been-----

What you are being asked is what should have been?-- The privileges-----

Given that document-----?-- The privileges that should have been allocated were for general surgery, but within the service definition at Bundaberg Hospital.

Thank you.

MR ANDREWS: Well, I suggest to you that being an unknown quantity - that is, an overseas trained doctor who nobody in

the area had any personal experience of-----?-- Mmm.

-----that Dr Patel should have been supervised; what do you say to that proposition?-- I agree with that.

There was nobody to supervise him, was there?-- There were a range of other surgeons in the town, or if the privileges committee had have asked an external surgeon, there may have been the ability to utilise that person to do - or you may have been able to set up a structure with other services and use their services to do that. It is difficult and complex but do-able.

Dr Patel should not have been appointed to a position of Director of Surgery in circumstances where he was registered as a Senior Medical Officer, Surgery. You would agree with that proposition, wouldn't you?-- The difficulty sometimes is that if you employ him as a Senior Medical Officer and there is no Director for the service, who manages the administrative side of the service, because the directorship is about administration, it is not necessarily about clinical leadership for that service.

COMMISSIONER: What's your answer to that question? I still haven't heard that?-- The answer is that you can employ - you can employ an SMO as the Director of the service because the directorship is about administrative duties. So, it is about doing rosters, supervising the junior staff to make sure that they are attending on time and so forth. The clinical leadership in many departments isn't necessarily just provided by the Director.

MR ANDREWS: Dr Mattiussi, where Dr Patel had received registration from the Medical Board as Senior Medical Officer, Surgery, there was an implication by the Medical Board and an inference to be drawn by any administrator that Dr Patel was to be subject to the supervision of a Director of Medical Services - I beg your pardon, a Director of Surgery. You would agree with that proposition, wouldn't you?-- I don't understand how you say there was an inference there from the Medical Board that he was-----

No, no, an inference to be drawn by any competent administrator. If you, Dr Mattiussi, received a new employee who was registered as SMO, surgery, would you allow that person to perform unsupervised at your hospital?-- I would ensure that there was a mechanism for someone to audit their clinical performance.

Do you mean you would allow them to practise unsupervised?-- Senior medical officers can practice as a consultant on call, so therefore they can work as the senior doctor without someone looking over their shoulder to perform procedures-----

COMMISSIONER: We are talking about this man?-- Sorry, Commissioner?

We are talking about this man. With what you would have

known, as the head of the - what's it called - Director of-----

MR ANDREWS: Director of Surgery.

COMMISSIONER: Director of Surgery-----

MR ANDREWS: I beg your pardon.

COMMISSIONER: Director of Medical Services - what you knew as the Director of Medical Services, from what the Medical Board had certified, and what you knew of the history of this man as it appeared to you when he came to the hospital, would you permit him to operate without supervision?-- I would permit him to operate without supervision, but with someone auditing his clinical practice.

MR ANDREWS: Now, audits of clinical practice, that might be somebody simply coming to a mortality and morbidity meeting?-- There are a range of mechanisms to audit clinical practice. Mortality and morbidity meetings and analysis of that data are one facet of that.

And you would content yourself with that?-- No, I didn't say that.

Well, would you explain what kind of auditing you have in mind?-- You would be looking at his complication rate, you would be looking at complications or - and complaints from other members of either the health service or from the public-----

COMMISSIONER: Well, how long would you let him loose for before you audited his procedures?-- Clinical audit is an ongoing process.

No, no, when would you first - when would the clinical auditor first look at this from the time he started?-- It depends on what's actually happening. You would organise that he would link into the regular morbidity/mortality audits. Most of those occur either monthly or quarterly within health services.

He would be going for a month or a quarter at least before anything would be done?-- I didn't say that nothing would be done. Part of the review is to have a look at the information, but you would have to get the information consolidated over a time period.

Quite. Over a month or a quarter?-- Yes.

So, you would be happy if someone like Dr Patel, with the qualifications he presented, could continue unsupervised for a month or even a quarter before anything could be done about him - anything would be done about him; that's what you are telling us?-- Not exactly, no. That's why, when I'm answering your questions with yes and no, I'm not convinced that the message is getting across because of the way you are

asking the questions.

Forget the message. Just answer my question?-- If I had a surgeon working within my health service-----

Not any surgeon, this surgeon we are talking about?-- If I had a Senior Medical Officer-----

This surgeon, Dr Patel, with what you would have known of Dr Patel?-- At the time when he was employed?

Exactly?-- Not subsequent history.

No, not in hindsight?-- You would have a look at what was happening along the way. If someone raised a concern with you, you would look into that specific concern and investigate and address that concern.

All right. But if no-one raised any specific concern, you would wait until the end of the month or quarter?-- You would be monitoring as you go along, because some of the issues that are raised-----

How do you monitor going along? I don't understand what you are talking about. How does the auditor "monitor going along", as you call it?-- What you find is that if complaints are being raised about a particular clinician or staff members come to you and raise a concern, and if you are a Director of Medical Services and intuitive and working with your staff, these things would be raised, typically, fairly early.

You are the Director of Medical Services at Bundaberg at the time. Put yourself in that position?-- Right.

Who would you have had to audit Dr Patel's performance?-- I would have been - and I don't know the other people that are in that area - but I would have been looking for another surgeon to assist me to do this as the Director of Medical Services.

Another surgeon. Employed in the system or as a visiting medical officer?-- It doesn't matter.

Well, it does in the sense that a visiting medical officer may not have the time to do the sort of things that you are talking about?-- Sorry, you are asking me for a response for whether they would have the time.

No, no, I'm putting to you that it does make a difference whether it is a visiting medical officer or someone employed in the hospital. You don't agree with that?-- I think that senior medical officers - so that's including specialists - employed within the health services tend to be there all of the time because you employ them to be there all the time. Visiting medical officers come in on a sessional basis, but on many occasions visiting medical officers can provide you with this sort of supervision or assistance at the same or equivalent level to senior medical officers. Sometimes it is

about the personality - whether they are keen to do that for you.

All right. Sorry to interrupt you.

MR ANDREWS: If, for instance, you had been the Director of Medical Services at Bundaberg wanting to have supervision of Dr Patel by way of audit, if you used a surgeon from within the hospital, wouldn't there be a problem in that the surgeon you engaged would have been - would have had Dr Patel as his or her line manager because Dr Patel was the Director of Surgery?-- That may have created complications, yes.

And let's assume that you could find a VMO with the time - or a full-time staff member of the hospital who was a surgeon - what kind of audit would they be doing of Dr Patel?-- There are a range of surgical audit tools and the specialist surgeons would be able to give you more information about this, but there are tools such as Otago - there is coded clinical information that you can get out of your health department-----

Let me interrupt there. Are these different types of audit tools that you are speaking of systems for the discussion of prior surgical episodes at formal meetings?-- Sorry, tools for the discussion of prior-----

Are the tools that you speak of - for example Otago - is it a tool used during the discussion - during a meeting to discuss surgery that may have occurred a week or a month prior?-- The tools are typically databases and they allow you to extract information to compare performance, either across time or between surgeons.

So, when you say you might supervise an unknown quantity such as a - an overseas trained doctor who doesn't hold Australian qualifications, you mean you'd allow an audit process to run along until it picked up something untoward in that doctor's practice?-- You would use the audit process as one of the tools to assist you in that supervision.

Well, I suggest to you that that's, in circumstances where you have an overseas trained doctor about whom no-one at the hospital has any personal knowledge - it would be appropriate to have physical supervision for a time, as is suggested in the policy document at the clause 6.1 at the 8th dot point that was shown to you before. Do you agree with that proposition?-- It says, "undertaking a period of supervised practice". It doesn't specify that someone needs to look over their shoulder.

COMMISSIONER: Well, supervision surely means supervising what he's actually doing. It doesn't mean conducting an audit process, in plain English?-- Supervised practice means ensuring that you are comfortable that what this person is doing is reasonable practice. That doesn't mean-----

No, "supervised practice" means seeing what he is doing;

that's what "supervised practice" means in plain English - seeing and supervising what he's actually doing; that is, during the course of surgery?-- There is a process utilised by the college where they supervise people who are being - and the colleges would give you more information about this - where they supervise practitioners, and that does not necessarily involve standing in the operating theatre looking over their shoulder, and that's classified as supervised practice.

MR ANDREWS: Yes, one can have supervised practice, so long as the supervisor is within a reasonable distance and can come and assist; do you agree?-- I agree that the supervisor needs to be within a reasonable distance to be able to supervise. Coming to assist depends on the level of competence of a particular practitioner.

And supervision will mean that there will be consultation between the supervisor and the supervised?-- I agree.

Please turn to page 33 of the report. At pages 32 and 33, you have set out some information that you understood to be the history at Bundaberg and, paraphrasing, it is that on the 19th of May, a Mrs Glennis Goodman and Ms Hoffman met with Dr Keating regarding Mr Phillips who had died following an oesophagectomy. One of the issues - one of the three issues raised was that the ICU in Bundaberg was level 1, not capable of providing the level of care required to support such surgery. Then on the 5th of June, you understand that Dr Joyner raised concerns with Dr Keating about a patient, Mr Grave, who had undergone an oesophagectomy. Now, you speak of, in those circumstances, an opportunity for intervention being a multi-disciplinary meeting to address the concerns raised. Is there a protocol in Queensland Health that requires the holding of such a meeting?-- Not that I'm aware of.

Is that something that you, in similar circumstances, would have recommended?-- Yes.

And convened?-- Yes.

Is that something which any reasonable Director of Medical Services ought similarly to have convened?-- I believe so.

At page 33, at the bottom of the page, you speak of a document provided by a Dr Miach, eventually to Dr Keating, which was a complication report?-- That's correct.

Which had to do with the insertion of Tenckhoff catheters?-- That's correct.

Now, I do see that the information that was provided was that the document outlined a 100 per cent complication rate - six out of six patients. Now, I want you to consider another hypothesis: that the document revealed complications with six patients, but it didn't reveal whether they were 100 per cent of the patients or a lesser number of patients; that is, you

couldn't tell whether only six catheters had been inserted in six patients, or whether there had been six in a greater number of patients?-- Right.

On either basis, would you regard the report as calling for some action by either the District Manager or the Director of Medical Services?-- I believe it would have warranted a conversation with Dr Miach about what his specific concerns were.

Now, you observe, "The opportunity for intervention was that given that several senior clinicians had expressed several concerns about the outcomes for patients of Dr Patel's surgery, consideration should have been given at that stage to obtaining formal external peer review." Is there any Queensland Health protocol which required such a thing?-- There's no protocol. It is about clinical practice. That's why we formulated that opinion.

And would you regard that as reasonable for either the Director of Medical Services or the District Manager to have called for a peer review?-- With the concerns being raised as previously detailed in the document, reviewing Dr Patel's clinical practice by a group of peers would have been reasonable at that stage.

And which of those two persons ought to have been the one to have called for that review, a person holding the position of Director of Medical Services or the District Manager?-- I would have viewed that the Director of Medical Services would have initiated the discussion. If we thought that there was disciplinary action to be taken or potential for disciplinary action to be taken, then it would need to be referred to the District Manager, because they are the only person who can undertake disciplinary action.

But if it is a surgeon performing incompetently, that may not require disciplinary action. Surely you don't discipline a surgeon who - simply for being incompetent?-- If a surgeon was incompetent, you would have thought he would stand them down. That would be disciplinary action. That hasn't been ascertained until the review was undertaken at that stage.

Page 34, a second opportunity for intervention is said to have arisen after ASPIC minutes suggested that wound dehiscence rates were high. Now, I notice that it was reported back to the ASPIC committee that there had been a definitional issue, that there had been a further review and the infection control nurse said that she was satisfied with the results of the audit. Despite that, do you still regard this as an occasion when there ought to have been a call for external peer review?-- It is incremental in the information that leads you to think that there may be something going on here that you need to look into.

Is it your opinion that a competent Director of Medical Services would, on this occasion, have called for peer review?-- I probably would have called for peer review a

little bit earlier when you had the Tenckhoff catheters and the oesophagectomy patients where concerns were raised.

From the bottom of page 34 to page 36, there's the discussion of the death of Mr Bramich. Do you regard that as again calling for a peer review because of the cumulative effect of other matters?-- The Bramich case is quite complex, and I'm not sure whether Peter Woodruff has taken you through this case. There are a range of factors in relation to the Bramich case which aren't just linked to Dr Patel, and you would need to, in my view - and I haven't detailed through the clinical record of Mr Bramich - but you would have needed to have looked at that in the multi-disciplinary team first to try and understand all the different dynamics in that particular case.

So that's quite separate from the issue of whether there ought to have been a peer review of Dr Patel, there ought to have been a multidisciplinary team review of the death of Mr Bramich?-- That's correct.

That didn't-----?-- And that may have added to previous concerns.

That didn't occur, did it?-- There was an investigation, as I understand it, that was started by Dr Keating, Director of Medical Services. I don't believe that there were any findings in relation to that because other events seemed to close that down.

Now, a multidisciplinary team review, how does that compare with the investigation started at the behest of Dr Keating?-- As I understand the information, Dr Keating had spoken to a range of clinicians individually rather than bringing a team together such as a root cause analysis.

And I gather you would recommend bringing a team together to conduct a root cause analysis?-- It is easier to do that because then you get all the information together in one place. You may need to go a away and talk to people individually as well. If you try and do it individually and talk to individuals without pulling together the whole lot, it is really hard sometimes to put the pieces together, specially in complex clinical cases such as this.

And bearing in mind there was a sentinel event, was there not also an obligation to inform the head office at Charlotte Street?-- Yes, there is a sentinel event process for notification.

And whose obligation do you understand it to have been?-- District Manager.

To have informed, what, the audit and review branch?-- No, to provide a notification which goes to, as I understand it, the Patient Safety Centre.

In Brisbane?-- In Brisbane.

And you saw no evidence that that had occurred?-- From what we understand, no.

On page 37 at the bottom paragraph, you observe that on the 24th of December, the Director of Medical Services had written to Dr Patel to offer a further extension of his contract for a period?-- Uh-huh.

Now, you say that "the review team was unable to find any documentation of a merit-based process to support this." Was a merit-based process required under any Queensland Health protocol?-- If you are appointing for 12 months, district managers can do that at their discretion. Longer than that usually requires a merit-based process.

Now, the offer of an extension seems to be for four years?-- That's correct.

If, for instance, it was an offer of an extension or intended to be an offer of an extension, for argument's sake for only one year, should there have been a merit-based process?-- No, you don't need to do a merit-based process for appointments up to 12 months.

But for two years there ought to have been?-- Mmm.

At page 38 in the second last paragraph, "I observe that on the 2nd of February 2005 Dr Keating completed a special purpose registrants assessment for Dr Patel for the period to January 2005 rating his performance as better than expected and his procedural skills as consistent with level of experience." To rate the procedural skills of a Director of Surgery, ought one to be in a position to assess them?-- You would hope that you had some understanding of the procedural skills and/or had someone who provided you with support or assistance to that.

Would you regard it as inappropriate for a Director of Medical Services to rate someone's procedural skills as consistent with level of experience unless they had either been in a position to form that opinion themselves or been advised by another person who was in a position to assess Dr Patel?-- That's a fair statement.

Well, you yourself wouldn't rate someone as having appropriate procedural skills if you weren't in a position to assess it, would you?-- That's correct. I would either have advice or have looked at, as I said, the range of indicators that I spoke before about audit.

Now, the range of indicators about audit that you now describe?-- Which you keep coming back to.

Yes. It is the case, isn't it, that Dr FitzGerald looked at a range of indicators relating to the hospital generally?-- The Chief-----

Is that correct?-- The Chief Health Officer provided a report which provided some comment on complication rates and other indicators.

And, indeed, it suggested that there was an abnormally high complication rate for a number of procedures at the Bundaberg Base Hospital?-- That was the conclusion of the report, as I understand it, yes.

Now, is that the kind of indicator that you might look at when trying to assess whether to certify that a doctor's performance was consistent with level of experience?-- That would be the kind of indicator. The indicators that were used for the FitzGerald report, if we can call it that, were at a high level taken from a central area within Queensland Health.

Didn't appear from our discussions with the health information unit at Bundaberg Hospital to be validated by the clinicians. So that if there were indicators similar to those but had some clinical validity, then I would be comfortable using those.

You say at page 39 under the heading (g) in the second sentence, that "it appears that the Director of Medical Services operated outside of standard Queensland Health human resource accepted practices", and that "there had been little if any human resource department oversight for Dr Patel's extension and subsequent contracts". Is there any impropriety involved in that, or is this a case of someone just taking more responsibility than they needed to?-- I don't believe there is impropriety in this. I mean, this comment is in relation to an extension of a contract longer than the time period within which you are theoretically allowed to appoint without a merit base process. It is in relation to offering locum rates, however they are so determined, but underneath an award that doesn't have a structure in it for locum rates. So it is, from what I can see, more of a - wasn't abiding by the policy or practice, rather than be impropriety, if you are thinking of impropriety intent to do bad things.

At page 44 there are a number of recommendations. The third of them appears on page 45, "Ensuring that all medical staff are provided with written clinical privileges upon appointment consistent with service capability and credentials." Well, do I understand your evidence to be that if somebody is being appointed SMO surgery, you would always simply provide them with privileges that say "general surgery"?-- They would have privileges are allocated as general surgery. Management then, of the operations that they do, would be managed as a management issue within the health service because it is too difficult to say general surgery excluding this procedure, that procedure, this procedure, that procedure. The list would be so long that it is unmanageable, which is the point I was trying to make before.

So would it be for the Director of Medical Services then, when looking at his Director of Surgery's credentials, to determine whether or not the hospital was adequate to permit oesophagectomies or Whipples procedures?-- It is the executive of the health service that needs to make that determination because it is not just a medical issue, as you can see in this case, related to whether the nursing staff have relevant skills and so forth, whether you have relevant infrastructure, from the point of view of operating theatre, intensive care. So it is an executive decision.

Among each of these recommendations, I see there is no recommendation that it is inappropriate to promote a person employed as SMO surgery - I beg your pardon, a person registered as SMO surgery for an Area of Need to the position of Director of Surgery?-- Sorry, no recommendation or no finding?

No recommendation?-- There wouldn't be a recommendation in regards to that.

It would be a sensible recommendation, wouldn't it, that if a person is registered for an Area of Need as SMO surgery, that they ought not to be appointed Director of Surgery?-- There is a reasonable recommendation that if someone as a senior medical officer, you would want to employ them in a position where you could supervise that practice, yes, and the debate about what "director" actually means resurfaces again in relation to administrative rather than clinical leadership.

You have made the point that it is appropriate to make a recommendation that they be appointed to a position where you could supervise their practice. But isn't there also another matter to do with registration itself that where someone is registered for an Area of Need as SMO surgery, they are not registered to practise as a Director of Surgery?-- The-----

So there could be a complication with the registration, there could be a breach of it, don't you agree?-- The allocation of whether someone is a director or not is about administration of a particular department. The registration about whether they can practise medicine at a particular level is a Board issue and the Board allocates where and how they can practise sometimes.

And if a Board says "SMO surgery, Bundaberg Base Hospital"-----?-- Yes.

-----doesn't that mean that they are not registered by the Board to be the Director of Surgery?-- You would have to clarify that with the Board. I don't believe the Board when they determine whether it is the Senior Medical Officer-----

COMMISSIONER: It is a matter of interpretation, I think, Mr Andrews. It is probably not a matter for this witness at all.

WITNESS: He is making a definition about whether they can be the director or not. They are saying they are not a specialist in surgery.

MR ANDREWS: Is that a matter that the Director of Medical Services ought to take up with the Board before promoting the SMO to the position of Director of Surgery?-- No, I don't believe so. The Director of Surgery, as I said, is an administrative head, not a clinical leadership head necessarily.

At page 65 at 3.3.8, is this a section of the report prepared by you?-- This is a section of the report I think drafted by me but prepared by the entire team, as I have outlined before.

When did you draw that section of the report, do you recall?-- No.

Do you know whether you - do you recall whether you paid attention to the publicity relating to the evidence given in the inquiry before Commissioner Morris about this?-- To be

frank, as soon as that came on the TV I started switching the television off.

Were you aware that Dr Miach gave evidence?-- I was aware that he was being called for evidence, yes.

And did you draft this before or after you became aware that he was being called to give evidence?-- I can't recall.

Well-----?-- Those events occur around the same time, as I understand. We were drafting this report from when we returned from Bundaberg after the first - sorry, after the second visit which was - and I need to check the dates, but - let me check the dates, it is easier. Our second visit to Bundaberg was in May. I am looking through the interview schedule here. It was around the 9th to the 13th-ish. So from when we returned from that visit until the end of June we constructed this report and also undertook further interviews and clarity for information.

Well, does that clarify in your mind whether you drafted this before or after you learned that Dr Miach was giving evidence?-- No.

At the bottom of page 65, you deal with Dr Miach's registration. Now, Dr Miach, was he a person personally known to you?-- No.

Had you ever worked yourself at the Bundaberg Base Hospital?-- No.

Can you tell me why you were looking at the registration details of Dr Miach?-- We looked through all - sorry, I looked through all of the personnel files of the senior medical officers and VMOs, because under term of reference 3, we had to look at other clinical services and other services within the hospital that weren't just related to surgery. Under term of reference 4, we needed to look at the clinical risk management framework, and prior to attending the first session up in Bundaberg where we undertook interviews in April, the Director-General said, "Mark, make sure there is not another Patel up in Bundaberg." And therefore it was reasonable for us, we thought, to ensure that the particular clinicians who were there were appropriately registered and credentialed.

COMMISSIONER: Did you think Dr Miach was another Patel?-- No. We wanted to make sure that out of all of the senior medical staff up there, there wasn't another one. It would be very difficult for this report to have significant credibility if we missed an issue of another clinician up there when one of our Terms of References was to look at all of the other clinical services.

MR ANDREWS: You have just said that one of your issues was to see that, not just in surgery but in the other disciplines that medical practitioners were appropriately credentialed and registered?-- That's correct.

Did you determine how many other medical practitioners were not appropriately credentialed?-- The registration for all of the senior medical officers was within their P file. There was a copy of the public access document-----

My question is how many were not credentialed.

COMMISSIONER: Listen to the question, please. Do you mind asking it again?

MR ANDREWS: Did you determine how many other medical practitioners were not credentialed?-- I am trying to understand your question. The other medical officers had qualifications which were detailed in the-----

COMMISSIONER: You know the process of credentialing?-- Yes, I do.

We've just talked about that. You are being asked about that process?-- Of credentialing, or privileging credentialing?

Credentialing?-- The process of credentialing-----

MR ANDREWS: Credentialing and privileging, yes. All right, credentialing - it was your word - that you checked to see how many were credentialled and registered?-- That's correct.

How many were not credentialed?-- There - I didn't find any senior medical officers in the P files that I had that didn't have qualifications and registration that would lead me to be concerned. The issue for Dr Miach wasn't that he didn't have the credentials to undertake the duties that he was performing but his P file highlighted a significant issue about whether there is a specialist register within this State and whether medical officers who come from outside of this State understand that, and, in fact, whether the Australian government understands that.

That had nothing to do with Dr Miach's clinical competence, did it?-- No, I never said I looked at the P file for his clinical competence.

COMMISSIONER: Why did it have anything to do with your report? I don't understand why you put it in. It doesn't make sense to me at the moment. Perhaps you can explain that?-- Can I try and explain why it is in the report?

Yes, by all means?-- In Queensland we have a specialist register for medical practitioners. So you can be registered as a generalist or as a specialist. Okay? In other States within Australia that isn't necessarily the case. So if you are a medical practitioner who came from Victoria where there is one medical registration process whether you are a generalist or specialist, you just apply to be registered and you transfer from Victoria to Queensland and you put in general registration, then in Queensland you won't be registered as a specialist unless you know to apply

specifically as a specialist. Similarly, if you came from Western Australia, the same would apply because those two States do not have a specialist register. We're in a situation where Dr Miach, and as highlighted in the report, has the credentials to be a specialist - and I don't doubt his competence - came from Victoria to Queensland, applied for registration and was registered as a generalist, not as a specialist. He was subsequently employed by Queensland Health as a specialist, paid as a specialist and provided with a private practice option. So when the Director of Medical Services and the doctor, both from another State, reviewed his registration, everything looked okay because they are not used to looking for specialist allocation of registration from the Board. So no-one picked it up. Subsequent to this, I investigated a little further, because this is a significant anomaly. And when you look at Dr Miach, he also holds a specialist level billing provider number for Bundaberg. So we have a practitioner in a State which does not - which has a specialist register and is not registered as a specialist, and the Health Insurance Commission has also provided him with access to specialist level provider or billing numbers for Medicare. This is a significant issue from the point of view of system and structure about whether we have a specialist register in Queensland. If we don't, let's get rid of it. If we do, people should be looking at it and abiding by it. That's why it is in the report.

MR ANDREWS: It has nothing to do with his capacity to deliver clinical services, does it?-- That's correct.

And this is the review of clinical services, isn't it?-- Yes, except that this was an anomaly that was noticed while we were looking to see that all of the practitioners were appropriately credentialed from the point of view of their ability to provide clinical services.

COMMISSIONER: But he was. You told us that?-- Had we found that in fact this fellow was another Patel - and I am not suggesting that he is, right-----

MR ANDREWS: Well, how could you? How could you suggest it? He is a Fellow and member of the Royal Australian College of Physicians. There is no comparison, is there?-- To?

Dr Patel.

COMMISSIONER: I heard what you said. This seems to me the most absurd piece of evidence I have heard since I was sitting here. Go on.

MR ANDREWS: There is no comparison, is there?-- Between a surgeon and a physician, no.

Between a Fellow of the Royal Australian College of Physicians and a person misrepresenting his overseas status, and applying, as a result of that, misrepresentation for a position as a Senior Medical Officer?-- That's correct.

For an Area of Need?-- That's correct.

As the team leader, were you the person in control of this draft report?-- No, this was a cooperative effort. The team leader position was really about coordination, just to make sure everything happened and happened within an appropriate time-frame. Parts of the report were written by different members of the team and brought together, and then wordsmithed by the team as a whole by and large.

Did you forward it to a public relations officer for Queensland Health?-- No.

On page 67, at the top of the page you refer to "inexperienced junior doctors required to provide unsupervised care." Is it your understanding that there were persons of a status less than SMO who were providing unsupervised care after hours and on weekends?-- This relates to a number of junior medical officers or junior house officers who after hours were working with consultants offsite supervising them, and they were at times the senior person within the health service for those particular areas.

Well, that means they weren't working with consultants offsite, doesn't it?-- Sorry, I miss-----

Where the expression appears "required to provide unsupervised care", is that intended - at the top of page 67 - to mean they were providing care without any supervision by a specialist?-- They were providing care in the health service, the specialists were - if it is after hours, either at home or on call in the proximity of the health service.

But there is nothing wrong with a specialist being on call and having a junior doctor at the hospital while the specialist is at home and on call?-- This is not a criticism of the senior doctors, this is a comment that in the health service you would prefer to have principal house officers supervising the junior house officers. So that if there was a need for someone to attend urgently, because the consultants are usually half an hour away or up to half an hour away, that there was someone there to provide that support on site.

Were you the draftsperson of that section at the top of page 67?-- No.

Surely it is intended to be read as suggesting that there were inexperienced officers required to provide care when there was no specialist on call with a duty to supervise them?-- No, that's not the way it is meant to be read.

Because is it the case that there would always be a need to have a specialist, whose duty it was to be on call and to supervise if required the person who was attending at the hospital?-- There is an expectation that if you need to organise for a consultant to see a patient, that one would be available and that's why consultants are placed on call.

At page 73 you observe that "the District Manager for the Bundaberg Health Service District was responsible for ensuring that the risk management policy was implemented." This is in the section 3.4.3 at the bottom of page 73. What should the District Manager have done to implement the risk management policy?-- They needed to ensure - and this is John Wakefield's area, he wrote most of this - but they need to ensure that there is a process for reporting clinical incidents, there is a process for monitoring those incidents, and that there is a process for investigating incidents, and once you have done that, any information that comes out that highlights areas where you can mitigate risk also need to be managed and there needs to be a process in place for that, in general terms.

You're a district manager yourself?-- That's correct.

You'd be in a position, would you, to comment on these findings?-- I'd be in a position to comment on some of them in general terms. A lot of the specifics about detail of dates and times John Wakefield would be in a better position to comment on.

Well, where staff in the office raised concerns with the District Executive that they didn't have sufficient resources to effectively support the implementation of risk management systems, what should the District Executive have done?-- It depends on what the issue is. Sometimes you can change your structures so that the reporting - or the arduousness of reporting or management or monitoring can be changed and other staff can look after that. Otherwise you may need to find resources in order to boost them up so they can undertake their role.

Is it a case that this is a significant - that is important - thing, and that extra resources should have been found or something should have been done immediately by the District Executive?-- Like any other aspect within a health service where you're always finding it difficult for additional money, there are competing resources. So you need to weigh them up, which is why District Executive needs to work out what's the best way to meet this need.

I have no further questions, Commissioner.

COMMISSIONER: Thank you. Who wants to ask questions of this witness? Yes, Mr Mullins.

MR MULLINS: Thank you, Commissioner.

CROSS-EXAMINATION:

MR MULLINS: Dr Mattiussi, the credentialling and privileging process is specifically designed to ensure that the people who are appointed to particular positions have got the right qualifications. That's correct?-- That's part of the process, yes.

And are limited to those things that they can perform proficiently?-- Are limited to those things that they can perform proficiently within the scope of the health service.

The credentialling process, or that a person is credentialled has a specific meaning, doesn't it?-- The credentialling has a meaning that looks at what they're capable of doing. The privileging side of it is what you will allow them to do within your health service.

That's correct?-- Just because someone can perform neurosurgically, doesn't mean that you will allow them to work and do neurosurgical procedures in some facilities.

The second part of Exhibit 279, which is the credentials and clinical privileges document that Mr Andrews showed you, clearly identifies that it's not enough just to credential or privilege a particular practitioner. They must be both credentialled and privileged?-- You credential them and then you allocate clinical privileges.

That's correct. And the committee that carries out this task both credentials and privileges?-- The committee assesses the credentials, allocates a recommendation for clinical privileges to which the District Manager then signs off on.

That's right. If you look at the sixth page of that document, which is the second document in Exhibit 279 - does the Commission have a hard copy of that?

COMMISSIONER: I don't, no.

MR MULLINS: I have a spare copy.

COMMISSIONER: Thank you.

MR MULLINS: In fact if we turn to page 5 we can see at paragraph 2.2 that the credentials are defined?-- That's correct.

And on to page 6, in the first paragraph we can see that the clinical privileges are defined?-- That's correct.

And at paragraph 2.4 at the bottom of the left-hand column on page 6, we can see - I'll have this put up. It's paragraph 2.4 on the left-hand side of the page at the base. We can see, "The process of assessing the credentials of an applicant and recommending clinical privileges is one undertaken by medical practitioners who form a credentials and clinical privileges committee. Thus it is a peer process. The committee review the credentials of applicants" - up to the next page - "having regard to the needs and resources of the health care facility." If we continue on we see that, "The recommendations of the credentials and clinical privileges committee are provided to either the recruitment and selection appointment committee", and in some cases, obviously, the District Manager in cases of existing employees undergoing a review?-- Mmm hmm.

Now, the important paragraph is the next one - the next two. "The final decision is made by the District Manager who has the delegated authority for either the appointment of a practitioner to a specified position or for the endorsement of admitting rights to a specified public health facility. The District Manager will consider the recommendations of the credentials and clinical privileges committee as well as the administrative and resource implications for the facility." Now, the recommendations of the committee are particularly

important when the District Manager is not a clinician. Isn't that correct?-- That's correct.

In fact the District Manager should not be making decisions about clinical privileges or credentials for any practitioner if that District Manager does not have clinical qualifications. That's correct?-- You could go so far as to say that you'd need the committee to provide recommendations or the Director of Medical Services to provide recommendations, even if the District Manager was a nurse.

Yes. Well, if the Director of Medical Services was not a practising clinician either, he is neither in a position to be credentialling or privileging, is he?-- Depends what you mean by "practising clinician". If the Director of Medical Services is a registered medical practitioner, which they need to be in this state to hold that title, even if they're not practising clinical medicine, they could be in a position to provide some degree of recommendation. But usually it would be on advice from some peers to support that.

Well, the peers that you're talking about are - or the advice from the peers is the credentialling and privileging committee, isn't it?-- Correct, or if you have to do it for a short-term locum you may ask another surgeon or get some advice from another surgeon, if it was the case for a surgeon.

The fact is that in this case Mr Leck was in no position himself as District Manager to make any recommendations in respect of privileges or credentialling?-- Yeah, I'd agree with that.

Dr Nydam was the person who first appointed Dr Patel to the position of Director of Surgery - or Acting Director of Surgery as he called it?-- That's correct.

Did you believe he was in a position to do that without some sort of peer advice?-- He could have provided advice to the District Manager. You would hope as part of that advice that he would have sought some assistance from a surgeon.

COMMISSIONER: You would expect that, wouldn't you?-- You would.

MR MULLINS: And if he didn't, then you would accept that Dr Patel should never have been permitted to operate within the boundaries of the Queensland Health policy on credentialling and privileging?-- Yeah, you would say you wouldn't be allocating privileges to him to operate.

You say at page 31 paragraph 3.1.2 - do you have a copy of that?-- Sorry, is this the report?

Sorry, the report, Exhibit-----?-- What was the page again?

Exhibit 102, page 31?-- Page 31?

Yes. Paragraph 3.1.2 under the heading "What Happened"?-- Mmm hmm.

You say about six lines down, "Formal clinical privileges were first mentioned as being sought in June 2003." Can you see that?-- Yes.

"This was recorded in the letter of 29 July 2004 from Dr Keating to Dr Patel", and then, "On the 29th of July 2004 the Director of Medical Services, Dr Keating, wrote to Dr Patel following up on the previous correspondence of November 6, 2003 regarding the allocation of clinical privileges." Now, there's three dates mentioned there. One's June 2003, the second is 6 November 2003, the third is 29 July 2004. Did you have correspondence in respect of each of those dates or was there only the correspondence of 29 July 2004?-- My recollection is there was only the correspondence of the 29th of July 2004 and that made reference to June and November 2003. That's my recollection. I'd have to look through the source documentation again.

You had a copy of Dr Patel's personnel file?-- Yes.

You say that the formal clinical privileges were first mentioned as being sought in June 2003. Was that formally sought from Dr Patel in writing or simply-----?-- I can't comment on that. There was a reference in a letter that referenced seeking clinical privileges on that day. As I say, I can't remember the entirety of that letter, but that letter would be available on our source documents if you wanted a copy.

All right. In any case, your investigation revealed only those three occasions where clinical privileging was ostensibly discussed with Dr Patel?-- Yes.

Did you interview Dr Keating as part of this process?-- Yes, we did.

If I can ask you then to briefly touch on the events that occurred over the ensuing 12 months, you've mentioned at page 32 the events of 19 May 2003 when Glennis Goodman and Ms Hoffman met with Darren Keating?-- Mmm hmm.

You mention at page 33 that on 5 June 2003 Dr Joyner met with Dr Keating to raise concerns over the patient we described as P18?-- Yes.

Did you learn of a complaint made by Mr Fleming to Dr Keating on about 30 October 2003 where Dr Patel was raised?-- We reviewed a range of - we as in the team, not me as in personally - reviewed a range of patient complaints from the Bundaberg health service. I'm not sure whether that was one of the complaints that was reviewed within that group.

Were there some complaints before, for example, 1 April 2004 from patients in respect of Dr Patel to your recollection?-- I'm sorry, I can't recollect. I'd have to go back through the

source documents.

You mentioned the document of 6 February 2004 that Dr Miach provided to Mr Martin and Dr Keating in respect of the complications. Did you know that on 27 November 2003 Nurses Aylmer and Pollock met with Dr Keating to discuss concerns they had about the treatment of renal patients and surgery in the renal unit?-- I didn't interview those two people.

Did you know that the genesis for the report that Dr Miach handed over was in fact meetings that had occurred the year prior where concerns had been expressed by nurses about the quality of care being delivered by Dr Patel?-- We knew that the genesis for Miach's letter was that there was concerns raised about the insertion of Tenckhoff catheters and complication rates, and that those concerns had been raised within the renal unit, not the specifics of who. As I said, I didn't - as I said, I didn't look at all of the source documentation. This is a compilation from a range of members of the team, so other members of the team may have recollection of this information because they had reported-----

You say at page 34 that given that several senior clinicians had expressed concerns regarding the patient outcomes from Dr Patel's surgery, consideration could have been given at that stage - that's about February 2004 - to obtaining formal external peer review?-- That's correct.

Well now, Dr Patel's contract was coming up for renewal, wasn't it?-- March, yeah.

Wouldn't this have been an appropriate time to have him credentialled and privileged in accordance with the policy in Exhibit 279?-- The appropriate time would have been at the beginning, as we discussed before.

Yes. Would the appropriate time on the renewal of the contract-----?-- You mean the next appropriate time?

Sorry, the second appropriate time?-- It would have been another time in which you could have looked at his privileges, yes, but that's not to say you shouldn't have done it earlier.

You then document other incidents during the course of 2004 on page 34, reference to the ASPIC minutes of 2 July 2004?-- Yes.

On the 2nd of August 2004, the complaints by Ms Hoffman about Mr Bramich?-- Yes.

Page 36, the complaints on 26 October 2004. Can I take you through to page 37. You note that on the 24th of December Dr Patel wrote - sorry, Dr Keating wrote to Dr Patel to offer a further extension of his contract from 1 April 2005 until 31 March 2009?-- That's correct.

Now, if you flick through to page 38, you note that on 21 December 2004 Dr Patel had undertaken another oesophagectomy, and that was Mr Kemps?-- That's correct.

The event involving Mr Kemps was obviously a major event within the hospital?-- It would appear so.

There were expressions by senior clinicians about concerns about the conduct of that surgery?-- Yes.

Now, did you ask Dr Keating why it was that he offered Dr Patel a five year contract from 1 April 2005 until 31 March 2009 when he had never been credentialled, when he had never been privileged, when he had by this time a long history of problems and complications, many of which had not been resolved? Did you ask Dr Keating why it was he offered him a five year contract at that point?-- We asked him - I'm trying to remember the interviews now, which occurred back months ago. We asked him around the, "Why did you extend this guy? What were you thinking at the time", and his response was that it was initially thought that this was a conflict between staff rather than just a competence issue with Patel, and there were some questions raised about what Patel's skill was like, and if I remember Dr Keating's response it surrounded, "Well, some clinicians thought he wasn't the best surgeon in the world, but they thought he was okay." So it appeared that he had advice from other people within the health service to that effect.

Well now-----?-- And as I said, I'm trying to remember this from some time ago.

Can you identify the people that he had advice from that Dr Patel was okay?-- Our report highlights that there were a number of clinicians along the way that Dr Keating spoke to, including the Director of Anaesthetics. There were other people that we spoke to during our time in Bundaberg interviewing people who provided comments - and you'd have to look through the report because they're here specifically - that Dr Patel, I think, wasn't - something like he wasn't the best surgeon in the world, but, you know, he's not as bad as others. There were some comments that Dr Patel was a competent surgeon provided to us by members of the medical staff at Bundaberg.

Doctor, you are the District Manager and District Director of Medical Services at the Logan and Beaudesert District Hospital?-- Yes, that's correct.

You would agree with me that this offer of a five year contract, given the matters that were hanging over Dr Patel's head, was an extraordinary offer?-- Yes.

There was no justification whatsoever for making it, was there?-- I don't believe if I was in his position I would have necessarily done, knowing what I know.

In fact it was completely irresponsible to make that offer given the history that Dr Patel had at the hospital?-- Are you asking me a question or making a statement?

Yes, asking you a question?-- In his position no, I wouldn't have made that offer.

Doctor, we then move to page 38 and the 2nd of February 2005. Now, although the review by Dr FitzGerald may not have actually commenced at that point, I think there had been preliminary discussions about it before that time. Is that your recollection?-- I wasn't involved in those discussions about when FitzGerald started reports.

You say - the report states in the third paragraph, "On the 2nd of February 2005 the Director of Medical Services, Dr Keating, had completed a Special Purpose Registrant's section 135 Area of Need Queensland assessment for Dr Patel and had rated Dr Patel's performance primarily better than expected." In your experience as the Director of the Logan Hospital, have you ever experienced a surgeon with as many complaints and problems as Dr Patel over a two year period?-- No. Bearing in mind I've only been at Logan for 18 months, but no.

Prior to your time at Logan, had you ever experienced a surgeon with as many complications and complaints as Dr Patel had received?-- I would have been concerned had one of my surgeons had the number of concerns raised by senior staff about the procedures that they're undertaking.

COMMISSIONER: That wasn't the question?-- Sorry, ask the question again?

MR MULLINS: Had you ever, in your history, experienced a surgeon who had the same sort of complaints over a two year period?-- No.

If you had experienced Dr Patel's complaints as a Director of Medical Services, you wouldn't report his performance as being better than expected?-- No.

Because your expectations would have been very, very low. I mean-----?-- The expectation part is better than expected of someone with the same credentials, not your own expectations, as I understand the question on the form.

Doctor, did you ask Dr Keating what he meant by saying his performance was better than expected?-- No.

He also rated emergency skills, procedural skills and team work and colleagues as consistent with level of experience. Did you ask Dr Keating what he meant by that?-- No.

And his professional responsibility and teaching as performance exceptional. Did you ask Dr Keating what he meant by that?-- No.

I have nothing further. Thank you.

COMMISSIONER: Thank you. Anyone else want to ask questions?

MR ALLEN: No, thank you, Commissioner.

COMMISSIONER: No-one else?

MR DEVLIN: I'm got some, Commissioner.

COMMISSIONER: Yes.

CROSS-EXAMINATION:

MR DEVLIN: Ralph Devlin for the Medical Board of Queensland, doctor. Going back to a couple of the passages in pages 30 and 31, right at the bottom of page 30 the report states, "Dr Patel was subsequently appointed as the Director of Surgery by Dr Nydam as the position remained unfilled, and out of the two full-time surgeons, Dr Nydam felt Dr Patel would be the most suitable." Now, we heard - the first Commission of Inquiry had the benefit of Dr Nydam's evidence who, in effect, took the position that to place a senior medical officer, being a non-specialist, as the Director of Surgery was something that, in his view, could occur where the particular medical practitioner was not a specialist. Now, do you subscribe to that view?-- There are a number of departments within Queensland Health where the Director is not a specialist, and this has occurred primarily in Emergency Departments, and in those cases, yes, I subscribe to that view.

We did hear from Dr Nydam, though - or the first Commission did - where he acknowledged that not to get back to the Medical Board to say, "This person is no longer a senior medical officer, but the Director of Surgery at Bundaberg" was an oversight. Do you subscribe to that view? That there ought to have been further advice to the Medical Board about the change in Dr Patel's circumstances?-- If the change - and this comes back to the discussion we had before about whether the Director's an administrative head or a clinical leader - if - and I subscribe to the view, as it is in the IR - in the Industrial Relations Manual, that the Director is actually the administrative head, and going back to the Medical Board, in my view, under those circumstances, wouldn't change whether you put them in that role.

But don't we see here that he became the clinical practice head? He became the figurehead in terms of surgical procedures?-- In my view what we see here is that his practice, or his supervision of his practice is the issue in question, not about whether he was the Director of the department.

Against that background then, taking the supervision as the issue as you see it, do you agree with Dr Nydam's assessment that it was an oversight not to get back to the Board, not to revert to the Board on that issue?-- The issue would be whether the Board would be comfortable that this practitioner was operating in a supervisory, unsupervised capacity, that the Board may have wanted to know about.

Yes. So is your answer yes then?-- Yes, in that frame of what I just said.

In that framework?-- Yes, that's correct.

Thank you. Now, there's another part where Dr Nydam is referred to, and that's at page 31 in the passage that Mr Mullins just took you to about line 6/line 5 in 3.1.2, "Dr Nydam reported that short-term locums were usually not formally credentialled and allocated privileges." Do you subscribe to that view?-- Short-term locums are credentialled and allocated privileges, and that would be my view, that they should be.

Thank you.

COMMISSIONER: Sorry, what would be your view?-- That they should be credentialled and allocated privileges as short-term locums.

MR DEVLIN: In the context of a discussion about pages 65 and 66 of your report and what you reported on Dr Miach and his credentials, the question I have for you is during your investigation, did you discover that other medical practitioners had not been privileged like Dr Patel other than Dr Patel?-- During the review of the personnel files, there were letters in those personnel files similar to that with Dr Patel that said, "We have had problems in the past with getting credentials and clinical privileging committee up and running", and I think they're all dated about the same date, I think, which was still July 2004, allocating privileges to those people based on an arbitrary - "Yes, you've got privileges" rather than, "Yes, we've got the committee up and running."

Do you say that the report gives that situation sufficient prominence? That privileging just was not achieved?-- In my view the report highlights that the credentialling and privileging process needs to be appropriately re-established or embedded in Bundaberg health service.

The implication of the questioning by counsel assisting seemed to be that you had unfairly targeted Dr Miach in terms of the credentialling issue. Do you accept or reject that suggestion, if that's the suggestion that was being explored?-- If that was the suggestion, I would reject it. I don't believe I've unfairly targeted Miach in relation to that.

And in terms of pointing out that other privileging had not occurred, do you say you gave sufficient weight to that in the report in its final form?-- Yes, I believe so.

COMMISSIONER: Where did you do that? Where did you mention that none of the doctors had been sufficiently-----?-- We didn't mention that none of the doctors were credentialled and privileged. I'm trying to - and I'm sorry, I haven't read this report in detail recently, but there is-----

Anyway, you did not say that none of the doctors had been credentialled or privileged?-- No, because some - they had been allocated privileges with a letter in July 2004. The credentialling and privileging process was the issue that was highlighted.

Yes?

MR DEVLIN: Doctor, there are current requirements in place for certification of supervisors when applications are made to the Medical Board for re-registration of overseas trained doctors or international medical graduates. You're aware of those new arrangements?-- I'm aware with the new arrangements you have to be a locally registered practitioner in order to supervise someone.

And do you accept from your general knowledge in your day-to-day activities down at Logan that there are - there is increased attention being given to the certification of supervisors for reregistration of IMGs for area of need?-- There appears to be now, yes.

And in your practical experience, do you see that as at least being one measure to ensure that proper supervision does take place of IMGs?-- It is a mechanism of ensuring that someone has a base level of acceptable credentials to the Board that they can supervise someone else; in other words, that they have their own practice, because what you are requiring is for somebody to be a registrant, rather than an international medical graduate special purpose registrant to supervise someone else; so, yes, I would agree.

COMMISSIONER: How much longer would you be?

MR DEVLIN: That's my last question, thank you.

COMMISSIONER: Any other questions?

MR DIEHM: I would expect half an hour.

COMMISSIONER: Who else is there?

MR BODDICE: I have some questions.

MR ASHTON: I have a few, Commissioner.

COMMISSIONER: How long will you be?

MR ASHTON: As a starting point, maybe 20 minutes, but I suspect Mr Diehm will otherwise cover ground I would expect to cover, so I would expect no more than that, Commissioner.

MR BODDICE: There is, however, a difficulty which I explained to Counsel Assisting yesterday. Dr Mattiussi was arranged because there was going to be a gap in evidence. He had appointments with patients about complaints this afternoon which were put back to 2 o'clock at Beaudesert, and so it had been indicated to Counsel Assisting that he would have to cease at lunchtime in order to be able to attend to that and I understand Dr Kerslake was agreeable to coming this afternoon.

COMMISSIONER: I didn't know that. That's fine. Adjourn until 2.30.

THE COMMISSION ADJOURNED AT 1.04 P.M. TILL 2.30 P.M.

THE COMMISSION RESUMED AT 2.32 P.M.

MS DALTON: Commissioner, could I mention a matter before we start? You recall I asked Dr Buckland about Exhibits 30 and 31 to Mr Walker's statement and, in particular, the gap between the 2003 Cabinet documents and 2004 documents, and you recall they were the documents that came very late while my client was giving evidence and he didn't have time to go through the annexures. I have instructions about that matter. There was $20 million extra funding as part of the February 2004 election promises and my instructions are that there will be documents that went to Cabinet relating to that from February 2004 onwards. Also, reports about the use of that money that went to - from the Health Department to the Health Minister but also to the Department of Premier and Cabinet and, if anything, there should be more documents to Cabinet and to Premier and Cabinet through that time from February 2004 onwards.

COMMISSIONER: Right.

MS DALTON: We are not sure whether by August 2004 it got back into its regular quarterly reporting pattern or not, but at least from February 2004 onwards. I would ask you to order that those documents be sought out and produced.

COMMISSIONER: Yes, can you identify them more accurately than-----

MR ANDREWS: It is not very accurate.

COMMISSIONER: How is the best you can identify them?

MS DALTON: Information submissions to Cabinet relating to elective surgery funding or waiting lists and, in particular, the elective surgery funding of $20 million which was an election promise in the February 2004 election, and reports-----

COMMISSIONER: Can you identify the period of those documents, the ones you have specified so far?

MS DALTON: Only to say February 2004.

COMMISSIONER: Relating to an election promise.

MS DALTON: Yes. Also reports from the Department to both the Minister for Health and to the Department of Premier and Cabinet as to how that $20 million was being used; you know, whether it was being used and how, and apparently there was more reports through that time, not less, because people were interested to know what was happening to that money.

COMMISSIONER: All right. Well, as best you have identified them, I order that those documents be produced, and, of course, that order is subject to any legitimate claim for

privilege.

MS DALTON: Yes. Thank you, Commissioner. Mr Andrews?

MR ANDREWS: Commissioner, I call Mr David Kerslake.

MR PERRETT: Commissioner, my name is Perrett, solicitor at Clayton Utz. I appear for Mr Kerslake.

COMMISSIONER: Yes.

DAVID ARTHUR KERSLAKE, SWORN AND EXAMINED:

MR ANDREWS: Mr Kerslake, your full name is David Arthur Kerslake?-- That's correct.

You are the Health Rights Commissioner for Queensland?-- Correct.

Mr Kerslake, you have for this second inquiry prepared a shorter version of a statement that you prepared for the earlier inquiry; is that correct?-- That's correct, yes.

I have a copy of a statement of yours dated 19 September 2005 of 93 paragraphs with five annexures; is that your statement?-- That's my statement, that's correct.

Are all the facts recited in it true to the best of your knowledge?-- Yes, but I'd like to make two points - minor points of clarification, if I may.

The first at paragraph 49?-- Paragraph 49, that's correct. In relation to that, my legal advisors have drawn to my attention that there were a couple of newspaper articles in late March referring to the fact that Dr Fitzgerald was conducting investigations in Bundaberg. I don't recall whether I actually read those particular articles or not, but if I did, it didn't register with me to be of anything of significance. So, the first significant information that came to my attention in relation to that was the article on the 8th of April from The Courier-Mail.

And do you have a correction at paragraph 56?-- That's correct, in that paragraph, to delete the words, "Since that date", which are in there, which are done by error.

Will you permit me to delete them from this copy which I'll tender?-- Certainly.

Are the opinions expressed within your statement honestly held by you?-- That's correct.

I tender this copy of your statement.

COMMISSIONER: Exhibit 354.

ADMITTED AND MARKED "EXHIBIT 354"

MR ANDREWS: Mr Kerslake, you, as Health Rights Commissioner, have, as a main role, to impartially review and resolve complaints about health services provided anywhere in Queensland in public and private sectors?-- Yes, that's correct.

Do you have any power to punish or sanction?-- No, I do not.

And is it the case that you can respond only to complaints you actually receive so that, for instance, if you were to see some matter of concern relating to health services discussed in the media, you have no statutory power which enables you to investigate it unless a complaint is first made to you?-- Not unless I receive the complaint.

And another basis might be if a Minister refers something to you?-- The Minister may refer a matter to me to be investigated or he may refer a matter to me to conduct an inquiry.

Now, within Queensland, the body which would determine whether to prosecute an individual registered medical practitioner would be the Medical Board of Queensland?-- Medical Board of Queensland, that's correct.

Do you liaise with that body in a cooperative way?-- Yes, and on a very regular basis.

Your Commission, through its employees, receives something in the order of about 4,500 complaints and inquiries a year?-- Correct.

And in 2004, did your reception receive approximately 11,500 calls?-- That's correct.

Is, within Queensland, the opportunity for those who have a complaint about health matters a potentially confusing array of choices? They might go to Queensland Health, they might go to a patient liaison officer at a hospital, if there is one, they might go to the Health Rights Commission, the ombudsman, the Medical Board of Queensland.

What do you do, or what do your staff do when persons wishing to complain about a matter outside your jurisdiction telephone your reception?-- Our policy is that if we receive a complaint outside of our jurisdiction, to put that person in contact with whatever body can assist them.

Is that sometimes difficult to determine in Queensland?-- In some cases it can be difficult to determine, but if we can, we

will try to find whatever body can be of assistance to them and point them in the right direction.

COMMISSIONER: Do you have an overlapping jurisdiction with the Medical Board?-- Sorry?

Do you have an overlapping of jurisdiction with the Medical Board?-- In a sense, yes. We have a power to assess all complaints and-----

And to investigate complaints?-- But we can only investigate complaints about non-registered providers; for example, a hospital or a hostel. We cannot actually formally investigate individual registrants. Only the Board can do that.

Right.

MR ANDREWS: To make that clear, if a complainant had contacted the Health Rights Commission to make a complaint about the competence of Dr Patel, would you have been, with your jurisdiction, entitled to investigate it?-- Not to formally investigate it, no. We would only be entitled to conduct an assessment or, if you like, preliminary inquiries. We could not formally investigate it.

COMMISSIONER: And pass it on to the Medical Board?-- And if it warranted, for example, disciplinary action or investigation of possible disciplinary action, we would refer it to the Medical Board.

MR ANDREWS: Now, that, of course - or that involves a two-step process, doesn't it, for the Health Rights Commission to make its own assessment and then to refer it on to the Medical Board?-- Yes, well, it can occur in two ways: it may be that, on the face of it, the complaint is of a sufficient level of seriousness that it would warrant immediate consultation with the Medical Board. It may be that the need to refer it to the Medical Board might not become apparent until after you had conducted some inquiries.

And I expect that when it comes to medical complaints, a member of the public, who suggests clinical incompetence on the part of a medical practitioner, is not an expert, not a person in a position to persuasively argue a case that there was clinical incompetence?-- I think that would be a fair comment.

If a person, suggesting a botched medical procedure had been performed by Dr Patel or someone else on him or her, were to make contact with your Commission, would you begin by exploring whether the person wished to pursue a conciliation process, or would you refer them immediately to some other entity?-- In many circumstances, we would suggest that, in the first instance, they take the matter up with the provider to see if they can successfully resolve the matter with the provider.

That would be the medical registrant?-- It depends. In the

case of a hospital, it would be the hospital itself. In the case of a private practitioner, of course, it could be the individual registrant.

If-----?-- Can I clarify that? In the case of a public hospital which employs the doctor, you would refer them to the hospital.

So, let's consider the hypothesis of one of Dr Patel's patients who complains to your receptionist that he or she has been subjected to incompetent surgery and has physical consequences. You'd first refer them to the public hospital at Bundaberg?-- In the normal course of events. There may be circumstances where, in some types of complaints, the nature of the complaint would warrant immediate - drawing immediately to the attention of the Board, and that might be, for example, a sexual misconduct complaint, but, as a general rule, we would refer them to the provider, yes - to the hospital.

Yes. If it is a complaint about clinical competence, it is more likely that you can't judge. It is a matter for the Medical Board. It is more likely that you will refer them, I suppose, to the public hospital at which the procedure was performed?-- More likely, at the outset, we would refer them to the public hospital.

Then on the assumption that they don't get satisfaction there and they return to you and say, "We were dissatisfied at the public hospital.", what process do you then instigate?-- What we would then do is we would contact the hospital, as a general rule, and seek from them further information, and under our act we are required to give them an opportunity to respond to the complaint. We would seek their views on the complaint. We would seek any relevant records and so on that would assist us to assess the merits of the complaint.

And how long must you give them to respond - that is, the hospital?-- I'd have to double check that. I think it is 28 days, but I'd have to double check it.

And can you say, as a general rule, what - after receipt of a response from the hospital, what time it takes for the Health Rights Commission to then move to the next step; that is - well, you can tell us what the next step is?-- Well, the next step would be to get that information and assess the complaint. How long it will - may take depends very much on the complexity of the case. It is a bit like how long is a piece of string.

If it is someone who says, "My bowel surgery has left me with pain that I shouldn't be suffering.", it would be difficult for you, wouldn't it, to explore whether it was as a result of clinical incompetence or bad luck?-- In some cases, that can be very difficult.

Once you have received a response from a hospital after, perhaps, 28 days, and you've assessed the hospital's response, if the hospital and the complainant are not ad idem, do you

then instigate a conciliation process?-- No, in our inquiries we would seek to get as much information that we can that is going to shed some light on the complaint one way or another. We wouldn't automatically put the case into a conciliation process if, as it were, there was nothing to conciliate. In some cases, it may be appropriate to arrange a meeting between the parties to facilitate discussions, but that does not automatically have to go through a conciliation process to achieve that.

With respect to the Bundaberg Base Hospital and complaints in respect of Dr Patel, has a review - does your database show the doctors in respect of whom complaints are made if the complainant named the doctor?-- Yes.

And can you say what complaints there were in respect of Dr Patel before there was media coverage?-- Before there was media coverage, we had received three inquiries from members of the public that named Dr Patel, and in each of those cases we have referred them to the hospital and made clear to them that if they were dissatisfied, they should come back to us.

COMMISSIONER: Did you do that in writing?-- No, these inquiries usually come in by telephone, and then there would be a discussion that takes place-----

But when you refer the matter to the hospital, do you do that in writing?-- No, not as a general rule.

How do you refer it to the hospital? Orally?-- We refer them.

You tell them to go to the hospital?-- Sorry, we refer the complainant to the hospital.

Right?-- And advise them how they can take the matter up with the hospital.

So, what are your records of those complaints? Just a noting that someone rang? You have a noting on your own records? How do you know you had three phone calls about it?-- We would note the name of the complainant, their address details and so on, the name of the person or the service they are complaining about, and we take down details - a brief synopsis of the issues that they have raised in their complaint, and also make a note of what action had been taken at that point.

Thank you.

MR ANDREWS: Are you in a position to tell us what the services were that the complainants complained about - that is, the three?-- I would need to refer in some detail to our inquiry forms to give you more information on that. I believe I would have it here, but if you bear with me, I will see if I can search through it.

Thank you. Commissioner, before I proceed possibly to ask Mr Kerslake to name any particular patients, I submit it would

be appropriate for you to make an order that any patients named be protected by an order that their names not be published. The Inquiry can make steps to contact any persons who are named within this room to determine whether they object to their names being published.

COMMISSIONER: All right. I so order in respect of those names about to be mentioned by Mr Kerslake.

WITNESS: Sorry, I was searching through. Do you want me to not mention their names at this point?

COMMISSIONER: No, you can mention them?-- One person was a Mrs Vicki Lester, and she phoned to say that she had a hysterectomy some years before, had undergone a laparoscopy in September 2003, but she'd had a staph infection subsequent to that procedure, was treated with antibiotics.

MR ANDREWS: Did you refer Ms Lester to the Bundaberg Base Hospital to pursue her complaints?-- That's correct. And she did not-----

Return to you?-- She did not return to us prior to the publicity in April.

Commissioner, Ms Lester has given evidence and her name is on the patient key.

COMMISSIONER: Thank you.

WITNESS: Another person was Beryl Crosby who contacted us and stated that she had been told that she had terminal cancer. She said it had been explained to her that the clinician would need to identify the primary cancer site. She said tests were conducted, bowel and oesophagus were ruled out. A biopsy was taken. She said she overheard another practitioner saying to the radiologist - sorry, she over heard the practitioner, Dr Patel, saying to the radiologist that it was haemangioma. Later she saw the Registrar and was told that that cancer could not be ruled out as the results were inconclusive. She had other tests which were done which ruled out haemangioma and she was told that she had adenoma tumour which can turn to cancer. She then says that she saw a person privately who advised her that, in fact, her correct diagnosis had been haemangioma.

COMMISSIONER: That was on the 22nd of June 2004, correct?-- Sorry, I'm a little bit hard of hearing on this side.

That was on 22 June 2004?-- That's correct.

Yes?-- And a third person was a Mr Geoffrey Smith who contacted us on the 8th of March 2004 to say he had undergone day surgery at a public surgery. He requested a general anaesthetic, but the doctor had said he didn't need a general anaesthetic and that he should have a local anaesthetic. He said that he was nervous about the local anaesthetic, but the doctor gave him a form to sign and he did sign the consent for

local anaesthetic. He said the procedure had been upsetting because he could feel and hear what was going on and he said - he also raised why he was not given a certificate to have the next day off work and he was referred to the hospital as well.

MR ANDREWS: Where Mr Smith and Ms Crosby in DK3 are shown as - with a "yes" in the column "Complaint Involves Dr Patel", can you explain why Ms Lester's complaint doesn't appear within DK3?-- My apologies. I think - I'm not sure Ms Lester named Dr Patel, but named him at a later date.

On the 4th of February 2005, you met Ms Barry and Ms Simpson, representing the Queensland Nurses Union?-- That's correct.

So far as you are aware, did they ask you to - or did they make a complaint that you were capable of investigating?

There have been, you say at paragraph 56, "40 inquiries received, not yet the subject of formal complaints." Are these calls to your receptionist?-- These are calls with people who have spoken to our intake officers and given a rundown on their concerns initially. Under our Act, we are required to ask people to write in the complaint in writing, and those people would be advised of their right to do that but they haven't come back and confirmed their complaint in writing-----

Mr-----?-- -----at a later date.

Mr Kerslake, can you only act after you have received the written complaint?-- Well, the Act says that people are required to confirm their complaint in writing, unless there is a very good reason why they - why they shouldn't.

You have "notified the Medical Board of Queensland of complaints, and we will keep the Board informed." I see that from paragraph 58. Which complaints do you inform the Board of?-- We-----

Are those in DK2?-- Generally we refer - notify the Medical Board of any of the formal written complaints that we have, that we have received.

What's the likely time-frame for resolution of a complaint that's been referred to the Board on the assumption that it is a matter that involves clinical incompetence?-- That's probably a question better put to the Board, if we have referred it to them.

And what's your experience?-- It can - it can vary. We have - we have - I have the power to comment on all Board investigations. Some of them are done fairly quickly, some of them do take, you know, a couple of years or so before they are completed.

You say that "a considerable number of cases have already been reviewed" - this is at paragraph 59 - "which reviews have identified a range of significant inadequacies in the standard of care provided to patients of Dr Patel. The results of the reviews will also be made available to the Medical Board of Queensland to assist in its deliberations."?-- That's correct.

Can you give me some particulars of the range of significant inadequacies in the standard of care which your reviews have identified?-- Yes. We have an independent expert who has been looking at quite a few cases for us.

Would you say the doctor's name again?-- Dr Allsop - John Allsop, and based on his reports, his reports raise serious concerns about Dr Patel's competence to perform surgery, and even whether he was competent to perform even relatively minor surgery, and his judgment of whether surgery was actually necessary, or, in some cases, judgment as to the type of

surgical procedure that was necessary.

Mr Kerslake, has Dr Allsop committed these opinions to writing?-- We have - yes, we have around about 25 reports to date.

And are you in a position to produce those to the inquiry?-- Yes. We still have - bear in mind we still have some sensitive mediations to go through with that process, so that needs to be borne in mind.

You will have to explain to me, is there some statutory impediment?-- No, no, I am simply pointing out that as a practical issue, the end result of those cases, we will be bringing parties together, perhaps to look at possible negotiating settlements.

The parties being Queensland Health on the one side and the patient on the other?-- The patient on the other. Not all of those patients have gone public with their concerns, so it may be necessary to sort of protect their identity.

And, Mr Kerslake, is that a judgment that can be made on a case-by-case basis after production of those 25 or so reports?-- I think it is a difficult judgment to make on a case-by-case basis without actually - we would need to contact the individual patients to make that judgment, but there would be no impediment to them being available if the names were not made available and the content of the reports was of interest to the Commission.

Is that something that can be provided promptly?-- Yes. Yes.

Thank you.

COMMISSIONER: I can't see why the names can't be provided to the Commission on the basis that for the moment they will not be disclosed.

MR ANDREWS: Do you have a list of those names with you at the moment?-- No, no, I don't.

COMMISSIONER: But they will appear in those files that you were talking about?-- Oh, yes. Yes, each of the reports will have the name of the patient on the report.

All right.

MR ANDREWS: Will you be able to supply the inquiry with contact details for Dr Allsop?-- Yes.

Thank you?-- There were other - I don't know whether you want me to continue, there were a few other issues that had been raised, if you like, by Dr Allsop.

Thank you?-- He has drawn attention to grossly inadequate documentation, including documentation of symptoms and of test results.

COMMISSIONER: Did he do this in a document?-- Sorry?

Does he do this in a document?-- Dr-----

Does he do this in a document? Is there a document in which he has set out these things?-- Dr Patel?

No, Dr Allsop?-- Allsop, yes, in each report that he has done on individuals, if there are concerns that he has had with the level of treatment or whatever.

We can see that from the reports?-- Yes, that will be evident in the report.

All right?-- I am just providing a summary of the issues that he has raised.

I don't know if we need that if we're getting them in the reports.

MR ANDREWS: Thank you. You say that "the Health Rights Commission Special Unit is reviewing systemic problems with the delivery of health care services at Bundaberg Base Hospital to determine to what extent changes may be necessary to improve the quality and safety of these services." Are there any findings yet?-- We have preliminary findings, some preliminary findings. In some instances we want to get our findings reviewed by an appropriately qualified expert to ensure that, for example, recommendations were made for a sensible solution to problems we identify, but the issues that we have - issues including patients being discharged too early, and we are currently gathering a number of examples of that through our reports, and we've currently reviewing the hospital's discharge and follow-up procedures. The scope of surgical practice, there are issues that called into question the adequacy of supervision of practitioners at Bundaberg to ensure that appropriate cases are referred to other tertiary hospitals. Consent, a number of issues in relation to informed consent, and I will be raising those issues with Queensland Health generally with a view to reviewing its informed consent procedures across the board. Monitoring of infection rates, which I note has also been noted from the Queensland Health internal - the review conducted by Dr Woodruff. We have some concerns there about whether there is adequate auditing undertaken in those areas.

I was interested more in the preliminary findings as opposed to concerns that were raised by complainants?-- Sorry, I haven't made that clear. What I am saying is that on our preliminary review of those cases, we - these are concerns that we hold based on the complaints.

COMMISSIONER: Is your preliminary review committed to writing?-- There is a draft memo that's been sent to me that I would be happy to make available to you if you would like.

All right, thank you. Seems to be a lot of duplication going

on here.

MR ANDREWS: Who is the author?-- Of?

Of the preliminary review in draft?-- That's my staff who have been looking at issues coming out of complaints.

I see. Does the draft memo identify its authors? Do you have a copy of it with you?-- I have a copy of it with me, yes.

Can you tender it - would it be convenient for me to have it tendered now?-- Look, I don't see any reason why not. As long as it is understood that this is a - it is a draft put to me for - in the sense-----

COMMISSIONER: You have seen it and you agree with it?-- Sorry?

You have seen it and you agree with it?-- I have seen it. I agree that there are preliminary views - the preliminary views need to be - there are concerns. In some areas, as I said, we will want to confirm some points with some highly qualified experts in appropriate fields.

MR ANDREWS: Do you understand the draft to contain the honest opinions of its authors?-- Yes.

And can you tell us the names of the authors?-- You are trying to embarrass me by not being able to remember my own staff's names.

COMMISSIONER: It doesn't matter.

MR ANDREWS: You can tell me afterwards?-- I will tell you after.

I tender the draft.

COMMISSIONER: Yes, that will be exhibit - this doesn't mention any patients' names, I take it?-- I don't - I don't believe it mentions any - from memory I don't believe it mentions any patient names.

That will be Exhibit 355.

ADMITTED AND MARKED "EXHIBIT 355"

MR ANDREWS: With respect to term of reference 2(a), which you discuss at paragraph 64 and following, you observed a problem with respect to one of the Medical Board's initiatives for improvement with respect to the registration of overseas-trained doctors for an Area of Need?-- That's correct, yes.

And am I right in thinking your concern is that the Medical Board's insistence that details of supervision be supplied to the Board prior to determining whether there should be registration, while a very practical initiative will not prevent the situation of an overseas-trained registrant being left unsupervised during his year in the regions?-- That's correct. My concern is that a person might be allowed to - granted that registration on the basis of supervision, that if - that supervision may be in place but the supervisor might leave for some reason, the Board might not immediately become aware of that fact. I am also concerned that one of the other conditions that's imposed is that an assessment of the registrant needs to be undertaken by the relevant college, which normally would seek to do that within the first couple of months, but if for some reason the college was not able to carry out that assessment promptly, the Board may not be notified that the assessment has not been carried out. Neither of those factors may become known until a year passes and the registration comes up for renewal.

The instance of delayed assessment by a college, can you explain that? I didn't understand, for instance, Dr Patel to require assessment by a college?-- In some cases in areas of need, it is a requirement of the Board's agreement that the relevant college come in and conduct an assessment of that person in the workplace at an early stage. I don't know that that's a universal requirement.

COMMISSIONER: The Board can impose that as a requirement?-- Yes. It can impose it as a requirement. My concern-----

I don't think we have seen it in any relevant cases here but that is something that it can and, it seems to me, perhaps should apply as a requirement in many cases of overseas-trained doctors?-- I don't have a problem with the Board's requirement that the college conduct an assessment. My problem is that if the college for some reason is unable to get around to conducting that assessment within the time the Board specifies-----

I understand your concern, yes?-- -----the Board may not be notified.

Yes.

MR ANDREWS: Your recommendations for additional steps appear on page 15 of your report. Have you considered whether the Board has the statutory power to insist on each of these recommendations?-- No, I have not gone into that.

At paragraph 72 you deal with complaints relating to the orthopaedic section of the Fraser Coast; that is 11 of 36 complaints from the Fraser Coast health region appear to have related to orthopaedics. Is that correct?-- We have had a total of 36 complaints in recent times from Hervey Bay. Not all of those complaints relate to orthopaedic surgery. 11 specifically do.

Would you be in a position to give me the names of the complainants, in particular the remaining complaint with respect to Dr Sharma. Perhaps that's the first one with which I should start?-- Yes, I can obtain that information.

It is not something you have with you?-- No.

Will you be able to obtain that for me this afternoon? The only reason I ask is that Dr Sharma is giving evidence tomorrow so there is some urgency about it?-- I can see if I can arrange that very promptly.

Thank you. At paragraph 77 you observe that you are concerned there was no patient liaison officer in place at Bundaberg Base Hospital. Is this a systemic change that you recommend-----?-- Yes.

-----for regional hospitals?-- And our review was looking at complaints handling generally for the areas - a number of issues relating to complaints handling in Queensland Health.

I have no further questions, Commissioner.

COMMISSIONER: Mr Kerslake, what staff do you have? How many people work in the Commission?-- My normal full-time staff is 27. We have recently increased that to around 31 as a result of the recent influx of complaints.

All right. And what's your annual budget, approximately?-- In round terms, around about $3 million.

Do you know what the staff of the Medical Board is, approximately?-- I am guessing in saying around the 50 - the office of registration - Health Registration Board, not just the Medical Board, I think would be around 50, at an estimate. I am a little bit guessing there.

Right. Do you derive your funding from different sources? Is there some Commonwealth funding that goes to either you or the Medical Board?-- No, our funding comes solely from the State Government.

And so does the Medical Board's?-- I believe the Medical Board - that it obtains funding through fees that are charged to registrant practitioners.

I see. But no funding from the State?-- As far as I am aware, I think the Medical Board got some recent funding from the State following the Bundaberg incident. I am not sure whether that was a one-off or continued. I only know that because I was at the estimates - budget estimates hearing and Mr O'Dempsey was there and it was his first time there.

Well, no doubt we can find that out elsewhere. But there is a considerable overlapping of your functions, so it appears?-- Yes, there is some overlapping of our functions, but there is one area that the Board - one thing the Board can do that we can't-----

I understand-----?-- -----is investigate individual registrants.

I understand that. But apart from the fact you are constituted under different pieces of legislation, there is no reason then why your Commission and the Medical Board could not be amalgamated in one body?-- There is one very significant thing that needs to be borne in mind and that is that the Board's sole power is to look at disciplinary action.

Yes?-- We focus very much on two areas, one is systemic improvements and the other is individual complaints and whether people are entitled to compensation or some other settlement as a result of that complaint. My view is that to combine the, if you like, more punitive role that a Board fulfills with the more conciliation function, complaints resolution function that we fulfil, I do not believe they fit readily together.

They fit pretty well together in many Courts?-- Sorry?

They fit pretty well together in many Courts?-- That may be the case. They also fit together in the New South Wales Health Care Complaints Commission. No other State or territory around Australia follows that model and I think all other Commissioners, as well as me, have considerable reservations about that New South Wales model.

And what's your reservation about it?-- That on the one hand you are trying to work with parties to help them resolve a dispute and arrive at a fair settlement working together, and then in another sense you are wearing the policeman hat prosecuting people for doing the wrong thing. You don't get a lot of cooperation from providers to work together in conciliating outcomes if you are also wearing - if you are also holding the big stick.

I see?-- And the record in New South Wales, or certainly my perception and other Commissioners' perception of the record in New South Wales, is the Commission does not get anywhere near the level of cooperation from health providers there that we enjoy here in Queensland, or as is the case in other States.

I see. Yes, now who wants to examine this witness? Yes, Mr Mullins?

MR MULLINS: Thank you.

CROSS-EXAMINATION:

MR MULLINS: Mr Kerslake, my name is Mullins. I appear on behalf of the Patient Support Group?-- Mr Mullins.

Can you just explain the intake process that existed between 1 April 2003 and 31 March 2005? Just the precise process?-- I need to preface my comments by saying that in that period of time the intake process was in fact changing. So if you will bear with me, perhaps I can deal with it in two parts: when I arrived at the Commission in 2002, the intake process really consisted solely of receiving the staff - receive complaints, referred them on as appropriate or referred them to elsewhere in the Commission, and they were part-time staff. I have increased their level and I have made them permanent staff. They now still do those things but they also do more resolution work, they will do more informal inquiries, some ringing around to get information that might be able to answer the complainant's questions. So, in short, our role in the intake is to receive the complaint, make sure that we understand the issues that the person is raising.

Just before you go on-----?-- Yes.

-----everything recorded here - all your words are typed down - you used the word "complaint". Your own statement makes a specific distinction between an inquiry and a complaint. Do you receive an inquiry?-- Yes, look we do. We receive an inquiry and it becomes a formal complaint when it is written. My apologies, we tend to generically refer to people's concerns as complaints.

So you receive an inquiry. Now, you have a bank of staff taking telephone calls?-- Yes, we have four - five staff in the intake area who take those calls.

Do they have a pro forma document that they record details on?-- They would record details directly into our database which will record those details.

So they sit in front of a computer?-- Yes.

And what do they see? What details do they have to fill in?-- They will fill in the details of the date, the name of the caller, their gender, their address, the type of contact, which is usually by telephone, the name of the provider, if indeed a provider is named, and the date of the health service they are complaining about. We record whether we have explained the Health Rights Commission process - these are just tick a box things - whether they have explained the process, whether we have sent them information, and whether - then we provide a brief rundown of the details of the person's complaint - in this case it is about half a typed page, on this particular one - the duration of the call as well.

All right. Does the intake officer specifically ask for the name of the surgeon or doctor who the complaint is being made about?-- That will vary. You would generally ask them the name of the provider, in the sense of if it is a hospital, you would know what hospital, you don't necessarily know the name of the doctor who is in the hospital. The complainant often doesn't know that themselves.

Is the intake officer instructed to ask for the name of the doctor?-- I would have to double check that with my complaints manager who runs that section. I understand that's the case.

All right. Now, you have copies of the full history sheets in respect of the cases identified in DK2 and DK3, have you?-- Yes.

All right. How bulky are they?-- That's DK2, DK3.

I am sorry, you were reading before from the Vicki Lester sheet?-- Oh, sorry. Yeah, those are particular - that is just a small number of particular cases of people who inquired to us prior to April 2005.

Right?-- Yes, I have those here.

And the documents you have, are they the full records of your organisation in respect of those people?-- As far as I am aware, yes.

Now, at paragraph 45 of your statement-----?-- Sorry, can I clarify, they're - they are the full records of all of the inquiries that was made. I believe that one of them may have come back at a later date, so there may be a written complaint that goes with one of them. I am not sure.

At paragraph 45 of your statement, you mention that you receive a number of telephone inquiries and a number of complaints and you have distinguished between DK2 and DK3, the latter being the telephone inquiries?-- Sorry, Mr Mullins, what paragraph was that?

Paragraph 45?-- Yes.

Sorry, don't refer to DK2 and DK3. Paragraph 45 you talk about the complaints that you received?-- Yes.

And the inquiries that you received. Do you treat a complaint only as a complaint after it is reduced to writing?-- As a general rule, yes.

The Act doesn't require you to have a complaint in writing before you can act, does it?-- No, it doesn't, no, and if we - if we received a complaint that was something that immediately alerted us to something extremely serious and we, for example, needed to notify the Medical Board, we could do so from that point.

Can we take you to DK3? You mentioned that there were three telephone inquiries about the Bundaberg Hospital received over the period 1 April 2003 to 31 March 2005, and for ease of reference, I have identified them as P96, Beryl Crosby. On the second page Rob Messenger, who referred various patients?-- What page is that on there, please? Okay, what page are we on?

Second page. My pages aren't numbered?-- Of DK3?

Yes?-- Sorry, no. Yes, I found that. Yes.

P293, ...P293?-- Yes.

And just under that name, Geoff Smith?-- Yes.

47251. That's right?-- Yes, Geoff Smith's there, that's correct.

You obviously weren't counting Mr Messenger as being one of the complaints - inquiries that you received?-- No, that's correct. We had - when we received Mr Messenger's letter, that was around about the 23rd of March, if my memory serves me correctly, and when we received that letter I contacted him to advise that we would - or his office to advise that we would refer the matter to the Medical Board. His office didn't contact us - get back to us - or I got back to them again when they didn't late in the month, and we referred those cases across to the Medical Board on the 1st of April.

Can I ask you to refer again to your note of the Beryl Crosby case?-- To my database listing? Yes. Bear with me a moment, please. Yes.

Can I just ask you again, what do you say the advice was given to her?-- In our database it says, "I advised of the Health Rights Commission procedures and said to write to the District Manager with her complaint, keeping a copy of her letter. I said to ring the HRC when a response is received if it is not acceptable."

All right. I suggest to you that that wasn't the response she received. In fact she received the response that, "If you want to take it further with the HRC it should be reduced to writing." That's inconsistent, obviously, with your records?-- That's not what's recorded here, no. This is a note made on the 22nd of June 2004.

Let's try Vicki Lester. Now, Lester doesn't appear as a telephone inquiry in DK3, but it appears as a written complaint in DK2. Can you just advise what your note says about the Lester contact, how the first contact was made?-- By telephone.

Do you have any explanation as to why Vicki Lester's telephone inquiry does not appear in DK3?-- I believe the reason for that is that if people write in at a later date with a formal written complaint, we - their name goes off our database for inquiries and goes on to our database for written complaints. Otherwise we'd end up counting every complaint twice.

All right. Thank you. Can you tell us again how that claim - or that matter was finalised?-- In the initial discussion it says, "I asked the caller if she had discussed any of the issues she has raised with the hospital. Caller advised me that she had not. I asked if the caller would agree to me

contacting" - that's PLO - "the hospital to discuss the possibility of having the other surgical team care for her. The caller agreed to this."

No further contact?-- No - yes, there's a number of discussions that took place subsequent to that with Ms Lester.

All right. There is a significant dispute that you're aware of between what Ms Lester says the advice she received was and what your office says the advice she received was. You're aware of that dispute?-- Remind me of the details. I do recall that a while back, but it's been a little while.

I'll show the witness a copy of the transcript.

COMMISSIONER: Thank you.

MR MULLINS: I have the pages marked. It's probably easier - I have a copy for the Commissioner.

COMMISSIONER: Thank you.

MR MULLINS: You will see at the first flag I've boxed some material?-- Yes.

It runs on to the page after?-- Yep.

At the second flag I've boxed some material, and I've done the same with the third flag?-- Yes.

Now, Ms Lester had a most unfortunate experience with Dr Patel and was terrified, on her evidence, of going back to Dr Patel, and her major concern was what she could do if, as a matter of urgency, she had to attend the Bundaberg Base Hospital in respect of Dr Patel operating on her. I'll read into the record that I've highlighted pages 2459 lines 29 to 60, page 2460 lines 1 to 35, page 2461 lines 25 through 52, and page 2466 lines 15 to 22 and lines 38 to 48. Commissioner, rather than - I have specific instructions to put this material. Rather than go through it, can I ask the witness to take two minutes to read it?

COMMISSIONER: Yes, certainly.

MR MULLINS: Then I can ask a few questions about it. Can you read those boxed areas, please, Mr Kerslake?-- Sorry?

Can you read the boxed areas?-- Do you want me to read what's in that material?

Yes?-- Read it out loud?

No, no, read it to yourself?-- Oh, sorry. I've read the first lot.

Keep reading and then I'll ask you a couple of questions about it?-- Yes, Mr Mullins.

You've read all three of those passages?-- I've gone through that, yes.

Now, you can see that the concern that Ms Lester had was that in the time that it would take to process the complaint, she might need to go back to the hospital and might be treated by Dr Patel. That's correct?-- That's what she's listed there.

And she says - and I'll place on the record that there is a dispute about what was said between the Health Rights Commission and Ms Lester, but she says the advice that she received was that she was a public patient and she'd have to tell Dr Patel that - it was basically up to her, when he came to the bed, to say, "I don't want you operating on me." Now, as I understand, the Health Rights Commission denies that advice was given by your representative?-- I've spoken to her and, yes, she denies that's the case. If it would assist you, I'm also happy to go through file notes of conversations to let you have our record of those discussions.

Well, I'll hand up Exhibit 177 which is a chronology which includes that material. I'm just interested in this comment, Mr Kerslake. If the version of Ms Lester is correct, that's completely unsatisfactory advice, isn't it?-- That, "You're a public patient and you"-----

You have to tell the doctor when he comes to the bed?-- -----"take what you get"? Yes, that would be incorrect. But that's clearly not the advice that she was given.

Taking you back to DK2 and DK3, you say at paragraph number 52 that - runs on from 51, obviously, but the last line in 51, "My complaints manager attended Bundaberg for the purpose of facilitating receipt of complaints for the week of 18 April to 22 April 2005."?-- That's correct.

You actually set up an office in Bundaberg?-- We obtained an office in a government department up there and - no, sorry, on that occasion we obtained some rooms in Bundaberg.

The Health Rights Commission's presence in Bundaberg was advertised in local Bundaberg media?-- Correct.

And over 70 formal complaints or inquiries were received in the course of that week?-- Yes.

I've checked DK2 and DK3 and counted the number of inquiries in April 2005 and there's 45. Can you explain that?-- Well, a lot of those people were - put in written complaints. A lot of those people met with our complaints manager, discussed the issues, were given whatever assistance they required and subsequently put in formal written complaints. Some people during that same week did not meet with our complaints manager, but they rang our office direct and made inquiries through our intake area.

Well, the former, that is those who put in written complaints, are in DK2?-- I assume so.

That would be correct? The people who put in written complaints are in DK2?-- Yes, and the others are in DK3.

I've counted all the ones from April 2005 and there's 45. Would you like to check or-----?-- You mean the total of the two in-----

Yes, is 45?-- I don't know. That's the information that I have. I spoke to my complaints manager, he went through his diary to talk to those people. It may be that some people came in and spoke to us, didn't decide to take the matter any further and didn't - didn't ring the office, didn't write into the office, but nevertheless he saw them at that time in Bundaberg.

Is it possible that your database may not be entirely correct?-- No, I don't believe that's the case. I believe that figure came from Mr Kake checking his diary to see how many appointments he had, and those figures would have been added to the number of telephone inquiries that were made independently of Mr Kake's meeting.

At paragraph 49 you say that after 8 April 2005 you recognised that there would be a larger number of complaints and a broader range of issues to be addressed and the Health Rights Commission's involvement would be important. That's correct?-- Would be important?

Yes?-- Yes.

It's the case, isn't it, that by doing so the Health Rights Commission was encouraging people to go through the Health Rights Commission process?-- We were making ourselves available to people should they wish to use our service.

Do you see the process as an alternative to the legal process?-- Yes.

And you've mentioned to the Commissioner earlier that the process involves the original complaint, that's correct?-- Mmm.

Yes?-- Yep.

The assessment process?-- Yes.

And then a conciliation or mediation process?-- That's the complaints process.

Yes?-- Yes, it doesn't invariably. It can involve all three of those. Not invariably.

And it's the case, isn't it, that at the mediation or the conciliation there might be a settlement?-- That's correct.

And the settlement might involve the payment of money, in these cases, between Queensland Health and the particular

individual?-- That's correct.

Because you see it as an alternative to the formal legal process, many of the persons involved are not legally represented. That's correct?-- Some are not. Some are and some aren't.

Can you give us a break-up of what the balance is? Not just in respect of the Bundaberg Hospital-----?-- No, I can't, because people don't always tell us if they've been to - if they've been to a solicitor.

Let's take, for example, one of the Patel patients. Have any of them had cases resolved yet?-- In terms of settlements?

Yes?-- No.

In a case where we have an individual who has a complaint about a hospital, if there is a settlement, there will be a discharge signed at the conclusion of the settlement?-- That's correct.

And the discharge would invariably involve a confidentiality clause?-- Not necessarily.

Invariably?-- Look, I don't know that that's the case at all. I don't. I really don't know. I've seen many settlements that simply state that the parties specify what it is they're settling and the amount agreed.

Right. What about cases involving Queensland Health? There is generally a confidentiality clause, isn't there?-- I would have to check that. I would really have to check that. I don't know.

Okay?-- I don't - I have a panel of conciliators who conduct those conciliations. I don't know whether that's the case or not.

The second matter that a discharge might invariably include is a waiver of any entitlement to proceed further with a claim for compensation?-- Generally when people settle those cases they are settling them once and for all, that's correct.

And, as you say, some of those people involved don't have lawyers?-- They may not have lawyers at this stage of the process. If what you're alluding to is the possibility that people might arrive at a settlement without the benefit of legal advice, that's not - would not be the case. Where we take a process through in conciliation, and if we get to a point where we have advice that suggests a person may well be entitled to a financial settlement, at that point we would always - invariably advise the complainant to get legal advice so that they can get advice on quantum, so that they do not - so there can be no suggestion they've been disadvantaged or they've accepted - or they've been diddled in the offer-----

At what point do you give that advice? At the conciliation conference?-- No, no. That - no, it would be well before that. In many of those cases people would be either seeking that advice - they would go away and get that advice. They may well come back to that conference with a solicitor in tow, even though they may not have had a solicitor in the first place.

Sorry, just clarify with me again - I might have misheard that. At what point do you say you give that advice to get legal advice?-- It would be - it may well vary from case to case, but it would not - we would not give that advice at the conciliation settlement conference. That would clearly be a waste of time. It would be too late. You would give people that advice - and generally it would be when you've got information that suggests that a settlement way well be warranted, and you would then suggest - in a typical process, if that's the case, the other party may well come back and say, "Well, look, okay, based on the information we've got there have been some criticisms made here. We would be interested to know what the other party - what they're seeking and under what headings", and at that point we would seek - suggest to them that they go and get legal advice to assist in that regard.

Is it the case that for all of the patients for the Bundaberg Base Hospital where they have a claim related to Dr Patel, that you're giving them advice to get legal advice to assess the quantum of their claims?-- Is it the case that we - at this stage we've received a number of reports, but we have not yet given that - well, I'm not aware that we have given that advice because - we have not moved that into any form of - those reports into any form of mediation process.

Well, it's the case, is it, that you are going to give that advice to each of the Patel patients to ensure that they understand what their legal rights are?-- Certainly.

We mentioned before the confidentiality, and you say that you're not certain yourself whether that is invariably the case, that Queensland Health require confidentiality as part of a settlement?-- Look, I don't know. As I said, those - the actual negotiations are conducted by - under our Act you have to be specifically appointed as a conciliator to conduct those negotiations, and they are conducted by our conciliators.

You mention that on 26 April 2005 you had a meeting with Ms Crosby and Mr Fleming?-- In Bundaberg, that's correct.

The representatives of the Patient Support Group?-- That's correct.

Mr Fleming and Ms Crosby attended at the office that you'd set up in Bundaberg on that day?-- I had - yes.

The only people present at the meeting were you and Mr Fleming and Ms Crosby?-- That's correct.

It's the case that you said at that time you wanted to help the patients get access to records?-- I don't recall.

Do you recollect Ms Crosby saying, "Well, we've already got the records and we've worked that out ourselves."?-- No, I don't. I don't recall.

When I say "We've already got the records", "We've already worked out how we're going to get the records and have got access to some."?-- Look, they may have said that. I don't know. I don't recall.

You told them that the Health Rights Commission can help people get medical help. Do you remember saying that?-- What I would have advised them is that an arrangement - our first priority with patients at Bundaberg was to ensure that if anybody had a serious condition that needed to be dealt with immediately, our first priority was to ensure that they got that treatment. Now, that was done in conjunction with Queensland Health where they were arranging a lot of second opinions, and we would put those complainants in touch with Queensland Health's patient liaison officer if they felt - if they had ongoing symptoms and wanted to arrange further treatment.

Well, did Ms Crosby tell you they've already fought that fight on their own and they've been liaising with the hospital and the patients were getting treatment where needed?-- She may well have - she may well have told me that. I'm not privy to what discussions she would have had. I would have gone there to set out what things we could do, if they needed that assistance.

And do you recollect saying that, "Well, if you've got that, we can get some compensation for the victims and we can run cases through where people get up to $500,000."?-- I think you'd have to be on a different - whoever thought that must have been on a different planet from the one that I was on. I would not-----

COMMISSIONER: Either you said that or you didn't?-- Sorry?

Either you said that or you didn't?-- Sorry. No, I didn't.

MR MULLINS: The issue of compensation through the Health Rights Commission was discussed at that meeting, wasn't it?-- If it was discussed, it would have been as a possible outcome in some cases. Let me be clear on one thing. Where we deal with cases we're very, very careful not to give people the false expectations or false hopes of the outcome of a complaint. We just don't do that.

I suggest to you the figure of $500,000 was mentioned twice?-- No, definitely not. Categorically, no.

Either at that meeting or later they asked - that's Ms Crosby and/or Mr Fleming asked that you attend a Patient Support

Group meeting?-- Yes, they did.

And you refused to if the Group's lawyer was present?-- What I said to them - what they were proposing was that myself and the Group's lawyer should get up on stage and have, if you like - they didn't use these terms, but, you know, a bid - see if we could out-bid each other, who was going to go what way, and I pointed out it would be entirely inappropriate for the Commission to be seen to be touting for business. I pointed out people had the right to seek legal action, and I also pointed out to them it was important that they also knew that they had the right to pursue other channels if they wish, and ultimately the choice was theirs, and I said therefore it would not be appropriate for me to go up on a forum where I'm trying to attract people away from the solicitors. That's just not an appropriate image for the Commission to convey.

Well, did Ms Crosby and Mr Fleming suggest to you that you were trying to attract people away from the solicitors?-- Not that I recall, but if they had, I would most certainly have said that that's definitely not the case.

Did you perceive yourself that you were trying to attract people away from solicitors?-- No.

Well, why did you think that if you went to a meeting with the lawyer and you were both up on stage, that you would be seen to be competing?-- What I said to them was I was perfectly happy to go and talk to the meeting, but if I did, I would like to go and talk to the meeting on my own so that I could simply explain to people what the Health Rights Commission's functions were, and then they would be fully informed.

Excuse me, please, Commissioner.

COMMISSIONER: Yes.

MR MULLINS: At paragraph 45 you mention that the complaints manager identifies patterns of complaints. How does that process actually work? What does the complaints manager do?-- It may be that we've had a similar type of complaint from the one region, a recurring pattern. Not against the same provider but the same type of issue in a hospital, for example. It could be that we've had a significant volume of cases against a particular practitioner where, even though one of them may not be particularly serious on its own, a large number might suggest a pattern that needed to be looked at.

All right. And was the search done manually or through the database itself by a search engine?-- The staff, when they look for - when they enter the names of cases or individual providers, look for a match initially and that information is brought to the attention of the complaints manager if there's any significant number.

Thank you, Commissioner.

COMMISSIONER: Thank you. Does anyone else want to ask this witness a question? Mr Allen?

MR ALLEN: Thank you, Commissioner.

CROSS-EXAMINATION:

MR ALLEN: Mr Kerslake, John Allen for the Queensland Nurses Union. Whether it be the Health Rights Commission or some modification of it, or some new body charged with the regulation of health standards in this state, from your experience with the Health Rights Commission, there are certain matters which would have to be - certain matters upon which the current Health Rights Commission could be improved?-- Yes, yes.

One you point out is that any such body should have the power to investigate of its own motion?-- Yes, that's correct.

It shouldn't be dependent, as the Health Rights Commission is, upon receiving a complaint?-- Yes, I agree.

Such a body should retain the power and responsibility of a Health Rights Commission to investigate matters occurring in both the public and private sectors?-- Yes.

Does the Health Rights Commission currently have power to investigate matters in relation to provision of aged care services?-- Yes, it does, and its jurisdiction in that respect overlaps with other agencies, including Commonwealth agencies.

Any body, being a modified Health Rights Commission or a new body replacing it, should retain that power?-- I haven't given that a great deal of consideration, to be honest, and I don't really want to speculate too much on the spot. There would be issues - there are - there is duplication in the current system. That is not necessarily a bad thing.

No, and the fact is that there are doctors and nurses providing health services in that industry really at an increasing rate with the ageing population?-- That's correct, and one of the benefits of the Health Rights Commission being able to look at those issues is that you can identify whether it's the doctor providing the services to the nursing home or the facilities in the nursing home that are the source of the problem, and you can marry all of that up.

Yes. Should there be some greater coordination amongst the relevant agencies which at times investigate health service delivery such as the Health Rights Commissioner, the State Coroner and other coroners, Queensland Health's own investigative bodies, in your opinion?-- In my opinion, yes. I can give you a couple of examples. I believe that if

Queensland Health undertakes a major investigation, that at the very least the Health Rights Commission should be notified. I think it would be preferable in major cases that the matters actually be referred to the Health Rights Commission so it can be seen to be investigated independently. With regard to the coroner, as I understand it, if the coroner makes recommendations, the coroner doesn't necessarily have the power to monitor the implementation of those recommendations, and I would see benefits in-----

Sorry, you would see benefits?-- -----see benefits, if the Coroner makes recommendations for systemic changes, if they were passed to the Health Rights Commission to monitor the implementation of those changes.

So, we currently have the absurd situation whereas one Coroner might investigate a death in a private hospital, and it may be recognised by the hospital and, indeed, in recommendations by the Coroner that there should be some change of the system or protocol which contributed to that death, that doesn't get communicated to other private hospitals as a matter of course, or, indeed, to any public hospitals; is that so?-- I'm not an expert on all the Coroner's functions, but I understand that to be the case.

So, then we have another Coroner, two years later, investigating a similar death in another hospital which hasn't got that improved protocol and making the same recommendations?-- And one of the areas that - that's one of the areas I said if those recommendations were passed on to the Health Rights Commission to monitor their implementation, you would then need to look at what the Health Rights Commission's powers were to - if the recommendation was that this should be across the Board, ensure that they occur across the Board.

What you would need to consider in that situation is that there's some type of Health Regulatory Authority which could direct that certain protocols and policies be applied consistently across the public hospital and private hospital system?-- Look, on that point, I'm not sure. I'm sure there's a variety of ways that you could do that. I simply agree with you in principle that there is scope there for further monitoring to be done.

Not only monitoring, I'm suggesting, but actual regulation and direction so that the policies and protocols are consistent across the whole of the private and public hospital system where that's appropriate?-- And I think the point that I'm really trying to get at, where it is appropriate, you may get different views on how far that should go. But certainly I agree that there may be recommendations made, and there may be recommendations made by the Health Rights Commission that are made to particular hospitals, or maybe made to the whole of the public sector, but may not be made to the private sector because we don't have a complaint, but where there might be merit in raising those issues with the private sector. But what I'm not sure about is there are issues in relation to how far the powers should go of enforcement as opposed to recommendations and so forth.

But the basic principle, I suggest, that would determine that is patient safety?-- Yes, yes. That's paramount.

For instance, there's legislation, isn't there, that prescribes across all health providers, whether private or public, who can administer certain drugs?-- I understand that

to be the case, but, look, I'm not - I'm really not an expert on that area.

You are not aware that Schedule 8 drugs, for example, can only be administered by a registered nurse or doctor rather than, say, an enrolled nurse?-- I'm aware that there are restrictions, but I don't know the detail of a lot of those restrictions.

See, you would have come across matters in the course of your tenure as Commissioner where medication errors, for instance, have occurred because of the lack of appropriate protocols in place at hospitals?-- That's correct.

And such errors can sometimes be fatal?-- That's correct.

In a system where there is increasing mobility of the workforce, both doctors and nurses between public and private hospitals, and, indeed, increasing reliance on agency nurses, where you may work in a different hospital each day, it is important, I suggest, that there be some consistency of protocols for such matters?-- Mr Allen, one of the things I strongly agree with you on is the principle that in different areas of the health sector, you should be able to learn from other people's mistakes, not just your own, so I strongly support that as a principle, and then that led you to then consider the question how do you disseminate that information across the system so you can benefit from those mistakes. I'm simply saying that there's probably a number of different models you can adopt in the attempt to achieve that.

Okay. And a number of possible models, all of which would be preferable to a situation as it now exists of a complete absence of such co-ordination?-- I agree that's an issue that should be looked.

MR ATKINSON: Now, whether it be a modified Health Rights Commission or a new regulatory body, it should be quite clear that such a body can accept complaints not only from patients, but also from doctors or nurses?-- Correct.

It is not so clear at the moment, is it, when one looks at the terms of the Health Rights Commission Act, whether or not the Health Rights Commission can accept complaints, for example, from a doctor or a nurse regarding a patient's care?-- I think the legislation is clear on that point.

Section 59, subsection 1 of the act provides that a health service complaint may be made to the Commissioner by certain persons?-- I have only got - if the public interest - the Commissioner can accept the complaint from other persons in the public interest.

COMMISSIONER: Why are you asking this witness to interpret the act?

MR ALLEN: Because the witness gives an interpretation of that provision in his statement-----

COMMISSIONER: Yes.

MR ALLEN: -----which it is suggested to the witness is not as clear from the terms of the section itself.

COMMISSIONER: And the consequence of that is?

MR ALLEN: It is basically the proposition that is being put to the witness which he failed to accept that the legislation should be clear that doctors or nurses can make complaints and it isn't currently clear, but it may well be a matter of submission to the Commission.

COMMISSIONER: Sounds like it.

MR ALLEN: I accept that. Thank you, Commissioner. Just before you leave that, you mentioned the public interest category?-- Yes.

Can you recall any instances under your tenure where complaints have been accepted pursuant to section 59(1)(d)?-- If you are asking me for a specific one off the top of my head, no, but I'm sure that they have. That's accepting in the public interest?

Yes?-- Yes, I'm sure that they have, but I can't list you a specific example at this stage, but over the years, there's quite a few.

Did you recall any being accepted from nurses or doctors?-- I - as I sit here now, no, I can't, but I'm sure they have. I simply don't recall one way or - or any specific case right at the moment.

Now, just in relation to that meeting that you had with certain representatives of the Queensland Nurses Union on the 4th of February 2005, you mention Ms Barry and Ms Simpson?-- That's correct.

There was also present a Ms Chris Jensen?-- I can only remember two.

You didn't actually take any file notes of the meeting at all?-- No, I didn't. It was a very high level meeting, so I didn't have any notes.

And you can't recall the details that were supplied to you in relation to Dr Patel?-- What I can recall is that there really wasn't any detail.

You can't recall whether or not his name was mentioned?-- No, that's correct, but my practice would be if people came to me with detail about a complaint, I would either make a note of that, or I would get another staff member in to take down details of that complaint, and that's why I'm confident that there was no - that that detail was not provided.

It is the case, isn't it, that you say that you can't remember whether or not the doctor's name was mentioned, but you accept that it may well have been?-- It may well have been - his name may well have been mentioned, yes.

I suggest that it was Ms Barry who provided detail in relation to the nature of complaints that had been made about Dr Patel by nurses to Bundaberg Hospital management?-- Well, look, as I've said there, if there were any of that detail, it was very high level discussions. If I had that detail, I would have made a note of that. There was not that level of detail. What they came to ask me about, which I do recall, is that they wanted me to go through the HRC's legislative powers and processes. They did mention that they had members who had concerns, but they didn't go into detail of what they were. They wanted to get information about our powers and processes to report back to the members.

Do you recall whether you were told that complaints had been taken to management at the hospital and apparently not acted upon?-- No.

Can you say whether that was said to you one way or the other?-- I don't believe that was the case.

I suggest that it was said to you?-- I don't believe that was the case.

Was there any discussion about - or suggestion by the persons from the QNU as to the inconsistency of approach adopted by management when a concern was raised about a nurse's conduct as compared to a doctor's?-- They did make a comment along the lines - and they didn't go into detail - but they did make a comment along the lines that if - whatever matters they were concerned about had been done by a nurse, the outcome would have been different, but they didn't give me any detail about what, in fact, that was.

Well, they suggested that on receipt of a complaint of such a nature about a nurse, the nurse would be suspended immediately pending the outcome of an investigation to ensure the safety of the public?-- The only matter that I recall is that they were - they obviously had concerns with - about management and believed that their members were not being treated the same as others would be in the same circumstances, but they didn't go into detail about what those circumstances, in fact, were.

Did they say that if complaints of such a nature had been made about a nurse, the nurse would be immediately suspended?-- They said something to the effect that - I don't know whether - I don't recall whether they said that the nurse would be suspended, no, I don't. I don't recall that. They did say that their members would have been treated differently from doctors in that situation.

You signed a previous statement to the one that's been admitted into evidence?-- That's right.

And I suggest when dealing with this matter in the previous statement, paragraph 74 of that earlier statement dated the 12th of August 2005, you said this in relation to Ms Barry and Ms Simpson: "I recall them saying something to the effect that if nurses had behaved in the manner these doctors had, they would have been suspended, but that nothing had been done."?-- Then, I'm sorry, I correct that.

You accept that?-- I accept that, and I accept that's an accurate record. That statement - can I just add, that statement was made a long time ago - you know, some months back when that was first raised.

So, it is fair to say that the representatives of the QNU were talking about concerns in relation to doctors of such a seriousness that if they had been made about nurses, their view was the nurses would be suspended immediately?-- That's correct.

Do you still maintain that there was no detail given in relation to the seriousness of the allegations?-- Yes.

You still maintain that?-- Yes, if they had made serious allegations, then I certainly would have made a note of what those allegations were, and I certainly would have got a staff member in to take detailed notes of those allegations.

But you told them, basically, that if the Health Rights Commission got a complaint - a serious complaint about the - relating to the clinical competence of a doctor, that that would simply be referred to the Medical Board?-- I told them that if we - I went through - I didn't just address that issue, I went through a wide variety of the Commission's processes, including the whole of section 59 that you refer to, and other aspects of the Commission's processes.

Did you tell them that if there was a serious complaint in relation to the clinical competence of a doctor, that would be referred to the Medical Board and the Health Rights Commissioner would not be able to do anything with the complaint until it was determined by the Medical Board that there was substance to it?-- I told them that if there was a serious complaint about the conduct of a medical practitioner, we would consult with the Medical Board with a view to referring it. The consultation process has to be - the Board has to agree to accept the referral. I told them that we would consult with the Medical Board with a view to referring it to them.

Referring it to them. Quite consistent, I suggest, with what, in fact, happened, as detailed in paragraph 48 of your statement when, on the 23rd of March 2005, the Commission received a copy of the letter from Mr Messenger MP to the Minister for Health detailing complaints about Dr Patel?-- It's consistent in that they asked me to explain the process, and that's the process that I explained to them.

See, you are given a copy of this actual document detailing

complaints about Dr Patel, and as you explain in your statement, you advised Mr Messenger's office that as the letter primarily raised competency issues concerning a registrant, the Medical Board was the most appropriate body to investigate the concerns?-- That's correct.

So, even when you have got that detail in black and white referred by a member of parliament, your response is let the Medical Board look after it?-- No, that's incorrect. The primary issue that we would look at, the first and foremost, is whether there is a practitioner there who is a threat to the public - to the public safety. If we have information there that suggests that to be the case, then we would refer it immediately to the Medical Board, because they have the power to immediately suspend a registrant who may be considered to be a threat to public safety. So, our priority would be to get that case to the Medical Board in the first instance so that if they felt that there was action needed to be taken to suspend that registrant, they could do so forthwith. That's the priority in terms of protecting the public safety.

You said that if Mr Messenger was agreeable, you would confirm with the Medical Board that it would be addressing the matter. I am reading from your statement, paragraph 48?-- That's correct.

The Health Rights Commission didn't start an investigation into Dr Patel at that time, did it?-- No.

Didn't open a file?-- No.

Didn't engage in correspondence with the Medical Board seeking further information in relation to Dr Patel?-- The Board - the Health Rights Commission notified the Medical Board of Mr Messenger's complaint on - the 23rd of February we received the complaint, on - it took about a week - I think it was the 31st of April, when either Mr Messenger's office got back to me or I got back to them because they hadn't, and they agreed that the matter be referred and the Medical Board was noted as contacted on the 1st of April, the very next day.

Yes. But it was referred on to them; the Health Rights Commission didn't start its own investigation?-- No, I haven't said that we did.

Or take any further action?-- I have already explained the reason for that, that the priority was to ensure that public safety was addressed and that involved getting the matter immediately to the Board so that they can consider any competency issues in relation to an individual practitioner.

See, it seems from the terms of your statement and your evidence the Health Rights Commission didn't do anything until it became a major issue in the media and by that time there were other investigations already underway?-- Not correct.

What did the Health Rights Commission do before that time?-- I have just explained to you-----

You sent it to the Medical Board. Anything else?-- We notified the Medical Board.

Anything else?-- At that point, no.

No. Because in your statement you say it was only after media reports that you - the Health Rights Commission first became aware that there may be broader issues concerning Dr Patel?-- Of the importance of those broader issues, yes.

So was it the media reports bringing those broader issues to your attention which finally provoked the Health Rights Commission to do something in addition to having referred it to the Medical Board?-- It is difficult to answer that yes or no because I don't accept the reference to the way you put it "do something".

Did you tell the representatives of the QNU at your meeting in February this year that the Health Rights Commission had

not received any complaints about Dr Patel?-- Not that I am aware of.

Because that would-----?-- I can't see how I could possibly have done so because I wouldn't have that information at my fingertips. I would have to go and do a database search to be able to confirm that, so the answer I would be very confident would be no.

Was there a discussion about a system of monitoring recommendations from coronial decisions?-- I don't recall one way or the other on that.

Don't recall one way or the other?-- No.

And that was not the first time that you had been visited by persons from the QNU in relation to concerns about the Bundaberg Base Hospital, was it?-- I can recall a meeting with - that involved Kym Barry some time well before that - some time before that, I don't know, but on my recollection.

2003 in relation to issues concerning the Mental Health Unit at that hospital?-- I don't recall.

Do you recall any indication given then that - by yourself that your powers were limited to dealing with complaints from the user of the health service or their representative?-- No, most certainly would not have said that. I mean, that's just totally contrary to the Act.

Because of the public interest provision?-- I can accept complaints from the user of a health service, I can accept complaints from a representative acting on behalf of the user. I can accept complaints from another person in the public interest. I can be directed to conduct an investigation by the Minister.

Yes. And you have already told us that you can't point to any instance where you have exercised the public interest power to investigate a complaint by a nurse or a doctor?-- No, I told you that sitting here right now I can't think of a particular case. We deal with four and a half thousand case complaints a year. I don't carry them all around inside of my head.

So you reject the suggestion that you indicated at the meeting in February this year that you were limited to dealing with complaints from users of the health service or their representative?-- Totally.

Or as directed by the Minister?-- Totally.

That you appeared disinterested in the proposition that you could act further than that based on public interest?-- Could you say that again, please?

Yes. You indicated disinterest as to exercising the public interest power to investigate matters from other persons?-- Totally reject that.

Thank you.

COMMISSIONER: Yes. Anyone else?

MR DEVLIN: I have some questions. I don't know whether I could match Mr Applegarth's promise of brevity.

COMMISSIONER: See how you go.

MR DEVLIN: Thank you.

CROSS-EXAMINATION:

MR DEVLIN: Ralph Devlin from the Medical Board, Mr Kerslake. You said earlier in your - early in your evidence about the ability for the Minister to refer matters for investigation. Have you ever considered your capacity to ask the Minister to refer to you matters of interest?-- Yes, yes, and on numerous occasions the Commission has done that.

Thank you. So with the public interest power and that capacity then, there is a somewhat broader means of bringing a matter for assessment and investigation-----?-- Yes.

-----than the Act would at first suggest?-- Yes.

Thank you. Now, in relation to the practical way in which your Commission and the Board interact, the Act requires that you advise within - the Commission advise the Medical Board within 14 days of the commencement of an assessment process, is that right?-- That's correct.

That part of your process will involve conciliation and you will then refer, for disciplinary action to the Medical Board or other Board, any matter that comes to your attention that you think is of sufficient seriousness?-- That's correct.

There is a power as well to refer, in section 68, without assessment?-- That's correct.

Now, in terms of how the Medical Board deals with matters that have first come to your notice and has been referred to them, you would accept, I take it, that some cases are rather more complex than others-----?-- Yes.

-----firstly. And secondly, that the bulk of them - in current days, the bulk of those matters referred by you seem to be progressed in a matter of months rather than a longer period of time?-- There has certainly been in recent times a very great increase in the speed with which the Board investigations-----

COMMISSIONER: What do you mean in recent times? Since

when?-- Sorry?

What do you mean in recent times? Since when?-- In the last couple of years.

MR DEVLIN: So you would be conscious there was a large backlog some years ago that has been cleared?-- I am conscious of that.

Rather large effort by involving firms of solicitors and so on?-- That's correct.

Thank you. Just looking then at the broader picture, it is undoubtedly a significant feature of the Commission's current function that it can achieve outcomes by informal means, including conciliation, correct? That the maintenance of professional standards for the various health professions, you would accept, rests properly with the various Boards that govern those professions?-- That's correct.

And including the Queensland Nursing Council? Certainly the medical colleges have some role in keeping up standards, but they certainly don't have power to prosecute disciplinary matters?-- No, that's correct.

You, the Commission, will refer suspected unprofessional conduct for investigation and then you have the opportunity to comment on what the Board comes up with?-- That's correct.

And you exercise that power actively, do you not?-- That's correct.

And then once you have made your comment on the outcome of the investigation that you have referred to the Board, the Board is, by legislation, required to consider your comments before making a final determination as to the action it will take?-- That's correct.

Thank you. And, as you said to the Commissioner earlier, the important function of conciliation is so important and you are so adept at it that to have the policeman's hat would be definitely counterproductive?-- Yes.

Thank you.

COMMISSIONER: Thank you.

MR DIEHM: I have no questions, Commissioner.

COMMISSIONER: You have none?

MR DIEHM: Yes, that's so.

MR FITZPATRICK: No questions, thank you, Commissioner.

COMMISSIONER: Mr Perrett, do you have any questions?

MR PERRETT: I have no questions, Commissioner.

COMMISSIONER: Thank you. Mr Andrews?

MR ANDREWS: No Commissioner.

COMMISSIONER: Good.

MR ANDREWS: Subject to Mr Kerslake's producing some documents and the possibility that they may lead to a need to ask him some clarifying questions, may he be excused?

COMMISSIONER: No objection to that? Mr Kerslake, subject to those further documents requiring you coming back, you are excused from further attendance. Thank you?-- Thank you.

WITNESS EXCUSED

COMMISSIONER: We will now adjourn.

THE COMMISSION ADJOURNED AT 4.31 P.M. TILL 10.00 A.M. THE FOLLOWING DAY