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 23/09/2005

..DAY 10

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

THE COMMISSION RESUMED AT 10.00 A.M.

COMMISSIONER: Mr Andrews.

MR ANDREWS: Good morning, Commissioner. I call Dr Sean Mullen back to the witness box.

MR McDOUGALL: Before Dr Mullen comes, your Honour, I seek leave to appear on behalf of Dr Terry Hanelt. My name is McDougall, initial J, of counsel.

COMMISSIONER: Yes.

MR McDOUGALL: Thank you.

COMMISSIONER: Yes.

SEAN ANDREW MULLEN, CONTINUING EXAMINATION-IN-CHIEF:

MR ANDREWS: Dr Mullen, do you-----

COMMISSIONER: Mr Andrews, just before you go into evidence with Dr Mullen, there are some documents which I think I should make public. It is an exchange of e-mails between me and Ms Deanne Walls of Rockhampton and a letter from me to the Premier. The point of the exchange is that Ms Walls inquired why I was not examining Rockhampton hospital fully having been told by Mr Schwarten, her member of parliament, that it was a matter for me. I clarified with her that the matter was not one for me but for the government, that it was outside the terms of my inquiry as I understood them and that, in effect, she should take the matter up with the government, and I then wrote a letter to the Premier explaining why I had done that and indicated the possibilities for change that might exist. I'll tender that bundle of documents as an exhibit and they will be Exhibit 369.

ADMITTED AND MARKED "EXHIBIT 369"

COMMISSIONER: Thank you. Yes, Mr Andrews.

MR ANDREWS: Mr Mullen, do you retain a copy of your statement?-- Yes, I do.

Would you look, please, at paragraph 23?-- Yes.

You see that you've discussed there an incident without naming

a particular patient?-- That's right, yes.

And in it you recall some details with respect to the patient and a conversation that you had with Dr Sharma?-- Correct.

I'd like to ask you, in the meantime have you had some recollection as to who the patient was?-- Well, I had some knowledge of one - one patient whom I thought it may have been, however, on chasing that chart, it turns out that patient was a patient with a similar problem with a similar complication during surgery but it was the - a different patient. We've made attempts during the week to find that chart. I believe it may have been located but I haven't had access to that chart to date.

Thank you. In the circumstances, I will tell you some of the recollections that Dr Sharma has with a view to asking you whether they provoke any better memories for you. You will see you describe that patient between paragraphs 23 and 26?-- That's correct, yes, I did.

Dr Sharma recalls an incident, and it may or may not have been with respect to this patient because, as you say-----?-- Yes.

-----you can't identify the person?-- That's correct.

But at the transcript at page 5698 at about line 23, Dr Sharma observed, "I was not the surgeon but I was scrubbed for the case - that was not done by Dr Mullen, it was completed by Dr Krishna actually. But this patient had other injuries that I think - which was late in the afternoon, Dr Mullen was on-call and he did take over the management of the other part of the injury", and then at about line 35, "I mean, the reason I said yes" - meaning the reason Dr Sharma expressed concern about the lack of supervision. "The reason I said yes was because this was a procedure that I have never done before so I would definitely have got somebody in to do it for me and to show it to me. But, again, I assume that as Dr Krishna has been working in this country and he had done that procedure, so he did it, and I wanted to have a look at it too so I was in theatre assisting him." Now, that recollection of Dr Sharma's brings to mind two matters that don't appear in the outline in your paragraphs 23 to 26. The first is that while Dr Sharma was scrubbed for the procedure, it was Dr Krishna who performed it. Now, do you have a recollection of a procedure where that was the case?-- Yeah, I do. The situation that developed that evening was that I had been operating at the private hospital during the day and I was on my way home in my car and I received a phone call from the Medical Superintendent of the hospital asking me to please assist in a case, which was being performed at the hospital.

Medical Superintendent being Dr Hanelt?-- Dr Terry Hanelt. Because there were concerns, because the theatre sister - and at the time I think I remember it was Sister Liz Wilmott, was concerned about the progress of the case as it had started roughly 1 o'clock in the afternoon and had been going all afternoon and there had been concerns about the patient in that there had been problems with some reasonable blood loss

and there was a problem, an intraoperative fracture that occurred during the procedure. And so, the patient was - was still in the operating theatre and I think I was - I may have been on-call that evening. I often was one evening a week. And so, I agreed to attend the case, which was my responsibility. So I arrived at the theatre complex and the patient was anaesthetised and Dr Krishna and Dr Sharma were doing the case. Now, I don't know how the arrangements were in terms of who was the primary surgeon because I hadn't been involved in organising that, that was Dr Naidoo's responsibility, but there was a fracture of the femur which had occurred during placement of the nail which had been put in place and I think they were completing that by the time I arrived with putting some screws into the femur. The patient also had a fractured ankle and because of the extended period of time the patient has been anaesthetised and the blood loss, I thought it was best that I fix the fractured ankle as quickly as possible to get the patient back to the ward because the anaesthetist were concerned about their temperature and their general condition. So that's what I did. At the time, my concerns with that situation were - were more again not to do with the fact that the case was being done and that a complication occurred. I have been involved in cases myself where a fracture has occurred whilst nailing a femur and that's not unexpected. The problem is that the selection of device to use in that particular situation was in my opinion inappropriate, mainly because the device was a newer device which requires greater skill to place, which often needs two assistance because there is no external support to hold the patient in place.

What was the device?-- It is recalled a retrograde femoral nail which essentially is placed through the knee to fix a fracture of the femur and normally those nails are designed for fractures for the very end of the femur bone near the knee so that you can get stabilisation easily. But this fracture was more up towards the mid part of the leg and it's difficult to do those fractures with that device and because of the type of fracture that was present, it was more likely that an intraoperative fracture would occur because of the difficulties with the situation. So my feelings were that if that device had been selected to be done for that case, given that it was difficult, I myself, and I've worked at a trauma centre, I would say from my hands, very limited experience with the device - and I have worked in a level 1 trauma centre where I used the device quite a lot - where we used the device quite a lot. I would have said that that device was the wrong selection and I would have thought that Dr Naidoo should have been supervising that situation given the complexity of the case, the difficulty with the device selected and the lack of experience of the two junior surgeons.

Let me interrupt for a moment?-- Yes.

If one was obliged to use that device, is it your evidence that two persons should have been involved in the procedure because of the difficulty in fixing that device?-- Yeah, that's my experience with that device. Because you can't use

a special fracture table to hold the leg to do - to do the nailing. You need one person who can hold the leg still to reduce the fracture and another person to place the nail. So, it is in usual practice to have two experienced people doing that case.

The next item I'd like you to clarify, you said it was Dr Naidoo's responsibility at an earlier stage in your evidence this morning. Did you mean that to indicate that you understand that during the day before you were on duty, because you were on-call that evening, during the day Dr Naidoo was the orthopaedic specialist who was on duty?-- That's correct. He was responsible and he had been contacted several times by the nursing staff during the afternoon because of difficulties that were being encountered.

How did you learn that?-- The nursing staff supplied me with that information when I arrived and I - and, again, that information was given to me by Dr Hanelt when he discussed the situation with me on the telephone.

Did anyone, either the nursing staff or Dr Hanelt, or perhaps even Dr Naidoo, explain to you where Dr Naidoo was?-- No, I didn't ask at that time because my experiences have been that Dr Naidoo was difficult to be contacting and at that time my thoughts were I needed to deal with the problem, that I - that I didn't know the patient, I hadn't seen the patient and the patient was already anaesthetised, so I think my thoughts was how I was going to deal with this problem rather than where Dr Naidoo was.

Do you recall whether you discussed this particular incident with Dr Hanelt before contacting the Australian Orthopaedic Association as you describe in paragraph 27?-- I discussed this case with Dr Hanelt the night that it occurred and when he rang me I expressed again my concerns about the supervision situation at the hospital and that I was unhappy about constantly being called to deal with problems that I hadn't been involved in from an early stage and, I must admit, I was getting concerned about issues of patient safety in the presence of these situations. Remembering, I'm only - I was only a visiting medical officer, I only had limited visiting sessions and I was starting to feel that my responsibility was becoming much larger, and I've worked as a full-time orthopaedic surgeon in a big hospital and there was no way I could carry out those sorts of responsibilities as a visiting medical officer by proxy. These were my concerns at the time and I expressed that to Dr Hanelt when I - he discussed the case with me.

Commissioner, currently paragraphs 23 to 26 of the statement have not been tendered. I tender those also in Exhibit 330.

COMMISSIONER: Yes.

MR ANDREWS: Would you turn, please, to paragraph 31. Dr Mullen, paragraph 31, do you understand that - I beg your pardon. Is it your recollection that it relates to a child

P434? -- That's right, P434, yes.

Now, you were good enough to give to the inquiry while you were in the witness box the other day a bundle of notes that you'd retained with respect to a number of patients?-- Yes.

Do you have a copy of that or would you like that bundle for the purpose of refreshing your memory?-- I have - I have a copy of those, thank you.

You say about this patient that, "There was a poorly treated distal radial fracture", that is a wrist fracture, "with a lack of supervision in the after care." Now, is the problem for this child the after care or the initial surgical treatment?-- No, this child - I actually performed the surgery on this child initially and so this case, I believe, I wanted to discuss because I think it represented the problem that we were having in the outpatients in terms of the supervision of the outpatient clinics. This child was a 14-year-old child that had a fractured wrist from a fall and he had a fracture called a Galeazzi fracture, which is a fracture of the end of the wrist bone where the joint is dislocated. And it's quite a difficult fracture because often it leads to problems with stability of this joint and the fracture can move position over a period of time in the post fracture weeks and so it needs close supervision. I actually - when I mentioned whether I thought it was Dr Krishna or Dr Sharma who attended the child first, it was actually Dr Ali who attended the injury first who was another SMO working in the hospital system at the time and it was - the other two Fijian doctors weren't actually at the hospital when the injury occurred, or maybe Dr Krishna had just begun working there. And the child was presenting to the casualty department, had a fractured wrist. I took the child to theatre myself that evening with Dr Ali. We reduced the fracture and the child then was placed in the orthopaedic review clinic, that was my supervised clinic, on the 18th of September, which was one week later. I saw the child and the fracture was in an acceptable position. I then reviewed the child a week later to check the position. It was also acceptable. At that time I had - that was the same time that my elective work had dropped back to just on-call work, which was the arrangement which we had at that point in time, and Dr Hanelt had indicated to me that he wished me to organise my own clinics and make sure that my own clinics were properly organised once I was going back to on-call sessions only. So one of my staff in my rooms spent most of the day organising the clinics with the staff in the outpatient clinics to ensure the proper follow-up and all of my patients that were being seen at this follow-up clinic were supposed to go to Dr Naidoo's Orthopaedic Review Clinic and, indeed, that was the arrangement.

Well, as I understand your evidence then, you followed up this patient personally seven days after surgery and seven days after that?-- Correct.

Then your duties at the hospital were on-call duties only,

meaning that you'd attend, what, once a week in the evenings if required?-- At the time it was one weekend in four I think and then also one week - one week day a week was the arrangement at that time I believe.

And the inquiry has heard evidence that, usually, the surgeon who performs a procedure retains a continuing responsibility to be concerned with follow-up-----?-- Correct.

-----care of a patient. But in this particular case, did that responsibility continue with you after two weeks?-- As I say, at the two-week time, my arrangements changed and I no longer had elective clinics, so I had no more clinics to see patients in at the hospital.

In the circumstances, who had responsibility for the after care of this child?-- I believe it was Dr Naidoo, who was supervising the orthopaedic follow-up clinics in my absence, and of course the administration, to ensure that patients were properly followed up. And I had discussed this situation extensively, we had arranged what was going to happen and my girls had spent, as I say, the most part of a day making sure that these things actually happened.

With whom had you discussed it extensively?-- Dr Hanelt actually wrote a letter to me explaining to me that he - the things he wished me to do for the arrangement, for me to have a little - to have less elective work and just on-call arrangements, and he indicated in that letter that he wished me to organise the outpatient clinics and in the follow-up of my patients.

But my question is with whom did you discuss this patient. I wondered whether you, for instance, had a discussion with Dr Naidoo, well, whether it was with your own staff?-- No, no, this - at the time of the - at the time of the fracture and when the patient was seen in my clinics, I arranged for the patients's follow-up - in fact, all of my patients that were seen at my orthopaedic review clinic were then organised to be seen at Dr Naidoo's or the supervised orthopaedic review clinic in my absence.

With whom did you make the organisation that your patients would be seen by Dr Naidoo?-- Oh, I'm sorry, yeah, the girls in the outpatients, which were the administration girls, that was discussed with - my staff discussed that with them, they organised that, and we were assured that those patients would be adequately followed up through that clinic. I'm sorry, I'm missing the point, aren't I.

No, you seem to have found the point. This child's after care treatment, is it your opinion that there is something you saw in the child's ultimate condition that was caused by the after care treatment?-- Well, I believe with this situation, because I assumed that the after care at that situation when I had pulled back my elective work to on-call work, I believe that was all arranged and therefore I had no further thoughts on the matter. And then I saw the child in my private rooms

because the mother remembered me from the time of the surgery and came to my private rooms for an opinion because she was concerned about further problems the child was having at that time. And that was on the 10th of November 2003 and that was quite a long period of time after the original accident.

The hospital notes and your own notes seem to be different as to the date when this child injured himself playing Gaelic football. The notes that you have delivered suggest it was on the 11th of November 2002. The hospital notes suggest the 11th of September?-- Yes, the hospital notes would be correct because this information is from the mother and when the mother gives a history, of course it is easy to get the dates wrong and she was talking about an event that was probably nearly a year ago.

As I see your notes, you summarised in about February of 2004 that you thought the boy was suffering from subluxation of the distal radioulnar joint on the right-hand side from a malunited Galeazzi fracture?-- That's correct.

Now, was that the primary problem that you saw?-- The - yeah, that was the problem I saw the child about, that's right.

How was that related to the after care?-- The treatment of these fractures as I was alluding to earlier is difficult because the joint is unstable at the time of the injury and the fracture has a tendency to move into a less optimal position with time and one of the things that we do early on in the after care is ensure that the joint remains stable by examining it and also checking X-rays regularly to check the position hasn't been changed in an adverse way. And once I realised in my rooms that this child hadn't seen another orthopaedic surgeon through the public hospital since I saw them, I was concerned about the situation, because my whole intention of ensuring that that patient - in fact, all of my orthopaedic review patients - attended another supervised clinic was that an orthopaedic surgeon, qualified orthopaedic surgeon, would get to review these patients. As I have previously mentioned, it is a difficult fracture. It is not the fault of junior staff that they didn't recognise that the joint remained unstable because it is sometimes difficult initially, but I believe a qualified orthopaedic surgeon with experience would be able to make that determination and treatment could have been undertaken a little earlier which I believe would have made the outcome easier for the patient, less traumatic and certainly a lot easier to correct at an early stage.

What has been in your opinion the outcome for this child due to the want of an orthopaedic specialist seeing him in outpatients?-- I think in the long term, his long-term outcome will be excellent because the orthopaedic surgeon who did his care in Brisbane did a very good job at reconstructing the joint but I believe that it would have been much easier for the patient and less traumatic in terms of the size of the surgical procedure to have it corrected at an earlier time, would have been a much smaller procedure, often just requiring

a remanipulation of the fracture rather than a complex reconstruction of the joint, which was what was required to be done.

Dr Mullen, within the notes that the inquiry has custody of relating to this particular patient there are reports by you, reports by Dr Peter Rowan and a health summary which you have as a covering sheet. In so far as your own health summary and reports express opinions, are they honestly held by you?-- Absolutely, yes.

Where they recite the facts, are they true to the best of your knowledge?-- Absolutely, yes.

Commissioner, I intend at the end of the evidence, because these are all bundled together, to tender the various matters.

COMMISSIONER: Sure.

MR ANDREWS: Would you look, please, at paragraph 32 of your statement, Exhibit 330?-- Yes.

Have you been able to identify this lady?-- No, I haven't. Dr Blenkin, who is the primary treating surgeon of this lady, has been away on holiday for two weeks and his rooms are not available to discuss this matter so I haven't been able to find the name of this lady.

How is it that you're aware that Dr Krishna performed the procedure?-- The way-----

MR FARR: Commissioner, before that question is answered, if we're in no different position to last week in relation to this particular patient, in my submission evidence should not be given on this because we're in no position to cross-examine. We don't know who we're speaking of, we don't have the notes to cross-examine in that regard. And if it can't be said who the patient is, if we can't be told who that is and we cannot look at the notes, then the evidence simply should not be given about this issue.

COMMISSIONER: I appreciate you have difficulty in cross-examination about that but that's a matter you can address subject to a right to cross-examine when further materials comes.

MR FARR: The difficulty might be that we have now - well, this is the statement dated the 7th of June. He has given evidence last week. There has been a week to find this person.

COMMISSIONER: Well, it is not his fault. He has explained why he can't get it.

MR FARR: No, but the danger is that it might never occur and we might never be able to cross-examine on it because-----

COMMISSIONER: We know that the treating doctor is Dr Blenkin.

MR FARR: But we still don't know who the patient is.

COMMISSIONER: Dr Blenkin knows who the patient is.

MR FARR: Well, that might not necessarily be the case.

COMMISSIONER: I think I will let him give this evidence, Mr Farr, and if in fact that unlikely event turns out to be the case, then I will strike it from the record.

MR FARR: Thank you, your Honour.

MR ANDREWS: How is it that you know that Dr Krishna performed the operation?-- This lady became aware to me - again not because she was a patient of mine, but because of the situation at the hospital we were often getting referrals from local practitioners about patients that had been treated at the hospital for me to review them in my private rooms to give opinions because of concerns that were raised.

Did you review this patient yourself?-- I didn't see this lady myself, no. The situation was that the referral letter from the general practitioner and conversations with the patient when she was trying to make appointments with us indicated that she had had this procedure done, and again, as I say, she alleged - this is just alleged - she had not given consent for this particular procedure and she told us that Dr Krishna had done the operation for her because she specifically remembers his name.

Dr Mullen, is it the case that if I want accurate details of the procedure relating to this patient Dr Blenkin or Dr Krishna would be a better source?-- Correct, yes. Yes.

Is it your opinion that a big toe fusion is something within the competence of Dr Krishna to perform without supervision?-- Well, again, my situation is that I haven't had any opportunity to properly assess either of these men as to any competence, but I believe strongly that the level of training would indicate that this procedure is a procedure done by a very a senior training registrar under supervision or by a consultant only, because the problem with a toe fusion is that if it's fused in the wrong position it allows for very poor function of the foot, and it is actually quite difficult to get the position right. It takes a fair amount of experience to do that. So, I do believe that it should not have been done unsupervised by Dr Krishna.

At paragraph 33 do you speak of the patient P435?-- That's correct.

And you have notes with respect to that patient in your - in the bundle you supplied to the Inquiry?-- That's correct.

This was a 53 year old lady who suffered a fracture of her distal left tibia and fibula in January 2005?-- That's

correct.

The statement at paragraph 33 doesn't identify the person who performed a procedure on this patient. So I ask you, please, to look at two pages from the hospital record and tell me if they identify the patient. I see from the codes at the bottom of the page that one is page - the last three digits are page 203 and the other is page 220. Can I see the code at the bottom of that page? Yes. From page 203 one can see an operation report dated the 11th of January 2005. Does the name of the surgeon and assistant appear to be a Dr Krishna for the surgeon and a doctor whose surname begins with G?-- Dr Gamini, that's correct, yes.

-----as the assistant?-- That's correct.

And do we see the name of the patient P434 in the top right-hand corner?-- That's correct, yes.

And "very comminuted distal fibula" is your own - that would accord with your own opinion?-- Correct.

May I see the next page, please? This page of the hospital report appears to show that on the 5th of January - I don't understand the abbreviation "NSG". Do you?-- I must admit, I don't know what that means. It might mean "nursing staff" something, but I'm not sure, no.

But it seems the patient was prepared for operating theatre?-- That's correct.

But it was cancelled at 12 noon, and the patient-----?-- Correct.

-----was very unhappy?-- Correct.

Is there any indication of why it was cancelled?-- There's not - not on that page there, but on reading the charts and the notes there is information that - that the patient did tender a report to the Health Rights Commission discussing her problem and she did mention that she'd been told it was cancelled because the plate wasn't available and that the surgeon was away on sick leave or stress leave and wasn't available at the time or because they were short-staffed, and I believe that she was then delayed for a week and sent home in a plaster while arrangements were made. Again, this is all I have seen from the chart itself. I didn't actually get the history from the patient at the time.

Thank you. Now, with respect to this patient, is there anything about the fact that she was treated by an SMO as opposed to an orthopaedic specialist that you think affected her outcome?-- I do. I saw this lady in my private rooms and I would like to explain how that came about. The lady had sought a second opinion regarding her treatment at the hospital and had made appointment to see me in my rooms. Concurrently, she'd also been reviewed by Dr Simon Journeax, who was a visiting orthopaedic surgeon from Brisbane, the

Mater Hospital, and he was visiting the hospital, I believe, on behalf of the Department of Health to review patients who had surgery there and to assess their outcomes, and he had also seen that lady around the same time. When I saw her, I reviewed her X-rays and it was apparent from her X-rays that she had a very badly damaged fracture of the tibia which extended the whole way down into the joint surface and a very nasty fracture of the fibula bone which was also in many pieces. This was a fairly difficult fracture and, in fact, it has a high instance of complications associated with treatment and, indeed, it's very hard again to adequately stabilise that fracture for most competent experienced trained orthopaedic surgeons. When I looked at the technique that was used to reduce it, it was reduced to a - had a plate placed on the bones. What we know now with contemporaneous orthopaedic treatment of these injuries is that it is better not to open the fracture widely, place large plates on it, particularly given there was the delay of one week and there was swelling at that time. It would have been better to do a different technique, which we do use now where we use frames or nails to try to achieve the fixation without having to widely open the fracture and expose it to the environment with swelling and other sorts of problems. Again, that treatment as has been described, that was done. Certainly where Dr Krishna was practising in - certainly in Fiji it was - probably was standard treatment because of not always having access to these things.

Do you mean-----?-- Using a plate on the tibia bone.

Yes?-- It's not something we routinely do now and certainly it's something which has been out of favour in most places for quite a period of time. Again, the situation became difficult because Dr Krishna was the only person looking after that lady from the time of her admission to the time of her discharge from hospital. There was no covering orthopaedic surgeon to get advice from or to give advice on the treatment of the fracture initially, and that's again my concern for this case, is that this lady had a very complicated fracture, has a known high complication rate, and the technique that was used was, I think, less than ideal, and then she developed complications from that, which could well have happened at any time to anyone, but indeed there was no-one to get advice on when those complications occurred.

Do you mean had there been an orthopaedic specialist either performing the procedure or supervising it, that the risk of complication for this lady would have been lessened?-- I believe so, because I believe a different technique would have been used. I believe that the patient would not have been delayed a week for surgery, and I believe that in the early phases of her post-operative care when she developed her infections, earlier aggressive treatment of those infections may well have prevented her recurrent infections. Those recurrent infections delayed her having any further surgery for her fracture, which wasn't healing, and it wasn't until I saw her and Dr Journeaux saw her and we were both of the same independent opinion that this lady needed to have further care

and we organised for her to be transferred to the Limb Reconstruction Unit as Royal Brisbane Hospital where these difficult cases are undertaken.

Can you contrast, please, the likely outcome which would have ensued if the lady had a treatment with the supervision of an orthopaedic specialist and the outcome which she now has?-- In my opinion, my treatment - my treatment would have been to put an external frame on the injury immediately to avoid damaging the soft tissues. There would have been no incisions or minimal incisions around the fracture site. The risk of infection would have been far less and if the fracture wasn't healing at an early stage, because of the absence of infection, I would have been able to go and do something about that early, such as a bone graft or some other technique to stimulate healing.

Is the lady likely to have more disability than she otherwise would have suffered?-- If the fracture is treated now, which it is being done, then - and she gets a good outcome from that, then she may well have no further disability.

Has the further treatment that you are speaking of been necessitated because of the method used when she was treated in January?-- I believe that the fact the fracture has not healed in six months is strongly related to the type of fixation that was used and the technique used to achieve fractured limb-----

Bearing in mind it's possible Dr Naidoo, the Director of Orthopaedics, was on leave at the time that this procedure was performed, what ought to have happened when this patient presented in the Fraser Coast region?-- Well, I believe that this - without the presence of an orthopaedic surgeon to supervise, the patient should have been transferred to another unit where that care and supervision was available. There was a one week period where the fracture was not treated and that was adequate time to arrange transfer to another area.

Now, when you say she should have been transferred to another area, I don't know whether you are talking about best practice or reasonable practice. Was it unreasonable to leave her for treatment at the Hervey Bay hospital by an SMO?-- I believe it was unreasonable, yes.

Do you mean that the reasonable conduct of the hospital ought to have been for her to have - her transfer to have been arranged?-- Correct, yes.

And whose responsibility is that in the absence of a Director of Orthopaedics?-- Well, I believe it would have been the responsibility of the administration staff, the Director of Medical Services, or his locum, his or her locum at that time.

At paragraph 34 is it P436 of whom you speak?-- That's correct.

Perhaps before I go to that, in your bundle of documents you

have about P434 and, indeed, about P437, P430 and P434-----?-- Correct.

-----reports and/or health summaries written by you. Do they - where they express opinions, are they honestly held by you?-- Correct.

Where they recite facts, are they true to the best of your knowledge?-- Yes, they are.

Now, with respect to P436 , paragraph 34 speaks of there being no supervision in the outpatients by Dr Naidoo. Well, bearing in mind that you say that Dr Krishna carried out an unsupervised procedure, whose responsibility would it have been to follow up the patients - this patient in outpatients?-- Again, the responsibility of follow-up is the surgeon who performs the operation and, indeed, in a situation where supervision is supposed to be carried out it would be undertaken by the surgeon with supervision of his outpatients clinic. So there should be supervision of that procedure the whole way through from time of surgery to follow-up. But it is certainly important for a doctor to - who carries out the operation to have some input into the post-op care if possible.

The hospital note suggests there was an acute admission for this patient on the 26th of March 2004. You wouldn't disagree with that date as being his date of admission?-- That's correct.

And the fixation of his fractured hip, you say, was inadequate. Can you explain-----?-- The injury that occurred to this gentlemen was more than the normal injury that occurs to a person who falls over at home and breaks their hip. Most people fall from a standing position and fall on to their hip. So it's a low velocity injury. This man fell four feet from a boat ladder. He's a heavy man, about 107 kilograms, so there was a large amount of force involved in the fall. So this fracture which was what we call a subtroc anteric fracture, which is a fracture at the point where the hip bone meets the thigh bone, and it's a dangerous area because it's very difficult to get fixation there. Often fixation failure occurs and there are different techniques that have been designed to try to deal with that problem to try to achieve stable fixation. This fracture was also comminuted which means it had multiple fractures, and the man was very heavy. So the warning bells go off in that situation that that fracture is going to be far more difficult to pick than a simple fractured hip in an old lady from a nursing home. And when I reviewed the X-rays, when I saw Mr P436 in my private rooms, the X-rays to me indicated that the type of fixation used was very inadequate. There was only four screw holes in the plate to fix the bone to the shaft and in this situation if that technique was going to be used, you would need between eight and 12 holes on the femoral shaft to get good strength on the bone. Additionally, there are some different techniques that are now available to deal with that problem that don't require plating such as nailing procedure.

COMMISSIONER: You say "now". Do you mean at the time of this operation?-- At the time the operation was done, yes, that's right, Commissioner, and those techniques were probably better suited to this situation with a very big man who's very heavy with a very unstable fracture, and they would have been a better choice initially and I believe would have had a lot to do with preventing his ongoing problems.

MR ANDREWS: What are those techniques?-- As I say, either using a very long plate, which has a different type of screw into the ball of the femur which gives better fixation so that the fracture can't move as much, or using a big long nail that goes into the canal of the bone that can give more stability and they have been designed for these particular situations.

In your notes it appears your diagnosis was a right nonunited proximal femoral fracture with femoral head osteonecrosis collapse and osteoarthritis?-- That's correct.

If there had been an orthopaedic specialist supervising or performing this procedure - I beg your pardon, the surgery that was required for this patient, what are the prospects that there would have been such a diagnosis after the procedure?-- It's my experience with these fractures that even with high level care and appropriate devices there is still a chance that that fracture may not heal. However, the literature shows that the incident of not healing is far, far lower when you use these devices in the appropriate situation and, indeed, they are designed specifically for this problem because of the problems we know that we do encounter with the fracture not healing. So I believe that if an orthopaedic surgeon was present to at least again give advice about the type of technique and the type of structure that was required, it would have been much gentler on the surgeon who was having to do the procedure, and again some supervision to help him through the case, I believe, may have led to less problems for this gentleman, which were quite significant for this man and required a fair amount of reconstructive surgery at a later stage.

Doctor, at paragraph 34 you say in the final sentence, "The patient subsequently required a six hour joint reconstructive surgery that could have been avoided by appropriate earlier supervision." Do you mean supervised surgery or supervision in your patients?-- I think it applies to both situations with this man, because the surgical selection was not ideal and then in outpatients this man also had follow-up once with Dr Krishna - one appointment with Dr Krishna in outpatients and there is no record that I can find that an X-ray was performed at this time. He saw Dr Krishna on the 11th of June 2004 in the clinic and he was discharged from the clinic at that time. However, he had complained about groin pain on the 7th of May in the same year in the A & E department and, therefore, had had symptoms that were concerning to him and they hadn't been addressed by an X-ray at that time that I can see, and, indeed, I then saw Mr P436 on the 8th of the 7th, which was less than a month later, and organised an X-ray

which showed the significant problem of not healing of the fracture. My point with that is again these injuries we know are unstable we can monitor them closely. If the fracture is showing signs of not healing, there is the potential before the plate fails to place a bone graft or do some procedure to encourage it to heal, and that's often not always successful, but it is an option to prevent having to then go and perform a joint replacement, which is what's happened in this situation.

I see. Yes. Do you have an opinion as to whether the - well, you - you have expressed your opinion, I see, in your statement. At paragraph 37 is the patient you speak of P437. Have you prepared a note the other day that-----?-- Correct. That's correct.

That set out at the time your opinion as to who these patients were?-- Correct.

And does that note identify that in paragraph 37?-- Yes, it does.

It's P437?-- Yes, it does.

Commissioner, I tender paragraphs 31 to 34 of the statement.

COMMISSIONER: Yes.

MR ANDREWS: Do you have with you, doctor, two documents that I handed to you shortly before you entered the witness box, being scope of-----?-- Yes, I do.

-----service for Dr Sharma. Are they both marked 365?-- That's correct.

They are, Commissioner, copies of Exhibit 365, the January 2003 versions of the Orthopaedic Surgical Services, Dr Sharma Scope of Service For Orthopaedic Trauma and the one for elective orthopaedic surgery. Have you - did I give you sufficient time to mark those procedures which you believe Dr Sharma should have been supervised with?-- I haven't finished them, no.

Commissioner, would it be convenient if at the 11.15 break-----

COMMISSIONER: Yes.

MR ANDREWS: -----Dr Mullen completed that, because I imagine I will have finished my examination-in-chief within a couple of minutes.

COMMISSIONER: All right.

MR ANDREWS: The scope of service documents, Exhibit 365, were you ever shown those or equivalent documents for Drs Sharma or Krishna?-- No, I have never seen those documents. I didn't know they existed until the Commission.

Would it have been useful for you to have been shown those?-- It would have been helpful because it could have given me some idea about what I perhaps thought they were able to do. Can I say, my problem has been that at no time was I given access to Dr Sharma or Dr Krishna to properly assess them because they were always put on call as the consultant orthopaedic surgeon the weekend after or the weekend before I was on call so, therefore, I couldn't work with them over a weekend to assess them. When I was at clinics, very rarely were they in clinics with me. Occasionally they would do a fracture clinic at the same time as I would, but they would be treating patients independently, they wouldn't work with me so I could assess them. So, there was no scope to assess these gentlemen in terms of what they could and couldn't do.

Other than by seeing the results of their procedures when patients of theirs-----?-- Correct. And yet - and yet - and that's correct. And yet there were times when I would see things that had been done where I would think that they were done very well, and I would see them in outpatients or fracture clinics. The problem was I was never there to see the procedure, I just got snapshots of these things intermittently, and that was the point I am trying to make, is that I don't believe every single thing that was done was terrible. I believe a large amount of the work performed by these men was of a good standard of what I saw, but the problem was I never got an opportunity to make an assessment, and unfortunately I was involved in some adverse things as well.

Have you ever been on a committee which has credentialed and privileged persons working in orthopaedics?-- I have never been involved in such a committee. The only time I have been involved in that process is as a supervisor sort of training registrars at the public hospital in a full-time capacity and I guess in a way I give mentor assessments of those people, so in a - in a fashion I am giving credentialing to those people, but I've never been formally involved in a credentialing committee, no.

The documents that you have before you are copies of Exhibit 365. Where they set out in detail a number of procedures they can be contrasted with, for instance, privileging somebody as generally for orthopaedic surgery, can't they?-- Correct, yes.

You, yourself, no doubt, have been privileged by others during your career?-- Correct. In fact, we have a process of mentor assessments six monthly during our training process to assess our capabilities and our standards, and that's reassessed for a four year period.

Well, as a Junior House Officer or Principal House Officer or Senior Medical Officer or training Registrar, will you have had varying privileges during your career?-- The answer to that is yes, there are differences in who will allow you to do when and what. I think it comes down to the level of confidence that the person who is supervising you has in your ability. However, as a junior member of a training program, you are universally supervised, and that's a standard process across all training.

By "junior member", you mean Junior House Officer?-- No, no, I mean a first year training Registrar in the scheme. As a Junior House Officer, then you would be supervised if possible.

And a Senior Medical Officer?-- The Senior Medical Officer is probably different. I can think of situations in Queensland where there are senior, in inverted commas - senior medical officers who have been working in the system for maybe 30 years who, through working with other orthopaedic surgeons, have obtained a high level of competence and they are allowed to work independently in a large number of cases.

Indeed, some senior medical officers are Fellows of the Royal College of Surgeons in an orthopaedic specialty?-- That's correct. There is a way of moving from a Senior Medical Officer to the college with the appropriate credentialling. The situation here, as I say, is we have a problem with uncredentialled, untested young men and woman who haven't had the opportunity to be looked at for that period of time.

Are you able to - do you have the experience with credentialling and privileging processes, either as a - as the target of a committee, or through knowledge gleaned during your time in practice - to advise whether - advise on this proposition: that when, for instance, a surgeon - I'm not speaking particularly of an orthopaedic surgeon - but when a surgeon comes to a public hospital, it's appropriate, when considering credentialling and privileging, to privilege that surgeon for general surgery and then subsequently to look at a scope of practice to determine whether there are items that would be excluded from the general surgery. So, my first question is whether you are in a position to comment on that?-- I think - the difficulty for me on that is because I don't have the experience in personally credentialling people, the whole process is not 100 per cent crystal to me, and, in fact, it is complicated, and I would find it hard.

Subject to asking Dr Mullen questions about those documents that he retains, I have nothing further, Commissioner.

COMMISSIONER: All right. Have counsel agreed upon an order of asking questions?

MR McDOUGALL: I think Mr Farr next.

MR ANDREWS: Although, I should tender that bundle of Dr Mullen's notes which he provided to the Inquiry the other day, and which the Inquiry retains custody of.

COMMISSIONER: Yes. No objection to that?

MR FARR: Commissioner, just one: I don't know whether my bundle is the same, but the first patient mentioned in the bundle that I have is one that's not been referred to at all.

COMMISSIONER: P432. That's right.

MR FARR: Yes.

WITNESS: That patient was a patient which I didn't wish to tender.

MR ANDREWS: I should exclude that patient?-- Yes, please.

COMMISSIONER: That bundle, will be Exhibit 370.

ADMITTED AND MARKED "EXHIBIT 370"

COMMISSIONER: Mr Farr, you are going to go first?

MR ANDREWS: Commissioner, again an oversight: the Inquiry has received copies of the hospital patient files in respect of a number of patients. I'll identify which ones they are that have been the subject of testimony by this witness and tender them, but perhaps I can do that after the break.

COMMISSIONER: Yes, you can do that after. Yes?

CROSS-EXAMINATION:

MR FARR: Dr Mullen, my name is Brad Farr. I appear on behalf of Queensland Health, and, of relevance for your evidence, also doctors Krishna, Sharma and Mr Allsop. Can I commence my questions of you by perhaps just trying to correct some matters that appear in your statement that might not be entirely correct so that we put the correct material and the accurate material before the Inquiry. Do you have a copy of your statement in front of you?-- I do, yes.

Could I ask you, if you wouldn't mind, please, to turn to

paragraph 5, and you speak in paragraph 5 - and I think you said in your evidence-in-chief on the previous occasion you were here - that at the time you commenced at the Hervey Bay Hospital, Dr Naidoo was the Director of Orthopaedics. I have instructions that he was appointed the Director of Orthopaedics on the 22nd of August 2002?-- The Director of Orthopaedics is a title that is used to indicate the senior orthopaedic surgeon - staff orthopaedic surgeon in the department. I realise Queensland Health has a different use for that term, but I believed at the time that Dr Naidoo was the director of the Orthopaedic Department. So, if that is the case, then that's - I'm sure that's correct.

You have been speaking of him in the context of him being the senior orthopaedic surgeon, if you like?-- That's correct, yes.

If you then turn to paragraph 15? You speak there of the reasons for your resigning from doing elective work?-- Correct.

We know from your evidence previously that the patient that you spoke of in paragraph 6 to 14 in fact referred to the year 2000, rather than 2002?-- That is - yes, that's Mrs P430?

Yes?-- Correct.

The way your statement reads is that the P430 matter preceded the resignation, if you like, from your elective commitments, but we know that there was perhaps a two year time period, or something in that order, between those two events?-- That's correct.

You resigned, you told us on your previous occasion here, for a combination of reasons, but we can date the resignation, at the very least, because it coincided with - or shortly thereafter the birth of your second child?-- That's correct, yes.

If I were to suggest to you that your resignation was effective from the 30th of September 2002-----?-- That would be fair, yes.

That would be correct?-- Yes, that's right.

Now, in paragraph 16, you say, "About six or nine months later, I approached Dr Hanelt again and indicated I would be prepared to return.", and that you did, in fact, return to work?-- Yes, yes.

Can I suggest to you that the period of time between your resignation and your return-----?-- Yes.

-----was 16 months?-- Could well be. Absolutely. It's - as I say, time goes very quickly. It could well have been 16 months. Absolutely. I think I returned, actually, in February 2004.

Yes. In fact, these dates might assist you?-- Yes.

4th of February 2004-----?-- That would be right.

-----for out-patients?-- Exactly so. It was 16 months before I returned to out-patients.

And 15 March '04 before you returned to elective surgery?-- That's correct.

If we then go to paragraphs 17 and 18, you say when you first went back - that would seem to refer to after this absence?-- No, that was the time - no, no, that was the time I went back once I changed my on-call arrangements; in other words, when I went back to doing just on-call and no elective work. So, that was around about September 2002.

Right. But in September 2002, we know that the 30th of September was when you stopped your elective surgery?-- That's correct. And that was around about the time, I think, that Dr Krishna arrived at the hospital.

Yes. The concern - if you look at your statement, you will no doubt agree with me - it would seem to read that you resigned from elective work, you were away for a period of time, you returned, shortly thereafter you were spoken to by Dr Naidoo who tells you of the imminent arrival of two Fijian doctors?-- That's not what I meant by saying that. What I meant was I took away my elective work, I did on-call work. When I returned to do just on-call work, Dr Krishna and Dr Sharma had just started to arrive.

All right. So, by February 2004, Dr Krishna had been employed at the hospital for about 18 months or so by that stage. If I put to you he started 22 July '02?-- When I returned in February 2004 doing elective and trauma work.

Yes?-- That's correct.

Dr Sharma, I understand, started on 6 March 2003. Does that accord with your understanding?-- That's correct. About early 2003.

He was there probably 11 months prior to your return to elective and trauma work?-- Return to elective work, yes.

Okay. Now, can I take you to some particular cases that you have spoken of?-- Yes.

And can I take you to paragraph 31, which is the paragraph that deals with the patient P434?-- Yes.

Now, this was a - I note that your statement is dated the 7th of June 2005, and I see that it was witnessed by a Mr Raymond King, who I think is one of the Commission of Inquiry investigators?-- Yes.

I take it he sat down with you and assisted you with the compilation of your statement?-- Correct.

And I dare say you would have been advised that it is important to be as accurate and as truthful and as thorough as you possibly can be?-- Absolutely, yes.

And no doubt you attempted to do so?-- Bearing in mind I was giving my statement from my rooms with no access to the public hospital charts.

I was going to confirm that with you. Your statements would have been taken from memory?-- Correct. Pretty well from memory, yes, and some simple recording that I made along the way, but you are quite correct, mostly from memory.

From memory. And you were giving the information contained therein, obviously, to the best of your memory?-- Correct.

You, I dare say, would have been careful in the choice of the words that you used when giving a statement to a Commission of Inquiry investigator to attempt to convey their true and correct meaning?-- As careful as possible, yes.

Now, in relation to this young fellow, you say that there were, in paragraph 30, a number of other incidents involving the two doctors-----?-- Mmm.

-----and the lack of supervision and interference by management that drove you to make contact with the AOA?-- Correct.

You then go on to speak of P434, and first in order?-- Correct.

P434 - I take it that case does not come within the "interference by management" category that you-----?-- No, not at all, no. Not at all.

-----qualified the statement by?-- Not at all.

You commence your statement with the sentence that, "It was a case of a child with a poorly treated distal radial fracture."?-- Correct.

"With a lack of supervision in the after care."?-- Correct.

Now, the poor treatment that you speak of in that statement, was that treatment in the after-care process?-- That's correct. The treatment starts at the time of the surgery and ends at completion of the patient's recovery, so the treatment I'm talking about is the after-care phase - in the out-patients.

All right. The original attendance upon the child would be on the day of the injury and the presentation to hospital; you would agree with that?-- Correct.

The original treatment would be the correction of the injury, and, in this case, it was a treatment that was performed by yourself?-- So, the beginning of the treatment was the fixation of the fracture by closed reduction. Correct. That was the beginning of the treatment phase. It wasn't the after-care phase.

I understand. You said in paragraph 31 this: "I'm not sure which of the two new doctors attended to this injury originally, but the child was treated in an unsupervised clinic that I'm aware of and I know that Dr Naidoo did not supervise that clinic."?-- Correct.

You seem to be suggesting that you were not sure which of the two Fijian doctors, Krishna or Sharma, was the treating doctor at the original presentation?-- Not at all. If you read the chart at the time of presentation to hospital, the Senior Medical Officer saw the child in casualty for the first time and attended to the injury in casualty. In fact, the treating doctor in casualty that attended to the injury was Dr Ali, who was also another overseas Senior Medical Officer that was actually working in the hospital at the time. So, I was of the impression that it was Dr Sharma or Dr Krishna when I was giving this recollection. In fact, it was also Dr Ali who was there at that time.

The original injury that brought this boy to hospital was on the 11th, I think - my learned friend may have already spoken of the date of his admission - 11 September 2002?-- Correct.

So, we know that that was approximately 16 months before Dr Sharma even commenced at the hospital?-- That's correct, yes.

When you made this statement-----?-- Yes.

-----working from memory-----?-- Yes.

-----had you forgotten that you were the doctor who treated the child?-- No, not at all. I knew I had treated the child, because the reason that this case made it here for discussion was that the mother presented to the private clinic and she had remembered me from the time of the original reduction of the fracture and so I knew I treated the child. I just couldn't remember what happened with follow-up, because you can imagine I'm the - I'm seeing this patient in my private rooms some 12 months later or longer, and I couldn't understand how the fracture had ended up with an unstable distal radial-ulnar joint, because it appeared as if the follow-up should have been complete, and it was only then that I started to wonder why the patient had gone so far without any further care. That was the situation that arose, yes.

What, therefore, was the poor treatment that you speak of in paragraph 31?-- Treatment, as I say - the definition of treatment is the care of the patient from the time of the surgery to the end of the after care. So, I'm talking about, as I say in my statement, the treatment in the after-care

phase, and that is in the Out-patients Department.

I understand - and please correct me if my understanding is wrong - but I understand that in almost all surgical procedures, the most important and the most crucial post-operative period of time is the immediate time after the surgery, within a few weeks. That's the most crucial; is that correct or is that incorrect?-- I don't think it is incorrect at all. I think that is fair comment. However, I would say that there are selected injuries in which the care of the patient in the intermediate phase becomes more important, and this is one of those injuries where the instability of the joint and the further loss of reduction doesn't occur in the first couple of weeks, it develops in a period of sort of between six weeks and perhaps 12 weeks, and that period is just as important in the care of this particular injury, but I do agree that in a lot of situations, the acute care in the first few weeks is important.

And we know from your own evidence that the first two follow-up consultations, post-operatively, were conducted by yourself?-- Absolutely, yes.

They being on the 18th of September and the 25th of September?-- That's correct.

So, I think a week and two weeks after the operation?-- Two weeks after surgery, that's correct.

He, at the time of the operation, was assessed as having a five degree angulation?-- Less than five degree.

Less than five degrees. You are quite right. Less than five degree angulation, which was within acceptable limits?-- Five degrees is the accepted normal limits of alignment when you are dealing with this fracture, yes.

And I understand - and again please tell me if I'm wrong - but I understand that the measure of degree of angulation is not necessarily precise to the degree, it can have some give and take, depending upon the nature and skill of the X-ray operator, the position of the hand at the given moment when the shot is taken, that type of thing can have an impact?-- Absolutely true; however, there are several studies now to deal with spinal surgery where it has been shown that inter-observer error, when it comes to measuring angles, is very accurate within three degrees.

Right?-- So, you have an error factor of plus or minus three degrees that would be acceptable.

So, do I understand you to say from that that if a subsequent X-ray was taken and it showed a degree of - an angulation of eight degrees, given that it had been something less than five, a competent practitioner might look at it and say, "Well, this is within acceptable limits, but we might look at it again in a period of time."?-- That's absolutely true.

If it was something like 15 degrees, then that would be a clear indication that something was amiss?-- Correct.

Thank you?-- Can I just add to that, please, that the measure of angulation in this fracture is not the most important factor.

No?-- The stability of the joint is the most important factor, and that is a clinical examination.

Certainly?-- So, the measure of the angulation is very important, and certainly has variability, but when it comes to the assessment of this injury, it is the clinical assessment of the joint stability at the time of follow-up, and it is actually difficult sometimes to assess that joint, and that's why I feel that for these junior doctors, that would have been a very hard decision to make clinically.

I take it that the degree of angulation is something that can be taken into account when assessing stability. It is one of the matters?-- No - yeah, the angulation has a relevant feature to stability because the angulation can change the configuration of the joint, that's correct.

Can I word it this way - and perhaps more appropriately - if there is a significant change in the degree of angulation, beyond the three degrees that you spoke of, that might be something that a practitioner would take into account when attempting to assess stability?-- That's true, and I would believe, too, any change in measurable angulation over a period of time would make you look at the joint stability.

Certainly.

COMMISSIONER: But examination would be necessary in any event. So, you may have no noticeable increase in angulation, but examination may show instability?-- That's correct, Commissioner. That can happen, yes.

MR FARR: Now, can I ask you, if you wouldn't mind, please, to have a look at these documents. We can put them on the screen.

COMMISSIONER: Perhaps while you are doing that, I might have a brief adjournment.

MR FARR: Certainly.

THE COMMISSION ADJOURNED AT 11.24 A.M.

THE COMMISSION RESUMED AT 11.40 A.M.

COMMISSIONER: Yes, Mr Farr.

MR BODDICE: Thank you, Commissioner.

SEAN ANDREW MULLEN, CONTINUING CROSS-EXAMINATION:

MR FARR: I'm just going to ask you to have a look at a couple of documents from Brendan's file and I understand these documents will be on that file when it's tendered. Would you mind having a look at them in the order that they appear there. These are the outpatient notes. The first page I think will show us the first two post-operative attendances which you conducted?-- Yes.

And if we move down the page, you will see the 25th of September and the highlighted section which I put in: "X-ray less than five degrees of dorsal angulation"?-- Yes, correct.

If we then move on to the next page, thank you, we will see that the next consultation was the 23rd of October?-- Yes.

Which I think was consistent with the last entry of your notes, "Review in month's time"?-- Yes.

Now, you didn't conduct this consultation?-- No, no.

Do you know whose signature that is?-- Yeah, that's - I think that's Dr Ali, who was the doctor who assisted me with the operation who was one of the Senior Medical Officers at the time who has since left, yes.

Right. Okay. Again if we move down we will see another consultation on the 6th of November '02 by someone called Bacon?-- I don't know that doctor at all.

And then we have the 29th of May 2003?-- Correct.

And I think if we go over the page where the signature would appear, that might be the signature of Dr Sharma?-- That is Dr Sharma's signature.

Right. And then the final entry is the 16th of June 2003?-- Correct. Correct.

And, again, that is the same signature?-- Correct. Yep.

And can we take it from those dates-----?-- Yes.

-----that these were the dates that the child presented for review if you like?-- Correct.

Okay. And we know, therefore, that there was that gap between I think November '02 and May of '03?-- Correct, correct.

Then in June of '03, so about a month after the May consultation, he was back again. It speaks of - now, you might have to assist me in the interpretation of these notes as best we can?-- Yeah.

But I take it the first part of the 16th of June entry says, "X-ray shows"; is that what that abbreviation means?-- That the fracture - yeah, the abbreviation means fracture. Do you want me to-----

Yes, that would be helpful?-- "Had healed in about eight degrees of angulation".

All right. That eight degrees of angulation, it would seem to fall within that - the plus or minus that you spoke of earlier?-- Correct.

Then we see in the highlighted section, "Has discussed these", something?-- "These X-rays with Dr Naidoo on the", something, "of '05" and he thought it-----

COMMISSIONER: 24/05?-- 24/05 and he thought it something, something, and I can't read - the rest of it is very hard. Something he would remodel - he would remodel.

MR FARR: And in the last couple of lines, can you-----

COMMISSIONER: Something implant, is it?-- No, there wasn't an implant in there, Commissioner.

No, no.

MR FARR: The last line might be, "See one year"?-- "See one year." It was definitely "see one year" because the mother told me when I saw her that she had been told that she would be seen in one year.

All right. The date - that looks like "24/05". It might well be 29/05 given the 29th was the date of the previous consultation?-- It could well be or it could be the 24th.

And we're dealing - we must remember we're dealing with photocopies here?-- Oh absolutely, yes, yes.

Now, the entries in those pages however would tell us it would seem two things: firstly, the first involvement of Dr Sharma in this particular case-----?-- Yes.

-----was the 29th of May 2003?-- Correct.

Which is about nine months after surgery?-- Yeah, that's correct.

So he really comes into it well down the track, doesn't he?--

He does, and can I make a comment on that just briefly when you mention that? Can we go back and just look at something?

The previous page?-- Yeah, just the previous page, I just want to make this point, which I was trying to make. If you look at the heading of the clinic that Dr Sharma was doing, that was the Orthopaedic New Clinic, which means he was on his own consulting on new patients in an orthopaedic clinic and given that he had only just arrived in the country and was working in the hospital, I felt again, that's my point, that was very unfair to expect him to do that clinic in that situation.

All right. So we know that his first contact is about nine months after surgery?-- Correct.

Which is a considerable time post-operatively?-- Absolutely, yes.

And if we then go to that last page again, thank you, what we do know, according to the records, is that Dr Naidoo had some supervisory role, to what degree we don't know but some supervisory role in that it is clear that this case was discussed between them as to what might be the appropriate approach to take?-- Correct. Can I say though that, as we mentioned before, to discuss this case with someone at a distance who hasn't examined the distal radioulnar joint and to say that a 14 and now 15-year-old boy will remodel their radius are two statements which are incongruous. It is not possible to give a proper consultation and decision regarding that fracture without seeing the patient and actually looking at them, and I would contest that remodeling at age 15 in a boy is very minimal.

All right.

COMMISSIONER: So your criticism as I understand it, Doctor, is not so much particularly about Dr Sharma?-- Not at all, Commissioner.

But he has been in a position where he has to make these assessments unsupervised by an orthopaedic specialist?-- Absolutely, Commissioner.

Yes.

MR FARR: All right. I'll have those documents back. Thank you. Now, you saw Brendan for the first time as I understand it on the 30th of October 2003?-- 30th of October, that would be the date - you mean, in my private rooms, sorry?

Yes?-- Yes, in my private rooms that's the first date, yes. Let me just double check.

Certainly?-- That's right. That looks like the first date, yes.

And it was at that stage that you ordered some X-rays to be taken?-- Correct.

And those X-rays revealed that there was then 15 degrees of dorsal angulation?-- Correct.

All right. Thank you. Now, can we move on to paragraph 33. That's P435 ?-- Yes.

I suppose just for the record I should ask you this before we do move on to Ms P435 ?-- Yes, yes.

It is quite apparent, having been through the records now-----?-- Yes.

-----that the patient P434 has no relevance to Dr Krishna?-- Absolutely true, yes.

Thank you. Moving on to P435 , now, as I understand the complaint as you voiced it today, your particular concern was the nature of the surgery that was undertaken?-- Correct. And the fact that there was a necessary delay in further treatment because of the type of treatment that was undertaken early on.

All right. So there's two features to it if you like?-- I believe there is, yeah. I think that the way the fracture was treated initially and then the slow response to the developing complication delayed the possibility of having further intervention till much later than we normally would have liked to have done.

We know that in this case the injury occurred on the 4th of January 2005?-- That's correct.

There were - I think my learned friend Mr Andrews took you to this. There was a delay whilst the appropriate materials were brought to the hospital to use for surgical purposes, the plates of a particular type?-- That's correct. I didn't get that history from the lady herself. I just got that from the charts-----

All right?-- And as you did.

I won't put the documents before you on areas that you agree with?-- No, no.

Just to save time and paperwork?-- Yes, yes.

Did you also note from the records that the surgery had been scheduled for the 6th of January?-- Correct.

But it was delayed due to the ill health of the surgeon concerned?-- That's true. I saw that written there. Can I - I wasn't sure who that was referring to.

No. Look, I'll show you that page because you might be able to assist. Would you have a look at this page for me, it's page 221 in the file. Just to the highlighted section. You will see the date the 6th of January '04. And you'll see-----?-- Yes, I see that.

-----it was scheduled for operating theatre?-- That's right.

By Dr - now, can you understand?-- It's requires "open reduction, an internal fixation and was scheduled for OT by Dr Krishna today but", something, "away".

He is away sick?-- Sick. "Inform the patient there is"-----

I don't need to take you beyond that passage for a moment?-- Yes, yes.

But is that your understanding, a reference to Dr Krishna?-- I believe so, yes.

So it may be that Dr Krishna was a person who was sick on that occasion?-- It could well have been, yes.

It then seems to speak of the fact that there is another case that had to be of priority and that had to be explained to Ms P435 ?-- Yes, yes.

And was subsequently rescheduled to the 11th of January?-- That must be the explanation of someone being sick.

All right. I'll just have that returned. We know from evidence that we have heard that Dr Naidoo took some form of extended leave, I don't think we have heard what type it was but some form of extended leave some time in January 2005?-- I have no idea of that, I'm sorry. I don't know when Dr Naidoo was on leave unfortunately.

Do you know Dr Kwon?-- I do know - of Dr Kwon. I met him once or twice at the hospital.

Now, the inquiry has heard that Dr Kwon was appointed the Acting Director of Orthopaedics-----?-- That's correct.

-----for Hervey Bay. The evidence I think we have heard is that occurred some time in January this year until his resignation perhaps some time in June?-- Can I say that I - just again, I haven't got a clear record of this but my understanding was that Dr Kwon didn't really start working at the hospital to the very end part of January 2005. He was not working at the hospital the very early part of January.

All right. I don't have details to give you on that?-- That's my understanding because I remember when he arrived, yeah.

No doubt that can be checked and I take it that's just to the best of your recollection?-- That's correct.

In any event, for the majority of the time that we're concerned with the post-operative care for Ms P435, Dr Kwon would have been the Director or the Acting Director of Orthopaedics?-- Absolutely. And, in fact, Mrs P435 explained to me that Dr Kwon was extremely helpful, very sensitive to her needs, explained everything very clearly and

was involved in trying to help her through this period. Again-----

She - sorry?-- Sorry, I was going to say, again, Dr Kwon, a very good orthopaedic surgeon, provides excellent supervision for the period of his tenure but can I say that, unfortunately, Dr Kwon was not present for the first two to three weeks of this injury at the critical time when the infection developed and there was no supervision by Dr Kwon of the operation. Dr Kwon, like myself, was caught up in the same situation with having to then take over the care of a patient whom he had not been involved in the index procedure and he did have a very good job trying to deal with that problem. Unfortunately he was not able to intervene surgically with her because the infections that she developed occurred repetitively and it wasn't until very late in the piece, in fact I think he may have left by the time that Mrs P435 saw myself and Dr Journeaux and then we arranged for care and treatment. So Dr Kwon supervised very adequately through that time and helped that lady through a difficult period.

All right. So your complaint does not extend to the period of time of Dr Kwon's-----?-- No.

-----tenure at the hospital from whenever date-----?-- That's correct. It is the initial period of that operation and that initial two or three week post-operative period where there was no clear supervision for this gentlemen and they had a difficult problem they were dealing with at the time.

All right. Thank you. Do you also understand it to be the case that whilst Dr Kwon was the Acting Director, that he would attend upon Ms P435 frequently with Dr Krishna-----?-- Correct.

-----and both of them would discuss issues with her?-- Absolutely. Mrs P435 told me that herself, that Dr Kwon would ask Dr Krishna questions about the case and try to help him understand the situation and would take him through the situation fairly clearly and she felt that there was a lot of teaching going on between the two of them during her time at the-----

Was she aware that Dr Kwon was the senior person of the two or-----?-- She-----

I get the flavour that she might have thought it was the other way around?-- I think her impression initially that I got, she thought that Dr Krishna, when he came, was the orthopaedic surgeon because when he presented to casualty to see her on the day of injury, the nursing staff had told her that, "Your orthopaedic surgeon would be here to see you soon." When he arrived, she assumed he was the orthopaedic surgeon and from that point on I think she was confused about the relationship.

Right?-- But Dr Kwon was definitely the supervisor at that time.

Yes, thank you. Now, can I ask you to explain this entry for me, if you would. This is page 211 of the file. It would appear to be an admission form. Perhaps admission and discharge?-- Correct.

Relating to, you can see there in the centre of the screen, the 4th of January?-- That's right.

Which we know is the date of the accident?-- Correct.

On the right-hand side we can see the treating doctor is Dr Naidoo?-- Correct.

I take it you have seen these forms before?-- Yes, I have.

Now, that form, what is that supposed to mean when it says "treating doctor"?-- These forms are - you're quite right. These are very ambiguous forms because what happens is the staff within the - and, again, this is to the best of my ability but I believe I understand this. The staff who are doing these forms in the administration area are told that the person - I think the person who admits the patient - sorry, I will start again. The person under whom the patient is admitted will be the supervising surgeon. So they have a list of supervising surgeons and, indeed, Dr Krishna and Dr Sharma would never appear in that box independently. It would be myself, Dr Naidoo, Dr Kwon when he was present. So if Dr Krishna looked after that patient for a period of three weeks, did the operation and supervised the after care, Dr Naidoo's name would appear as the supervising doctor.

All right. And I take it that that would mean, if that was the way things were treated-----?-- Yes.

-----that Dr Krishna for instance would have and should have the expectation that Dr Naidoo would be his supervisor and perhaps the treating doctor?-- I believe that both those gentlemen had the strong understanding that they were being supervised by Dr Naidoo.

All right.

COMMISSIONER: They must have given up on that expectation at some stage though, Doctor?-- Well, they had talked to me, Commissioner, about these problems. This is one of the things that we had come along with. Both of these gentlemen had talked to me in private in situations where they had shown concerns. That is one of the reasons why I had been so aggressive about trying to get this situation sorted. Both of them were aware that they were doing things that weren't under their, necessarily, level of supervision they should be doing. Both of them were uncomfortable with the situation.

Yes.

MR FARR: All right. I will have that document returned, thank you. Now, the nature of the - the nature of this injury

is such that it's a notorious type of injury for complications, isn't it?-- Yes, it has a very high rate of complications with this injury, yes.

And non-union is one of the common types of complications?-- Yes, and non-union rates could be up to 10 per cent for this injury.

This patient had further difficulties in that there was a history post-operatively of infection?-- Correct.

And I understand that infection can also be a cause of non-union?-- Yeah - yeah, that's correct. Infection is a very common cause of non-union.

And, in fact, can occur for any number of reasons and frequently one never discovers the reason for it?-- Correct.

So here there was not only the nature of the injury itself but the further complicating factor if you like or perhaps contributing factor of this post-operative infection history?-- That's true. Can I add though that the big problem with non-union and that fracture was not the infection I believe but the fact that the bone had been stripped of all its soft tissues, which supply blood to the fracture, by the application of the very long large plate and that's one of the reasons why we don't like using that technique much anymore because if you combine taking away the blood supply of the bone and then developing a subsequent infection because of the large wound, you then have a really big problem for development of non-union.

Now, your evidence as I understand it again is that you don't offer particular criticism of the apparent skill level-----?-- No.

-----involved in the surgery which was carried out?-- No, I-----

But you do offer criticism in the sense that had adequate supervision been in existence, then perhaps a different procedure might have been carried out?-- That's correct, the procedure that was done and, again, I wasn't at the procedure but looking at the X-rays, there was an adequate reduction with the plate in the right position, the screws were acceptable, I agree with you. If you use a plate like that, then the actual reduction that was achieved was reasonable, but the actual selection was the problem.

COMMISSIONER: And it was an unreasonable selection?-- It was an unreasonable selection in that situation in my opinion, yes.

MR FARR: Is it an unreasonable selection per se or would you accept that opinions might differ on that topic?-- To put it in perspective, when I was working as the full-time orthopaedic surgeon at Princess Alexandra I never saw one of those techniques or devices inserted for that type of

fracture-----

Right?-- -----in my one 12-month tenure there, and we dealt with a lot of multiple trauma. So if you look up a text book, you will find that that technique is still included in the text book; there is always an added or addendum to indicate that it is definitely the least desirable choice.

Okay. Now, the post-operative follow-up care, I understand that she had the operation on the 11th of January, remained in hospital until the 21st of January?-- Correct.

I think during which time an infection raised its ugly head?-- And I think she had some significant blood loss from the wound.

Yes. And I understand you've had the opportunity of going through these hospital notes and-----?-- Correct.

-----you have had the chance to refresh your memory?-- Correct.

And the notes for that period of time seem to indicate appropriate and adequate care for her during that period of time?-- Yeah.

Do you agree with that?-- In terms of she was not treated badly, she had appropriate antibiotic therapy and she had elevation, all the things that you would certainly do. My only criticism of that period of time was that when an infection develops with bleeding and haematoma in an incision that's large like that with a plate very close to the surface of the skin, then it is very common practice to return to theatre early, remove the haematoma, which is colonised with bacteria, and try to clear it from the area of the plate because it is well known that the bacteria which adhere themselves to the plate in the first two-week period or, in fact, in the first several day period and if you miss that golden period, it becomes harder then to clear an infection easily and quickly.

COMMISSIONER: That's something which would be known to an orthopaedic specialist?-- Absolutely, because it's applied widely in treatment of joint replacement.

MR FARR: We know from the records she was discharged on the 21st of January?-- Correct.

And then, I think, returned some weeks after that?-- That's right. With repeated infection, that's correct.

Yes. Just on that topic, infection is also a not uncommon complication from this nature, type of injury?-- Not at all. If you treat it with open reduction, that's correct.

The period of time, then, that we're really interested in, insofar as the lack of supervision you speak of-----?-- Yes.

-----is the 11th to the 21st of January?-- Correct.

Assuming that that is the time - a time prior to the arrival of Dr Kwon?-- That's correct. On a view of the chart there is no need for - there is no need for Dr Kwon for that period of time and then Dr Kwon gets involved in caring for the infection which he does, as I say, in a very competent way.

Right. Thank you. The referral to yourself occurred about four and a half months post-operatively, I understand?-- Correct.

And can you confirm this for me, that it is not uncommon for patients who have had a procedure of this nature following an injury of this nature to be getting to the stage of seeing someone such as Dr Tetsworth? Now, just for clarification purposes, Dr Tetsworth was the specialist to whom you referred P435 ?-- Yes, myself and Dr Simon Journeaux, that's right. He subsequently referred her to Dr Tetsworth as well because of Dr Tetsworth's experience in these procedures.

Yes. I understand that often patients with this type of injury with this type of complication can unfortunately undergo a series of procedures in an attempt to correct the problems before ultimately getting to someone like Dr Tetsworth.

COMMISSIONER: You are talking - you are presuming in that question, are you, that the initial procedure is the insertion of a plate?

MR FARR: For the purposes of my questioning, the procedure which was, in fact, carried out.

COMMISSIONER: Yes.

MR FARR: Yes.

COMMISSIONER: All right. I am sure the doctor understands that.

MR FARR: Yes?-- Sorry, I have lost the track of that question.

I understand for a procedure of this type, that-----?-- Yes.

Of the type that in fact was carried out?-- Yes.

Patients often can unfortunately undergo a number of other procedures in an attempt to correct the problems?-- Yes.

Before ultimately getting to someone like Dr Tetsworth?-- That's correct. That often happens. Dr Tetsworth would probably see the majority of his patients as a secondary or tertiary referral.

Right. In the case of Ms P435, those intervening procedures didn't occur?-- That's correct.

And I understand that to be the optimal situation, if one needs-----?-- Correct.

-----to see Dr Tetsworth then one's best not to have had the intervening-----?-- That was my feeling from my private rooms that I did haven't the skill level at that stage, I believe, to give her the best chance of a good outcome compared to what Dr Tetsworth could do because of his experience, that's correct.

Thank you. All right. Can we move on then to paragraph 34 of your statement. That's Mr P436. And again I should say, I suppose, insofar as P435 is concerned, it's quite apparent that in her case Dr Sharma has no involvement whatsoever?-- Dr Sharma had no involvement.

Right. Thank you. In fact, that's also the position with P436, I understand?-- Correct.

Now, the injury that Mr P436 suffered was one that was slightly lower and slightly more unstable than normal; would you agree?-- That's correct, yes.

And the treatment that he received was the treatment that would be standard for the injury that might be slightly higher and slightly less unstable?-- That's correct.

Slightly less unstable - yes?-- The standard treatment for a normal - what we would call an intertroclea fracture, which is bit higher and less unstable, is a pin and plate with four holes.

Right?-- That's a good device and it works very well.

Okay. This was a treatment carried out - procedure carried out by Dr Krishna?-- Correct.

Once again, these are the sorts of fractures which are notorious for not uniting?-- Correct.

Or not uniting correctly?-- Correct.

Inadequate fixation can be a cause of a nonunion, but it is at times very difficult to determine whether fixation is adequate or not, as I understand it; that is, that the - if the fixation comes loose, it can happen for one of or a combination of a number of reasons?-- That's absolutely correct. Like all fractures healing, there can be many reasons for failure of fixation.

COMMISSIONER: But in this case, can you say what the failure was?-- In my opinion, this time the failure of fixation was because there was an inadequate device used on a very unstable fracture in a heavy man. That's my opinion.

And a device which an orthopaedic - a qualified orthopaedic surgeon would not use?-- No, very unlikely to use that device.

Thank you.

MR FARR: The fact he was a heavy man can play some role in the success of fixation device, can't it?-- I think it's a very important factor.

And infection can play a role in the success or otherwise of fixation devices?-- Correct. Deep infection-----

Yes?-- It's a difference between deep and superficial infection.

Yes?-- And certainly deep infection that involves the metal work, absolutely, yes.

Mr P436 had a history post-operatively of infection problems?-- He had a superficial pseudomonas wound infection, yes.

COMMISSIONER: Not a deep infection?-- No.

MR FARR: There was concern, I think at least on your part at one stage that there was a deep infection that would need to be investigated?-- I exclude deep infection before I look at doing a joint replacement in these situations because if I put a joint replacement in, it will get infected and it will be a disaster. So I actually did some blood tests, which did not indicate that that was the case. I then took out the fixation and cultured the fixation and the area around the fracture and I grew no bacteria. So I made the assumption that there was no deep infection.

When did you - when were you able to form the opinion that the fixation used was inadequate?-- My opinion was - when I saw Mr P436 and looked at the fracture, when I saw the X-ray that I performed when he first saw me on the 8th of the 7th 2004, which is the first time I saw Mr P436 in my rooms, it was apparent that the screw was what we call windscreen-wipering, which means that because the fracture wasn't healing, it

appeared as if the screw was moving in the head of the femur bone...and that can indicate loose fixation. It doesn't always indicate that that the fracture hasn't healed. It may be the fracture has been loose, has not healed, and then has subsequently healed. But it's an indicator that the fracture is unstable still, and there was also evidence that one of the fragments may be a separate piece. But I must admit, even to me, it wasn't easy to make that determination and I had to see the patient twice to do that. But finally investigations and imaging indicated that it was loose and that was confirmed at surgery. But you are quite correct, the position of the device gives you clues, but it doesn't give you an absolute indication.

Okay. You mention in your statement the fact that you didn't - I will turn it up. Towards the bottom of page 6 you say, "Subsequently I was asked to see him in my private rooms nine months later"-----?-- Yes.

-----"by his GP."?-- Correct.

"At that time he had a nonunited fracture"?-- Yes.

Et cetera?-- Yes.

The period of time between operation-----?-- Yes.

-----and perhaps seeing you and then having-----?-- Yes.

-----further tests performed-----?-- Yes.

-----is that a significant period of time?-- Yes, it is, yes.

So, I take it, the longer between operation and correction, if you like, the greater the potential danger for being not successful?-- I think that's right. I think the longer the time the patient has a nonhealed fracture, the greater the chance that the fixation method will fail.

All right?-- That's correct.

So I take it from what you have said nine months is a reasonably substantial period of time for something of this nature?-- Correct.

And then there would be the additional period of time after he first sees you before whatever is ultimately done is done?-- That's right. There was - we - that's right. Because then we took out the metal work and removed all that, allowed the wound to heal, planned for our revision procedure, and then I think it was some time, three or four months later we replaced and did a major femoral acetabulum, which is the cup, the femur reconstruction, which took about six hours.

So, for instance, if you'd seen - with the same problems - but if you'd seen Mr P436 months earlier, then perhaps his - the subsequent treatment might have been less radical or less extreme?-- That's the point I am making. It's just that if

the patient is seen at six weeks after surgery or eight weeks after surgery and an X-ray is performed and there is evidence then of the fracture not healing, it is a very good sign that either the fracture needs to be watched closely or bone grafting or something additional needs to be done then, because there is a chance if you get in early before the fixation fails that you may be able to salvage the situation and end up with a healed fracture.

All right. Can I, therefore, remind you of just the dates that we are concerning ourselves with insofar as Mr P436 is concerned. His accident, according to the records, occurred on the 26th of March 2004?-- That's correct.

And he sees you, on my understanding - on your records, on the 5th of July. I think you said the 8th but in any event the first week in July?-- Correct.

So that's about three months and one week-----?-- Correct.

-----after the injury itself?-- Yes, indeed.

So, the nine months that you speak of in your statement is just a mistake?-- It may be a mistake, correct, yeah, exactly, yeah.

And three months is - it's a significantly period of time when dealing with an issue of this nature, isn't it?-- It is, but again, as I say, if - in fact, it's probably more significant in a way.

COMMISSIONER: That is four months, sorry?-- Four months.

MR FARR: Three months and one week.

COMMISSIONER: 7th of March.

MR FARR: 5 to 26 March.

COMMISSIONER: All right.

WITNESS: The patient - when the patient has evidence of fixation failure at three months or four months after injury, that's even more significant that the fixation has been very inadequate at the start, because - see, very often with these fractures, if there is a fixation which is relatively stable, you can get a long period of time where the patient manages, but eventually the fixation will break because the fracture hasn't healed. But if there is gross instability early, the patient will often have evidence of loosening of the implant very early on and Mr P436 did go to Casualty once or twice and represent himself with groin pain, which was worrying him. He also saw his again practitioner several times about this groin pain and this was prior to seeing Dr Krishna on the 11th of the 6th. So, at that time I think he was probably experiencing some symptoms of early instability, and again my only comment is that if it - if Dr Krishna had been supervised, he would have had the opportunity for the

orthopaedic surgeon to say, "Groin pain at this stage is an indicator of early instability and an X-ray is needed and perhaps we need to look at doing something", and that is the - that is possibly the better way to go about things, rather than looking at having to do it later with radical surgery.

MR FARR: Even with the best minds involved and top best expertise involved, it's not necessarily the case that if Mr P436 presented one would embark upon further surgical steps?-- If Mr P436 presented at six weeks with those symptoms?

Yes, or at three months?-- Depends on time period. If Mr P436 presented at six weeks with a fracture that was showing evidence of instability, you are quite right, I am not sure that I would definitely do anything about it at that time, unless there was evidence of the fixation failing. But certainly if he still had symptoms that were no better at three months and no further indications that the fracture was progressing, I think it's important to look at the possibility of doing something at that stage.

Certainly. But even you when you saw Mr P436 -----?-- Correct.

We know you saw him in the first week of July?-- Yeah.

Then you saw him again later in July?-- Correct.

On that subsequent occasion-----?-- Yes.

-----he presented to you feeling much better?-- Correct.

His pain having subsided?-- Absolutely.

He seemed generally like things might be on the improve?-- You are quite correct. That he did. Presented, explained his pain had got better, and that's when I explained to his GP that at that time we should get some further investigations and see how things went over the next eight week period and look at those further investigations, but Mr P436 returned earlier than eight weeks.

Just short of the eighth week, wasn't it?-- He said to me he still had increasing pain again. So I think probably had a period of - I can't explain why his symptoms were different at that time. I expect he may have been certainly concerned about the severity of the operation that we were discussing for him at that time.

He was - sorry, I interrupted you. He was a man with a number of other problems, health problems?-- You mean health problems?

Yes?-- He was an acknowledged insulin dependent diabetic. He was overweight. He had some cardiac problems that were pre-existing.

All right?-- He was not a well man.

You adopted a conservative approach, and I'm not being critical in my way-----?-- No, absolutely.

-----by telling Mr P436, "Look, given that you are feeling better, pain has subsided"-----?-- Yes.

-----"we will give it eight weeks"?-- And get some-----

"If it returns come back to me"?-- That's right.

"If it doesn't, come and see me in eight weeks time"?-- That's right. We organise - that's right, we organised some tomography to have a look at his hip as well which gives you better access to the fracture and gives you more information, because I didn't want to undergo any surgery of the radical flavour we were talking about until I was really very sure, but that decision was made for me.

Tomography gives you a much more accurate information in relation to the union of a fracture, for instance?-- It does, particularly when you are dealing with a big man who has a lot of soft tissues and the fracture is difficult to visualise, tomography is a good tool to use for that, that's right.

You mentioned in your evidence-in-chief that you could find no record of Dr Krishna ordering an X-ray, I think, on the 11th of June?-- There was nothing in the chart about an X-ray. In fact, I should - I will put that differently, which is more appropriate. Dr Krishna in his notes did not indicate he had done an X-ray or reviewed an X-ray at that stage. I don't believe whether Dr Krishna had done an X-ray because I wasn't able to get those notes or charts from the hospital to my rooms, but there was no record of it.

The hospital records you have seen do show, I'd suggest, that X-rays were taken on many occasions?-- They were, yes.

I think through till about late May or so?-- Correct.

And what's occurred from, there I can't say?-- Can I say those X-rays were mostly done in the out - in the A & E department.

Right?-- Because Mr P436 would present with problems and he would have an X-ray performed by the Casualty staff.

Yes?-- And then that X-ray - because of the situation at our hospital, those X-rays are not automatically reported by radiologist. They go away, some are left. Some of them are never reported. So, those X-rays remain in the hospital system for a large period of time. Not all those X-rays are seen. so, it is possible that X-rays were done and not necessarily reviewed other than by a Casualty staff member.

I take it, though, it's also possible Dr Krishna may have seen X-rays on the 11th of June, for instance?-- Yes.

That would have been taken in late May?-- There is every possibility he may have seen those, correct.

Now, once again the surgical skill involved in the procedure which was performed, I understand, is not the subject of your criticism?-- Not at all. If that - it's the decision making and the type of fracture that was selected for application of that device.

All right. Thank you. Now, can I deal now with the incident that you speak of, I think commencing from paragraph 37, and this would, I think, seem to be an incident that doesn't involve Dr Krishna or Dr Sharma. You have detailed that, I think, on a prior occasion you gave evidence here?-- Correct.

Can I just run you by the chronology to see if you agree with this, if you wouldn't mind? You would agree with me that the operating theatre at Hervey Bay at that time at least was staffed on weekends for emergency admissions?-- Correct.

You sought to perform an operation?-- Can I - sorry, sorry, to interrupt here but it's important point. The hospital was staffed for two days. In other words, the staff were available from 10 o'clock in the morning till 6 o'clock at night. In other words, they were available for procedures. Not just emergency procedures were done during those days. Often abdominal hysterectomies from gynaecology that were not able to be done the week before were done in that period of time. They did do elective cases in that period of time because the staff were staffed from 10 till 6. So, it wasn't just emergencies, but in my point is because of what I was doing the only cases I was doing on a weekend were emergency cases.

All right. Can I suggest to you that there in fact was a hospital policy that existed at the time that weekend surgery was for emergency cases?-- The policy existed.

Are you aware of that?-- Absolutely. The policy existed, but it didn't always happen.

COMMISSIONER: You understand that practice was contrary to the policy?-- Correct.

MR FARR: When you say "contrary", I take it the practice was by and large followed, but there might be exceptions at times?-- Correct.

And those exceptions might have particular circumstances that justified the exception?-- Usually, yes, that's right.

Right. Now, you sought to conduct an operation on a Saturday and it came to your knowledge at some stage that approval for that operation had not been given?-- Correct. The nursing staff in theatre rang me and told me that Mr Allsop had cancelled the case.

All right. And you were, therefore, not present, I take it, for any conversations or information that may have been conveyed by the staff at the hospital to Mr Allsop?-- Well, more importantly, I wasn't included in any of those conversations.

No, but that's the point I am making?-- Yeah. I wasn't included. That's right. Sorry, yeah, I wasn't asked about that case and I wasn't included in any conversations that were made about cancellation.

Okay. The first that you were aware is that you were just given the advice or the information that it had not been approved, Mr Allsop said it can go ahead on Monday rather than Saturday?-- The words were not "approved", the words were that Mr Allsop has cancelled the case.

You were of the view that that was clinically not wise?-- That's correct.

There was good clinical reason to perform that operation-----?-- Correct.

-----within the 48 hours that you speak of on the last occasion?-- Correct, correct.

As I understand it, you then spoke to Mr Allsop yourself, I think it by telephone?-- Yeah, that was difficult because I couldn't get the hospital to give me access straight away to Mr Allsop, and that took quite a bit of doing.

All right?-- You are quite right, I finally got hold of Dr - Mr Allsop and we discussed the case with him.

All right. We have been using Mr Allsop for a reason. He's not a clinician?-- And to be respectful, that's correct.

In this course of your conversation with Mr Allsop, you have explained to him the reasons why you considered it is in the patient's best interest for the operation to occur as soon as possible?-- Correct, I did. I just explained that the lady was going to be compromised significantly if she couldn't have early surgery.

I don't need to go to the details?-- Sure, sure.

That was the essence of the conversation from your point of view?-- Yes, yes.

And I understand that you were told by him that he had received contrary information and the contrary information came from perhaps nursing staff and either directly or via nursing staff that an anaesthetist was of the view that it should not take place?-- That's not entirely correct. The nursing staff - when Mr Allsop talked to me about this he said to me that he had been talking with a senior nursing member. The person was not identified to me.

Right?-- That this case did not need to proceed at that time because the patient was not unwell and that this was a semi-elective case.

Right?-- But it was not indicated to me that he had discussed this with any anaesthetist or anyone else.

I'm not suggesting that-----?-- No.

-----it was suggested to you-----?-- No, it wasn't suggested to me.

You didn't let me finish. He did say to you that he had received information that an anaesthetist had said that it would be appropriate - he had conveyed to you that he had received that conflicting advice?-- Not at all. I don't remember. He mentioned to me that the nursing staff member had told him that the case should not proceed because the patient was not an urgent case. I don't remember discussing - we got on to anaesthetists when we discussed that Gerry Meijer, my anaesthetist, who asked to see the patient, had actually seen the patient and then the discussion came up that he believed that a hospital anaesthetist had also seen the patient.

All right. So, he didn't mention that to you?-- Yes, he did, but not in the same context of that discussion.

All right. But in the course of conversation, he mentioned to you that he was in receipt of information - how he got it, it doesn't matter - but he was in receipt of information that a hospital anaesthetist had thought it was not correct to proceed?-- That's correct. I do believe it is important, though, how he got that information.

No, but just listen to my question and answer it if you would? Is that correct?-- Can you repeat the question again?

He indicated to you that he was in receipt of information to the effect that a hospital anaesthetist had indicated that it was inappropriate for surgery to take place that day?-- He had indicated to me, yes, that an anaesthetist had seen the patient - a hospital anaesthetist - and indicated they would rather the case was done on a Monday, correct.

And there was, as you say, at around this time, the discussion then about Dr Meijer having had some involvement with this patient?-- That's correct, yes.

And ultimately, as I understand it, the position was that Mr Allsop was going to allow Dr Meijer to give him an opinion as to whether the procedure should take place upon the weekend or be delayed until the weekday?-- Yeah, that's correct. The conversation went that I indicated that the anaesthetist who saw the patient was a junior anaesthetist - a Senior Medical Officer anaesthetist, not a qualified anaesthetist - and that I had subsequently had a medical review of the patient done by the medical team who were actually there that weekend who indicated very clearly that the patient did not have a chest infection, they had a normal chest X-ray, and that the patient was not, in their opinion, medically unwell. So, I indicated

to Mr Allsop that I felt that I needed to talk to Dr Meijer, because Dr Meijer is a senior anaesthetist who saw the patient the previous evening, and indicated that, in his opinion, that the lady was fit for surgery and he would be happy to do the procedure.

And Mr Allsop agreed to that and do you know if he, in fact, spoke to Dr Meijer?-- I believe he did, yes.

And as a consequence, I take it, of the information that you had given him, plus whatever the information was that Dr Meijer gave to him, it was - the operation was approved to go ahead on the Sunday morning?-- Yeah, another 12 hours later, that's correct. I felt we should have been able to proceed with the surgery that evening.

Okay?-- Can I-----

But the position-----

COMMISSIONER: Let him finish.

WITNESS: Can I please finish? At that stage, it wasn't just a discussion about the anaesthetist. At that point in time I was also questioned on the type of device that I was using for that patient because of the fact that I was using a much more expensive device than would normally be used. So, that conversation preceded the conversation about the anaesthetist, and I'm sorry to be pedantic about it, I don't mean to be, but it was just that that was the course of events and that's how this thing evolved, and I said that the device was needed for these clinical reasons, and I indicated the reasons why I needed to use that device.

MR FARR: Did you use that device?-- Indeed I did, and I indicated that in the chart, and then I talked to Dr Meijer and, you are quite correct, Dr Meijer then discussed the case with Mr Allsop and I rang Dr Meijer back afterwards and he said he indicated to Mr Allsop that the case should proceed.

Just on the topic of the device, I take it you used that device with the authority to use the device?-- You mean I talked to Mr Allsop and he gave me the authority?

Yes. You weren't going behind his back when you used it ultimately?-- I hadn't actually asked him about it. I made the clinical decision initially to use the device. That's my clinical decision. He wanted me to qualify it.

That's fine.

COMMISSIONER: Did he indicate that that was a more expensive device?-- He asked why I was using a more expensive device and I indicated the reasons why, and I believe that again I - that he had been told I was using that device by the nursing staff who I had booked the case with, and I think there were concerns about costs, yes, and I don't have a problem with that. That's fair.

MR FARR: The position that would have confronted Mr Allsop, if we can try and put ourselves into his shoes for a moment, from what we understand, is that he would have been, it would seem, in receipt of some degree of conflicting information of a clinical nature from yourself and perhaps from the staff anaesthetist - whether that was direct or indirect, it doesn't matter - but there would have been some degree of conflict?-- Can I just agree with that at the end? Can I suggest that he had no conflicting information available to him when he cancelled my case. He only had one side of the story and-----

And one side of the story-----

COMMISSIONER: Let him finish.

MR FARR: Sorry?-- That was the thing that upset me and made me uncomfortable about this was the fact that I - I had no problem with being contacted about a case to discuss the situation, and that's open and clear, but the problem was that the unilateral decision was made on information from a nursing member who had not visualised the patient or discussed it with me, and then - the only way the case was going to proceed was if I took it up with Mr Allsop and quite forcibly put my case forward as to why I should do the case.

What you are really saying, though, is that you think it would have been better handled if he had, in fact, contacted you and said, "Look, this is the information I've just been given."?-- Correct.

"On the face of it, this case should be delayed until Monday. Do you have a different view?"?-- Absolutely.

So, a management style-----?-- Before cancelling the case, he could have rung me and discussed it with me and I would be very happy to go through it with him in a clear manner and discuss it with him, and that would never be a problem.

All right. At the time that he indicated that it was cancelled, I take it, from what we know again, that the only information that he would have been in receipt of then would have been the information supplied by the nurses - or the nurse - that it was inappropriate, with the support, however it was given to him, of the opinion of the staff anaesthetist?-- Well, the information - as you say, I'm sure that the information he had was, as you say, from those two sources. I can't confirm that, but-----

Just before you continue, the purpose of that question is there is no other information that you are aware of that he would have had at that time; is that the case?-- Absolutely. No, I have no idea.

Now, can I ask you to try and test your memory? That conversation that you had with Mr Allsop that weekend I would suggest to you was probably the last time that you two have spoken to each other. I don't mean that there's a deliberate

not speaking, but that was the last interaction you actually had?-- That's correct. I had very little direct discussions with Mr Allsop during my time there. Probably only on several very rare occasions, that's true.

Okay?-- That's correct.

Just excuse me for one moment, if you would? In paragraph 40 of your statement you say that you have subsequently felt bullied and harassed by the administrators Dr Hanelt and Mr Allsop. I'm not appearing for Dr Hanelt, of course, but could I suggest to you that, perhaps, that paragraph would more accurately read "by Dr Hanelt" and delete "Mr Allsop", given that you have not had any further interaction with him since then?-- That's true, but what I'm saying is that that incident to me was a harassing incident. Can I put it in the perspective of being a clinician in a situation where I have multiple patients to deal with on the weekend, there is a sick lady whose family I have just discussed the situation with, who is then cancelled, and then spent two hours of my valuable time away from other patients discussing the case on the phone with hospital administrators. That, to me, in my definition, is harassment. It may not be the legal definition, but as a person, I find that-----

Can I attempt to clarify what you say in paragraph 40 to determine your intent?-- Sure.

When you say that you have subsequently felt that you were harassed, you are not suggesting by particular word or deed, subsequent to this incident; it is just how you have felt about this since the incident?-- Correct, and I've never been treated with intemperate words or violence or anything of that nature, it has only been the actions that have occurred that have led to the feeling of harassment.

Thank you. On the 2nd of July 2004, Drs North and Giblin had a day trip to Hervey Bay and spoke to a number of staff at the Hervey Bay Hospital. You are aware of that?-- Correct.

Did they speak to you?-- Yes, I had - I would say probably a 15 to 30 minute interview with them in the middle of the day, yes.

You have - can I ask you this: were you asked by them your opinion of the clinical competence of Drs Sharma or Krishna?-- At that time, I believe that question may have been asked, yes. Again, it is very difficult recollecting, but I believe I was asked, and I felt that - I expressed that I felt Dr Sharma was more clinically adept than Dr Krishna. Both of them required supervision. Both of them, in my opinion, needed further training, further supervision before they could work unsupervised, and-----

I take it - sorry to interrupt you-----?-- No, that's-----

I take it that the information that you would have provided would have been - I appreciate this is a much longer process -

but it would have, by and large, been the type of information that you had been supplying in your statement and old testimony before the inquiry?-- Correct.

In relation to those two doctors?-- Correct. I don't have a lot of experience with Dr Sharma and Krishna on the ward environment, because I wasn't allowed or given access to them in that teaching role, so I don't know how they performed on the ward or in teaching, but all I was aware of was the limited exposure to their clinical skills and the situations I had been put in, their supervisory levels needed to be higher.

That would have been the focus, no doubt, of what you were speaking of on that topic?-- On that topic, yes.

And I assume that you have mentioned to us today that you have seen - I don't think you put a figure on it - but many examples where they have carried out procedures perfectly-----?-- Yes.

-----where you have no criticism whatsoever. I take it you would have conveyed that type of information to the investigators?-- Well, the simple procedures they carried out were things, as you say, which were expected to be able to be undertaken by people with some limited experience. I'm not talking about procedures that you would expect someone with experience to be able to do. We are talking about simple closed reductions of fractures, things that were - I would expect a junior person who was given some experience could do. I can't remember if we discussed those particular events at the interview, but, indeed, it is my opinion that some of the simple things they did were quite adequate and quite good in some cases, and I wouldn't expect that to be universal or anything.

At the time - let's say for the last - the first six months of 2004, for the first half of that year, my understanding of your degree of involvement with the Hervey Bay hospital was that you resumed your elective surgery-----?-- Correct.

-----and the clinics on the dates we have discussed before?-- Yes.

And then you had approximately one session a week?-- Correct, that's right. It worked out to be two sessions a week, twice a month, which was essentially - as you say, evens out to one per week, and the plan was then, as time went on, to increase that again to two sessions a week again.

All right. But I understand up until, say, July, when Drs North and Giblin arrived, that frequency had stayed the same?-- To July 2004?

Yes?-- From when I started in February 2004 to July 2004, I was doing, that's right, one session every four weeks. That's correct.

All right. Your involvement, as such, was relatively minimal

for that period of time with the orthopaedic section of the hospital?-- That's true. One session - in that period of time, it is a minimal involvement, as you say. That's correct.

And this is no criticism of you in any way, but I take it you wouldn't describe that situation this way: that you and the nursing staff kept the place running during that time?-- You know, again, I read the report, as you have. My impression of that statement was to say that when there was a problem that occurred, the nursing staff would call me, and if you talk to the nursing staff in the orthopaedic ward, it was easier for them to grab me in the corridor or grab me as I'm walking out and say to me, "Hey, Sean. Can you look at this?" So, I think the impression that was being put across was that there was very little supervision and therefore there was a - and one of the reasons why I was struggling to maintain all of the work that I was trying to do was that I was required to, perhaps, by proxy, supervise, when I wasn't meant to be doing it. So, maybe - I don't know, maybe that's the impression that was trying to be given with that statement.

So, I think in that answer you seem to have acknowledged that perhaps the statement conveys an incorrect message?-- Not at all.

COMMISSIONER: Not at all.

WITNESS: I don't think that's true. I don't think it is incorrect. What I'm trying to say was the statement meant I was officially running the department. The problem at the time, when you talk to the nursing staff in the departments, was they felt they had no-one to talk to about certain things, and sometimes they would come to me on a regular basis and say to me - what I'm trying to say is that I think that statement indicates that we were trying to run the department in a supervisory role by proxy, and I agree with you, it was not ideal and I was very uncomfortable about that situation because I believe that that can lead to trouble.

MR FARR: And it would seem to be a statement that is relevant to the supervisory aspect?-- Supervisory, correct.

Thank you. I have nothing further.

COMMISSIONER: Anyone other than Mr McDougall?

MR DEVLIN: I have some questions about one other patient; that's P430.

MR ANDREWS: Perhaps I should go first because there are some things that Mr Devlin may wish to ask about.

COMMISSIONER: I hope not, but all right.

FURTHER-EXAMINATION-IN-CHIEF:

MR ANDREWS: I've found - I beg your pardon, Queensland Health was good enough to supply what may be the records relating to the patient referred to in paragraphs 23 to 26 who Dr Mullen has been struggling to identify, and those came to hand only as Dr Mullen was beginning his evidence, and I haven't had the opportunity to ask him about it. But, doctor, from the records, I've flagged with green tags four pages that may help you to determine whether this is the patient - perhaps the one I've got open is the one you should look to first. Can you tell me the patient?-- P449.

The page that I had open shows that there seems to have been surgery done on a day by Drs Sharma and Krishna, and further down the page it shows that there was surgery done by - I think it says Mullens, but I assume it is you?-- That's me, yes. I believe that's the patient.

Commissioner, none of the parties have had an opportunity to review that file, unless, perhaps, Queensland Health has. I have got copies of that file on disc that I can disseminate so they can read them over lunch.

COMMISSIONER: I see. We will be going after lunch, I presume?

MR ANDREWS: Yes, it seems that way.

COMMISSIONER: All right.

MR ANDREWS: Dr Mullen, you have also done for me during the break an exercise of indicating on Exhibit - I think it is 365, which appears in the transparent envelope - the procedures on the orthopaedic trauma list and on the elective orthopaedic surgery list which you regard as warranting a comment in the "perform independently" columns; is that correct?-- Yes.

Could I have them put up on the screen, please? Would you hand that envelope of procedures to the Orderly? Thank you.

COMMISSIONER: These were with respect to Dr Sharma. Whatever comments you are making, do they relate also to Dr Krishna?-- I believe they do, yes.

MR ANDREWS: From the orthopaedic trauma list, on the first page I see you circled eight items in the "perform independently" column. Should I gather that each of those eight - only two appear on the screen currently - each of those eight items, in your opinion, they are items that should not have been performed independently?-- They are. And can I qualify, before I talk about this, the thing that I have to make clear is that I didn't get a large amount of time with these two gentlemen to properly qualify these comments, so-----

COMMISSIONER: Yes, I think you have made that point well?-- I will try and look at it in terms of their level of experience and what I would be happy for them to do.

Yes?-- Do you want me to discuss the individual-----

MR ANDREWS: Yes, well - yes, very well?-- The first couple of cases, both of those - the reason I wouldn't be happy with them independently performing those two early cases is because a fractured clavicle, particularly, there is a high chance of inadvertent screw penetration causing vascular injury up around the neck, and, indeed, it is my practice, if I can, to have a general surgeon around at least aware because of the high incidence of this injury, and so, again, I don't think it is fair for these young people to be doing this operation, because if that event occurs, it is a significant job to deal with the problem to prevent it becoming life-threatening. The similar thing applies for the last case, although it is not as significant-----

Do you mean the acromio-----?-- ACJ dislocation. Not as difficult, but there still can be problems associated with screw penetrations to the wrong area. These cases - medial epicondyle and lateral epicondyle fractures are children's fractures, and they can be difficult and they can be difficult to undertake, and again it would be better to have supervision for these, mainly because of the fact that, in children, in the medial epicondyle fracture, there is a nerve close to where we operate, and that nerve can be damaged during the fixation of the fracture. So, again, there is a bit of experience involved in locating the nerve and ensuring it doesn't get injured at the time of the fracture reduction. The reason I circled "supracondylar fracture", as I mentioned last time I gave evidence, it is - in most cases, supracondylar fractures can be very simple fractures and managed simply, however a complicated supracondylar fracture is very difficult to distinguish before the operation, so it is not until you are actually in the case doing the operation that you can become aware that the fracture is more complicated than you thought and it can become difficult because of problems of blood supply to the limb. So, again, with these fractures, there are a lot of experienced orthopaedic surgeons, including myself, who are very nervous with this fracture because of its unpredictable nature, and the fact is that nine out of 10 times it could be easy, but the one out of 10 times you could run into trouble with complications, and I think, again, supervision with these would be best, particularly until there is adequate assessment of the ability to deal with those problems. These fractures down the bottom end are difficult fractures of the wrist and the hand, and again most centres now have a hand surgical unit that will specifically deal with these problems because the associated morbidity from the injury is very high, and so these things are often difficult to reduce. Sometimes the nerve is injured or damaged, and sometimes it requires further surgery at the time of the injury that maybe the inexperienced surgeon would not be able to perform.

And on page 2, you have five items marked?-- These ones again - the reason I put down "phalangeal fracture of the hand" is because - with the nature of the hand, this fracture can often lead to severe stiffness of the joints because of its location, and, again, hand surgeons are usually involved in dealing with that fracture at a primary level.

And I recall you have told us about the acetabulum?-- Yes, certainly. I must admit, at this stage in Queensland, because we have access to surgeons who have a large amount of experience with these fractures, we would refer them all on to these surgeons who are doing the predominant amount of this sort of surgery at one or two institutions, and none of us gain enough experience with these fractures during our training period to be really competent with the treatment of this fracture anymore.

And further down the page, the third item?-- Yeah, I wanted to clarify this, because it is difficult to explain. There are some fractured hips which are quite suitable that junior staff can do, and often unsupervised, and I can see there are situations where it would be reasonable to do that if the person had an element of experience, but the reason I circled that is because it includes the high subtrochanteric fracture which is a completely different problem, and we said before the treatment of that fracture can be extremely difficult and, as I say, that's the sort of fracture that should not be done without supervision. Again, very simple procedures - I note there, too, it talks about the femoral shaft fracture complex, retrograde nailing; that's the very case that I was trying to discuss where Dr Naidoo was not able to supervise, and he's ticked at that stage - I assume Dr Naidoo has ticked - that it is actually suitable to be done only under supervision. So, I agree with Dr Naidoo there that that case should definitely be done with supervision. In the bottom case, tibial plateau fracture, is a fracture about the knee joint, and again, because of the nature of it, it is very hard sometimes to get that fracture to reduce properly to get a perfect knee joint. The long-term morbidity of these fractures, if they are badly treated, is very high and, again, they are complex fractures which require a fair amount of experience to perform.

And so the femoral shaft fracture complex that Dr Naidoo ticked as something that should have been performed with supervision, would the procedure described for the patient from paragraphs 24 to 26 of your statement be one of those?-- Yeah, that's the same case, yes.

And on the third page, you have circled one item, "severed digital nerve"?-- The reason I include that is because the use of a microscope to repair the nerve is not a routine thing that's actually looked at in your training period, and even some training registrars may not have the ability, as orthopaedic surgeons, to perform that procedure, and, again, very often that procedure is referred on to a hand unit, where there are experienced hand surgeons who do this on a regular basis. Again, that procedure is something which requires a

high level of skill.

And the other document is the orthopaedic - elective orthopaedic surgery list?-- Again, if we look at these procedures, I must admit my concerns with this are that when we are looking at elective orthopaedic surgery, the young or inexperienced orthopaedic surgeons - and these gentlemen probably fit into that category - would have had even less experience or exposure to elective orthopaedic surgery, because that's a place where the surgery is taught very much on a supervisory role because of the subtleties of the actual procedure. The reason I can talk about the first one, open acromioplasty - and you can have a repair - again it is the situation where a large number of orthopaedic surgeons now are referring these cases on to the shoulder surgeons because of the complexity of what's available now in repairing the rotator cuff. There are now biological techniques available to do this, which are just not within the realms of someone who doesn't have the experience. When I look at the cases in the hand surgery list, no doubt carpal tunnel decompressions can be performed by people who have limited supervision if they have clear exposure, because it is a procedure which can usually be mastered quite well, but Dupuytren's contractures - this is an operation where the Z-plasty component of the procedure is a soft tissue procedure which is a plastic surgical procedure, and again that can be quite complicated and you can lose the flaps which can lead to significant wound problems post-operatively, and, again, with a Dupuytren's contracture is often very difficult to get a good result. Again, talking about extensor tendon ruptures of the thumb, you are talking about tendon transfers. Again, tendon transfer procedures are things that very few orthopaedic trainees, unless they are in a properly organised training program, may not have access or exposure to. They are learned over a long period of time and they are difficult to do and make work well, so, again, I wouldn't undertake a complex tendon transfer. I would send that away, and I have had some hand surgical training. The last cases also apply. Wrist arthrodesis is also a very difficult operation. It is very hard to achieve a good arthrodesis, and again requires a lot of experience. The foot cases there - the reason I put those down is because poor outcomes after foot surgery are some of the biggest reasons for a bad - or unhappy patients in elective orthopaedic cases, and bunionectomy, which is removal of a bunion, has notoriously bad results in a large number of cases, except in expert hands. It can be a very difficult procedure. Although it seems a small thing, it is actually a very difficult procedure, and this includes the arthrodesis of the big toe, which also can be very, very difficult and requires a lot of practice to get the position right. Arthrodesis of the foot, again, same thing. Arthrodesis of the foot and ankle joint region is very difficult, and often bad results from this can lead to amputation if the result is poor.

And on the next page there are three items?-- I mentioned diagnostic arthroscopy. The knee arthroscopy is a difficult procedure. It - in fact, just as a personal issue, I found it very hard in my training, I think a lot of training registrars found it very difficult, because it requires skills of what we call triangulation where you have to be able to work off a screen while doing things into the knee joint and to do it properly can take many, many, many years of experience. I think it probably took me all of my four years of training to feel even competent of being able to do it unsupervised and that goes on for all of the arthroscopic knee procedures, are all done as I say in most cases by surgeons who have a lot of experience in knee surgery.

Thank you, Doctor. Is this a convenient time, Commissioner?

COMMISSIONER: Yes, it is. I want to be sure, though subject to Dr Blenkin's patient and any questions that may arise out of that, we finish Dr Mullen's evidence this afternoon so I propose to resume at 2.15. So, adjourn until 2.15 p.m.

THE COMMISSION ADJOURNED AT 1.54 P.M. TILL 2.15 P.M.

THE COMMISSION RESUMED AT 2.14 P.M.

SEAN ANDREW MULLEN, CONTINUING EXAMINATION-IN-CHIEF:

COMMISSIONER: Yes, Mr Andrews.

MR ANDREWS: Commissioner, would you order that the names of patients raised in evidence today remain confidential.

COMMISSIONER: Yes, I so order.

MR ANDREWS: Dr Mullen, I'll put this one page on screen of the P449 patient file. Does it show that on the 9th of April 2003 there was a procedure performed where Doctors Krishna and Sharma are revealed to be the persons responsible for the procedure and does it relate to the patella?-- To the femur, sorry, yes, the fractured femur, yes.

And further down the page does it show that you were involved on the same day in an open reduction and internal fixation of the right ankle?-- That's correct.

And that will be the procedure described in paragraphs 23 to 26 of your statement?-- Correct.

I tender that bundle of patient notes. You've looked through that bundle, have you not?-- I have had a look at that, yes.

Do you see that?-- Yes, I see that, yes. That's not the age that I had in my notes but that must be right if that's the case, yes-----

Right?-- Actually, sorry, no, you are right. I am confusing her with Mrs P437, that's correct.

Very good. Next page then, the admission through accident and emergency originally was on the 25th of July 2000 at 9 p.m.?-- Correct.

And the presenting complaint was this break of the humerus?-- Correct.

She came via ambulance and one of the notes made on presentation was, "Dementia"?-- Correct.

"But coherent on presentation"?-- Correct.

Thank you. Go to the next document in the bundle. We have the notes, "Orthopaedic admission", on the 25th of July at 2300, 11 p.m., and again a notation that she's a 78-year-old woman, a resident of a nursing home and some reference to the dementia unit again?-- Correct.

Then the next page takes us to the next day, the 26th of July 2000. You might have to help me with the writing if you can but it appears that the patient was received in CCU, the Coronary Care Unit?-- That's correct.

You're aware of that?-- Absolutely, yes.

And we find a few reasons for that on the next page?-- Yes.

The date of this might appear - the date is a bit cuff off there, unfortunately, but I think it is at about the same time?-- Yes.

Found to be in heart block and admitted for overnight cardiac monitoring?-- Yes.

And then down the bottom, "Discussed with nursing home staff. Until yesterday she was living independently with her husband. Increasingly unsteady on her feet", is that "shifting dementia"?-- It certainly - I mean, I'm not an expert on dementia but from my experience dementia often has periods of lucidity followed by confusion.

Yes, right. And, "Known to have heart block by the GP", and it's described as "a collapse fall "and is that asymptomatic as far as the heart is concerned?-- That's correct, yes.

So she's done - she's been delayed one day anyway with-----?-- Yes.

-----concerns about one of her comorbidities I suppose?-- Yeah, exactly. She had existing heart block and I think they were just making sure that that wasn't new for the reason for

the fall and that was established I think.

Now, we go to a stapled bundle there and the first note might be a bit hard to pick up but the notation seems to be about not for resuscitation in the event of cardiac arrest?-- That's correct.

So, she's a pretty ill lady to start with. That would seem so from the medical notes?-- Correct.

Move to the next one, 27th of July 2000. "The patient was found this shift" - this is the nursing note - "with plaster removed from her arm"?-- Correct.

Then the next note from the RMO: "X-rays reviewed by Dr Naidoo", so he's obviously on the spot?-- He saw her for the-----

On the 27th?-- That's right, yep.

"Patient for manipulation", what does that mean to you in this circumstance?-- In this situation I think what Dr Naidoo was doing was trying to get the fracture into a better position to put a plaster on. I think that's probably what he was considering at that time.

Right. And then the nursing note still on the 27th of July at 1340 hours, down the bottom, "Broken area of skin noted over the fracture site"?-- Yes.

Dr Kate T R, who is that?-- She was one of the English residents there at the time. I think her full name is further in the chart. Taylor-Robinson.

Yes, thank you, we struck her in Bundaberg. "Patient sponged and ready for theatre." I'll pick up the next few words "patient very confused"?-- Yes.

"Trying to roll over on her left arm"?-- Yes.

"Husband in attendance"?-- Yes.

Still on the 27th but over the page, at 8.20 p.m. the note is "Returned to the ward from OT" - operating theatre - "at 7.50 p.m. following closed reductions of the left humerus"?-- That's correct.

Then we drop down the page a bit to the 28th of July 2000: "Ward round Dr Naidoo. Plaster still in situ. Strapping requiring tightening. Patient not agitated"?-- That's correct.

So she's come in on the 25th and up to the 28th of July is there anything about the history so far that you found or find unacceptable?-- The thing that in retrospect concerns me when I looked at the chart was that the nursing staff had mentioned to me when I was asked to see the patient some time later that they thought that she had an open fracture at the time of her

manipulation and the nursing notes indicate there was a break over the fracture site of the skin which I believe refers to that concern they had and that's why they rang the RMO that was on at the time to come and review the patient because they felt that was a compound fracture at that time.

Now, I think in fairness to your recollection, I think at an early point in the notes, and I won't be able to put my finger on it quickly, but I think at an early point in the notes there is reference to a compound fracture?-- There is earlier mention to that but there was no mention from the nursing staff about the compound fracture. It was at this stage the nursing staff mentioned the problem with the - they thought there was a wound over the fracture site. That was the first time that the nurses actually mentioned that and they did ask Dr Taylor-Robinson to look at that.

I see. Well, certainly broken area of skin is mentioned on that previous entry we just looked at?-- Correct, yes.

Do you believe it might have been earlier than that?-- I believe that it was probably around that time. It sounds like that she was demented and she was finding it - they were finding it difficult to hold her still and I think she had a sharp fragment which was moving against the skin.

Right. So on the 28th over the next page, still on the 28th, there's some notation now of a chest infection right at the top of the page. Can you make any sense of that?-- I think what was being said at that stage was there was a risk of chest infection because-----

Oh, yes risk, yes?-- Yes, because of her comorbidities, the fact that she was not mobilising and her age group and so I think that was probably more of a preventive measure to ensure that chest infection did not develop.

Thank you. Then 29th of July the nursing note at 1345 hours: "Still confused and stripping off her clothes. Skin tear in arms. Redressed. Has a pressure bandage to control blood ooze." Then we see the next note at 9 p.m. by the look of it, 2100 hours, by the principal house officer; is that - would you agree with that?-- That's correct.

"Patient known dementia. Been fiddling with the" - is that "POP"?-- That will be plaster of Paris, that's right.

Yes. "And bandage. Noticed bleeding." There is reference to the back slab, reinforced. Okay. Now, over the next page, still seems to be the 29th of July against the letter "P", P in the circle, "Dr Naidoo contacted. Advised patient medically very unfit." What's the next one?-- "Put in a sofratool"-----

S-O-F-R-A-T-O-O-L?-- I think it is actually T-U-L-L but that might be the way they're spelling it. T-O-O-L, that's right. Back slab and reinforce the bandage.

Sorry, I should have asked you before, did you have some issue with the procedure that was performed earlier to deal with the problem?-- Well, I was concerned because the nursing staff had explained to me that the fracture had come through the skin before the patient went to the operating theatre the first time and it seems to indicate that from the chart and, again, this is not - I can't verify that because I only saw the patient some time later.

Right?-- But my concerns was that the management of a compound fracture is to deal with the wound problem and stabilise the fracture and if there was an open fracture before the first operative event, then that was not the appropriate operative event for that problem. There should have been stability achieved at the time of the skin being breached by the bone.

And stability achieved by what means in your view?-- Well, it is variable. I mean, in my experience, I would have used a intramedullary device. You could have used - it could have been plated depending on the bone quality, but an external device as a plaster is not really a very suitable device.

Well, let's focus on the very question here though?-- Yep.

Would you agree that the notes appear to give the impression that there is an attempt to conservatively manage a lady, an old lady, with a number of comorbidities? Is that not a correct view to take of the chart so far?-- I would agree that, I would agree that the initial attempt was to deal with a lady who had comorbidities. My impression from the chart and also talking to the medical people since and looking at the notes is that this lady didn't have a significant number of really severe comorbidities. She had a second degree heart block which was stable. She spent a night in a coronary care unit under supervision, observation and was given a clean bill of health the following morning that she in fact didn't have any compromise.

Is it, however, a matter upon which minds might differ, competent minds might differ about management and secondly - the second part of my question is, is it possible that conservative management can often be rethought retrospectively?

COMMISSIONER: Well, these are two different questions.

MR DEVLIN: They are and I want to take him to one at a time.

COMMISSIONER: Perhaps if you do them one at a time?-- The first question was if conservative management as a reasonable treatment could be undertaken for that fracture.

Is it a matter, being as fair you can, that minds might differ?-- And being very fair, if the patient did not have an open wound with a compound fracture, then it is a fair thing to attempt conservative treatment for this fracture.

COMMISSIONER: But if she had, as you thought, a

compound-----?-- But if she had a compound fracture, it should have been treated differently.

Thank you.

MR DEVLIN: And you would describe the failure to treat that as unacceptable?-- In my experience that is not the appropriate treatment of a compound fracture.

And you believe that's not something upon which competent minds might differ?-- No.

Thank you. 29th of July then down the bottom, just notations about bleeding being noticed by nursing staff. So we're still on the 29th of July and you're asked to come into it on the 2nd of August?-- Yes.

Now, I didn't include some of the further notes so we better look at two other pages which I will give the operator. Excuse me, Commissioner, I forgot to include them. This attempts to track the next couple of days before you're involved if you don't mind?-- Yes.

Just the first entry in yellow, thanks, Mr Operator. So there's reference to the bone sticking out of the skin. So that's a pretty serious observation; correct?-- Correct.

Move down a bit then: "The bandage is removed. Confirm that the bone is sticking up. Dr Naidoo contacted. Advised patient medically very unfit". So Dr Naidoo-----

COMMISSIONER: We have had this page.

MR DEVLIN: Sorry?

COMMISSIONER: We have had this page, haven't we? I thought I'd seen it before?-- Yeah, we have.

MR DEVLIN: All right then. If we could turn to the next page then. It's over the other side. No, turn the other page on your left. It's a bit out of order. Now, there's another note about Dr Naidoo. I don't know whether you can pick it up there?-- It says "Dr Naidoo informed last night."

Oh, "informed"?-- "Informed last night".

If we could just slide that up?-- And she's "medically too unwell. Discussed with Dr James", a medical PHO.

Do you know who that James - the PHO is?-- No, I don't, I'm sorry.

Now, again, does there appear to have been a judgment formed by Dr Naidoo that at least at that stage the 30th of July, she was too unwell for an operation?-- Yeah, I think that's the judgment that Dr Naidoo made.

And, again-----

COMMISSIONER: But it is not clear whether Dr Naidoo was present and saw-----?-- I don't - it is not clear from those things. I think from the way I read it, Dr Naidoo was discussed - this was discussed with him on the telephone.

MR DEVLIN: Yes?-- And he made that decision about her being unfit.

Thank you. Then 30th of July then, getting closer to when you're being involved, "Patient sponged in bed", et cetera. And she's obviously taken food, so that gives us the status at that point. Now, I think there is also some entries for the 1st of August. I'm sure they will be shaded in yellow. Let's hope these are they. 31st of July, "Transferring to 511". Does that make sense to you?-- It could be 5U. It might be a bed or a unit, I'm not sure what that represents.

Sure, yes. What's 5U at Hervey Bay?-- I don't know that term. I'm not sure what that relates.

And ECG?-- That's a heart tracing.

Does that suggest a further concern about her coronary situation?-- I don't think so. Normally the elderly patients will often have three or four ECGs done whilst they're in hospital. It's a routine thing to be done by the resident staff.

But do we see here some notations about respirations are laboured?-- I see that, absolutely.

So it looks like on the 31st then there is another cause for investigation at least?-- That's right. I think the concern was there that she'd may have some chest problems, correct.

Thank you. If we move down the page, thanks, Mr Operator, principal house officer - just up a bit, sorry, there is one little entry there. The principal house officer seems to have been present for the - is it the "back slab taken down"?-- "Taken down" and "++ soaked".

Yes. So it's removed and the state of the wound is looked at. Then down, 31st of July. Further down, please?-- Yes.

She says she didn't want morphine. The pain is not so bad according to her?-- Yes.

Then we got to the 1st of August, "Patient plucking at dressing. Wound exposed. Redressed. Hands swollen. Radial pulse present. Arm resting in collar and cuff. Oral analgesia given at 0300 hours. Patient settled well." Now, I think we can go back to the other documents now for where there's a summary. We're up to an RMO summary. We don't have to retraverse a lot of this but if we go down a bit to the 1st of August, let's say, further down, thanks, Mr Operator. Yes, 1st of August, it simply recites: "The puncture wound one centimetre. Dressings reset and rebandaged"?-- Mmm-hmm.

Then 2nd of August, "Booked for theatre"?-- That was my - that my theatre case, that I think it was 2nd or 3rd of August that I saw the patient.

We will just come on to that straightaway now. Over the next page, please, Mr Operator. Now, I'm sorry, but the notes don't seem terribly continuous at this point but there are entries here that you made?-- Yes.

You've said with great emphasis, "This requires emergent external fixation and wound" - is that "debridement"?-- "Debridement in operating theatre", yes.

Further down: "Will discuss with the family the risks"?-- Yes.

And then over the next page, "I have"?-- "Discussed with Dr Naidoo that he wishes me to do the surgery of this lady because he is currently unavailable."

Presumably you got him on the phone?-- Yes.

You don't know where he was?-- No.

You don't know whether he should have been rostered on-----?-- I must admit, I have never checked as to where he should be that day.

That's okay. Did you discuss the history of the matter to that point with him?-- Yes, indeed.

Did you take him to task over the management at that point?-- I explained to him that I was concerned about this patient, yes, and that I felt uncomfortable taking over the care of that patient at that point but that I was willing to do it and that I'd be happy to take the patient to theatre and explained what I thought the patient needed. As I said previously, it is an ethical dilemma here because the patient was not my patient and I had discussed it with the family and, so, I felt that discussing it with Dr Naidoo at least gave him the opportunity to understand what I was doing to his patient.

Thank you. I don't wish any of these questions to imply any criticism of you; I'm just interested in a couple of things about what you've said. Firstly, uncomfortable, was that simply because of the ethical position or because of the history of the management of the patient which you saw as unacceptable?-- Well, I felt that the management was unacceptable to start with and - but in that situation, when I had a patient who was - who was having major problems and needed attention, I did think that it would be very unprofessional to attack Dr Naidoo in any way on the telephone because the situation required a professional conversation about a difficult problem.

Dealing with the problem at hand rather than-----?-- Absolutely.

cases when I wasn't the primary surgeon and, indeed, wasn't actually there to make decisions beforehand.

And you recall any response that Dr Hanelt gave to your concerns?-- Well, at that time there was never really any strong response. It was more an acknowledgment of my concern and then I didn't take the matter up with him anymore and I must admit my biggest concern - my biggest regret is that I did not write more letters but it is a difficult situation because I expected that I would be able to discuss it and the situation would be taken further and that was my understanding.

You came back at least on the basis of a session a week on average?-- Correct.

After February 2004?-- Correct.

Did the number of sessions increase then through that year at all?-- No, because I was concerned about the situation and I didn't feel comfortable extending the sessions at that time. At that time during that year, we had the discussions with the AOA and there was a lot of concerns around the hospital and, so, I felt more comfortable doing the single session at that stage.

Did you - did it - well, it seems to have occurred to you that the lack of opportunity for supervision being afforded these two gentlemen was significant in your mind?-- Correct.

Did you ever, and again I don't imply criticism here, but did you ever take up with hospital management the prospect of you being able to afford more supervision yourself?-- No-----

Or was that never in prospect from your point of view?-- The only time that I discussed this with them was that we had a meeting where I was looking at returning to the hospital to do these extra elective sessions and we discussed the situation and I-----

You and who else, sorry?-- Dr Naidoo and Dr Hanelt. And I just indicated to them at that meeting that I was happy to provide an after hours one and two on-call provision so that I was a second on-call person for them and it wasn't something I wanted to do from a personal point of view because it would make it very hard for me to manage my other duties but it felt like that something that I might be able to offer these gentlemen in the interim till we worked out a better solution and that was the only offer I made to do any available services.

Can you orientate that suggestion in time?-- That was done at the meeting that I had before I returned, so it must have been in January 2001 - 2004 at that time.

Do you recall the response you got?-- At that time the response was negative. Initially the discussion was about that it would be expensive and I understood that that would be

expensive to have me as second on-call, I offered to do the services free of charge-----

Sorry, you have said this before?-- Yes, that's right. I won't-----

I won't retraverse, sorry. I realise you said that last time. Thank you, Commissioner.

COMMISSIONER: Thank you.

MR REBETZKE: Commissioner, I should announce my appearance in lieu of Mr Allen on behalf of the Queensland Nurses Union. My name is Rebetzke, R-E-B-E-T-Z-K-E. I'm a solicitor from Roberts and Kane.

COMMISSIONER: Yes.

MR REBETZKE: I have just got one matter.

COMMISSIONER: Yes, certainly.

CROSS-EXAMINATION:

MR REBETZKE: Doctor, is it fair to say that a number of concerns that you have given evidence about today were raised with you by members of nursing staff?-- Well, that was the general - that was the general impression I was trying to give when I was asked about the - the fact of - the comment about holding up the system. The nursing staff would often ask me questions when I was doing a ward round or I was in the corridor seeing another patient, an intermediate patient or another public patient, and they used to raise those concerns with me at that time and this was one of the reasons why I was feeling more and more vulnerable, because it was difficult for both parties because the patient was not mine and the nursing staff were uncomfortable about discussing it but most of those patients were patients who were discussed with me by nursing staff.

Yes. And, in general, nurses are very good patient advocates?-- Correct.

And they're, of course, the member of the clinical team who spend the most time with patients?-- I find that nurses are people who pick up the little things.

Yes?-- For example, a break in the skin over the fracture, a bruise somewhere, something which is - may be glossed over in the medical situation when you're very busy. The nursing staff have a role to play because they spend so much time with the patient.

And you certainly took the matters raised with you by nursing staff most seriously and immediately investigated those matters yourself?-- Correct.

And including to the extent of seeing patients who weren't your patients?-- Correct, yes.

And as a general proposition, would you agree that there's really no excuse if serious concerns arose among members of nursing staff for them to not to be attended to immediately?-- I think my experience is that some of the mistakes I have made in my career have been not listening to the nursing staff closely enough with some issues because they do pick up on things that are not necessarily immediately obvious. But I do agree nursing staff have a big role to play.

Yes. Thank you, your Honour.

COMMISSIONER: Thank you. Yes, Mr McDougall?

CROSS-EXAMINATION:

MR McDOUGALL: Dr Mullen Mr McDougall. I appear for Dr Terry Hanelt. I will endeavour not to traverse ground that's been already traversed, so far as possible in the cross-examination. But there are some areas that may cover the same thing. In your statement that's been tendered in these proceedings, at paragraph 15 you said that, "As a result of the inaction by Dr Hanelt I indicated to him that I was going to take a period of time off away from the hospital." It was the case, wasn't it, up until this time there was only one incident about which you referred in your statement and that was the incident leading to the amputation of-----?-- Yes. There was only one serious event. What I was indicating to Dr Hanelt was that the situation of having to be involved in this proxy supervision was making it very difficult for me.

Was that a proxy supervision - it was a proxy supervision of two Fijian doctors, was it, at that stage?-- No, it wasn't. It was the other junior staff that were present, because at that stage Dr Naidoo was supposedly supervising the other junior staff.

All right. The Director of Surgery was supervising junior staff at that time was well, wasn't he?-- The Director of Surgery was Dr Griffiths, I think, at that time and his qualifications were those of a general surgeon, and he was providing some supervision but in his own admission at that time he was very uncomfortable about the supervision of orthopaedic cases.

In your statement you only refer, though, don't you, to this incident where - that led to the amputation - up until paragraph 15 of your statement?-- That's correct. That's

correct, yes.

You made a complaint - you approached Dr Hanelt and you raised your concerns about this patient with him and he gave you the go ahead to perform the urgent surgery?-- That's correct, yes, he did.

So he acted entirely appropriately in that respect?-- Oh, absolutely. He was, can I say, very helpful in helping me out doing the case and making sure that it did occur, yes, that's true.

You raised your concerns about the treatment of this unfortunate patient at the hands of Dr Naidoo with Dr Hanelt?-- Correct.

And he took only board your complaints?-- I believe he did. He didn't-----

And so far as you are aware, he took then up with Dr Naidoo?-- That is my impression, correct.

All right. That's really the only incident of issue, real issue that you raised with Dr Hanelt up until the time you tendered your resignation from the services you were providing on the 2nd of September 2002?-- Yeah. That's not entirely correct. That's the only incident of major importance which I thought led to major patient safety problems, but I had discussed issues with Dr Hanelt many times in the outpatients environment, walking to his car, going to his office at lunch time, when I was there on a Wednesday. We often discussed situations and-----

He took those-----

COMMISSIONER: Just let him finish.

MR McDOUGALL: Sorry, your Honour - Commissioner?-- Those issues, I assume, were taken on board and never - and I admit I never chased them down any more than telling Dr Hanelt that I was concerned.

You have got no reason to believe Dr Hanelt didn't take them on board and treat them appropriately?-- You are absolutely right.

So by the time you signed this statement, as a result of the inaction taken by Dr Hanelt you tendered your resignation or withdrew your services?-- Correct.

It really wasn't the cause of your withdrawing your services, was it?-- No, it was. The reason that Dr Hanelt didn't act in the way that I thought was appropriate was that he did not insist there were morbidity and mortality meetings to assess the problems that were occurring at that time. He did not ask me to be involved in any sort of discussion about the cases at a further point that could help with preventing the action occurring again.

You wrote to Dr Hanelt withdrawing your services on the - advising him that you intended to withdraw your services?-- Correct.

On the - from the 30th of September 2002?-- Correct.

By letter of the 4th of September 2002?-- That's correct.

You didn't mention any of that in your letter, did you?-- Not at all.

He wrote back to you and acknowledged the letter?-- Yes.

And acknowledged your reasons-----?-- Correct.

-----for-----?-- Correct.

-----withdrawing your services?-- Can I explain that letter? When I wrote that letter to Dr Hanelt, I had discussed these cases with him several times, over several long periods of time, and it did not seem to me to be of any (a) value and (b) there was no further point in discussing these issues any more. I just laid it on the line that I had problems managing my family life, with dealing with my private practice, and also dealing with the patients that I was supposed to be trying to deal with as well in the public system.

Well, there was the perfect opportunity, was it not, in your letter of resignation to set out your complaints?-- Can I say I disagree with that. I believe that that was the wrong place and the wrong forum to be discussing this problem. I believe the right forum was a forum where all of the doctors could be present together, that discussions could be had in a free and open fashion, and we could spend the time working out a solution to the problem rather than me using this problem as a reason for resignation.

But in terms of your reasons for resignation, writing a letter saying you are withdrawing for family reasons, if those weren't-----?-- They were.

-----real reasons - the true reasons-----?-- I think I have explained that previously, that family reasons were the - were - came about because I could not devote enough time to my family because I had a workload that was unmanageable because of the extra work required of me at the public hospital when I was supervising at odd times that were not expected of me. So the family reasons were a definite driving force, but the problems I was experiencing in the public system drove me to having those difficulties.

You had a great deal of difficulty meeting your commitments in a one - on the one in four roster of being on call from the beginning, didn't you-----?-- Can you-----

-----Dr Mullen?-- How do you mean that? Do you mean being available on call one in four?

Well, not being available when you were on call?-- Excuse me, can you please describe that? You mean not being able to see patients when I'm on call?

No, not being able to be paged, for example, from emergency departments?-- Well, I will let you know that my paging system is available through the public hospital system as well as the private system. I have private patients in hospital constantly and those private patients are always able to contact me day and night. The public hospital system, if they had troubled contacting me it was nothing to do with my paging system. It may have been to do with the way they were going about it. I never had anyone complain to me from the medical point of view or a nursing staff member they could not contact me when I was required.

It was your practice, wasn't it, to refuse to take calls from Accident and Emergency?-- Can I explain that and that's to - that's a very unfair observation. I will explain that comment so that people understand. This situation developed where the Accident and Emergency Department would often ring me at my private rooms about public patients who I may or may not have seen to discuss the situation with me while I'm seeing private patients. So, I was trying to work a private practice, I had interruptions from the hospital about public patients. I was not the full-time orthopaedic surgeon. They were not necessarily my patients or I had ever seen those patients, and so we had to get a situation so that I could actually have a 30 minute consultation with my private patients without interruption. So, when I had a problem I had to deal with when I was on call, I was always available for the emergency department to deal with that problem.

All right. Well, what about an occasion, for example, on about the - on or about the 6th of September 2003, for example, a Saturday night. You were on call. "Had trouble contacting Dr Mullen. Paged him three times with no response. Eventually HBH got a message to him to phone us. This all happened around 5 p.m. At about 8.30 p.m. Dr Carey wanted to speak to him again, so I paged him with no answer. After 15 minutes I asked HBH to page him for us. Should I point - I should point out that he does not have a hospital pager but uses a paging service. HBH uses the same number we do. He answered them straight away and informed the switchboard operator that MBM is not meant to page him and we have to go through HBH."?-- So can I answer that question in two parts?

Mmm?-- The first part is that the paging system - I will describe the paging system that we use. The paging system I use is transferred to Brisbane and there is a central Brisbane paging service that uses the number and then sends a text message back to my telephone. Depending upon where I am in the town, that message may not be received initially. I may be out of contact of the network for periods of up to 20 minutes, half an hour, an hour, depending on whether I'm in Maryborough seeing patients or in Hervey Bay. So, this message will then come to me whenever I return to the network.

So not getting me straight away on my paging system is not a problem with my ability to give service, but the problem with the paging system to be able to be reliable. In answer to the second part of the question, that particular situation that arose is a good example of the problems we're experiencing in the region in terms of management and supervision. There was a situation that evolved where Maryborough Base Hospital would accept patients for their A and E department, other patients, when I was on call or the other orthopaedic surgeon was on call. Those patients would then be seen by a PHO or registrar or junior personnel in the A and E department at Maryborough. Then they would ring me direct and try to organise a transfer direct to the Hervey Bay Hospital without discussing the case with the PHO or registrar on call at the Hervey Bay Hospital. The correct procedure, which I explained to the administration several times, which works in every other centre where transfers are organised, including Brisbane and Logan Hospitals, PA and Logan Hospitals when I was working at PA Hospital, is that the junior staff member at the transferring hospital rings the junior staff member at the hospital receiving, the discussion is had, the PHO at the hospital receiving then rings me and we discuss the case at that point, because it's dangerous for a patient to move from a hospital to another one without the receiving junior doctors knowing about it.

Another occasion, 20th of March 2004, "Just to let you know that Dr Mullen was on call for orthopaedics on the weekend but refused to take any calls from Maryborough and"-----?-- Same situation. Same problem. And I discussed the situation with Terry Hanelt several times and explained to him my reasons for believing this was a dangerous situation, and I explained that we needed to have a system whereby the receiving PHO or registrar could deal with the problem first, discuss it, then discuss with me so we could appropriately organise triage. I have seen situations where patients have arrived without the junior doctor being aware and the patient being sent straight to the ward because the receiving hospital thinks that the doctor on call is aware of the patient. So they are my reasons for those situations and I clearly outlined them several times.

Mmm. So, you agree that you refused to take calls from A and E as they - when you are on call?-- No, I didn't. I refused to discuss the situation with the Maryborough junior doctors. I talked to them and said to them, "We have a relationship that we have organised through Dr Hanelt. He's agreed to me that that is an appropriate thing." The doctors at the Maryborough Hospital were supposed to ring the PHO under me at Hervey Bay hospital. The doctors at Maryborough Hospital were not informed of this regularly and often they would forget that. I would tell them that this is not appropriate, you need to talk to the doctor at PHO, I'd give them their name, their paging service, how to get them and then they would ring me. That's the appropriate protocol.

You are also often changing your availability on days when you are on call without making arrangements for a substitute, were

you not?-- Can I - I'm not sure. You will have to explain them to me and tell me the days. Because things would happen and we would have things that we had to arrange and I'm not sure what the situation was, remembering, of course-----

There were many of them-----

COMMISSIONER: Let him finish.

MR McDOUGALL: Perhaps if I - at some stage we will tender the documents-----?-- Okay.

-----to let you-----?-- I am Visiting Medical Officer. I visit one session a week. I have to cover my one session a week properly. I have to deal with my private patients. I have to make sure I am available all the time for them. When it came to rearranging my essential arrangements, often what would happen is I would get a phone call very late in the piece from the hospital explaining that I would now be doing a particular day. My roster would change three or four times in a week and arrive three or four different times, so I would be on three different days in one week that were changed. At the end of the time, I could not run my private practice and there were times when I said to the rostering people, "I cannot do that day. You have to rearrange it."

All right. Doctor, you agreed, I think, this morning to a question put to you by my learned friend Mr Andrews?-- Yes.

I think you'd already given this evidence-in-chief on an earlier occasion, but the protocol was that once a doctor takes a patient, for example, an emergency patient on in an emergency situation, perhaps when he's on call, then the patient - that doctor generally follows through with that patient?-- No. That wasn't entirely the truth. I discussed with Dr Hanelt that my understanding is that when a Visiting Medical Officer is on call for the weekend and the patient is then in the ward, the rest of the week, if there is a problem with that patient during the day when the Visiting Medical Officer is in their private practice or in the operating theatre at the private hospital and unavailable, that the doctor on the site, which would be Dr Naidoo or the full-time doctor, deals with the problem, sorts that problem out if it's an emergency and then we can contact each other later to organise appropriate follow-up care. I can't be available safely 24 hours a day seven days a week for every patient and my responsibilities were when I could be available. The appropriate person to look after things when I'm not available and operating elsewhere is the full-time surgeon.

What's the situation when a patient's admitted under your care to the hospital?-- That is very big question. It depends when the patient's admitted, whether it's in the morning, the evening, whether it's on a Sunday night or a Saturday morning, whether it's during the week. It depends. If the patient is admitted on the weekend under my care I will do everything in my power when I am on call that weekend to ensure this patient

has their surgery that weekend. If I admit a patient at 12 midnight on Sunday, the patient then is admitted to the ward, the doctor then who is the staff doctor, who would be Dr Naidoo, would then be able to arrange at some stage for that patient to have a surgery, if necessary. If I had a elective operating list on the Wednesday, I would do the case on the elective operating list on the Wednesday, so I would fit that patient in as best I could to my week.

All right. Well, a patient comes into the hospital and your name appears as treating doctor on the admission sheet. I think my learned friend Mr Andrews has shown you this morning-----?-- Correct.

That had Dr Naidoo's name on it?-- Yes.

That's how it would appear in circumstances where a patient is initially treated by you at the hospital?-- Correct.

And if you are able to follow-up you would?-- Correct.

As I understand it?-- Yes.

If you weren't able to follow-up, some other doctor might perform the surgery?-- No, no, Dr Naidoo. Not some other doctor, Dr Naidoo. If Dr Naidoo was not able to supervise the case, then the patient should not be done and the patient should be sent on to another institution.

But you can supervise the case, couldn't you, if it's your patient, if your-----?-- Can I explain? If I have a patient admitted, it's Sunday evening 12 o'clock, and I am working privately the next day with on operating list, on options are I cancel the whole day of private operating and consulting and I go to the public hospital and do that case, or what happens in all public hospitals around the State is that the full-time staff orthopaedic surgeon deals with that patient on a supervised trauma list. That patient is then dealt with and then appropriate care is arranged.

You've done that exact process, haven't you, on a number of occasions?-- That's - there have been cases where that's occurred, from-----

Where Dr Krishna was doing the surgery?-- I was not aware Dr Krishna was doing the surgery. These situations were always organised so that Dr Naidoo would supervise the doctor doing the case. If Dr Naidoo didn't supervise the person doing the case, I was not responsible. I wasn't aware that that was being done without supervision.

These are cases where Dr Krishna, for example, discussed the case with you, then the surgery's been performed and you have just discharged the patient?-- Sorry, I have discharged the patient? How do you mean by that?

You were the doctor on admission and the doctor on discharge?-- I haven't seen that case. You - I will have to

have a look.

I will give you some examples in a moment. Just talking generally at the moment, though, would you be available to supervise, for example, Dr Krishna in surgery?-- Can I say that I was never on call on a weekend when Dr Krishna was on call as well. I was always put next to those doctors. I was never on call when Dr Krishna was on call. If I was on call for the weekend, I would supervise Dr Krishna.

What about if you were in the hospital during the week?-- If I was - in what way? If I was in the hospital grounds?

No, in the ward?-- Yes, indeed. If I am in the wards during the week, I do a clinic in the morning and I do an operating list in the afternoon. When I do the operating list in the afternoon, if Dr Krishna is doing another case in the theatre next to me, I will be supervising from my theatre doing elective cases. I am never at the hospital and not even the outpatients or the operating theatre.

So in those circumstances, would you regard yourself as supervising, for example, Dr Krishan?-- Absolutely. If I felt that he should do that case I would be in the theatre next to him. If he had a problem with that case, I could then move to the theatre and help him out with that case. I cannot remember the situation, but if that happened, that would be reasonable, yes.

Well, would you look at these cases, please. I will just take these markings off. They are not full charts, but they are enough to get us started at least.

COMMISSIONER: Shall we put these up on the screen, Mr McDougall?

MR McDOUGALL: We have another copy. Take the first case in that bundle, a Mr P438. You're noted as the treating doctor?-- Correct.

Turn over the page. I think you will see that on the 8th of April 2004 - I think there was a discussion with you about the patient - sorry, 8th of August 2004 about the patient. See that?-- I can't see that, sorry.

COMMISSIONER: Where is that, Mr McDougall?

MR McDOUGALL: I think your name appears?-- Dr Meijer.

A bit further down the-----?-- "X-rays seen by Dr Mullen".

In other words, you had involvement in the case?-- I saw the case, I imagine I saw the X-rays, that's correct.

If you go further into the document, you will find the operating notes to indicate that the surgery was performed by Dr Krishna?-- Correct.

All right?-- Correct.

Now, that's an example, isn't it, of a circumstance where you are the treating doctor in the circumstances?-- Absolutely.

The patient was discussed with you?-- Yes, absolutely.

Surgery was performed by Dr Krishna and the patient discharged?-- What date was that? That was the?

8th of August?-- Yeah, 2004. By that time Dr Krishna had done several of these operations with me.

So when you told us - told the Court this morning that you'd never had the opportunity to supervise Dr Krishna-----?-- No.

-----that wasn't entirely accurate?-- No, no, I didn't have the opportunity to supervise Dr Krishna on a regular basis. Occasionally I saw Dr Krishna, occasionally I saw Dr Sharma. I was never given them on a regular basis to see them. Every now and then I would be required to supervise them. Often on an afternoon when I had an elective list and they were doing an operation in the theatre next door I would supervise them doing a case. This operation-----

So it's not the case that you have never seen Dr Krishna operating, is it?-- I never said I didn't.

COMMISSIONER: He didn't say that.

MR McDOUGALL: You gave this Inquiry the impression, didn't you, that you never had the opportunity-----?-- No, not at all. I give the Inquiry the impression I was never given the opportunity to spend time to supervise Dr Krishna or Sharma on a regular basis. This fracture, I was happy with Dr Krishna doing the operation because I'd taken him through that operation before and I was happy with him doing that operation.

All right. Could you turn to the next one, Mr P439. You are the admitting doctor - sorry, the treating doctor?-- Yes.

If you turn to the first page, there is a discussion with you about the treatment, about halfway down the page-----?-- Correct.

-----below the diagram of the hand. Can you just move that down a bit?-- Correct.

That patient also goes on to theatre?-- Correct.

And that surgery is performed by?-- Dr Krishna.

Dr Krishan?-- I remember that case. That was a very simple detipping injury of the finger. Often that operation is done in Casualty by the Casualty officers. Dr Krishna was very competent to do that operation.

Okay. Now, did you supervise him in that at all?-- Not at all.

Okay?-- Did not require supervision.

All right. Perhaps we could turn to the next one, Mr P440, is it? You are again the treating doctor?-- Yeah. That operation was done - that operation to me looks like it was done the following day, which means that that patient was admitted late one night and that patient was then - this was the case I was talking about where patients are admitted late in the night. It would have been Sunday evening - likely - and - or a Wednesday evening. The patient was operated on the next day supposedly on a trauma list that was supervised by Dr Naidoo. That was the arrangements that we'd come to for patients that came in late at night who needed to be done the next day.

All right. Dr Krishna did the surgery?-- Correct.

All right. We will pass-----?-- Supposed to be under the supervision of Dr Naidoo, which did not happen.

All right. Pass on to the next one then. Vivian - Mr P441. Again you're listed as the treating doctor?-- That's another one that came in at 0045 as well.

You saw that patient?-- Correct. That was another patient which was supposedly to be done the next day on the list. The same thing, the hours 0045 - these are the patients which come in the early hours of the morning when I'm on call, I'm not available the following day for other commitments, the patients are supposed to be done on a supervised list with Dr Naidoo.

All right. If you could pass those back, please?-- Thank you.

So, on how many occasions would you think you supervised Dr Krishna performing surgery, for example, in 2004?-- Well, for that fracture of the radius and ulna, that was one operation which I definitely supervised him once. I can remember doing that with him when he was doing that in the theatre next to me and I helped him out with that case. I don't know how many other times. Very limited. I wasn't given the opportunity because, as I explained to the Commission, the situation is not set up so I could supervise these people. It was ad hoc. Occasionally I supervised them and they would do something which I was comfortable with. As I said previously, that operation is a reasonable thing for him to do unsupervised provided he's been assessed. I saw him do it, I was happy with him doing it. It's not a complicated operation.

All right. Now, you gave some evidence about the meeting on the 16th of January 2004. Do you recall that?-- I remember the meeting, yes.

And do you recall the evidence you gave? There was discussion as to why you didn't sign the - I suppose the minutes of the meeting?-- I didn't - I have no signed minutes of the meeting available to me.

I think you gave evidence as to why you wouldn't sign?-- Well, there was - there was certainly concerns about what was at that meeting, yes. I wasn't happy and we had various attempts to try and get the minutes of the meeting correct. I can remember back and forth with our office and our rooms with Terry Hanelt's office to get the minutes correct, because I believed they didn't represent the full content of the meeting.

Well, can you explain to us, is that the reason why you didn't sign them?-- At that stage I believe so. As I said, I don't know whether I signed them or not, but I only have an unsigned copy. I assume it didn't make resolution of the decision, yes.

What do you think the significance of signing them, the minutes-----?-- Well, if sign the minutes you assume there is a reasonable content of those minutes.

All right. So you wouldn't be surprised to see that, in fact, you did sign the minutes?-- Not at all. That could happen. As I said-----

Look at this document?-- The minutes I had were unsigned and the contents of them we discussed several times, so what I've - whether that's signed was something I would have been more acceptable with from that meeting.

So eventually we can assume, can we, doctor, that by affixing your signature to the minutes of the meeting-----?-- Yes.

-----you accepted-----?-- Yes.

-----what took place?-- I will actually explain what I - what changed there that I was happy with. If you look at the comments about all patients in the public hospital, "The hospital's patients not a specific doctor", which was an argument that we were having for a period of time about these patients of mine on weekends as a VMO being required to remain under my care 24 hours a day, seven days a week whilst I was doing private work, "I am happy to discuss patients that I have operated on"-----

Do you think you need to read it out?-- What I'm saying.

You are happy with that?-- That arrangement I was much happier with.

You were also happy with the arrangements contained in the penultimate paragraph?-- It's says penultimate - says, "Issue of availability of consultant at all times was discussed." Is that what you are talking about?

Yes?-- "Agreed that the ideal to have"-----

COMMISSIONER: You don't have to read that out?-- Sorry about that. I am reading it for myself actually.

MR McDOUGALL: Take your time and read it before you answer. I want you to understand what's in it?-- That's correct. That's what we discussed. We discussed that there were - would be limited things that could be done. I had different opinions about that and I at no stage was given the opportunity to give my impression of what the clinical privileges and what recommendations I had for these people to do this work.

That was the very purpose of the discussion, though, wasn't it?-- At all the-----

That's why you did air-----?-- No.

-----opinions-----?-- No, the discussion wasn't about that. The discussion was about what I was happy to look at doing when I came back in terms of supervision, and if you look at what I said there, I wasn't happy with the supervision of the clinics, and this was done - this did not reach agreement. I was - at one stage in the meeting the idea was that the - these doctors would be able to do everything. My attitude was that there would be very limited things they could do, under supervision, and I mention at the back - at the back was, "The process of the assessment for granting clinical privileges is to be developed in consultation with the Australian Orthopaedic Association." In other words, there had to be a guideline set up for these things. I indicated there were limited things I was happy for these men to do. I supervised them on the occasions that needed to be done. One or two cases that they did I was happy with them to do unsupervised. Both cases are cases that are very simple, not complicated cases. Two cases that was supposed to be done the next day by Dr Naidoo in a supervised trauma case were not done by him and not supervised.

But you accepted that that was an accurate record of the meeting?-- At that stage, yes. Well, I signed it, so I must have been happy.

You say you wrote to the - or contacted the AOA at what time during the - during your association with the hospital?-- I discussed it with the AOA - the problems - after the issue I had with the fractured femur, which would have been - I think the first time I contacted them was in 2003.

Early 2003?-- That's right. The time I was concerned about the roster and consulting roster, that's correct.

Did you have any more discussion with Dr Hanelt about that?-- About what?

About any of these issues?-- Yes, I did.

I'm sorry, I should clarify that. Prior to 16 January 2004?-- Did I discuss any of these issues with him prior-----

Mmm?-- You mean in terms of clinical privileging, et cetera?

Mmm?-- I discussed the situation a lot with Dr Hanelt.

What did he tell you about those things?-- He was happy. He felt it was appropriate. He had a feeling, too, that the colleges were making it more difficult for these men to do their work, and I indicated to him that I thought the colleges were there to provide standards and safety and I felt that we did need to look at more supervision and look at it more properly.

At no stage during your association with Dr Hanelt has he ever bullied you, has he?-- In a physical way, never.

Or in a verbal way?-- No, he has never spoken to me in a harsh way.

He may have disagreed with you from time to time?-- He treated me with difficulty because of the way that he made my work awkward when I approached him-----

What do you mean he treated you with difficulty?-- What I mean by that is when I approached him about these problems, he showed an indifference to the problem that I was trying to bring to bear. He made it hard for me to discussion the situation with him because those issues did not seem to be important at that time, and I found that my clinical governance and safety issues were very much undermined by the fact I couldn't get him to listen to why I was so concerned. He seemed indifferent to it.

I suggest to you that he took on Board everything you told him?-- He never indicated that to me.

How did he indicate to you that he wasn't taking it on Board?-- Because the same problems that I was facing

continued to happen.

They might have been problems, for example, that he wasn't at that stage able to overcome?-- In terms of supervision?

Mmm?-- How could he not change the supervision problem?

COMMISSIONER: I can't understand how he couldn't either, I would have to say. It is a simple matter of stopping these doctors working except under supervision.

MR McDOUGALL: Yes, Commissioner. We will hear from Dr Hanelt about that anyway.

COMMISSIONER: Yes, no doubt.

MR McDOUGALL: I have nothing further, thank you.

COMMISSIONER: You have some questions, do you?

MS GALLAGHER: I have obtained leave, indeed, to appear for Dr Mullen. I was hopeful of some re-examination.

COMMISSIONER: Yes, by all means.

MS GALLAGHER: Thank you.

RE-EXAMINATION:

MS GALLAGHER: Doctor, you started to explain - and I don't know that you finished - that there is a system that revolves around you having VMO or on-call status on a Saturday and a Sunday?-- Yes.

What, briefly, please, is the industry standard at the PA, Royal or anywhere else if, in fact, you are on-call on Saturday or Sunday and don't perform the surgery?-- If I'm on-call on the weekend and a patient gets admitted under me but the surgery cannot be done, then the staff surgeon or surgeons take over the care of that person through a trauma clinic - sorry, through a trauma list, which essentially is a list allocated for patients to be treated for their fractures, et cetera, under supervision. The registrars get to learn, and the surgeon - staff surgeon is able to teach them how to deal with those problems. There is no expectation that the visiting medical officer will come in on a Monday and do that case during the day when he's trying to run the private practice as well.

Do you remember Mr Farr showing you an admission sheet for a patient called P435, and it said "admitted under Dr Naidoo"?-- Correct, yes.

If a patient came to you on a Saturday or Sunday, would that

admission sheet have your name on it?-- Yes, it would.

When you, as I understand it, in effect, handed your care over to Dr Naidoo by default of the system the next day-----?-- Yes.

-----would anybody change the name of the doctor under whom the patient was admitted on the admission sheet?-- No.

Would it therefore look like they were patients discharged by you, indeed, once they ultimately left the system?-- That's what happens. The patient remains on a discharge and will be discharged under me.

Would you necessarily know, if, rather than Dr Naidoo conducting the surgery himself, or supervising, either Dr Krishna or Sharma did the surgery in the week that followed?-- No, I have no feedback.

Does it help you if I tell you, and you will just have to believe me, that the patients to whom Mr McDougall referred you were patients admitted on a Wednesday, a Sunday, a Sunday, a Wednesday, and a Sunday?-- Yeah, because all of those days were my admitting days on-call, so all of those patients would have been admitted when I was in the hospital, under me, and then I was unable to do their surgery because I was then at my private rooms for the rest of the week.

All right?-- So, the plan is that at that stage, which is the - and as I've said, I've discussed this before with the administration, that then the Director of Orthopaedic Surgery or the staff surgeon could look after those patients and deal with their problems. It sounds like there's only four or five patients, but I must have treated thousands of patients at Hervey Bay Hospital in that situation. The majority of my patients would be dealt with when I could, when I was actually in working and on-call.

But, indeed, you have also explained to us the difficulties you faced getting any surgery done on the weekend?-- It is very difficult, because my concerns - and that was the problem, too - I was very keen to get these operations done on the weekend because I knew if I didn't get the job done on the weekend the patient would still be there next week and someone else would have to do the surgery, so I did my utmost to do every surgery I could do - physically possible - unless it came in on the early hours of the Sunday or the Saturday.

Indeed, if you could convince those who managed the purse strings that there was sufficient clinical urgency to warrant the surgery on the weekend?-- Correct.

Can I move across to on-call? Is it the case that you have ever, at your time in Hervey Bay, failed to respond to an on-call?-- I have never had a situation where I have not attended a patient that has been referred to me when I was on-call. Never.

In fact, it is something that you would view very seriously?-- Absolutely.

As a professional misconduct?-- Absolutely. And my experience with it is that the hospital paging system is difficult sometimes. I always eventually will answer my call when I get it. It is not always my problem, it is a locality problem, and I always attend, and I have to see that patient.

And we have had explained to us the difficulties the duopoly of hospitals in that particular district has caused for you?-- That was the point I was trying to make about the fact that when a patient is admitted to the Maryborough Hospital A & E to be seen, the junior doctor there was instructed to directly ring the consultant doctor at the Hervey Bay Hospital. Now, the PHO or junior doctor working for me that weekend would never have that information, wouldn't get that information. Then I would have to go and ring him and go through the process. The way it works better is that the two doctors talk together, then the PHO at my hospital rings me and we discuss the case, and that was the arrangement that I indicated.

I have only one matter for you left, and that's in respect of the report of Dr North and Dr Giblin?-- Yes.

When did you first sight the report?-- I saw that report on the Internet when it was released - the evening that it was released. I can't remember the date of that, but the date the report was released.

Do you mean on the former Inquiry website?-- It was on the website for Bundaberg Base Hospital Commission of Inquiry. I was given that website address like everyone else and that's when I saw it.

Had the grapevine, for want of a better description, informed you of what you could reasonably expect to find on perusal of that report prior to your reading?-- Well, there was certainly talk amongst all orthopaedic surgeons about what the results would be, and that was something that was obviously discussed, as it is a topic of very high interest, and we all would discuss that, but - and we all had our own views as to what would happen, but I never saw that report before everyone else did, and it was very carefully protected.

That's actually what I was asking. Was there any leaked version of the information from the AOA or any otherwise reliable source?-- Not at all. I never saw any information other than what I saw on the Internet at the time it was released.

Thank you, Commissioner. Thank you, doctor.

COMMISSIONER: Mr Andrews?

RE-EXAMINATION:

MR ANDREWS: Doctor, you, in answer to a question before lunch, said that both Drs Sharma and Krishna were aware and talked to you privately - and the note I have paraphrases things - but talked to you privately about the level of care, and "this is why I was aggressive" or "so aggressive with management"?-- Yes.

Now, can you tell me, with respect to Dr Krishna, do you recall an occasion when Dr Krishna spoke with you about the level of care - that is, the level of supervision?-- Dr Sharma certainly did on several occasions. Dr Krishna - there were times when we did discuss it as a group with Dr Sharma and Dr Krishna and myself - both of us present - but I don't think I ever spoke to Dr Krishna on his own about the situation.

When you say an occasion or occasions when you discussed it as a group-----?-- Well, often we would be doing-----

What's the-----?-- We would be doing a ward round together and we would discuss the situation, or I would see - I would talk to them in the tea room or in the corridor, just discussing the problem with them, because there were concerns.

Now, to avoid any confusion, what's the problem - can you-----?-- Yeah, the problem is that-----

-----tell me what they raised with you and-----?-- The problem they had was that they felt that they had come from another country, they had sponsorship by Queensland Health, they weren't comfortable that they would be completely safe with being in the country if they didn't do things that were supposed to be done at that time. They felt-----

COMMISSIONER: You mean expected of them?-- Yes, indeed.

Mmm?-- They felt pressured that they were expected to do these cases because it was what was required of them by the hospital, and they were very unhappy about this, and they expressed this to me. I felt it was my responsibility-----

MR ANDREWS: Now, were they unhappy because it meant there was - they had to work hard or was it a different-----?-- No, I think they were used to working hard, some of them. I think they probably-----

If it wasn't that they were working hard, what was the problem?-- It was the fact that they weren't being supervised to do this work. They felt they were having to do cases that were beyond their capabilities. They felt that they couldn't call on help when they wanted to. They felt that there was problems with patients who they thought they could do better with, but they didn't have the supervision to do so.

Well, if you heard those complaints from the two SMOs, did you pass those on to anyone?-- Well, I talked to Dr Hanelt several times as well, and when we were discussing these things - which, can I say, we have a good relationship - I would consider that we had an open relationship - we would talk a lot-----

Well, with respect to those items - one, that these doctors who had come from overseas were concerned that they had to do everything that was expected of them-----?-- Yes, that's right.

-----would you have bothered to have explained that to Dr Hanelt or would you have confined your discussions to the problem that there was inadequate supervision for these two?-- I'm not sure that I - we got to the stage where I discussed the personal feelings of Dr Krishna and Dr Sharma with Dr Hanelt. I felt a little uncomfortable about that because they had actually talked to me in private, and I thought that it was a conversation we were having about their personal feelings, and I didn't believe that was relevant. The supervision side of things I believe was the relevant issue at that time.

Thank you. I have nothing further, Commissioner.

MR McDOUGALL: Commissioner, I should perhaps tender a copy of the signed memo of-----

COMMISSIONER: Yes.

MR McDOUGALL: I don't know if the original will be forthcoming, but that's the photocopy I have got at this stage.

COMMISSIONER: That's satisfactory, I'm sure.

MR McDOUGALL: If the original comes up, it will be handed up.

COMMISSIONER: That will be Exhibit 372.

ADMITTED AND MARKED "EXHIBIT 372"

COMMISSIONER: I don't think I can excuse you from further attendance, Dr Mullen, because of the unknown patient of Dr Blenkin, but subject to that, you are free to go and if we do need you back, we will try to find some time convenient to you?-- Thank you very much, Commissioner.

WITNESS EXCUSED

MR ANDREWS: Commissioner, an exhibit was tendered by me earlier that, I think, is - the secretary knows the number - 371. It contains a lot of patient details.

COMMISSIONER: Yes.

MR ANDREWS: Commissioner, I should have asked that it be made a confidential exhibit for that reason.

COMMISSIONER: Of course. I so order.

MR ANDREWS: Commissioner, with respect to records, the hospital records relating to P430, P434, P435 and P436, I tender on a confidential basis, because it may be that when Dr Krishna is called, they will be-----

COMMISSIONER: They will together be Exhibit 373.

ADMITTED AND MARKED "EXHIBIT 373"

MR ANDREWS: The secretary is reminding me now - I see that I have tendered also Dr Mullen's own notes, including some opinions and extracts from patient hospital files. I ask that it be made a confidential exhibit also.

COMMISSIONER: Right. I so order.

MR ANDREWS: Thank you, Commissioner.

MR McDOUGALL: Commissioner, one other thing: I did hand over to the witness some patient records.

COMMISSIONER: Yes.

MR McDOUGALL: And they were shown on the screen. I would like those returned to me at this stage.

COMMISSIONER: Yes, certainly.

MR McDOUGALL: And we will make a decision about tendering the whole chart.

COMMISSIONER: I haven't seen them, so I don't know what they are.

MR McDOUGALL: No. But I think Dr Mullen may still have some in his possession-----

COMMISSIONER: Well, I'm sure he will be happy-----

MR McDOUGALL: -----accidentally.

COMMISSIONER: All right. Thank you. We will adjourn until 10 a.m. on Monday.

THE COURT ADJOURNED AT 3.32 P.M. TILL 10 A.M. MONDAY, 26 SEPTEMBER 2005