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Transcript of Proceedings

THE HONOURABLE G DAVIES AO, Commissioner

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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 17/10/2005

..DAY 25

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THE COMMISSION RESUMED AT 9.17 A.M.

STEPHEN MICHAEL BUCKLAND, RECALLED AND FURTHER EXAMINED:

COMMISSIONER: Before we continue with the evidence, Mr Douglas, can I raise two matters generally with respect to submissions? The first relates to complaints. It seemed to me that if I make findings pursuant to paragraph 2A of the Terms of Reference relating to the way in which complaints have been handled by various people, it may be that I would in consequence make recommendations with respect to future legislative or administrative changes with respect to the complaints procedures, and that may involve also recommendations with respect to amendments or repeal of a number of pieces of legislation which relate to complaints procedures.

Now, I mention that because it may be of particular interest to specific parties, Queensland Health, the Medical Board, the AMA and the Nurses' Union, and possibly others, but I think that you should bear that in mind when you are making your submissions.

The other relates to budgets. It is obvious that I don't want to go into major systemic issues which are outside my Terms of Reference, but some of the conduct of officers of Queensland Health, it might be argued, were explained or even justified by budgets which were imposed on them. And so because of that, I will no doubt have to deal with the budgets, that is the budget imposed on officers of Queensland Health by the government, and the budgets imposed by officers of Queensland Health on the various hospitals. So at least in that sense, and perhaps a little more widely, I may want to deal with the question of budgets. So I think counsel should also bear that in mind when making their submissions.

Yes, Mr Douglas?

MR DOUGLAS: Commissioner, there is another issue that I wanted to raise before we proceed with Dr Buckland. I have received an inquiry from the - some of the parties to this Commission to the effect that when it comes to submissions, they may wish - or an individual submissioner may wish to attach documents to those submissions, for instance it may be a patient record or something of that nature in order to properly advance and articulate the submission.

COMMISSIONER: That's a document which is already an exhibit?

MR DOUGLAS: Actually, it is Ms McMillan who raised the issue with me. I understand that to be the case.

COMMISSIONER: Oh, yes, there is nothing wrong with that, of course. In fact, it is helpful.

MR DOUGLAS: In fact, it must be a document already in evidence, otherwise it would be a fresh piece of evidence.

COMMISSIONER: Yes. I am sure that will be helpful.

MR DOUGLAS: Thank you. I have arranged for Dr Buckland to give further evidence.

COMMISSIONER: Yes.

MR DOUGLAS: And, Dr Buckland, you are on your former oath, as you have already been advised by the bailiff?-- Yes.

Can I proceed with that now, Commissioner?

COMMISSIONER: Yes.

MR DOUGLAS: Thank you. Dr Buckland, I am aware you are somewhat disabled from an operation last Friday, but, again, if at any time you wish me to repeat a question or put it another way or slow down, please say so?-- Thank you.

Don't hesitate?-- Thank you.

Thank you. You were requested by my staff to provide a further statement attending a number of issues raised in the evidence?-- That's correct, yes.

And with the assistance of your lawyers, a further statement was produced?-- That's correct.

That statement is dated the 7th of October 2005?-- Yeah, that's correct.

You have signed that statement?-- I have.

You have a copy with you in the witness-box?-- I have, yes.

Is the content of that statement true and correct to the best of your knowledge and ability?-- It is, yes.

I tender that statement, Commissioner.

COMMISSIONER: I think that's Exhibit 458 but I am not sure. I will give it the appropriate number at the appropriate time anyway. 459.

ADMITTED AND MARKED "EXHIBIT 459"

MR DOUGLAS: Yes, 458 was the supplementary statement of Dr FitzGerald.

COMMISSIONER: Right.

MR DOUGLAS: Dr Buckland, can I deal first with RecFind? Do you agree that the effect of your evidence in your further statement tendered this morning was that in 2003 you knew little about the nature or the metes or the bounds of RecFind?-- That's correct, yes.

In 2003 you did know that RecFind consisted of a document tracking system?-- I knew it was a mechanism for registering documents. How it actually - the mechanism of how it worked, I don't know.

You knew in 2003 that in broad terms RecFind was a means of recording the passage of documents through from the originator of the document, or progenitor of the document and the senior officer who would ultimately receive it?-- Yeah, that's true, yes.

You knew in 2003 that RecFind comprehended, among other things, submissions which were being made by senior departmental officers to, among other people, the General Manager of Health Services?-- Yes.

That was the position you occupied in 2003?-- Yes, yes.

In paragraph 1 of your statement, you give examples of overhearing conversations with staff about RecFind, about the fact that it was crashing and these staff were apparently deliberating whether documents should be entered on RecFind at all?-- Yes, that's right.

They were within cursory hearings that you made of people saying things about it without going into detail?-- Yes, just where - the collocation of the correspondence unit was just where my offices were, yeah.

You also say in your statement, under the heading paragraph 20: "I knew that some documents going in and out of my office would be registered to RecFind by Cheryl but I was not involved in that process." This is under the heading paragraph-----?-- Yes, that's correct, yes.

Cheryl referred to there was your executive assistant, Ms Cheryl Brennan?-- That's correct, yes.

You also go on to say - and I quote from your statement: "I did not and still do not know what documents are registered on RecFind."?-- Yes, that's correct.

That's not entirely correct, is it, because, as you just said to the Commission - and I don't criticise you for it - you knew that, among other things, submissions made to you as General Manager of Health Services somehow were tracked on RecFind?-- Mr Douglas, my understanding is that not all documents are necessarily on RecFind. That's the purpose of what I am saying. I don't know which ones do go and which ones don't go. But-----

Did you know - please go on?-- No, that-----

Did you believe in 2003 that if a submission was prepared by a senior officer to be submitted to you as General Manager Health Services, that that document would be tracked on RecFind?-- That - that would be my assumption, yes.

That was your belief in 2003?-- That's what I assumed to happen, yes.

The point of your statement that you just took us to in this statement, about not knowing what documents were registered on RecFind, is a comment directed at various documents but the comment doesn't comprehend submissions?-- It is a comment on basically all documents. I am not sure that all submissions necessarily go on to RecFind. I mean, I just don't know whether they all go on or not. I assume they do but I don't know if they do.

I am asking you about your belief in 2003. So please be focussed on that?-- Yeah.

In 2003, if a document did happen to have - find its way on to RecFind and you were told that, I suggest to you that if that document was a submission, you can conceive of no circumstance, in 2003, why that document would be removed from RecFind?-- Sorry, can you - I-----

I will start again. Focus on your belief in 2003. I want you to assume that in mid-2003, or thereabouts, you had been told that a submission which had been made to you as General Manager Health Services, and which hadn't yet been dealt with by you-----?-- Mmm.

-----in the sense of being approved or disapproved or commented upon, was the subject of some direction from another immediately below you that it was to be removed from RecFind. Can you assume that scenario, please, in mid-2003? Can you assume that, please?-- Yeah, I am struggling with what you are asking me, but okay.

Are you struggling with making the assumption?-- No, I am not clear, sir, what you are actually - what you are actually putting to me.

I am not putting anything to you, I am just asking you to assume that which I just asked you to assume?-- Okay, all right.

In that hypothetical circumstance, can you conceive of any circumstance at about that same time in mid-2003, in which someone within your office would say, "That document ought be removed from RecFind."?-- Well, I can't recall any - any conversation about taking documents off RecFind.

COMMISSIONER: That's not what you were asked. Can you conceive of any circumstance where anyone could suggest or

require that that document, being a submission, be removed from RecFind?-- Not - not generally, no.

Well, not at all?-- Well, Commissioner, I don't know all the circumstances that sit behind RecFind. All I am saying not generally I would assume that that would come off, no.

MR DOUGLAS: Dr Buckland, you have been made aware by your solicitors that Queensland Health late last week provided to my staff and also to your solicitors a bundle of documents headed "Corporate Office Document Management Documentation"?-- Is this - these are the ones I received this morning, yes.

You have a copy of that with you in the witness-box?-- I do, yes.

And you received a copy of that from your solicitors this morning?-- It was handed to me this morning while I came in, yes.

You informed me before evidence commenced this morning that you really hadn't had an opportunity to look at it?-- That's correct, yes.

Thank you. Before we started this morning, I asked you to direct your attention specifically to a particular portion of that?-- That's correct.

Thank you. To start with, can I ask you some general questions about this bundle of documents? This particular bundle would appear to consist of a number of extracts comprehending the period from 1998 to date from a document which is described as Executive Services Guidelines?-- Yes, this bit here?

Yes, thank you. If you need any assistance at all just ask the bailiff, Dr Buckland?-- Yes, thank you.

Do you see the language spread throughout the document depending upon particular sphere - "executive services" - and at the base of the specific page I asked you to look at, "Executive Services Guideline"?-- Yes.

On that page, which is the page for July 1999 - for those behind me and beside me, page 9 - it would appear to be an extract from that particular document?-- It would appear so, yeah.

Could you tell the Commissioner whether in the period from 1998 to when you ceased as Director-General this year, you were familiar with a document, or series of documents described as "Executive Services Guidelines"?-- I wasn't - wasn't overly familiar with it. I mean, no, obviously they existed but I hadn't read it, no.

Was it a document in its form at any particular time throughout that period, the observation Executive Services Guidelines which you had read?-- I don't recall reading it.

I mean, I didn't manage documents, so I probably didn't read it. I mean, I don't recall.

You took up your position as GMHS on the 29th of July 2002?-- I think that's right, yes.

Were you acting GMHS prior to that time?-- I think I had acted for a few weeks at various times but not for any extended period, no.

Thank you. Prior to taking up the position as GMHS on 29 July 2002, you were the Southern Zone Manager for Queensland Health?-- That's correct, yes.

In your capacity as Southern Zone Manager for Queensland Health, there would have been a number of occasions when you, at the very least, cleared submissions made to your predecessor, Dr Youngman?-- That's correct, yes.

Dr Youngman was GMHS for some years prior to July 2002?-- Yeah, that's correct.

Just look at the page then that I directed your attention to, and I flagged it in the copy that you have, Commissioner.

COMMISSIONER: Yes.

MR DOUGLAS: It would appear to be the extract from the Executive Services Guidelines, designated date July 1999, page 9, would it not?-- Yes.

Thank you. And it purports to deal with the subject matter of submissions?-- Yes.

And if you look down the page, you will see there is a bold type statement - and I will precis it - to the effect that a recommendation obviously contained in a submission, should be supported by sufficient information required to reach a decision. Do you see that?-- Yes.

Thank you. And then if I can precis what appears below that, there is a direction that "submissions must be cleared". Do you see that?-- Yes.

Then there is a direction that "submissions must be delivered or faxed, not sent in electronic form, to the Executive Support Unit at Queensland Health." Do you see that?-- Yes.

And then it is said that "submissions are then registered on RecFind (the tracking system) prior to being forwarded to the Minister/Director-General/Director-General Policy and Outcomes/Director-General Health Services"?-- Yes.

And that's then described as "an important step". Do you see that?-- Yes.

And the author of this document, the Executive Services Guidelines, seems to then go on and give a reason for that in

bold type. Do you see that? The reason apparently being-----?-- Yes.

-----"to avoid the document being misplaced or not actioned"?-- Yeah.

Just pausing there, Dr Buckland, what we've been through thus far, did that, or does that in any way assist you in recollecting whether this was a document that on or after July 1999, when you were Southern Zone Manager, that you had read at any time?-- No, it doesn't. I mean, my reading of that is simply that it is a process outlined for the people who manage the documents, movement of documents through the organisation, and that happens at executive support level. You know, they are not registered or moved, in fact, by executive members. So I assume it is a guideline for - for the tracking - for the movement of documents by executive support people. Not by the - well, not by me.

Can I then go on to the next item? It says "if a submission is returned for amendment, the original submission must be returned with the amended version". I think I have correctly recited it?-- Yes.

Thank you. Put yourself back in the position you were, if you could, after 1999 when you were Southern Zone Manager and then subsequently when you became General Manager Health Services. In what circumstances might a submission be amended and then returned?-- Sorry, returned for amendment, or amended and then returned? Sorry.

I am asking you about this particular document we have been given by Queensland Health?-- Yeah.

I am asking if you can assist in terms of the anecdotal, on the ground circumstance which is described as "a submission being returned for amendment"?-- Well, I think - I mean, one that comes to mind, Mr Douglas, is the one that related to Berg that I sent back and said, "This submission is incomplete", and it was, to my understanding, then sent back and redone.

I see?-- So, I mean, that's one off the top of my head.

All right. And the example that you just cited is one in which you believe that further information was required in order to make a decision on that particular subject matter; is that so?-- Yeah, at the time I believed that - the information was incomplete and not as sufficient to be able - or didn't actually carry all the information that needed to be in it.

I don't want you to turn over the pages because I am conscious of your present disablement, but it would appear that in 2002, in this bundle, there seems to be a - almost a facsimile set of instructions as to the manner in which documents were dealt with in the instance of submissions. You have that, Commissioner?

COMMISSIONER: Sorry, yes.

MR DOUGLAS: I have invited the witness to turn over several pages. I haven't flagged it for you.

COMMISSIONER: That's all right.

MR DOUGLAS: It is pages 9 and 10 of the equivalent document Executive Services Guidelines, March 2002, the date appearing at the foot of the page.

COMMISSIONER: Yes, I have that.

MR DOUGLAS: Do you see at the top of page 10 there seems to be a similar recitation or prescription of dealing with submissions?-- Is just the bit about "all submissions must be cleared"?

Yes?-- Yep.

If you can just turn back a page, the author of this document seems to have enjoyed some prescience because towards the foot of the page you will see that, as an example, you are noted as being General Manager Health Services notwithstanding the date of the document, March 2002. Perhaps in anticipation of your ascension, Dr Buckland. Do you see-----?-- I see the signature block, yes.

Perhaps it was changed subsequently. In any event, you didn't read this document, even in 2002 when you ascended to the role of GMHS, that is the Executive Services Guidelines?-- No, I don't recall, Mr Douglas, reading it, no.

Thank you. Commissioner, I tender that bundle of documents.

COMMISSIONER: Yes, all right, that will be Exhibit 460.

ADMITTED AND MARKED "EXHIBIT 460"

MR DOUGLAS: Commissioner, it isn't supported by a statement at all, but in the circumstances in which it is provided, I don't require that.

COMMISSIONER: No.

MR DOUGLAS: And I don't submit to you you should require it, but if some party requires it to be so supported, then they can make a submission to that effect.

COMMISSIONER: Yes.

MR DOUGLAS: Thank you. Can I just come back briefly to the concept of a submission being the subject of amendment - or

possible amendment. I suggest to you, from your experience, Dr Buckland, that there is good reason for the original submission, that is the unamended submission, to be tracked because eventually the document, presumably, will have to come back in an amended form for some decision by the decision-maker in question, namely, in the examples we're giving, the GMHS?-- Yes.

So whether it goes up and is sent back for some amendment, it is important to track it through because, as the guidelines quite helpfully suggest, documents, that is important documents, submissions, might be misplaced within the system unless there is some means of seeing where they are in the process at any particular time?-- Yeah, I think the question is where would they be held. But, yeah, fundamentally that is right, yes.

You say in your statement that you don't recall having any conversation with Ms Miller in which she advised you that the 30 July 2003 submission from the SAS should be removed from RecFind. Do you recall that?-- Yeah - no, I don't recall her - yeah, I recall what I said in the statement. No, I don't recall that conversation.

You go on to say that you don't deny that such a conversation might have occurred?-- That's correct, yeah.

I don't want to play with words. What you are really saying in that respect, I suggest to you, is it may or may not have been said. It isn't one of those circumstances whereby "I can't recall, but if it were something important, I would remember it."?-- No, I actually don't recall ever having any conversation about documents coming off RecFind.

The point you are making in the statement is in or about mid-2003 you weren't offended by the notion that a person in Ms Miller's position, an advisor to you, is suggesting that a document in the nature of a submission should be removed from a Queensland Health tracking system. That's the import of what you are saying?-- Mr Douglas, what I am saying is I don't recall ever having had that conversation. All I am saying is I don't deny it happened. If it did happen, I can't recall it happening. But, I mean, the management of documents didn't occur by me. If somebody came and advised me and said, "We think you should manage a document in a particular way", then that's the advice I would accept. I mean, there are thousands and thousands of documents that come through on a regular basis and that's - you know, once I have done my bit with the document, it is managed by other players, not by me.

But you were the General Manager of Health Services. I suggest to you you must have had some interest in ensuring that among those thousands of documents/submissions that came to you from your senior officers should be properly recorded within the system?-- Yeah, and that's true, but I don't see the linkage, I am sorry. I mean, I just - if that's the - I don't manage the documents, I have never managed the documents, and they are managed by people who know what they

are doing with documents, not by me.

Were you interested in ensuring that your staff did properly manage documents?-- Well, I assume they would have carried out their duties appropriately, yes.

But in this particular instance, the officer in question, Ms Miller, specifically put to you that she proposed to remove it from the submission tracking system which you knew that Queensland Health had on foot?-- Well, that's what she says. I don't recall that conversation.

Assume she did say it to you in 2003. Just assume hypothetically you are told that. Wouldn't that notion be offensive to you, to the extent of you thinking to yourself, "Why is it this person's telling me that a submission that's come to me for my consideration, albeit one that we think requires further information, ought be removed from what I know to be the document tracking system for this type of document?"?-- I mean, I honestly haven't thought about it and if the advice to me was that was the appropriate way to manage the document, then I would have accepted that.

COMMISSIONER: It didn't seem to you at the time a very strange piece of advice, perhaps even illegal piece of advice?-- Commissioner, the documents that I have seen are only guidelines. They're not rules and set in concrete. They're Queensland Health guidelines.

No, no, we're talking about removing a document from a document tracking system?-- I think in hindsight, probably, I would have probably - if the conversation had occurred, I probably would have paid more attention to it but at the time, look, amongst a myriad of conversations, it doesn't - I just don't recall it I'm sorry.

You're not denying the conversation occurred?-- No, I just don't recall it happening, no.

All right.

MR DOUGLAS: You know that the document about which Ms Miller gives that evidence is this memorandum of the 30th of July 2003?-- I'm aware of that, yes.

That was a document I suggest to you, having regard to its content, that you were irritated to receive?-- No, that's not true.

I suggest you were irritated to receive it because you believed that the SAS ought to have consulted the health service districts before making the submission to you?-- No, I - no, I wasn't irritated by it. I mean, I had a set of beliefs and there were clearly instructions afoot of how documents should have been managed by the Surgical Access Service before they came to me for decision and that was well articulated, well known.

Did you believe that the 30th of July 2003 submission from SAS didn't comply with those requirements?-- I thought it had - it certainly short-circuited them because it was still a document worthy of consideration. I thought they could have done a lot better with it. In fact, that's what I would have expected of them.

But you still believed it to be a document worthy of consideration?-- Well, I had a meeting about it, Mr Douglas. I thought it was an important piece of information.

That's why you had a meeting, because it was so important?-- Well, it was an important piece of information, that I wasn't going to get caught up in a bureaucratic process of going backwards and forwards. I mean, it was there; I needed to understand the meaning of it. And even though the process hadn't been appropriately followed, I still needed to get an understanding of what was - what was in that document, yes.

Thank you. Commissioner, for your benefit and for the benefit of those representing parties here, in respect to the questions I'm now about to ask, I'll be referring to pages 6613 and the following page of the examination by me of

Ms Miller.

COMMISSIONER: Yes.

MR DOUGLAS: Dr Buckland, I'm not sure whether you've read the transcript at all of other witnesses since and I'll proceed on the footing for the moment that you haven't or haven't thoroughly read that transcript?-- Yes.

Thank you. Ms Miller has given evidence to this Commission that generically a submission in 2003 made to the General Manager Health Services is what she described as a draft document. Can I go one step further: the effect of her evidence was that until it was signed off by the GMHS, it ought not be placed on the public record. Do you have any comments upon that approach to characterisation of submissions made to a GMHS of Queensland Health in 2003?-- Yeah, I - what you're putting to me is that any document that comes up that I haven't signed is a draft; is that what you're saying?

Yes?-- Yeah, no, I don't agree with that.

It is nonsense?-- Well, I don't understand that, yes.

Thank you. I want to take you now to - specifically again to the 30th July submission, that is 30th of July 2003 submission. I don't want to take you to the detail of it; I merely want to identify it as a document for the purpose of my questions. You've already told the Commissioner a short time ago that you saw that there was some substance to the document in the sense that it was worthy of consideration and in turn for you to have a meeting with is SAS team in relation to the subject matter?-- That's right, yes.

Your statement refers to the fact that on or about the 15th of August 2003 you recall having a meeting with the SAS team?-- That's correct, yes.

Ms Deb Miller was also present at that meeting?-- That's correct.

You know that among other things because there was some notes made by her apparently on that day?-- Yeah, that's right.

The upshot of that meeting was that you gave permission to the SAS team to approach the individual hospital districts to elicit further information?-- Oh, there was a lot more to that meeting than just that outcome. I mean, the issue for me at that meeting was really about what - how the information was gathered, what the document meant, what the - were explanations for the document as presented - table 1 probably was the main - the most important part of the document, for me to understand that, because it wasn't clear from my point of view that consultation hadn't occurred with districts at all or with zones, that in fact that the elective surgery team or SAS had working knowledge of explanations for - for that data and, clearly, we needed to be able to - and some of - some of it was clearly aberrant, like the Nambour data. So, clearly,

we needed to go back and understand the full meaning and implication of that.

When you say some of that data was clearly aberrant, namely, Nambour?-- Yes.

What did you mean to communicate to the Commission by saying that?-- Well, it looked - it looked extremely unusual, the Nambour data. When - I haven't got the document with me but from recalling it and reading it recently, I mean, the Nambour data is - is of some significance in that it's a deviation from what you might have expected.

Thank you. Your view at the time of that meeting on the 15th of August 2003 was that notwithstanding instances such as the Nambour aberrant data, that the SAS team had provided this submission to you without first going into the field and eliciting and descending in this 30th of July submission to other explanations for the data they were presenting?-- Just - can I - just to go back a little bit. I mean, the instructions that had been in place were really that any - any submission which involved performance, business rules or funding needed to be properly consulted before it came up because, I mean, just the volume of work, you don't want to be going backwards and forwards being the person who's actually gathering all the big pieces of information from various parties. It should really come as one package that allows, you know, a timely and a reasonable decision making process rather than being the co-ordinator of many pieces of information. So that's the fundamentals behind it.

On the 15th of August 2003 was it your view that the way in which the SAS team had presented the data and arguments in the 30th of July submission was such that such document could be characterised as being embarrassing?-- Oh, no more than many other documents that we see. I mean, any - any process that highlights, you know, a difference in practice whether it be clinical or financial or this sort of data always had potential I guess to be embarrassing, but I don't think this is any more - my concern for this was that it wasn't properly researched more than, you know - I mean, more than the data per se. It just wasn't properly researched.

The 30th of July 2003 document in your view as at 15th August 2003 was an inadequately researched document which didn't present all of the alternative explanations and which was undertaken without consultation?-- Well, it could have been a lot better done, yes.

In your view, as at the 15th of August 2003, that document was a wholly inadequate document?-- Oh, no, I wouldn't - I wouldn't say it was wholly inadequate. No, that would be unfair comment. But it was - it was - it wasn't the sort of document that I would have liked to have seen. I mean, there is no doubt that there was a significant amount of work behind it which highlighted issues which needed to be looked at, so I wouldn't say the document was an inadequate document. I mean, it just wasn't in a format that made it really easy to be able

to say, "Okay, this is what I'm dealing with and this" - really, when things come to the general manager of health services, I mean, it really is about - particularly submissions, really about decision making or should be as much about decision making as they can be rather than going back and instigating a whole new series of research. So from that point of view it is disappointing but in terms of the fact that there was information in it which I had not seen before, that was important.

Dr Buckland, can I ask you some questions now about Cheryl Brennan?-- Yes.

Cheryl Brennan was, in effect, your executive assistant?-- That's correct?-- Yes.

She was your executive assistant as General Manager Health Services?-- Yes.

In fact, you know that she was a person fulfilling a similar role during the tenure of your predecessor, Dr Youngman?-- That's correct, yes.

You would describe Cheryl Brennan in your opinion as a thoroughly reliable person?-- Yes, Cheryl - Cheryl certainly was very competent. The only - yeah, I'll leave it at that.

You would describe her as a thoroughly reliable person?-- Most of the time, yes.

She was a person who in your experience was vastly experienced in acting at a senior level as an executive assistant?-- Yeah, she - she had a lot of experience. I - yeah.

Having regard to your experience with her as your executive assistant, you always observed and saw her to act strictly in accordance with your instructions?-- Most of the time that's true, yeah. Mr Douglas, I don't want to go into people's individual personalities. I mean, Cheryl was an anxious individual who sometimes needed to be properly looked after. Obviously was concerned about a number of personal issues which I don't think I would like to go into, but in general the statement is true, yes.

By the end of the 15th August 2003 meeting with the SAS is it fair to say that you were apprehensive that the information and views assembled in the 30th July 2003 submission may find its way into the hands of the hospitals themselves or wider audience?-- No, not at all. I mean, we needed to go out and check with the hospitals so, no, I wasn't concerned with the document. I mean, that was the information that needed to go out there so we could understand what the balance was.

Were you concerned that the press may get their hands on it?-- No, not at the time. I mean, I was far more interested in getting a balanced view so I could make a reasonable decision on what had been presented to me.

It raised the issue, among other things, of allegedly illicitly claimed funding?-- Yeah, that's one interpretation of it. There were lots of interpretation of that data and that's what I needed to understand, yes.

I did say allegedly illicitly claimed funding?-- Yes, that is one interpretation of it, yes.

Did you think that that was the sort of stuff that may be embarrassing if it were to find its way into the press?-- I mean - well, it probably would have been, yes, but as I said, there is a lot of information that comes across your desk that may be embarrassing. Of more concern, Mr Douglas, for me was the fact that it would have been - it may well have been interpreted by hospitals as being adversarial at a time when we were trying to work through a program in a - in a meaningful way and it's a complex program, the surgical program, and I was more concerned about the them and us attitude and, if you like, the bureaucratic red tape that sat around what was happening as opposed to what other players might think about it at the time.

For that reason was it your view at or about the time or following the 15th August 2003 meeting that it would be best if, in effect, the SAS started again and that the 30th of July submission be removed from history?-- No. That's not my view.

I beg your pardon?-- No, no, that's not my view.

It wasn't your view?-- No.

It was a document I suggest to you, come 15th August 2003, which was in a form which you thought highly inappropriate?-- It was a document that - that had some significant statements to make but it wasn't properly researched. I don't - I wouldn't go any further than that with the document.

Dr Buckland, think carefully about my next question before you answer. I'll repeat it if you wish?-- Yes, I will.

Do you deny that following the 15th August meeting you instructed Ms Brennan or one of your other staff to communicate to the SAS team that electronic and hard copies of the 30th July 2003 submission should be electronically removed and destroyed respectively?-- Yes, I deny that.

You exclude the prospect of you having said anything to that effect to your staff?-- Yes.

You understand why I ask the question, having regard to the evidence of Dr Cuffe?-- Yes, I'm aware of - at least in part of Dr Cuffe's evidence and, no, I didn't instruct anybody to do that with the 30th of July document.

Thank you. Dr Buckland, I want to go on, so I can telegraph to you precisely where I'm going, to deal with your conversation with Dr Cuffe which occurred in early 2004 which

led to your - in turn to your discussions with Mr Walker. Do you know that to which I'm taking you?-- Yes, yes.

Thank you. You deal with this in paragraph 4 of your statement and, Commissioner, for your assistance and for the assistance of the parties, I refer to my examination of Dr Cuffe at page 6557 lines 10 to 30 of the transcript and the cross-examination of Dr Cuffe by Mr Applegarth at pages 6580 lines 40 to 60. Dr Buckland, you acknowledge and recall having a brief conversation with Dr Cuffe in early 2004 in which you raised a number of issues, one of which was a document which was seen on the desk of the SAS team secretary?-- That's - that's correct, yes.

You say in your statement that you recall initiating that discussion with Dr Cuffe, words to the effect that, and I'll quote from your statement, "I've been told that a document by Mr Walker on reclassification has been seen on Mr Walker's desk", or words to that effect?-- Words to that effect, yes.

Just pausing there for a moment, come early 2004 we know that by that date the new rules for elective surgery funding for 2003/2004 had been signed off in October 2003?-- At the end of October, that's right, yes.

In fact, the document is in evidence, but you signed that and the various zone managers signed it as well?-- That's correct, yes.

Thank you. And by early 2004, as you record in your statement, and you take this up from Dr Cuffe in effect, a truce had been declared between the SAS and the hospitals in respect of that topic?-- Yeah, I mean, that's a - it's - I'll accept that as an interpretation, yeah. I mean, we worked our way through some very difficult negotiations and I think we got a reasonable outcome, yes, so a truce is probably a fair - a fair comment.

Dr Buckland, have you read the transcript of what Dr Cuffe says about your conversation that you had in early 2004 and the document which was identified?-- I have but I don't - I had read it but I'd need to refresh my memory.

I propose to remind you of it; in fact, put it to you at this particular point?-- Okay.

I suggest to you that in this conversation you had with Dr Cuffe the effect, indeed words that you used were along these lines, that you said to him that the document that had been seen on the desk of Mr Walker was, "The document I asked you to be destroyed." What do you say to that?-- I completely reject that.

You did use the word "destroy" in this conversation, didn't you?-- No, I didn't.

There was only one - I'm sorry, I'll start again. As at the time of this conversation, there was only one recent

submission which was in your mind at that time totally offensive in terms of its presented form and that was the submission from the SAS dated 30th of July 2003?--
Mr Douglas, I wasn't talking about any submission that was offensive to me. What I was talking about was a document that had been seen in relation to reclassification. To my view of the reclassification debate, we had gone through a fairly arduous process and there is a fairly lengthy audit trail to show that to - to get what was a reasonably agreed outcome on a way forward, the change in business rules and then we changed the financing over the next 18 months. So I was more concerned that we were just going to see the whole thing come back. I mean, if you had have said what date was on the document, I mean, it is irrelevant to me. The document date or when it was is of no concern to me at all. So-----

I don't suggest to you that you mentioned the date to Dr Cuffe?-- No, but you put to me that's the document of any concern but it is not a document of concern. It is a document which we actually acted on and took significant action on.

You were fairly relaxed about all the other submissions that were put by the SAS to you between the 30th July submission and the signing off of the rules in October?-- Yeah, relaxed would be a generalist word but, I mean, the - it's business as you go through and as each evolves you gather more information and your decision making becomes more honed, but even for the 30th of July document, it is not a document that, you know, has - is an alarm bell document.

Why would you be concerned about any reclassification document-----?-- Well, because-----

-----Being - let me finish my question?-- I'm sorry.

Why would you be concerned about any reclassification document as opposed to the 30th of July document individually being on the desk of an SAS secretariat?-- Well, I would be concerned because this was a story that had gone on for a very long number of years, long before I even came into the general manager's job, and it had been - it had been agitated and re-agitated and reborn and had been discussed and decided on and come back again and my view was that we had reached, in my opinion at least, a fairly reasonable compromise on a way forward and to suddenly come back to - what I was - to suddenly come back for, "Oh, here we go again", you know, "How many times do we actually have to discuss this and try and put it to bed", was really what the issue is about. Not about a particular document. It is about the issue itself which has gone through a series of iterations, a series of briefs and submissions, a series of decisions that it would be disturbing to think, "We're going to go back and have to do this all again."

Well, why not then say to Dr Cuffe, if that was your view, "Look, I understand that your staff have reclassification submissions sitting on their desks and I am concerned that they're going to regenerate this issue again."

Why not say that to him?-- Well, the conversation was about two milliseconds long. It was basically saying, "I've been told there's a document on reclassification on Mr Walker's desk. What's going on? And by the way, he did something at a med supers conference which I'm not happy about." And, that Mr Douglas, was the total - totality of the conversation. It wasn't - it was surely - just a corridor conversation. It wasn't a, you know, "Come and meet with me. We have got serious things to talk about."

Did you ask him for a formal response?-- I don't recall that I did, no. And then Mr Walker contacted my office subsequently.

You have known Dr Cuffe for some years?-- A fairly lengthy period of time, yes.

You would expect that if you raised an issue like that with Dr Cuffe, that he would not just let it go through to the keeper, that he would act upon that?-- No, I wouldn't know that. I mean, no, it wasn't that sort of conversation. It wasn't a, you know, bring-someone-to-me conversation. It wasn't like that.

Why did you think it necessary to raise it with him?-- Well, because he is the boss. He is the boss of SAS. I'm just saying, "What's going on? Don't" - basically, the message is, "I hope we're not going to go back and do this all over again."

COMMISSIONER: Aren't you saying to him, "Find out what's going on and get back to me"?-- Commissioner, it was a conversation. It is not a direct instruction of saying, "I want it back by this time." The question is, "What's going on?" Now, he could see me in a month's time and said nothing, you know, the issue is pretty much dealt with and gone to bed.

MR DOUGLAS: I suggest to you that your view was at the time you had this conversation that this document, namely the 30th July document you'd received and conferred about on the 15th of August, was one which, contrary to your instruction, hadn't been destroyed?-- No, I reject that completely.

Yes. That's my examination, Commissioner. Unless there is some other issue you wish we to take the witness to?

COMMISSIONER: No. Is there anyone else other than Mr Applegarth who wants to ask questions of this witness? Mr Applegarth.

MR APPLEGARTH: Commissioner, you make a wrong assumption. I don't want to ask the witness any questions.

COMMISSIONER: Good. Thank you. Well then, we don't need to keep Dr Buckland here anymore, do we?

MR DOUGLAS: No, we don't, may Dr Buckland be excused?

COMMISSIONER: Yes.

MR DOUGLAS: And thanks for making yourself available, Dr Buckland?-- Thank you, and thank you for allowing me to be semiclothed.

COMMISSIONER: Yes.

WITNESS EXCUSED

MR DEVLIN: Commissioner, I seek leave to tender an affidavit of James Patrick O'Dempsey.

COMMISSIONER: Yes.

MR DEVLIN: The board communicated with the secretary late last week.

COMMISSIONER: Yes.

MR DEVLIN: It is a document which goes to the administrative arrangements for the registration of medical practitioners in Area of Need. I have an original and I have a copy.

COMMISSIONER: All right. Thank you.

MR DOUGLAS: Commissioner, if you could also receive at this time, there is a further statement of Michael-----

COMMISSIONER: I'm sorry, that will be Exhibit 461.

ADMITTED AND MARKED "EXHIBIT 461"

MR DOUGLAS: Yes. It is dated the 4th of October 2005. It was produced by Queensland Health.

COMMISSIONER: I'm sorry, what is?

MR DOUGLAS: I'm sorry, you are dealing with something else.

COMMISSIONER: I'm marking the affidavit from Mr Devlin.

MR DOUGLAS: Thank you.

COMMISSIONER: What else did you say you have?

MR DOUGLAS: A statement, a further statement of Michael Carlo Zanco, Z-A-N-C-O, dated 4th October 2005.

COMMISSIONER: Yes.

MR DOUGLAS: It is a document dealing with data collection in relation to elective surgery. He has already provided a number of statements. I don't require Mr Zanco to present for examination.

COMMISSIONER: That will be Exhibit 462.

ADMITTED AND MARKED "EXHIBIT 426"

MR DOUGLAS: Thank you, your Honour.

COMMISSIONER: Anything further before we adjourn to go to 32?

MR DOUGLAS: Not on my part, your Honour.

COMMISSIONER: Nothing from anyone else? We will adjourn until we are ready to proceed with Mr Leck.

THE COMMISSION ADJOURNED AT 10.14 A.M.

THE COMMISSION RESUMED AT 10.47 A.M.

MR ANDREWS: Commissioner, if I may, I call Peter Leck, but in the circumstances, I would ask Mr Leck to remain seated.

COMMISSIONER: Certainly.

MR ANDREWS: I wonder if I can do the same?

COMMISSIONER: Yes.

MR ANDREWS: Thank you. Mr Leck needs to be sworn.

PETER NICKLIN LECK, SWORN AND EXAMINED:

MR ANDREWS: Is your full name Peter Leck?-- Peter Nicklin Leck.

Mr Leck, have you prepared a statement on the 11th of May 2005 of about 70 paragraphs?-- Yes.

And you've signed that document?-- Yes.

Do you have an original with you?-- Yes.

Are there some changes that you would care to make to have it more accurately reflect matters?-- Yes. Item number 14, it says, "In March 2004 Ms Goodman retired." It was by March 2004 she had retired.

Thank you?-- And then item 24, it says, "I gave Dr Keating a verbal summary of the letter and showed it to him." I'm now not sure that I actually showed him the letter.

Would it properly read then, "And I may have showed it to him, but I cannot now recollect."?-- Yes.

Are there any others?-- No.

Thank you. I tender that statement.

COMMISSIONER: That will be Exhibit 462. We can arrange the exhibit numbers correctly later on.

MR ANDREWS: Mr Leck, have you prepared, with the assistance of your instructing solicitors, a chronology?-- That hadn't been personally prepared by me, but there's been discussion with my solicitors in relation to that.

With respect to that chronology, are you able to say whether, so far as you can recall, it appears to accurately set out a chronology of some relevant events?-- Yes, as far as I can

recall.

Well, I tender that document.

COMMISSIONER: That will be Exhibit 463.

MR BODDICE: Commissioner, I have a record that Mr Zanco's statement was 462.

COMMISSIONER: Thank you very much. Well, these will be 463 and 464 respectively.

ADMITTED AND MARKED "EXHIBIT 463"

ADMITTED AND MARKED "EXHIBIT 464"

MR ANDREWS: Mr Leck, I see from your statement at paragraphs 5 and 6 that since about November 1992, you've been engaged in the roles of District Manager at the Mount Isa Hospital and then at the Bundaberg Base Hospital?-- That's correct.

Indeed, I suppose, more accurately, one says that you are a District Manager of a Health Service District?-- Yes.

The appointment to the Bundaberg Health Service District will have carried with it a number of obligations for you as a District Manager. Am I right in thinking that the documents that I should refer to to determine just what duties you, as a District Manager, had, would be your initial job description and then a number of service agreements?-- Yes, they would cover my role.

I put the job description on the monitor. This is a Queensland Health position description. It seems to have a review date of May 1996, but I understand, and I would like you to confirm, that this was the position description at the time of your appointment in 1998. You can perhaps determine that by looking at some features of the document?-- I can't actually recall receiving a position description at the time I was appointed. It was more based around the contract of employment.

Thank you. It comes as no surprise that you wouldn't recall a document that would now be seven years old. Would you please turn to the first flagged page within that document? I beg your pardon, on page 1, are there any items that have been revealed by highlighter? That position description document suggested that there would be formal service agreements established to detail the scope of services and activity levels to be delivered within the allocated budget. Do you remember whether you received a series of service agreements annually?-- Yes, yes, we did. Yes, I did.

And it suggested that Managers, presumably District Managers, would be responsible for development of operational plans and strategies to maximise health service outputs. Do you see that?-- Yes, I do.

Now, you have no clinical expertise?-- No, I don't.

Is anything in that document currently requiring or suggesting that a District Manager is required to call upon personal clinical expertise? It doesn't appear to, does it?-- No.

May I see the next marked page, please? Within that position description document, at 4.1, it was suggested that one of the principal responsibilities was to deliver quality health services in accordance with the service agreement. Did you regard one of your responsibilities as the delivery of quality health services?-- As part of my overall responsibility, yes.

Thank you. Is there another flagged page? You understood one of your responsibilities to be to implement Queensland Health policies?-- Yes.

Thank you. I have a number of service agreements spanning the years 2002/2003, and 2003 /2004, 2004/2005. I will ask you to look at them, or at certain passages within them, to identify them. As I understand it, they are service agreements for the Bundaberg Health Service District, but I'll ask you to confirm that. Do you see on the monitor that this Service Agreement for 2002/2003, on its second page, seems to relate to the Bundaberg Health Service District-----

COMMISSIONER: 2001/2002.

MR ANDREWS: I beg your pardon, 2001/2002, thank you, Commissioner. Could the first or the covering page of that document be revealed? Now, the document that you have before you plainly contains a contradiction. On the first page it suggests that it is the Central Zone Management Unit Service Agreement for the Bundaberg Health Service District for the years 2002/2003, but on the inside, the next page within, it suggests 2001/2002. However, you will see further down the page, it refers to Schedules 1, 2 and 3 with activity targets, and approved budget and business rules for 2002/2003. Now, bear those contradictions in mind as we move within the document to some of the passages I've marked with a highlighter. Could I see just below that where there is a dated section? This particular copy is unsigned, and appears to be marked with the date 2002, but do you - do you see the paragraph above? It seems, from my reading of three years of agreements, to be a standard form which appears in each of the service agreements; that is, it suggests that it is an agreement between the General Manager of Health Services, the Zonal Manager and the District Manager. Do you recall that your service agreements were framed in such a way?-- Yes, it looks typical of what they were like.

Thank you. It is said to constitute the accountability of the

District Manager to the Director-General in relation to the resources allocated to the Health Service District for 2002/2003, and the corporate responsibilities to be discharged. Is that typical of the service agreements?-- Yes.

Underpinning the agreement is the obligation to adhere to policies, practices, guidelines, among other things; is that typical?-- Yes.

And did you understand your duties to be including adherence to relevant policies, practices and guidelines?-- Yes.

Bearing in mind that it does seem to refer to resources to be allocated for 2002/2003, it seems likely that that's the service agreement relating to that financial year; would you agree with that?-- I think that's likely.

May I see the next flagged page? A key undertaking seems to have been - and the first of them was - to maintain budget integrity. Was that something you regarded as one of your primary responsibilities?-- Yes, I think that Queensland Health made it clear that budget integrity was a major focus.

And before you could introduce any new services or enhance any services, you had to obtain Zonal Manager's approval?-- Yes.

And was that even if it was obvious to you that they would be useful enhancements, you would have to obtain somebody else's approval?-- That's correct.

Now, within the key undertakings, are there any that appear to you to relate particularly to a concern with - well, directly, patient outcomes, or are they more to do with other matters?-- It appears to be focused on resource management, budget, those sorts of things.

Thank you. Can you turn up, please, the next page marked, and, in particular, any section shown with a highlighter. Which page number is this? Is it marked on the bottom of the page.

DOCUMENT MANAGER: It just says "Service Agreement".

MR ANDREWS: Well, from within the schedules, do you see certain targets and undertakings?-- Yes.

And one of your targets was the effective management of activity?-- Yes.

And the measures and strategies that you were to use included "meet weighted in-patient separation target" and "meet elective surgery target". Do you see that?-- That's right.

Each were - it says "TBA". Is that "to be advised"?-- "To be advised", yes.

"Weighted in-patient separation target", the Inquiry has heard

some evidence explaining the meaning of "weighted separations". Does "weighted in-patient separation target" have to do with the District's aim to have - or to meet a target of numbers of procedures of certain degrees of complexity?-- I wouldn't use the word "procedures". It is about - it is value-based on the complexity of the care that is provided to a patient.

And so a simple procedure might have a weighted separation of one and a complex one might have a higher number of weighted separations?-- Yes, that's right.

And you were to meet - or a measure or strategy was meeting an elective surgery target?-- That's correct.

Now, I note that you were to provide reports to the Surgical Access Team as required. What was the Surgical Access Team?-- It was a unit in Corporate Office that was set up to assist manage elective surgery across the state. There were some rules that the Surgical Access had in relation to what was elective surgery and what wasn't, and they set targets and monitored activity on a state-wide basis.

Thank you. The different targets that you had and the measures and strategies don't seem directly to have involved health outcomes; that is, best outcome for patients. Am I right in making that generalisation?-- Yes, it's not a focus of the document.

I would like you to look at some pages of the Health Service Agreement for the years 2003/2004. While that's being put on the monitor, Commissioner, I tender the Health Service Agreement for the years 2002/2003.

COMMISSIONER: That will be Exhibit 465.

ADMITTED AND MARKED "EXHIBIT 465"

MR ANDREWS: Now, for the year 2003/2004, do you see that again there was a similar preamble that you were to adhere to policies, practices and guidelines?-- Yes.

Would you proceed through the document to the next flagged page? Again, the key undertaking seems to have been a list, headed by "Maintaining Budget Integrity"?-- Yes.

Some of the targets seem to be different. One is "Enhanced Revenue Performance". You were to develop and implement revenue improvement strategies, with a target to be advised, and you were to report those strategies to the Zonal Manager by 1 December 2003, at least initially, with a final report six months later?-- Yes.

What capacity was there for you, in your district, to improve

revenue?-- Mostly it was just ensuring that clerical staff undertaking the admission process asked patients whether they wanted to be admitted publicly or privately, so there was often just an assumption that patients coming to a public hospital would want to be admitted publicly. So, simply raising the question or ensuring that it was raised on a regular basis as part of that process assisted.

Was there anything about elective surgery targets that you could influence so as to improve revenue?-- Elective surgery wasn't. Revenue in that sense wasn't considered to be elective surgery. It was more about revenue from private patients.

I tender that Service Agreement.

COMMISSIONER: That will be Exhibit 466.

ADMITTED AND MARKED "EXHIBIT 466"

MR ANDREWS: The service agreement for 2004/2005, I think you will see begins with a similar preamble, requiring you to - or having your obligations underpinned by adherence to policies, practices and guidelines of Queensland Health?-- Yes.

And within it, in Schedule 1, an important undertaking was to achieve budget integrity and it suggested you would achieve it in two ways: managing all elements of resource expenditure and revenue generation. Does that just mean keep the costs down and keep the revenues up?-- That's a very simplistic way of saying it, but, yes, it was about - I mean, essentially the management of resources is about how you manage costs, and revenue in relation to that, I think, refers to private patients again as well.

And the achievement of activity targets negotiated between the zone and districts - what does that mean?-- There was a target for in-patient separations. I can't recall whether there was a target now for non-in-patients, and the zone would - my understanding was that the zone had its target for the whole zone and then it worked out what the target would be for each district based on history and any changes that the districts thought might be possible or advocated.

Tell me whether meeting a weighted separation target and meeting an elective surgery target are the same thing, or is it possible that one meets a weighted separation target by doing more trauma surgery?-- Yes. Weighted - a total weighted inpatient separation target relates to all admissions, whether they're surgical, internal medicine, obstetrics, or whatever. Elective surgery is a component that relates to elective surgery.

The hospital's revenue was, as I understand it, dependent, to a certain extent, on meeting the elective surgery target, is that correct?-- I am sorry, can you-----

The hospital's revenue was dependent, to some extent, on meeting the elective surgery target?-- Yes, that's right.

Was its revenue in any way dependent upon meeting the weighted separation activity target?-- Elective surgery was counted when it was reported as weighted separation. So you would have the target for elective surgery being X amount of weighted separations.

Would trauma separations have - whether you had a high or low number, would that have affected the hospital's revenue?-- No - well, no - I mean, it was - there was a - in the service agreement there is a requirement to meet the total weighted inpatient separation targets. So trauma, as part of that, is - trauma is a part of that. But it wasn't separately identified and funded like elective surgery was.

Thank you. From within the same service agreement, there was an undertaking relating to measured quality, to "actively address significant variances identified in the measured quality process". Measured quality, was that - now, this doesn't appear in the earlier service agreements. Was this a new phenomenon?-- Yes, I can't remember exactly when it was introduced but it has been in the course of the last few years. It was a corporate system to look at a range of indicators.

Including health indicators?-- I am not exactly sure what you mean by that question, but it was - it looked at indicators ranging from efficiency through to mortality rates, length of stay, that sort of thing.

Well, indeed, mortality rates and length of stay are concerned with patient outcomes, aren't they?-- Yes.

And the measurement - the measured quality process where it relates to patient outcomes, would have had in mind eventual improvement in identification of problems?-- Yes, that's right.

Were you, during that financial year, kept appraised of the findings made in the measured quality process?-- When - when the measured - I did receive copies of the measured quality report or access to it on a secure electronic system.

How often did it come?-- Once a year.

At what time of the year? End of financial year, end of calendar?-- No, I think it was around March or April of each year and it related to the previous financial year.

And so in 2005, in March or April, you'd have received a measured quality report relating to the year ending 30 June 2004 - effectively nine months earlier?-- I hadn't. I wasn't there - I wasn't in Bundaberg. There had been no report released at the time that I'd left in relation to the previous financial year.

Does that mean that the last measured quality report that Queensland Health had sent to you would have been for the period ending on 30 June 2003?-- Yes, I think that's right, although it did look at indicators over a period of years. So whilst it had the latest year, there was also reference to - there were indicators that were over a duration of time - of years.

The reason - and - well, you, as a district manager, would you have either personally or had somebody else look at the measured quality documents that would be received in about March or April of each year to see whether there were any dangerous indicators that arose?-- Members of the executive and the manager of the District Decision and Quality Support Unit were made aware of the documents. There was also presentations conducted by the - from - by some staff from the corporate office unit that produced the material who came out and did a seminar that looked broadly at the information, and senior staff, both medical and nursing staff, were invited to those presentations.

Well, to monitor whether things were safe for patients, I imagine that a document such as the measured quality document would have been very useful if it had been delivered to you in a timely way?-- We did find it a useful document in terms of indicating those areas where we could improve and also identifying those areas where we were doing well.

Dr FitzGerald, of course, did a report on the Bundaberg Base Hospital?-- Yes.

And within it - I don't know whether you'd taken leave before that report - or did you read that report?-- Dr FitzGerald provided a report not long before I left in April.

Within that report, Dr FitzGerald seems to have relied upon some statistics that showed some variances between outcomes at the Bundaberg Base Hospital and some other hospitals appropriate for reference. Do you have any recollection of that? It is just that one of them was alarming?-- I don't actually recall - I think it was an annexure to the report. I don't recall that being attached to the document when I received it, although I have seen it since as part of the Commission's documents.

While I am trying to turn up a copy of Dr FitzGerald's report, as I recall within that report it suggested that there was a complication caused when doing laparoscopic cholecystectomies and it was to do with, I think, a perforation of the bile duct?-- I don't recall anything about that.

Would you be aware that a laparoscopic cholecystectomy is a bread and butter operation for a surgeon, run of the mill, to use another cliche?-- It is a fairly normal procedure.

The report of Dr FitzGerald suggested figures that showed that the outcome for complications from that fairly normal procedure was increasing over a period of time at the Bundaberg Base Hospital to a stage where it was about 27 times what - 27 times the results that had been obtained from similar hospitals. Now, I am still trying to find the document so I could show it to you, but take my word for it in the meantime. Work on that hypothesis. Where would Dr FitzGerald have obtained those figures relating to the Bundaberg Hospital and how would he have been able to obtain figures showing that alarming comparison?-- I don't recall Dr FitzGerald's report actually being - having any specifics in relation to that when I saw it. But presumably he would have obtained that information from our decision support unit, which in turn is able to draw information from data that is coded for inpatients.

I have a copy of that report here, and, like the one that you first saw, it has no final annexure, but if you look at pages 9 and 11, you can confirm for me the matters that I have put to you hypothetically. "The rate of patients having bile duct injury requiring operative intervention", you will see went from a rate of zero in the period January to June 2003, to 3.77 per cent in the next half year, 5.36 in the next half, and 8.06 in the next half. And on page 11, Dr FitzGerald describes that process. In the orange section you will see "the rates of bile duct injury during laparoscopic cholecystectomy (page 9) at Bundaberg Hospital in 2003 were", and you will see he recites those same percentages. And he says the ACHS rate for 2003, the most recent data, was 0.29." I hope you can accept my mathematics that 8.06 is about 27 times 0.29. So there was, to anyone looking at the figures, an alarming increase in the number of complications from this fairly routine form of surgery. Now, when would you have got the - or the hospital have received the ACHS rate for 2003?-- Oh, look, I am not sure exactly when we would have received that. There was a-----

Would that have been in March 2004?-- I would be guessing. I am not sure exactly when the data would come out.

Since these figures were all within the Bundaberg Hospital system, who was charged with spotting this anomaly, using the figures to advantage? Did anyone have that particular duty? The quality coordinator or-----?-- The quality coordinator collected the information and, when it was received from the ACHS, distributed that information to a variety of individual

clinicians and some committees. Many of these specific clinical indicators I wouldn't see.

But was there anyone who was charged with the responsibility of looking at these things from a risk management point of view, spotting significant anomalies like this one, or did all this get forwarded to head office to do that process?-- No, it didn't get forwarded to head office. My expectation is that any anomalies would have been picked up first of all by the quality coordinator and by the relevant director. So in the case of surgery, it would be the Director of Medical Services but you would expect also that the Director of Surgery would receive that information as well.

And so for argument's sake, let's assume the ACHS rate for 2003 of 0.29 had been received in April 2004. Can we work on that hypothesis?-- Sure.

The quality coordinator ought, by April of 2004, have been able to look at the July-December Bundaberg Hospital rate and seen that it was - well, significantly higher than the ACHS rate because it was 3.77 per cent?-- I - given the numbers of patients involved, it may not be the case that somebody would attach particular significance to that.

Well, then, the quality coordinator - that was Leonie Raven, as I understand?-- Yes.

Would then, by June of 2004, have been able to observe what the next hospital statistic was to compare it and would have seen 5.36 per cent. Again, significantly higher than the 0.29, and by December of 2004 would have seen the 8.06 statistic which was 27 times greater. Would I be right in concluding that those statistics would have been available at those times for her to see had she looked?-- I would imagine so, yes.

And would I be right in thinking that it was her responsibility to, what, draw them to the attention of the Director of Medical Services and his responsibility to ask about them?-- Yes, that would be my expectation.

And would I be right in thinking it is not the responsibility of the district manager to go looking for those things; you would have anticipated your Director of Medical Services would have looked for them and brought them to your attention, if needs be?-- Yes. I am - as somebody without a clinical background, I would not normally involve myself in clinical issues.

All right. As an administrator, though, you'd have had a duty to have someone charged with the responsibility of looking for these things? If you were to be criticised at all, it will only be with respect to whether you have considered the importance of giving someone this duty; would that be right?-- My expectation would have been that the - or was that the quality coordinator would ensure that the information was collected and then passed on to the relevant director and

perhaps highlighting if there were any concerns that had been noticed.

Commissioner, I won't tender again Dr FitzGerald's report.

COMMISSIONER: No.

MR ANDREWS: It is within the material already. But looking back now at the service agreement for 2004/2005, within schedule 1 there is another undertaking. It says "it is important and should be achieved: credentialing and privileging". When would you have received this service agreement? At the start of that financial year?-- I am not sure. It was often the case that the service agreements came in late, but I'm - I'm not sure when I received that.

And you see that-----?-- I can - I have just - it has just been pointed out to me that I signed off that service agreement on the 8th of November 2004.

Thank you. And you saw that there was a suggestion that "credentialing and privileging ought to be achieved prior to the commencement of clinicians"?-- Yes.

But that would have come as no surprise to you by that stage. That was the orthodox recommendation in any event, wasn't it?-- Yes, it was - certainly there was an expectation that - that there would be a credentialing and privileging process. And, yes, mostly that should be done before the commencement of staff.

Within the same schedule there is a reporting requirement "internal district process for monitoring of compliance with credentialing and clinical privileging." That would have been of particular concern to you by the time you signed off in November 2004 because both your district and the Fraser Coast District were well behind on credentialing and privileging at that stage?-- We'd been attempting to put in place a more effective credentialing system for a period of time.

I tender the service agreement for '04/'05.

COMMISSIONER: That will be Exhibit 467.

ADMITTED AND MARKED "EXHIBIT 467"

MR ANDREWS: From Exhibit 467 I would like you to look at some other pages. "Key budget performance principles". You will see paragraph 2 shows that your service agreement obligation includes that you must meet it from available resources, that where activity targets are not achieved, funding may be adjusted. That would be adjusted downwards, wouldn't it?-- I would expect so, yes.

You should not have an expectation to receive additional funding for exceeding targets unless you had a prior agreement with the General Manager of Health Services? Now, that's included for the first time in the three service agreements that I have shown you, but you would have - am I right in thinking that was a principle that you would have well understood in the prior years?-- That's correct, yes.

At paragraph 4, "Patient activity targets ... will be established", and "patient activity information must be routinely reported ... to zonal management and corporate data collections." That wasn't in the prior agreements. Is that to do with measured quality, or is this - is this-----?-- My interpretation would be that it's stating what in fact already took place, and that is reporting inpatient weighted separations and we were reporting non-inpatient activity as well.

Mr Leck, to Dr Nothling you made a number of observations which are of great interest to me. I have tried to use my highlighter to separate different discrete topics. The first is you explained you had to come in on budget and that caused conflict between coming in on budget and delivering services. Can you expand on what you meant by those two sentences?-- There was always more demand for services than there is resources to be able to - to meet that demand.

Well, there has been significant publicity within the last couple of months about further money being required for the health service. Were you in a situation where whatever your ambitions for the health service, you were constrained by your budget to deliver a health service that met the budget?-- Yes, we were required to operate our services within the budget.

Now, you say "a lot of managers around the State had been removed". Is that in the context of the conflict between budget and delivery of services?-- My understanding is that, yes, there were a number of district managers over a period of years that lost their jobs because they were over budget.

You speak of mixed messages that would come from above. I gather that "above" means the head office in Brisbane?-- Yes.

What were those mixed messages?-- That on occasion, whilst there was a requirement to meet budget, actions taken to work within that budget particularly where there was adverse publicity was not welcomed.

Do you mean if by complying with the budget adverse publicity was caused to Queensland Health, you might be in trouble for doing - for budget compliance?-- It was more about being - it was more about the fact that there was adverse publicity not being welcomed and therefore some of the decisions made to comply with budget were stopped or postponed.

Some of the decisions to comply with budget were stopped or postponed. Can you elaborate on that, please?-- We - not long after my arrival in Bundaberg it was obvious that their health service was - had a significant budget problem. It was also obvious that some of our non-clinical services, particularly our operational services, which are services like cleaning and catering and porterage and so forth, were - were not efficient or appeared not to be efficient, so we went through a long period of consultation and review to make those services more efficient so that ultimately the funding really could be spent on clinical care, on seeing more patients, but there was adverse publicity and some union activity in relation to that so the progress on that was stopped on a couple of occasions although it eventually proceeded.

Was adverse publicity frowned upon or did you believe that it was frowned upon by your head office?-- Yes.

And, indeed, is that a topic that you also raised with Dr Nothling, that it was not looked on well if complaints were made to the press about the local health service?-- Yes, that's correct.

Do you mean or did you mean to distinguish it was - I assume it would have been anticipated in Queensland Health that there would be complaints about the local health service from patients, staff. Is this a problem that complaints ought not to have been made to the press, or was Queensland Health's concern that anyone would ever have a complaint about its health service? It would have been the press, wouldn't it?-- I'm sorry, can you repeat the question.

Yes, it was very long. You see the item I have highlighted with pink, item 4?-- Yes.

Queensland Health's concern was that there would be bad publicity?-- Well, corporately a bad or adverse publicity was not welcomed.

COMMISSIONER: Were you expected to enforce that in some way, to stop people going to the press?-- There was no way that you could - I mean, if patients went to the press or as somebody - that wasn't something that you could deal with, but certainly in relation to staff going to the press, that was in breach of the code of conduct.

Dr Baker went to the press on occasion, didn't he?-- He did go to the press, yes.

Did you speak to him about that?-- I spoke to - I spoke to him at the time when that was happening. I don't recall specifically raising with him the fact that he had gone to the press.

MR ANDREWS: But you'd have regarded it as expected of you to discourage anyone from going to the press?-- Yes.

The next topic to Dr Nothling you will see, there were clinical indicators to assess the medical services but you relied on the judgment of the Director of Medical Services. Now, the clinical indicators to assess medical services, would they have been the indicators collected by Leonie Raven?-- Yes.

Perhaps you should tell me what you mean by but you relied on the judgment of the Director of Medical Services?-- I relied on the Director of Medical Services in relation to clinical issues so if there are any clinical issues or matter of clinical judgment, I didn't have the skills or the expertise to be making those sorts of assessments, so I relied on him.

You thought that an effective credentialing procedure would have picked this up?-- Yeah, I was particularly down and despondent in relation to everything that has - that has occurred and obviously I wasn't aware that - that Dr Patel had a history in the States. And so, you know, I was concerned that, you know, we'd employed him without knowing that background.

Number 8: "The systems had not been in place to handle the concerns raised"?-- I'm not - I don't actually recall saying that. My - my view is that the - that we did have systems in place but staff didn't raise concerns until obviously Toni Hoffman did in late October. So my concerns weren't so much the systems but simply the fact that staff hadn't raised it.

Well, because systems is capable of so many meanings let me ask you whether you had in mind, for example, that there would have been meetings of one kind or another but for the purpose of auditing past events, I have heard them described as clinical audits, I have heard them described as morbidity and mortality meetings, but as I understand it, whichever name they have, their purpose is to review events over the past recent period with a view to suggesting to improvements. Am I right that they're the purpose of such meetings?-- Yeah, in fact, it was not long after I'd started that I felt that there needed to be the establishment of a better structure to ensure that people could review what was occurring. So I was - I mean, there had been some mortality and morbidity committee meetings in place but it wasn't comprehensive across the health service. I would encourage or tried to encourage the establishment of committees such as - well, first of all, the clinical service forums and then ERROMED to - to enable the

senior staff to participate in the management of the service including the clinical aspects of their service delivery, and that was the purpose for having that structure established. And those committees would be given data to review such as you've indicated, but I would have also expected raised any issues that they had so that they could work together to address anything from patient issues to financial issues within their own unit. And there were some committees that were effective at that. Paediatrics was very effective, mental health was effective and obstetrics seemed to - seemed to be making quite some progress.

Well, the first of them, morbidity and mortality, you observed that you had concerns that they weren't being consistent across the district I think you said, or words to that effect?-- Yes.

Do you mean by that that you understood that they either weren't happening often enough or if they were happening, they weren't being conducted well enough?-- That they weren't covering all aspects of the service. Mental health, for example, didn't have any - initially didn't have a forum like that.

My more immediate concern is to do with the meetings that would have considered surgery. What feedback did you have? Did you know, for instance, that there were some issues about the meetings conducted by Dr Patel?-- No, I wasn't aware of that.

If there were issues raised by staff that the morbidity and mortality meetings were being controlled by Dr Patel in a way that made them ineffective, who is the person who ought to be dealing with that issue?-- The Director of Medical Services.

Now, again, systems hadn't been in place to handle the concerns raised. In the last couple of years there has been an effort by Queensland Health to create a risk management system in the districts?-- Yes.

Was it up and running efficiently by the time you departed the hospital?-- Part of the structure I was talking about was actually about addressing risk management issues so it was - it was part of the implementation of risk management. I thought it had been working reasonably effectively. I had no reason to believe that it - that it hadn't been. We - there had been some difficulty in getting all of the various committees to finalise their risk plans. It's not actually the word but I can't think of it at the moment. So, basically a document where they would discuss what they considered their major issues to be and address them. So while just some areas had been doing that well, there were others that hadn't. But I wouldn't have considered that any new - any process of introducing systems and change means that it will take staff some time to come on board and for things to work as well as you might hope.

The ninth item: "Staff were simply not confident under the

Health Department regime to raise concerns"?-- I - no, I - that's not my recollection of that particular comment either. I think my comment was more along the lines of I was concerned that staff weren't confident because no issues had been raised prior to Toni Hoffman's letter in late October.

And what would make them not confident?-- I don't know. But in thinking about that, I also think that it's - it goes back to trying to change the culture which is what the risk management - was at the heart of the risk management process. So I don't think that this was an issue just for Bundaberg. I think part of the promulgation of risk management policy across the state was to advocate moving out of a blame culture and realise that error is something that occurs in all hospitals and health systems and that it was about putting a framework and a system around it to try to reduce it and manage it.

Is it the case that staff of Queensland Health would be concerned about raising issues about other staff members because of the code of conduct?-- Not to my knowledge, no. I mean, I - there were - my expectation is if staff had concerns about another staff member, they would - they would raise it with their line manager.

I tender a copy of the excerpts from pages 5 and 11 of Dr Nothling's report of 22 September 2005.

COMMISSIONER: They will be Exhibit 468.

ADMITTED AND MARKED "EXHIBIT 468"

MR ANDREWS: Part of your obligations I discern from looking at the position description that was given to Dr Keating - would you look at the document on the monitor. It suggests that when Dr Keating's role was delineated, he was to continually consult with you. Did you understand that that was part of the role of the Director of Medical Services?-- Yes, I expected him to consult with me regularly.

Well, indeed, I think it said "continual" as opposed - regular might be like clock work once a month. Was your relationship one of continual consultation?-- No. In that context I see that meaning more as regular rather than continual. I mean, the position description also says that the position works with, you know, a significant level of independence. So I wouldn't expect a continuous consultation but I would expect regular consultation.

Indeed, how often did you speak?-- We usually had a meeting set aside initially once a week and later once a fortnight. Occasionally we - you know, there was a cancellation of that but we would catch up with each other in meetings or, you know, in the corridor, that sort of thing.

Further down the page I see that Dr Keating's duties and responsibilities included monitoring clinical outcomes and standards including the hospital clinical indicators. Would that involve monitoring such things as the laparoscopic cholecystectomy bile duct complication rate?-- Yes, any of the indicators that we were collecting, that were specific to medical services.

Thank you. Is there anything else on that document? Anything further? That can be returned now. It is already an exhibit. Mr Leck, there has been evidence before the inquiry about the relative benefits of visiting medical officers, staff specialists and a mixture of the two so as to provide adequate numbers of personnel to allow for a healthy on-call roster and manageable hours. Dr Baker was employed as Acting Director of Surgery from about the 14th of January 2002. Do you agree?-- I recall he was the - yes, employed as the Acting Director of Surgery.

Here, I'll put a letter on screen that appears to be signed by you to Dr Baker. Can Mr Leck be shown the top of the page so that he can see some dates. It seems to be signed "Lyn"?-- I would think that would be Lyn Hawken, who was acting as the Director of Medical Services.

And the second page you will see bears what appears to be your signature?-- Yes.

On the first page in the offer to Dr Baker you were going to explore all financially viable options to provide a one in three roster for the general surgeon as soon as possible. Now, there has been evidence that Dr Baker's workload and, indeed, other surgeons in the Bundaberg health district was impossibly high. Sometimes on-call every night and sometimes on-call one night in two. Does that accord with your recollection of things?-- Yes. I also thought that there weren't sufficient general surgeons on the roster. And there had been various times when we had made requests corporately for additional funding so that we could increase the number of surgeons but there was nothing I could do when we had no money to do it.

You speak of many requests for funding for the surgeons. Can you give an indication of how often you would requested such things?-- I remember when Charles Nankivell was there, there had been a submission that had been prepared. I don't know. At the time, when we had a surgeon like Dr Baker who was wanting - was considering leaving, we would make requests corporately of that. I think the same happened when Charles Nankivell resigned. So it was a few times.

And you needed extra because of the-----?-- I also had concerns about the frequency of on-call.

And that's a matter that affects patients' safety?-- It can do, yes.

Now, your alternative, and we can explore whether it was practical or not soon, but your alternative I suppose was to sack all the surgeons, close the surgical department and/or run with a surgical department that was understaffed. They were the two alternatives you had, weren't they?-- Yes. I wouldn't have thought of sacking the surgeons and closing the department but, yeah.

COMMISSIONER: Or keeping the surgeons perhaps and staying only with emergency surgery. That was a possibility, wasn't it? That is, to have no elective surgery?-- Yes, and there were periods when elective surgery was - was reduced because there was a surgeon away on leave or those sorts of - that sort of thing. So there were times when that happened.

But never stopped entirely?-- I don't recall whether or not we stopped elective surgery entirely I'm not sure.

It would have been your decision, wouldn't it, to do that?-- It would have been a decision I would make on the advice of the Director of Medical Services.

Did it ever occur to you that that might be an appropriate course to take?-- No.

MR ANDREWS: If you'd done it, if you had determined that there'd be no more elective surgery because the workload for the surgeons was too high to be safe, would the result have been that Queensland Health would have asked why and then leapt to your assistance by providing more money or would it have been a black mark against you?

COMMISSIONER: Or don't you know?-- I don't know.

MR ANDREWS: Well, the fact is, if you closed down the elective surgery list, it would be likely to be something that would have caused adverse publicity, wouldn't it?-- Yes.

Adverse publicity would have been frowned upon, would it not?-- Yes.

Now, I'll ask that Exhibit 273 be returned and I will put on the screen Exhibit 413. This is a letter from Dr Baker to you of the 6th of May 2002 requesting two alternatives, either that he go 0.5 part-time as staff specialist and acting Director of Surgery from June 30 or that he'd do four VMO sessions a week and participate in the on-call roster. Now going 0.5 part-time, how many days a week that would involve?-- Two and a half.

And four VMO sessions per week, how many days at work would that involve?-- I presume there would be three hour sessions, so it's probably 12 hours of work.

Now, you didn't accommodate either of those requests?-- I don't recall the details about what happened at that point.

Well, you would recall whether you appointed him as a part-time staff specialist, Acting Director of Surgery. That didn't happen?-- No, that didn't.

And you didn't engage him to do four VMO sessions a week?-- No.

As a result, some months later, Dr Baker resigned; is that the case?-- He resigned - I don't recall the reasons that he gave for that at the time.

But would one of them have been that the workload was simply too much for him?-- I don't recall. It may have been.

There has been some evidence that the Surgical Department at Bundaberg had been a very efficient one, well staffed, with a good mix of staff specialists and visiting medical officers. It had had Drs Anderson, Nankivell, Dr Thiele occasionally. It was a training department that had its own Registrar sent from Brisbane because it was not just a training hospital, but a desirable place for a Registrar to train. Do you remember that to have been the case during your tenure as District Manager?-- When I arrived, there were two full-time surgeons, being Dr Anderson and Dr Nankivell. Brian Thiele was doing some sessions in vascular surgery occasionally. There was a Registrar there at that time, yes.

Now, from a District Manager's point of view, is there any significance if a department is also a training department? Did that mean anything to you?-- It had the potential of safety with recruitment in terms of training because there was kudos associated with it. So, yes - I mean, I thought that was a positive thing.

It is more significant than just kudos and the potential to recruit. Isn't it the case that if you have a training department, you have got the opportunity to attract, annually, registrars to the department with the ambition that perhaps some of them might ultimately settle in the district?-- Yes, that could be an advantage as well.

And registrars who train in such a department, don't they provide a benefit to the specialists on call in that the registrars are - well, very - likely to be very skilled for persons who don't have a specialty and they will be able to give good quality service to the patients before any specialist is called in?-- Yes, there's often a system of second on call, so the Registrar would be available with the specialist as back-up.

Now, in an ideal world, wouldn't a District Manager do all that he or she could to maintain a training facility for reasons such as those?-- I'd certainly encourage it.

Were you alerted to the fact that your hospital's Surgical Department was going to lose its training status if any - if a particular surgeon left?-- Not at the time. Not at the time.

Did you learn after the event?-- I learned after the event, yes.

That kind of strategic planning for departments, is that something that's simply not catered for in the budgets that are provided for you - the ability to - or the need to plan ahead?-- No, they are not. The budget is allocated on an annual basis and, as I'd said before, we are expected to work within the budget that was given to us.

COMMISSIONER: They were based on an historical basis, the budgets in those days; is that correct?-- Largely that's correct, with an additional amount specifically for elective surgery.

Apart from elective surgery, though, it was historical budgets?-- Yes.

MR ANDREWS: When you learned that you had lost a training position for the Surgical Department, did you attempt in any way to retrieve the situation?-- There wasn't any specific action that I took that I can recall.

From Queensland Health, have you seen any directives, memos, suggestions, either from Head Office or from your Zonal Manager, that there ought to be an emphasis on trying to encourage training positions in departments?-- In recent times - so, some time in the last 12 months - there had been a request - or a request letter come out asking those hospitals who wanted training positions to identify themselves and we did that, and not just in surgery, but across various disciplines.

With Dr Baker's impending resignation towards the end of 2002, there came a need to find a replacement. Can you identify this document, Exhibit 280? Is it to do with authorising an advertisement?-- Yes, it is. Sorry, I just can't see the bottom of it.

Yes, would you like to see the bottom or the top?-- No, it's all right, I've got it here.

Now, you have signed at the bottom of the page on 31 October as District Manager?-- Yes.

And now see the portion shown in highlight? The position was shown to be full-time, 80 hours per fortnight. There was no suggestion that there might be flexibility of part-time. Did you consider whether or not to offer a part-time position?-- No.

There was some evidence that a way of attracting specialists to the regions might be for public hospitals to allow them to have the security of some income from the public hospital with the opportunity to earn higher income privately; for instance, by doing some sessions privately and working only part-time in the public hospital? You would be familiar with such a phenomenon, wouldn't you?-- Yes.

That's the VMO situation, isn't it?-- That's correct.

Isn't there - would it be sensible, when advertising for such a position as Director of Surgery, to advertise that you were flexible about whether the person should be employed full-time or part-time?-- I took the view that a position of Director of Surgery - a person in the position of Director was better off being in the hospital on a full-time basis, and the reason for that is that - so that they were available. It is usually that person that, you know, organises education for staff, assists with medical students that might be there. I just felt that it was better that the Director of Surgery position be full-time. VMOs spend the majority of their time usually in private practice and that's their main focus, as you would expect it to be, and they're important in the health system, but they are not on site.

Within the document, it advises that, "Vacancies will only be advertised following determination by SSDS that there are no surplus employees suitable for appointment." What's SSDS?-- I'm not sure, but I know that there's a process where all of the advertising is coordinated through an office in Corporate Office, and they have a process of checking to see if there are any surplus - or people who have been identified as surplus before approval for that advertising occurs.

Now, there was a Dr Jayasekera employed at the hospital at the time in surgery?-- Right, yes.

And he was a Fellow of the Royal Australian College of Surgeons?-- Yes.

Now, he was a surplus employee suitable for appointment, wasn't he?-- I don't think he had been identified as surplus, no. He wasn't a surplus employee.

He was employed in the department and suitable for appointment?-- He was - we went through an - we went through a recruitment process and Dr Jayasekera was an applicant at one stage.

I'm thinking about the stage where you chose to advertise?-- We advertised a couple of times, as I recall, and he was an applicant at - on one occasion and not on the other occasion.

Were you obliged to advertise without encouraging him to apply for the position?-- Yes, we had to advertise the position.

It is just the form tends to suggest the contrary. The form

suggests that you will advertise only after somebody has determined that there aren't any suitable employees?-- The issue around surplus employees is usually around where there has been a decision made that there are too many employees in an area, so an area that can be made more efficient, and people are given the chance to work elsewhere and put up their hand and say, "Yes, we would like to do that.", so that's what that was about. So, it would be unusual for a doctor to be identified as surplus. They tend to be other positions.

You understood that for the Director of Surgery position, you wanted a general surgeon who was acceptable for specialist registration?-- Ideally that would have been the case, yes.

In fact, the position description for Director of Surgery was - here, I will put Exhibit 273 on the screen. You see that position description of November 2002 for Director of Surgery for the Bundaberg Health Service District?-- Yes.

Would you look at the second page now? "Qualifications as a general surgeon acceptable for specialist registration by the Medical Board of Queensland." Do you agree you required a specialist or a person who was capable of being registered as a specialist for that position?-- That was the preferred thing, yes.

COMMISSIONER: That was the qualification - the necessary qualification for the job.

MR ANDREWS: You wouldn't have wanted a Director of Surgery who wasn't capable of getting specialist registration, would you?-- I would have preferred-----

Not when you had Dr Jayasekera about?-- I would have preferred to have had somebody with specialist qualifications, but Dr Jayasekera, as I recall, was not the preferred applicant at interview.

Now, do you remember that the preferred applicant at interview was a doctor from Yugoslavia?-- I have learned as part of this process that it was a Dr Strekov.

Dr Strekov. He was initially offered the position, but eventually declined?-- Yes.

One of the other applicants at the time was Dr Jayasekera?-- Yes.

And he was an acceptable applicant, but not the preferred one?-- Yes, he was - yep, he was acceptable. He made it to interview, but was not the preferred applicant, that's correct.

Were you one of the interviewers?-- Yes, I was.

When Dr Strekov resigned, why was Dr Jayasekera, as an acceptable applicant, not approached and asked if he wished to accept the position?-- Kees Nydam was the acting Director of

Medical Services and he indicated to me that he did not think that Dr Jayasekera was appropriate for the position.

Did he tell you why?-- Not that I recall. He just - I think there may have been something about he just didn't think he was suitably experienced.

Well, you know that eventually you recruited an overseas trained doctor for the position?-- Yes.

To embark upon that process of recruitment, did you understand that you had to suggest to Queensland Health, or that a suggestion had to be made by somebody that there was an Area of Need?-- Not me personally, but I understand that that's what occurred.

Well, did you know that if Dr Jayasekera wasn't used, that one of the employees of the hospital would be submitting an application to have an Area of Need declared for a Senior Medical Officer to fill a position in the Surgical Department?-- No, I didn't think of that.

COMMISSIONER: What did you think was going to happen?-- That we would readvertise.

MR ANDREWS: You knew that Dr Jayasekera was performing surgery independently in the Surgical Department?-- Yes.

And Dr Nydam did not articulate any reason why that gentleman should not be a Director of Surgery?-- Not to my recollection, no.

Did you know that Dr Nydam - he was then the Acting Director of Medical Services, wasn't he, in late 2002?-- Yes.

And you would have been consulting with him about weekly?-- Yes.

And at other meetings?-- That's correct.

Surely he kept you appraised of the situation of filling the position of Dr Baker?-- He would have kept me appraised of advertising - that he was advertising and so forth, yes.

And he would have alerted you that he was going to seek an overseas trained doctor to take the position of Director of Medical Services - position of Director of Surgery?-- I don't recall the specifics, but he - we had advertised again and there were either no applicants or no suitable applicants and, in that circumstance, we'd - the normal process was to look at using a recruitment agency.

Did you sit at a staff advisory committee meeting in February of 2003 shortly before the departure of Dr Jayasekera in which a motion was put relating to the resignation of Dr Jayasekera?-- Yes.

And do you recall that motion being put?-- Vaguely, yes.

Well, it must have been of some significance to you that here was a - well, a very strongly worded motion from a number of clinicians suggesting that Dr Jayasekera's resignation was leading to the effective demise of general surgery?-- It is concerning, yes.

Well, is that something that happens just in the day-to-day business of a District Manager, or is this a - somewhat remarkable?-- Dr Anderson had left the hospital in circumstances which questioned his - which related to his integrity - related to fraud, and-----

He wasn't engaged again until, what, some time early this year?-- No, I think it was earlier than that.

I see?-- I'm not quite sure when he-----

Early 2004, after a visit from the Premier?-- He would have been re-engaged, I think, by this. For him to be - I'm not sure - for him to be at the Medical Staff Advisory Committee, he would have been a VMO.

Thank you. I've forgotten my own chronology?-- And-----

So, he was the member of staff who proposed this motion?-- Yes. It was - Dr Anderson, as a result of his initial departure from the hospital, had been very hostile and-----

He hadn't been allowed back to treat even the patients who had been under his care; isn't that the case?-- I don't know. I actually wasn't there when he left. I was on holidays. But he was hostile and he'd been in the community for a long time and knew many of the medical staff and interacted with them, both professionally and socially, and to me this was just evidence of his overall hostility related to the circumstances of his departure - his initial departure.

COMMISSIONER: What about Stumer? Did he have hostility towards the hospital?-- Yes, Dr Stumer had been suspended at one period for-----

How did he demonstrate his hostility to the hospital?-- Just his manner and approach on occasion.

Dr Chaudhry?-- No, I didn't consider Dr Chaudhry hostile.

Dr Robinson?-- No.

Dr Kingston?-- No.

Dr Joiner?-- No.

Well, then, wasn't it of grave concern to you - alarm - that these doctors, who had no hostility towards the hospital, should take part in a proposal of this kind - a motion of this kind?-- It was concerning, but not alarming, because I just saw it was part of Dr Anderson's influence and approach.

You didn't ask them about that?-- No.

Did you think that they might know better than you that this would lead to the effective demise of general surgery at Bundaberg Base Hospital?-- That wasn't something that I thought about at the time.

Why not?-- Because my expectation would be that we would fill the position that had become vacant.

MR ANDREWS: Now, in filling the vacant position created by Dr Jayasekera's departure, there were, I - I suppose one way of doing it would have been to urge Dr Jayasekera to remain, but I imagine you expected that there was some high emotion behind his resignation?-- Yes.

So, does it mean the easiest alternative was to have somebody at the hospital claim that there was an Area of Need and to import two overseas trained doctors to fill the void?-- I'm sorry, can you repeat that again?

Is it the case that you thought the easiest alternative was to declare the area - the hospital an Area of Need for senior medical officers in surgery and to import a couple from overseas?-- It wasn't an easier solution. It was not something that I thought of or would think of.

How many Area of Need applications would the hospital make annually - for instance, in 2003?-- I don't know. Those recruitment issues are looked after by the Director of Medical Services and his secretary.

There has been some evidence that persons working at a district on the basis of Area of Need have some features of their employment that make them less likely to complain. Would you be aware of that phenomenon?-- I have heard that been said I think as part of this, but that wasn't - as part of the Commission but that wasn't something that was in my mind or I had thought of, no.

Well, if, for argument sake, you had the truculent Dr Anderson working at the hospital on the basis of an Area of Need, if you were unsatisfied by him, it would be as easy to get rid of him as just not applying for an Area of Need the next year, wouldn't it, and he'd have to go home?-- I am sorry, I am not quite understanding the question.

Persons who come on the basis of an Area of Need come for one year at a time, don't they?-- I understand that that's the case, but I am not familiar with the detail.

When looking to fill Dr Baker's position, did Dr Nydam inform you in December 2002 that one of the candidates - that's Dr Patel - looked satisfactory?-- I can't recall specific discussion with Kees - with Dr Nydam about the applicants. I remember being told that - that he had secured a couple of Americans, and I was pleased about that because that meant that they'd been working in the western world and were more likely to be familiar with western medicine.

And did Dr Nydam tell you that one of them would be satisfactory as Director of Surgery?-- I don't, again, recall specific discussion from Kees in relation to that, although I know one was brought on board as the Director of Surgery.

Did you appreciate that in the absence of responses to your advertisement for Director of Surgery, that Kees must have had in mind to use one of the two overseas-trained recruits?-- I would have expected that one of the surgeons would be director, yes.

Dr Nydam wrote, one sees from exhibit 274, to Dr Patel in February, encouraging him to seek specialist registration in Australia and saying it was a win-win situation for both sides. That is Dr Patel could get more salary and the hospital could charge patients at a specialist rate. When does the hospital charge? Is it for those patients who come as private patients?-- Yes.

Did Dr Nydam ever discuss with you the prospect that Dr Patel would obtain specialist qualifications within months?-- I don't recall that, no.

Actually, when Dr Patel was appointed an SMO, you understood, didn't you, that he was not the holder of Australian specialist qualifications?-- I don't recall the details around what his employment actually was. I wouldn't normally deal with that. I have a vague recollection of being told that he was a senior medical officer, but I don't recall any - any specific detail.

Was it of significance to you that the Director of Surgery was a person who did not hold Australian qualifications?-- Sorry, can you-----

Was it of significance to you that your hospital's Director of Surgery did not hold qualifications that would make him suitable for obtaining Australian specialist qualifications?-- I just didn't think about it. It was not something I considered.

Isn't that something that in hindsight you ought to have thought about; that is the calibre of the qualifications of those employed in such senior positions?-- Given what's happened, yes, but-----

Well, I am not thinking about Dr Patel's situation in particular, but the issue of whether a district manager ought to concern himself or herself with the issue of whether the holders of a position so senior as Director of Surgery ought to be persons capable of obtaining Australian specialist registration?-- I saw the role of the director as an administrative role rather that a clinical one. So the director was the person who would ensure that, you know, on-call rosters were sorted out, that people got their leave, that any requirements we had in relation to medical students were fulfilled, those sorts of things. I didn't see it in a - the light of their clinical experience or knowledge.

COMMISSIONER: But during the whole time you were there, the Director of Surgery spent more time doing clinical things than doing administrative things; isn't that correct?-- Yes, that's right. But the director is - in a place the size of Bundaberg, you would expect that there would be - that they would have a smaller administrative role than somewhere such as Royal Brisbane Hospital, for example.

Yes.

MR ANDREWS: The Medical Board of Queensland wrote to Dr Patel on the 1st of April 2003 with a carbon copy to the Medical Superintendent/manager advising "you are not registered as a specialist". Can you look at the second page of the document where it says "cc medical superintendent/manager Bundaberg Base Hospital"?-- Yeah.

Would that have come to you?-- No. Anything that was from the Medical Board of Queensland would have gone directly to the Director of Medical Services.

That would have been Dr Nydam, I suppose, on the 1st of April? He'd have been the acting director?-- Yes.

I tender that document.

COMMISSIONER: That will be Exhibit 469.

ADMITTED AND MARKED "EXHIBIT 469"

COMMISSIONER: I see it is nearly one o'clock, if you are moving on to something else.

MR ANDREWS: Thank you, Commissioner, it would be convenient.

COMMISSIONER: We will now adjourn. Mr Leck, you would prefer to go out the back way, would you?-- I think I will stay in here because I think my solicitors have arranged for lunch to be brought in.

In this room?-- Into one of the rooms.

But going out that way, is that right? You will go out there? All right, okay. Well, I think we might lock this room over the lunch hour because I want to leave my things here. Others might prefer that, too. We will adjourn till 2 o'clock.

THE COMMISSION ADJOURNED AT 12.55 P.M. TILL 2.00 P.M.

THE COMMISSION RESUMED AT 1.58 P.M.

PETER NICKLIN LECK, CONTINUING EXAMINATION-IN-CHIEF:

MR ANDREWS: Commissioner, are you ready to proceed?

COMMISSIONER: Yes, certainly.

MR ANDREWS: Mr Leck, as district manager, were you aware of the forms of position description for senior medical officers surgery, to this extent: that you'd have been aware of what qualifications were filled in in the pro forma position descriptions for that position?-- No, I - I - the response - the responsibility for position descriptions reporting to the Director of Medical Services, or any other member of the executive, was something that they looked after.

Now, for instance, I'll be placing on the monitor a position description for senior medical officer surgery, and on the document, somewhere towards the top of it, you will see shortly that it bears the words "review date February 2002". Now, I have no control over the mechanics that will get the thing on to the monitor, but review dates, they are generally suggestive of a pro forma document, aren't they, something that will be used again and again until it is next reviewed?-- Yes.

Are the contents of position description documents discussed with district managers?-- Not unless the position directly reports to me. The only other discussion I can recall was about some of the - with the HR manager about the beginning of the position descriptions, which, you know, outlines what the district is and which communities it covers, that sort of thing.

Well, we may never see this document but the significant feature of the document for position description for senior medical officer surgery is the qualification required which appears on page 2 towards the bottom. And, as I recall, it says "possession of qualifications appropriate for registration as a medical practitioner in Queensland". Now, is it your recollection that you wouldn't have been aware of that within the document?-- I would expect that any document where there is a doctor being employed would say that they would have - be able to be registered in Queensland, but I - I'm - individual job descriptions, I wouldn't see or sign off on or anything like that.

Well, the significance of that qualification is that it is for "registration as a medical practitioner", as opposed to "capable of registration as a specialist". You would understand that that's a significant difference, wouldn't you?-- Yeah.

And the position description, dated November 2002, for Director of Surgery had a qualification on its page 2 "qualifications as a general surgeon acceptable for specialist registration by the Medical Board of Queensland", among other things?-- Yep.

Now, as director - I beg your pardon, as district manager, you'd have negotiated with various employees their pay rates?-- Occasionally I would but normally they would be set.

As I recall there was evidence given by Dr Jayasekera that there was some negotiation between you about what was an appropriate pay scale for him in his position as senior medical officer?-- Yes.

And he was a senior medical officer, very well qualified for the position in the sense that he had specialist registration?-- Yes.

You would have been aware that senior medical officers in surgery didn't all have Dr Jayasekera's special qualification?-- I hadn't given much thought before this process, but, yes, now I am.

And, in fact, senior medical officers are commonly - could obtain that position despite having only general registration?-- Yes.

So when you were aware that Dr Nydam had an intention to recruit one of the intended senior medical officers who were coming from overseas to the position of director of medical - position of Director of Surgery, did you think at all about the possibility that you were having a person engaged who might not hold qualifications acceptable for specialist registration?-- No, it is not something I thought about.

COMMISSIONER: Dr Nydam did not raise it with you?-- No.

MR ANDREWS: The Queensland Health department had a credentialing and privileging procedure published prior to a revamped version which occurred in 2002, didn't it?-- Yes, there had been some documents for a while.

And even prior to the 2002 version, which I will show you shortly to ask for some comments, even prior to it you understood that Queensland Health had a policy relating to credentialing and privileging?-- Yes.

That one of its features was that prior to the appointment, the credentials of applicants must be verified and appropriate privileges should be recommended?-- I don't remember the specifics of the document but it sounds it is what it is.

Let me hand across the table to you the first page of exhibit 290B, and you will see that I have with a highlighter - oh, Mr Leck, technology has caught up with us. I will put it on the monitor. This in fact is annexure JGW-B from exhibit 290B. And further down the page there is a portion I have marked

with a highlighter. In essence, Queensland Health policy "secondly states that prior to appointment the credentials of applicants must be verified and appropriate privileges should be recommended." Now, you will have understood generally that was policy for a long time?-- Yes.

I think at the bottom of the page it may date the document. That's an August 2000 version of policy?-- I don't recognise the document particularly, but-----

All right. The last paragraph suggests that its purpose was to outline the specific requirements for the Bundaberg Health Service District. It is something that you would have, in the course of your duties in those days, have seen?-- It is likely that I would have.

May I see the second page of the document? May I see the last page of that document? Does it show at the bottom of the page - at the very bottom of the page a provision for your signature?-- Yes.

Now, within that document, at pages 3 and 4 - while they are not numbered, they are the third and fourth pages from that exhibit - do you see that it contemplated a permanent credentialing and clinical privileges committee?-- Whereabouts, sorry?

If you look at the monitor?-- Oh, sorry.

You will see I have used a highlighter to indicate some passages?-- Yes.

That it even then contemplated also some variable members-----?-- Yes.

-----to join the permanent members?-- Yes.

And among the variable members would be relevant learned college representatives?-- Yes.

May I see a little more of the document, please? And other representatives as appropriate?-- Yes.

That it would include the clinical director of a specialty department - pink?-- Yes.

That the quorum was to be a minimum of three?-- Yes.

The learned college representative must be within the quorum?-- Yes.

And the committee could be as many as seven members?-- Yes.

Now, while the policy was revamped in July 2003, generally it didn't change - those characteristics didn't change, did they?-- I'd - I don't think - I don't think it was as specific as that but I don't recall and probably I would need to look at the other document.

Now, by the time of Dr Patel's appointment - by the time there was negotiation to offer him a contract towards the end of 2002, and by the time of his arrival at the hospital in 2003, there for some years had been, to your knowledge, a requirement for a district manager to create the credentialing and privileging committee?-- Yes.

And in that respect, you were remiss?-- We - for some period of time we'd tried to get a privileging and credentialing committee up and running more effectively. As I recall when I first went to Bundaberg, the credentialing and privileging would be done by the appointment - selection committee and they - that selection committee may or may not have been the people that are listed in that document.

Well, that was 1998?-- That's correct. There had been some difficulty for some time in getting an effectively functioning committee up and running. I had - have always in my career delegated the management of credentials and privileging committee to the Director of Medical Services, and, in fact, that's my experience of every hospital, that that's what generally happens. But it is correct that an effectively operating committee wasn't working for a period of time.

Well, it wasn't working in 2003 or certainly late 2002 when Dr Patel's candidature for an SMO's or director's position was being considered?-- It wasn't operating at that time, no.

And it wasn't operating in 2003 or 2004?-- No, it wasn't operating in 2003, and then some time during 2004 it recommenced.

First meeting about 26 November 2004?-- Yeah, I think it was late 2004.

Now, first proposition is the duty - you know the expression "the buck stops here"? The buck for creating the committee, that is the credentials and clinical privileging committee, stops with a district manager, doesn't it?-- It is part of my responsibility to see that one is operating, and I had delegated that function.

And you'd have known that your delegate had not created the committee?-- I knew he was working on it but, yes, it had not been created.

And you would have knowingly tolerated the delay?-- What actually happened is that not long after Darren Keating started work I had - as part of apprising him of what my expectations were, et cetera, I had indicated to him that I expected him to take responsibility for clinical governance and the first thing that we or that the priority I put on getting that sorted out was privileging and credentialing.

Well, did you tell him that there was no committee and that he was to get on to it?-- Yes.

Did you tell him that Queensland Health had a policy and he should refer to it?-- I can't recall the detail. I would think that's likely but I don't know for sure. I had met with Darren Keating on several occasions in relation to getting the committee up and running and this went on for quite some time, probably about a year or thereabouts, and at that point I kept on pressing and he became a little short with me and basically said that he had a lot on his plate and that he couldn't work the hours that I worked because he had family, and then at some other point I asked him whether he wanted me to intervene with the Fraser Coast because they had - Terry Hanelt, the Director of Medical Services there, apparently had some duties in terms of - I was advised had some duties of getting this sorted out and Darren said no and then, thereafter, a credentialing committee was established and it progressed with the physicians and the pediatricians and so forth.

Well, what do you say to this proposition: it appears that the time that it took from late 2002 until November 2004 was just too long? You'd agree with that surely?-- It was longer than I would have liked because - and that's why I spoke to Darren about it. In my experience, credentialing and privileging within a hospital environment has largely been a rubber stamp, which is why we - which is what we wanted to change, and the issue had first - the issue of joining with-----

Let me take you back. Your experience, would that have I suppose for about 10 years prior to 2002 been at Bundaberg and then before that, Mount Isa?-- That's right. I'd also acted in the regional office over in Townsville for a period of seven months.

Now, your experience with credentialing and privileging being very much a rubber stamp was your 10 years' experience based upon hospitals in which you were the District Manager?-- Yes, I was the District Manager. Credentialing and privileging has operated for a long time. It's traditionally been - it's done by medical staff and in my experience it has largely been a rubber stamp, yes.

Now, the improved version of it that you had many mind, at least by the time Darren Keating came to be employed, what improvements were your ambition, that there'd be a serious

consideration of the particular practitioner and his or her skills?-- There was - Kees Nydam had first raised concerns about credentialing and privileging committees in a small community being such that they were - all of the practitioners knew each other, both professionally and socially, and there was the potential - and there was more potential for it being that rubber stamp because of that and that it was therefore better to try to make it more independent by expanding it and also because the difficulties in getting people to actually attend a committee, because that's not an easy thing to get a variety of people together. There was a bigger pool by expanding it to the Fraser Coast as well.

COMMISSIONER: The rubber-stamping as I understand it was because the people who'd be on the committee would know the applicant. That's what you meant by rubber-stamping?-- Yes, and they would - they - the privileging almost invariably had - there was no restriction in any sort of practice. It would always say, "This person is privileged for surgical services", or paediatric services or whatever.

But the rubber-stamping was because the members of the committee knew the applicant. That's what you meant by rubber-stamping, is it?-- That's not what I meant but they would know the applicant usually.

Well, what do you mean by rubber-stamping? I didn't understand it in any other sense?-- That there - there wasn't a more independent review of what that practitioner - what their experience was.

But I thought that was - when you said they all knew each other in a small community?-- Mmm.

I thought that was because of that, because they knew each other in a small community. Is that not the reason?-- I'm not quite sure that I understand.

Well, what was the reason for the rubber-stamping? Was it because the people knew each other in a small community, which is what you mentioned when we were talking about rubber-stamping?-- Yes.

Or was it for some other reason?-- I think it was largely because there wasn't a - there wasn't value placed on what the process was, so it became more of a rubber stamp because there was no value seen in it.

MR ANDREWS: Do you mean by that that it wasn't done properly?-- Well, I don't think it was done properly, no.

COMMISSIONER: But what did that have to do with them all being in the one town? I just didn't understand why you said that?-- I think that because of the social and professional connections it would be less likely that somebody would say, "I don't think this person is right", or, "I don't think they should be doing these procedures."

Because they knew that person?-- Yes.

Well, that didn't happen, that wouldn't happen if the applicant were someone from outside the local community, would it?-- No.

So that problem will not arise where the applicant was someone from either outside Queensland or overseas?-- No, that's right.

MR ANDREWS: Did it occur to you that with the category of potential employee who was an overseas trained doctor and unknown to local practitioners, that the process of credentialing and privileging would require more attention to detail by the committee than had been the case historically with local employees?-- Can you - I'm not quite - I'm just not sure I understand.

Do you agree it would be easy to credential somebody you knew and to privilege than somebody you'd never encountered before?-- Yes.

And would you agree that for overseas trained doctors coming to Australia to fill an Area of Need it would be difficult to credential and privilege them?-- I don't know that it would be difficult but obviously the members of the panel wouldn't know them, wouldn't have any experience of them.

They would have to have more reliance than usual on their references?-- Yes.

They'd have to consider foreign institutions that perhaps they may not have heard of?-- Yes.

Being the institutions at which the candidate obtained qualifications?-- Yes.

And where they saw that the candidate had worked for a time in a particular institution, they might need to inquire what kind of hospital it was, large or small, tertiary or secondary or primary?-- Yes. I haven't given consideration to that but that's - might be the case, yes.

Should Queensland's District Managers give consideration to that when considering the performance of their duties under the Queensland Health policy for credentials and clinical privileges?-- I think that there is room for the credentialing and privileging process to be strengthened and certainly my experience from this is that I need to be more - would have needed - or would in the future need to be more cognisant and watchful of what's going on.

I'll put up on the screen Exhibit 279 which appears to be two documents, each of which relates to the Queensland Health credentials and privileges policy applying from July 2002. Would you look at the top of the page, please, to see if you can identify the document. Policy 15801, "Queensland Health Policy Statement" and the title seems to be "Credentials and

Clinical Privileges for Medical Practitioners" and at the bottom of the page there is probably a date. Would you look at the top of the page. Do you see the first highlighted section refers the reader to the "Queensland Health Document Credentials and Clinical Privileges Guidelines for Medical Practitioners, July 2002"?-- Yes.

Do you accept, do you, from the annual service agreements that it was your responsibility as District Manager to apply Queensland Health policy?-- Yes.

And so it was your responsibility to apply the policy set out in this document and in the Credentials and Clinical Privileges Guidelines For Medical Practitioners, July 2002 document?-- I delegated that responsibility but, yes.

Well, to whom did you delegate that?-- To the Director of Medical Services.

Who was that?-- Darren Keating.

Well, not in 2002 it wasn't?-- Oh, prior to that to - I mean, to every Director of Medical Services.

Well, do you mean that you didn't take responsibility for it so it must have been theirs, or do you mean that with each one you would say, "I delegate to you the responsibilities under the Queensland Health policy for credentialing and clinical privileging and ask you to perform that duty"?-- With Darren, I was very specific. With the others, I can't say I was that specific.

You didn't put it in a memo to Darren?-- Not - no, not that I recall.

Now, the responsibility that - you understood even in 2003 that the responsibility you were to delegate to Darren Keating when he arrived was to ensure that there was a peer review process?-- Our - yes, our policy - the peer review in terms of this was tri-annual as I recall, every three years.

You would have understood that Dr Patel was not credentialed nor privileged?-- He was given interim privileges but he didn't go through a process.

You'd have understood when Dr Keating was first engaged that Dr Patel had been in employment without first having been credentialed or privileged?-- It didn't specifically come to mind but, yes, obviously that was the case.

Did you tell Dr Keating that he needed to be credentialed and privileged by a peer review process?-- I didn't go into that detail. I just recall, as I said, saying to him that he needed to get the credentialing and privileging process sorted out.

When was it that you had in mind to improve upon the credentialing and privileging process of the past, that

rubber-stamping process, and to instigate something better?-- When?

Yes?-- When Darren first arrived it was one of - you know, it was very early on after he had started and we had talked about clinical governance and I indicated to him that I wanted that sorted out but I don't believe I gave him a specific time frame.

When you say you told Darren that you were delegating to him clinical governance?-- Yes.

That's an expression that covers a wide variety of particular duties; do you agree?-- Yes.

Did you tell him you were delegating to him your responsibilities under Queensland Health's policy for credentials and clinical privileges?-- I wasn't as specific as you're saying but my intent of what I said to him was that, yes.

As I understand it, you wanted something better for credentialing and privileging than had been historically your experience?-- Yes.

And yet for Dr Patel you allowed - I beg your pardon. You'd have been aware that he was employed without first being credentialed or privileged; you agree?-- Yes.

That he didn't even undergo the rubber-stamping process of having a local committee credential and privilege him; he just had interim privileges awarded him by Darren Keating that lasted 18 months. You'd have understood all of that?-- I didn't take it in at the time but I understand from what I've seen that's the case, yes.

And what special qualities did you think Dr Keating had to privilege this overseas trained doctor? Was Dr Keating a practising clinician?-- He had been up until Bundaberg but he wasn't in Bundaberg.

What was his clinical experience that you were aware of?-- He'd been working as a senior medical officer in Western Australia and he'd been in the army for a period of time.

You don't know in what particular area of medical practice?-- No.

Is it fair to say that he would be an - but for the fact that he was Director of Medical Services, you have no way of knowing whether he'd be an appropriate person to review Dr Patel to determine privileges?-- Other than the fact that he was a medical practitioner, no, I didn't know about any special knowledge that he would have.

Well, did you understand that the principle that it should be a peer review process meant a process by persons with similar experience or specialist interests to the applicant?-- Yes,

in a question setting, yes.

May I see the next page marked with a flag it is. That policy is effective from August 2002 you accept, policy 15801?-- Yes.

Now, did you understand that the clinical privileges represented range and scope of clinical responsibility a practitioner could exercise in a specific facility?-- Yes.

And that it would relate or it could relate to performance of specific operations and procedures?-- Yes.

That it might vary depending upon the facilities at your hospital?-- That's right.

The resources available at your hospital?-- Yes.

Did you appreciate that those matters could include the capacity of the Intensive Care Unit to provide ventilation for patients?-- It's not something I specifically considered but, yes-----

That would be the sort of thing referred to in the paragraph identified on that page?-- Yes.

Now, the document Exhibit 279 continues with a Credentials and Clinical Privileges Guidelines for Medical Practitioners brochure dated July 2002. Would you put up the first page that's marked with a flag. Perhaps the first page that's marked with highlighting. Now, Mr Leck, did you understand that the core membership of the credentials and privileges committee did not require specialist representation; that core membership could be made up of persons who did not come from a college?-- I haven't given that any - I don't know. I haven't given that any thought. I - mmm.

And that would have been the case for a number of years, at least since the year 2000 as we saw from the prior credentials and privileging document.

MR FREEBURN: Do you mean permanent membership, core?

MR ANDREWS: Yes, permanent membership, thank you?-- My recollection is is that it would normally be chaired by the Director of Medical Services and that would usually be somebody from the discipline on the committee, so from surgery, from medicine or whatever. I had - I did have an expectation that there would be somebody from the relevant college on the selection panel and there had been some difficulty in getting hold of a representative from the College of Surgeons in relation to the credentialing process of surgeons.

Now, do you understand that as District Manager, you were to consider the recommendations of the committee and the administrative and resource applications for your hospitals?-- Yes.

Now, you didn't do that. Do you know whether Darren Keating did it?-- In relation to?

Dr Patel or, indeed, anybody else?-- Not in relation to Dr Patel that I'm aware of, no.

Well, who considered the hospital's administrative and resource implications in relation to any other doctor?-- When the - I mean, obviously the - when the credentialing was done for physicians pediatricians and so forth, a recommendation came to me and signed off on that.

When were you getting credentialling done for them?-- You referred earlier to late November 2004.

Thank you, yes.

COMMISSIONER: But the administrative and resource implications were yours - solely your responsibility, weren't they?-- Certainly - yes, they are my responsibility. Not solely my responsibility, but, yes, part of my responsibility.

They weren't the sort of things that you would generally delegate to the Director of Medical Services?-- I would expect the Director of Medical Services to consider those things, yes, particularly.

But you would also?-- Yes.

MR ANDREWS: Would you look, please, at part of Exhibit 448, being DWK82? Do you see that you wrote to Dr Patel?-- Yes.

Saying that a formal process of obtaining credentials and clinical privileges would be undertaken in the near future?-- Yes.

The date of that is 13 June 2003?-- Yes.

It didn't happen before Dr Patel left in April 2005, did it?-- No.

May I go back to the credentialling and privileging document? When assigning interim privileges to Dr Patel, did you consider the administrative and resource implications of the Bundaberg Base Hospital? In particular, you understand that for oesophagectomies and Whipple's procedures, there was, according to some of the evidence heard to date, the complication that, firstly, the ICU was inappropriate because it really had the capacity only to deal with ventilated patients for up to 48 hours as a general rule, and there was a second problem with respect to oesophagectomies: that they, apparently, being such complicated procedures, ought to have been done only in facilities where there were up to 30 of them done per annum. Now, those two features of oesophagectomies and Whipple's procedures, they'd be things that you ought to be thinking about as part of your consideration of administrative and resource implications, would you agree?-- Something as specific as that is not something that I would have thought of. We'd employed a number of general surgeons over a period of time, so my expectation was that Dr Patel would continue just as had happened in the past, and I didn't expect that there would be any impact on resource or administration issues.

Do district managers all go to a District Managers Conference where they deliver papers and ask what do these things mean? So, do you ring up your friends, who are district managers, and say, "What am I supposed to look at when I consider administrative and resource implications?" Does that ever

happen?-- Not that I'm aware of, no.

What does it mean to you, administrative and resource implications, or did you never look at it and never consider it?-- I didn't consider it in the context of appointments that were filling vacancies. I would only consider it in the context of whether we were looking at establishing or enhancing a new service.

Now, towards the bottom of that page, you will see a paragraph, "Where it cannot be confidently established that an applicant has the necessary knowledge, skills and experience in the area of medicine for which they are applying based on their CV and referee reports, the applicant must undergo a period of supervision by a specialist." That continues, "...in the area of medicine, before being granted clinical privileges, and the supervisor will be required to provide a written report in relation to the applicant's knowledge and skills." Now, it occurs to me that with respect to an overseas trained - for instance, Senior Medical Officer, who is not known to anybody, who comes from facilities that haven't been assessed or aren't known, for instance, to your Director of Medical Services, that that aspect could be particularly useful in practice; do you agree - that granting them interim privileges or - I beg your pardon, requiring them to be supervised by a specialist before they are granted clinical privileges could be very practical as a safeguard?-- Yes, it could.

Have you ever seen it employed?-- I personally haven't, no.

Do you know whether it is used by other district managers in the regions?-- I don't know.

Do you have an opinion about whether it might have been useful in the case of Dr Patel?-- Certainly in hindsight it would have been useful, yes.

But then who could have supervised - what specialist could have supervised Dr Patel if he was appointed Director of Surgery?-- The only way it could have been done was from another hospital, so, a link with, say, a tertiary hospital in Brisbane.

COMMISSIONER: That would have been impossible, wouldn't it, for someone in a tertiary hospital in Brisbane to supervise Dr Patel in Bundaberg?-- Yeah, it would have been difficult for hands-on supervision, that's correct.

MR ANDREWS: Now, "Delegated supervisors must have their credentials assessed and clinical privileges delineated." Would you have regarded the Director of Surgery as a supervisor for junior medical officers?-- Yes.

And where there was a requirement for a delegated supervisor to have credentialling and privileging, is this in respect to their teaching skills or was this just another imperative requiring credentialling and privileging?-- I don't know.

Thank you. Well, you didn't ever discuss, I suppose, the variable membership or decide on a variable membership for your credentials and privileges committee?-- No.

And did you ever remonstrate with Dr Nydam as to why he didn't have Dr Patel and Dr Gaffield credentialled and privileged before they were appointed?-- No.

And did you appreciate that you might, for instance, have engaged the services of some surgeons in Bundaberg to sit on a credentials and privileges committee?-- Not in this instance, no. There had been occasions when people had been recruited where there would be VMOs that would sit on the panel anyway as those variable members that you spoke about, but, no, not in this instance.

Well, looking at what a District Manager in 2002/2003 ought to have done, I suggest to you that one ought to have considered the recruitment on to a credentials and privileges committee of some surgeons from Bundaberg for the purpose of credentialling and privileging the new appointees to the Surgical Department and, in particular, for credentialling and privileging the new Director of Surgery, and especially because those persons were coming from overseas?-- In hindsight, it would have been useful to have - obviously to have had that committee meet, although, as I said in the - as I said before, I guess I wasn't confident that any local process was any more than a rubber stamp, which is why we were trying to change it.

Now, Dr Thiele gave evidence that he, in fact, had experience with one of the institutions at which Dr Patel had worked. You mightn't have known that in advance, but wouldn't Dr Thiele have been one of the persons from the town who might well have been invited to sit on a credentials and privileges committee, especially bearing in mind that he was a VMO at the time?-- He might have, yes.

Now, you would know him better than I would, I having heard him only as a witness giving evidence, but he didn't give the impression of the kind of person who would simply rubber stamp an application. He gave the impression of the kind of person who would consider it?-- Yes, Brian Thiele is a highly ethical man. As I said before, we were actually trying to improve the system. Previous processes I did view as a rubber stamp and obviously Kees Nydam did as well, and that's why we wanted to change it.

COMMISSIONER: But when nothing was happening over a period of two years, Mr Leck, didn't you think there was some way in which you could overcome that bottle neck and get some local committee which would not rubber stamp, such as by people of the calibre of Dr Thiele?-- I had been attempting to get the committee up and running. As I said before, I had spoken to Darren Keating and emphasised to him on a number of occasions that that's what needed to happen. I can't be sure that having a credentials and privileging committee would have

actually stopped what occurred from occurring.

You can't be sure it wouldn't have stopped it, though, can you?-- No. You know, as I said, my experience of credentials committees is that they weren't considered by the participants of any real value.

That was your experience from Mount Isa and Bundaberg?-- In fact, in New South Wales I think the same applied there with credentials committees there in the hospitals that I worked at as well.

Prior to 1992?-- Yes.

At Mount Isa and Bundaberg, where it was an unsatisfactory process, it would at all times have been a process that was under your control as District Manager?-- I'm sorry, I don't really understand the question.

Isn't it the case that credentials and privileges committees make recommendations to the District Manager who makes the decisions?-- Yes, that is correct.

And that was the case in Mount Isa and in Bundaberg?-- Yes.

And so if you heard feedback from your credentials and privileges committee, or otherwise had evidence that they were rubber stamping these decisions in an unsatisfactory way, you were the one to remonstrate with them and make them improve?-- I don't think what happened in Bundaberg or in Mount Isa in that regard was different from anywhere else, and I certainly think that the processes of credentialling and their emphasis can be improved, and we were trying to go about doing that.

At the first credentialling and privileging committee meeting in November 2004, I notice that the internal medicine clinical privileges were the topic of discussion. I'll put up the second page of the minutes of that meeting. There's a Dr Strahan, a person who I understand has given evidence, and Dr Strahan is a fellow of the Royal Australian College of Physicians, and, indeed, most of the people being privileged there were specialist physicians; isn't that the case?-- Yes, that's right. Some of them I don't know, but, yes - Dr Miach, Dr Smalberger, Dr Conradie. The others are FRACPs, yes.

Dr Miach, for example, was privileged subject to evidence of the college and then some other body I can't interpret - MOPS - and subject to his providing an audit of renal biopsy procedures at his next application?-- Yes.

And Dr Strahan was privileged, and, in particular, it included gastroscopy and colonoscopy, subject to evidence of a conjoint committee certification in gastroscopy and colonoscopy, and to providing evidence of an audit of endoscopy procedures at the next application?-- Yes.

Now, is that the kind of privileging that you'd had an ambition for?-- Yes.

MR FREEBURN: Commissioner, is it possible to take a break fairly soon - a 10 minute break?

COMMISSIONER: Make it 15 minutes.

MR ANDREWS: That's very convenient for me also.

THE COMMISSION ADJOURNED AT 3.04 P.M.

THE COMMISSION RESUMED AT 3.19 P.M.

PETER NICKLIN LECK, CONTINUING EXAMINATION-IN-CHIEF:

MR ANDREWS: Mr Leck, with respect to the establishment of a credentialling and clinical privileging committee, in the long period that there was none prior to November 2004, did you at any stage take the matter up with someone above you in the line, like your Zonal Manager or Head Office?-- No.

I'll move to another item from the policy relating to credentials and clinical privileges, which seems to be on page 10. It suggests that one can seek information from colleagues other than simply the referees. In your experience, was that ever done?-- No.

That process, for an overseas trained doctor, seems to be potentially very useful; do you agree - that is, approaching some of their foreign colleagues with a view to learning some background about their skills?-- I wouldn't have thought of it before this, but certainly in the circumstances, yes.

COMMISSIONER: Did you read this document, Mr Leck?-- When it first came out I would have read it, yes.

It didn't need to occur to you before if you read the document, because it is in there as a suggested course to take?-- Yes.

Anyway, you didn't take it.

MR ANDREWS: At 7.3 of the document, it speaks of a mechanism for granting short term privileges - I beg your pardon, temporary privileges for short-term appointees, such as locums. Now, Dr Patel wasn't a locum, nor a short-term appointee, was he?-- Dr Patel would be considered as a locum, yes, or a temporary employee.

Well, you say "would be considered" as well-----?-- Well, was considered as.

COMMISSIONER: Isn't a locum someone who is brought in to temporarily replace someone else?-- That's usually the case, yes.

Well, he wasn't that, was he?-- No, he was filling a vacancy.

Yes.

MR ANDREWS: And a review of clinical privileges is something that can occur where there are poor outcomes; do you see that?-- Yes.

As contemplated by the policy at pages 11 and 12?-- Yes.

In your experience, were there ever reviews of clinical privileges at any hospital at which you were a District Manager when poor outcomes came to be noticed?-- Yes. With Dr Malcolm Stumer, who was an obstetrician, and there had been some concerns raised about him.

And were his privileges changed after a meeting of the committee?-- Dr Stumer was suspended. There was - I can't remember all of the details, but there was a move to restrict some aspects of his practice, but I just can't remember all the details of that.

Who exercised the suspension power with respect to Dr Stumer?-- I think it was the Zonal Manager, but I'm not exactly sure.

Who referred the matter to the Zonal Manager?-- I think that was the Director of Medical Services.

And who was that person at the time?-- John Wakefield.

So, that would have been some time prior to mid-2002?-- Yes.

Do you, as District Manager, have the power to suspend the services of a medical practitioner in your facility?-- Yes.

Have you ever done so?-- Yes.

When was that?-- That was relating to - not a Senior Medical Officer, but a junior medical officer, Dr Qureshi.

That was with respect to suspected significant behavioural problems, wasn't it?-- Yes.

Do you have the authority to suspend a Senior Medical Officer?-- Yes.

But you have never done so?-- No.

And what's the protocol you have to go through before suspending a Senior Medical Officer? Do you just determine that there are grounds for cause and then do so?-- Yes, that's right.

And I suppose you give them - the Senior Medical Officer - the opportunity to appeal your decision?-- That's what I would do, yeah.

And can you suspend a person on full pay?-- Yes.

With Dr Qureshi, did you suspend him on full pay or without pay?-- He was suspended on pay.

And he was suspected of serious sexual misconduct?-- Yes.

Was he also suspected of poor clinical performance, or was that a basis, rather, for his suspension?-- It wasn't a basis for his suspension, no.

Why didn't you - did you consider suspending Dr Patel on pay or on any other condition?-- The thought crossed my mind; however, the Director of Medical Services was quite adamant that the issues were personality based, and that there was personal conflict that was leading to the allegations being made, and we also - there'd been no clinical indicator or clinical information that had been brought to my attention that gave immediate grounds for concern.

When did the thought cross your mind to suspend Dr Patel?-- After I had received the correspondence from Toni Hoffman.

Some time after the 20th of October 2004?-- Yes.

Did you discuss that option with the Director of Medical Services?-- I don't recall discussing it. I don't recall discussing that option with him, no.

As 2005 progressed, did you again consider suspending Dr Patel?-- No.

But as 2005 progressed, you became more concerned about him than you had been in October 2004, didn't you?-- Yes.

By January 2005, even your Director of Medical Services was having second thoughts about Dr Patel?-- He hadn't made, that I recall, representation to me about concerns of a clinical nature.

So would it be correct for me to conclude it was shortly after Toni Hoffman's meeting in October that you had your first and last thought about the suspension of Dr Patel?-- I can't recall thinking about it again since - other than that, no.

COMMISSIONER: Can you explain why, when you did think about suspending him in October, you didn't communicate that thought to Dr Keating; raise it with him as a possibility?-- Because he - he was very adamant that this was a personality-based problem. He said that he was a - he wasn't a great surgeon but he was a good one. So I relied on his judgment.

Thank you.

MR ANDREWS: From his 225, annexure GF9 shows some e-mails I would like you to consider. The top of the page reveals that this was an email to John Scott. Now, you see it is written on the 13th of January 2005?-- Yep.

You say, "I actually do have some concerns about the outcomes of some of Dr Patel's surgery." "Until last week my Medical Superintendent did not believe the complaints were justified and were completely driven by the personality conflict - however he has now expressed some concern although he still believes most of the issues are personality driven." Do you recall what it was that Dr Keating said to you to reveal his change of mind?-- No, I don't - no, I don't recall the exact words - well, I don't even recall, really, the words that he used.

Well, the fact that you were communicating with Dr Scott suggests you were becoming concerned by your Director of Medical Service's change of view?-- I was - I was concerned about getting the investigation done as soon as I could, and there had been that issue relating to Steve Rashford, and that led to me sending the email.

Yes, Steve Rashford had written an email suggesting that there was a sentinel event arising out of circumstances relating to the treatment of a 15 year old boy?-- I don't recall it being described as a sentinel event but I do recall that there was some correspondence, yeah.

Well, however it was described, that correspondence disturbed you?-- Yes.

Did you discuss with the Director of Medical Services whether it was appropriate to suspend Dr Patel? Well, I know you didn't. Why didn't you?-- Well, Dr - Dr Keating didn't have

concerns about the Steve Rashford case.

What were his concerns about?-- I'm - no, I'm not sure exactly why Darren became more concerned.

COMMISSIONER: But you had some concerns not only about the Rashford matter but about, you say, outcomes, pleural. What were the other outcomes apart from the one about the 15 year old boy?-- The material that was in Toni Hoffman's correspondence.

But you weren't - you were more concerned about those in January than you were in October?-- Well, yes, because this event in relation to the matter raised by Dr Rashford.

I see, all right.

MR ANDREWS: Well, if you were becoming increasingly concerned and you knew that the medical superintendent was changing his mind, surely you must have asked the medical superintendent why he was changing his mind?-- I - I just can't recall the conversation that took place.

Before I leave the email at the bottom of the page, you talk about nursing staff going to the QNU and you say, "Thankfully the QNU advised them to report to us." Is that because it limits bad publicity?-- That was my view, yes.

Now, the email from Dr Rashford about which you spoke, or the communication, seems to be part of Exhibit 317. I will put up the first page of that email. Do you see it is from Steve Rashford to Mr Bergin, Dr Keating and you?-- Yes.

And it is on the 4th of January?-- Yes.

And the subject is "sentinel case"?-- Right, yep.

Relating to "an event on the 1st of January for an urgent transfer of a boy whose leg was ischaemic and septic ++". That's the Rashford incident that you were concerned about?-- Yes.

Would you look further down the page, please? You see that Dr Rashford is suggesting that his group would be urgently examining their role in that type of case?-- Yep.

That was a responsible approach for them to take?-- Yes, I think it was, yes.

Was Dr Rashford a person known to you?-- No, he may have met me once or twice but I don't recall him.

Did you have a view about whether he was a responsible person?-- I had no particular view.

Thank you. Sentinel event or sentinel case is a term of art in Queensland Health, isn't it? It is one of the very serious problems warranting investigation?-- Yes.

Did you speak to your Director of Medical Services about this?-- Yes, I did.

Now, a sentinel event, in fact, is a matter that requires certain action by you as a district manager?-- Yes, normally either myself or the Director of Medical Services would send a fax with some of the details to corporate office.

So it is - if it is a sentinel event, you don't just deal with it locally, you must alert corporate office first?-- Yes.

Or contemporaneously?-- Yes.

Would you look, please, at this email of the 5th of January from you to Mr Bergin relating to the patient issue raised by Dr Rashford? You observe that "Darren is not sure in the circumstances that an external review is warranted."?-- Yes.

Did you mean by that that Darren was indicating that there may not be a need to involve head office?-- Darren had reviewed the matter and didn't feel that the patient's management was - well, he thought the patient's management was okay, so that he didn't feel that it was a sentinel event or there was a problem with the management of the case.

Did you accept Dr Keating's judgment on that?-- Yes.

And did you appreciate that by accepting Dr Keating's judgment, you were relieved of the obligation to notify head office?-- Yes, because it - because it was not a sentinel event in his view.

The obligation on a district manager to notify head office of sentinel events is not an obligation that's conditional upon the approval of the district manager, is it?-- I am sorry?

If somebody notifies that there has been a sentinel event, a district manager is obliged to notify head office?-- Yes.

He is not obliged to take a second opinion from a Director of Medical Services?-- Usually it would be - I mean, because I am not clinically - I haven't got a clinical background, I would take the advice of the Director of Medical Services as to whether it was a sentinel event or not.

This wasn't the first sentinel event that was kept in Bundaberg without being referred to head office, was it?-- There were - anything that had been declared as a sentinel event was sent. There had been a case where there was a query as to whether it was a sentinel event or not. That was Mr Bramich.

Let me see, Dr Rashford assessed this as a sentinel event and it is not as if he is just a member of the public, is it?-- No, he is not, no.

COMMISSIONER: What were his qualifications?-- I think he was

a Director of Emergency Medicine, but I am not sure exactly. I don't know his background.

But why would you think that Dr Keating was better qualified than Dr Rashford to second guess this matter?-- I didn't think along those lines.

Why did you accept his opinion and, in effect, reject Dr Rashford's that it was a sentinel event?-- Because Dr Keating had the matter investigated and was not concerned by it.

But when you say had it investigated, looked at it himself?-- He would have asked for advice on it.

Do you know he did that?-- As I - as I recall he did, yes.

Whose advice did he seek? Did he tell you he sought advice?-- No, I don't recall that. I think I recall that only in the context of the information that's been through the Commission.

I see. But you didn't know at the time that he had sought advice?-- I would have expected him to but I don't recall discussing that with him.

MR ANDREWS: Mr Leck, on the 5th of January there appears to be a brief to the zonal manager prepared by Dr Keating, a briefing note. Let me put it on the screen. Is that the document that was - well, the email that I had just shown you referred to an attached brief and background material prepared by Darren Keating?-- Yes.

Would this have been the attached brief and background material?-- Yes.

Would you look at the next page, or the second page of it? "Related issues", "Public affairs increased, risk of negative publicity related to delay in transfer to tertiary facility". That's a relevant thing to raise?-- With the zonal manager, yes.

"Actions taken", and "required to institute a policy of transfer to tertiary facilities of patients with emergency vascular conditions when the condition is stable"?-- Yes.

Was there any suggestion that there had not been a sentinel event in that briefing note?-- Not in the briefing note, no.

Mr Leck, I would like to put on the screen the other sentinel event form of which you spoke, being the - at least the first page of a sentinel event which form part of exhibit 225, coming from attachment GF10. Sentinel events are matters that have to be brought to your attention, or they did, at least from about June or July of 2004. Isn't that the case?-- Yes.

And this was a sentinel event relating to Desmond Bramich, marked as a serious and rare event?-- Yes.

And the author seems to have said that the patient was readmitted - the author seems to be Toni Hoffman, I see from up above - but "readmitted in extremis". Do you see that?-- Yes.

And you would interpret that as readmitted to ICU?-- Yes.

Now, marked in yellow it seems to me to read "need to T/F" - that is transfer - "PT" - that is patient - "to Brisbane where" - and then there is an arrow pointing upwards. It must mean better facilities. Do you see the arrow?-- Increased facilities.

Oh, increased facility, thank you. "PT" - well, I am not sure. Something before the word "Gaffield". Perhaps it is "Dr Gaffield patient's attending surgeon. Dr Patel informed staff patient did not require thoracic surgeon or transfer." Now, Toni Hoffman, the author, would be a person in a position - in a good position to assess whether this was a serious or rare event, wouldn't she?-- Yes.

Now, a sentinel event form, you were obliged, weren't you, to refer sentinel events to corporate office?-- I did, but in this case there was a question as to whether or not it was a sentinel event.

Who said that it wasn't?-- I had spoken to the quality coordinator. I am not sure at that time whether it was Leonie Raven or Jane Truscott. Jane had relieved in that position for a while.

And Jane's - Jane had some significant academic qualifications, as I recall from someone else's evidence. What clinical qualifications did she have?-- She was Dr Jane Truscott. So she was a registered nurse but she had post graduate qualifications. I can't remember what they were.

Yes, I am thinking of her clinical experience rather than her qualifications. Did she have much clinical experience?-- Yes, I believe so.

Was she engaged in a clinical capacity at your hospital?-- She had been engaged as the CNC of the palliative care service.

Well, she was a person whose opinion you would respect?-- Yes.

Was Toni Hoffman a person whose opinion you would also respect?-- Yes.

Did you tell Toni Hoffman you weren't treating this as a sentinel event when you failed to notify head office?-- I don't recall speaking to Toni Hoffman about it, no.

Well, the form's dated 2nd of August 2004. It would be the case that you didn't discuss this with Toni Hoffman until - well, at least the 20th of October, wouldn't it?-- Yes.

Why would you take Ms Truscott's word over Ms Hoffman's about whether this was a sentinel event?-- My understanding was that - well, I am not sure whether it was Jane or Leonie had spoken to Darren Keating, who indicated that it also wasn't a sentinel event, and there was specific classifications in corporate policy in relation to sentinel events. The issue - the main issue from my perspective was that it be investigated because you would do that whether it was a sentinel event or whether it was rated as a serious incident.

Did you say there were serious consequences depending on whether it was rated as one or the other?-- No, you would - the action that would occur would be the same, whether it was classified as a sentinel event or as an incident - a serious incident or adverse event.

Well, a serious incident or adverse event would not be notified to head office, would it?-- No.

So the action wouldn't be the same, would it?-- What I mean is that even when a sentinel event is notified to corporate office, their requirement is that there be an investigation into the matter, and, so, the action - the action in that sense would be the same.

With respect to the Bramich matter, did you - were you aware that the patient had been in the surgical ward before being readmitted in extremis; that is that the patient had not been in surgery but the surgical ward?-- I don't - I mean, I didn't recall that at the time as part of this - the Commission process. I had heard that that was the case, yes.

That, in fact, the patient had undergone physiotherapy in the surgical ward on the day - on the day of his death and prior to his readmission into the ICU?-- I am not familiar with all of the clinical aspects of the patient's care.

That would suggest, wouldn't it, if that were the case, that this was an unexpected death?-- In this instance - look, I don't know whether it was - I can't say whether it was unexpected death or not.

Well, it doesn't seem to have been unexpected in the last hour of the patient's life, but when judged from an earlier time that day, it was an unexpected death. It is in that sense that I use the expression?-- Yeah, as I said, I am not - I am not familiar with the clinical history of the patient and I wouldn't go into those sorts of details normally.

When a person has elective surgery, in particular an oesophagectomy, it is not a condition which is immediately life threatening, is it; that is, the condition for which they have the oesophagectomy? They would normally be expected to survive months?-- I - you wouldn't expect that a patient undergoing an oesophagectomy would die immediately but, I mean, usually-----

So to die on the day of-----

MR FREEBURN: Let him answer.

WITNESS: Usually those patients are very sick anyway, so you would not expect them to have a long life expectancy.

MR ANDREWS: Thank you. So to die on the day or the day after an oesophagectomy would be classified as an unexpected death?-- Yes, it could be. I guess you are asking me questions relating to a clinical opinion on patients.

COMMISSIONER: Well, not really. If in fact a person goes into hospital for an oesophagectomy and if statistically the results are that death is not an expected result and that person dies, that is an unexpected death, isn't it?-- Yes.

And that's what happened here, isn't it?

MR ANDREWS: With Mr Kemps?-- With Mr Kemps, yes, as I understand it, that's right, yes.

The expression "unexpected death" is a term of art in the Queensland Health sentinel event context, isn't it?-- Yes.

If there's an unexpected death, that's an event that classifies as a sentinel one which ought to be referred to head office?-- Yes.

And so, when Mr Kemps died during the - or immediately after the surgery performed by Dr Patel in December 2004, it's the sort of event that ought to have been reported and reported as a sentinel event?-- Yes, I think that's right.

Now, you learned of Mr Kemps' death as a result of that surgery shortly afterwards?-- I can't recall exactly when it was. I didn't actually know that there had been - that it was Mr Kemp until this process, but I was advised that there had been a death some time later.

You didn't know it was Mr Kemps because in the hospital there's a protocol for keeping patients' names confidential by using numbers; isn't that the case?-- That's correct.

Mr Kemps died on about the 21st of December 2004?-- Yes, I think that's right.

Would you look at this e-mail, please, from you to Dr Keating dated the 21st of December 2004?-- Yes.

Do you agree you wrote to Dr Keating, "The oesophagectomy concerns me somewhat. Have any of these patients survived?"?-- Yes.

Now, the subject was a "night report". I gather that one of the staff had sent you a report about this death?-- The after hours - as I recall it, the after hours nurse managers provide a report at the close of every shift and I think there was something in that.

Did you see to it that a sentinel event form was created and forwarded to head office?-- No.

Did you notify head office?-- No.

You agree this was a sentinel event?-- Yes.

Do you agree that as District Manager, the lot fell you to you to notify head office? I'll take you to it shortly, that it was a responsibility that you may have shared with others but you were one person with responsibility to advise head office?-- Yes.

What was Dr Keating's response to that e-mail?-- I don't recall him - I don't recall a response.

Well, your relationship wasn't so - your contacts weren't so infrequent that he would have failed to respond?-- No, I - I would expect that he did. I just - I have no recollection of it.

Do you remember hearing from Dr Keating at any stage what the hospital's statistics were for Dr Patel's oesophagectomies?-- No.

Now, the fact that you don't recall it, does it suggest to you that Dr Keating probably didn't inform you of that statistic?-- I don't think he informed me, no.

COMMISSIONER: A pretty important question, isn't it, "Have any of these patients survived?" It was something about which you were anxious at the time?-- Yes.

You don't recall chasing it up?-- No.

MR ANDREWS: I tender that e-mail.

COMMISSIONER: That will be Exhibit number 470.

ADMITTED AND MARKED "EXHIBIT 470"

MR ANDREWS: Mr Leck, that's a thing that a District Manager ought to follow with his Director of Medical Services, isn't it?-- My e-mail?

Yes, this query about the oesophagectomies and the rate of success, rate of survival?-- Well, I was - I was following it but I just don't recall what Darren had indicated.

Thank you.

COMMISSIONER: How did you follow it up?-- Oh, I mean, obviously it was an issue that I was - rather than following it up I guess, it was an issue which I was concerned about which I had-----

But I thought implicit in what you said to me that you don't recall ever following it up after that e-mail?-- No, that's correct.

MR ANDREWS: I would like you to consider the Queensland Health policy relating to sentinel events. From Exhibit 290A, which contains annexure JGW6, there is a series of pages, some of which seem to be the incident management policy. Do you recognise that as Queensland Health's Incident Management Policy of the 10th of June 2004, at least that first page of it?-- Yes.

May I see the next bold portion. The aim to improve safety, reduce risk and learn, among other things?-- Yes.

Within that document it comes to discuss sentinel event list. "Where a sentinel event occurs, it must be immediately reported, then investigated, actioned and communicated in

accordance with the incident management model contained in this policy"?-- Yes.

"Queensland Health has deemed the following actual incidents as sentinel events:" If I may see the next page, please. Deaths including "unexpected death of a patient during surgery", or "unexpected death of a patient"?-- Yes.

Now, that would include Mr Bramich, Mr Kemps. There is no doubt about that, is there?-- I - in relation to the management and the outcomes of patients like that, I - I just didn't think of it in terms of a sentinel event.

And as I understand it, by not classifying it as a sentinel event, from your point of view it meant that it got investigated by some persons in Bundaberg as opposed to being investigated by some persons from Brisbane?-- No, that's not correct. So in terms of a sentinel event, I wouldn't expect anyone from Brisbane to conduct an investigation and they hadn't previously in Bundaberg that I'm aware of.

There had been a prior sentinel event relating to the Mental Health Unit?-- Yes.

What had Brisbane done in that case?-- I requested the matter be investigated, which it was.

Is that your only experience with sentinel events?-- That I recall, yes.

Now, here is another page relating to the reporting of sentinel events. It suggests that the District Manager is required to notify the Director-General via the secretariat of the Risk Management Advisory Group immediately, using a particular report template. Now, doesn't that suggest that the Risk Management Advisory Group would be likely to exercise a judgment about what to do depending on the kind of sentinel event reported?-- I'm sorry, which group was that?

Risk Management Advisory Group. It looks as if they'd work out what to do, doesn't it?-- Yes.

And it looks from the form as if, among other things, they may choose to investigate with some investigators independent of the district?-- They could do but that wasn't my experience.

But your experience was limited to one instance, wasn't it?-- Yes, and I hadn't heard of that happening before in other districts.

This regime relating to sentinel events had been in place since about June or July 2004?-- Yes.

I think this is part of the policy relating to risk management. I won't trouble you with that document at the moment, Mr Leck. Do you recall that risk management came on the agenda - was put on the agenda by Queensland Health some time in the last few years?-- Yes.

And as a result you appointed was it Leonie Raven to create some risk management policies?-- That's correct.

She at one stage complained to you that she was over worked, she needed more resources to adequately fulfil that task?-- I don't recall her saying that specifically in relation to that task but she had raised concerns about a lot of work, yes.

Were you in a position to fund assistance for Ms Raven? Was your budget such that you could have given her assistance?-- No.

One of the things that is an element in risk management is assessing risks from negligible to extreme, isn't it?-- Yes.

And for risk management, you had not just risk management with respect to risks relating to patients but with respect to risks relating to a variety of things; is that the case?-- With respect to staff incidence as well, yes.

Here is a risk matrix that is part of Ms Raven's statement Exhibit 162 and part of adverse events management document LTR4 as I apprehend it, although it may indeed be LTR5. Do you recognise that document?-- Yes.

Do you see in the column on the left there are a number of types of risk. There's an adverse clinical incident and it can be rated negligible to extreme?-- Yes.

Damage to reputation also can be rated negligible to extreme. Disruption to operational delivery likewise can be rated negligible to extreme, and then there's financial. Now, financial I see being 10 per cent - let's look at the extreme right-hand side. Being 15 per cent I assume over budget, over monthly budget, is rated extreme like multiple deaths and like sustaining national adverse publicity or having Queensland Health's reputation significantly damaged?-- Right.

Now, it does suggest to the reader that you were made to place a high priority on protecting Queensland Health's reputation?-- Yes, that was a high priority, yes.

And you were made to place a high priority on not going over budget, even in a month?-- Yes.

Indeed, as a risk rating exercise, that matrix, did that - that came from Queensland Health's Corporate Office, didn't it? It wasn't an invention of Leonie Raven's?-- No, it was a Corporate Office document.

And on the bottom of the page does - I beg your pardon. Allow me to show you part of what seems to be the corporate policy from Exhibit 293. You will see that here again there are risk ratings negligible through to extreme and multiple deaths in that document is rated as extreme as is sustained national adverse publicity and Queensland Health's reputation being significantly damaged and at the bottom of the page it shows

the source of this document, at the very bottom, "Sponsor: Deputy Director-General, Policy and Outcomes", "Issued by: Health Strategy and Funding Branch." Do you see that? On the monitor you can see it at the bottom of the page?-- Yes.

And as you understand it, part of your task was to contain adverse publicity?-- That's correct, yes.

As you became more concerned about Dr Patel, I gather that after the oesophagectomy death in December, you'd have become perturbed?-- Yes.

And after Dr Rashford had written calling the 15 year old's a sentinal event, you would have become more perturbed in early January 2005?-- Sorry, I've lost concentration for a moment.

I'm thinking of the things that would have concerned you from late 2004?-- Right.

Suddenly, on the 21st of December, you learn of an oesophagectomy death, and you are so worried about it, you E-mail Dr Keating. That would have cranked up your levels of worry, wouldn't it?-- I was increasingly worried, yes.

And when Dr Rashford wrote about 10 days later, or perhaps two weeks, about what he called a sentinal event, you would have become more increasingly worried?-- I - it was more the issue of the matter of Rashford that caused me concern. I just don't recall a whole lot about the incident concerning Mr Kemp. It was really the Rashford matter when I was becoming increasingly anxious.

Have a look at an E-mail of 13 January, from Karen Smith to the executives and nurse unit managers. "Dear all, treacherous day. Regards, Muddy." Now, that means nothing to me, and I gather it meant very little to you, because you replied in an E-mail - would you put up the next flagged page, please - from you to the Nurse Unit Manager, who was Linda Mulligan-----?-- She was the Director of Nursing.

I beg your pardon, yes, of course, Director of Nursing. "Please explore what is meant by 'treacherous day'. I assume it relates to Jay." That would be Dr Patel?-- Yes.

"So we need to quieten this down." Do you remember sending this E-mail?-- Yes.

Why?-- That was the day that we had met with - Darren Keating and I had met with Dr Patel to advise him that complaints had been made about him and we were having them investigated. So, I assumed from that that Dr Patel had told Muddy or others what had happened, and I didn't want a lot of gossip or publicity until there was a proper investigation conducted.

I'd like you to look at Exhibit 148. This precedes that by a number of days. It seems to be an E-mail from Linda Mulligan to you about theatre staff. It seems Ms Mulligan had three staff come to see her from theatre re: "serious concerns over a surgeon from a clinical and a professional behaviour perspective". Who was that surgeon?-- I - I presume it was Dr Patel. I actually don't recall the E-mail, other than in

the context of the Commission, other than that Linda had approached me about EAS at some stage.

What's EAS?-- Employee Assistance Service.

Well, by the 7th of January, you - it must have been a difficult two to three week period for you. You had heard about the oesophagectomy death, you had heard about Dr Rashford's concerns, you had heard from Linda Mulligan. Did you think then of discussing with anybody suspending Dr Patel, even on full pay?-- No, I don't recall discussing it with anybody.

COMMISSIONER: Is this a convenient time?

MR ANDREWS: Yes, thank you, Commissioner.

COMMISSIONER: We will adjourn now until 9 o'clock tomorrow morning. I just want to say to you, Mr Leck, if you ever need to break at any time, please just let your solicitor know or let me know and we are happy to accommodate you?-- Thank you.

MR DIEHM: Commissioner, was that 9 o'clock?

COMMISSIONER: Yes. Is that too early?

MR DIEHM: No, that's fine.

THE COMMISSION ADJOURNED AT 4.27 P.M. TILL 9 A.M. THE FOLLOWING DAY