State Reporting Bureau

Queensland Government
Department of Justice and Attorney-General

Transcript of Proceedings

MR A J MORRIS QC, Commissioner

SIR LLEW EDWARDS, Deputy Commissioner

MS MARGARET VIDER, Deputy Commissioner

MR D C ANDREWS SC, Counsel Assisting
MR E MORZONE, Counsel Assisting
MR D ATKINSON, Counsel Assisting

IN THE MATTER OF THE COMMISSIONS OF INQUIRY ACT 1950

BUNDABERG HOSPITAL COMMISSION OF INQUIRY

COMMISSIONS OF INQUIRY (No. 1) 2005

BUNDABERG

..DATE 20/06/2005

..DAY 10

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

THE COMMISSION RESUMED AT 9.35 A.M.

MR P MORRISON QC (instructed by Brian Bartley & Associates) for Ms Mulligan, Director of Nursing

COMMISSIONER: I would like to begin this segment of the Inquiry's proceedings simply by welcoming you all here. One of the first decisions we made when we were asked to constitute this Commission of Inquiry was that it was very important to come to Bundaberg to hear what people have to tell us without causing them inconvenience, and hopefully to get some sense and some feeling of what so many people in this city have been through.

I think it's not inappropriate for me also to add that at a personal level I'm particularly happy to be back in Bundaberg. I had some very fond times here when I was a school boy at the naval cadet unit TS Bundaberg. That's more than 30 years ago so I won't go into that, and I know that both Sir Llew and Deputy Commissioner Vider have fond connections with the town as well. So we're pleased to be here and we're pleased to welcome you here.

Some necessary security arrangements have been put in place with hand-held scanners and so on. I apologise for that, but we were advised by the Attorney-General's Department that based on duty of care considerations they felt that had to be done. We hope that that won't discourage people from attending and feeling that they're free to come and go as they choose.

We have a lot of evidence to get through over the next two weeks, three weeks, so I suppose we better get started. Before I invite Mr Andrews to proceed, I notice Mr Morrison is present.

MR MORRISON: May I announce my appearance for Ms Mulligan.

COMMISSIONER: Thank you, Mr Morrison. Are there any other additional appearances beyond those previously? In the case of Ms Mulligan, I think, Mr Morrison, your client's previously been given leave to appear.

MR MORRISON: That's so.

COMMISSIONER: She's in the same situation as other individuals represented in this proceeding in that you are not expected to be present at all times unless it's convenient. We wish to make arrangements as convenient as possible to minimise cost, and you, of course, will be very welcome whenever you are able to be here, but we understand that it may not be necessary for you to be here the whole time.

Also, I've indicated previously that I'm not taking any traditional views about counsel appearing interchangeably with their instructing solicitors, and if that situation arises that is perfectly acceptable to us as well.

MR MORRISON: I'm grateful for that.

COMMISSIONER: Thank you, Mr Morrison. Mr Andrews?

MR ALLEN: Excuse me, Commissioner, there's one brief preliminary matter. I appear for Ms Aylmer who is the first witness today, and she instructs me that she would prefer, if possible, not to be filmed or not have any filming of her evidence published. She instructs me, basically, that she's camera shy, even in a social context, and that she would feel uncomfortable if she felt that her evidence was being televised. I can't put it any higher than that.

COMMISSIONER: Now look, I thank you for those submissions. It is, as everyone is aware, a rather novel idea to allow television cameras into a hearing like this one. The decision to allow that was made really as a matter of balance to encourage public knowledge of any participation in the proceedings. If that's going to make particular witnesses uncomfortable, I would be very reluctant to put them to that discomfort, so subject to - yes, I think we will accede to that request and we'll ask that the cameras not be operated whilst Ms Aylmer is giving evidence, and that extends to still cameras as well as video.

MR ALLEN: Thank you, Commissioners.

COMMISSIONER: Did anyone else wish to be heard about that? I guess I was a bit pre-emptory. Mr Andrews?

MR ANDREWS: After Ms Aylmer's evidence the Commission will hear today from some witnesses - and I should outline them because the parties were notified of a different order of witnesses mid-week. The parties had expected that after Ms Aylmer they would hear from Ms Raven and Ms Kirby. The statements of those two witnesses were made available to the inquiry staff only at about 7 p.m. on Friday night, and in the circumstances they have not yet been circulated to the other parties. I'm hopeful that during the lunchtime adjournment those statements which are available to the Commission only in hard copy might somehow be made available to all of the parties so that they've got an opportunity to read them overnight and those two witnesses might be called tomorrow.

In the circumstances, after Ms Aylmer and - yes, it would be my intention to call Ms Lindsay Druce, and hopefully Ms Robyn Pollock.

COMMISSIONER: Okay.

MR ANDREWS: Perhaps later in the day Jennifer White. In the normal course of events when the statements have been circulated, to save time I propose not to open as fully as one

might expect in a trial, but in the case of Ms Aylmer's evidence there will be a suggestion, I anticipate, from Ms Aylmer, of something which could be said to be adverse to the interests of another member of staff of the Bundaberg Hospital at the time, and I should open that there's contrary evidence from a nurse Patrick Damien Martin which is anticipated, and because of that controversy I should open those two pieces of contradictory evidence.

COMMISSIONER: Just before you do that, Mr Andrews, I should make clear to everyone at the Bar table - obviously for the first two weeks of sittings in Brisbane things were running at a fairly frenetic pace and it wasn't always possible to get witness statements out in advance. Now that we've had the two week break and the opportunity to catch up a little, it is our earnest desire to make sure that everyone gets statements in advance of the evidence. For the benefit of members of the public here, the object of that is simply to make things work more efficiently, so that if the barristers and solicitors here know what the evidence is going to be, that hopefully enables them to make their questions a lot more concise and to the point.

I trust that everyone at the Bar table is happy with the arrangements Mr Andrews has foreshadowed. There's no difficulty with the order of witnesses just announced?

MR MORRISON: No.

MR ANDREWS: Before proceeding further, Commissioner, I'm instructed that the radio media ask whether they may, in the circumstances, continue to record.

COMMISSIONER: I think there are two considerations. Firstly I should ask whether your client has a difficulty with that.

MR ALLEN: There's no difficulty with that, Commissioner.

COMMISSIONER: All right. It's just the still and video photography to which your client takes objection.

MR ALLEN: That's so.

COMMISSIONER: We'll allow voice recording to continue.

MR ANDREWS: Before calling Ms Aylmer to the stand, I observe that within her statement at paragraph 22 Ms Aylmer observes that some time after February 2004 Patrick Martin discussed with her ongoing concerns about the infection rate of patients in the peritoneal dialysis program. Statistical data which was requested by Dr Keating in November 2003 was made available at that meeting and Patrick Martin told Ms Aylmer that Patrick had discussed the issue with Dr Keating, and that Dr Keating had made a comment of words to the effect, "Well, if they want to play with the big boys, bring it on", and Ms Aylmer interpreted that comment as an intention by Dr Keating that she was - or anyone bringing these issues to the attention of management was a troublemaker and that no

appropriate action would be taken.

Mr Martin has provided an interview, and it's anticipated that his evidence will be that he raised the issue with Dr Keating, and in the course of a conversation Dr Keating said something like, "If the nurses want to play with the big boys they have to get their facts straight." Mr Martin says that he relayed the conversation back to the nurses, and only in subsequent conversations did he realise that the comment that he'd relayed had been misinterpreted as aggressive along the lines of, "If you want to play with the big boys, well, bring it on."

Mr Martin will say that's not how the comment originally came across from Dr Keating to him. It was more in the nature of Dr Keating suggesting that the nurses should make sure that they have their facts straight.

COMMISSIONER: Mr Andrews, subject to what you or anyone else wants to say, it really does seem to me that paragraph 22 is hearsay in the strictest legal sense. Given that the source of the hearsay, Mr Martin, doesn't support the version given here, I'm inclined to think the best thing we could do is to strike out paragraph 22 and hear the evidence from Mr Martin first hand as to what went on rather than relying on second-hand information.

MR ANDREWS: The paragraph has one purpose though, Commissioner. It does show why the witness would, after that time, have an explanation for not persisting with what she might otherwise have thought to be her duty to bring things to the attention of management.

COMMISSIONER: All right. So we will regard paragraph 22 commencing with the last line on page 8, "Patrick Martin told me" as evidence relevant only to her state of mind rather than evidence against Dr Keating or anyone else of the truth of what he said.

MR ANDREWS: Thank you. I submit that would be appropriate, Commissioner.

MR DIEHM: I can't say anything against that course, Commissioner.

COMMISSIONER: Indeed might you support it?

MR DIEHM: Well, I certainly do. I meant in the sense of not pressing further for it to be struck out altogether.

COMMISSIONER: Yes, thank you. All right. The evidence in paragraph 22 of the statement of Ms Aylmer commencing at the foot of page 8, the sentence, "Patrick Martin told me", will be disregarded except to the extent that it's relevant to the witness's state of mind.

MR ANDREWS: Thank you, Commissioner. I call Gail Margaret Aylmer to the witness box.

GAIL MARGARET AYLMER, SWORN AND EXAMINED:

MR ANDREWS: Ms Aylmer, what's your full name, please?-- Gail Margaret Aylmer.

Your address?-- Do I have to give that?

Known to the Queensland Nurses Union?-- Yes, as known to the Queensland Nurses Union.

COMMISSIONER: We can contact you through the Nurses Union if necessary?-- Yes.

MR ANDREWS: Ms Aylmer, have you prepared a statement in this matter of 19 pages, dated 24 May 2005?-- I just have to check the pages, but yes, I believe so. That's correct.

And are all the opinions expressed in that honestly held by you?-- Yes.

And the facts that you recite in that statement, are they true to the best of your knowledge?-- Absolutely.

I tender that statement.

COMMISSIONER: Subject to the ruling which I made earlier concerning contents of paragraph 22, the statement of Gail Margaret Aylmer will be admitted into evidence and marked as Exhibit 49.

MR ALLEN: I believe that should be 59.

COMMISSIONER: Yes, you're perfectly right. Exhibit 59.

ADMITTED AND MARKED "EXHIBIT 59"

MR ANDREWS: Ms Aylmer, you're a registered nurse and have been since 1995, and you were an enrolled nurse for about 17 years?-- That's correct.

You hold a Bachelor of Nursing from the University of Southern Queensland?-- That's correct.

You hold a Master of Nursing and a Master of Mental Health Nursing awarded in 1999 and 2002 respectively?-- That's correct.

And you're currently undertaking a graduate certificate in infection control at Griffith University and you hope to complete it at the end of this year?-- That's correct.

Since the 2nd of June 2002 you have been the Infection Control Clinical Nurse Consultant at the Bundaberg Base Hospital?-- That was the day that I commenced - there was a handover period and that was the day that I was solely in that position, that's correct.

Now, you've also been nurse practice coordinator during Dr Patel's time at the hospital. Is that correct?-- In an acting period for about a month, yes.

Well, during that month would you accompany Dr Patel on patient rounds?-- That's correct, yes.

Was that daily?-- Monday to Friday, depending on other doctors being in the wards at the time, yes, that would - mostly you would go with your - the surgeon that had the most patients.

Now, as an Infection Control Clinical Nurse Consultant, should I deduce that you were particularly interested in matters about containing infection and preventing the spread of it?-- That's the basis of the role, I believe, yes.

And what did you notice during the month that you accompanied Dr Patel?-- What I noticed was in regard to hand washing. While doing these rounds we're going from patient to patient, and on a surgical ward you'd be looking at wounds, and perhaps examining patients, listening to their chest and those sort of things, and what would normally happen between patients, people would - to minimise spread of infection you would actually wash your hands before going on to the next patient, and that's a well accepted fact of what should occur, but what I noticed with Dr Patel, this was not happening. It's very difficult when you're with patients to - you don't want to - you want to try and inconspicuously sort of give him the nod to remind him about doing those practices.

Did you inconspicuously give Dr Patel the nod to wash his hands?-- On many occasions, and it got to the point that I wasn't getting anywhere with that so I took an approach where I grabbed a box of gloves and basically put gloves in his hands, and again the basis of this was that surely he would take the hint and practise as he should be.

Well, for how long did you persist with attempting to have Dr Patel wash his hands? Was it a single day or a couple of days?-- Oh, it was certainly over days. I can't really exactly remember when he started, but it could only - the whole time-frame that we're talking here might be only a fortnight. It was just in the duration of the time that I was there, and then I left that position.

And when you gave Dr Patel gloves, did that achieve a sanitised end?-- It helped. He did use them - when they were put in his hands, basically, he did use them, but again wearing gloves is not a replacement for hand washing. You still should be washing your hands before you put on gloves and after, when you remove the gloves, so that's - the fact of

wearing gloves is not a replacement for hand washing, but it helps.

Now, can you explain - was this simply a matter of principle or was there something significant? Was Dr Patel simply touching patients on the head?-- Oh no, he was touching their wounds, pulling off dressings to have a look to see how the wound is going, poking around the wound. So it wasn't just limited to the fact of just listening to their chest. He was actually really touching the wounds, where I felt that there was a risk to the patient and to the next patient that he then went to as well.

Well, are you suggesting that Dr Patel would touch the wounds of one patient and walk to the next patient and touch that patient's wounds?-- I did see that happening. Touching other things in the course of that, but primarily with no appropriate hand washing in between - or no hand washing in between.

And the procedure that you instituted for him of handing him gloves, what - how would that protect the second patient touched?-- Well-----

Wouldn't the glove need to be washed?-- Well, you don't wash gloves, but you're quite right. The fact that putting gloves on with dirty hands - depends on how he puts it on, but you're actually contaminating the hand just - the gloves just by holding them. So I felt that it was better than what he was doing. It was - and again it does come back to the fact that this is a surgeon that should - would well understand the message that I'm trying to give.

COMMISSIONER: Just so I understand, were you handing him a new set of gloves for each patient?-- Absolutely, yes.

And he was putting them on when you gave them to him?-- He would, but I literally walked around with a box of gloves.

As you say, even putting on gloves isn't particularly satisfactory because you handle the gloves taking them off, and handle them putting them on. So it's not an entirely effective measure for infection control?-- No.

D COMMISSIONER VIDER: I was going to ask the same question if he did change the gloves between patients. So he understood that you were looking for an individual approach. He didn't wash his hands?-- Absolutely, yes, he would have. I mean, that's an accepted practice, that you not only - in so far as wearing gloves, not only do you wear a different set of gloves for different patients, but if you're doing different procedures on the same patient you change gloves between different procedures on the same patient.

COMMISSIONER: I realise that one of your areas of expertise is in infection control. I assume that means both bacterial as well as viral infection?-- That's correct.

The sort of practice you're talking about I would imagine, not being a medical person myself, could lead to transmission of some really nasty - both bacterial and viral infections?-- It's well accepted that the hand washing is the one thing that - the most important thing that people can do to prevent the spread of infection is basic hand washing, and that is a well accepted fact, a simple thing as hand washing.

MR ANDREWS: Did you devise a tactic to ensure that this was brought forcefully to Dr Patel's attention?-- I did. When I gave him the gloves, I basically said to him, "I shouldn't have to be giving you these gloves", and he just sort of - I don't remember what his reaction was at the time, and of course I, at that stage, expected that he would improve his practice, and on one other occasion I did actually say to him that - I remember when we were alone, basically, in the office area of the surgical ward, and I basically said to him that, you know, "I'm concerned about your practices with hand washing between patients", and he assured me that, you know - that he does everything right basically. But again I can't remember the exact wording that he said at that time.

Is there a thing called an inservice?-- Absolutely, and as a result of that I went into - a few weeks later I went into the infection control position and, as you will note in my statement, because of my concerns at that time with Dr Patel, one of the issues that - one of the things that I did in the very first few weeks was do inservices for medical staff on hand washing.

Is that a lunchtime lecture?-- It's a very short - inservice is just basically an education program, just an education session, and I focused on all the different - the surgical team, the medical team, the paediatrics, the different teams of doctors, and I just did a very quick test. It's basically called a glitterbug test. You put some fluorescent cream on somebody's hand, you get them to rub it in your hand, you get them to wash their hands like they would normally do in a clinical situation, and then dry their hands properly. Then you use a UV light in a darkened room, and anything that you still see that glows with this UV light is sort of indicating that their hand washing - just showing you how well their hand washing technique was. So it's more - it's a very good tool, and it's more so that people can see for themselves how effective they've been when they are washing their hands.

Now, you conducted some of those for staff. Did you arrange for one that could be attended by Dr Patel?-- Absolutely. That was the prime purpose of doing the in-services was to target Dr Patel.

Well, did Dr Patel attend?-- He was - he did come to the in-service initially. He did arrive, he was there, and as soon as I got up and started to go ahead with the in-service, he got up and left the room and I could hear him out in the corridor and I assumed he was talking on the telephone or something, but he did not come back into - while I was in the room doing the in-service.

Towards the end of June 2003, staff comments to you were on the topic of wound dehiscence?-- Mmm.

Do you recall that?-- Absolutely. At that time, wound management is not part of the infection control position, it never has been. It is not part of my position description. I guess there's a link to wounds if it is involving some sort of an ineffective process; so, basically, I did think that I would investigate this as I was hearing about these incidents.

Is wound dehiscence the opening up of a wound?-- Yes, that's-----

Or a reopening of a wound created through an incision during surgery?-- That's correct.

And can dehiscence occur either as a result of infection or some other cause?-- Absolutely, that's correct. That's my understanding.

Now, what did you do when you discovered that there was staff concerned about the incidence of dehiscence?-- I asked - I sent an E-mail out to staff asking them to collect whatever data they may have had about any incidents. It seemed there had been quite a number in a short period of time, and you do, from time to time, come across wound dehiscence, but they are not really that much of a common event. They will happen from time to time for various reasons, but to have so many in a short period of time seemed to be an issue. So, people - I organised people to come to a meeting and to bring whatever data that they could.

And this was, what, about the middle of 2003. I see your E-mail was the 3rd of July?-- That would have been when I sent the E-mail out asking people to come to a meeting and I think I asked them to come to a meeting on 7 July.

Now, at that stage, you'd, yourself, looked at a couple of instances of dehiscence and determined that it did not seem to be caused by infection?-- That's correct.

If a wound opens for a reason that doesn't appear to be infection, what's the next most probable cause?-- It is my understanding - what I was concerned with was a query with the

surgeon's technique or some sort of faulty closure product.

And now a closure product is the material used to either suture or staple a wound closed?-- That's correct.

D COMMISSIONER VIDER: Excuse me, Mr Andrews, were most of these abdominal wounds?-- Yes, they were all abdominal wounds.

And you saw the majority of them?-- I didn't see any of them, actually, from the perspective that they weren't infected and I was not aware - I had not otherwise been aware of them except when people brought their - or their cases to me and then I compiled them.

Their description of the case, though, was that it was a full opening up of the wound and evidence of lower layers - like down to muscle and-----?-- Yes. There was - this became difficult from the way - when the staff brought their facts together, we were looking at down to fascia. Basically we were not considering the wound dehiscence as just being the skin or to the fat. It was deeper than that. There became issues in relation to definitions of wound dehiscence as well.

Did any of these wounds have bowel, omentum or any of those things protruding?-- Yes.

D COMMISSIONER EDWARDS: None of them, you would recall, were related necessarily with wound infection?-- No. I think there was one that I actually - there was some pathology with, but it wasn't the cause of the dehiscence.

MR ANDREWS: Ms Gallagher, I say from your E-mail of 3 July 2003, which is Exhibit GA2 to your statement, that you write to people, "It does not appear that the dehiscence is relating to infection." Did you draw that conclusion from things that had been told to you by those reporting the events of dehiscence?-- At that stage I didn't have all the facts, but from what - the facts that I did know, it did appear that it was relating to infection, that's correct, and I needed to investigate that further.

Now, I see that you have written to a number of people. Was there, in July 2003, no register upon which things such as wound dehiscences were accurately recorded?-- Not that I'm aware.

COMMISSIONER: The people to whom you sent that E-mail - Allan, Liz; Baxter, Sharon; Hoffman - were they all nursing staff?-- Yes, they are all nursing staff.

And you also CC'd it to people on the foot of the page?-- That was the Director of Nursing at the time and the Assistant Director of Nursing.

MR ANDREWS: Now, the meeting took place as you requested?-- That's correct.

And was it 13 patient charts that you were directed to?-- Yeah, 13 patient charts, that's correct.

Now, you provided a report on the 7th of July to the leadership and management. What group is that?-- That is a group that consists of the six members of the hospital executive.

Mr Leck, Dr Keating, the Director of Nursing, Director of Corporate Services, Director of Community Services and Director of Integrated Mental Health Services?-- That's correct.

COMMISSIONER: So, it wouldn't include, for example, Dr Patel as Director of Surgery or Dr Miach as Director of Medicine?-- No, this report specifically at that time was being done monthly and that's specifically just my report to the eICATs and it includes - attached to that report would be things like the statistics and also minutes of meetings and those sorts of things.

MR ANDREWS: But in answer to the Commissioner's question, it wouldn't be a report that would be provided to the Director of Medicine nor the Director of Surgery?-- The Director - no, no.

Now, after delivering the report to Dr Keating, you had a visit to your office?-- That's correct.

Let me understand something. At the meeting with - that is, at the monthly report to Leadership and Management - do you recall whether you handed over a report - I ask that because at paragraph 12 of your statement, it does appear that after that meeting, you correlated data and produced a wound dehiscence report?-- Yeah, that's correct. At the report that you would have as GA3, you can see there I have got, "Concerned re: high number of wound dehiscence since early May. Currently investigating 13 patient charts at the moment. Query technique. Query fault with closure product used." So, at that meeting on that Monday morning, my purpose was to let the Executive know that this was occurring, that there were concerns, they weren't fully investigated at that stage. From that time, I went back and got the data and then put the data together as quickly as I can, and it was the next day that I gave a report to Dr Keating.

MR ANDREWS: Now, you had a visit at your office by Dr Patel. How soon after handing over the report to Dr Keating did this visit occur?-- It was the same day.

And who raised the topic during that visit of wound dehiscence?-- That appeared to be the purpose of why Dr Patel came. He had the report in his hand.

D COMMISSIONER VIDER: So Dr Keating had given Dr Patel the report, was your understanding?-- It's my understanding.

Can I just go back and clarify something? You have talked

about 13 patient charts. Did those records contain information about the wound dehiscence?-- That's basically where I got the information from, yes. I read through the notes.

Was that entry in the notes from the nursing staff or was that entry about the wound dehiscence from Dr Patel?-- There was - it was both. There was - I'm not sure if it was Dr Patel's writing or one of his team's writing in the notes.

MR ANDREWS: How common was wound dehiscence in your experience? Perhaps I should ask first, are you a person who would have known how common wound dehiscence was at the Bundaberg Hospital prior to, say, March 2003?-- I had worked there since the end of - beginning of 1996 on the surgical ward for a reasonable period of time and, as I stated earlier, a wound dehiscence will occur from time to time, but - and you could have, I guess, what's called a run of things where they seem to happen, but even a run of wound dehiscence - this situation seemed to be extreme that you would have sort of 13 in a six to eight week period. You - in a run, you may have two or three.

COMMISSIONER: And if there were a run, you would expect there to be some logical explanation, whether it is the suture material was defective or a particular infection was present within the surgery, or something like that, that explains why a number of things are happening?-- You would expect that there would be something.

And you would also expect if there was a run that it would normally be all of the surgeons rather than just one - if it was some factor like-----?-- If it was a closure product, you would expect it would involve other surgeons, and what I haven't said is - said this morning is that, as I remember, the incidence of wound dehiscence involved primarily most of Dr Patel's patients.

MR ANDREWS: Are you suggesting that some of these 13 involved other surgeons' patients?-- I can't - it is difficult - this is jumping the gun a bit in the statement, but what I did do is print off this report that listed all the 13 cases, but after Dr Patel came down to me - and this is the problems with computers - I basically went back to the computer and pulled the report up in table form and just deleted the other patients. Now, the only person that I believe that would have - still have a copy of that is - would be Dr Keating - if he kept a copy - or he just gave Dr Patel his only copy. I did try and get that off the computer - if they could retrieve it - but it wasn't possible.

COMMISSIONER: Mr Diehm, are you able to assist us with that?

MR DIEHM: Not immediately, Commissioner, but I will make inquiries.

COMMISSIONER: Thank you.

MR ANDREWS: Ms Aylmer-----

D COMMISSIONER EDWARDS: Sorry, is that the reason there was 13 reduced to five in the-----?-- That's correct. After Dr Patel's visit to me, yes.

MR ANDREWS: Tell us about that visit. I think you have explained so far that Dr Patel came to you on the day that you handed your data to Dr Keating and he talked to you about dehiscence?-- Okay. Dr Patel did come to my office and I was quite surprised, because in giving the report to Dr Keating, I didn't actually expect that he would send Dr Patel to me. I thought I would get feedback from Dr Keating about the report, but I didn't expect a visit. But Dr Patel did arrive. He did not bring any charts or anything - patient charts with him. He just basically arrived, came to my office, said that he wanted - had the report in his hands, said that he wanted to talk about the wound dehiscence. So, he stood over me and basically just held the report and said, "Well, this patient - this relates to that patient", and continued going through the list. I have to say that at that time, it seemed to be - they were seemingly reasonable explanations that Dr Patel gave, but, again, I am not - do not have the expertise - don't profess to have the expertise to be able to gauge whether they were. It is not in my role to be able to review a surgeon's surgical expertise. So, while they seemed reasonable to me that he could account for each case, it's beyond my scope of practice to be able to argue those points with him or to discuss it or to debate it in any way.

COMMISSIONER: No-one would expect you to remember the precise words of the conversation that long ago, but can you give us some of the flavour of the explanations he was saying. Was he telling you that it wasn't dehiscence because it didn't go deep enough, or-----?-- He definitely did have reasons for all of these - the situations. There was no comment about it being the closure product, though. There was nothing in that way. There was a couple of cases that he did say it was technique and - as well. He did a bit to technique. But for which cases now, I do not know, but I presume they are the ones that are still on the list.

D COMMISSIONER VIDER: In terms of technique, I presume, as the Director of Surgery, Dr Patel provided supervision to junior staff. Did he imply that some of the closure might have been done by junior house officers?-- I do think so, yes. There was a link to one of the junior staff.

Was there any indication from Dr Patel that this required any further investigation from him?-- I think that he felt that it was dealt with there and then after just speaking to me.

So, 13 reported episodes of wound dehiscence in six to eight weeks from a surgical ward did not appear to him to be alarming?-- No.

COMMISSIONER: Mr Andrews, there's something else I wanted to follow up. It might be a convenient time. You will

understand that one of the things this Commission of Inquiry is looking into is complaints handling processes and methods. It strikes me from what you have said - and I'm just going to raise this with you for an opportunity to comment on - it strikes me that when you go to - for example, the Medical Superintendent within the hospital and make a complaint about another doctor, it is somewhat intimidating to have the doctor that you have complained about handed a copy of the report and coming to see you to tell you you have got it wrong and you don't know what you are talking about. Is there a way you would have preferred the matter to be handled?-- I certainly did feel uncomfortable and, as I said, I did not expect that Dr Patel would be coming to see me. I felt that Dr Keating would arrange for somebody with the appropriate expertise to investigate these cases - another surgeon or some sort of review panel. But I certainly did not expect that Dr Patel would come to me and stand over me and - I mean, at that time, he was certainly letting - very clearly stating what all his accomplishments were, all his experience - that he worked in New York, that he was, you know, very experienced, and it was quite intimidating, and I, at no time, felt that I - I was well out of my depth and I knew I couldn't debate these things with him. So, I did not expect that would be the approach that would be taken.

At the time of this report, were these patients still in the hospital or had most of them been discharged?-- I believe that most of them probably had been discharged, but I'm not sure, I'm sorry, because it had been over a six or eight week period, so you would expect some of the earlier ones would have gone.

And you, yourself - none of them were, in a sense under your direct control, so none of them were ones that you had an occasion to review or monitor?-- That's correct. It is not part of my role to investigate surgeon's complications.

If it had turned out that some proportion of those dehiscences were infection related, then that would come within your purview, but otherwise it was outside of your control?-- And it does, and I hope I would have known about them otherwise, if that had been the case.

You mentioned that - I'm not sure whether you said in one instance or a couple of instances there was some pathology involved, but you were able to exclude that as a cause of the dehiscence?-- Mmm.

Is that right?-- I just can't remember now at the time what the - what the pathology related to, but - what sort of swab it was at the time.

Looking at your report GA4, if you can turn that up? You will have to understand that I don't come from a medical background. I have got the support of people on either side of me who do, but some of the things I read here would strike me as very frightening, particularly the third one with "bowel visible through staple line, one staple embedded in bowel,

suture wound dehiscence"; that sounds pretty awful?-- Mmm.

Where did you get that information from?-- I read that directly out of the chart.

I see. And you don't recall what Dr Patel said about that?-- No.

Or what Dr Keating said about it?-- I didn't discuss these cases individually with Dr Keating.

You just gave him the list?-- I just gave him the list.

Did you ever get any feedback from Dr Keating about it?-- No. No, I didn't, but I did send Dr Keating an E-mail back, now, I believe.

Thank you. Thank you, Mr Andrews?

MR ANDREWS: The report that you had given to Dr Keating and which was within the hands of Dr Patel on that same day, do you recall whether you had indicated in it your opinion as to whether infection was excluded as a source of the dehiscence?-- Not on the actual report. The report was basically as you see, as in GA4, except that it had the 13 cases on it. It was no more than that. But in my - the report that I gave to the leadership and management committee, which is GA3, that was where I mentioned that it wasn't involving any - I don't know that I have actually said that. That was a report that I - I was actually present and presented this report to the leadership and management committee.

And from GA3, I see in the middle of the page, under the heading wound dehiscence, you have got "question mark technique; question mark fault with closure product used". Did you speak at that committee or simply deliver that document GA3?-- No, I did speak at the committee and explain these points.

D COMMISSIONER VIDER: Could I just ask a question? The wound closure, was it predominantly done with staples, or was there a variety of materials used?-- That's something I can't answer.

I'm just wondering whether there was frequently-----?-- I know they do mass closures in layers, but that's not something that I'm familiar with, I'm sorry.

MR ANDREWS: Now, you have explained that you wouldn't have expected Dr Patel to be discussing these matters with you in the way in which he discussed them. Do you know where you have done a report about wound dehiscence which raises issues of, perhaps, technique or a fault with the closure product. What would be the correct - was there a protocol for how such a matter would be investigated?-- I had never done a report about wound dehiscence in the past. Again, as I said, it is not relating to my role, so I was not aware if there was a

protocol. I just had an expectation in how I thought it would be dealt with.

Well, was an infection control person the appropriate one to be judging whether it was a fault of technique or with the closure product?-- Not at all.

What sort of person would be appropriate to judge such things, do you know?-- I would expect a surgeon.

You did, after speaking with Dr Patel, send an E-mail to Dr Keating. Would you please look at this document which doesn't currently appear in your report, an E-mail which appears to be dated the 8th of July 2003. Probably the best idea is to put it on the monitor so we can all see it. Would you be kind enough to turn it around? Thank you. Ms Aylmer, should I deduce from that - first of all, is that an E-mail that you sent?-- Absolutely.

Did you not have a copy of that at the time when you prepared your statement?-- No, I didn't. We were encouraged to delete - to make disk space, to delete items that aren't necessary, so I did delete the majority of my 2003 E-mails.

It seems that Dr Patel admitted to you that technique was a problem with one patient; that is, UR128142. Do you recall whether Dr Patel admitted that it was his own technique that was at fault?-- I'm not so sure - that is the second patient on the list where there was a dehiscence of the greater omentum protruding from the wound - with the greater omentum protruding from the wound which required resuturing; so, no, I don't recall that, but certainly with the next one, the 130224, I have written there "stitch broke while in X-ray", so it would seem to me that the stitches broke, basically, so there's another reason other than himself for that.

And he had explanations for the other two?-- I can't - I don't remember.

In any event, do you remember whether Dr Patel conceded that any of the dehiscences were his own fault or the fault of his own technique?-- Other than saying what I have written there as being the best account of what happened on the day, that I wrote that e-mail on that day, so other than what's written there I don't - I don't believe any more than that that he accepted that much responsibility for it, no.

And the other eight that were excluded, I suppose you don't remember what the explanations were?-- No, but I have to say that they did seem reasonable explanations to me at the time but, again, I guess I was - I did not have the experience or the knowledge to be able to debate that and he was certainly giving an account which - you have to remember at that stage I had no real reason not to believe Dr Patel at that stage. When he came down to me, you know, he would always let you know how experienced he was, so I really had no reason not to believe him. So while I would have to say that I was - I can say there that I was pleased to say that I've been able to exclude these cases, and with seemingly reasonable explanations, I think that because of that I did feel that I needed to trust him with this situation. But it still isn't to say that I still didn't feel disappointed with the outcome of the meeting, because I do believe that I was put in a situation that I shouldn't have been, I was out of my depth, I felt out of my depth, I knew it, and so in making - in looking at that e-mail now, you know, I have said I am pleased about that and have no further concerns and that was with Dr Patel coming down with his wealth of experience and saying, "This is right. This is right. This is right. This is all accounted for," I'm afraid I did feel that I needed to trust him.

In your role as Infection Control CNC, would you update data about infection at the hospital?-- Yes

And was there a database called the electronic Infection Control Assessment Technology database?-- That's correct.

And the data included in that database would be given monthly to the Leadership and Management Committee and it would be appropriate for such a committee to be informed monthly about the degree of infection control and its success in the hospital?-- That's correct. In regard to infections, basically we have targeted surveillance, in that not all infections that occur in the organisation - it's not physically possible to investigate everything, so it is targeted surveillance.

Now, I see from the end of paragraph 14 of your statement, you say that the information contained in the reports details in-hospital and post-discharge surgical site infections from identified clinical indicators. Who would be targeted? What percentage of the in-hospital patients would be targeted? All of them?-- Basically what that means is that there are some clinical indicators based on surgery that we perform in the

hospital and based on what CHRISP - Centre for Healthcare Related Infections Surveillance and Prevention - which is the people that run the eICAT program. So they have indicators that we can choose from and which they use and they benchmark against as a Statewide initiative. You can also use this program at - you can also use this program at a local level and you look at what surgery is performed in your hospital and it's one way of doing surveillance on that surgery.

Now, if one were interested to see whether your observations of Dr Patel's poor infection control techniques resulted in any increased in infection, would it be the eICAT reports to which one would go?-- You would like to think it would be. Unfortunately, it is - in regard to capturing the in-hospital data, this is for the patients while they are still in hospital, you have a better opportunity of finding out and capturing this data. But with short-stay admissions, people are going home much quicker than they used to and, for example, if you have a day case hernia, you wouldn't expect to get an in-hospital infection or to know that that occurred in that short frame in time. So with the procedures that are kept - that are under surveillance, as in the chosen clinical indicators, you actually follow up those people when they go home. So that's what is referring to the post-discharge, that's what that means.

How many of them get followed up and how accurate is the information you obtained?-- All the people that are under the clinical indicators, they all get followed up. I shouldn't say "all", because for a start the person had - the patient had to elect on a form - which is called a Patient Election Form - they had to tick a box and sign to agree that they would have feedback, they would like to have feedback from the hospital and they would like to be not just involved in this process but having feedback from the hospital. So they had to first tick a box and give consent so that I, for example, could send out a form for them initially. So basically you had to first have their consent to do that. Then it's automatically generated to print these reports out and I would send it out to each of the people that were the relevant clinical indicators and I would attach a return envelope for their convenience to send it back.

And, Ms Aylmer, do you regard that as a satisfactory system for measuring post-discharge data on infection?-- It's a start. Basically there's too many dependents. You are relying on the patients (A) to first complete that, but at the same time you are also asking the patient to in a way to determine themselves whether they have a surgical site infection and that again would probably be in the realms of - for them to be able to identify, for example, between just a normal stitch abscess and a superficial wound infection, I think it would be very difficult. So there's things on this letter that asked them: do they have swelling; do they have redness; have they been to their general practitioner; if they have, has their general practitioner said they had a wound infection; have they given you antibiotics, and those sorts of things.

Well, at your monthly leadership and management report time, at those meetings did you express to the assembled group your view about the reliability of post-discharge data?-- I certainly did. From the perspective that was the one when I first came into this position, I was quite surprised in how all of this worked myself. I think I was thinking it would be somewhat different. But it was important to realise - I realised that managers rely on data, they want - they rely very much on data and it was important for them to realise that in regard to relying on this data for a start, the numbers are quite often small and the data can be, you know - it's the interpreting that can be skewed from the fact of the small numbers, but also from the point that you're relying - it's not necessarily reliable. There's a very poor response rate or had been quite a poor response rate from the patients returning the forms as well. I have to say that's picked up recently and that-----

Did you tell the meeting that the post-discharge data couldn't be relied on?-- Yes.

COMMISSIONER: Mr Andrews, if you are about to move on, that e-mail of the 8th of July 2003, from the witness Gail Aylmer to Dr Keating, should be admitted and marked as Exhibit 60.

ADMITTED AND MARKED "EXHIBIT 60"

MR ANDREWS: Thank you, Commissioner.

COMMISSIONER: Were you about to move onto the Renal Unit?

MR ANDREWS: I was.

COMMISSIONER: We might take a break, if that suits everyone. Can I urge to the press and the media that Ms Aylmer has expressed her reluctance to be photographed. I can't prevent anyone from doing anything outside of this room, but I encourage the press and media to be sensitive about her concern.

THE COMMISSION ADJOURNED AT 11.40 A.M.

THE COMMISSION RESUMED AT 10.54 A.M.

COMMISSIONER: Whilst the witness is returning, Mr Ashton, there was one thing I overlooked dealing with this morning. When we scheduled these Bundaberg sittings, it was mainly

intended to meet the convenience of people who live and work in the locality. I understand that your client is on leave, as it were, and from speaking with Mr Andrews it may be that there will be some difficulty in covering all of the witnesses during that period of three weeks. I know that I've made it clear to both you and to Mr Diehm that if your clients are anxious to give their evidence at an earlier stage, they will be given that opportunity, but I understand that there are some personal reasons why, in fact, your client would prefer to give his evidence in Brisbane anyway, which are entirely personal to him and no-one else's business; do I understand that right?

MR ASTHON: Yes, Commissioner, and in fact it seems likely that this program here is crowded and it would not be inconvenient that he gives his evidence when the Commission returns to Brisbane.

COMMISSIONER: I would be inclined, Mr Andrews, to adopt that course and we will offer Dr Keating the same opportunity. If he is anxious to give evidence whilst we're in Bundaberg, he will have that opportunity again, given that as I understand it he's on leave. It's probably better for people who live and work in Bundaberg give their evidence here whilst we're in Bundaberg and that may mean putting Dr Keating off until we return to Brisbane, unless, as I say, he is anxious to resume his evidence at the first opportunity and I'm happy for you to take instructions about that.

MR DIEHM: Yes. He does, of course, live in Bundaberg, Commissioner.

COMMISSIONER: Yes.

MR DIEHM: So it would be a slightly different situation for him. He would be anxious to give his evidence, but also anxious not to do so until all of the matters as it were against him have been canvassed and certainly respond to them in his evidence

COMMISSIONER: That makes sense as well. Perhaps I can ask you then to liaise with Mr Andrews and we might proceed on the basis that Mr Leck won't be called during this three week session, but if Dr Keating wishes to may be if we can fit it into the schedule.

MR DIEHM: Thank you.

MR ANDREWS: Thank you, Commissioner, that's convenient from my point of view.

COMMISSIONER: Thank you.

MR DIEHM: Commissioner, while I'm on my feet, you inquired about that document that that witness has spoken of. My client doesn't have that document in his possession. If it continues to physically exist, it would be amongst the records at the Bundaberg Hospital, which he doesn't - does not have

completely free access to in the circumstances of his current employment status.

COMMISSIONER: Yes.

MR DIEHM: Commissioner, he is instructing me he is willing to obtain the necessary consent to go look for the document at a convenient time. It's not one that he can conveniently produce to the Commission to have.

COMMISSIONER: That's very helpful. Please pass on my thanks for that. We might arrange for one of the Inquiry staff to go up with him, if that would be convenient, and-----

MR DIEHM: Yes.

COMMISSIONER: -----search for whatever documents, not only that document, any others that may be useful.

MR DIEHM: Thank you

COMMISSIONER: Thank you. Yes, Mr Andrews?

GAIL MARGARET AYLMER, CONTINUING EXAMINATION-IN-CHIEF:

MR ANDREWS: Ms Aylmer, there were some issues relating to the Renal Unit, infection control issues?-- That's correct.

They were brought to your attention on about the 25th of November. Paragraph 17 of your statement may help you to refresh your memory?-- I received an e-mail from Robyn Pollock. Robyn is the Nurse Unit Manager of the Renal Unit, and I believe the e-mail is GA6 where Robyn expressed concerns of lack of appropriate aseptic technique with Dr Patel in that unit on that day.

In any event, Robyn sent you an e-mail suggesting that Dr Patel refused to wash his hands and said that doctors hands don't have germs?-- That's correct.

Now, you did something about this?-- That's correct, I immediately telephoned Robyn on receiving her e-mail and then I went down to the unit and spoke to Robyn and some of the staff that were there at the time.

The Commission will hear evidence from Robyn Pollock as to what occurred on that day.

COMMISSIONER: Yes.

MR ANDREWS: It seems that Robyn led you to believe that Dr Patel didn't wash his hands before attempting to unblock catheters. Did you understand it to be that Dr Patel was treating two patients each who needed - each of whom needed a

catheter unblocked?-- That's correct. There were two patients who were side by side that had blocked catheters and he was endeavouring to unblock them.

From an infection control point of view is that inappropriate?-- What Dr Patel did was inappropriate in that for a start he would not wash his hands. The Renal Unit staff were very persistent. They certainly did not stand back and let Dr Patel proceed, but he was endeavouring to unblock these catheters, so that he did consent to put on a pair of sterile gloves, but, again, he did not wash his hands prior to doing that.

And what degree of significance does that have from an infection control point of view?-- A higher degree of significance because we're talking about central access lines here and that's more - far more significant than perhaps a peripheral IV line, although that is certainly significant as well. But central lines are far more significant and very much from the point of view that an aseptic technique has to be used and there should be no moving from one patient to the other patient. One patient should be dealt with first and then proceed to the next patient.

Is a central line a tube through which something passes directly into the neck of the patient?-- It is a - in this instance, with the renal patients, it was a tube that was used for - I'm not exactly - Lindsay Druce, who was the CNC in the unit at the time or Robyn Pollock herself may be able to explain that further, but these were central lines that were used for the delivery of either haemo or peritoneal dialysis.

And patients undergoing either form of dialysis, are they immunosuppressed at the time, making them more susceptible to infection? Is that something outside your field of expertise?-- It is.

So, you did what with this information?-- Robyn and I - I made an appointment to meet with Dr Keating, and Robyn and I went together to see him, and that was on the 27th of November, and - just to advise him of the situation. I do remember that - at the time Dr Keating asked us why we didn't go straight to Dr Patel, but at that stage, at the end of 2003, we, neither Robyn or I, felt we had a good relationship with Dr Patel, certainly since the - because of the situation he treated me with total disregard and Robyn had similar experiences as well. So we felt that we would go straight to Dr Keating.

What do you mean he had treated you with total disregard? How did he show that disregard to you?-- I suppose from the point of view that he - look, he basically ignored me. From this point in time, from then on there's only been one occasion that he has ever either e-mailed me back or phoned me back or responded to me in any way other than me going up to him and speaking directly to him.

So-----?-- So he did not - yeah, I suppose, he just ignored me basically where possible.

Ms Aylmer, I don't understand on how many occasions you tried to initiate contact. Was it one occasion when he ignored you or-----?-- Throughout the statement there's examples of other occasions, but there's-----

What was Dr Keating's response?-- He understandably wanted to see statistics relating to our concerns. We expressed to him that there was a number of patients - number of staff that witnessed the situation with Dr Patel. I, of course, wasn't there myself, but they expressed the concerns that the staff had at the time and the fact that - you know, Dr Keating - Dr Patel was reluctant to follow normal aseptic technique and the staff had to basically be very assertive to ensure that he did to some extent. So, there was - my concerns were that we have three or four renal unit staff that were - had one - had concerns about what happened in the situation and I think that they needed to have been heard. Yes, I do understand Dr Keating did ask for statistics to be produced and that was something that-----

You regarded that as reasonable. What sort of statistics did the doctor ask for?-- Just to basically - to show that there were issues with - their concerns with Dr Patel's technique, if there was any statistics that would show that.

COMMISSIONER: Sorry-----?-- As I remember-----

-----I'm not quite understanding this. Were you being asked for specific statistics arising out of the renal unit or out of Dr Patel's patients or some sort of general statistics within the health industry to show that these techniques were-----?-- It was relating to the renal unit, was my understanding. He was talking about that we had concerns about Dr Patel's aseptic technique. Dr Patel in all seriousness made a claim that doctors don't have germs, and I

assume Dr Keating wanted us to get some statistics to support that in regard to the renal unit, that if we had these concerns to get him some statistics to show there was reason for concern, rather than emotive kind of comments.

The reason I ask that, and again please understand I'm only - I'm speaking as a lawyer not as a medical person, but I understood that there were groundbreaking studies in the 19th century that - and I asked Deputy Commission Vider and she gave me the name of it, I think Semlevious.

D COMMISSIONER VIDER: Semmelweis?-- Semmelweis, yes.

COMMISSIONER: From memory, in an obstetric hospital in Vienna, and it showed something like an 80 per cent reduction in infection just by washing hands?-- Absolutely, yep.

Yes. One wouldn't think that a great deal of statistics were necessary in order to reinforce that point?-- No.

D COMMISSIONER VIDER: Were you asked for statistics from the renal unit or were you really asked to document incidents when Dr Patel did not observe aseptic technique?-- I think it was statistics, but I think the other part would be - you know, perhaps assumed as well. I'm not sure.

MR ANDREWS: Ms Aylmer, as well as you can recall it, what is it that Dr Keating asked you for?-- Basically to provide some - we came there with this complaint that Dr Patel had poor aseptic technique and I think he asked for statistics to support that complaint.

Did either you or Robyn Pollock collect statistics for Dr Keating?-- The renal unit did collect those statistics and they were presented earlier in 2004.

And the statistics of which you speak, did you see them?-- I have seen them, yes.

And do you know whether they revealed anything unusual?-- They did. There was six cases and as I recollect and all revealed that there was an infection in the - the six cases relating to lines being inserted in the renal unit by Dr Patel. There was the 100 per cent infection rate from that perspective, six of six.

Are you able to say whether Dr Patel assisted any other patients with the insertion of lines in the renal unit?-- Couldn't say.

D COMMISSIONER VIDER: These were all central lines?-- Yes.

MR ANDREWS: Now, Dr Keating, did he get back to you after you raised this issue with him?-- He did.

Did he inform you that he told - that he'd spoken with Dr Patel?-- Yes, he did. He did tell me that he had, and

this wasn't by way of e-mail. He did tell me that he had talked to Dr Patel, and that was fairly quick feedback, and that Dr Patel's version of the story differed to what was given by nursing staff, and it was my impression that Dr Keating did prefer Dr Patel over the nurses or what was given by nursing staff, which I was a bit flabbergasted from the perspective of - I just wondered how many nurses it would take to be believed over the top of Dr Patel, was my thought at the time.

How-----

COMMISSIONER: How could a different version - if you have 100 per cent infection rate, how can any doctor come up with a version that can justify that level of infection?-- The version of - what I was addressing, referring to there, was - I'm sorry, was that in regard to what happened on that day with accessing the two patients at the same time, trying to put the equipment from one patient on to the other person - patient's equipment tray, and those sorts of things, and the fact that about hand washing, about him not wearing gloves and stuff, that was the version of the story that - when Dr Keating fed back to me that that - it was Dr Patel's version about that that was different to what the nursing staff's version was.

MR ANDREWS: I would like to clear up one matter that may be causing confusion. The occasion when Dr Keating told you that he'd spoken with Dr Patel seems to have been around about the 3rd of December 2003. I deduce that from looking at your e-mail in response, GA7. Would you agree that Dr Keating must have responded to you before the 3rd of December 2003?-- Yeah, I realise - not sure - exactly sure when he responded, but I - it was - was reasonably quick in responding.

And the information you have told us of that showed that there was infection after the insertion of six - of central lines for six patients, that came some time after the 3rd of December?-- Sorry, Gail Aylmer - yes, that's correct, the statement further on.

COMMISSIONER: Did you get any response to the e-mail you sent to Dr Keating on the 3rd of December?-- No.

MR ANDREWS: Now, you had ongoing concerns despite your meeting with Dr Keating in December and they caused you to do something in February 2004?-- That was not so much myself, that was Robyn Pollock and I believe Lindsay Druce as well had a meeting with Patrick Martin and they presented the statistics to him then and he passed them on to his - then went and saw Dr Keating. So I was not actually involved at that meeting.

And Patrick Martin, his position at that time was?-- He was in the Acting Director of Nursing position.

And he passed something on to you that you understand Dr Keating to have said?-- That's correct.

And you believe from what Dr - from what Mr Martin passed on to you that Dr Keating had said, "Well, if they want to play with the big boys, bring it on."?-- Absolutely. Words to those effect, that's correct.

You didn't actually hear Dr Keating say those things, you have to rely upon what Mr Martin passed on?-- That is correct. I would like to say, though, that during the course of the next year, from February 2004 to basically February 2005, when I had another conversation about Mr Martin about this, at no - this came up in conversation where there was myself and Mr Martin. We spoke about this, and at no - he was quite aware of how I took the comment and at no stage in that year did he make any attempt to let me believe something different.

And did that information you received from Mr Martin affect the way you behaved thereafter?-- Absolutely. I wondered at the time if it hadn't have been meant as a bit of a challenge, but it certainly probably at that stage in time, it didn't - I didn't take it as a challenge, I took it more in a defeatist attitude, that what was the point in - unless I have statistics to support everything, which I felt was very - could be very difficult, that there was no point taking these things any further.

As an infection - I am looking again at your title, as the infection control clinical nurse consultant was it part of your duty to have discussions with nursing staff in hospital?-- That's correct.

And by December 2003 had you formed a view about hospital acquired infections?-- I had. I felt - not so much infections as such, but I felt that I was hearing about an increasing number of complications. You would hear about that - you know, that something had been nicked during surgery and leaking this and those sorts of complications, which you would normally think - and haematomas and things like that - you would normally think could well be linked to infection, and I was concerned that through the formal channels that I was formally being notified about infection or should be notified about infections with these type of things that were occurring that I should be hearing about more infections.

I see. Were you hearing about these things from talking with nurses but not hearing about them through formal channels?-- That's correct.

What are the formal challenges you speak of?-- There's a number of formal channels., probably the primary one for staff is an Infection Control Notification Form and that is where your staff, when they come across an infection, whether it's a post-surgical infection or something to do with an IV line or any sort of infection, or even something that - somebody has na infectious condition that needs to be isolated, I ask that they complete this form and that they let me know, and that is my notification for me then to proceed to do some follow-up with that. So they are sort of available all around the

hospital in various areas.

Well, when Patrick Martin conveyed to you the comment that was passed on to you from Dr Keating or you believed to have come from Dr Keating-----?-- Mmm-hmm.

-----was there any more information you might have been able to gather to persuade Dr Keating?-- As I have said before, I think the managers have - do have a reliance on statistics, so, yes, there - I looked at what we were already - the data with the clinical indicators we were capturing at that stage, and I also looked at what surgery Dr Patel undertook and saw that there was a need to try and choose some extra clinical indicators that was of surgery that Dr Patel undertook.

D COMMISSIONER VIDER: You revealed just surgical procedures performed by Dr Patel or were you looking at all surgical procedures at that time?-- At that stage the extra ones that I looked at were hernia and mastectomy. I was looking at clean surgery, but I have to say that I was concerned about Dr Patel and that I was - there was some - bear in mind Dr Patel seemed to be the person doing most surgery too, a lot of work in the organisation, so it was a matter, I thought, that I would pick up two extra clean cases, they're regarded as clean cases. It's regarded - hernia and mastectomy were two that I chose, going by what we do a lot of, a number of anyway.

And the form that you say you were going to use to collect the data from the ward staff regarding infection-----?-- For them to notify me.

-----for them to notify you, had the form been in existence prior to you commencing in the role or did you introduce this form?-- No, there was - there's always been a type of form and when I did commence into the role I did adapt it to - to put a little bit - so I could get - glean more information from what was actually on the form. So I did adopt it.

So when you say that you perceived there might have been a lack of reporting at that stage, had staff been familiar in reporting incidents?-- I think there had always been a fairly poor reporting from staff and I've talked to other infection control practitioners across the State and that's the general feeling that they have as well, that staff don't necessarily report - whether they believe other people may have done that or something, I'm not sure, but that's right. There's other ways I get to know about infections. I get an automatic - from the pathology service I get an automatic - comes through a list of all positive notifications for positive pathology.

MR ANDREWS: Did you see a need to capture data on infection?--I did.

So did you devise a form to capture post-discharge data?-- Two things I did. I started commencing to collect the two extra clinical indicators and also thought that I needed to find out more about the postdischarge information and it's

more than just relying on the patient to send back the data. I looked at the definitions and felt that - because - a surgical site infection basically involves evidence of infection occurring within 30 days of the procedure. So, I was basically trying to think that - a lot of people - patients come back for a review at the surgical outpatients department and I was thinking, well, that in time when they came back for that review that if I could get the surgical team to actually complete this form, and that was just another way and another attempt to try and catch more data than I might have otherwise been getting.

And you devised a form and it was introduced in May/June 2004. We can see a copy of it within your statement. But did you find some trouble with the staff in having the form completed?-- Absolutely. From the perspective of - I found a couple of different problems in that I did ask staff too that they - on the form they were required - as I remember that they had to write down the patient's name and I might have even asked for their diagnoses as well, but what I was really after was whether they had a wound infection or not, and I had asked whether they had taken a wound swab, but they felt that they were under a lot of pressure and they felt that was far too much writing and another issue that I-----

Would you comment, please, on how many such forms would have been required to be filled out? I see from GA9 that there were 20 boxes to - I see. There are three boxes to fill in per patient?-- I will just have a look. That's correct. You would - basically the way I envisaged this being used was it was being used for the clinic on that day. So they might have seen 20 patients on that day, so you put the in-patient UR number, their surname, what procedure and then basically whether they have an infection or not. So that was asking them to do that, and that was - and they are under a lot of pressure to get - to get through the workloads, to get through the - to see the patients. So later on I did accept that I could simplify that form.

Now, Dr Keating told you he'd speak to the staff about the importance of completing that form and checking the data? I see that from paragraph 28?-- I think Dr Patel also - that was - initially when it first came up Dr Patel had said he supported the use of the form and that he would educate his staff on what we were going to-----

Did he say that a formal ASPIC meetings? Did he say that at formal ASPIC meetings?-- That - no - sorry?

Would Dr Patel say such things at formal ASPIC committee meetings?-- That's true, yes. He would say that he was - appeared to be quite supportive to me in the formal sort of meeting, but in regard to - you were asking about Dr Keating. Dr Keating responded saying that he would help out, that he would speak to the medical staff, and this was after it was identified they were having problems with it and that they were saying why do we have to do it if we don't have to do it at Royal Brisbane and questioned the need for surveillance in

general, and Dr Keating sort of said he would step in and have a word with them to get them to understand the importance.

COMMISSIONER: Anyone else finding this noise annoying? Do we know what's going on? I think we will have to put up with it until the lunch break. The technician's on his way. We might take an early lunch so it can be attended to and resume. I find it very distracting.

MR ANDREWS: Ms Aylmer, is it the case that the infection control data collection at Bundaberg doesn't include the collection of data from persons treated in outpatients or day surgery?-- Sorry? Can you repeat that?

Is it the case that the infection control data is not collected for patients who are attending outpatients or day surgery patients?-- In regard to outpatients, it depends if they have been a patient and this is some sort of follow-up, they have come in for a review of their wound or something like that, if they have had some sort of delay in wound healing, so then certainly I do deal with people in outpatients if they have had surgical - surgery. So that's from that point. From day surgery, if we are talking about CHRISP in that this definition for CHRISP in checking data is that it's not the same day case, that they come in on the same - if they are admitted and discharged on the dame day that we don't collect that data from - the data does not get picked up by CHRISP, if that's what you are referring to.

Yes. Would Dr Patel have participated in day surgery?-- As it turns out, with the hernias he did. So insofar as - because Dr Patel to started doing day case hernias, so from that perspective while CHRISP would not - some of those day cases did end up staying in overnight if they were later in the day, whatever, some sort - for whatever reason but they would generally - generally CHRISP would not pick up that data but it was still data I collected.

It was still data you collected?-- Absolutely, because it was a clean procedure that occurred in this hospital. It is just CHRISP would not use the data.

Would you tell us, please - you were-----?-- I'm collecting it still for my own - with the surveillance, there's two ways of looking at it. It's what I find useful for me - for us in the hospital to gauge what's happening there, but then there's another point where it goes off with - CHRISP use it and they have a rule that it's not a day case, not admission and discharge on the same day, so they would not be interested in the day case hernias. That would be being excluded out of what they collect from what they - the information I export to them.

Does that introduce an unreliability to the infection data if CHRISP does not include figures from day surgery?-- I think that all hospitals will collect more data than just what goes to CHRISP. CHRISP choose a certain number of procedures and that's what they focus on. But I think you will find that all

hospitals will collect more data then what we spend to CHRISP.

Can you tell us, please, about the theatre attire and Dr Patel?-- I was concerned with the - I was seeing inappropriately wearing of theatre attire and what I mean by that is people wear the blue generally trousers and a shirt, they wear a theatre cap and have some sort of overshoes or some sort of inside shoes on when they are actually in the theatre complex. I was concerned because I was seeing staff, that - walking around the organisation and outside of the hospital buildings wearing their theatre attire still outside, and in some situations they made an attempt to put an overgown on, and not all staff did this, but some times that overgown wasn't done up, it was left nearly untied, and at other times there wasn't even an overgown at all.

This wasn't a problem related solely to Dr Patel but to other theatre staff?-- That's correct.

COMMISSIONER: I realise this isn't fully covered in your statement but I would like to understand - I'm sure that Sir Llew and Deputy Commissioner Vider understand how these things are normally done. It's certainly been my experience visiting friends and family members and so on in - mainly private hospitals, I have to admit - that anyone who goes near surgery has to go through the scrubs process and, as it were, descrub as they come out, that clothing worn outside the theatre are never worn inside the theatre and vice versa. Is that the accepted methodology?-- I mean, certainly coming back to Semmelweis again in regard to what's regarded perhaps if people were wearing down the street, say, for example, as in street casual, normal clothes, that you wouldn't wear those clothes into a theatre area, you would change fully and wash your hands, change fully and go in in appropriate attire. There are some variances in what happens and what we were trying to do was to work out - I saw it as being the sort of - it may have been an indicator that standards were slipping and I took it from that perspective, but that there is some differences - there are different things that you could do. For example, you can take the approach that nobody was leaving the theatre complex and they fully change before they went out - out of the theatre complex into their normal work, other work clothes or you could - if you are coming up to clinical areas, you would put - put an overgown, take your hat off and go - if a doctor or a nurse needed to go to a clinical area.

But if you were going to leave the building or go downstairs for lunch or whatever, that you should change.

I was going to say, I'm sure you need to have some flexibility if there's an emergency and the doctor has to leave the theatre and go to the ICU or something like that. You have to have some allowance for that?-- That's right, and then under emergency situations in particular, that's right, they should go, and then what you would want them to do is to change - or expect them to do is they would change fully when they came back in, but that would be an emergency situation where they wouldn't attempt to put a gown on. You wouldn't expect them to do that.

Yes?-- Given a circumstance where they're just ducking out to see a patient or something between cases or something like that, you would expect that they would put an overgown on and dress appropriately.

I saw somewhere Dr Patel complaining about the overshoe things. They're the flimsy - I think they're pale blue things that slip over your footwear?-- That was something I'd actually brought up first and Dr Patel made that comment as well, but I had already said that when I had been in there I had noticed that there was an issue when staff had alerted me that there were issues with the shoes and that - and Dr Patel then did make a comment about that as well.

I've noticed some - I think UK trained doctors rather than American or Australian trained tend to wear almost gumboots when they're in surgery?-- Staff that are permanently in theatre do choose to wear what's called inside shoes, and they change into those shoes and that's what they wear inside the theatre the whole time, and then as they leave then they put on their normal shoes.

So they actually leave them in the theatre?-- They stay in the theatre all the time.

MR ANDREWS: You emailed Dr Patel and Dr Carter because of your concern about theatre staff and their attire, and I see an email at GA14. Why is it that you emailed Drs Carter and Patel if it was not a problem confined to Dr Patel?-- I emailed Dr Patel as he's the Director of Surgery, and emailed Dr Carter as he is the Director of Anaesthetics.

And would they be the persons best in a position to ask the other staff working in surgery to remove their surgical attire when leaving surgery?-- I felt so.

COMMISSIONER: They're the two clinical directors involved with surgery?-- That's correct.

There's no point asking Dr Miach because he's not concerned with surgery?-- That's correct.

MR ANDREWS: After sending that email GA14, you spoke with - and I see you also sent copies of it to Dr Keating and Linda

Mulligan. You spoke with Dr Keating, didn't you?-- That's right, yes, I did, and at that time it was Dr Keating's understanding, as I assume he'd been told by Dr Patel, that Dr Patel and Gail Doherty, who is the Acting Nurse Unit Manager of the theatre, that they - that the issue had been dealt with. I remember querying at the time, because I had not long been speaking to Gail, and she hadn't mentioned that to me.

Now, if Dr Patel had advised Dr Keating that he'd spoken with Nurse Unit Manager Gail Doherty, tell me, would Gail Doherty have been the appropriate person for Dr Patel to discuss these matters with?-- From the nursing perspective in the hospital, yes, that was appropriate, that Dr Patel could have spoken to Gail Doherty, but according to Gail Doherty that conversation didn't happen.

And so - well, did you speak with Gail after Dr Keating had passed on to you what he'd heard from Dr Patel?-- I did because - just to find out from her, and that's when they said to me that Dr Patel had not talked to her about this.

So you sent email GA15 on the 15th of November?-- That's correct, and I made a point of saying in there that Gail had not talked to Dr Keating - not Dr Keating, sorry, Dr Patel about this, and that wasn't Dr Keating's understanding of what he'd been told.

Is it in the second paragraph, "Neither Gail Doherty nor I have had any feedback from you", meaning Martin Carter and Dr Patel?-- Yes.

That you were demonstrating that the information that had been passed on to you by Dr Keating was false?-- I believe that Dr Keating was told - that Dr Patel told Dr Keating that he had in fact talked to Gail, but-----

Dr Keating may well have been deceived by Dr Patel?-- Yes, that's what I'm saying.

Did you have any feedback from either Dr Patel or Dr Keating in response to this email, GA15?-- I think - yes, basically - because what accompanied this email was a memorandum which I sent out to all medical and nursing and operational staff that entered the theatre complex setting out - it's called "Wearing of theatre attire outside the theatre complex", and I also sent copies to Darren Keating and Linda Mulligan and Martin Carter and Dr Patel, and it's only after I sent out this memo - memorandum - that was put to us listing-----

It's an attachment to GA15, isn't it?-- That's correct. Only after that then did Dr Patel then actually respond to me.

Are you able to - the response is GA16?-- Mmm hmm.

Are you able to say what the studies are yet that have shown it's acceptable to leave theatre with scrubs for short patient care cases?-- What Dr Patel was saying here was - basically

he never did produce those studies, no.

Have you since found out what those studies are?-- No, I haven't.

COMMISSIONER: I assume, given that not only do you have a Masters degree in nursing, but you're now doing a graduate certificate in infection control at Griffith University, if such studies existed, at least if they were reported in reputable journals, you wouldn't have too much difficulty finding them?-- There is - you could certainly - I'm not actually disputing - from the point of view of what Dr Patel says, that is the compromise that I had proceeded to agree to. I started going out - what I was thinking of, like a Prince Charles model where they're very careful and they - because I obviously did speak to the Brisbane hospitals and they all felt that they - this was the ideal, what I was trying to do in this memo, but they accepted that from the perspective of getting that compliance is another thing, and that I looked at a compromise. Instead of the compromise from the fact that if people do need to leave the theatres, as I stated before, for, you know, not just emergency, but need to go to clinical areas for a clinical reason, that they could just put on their overgown. I didn't necessarily disagree with everything that Dr Patel had said in this email, no.

But the difficulty is that that's what he says to you in the email, but what he's actually saying to other people is quite different?-- That's the point, and that was the continuing pattern I found with Dr Patel. What he said and what he did were two different things.

MR ANDREWS: On the 3rd of February 2005 you sent an email to Dr Patel alerting him to further incidences of inappropriate wearing of theatre attire outside theatre?-- That's correct. What had happened then was I had been told - I'll just find that email - sorry, what number was that?

The email is GA18?-- Thank you.

COMMISSIONER: That's Dr Patel's, isn't it?

WITNESS: No.

COMMISSIONER: Sorry, that's 16. Eighteen.

WITNESS: I was very concerned when I sent this email because it kind of - it basically confirmed something I felt that I already knew, that from the first point that I'd made there, that theatre staff had confirmed to me for the first time that they were seeing medical staff walk out of theatre with absolutely - with no overgown on and actually walk back into a theatre without changing.

MR ANDREWS: How serious is that from your point of view?-- Well, very serious. Very serious. They were going back to proceeding to another case. So that greatly alarmed me, and the other point that alarmed me was that I was told - and

certainly with this email, I spoke to Linda Mulligan before I wrote this and she assisted me with some of the wording, but I was told there was a senior - and I can give the names of who these people were if you wish, but I didn't use them in the email, but which basically said that Dr Patel was overheard by several people saying that in regard to the wearing of theatre attire outside, that this is a whole lot of - "They go on about not wearing theatre attire in the corridor and stuff, but that's a load of rubbish" and stuff. So he was undermining what I was trying to do, and what I then progressed to do was to - and Darren Keating definitely supported me in what I was trying to do here - that I did up some signage that - pictorial signage where I was showing, "This is what you should look like, and this is what" - with a big line through - "this is what you don't wear out". You don't wear your gown undone, you don't not wear an overgown, and those sort of things, and I felt if I could get somebody with authority such as Darren Keating to authorise that, it would carry some weight, because clearly I'm not listened to. But the other person I wanted to co-sign was Dr Patel, because I felt if he had to could sign it, he could not knock it.

I see. Did you get a response from Dr Patel to your email GA18 where you've suggested to him that he was overheard telling junior medical staff, "They go on about trying to stop us wearing theatre clothes in the corridor, but that's rubbish."?-- No response.

Not even an oral response?-- No response from anybody, from either Darren or Linda, but again as I said, Linda was aware that I sent this.

Well, I think you've said that Linda helped you phrase it?-- Yeah, I thought it could be an email that I was concerned about sending, and I wanted just to - and she assisted me with a bit of the wording in there about perceptions.

You've said that Dr Keating did assist to the extent of agreeing and facilitating the putting up of signs. Was that after you've sent this letter by email?-- All along I felt that Dr Keating did support the initiative.

D COMMISSIONER VIDER: Are you forming an opinion that there is a consistency from Dr Patel about his reluctance to acknowledge a thing called cross-infection?-- Absolutely.

Your report is indicating first of all in ward areas where there is a reluctance to even wash hands between cases. Now you've got an indication of theatre attire where there's, once again, no recognition of the need to particularise things between patients. Were you getting the impression that cross-infection was something he didn't acknowledge, believe in, or practise?-- Absolutely. I mean, the man did say in the renal unit that day, in all seriousness, that doctors don't have germs, and I certainly did feel that way, and I also felt that while to my face or at meetings that he would say supportive things and he said that he would do - you know, speak to the staff and he would - you know, that he did

certain things, I found that that didn't seem to be the reality of what happened. In a way I came to the realisation that I felt that he was totally trying to undermine the whole infection control from the perspective that he was trying to undermine what I was trying to do.

MR ANDREWS: After you had agreed to a compromise protocol for the wearing of theatre garments, can you tell me the occasions that you observed Dr Patel outside the hospital buildings inappropriately dressed in theatre attire, was that a breach of the new protocol?-- Both. It was before and after. Dr Patel smoked and he would go out, leave the buildings and go and sit in his car or wherever else, generally out of sight, I thought, but on occasion I ran across him in the carpark, and I certainly did ask him about his theatre attire, and he always assured me that he changed when he went back in. Again, I have to trust him on that.

In any event, that was a breach of even the new protocol?-- That's correct, because you should not leave the hospital buildings. That's why I was so specific about including that in there for the very purpose that Dr Patel was leaving the hospital buildings to go off to smoke.

Who would sign the assessments of doctors and students?-- From the perspective - talking about what's in my statement here in regard to the surgical stream students, Dr Patel, I understood, did sign their assessments, if we're talking in regard to being perhaps told what to say and what not to say on discharge summaries and in notes, yes.

I notice in paragraph 39 you have, in the second last line, "doctors/students"; do you mean that Dr Patel would sign off on assessments signed by other doctors?-- It was my understanding, if you're talking about the Junior House Officers and stuff - again I am not 100 per cent sure on that, but that was my understanding, that the Junior House Officers were - had some responsibility - I mean, he had some responsibility in doing their assessments.

COMMISSIONER: Mr Andrews, if you've reached paragraph 40, there are a couple of questions I wanted to ask about that. In your paragraph 40 you talk about the seminar provided by the Ethical Awareness Information Unit and discussion about appropriate channels to disclose information and so on and so forth. Is it your view that with respect to the infection control issues about which you've given evidence, you did everything within your power to raise that through the appropriate channels?-- With what was coming up in the data - because the problem was the data didn't indicate - as in statistical data didn't indicate that - I could not identify anything significant other than what was in the renal.

Was the effective result of that that going through the appropriate channels just didn't resolve the problem?-- With the overall - I felt that from the perspective of - staff would tell me things from time to time, different things that weren't necessarily related to infection, but I just felt that

staff overall had a feeling that there was no point in saying anything, and this - Dr Patel was certainly the person that would go around saying that - you know, saying that he was protected by the executive, that he was making all this money for them and those sorts of comments, which are certainly well documented by now, but the thing was the impact that had on people was, "What's the point?"

From your evidence so far, you've battled with this problem effectively for two years, from about April 2003 through until the earlier part of the present year. What is your sense as to whether or not the problem would have been brought out into the open and dealt with if it wasn't for people like Toni Hoffman going outside the ordinary channels or the proper channels?-- Well, I think that that needed to happen really, because I don't think that it was getting dealt with otherwise. I think - from my perspective, I think that while members of the executive knew about things, I don't think that they managed things, and me informing them about different things along the way, I don't think that they actually - what I called managed something, that they got the parties together and dealt with these things and looked at it along the way. I think it should have been managed.

Your evidence identifies a number of occasions on which either you individually or with other members of the nursing staff raised problems with the executive manager at the hospital. Was it ever suggested to you that it was just a personality conflict between yourself and other nurses on the one hand and Dr Patel on the other hand?-- It was never so much said that openly out in words to me, no. It was never sort of said that, but you certainly did feel that way. You certainly did feel that you were a troublemaker is what I keep coming back to. I just sort of feel that, "If you're not going to deliver me good news, I don't want to know any news", and I just felt that you felt that you were being judged because you were trying to bring up things that they may regard as being emotive, but at the same time somewhere - sometimes you can't have the statistics to show that you would like to have, and I think that somewhere along the track you think the mud's got to stick a little bit to at least take it further and look at it further.

I haven't been through your statement to check this, but I can't recall any reference to your having any dealings with Mr Leck about any of these problems. Is that right?-- Only - no, only through the Leadership - and whenever I did my reports to the Leadership and Management Committee, he would have been there at the time. He would have been aware of the wound dehiscence and the 13 cases at that time and - but no, no great dealings at all.

By contrast, you had a lot of dealings with Dr Keating in relation to these matters. Can you outline to us the extent of his presence within the functional parts of the hospital? Did he visit regularly? Was he in the wards and the surgical theatres?-- I couldn't really say.

You also refer, towards the end of your statement, to Mrs Mulligan who had only come on the team later. Again, can you comment on her management style, as it were, in the hospital?-- Okay. I certainly did welcome Ms Mulligan when she did come to town, because I did feel that we did need - as nurses we did need a nurse to - a strong nurse presence to, what I would say, buffer us, to - you know, we needed a supportive nurse leader, basically, and I do - over time I did come to the realisation that Ms Mulligan was a - not so much the person that perhaps I felt that we needed, but more a manager as such, and her management style, I believe, and my opinion is that of a micro manager, and that she was very - I don't know. It's - yes, she had a very different style, but she did not - like, I really felt that there were things that in our positions as - because I am actually Nursing Officer Level 4, that at that level you and the - and the Level 3s as well, that you have responsibilities of budgets and numerous other responsibilities in your role, and I just think that there's responsibilities that we had that I felt that she either took away from us or just clearly didn't trust us with. I felt that she - to me it's like she arrived, and within a short period of being there just didn't trust us. I don't know why that would be the case, but I felt - that's how it made me feel, that, you know - yes.

D COMMISSIONER VIDER: I get the feeling from your evidence, and in your statement, that on a number of occasions, from the efforts that you made to try to draw attention to issues that were of concern to you, you felt that you were left thinking "Why bother". Am I correct in presuming that somewhere in all of this, the instances and the issues that you raised, the patients were never the centre of attention in the responses that you were getting? I find it hard to be able to recognise where the executive - or those people you reported this to came and said, "What's happening to these patients?" I mean, we're meant to be here to look after the sick. You're raising areas of concern time and time again?-- I agree. As I said before, I felt that while they're aware of these things, they didn't manage them. They didn't manage these issues. They didn't manage the situation. They just let it all happen and hoped, I suppose, perhaps that it was going to all pan out, but they didn't manage the situations, I felt, didn't deal with them.

COMMISSIONER: I suppose I then should ask you the next question. From your experience at your quite senior nursing level, what sort of changes to hospital structures and administrations would you like to see that would give you more confidence in the people that you're reporting to to be able to deal with them? Would you, for example, like to have people in those management positions who are actually clinicians and know what's going on within the operational part of the hospital? What would your preference be?-- I think that that is important, that there's an understanding, because I don't think - I think it's difficult sometimes to perhaps expect - as you may well be finding in your own situation here, it's hard to have an understanding and appreciation of what's gone on if that isn't your background.

So I think it's easier for people that do have that background to understand and manage and deal with situations better perhaps. But I mean, I wouldn't like to say. There's certainly things in regard to infection control that I can see there's a possibility of some improvements and things from that perspective in regard to infection control surveillance and things like that.

One of the other things we've canvassed with a number of witnesses is a sort of what I've described as a onestop shop for complaints, not only from outside the system by patients and families, but complaints within the system, really as a means of ensuring that people like Toni Hoffman aren't forced to go to the press or to the politicians so that there's someone they can resort to. What are your views about that sort of model?-- Clearly there needs to be somebody like that, clearly, because this hasn't worked, and so therefore I agree that there does need to be something that - I can't suggest anything that - I can't think of anything, but clearly what we have at the moment does not work and - yeah.

MR ANDREWS: I would like to deal with one further aspect of paragraph 40 of your statement in which you advise us of an ethical awareness information session conducted by a number of presenters from Corporate Office. Do you recall whether, during that presentation, you were advised about the Whistle Blowers' Protection Act?-- We were - it did come up in the conversation about managing whistle blowers, and while I don't remember the whole content of the meeting or the in-service, basically what I do remember was the fact that - how it related to what I was, at the time - was in regard to that I was aware that Toni had talked to the union about - in dealing with this situation out of - she had gone to them out of - basically out of frustration and wanting support - was that she was considering going to - what I thought Toni had said was the CMC - it might have been the Health Rights Commission - I thought Toni had said the CMC - and I remember thinking from what I had heard at this meeting that I was concerned - and very concerned for Toni as a friend - that had she taken that approach and gone outside of Queensland Health with her concerns, that she would have got herself in a lot of trouble, and that was the take-away feel I had from that meeting.

As a result of the things that were said to you by the people from the Corporate Office?-- I have since found documentation about that, and I still think it was Corporate Office, yeah. It was on E-mail.

Ms Aylmer, isn't it the position, though, that under the Whistle Blowers' Protection Act, there's protection given for people who go to the CMC?-- Sorry, all I - I'm not sure of that act, but it was just what - the impression I got from what was said on that day.

See, you left with the impression that even going to the CMC about a concern might mean that one would be in trouble?-- Going outside of Queensland Health in general.

COMMISSIONER: Do you recall there was a discussion about the code of conduct?-- Yes.

I think it has been suggested by another witness that there may even have been a discussion about gaol terms and so on for breaching the Code of Conduct. Does that ring a bell with you?-- It does ring a bell, but not a big bell.

MR ANDREWS: Would you have a look at this document, please? Actually, I would ask that it be put up on the screen. It is a two page document, Ms Aylmer. Could you look at the screen and see if, from it, you can identify it?

COMMISSIONER: Perhaps reduce the scope a bit so we can see the whole document.

WITNESS: That was what I subsequently found on - well, on E-mail. I had actually deleted it, but I went and asked another nurse if she could find it and she was able to find it, just because I wanted to get more of a background, but I

found this after I had done my statement.

MR ANDREWS: How did you come to receive that document?-- It all came through E-mail, originally.

Do you remember when? Did it have anything to do, for instance, with the timing of the Ethical Awareness Information Session or-----?-- This is relating to that. This is relating to that, yes. This is advertising - you can see at the bottom of the screen there, it said - it's got the date it was on in Bundaberg - the 14th of October. So, it is relating to that session that we are talking about. And you can see there on the second page - but it does talk about managing whistle blowers from a Queensland Health perspective, managing whistle blowers as being the manager, rather than being a whistle blower.

And not having seen that document myself, is there anything within it that alerts the reader that they have - they are at liberty to go to the CMC under certain circumstances?-- No, no, it wouldn't have - it was just basically a document sort of saying about the information session and giving a bit of information about what might be covered in that session, and when this came up on that day, I'm not sure whether it was - you know, there was some questions and stuff, so I'm not sure if it was a response to somebody's question or just how it came out. I mean, you don't - but, it is just my - I made this comment to Toni at the time and I just - so - but this is just basically information about the session and, in general, what it would contain.

Is it the case, then, that if one had any complaints to make, one - an employee of Queensland Health was to make it through appropriate Queensland Health channels rather than to an outside organisation?-- That was my understanding of part - some of the content, yes.

I tender that document.

COMMISSIONER: How shall I describe it, Mr Andrews? Would the ethical awareness document suffice?

MR ANDREWS: I think E-mail relating to ethical awareness information.

COMMISSIONER: Do you mind if I put "ethical awareness" in inverted commas?

MR ANDREWS: No, Commissioner.

COMMISSIONER: That document will be admitted into evidence and marked as Exhibit 61.

ADMITTED AND MARKED "EXHIBIT 61"

COMMISSIONER: We don't have a precise date, but your evidence was that it was some time shortly before the dates mentioned here - around October 2004; is that correct?-- That's correct.

MR ANDREWS: You were asked about patient care. Dr Patel's concern for patients, can you tell us what happened with respect to patient P54 who had undergone a breast biopsy performed by Dr Patel?-- I included this because it was an example of what I had to deal with with Dr Patel sometimes in regard to patients. This was a lady that rang me. She had surgery for breast biopsy on the Monday. She rang me on the Wednesday very concerned that the area around her breast was hard, hot, black and felt sore. She - it was sort of about say, 10.30, 11 of that day, and I said to her I would get in contact with Dr Patel. I rang theatre and I spoke to Gail Doherty, who is the Acting Nurse Unit Manager. She said Dr Patel was scrubbed in at the time and she would pass on the message and get him to ring me. I did give her brief details that it was about - relating to a breast biopsy case that had been on on Monday and there was concerns. So, do you want me to continue?

Yes?-- So, basically what happened then was that I saw Dr Patel - he was having a late lunch, so he probably had not long left theatre, I would say, and-----

Did you describe to Dr Patel the symptoms as you understood them to be?-- I did, I did.

And can you - are you able to say whether those symptoms are consistent with a temporary matter, or could they also be consistent with something serious?-- Something serious, and when I spoke to Dr Patel at the time, that's certainly how he took it. He said to me, "This is good to know about this, because people go home and these sorts of things happen and the GPs get to know about it but we don't necessarily get to know about it and I need to see this lady." He did tell me, prior to getting to that conversation - he did say to me that he - because Gail had to ask him to actually contact me and he did say that when he saw me he was going to ring the woman, but I thought that was very - it would be difficult for him to do because I hadn't said the patient's name or hadn't given any further details. It may well have been that was the only breast biopsy on that Monday, I don't know, but I hadn't given any details for him to be able to contact her. She wasn't staying at home, so I gave him her mobile phone number and he said that he would contact her, and I rang her back to say she should expect to hear from Dr Patel.

In any event, are you able to say whether Dr Patel did contact her using the number that you supplied to him?-- The patient tells me no.

How many days later had he - how many days had passed without his contacting her?-- That was on the Wednesday. I rang her - I rang her daily, but I rang her again on that next Monday,

and things had settled down. She had taken - she had gone to a local rural hospital and was given oral antibiotics and obviously the infection had settled down at that point in time and she was due back for her follow-up in a few weeks, but she didn't see Dr Patel at that time either.

And you sent E-mails to Dr Patel on the 20th of January and then again on the 4th of February about this patient?-- Initially just to make sure that - because I just gave him the phone number and he still hadn't contacted her and I gave him a phone number on a piece of scrap paper that - he actually had the number so he could ring her, and the later E-mail was in regard to asking him for follow-up in regard to that.

By that stage, did you already know that she had taken oral antibiotics?-- I did.

Did Dr Patel follow-up or-----?-- No.

And he made no contact with you?-- No.

You speak of - at page 18 of your statement - about being confronted by a barrage of negative comments. I think you were speaking of a meeting held on the 23rd of March 2004 - an Improving Performance Meeting?-- That's correct.

From whom did the barrage of negative comments come?-- They were primarily - it wasn't related to infection control, it was talking about a survey result - results in regard to - that sent out patient satisfaction, so I just happened to be a member of that committee at that time and the barrage of questions were coming from the Executive members that were there at the time and a number of other individuals that are in high positions at the time. Basically we were looking at - there was concerns that things weren't being followed up from the nursing side in regard to dealing with the Press Ganey report - dealing with following up those things.

As I understand it, did you present some data?-- No, I didn't. I was not - I just happened to be at the meeting and being the only nurse at the meeting, this topic came up, and because it had come up at a meeting earlier where - where Ms Mulligan had been at and we had discussed it - she happened to be an apology for this meeting that day-----

Ms Mulligan wasn't one of the executives present?-- She wasn't one of the people present. There was an apology. I was basically handing over some information that I knew was not prepared - this was nothing that I prepared or was asked of me, it was just that being the only nurse there at the time, they asked me to make comment.

You handed over some information about patient surveys; is that the position?-- Not so much information, but in regard to nursing's progress in dealing with these issues, and there were some issues that related to - you know, there was some queries statistically with the numbers and stuff and, you know, there was just a bit of conversation.

No, I don't know?-- Okay.

There was some statistics with numbers, were there?-- Basically the Press Ganey report came back there was a number of 10 items that we were to focus on or a number of items we were to focus on and there were those that related to nursing - perhaps there were comments - I can't think of them - but doctors and nurses might not communicate enough or there was - the patient - the main point, I think, of that day was that the rights and responsibilities of - for patients - that nursing staff was not making sure that patients understood their rights and responsibilities enough. I think that's what it was about.

So, there was a topic for discussion about whether nursing staff made patients understand their rights and-----?-- Responsibilities.

Patient's responsibilities and patient's rights?-- Yes.

And when that topic was raised, you were asked to comment; is that the position?-- That's correct.

And did you feel after you made comments about it that the members of the executive who were present subjected you to negative comments?-- With the exception of Dr Keating, yes. Dr Keating was supportive of me in that situation, in that he understood what I was trying to say and with the exception of Dr Keating, that's true, and I felt that there was - there was comments there that - there was a checklist - there were patient admission forms that nurses were merely ticking the box for and they weren't really telling the patients about their rights and responsibilities, they were just ticking the box.

And the Executive who confronted you with the barrage of negative comments didn't include Linda Mulligan nor Dr Keating?-- That's correct.

Who was it, do you recall?-- Well, the rest of the Executive, and there were other-----

I'm unaware of who-----?-- The Quality Coordinator was there, the HR Manager was there, and I'm not sure of the other person's role, but she deals with transition and - I'm not sure what that role is.

Not Mr Leck?-- Mr Leck was certainly there, yes. He certainly aired his disapproval.

Of the performance of the nurses?-- That's correct.

The Quality Coordinator, what's that person's name?-- Leonie Raven.

Ms Raven, did she participate in the barrage of negative comments?-- Yes.

COMMISSIONER: Is Quality Coordinator a clinical role or an administrative role?-- I think it is an administrative role, but she is a nurse. Her background is a nurse.

MR ANDREWS: Did anyone give you any constructive comments as to how the patients should be informed of their rights and responsibilities?-- No, but I did say - try to say how we were trying to progress this and that we were progressing it, but it was felt we weren't progressing it quick enough, and my point - issue was I don't believe we were the only people on the staff that wasn't addressing it, and we had gone through a period of time where we had had a number of Acting Directors of Nursing.

You said in paragraph 46 that Mr Leck was extremely angry and accusatory in his tone?-----

COMMISSIONER: This is a subsequent meeting, isn't it, I think?

MR ANDREWS: Indeed it is. A full year later. March 2005. You will see a meeting described at paragraph 46?-- This is true.

Now, the meeting at paragraph 45 is not a misprint; that was intended to be the 23rd of March 2004?-- That's correct.

COMMISSIONER: Shortly after Ms Mulligan started in the position?-- That's correct.

Then we go through 12 months later to the meeting in March 2005?-- That's correct, yes.

MR ANDREWS: Who attended that meeting?-- In paragraph 46?

Yes?-- That was - we were called - there was nursing officers 3, 4 and 5 - and this was after the initial leak to the media - we were all called up to the Executive Conference Room by the Acting Director of Nursing, Deanne Walls. So, it was basically levels 3, 4 and 5 that could attend.

COMMISSIONER: They are all the senior nurses, in effect?-- That's correct.

MR ANDREWS: It was after Mr Messenger's speech to Parliament?-- Yes.

That would make it after the 23rd of March?-- That would be correct.

You speak of Mr Leck's tone rather than his words. What did Mr Leck say that offended you?-- I think - sometimes it is easier to remember tone than words. It is very - like, from - he was very unhappy. He was - I felt that I was accused - or - of this - what had happened; that he was basically saying that - he was very angry and, to me, he was laying his anger on us.

Now, the group of nurses, or you in particular?-- Well, I certainly individualised it as well, but, yes, as a group, but certainly personally I felt that as well, and I felt that we were - we were very quickly being blamed for this situation.

For the leak-----?-- For the leak.

-----of information. Was there any discussion about whether the information leaked was true or false?-- By Mr Leck?

Yes?-- He did say that he had very reliable sources that a nurse was involved.

COMMISSIONER: I think that Mr Andrews was asking, you know, Leck was talking about the leak as something that shouldn't have happened, but did he discuss at all whether the information that had leaked - whether that information was actually true or false?-- No, he did not discuss - that did not - was not entered at all. It was more the fact that this leak should not have occurred.

D COMMISSIONER VIDER: Was this the first occasion where you had all gathered or been at a meeting where you came out of that meeting and you felt you had been blamed for what had happened?-- Relating to this situation?

No, just in previous - any meetings you might have gone to regarding issues that might have been raised in the previous 12 months?-- I certainly have felt that if you are the bearer of good news, you are well received, but if you aren't, then they might not necessarily want to know, but as a meeting as a whole - as a meeting, probably - I can't really think of any other examples, but certainly I had felt that way, but not necessarily after a meeting.

You had walked away before having felt that you had been blamed for what had happened?-- Other than the meetings since this when Mr Nuttall and Mr Buckland were in town and things like that, I certainly felt exactly the same way.

MR ANDREWS: You must have read or seen in the media reports attributing to Mr Leck that it would be difficult to find doctors for Bundaberg. Did you ever hear Mr Leck say those things?-- I did, yes.

COMMISSIONER: How did that make you feel?-- Basically, from that point, I felt that he was just making the situation worse. In saying that, it was like that we were in a habit of making these malicious claims, which is the way that I felt that they were implying - that we had done this before, and he would expect that we would do this again - like, that was the impression that I - that I felt - what he was saying was that, you know, "You can't trust these nurses. Look what they have done here, and they will do it again.", basically, and that was - I was very annoyed.

I guess the other side of the message, too, was along the

lines, you know, "Look at what these nurses have done: made a mess for Bundaberg; got rid of this brilliant surgeon we have got here, and now we are going to have trouble getting another one."?-- That was being - that certainly was said as well. Not necessarily "brilliant", but that was the feeling as well - that we had a surgeon here and we basically now have lost him, and it was - my concern was that nurses were going to be made a very easy scapegoat for this and I thought, "It is hard enough to stand up and do what Toni has done, and with this situation, it was only going - nurses in future will be less discouraged to stand up and be heard and stand up for patients because they are too easy to be made the scapegoat."

MR ANDREWS: Had you been advised by the occasion of 23rd March 2005 - I beg your pardon, the meeting in March where Mr Leck spoke angrily, had you been advised that there was, in fact, a review being undertaken at that stage into issues raised relating to the hospital and Dr Patel?-- That's true. I had participated when Dr Gerry Fitzgerald came in - I think it was the 14th of February - and I was interviewed by Sue Jenkins, I think the lady's name was - so I was involved in that.

What did you tell Sue Jenkins?-- Basically - I had early put a few things together at the time, but basically obviously not as full a summary as this, but basically I did have concerns. I can't remember the whole detail now.

Very well. On the 7th of April 2005, the Director-General of Queensland Health, Dr Buckland, visited and was accompanied by the Minister for Health, Mr Nuttall. Do you recall that meeting?-- I do.

You were present?-- I was.

How many other staff were present at the meeting?-- There was - it was held in the staff dining room and there was quite a full room - standing room.

You speak of an aggressive tone. Who used it?-- I felt more Mr Buckland than Mr Nuttall, but - yes.

Now, was it a question of feeling that it was aggressive, or was it - I can imagine you would have been fairly sensitive after your meeting with Mr Leck previously. Could you have been imagining the aggressive tone?-- I think your feelings obviously do play a role, however they came - the way that they did speak I felt was aggressive in that they came and they had told a story how they had been off to Springsure opening up this wonderful - and it sounded very good - sort of facility there, and then they had to - and what a great place that was, and then they had to come to Bundaberg, and it was sort of basically, I felt, mentioned in that way that we - my impression was that, you know, "Bundaberg's problems again", but they - when they spoke to one of the nurses - and I think it was probably an ICU nurse called Karen Jenner - this was after they had said to us that, you know, "As a result of Dr Patel leaving the country, we cannot release the Fitzgerald

Report.", and I had said something about it being - you know, disbelief, basically, with that, but I think Karen Jenner was also in great amount of disbelief and she queried it, and while I can't remember the words exactly, I remember hearing them say, "Which part of that don't you understand?" - that you won't have the release of the report.

COMMISSIONER: Do you recall specifically whether that was Dr Buckland or Mr Nuttall who said that?-- No.

Similarly the comment about-----?-- I suspect Buckland, but I don't know. Karen would-----

Similarly the comment about Springsure?-- I think that was probably Nuttall - Mr Nuttall. But again, for example, if you ask Karen Jenner, she obviously will remember the conversation better.

Now at any stage during this meeting - I assume it is a fairly rare thing for the staff at Bundaberg Hospital to be graced with a visit from the Director-General and the Minister at the same time. It is not something that happens-----?-- Probably - certainly when the Minister did take over, he did come around and we had a similar meeting - not a similar meeting, but we had a meeting at the staff dining room as well.

Did either of them show any interest at that meeting in getting to the truth of what had happened - whether the allegations concerning Dr Patel were valid or not - or was it just about how this had got out into the press?-- Basically about working as a team, but also the fact that we had to - I've lost my train of thought then. Sorry, I have just lost it.

What I was trying to ask was whether on that occasion either of them asked questions or engaged in discussions to get to the heart of what had gone wrong, whether Patel was as black as he was painted, or whether there was something-----?-- Because they were not-----

-----improper going on?-- Sorry. Because they weren't prepared to release any of the findings, or even make mention of it, I think had they said, "Look, there are some issues with Dr Patel and we will investigate them, but we can't release them because Dr Patel has left," even if they said something like that I felt would have been more appropriate than basically in leaving me feel that I was part of this big - helped cause this whole situation and that we were basically left to feel that you've caused all of this mess and you've - there was no, like, vindication basically, and we clearly felt there had to be, but there was no - we were just really made to be felt left feeling you were the bad guy basically still. There was no acknowledgement that, okay, there were some issues, but it was just sort of left hanging.

D COMMISSIONER EDWARDS: Ms Aylmer, do you feel they had any acknowledgement of the problems that really there was or was it just a face-saving meeting?-- I don't think they acknowledged that there were problems there at all and to me it was face saving, because had they tried to acknowledge there were problems, you know, I would have seen that as a positive thing. But they did not at all and I really do believe that they really inflamed the situation, that visit really inflamed the situation, and certainly not just from the people that were actually involved, you know, one of the admin staff that works in Pharmacy made a comment at the next meeting and I hadn't realised at that time how upset that she had been and she was like more indirectly related to the situation and she had been very offended. So while I thought it was more us, it was sort of - it really did have far-reaching effects.

MR ANDREWS: You told us that at the meeting of 7 April 2005, someone said that because Dr Patel had left the country, the Fitzgerald Report would not be released. That's different from the last sentence of paragraph 47, which is, "We were told due to the leak to the media the outcome of the clinical audit by Dr Fitzgerald could not be released."?-- What did you say in the first part?

I said the first observation I made is that you told us this morning that someone said at this meeting because Dr Patel had left the country, the Fitzgerald Report would not be released?-- Well, can't it be both? From the perspective of - okay. I've got here "due to the leak in the media" and it became a public issue and media issue, which then I assume - I'm not sure whether Dr Patel left, but he - we were told because of the natural - the justice that was deserved to him that they couldn't relieve - release the information because he had left the country.

I see. Did the fairness to Dr Patel get raised at this

meeting?-- Oh, it did, yes. Yes.

By the nurses or by one of those who visited?-- No, certainly that was why they were saying that they couldn't - they couldn't release the information because bearing in mind the fairness to Dr Patel. Sorry.

Thank you. Were there any - was there any discussion about consequences for the staff of the Bundaberg Hospital who may have been responsible for leaks, either perhaps at this meeting or at the meeting with Mr Leck previously?-- Not that I - certainly not at that meeting.

Not at the one that Dr Buckland attended; is that what your evidence is?-- No, I don't think so.

Was there any discussion at the meeting about arrangements for patients or looking after patients who might have been affected by the care given by Dr Patel?-- I can't be - I can't be sure. I suspect that there was. There was also - I know that the Acting Director of Nursing at the time did ask a question in regard to - that while they couldn't give a public feedback, could the individual people that were involved in that Fitzgerald, well, investigation - we were told it was a fact-finding mission at the time - but if they could get some feedback about the outcomes. But from - I can't - I can't now remember. There's been too many forums and things since then.

And do you remember what the response to the Acting Director of Nursing's request for feedback was?-- I think there was going to be some consideration of that, but I don't recall any other answer.

I have no further questions.

COMMISSIONER: Mr Allen, do you expect to be long?

MR ALLEN: No, I don't, Commissioner.

COMMISSIONER: What does that mean, 10 or 15 minutes?

MR ALLEN: Yes.

COMMISSIONER: Yes. Well, go ahead, please. Just for the benefit of others at the Bar table, particularly Mr Morrison who hasn't been here before, I try to structure the cross-examination so that those who have interests most closely aligned to the witness come first and those whose interests are more adverse come afterwards. It's hard to be precise about that, but I suspect that that means Mr Ashton and Mr Diehm and yourself will be probably towards the end if that's convenient.

MR DIEHM: Thank you.

MR ANDREWS: May I interrupt? Commissioner, Ms Aylmer was asked to consider some matters that were raised in the evidence of some other witnesses and she has, I understand,

prepared a supplementary statement dealing with those matters during the weekend and I would like to ask that it be identified and tendered. I have no further questions to ask.

COMMISSIONER: Why don't we take the luncheon break now and circulate that so that everyone has had a chance to read it?

MR ANDREWS: Indeed, it was circulated when we arrived this morning.

COMMISSIONER: Okay. Circulation didn't reach up here, I'm afraid.

MR ANDREWS: Point taken. A lunchbreak now seems a very good idea.

COMMISSIONER: All right. We will resume at 2 o'clock?

MR ANDREWS: Thank you, that's convenient.

COMMISSIONER: Does 2 o'clock suit everyone?

MR DIEHM: Yes.

THE COMMISSION ADJOURNED AT 12.38 P.M. TILL 2.00 P.M.

THE COMMISSION RESUMED AT 2.03 P.M.

GAIL MARGARET AYLMER, CONTINUING EXAMINATION-IN-CHIEF:

COMMISSIONER: Yes, Mr Andrews?

MR ANDREWS: May Ms Aylmer be shown a copy of her further statement, that's the five page document prepared during the weekend? Ms Aylmer, do you have a copy of that?-- I do have a copy.

COMMISSIONER: Do you say that the contents of this statement are true and correct and that to the extent it mentions opinions, they're opinions which you genuinely hold?-- That's correct.

MR ANDREWS: I tender it, Commissioner.

COMMISSIONER: Thank you, Mr Andrews. That will be Exhibit 62, the supplementary statement we will call it of Ms Aylmer. Is there a date? Mine's actually blank. That's dated June 2005.

MR ANDREWS: Mine's blank also?-- I signed it last evening.

Ms Aylmer has signed one. Can you relinquish that one, Ms Aylmer, as an exhibit, unless it has got other writing on it?-----

COMMISSIONER: That's all right, Mr Andrews. This one is signed but not dated and I will date it yesterday's date, 19th of June, and it will become the exhibit.

ADMITTED AND MARKED "EXHIBIT 62"

MR ANDREWS: Thank you, Commissioner.

COMMISSIONER: Thank you.

MR ANDREWS: I have no further questions.

MR ALLEN: Thank you, Commissioner.

EXAMINATION-IN-CHIEF:

MR ALLEN: Ms Aylmer, you gave some evidence about the aspect of wound dehiscence and the report in two forms was prepared in relation to the period May/June 2003. You have also mentioned that wound management is not part of the Infection Control CNC position?-- That's correct.

And that is apparent from the position description that you have annexed to your statement. After June 2003, did you have any involvement in monitoring any further episodes of wound dehiscence?-- No, that was the Nurse Unit Manager of the Surgical Ward, she's been capturing that data.

I see. So you wouldn't be able to speak firsthand as to whether or not that problem continued into the future or not?-- No.

You gave some evidence about the steps you took to try and introduce a post-operative follow-up form to monitor any infections that might have been apparent from post-op examination of patients and you said that Dr Patel, in the formal setting of the ASPIC Committee meeting, gave the impression that he was supportive of such a step?-- That's correct.

Did you receive any information to the contrary which indicated that, in fact, he was not supportive?-- The fact that there was - I was receiving very few of these forms that were completed by medical staff and the fact that the nurse that works in the Outpatients Department made a comment to me that - because when the doctors come down to the clinics they get the forms out ready for them to use and on one occasion when she was asking Dr Patel to use it and he just scoffed at her - scoffed and laughed at her.

And the form, as it eventually evolved, is exhibited at GA12 to your first statement?-- Yep.

And do I take it from that that the form as it eventually evolved had a space for affixing the patient identification label?-- That's correct, that's for the doctor's to put the patient's name down.

They are commonly produced as part of the patient's chart so they are there for ready use?-- No, they're not - no, not in that way. They are used down in the specialist Outpatients Department and the nursing staff down there put it out on the days they are doing the surgical reviews and the staff have been very good in putting them out there for the doctors to use. It's just a compliance of whether the doctors used it or not.

So in relation to any particular patient in the Outpatients, all that would be involved in complying with that procedure you derived would be sticking a label on the page and then

ticking either yes or no for whether or not there was an infection?-- That's correct.

And if there was an infection, ticking a box to indicate that a wound swab had been taken?-- That's correct. Basically the reason I wrote that there was also as a bit of a prompt that they might consider doing the wound swab.

And was this the procedure which the medical staff seemed to regard as being too onerous?-- That was the first case form that they had where they had to write the name and, yeah, the name and diagnosis, and things like that. There was too much writing. This is why I simplified it down to this where they merely had to stick a label on it, tick a box and I felt that was a very reasonable thing to ask of them.

Was it before or after when you had come up with that final form that you received feedback that Dr Patel had scoffed at a suggestion that he complete such a form?-- Not exactly sure when that was, but I was receiving negative feedback the whole time. But that actual comment, I'm not sure. The nurse involved may remember - recollect that time better than myself.

And you've mentioned the name of that nurse in your statement as being an Enrolled Nurse, Janice Williams?-- That's correct.

Now, you gave some evidence about the meeting that occurred on the 7th of April 2005, attended by the Director-General and the Minister for Health?-- Yes.

And you stated that you were disbelieving of the comments being made that because of either the media publicity or Dr Patel leaving the country that there would be no release of the findings of Dr Fitzgerald?-- That's correct.

Did you, in fact, at that meeting express any disbelief?-- I did.

And how did you do that?-- Basically I just asked - I'm not sure whether it was Mr Buckland or Mr Nuttall - just basically tried to - I'm not sure of my wording, but it was basically I was trying to comprehend that they were saying to us that they weren't going to release any information about this.

So did you do that by asking a question of them?-- I asked - yeah. I think it was more - it could have even been a statement like, "Are you trying to say that we're not going to - we're not going to find out the outcome of that report?", to that effect.

Do you recall if there was any response to that query?-- Well, I think the response was, "We can't give you" - you know, "The report can't be released."

COMMISSIONER: I think you told us earlier that some words were said along the lines of, "What part don't you

understand?" or-----?-- That was to - that was addressed to an ICU nurse.

Right?-- That I had spoken first and then that nurse obviously felt the same disbelief as I did and she asked that - asked that question. That was the response that was given to her, which we thought was very inappropriate.

Yes.

MR ALLEN: So the response to that nurse was to the effect of, "Which part of 'you're not going to find out' don't you understand?"?-- Yes, I was saying to you, "We're not going to tell you and yet you are still asking, as to what part of that don't you understand?", yeah

So what part of the statement-----?-- That you are not going to find out.

That you are not going to find out, right. So in response to some questions from the Commissioners, you agreed that during that discussion there was no acknowledgement of any problems that might have been given publicity? No acknowledgement on the part of the Director-General or the Minister that there were problems that needed to be addressed?-- That's correct.

And, indeed, the effect of the indications were that the matter was going to be dead and buried?-- That's the way it seemed to me.

In your supplementary statement, at paragraph 7, in the third last line of that paragraph you refer to a pathology form?-- Mmm.

And if you also go to the last paragraph of the statement, paragraph 14, there's reference there to a pathology slip?-- Yes.

You are referring to the same thing there?-- Yes.

Would you have a look at this document, please? I do have copies for the Commission to assist and for any parties. Is that a copy of the pathology slip that you referred to in your statement which was filled out in your handwriting and given to the person who has been referred to as patient P99?

MR MORRISON: Mr Commissioner, can we have that on the screen perhaps?

COMMISSIONER: Yes, that's a good idea. I will have Mr Groth do it.

MR ALLEN: So are you able to identify that as being a copy of the pathology slip that was given to patient P99?-- That's correct, it's a scanned image and I've just printed it off from there.

I will tender the copy of the pathology slip, please,

Commissioner.

COMMISSIONER: Yes, that will be Exhibit 63. I haven't quite worked out what any of this goes to, but I'll assume, Mr Allen, you wouldn't be tendering it unless it is has some significance in the events.

MR ALLEN: It's in relation to matters which I understand will be led from other witnesses at a subsequent time as well.

COMMISSIONER: Yes, thank you. That will be Exhibit 63.

ADMITTED AND MARKED "EXHIBIT 63"

MR ALLEN: Those were the only questions I had. Thank you, Commissioner.

COMMISSIONER: Thank you, Mr Allen. I think probably, Mr Mullins, you'd be next in the pecking order, if that suits you.

MR MULLINS: Thank you, Commissioner.

CROSS-EXAMINATION:

MR MULLINS: Ms Aylmer, can I take you back to 14 April 2003, which was the time that you first came across Dr Patel in your position as Acting Nurse Practice Coordinator?-- I didn't - that's when I first went into that position. I don't think that Dr Patel was actually there at that time. I'm not sure. He came in that month when I was working on the ward.

COMMISSIONER: I perhaps should have explained for your benefit, the gentleman asking you questions, Mr Mullins, represents the patients of Dr Patel.

MR MULLINS: In your statement you say you were Acting Nurse Practice Coordinator between 14 April 2003 and 11 May 2003 and Dr Patel commenced employment during the course of that time?-- That's correct.

And you've told the Commission that you accompanied him on his rounds during the course of that time?-- That's correct.

And you had some concerns about his technique, particularly his hand washing and his touching patients; that's correct?-- That's correct.

Now, had you in your experience in the Bundaberg Hospital dealt with many surgeons before that time?-- A number, yes.

Was this problem with Dr Patel a problem that you had experienced before?-- It is not an uncommon problem with any - with all levels, all types of staff. It is, unfortunately, a problem generally, but in certain circumstances - just in normal cares people tend to be a bit more lax, but where they are actually doing things where they are touching wounds and things they need to take more care. But certainly people in general don't wash their hands as much as they could.

COMMISSIONER: My impression from your evidence earlier was what made Dr Patel stand out, not that he had any problem with washing his hands but he wouldn't do anything about it when you suggested it to him on a number of occasions?-- You would think by speaking to him and putting gloves in his hand he would act to improve his practices.

MR MULLINS: It's the case, isn't it, that for the majority of medical practitioners a gentle reminder will get them back up to scratch?-- That's correct.

And they will then start washing their hands on a regular basis, particularly if in your presence?-- That's correct.

The problem with Dr Patel was his recalcitrant grudge to the matter and that he refused to go through the process, even with your encouragement?-- He did at that time, that's for sure.

Now, as time evolved and you observed this, did you regard it as a serious problem?-- I regarded it as a problem that - yeah, certainly a problem that I needed to be persistent with.

Did you regard it as serious for his patients?-- It's difficult - on what circumstances are we talking about? Again, if we're talking about where he is actually, for example, the Renal Unit situation, I regard that as being very serious, and less serious if he's just going along and listening to somebody's chest from patient to patient.

By the middle of 2003, by June/July, you had decided to conduct the inservice training?-- Mmm.

And you mentioned that your prime purpose of that was to target Dr Patel to ensure that he was encouraged to maintain standards?-----

COMMISSIONER: I don't think, Mr Mullins, it was quite put in those terms. That was a purpose.

WITNESS: It's not the only purpose because I do target catering staff and operational staff as well, but certainly because I had observed Dr Patel's practices just going into that position, I felt that this was something that I wanted to, you know, target straight away basically. I wanted to - and certainly I was concerned about his practices more than others at that time.

MR MULLINS: Now, from your own observations were you able to say one way or another whether Dr Patel's practices had improved?-- I did keep - I did ask staff on the ward, on the surgical ward, and it seemed that sometimes he was better than others on other occasions, and they certainly did take up the same practices that I did, in that they were prompting him and felt that they needed to prompt him, you know, when they could see that he wasn't doing as they felt he should.

By July 2003, you also had discovered that there was a second problem, which was the wound dehiscence?-- That's correct.

And that arose specifically to your knowledge in respect of Dr Patel's patients?-- Mostly that's correct.

Now, you had no record of the other eight or nine patients that you surveyed that you were presenting in the report of 7 July 2003?-- No.

Could I ask you to have a look at these records? This is the record of Ian Fleming?-- He may have been one of the patients, I don't know.

I will ask you just to flick through the first few pages to see if that assists your recollection at all and then the last page in particular?-- The last page?

May I ask you to put the last page on the screen, please? Now this appears to be a note of Dr Britten. Can you interpret the first line?-- I think it says, "Day 16, post-sigmoid colostomy for Diverticulitis."

And the second line?-- That he had - well, I'm assuming he is meaning he is Day 5 post-wound breakdown, and he has "dehiscence" written there, that's been crossed out, initialled and "infection".

We can see that's dated 4 June 2003 the note itself?-- Mmm.

That falls within the boundaries of your research. I think you said your research was between May and June 2003?-- Basically - yeah, my research was the gathering of - the people that were working in those areas brought along whatever they had. So presumably if this person was on the surgical ward, the Surgical Ward Nurse Unit Manager would have brought along this information.

Now, does that assist in jogging your memory-----?-- No.

-----as to whether Mr Fleming may have been one of the patients concerned?-- Not at all. Sorry.

Thank you?-- I don't know. Have you checked if his UR number is one on that list?

The UR number is not on the list?-- It's not. Sorry, I don't-----

COMMISSIONER: It's certainly not one of the four or five that were left on the list. I think Mr Mullins is asking whether he might be one of the seven or eight?-- I really can't say and perhaps the Nurse Unit Manager of the surgical ward, she may have that information in what she compiled.

MR MULLINS: Thank you.

COMMISSIONER: These are clinical notes relating to Mr Fleming?

MR MULLINS: That's correct.

COMMISSIONER: Do you wish to tender them?

MR MULLINS: Not at this point.

COMMISSIONER: Not at this point, all right. If you plan to tender them at some stage, it would seem to be sensible to have them go in now so the record makes it clear what the witness has been referring to.

MR MULLINS: That's not the entire clinical notes.

COMMISSIONER: Okay. I will leave it to you then.

MR MULLINS: Thank you, your Honour. I will take you to the meeting of 27 November 2003. It's referred to in paragraph 19 of your statement. It's the meeting you attended with Ms Pollock, Mr Keating and I think yourself?-- That's correct.

Were they the attendees at that meeting?-- Yes.

Now, in your evidence you suggest that there was a discussion about the problems in the Renal Unit, particularly those that had arisen in the preceding days?-- We - the purpose of this meeting was to discuss the situation where Dr Patel had come to clear the blocked lines.

Ms Pollock in her evidence suggests that you also raised some other staff complaints that had come to you from other areas regarding Dr Patel's practice. Can you recollect raising other issues with Dr Keating at that time about Dr Patel's practices, such as the two you identified, the washing of the hands?-- I can't be sure.

At that meeting on the 27th of November 2003-----

COMMISSIONER: I'm sorry, Mr Mullins. You wouldn't dispute Ms Pollock's recollection?-- No, I don't dispute it. That's very likely but I just don't recollect it myself. But it would fit into the nature of the conversation, so that would be very reasonable. I certainly wouldn't dispute that.

MR MULLINS: By 27 November 2003 your own experience had been a problem in April/May with washing Dr Patel's hands?-- That's correct, yeah.

Problem in June, wound dehiscence?-- That's correct.

And this problem in the Renal Unit in November 2003?-- That's correct.

It's reasonable to say all of those things would have been discussed at that meeting?-- I think that's reasonable to say.

Did Dr Keating tell you during the course of that meeting that there had been discussions or complaints or issues about Dr Patel's surgical practice raised by Toni Hoffman?-- No, I don't think so.

Did you have any knowledge whatsoever in that meeting that Toni Hoffman had also made complaints about Dr Patel's conduct?-- I certainly did have knowledge of that, but I don't believe that came out in that meeting. I do have knowledge of that though.

Did you have any knowledge independently at that meeting, that is not from what Dr Keating told you but from contact with Toni Hoffman, that there were other complaints coming through other channels in the hospital to Dr Keating about Dr Patel's conduct?-- Absolutely.

So you did know at that time?-- Yes, I did.

COMMISSIONER: Did you know that those complaints had got as far as Dr Keating?-- I believed that they did.

Well, is that because Toni Hoffman or someone else in the nursing staff told you?-- No, Toni - Toni is a friend of mine and I was aware that she had and Dr Joyner had gone, so we often speak so I certainly was quite well aware.

So any information you had about that came from Toni Hoffman and not from Dr Keating?-- That's correct.

MR MULLINS: Did Dr Keating advise you in that meeting that he had had a lengthy conversation with Ian Fleming about problems or a complaint from Ian Flemming about wound dehiscence and infections in a wound?-- No, not at all.

Did he give you any indication during the course of that meeting that there had been complaints from patients direct to him about problems associated with surgery with Dr Patel?-- No, that wasn't part of the conversation at all.

Was there any method at the time for a person in your position to determine whether other complaints had been made in the hospital on any associated issues?-- No. You just found out from informal - through informal channels. If you happened to be talking to the person, and again we're not always in the habit of sharing that sort of information, we were careful with who you do speak to and it's probably through confidentiality matters, and that probably in fact could have been part of - so while you are aware of certain things, I don't know that I was aware of all the things that did happen and Toni would have been aware of other things that I didn't know.

Is this font of knowledge of all of those matters, that is the ultimate source, likely to have been Dr Keating?-- I think that's likely.

And is it the case that unless he shared it with you or that you found out through hearsay elsewhere you would have no knowledge of it?-- Well, unless somebody else did share it, that's correct.

Nothing further, thank you.

COMMISSIONER: Thank you, Mr Mullins. Mr Devlin, do you have any questions?

CROSS-EXAMINATION:

MR DEVLIN: Just a few, Commissioner.

COMMISSIONER: Thank you.

MR DEVLIN: Ralph Devlin is my name. I appear for the Medical Board of Queensland. Just a couple of aspects to clarify with you. If you'd like to go to page - sorry, paragraph 12 of your statement which deals with the reduction of the 13 suspected instances of wound dehiscence down to, I think, four, although your statement says five. We have the benefit of GA4?-- The reason being that one patient had two wound dehiscence.

Good. Thanks for that clarification. Now, you said in your

evidence earlier that Dr Patel gave some explanations which seemed reasonable to you at the time. Do you have any evidence now which would cause you to doubt the explanations which led to you - led you to remove the eight cases?-- No, only the evidence that we are all here for at the moment.

So it's more looking backwards?-- At the time I felt they were seemingly reasonable explanations to me, but bearing in mind I don't have that expertise, that is not my knowledge base.

Yes. So, you can't be specific enough now due to the lapse of time, I take it, to say, well, in retrospect a particular patient or the explanation given to me in respect of a particular patient I would no longer be prepared to accept or I will start to doubt?-- To give you the situation, you are looking at a report, as you can see, that's got four or so patients still there in that report. There's no names there. There's very limited information. I have got some details, remarks about the dehiscence part of it.

Yes?-- So Dr Patel came in, didn't bring any charts with him and just basically stood over me and went, "Well, this", and I don't even know how he can tell from the UR number who he was talking about anyway if he stopped to think about it, but I presumed that he had knowledge of dehiscence and he was identifying the patient by what I - the comments I'd written about those dehiscence, but he basically went through, well, this patient's this, this patient's that, whatever. You know, I do not remember all the details.

Although at the time the terms of your response e-mail on the 8th of July, Exhibit 60, you seem to be quite clear that you were pleased to reduce the number, I think, was the word you use?-- I was pleased there were seemingly reasonable explanations that was said to me at that time.

Yes?-- So I was - I was pleased that he could come up and say, bearing in mind Dr Patel had only just be there a very short period of time.

Yes?-- He explained to me on more than one occasion how experienced he was.

Yes?-- So, at that stage I thought that - you know, I basically trusted - felt that I needed to trust him. But it's not to say, though, that even though I did say that they were simply reasonable explanations that I still felt comfortable about that.

Right. Although the terms of your e-mail seems to be an unreserved preparedness to reduce the number?-- If we were to believe Dr Patel, that's exactly right.

Very well?-- From that perspective but bearing in mind what I think is important is that I'm a clinical nurse, clinical nurse consultant, infection consultant. It is not my role, nor would anyone think it was my role to review a surgeon's

surgical expertise.

That's understood?-- From my perspective I wrote that e-mail from my perspective with how I felt at the time. But that still does not take away from the fact that I could feel uncomfortable that I was put that this situation, and as I-----

Which leads me to the point. Your point seems to be at the bottom of paragraph 13 of your statement that in the best of worlds you shouldn't have been put in that position. In the best of worlds, Dr Patel, you having queried 13 patients, ought to have been accountable to somebody for the clinical aspects of his care. Is that what you say?-- That's correct.

That you shouldn't have - just have been up to you to query him and then really be in the position of having to accept in eight cases-----?-- Yes.

-----his explanation?-- I agree.

That's really your point, isn't it?-- Yes, that's my point.

Thank you. Now, going to the renal unit incident, I just want to clarify that. There was the advice from Dr Keating that he ought to be supplied statistical data to support the concerns about Dr Patel's aseptic technique. Now, can I just get this clear. Was data from November '03 collected and supplied in some form?-- You will need - the renal unit staff can - are the people that actually provided that data subsequently, so they would be the best people to answer that, but it is my understanding that that data that Dr Keating wanted was obtained and given to him and - which he received later in February.

In respect of the particular renal unit incident, you speak of Dr Keating telling you that he'd received Dr Patel's version of the incident?-- That's correct.

You don't now have any recollection of what that version was?-- I don't know that I ever knew other than it differed from what the nurses said.

Right. And you again were moved by terms of your e-mail GA7 to say that the staff you then spoke to were pleased at least at the fact that Keating had spoken to Patel about it?-- Absolutely.

That was your state of mind at the time, you weren't glossing that at all?-- No, no, that was - they - I mean, I have also added in here too so that Dr Keating had an awareness that last line that was, "Just for your information because I think it should be noted Dr Patel visited the unit today and said that he had - that he has had enough of renal and he wasn't going to do it any more."

Yes?-- So I wanted Dr Keating to be aware of that, that Dr Patel was making these statements.

Yes?-- But I was pleased that Dr Keating had talked to Dr Patel.

Thank you. Can I just track through now finally a couple of your documents for what they tell us about - what they are reporting to the meetings and so on?-- Mmm-hmm.

On the 22nd of September meeting of Infection Control Committee, which is your Exhibit 8, so 22nd of September '03, your number 8?-- Mmm-hmm.

You are recorded as being present and under the heading of "Reports", the third dot point says, "Nought per cent infection rate for Bundaberg surgical site surveillance for July."?-- Yep. Yes.

So, at that point statistically there was no statistic for an infection rate, it was at zero per cent?-- That's correct, and that-----

But at this point you have decided on including new clinical indicators to cross-check your concerns. Is that a fair way to put it?-- I mean, that's basically coming down. When I looked at the clinical indicators there was very few or - for general surgery.

Right. So, it's a combination of things, but it really adds up to a paucity of statistical information?-- I wanted to make sure if there was anything - if I could capture more data, I may be able to get some - I suppose it's intuitive thing.

But officially the infection rate was zero per cent. Is that what we read from that entry?-- Well, that's correct.

Thank you. If we move over then to another part of the same document, next page, under the heading CHRISP, C-H-R-I-S-P for the record, the two dot points in the discussion part is, "Data from report presented due to small number of cases", that's your point about lack of statistical data?-- Mmm-hmm.

"Very difficult drawing a conclusion. However, our rates fall within acceptable ranges."?-- Mmm-hmm.

And you had presented that to the leadership and management group?-- That's correct.

So that's the official position as at September of '03?-- That - however, that would - what we are talking about there with CHRISP wouldn't have been talking about the September '03 data. That's collected over a six month period.

So we are talking-----?-- That was where the report came back to me and said we are talking about - that - the collection period before that time.

You know what collection period that would have been?-- Well, basically the collection periods go from October to April and

then so - and then the other six months. But, say, for example, the April - the end of April figures now, I still haven't been asked to submit those as yet, but normally you would do that by June.

Yes. So this being September, is it possible that it's for the period up to April '03 that that's being discussed?-- That is September - yeah, that's correct.

Because the October period hasn't finished?-- That's correct.

Thank you. Next in relation to the 9th of December 2003 under "Reports" dot point, "Gale discussed new approach to obtaining new information on post-discharge surgical site surveillance. Dr Patel has agreed to trial a process where the medical officers seeing the patients at follow-up visits will complete an infection control form." Was that the fact? Did Dr Patel agree with you to trial the new documents?-- Yes.

And did that in fact happen?-- I don't-----

Unable to say?-- Which bit? What did - what happened? He agreed to trial it.

Yes?-- That - but in agreeing to do that he was also agreeing to inform his staff of that.

Yes?-- So I don't know if that happened or not, but what I can say is I got very few back.

Thank you. Then we skip to 24th of August 2004. That's not necessary. The report to leadership and management, August 2004, under the heading "Infection Control" which is your Exhibit 11. Here there's reference to the CHRISP report?-- Mmm-hmm.

"A reasonable comparison for Bundaberg against 23 Queensland Health facilities. Must remember data set is small and the data should only be used as a guide." So, again, the official document at least shows a favourable comparison on limited data?-- That's exactly right.

Is that data that you collected or others that we need to hear from eventually?-- No, only what I collect.

Thank you. Now, there is just one other matter. In relation to the ethics session that you had, document 61 I think it was, Exhibit 61, showed reference to my client, the Medical Board of Queensland. I am just interested in your own sense of what was available as a complaint mechanism to you as a senior - relatively senior nurse in the structure. Was it ever clearly in your mind that other forms of complaint outside the system were an option or was that never clear in your mind?-- I never felt there - that the complaints needed to stay within Queensland Health, that there was options to go outside the system.

Say that again, you never-----?-- I felt the only option we

had to was stay within Queensland Health, that we were advised not to go out of Queensland Health.

Can you expand on that? Who advised you?-- That was my understanding of what was - what was said that day.

Did you notice on Exhibit 61, though, the one that you found, that there was reference to the Medical Board and the Health Rights Commission and so on? Do you recall any of that - anything being canvassed about those organisations?-- I believe that - all I can say is that it is a long time ago now.

Yes?-- And-----

If you don't recall, I don't want you to guess?-- No, no. It's just more a case - I just remember particularly the comment - that what related to issues that I felt at the time, and that was that the warning to Toni that she needs to be careful.

We now know that representatives of the Queensland Nursing Union raised matters of concern with the Medical Board of Queensland at some point. Would it be fair to say that one recourse that you would have always been aware of was to go to your union with any serious concerns?-- Well-----

Or again, or again, was that - did you yourself - I don't want you to answer for anyone else - but was it your own sense of it but that even to go to your union was not really an option, and I don't want to put words to your mouth, I am interested in a fair answer?-- I don't think I thought about that-----

Okay?-- -----as an option.

Thank you. So to summarise it then, in terms of pursuing a complaint, your own mindset, and I'm not being critical by the way I put the question, your own mindset was to go - work up through the system as best you could?-- That's correct, at a local level.

Thank you very much. Thank you.

COMMISSIONER: Mr Devlin, before you sit down, when Mr Devlin says your own mindset, your own mindset as a result of what was said at that forum or your own mindset before you went in to the meeting?-- I think that did concern me after that forum, that I did - I think that - I don't think that I realised that there was - it seemed to me that really limited the options that you could do, and I don't think that I'd really had a reason to think about that in the past, that I had issue to have thought about that in the past. So after going to that forum, I certainly did come away thinking that there's really nowhere to go.

Does that help, Mr Devlin?

MR DEVLIN: Yes, that seems to clarify it.

COMMISSIONER: Thank you. Mr Boddice?

MR BODDICE: Please, sir, I have mentioned to Mr Diehm, Mr Ashton and Mr Morrison that - as to whether I went last, we went last simply because of my shortcut cross-examination, a bit like Dr Malloy.

COMMISSIONER: Yes, certainly. Certainly. Well, is there any preference between the other three gentlemen as to who goes first? Mr Morrison, I am looking forward to hearing from you.

CROSS-EXAMINATION:

MR MORRISON: It would never be my intention to deny, Mr Commissioner, you any pleasure.

Ms Aylmer, I am Phil Morrison and I am acting for Linda Mulligan. Just so you know who I am. Let me talk about a few things with you. You said a couple of times in your evidence earlier today, and I made something of a note of them, that - the precise text probably doesn't matter - but a couple of times you have said things like for documents that nurses were supposed to fill in or medical staff, I think was the actual term in your statement, you didn't get the things that you thought you should be getting?-- Probably again Infection Notification Forms.

In's one instance I-----

MR ANDREW: Excuse me, Mr Commissioner. The tête-à-tête between Mr Morrison and the witness isn't audible in this particular forum. I wonder if Mr Morrison would be kind enough to raise his voice?

MR MORRISON: No disrespect to you, I am going down there. You mentioned the Incident Report Forms - the Infection Report Forms. You were expecting to receive that sort of documentation and as it happens you didn't?-- That's one of the ways that I find out about infections.

Mmm. There were forms that, I think, you are aware should have been filled in from time to time when an incident occurred called an Incident Report Form?-- Mmm-hmm.

You know about that system?-- Yes.

It's a system that's been in place for some time and when a particular incident however defined happens that warrants such a report, it's the obligation of whoever's involved in that or whoever sees it to fill out such a form. Could you respond verbally, please?-- Yes, sir.

Am I right in thinking from what you say that there was a degree of laxity in that area as well?-- In the incident monitoring?

Mmm?-- I believe that could be correct.

Yes. And I think you said this wasn't just a Bundaberg problem, if you understand, this is sort of across the State?-- In regard to the Infection Control Notification Forms, filling those things out, I - yeah.

That's certainly your area that you know most about?-- Yeah. I think that's a - would be a common problem.

Your position as the lady in charge of infections is what might be described as a manager position, middle management; is that right?-- Yes.

Okay. You're, as it were, on the level of a NUM or maybe higher, I'm not sure?-- It is similar - a Clinical Nurse Consultant and Nurse Unit Manager are a similar level. It's just depending on looking at your actual role and responsibilities.

Right. And in that position you would be aware, and the Infection Report Forms are a good example, that the ability to do your job is limited by what you know?-- That's quite correct.

And your training as a nurse and your experience, considerable experience as a nurse would have also - would also tell you of the great need for accuracy in your profession. Would that be fair?-- Well, we do strive for it, yes.

Perhaps no-one reaches perfection?-- No.

But it is the goal all must strive for because the ability to do that - perform your job depends on it. Is that fair?-- Correct, that's fair.

Particularly in the case as you know where you have to react to something else, something that's happened to someone else, to another nurse, to a doctor, to a patient, whatever, and you weren't there yourself to see it, that it's particularly critical then to have accurate information, isn't it?-- That's correct.

And that's why - I think I am right in saying that's why in your position you go and speak to staff to get first-hand the information, not only for your own information but because you then have to forward it on?-- That's right.

And I remember someone telling me or giving me - to do with computers, that's garbage in, garbage out. That's applicable here, with no disrespect. If you get told less than you should or information that's not as accurate as it could be, your ability on the job's lessoned. That's fair?-- That's

fair.

The whole purpose - I'm not saying it's achieved its purpose - but the purpose behind the sort of systems you have in hospital are designed to achieve if they can the recording of accurate information so that accurate information can be passed. Fair?-- Can't argue with that.

No. The very purpose you develop that form was to get more accurate and more detailed information than you had been getting to that point?-- That's right.

Thank you. Now, you mentioned in a different way, I think, during your evidence this morning, I have down here, that managers rely on data. I think your phrase you used?-- Yes.

And I think you mentioned that Dr Keating - it was reasonable for him to request statistics, and we're talking about the things that I have just been mentioning to you, the need for accurate information so that you can discharge your functions?-- That is true, but one has to realise with - that when it comes to some data you can't necessarily rely on it. You have to - it has to be acknowledged.

Yes?-- It can only be used as a guideline.

Quite. I am not getting into just how one treats it, I am talking about the most basic need for you as a manager to fulfil a very important role. One of the basic needs at least is to have accurate information given to you or found out by way of process so you you don't then go off on a tangent, that you are making responsible decisions based on the best information you can get. That's a fair comment?-- That's fair.

And that really applies to all the management level, to all the NUMs in all their diversity and one doesn't want to say that the NUM in surgery is more important than the NUM in somewhere else?-- Mmm-hmm.

Everyone is affected the same way, aren't they?-- That's correct.

Okay. Let me just ask about this. There was a reporting hierarchy in the hospital, wasn't there, in the sense that all of you had line managers that you had to report to?-- That's correct.

And that's a system that's been in place for some time. It might change from time to time but the idea of having direct reports to people is not new?-- No.

And your direct report was?-- To Linda Mulligan.

Linda Mulligan?-- She wasn't - although she is my direct reporting line - but I certainly do - because I deal with all the disciplines of staff, that if I was dealing with something that related to operational staff I would talk to the director

of that area.

Quite. I'm not saying that you confine who you speak to or report to, but in an organisational sense your direct line-----?-- Professionally my - professionally my line would be to my Director of Nursing.

Yes. That's the case with all the NUMs, isn't it?-- I believe that would probably be right.

Yes. And then from her to the District Manager; is that right?-- I would say - yeah.

Okay. And I'm not in the worried about human resources. For those with whom you work, that is to say the nurses within either the infections area or those nurses working in the areas that you come in contact with, probably principally surgery, they report to their NUMs, those NUMs report to you and so on?-- They are - the NUMs of those areas don't report through to me.

As a matter of practice?-- Relating to infection control, yes.

Yes. But as you pointed out I think earlier on, one is best to stick within the area that one is - works for?-- But at the same time, though, it's not that if there was a nurse on the ward came across an infection they would wait until their NUM came to work.

No?-- They would report straight to me.

Quite?-- Yes.

Absolutely. You'd expect them to, wouldn't you?-- Correct.

Now, with the reporting hierarchy on the one hand, there was within the hospital, and no doubt it's still the case, a network of committees on which various people sat?-- That's correct.

You were on some?-- That's correct.

I don't know that I can necessarily bring them all to mind, but I think I can get a couple. For instance, let me - I will start with the ones I do know and you can tell me if I'm wrong. There's the leadership and management committee?-- No. I'm not on that.

No, no, I'm not suggesting you are on it. I am just going by way of hierarchy?-- Yes.

On the leadership and management committee are all the directors, including the District Director of Nursing?-- That's correct.

Right.

COMMISSIONER: Sorry, when say all the directors, that doesn't include Directors of Surgery or Director-----?-- Sorry, that's correct. Yes. It includes the executive members, leadership and management, the six executive members.

Yes?-- Sorry.

MR MORRISON: So far as you know, they met and probably still meet every Monday?-- I believe that they do.

So it's a weekly meeting?-- Yes.

Under them was a subcommittee established called Safe Practice and Environment Committee?-- Basically the other committees come under as part of being the EqUIP functions, so the Safe Practice Environment is EqUIP functions and that is the committee and I am on that committee.

And you then reported from that committee to the leadership and management committee?-- The director of corporate services is a chair of the Safe Practice of Environment, so he would report-----

Yes?-- Safe Practice and Environment back to the executive.

And if there was a matter that you would provide information on or a report on and so therefore it was your information, that one would be put up in the Leadership and Management Committee no doubt?-- Yes.

And there was also an Infection Control Subcommittee?-- It's not a subcommittee, a committee, yes.

I call it a subcommittee. That's the way I view them in my head?-- Yes.

But you are probably right. And it reported to the Safe Practice and Environment Committee?-- That was one area we reported to, also to the Leadership and Management Committee.

Yes. And on the Infection Control Committee - sorry, the Acting Director of Nursing was on that committee?-- No, the Assistant Director of Nursing-----

Assistant. Sorry, I said "acting". I meant "assistant". Also the Director of Corporate Services?-- Yes.

And you were on some other committees, I think, were you not, the Productive Review Committee?-- Product Review, yes.

Right. And there were a number of forums that were held from time to time and one of those was that one that's ASPIC?-- Mmm-hmm.

Which, I think, is actually a Clinical Services Forum?-- That's correct.

And so far as you understand it, the forum, an executive member sat on each of the forums?-- I don't know that that is the case with the other forums, but it was the case with ASPIC.

Okay. And I think on ASPIC Nurse Hoffman was on that one?-- ASPIC basically stood for Anaesthetic Surgical - Infection - ICU, so - but, yeah.

Okay. And also on that one was the NUM surgical?-- Yes.

Jenkins, the NUM theatre?-- Yes.

Which was during the times Levings or Doherty-----?-- And Jenny White before that.

And Jenny White. Mr Blenkin and Dr Keating?-- Also the preadmission, Margy Mears.

There may have been more. But certainly quite a number of NUMs in areas such as the surgical, theatre, ICU and infection control?-- The surgical stream.

In addition to those - those forums met, I think, monthly?-- Yes.

And then in addition to those there were ward level nursing meetings, there was, as I understand it - and you can correct me if I am wrong - and it was really up to the NUM to organise those?-- In regard to the ward level ones I had no - unless I was asked to come along and speak at a meeting, that was purely their area, but there were also the levels - there were two other professional sort of meetings relating to nurses as well. One had been called Nurses Services, Nurses Heads of Department, and the other one was a professional one.

I was coming to the professional one?-- Yes.

That was a monthly meeting?-- Yes.

All nursing heads were on that, Levels 2, 3 through to 5?-- Yes.

And the District Director of Nursing chaired it?-- That's correct.

Then in addition to that there were Level 3, 4, 5 and 6 nurse meetings. They occurred monthly?-- Yes.

Chaired by the District Director of Nursing?-- That's correct.

All NUMs were on that one?-- Yes.

And it would be right to describe that as pretty much an interactive sort of meeting, that one, the three, four, five and six?-- I think probably mostly all the meetings were fairly interactive.

Okay. Good. You were on the three, four, five and six nurses meeting - you were part of that?-- I attended when I could.

The incident reporting forms and processes, they were in place from some years back, weren't they, in one form or another?-- They have changed form.

And there were courses that were run called HEAPS courses, Human Error and Patient Safety, H-E-A-P-S?-- Yes.

They were run by Dr Keating, I think, and - I forget the position - Kirby?-- Yeah, I forget that position as well. I'd actually been to a two day HEAPS course as well that was run by Dr Peter Lee, I think his name is, which is actually the one that Dr Keating attended as well.

On the incident reporting forms, my general understanding of them is - you will know this much better than me, obviously - that it be done within 24 hours of an incident and given to the immediate supervisor?-- Staff were asked to complete them as soon as possible, obviously for their recollection and those sorts of things.

That's another aspect of the business about getting truly accurate information?-- Yep.

And the supervisor themselves would have to complete a section on that form and then the form would go to DQDSU, the quality people?-- I believe that's where the forms go to, yes.

DQDSU would then decide which appropriate area that was to be referred to?-- I believe that's the process.

Now, none of that is a blow-in process from the last couple of years. That general process has been in place for some time?-- I think that aspect of it hasn't changed that much, although I think the Assistant Director of Nursing in the past has had - did actually have something to do with the incident forms, but to be honest, more recently - but I think that changed, but again I'm not - I wouldn't be the best person to ask.

No.

D COMMISSIONER VIDER: Could I just ask a clarifying question/

MR MORRISON: Of course.

D COMMISSIONER VIDER: You have replied by saying you believe that to be the case in relationship to these various meetings. Meetings very often have resolutions and issues that arise out of them that need action. What was the process of feedback coming back to members of the committee that you could then take back to your staff that would be the outcomes of all these meetings that you went to?-- Basically on the minutes there was always a section where you were talking about what your plan was and who was going to do it and what timeframe they had to do it. So then basically, in general, that would be that they had to report back to the next meeting. So from then you would then - the Nurse Unit Managers that had staff would then feed back to their staff.

Was that generally followed through?-- I imagine so, but these minutes are also all posted on a common drive on the computer so that anybody could access those.

MR MORRISON: There's a deal of information flow within the hospital via the commuter and the intranet system, aren't there?-- Yes.

You yourself utilise the email system quite substantially, I think, for communication in a variety of ways. We've seen with Dr Keating-----?-- It's an easier format when you can't necessarily get to talk to somebody on the phone.

Quite. Just apropos that - this applies no doubt to yourself, it applies no doubt to other people as well - there are occasions within the practice of a hospital where you simply can't be available to speak to someone because you might be in the middle of something quite important and can't stop, to do

with a patient, and notwithstanding that someone wants to talk to you on the phone, you're just really not available to do it. That's fair, isn't it?-- That happens from time to time, yes.

And that's part of the reason, I think, you and others have used - find the intranet system pretty good, because you can send the email and everyone knows to check it and you can get a fairly prompt response?-- Emails are convenient for that, but I think - I think there's an issue with emails that sometimes it's much easier to say something than what it is to put it in writing.

Sometimes the face-to-face really can't be replaced, can it?-- That's true.

That applies to phones as well. It's so easy to be talking at cross-purposes on a phone and perhaps not get your point across because you're not actually there making that face-to-face contact. I understand that, but in terms of dissemination of information from you to others and others to you, that intranet system is used, and has been used pretty heavily?-- That's right.

I just want to ask another thing about that. I'll go to them if I need to, but I gather you probably will agree with me. As between you and Linda Mulligan, there's quite a large degree of email correspondence, wasn't there?-- I think so, a reasonable amount.

One of the emails you sent - just while it's in my head - is GA7, and that was sent to Beryl Callanan?-- Mmm hmm.

Who is Beryl Callanan?-- Beryl was actually - when Glennis Goodman, the longstanding Director of Nursing was here, she resigned, I think in September '03, and Beryl Callanan was from the PA Hospital and she was an Acting Director of Nursing, one of those at the PA - or a Nursing Director, and she actually came to Bundaberg for - I'm not sure whether it was eight weeks or a little bit less than that.

As a DON?-- As the Acting Director of Nursing.

When you say "PA" you mean Brisbane?-- PA Hospital, Brisbane, yes, Princess Alexandra.

That's all right. I'll move on to something else. Just apropos the business about filling out forms, one of the comments that I noted that you said - and I think you've agreed with me about that - in respect of those infection control forms, that there had always been a fairly poor reporting level by the staff across the state. Now, what I want to know is - and maybe the Commissioners do too - that reflects, it seems to me, can I put it to you, a little resistance to change?-- Actually I think it reflects on peoples workloads.

Right. Okay?-- I think people are very busy, and I think that part of that is the workload issue, that it comes back to - an example is the doctor said, "I'm too busy to fill out this form", so I try to simplify it. I think it's a case of when you're having three nurses look after a patient in a 24-hour period, you come along and you're really busy and you know that there's - this should be notified, I guess in a way you're kind of hoping, I suppose, that somebody else has done that, or that it leaves it to the Nurse Unit Manager to do or something like that.

It can't just be workload though, because once the work eases off a little bit during the day-----?-- I don't see it's a change thing for the fact that the process has been in place for some time. I think it's staff feeling that they've got the time to do that sort of paperwork.

It may be a combination-----?-- And they want to focus on clinical-----

It may be a combination of things, workload that eventually becomes a bit of habit?-- Bit of a habit, sorry?

After you haven't done it for a while you're not in the way of thinking that you should do it, so it becomes easy not to?-- I guess you could say the same about hand washing.

Well, precisely. Precisely my point. Those people who have been doing it for so long, they just become a little too casual about it. Fair?-- I'm not really sure why people don't fill out the forms, so - but I suppose that's a fair comment, but-----

Okay. Now, one thing you just mentioned a minute ago - and I just want to make sure I understand it, when it came to filling out that infection form where people said it was too much writing, did I understand you to say that that was really more the doctors than the nurses?-- That form that I was relating to was a form that was to go to the surgical review clinic. That was the clinics people came back to a number of weeks after their surgery and they were reviewed again by the surgeon. So it was at that time where I was hoping to find out if they'd had any infections post surgery. That was a form purely for medical staff to fill out.

When you say "medical staff", you mean doctors?-- Yes.

COMMISSIONER: You wouldn't normally have a patient reviewed by a nurse at that clinical review?-- No.

MR MORRISON: That form, the people who were saying it was too time-consuming to fill out were the doctors rather than the nurses?-- That's right, it was the doctors.

It was in response to them that you then modified the form in a way that would be easy for them?-- That's correct.

Let me just ask you this: in relation to your affidavit - I was interested in a couple of things. One was the meeting - sorry, the surgical site surveillance data that was mentioned in paragraph 16, and you were saying that you presented the reports to various committees, you were careful to point out that the data couldn't be relied on, and that's largely a product of it being from a skewed base or a-----?-- Basically it's because-----

I don't need all the reasons again. There was some reason for it anyway, wasn't there?-- That's right.

You felt it shouldn't be relied on?-- There's reasons why people should not take that as being accurate.

That's a good indication of a system that's not capturing the sort of information you want, or as accurately as you want, isn't it?-- Yes.

I think I'm right in saying-----?-- There's many aspects to why that's the case though.

Right?-- Not just the staff not filling out the forms. There's many other aspects.

I'm not suggesting it's that. It's just simply one of the indicators there which points out that the systems need to capture information accurately and, for that purpose, quickly and carefully. Isn't that right?-- That's correct.

Okay. This particular problem, I think I'm right in saying, was one that wasn't specifically raised with Linda Mulligan, this business about this statistical data?-- Whenever - at the time it - I think it was towards the end of last year that - with the Leadership and Management Meetings that we just gave a report and we didn't have to actually present-----

Separately raise them?-- No, we didn't actually have to attend. They would call us if they needed us, but up until that time of, I think, October last year, we actually attended and presented these reports ourselves, and in that time up until the point that I felt that everybody was well aware that - I can't - to me that was the most important fact, that people had to realise the capturing the post-discharge data was very difficult, and that I wanted to make sure that as managers they were aware-----

They understood that point?-- They understood that point.

All right. That's what you were making clear to them, "This particular bit of information, treat with caution"?-- Yes.

Okay. You mention - I just want to get one thing right, if I may. When you went to - in paragraph 21 you gave that email that I referred to you earlier, GA7, to Callanan, was there some follow-up by Callanan?-- What date was that?

Sorry, it's on 3 December 2003 and then you sent an email - paragraph 21, this is about the hand washing and so forth - the renal stuff?-- Actually, Miss Callanan left very soon after that, as I recollect.

So there wasn't really any opportunity for her to follow it up?-- No.

She was replaced by?-- Patrick Martin.

Did he pick up the barrel and run with it? Perhaps not?-- No.

No? I see. He was-----?-- Well-----

-----Assistant Director of Nursing?-- He was the Acting Director of Nursing.

Acting Director of Nursing. There's no follow-up from him either?-- If we're talking about - getting back to what we're talking about, we're talking about the renal issue here. There was actually follow-up, because that was where he then spoke to the Renal Unit people in the February.

Right. In the February? Took a couple of months?-- I'm not - they will be able to tell you the process there, I'm sure.

Okay.

COMMISSIONER: Mr Morrison, were you down to your last couple of questions? We normally have a five minute comfort stop-----

MR MORRISON: I'm not down to the last couple.

COMMISSIONER: All right. We'll just break for five minutes.

THE COMMISSION ADJOURNED AT 3.14 P.M.

THE COMMISSION RESUMED AT 3.22 P.M.

GAIL MARGARET AYLMER, CONTINUING CROSS-EXAMINATION:

COMMISSIONER: Ms Aylmer, we've had a request from the press. They want to take some photographs from behind you, just of the room. You won't be in the picture, I'm assured?-- Actually, I have consented. That's fine. It was more being televised that was the issue.

That's fine. Whatever you feel comfortable about anyway. Thank you, Mr Morrison.

MR MORRISON: Thank you, Mr Commissioner. Nurse Aylmer, paragraph 23 of your statement, I just wanted to touch on something there fairly briefly. By the end of 2003 you had formed the view that hospital acquired infections were occurring, but not being reported through the formal channels. This is an example of the Infection Report Forms not being properly filled in. This is a comment not restricted to doctors, is it?-- No.

In one sense it reveals what otherwise might be called a system breakdown. There was a system there that wasn't being followed?-- Basically what I'm saying there is that I only had - I'd formed the view that they were occurring, because I was hearing about haematomas and complications that would normally be linked to infection, so I didn't know that that was the case, but I was - I'd formed a view that was very possible that could be happening, from those complications.

In fact you then went on to have a look at why that was so?-- I worked towards trying to look at that, yes.

Could I ask you something else. Paragraph 30, on this topic of filling in forms again - this is Dr Patel - you've got a second-hand account from Janice Williams who related something which she said Dr Patel had done. So what you got was her account or opinion of what he was doing in response to her?-- She was - would have been asking him to fill out the forms which were forms that he had agreed to support, and that was his reaction.

As related to you by her?-- As related to me by her.

Right. Okay. Well, it seems at that point that data was being lost. What happened was a result of that occurrence. Did you follow that up in some way? Here was Dr Patel not only not following the agreed course, but laughing - at least laughing at her, or laughing at the process, I'm not sure which?-- Other than what I've said we've done with where the difficulties were with getting people to understand the importance of doing surveillance, but-----

Well, I was just wondering whether that particular incident was followed up by yourself, for instance?-- No.

Let me ask something else. You - on the topic of the wearing of theatre attire, at paragraph 32 you say you sent an email to Carter and Patel, and Keating and Mulligan also got copies where you sought their comments. Do you see that?-- Mmm hmm.

You can look at GA14 if you wish to. I don't know that it helps you much, but it might. The comments you got from Linda Mulligan, can I suggest, were along the lines that she'd said to you a number of times - not about this particular issue, but generally, that is to follow these things through you really have to do it in a professional manner, get the

facts-----?-- I never had any comments from Linda Mulligan about this at all.

Didn't you?-- No.

Can I suggest that she suggested that you were, in a professional manner, to get the facts together and make sure that you've talked to Keating and got him on side in order to take the next step?-- No.

It seems in paragraph 33 you were distrusting of Dr Keating. You went and checked up on what he'd said?-- Actually, it wasn't I was checking up on Dr Keating. Dr Keating said to me that Dr Patel had told him that he had talked to Gail Doherty.

And you got information-----?-- I found - I was speaking to Gail, and I think I may have said to Dr Keating at the time, "I'm surprised, because I've not long talked to Gail", and it wasn't so much I was checking up on Dr Keating at all. It was - the fact was that I felt that Dr Patel had misled Dr Keating and I wanted Dr Keating to be aware of that, that Gail - Dr Patel had not in fact talked to Gail as he had told Dr Keating.

You're fairly confident that's what you conveyed to Dr Keating?-- I think in the email I sent to everybody after the conversation I'd had with Dr Keating that he may have got that out - that point from that email.

Okay. Let's go forward one - a couple of steps to the email, which I think is GA18 - yes, it is. This is the one where you wanted to send an email to Dr Patel himself about these further incidences of the theatre attire issue, and this was going to be a particular step because you were now about to send an email critical of the doctor to the doctor himself. That's essentially the nub of it, isn't it?-- Basically in - all the emails that I sent were basically to the Director of Surgery and to the Director of Anaesthetics, and at all times I knew that Dr Patel was one of the perpetrators of this, but I chose not to ever mention that in any of the emails and I made it a more general type of email. When it came to this email was in response - we'd gone a certain period of time not getting any further, and I'm now hearing that Dr Patel is going around and making these comments basically saying that, "This is a load of rubbish" and undermining what I'd been trying to say. So this email was a response to that.

Yep. Okay. But you felt concerned enough about it to go and seek out Linda Mulligan's assistance?-- I did, absolutely. I did ring her.

Which you got?-- Sorry?

Which you got from her. She helped you to draft part of it?-- I'd done virtually the basis of the whole email and she just added a line that was basically the line about, "I recognise that I've not heard this first-hand", and about the perceptions I might be perceiving. That was to do with that line.

And she suggested you put in a line to that effect because - urging you to take more or less - perhaps a less confrontational draft - less confrontational wording?-- I don't know if it was less confrontational, but it was from the point of view of the fact that it was hearsay and that we were talking about the perceptions that other people - from that way.

So, she suggested that extra line be put in and the E-mail sent in that form?-- She was happy once I put that in to send it, yes.

Now, let me just ask you one or two other things: in paragraph 42, you deal with the heading "Executive Management", and you refer to the concerns that you think nursing and medical staff had about Dr Patel, about the feeling that they had that there was no point pursuing reporting him because he was so well supported by the Executive. You see that paragraph there?-- Mmm.

Now, there was, rightly or wrongly - let's not debate right or wrong at the moment - a perception that - it seems - that the nursing services didn't have the best of reputations, according to this - people were referring doctors' accounts to the nurses?-- Sorry, I don't understand.

It seems from what you write there Patel was well supported; nobody would go and bother complaining because he would continue to be well supported; the nurses wouldn't be listened to?-- I'm not saying that only nurses were complaining, there was other medical staff as well.

I mean, concentrating on the nurses for the moment, it seems to follow from that that at least as a matter of perception, the nursing services didn't have the best reputation; that they might have been seen at complainers, and so forth?-----

COMMISSIONER: By the particular individual we are talking about here?

MR MORRISON: Or a number of individuals. That's really what underlines this. I think you referred to this earlier today. You were saying that nurses were seen as - what was the word you used - either disruptive - or something like that?-- I wouldn't say that was particularly relating to this situation. It wasn't particularly - in general - a general - that-----

No, it was a perception?-- Prior to this.

Some people had that perception, though, it seems; is that fair?-- That's probably - just - I would like to clear that perception again?

It seems from what you said-----

MR ANDREWS: Mr Commissioner, it would be very helpful if Mr Morrison were to identify the people - or perhaps even the

group who held the perception about the nurses.

COMMISSIONER: I'm not going to interrupt him. I think Mr Morrison is a very experienced counsel and I will let him ask his questions this way.

MR MORRISON: Can I ask you to direct your attention to 42. Indeed, you relate your belief about certain things, about the concerns of medical and nursing staff and what they felt about whether there was any point in pursuing the reporting matters and the support of Patel by the Executive. That's what I'm directing your attention to. What I'm saying is it seems the underlying text of that seems to be that some people had a perception, rightly or wrongly, that nurses were, you know, wrong complainers; they were sort of unjustified complainers or trouble makers - that's the phrase you used this morning?-- That's certainly not what I meant when I wrote that paragraph.

But is it right, though? What I'm putting to you is right? Some people had that perception?-- It may be some people's perceptions.

I'm not debating whether it is right or wrong; just at the moment I'm interested in to know whether it is your experience that certainly some people had that perception that nurses came with a bad wrap, as it were?-- I certainly did make the comment, even to Linda Mulligan, that I do think that nurses are - do have - and probably the comment where that came from was the Press Ganey issue; when she first came, I made the comment that nurses are generally regarded by the Executive, I believe, poorly.

In other words, they didn't have as good a reputation as they should have?-----

COMMISSIONER: With the Executive?

MR MORRISON: With the Executive. That's the thrust of what you told her?-- That was my concern.

And you understood, I think I'm right in saying, that part of what she was engaged in was to better that relationship; in other words, to elevate the position of nurses in the eyes of those who had looked down upon them?-- Certainly when Linda first came, that's what she said was her goal - that we would do something about that.

It was part of the strategy - you are aware of the strategy chart for the hospital?-- That's basically the whole district's, yes.

The whole district strategy includes maximising staff preparedness to meet change in demands. That's the idea of bringing forward nurses in their ability to cope with change, and so forth, and increasing-----

COMMISSIONER: I think, Mr Morrison, that's getting a little unfair. You are asking the witness about a perception and as

to whether that perception is true or not - not that you said it was irrelevant - but then to transmogrify that into willingness to accept change and so on is rather-----

MR MORRISON: I don't think it is unfair, but I'll do it another way. One of the things on the strategy map for the whole district was maximising staff preparedness to meet change in demands. You know about that. Would you like to look at it just to check?-- I'm quite familiar with that.

That includes the nurses?-- I believe that as-----

Is it right to say it includes the nurses?-- It includes everybody.

All right. Okay. If I can just go on a little bit, we might succeed. Part of Linda Mulligan's job was to pursue those strategies?-- Part of all our jobs were to - we - we all were structuring our own unit plans based on that.

Quite. And so part of her charter, would you agree - part of her charter - part of everyone's charter - was to ensure that if change occurred, it was handled by the staff who were subject to the change; in other words, they were better prepared to deal with the change to their circumstances?-- I'm just not - are you talking-----

You are wondering where I am going?-- Yes.

How about answering the question?-- Could you-----

MR ANDREWS: Mr Commissioner, I couldn't understand it either.

COMMISSIONER: That's three of us now, I think. Why don't you try again, Mr Morrison.

MR MORRISON: I read out to you the part of the strategy which says part of the strategy is - and you agreed it is everyone's job - to maximise staff preparedness to meet change in demands - staff preparedness to meet change in demands. You agree that that includes the nurses, yes?-- Yes.

And you agree-----?-- What particular aspects of staff preparedness are you relating to?

I'm not yet. And part of her job, just as it was part of your job, is to pursue that strategy with the staff for whom you are responsible, correct?-- I'm not sure what her - I imagine that would be her role.

And so - and, no doubt, other people within the hospital as well, part of the task they have to do, if they are in a managing or directorial role, is in respect of the staff for whom they are responsible to make sure that those staff are able to meet changes - they are prepared for changes in the systems or their work or whatever?-- That would be part of her role.

Thank you, that's all I was asking. Now, you understood, didn't you, that part of the approach that Linda Mulligan was taking was to do that - to oversee changes in a way that staff could cope with them and weren't disruptive, correct?-- I would see that as part of her role, but I do not believe that that is what she did.

You had some particular issues, I think, or a group of you did, with some changes she made, one of them was in respect of rosters, wasn't it?-- Mine wasn't so much with rosters, but-----

You understood the rosters were an issue?-- They may have been an issue for other people, but I don't say that was my issue.

And the issue with the rosters, as you understood it at least, was that people were signing off their own rosters - in other words, NUMs were signing off on their own rosters so there was no independent check, and Mulligan wanted that changed so that there would be a sign off on the rosters, especially when it came to leave, so that the person taking the leave wouldn't grant themselves the leave, someone else would have to have a look at it; you understood that?-- Can you repeat that again? You are saying that in regard to the rosters - what do you mean that we are signing off our own rosters? Can you please explain that?

Was it the case, as you understood it, that in respect of some NUMs, their rosters would be arranged by the NUMs - the NUMs?-- NUM or CN or some other staff member may have made the rosters. Most nurse unit managers worked Monday to Friday.

That's part of the charter for an NUM?-- They are there to make sure the shifts are covered adequately.

In as far as the rosters permit the NUM to take leave, can I put to you one of the issues Linda Mulligan was looking at was to change the system so the NUM didn't sign off on their own leave, that someone else did?-- I don't believe anybody had a big issue with that.

Okay. There was a question about TOIL, T-O-I-L; is that right?-- Yes.

Time off in lieu?-- Yes.

That was one of your issues?-- Yes.

And the issue there, I think, was that a number of people - doesn't matter who - had racked up quite a number of TOIL hours?-- I don't know about a number of people.

Speak for yourself then?-- I hadn't, no. In regard to TOIL, I really do understand that a manager has a responsibility to keep an eye on what's going on with TOIL, and if I was to take TOIL, I would expect that I would tell my manager that I was

doing that. Now, I do accept that. I have no issue with that.

Sorry, just pause for a second. I obviously know what you are talking about, but the rest of us might not.

COMMISSIONER: On this occasion, I understand.

MR MORRISON: There was an issue where Linda Mulligan was interested to ensure that TOIL was, as it were - "forwarded" is not the right word - overseen by someone other than the person racking it up?-- No problem with that.

Well, what was the issue with TOIL as far as you were concerned?-- The issue - as a Level 4 nurse with responsibilities in regard to budgets and other responsibilities that I have in my role, that if I was to contact my line manager and say that I have - "Some things have come up. I need to" - you know, "My workload is quite considerable at the moment, I'm going to have to" - you know, "I need to catch up, basically, before I get too far behind." - if I was to contact her - another example could be somebody with some sort of infectious condition could come in before you go home and one afternoon you needed to stay back beyond your hours, I would see that as acceptable from that perspective, and if I contacted her and said, "I need to work TOIL this afternoon", that she would accept, in my level of responsibility, that that would be reasonable that I, from that perspective - that I have contacted her, given her a brief outline of what the - why I need that, and I would expect that to be reasonable, but I wouldn't expect an inquisition and asking why this couldn't be done in my usual work hours.

So, do I understand what you are saying is that you are saying Linda Mulligan should have trusted you more on the issue of TOIL?-- Yes, I am saying that.

And that's where - is that really what we understand - I think you said - yes, that's right, you felt that "she didn't trust us". That's what you are talking about?-- Yes.

D COMMISSIONER VIDER: Could I ask you a question in relationship to that and following on from that and sticking with that example?-- Yes.

If you gave us an example that a patient was admitted that required your attention beyond your normal working day and you contacted your line manager - in this case Linda Mulligan - and said you would be working TOIL tonight, this afternoon, whatever, did Linda Mulligan ever come back to you the next day and ask you for any outcomes, consequences or any queries, comments about the patient or the incident that required you to work back?-- Basically - from the situation - that didn't happen because I didn't ask for TOIL. Basically what primarily happened was that if you had a situation that was very clinically based, that was fine, but, for example, I was sent away for a week earlier this year, totally unrelated to

infection control - it was aggression management - and I was out of hospital for a week. A month before that I knew I was going, I asked to have relief from my position for the time I was away and that wasn't organised. So, as a result of that, I thought that it was fair and reasonable that I would need some support for - and that I would even probably have to work some TOIL - if you go away from your job for a week, that's a week's worth that you haven't done that you then have to try and catch up - and I was not made to feel that this is something I could do. Basically she did offer to get me somebody to help me with data entry, but as I pointed out to her, nobody else can do that form of data entry. So, it became that I do work out extra hours, and - but I don't ask them to be credited to me at all, because I felt that it was - I didn't feel it was worth the effort.

MR MORRISON: What I'm raising with you is this: the issue from her point of view, as explained to you or mentioned to you, was that there was no documented record of TOIL in some cases and that was required by the district policy?-- Well, certainly there was in my case.

There may have been in your case, but didn't you understand her to tell you that that was an issue she had with TOIL; that in some cases, there were no documented records of the TOIL and documentation was required by district policy; is that right?-- I'm not aware that there was no cases of documented-----

Do you understand that's what she said?-- No, I don't remember that at all, I'm sorry.

And she was inquiring how it was that all the TOIL had been accumulated, what had caused it to accumulate?-- Basically on the forms that I have seen, you actually write the reason down for the TOIL, so it should have been fairly easy to track back what it was.

It should have been if there had been documentation, you are right?-- I can't speak for something I don't know of.

All right. And part of her concern was that if a lot of TOIL was being accumulated, that might indicate that that particular person was being overworked; the workload might need to be adjusted?-- I don't think that was - that wasn't obvious to me that that was the way she would be looking at it, from my own experience.

And if the person was being overloaded, from a manager's point of view, from her point of view, it may be that you needed a little more staff, maybe one and a half staff for the job or two staff or whatever - some staff adjustment; isn't that - you are aware of that, aren't you?-- I think Ms Mulligan would have been well aware that I was working time away, that I wasn't asking for TOIL. In fact, I had told her that.

I'm not suggesting it is confined to you?-- Again, I can't respond to that generally.

And it is the case, isn't it, that one person had something - I forget - I can't remember the exact figure - 200 hours racked up of TOIL?-- Again, I'm not aware of that.

Okay. Now, you say in paragraph 43-----?-- So, just out of interest, though, that person that did have the 200 hours, did Ms Mulligan act to check their workload and in that - was that looked at, as you have suggested, that she would be doing?

The Commission will be hearing about that?-- Good. Thank you.

In paragraph 43, you refer to Ms Mulligan's management style and say it is micromanager. Can you say what you mean by that - micromanager?-- Basically, again, it comes back to we do have responsibilities and expectations in our role to perform, and while, as our line manager, she does need to oversee what we are doing, she did seem to become involved in, perhaps, things that she may not necessarily have needed to. Basically she - I will just have to think of some examples-----

Paying attention to too much detail rather than too little detail; is that right?-- No, I think sweating the small stuff. I mean, basically-----

Sorry, sweating the small stuff; is that the comment?-- Well, it was a comment, but basically-----

If that's the expression of it, I can understand what you are saying.

COMMISSIONER: Mr Morrison, please let the witness finish her answer.

WITNESS: From the - I forgot what I was going to say now. No, I've lost it, sorry.

MR MORRISON: Your comment was "sweating the small stuff", which I take to mean she might have been concentrating on things that didn't warrant that much concentration?-- They were things that were - I would see that - I understand that when she came she felt that there could have been some better systems and different things in place, and that was fine, and nobody doubted or thought that that was unreasonable, and we were quite acceptive and - when she came. There was not an issue. We hadn't had a Director of Nursing for a period of time and we welcomed the arrival of a new person. There was no issue with change as such. I think change from that perspective, everybody saw that change was necessary, and I don't think there was a problem with that. There were times where it might have been locked from certain respectives, say in terms of public holidays, which you may be going to come to, but that was more in the point of - it comes back to the trust aspect - that we felt that we weren't able to trust her.

You felt that she should have taken your word for more things, that she was demanding documentation about it; is that it?--

Yes.

Okay. I understand. Now, in relation to the meetings, you say she was very controlling in meetings, and when issues were debated, she had a habit of targeting certain nurses?-- Mmm.

You have one particular staff member in mind there, don't you?-- Not only Toni Hoffman, but another person.

I was thinking of Di Jenkins?-- Oh, well, Di was the other person.

Mmm?-- And it has been suggested myself as well by somebody else.

That she was a bit controlling? Sorry-----?-- No, in regard to - what I meant by that statement, "targeting nursing staff and silencing them", was more from the perspective of her tone of voice and the way that she spoke to them.

All right?-- That you could tell that she was displeased.

Well, is it really - I mean, it is a question of manner rather than anything else. She didn't want the meetings railroaded into peripheral areas and kept it on track, and her manner might not be seen as suitable; is that basically it?-- Basically Linda led the meetings and probably spoke the most at the meetings.

And where she was chair of the meetings, that's not a crime, is it?-- No.

I mentioned Di Jenkins because she was one person who was given to sort of semi taking over meetings with her own views about whether doctors got all the lurks and perks and nurses didn't?-- I don't recall that mentioned on that many occasions, no.

I suggest to you that that was one of the aspects about nurse Jenkins-----?-- I think any person that's chair of a meeting does have to control a meeting, that is true, but, at the same time, my comment related more to the fact that-----

The manner of it?-- She may have been - yeah, displeased with some of the - or trying to dismiss some of the staff.

All right. And one of the things that Linda Mulligan did go on about from time to time was one of the things we talked about earlier on, and that is the need to document things, the need to get the facts right; that's correct, isn't it?-- That seemed to be - she did say that when she came, she - that that was important for her, and it seemed to be that there may have been some history there and she devised this tool - this format of what's called a "file note" and wanted staff to use it, yes.

And I think that's also something that you don't find unusual, because I remember you saying in respect of the Keating

statistics business, it was reasonable for him to ask for statistics rather than emotive comments; remember that?-- That - basically, I don't want to take away from emotive comments, but I know that was something that Darren was focusing on, the statistics, but I think the emotive and the verbal has to be listened to as well.

Quite. But you made the distinction between working on statistics rather than just emotive comments. You might not disregard emotive comments, but if you are going to have concerns and then take them on, you really need to have them validated in some way, have a factual basis for them; you would agree with that, wouldn't you?-- This is true, but emotive stuff can come-----

That's what I'm saying. You don't disregard it, but you do need a factual basis. You may not have expressed it in these terms, but as a manager yourself with staff under you and people to report to, if you are going to go into bat for your staff, you really need to have the ammunition to go into bat for them, don't you?-- You make it your business to find out that information.

Quite. And that's what we were talking about earlier on. The absolute necessity - very much the necessity of having accurate information, it is essential, isn't it?-- You can't always get accurate information, but, true.

You may not get it, but you have got to strive for it. If you can get it, you should get it, shouldn't you?-- Very possibly.

In paragraph 44, you refer there to a comment given to you by Leonie Raven, attributed to Ms Mulligan at a meeting back in August '04. I think that GA20 is the E-mail - yes, it is. That seems to have come to you in April this year; is that right - 21 April?-- That's true. That comment was only made to me a day or so before that E-mail was sent.

Yes. But relating back to August 2004?-- That's what the E-mail says.

And do you know the background to what Leonie Raven was talking about?-- Primarily only that - what she has written.

You don't know how it came to be, if that comment was said, why it was said or anything else?-- No. I only know in the context that it was said to me that we were talking about basically the lack of trust with the Executive and the issues that we had - that we felt that we had with the Executive listening to us. So, that was the tone of what - what the context was, and this information was forthcoming. So, I don't know the context to the meeting.

Right. Or even if the comment was made beyond the fact that it has been related to you?-- That's correct.

I will leave it at that. Now, let me just pause and look at

something else. Now, you made a comment - can I just ask what you meant by it. I think you were talking about paragraph 45 of your statement where you mentioned the Press Ganey Report - that's patient satisfaction surveys?-- Mmm.

And you made a comment in respect of that that you had a number of A/DONs. What is it that sort of comes from that fact?-- Basically what we were talking about there - that Press Ganey has only really come in as an example from the perspective of - what I'm saying is the demonstrated disregard for nurses, that I felt that nurses were poorly perceived, and the purpose of that was that that was demonstrated to me during the course of that - that meeting, which is - but in regard to-----

Yeah, I understand all of that?-- Mr Leck was asking why nurses hadn't progressed any further with this situation.

With the feedback?-- Not so much getting the feedback, but progressing to doing something about improving, you know, addressing the things that were identified by the Press Ganey report and showing we were doing things, that patients know about their rights, responsibilities, and other points that came up by the Press Ganey report. So that the fact that - from the time that that report came out we had a number of Acting Directors of Nursing in that time, Ms Mulligan, for example, Mr Martin, Ms Hoffman and then not until March 2004 when it was Ms Callanan. So there was a number of people and there was obviously not good - you know, during that period people were only in those positions for a short time. Things were happening though, don't get me wrong.

That's what I was just going to come to?-- Yeah, they were happening.

Having a number of A/DONS was part of what might have let things slip?-- The other thing to be considered, over December and January things with committees being closed over that period, there's - it's a slow time as far as committees are going and progressing issues as well, so that also would have played a role in that as well.

I understand that. Thank you. One last thing, in relation to paragraph 41 and patient E54, that's the lady who telephoned you after her biopsy?-- Mmm.

I noticed that she phoned you complaining about her condition. You said you would contact Patel and tell him and someone would ring her back or contact her. I'm sort of curious to know why you didn't suggest she go and see a GP straight away?-- She had already been to Eidsvold Hospital.

She had already been to Eidsvold Hospital, I see?-- And by the Monday the antibiotics had worked. I probably-----

Okay. In relation to that - sorry?-- I'm - probably I shouldn't have said the hospital, but anyway.

What do you mean, the name?-- Yeah.

It doesn't matter, I don't think. You spoke to Linda Mulligan about that patient?-- I think I may have mentioned that to her but well after the fact. That was more a fact issue of Dr Patel. I think I may have mentioned it to her so that she was aware.

I was going to suggest to you that one of the things you said to her was in essence over this patient that you were trying to set Patel up?-- Exactly, and I will explain exactly that, because I had found - and I think I probably said today - from the perspective that in regard to Dr Patel I found that what he said and what he did wasn't right. Now, Dr Patel - and I did say that to Ms Mulligan, I do remember saying that.

Well, can I just ask you this - because I don't want to go into the reasons that you had, I'm more interested in what she told her - you had a discussion, or she had a discussion with you then about the appropriateness of that, of setting someone up?-- I explained - she - I don't remember a great conversation about that, but I did proceed to explain to her straight away that I was - I had concerns about Dr Patel and it's very hard to get concrete things on him. Now, what I had wanted - and I asked Gail Doherty in theatre because I was trying to get back to Dr Patel to find out whether he had contacted this person, and when I said that I was trying to set him up, had he told me or told Gail on my behalf that he had, in fact, contacted this person when he hadn't, I would have reported it. But I wasn't able to get a hold of him at the time. Because I felt that I could not rely on Dr Patel with his history, that he had said things in the past that he didn't follow up on, and that I was interested whether he was going to and I was - I suppose it was a desperate measure, I suppose, because I felt that if he had said that he had contacted this lady and he hadn't, then I did have something more concrete to take to Dr Keating.

COMMISSIONER: What you are telling us is this: that for quite some time you had been told by Dr Keating and Mrs Mulligan and others that if you were going to make complaints you needed to have some hard evidence to back it up?-- That's right.

And you saw this really as just a chance to get some hard evidence?-- That's right, I wasn't hiding it and I told her that this is the purpose of why I was, I suppose, desperate to get some - to get some hard evidence.

D COMMISSIONER VIDER: Was this the first time in your professional working life that you had ever found yourself in a situation whereby, to quote your words, you had to set somebody up?-- Absolutely, absolutely. And Gail Doherty, who I asked, I said, "Can you please ask Dr Patel if he had contacted that lady Eidsvold?" I was not hiding what I was - if he did the right thing, there was no issue and - but if he was going to lie about it I wanted that to be known and reported.

COMMISSIONER: Yes. You weren't setting him up in a sense of a fake note from a fake patient, or anything like that?-- No, no, it's very - he was the one that told me that it was very important that he saw this patient.

Yes. So you were only setting him up in the sense of checking whether what he told you was true or not?-- That's correct.

MR MORRISON: Is that why you rang the lady every day?-- Sorry?

Is that-----?-- I rang the lady every day to make sure that somebody was following her up, that she felt that we - you know, as support, and, yes, from that perspective and the lady

- from that Monday after though, when she said that she was feeling better, I did not ring the lady any more. But when she did come back for her follow-up visit, she did make an attempt to contact me.

Did I understand you to tell me a minute ago when she phoned you about her condition - yeah, when she first phoned you about her condition - she had already been to see the Eidsvold Hospital?-- Yeah, she - basically when I-----

Sorry, have I got that right?-- Yes.

I wasn't sure if I did?-- Yes, you did.

Did you mention that to Dr Patel?-- Yes, I did, yeah.

Right, okay. So you told him about her. He said he would contact her but he knew she had already been to Eidsvold Hospital?-- He also did say that comment then about the GPs, that the GPs get to know about this, but it is really important that he does see her.

Yes, quite. Now, I don't know that I will detain you with it, but going back to the TOIL issue, you corresponded with Linda Mulligan quite a bit about TOIL by e-mail?-- You may have something that I'm not aware of, but-----

Well-----?-- Just primarily the more recent one would have been the week that I was sent away and that would have been - that was February or March this year.

Yes, that's right, and part of what she said to you was, "I am happy for you to have an endorsed RN to assist you for a couple of days to catch up on some items since you will be doing training un-related to your IC role. Please let me know what dates you are suggesting that to occur." You and she corresponded about that?-- Basically what happened - can I just ask the date of that e-mail?

That e-mail is 23rd of February 2005?-- Okay. What happened there was, in regard to the TOIL, as I said previously, I asked to be relieved while I was away. It came to the attention that while I was away that I had to give a report and I was just basically letting her know that I wasn't going to be here and that was at the time when - anyway, I won't put that section, it's probably irrelevant to the story, but from the perspective of that I asked - she said - she offered then to give me someone from data, to data input and stuff and I said there was nobody else who could do that, and I think I was the one who suggested that I could have a nurse immuniser for a few days to help me with some stuff, help with - so it was actually my suggestion about asking that.

It doesn't much matter. Your suggestion was you and she came to an agreement about it?-- The better agreement would have had I been relieved for the whole week while I was away.

Okay. All right. I've nothing further, thank you.

COMMISSIONER: Thank you, Mr Morrison. Before I ask you, Mr Diehm, there are a couple of things arising out of Mr Morrison's questions. Can I ask you to go back to paragraph 42?-- Yes.

You might recall that Mr Morrison asked you some questions about this paragraph, and I was a little intrigued to hear him on behalf of the then Director of Nursing putting it to you that nurses had this reputation for being unreliable and providing-----

MR MORRISON: That's not quite fair, Mr Commissioner. With respect, I didn't put that.

COMMISSIONER: The record will speak for itself. I'm not going to debate it now.

MR MORRISON: I don't want you putting something I didn't put. What I specifically asked her about was on the basis there were some that had a perception of that.

COMMISSIONER: Yes.

MR MORRISON: That it was the case. I expressly said to the witness I wouldn't debate right or wrong-----

COMMISSIONER: What I put is "reputation".

MR MORRISON: A perception about that.

COMMISSIONER: No, the word "reputation", the nurses had a reputation.

MR MORRISON: I didn't put that.

COMMISSIONER: As I said - Mr Andrews, can you assist?

MR ANDREWS: It's my recollection the question was put many - several times and on at least one occasion the word "reputation" was used.

COMMISSIONER: Yes.

MR ANDREWS: But-----

COMMISSIONER: Anyway-----

MR ANDREWS: The record should-----

COMMISSIONER: If, Mr Morrison, when you have read the transcript overnight you wish to withdraw the word "reputation" and apologise on behalf of your client to the nurses for suggesting they had that reputation, you have that opportunity, but my note is very clear that you put it to the witness that the nurses had a bad reputation.

MR MORRISON: I most certainly did not.

COMMISSIONER: We will look at the transcript tomorrow.

MR MORRISON: And to say that I have the opportunity overnight to then apologise, with respect, the greatest respect is doing too much.

COMMISSIONER: I see.

MR MORRISON: If you wish to ask the witness questions, with the greatest respect, Mr Commissioner, you are of course free to do so-----

COMMISSIONER: Thank you.

MR MORRISON: -----but my concern is that you ask them on a basis that is fair.

COMMISSIONER: All right. Have you finished?

MR MORRISON: For the moment.

COMMISSIONER: Yes. What do you say to the suggestion the nurses had a reputation for being - making unreliable complaints?-- I think that in regard to - for example, that was my point, Mr Leck was saying that nobody will want to come to Bundaberg. He was implying then that we did have a reputation for making malicious comments, or whatever, and that we would continue to do that again and I think that's very unfair.

Was it your understanding that there was anyone within the Executive who had that feeling about either yourself or other nurses?-- I did feel that there was a disregard for nurses, I did feel that, and I certainly did say that to Ms Mulligan that I was concerned that nurses were not respected.

Mr Morrison asked you at the beginning of his questions whether your position was that of a manager and you agreed with him that it was. I guess there are different types of manager. You can have a manager like at the local bank who sits in his own office and managers from behind a closed door. A manager like McDonalds where the manager is someone who is actually serving customers and dealing with the public. Can you explain what your sort of managerial role is?-- Mine's a clinical role. It's regarded as a clinical position.

Yes?-- And I do have management in that I manage programs, infectious control programs, waste management, so I do manage people as well but I do not have any staff. I'm a one person department. I'm a one person department.

You were also asked some questions about this system of line managers and, of course, your line manager was Mrs Mulligan?-- Yes.

And in a sense she is the person you would report to within the hierarchy of the administration; she's your boss as it

were?-- Professionally, yes. Yes.

But the questions went along - as the questions went on there seemed to be the suggestion that the only channels of communication that were within the silos was that people only spoke to the people above them in the silo and that there was no exchange of information between one silo and another silo?-- I certainly deal with all disciplines of staff. That's the unique part of Infection Control, that there's no staff members in the organisation that I don't have direct dealings with.

Right?-- In that whether it's through staff health or occupation exposures or education, or whatever, so I basically deal with all aspects of staff. So in so far as speaking between disciplines, I think that, you know, I feel that I crossed - I don't have a - while I have a professional line up I do have - I report to other people.

Well, to take an example. If you need to find information from someone, let's say within the operating theatre-----?-- Mmm.

-----there would be nothing preventing you speaking to a junior nurse in operating theatre?-- I can speak to anybody, yes.

That person doesn't have to report up through their line manager?-- No, no, that's right, and the same as reporting things, infections or whatever, anybody can do that.

Right. In relation to the business of inappropriate wearing of theatre attire, this is in paragraph 31 following in your statement, Mr Morrison, I think - I think I have this right - suggested to you that you spoke to Mrs Mulligan about this and she gave you some advice as to how you should handle the issue and deal with it and he did take you later to the e-mail that she assisted you in drafting?-- That was right at the end of all of this.

Yes. Earlier on though you have been quite emphatic in denying his suggestion that Mrs Mulligan gave you any advice about that at all?-- No.

Apart from the e-mail, was there any occasion when you either sought advice from her or were given advice by her about that?-- No.

You were also asked a number of questions about the Mission Statement, or whatever it is called, that refers to maximising staff, preparedness to meet change and demands. Just thinking back over the things that you have been giving evidence about today - and I know it's been quite a long day for all of us - can you identify any of the things that you've been speaking about in relation to Dr Patel or the infection control system, or anything like that, where it could be said that the involvement of Mrs Mulligan or, indeed, anyone else from the Executive could probably be described maximising staff

preparedness to meet change and demands?-- I really would have liked to have heard examples of - from - of what was really meant there. I can't think of any examples. Whether it's just trying to get structures in place, and I know that Linda was dealing with things in regard to complaints management, and those sorts of things, so whether that's what she is looking at I'm not exactly sure what was meant.

Nothing further. Mr Diehm?

CROSS-EXAMINATION:

MR DIEHM: Ms Aylmer, I'm Geoffrey Diehm. I'm the barrister representing Dr Keating. I am one of the many faces here for him. In answer to some questions from Mr Morrison concerning a conversation that you had with Ms Mulligan, you've said that you did on the occasion concerning this lady with the persisting problem with respect to the breast biopsy, you did make a reference to wanting to, as it were, get some evidence on Dr Patel. Really, is the effect of what you were trying to do to catch him out?-- To catch him out with a lie, yes.

Yes?-- If he was going to make a lie I wanted to catch him out.

Because you thought that if you could catch him out on that you would have something solid to go on with a complaint to Dr Keating or Ms Mulligan that hopefully might result in some action being taken against Dr Patel?-- I felt that it would - again trying to find concrete evidence that I saw this was an opportunity that if Dr Patel chose to lie about this situation and say that he had seen this lady that, yes, I would let Dr Keating know that.

So as has been pointed out, the phrase you may have used of Ms Mulligan setting up perhaps didn't really represent what you were trying to do, you were really trying catch him out?-- I did explain what I was trying to do at the time.

All right. Now, the reason why you thought that was important, I suggest to you, was because you had a feeling which had grown over the better part of two years by that stage that there was some problems with respect to Dr Patel but that up until that point in time you didn't have any hard or solid evidence to present to management so as they may take some action again him?-- That's right. From my perspective of the statistics I was very frustrated, hence why I tried to introduce new things and collect more indicators. But at no stage did the statistics show that there was an unacceptable rate.

Yes. We heard some observations from the Commissioners earlier today about an old study going back more than 100 years which tells us that if one introduces into a hospital

environment safe hygiene practices, such as washing the hands, that that can cause a drop in infection rates of in the order of 80 per cent?-- Mmm.

What follows from that is that if there is routinely a failure to observe those sorts of safe practices, one would expect to see that reflected in the statistics showing an increase in the rate of infections; would you agree?-- Sorry, that was if-----

So if you take a hospital that hitherto has and observes safe procedures with respect to things like washing of hands and other hygiene practices and all of sudden perhaps the busiest surgeon in that hospital stops observing those sorts of practices routinely, you would expect to see a significant increase in the infection rate?-- That is possible that that would be the case, but it may not have been as obvious as you think because there are so many other factors that are dependent on the infection occurring.

Yes, all right. But the obvious logic of that demonstrates the problem that you and indeed the management of the hospital were faced with when there are allegations of a failure to follow safe hygiene practices but no statistics bearing out the consequences of that?-- Again, one - the awareness of the statistics are not necessarily to be relied upon. So one needs to look further than just the statistics.

But you accept, do you not, that absent those statistics there wasn't a hard or solid evidence that would be necessary to refute Dr Patel's denials that he was responsible for unsafe hygiene practices?-- Well, certainly the evidence didn't show anything out of the ordinary.

And that's why you were frustrated with that situation?-- Because I was hearing about complications and things like that which would normally lead to infection and because I had seen his practices and clearly it is accepted that that can cause infection.

You've mentioned in your evidence that Dr Keating was supportive of you in your attempts to improve the hygiene standards and practices at the hospital?-- Certainly when I spoke to Dr Keating he did support me. Yes, he did agree with me.

And that includes when you raised these matters in the presence of others, committee members?-- I have no problem that Dr Keating supported me at those sorts of meetings and things, yes.

Yes. The problem in practice seemed to be, did it not, that you and perhaps others would raise complaints about Dr Patel's practices, Dr Keating would respond to you that he had spoken to Dr Patel about those matters and that Dr Patel had in effect denied that he had engaged in improper practices; that was what was happening, wasn't it?-- That seems to be what happened, yes.

Yes. And as you've candidly acknowledged, in the meantime there are no statistics bearing the results that would have demonstrated that there was, in fact, a problem objectively with infections in trial?-- The fact that there was no statistics is, again, something that should be recognised from that perspective.

Yes. When you first worked with Dr Patel you described to us that you were involved in this acting position assisting in the surgical department and you've told us how in that period of about a month, I think it is from your statement, that you observed Dr Patel engaging in some unsatisfactory practices with respect to hygiene control?-- Mmm.

Now, in answer to some questions from others this afternoon, you have again candidly observed that those sorts of failures are not that unusual in the hospital setting, that other practitioners, whether they be doctors or nurses, to a varying extent engage in similar practices?-- Again, there is an issue with hand washing with staff across the board, but when staff are involved in more - where they are touching wounds and doing sort of things that require aseptic technique, I believe much more care is taken.

Yes. Some practitioners are better than others with respect to these matters?-- That would be the given, yes.

Some of them respond better to the gentle reminders that might come from another practitioner in their presence; would that be right?-- I would imagine that would be correct.

And the other thing that would be true, would it not, is that you having a special area of interest in infection control would probably be a bit more sensitive to observing the failings of others in those areas; would that be right?-- I think that you are - part of your role is that you are more observant, but at the same time some things when they are obvious, you know, not just again - just listening to somebody's chest and going to the next patient is one thing but actually pulling off dressings and sort of poking around near people's wounds is another thing. So while, you know - I think if you spoke to a lot of staff they would say there would be occasions where they would think that, you know, that should be hand washing. There are certainly, as I said, times when people do need to take more care.

Yes. I'm sorry, my question to you was - and it's not a criticism at all, please don't take it that way?-- No.

But as a nurse having a special area of interest in infection control, you would have a higher degree of sensitivity to the failings of other practitioners to observe good practice?-- I would certainly be on the look out for it.

Yes?-- But I imagine others would be too as well. I wouldn't be alone.

Thank you. As the Renal staff were, I guess.

Yes. Mr Commissioner, I wonder whether that's a convenient time?

COMMISSIONER: Well, I was going to ask you, if you thought you'd only be going for another five or 10 or 15 minutes, I'd prefer to finish this evening, but if it's going to be another hour or more-----

MR DIEHM: It would be half an hour, Commissioner. There are some documents I want to take the witness through as well.

COMMISSIONER: Can I ask, Mr Ashton, are you expecting to have any questions?

MR ASHTON: I think I will be at least half an hour, Commissioner, but perhaps longer.

COMMISSIONER: All right. Then there is no point, I suspect. Sorry to trouble you to have to come back again tomorrow. Is that convenient, may I ask?-- It's just I'm going on leave this week and I'm back - I had three days to hand over to the person that I was actually - that's relieving me. So - and today I have had to give him something else and so I have - it's basically giving me now two days to hand over to him.

I see. I have raised the possibility of continuing this evening after a dinner break, but I'd realise it's been a very long day for you in the witness box and I wouldn't seriously ask you or - we have got to bear in mind as well the lawyers here have been concentrating all day. Look, can I ask you to find out what the most convenient thing will be and we can start early if you like, or sit tomorrow evening or something, if that would assist?-- How early would - sorry. 8 o'clock?

MR MORRISON: Mr Commissioner, I think in fact Nurse Aylmer might actually prefer to go on tonight, like now, I suspect, and get it done.

MR ANDREW: That's certainly satisfactory for my purposes. I know Nurse Aylmer has a commitment later in the week that's not vacation related that she can't get out of.

COMMISSIONER: All right. Well, then I will have to come clean. I have to be on my way to the airport at 5 o'clock, but if we go for another 20 minutes or so, we'll break while I collect my wife, and then we will resume.

MR ANDREWS: Very convenient for my purposes.

COMMISSIONER: Does that suit everyone?

MR ASHTON: I aim to please, Commissioner.

MR BODDICE: I should indicate how long we may be.

COMMISSIONER: Yes, I'm sorry.

MR BODDICE: That affects the equation. As things presently stand, probably about 20 to 30 minutes, I would say, perhaps less depending on what questions arise here. So there could be a total of at least an hour and a half.

COMMISSIONER: That sounds quite feasible, doesn't it? Mr Andrew, would you expect to have much re-examination?

MR ANDREWS: No. I am sure the applicants will cover all the other points.

MR ALLEN: Not much, your Honour. Five minutes, 10 minutes-----

COMMISSIONER: All right.

MR ALLEN: -----at the most.

COMMISSIONER: All right. Why don't we take an hour's break now and resume at 5.30. Is that-----

MR BODDICE: Certainly.

THE COMMISSION ADJOURNED AT 4.34 P.M.

THE COMMISSION RESUMED AT 5.44 P.M.

GAIL MARGARET AYLMER, CONTINUING CROSS-EXAMINATION:

COMMISSIONER: Sorry to keep everyone waiting. Comfortable?-- Yes, thank you, Mr Diehm?

MR DIEHM: Thank you, Commissioner. Ms Aylmer, I want to ask you now about the investigation that you carried out in 2003 with respect to wound dehiscence and in particular you told us how you compiled an initial report that listed 13 instances of dehiscence and you presented that to the - I think it's called the Leadership and Management-----?-- No, I didn't present the report there, I said in - at that meeting my - in my report to the meeting that I was investigating 13 people and - 13 situations but then I actually had the cases but then I had to complete the table form of report. So I didn't actually have the report completed-----

Yes?-- -----at the time of that leadership and management meeting.

I'm sorry. Okay. So this document that you describe in your evidence earlier today, that was in a table form with 13 names on it, did that document ever go to the Leadership and Management Committee?-- No, because I hadn't - I hadn't completed it at that stage. I completed it the next day.

All right.

COMMISSIONER: I think the evidence this morning was it simply went to Dr Keating.

MR DIEHM: Yes.

COMMISSIONER: Yes, and that's why there seems to be only one copy in existence, if indeed that copy exists.

MR DIEHM: Thank you. So, it was the day after that committee meeting that you presented the document with 13 names on it to Dr Keating?-- I believe it must be, going by the date of the e-mail.

Now, when you addressed the committee with your information as you had it at that point in time, did the committee make any observations or ask any questions of you?-- Other than - no, I don't really remember anything in particular, other than I am sure they were interested that I was investigating it.

Yes. I suggest to you that Dr Keating in fact commented to you that it would be a useful exercise for you to take whatever findings you had and discussed them with Dr Patel?-- Well, they may have been Dr Keating's belief because he did send Dr Patel to me but I don't think he asked me to go to

Dr Patel, no.

No. Well, let's leave out for the moment whether he strictly speaking asked you to go to Dr Patel. What I'm asking you is whether he used words to the effect that you might discuss the matters with Dr Patel?-- I can't - I wouldn't dispute that.

And what I suggest to you is that you expressed a willingness to do that?-- I don't recall this. I don't know that that was said.

It wouldn't sound like a terribly startling proposition, though, would it, because where you have a situation where a clinical problem may exist, a problem of this kind and one health professional such as yourself is identifying a trend that may be emerging, to suggest that that person discuss it with another person who has responsibility for the area in which that trend might be emerging?-- The fact that - whether Dr Keating did suggest that or not and - or the fact that Dr Patel did come to me again still remains that I was not the appropriate person for that. Yes, I needed feedback. I had put the data together. But I wasn't in my role as infection control CNC not the appropriate person with the appropriate expertise to review that data.

Did you tell Dr Keating that?-- Dr Keating should know that. I am infection control clinical nurse consultant. That is well beyond my realms and my state of practice.

Looking at your e-mail of the 8th of July 2004, can you tell us where from that e-mail one gets even the slightest suggestion that you thought that this was an inappropriate process that you were not a person who was suitably qualified to be taking this matter any further?

COMMISSIONER: Mr Diehm, it's apparent that's not in the e-mail. I don't think we need to have sort of sarcastic questions. It's not fair. You can make submissions about that at the appropriate time.

MR DIEHM: Thank you, your Honour. Do you agree with me that by your e-mail of the 8th of July 2003 to Dr Keating you were giving him a clear impression that you were quite comfortable with the process of you discussing these matters with Dr Patel and reaching the conclusions that you did and that you expressed in that e-mail?-- I wasn't comfortable at all. I did say, as I stated earlier, that I was - I made the comment that I was pleased to get the seemingly reasonable responses or explanations to the cases that happened, as in Dr Patel offering those explanations. From that perspective again I say that Dr Patel stood over me, went from one point fairly quickly. He would not have been in my office very long and went from one patient to the other, and at that stage with what I knew of Dr Patel he was saying - he mentioned his experience. I went through all that in the past. So, I was not comfortable. To say that I did write in that e-mail that they - I was pleased that we could exclude those people, that Dr Patel seemed to have reasonable responses, but again that

is Dr Patel has reviewed these patients from that perspective and I was not in a - had the knowledge or expertise to be able to debate those with him or to argue any points with him about that. I was clearly out of my depth.

COMMISSIONER: I think Mr Diehm's point, though, is that whilst you may have felt discomfort you didn't convey that to Dr Keating, and you'd agree that that's true?-- No, I didn't, but again I think it's a given that this is not part of my role.

Well, whether or not that's the case, you accept the force of what Mr Diehm is putting to you, that when Dr Keating gets that e-mail saying that you are happy and so on, he could be readily forgiven for taking you at your word and when he reads the words saying that you are happy he could accept that?-- That could be how he would have felt.

Yes. You didn't tell him anything to the contrary?-- No.

MR DIEHM: Thank you. Now, the topic of wound dehiscence was revisited in a formal sense in 2004, was it not?-- That is an area that I'm not so - have not been so involved at that is an area that the nurse unit manager Dianne Jenkins has taken over.

All right. Were you present at an ASPIC meeting on the 18th of August 2004?-- I have would have no idea. Was I?

I will show you. I'm sorry, Ms Aylmer, I'm not meaning to be clever or trick you or catch you out, set you up even, but if you have a look at this document, please.

COMMISSIONER: Is this something we should have put on the screen or is it just to assist the witness's memory?

MR DIEHM: It will go on the screen, Commissioner, yes. Perhaps if the front sheet of that page, Ms Aylmer, can be given to the assistant? Now, you can see from about the fourth line down it lists those present at the meeting on the 18th of August 2004. This is the ASPIC Clinical Service Forum meeting and your name is the first there?-- Yes, I was - yes.

You see that the first item of business arising, and should we presume that means business arising from previous meetings?-- You would.

Yes. First item there is, "Wound dehiscence"?-- Yes.

All right. Now, what it goes on to tell us in the discussion section is that there was information from coded data and the document speaks for itself in terms of the information that it records. But do you recall that the history was that there had over a number of months, perhaps at meetings that you weren't necessarily at, but that there had been some discussion by this committee about incidences of wound dehiscence?-- I believe - well, that says, "Business Relations". I did believe it come up on a number of

occasions.

Yes. Tell me, being a member of the committee, if you weren't at the meeting did you still get a copy of the minutes?-- You still do get a copy of the minutes, that is correct.

Yes. All right. Now, is it your recollection that what in fact had occurred by the time of the August meeting is that the nurse unit manager, Di Jenkins, and she was in the surgical unit, was she not, had indeed pulled out some data with respect to the incidence of wound dehiscence over the two previous calendar years? Do you recall that?-- I believe that was the case.

And she provided to the August meeting the results of that survey that she carried out?-- I think what was looking here was - Dr Patel, I think, provided the data for this, I think was what-----

COMMISSIONER: It seems that - it doesn't tell us who actually brought the data together, but what it does give us is Dr Patel's analysis of the data. So, I think Mr Diehm's suggesting that it was Dianne Jenkin who actually assembled the data but then Dr Patel made the report that he reviewed the data and it was within boundaries?-- Again I really don't think that - again this is not part of my role and I have not looked at this recently, so I - I think there would be-----

MR DIEHM: Perhaps if I can clarify?-- Dianne Jenkin would be better to answer these questions.

If I clarify the background to that. I should have done this in the first instance. The report was initially tabled, I suggest to you, at the preceding meeting, a meeting held on 14th of July 2004 for which you had given your apologies, and that is why it comes up then as, "Business Arising" in the August meeting with the comment by Dr Patel who viewed the data provided at the previous meeting. Does that he have a - ring a bell to you?-- That rings a bell but-----

All right. The point that I want to get to, Ms Aylmer, is to show you then these two pages, if I may.

COMMISSIONER: On the screen?

MR DIEHM: Yes, on the screen please. The first page will be the one for 30 June 2003. Now, Ms Aylmer, I suggest to you that the two pages that were produced by Di Jenkins and the subject of discussion, certainly at the August meeting at which you were present, are consistent - consisted of that document and another one that looks the same except that it relates to the period July 2003 to June 2004, indicating the number of wound dehiscence incidents at the hospital in those respective calendar years. Do you recall seeing those documents at that time?-- No, I don't recall seeing the documents. From - I'm not saying that they weren't shown, I don't-----

You don't-----?-- Basically that was not my area of responsibility and when I felt that it was being taken over by somebody else, you know, I know that there was data shown, presented at the meeting, and that would no doubt be the data, but I don't necessarily recollect it.

Do you recall that it was discussed at the August meeting that what the data showed was that by the time of August 2004 and indeed after the preceding calendar year, so since July 2003, there had been a reduction in the incidents of wound dehiscence compared to the previous calendar year?-- I do remember that that was - was stated and I do remember that there was queries between what Ms Dianne Jenkin actually stated and what was presented, and there was some queries about coding of - on charts.

Yes?-- Coding for dehiscence.

COMMISSIONER: What do you mean by coding?-- Basically to get this data they would have had to have been coded. They would have to be indicated as - dehiscence was mentioned on the discharge summary, for example, and that would have to be picked up by the coders for them to be able to pick up this data, and I think - you know, while again I did not take that on Dianne Jenkin would be the better person to speak of this.

That coding, the staff who input that coding into the system wouldn't have necessarily have a medical training?-- No.

It's someone - the person with medical training is the person who writes up the discharge summary?-- That's right.

And says there's been dehiscence?-- So that needs to be mentioned on the discharge summary-----

Yes?-- -----or somewhere - I'm not sure exactly where the coders go to find their information. But it has to be noted by the medical staff that dehiscence has occurred for that to be coded in such a way.

And who would be responsible for doing that?-- The medical staff would write up the charts.

Well, it seems to me the obvious question is the previous year you had 13 suspected cases of wound dehiscence?-- There were 13 cases of dehiscence.

Yes?-- Yes.

Were they all noted on the discharge summaries or was there some coding system?-- Well, some of them were still - some of them would have been still in-patients at the time and that is - that is not what I looked at at the time-----

Yes?-- -----to know if that was the case or not.

I was just wondering how useful these statistics are if-----?-- Well, they are only as good as the information

that's been put on the chart for them to collect.

Yes.

D COMMISSIONER VIDER: We have heard information in these hearings previously that the impression was gained that Dr Patel instructed junior doctors to enter particular words into patients' records and discharge summary sheets. One example is the record that's been mentioned. Have you had any experience of that?-- Again - unfortunately it's only hearsay but I did hear of two doctors that had a conversation about what they should and should not write on discharge summaries in relation to infection, and I did proceed, I spoke to Jean Kirby as being one person about that, and I am just never sure what her role is but she - she does deal with these statistics and I also spoke to the medical education officer, Judy O'Connor, because I did have concerns that I was hearing this and I wanted to investigate but again found it difficult to get any information.

COMMISSIONER: The other thing that I find interesting about these statistics is they are not broken down by the respective surgeons. So if you have 7 per cent out of 99 abdominal operations, that may be well within the standard, but if Dr Patel was doing only a third of those operations and all of the dehiscence were associated with him, I don't know-----?-- No, that's not reflected there, no.

Yes?-- I know it was suggested at the time that what had happened with the dehiscence that - I think previously you have stated that what - the situation with the wound dehiscence has been worse before and that it was actually quite reasonable. That was what Dr Patel's - when he got Kay Ferrar or somebody to do, I assume, these stats. But again you need to talk to Dianne Jenkin. She is the one that I believe found that there was other patients that weren't included in the stats. So that would be her story to tell.

But on the face of it you'd accept the force of Mr Diehm's point, that if Dr Keating is at the meeting, these figures are presented on the face of them, they look as if there isn't a significant dehiscence problem?-- That's correct.

MR DIEHM: Thank you, Commissioner. Commissioner, to deal with the paperwork, I wonder if firstly the statistics can be received as an exhibit, the two sheets?

COMMISSIONER: Yes. The two sheets of statistics will be Exhibit 64. Just describe them into the record as two sheets of dehiscence statistics.

MR DIEHM: Thank you.

ADMITTED AND MARKED "EXHIBIT 64"

COMMISSIONER: Bit of a tongue twister. Do you also want to put into evidence the minutes of that meeting to which you-----

MR DIEHM: Commissioner, I should. I wonder whether I might do, with the liberal procedures that apply with respect to evidence, is if I receive that back here and put it in as part of a bundle of minutes of meetings of the ASPIC Clinical Forum between 19 May 2004 and 13 October 2004. Other witnesses will comment on them in due course.

COMMISSIONER: Just give me those dates again. 19th of the 5th '04 to?

MR DIEHM: 14th of October '04.

COMMISSIONER: And the entire bundle will be meetings of the ASPIC Clinical Service Forum for that period.

MR DIEHM: Thank you.

COMMISSIONER: Yes, I will hand that back. I don't think so much it a matter of liberal, I think it's just a matter of making the record easier to follow if we have them altogether.

MR DIEHM: Certainly. There are just two further pages of that document that the witness might still have with her, I think. If I can provide that bundle.

COMMISSIONER: All right. Exhibit 64, as I indicated, will be two sheets of dehiscence statistics, and Exhibit 65 will be the bundle of ASPIC clinical forum minutes for the period 19 May 2004 to 13 October 2004.

ADMITTED AND MARKED "EXHIBIT 65"

MR DIEHM: Thank you. Ms Aylmer, you have given some evidence about a meeting that you attended with Miss Pollock with Dr Keating in November 2003 concerning problems in the Renal Unit with respect to infection control. You've mentioned that Dr Keating asked for statistics at that meeting. Is that the only information that he was looking for?-- That is what I remember, that he asked for statistics.

Appreciating that recalling the fine detail of these sorts of conversations this long later can be difficult, what would your response be to a suggestion that in fact what he asked of you was for hard information with respect to the problems that you were relating, whether that be in form of statistics or specific instances and details that you could provide him?-- I don't believe that's the case, because that's exactly what we were there - we were there with the particular instance where Dr Patel had breached a septic technique. So that's not what I remember, no.

In any event, you can certainly recall him asking for some further evidence in the form of statistics?-- Absolutely, yes.

COMMISSIONER: Mr Diehm, may I say - I say this for the assistance of everyone around the Bar table. Bearing in mind we haven't got a jury here, and I think - I hope we can rely on us to be fairly sensible people. We don't expect everyone to have word perfect memories of conversations that took place two or three years ago, and I'll leave it to your judgment whether you feel a need to put a version of events that is substantially similar but perhaps different in detail if you feel it necessary to do so, but don't think you will be Brown v. Dunned if you don't put a precise version.

MR DIEHM: Thank you, Commissioner. In your statement in paragraph 14 you refer to the eICAT generated reports?-- Yes, that's correct.

And you make mention that you did not keep copies of those reports, but that you provided them to management, and management including Dr Keating, presumably?-- That's correct. Basically eICAT's a database, so I just put in the month - I can go back to any month now and print it out, but I

can't say that what I'm now printing out for March 2004 would have been what I was printing out in July 2004 for March 2004. It's a database that's evolving. It changes as you pick up more information.

It's right to say, is it not, that the information that was generated from that database revealed nothing in particular of significance in terms of trends or occurrences with respect to infections relating to Dr Patel?-- That's correct, or relating to any surgeon.

Thank you. Commissioner, I can inform the Commissioners that I have been provided by my client with a bundle of at least some of the documents that were provided by Ms Aylmer to Dr Keating. I don't want to clutter the record unnecessarily or take any further time given that it's common ground, I might say, between Dr Keating and Ms Aylmer that they don't show anything of any significance in terms of trends.

COMMISSIONER: Unless you see some forensic purpose for your client's interests to put them in, I share your sentiment about not cluttering the record.

MR DIEHM: I won't do it because I appreciate that probably means 15 copies for everyone, Commissioner.

COMMISSIONER: Yes.

MR DIEHM: Ms Aylmer, you've related the statement by Dr Patel that was made in your understanding to the nurses in the Renal Unit, and I think the way you described it in your evidence today was to say that Dr Patel had, in all seriousness, said that doctors don't have germs. Now, I'm right in understanding that's not something that he said in your presence?-- No, the staff that were there - that was their wording, that he said that in all seriousness.

And so they believed that he really believed that himself?-- Well, if somebody was to make a statement like that you might think that it could be in joke, but that was not the impression that Dr Patel was giving. They felt that he was very serious in making that statement.

You in turn think that he was very serious in making that statement too?-- I believe that he was. I can't - I find it hard to believe - comprehend that somebody could think that, but this is - I believe the staff when they said that Dr Patel, at that time, said that in all seriousness.

COMMISSIONER: I don't think you're suggesting, are you, that you thought Dr Patel believed as a literal fact that doctors never have germs, but rather he was putting out the viewpoint that doctors' germs don't matter. He can come and go as he pleases?-- I imagine that's - yeah. I mean, I don't think anybody could seriously think that they didn't have germs.

Yes?-- But the fact that when he made the statement he was serious in the way that he said it. It wasn't said as a joke.

MR DIEHM: Ms Aylmer, the email of 8 July 2003, to return to it, can you tell us why it is not referred to in your statement?-- Because basically we are encouraged to decrease space on the computer, so I deleted most of my 2003 emails.

Is there any criterion that you use as part of this electronic document destruction policy?-- Other than just we're asked to, I'm sure a number - I'm sure there's people that have never deleted anything, and then there's people that delete almost on a daily basis when things come in.

Which one of those people are you?-- In between.

In between. All right. Is there any particular criterion you use to decide which emails you'll delete and which ones you'll keep?-- I think that I tried to keep things that I could envisage might be important.

What about GA2 to your statement?-- That is actually - you're asking if I had kept that?

Yes?-- I actually got that from Toni Hoffman. I knew that I'd sent it out and she sent it to me, because she's one of the people that never deletes anything, and she actually sent that to me.

Are there any-----?-- But again I'm saying I didn't delete everything, but I did delete a lot of things.

Thank you. I don't have anything further, Commissioner.

COMMISSIONER: Thank you so much, Mr Diehm. Mr Ashton?

MR ASHTON: Thank you, Commissioner.

COMMISSIONER: Mr Diehm, at this time of night can I particularly express our gratitude for your promptness? I realise this is a very important matter for your client, and if it's of any comfort to him, I can assure him that your quickness hasn't in any way prejudiced his interests.

MR DIEHM: Thank you, Commissioner.

CROSS-EXAMINATION:

MR ASHTON: Ms Aylmer, I want to ask you about two meetings to which you've referred in your statement. The first occurs in paragraph 45 and the next one occurs in paragraph 46. I just want to put to you the way they read to me, and you just tell me whether you agree that I've correctly understood their thrust or not.

COMMISSIONER: I'm sorry, Mr Ashton. Deputy Commissioner Vider has reminded me, neither you nor I have introduced who you are, so-----

MR ASHTON: My name is Ashton and I am counsel for Mr Leck. Just referring to the first of those, that says to me - this is what it says to me, you just tell me whether I've got it right or not - that Mr Leck validly aired disapproval about lack of progress, but your complaint is that it was true of others as well. Is that a fair statement?-- Well, I think that's a reasonably fair statement, yes.

So you don't complain about his airing disapproval, but rather that-----?-- It was targeted at nurses.

Well, why do you say that? Do you know what-----?-- It was only nurses that were at that meeting, only looking at the - what came up at that meeting. It was not looking at other disciplines and what they had done about the-----

Do you know whether that was dealt with at some other time?-- It may have been after that, but at that meeting, at that time, that was the-----

All right. So you don't know what else was done at any other time, and you agree with me, do you, that he reasonably aired his disapproval on this occasion, but you didn't like the fact that it didn't mention other than nurses?-- I don't know that he reasonably aired his disapproval-----

You've changed your mind now, have you?-- In the fact - depends on what you would say is "reasonably". He was very - he definitely aired his disapproval, as I've got there, so I suppose it's whether that's reasonably or not in that he was very - he was angry.

Now, let's understand what we're talking about. I'm talking about was it reasonable to disapprove of the lack of progress?-- It's reasonable to disapprove, yes.

And was it reasonable of him to air that disapproval?-- Yes.

Yes, thank you.

COMMISSIONER: But do you have a comment about the way in which he aired his disapproval?-- I think it's the way in which he aired it.

MR ASHTON: I see. What's your comment?-- Basically that I felt that he was very - very angry.

Did he shout?-- He has shouted. I don't believe that he shouted that day, no.

What made you think he was angry? He was expressing disapproval?-- Well, there's more to just the words that one says. It's the tone and the way that it's said.

All right. What was the tone?-- That - an angry tone.

COMMISSIONER: Angry.

WITNESS: He was angry. I'm not saying that - as we've said, I can understand that he might not have been happy with the lack of progress, but I just felt that he - considering we had a number of Director of Nursings over a period of time, that I felt that he was probably a bit unfair in being as angry as he was.

MR ASHTON: So it's now that, as the Commissioner has helpfully pointed out, his angry tone-----?-- I actually said that, I think, before the Commissioner did.

It might have been a tie. But anyhow, the unfairness now lies, does it, are you telling me, in the degree of anger in his tone?-- The point that this has - why this has come up is because I - which I make in the first paragraph, is that the Executive demonstrated a disregard for nurses, and the point to bringing this up was to give an example where I felt that that was demonstrated, and yes, the District Manager can air his disapproval that nursing hadn't progressed, but I did think that he was quite angry.

So he was angry-----

COMMISSIONER: Mr Ashton, if we promise not to make any finding whatsoever regarding what is an acceptable or an unacceptable level of anger in the tone used by the District Manager, can we move on to something else.

MR ASHTON: If I have that promise in relation to this meeting, certainly, Chairman.

COMMISSIONER: In relation to that issue that you've been on now for five minutes, I really think it would help if you moved on.

MR ASHTON: Delighted to hear it, Commissioner, delighted.

COMMISSIONER: Thank you.

MR ASHTON: Let's move to the other meeting then. My impression here is that - and you tell me if I've got the impression wrong - my impression here is that again it may not have been unreasonable for Mr Leck to remonstrate, but you didn't like being the target of the remonstration. Is that a fair statement?-- I don't understand the word, sorry.

"Remonstrate"?-- No.

Complain?-- In regard - Mr Leck - this is relating to the - when he addressed us after the leak had been made to the politician, and we actually attended a meeting where we didn't even know Mr Leck was going to attend. He arrived and he was clearly upset, and I do understand that he would be upset, but he was also very unhappy. He was quite accusatory in that he

felt that a nurse - his reliable sources told him that a nurse was behind this, and he was clearly - and I understand that he was not happy, but he was clearly not happy.

Is my impression correct then, that it was reasonable of him to complain about this?-- It's reasonable for him to not be happy that this has happened. It's not reasonable to think that he could - that he has a right to take that out on us.

Well-----?-- Because he is then saying that he blames us for acute - that we are responsible for that. We're just - you see what I'm saying? He, by being angry at us, means that he's implying that we are the people responsible.

It follows, doesn't it, that he can't remonstrate with anyone then?-- Well, unless he knows who was involved. I mean, the thing is-----

It was in fact a nurse, wasn't it?-- It would now be known to be now, but the thing is it wasn't me and it wasn't the other people that were in the room at the time.

I see. You think it's unreasonable of him to complain other than to the person responsible?-- I think that it would be more helpful to have taken a different approach rather than being accusatory and taking that approach. At that stage I think it would be more helpful to say, "Look, we have a problem here" and whatever, but-----

I see?-- To take more of an accusatory approach-----

But you want him sacked for this, don't you?-- No, I don't. It has never - as far as I'm concerned it's never been about any of the Executive members. It's only been about Dr Patel.

But you've complained to the CMC that this was official misconduct on his part.

MR ALLEN: That's incorrect. That's false.

WITNESS: I have not.

MR ALLEN: It's quite wrong to put a false proposition to a witness.

WITNESS: In what way? I don't understand. How have I done that?

COMMISSIONER: No, come on. You told us earlier how people who chair meetings have to take control sometimes. Mr Ashton, is there a complaint to the CMC that you have in front of you that's the basis of what you're putting to the witness?

MR ASHTON: Yes, it's from the union. I'm presuming that you complained to the union who complained on your behalf?-- I did not say that to the union at all.

I see. The union made a complaint.

COMMISSIONER: So the union made a complaint.

MR ASHTON: Without your knowledge?-- Yes.

And without your approval?-- Well, if I didn't have knowledge I couldn't give approval.

You don't approve-----

COMMISSIONER: That's right, Mr Ashton, isn't it? Let's not be silly.

MR ASHTON: Well, with respect, Commissioner, it may be that she didn't in fact give approval. I'm asking her does she approve. She's told me now-----

COMMISSIONER: No, no, no. That wasn't your question, Mr Ashton. You said, "Without your knowledge?" She said, "Yes, without my knowledge." Your next question was, "Without your approval", and she said, "Well, if I didn't know about it, how could I approve it?" Now, that's fair enough, isn't it, Mr Ashton?

MR ASHTON: Implicit in that, Commissioner-----

COMMISSIONER: That is fair enough.

MR ASHTON: If she had known she might have approved it, and I'd really like to test that.

MR ALLEN: It's irrelevant whether she approved of it or not.

COMMISSIONER: Mr Ashton will tell us it goes to bias or something. We're not going to allow any opportunity for anyone to say that I haven't given Mr Ashton every opportunity to ask every question that he thinks is relevant.

MR ASHTON: Thanks, Commissioner. Let's return to it then. You think it was reasonable of him to complain-----

COMMISSIONER: Have you seen this complaint?-- Which complaint?

This complaint to the CMC-----

MR ASHTON: I'm now talking about-----

WITNESS: I don't think so. There was a letter that the CMC produced when I had my interview with them, but I think that was just a letter that was saying that - where the union asked for them to look at what was happening. I think it was just a mere letter like that. It wasn't any - this was way back in April, so-----

COMMISSIONER: Go on, Mr Ashton.

MR ASHTON: Did you give a statement about this matter?

MR ALLEN: To who?

WITNESS: To the CMC?

MR ASHTON: The CMC, yes?-- Not about that matter.

So you don't complain about this matter.

COMMISSIONER: Sorry, what's that mean? It's in her statement here. She's here as a witness. She went to the CMC as a witness, not as a complainant.

WITNESS: This was not discussed when I had my interview with the CMC, this point.

MR ASHTON: I see. Doubtless we've been promised the statement, so I presumably can have those.

WITNESS: We mainly just spoke about post-discharge surveillance when I was with the CMC.

MR ASHTON: I see. Thanks very much. Can we return to how you felt in saying these things in your statement? You understand it's serious, don't you?-- Yes.

Very serious for Mr Leck?-- Yes, I do.

So it's very important that we get it right. Whether it's the union or anyone else that's complained, a complaint has been made about this meeting and about what he said?-- Mmm hmm.

That makes it very serious, do you agree?-- Absolutely.

Thanks. Let's see if we can concentrate on it now. Can you tell me what he said?-- He did - I cannot tell you fully what he said, but he did talk about teamwork and people - he did talk about - again about the source, that he'd been told by reliable sources. He did say - talk about Dr Patel and his right to justice, and I'm not sure what else he did speak about.

And you agree with me, do you, that it was reasonable of him to raise those matters.

MR ALLEN: Is that a matter for this witness?

COMMISSIONER: Exactly. I'm not going to stop him.

MR ASHTON: We've heard all about how this witness felt-----

COMMISSIONER: Yes. Go ahead. Go ahead.

MR ASHTON: This paragraph is precisely about that.

COMMISSIONER: I'm not stopping you, Mr Ashton. Keep asking your question.

MR ASHTON: If it's not relevant, with respect, then it shouldn't be in here. If it's in here-----

COMMISSIONER: Mr Ashton, I told you you could ask the question. I didn't say you could argue with the witness. If you've got a question, ask it.

MR ASHTON: I was responding-----

COMMISSIONER: No, if you've got a question, ask it.

MR ASHTON: Thanks, Chairman. Tell me, you think it was reasonable of him to raise these matters in this meeting?-- It was reasonable for him to raise the matters, but it wasn't necessarily reasonable of him to take the tone that he took.

This was an upset tone, I think you've said this time?-- He was obviously angry, and I can understand that he can be angry, but he was very accusatory and blaming, and as I think I stated earlier, it certainly made - we were made out to be the bad guys. Sorry.

COMMISSIONER: We might take a 10 minute break.

THE COMMISSION ADJOURNED AT 6.27 P.M.

THE COMMISSION RESUMED AT 6.32 P.M.

GAIL MARGARET AYLMER, CONTINUING CROSS-EXAMINATION:

COMMISSIONER: Yes, Mr Ashton?

MR ASHTON: You have given us some indication for the things that Mr Leck said, Ms Aylmer. Do you remember one of the nurses in the group asking whether he intended to - "track down" I think might have been the expression, or something like that - track down the person responsible for the leak?-- That's true, I do remember that.

You remember he responded, "That's not my priority."?-- I think he did say that.

I have nothing else, thanks, Commissioner.

D COMMISSIONER VIDER: Could I ask a question for clarification, and I'll going back to paragraph 45 for one moment?-- Yes, okay.

Mr Ashton was talking to you about the mood of the District Manager at that stage and it would be apparent that nursing hadn't met expected targets, outcomes or whatever. Were the nursing staff aware of what the expected performance indicators for them were, be they in outcomes or as nominated in the strategic plan, or whatever, so if you were not meeting expectations and this was creating an angry response from a member of the Executive, were you well aware of where your shortcomings were?-- You were aware of what the Press Ganey report had indicated and there was a plan that nursing had started to develop, which again was delayed, of course, because of the staffing issues, but they were moving towards progressing and working on sort of achieving some outcomes and educating staff and reminding staff of different things. So, there was a plan afoot.

And were there datelines, or whatever, that at that stage the service hadn't met?-- No, not at that stage, but I would like to say in regard to that that when I was talking about how that led me to want to resign from that committee, the point that Mr Leck made was - his was only a small point there that he was concerned about - it was more the barrage of questions and saying that nursing wasn't completing this checklist as they should have. It wasn't Mr Leck that was saying that.

Thank you.

MR ASHTON: Commissioner, on your previous intimation, I don't have any questions arising out of that matter.

COMMISSIONER: Thank you, Mr Ashton. Who does that leave? Mr Boddice?

MR BODDICE: May it please Commissioner.

CROSS-EXAMINATION:

MR BODDICE: Ms Aylmer, I am Mr Boddice, one of the counsel representing Queensland Health. Could we start off-----

COMMISSIONER: Mr Boddice, I wonder if you could keep your voice up or perhaps-----

MR BODDICE: Put the microphone down?

COMMISSIONER: Yes.

MR BODDICE: Could I start with wound dehiscence, first of all? You have been asked some questions about that, and just so that I can understand it - and perhaps others - I take it there's a number of causes for wound dehiscence; one is infection?-- Yes.

Is that so?-- Mmm.

Another is technique or the suture material that you have referred to?-- Yes.

Another could be if the patient has poor blood supply?-- I'm not fully aware of absolutely all the reasons for wound dehiscence, but certainly they are as I'm aware.

And also, I suppose, if the patient is generally very unwell - that is, poor health - so therefore they don't heal as well as otherwise might be the case?-----

COMMISSIONER: Malnourished, or something like that?

MR BODDICE: I beg your pardon?

COMMISSIONER: Malnourished.

MR BODDICE: Yes, or generally poor health, poor immunity system, for example?-- That is more relating to the healing, but, yeah - in these situations, though, where the wound sort of broke down to a greater depth, you would assume it could be something to do with technique or closure products.

So, when you said that wound dehiscence wasn't within your area, do you mean by that that if it is caused by infection, it is within your area, but if it is caused by other causes, then it doesn't fall within your area?-- There's nobody - there's no person in the hospital that actually has - wound care is their responsibility. So, that would be - if there was somebody with that position, that would be their responsibility.

Yes. But is that why, for example, the Nurse Unit Manager of, say, theatre may start to get some statistics in relation to it, because you would only be given information about infection in your role?-- That's right. That's basically why the Nurse Unit Manager of Surgical Ward has taken on that role - it is more related to her position.

Now, in your first statement, one of the annexures was GA3, which is your report to the Leadership and Management Committee of 7 July 2003; do you have that?-- Yes.

Under "Wound Dehiscence" there is the reference to concern about "investigating 13 patient charts at the moment", and you queried technique, queried fault with closure product used, and then you said you would like to "implement that all wound dehiscence in the future be automatically swabbed for culture and sensitivity." Is that implementation then seen by the forms that you subsequently produced?-- No, I just basically asked staff to do that, but those forms that I subsequently produced were not so much related to wound dehiscence, they were related to post-discharge surveillance.

All right. So, is this something - did you actually put something into effect to put this implementation - implement this program?-- Other than asking staff to collect wound - if there was a dehiscence, to actually do a wound swab, and as they were unable to get the doctor to actually sign it at the time, that I could do that.

So, I suppose what I'm asking is here in the report, it says - this is what you would like. Were you given approval to do that?-- Yeah, I imagine - yes, I would have been, and also the fact that I think it came up in a meeting as well and - yeah, I have no problem that they gave approval for that.

Now, you were then subsequently asked some questions in relation to the eICAT program?-- Mmm.

And the CHRISP program?-- Mmm.

Did I understand your evidence to be this: what CHRISP does is basically identify a number of set procedures, in effect, that you can then have a state-wide benchmark as to how that works?-- That's basically it, bearing in mind, again, that the statistics aren't risk adjusted, so that even though you are state-wide benchmarking, there is a lot of analysis that has to go into that because it is not risk adjusted.

Yes, but it is one system which allows, in effect, a comparison?-- That's right.

Between various hospitals?-- That's true.

By picking certain set benchmarks so that you can ensure that you are comparing apples and apples and oranges and oranges?-- As much as you can.

As much as you can, allowing for, obviously, the variables in any system, but that's the intent of the system; is that the case?-- That's right.

But in addition to that, each hospital can undertake it's own program, so to speak, of looking at benchmarks that may be relevant to that particular hospital?-- So we benchmark internally, but-----

Yes?-- Yes.

So that's what you were referring to when you spoke about - that you were going to look at some additional types of procedures - that was from the point of view of Bundaberg Base Hospital and how you were performing in respect of those procedures?-- That's right, to try and capture more data from our own local knowledge.

And that's why - when you said it doesn't go into CHRISP, that's because it is actually meant for you locally?-- I actually do have it - from the point of view of hernias, when I first thought to have hernias, I wasn't aware - or I had not read this, but the fact that it wasn't - couldn't be the same - they didn't accept procedures for the same day, so when I decided to take on hernias, I thought that CHRISP would pick up that data, but they basically - their program is designed and it basically rejects any data that doesn't meet their definitions - same day admission and discharge - they wouldn't pick up that data. They would pick up some of it if the person had to stay overnight, but other than that, they wouldn't.

So, the intention was that you would get some extra information, in effect, for Bundaberg Base Hospital?-- That's right.

And the system allows the hospitals to do that?-- Absolutely.

And I take it that to get that information, that's where you need the patient's consent, obviously, to be using the material?-- You need the patient's consent to get - to follow up the post-discharge and send out the letter that's part of the CHRISP program. The eICAT program is a letter that's automatically generated and basically you need their consent to send that letter out to them.

All right. Now, you made the valid point that in some cases, the numbers will be small, so therefore, statistically, you have to look at it in that context - that it is a small sample?-- Yes.

But I take it that in the case of CHRISP, that could be the case in a number of hospitals, particularly the smaller hospitals, that the sample rate could be small because the number of patients that consent could be small?-- That's true. Sometimes, though, when you start to put the data in, I think they want you to have 50 cases a year. So, when you put the data in, it may be that you haven't achieved the 50 cases.

So, I'm not sure how CHRISP pulls that out or how they work that out, but certainly 50 cases - they would still say that that was - you know, quite a small number.

Mmm. And I take it that in the case of wound infection, however, you would - even in the post-operative situation, you would pick up some of those cases because obviously if it becomes a true wound infection, they may well come back to the hospital?-- If - that's true. If it becomes more of a system, I can include infection. There were people that were readmitted from that perspective, but, yes.

Or they may come back to out-patients and then be admitted from there?-- That's true.

So, the situation may be that from the post-operative point of view, you have the problem of the number of patients who may consent, first of all, and then you had the problem of patients that you may not hear back from, in effect, as to-----?-- Response rate to the questionnaires.

Response rate is not as prompt or as successful as you would like, obviously-----?-- No.

-----from a statistical point of view, but in the case of some of those, if there is a significant wound infection, then they may well come back into the system, in effect, because they come back through the hospital?-- And, again, I have an automatic notification through the pathology service, but also, then, it does come back to the point of being notified by staff.

Yes?-- And that's generally nursing staff.

Yes. Now, the wound dehiscence, can that also be a matter that can be reported through the incident system?-- I don't believe that it is.

But it could be, I take it?-- Yes, yeah.

But, as you understand it, it is not generally reported in that way?-- I don't think so. It probably should be, though.

Now, in GA5-----

D COMMISSIONER VIDER: Mr Boddice, could I ask a point there for clarification?

MR BODDICE: Certainly.

D COMMISSIONER VIDER: Would a major wound dehiscence, where you have got exposure of bowel and other abdominal contents, would that ever be a sentinel event?-- I'm not exactly sure of the definitions, but I don't think so. From the perspective - I think it is death, and there's some - there's - somebody else could say that, but I don't believe that that would be a sentinel event.

MR BODDICE: Do you recall whether, at some point in relation to this wound dehiscence, there was a discussion in the ASPIC forums about it being recorded as an adverse event or outcome?-- That again happened in 2004, whereas my recall of wound dehiscence focused in the 2003 time, but I think I even mentioned on the minutes here before that I think it was Toni Hoffman that suggested that - queried whether when things happened in theatre or when things happened, that there wasn't forms filled out.

COMMISSIONER: My recollection, if it helps, is that it was in the August 2004 minutes that was shown to the witness about half an hour ago.

MR BODDICE: Yes, indeed the October 2004, which may appear in that bundle, that was there, so perhaps we can look at that bundle-----

COMMISSIONER: If it is there, it is, but I don't think we need to trouble this witness since she has no recollection beyond-----

WITNESS: I do remember that that did come up, that's true.

MR BODDICE: This is a forum that you were a member of?-- I was a member, but I'm not - unfortunately can only get to every second meeting. It gets quite disjointed-----

I'm suggesting to you that in the October meeting, the topic came up and that the item under "open/close" in the column they have for a particular item, they said - the item "close" - "wards will obviously continue to report wound dehiscence as 'adverse events/outcome'" and that accords with your recollection, I take it, that at some point in 2004, that was-----?-- Yes, I'm pretty sure that was suggested.

Now, could I just take you to GA5, which is in relation to surveillance for follow-up post-discharge, and this is the report to the Leadership and Management Committee of 2 November 2003. Do you see under that heading "Surveillance" - see under the heading "Surveillance Follow-up Post Discharge", that you - it is listed there three options, which was: to "continue as is", "ask MO", which I assume is medical officers - "to notify"-----?-- Yes.

-----"an ICO" - I assume is infection control - and the third option: "give package to patient on discharge", includes follow-up letter with return envelope "Wound Information"?-- Mmm.

Again, in relation to that management committee, do you remember what was determined - what option?-- I think from the perspective of - now I really don't remember, but from the perspective of what I meant with the last option was that CHRISP was trying to do a - some research where they provided the patients with more information for when they went home and so they could make - make it easier for the patients when they were completing their form; so, no, I really don't now

actually remember what the outcome was.

All right. Now, in paragraph 33, you spoke about the discussions in terms of the conducive theatre attire, and you said in evidence that Dr Patel said that he would change his attire when you saw him outside in the carpark; for example?-- He said that he would.

I take it you don't know whether he did that or not?-- That's correct, I don't know.

And you also gave some evidence about the problems with hand washing. Is that really a world-wide problem?-- It is a huge problem. I think it is well accepted that hand washing, while it is mostly preventing cross-infection, is one of the things that is poorly done, but, again, as I tried to say, I think there are times when the contact between patients is not quite as at risk - if they were just sort of basically - depending on what the contact is.

There is a range - from your point of view in your role, what you were hearing in relation to touching wounds-----?-- What I was seeing.

What you were seeing, quite correctly, in touching wounds, was of a matter of concern for you?-- That's right.

Now, at paragraph 40, you deal with this meeting that you attended which was a lecture presentation, if I could call it that, in relation to-----?-- There was - yeah, Powerpoint Presentation.

That's what I was going to ask you. Do you recall that was, in effect, a Powerpoint Presentation?-- I believe so. There was certainly more than one presenter, as I remember.

And the form that was put into evidence as Exhibit-----

COMMISSIONER: 61, I think - the E-mail relating to ethical awareness.

MR BODDICE: Yes, that's the one.

COMMISSIONER: 61.

MR BODDICE: That suggested that, in fact, there were a series of meetings occurring throughout the state?-- Mmm.

Do you recall there were different states in respect of different-----?-- Yes.

And is that how you understood it was; it was a system where they were going around the state, in effect, giving these presentations?-- Yes, it was an ethical awareness, and they were doing that.

Bundaberg's date was 14 October as shown on that form?-- Mmm.

And do you recall that the session was one where quite a number of nurses attended?-- I don't believe that there was just nurses, I believe there was other staff.

Quite right. I should say quite a number of staff attended?-- Yes.

And do you recall that there were then these Powerpoint Presentations where slides were put up in respect of it?-- I think that was the case, mmm.

And do you recall that the areas that were covered in relation to the matters that were covered there included issues of, in effect, ethical awareness, if we can call it that?-- Mmm.

Which covered a whole range of things - official misconduct?-- To be honest, I don't recall exactly all of the content and really my only - I don't have too much recollection other than I have now seen - have seen that flyer - found that flyer and read that through, but up until that time, I didn't remember that much about it, other than what I have said in my statement.

COMMISSIONER: Mr Boddice, entirely up to you whether you pursue this, but I think the witness has very fairly told us already that she has got very little recollection of the detail of what was said on that occasion. I'm not sure much is going to be achieved by putting to her your instructions on the matter and I certainly wouldn't require you to do so.

MR BODDICE: In that case, I won't do so. As you indicated before, we provided the names of people who are going to provide statements and those-----

COMMISSIONER: You have also given us a copy of the Powerpoint Presentation.

WITNESS: I would, from that perspective, have thought that perhaps it could have come from a question that somebody had asked - you know, that comment - so that might not be necessarily what was said elsewhere, but I do remember - all I remember is that from what I had heard, that my concern was that if you take a report outside of Queensland Health, take issues such as I was aware was happening, that there could be issues, and I made that statement to Toni.

COMMISSIONER: Ms Aylmer, would this be a fair summary of the situation: that's the state of mind that you came away from the meeting with?-- Yes.

But if Mr Boddice were to spend the next half hour taking you through the details of everything that was said and that there was, in fact, discussion about you could take complaints to the CMC, the Crime and Misconduct Commission, you could take complaints to the Health Rights Commission, there are all sorts of other mechanisms you could use to deal with complaints, you couldn't really disagree with anything he puts to you?-- No. That's just my -----

MR BODDICE: Thank you, Commissioner.

COMMISSIONER: Thank you.

MR BODDICE: Can I deal then with paragraph 45 which is this meeting about the Press Ganey Report?-- Mmm.

Now, as I understand it, the Press Ganey report is something which is, in effect, a measure of patient satisfaction?-- Yes.

It was not something that is peculiar to Bundaberg, it is done through a whole range of places?-- Yes.

And it is done yearly?-- Yearly, I think. Yes, yearly.

In this meeting, was there really a discussion about certain items that had been discovered, or reported on, I suppose, for the Press Ganey Report in terms of recommendations of things that could be improved?-- I think they did a sort of top 10 of things or whatever, and looking at - I don't know whether they were looking at the top 3, but certainly one of the main issues was the patients understanding their rights and responsibilities.

Yes. And it was in that context that some of the recommendations dealt with nursing-related matters?-- Yes.

And you were there, in effect, as the nurse representative?-- I was there not so much to speak about this, though, but I was a nurse that happened to be on that committee.

You were the nurse representative on that particular night because I think you said Ms Mulligan put in an apology?-- Yes.

What I really wanted to ask you about was that you gave some evidence in relation to Leonie Raven, you said, who also was critical of you; do you recall giving some evidence in relation to that?-- Again, I don't - I just remember that on that day, that I had - it wasn't just Leonie, there was a number of people that - there was a barrage of comments that was made that related to whether nursing were just simply ticking a box and saying that they had told patients about their rights and responsibilities. So, there was basically what I felt was a barrage of comments about that.

And-----?-- And, sorry, were also talking about - one of the things that had been raised was in regard to the reliability of the data, and it wasn't so much that we were trying to be obstructive, or whatever, we were just - as far as the statistical numbers - and it just came up as a query as to, you know, how that worked as well - from that-----

That's actually the point I wanted to come to. In relation to Leonie Raven, wasn't that really the point of difference between the two of you; that is, that you were rating the

point - from the point of view of the sample - whether, in fact, you could say that it was a sufficient patient survey to suggest that there was a reliable conclusion?-- It was just a query that we had and that was actually the point that Dr Keating supported me on, in that he could see the point - I felt that he could see the point that I was trying to make.

But what I'm suggesting to you is that Leonie Raven's point, where the two of you were having a difference of opinion, was whether it was big enough - that is, as big as you would like - the fact is that it raised some concerns and meant deal with concerns, with what concerns were raised, rather than deal with, in fact, whether the sample size was big enough?-- Basically, it came down to the fact that we were not - at that point, when we raised that issue about the sample size, we didn't understand how the Press Ganey - whether he had 300 people or the 3,000 people - the way it is worked out that way - we weren't aware of that information at that time, and when that was explained, well, then, that was understood. But we were not - were not aware - when we were talking about the sample size at the meeting, at another meeting prior to coming - when I said what had happened at this previous meeting, at this meeting we are talking about here, with the nurses previously, where I came back and mentioned at this meeting that we were talking about improving performance meeting, I mentioned there there were concerns about the sample size, and then it was explained to me whether there were 300 or 3,000, it doesn't matter with the methodology that the Press Ganey uses, and that was fine, but we were not aware - and I think we did have a right to just ask - you know, if that - if that was - you know, from that perspective - to think that, you know, maybe the sample size was an issue, and when it was explained it wasn't an issue, that was all right.

Now, I'm not contesting that you had a right to raise it, I'm just suggesting to you that the difference between Leonie Raven and yourself that day was particularly about the fact that you were raising that point about the sample size and Leonie Raven was saying whatever the sample suggests is a problem and we should really try and suggest whether that's a problem at all?-- I have no problem with that.

Do you agree that was the point?-- It could have been. Yeah, it could have been. That's fine.

Can I deal with the meeting that occurred in Bundaberg with the Minister and the Director-General? As I understand your evidence, what you're saying in relation to the Minister and the Director-General is this: that there was a comment by either one of them, you can't recall which, that they had just been to Springsure and there was this wonderful facility that they had just opened and then they had now come on to Bundaberg. Do I understand what you are saying is really you took that in a negative way, you saw that as in effect a criticism?-- I felt that that was the way it was said.

So it was really your interpretation rather than anything more they said in respect of it?-- I think you would need to ask other people whether they had that same interpretation.

I'm asking you?-- Well, that certainly is my interpretation and-----

COMMISSIONER: So far as you were concerned, was it open to any other interpretation?-- No, and as I think I said previously, even the admin person that works in the Pharmacy area was upset with that so I found out later and that was clearly her interpretation as well.

MR BODDICE: Now, you then said that you recall that there was a discussion about the release of the Fitzgerald - the report prepared by the Chief Health Officer, Dr Fitzgerald, and as you recall the discussion was that it couldn't be - it wouldn't be released because there was a need for the allegations in effect to be put to Dr Patel, which hadn't happened, and therefore from the point of view of a natural justice point of view it couldn't be released; do you recall that?-- Yeah, that's - yep.

That's the effect of what was said?-- Yes.

Do you recall that also there was a discussion about the Chief Health Officer coming up and talking to the staff involved in the matter?-- I don't know. That may have been the response to when the Acting Director of Nursing at the time asked about some feedback for the staff that were involved and that might have well been the response to that.

Do you recall, in fact, the Chief Health Officer did come up?-- He did come up.

Within a couple of days-----?-- Yes.

-----I think it was. And that the Chief Health Officer did come up and give feedback to the staff in relation to his finding?-- He certainly did.

And do you recall that during this meeting somebody raised whether anything was going to be done to the person who had given this information to Mr Messenger?-- May have. I'm not sure.

What I'm suggesting to you is that that was raised and do you recall the Director-General's response?-- No.

I suggest to you that the Director-General's response was that nothing was going to happen, that he wasn't taking any action against anybody in respect of that, he wasn't interested in that aspect of it?-- Now that you say that I think I do recall that.

And that what he really wanted to do was to get to what were the facts in respect of it; do you agree with that?-- Yes.

And do you recall that the Director-General, in fact, came back to the hospital on the 6th of May this year?-- Yes.

And did you attend that meeting as well?-- I did. Well, I attended a meeting that the Director-General came back.

In about May?-- Yes.

And you recall at that meeting that, in fact, it was raised by somebody that in effect the Director-General's position in terms of Dr Patel seemed to be different to the meeting before?-- Yes, I'm just trying to think who said that, but somebody did say that and this is where the Pharmacy person spoke to the Director-General. But certainly, yeah, that was expressed.

And do you recall that the Director-General at this meeting agreed that since that meeting back in April he had received more information in respect of Dr Patel and that he had changed his mind; do you recall the Director-General said something to that effect?-- I think that could be right, yes. I'm not sure.

And that it was following - getting that further information that he had authorised the review team, which is Dr Matiussi and co, are you aware of that team?-- Yes.

That it was after getting that information that he authorised that review team to undertake a review and also for a patient liaison group to be established in terms of reviewing the patients; do you recall that?-- Well-----

Do you recall that was discussed?-- I don't dispute it. I don't dispute it.

All right. And, of course, you wouldn't have known what

information the Director-General had at his disposal at the 7th of April meeting?-- I assume they would have had some knowledge of Dr Fitzgerald's - the results or at least some interim sort of report. I assume they would have had that information.

Certainly you agree that the Director-General did - that you have agreed that the Chief Health Officer came up within a couple of days of that meeting and did provide feedback; that's the case?-- That's true.

And the Director indicated that the Chief Health Officer would provide feedback to the staff involved; correct?-- I think that was the outcome of the question that was said.

Yes, thank you.

COMMISSIONER: Thank you, Mr Boddice. Mr Allen, any re-examination?

MR ALLEN: Thank you, Commissioner, briefly.

RE-EXAMINATION:

MR ALLEN: Ms Alymer, I won't be much longer. You were asked some questions by Mr Morrison on behalf of Ms Mulligan in relation to the importance of accurate reporting, particularly being able to obtain information for those who are supposed to pass the information up the line to you?-- Yes.

And you in a response to such questioning said that therefore you go and speak to staff firsthand to get information?-- That's right.

And a little while later during questioning by Mr Morrison you said that you make it your business to find out these things?-- That's correct.

All right. Now, did Ms Mulligan apparently take that proactive approach of going and finding out whether things were happening?-- I don't believe so.

In relation to the issues you raised in relation to inappropriate wearing of theatre attire, in particular by Dr Patel, did she, for example, in your experience attend the wards or theatre or even the place where someone goes for a cigarette and see if that was occurring?-- I don't think so.

What about Dr Keating when that matter was raised with him, did you see him on the wards seeing if that was in fact occurring?-- I wouldn't know whether they did or they didn't. I didn't - if I saw them on the wards, I wouldn't know for what purpose they were there. But you didn't have to actually go onto the wards to see them - necessarily to see them

though, the people.

COMMISSIONER: Just so I understand that, where's your - do you have an office that you operate out of?-- Yes.

And is that in the Executive officers' admin area?-- No, it's in the clinical areas.

In the clinical areas, all right. Near a particular-----?-- Near the Children's ward.

Right. Okay. So, theoretically, Dr Keating could have gone to do ward reviews two or three times a day and you would never have known of that?-- That's true.

And I guess the same applies to Mrs Mulligan or to Mr Leck, or anyone else? Yes?

MR ALLEN: You said in response to a question from Mr Morrison that when Ms Mulligan started she said that her role was to, in fact, try and better the Executive's view of nursing staff. Did you form any impression after that as to whether, in fact, she did so or attempted to do so?-- I, in fact, didn't feel that - that's what she basically said. I mean, as I said, I was one of the people that said that I did have concerns about the way nursing might have been viewed in the organisation and I do know that when she started she did ask all the Level 3s what they thought about that, I believe that she did, how they thought nursing was perceived, and that she did say at the meeting that that was her goal to view - to improve the way that nursing was viewed. But I really do feel that she, as our manager, was not - that she basically did not trust us and the way she managed us clearly showed that she, you know - in so far as - I don't know how to say it, but basically she didn't - didn't trust us and didn't - wasn't doing anything to improve our image, in other words. Basically that she wasn't - I didn't find her encouraging or motivating or - in fact, I found her more the other way, that I, you know - whenever I would see her, I would always be sort of second thinking what I might say to her. So I didn't find that she was a motivating manager.

What about the advocate for the nurses that you had hoped that she would be?-- No, I didn't feel that at all.

Mr Diehm, for Dr Keating, asked you some questions about this aspect of lack of aseptic hand washing that you had observed-----?-- Yes.

-----and Dr Keating's request for statistics and it was suggested to you that without those statistics there was no hard evidence to refute Dr Patel's denials that he didn't carry out unsafe hygiene practices. Now-----

COMMISSIONER: I think we have got three negatives there. I think it was denials that he did carry out unsafe practices.

MR ALLEN: Yes, my fault. You recall being asked some

questions by Mr Diehm and the suggestion was basically made, well, how would Dr Keating be able to discount Dr Patel's denial without statistics; do you recall those questions?-- Yes.

All right. Now-----

COMMISSIONER: You had seen him doing this, hadn't you?-- Sorry?

You had seen him walking from one patient to another?-- That's correct, yes.

Without washing his hands?-- Yes, and then, of course, there was the issue with the Renal Unit as well.

What, did he want photographs or surveillance videos, or something?-- I don't know.

I don't understand why we're wasting time with this.

MR ALLEN: How many nurses had reported the renal aspects to Dr Keating as far as you knew?-- Basically I went with Robyn that day, so we reported together.

All right. And as I understand the evidence conveyed, the observations made by three other nurses?-- That's correct.

All right. Now, you wouldn't know if in response to that Dr Keating actually went down to the Renal Unit at any later times to see the techniques carried out by Dr Patel?-- I don't believe that he did, but I don't know.

MR DIEHM: The witness's evidence was that Dr Patel didn't go back to the Renal Unit after that.

COMMISSIONER: The witness's evidence, being entirely accurate, is that Dr Patel wouldn't go back to the Renal Unit. Whether he did go back or not - I think Dr Miach told us he did do some Renal surgery at a later time, but I don't think there's any conclusive proof one way or the other at the moment.

MR DIEHM: Yes, Commissioner.

MR ALLEN: Just one final matter, and it's in relation to some questions you were asked by Mr Diehm in relation to the aspect of wound dehiscences, and in particular you were talking about the minutes of the ASPIC meeting of 18th of August 2004?-- Mmm.

And you will recall that in the meetings there's reference to information from "coded data" and you've given evidence that there were concerns raised about the coding from patients' charts. Now, do I understand your evidence to be that the persons doing the coding would only record a dehiscence if the word "dehiscence" appeared in the chart?-- That's my understanding of how it works. They basically look for the

words and that's how the coding is done, but again I have not spoken to a coder to know if that's correct. But that's my understanding.

When Mr Mullins was asking you some questions, he showed you part of a chart of a patient, Mr Ian Fleming, and as I recall it - I don't have the document and it's not in evidence - but the part he took you to actually had some writing "wound dehiscence" and it was crossed out and "infection" written in?-- That's correct.

So do you know whether that particular - would that have resulted in a coding and a recording of the wound dehiscence?-- I would - depending what else was written in that chart, but certainly just from that entry that would not because it had it scratched out as if it was written in error.

Now, in relation to that topic, you were also taken to a document, which is now Exhibit 64, which, as I understood it, was a record of wound dehiscence and percentages of wound dehiscence per operation for the period July '02 to June '93-----

COMMISSIONER: And the same for the following 12 months.

MR ALLEN: Yes.

COMMISSIONER: '02/'03 and then '03/'04.

MR ALLEN: As I understood the document actually put on the screen, so we could see it was the first for those years-----

COMMISSIONER: I think that's right.

MR ALLEN: And it indicated in relation to May and June some figures. We also have in evidence your document GA4, which was the ultimate wound dehiscence report after the intervention of Dr Patel?-- Mmm

And it recorded, as I believe, four wound dehiscences-----

COMMISSIONER: Four patients.

WITNESS: Four patients - five dehiscences, four patients.

MR ALLEN: Five dehiscences, four patients, and the document you were shown, Exhibit 64, records one wound dehiscence for May and three wound dehiscences for June?-- I can't remember now.

All right. Do you know if they correspond to any of the five you have recorded?-----

COMMISSIONER: Mr Allen, I think this is probably a matter of submission now. I think we've gone beyond the point of asking a question.

MR ALLEN: Okay. The figure for June, as recorded in that

document, Exhibit 64, shows a 20 per cent wound dehiscence rate. Are you able to say from your expertise how that compares to a normal or general surgical rate of wound dehiscence?-- No, I'm sorry that's not my expertise.

Thank you.

COMMISSIONER: Thank you, Mr Allen.

MR MULLINS: Commissioner, for completeness I have that bundle of records.

COMMISSIONER: Very good. Thank you.

MR MULLINS: I tender the Bundaberg Hospital records of Ian Fleming for admission between 30th of May 2003 and 4 June 2003. I have numbered the pages and page 13 was the page which was put on the overhead.

COMMISSIONER: All right. Can you just give me those dates again, May 2003 to-----

MR MULLINS: 30 May 2003 through 4 June 2003.

COMMISSIONER: Right. Yes, okay. As you say you have marked the pages and there are a total of 29 pages. So that bundle will be admitted and marked as Exhibit 66.

MR MULLINS: Thank you, your Honour.

ADMITTED AND MARKED "EXHIBIT 66

COMMISSIONER: Mr Andrews?

MR ANDREWS: One matter, Commissioner.

RE-EXAMINATION:

MR ANDREWS: Ms Aylmer, I was left confused by an answer that you gave to Mr Devlin long ago. Do you know whether Dr Keating was advised by Dr Patel about the six peritoneal catheter placements?-- No, I wouldn't know.

I have no further questions.

COMMISSIONER: Thank you, Mr Andrews. Thank you very much for your evidence and particularly bearing with us through such a long day. It's greatly appreciated and it has been tremendously helpful and useful evidence and we thank you for that. You are excused from further attendance and we hope you

enjoy your holiday?-- It's not a holiday, but thank you.

WITNESS EXCUSED

COMMISSIONER: Ladies and gentlemen, just a couple of sort of housekeeping things I wanted to deal with before we all disappear. Two matters of personal explanation from me. One is that when I was out at the airport at about 5 o'clock I ran into Mr Paul Lucas, the Minister for Transport. He and I were at university together. We exchanged pleasantries, but if anyone spotted us conversing in the corner of the airport, neither of us was silly enough to talk about these proceedings.

Secondly, in a similar vein, it's been pointed out to me that I used an expression in the course of a question this morning, it certainly wasn't intended as one, it didn't even occur to me, but it was suggested to me that it could perhaps be construed as having racist connotations. I, in fact, said words to the effect that Dr Patel may not be as black as he is painted, and obviously I didn't intend anything at all by that, but I certainly apologise most sincerely to anyone who was offended by that form of words, it wasn't intended to have that connotation.

As a regards the transcript, the secretary, Mr Groth, has informed me that when we were sitting in Brisbane the practice is for copies of the transcript to be sent out to counsel by e-mail. The difficulty is that our e-mail facilities here seem to be pedal-powered, or something, old fashion dial up connections, or something, and it would take a long time to transmit the transcripts. So we're putting arrangements in place to have them put on CD, is that right, and if anyone is really keen to have them tonight I think you can stay back and get them, but otherwise we will have them available in the morning.

Speaking of the transcript, Mr Morrison, I looked up that passage. You might recall we had a difference of recollection in relation to a passage. I don't ask you to deal with this now, unless you wish to, but the passage I had in mind was on the second - those pages 1045 at about line 32 where the question was, "In other words, they didn't have as good as reputation as they should have?"

MR MORRISON: I see the passage. I will deal with it in the morning.

COMMISSIONER: Thank you, Mr Morrison, I will deal with that. Finally, talking about the morning, given that it's now almost 7.30, we might give ourselves a bit of an indulgence and start at 10 o'clock in the morning if that suits everyone. Is that acceptable?

MR ANDREWS: Thank you, Commissioner, yes.

COMMISSIONER: Never accuse me of being ungenerous, Mr Andrews. We will adjourn now until 10 o'clock tomorrow.

THE COURT ADJOURNED AT 7.22 P.M. TILL 10.00 A.M. THE FOLLOWING DAY