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IN THE MATTER OF THE COMMISSIONS OF INQUIRY ACT 1950

BUNDABERG HOSPITAL COMMISSION OF INQUIRY

COMMISSIONS OF INQUIRY (No. 1) 2005

BUNDABERG

..DATE 11/07/2005

..DAY 22





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THE COMMISSION RESUMED AT 10.01 A.M.

COMMISSIONER: Mr Andrews?

MR ANDREWS: Good morning, Commissioner. Commissioner, today there will be continuing the cross-examination of Ms Raven. I have been asked to inform you that Mr MacSporran, for Ms Mulligan, and Mr Mullins for the patients' group, are expecting to arrive some time shortly after 12. I know that Mr Mullins hopes to be given an opportunity to cross-examine Ms Raven upon his return.

COMMISSIONER: I think-----

MR ANDREWS: For that reason, for Mr Mullins I am asked whether it would be convenient if he could cross-examine last?

COMMISSIONER: I see no difficulty with that, if there is no objection. I am very anxious - I appreciate Ms Raven has given up the first day of her holidays to come along and give evidence today, so I am very anxious that we finish today. But as long as that's not compromised, I really have no difficulty if counsel at the Bar table work out amongst themselves what's the most convenient way to conclude their evidence today.

MR ANDREWS: Thank you, Commissioner.

COMMISSIONER: Does that sound satisfactory to you, Mr Fitzpatrick?

MR FITZPATRICK: Yes, thank you, Commissioner.

COMMISSIONER: Anyone else? Ms Raven, can I ask you to come back to the witness-box?

LEONIE THERESE RAVEN, CONTINUING CROSS-EXAMINATION:

COMMISSIONER: I will just formally remind you that you remain under oath?-- Sure.

Thank you, Mr Allen.

MR ALLEN: Thank you, Commissioner. Ms Raven, in your affidavit you give details of a system of committees in so far as those committees are relevant to your areas of responsibility of quality control and risk management?-- Yes.

And I just want to try and clarify the picture of those committees?-- Uh-huh.

Now, am I correct in thinking that at the top of the apex is the Improving Performance Committee?-- No, not really. In terms of the entire committee structure, the most important committee would be the Leadership and Management Committee.

The Leadership and Management Committee?-- Yep.

And who sits on that?-- The executive directors.

Anyone else?-- No.

Okay. So where does the Improving Performance Committee fit in?-- We have what we call six major committees that are aligned with the EQuIP functions, Leadership and Management Committee is obviously the executive directors. Then underneath that we have a Continuum of Care Committee, a Human Resource Management Committee, an Information Management Committee, Safe Practice and Environment Committee, and Improving Performance. And they're, I guess, what you would call the major committees across the organisation.

Well, I am looking at LTR3 to your statement, which is a risk management policy which you prepared?-- That's right.

And it is the policy to effectively manage all clinical and non-clinical risks?-- That's right.

And provide "systematic and rigorous process for identifying risks"?-- Yep.

If we go to page 2 of that policy?-- Uh-huh.

It seems that the way those ends are achieved are at the top of the page, "risks reported quarterly to the Improving Performance Committee"?-- Yes.

"For each of the risk registers"?-- Yes.

And also "that reporting requirements to corporate office are met"?-- That's right.

Okay. So then we find that the Improving Performance Committee establishes and maintains central risk register for the district?-- Yes.

And that risks may be forwarded to the Improving Performance Committee via the quality coordinator?-- That's right.

And then those other committees that you spoke about-----?-- Uh-huh.

-----which are listed in the table, they're subordinate to the Improving Performance Committee, in that they're-----?-- Only in terms-----

-----delegated responsibility?-- Only in terms of the way we report risks around the organisation. They come to the Improving Performance Committee.

COMMISSIONER: Ms Raven, I think you and Mr Allen may be at cross-purposes. When he asked what was at the apex, I think he met in terms of what's at the apex in dealing with risk issues-----?-- Oh, okay.

-----obviously?-- Sorry, I have interpreted that as the main committee of the organisation.

Exactly, exactly. The Leadership and Management Committee is essentially non-clinical; would that be a fair summary?-- Yeah, primarily.

And the risk issues, therefore, go in the first instance to a committee like the Improving Performance Committee, which involves clinicians?-- Yes.

And then if there is an issue that needs to be resolved at managerial level, it gets pushed up the line, as it were?-- That's right.

Is that a fair summary?-- Yes.

D COMMISSIONER VIDER: It is probably helpful just to point out, too, that these headings come out. ACHS, EQuIP, they are used nationally?-- Yep.

MR ALLEN: So it is not the case that those five committees listed in the table all report to the Improving Performance Committee?-- They report on certain things. Certainly those five committees would report to the Improving Performance Committee in relation to their preparation for survey. You know, each of those committees have a function that they have to address, and if there were problems in achieving, or whether if they felt that there might be some difficulty in meeting the standards, come to survey, that would be discussed at the Improving Performance Committee. And again, in terms of risk management, they report their risks, if you like, to the Improving Performance Committee.

Okay. In the policy it says "via the quality coordinator"?-- That's right.

So that's yourself?-- That's right.

And in relation to those five committees in the table?-- Uh-huh.

The one relevant to the sort of issues the Commission is considering would appear to be the Continuum of Care Committee because it seems to deal with clinical adverse events, medical management and patient care?-- That's right.

Right. So who is on the Continuum of Care Committee?-- Continuum of Care Committee, there is Mrs Mulligan - let me think - Di Jenkin I think sits on the Continuum of Care Committee. Who else - there is an Allied Health representative. I think Jason Simpson is currently the member

on that committee. Myself, Dr Keating, there is Margie Mears, who works in the preadmission clinic, Debra Spry from the paediatric unit was on the committee for a while. I am not sure if she has actually resigned from that committee at this stage, but she was for a while. We have a representative from the Division of GPs - or general practitioners. Good heavens, I am just trying to think who else. Quite a number of clinicians sit on the Continuum of Care Committee, for obvious reasons.

How often do they sit, the Continuum of Care Committee?-- They meet monthly.

All right. And how do they get information about those matters you have listed in the table about clinical adverse events and patient care, for example?-- Well, it is up to that committee. If there is an issue that somebody wants to raise for discussion, they put it on the agenda. Those members are representing the areas around the organisation in terms of what issues need to be discussed at that level.

So it is up to a member of the committee to put it on the agenda?-- That's right.

I see. So that committee, for example, doesn't have any responsibility for reviewing any data collected in the ordinary course of the hospital's management regarding clinical adverse events?-- I don't think it had got to the point where there was like, you know, a standing agenda item related to clinical adverse events but certainly that would be a committee where you might be able to discuss that.

But they would not, for example, review any type of data in relation to adverse event reports or anything like that?-- Only if one of the committees that - you know, that sit underneath the Continuum of Care Committee raised an issue and forwarded it on to that committee for discussion.

Okay. So when you say any committee that sits underneath the Continuum of Care Committee-----?-- Uh-huh.

-----is that when we go over the page, to page 3, to the clinical service forums?-- That's right.

And the relevant one in relation to the issues the Commission is considering seems to be ASPIC?-- That's right.

So how would ASPIC refer discussion to the Continuum of Care Committee regarding adverse events?-- Well, they may do it through, you know, one of the members of the ASPIC committee. For instance, Di Jenkin, she is a direct link to the Continuum of Care Committee. It is basically up to a committee to nominate someone to take it further up the line for discussion, if that's what's required, or, alternatively, you know, any member of one of these committees, or, indeed, anybody, can contact the chairperson of the committee and ask for something to be discussed.

Okay. But once again, there wasn't some regular system of ASPIC considering data in relation to adverse events and then reporting that in any formal way to the Continuum of Care Committee?-- No, we hadn't got to be that sophisticated but certainly it would be where we would like to head.

So it would be incumbent upon someone in the ASPIC meeting to move that a certain matter be referred to the Continuum of Care Committee?-- That's right.

D COMMISSIONER VIDER: Can I just ask then which committee would receive and review clinical indicators of the like of pressure areas, patient falls, medication errors?-- In terms-----

Where would they go?-- In terms of patient falls and pressure areas, there are subcommittees of the Continuum of Care Committee set up that's specifically just to look at those two types of adverse events. Medication errors should come up to the Continuum of Care Committee, if there was, like, a broad concern about medication errors. But each of these clinical service forums really should be looking at their own adverse events. We had tried to establish a system of what we called Error Medical Meetings. ERROMED is basically error in medicine and it is based on some workshops that Queensland Health had been doing. The paediatric unit actually do conduct ERROMED meetings, and at an organisation-wide survey in August 2003 were actually recognised by the surveyors as approaching best practice in terms of reviewing their adverse events, and one of our recommendations was that that model be then, you know, picked up, if you like, and transplanted around the rest of the clinical areas. And that's where we were certainly trying to head to, but it was taking quite some time to get that procession happening effectively.

Is it the Continuum of Care Committee that would oversee the development and implementation of the clinical pathways?-- Yes. There is a clinical pathway subgroup that also sits under the Continuum of Care Committee.

And all these subgroups report to-----?-- Report up.

-----the Continuum of Care Committee?-- Yes.

So that you can actually follow through-----?-- Mmm.

-----with a-----?-- And what had just started to happen is - I think there is five, altogether, groups or subgroups that report to the Continuum of Care Committee, which is clinical pathways, falls, pressure errors, consumer participation, and one other which just escapes me at the moment, and what we - what Linda had started to do was have the minutes of each of those meetings tabled at the Continuum of Care Committee so that we could look at what they had been doing; you know, whether there were issues that needed to be addressed, you know, at a broader level. So we were certainly getting there.

MR ALLEN: All right. What about things such as wound

dehiscence; would that be another category of adverse events which the Continuum of Care Committee was not considering?-- Well, wound dehiscence would be looked at by the ASPIC committee, and if they were having concerns with it, like, you know, if there was information that they could collate and send up to the Continuum of Care Committee, certainly that would be the committee to send it to.

This ERROMED system-----?-- Mmm.

-----is that a parallel system to the one you have described?-- Yeah, it is. Yeah, ERROMED - basically what happens is that as each of the nurse unit managers, or whoever, fills out an adverse event form - and I guess I have to use a paediatric unit as the example because they are the people who are doing it the best - and I know Di Jenkin in the surgical unit has certainly also started to do it - but I might get an adverse event form that Deb Spry, the paediatric unit, feels needs to be discussed, you know, by the clinicians, and she will have a note on that adverse event form saying "reviewed", or "referred to ERROMED". So then they take a copy of all the adverse event forms that they want to look at, the PHO generally chairs that meeting, any of the clinical staff from the paediatric unit who want to be involved, the staff paediatrician, they sit down once a month, they go through the adverse event forms that they want to have reviewed, you know, within their own clinical area, and come up with strategies to try to prevent the recurrence of the adverse events. For example, I know one of the things that the paediatric ERROMED forum has achieved is that all paediatric medication now must be ordered in milligrams per kilo to avoid any confusion - and that came about, you know, because of some medication errors in terms of - you know, in terms of the way a paediatric medication might have been ordered. So that group of clinicians then owned the problems that they found and come up with their own strategies to address it.

So does the surgical unit have its own ERROMED meetings?-- They had started to. I believe they had three meetings in all.

So they're different to the ERROMED meetings in relation to the paediatric unit?-- Yeah, every - every specific clinical area would have their own. You know, so the clinicians from surgical unit, including, you know, the surgical PHOs, the Director of Surgery, and so on, would sit together and look at what their adverse events were and try to come up with strategies to overcome them.

COMMISSIONER: Just so I have got this straight in my mind - I am having trouble understanding what's the conceptual difference between the Improving Performance Committee and the Continuum of Care Committee. It sounds to me, from my uneducated viewpoint, that there might be some overlap between what those committees do?-- I guess there is a slight overlap. The Improving Performance Committee broadly looks at the whole organisation in terms of our preparation for survey,

if you like. The Continuum of Care Committee really just looks at the specific continuum of care function.

Would it be too simplistic to say Continuum of Care is essentially only interested in clinical issues, whereas Improving Performance looks at the whole gamut of the hospital's operation?-- Yeah, that's basically what it is. I mean, continuum of care - not just clinical issues, but, you know, the whole process of getting our clients into the organisation, how we manage them while they're there, and how we support them when they go back to the community. That's the entire continuum. So it is not just, you know, specific clinical issues; it is how they - you know, how they get into the organisation, whether they have reasonable access to the information, what sort of information we pass back on to the GPs to support their ongoing care once they are discharged, and so on.

Would another way to put it be Continuum of Care is more patient focussed, whereas Improving Performance goes beyond purely patient-related issues?-- That's right.

MR ALLEN: Is there any overlap between what the ERROMED committee for the surgical ward would do and the surgical ward's participation in ASPIC meetings?-- Is there any overlap?

Yes?-- Not really. ERROMED really should be used specifically just to review adverse events. That's the intention of that meeting. Whereas ASPIC would, you know, look at a broader range of issues. You know, they might be looking at the waiting list for an outpatient appointment, or, you know, they might look at developing up, as I know they do in heparin infusion protocol, or they might be looking at when they surgically - ASPIC committee looked at, you know, developing up the care plan or clinical pathway for a lap choly day stay procedure. Whereas ERROMED really should be just specifically looking at what adverse events have occurred in their area - and, again, you know, within a system of not trying to blame individuals but to look at what's gone wrong, you know, the basic tenet of ERROMED is that, you know, people come to work to do a good job, they should be looking at, you know, what is it about the system that led these well-intentioned, intelligent individuals to make this mistake.

COMMISSIONER: And, again, just so that I can understand the concept of it, am I right in thinking that there aren't intended to be watertight doors between these committees; that if you have an issue like Mr Allen's mentioned, the example of wound dehiscence, you might raise that in an ERROMED committee if that's appropriate or you might take that to ASPIC? There is no cut and dried distinction between where you are entitled to raise it?-- No, that's right.

Or you might even raise it at a surgical forum?-- But generally, like, you know, things that are referred to the ERROMED meetings are purely based on what's been reported as

an adverse event. That's where they get their information to look at.

So, in a sense, using Mr Allen's example of wound dehiscence, if it was a specific problem relating to a specific patient which had been reported as an incident, that could go to ERROMED, whereas if it is just a general concern about the increasing trend in wound dehiscence, that's more appropriate to go to ASPIC?-- Probably, yes.

MR ALLEN: Is there any process whereby incident reports relevant to a particular unit, say the surgical unit, are referred to that surgical unit's ERROMED committee?-- That's the role of the nurse unit manager, to refer, you know, as she's - every nurse unit manager has to complete, you know, sign off the incident report before it comes over to us.

Right?-- And if she looks at it and feels it is something the ERROMED committee could review, then she takes note of that herself and keeps it in a file, or wherever she keeps it, and takes them, all the incidents she wants to have discussed at the ERROMED meeting, along to that group when they meet.

So the nurse unit manager has to refer it off to DQDSU but also make a decision whether it is referred off to an ERROMED committee?-- Well, she needs to make a decision whether it is something that - because the ERROMED meetings are very much owned by the clinicians. It is just the clinicians who attend them. So she would send a copy to me or send the adverse event off to me because of, you know, the requirement to have it registered. But if she felt that this was an incident that they need to get the chart and as a group of clinicians have a look at that, then she would make that decision herself.

Is there an ERROMED committee system in relation to the intensive care unit?-- I don't believe so. But certainly that was - I know over - well, since the organisation-wide survey in 2003 it has been something we have been trying to do, to get each of the clinical areas to get started on looking at, you know, the ERROMED system and implementing it in their areas.

COMMISSIONER: Is that because ICU tends to fall between a number of different departments, that the surgical department makes use of ICU facilities, the medical department makes use of it, I guess even paediatrics and gynaecology, and so on, make use of ICU in cases?-- It could make it somewhat difficult. Similarly, you know, some of the adverse events that, for instance, intensive care might want to look at could also involve the Department of Emergency Medicine.

Yes?-- But it is up to the clinicians who are taking charge of that ERROMED meeting to - I mean, anyone can be asked to come along and discuss an incident if there is, you know, another area that may have been involved in it as well. But, you know, primarily the clinicians themselves working in each area need to take ownership of the ERROMED process.

D COMMISSIONER VIDER: Can I ask a question? As I am listening to you discuss the various committees and forums that you have, it seems to me that you have got a lot of duplication?-- Mmm.

I am wondering whether in your role you can see ways of moving forward with this. It seems to me that we have got the ACHS EQuIP process?-- Yep.

Which is used Australia wide?-- Yep.

But running parallel with that you have got systems that Queensland Health are introducing, because all of those areas, like ERROMED and all those sorts of things, they are well and truly covered under ACHS?-- Yep.

So you have got a lot of duplication, it would appear to me-----?-- I agree.

-----and a tremendous doubling up of meetings?-- And I think - I don't think there is anybody who would disagree. Like, we do seem to have an inordinate amount of committees. Certainly when we introduced the committees that would, you know, align with the EQuIP functions, the intention was to try and get rid of some of the other committees that duplicated what those committees were going to take over, but sometimes it is very difficult to get people to give up committees. So we tended - we probably put another layer on without actually taking away some of the other ones that, you know, didn't necessarily need to continue. And I guess it does cause some confusion if you have got a lot of committees, in terms of, "Where should I send this to?", or whatever. It is definitely something I would like to try and get sorted.

Yes. I think most clinicians like to avoid committees because they take them away from what they primarily-----?-- Yep.

-----are there to do?-- Mmm.

My understanding of the ACHS desire with the Continuum of Care was to create that one forum where you complete the circle?-- Yep.

So you have got the patient entering and you have got the patient exiting?-- Yep.

And where you need to be able to improve it on the way becomes the seamless continuum?-- That's right.

So everything needs to come to there?-- Yep.

And that's where it all gets discussed?-- Yep.

At local level a department may discuss specific issues?-- Yep.

Be they related to patient outcomes, patient complaints-----?-- Uh-huh.

-----whatever. But that's the forum where the hospital-wide continuum gets addressed, and that's it?-- That's right, yep. Absolutely.

MR ALLEN: And duplication doesn't mean that things are done twice as well, does it?-- No, not at all.

No. And one of the dangers is that things will get lost in the system if it is not clear what the correct pathway is?-- That's always, you know, a potential problem.

And there is a real danger that people just won't turn up to some committees because they don't have time to go?-- That's right.

All right.

COMMISSIONER: Or because they don't recognise the importance of the committee work?-- Yep.

I think, since we're all on the same side here, everyone would agree that greater transparency, knowing where a matter should be referred to and ensuring that it is dealt with appropriately at one committee rather than being tossed around like a tennis ball from committee to committee is the desirable outcome?-- Absolutely, and it is certainly something that, you know, I am sure everybody would support in trying to improve our committee structure.

D COMMISSIONER EDWARDS: Are you aware of similar committee systems occurring in every other major hospital?-- Sorry, I didn't quite-----

Are you aware whether similar committee systems are occurring in every other major hospital?-- I am not sure that I could speak for, you know, all hospitals. Certainly some of the other districts that I am familiar with have - they may not exactly be identical but they certainly have similar committee structures and the same sorts of problems with, you know, too numerous committees and, you know, it is - yeah, but I am sure that there are districts in Queensland Health who have got quite well functioning committee structures.

COMMISSIONER: Sir Llew really anticipated what was going to be my next question: reading your statement from go to woe, I get the impression that you came into the quality control position and found that no systems were in place and really Queensland Health didn't have an established template, if you like, to set up a proper reporting system so you got to work devising an appropriate system for Bundaberg?-- Yep.

And whilst you were doing that, Queensland Health was also devising its own system and what we've ended up with here is a sort of amalgam of your best thoughts, Queensland Health's best thoughts and then the national approach?-- Yep.

And like all attempts to bring together three or four different strands of input, you end up with something rather more complex than was necessary. I would have thought that it would be possible for Queensland Health to devise a template system which, subject to minor modifications, you can apply in Bundaberg or Biloela or anywhere else in the State?-- And I believe that that's what they're doing, you know, Queensland Health is a big organisation.

Yes?-- And it's sometimes quite, you know, time consuming to get agreement across 39 districts or whatever it is about what a system should look like. In Bundaberg, yeah, very much so Peter Leck was concerned that we were - we just didn't have the time to wait for Queensland Health to develop something, so let's just do the best we can and then try to make our system look as much like the Queensland Health system will look like when it finally comes in so we can easily transfer over, but you know, for example, like as I was saying the other day, I first started hearing about the complaints database at Queensland Health, that Queensland Health were going to or is going to develop, you know, five years ago and they're only just getting that established now. So for five years a district can't sit and wait, so you just do the best that you can.

And from your position, I don't want to put words into your mouth, and I'm sure you wouldn't let me anyway, but it does seem rather scandalous that, you know, you're trying to do your job in quality care here and you're waiting for five years for Queensland Health to come up with a system that you can adopt and modify as necessary for Bundaberg?-- Mmm. I think it's just a system of a very big organisation trying to, you know, trying to make sure that what finally is developed will suit everybody's needs. You know, certainly, and I guess that's what they have to consider, what the Royal Brisbane might need could be, you know, glaringly different to what Thursday Island would need, so it's a big organisation trying to, you know, develop something that will be suitable for everybody.

But on the other hand, you shouldn't have a situation where in each district there are people like you in your equivalent position, in effect, having to reinvent the wheel because you you don't have any central guidance as to how to do these things?-- And we certainly try to minimise that, you know,

like I have a network of quality coordinators that I liaise with regularly and if we're looking at, you know, developing up something, it's certainly everybody talks to each other, saying, "Have you already got something that we could use?" For example, the form that we developed or that we used to report quality activities that are taking place came, you know, from another district, so the network of quality coordinators do try to utilise, you know, rather than sit and completely reinvent things.

Yes?-- We do try to share information between each other.

If Mr Allen doesn't mind, I did want to ask one other thing, and I'll admit straight away this is a loaded question, so feel free to deal with it as you think appropriate, but it does strike me as unhelpful that the leadership and management committee doesn't seem to involve any clinicians at all. I should have thought that the type of functions that have been spoken about with leadership and management would benefit from input from people on the sharp end of the hospital, people who are dealing with patients?-- I'd have to disagree, but only because the leadership and management committee exists, you know, consists of the six executive directors.

Yes?-- Who each are required to report on what's happening in their area. You know, it's a very important committee that has a lot of, you know, a lot of information and decisions that they have to make and like, I think it's fairly well known that the bigger the committee, the less productive it is.

Yes?-- So it's the role of those executives directors to make sure that they have information fed up to them and they would get that sort of information through their regular meetings with their, you know, heads of department and so on, so that when the six come together as the leadership and management committee, they have the information that they need to make decisions.

If we take the personalities out of this and just talk about it in the abstract?-- Mmm-hmm.

And I realise a lot of this evidence is infected, if you like, by thinking about the particular people who occupy particular positions, but if we put those to one side and just think about it in principle, it would strike me that when you come to issues like funding allocations, complaint management, community expectations, even things like strategic planning and policy development?-- Mmm.

The people you need to have providing input into those issues are the people dealing with patients?-- Yeah, but see, this doesn't reflect what the terms of reference of the leadership and management committee are, this is just the types of things that they may report risks to the improving performance.

Right?-- So their terms of reference would be quite different in terms of, you know, what they're required to do.

But would you disagree in principle with the proposition that things like - well, I'll take the most obvious examples, funding allocations, community expectations, complaint management?-- Mmm-hmm.

In an ideal system, that would be - those top level issues would be dealt with by a committee of clinicians and executive, not just by executive without involvement of clinicians?-- Yeah, I can see what you mean, absolutely. I guess the way our structure is at the moment is that the various other committees that sit underneath and all, you know, report up through the various chains of reporting would - ultimately, those issues would ultimately come to the leadership and management committee after having had some input by clinicians.

Yes?-- But, you know, by all means in a, you know, in an ideal world may be you would have, you know, a mix of clinicians looking at high level issues as well.

Thank you. Thank you Mr Allen.

MR ALLEN: If I could ask you about the risk management policy you created at LTR4?-- LTR3 I think it is.

Oh, excuse me, it's actually LTR4 "Adverse Events Management"?-- Yes.

So that's the adverse events management policy?-- That's right.

Which was implemented from February last year?-- That's right.

Okay. Now, the policy indicates that it's directed towards improved patient care, outcomes and safety?-- Yep.

Now, if we look at definitions on that first page, I note that there's a definition for "Incident"?-- Mmm-hmm.

But I couldn't find one for "Adverse Event" but is it the case that adverse event replaced incident so that definition of incident is in effect a definition of adverse event?-- They're basically interchangeable. Like, when we first put the policy out, we called them adverse events, but then when we updated the policy in December last year, we changed it to incident because that's what Queensland Health were calling it.

Oh, okay. So-----?-- They're basically the same thing, like an incident and adverse event.

So really, a fundamental thing that has to exist before someone even thinks about filling in one of these forms is that there has been an event or circumstance which could have or did lead to an intended and/or unnecessary harm to a person and/or a complaint, loss or damage?-- Or they can report a

near miss as well, and certainly we would try to encourage the reporting of near misses so like, that's the next - it's basically something that could have but didn't actually occur, so and like-----

Well, that seems to have been covered in the definition of "Incident" in any event "which could have or did"?-- Yep.

All right. So then if we go to page 3 for the procedure?-- Mmm-hmm.

Well, "Precondition" is of course when an adverse event occurs and we've just spoken about that?-- Mmm-hmm.

Number 2, "The staff member who was involved or discovered the adverse event completes the relevant section of the adverse event report form"?-- Yep.

Okay. It was never contemplated that you have half-a-dozen adverse event report forms in relation to the same incident being completed, was it?-- If that had occurred, that there's no problem with that, you know, I'd rather have six people reporting the same incident than nobody reporting it at all, so anybody, you know, there's no requirement for them to, you know, to check whether somebody else has already reported it if they've discovered an incident, you know, and that has happened on occasion where, you know, two or three people report the same incident but that's not a problem, so long as it's reported.

So that's not meant to be read as the singular, "The staff member who was involved or discovered the adverse event"?-- Well, one person, you know, the person who discovers it, but that person who's discovered it wouldn't know whether somebody else has already reported it so they should report it as well.

All right. Well, if there's a theatre nurse standing next to a surgeon who nicks a bowel and it's obvious to the surgeon, would he be the staff member who was involved in the adverse event?-- Or anybody who saw that happen could report it.

Well, would the surgeon be the staff member who was involved?-- Well, he would be one of the people who was involved, yes, he would be the person who would be involved.

Well, would the theatre nurse be involved as well?-- Well, she's in the theatre.

Helping an anaesthetist, for example?-- It depends, like, I'm not sure what you're trying to get at?

Well, I'm just trying to work out who's responsible for completing the adverse event report?-- Anybody can fill out an adverse event report form.

And then if someone hears second-hand that a bowel had been nicked, they've discovered an adverse event, have they?-- I believe so, that's my interpretation of it.

What, someone has mentioned it to them?-- Yes.

So therefore they've discovered it, have they?-- Well, I believe so.

I see. Now-----?-- The idea is for people to report incidents.

You were away-----?-- Mmm-hmm.

-----on sick leave when the actual education process in relation to this system was underway?-- Yes.

So you wouldn't have any knowledge as to what sort of education staff were given as to how to interpret those words in paragraph 2?-- No, I wouldn't.

Okay. You mentioned in your evidence that indeed, staff could put in anonymous reports?-- If they chose to, yep.

Right. Was that part of the education or can you not say because you weren't there?-- I couldn't say because I wasn't there.

Right, because there certainly doesn't seem to be anything in the policy or on the form itself which indicates that anonymous reports are possible?-- Well, I guess, you know, that's potentially a flaw in the policy, but, you know, they don't, like, there's no requirement to put, you know, a name to an incident report form.

Well, if you look at paragraph 5, that would seem to tend against any suggestion that anonymous complaints are possible, because it provides that the adverse event report form-----?-- Mmm-hmm.

-----is given to the shift supervisor or costs centre management manager?-- Yep.

So-----?-- That's the underlying process, you know, if people were concerned, you know, they could have still sent over an anonymous adverse event form.

Where?-- Well, just by sending one over.

To where?-- To the DQDSU.

I see, but that course of action isn't dealt with in the policy, is it?-- It doesn't say specifically you can report anonymously, no.

Now, the forms themselves don't have any type of receipting part, do they, so that the staff member who fills it out can have their own convenient record of having put a report in on a certain day with some type of number - reference number?-- They take copy of it, you know, before they send it over.

They take a copy? There's no carbon, is there?-- No, but every ward area has access to either a photocopier or a fax machine that will copy for them.

Okay, so where in the policy does it suggest that the staff member making the report should make a copy?-- It doesn't, but I do know that that was, you know, certainly discussed when this system was being implemented, that staff members and most staff would take a copy of a form anyway before they sent it over.

You don't think a staff member, in the absence of specific authority to take a copy, might even fear taking a copy?-- I don't think so, no, they wouldn't fear taking a copy.

As some type of breach of the code of conduct?-- It's not a beach of the code of conduct to take a copy of the incident report you're filling in.

Well, what education were given to staff that firstly, they are allowed to take a copy, and secondly, should take a copy?-- When we were first developing this system, it was - I had a - during a heads of department meeting, I spoke to the heads of department who include the nurse unit managers, about what they wanted, you know, we were going to change the system, okay, we had previously a carbon based system where this was not going to be, you know, because we were developing our own local form, but we certainly discussed it at that meeting that if they wanted to take a copy of the report, they could do that before they sent it over.

That they could do so?-- Mmm.

I see?-- And I know that, like, because a lot of the forms that I get are actually copies rather than the originals, I know that people do copy them, it's not - there's not a problem with keeping a copy.

But you'd agree that there's nothing at all dealing with that issue in the policy?-- Well, there's not but, like, you have to have a level of assumed competence most people would realise that they take a copy because, you know, to keep in the ward area if they choose to. It also says, you know, in the policy to record it in the patient record, so those people once they've recorded it would have to have a copy of the report before they send it over. I mean, it's just implied competence, I guess.

So you just assume that that's a competence issue, that people would know that they should take a copy?-- People - it's one of those things that people know and understand.

Is it?-- Yes, I believe so.

I see. Just in relation to that, you're referring to paragraph 6, the adverse event in the medical response should be factually recorded as soon as possible and in the patient's record?-- Mmm-hmm.

That doesn't seem to indicate that a copy of the adverse event form finds its way on to the patient's record?-- Whether they keep it in the patient's record or whether they keep it somewhere else is neither here nor there, the important part is that, you know, the adverse event is recorded in the chart, then, you know, for instance, they may keep a copy, like, they may have a ward file in their ward area where they keep all their adverse events filed there rather than in the patient chart.

Are you aware of any policy whereby it was Queensland Health policy that the adverse event form did not go on the patient's file?-- No.

Because therefore it would not be discoverable by way of Freedom of Information application?-- That's not the policy at all. I know Mr Brennan said the other day that we changed our system so that information about patient adverse events wouldn't be FOI-able, however, I think it's quite clear here that they had to report it in the chart, so it is recorded in the chart. It also says on the second page of the adverse event form, "Has this incident been recorded in the chart?"

Mmm-hmm?-- So it was never changed to, you know, to try to hide or, you know, prevent information from being discoverable, that's just not the case.

But there's nothing in the policy itself to indicate whether or not a copy should go on the patient's record or be held in the unit or simply the only copy go to DQDSU?-- No, there's nothing specific.

Right.

D COMMISSIONER VIDER: Can I just ask something about that as well just to follow through on the timeline for that?-- Mmm-hmm.

At the time of reporting and completing the adverse event form, that happens at the time of the incident?-- That's right.

And therefore it's very often the situation that the final resolution has not been reached?-- To manage the incident?

Yes?-- Yes.

That-----?-- Originally, the policy originally said that they should be sent straight over to the DQDSU, however, when we changed so that the costs centre manager or the unit managers were doing their own risk ratings, the policy was changed that they stayed in the unit until the nurse unit manager had seen them because that was identified as a problem to begin with, that nurse unit managers may not have seen adverse report forms before they came over to the unit so that they could put some comment on about what had been done to resolve the incident.

I'm looking at things though where the resolution long term might require contacting agencies outside the hospital, for example, they may be involved with the final outcome, resolution, whatever. My question is in what format does the reporting go up and where is the final loop fed back into the report that then goes into the patient's chart?-- Um-----

There's sections at the bottom that talk about where it's been reported to?-- Mmm-hmm.

And the outcome?-- Yep.

And this's got to talk about what actions have been taken up and sometimes they might involve a change in policy, something that's happened wide?-- Yep.

Whatever. If you put this, the original adverse event report into the patient's record?-- Mmm.

When do you come back and get that completed to go into the patient's record, otherwise you've only got part one in the record?-- Well, the adverse event report should include information about what they did for that patient when the incident occurred. In terms of when it, you know, comes over to be investigated, if a policy was changed, that information wouldn't get into the chart, it would just be, you know, in the register that, you know, a policy needed to be changed or whatever based on-----

So the incomplete information actually would be what ends up being filed on the patient's record?-- Well, it should be complete in terms of what they did for that patient to control or, you know, to minimise the harm to that patient then and there. In terms of whether that led to an organisational change of some description though, that wouldn't get into the chart.

No.

MR ALLEN: And that's indeed if the form gets into the chart at all because there's no process whereby that's required?-- That's right, but they are required to, as it says, to factually record the incident in the chart, so.

Yes.

COMMISSIONER: And that could be done in a number of ways: one would be copying the adverse event form and putting it in the chart?-- Yep.

The other would be noting the same details and hand write entered into the chart; the other simply might be to say "See Adverse Event Form"?-- Yep.

"Held in DQDSU" or something like?-- That's right.

But there should be something in the chart to tell you that

there should be something, an adverse event?-- That's right.

I'm sorry to interrupt. Getting away from sort of recriminations of what's gone wrong in the past, I think you've already told us that based on some questions I asked and based on some of Mr Allen's questions, you don't say the present documents are perfect and you're writing them with what, the benefit you've heard from this inquiry, you'd probably make some changes?-- Yes.

But let's look to the future. It seems to me that one of the real problems with all of this is that people, even clinical people in hospitals, have a reluctance to set a process in motion that they don't know what's going to be the end of?-- Yep.

Once you fill in one of these forms, it's out of your control and you don't know who's going to end up dealing with it and what's going to become of it?-- Yep.

Is that a fair comment of people's attitude?-- Yes, I guess that could be people's perception.

And then people prefer to report things informally, a nurse might speak to the nurse unit manager and nurse unit manager might speak to the DON?-- Mmm-hmm.

A junior doctor might speak to the director of the relevant unit, that sort of thing?-- Yep.

Is that your experience?-- Well, yeah, potentially, like, you know there's more informal chatter goes on about what's going on rather than formal reporting.

And it seems to me in a sense that there's - it's desirable to encourage that rather than discourage it because if the point is trivial, if, for example, a junior doctor in the medical ward thinks that something's a problem and reports it to the Director of Medicine, and the Director of Medicine might be able to say, "Well, sorry, you're on the right track there, what was done was perfectly right" and that's the end of the problem, it doesn't have to go to committees or get documented or whatever?-- Yep.

So I wonder whether you'd agree that some degree of informality is desirable and perhaps even should be encouraged to try and resolve things when they occur rather than immediately documenting and reporting everything?-- I guess up to a point. Only the problem would be if there's, you know, if people start to use an informal approach as the only approach.

Yes?-- Then you don't have any, you know - I mean, it's certainly in a health care organisation it's management by fact and you have to have data and information recorded so you can be sure that trends are being captured and actions taken where it's needed.

See, one of the things that occurred to me, and please understand I don't mean this as criticism in any sense, but when you look at the sentinel event form and also the adverse event form?-- Mmm-hmm.

I think they're both eight page forms, and for a busy clinician, that may seem a bit daunting to get out an eight page document and fill it in between patients rather than simply having a word to the nurse unit manager or the other relevant person saying, "You know, I'm a bit concerned about this, is it a problem?"?-- Well, the adverse - I'm not sure where you're getting eight pages from, but the sentinel event form is only one page long, it may be the policy that is that long.

Oh, sorry, I was going from your LTR6 which is the sentinel event and root cause analysis-----?-- Yeah, that's the policy.

-----policy, the first four pages explain the policy and then I thought the form begins at page 5 of the-----?-- This second part of it would really be for the person doing a root cause analysis but because we could never get any training on root cause analysis, that part was never used, but secondly, it was dropped from the first policy, but the clinician would only be able to fill out this page.

So what looks like an eight page form can only be filled out on one page?-- The clinician would fill out the specifics on the incident on here. This was something that I tried to develop in terms of, you know, when we got people doing root cause analysis, it may be a trick to guide the people through that process and I know Dr Keating continually tried to get some root cause analysis training, but you know, again, like we weren't a priority in terms of Queensland Health providing that, they roll it out generally, you know, they roll it out through the districts and you just have to wait your turn for those types of training.

I'm beginning to think, and please understand I'm coming at this as a lawyer, not as someone with any form of medical or clinical training, but it really seems to me that a lot of these things have to be left to people's commonsense, that you, the more you try and have fixed rules and procedures and so on, the more people are going to get confused and get reluctant to get involved in a formal process?-- Mmm.

And it may be that the best thing one can do is to let the nursing staff know that and the medical staff know that if they report something in a formal way, it will go through a formal process and go through a committee and so on, but if they're reluctant to do that, they have the opportunity to speak to other people within the department or unit to clarify whether there really is a problem and to get advice as to whether they should be putting in a formal report?-- Yeah, and that's certainly what I will see as part of the role of the patient safety officer when we do indeed recruit the patient safety officer.

Yeah?-- To be, you know, on the floor with the clinicians helping them fill out adverse event forms or a sounding board, you know, "Should I fill it out? Shouldn't I fill it out? What should I do?", so that would be the role of the safety patient officer which I think would be a key role in all districts.

Well, I don't want to re-open the wounds that we had on Friday, we've heard enough about dehiscence, but if we go back to the debate that you had with Mr Allen on Friday afternoon, it seems to me that there's some scope for saying that it's very difficult for a nurse in Toni Hoffman's position to put in a formal complaint about a doctor, and particularly a senior doctor, and it may have been appropriate in retrospect for her to raise her concerns in a less formal way in the first instance as they did in the - Mr Allen, you say in May or so?

MR ALLEN: May 2003.

COMMISSIONER: 2003, and only escalate those concerns to a written form once she found that nothing was happening?-- Again, that's if you're talking about making a complaint.

Yes?-- But in terms of filling out an adverse event form when something has gone wrong, I think, you know, it's - that's not unreasonable in terms of making a formal complaint about a surgeon or his clinical competence, quite a separate issue, but the adverse event reporting system was there to be used so we could detect what was going wrong.

Yes.

MR ALLEN: See, there's a problem there, isn't there, that distinction you draw? You say that there's a distinction between a complaint about a surgeon and filling in an adverse event form?-- They're two entirely different things and I realise that a lot of the legal people are getting confused with that but an adverse event is an accident or an incident that has happened. If you're talking about complaints in terms of, you know, the Bundaberg Health Service District, complaints are quite different. It's a complaint - and, like, if a staff member wants to make a complaint about, you know, another staff member then, you know, it may be more appropriate that they start that process formally through their line manager. But an adverse event form or the adverse event reporting system was certainly a system that we tried to put in place or we did put in place to detect the things that we were doing wrong in the - you know, the accidents that were happening.

See, you gave evidence on Friday of the fact that the staff complaints don't even come under the quality control system. They're a HR matter?-- That's right. The complaints that I look after, the complaint register that I manage is purely patient complaints.

Yes?-- So the patient complains about something in relation to their care or, you know, whatever. But the staff - if staff are making complaints about whatever, no, they don't get reported to me.

Well, let me ask you about this situation. A nurse becomes aware of circumstances which don't come up to be as high as the fact that she could - she can say that a patient suffered unnecessary harm. So it's not an adverse event according to the policy. She doesn't have enough to complain about the conduct of a doctor but she's got a concern-----?-- Mmm.

-----about the doctor's practice. For example, should the doctor be undertaking oesophagectomies at Bundaberg Base Hospital?-- Mmm-hmm.

It seems to fall within the systems. There's not enough there to lodge a complaint against the doctor, there is not enough there to lodge an incident report form; what should the nurse do?-- I'm not really sure that I'm understanding what you're getting at.

I'll try and be specific. I'll put a scenario to you?-- Okay.

The scenario that faced Toni Hoffman in May and June 2003?-- Mmm-hmm.

Included May of 2003. On the 19th of that month she was in the Intensive Care Unit when a patient arrived who'd undergone an oesophagectomy by Dr Patel?-- Mmm-hmm.

Ms Hoffman was there for the handover by the anaesthetist and

theatre nursing staff and it was reported to her that the patient has no obtainable blood pressure during the last 45 minutes of surgery?-- Mmm-hmm.

The anaesthetist made a comment which could be interpreted in various ways to the effect it was a very expensive way to die?-- Yep.

The patient was in a very bad state in ICU?-- Mmm-hmm.

It seemed Dr Patel was describing the patient as stable when the patient was not, at least in Toni Hoffman's opinion?-- Mmm-hmm.

And he eventually died?-- Mmm-hmm.

Now, there doesn't seem to be enough there that Toni Hoffman, really, with any confidence can make a formal complaint against Dr Patel. She wasn't there during surgery?-- Mmm-hmm.

He doesn't seem to have breached any specific rule or guideline?-- Mmm-hmm.

In relation to an adverse event, it would - one might reasonably say that perhaps there isn't enough there for her to be able to confidently state that that patient suffered unnecessary harm so as to be able to fill in an adverse event form?-- Well, she could have filled in an adverse event form saying, you know - like, inaccurate documentation. If Dr Patel was sitting there saying, you know, the patient's stable when clearly he wasn't, she could have used, you know - reported an adverse event in terms of what was documented in the chart.

Well, let's say that he was just saying that to the relatives. It was a verbal report by him?-- Mmm-hmm.

One could reasonably say, "Look, there's really not enough here for Toni Hoffman to be able to fill in a form saying that that patient suffered unnecessary harm." What is she to do if she forms the view that there's not enough there to fill in an adverse event report?-- Mmm-hmm.

And there's not enough to make a complaint, a formal complaint?-- Well, that's if she decides that.

Yes?-- I mean, potentially what she could have done then to - you know, is to ask that that patient's chart be reviewed, that she and some of the other clinicians get together and have a look and see what did go wrong.

Okay. So would she, for instance, get together with either the Nurse Unit Manager or one of the doctors in charge of ICU-----?-- Mmm.

-----and go and see Darren Keating? Would that be a reasonable way of approaching it?-- Well, maybe, if she had legitimate concerns.

Right. Okay. Well, that's what she did in fact?-- Mmm-hmm.

On two occasions?-- Mmm-hmm.

Okay. Now-----

COMMISSIONER: And you'd make no criticism of that as an appropriate way of handling such a situation?-- No.

No.

MR ALLEN: Because, indeed, even if it was considered an adverse event, according to page 3 of the policy, one of the important things seems to be that - and this is paragraph 8 on page 3 of the policy-----?-- Which policy?

The Adverse Events Management Policy?-- Yep.

"All units which will have in place a mechanism for alerting the relevant director and/or other management staff of the occurrence of a significant or serious adverse event"?-- Mmm-hmm.

"This alert should occur as soon as practicable"?-- Yep.

So that seems to be quite apart from the process whereby a form will go off to DQDSU, go into some type of register and then be processed through a-----?-- Mmm-hmm.

-----I don't know, a spreadsheet or whatever you use ?-- Mmm-hmm, spreadsheet, yep.

Yes. Because, really, part of that process is that the form's filled out and it goes off to you and there's all this computer analysis of it and it ends up in a register and someone can punch out figures later on and look at them?-- Mmm-hmm.

But that's not really going to produce any type of immediate action, if any is required, because of the circumstances, is it?-- But if it's a - if it's a significant or a serious adverse event, then that's what that's saying. Like, you know, alert the director immediately.

Yes?-- If that's what - do so by all means.

Okay. Alert the relevant person?-- Yep.

The Nurse Unit Manager, if it's coming from someone below them, the Director of Nursing or the Director of Medical Services?-- Mmm-hmm.

Okay. So, if that's done, it really doesn't matter except, I suppose, to the comprehensiveness of your ultimate statistics whether it's being done by way of a written form to DQDSU or whether it's being brought to the attention of the relevant director?-- But you're talking about an incident where you

said that there was not enough information to suggest or to warrant filling out an adverse event form. So, you know, going to Dr Keating, you know, because there isn't enough information or there is no reason for her to believe an adverse event form for that particular case is needed, then, you know, I'm not - you know-----

I will-----?-- -----I would expect that there would be.

I'll express myself better. Even if we take it up a notch higher and it is something which would fall within the definition of an adverse event, isn't it important to draw it to the attention of the relevant manager?-- It is, but it's also just as important to, you know, fill out an adverse event form so we have accurate data about, yeah, what's going on in the hospital.

But that's not going to produce the immediate - entitled immediate or even approximate response, is it?-- No, but as I say, one of the reasons why we have the adverse event monitoring system is so that we can identify trends.

Yes. Over time?-- That's right.

Okay.

COMMISSIONER: But, Ms Raven, let's be a little bit realistic about this. It is an extraordinarily difficult thing for any member of the nursing staff to accuse a senior medical practitioner of professional incompetence. That's a very hard thing for any nurse to do?-- Oh, I agree, mmm-hmm.

It would be beyond reasonable human expectation in the scenario that Mr Allen has described to expect someone like Toni Hoffman to fill in an adverse event form, going on record accusing Dr Patel of falsifying documents, killing a patient, misrepresenting the patient's condition to the family and so on. One couldn't fairly expect a person in her position to go on record without at least speaking to more senior clinicians and senior management people to make sure that she was on firm ground?-- I guess so.

And in those circumstances it's not unreasonable for her to go to, in fact, either the Nurse Unit Manager or the Director of Nursing or the Director of Medical Services, or whoever is the appropriate person, and say, "These are my concerns. I saw this happen. I'm aware of these facts", and she might be told, "Well, you're starting at shadows. There is nothing wrong there and it is perfectly okay." She might be told, "Well, this is a serious matter. You really need to fill in an adverse event form or a sentinel event form." But there is nothing wrong with a nurse in those circumstances going to senior management and getting their guidance?-- Oh, no, not at all. But certainly, like, back in - and by, you know, Toni Hoffman's own admission, back in May 2003 it was more concern about his behaviour that she raised.

Yes. And certainly that's not something that would be in an

adverse event form or a sentinel event form?-- No.

MR ALLEN: And I know you told us on Friday that it wouldn't make any difference to the opinion you'd expressed if I took you through various e-mails and written communications to management about concerns about Dr Patel, but if the fact of the matter is that Ms Hoffman, after May 2003, corresponded with the then Director of Nursing Glennis Goodman and with Dr Keating and other doctors about concerns about specific patients and Dr Patel-----?-- Mmm-hmm.

-----you wouldn't suggest, would you, that she failed to take appropriate action to voice her concerns?-- She was obviously voicing her concerns but, like, by - by early in 2004, she was still saying, "I don't need you to do anything about it." So how - like, you know, I don't want to get into another argument with you but, you know, how serious were her concerns if she was already - still saying in I think it was, like, February 2004, "I don't need you to do anything about this"?

You don't think-----?-- Can you blame people for not acting on that if she's already saying or she's still saying, "I don't need you to do anything about that"?

COMMISSIONER: I think the problem is we keep putting it in terms of blame, but the real question is whether she brought the problem to the attention in an appropriate way and I think you've already agreed that what she did was not an inappropriate way to raise these problems. Then it is a matter for others to explain how they dealt with the problems when it was brought to their attention?-- That's right.

MR ALLEN: Right. And, really, the truth of the matter is it wouldn't have made any difference if, contemporaneous with those approaches she was making, she filled in an adverse event form?-- Oh, it would have made a difference.

Well, it would have gone off to inform your statistics perhaps but it wouldn't have made any other difference?-- Can I give you an example. Over a three-month period I - because I read every adverse event form that comes in, I saw that there were three errors made at Childers Hospital about - you know, with the immunisation program. Nothing serious, no major outcomes or adverse events for the people involved but because I recognised them, I grouped them up, I sent them over to Linda and said, "We've had a few of these, like, three in the last three months. Do you think we should have a look at what's happening in Childers?" I would have done the same thing had I seen the same report coming in again and again and again, trending - and having somebody look at them individually every time they come is an important - you know, an important part of capturing good information.

So, do you seriously suggest that if you'd been able to speak to Dr Keating as well as Toni Hoffman raising those matters in relation to particular patients, that would have made a difference?-- I'm not saying I would have been speaking to Dr Keating. I'm saying if there were the same type of adverse

events being reported, I would have recognised that trend and alarm bells would have started ringing.

What trend would you have recognised in relation to these matters?-- Well, you know, like if they're saying that there were, like, you know, numerous wound dehiscences, if they'd have reported each of those, there would have - like, I would have recognised a trend. But there's only been one report, you know. Like - so, certainly, if she had continued or if she had reported - if she felt that she was getting nowhere, at least the report, I would have seen it and I would have done something about it as - you know, you can't have everybody coming at you and saying - you know, management by fact. You know, "Look, Darren, we've had four of these reports in the last four months. Do you think it's time to look at what's going on up in the surgical ward?"

Wound dehiscence, when you just said then we had one, that was one occasion of wound dehiscence?-- One report.

One report. Okay. So you would-----?-- And yet in the minutes, by their own admission they said that they were going to report all occurrences of it. The first one that's been reported didn't occur until August 2004.

Well, there was - we know at least there was a written report to Dr Keating from Gail Aylmer of six occasions of wound dehiscence in July 2003?-- And that was certainly before the adverse event system that I'm in charge of. That was before that was introduced.

Oh, I see. So that's why it wasn't discovered by you in searching the system?-- I've gone back and had a look through the records - like, the adverse events from 2002 to 2003.

Mmm?-- And no, no, there is no reports of wound dehiscence in there either.

COMMISSIONER: I think Mr Allen's question though is if the statistical concerns came to the attention of the hospital executive through a different procedure, does it make any difference then that it didn't come through your procedure? Let's take the Tenckhoff catheters, because that's a good example. Those didn't come through adverse events forms?-- No.

And therefore you weren't aware of them and you couldn't refer them up to the executive or to anything else?-- That's right.

But what difference does it make that the executive have got to hear about them directly from Dr Miach rather than from your office?-- Well, what - my point is that if Toni felt that nobody was listening to her, then - you know, that they were just ignoring her or whatever else, if the information that I was getting, the data, where - you know, this is the data that's showing us there is something going on, then I'm starting to be vocal about it as well. It is no longer just one person being ignored. There would have been, you know -

in my role I would have, like, from - you know, based on, like, this is the data we have, been able to start to approach it from a different angle. You know, it can't be - you know, you can't accuse us of being - suggest it is a personality issue if it's data, facts, that, you know, this is what - "We've had seven wound dehiscences. Do you think we should look at it?"

That's why I take the example of Dr Miach and Tenckhoff catheters. That is fact. He goes to Dr Keating with a list of six out of six-----?-- Mmm-hmm.

-----failure or complication situations including, I think, two fatalities?-- Mmm-hmm.

When the Director of Medicine goes to the Director of Medical Services with that information, what difference is it going to make if you were also going to the Director of Medical Services with the same information?-- Well, if he wasn't listened to for instance, as Toni is claiming that she wasn't listened to, then you would have more than one person seeing the same or having the same concerns.

But you'd agree, wouldn't you, that a person in Dr Keating's position shouldn't need to have - hear that sort of information from two people. If he hears it from his Director of Medicine, that should be enough to react to it?-- Well, you'll have to ask Darren that. It depends on what was said and how it was said I guess. But, yeah, Darren, I believe, would have reacted from it.

He didn't need to hear it from you as well?-- But any organisation needs to have data to base - yeah, to back up what - the actions that it's taking.

Yes?-- And we do things based on - another example. We had, you know, a product change because of a number of adverse events that we saw coming across that were causing injuries to patients. So I started to look at them, thinking, "This is happening all the time." Sent them over to the Product Review Committee; the product was changed. That's the point of having trends emerging. So that we can recognise that it is just not one-off events. It's something that's happening all the time.

D COMMISSIONER VIDER: Can I just take that ne example one step further; that might clarify something that I just need clarified?-- Mmm-hmm.

You talked about the products, something you said to the product committee. How did you get that information about the product that you sent into the product committee for evaluation?-- There were the same type of adverse events. It was about a - like, a - the name of it escapes me now.

Well, my point-----?-- Urodome.

So you got the information from the adverse event forms?--

Yes, the adverse events were coming over that, you know, in trying to remove these Urodomes, there was like, you know, skin tears, whatever, increased pain when the patient was having the Urodome removed. So we asked the Product Review Committee to look at that product to see if there was-----

My question for clarification - given that role and your coordination aspect of your role, I'm seeking clarification: is the source of your information adverse events?-- Yes.

What about other clinical indicators and do you gather information by - I know you establish trends. Do you gather information also by what you might hear around the hospital?-- Yep.

And do you go out to the different units and say to them, "I'm hearing such and such is a problem"?-- I don't do that as much as I'd like to but, primarily, it's a time issue.

Well, as you review how you allocate your time into the future, would you see that you would do more of that?-- I would, absolutely.

And would you see that relying, say, on a written report like an adverse event form may be a bit unilateral and you might need to go and open yourself up to other avenues of data gathering?-- Sure.

Everybody is wise with hindsight and it is easy to get bogged down in the paper?-- Yep.

Because you've got other clinical indicators?-- Yep.

And you can set your own clinical indicators?-- Yep.

I'm wondering whether clinical indicators - clinical indicators like unplanned return to operating theatre, unplanned admission to the ICU, they're ringing bells and lights for me as we hear information before us?-- Yep, yep.

So would you see that those things would also be indicators?-- They're certainly collected and reported, all of the - we - we submit, like, a whole suite of the ACHS clinical indicators and, yeah, each of the relevant groups then look at, you know, where their performance needs to be improved.

Because a root cause analysis on some of the unplanned returned to operating theatre would have told the whole story?-- Absolutely.

COMMISSIONER: Just while we're exploring these general issues, you mentioned earlier that patient complaints or public complaints are dealt with quite differently from staff complaints?-- Mmm-hmm.

I just wonder, and I'm really thinking allowed about this, whether that's appropriate. Let's take a specific example. I see Mrs Kemps is with us again today. If following the death

of her husband she has concerns, anxieties, but really doesn't feel in a position to deal with that and instead of her making complaint, one of the nursing staff put in a complaint which documents her concerns?-- Yep.

Why should that be treated any differently than if she herself had signed off on it?-- Oh, no, it's not, because it's still a complaint made on behalf of a patient. A staff complaint about another staff member, you know, quite different. But, like, the - any staff member can fill out a complaint form on behalf of the patient who is complaining and that would be dealt with the same way as what any other patient complaint would be dealt with.

Well, let's take it then one step further. Let's say it's not specifically on behalf of the patient or the patient's family because the staff member doesn't want to alarm the family, particularly in a situation of a recent tragedy, but that staff member thinks that something has gone seriously wrong and puts in a complaint, why shouldn't that be treated with the same respect as if it was made by the patient or patient's family or on behalf of the patient-----?-- I don't think it is not treated with the same respect. It is just treated or it is just managed through a different system.

Well, as I understood you, it goes to the human resources section of the hospital?-- That's what I believe, yep, yep. Staff members making complaints about other staff members.

That's hardly the procedure to deal with serious clinical issues, send it up to HR?-- Well, if it was serious clinical issues as you said, they may well go directly to your line manager.

Mr Allen, we might take a morning break if that suits you.

MR ALLEN: Yes, it does.

COMMISSIONER: Adjourn for 10 minutes.

THE COMMISSION ADJOURNED AT 11.23 A.M.

THE COMMISSION RESUMED AT 11.40 A.M.

LEONIE THERESE RAVEN, CONTINUING CROSS-EXAMINATION:

COMMISSIONER: Mr Allen?

MR ALLEN: Thank you, Commissioner. Leaving aside whether it would have made any difference or not you feel that the adverse events reporting procedures have not been followed stringently by hospital staff over the last couple of years?-- Yes.

Okay. Now, if we just try and work out the sort of factors that would impact upon that. You've already discussed that there may be some type of reluctance on the part of staff to attribute blame to others?-- Well, they're encouraged not to do that.

That might be one of the factors that impacts upon non-reporting?-- Oh, it could potentially be.

Okay. There may be perhaps some deficiencies in the education of staff as to when reports should be made?-- There may be.

Would you agree that there's currently no system whereby DQDSU formally notifies a staff member that they've actually received a complaint or an adverse event report?-- Yeah. That's certainly one of the areas that we didn't do terribly well in terms of letting them know that we have got it.

Indeed, there doesn't seem to be any system whereby the person that filled in the adverse event report gets feedback from DQDSU as to what's happening with that report?-- That's right. It was certainly our intention to try to do that, but I have to accept that we didn't do it terribly well.

Would it be the case that another factor which potentially impacts upon the effectiveness of that system is the work pressures of staff?-- Oh, yep, absolutely. They're busy.

And you'd agree that the documentation requirements imposed upon nurses and doctors have risen exponentially over the last 10 years or so?-- That's right. They are required to document a lot of information.

There's a lot of documentation required so as to be able to comply with the accreditation process?-- Yes.

And that's over and above the type of normal documentation required to assist treatment of patients?-- Not by clinicians. The ACHS framework requires some additional - like additional work by me by - in terms of coordinating the accreditation process. If clinicians are - or as clinicians are documenting and recording things as they are normally

required to do that then meets the ACHS requirements. They don't have to document anything additional in terms of their treatment plans.

What are they normally required to do now as compared to, say, 10 years ago is more-----?-- I see - sorry, I see what you mean, yes.

Sorry, yes. And it's the fact of the matter that if nursing staff, for example, find it hard enough to complete their clinical duties during their shift then it may impact upon their ability or willingness to fill out documentation such as adverse events reports?-- Well, it may impact, but, you know, generally they're encouraged. They know that it's important to fill out adverse event forms.

But, of course, it's also important to actually carry out their duties and care for patients?-- That's right.

And sometimes they don't have time to do that, let alone do both?-- I haven't worked in the clinical areas for a number of years so you have to ask them.

You couldn't answer that?-- No.

Okay. Now, you mentioned earlier in response to a question from the Commissioner that, sure, you understand as there would be informal chatter about the wards about clinical matters and perhaps doctors?-- Yep.

Okay. Did you ever become aware prior to March this year that Dr Miach, for instance, wouldn't allow his patients to be treated by Dr Patel?-- No, I wasn't aware of that.

Did you become aware that Dr Patel was nicknamed Dr Death?-- I had heard that, yep, towards the end of last year.

Towards the end of 2004?-- Yeah, I think so.

Had you become otherwise aware of a general feeling of concern about his clinical practice?-- No, not about his clinical practice. I was aware that there were a number of people who had intense dislike for him.

Okay.

COMMISSIONER: Were you aware of the reasons for that?-- From as - from what I could gather with just certain comments that I heard it was primarily personality issues, I think. You know, bit arrogant and a bit cocky as, you know, Dr Patel was. Some people perceived that so there were - you know, there were personality issues without a doubt.

There have been some discussions - it's not really within the scope of our inquiry - but we have had suggestions that he was excessively friendly with some of the more attractive female staff. Did you hear anything of that?-- I wasn't aware of anything like that, no.

MR ALLEN: From what you heard who did he have the personality clashes with?-- From what I heard Gail Aylmer, Toni Hoffman, Dr Carter. They were probably the three people that come immediately to mind.

Do you recall who told you that there was a personality problem between Dr Patel and Toni Hoffman?-- I couldn't swear, you know, confidently who actually told me that.

Or in relation to Gail Aylmer?-- Gail herself told me the issues that we had.

In relation to Dr Carter?-- Just witnessed it during, you know, ASPIC meetings primarily.

COMMISSIONER: I think on Friday you told us quite candidly that he and Dr Patel hated one another's guts?-- Mmm.

Is that based only on what you saw at ASPIC meetings?-- Primarily, yes.

MR ALLEN: Now, in October last year-----?-- Mmm.

-----you were contacted by Dr Keating in relation to matters raised with him by Toni Hoffman?-- No, I contacted Dr Keating about the sentinel event form when Toni Hoffman rang me, yep, so I talked to Darren Keating about whether he knew about the sentinel event form.

Yes, that was prior to October though. That was, I think, August 2004, wasn't it?-- No, I don't believe so. Toni Hoffman rang me and I - again, I'm thinking it was around October - and asked me-----

Okay. Paragraph 37 you received the telephone call-----?-- That's right.

-----requiring the status?-- Yep.

See, the reason why I ask you whether you were contacted by Dr Keating is that there's an e-mail LTR21 and - excuse me, I've got it wrong. It's from Peter Leck?-- Oh, okay, yep.

So Peter Leck asked you for any adverse events concerning Dr Patel?-- That's right.

And that seems to have coincided with a meeting between him and Toni Hoffman?-- That's right.

Okay?-- I believe that that meeting occurred that day and-----

Then you sent the e-mail back?-- Yep.

Which is LTR21?-- Mmm, I did.

And referred to that document enclosed with the sentinel event

form in relation to Mr Bramich?-- Bramich, yes.

And that's part of LTR9?-- Yes.

Okay. Can you just explain what then proceeded after the 21st of October 2004 so far as you were involved in looking into matters regarding Dr Patel?-- Peter just asked me to - Peter Leck asked me to look through the adverse events that had been registered in terms of, you know, what had been registered in relation to Jayant Patel and that was really about all, from memory, in terms of my involvement at that stage.

Right. So basically your assistance ended with your e-mail of the 21st of October 2004 referring to Toni Hoffman's letter regarding Mr Bramich and ventilated patient and one further incident about a wing breakdown?-- That's right, and I went over to Peter after that. He e-mailed me back and said, "Could you bring that letter over?" I went over and showed him the letter. He said he'd already seen it and, yeah, basically that was about it.

You weren't asked to make any further investigations?-- Not that I can recall.

Were you as quality coordinator kept informed as to what was going to occur in relation following up those matters?-- I knew that there was going to be an investigation at some point.

How did you know that?-- I can't really remember. I would imagine Peter may have told me that he would get someone to come in and investigate.

Do you recall when he told you that?-- No, I don't.

Was it before the end of 2004?-- I honestly can't remember. I don't know. Potentially. I'm not sure.

Were there any comments made by Mr Leck in relation to what would happen in the interim?-- No.

Can I just ask you about whether there's a system in place and, if not, what sort of system could be in place so as to allow nurses to report concerns about the clinical practice of doctors. Now, does the current system provide an avenue?-- Not specifically if they just want to, you know, raise general concerns about the clinical practice.

Let's say they want to get someone with appropriate medical expertise-----?-- Mmm.

-----to actually look at the practice of a surgeon and examine whether they're suitably proficient?-- Oh, that would, I would imagine, fall under the credentials of clinical privileges.

Sorry?-- Credentialing and clinical privileges. That's to - you know, that process determines what a doctor is or isn't

allowed to do. Is that what you're asking me?

What's your understanding as to how that system works?-- That's - well, I know very little of it other than it's - you know, it's the responsibility of the Director of Medical Services, I believe.

That's something which, what, vets the doctor before they start working at the hospital?-- Again, I'm not exactly sure how that process works. You have to ask Dr Keating.

Okay. Well, leaving that process aside-----

COMMISSIONER: Well, Mr Allen, since that's been raised I think we were told by Dr Thiele that when he was Director of Medical Services he had a Credentialing and Privileging Committee but that that had been disbanded after he left. That's my recollection of the state of the evidence. Do you happen to know, Miss Raven, whether that committee still exists?-- I honestly don't. No, I don't know.

Thank you.

MR ALLEN: Leaving aside that matter then-----?-- Mmm.

-----and looking at the situation where a surgeon has started practising whether they've been suitably credentialed or not they're working in the position. Does the current system have some type of avenue - formal avenue for a nurse or nurses who have concerns about whether that doctor is, in fact, sufficiently proficient to be carrying out certain types of operation?-- I don't know that a nurse has the qualifications to make that judgment.

Well, that's quite right, so I'm wondering what sort of system is in place so that those concerns can be considered by appropriate suitably qualified doctors to examine the competence of the surgeon in question?-- Well, that would be a task that a group of doctors would have to do.

All right. Can you point us to a committee that does that?-- Well, doctors have various - like there's morbidity and mortality meetings which I know also include nurses, but they do case reviews, those, you know, medical rounds. They have various medical and surgical meetings which are just exclusively the doctors where they can review particular cases.

D COMMISSIONER VIDER: But the mortality and morbidity reports would come to you as quality coordinator, do they not?-- No, not necessarily. They're generally kept by people that are running those meetings.

How can that be disconnected from the continuum of care?-- Well, from my understanding the morbidity and mortality meetings discuss particular - you know, specific cases. It's then, like, you know, if there's broader issues that, you know, can be implemented, like, you know, the broad outcomes

of those discussions it would be referred on to the continuum of care if something needs to be changed, but in terms of, you know, the M&M meetings, you know, discussing particular cases those - those minutes are kept by the clinicians.

Is that documented on the continuum so that the Continuum of Care Committee would know that a matter has come before it out of findings of the Mortality and the Morbidity Committee?-- Sorry, I'm not sure I understand your question.

Following on your line that if there are trends or outcomes-----?-- Mmm.

-----from the Morbidity and Mortality Committee after they've reviewed cases-----?-- Yep.

-----that will reflect the change in practice-----?-- Yep.

-----does that come to the whatever committee? I'm saying the Continuum of Care Committee would be one committee that it would go to. Would that come to that committee and be on the agenda as something that's coming from the Morbidity and the Mortality Committee?-- Yes. For instance, if it required a change in policy or a protocol then it would come under, you know, when they're reviewing policies and so on so it would - broad changes that needed to be made based on some of that review of that information would come and be identified, if you like, to the Continuum of Care Committee.

Yes?-- Yep.

D COMMISSIONER EDWARDS: That would come through the medical superintendent back to that?-- Through the medical?

Superintendent.

COMMISSIONER: Or the Director of Medical Services.

D COMMISSIONER EDWARDS: Medical Services?-- It depends on who - like, which meeting decided there needed to be a change. You know, it may not be the Director of Medical Services. It could be, you know, any one of - any one of the members of the Continuum of Care unit really.

D COMMISSIONER VIDER: Can I just put a scenario to you that's coming out for clarification in my mind and following on from what I have previously said to you about the importance of adverse event, but as it being only one way of gathering information from your point of view as the quality coordinator-----?-- Yes.

-----you've made statements that in your opinion the nurses could have filled out adverse event forms from the operating theatre regarding complications undocumented by Dr Patel?-- Mmm.

So that as I understood it, you have said that you would expect that if Dr Patel nicked the bowel, or a spleen-----?-- Yep.

-----or the aorta-----?-- Yep.

-----and didn't document it, one of the theatre staff could have?-- Yes.

Or should have?-- Yes.

In reality, the surgeon is the one that knows what is done?-- That's right.

The other bit of reality that we have touched on here is it would be very unusual for a nurse to document a factual finding that she thinks she's seen but she actually didn't do it against a doctor?-- It would be unusual, but that's, I guess, partly because of the culture.

Absolutely?-- It certainly needs-----

But I am getting to the point that if the nurse said, "The doctor nicked the bowel."-----?-- Uh-huh.

-----the surgeon's only got to say, "I did not."?-- Yep.

And then you are up to getting one or other to prove it?-- That's right.

I am probably coming back to say how realistic is it to have an expectation that an operating theatre nurse would document an adverse event when she's not actually the one with the scalpel in her hand-----?-- Mmm.

-----or the retractor, or whatever the instrument is that's caused the trauma?-- Yep.

That's the surgeon?-- Yep.

Or the assistant, the two in closest contact with the surgical field?-- Yep.

I suppose I am wondering how realistic it is to imagine that they would fill out an adverse event form in that situation?-- I think it potentially can become realistic if, you know, you just need to get people to accept that it is a no blame culture, that, you know, if you report this as an adverse event, we're not looking at, you know, necessarily trying to criticise your practice but, you know, if you have accidentally nicked a bowel during surgery, is there, you know, is there some contributing factors that we can try to fix to minimise the likelihood of that occurring again.

The blaming culture is a separate issue to this because the issue is not the person, it is the event and the event is what's happened?-- Yep.

The bowel has been nicked, or whatever trauma that was additional to the intended surgery-----?-- Yep.

-----that might have gone on. I suppose I'm really getting to the point of saying when in the Bundaberg scenario would all of this information be able to come together to say, "It would appear we have got a problem here."?-- Through the adverse events reporting system.

I am saying not only through the adverse events reporting, what other indicators or events, even if it be informal reporting?-- Uh-huh.

That you go back and investigate and say, "Something's going on". Because the focus of everything had to be the patient?-- Yes.

And by whatever means, you've now got evidence before you that would warrant investigation that you have got some unintended and unacceptable patient outcomes?-- Yes.

Where does that fit into your role?-- It probably fits more within, like, an ERROMED type structure. You know, in terms of what improvements are made to minimise the recurrence of that particular event, that would then be part of my role, in terms of, like, you know, documenting it and ensuring that it's promulgated throughout the organisation. But looking at specific cases of what went wrong, and coming up with, you know, what needs to occur to minimise the likelihood of it recurring, I think fits within an ERROMED type - you know, where the clinicians say, "Okay, we've nicked the bowel today. Let's go back through the procedure and think about why that might have happened or what we can do to prevent it."

For whatever reason, it didn't really come up through all those, if you like, normal channels, through the quality cycle?-- Uh-huh.

With its focus on patient outcomes. That didn't happen. It came to attention by another means-----?-- Uh-huh.

-----via another process. I am wondering then, in terms of all of the committees and all of the paperwork that supports the work of those committees, whether it would be an appropriate way forward from your position to go with the Australian Council on Health Care Standard guidelines?-- Uh-huh.

Use that and then get to the stage of doing your own evaluation under the Improving Performance Committee?-- Yes.

And get to the stage of simply saying, "We have far too many committees"-----?-- Yep.

-----"all duplicating one another, and we can do away with A, B, C, D, E, F, G, H" - and you could probably go through the alphabet, I think, and put them through the five of ACHS?-- Yes, absolutely.

Because I would suggest to you that one of the things that seems to be coming through in your story is the inordinate amount of time you all spend attending committee meetings?-- Absolutely, I agree.

And, you know, the focus is really go to a committee meeting, by all means, but it has got to have a productive outcome?-- Yes.

What's the purpose of this committee, how often do we need to meet, and what is the outcome?-- Yes, I agree.

COMMISSIONER: Just joining the dots between that series of questions and the ones that Mr Allen was asking, as I understood what Mr Allen was saying, well, who is there to make the necessary judgments and let's try and put it in a concrete example. Let's say that someone at the hospital is concerned that Dr Patel, while perfectly competent to remove an appendix or to do a colonoscopy or bowel resection, is biting off more than he can chew; he is doing operations that are either beyond his personal expertise or beyond the expertise and facilities of Bundaberg Base Hospital?-- Uh-huh.

Who is there to review that sort of issue so that if I'm a theatre nurse, or a nurse in ICU, or a nurse in the surgical ward and I raise those questions, who can that go to to say, "Well, Dr Patel should have his clinical privileges reduced and he shouldn't be doing oesophagectomies", or whatever the procedure is?-- I don't know who that can go to. I am not really sure who the right person would be. You know, there is a theatre management group, but I am not really that familiar with what that group does. But they may look at, you know, the scope of procedures being performed. You know, the Director of Medical Services, I guess, would be the other person, or the Director of Anaesthetics. You know, no surgeon operates in a theatre on his own, somebody has to put the patient to sleep. So maybe the Director of Anaesthetics would be somebody you could raise those concerns with.

From my understanding of Dr Thiele's evidence a couple of weeks ago, he was saying that when there was a - what is it called - Credentialing and Privileging Committee - it had external input from other specialists within the local community, who in turn had connections with their colleges, and so on. So they could bring in outside expertise and they were in a position to make a peer review of someone, even as high up as the Director of Surgery, and say, "Well, this man is not competent to be doing this sort of work."?-- Yep. I know we have a Credentialing and Clinical Privileges policy, but I am not sure how that process - you know, what sits underneath that to make that process work.

MR ALLEN: So in the absence of any type of alternative formal procedure, would it be the case that if a nurse did have those concerns about the - a surgeon acting beyond their own abilities or beyond the scope of practice of a hospital, the

only sort of avenues open to them would be to approach, say, the Nurse Unit Manager, take it up to the Director of Nursing, if necessary, or perhaps appropriately go to the Director of Medical Services?-- Uh-huh.

And even, perhaps, if that didn't seem to be doing anything, go up to the District Manager?-- Potentially.

And raise those concerns?-- Yeah.

You have also mentioned, of course, perhaps also speak to the anaesthetist-----?-- Yep.

-----about those, and even see if they would go along to support you in taking it higher up the chain, to, say, the Director of Medical Services?-- Yep.

Okay. Now, look, the evidence seems to establish that that's in fact just what Toni Hoffman and other nurses did over a period of about 18 months leading up to the end of 2004. Can I ask you firstly whether you accept that it is not correct, as you stated Friday, that Toni Hoffman chose not to voice her concerns to anyone. You accept that's not correct?-- Well, I think you are mincing words, but there were systems available that Toni chose not to use.

Do you accept that it is not correct to say that she chose not to voice her concerns to anyone?-- I am not privy to what she said during the meetings that she had with Darren Keating, so I can't say what she raised.

So therefore you cannot say that she chose not to voice her concerns to anyone?-- Okay, right, fine.

Do you agree?-- Yep.

Therefore, you would not stand by your earlier comments that if she had raised her concerns, then something different would have been done?-- No, I still stand by that. Absolutely I do.

How can you stand by that when you don't even know whether or not she raised concerns?-- I am saying to you if she had used the systems that were available to her to use, something different may have happened.

You have agreed that the systems available to her or any other nurse to raise concerns about the practice of a surgeon will be taken to their line manager to take to the Director of Medical Services and ultimately to the District Manager. Do you agree with that?-- I am talking about the adverse event reporting system. It is a very effective system for having data collected and practices changed. If she had used the adverse event reporting system, something different - the outcomes may have been different.

So if, in addition to taking all those particular concerns to those persons, she filled out some forms that would then

inform your statistics-----?-- Yep.

-----the outcome would have been different?-- It may have been.

It may have been because-----?-- Similarly if she had-----

No - all right, go ahead?-- Similarly if she had said to Peter Leck in February, "I do want you to do something about it", rather than, "I don't want you to do something about it", the outcome may have been different.

You weren't present during any conversation with Peter Leck, were you?-- I have read her testimony. I have read her statement.

I see. Well, let's concentrate on what you're saying. If she filled out these forms-----?-- Uh-huh.

-----in addition to the steps she'd taken?-- Yes.

You would have undertaken some type of trend analysis?-- Yes.

Which would therefore have led you going to see who?-- District manager.

And he would, therefore, have taken a different position to what he did when merely being informed by the clinicians involved?-- Well, it is-----

Is that your evidence?-- It is management by fact. I would have gone to him and said, "Here is the data, Peter. There is an issue. We need to do something about it."

You would have made all the difference, would you?-- I think so. I could have made quite a bit of difference.

I see. So you maintain your evidence that Toni Hoffman and the other nurses didn't do enough?-- They didn't use the system that they had available to them. They have all sat here and said no, they didn't fill out incident reports. Had they done that, we may have had some quite different outcomes for the patients.

Is that right?-- I believe so, yes. That's what I believe.

There may have been a different outcome?-- There may have been different outcomes.

Because you would have picked up some type of trend, would you?-- I would have, yes. As I demonstrated to you, I think before, that that's part of my role. I look at trends.

It would have turned up on one of these documents, an adverse incident register?-- It would - they would have come through as an adverse event report form, which I read and go through every day as they come into my office before they're entered on to the register, and, as I said to you before, one of the

roles that I undertake is to start picking up trends.

And there is some type of column there for the name of a doctor, is there?-- It doesn't - look, it doesn't need to have the doctor identified. They may have put the doctor on, they may not have. If I had had seven reports coming in saying there is seven reports of wound dehiscence, then I would have started looking at what was going wrong.

Okay?-- And whether investigation-----

Let's see how that would have made a difference. You could have then gone to, what, Dr Keating?-- I may have gone to Dr Keating, I may have gone to Peter Leck.

All right. And Dr Keating could have said, "Yes, I got a report on that from Gail Aylmer in July '03. Thanks a lot for telling me, though."?-- Well, you can't - you can't possibly know that that's what he would have said.

Well-----

COMMISSIONER: And, frankly, neither can you, can you?-- No, that's exactly right. I think we're just - you know-----

Is there any point, Mr Allen, taking this any further? I think you have made your point.

MR ALLEN: Probably not. Look, you gave some evidence about a conversation which occurred on the day or soon after Mr Leck stood down from his duties?-- That's right.

And is it the case you don't understand that anyone is making any criticism of you regarding how the documents in relation to Mr Bramich were dealt with?-- Yes, I realise that.

You understand that?-- Yes, I do.

Okay. Is it the case that prior to that conversation you are talking about, you spoke to Gail Aylmer over the phone - this is after the matters had become public in the newspaper?-- Uh-huh.

And said that you were concerned that you would lose your job because you believed your department may have mixed up two incident forms?-- No, that's not true.

You didn't say that to her on the phone?-- No, I did not. I had a conversation with Gail after - it was after I spoke to Toni about the sentinel event form. It was much after that. By this stage Linda had already been - I think she had already been asked to stay on leave. And because of the state of chaos in the organisation, there was another story started to float around that there was somebody coming from corporate office the following week to dismiss the rest of the executive and probably the quality coordinator, and the manager of the Divisions Support Unit would also be stood down. I had that conversation with Gail. I went downstairs to what we call the

smokers' hut. I was very concerned, obviously. And she said, you know, "That wasn't our intention. Don't worry we'll make sure that doesn't happen."

Well, in any event you were concerned at some stage?-- Uh-huh.

But Gail Aylmer reassured you - pointed out, in fact, you weren't even working at the time those forms went in?-- Yep. Yep.

Told you not to worry?-- In what - told me not to worry about losing my job.

She reassured you about your concerns that you might lose your job?-- That's right.

And I suggest that after that telephone conversation and on the occasion you're referring to speaking to Toni Hoffman, Gail Aylmer called you over to ICU?-- I am not sure that it was after that conversation - no, it would have been before that conversation because the conversation about me losing my job didn't occur until Linda was asked to stay on leave. So - and the conversation that occurred in ICU occurred on, I believe, the same - the morning after Darren was, you know, told that he was to stay at home, basically. About the 14th of April, I think it was.

I think you mentioned Mr Leck on Friday?-- Yeah, like, Peter had been stood down that afternoon, and I think on the news that night Darren sort of got the impression that he was to stay at home as well the following morning.

I suggest that Gail Aylmer invited you over to ICU to speak to Toni Hoffman about your concerns?-- No, she asked me over to ICU to speak about - to explain to Toni what happened to the sentinel event form.

You did explain to her?-- I did.

I suggest that Toni Hoffman tried to reassure you?-- No, Toni Hoffman was very emotional during that meeting. She'd became quite teary and said that, you know, they had been through hell in the ICU, and that's, you know, when I said, "Darren never downgraded this sentinel event. It was investigated as it should be.", and that's when she said, "It is a bit of a shame about Darren. I quite like Darren. But we have to make sure Peter never gets back."

Well, your evidence Friday went even further than that. You say that after you mentioned that the sentinel event form hadn't been downgraded, she said, "I know."?-- Yeah, "I know Darren didn't downgrade it. It is a shame about Darren, I quite like Darren, but we have to make sure Peter never gets back."

Did you just forget that bit a minute ago?-- No, I didn't just forget it, I-----

Look, I have already put to you that wasn't said; I am just putting to you-----?-- Well, I am telling you it was said.

Well, I am putting to you now a version of a conversation that I suggest occurred. I suggest that Toni Hoffman explained to you how Jane Truscott had been involved in helping her complete the form?-- Yes, that's right.

And about how Jane Truscott had told her that the sentinel event had been downgraded?-- She may have.

And I suggest that there was some conversation, at least between you and Gail Aylmer, about expressing concern about Darren Keating?-- No, Gail and I basically sat there primarily listening to what Toni was saying. I was leaning against the ledge, Toni was at the end of the table, Gail was on her left and we basically listened to Toni because she was venting about how distressed she was about the way Mrs Bramich was treated, and that's when I went on to say again to her, like, "The sentinel event was not downgraded, Darren didn't downgrade it."

I suggest that during this conversation you clearly expressed pleasure about the prospect of Peter Leck losing his job?-- I laughed with them, absolutely. You go into the lion's den, you don't let them know you are a sheep.

So, what, you laughed about him losing his job, did you?-- Laughed about him being stood down, yes, absolutely.

Did you say-----?-- Because I knew there was no point in trying to defend Peter Leck there, and then because I - I have known for a long time that Gail and Toni have had an intense dislike for the man.

But you were the one who cried out "woo-hoo"?-- I don't remember crying out "woo-hoo", but I may have.

And did you remember Gail Aylmer saying, "This was never about anyone losing their job"?-- No, I don't remember her saying that at all.

And Toni Hoffman saying something along the same lines?-- Toni Hoffman said, "It's a shame about Darren. I quite like Darren but we have to make sure that Peter never gets back."

Well-----?-- You are not going to get me to change that. That was what was said.

I suggest she said something similar to, "They may lose their jobs but they should have listened. They should have done something. If they lose their jobs, so be it?-- I don't remember her saying that, no.

COMMISSIONER: When you say you don't remember, is it possible something along those lines were said?-- Oh, it may have been, but I can - I can be - I can honestly tell you that what

I have said - what I do recall is what I have said has been said and it was said.

All right.

MR ALLEN: Thank you, Commissioner.

COMMISSIONER: Thank you, Mr Allen. Who is meant to be next? I think Mr Mullins is expected back this afternoon.

MR HARPER: No, Commissioner. I have the pleasure of being here this week. Commissioner, I am not quite in a position to commence at the moment. I have only just arrived.

COMMISSIONER: I understand. Is there anyone else ready to go now?

MS McMILLAN: I just have a couple of questions.

CROSS-EXAMINATION:

MS McMILLAN: I appear for the Medical Board. My name is McMillan. I just want to ask you a couple of questions, if I could?-- Yes.

Obviously your role is intrinsically related to the way complaints are dealt with at the hospital, in terms of your role. Now, I take it that you are aware of other agencies which exist outside the hospital that deal with complaints-----?-- Yes.

-----in relation to patients' care, such as the Health Rights Commission?-- Health Rights Commission, yeah.

Medical Board, for instance?-- Yeah.

You are aware of those agencies and entities?-- Yes.

Right. Now, firstly, in your role, I take it do you at times talk to patients or relate back to them in terms of the progress of any complaints they have made within the hospital system?-- No, that's not part of my role. My role is very much just the registration of complaints and producing reports based on that information.

So effectively logging and collecting data?-- Yep.

In essence?-- Yeah.

Are you aware of any measures taken to inform patients about, for instance, the agencies which do exist, such as the HRC and the Medical Board?-- Yes, we have a number of - well, every area has a laminated sign talking about, you know, "If you wish to make a complaint, you should speak to the person

involved in your care." You know, "If you are not happy, then you can speak to the District Manager. If that's not what you want to do, then this is the Health Rights Commission. This is how you contact them. This is how you write to them." So that's involved - like, that's in every area. Additionally, the letter, I believe, that gets sent out - like, every patient who writes a complaint gets an acknowledgement letter saying, "Yes, we have received your complaint. We will investigate it."

Yes?-- And it is either in that letter or one of the letters sent back to the patients - actually, it might be the final letter saying, "This is what we've found in relation to your complaint. If you are not happy with that, you can pursue this through the Health Rights Commission." I think they are given their - you know, their contact details again.

I see. What about in terms of - do you know whether there is any education in terms of the Medical Board's role in terms of clinical practice issues with doctors and its existence, for instance?-- I am not - for patients?

For patients and then all of their staff?-- Not that I am aware of.

What about in terms of training with staff and options which exist? For instance, you have been asked a lot of questions by Mr Allen about issues of clinical competence matters. Are you aware of whether there is any education with respect to staff about options which may exist? For instance, the Medical Board would be one?-- I couldn't be absolutely sure but it is probably something covered in the code of conduct training, potentially. I know that there is a lot of training produced by the HRM department but specifically whether it relates to the Medical Board, I couldn't honestly say.

So that doesn't fall within your bailiwick, if you like; your area?-- No.

All right. Just excuse me. Thank you, Mr Commissioner.

COMMISSIONER: Thank you, Ms McMillan. Mr MacSporran, have you any questions?

MR MacSPORRAN: No, I have nothing, thank you, Mr Commissioner. Thank you. Ms Feeney?

MS FEENEY: Yes, I do. Thank you, Commissioner.

CROSS-EXAMINATION:

MS FEENEY: Ms Raven, when Mr Allen was asking you questions he-----

COMMISSIONER: I am sorry, Ms Feeney, perhaps it is best making clear who you represent.

MS FEENEY: I am sorry, I represent Mr Leck?-- Yeah.

When Mr Allen was asking you questions and he put to you that it was - if somebody had a complaint about a doctor, it was - one option was to go and speak to a line manager about that, and that really adverse events would do nothing more than sort of inform the statistics?-- Uh-huh.

Is it the case that if the statistics are properly informed, line managers can determine whether a complaint brought to them is an isolated clinical event or forms part of a pattern of-----?-- That's right.

-----something that may be of greater concern?-- Absolutely.

Thank you.

COMMISSIONER: Thank you, Ms Feeney. That's all?

MS FEENEY: Thank you.

COMMISSIONER: Mr Fitzpatrick, does it suit you to go now or would you prefer to wait until - I was going to suggest that for the sake of Mr Harper I wouldn't expect him to be ready before lunch, so I am really giving you the option of going ahead now or we have an early lunch and you can follow on from Mr Harper this afternoon.

MR FITZPATRICK: Thank you, Commissioner, but we have no questions.

COMMISSIONER: Well, then, that solves the problem then. Well that only leaves you, Mr Harper. I see it is almost 12.30 so why don't we rise now and come back at 2 o'clock. Does that suit you?

MR HARPER: That would be convenient. It may be Mr Allen had some matters that were covered this morning.

COMMISSIONER: That's all right. If you want to liaise with Mr Allen and make sure they have not come out.

MR HARPER: Thank you, Commissioner.

COMMISSIONER: 2 o'clock then.

THE COMMISSION ADJOURNED AT 12.27 P.M. TILL 2.00 P.M.

THE COMMISSION RESUMED AT 2.01 P.M.

LEONIE THERESE RAVEN, CONTINUING:

COMMISSIONER: Mr Harper, are you ready to proceed?

CROSS-EXAMINATION:

MR HARPER: I am. Miss Raven, my name's Justin Harper, I appear on behalf of the Bundaberg patients?-- Yes.

Just a few questions for you. Can I take you firstly to the attachment LTR4 to your statement?-- Yes.

Can I ask that you to look in your paragraph 21, that that commenced in February 2004?-- That's right.

Prior to that time, what systems were in place for reporting adverse events?-- There was a different form or there were actually a number of different forms. There was like a medication error form, there was a form for, I think from memory there were about five or six and depending on what type of adverse event you were reporting, you filled out the relevant form and sent it off to again, there were a number of different areas that had to be sent to, primarily the Assistant Director of Nursing received most of those adverse event forms prior to February 2004.

Okay. Were they recorded in separate registers then?-- I'm not sure exactly how Carolyn registered them as such or what sort of records she kept, I think there was a monthly report that was sent to the nurses services committee.

Right?-- But that was one of the reasons that we were unsure of, you know, where all of this information had been kept was one of the reasons for implementing a new system.

Okay. In relation to problems arising from surgical treatment?-- Mmm-hmm.

Was there a separate form to how those were done?-- No, there was an old pink form basically and most staff would be familiar with the old pink forms.

Yeah?-- Surgical problems would have been reported on those ones.

And-----?-- Which was just a general patient, you know, incident form.

Can I take you, as I mentioned, to LTR4?-- Mmm-hmm.

And the policy on adverse events management firstly?-- Yes.

Can I ask in your view is it appropriate that patient complaints when they're received should, if warranted, result in the filling out of an adverse event form?-- It potentially could have been an appropriate way to or appropriate use of that information, but certainly it wasn't something that was done within our current system.

Would there be some benefit in that occurring?-- With the current system that Queensland Health is developing, there is a database related to the recording of adverse events and in the same database so that the two systems can talk to each other, if you like, will be the complaints management database as well, so I believe that they're trying to look towards, you know, being able to marry up information relating to adverse events and complaints.

But within the Bundaberg Hospital that clearly didn't occur though?-- No, not at this stage.

Is it fair to say though that that was the intention of this policy?-- No, this was like very specifically aimed at adverse events.

Well, could I refer particularly on page 1, "Definitions"?-- Mmm-hmm.

This section "Incident" and I'll read that out, "An event or circumstances which could have or did lead to unintended and/or unnecessary harm to a person and/or a complaint"?-- Yep.

So would it not be that where a complaint is received by definition, wouldn't that lead to - shouldn't that have led to an adverse event incident report?-- No, it's basically the other way around, it's like if it's an adverse event that could potentially lead a patient to make a complaint, but it's - our system didn't go back the other way that if we got a complaint, we would look at, you know, filling out an adverse event.

Okay. But just to be clear, and I'm happy to take it to you if you like, but the complaints register will not correlate with the adverse events register?-- No, not within the systems that we have at the moment.

Can I take you then to the fourth page of the policy on adverse events management?-- Yep.

The section headed "Open Disclosure"?-- Mmm-hmm.

Would you agree with me that that sets out quite a rigorous and detailed process by way the patient and/or relevantly, their family should be advised about an adverse event?-- Yep, it certainly does. Open disclosure is actually an Australian

standard that's been introduced. We had had some primary information about open disclosure and that's why I put - because Dr Keating had been to a workshop where he was given, you know, a number of resources related to open disclosure, Darren and I had a discussion about how we can best provide training around that and we were at the point of asking whether the medical education officer could take that up because it's primarily aimed at medical officers.

Yes?-- At about that time I went on sick leave. While I was on sick leave, Queensland Health have actually developed up their own training package and they're trialing it in pilot sites, so again, Bundaberg hasn't become yet one of those districts where open disclosure has been properly rolled out, so open disclosure doesn't really occur according to the standard at Bundaberg because our clinicians have not been trained in it yet.

Would it be fair to say that in relation to the events recorded on the adverse incidents register?-- Mmm-hmm.

It essentially didn't occur at all?-- That disclosure to the patient?

Yes?-- I can't ascertain that from what's recorded on the adverse event report form, it would be up to the clinicians involved, they would be better able to tell you how much information was given back to the patient in terms of what error had occurred.

Correct me if I am wrong though, your role, wasn't it, was to oversee the implementation of this policy about adverse events management?-- Yep, yes.

And wasn't it a critical part of this policy the introduction of that policy of open disclosure?-- Yes and no. Like, people have given information about, I believe, people are or patients are given information about what has occurred to them, open disclosure is a very specific standard that, you know, steps you through a whole series of, you know, information that you have to give to patients. As I was saying, you know, in utopia in an ideal world, that package would have been rolled out from corporate office or we would have, you know, been able to proceed with the try to implement our own education for clinicians, but as I say, for a number of events, you know, a number of events are beyond anybody's control, that process like fell over when I went on sick leave and somebody else took over my role.

Was it fair to say then that there was no coordinated policy on disclosure to patients and it was left essentially to individual staff members?-- At that stage, yes.

Could I get you to have a look at the adverse incidents register, and I'm interested in the sorts of matters which are recorded on there. Have you got a copy handy?-- No, I don't.

And again, you've probably covered some of this in your

evidence previously?-- Mmm-hmm.

But just browsing down I think it's the far right-hand column where they identify the categories of adverse incidents?-- The type of event?

Yes, and you'll see ones there some are I think for-----?-- Yep.

-----medication?-- Yep.

Would it be fair to say, and you browse through or speak from your own experience, there are very few complaints there that are recordings of treatment?-- Bodily injury would probably be the - it just depends on the, you know, the way the event is described.

Right?-- In terms of what the AO who's registering this information into the register has to pick from, you know, a number of categories, so-----

Is treatment one of those categories though?-- I'm not exactly sure to be quite honest with you, I think it might be, but I honestly have to have another look at the register. I couldn't be quite sure, it's more likely to be bodily injury, perhaps, I know certainly when Marilyn's categorising those incidents, if she's not clear on what category it should fall into, you know, her and I have a discussion on that and try our best to categorise it into its appropriate event type.

Could you pass that back to me please? I'll just put one proposition to you and it's more that I'm interested in your general comments on?-- Mmm-hmm.

Would it be fair in your view to say that the process of this reporting is focussed far more on the routine things which might happen in a hospital day-to-day rather than concerns about identification, correction of poor clinical treatment?-- No, I don't think that's a fair comment. You know, obviously when you look through the register, you know, we do have a lot of falls, you know, registered, a lot of medication errors, pressure areas, they're obviously they're the big three types of events that are reported.

Mmm-hmm?-- But errors in clinical treatment are still included in that system. I don't think you can say that it's more heavily focussed on one or the other, it's a system that's open or, you know, able to be used for all manner of adverse events that occur.

COMMISSIONER: I think perhaps what Mr Harper was driving at though is that the form is very suitable for picking up statistical indicators of the usual sorts of problems, if I can use that expression, so if there's incorrect medication prescribed or supplied to the patient, if they're pressure issues, that sort of thing. The system is great for getting a statistical indication that this is a problem in this ward or this section of the hospital?-- Mmm-hmm.

But when you get to a dramatic problem as has been suggested was the case with Dr Patel where a surgeon's simply doing operations which are beyond his competence or beyond the competence of the hospital, it's really far beyond what this form was intended to deal with?-- Oh, certainly in terms of like, you know, his credentialing and what his scope of practice is, it's not the intention of this form to pick that up, but certainly complications arising out of surgery that he performed would have been, you know, could have been picked up by the system.

In a funny sort of way, the less serious the problem, the easier it is to have a system pick up a statistic, so - and I'm not saying it isn't a serious problem if patients are given the wrong medication?-- Mmm-hmm.

But that could be a slip of the pen or a simple dispensing mistake and it's relatively straightforward if you've got the system in place to work out, as you told us earlier, if there's a problem at Childers or a problem at Gin Gin you could work out that there had been four in a row and something should be done about it?-- Yep.

But when it comes to something like patients dying from very serious surgery, there is an expected death rate?-- Mmm-hmm.

If you're doing oesophagectomies you might expect to lose one patient in 10 or one patient in 20?-- Mmm.

And the system really doesn't have the finetuning necessary to pick up when that failure rate is higher than acceptable?-- Probably not this system, no.

Does that help at all, Mr Harper?

MR HARPER: It does, Commissioner.

Could I take you then to the attachment LTR6 which is the policy on sentinel events?-- Mmm-hmm.

And again, as I understand it, your evidence was that any person who observed or becomes aware of a sentinel event?-- Mmm-hmm.

Should report it?-- Yes.

And the process is then that that undergoes a proper external investigation?-- No, it will still be investigated internally, like, by - it would go to the relevant director.

Yep?-- Who should appoint an appropriate investigation officer which would be somebody from inside the district.

And in the case of Dr Patel?-- Mmm-hmm.

Who would that have gone to, a sentinel event form, who would it have gone to to do an investigation?-- Well, it would have

gone to Darren, to Dr Keating and he would have appointed somebody to investigate the sentinel event.

Okay?-- And I believe in the case of Mr Bramich he appointed Dr Carter.

Am I also right in my reading of the policy that sentinel events ultimately further through the chain get reported to the Director-General?-- They do, yes.

And can I then take you to page 2 of that policy?-- Mmm-hmm.

At the second last paragraph where it talks about the liaison with the patient family and such?-- Yep.

There's no specific section in there similar to the adverse events policy about open disclosure?-- No, that's - because the adverse events and sentinel events policy technically could have been, you know, you basically manage them in the same way in terms of, like, what the patient is told or what have you. I know it was just a Bundaberg decision that they wanted a separate sentinel event policy because it was a much more serious event and so this was just particularly in relation to, I guess it's just an oversight on my part by not referring to that in that paragraph.

But what I'm interested in though is that the person who is to do that, to do that discussion with the family is a designated executive member?-- Yep.

Again, in the case of any problems arising from Dr Patel, who would that have been who would have done that liaison with the family?-- Oh, it would have been Dr Keating.

Could I - just one moment, Commissioner. Could I ask you do you have some knowledge of the circumstances arising, leading to the death of Mr Kemps?-- No.

Have you become aware of it subsequently though?-- Only from what I've heard in evidence here.

From what you've heard in evidence, are you aware that in relation to the circumstances surrounding the death of Mr Kemps, that there was some concern raised by Dr Smalberger that treatment should not have been given in the first place?-- No, I'm not aware of that, I didn't hear Dr Smalberger's evidence.

Were that to be the case, would that in your view have required the filling out of a sentinel event form?-- What, that he shouldn't have had the treatment?

That my recollection of Dr Smalberger's evidence?-- Mmm-hmm.

And I am to be corrected, that his recommendation was that the surgery which Dr Patel ultimately performed should never have been performed?-- Right.

Were that to be the case, would that in your view have warranted a sentinel event form?-- Yeah, it probably should have had a sentinel event form filled out because under the new policy the unexpected death of a patient, so potentially.

Are you aware as well that Dr Berens and Dr Carter, after the operation on Mr Kemps, were concerned about that, the way that operation was conducted, precipitated the death of Mr Kemps?-- No, I'm not aware of that.

Were that to be the case, would that in your view have warranted the filling out of a sentinel event form?-- Absolutely.

Are you aware that they also went and discussed with Dr Keating the prospect of it being reported to the Coroner?-- No, I'm not aware of that.

Were Dr Keating have been informed about the circumstances and those concerns, would - should he in your view have filled out a sentinel event form?-- It's not very - it's not very usual for one of the executive directors to fill out a sentinel event form. Darren may have suggested to them to fill one out so that it can be reported, you know, appropriately, but I - you know, I doubt that Darren would have filled one out himself.

But given that he would be the one who was responsible, as you said, for liaising with the patients?-- Mmm-hmm.

Would that not have been a matter of concern to him?-- Oh, I'm sure it would have been.

Would it have been incumbent upon him to in those circumstances have proceeded to fill out that form?-- I couldn't really answer that.

Commissioner, I have nothing further.

COMMISSIONER: Thank you Mr Harper. Mr Fitzpatrick, any re-examination?

MR FITZPATRICK: No, thank you, Commissioner.

MR ALLEN: Commissioner, excuse me. There was one matter that I neglected to ask about.

COMMISSIONER: Certainly.

MR ALLEN: I would be brief.

FURTHER CROSS-EXAMINATION:

MR ALLEN: This controversy about whether or not Mr Bramich

was treated as a sentinel event, would one way to ascertain the truth of that-----?-- Mmm-hmm.

-----be to consider whether or not the matters concerning Mr Bramich were actually communicated to the corporate office as is required by the policy governing sentinel events?-- It could be, yes.

Who would be responsible for notifying the corporate office of a sentinel?-- Either the district manager or the Director of Medical Services.

Now, you weren't in fact working at the time-----?-- No.

-----that those reports were generated?-- No, I came back two days after that report was submitted.

Do you have any knowledge as to whether or not in fact the corporate office was notified of the events concerning Mr Bramich?-- I don't know.

Thank you. That was the only matter, Commissioner.

COMMISSIONER: Thank you Mr Allen. Mr Andrews?

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

COMMISSIONER: Miss Raven, you're excused from further attendance. Would you permit me to say that it is very important for an inquiry like this to hear a range of different viewpoints?-- Mmm-hmm.

You've expressed some viewpoints very firmly and, if I can say so, courageously, they're views that perhaps some people here don't agree with?-- Yeah.

But that doesn't make it any less important that we have the opportunity to hear your views and to have the opportunity to take that into account in considering all of the other evidence that comes before us. Thank you particularly for making your time available on your holidays to come in today, and as I say, you're excused from further attendance?-- Thank you very much.

Thank you.

WITNESS EXCUSED

COMMISSIONER: Mr Andrews?

MR ANDREWS: Commissioner, I call Jennifer Kirby, and Commissioner, Miss Raven kindly did as I asked the other day and left behind the statement which is to become an exhibit.

COMMISSIONER: Yes. Now, Miss Raven's statement has become Exhibit 162, I believe, I believe that I've given it that number already.

MR ANDREWS: Yes, Exhibit 162.

COMMISSIONER: Thank you.

ADMITTED AND MARKED "EXHIBIT 162"

JENNIFER KIRBY, SWORN AND EXAMINED:

MR ANDREWS: Miss Kirby, would you tell the Commission your full name please?-- Jennifer Kirby.

Now, you've prepared two statements, haven't you: one a bulky one with a number of attachments which was your first statement and it was signed on the 17th of June 2005?-- That's right.

Are the facts recited in that statement true to the best of your knowledge?-- They are.

And are the opinions expressed in it opinions you honestly hold?-- Yes, they are.

I tender that statement, Commissioner.

COMMISSIONER: Just at the moment I don't have a copy in front of me so can you tell me the date?

MR ANDREWS: Yes. It's dated that as signed on 17 June 2005.

COMMISSIONER: All right. Well, the statement of Ms Kirby dated 17 June 2005 will be Exhibit 169.

ADMITTED AND MARKED "EXHIBIT 169"

MR ANDREWS: Ms Kirby, the version that you have before you, is it unmarked? Does it have any of your own handwriting or notes on it?-- It does.

Very well. We'll obtain a clean copy for tendering when the time comes.

COMMISSIONER: Well, my copy's unmarked so that will become the exhibit in due course.

MR ANDREWS: Thank you. And have you subsequently prepared a brief supplementary statement signed on the 8th of July 2005?-- I have, yes.

Do you have a copy of that with you?-- Yes, I think I do.

I've got spares.

MR MACSPORRAN: Commissioner, I wonder whether I could have one of those spares?

COMMISSIONER: Of course. I think you may not have been here this morning when they were given out.

MR ANDREWS: It seems they were all missing when they were given out, Commissioner. I wonder if Queensland Health has a spare copy of Ms Kirby's statement of the 8th of July because currently Mr Allen seems to be missing-----

COMMISSIONER: I think we're having copies made at the moment.

MR ANDREWS: Thank you, Commissioner. That statement of yours signed on the 8th of July, are the facts within it correct to the best of your knowledge?-- Yes.

And are the opinions expressed in it your honest opinions?-- They are, yes.

I tender that.

COMMISSIONER: Mr Andrews, is there any merit in giving that another exhibit number or can they form the same exhibit?

MR ANDREWS: There's some merit in giving it another number.

COMMISSIONER: All right. Exhibit 170 will be the supplementary statement of Jennifer Kirby signed on 8 July 2005.

ADMITTED AND MARKED "EXHIBIT 170"

MR ANDREWS: Thank you, Commissioner.

Miss Kirby, you're the manager of DQDSU? We have the benefit of your job description at JK2. Some of these job descriptions have considerable generalities in them and can be difficult for a person not used to hospital practices to understand. Allow me to put up on the monitor your Exhibit JK2 with some highlighting that I used for my own purposes.

I wonder if the exhibit could focus only on passages that have been marked with yellow highlighter, please. Now, you report directly to the Director of Corporate Services. Now, that's not a person with clinical responsibilities, is it?-- No, it's not.

Could you move, please, to the next section that's marked. You manage the clinical benchmarking information system to provide patient costing information?-- That's right.

You deliver monthly reports on activity targets in accordance with service agreements. Can you explain that?-- On a monthly basis, the throughput through the hospital is monitored. That's the activity. So activity is what we call discharges, separations and-----

So that's the quantity or the number of patients-----?-- Absolutely. Yes, it is.

-----through?-- Yes. And the service agreement will be the agreement between the hospital and Corporate Office Queensland Health Central Zone Management Unit about what sort of activity we will be putting through.

Is there annually a service agreement or-----?-- Yes. Yes.

In accordance with it, is the hospital required to seek to ascertain numeric targets?-- Yes.

And you provide activity and costing reports to managers and clinicians. Now, the activity and costing reports, are they two different things or one thing?-- They can be two different things and they can be combined depending on the department, but the activity is what I said before: the throughput through a particular department or unit. The costing reports will be financial and payroll information; the actual costs that have been incurred for delivering that service to that unit. So that's where we've had some discussions, I think here already, about cost centre managers. That's what that is referring. Every department head or many of the department heads are responsible for a cost centre which is the financial transactions that are going on for that particular department.

You analyse and promote the utilisation of financial and activity information for improving the organisation's understanding of the cost of products-----?-- Mmm-hmm, yes.

-----of budgetary management and the hospital's performance against peer hospitals?-- That's right.

That seems, to this reader, to suggest that you're an analyst of financial as opposed to clinical quality matters?-- It's a bit of both. The clinical benchmarking information system is an information system that is trying to bring to a hospital the fact that we know how much - how many dollars we spend on something, we know what our payroll information is and what staff we have; but what is that cost at a patient level for providing clinical care at the patient level. So, it's where

we start to look at groups of patients and the type of care that they're receiving and how much that care actually is. So when we're talking products further back, products can be pathology, the price of pathology testing that we do, the cost of radiology testing that we do, the clinical supplies that we provide. There's a whole range of things that come into what clinical costing is.

So a person would go to the manager of DQDSU to ask how the Bundabger Base Hospital compares with another hospital for the number of procedures that are done and costs to the hospital per procedure?-- Associated with that.

They wouldn't go to the manager to ask, "Does Bundaberg Hospital provide better patient outcomes than another hospital"?-- They can. The information that comes into the clinical benchmarking system is aggregated information. It's summary data. So there are indicators there about patient outcomes, complication rates.

That's not something that you'd routinely report though, is it?-- I do if I'm asked, absolutely.

But when I say routinely report, you don't attend a monthly meeting where you come with data revealing patient outcomes, or do you?-- There are - as - as the hospital became more familiar with types of information that were in there, more and more people would come and ask me for particular types of information and they may want that on a one-off basis or they may want that regularly. So, there are reports that I write for staff which are about - that they use for their morbidity and mortality meetings, which there's reports that I routinely - we routinely run for the Infection Control Coordinator, who wants to know for these particular patients who have these particular procedures, they want to know any infection rates or - that have occurred. So it would depend on who was asking for that information but, certainly, the system is capable of getting that out.

D COMMISSIONER VIDER: Can I just take that further because I'm having a little bit of difficulty in my own mind clarifying what is the differences between your role and the quality co-ordinator's role. You're saying now, as I'm hearing you, that your focus is, under the DRG arrangement, looking at the disease as a cost centre; is that right? You're looking at what the cost of delivery of care is?-- Not just the cost. I guess in separating what my role is and quality co-ordinator, my role - I'm a data manager, so I'm looking at a whole range of information systems - some of them are about costing and some of them are about clinical care - and getting that information out of all these information systems that Queensland Health enters this into and pulling it out so that people can start to use that information.

But you're the manager of the District Quality and Decision Support Unit?-- Mmm-hmm, yes, I am.

And that reports to the Director of Corporate Services?--

Yes, it does. Will we just take it back a step? Is that all right?

MR ANDREWS: Well, if you feel you've answered Deputy Commissioner Vider's question?-- In terms of the role of what the manager is, I look after - the quality co-ordinator and I work beside each other. We're on the same level. The quality co-ordinator actually reports to the District Manager-----

D COMMISSIONER VIDER: Yes?-- -----for quality. However, in terms of managing the functions of the unit, I look after the unit from a HR perspective. So we-----

But you don't report to the quality co-ordinator?-- No, I don't.

You report to the Director of Corporate Services?-- Yes, I do.

It is not clear?-- It is not easy, no.

It is not clear to me how that would work at all. You have got two people dealing with quality but with two different perspectives and two different line responsibilities?-- Yes.

Is that right?-- That's true. It's not easy.

COMMISSIONER: If we can bring up page - sorry, if we can bring up the previous page, towards the top under "Role of the Department". Yes, just above that, a little higher up the page. You see in that paragraph it talks about the key objective being to ensure the needs of clients for financial/casemix/clinical benchmarking data are met. Now, we heard a couple of works ago that "clients" is a new word for patients, but this is a different type of client, is it?-- This is staff, this is external departments, this is - I mean, I get requests from the police department for information, so clients is not patient. It is not in reference to patients at all.

Principally the clients would be the - what, the people in the head of operational units within the hospital wanting information from you regarding their units?-- Certainly.

All right. So that the Director-----?-- And Queensland-----

The Director of Medicine might be a client or the Director of Surgery might be a client?-- Certainly.

Then it talks about their need for financial data. I can understand that. Casemix data, what's that refer to?-- Casemix data is a classification system that's used within Australia. For the in-patient we use the Australian national classification where similar groups of patients, clinically meaningful groups of patients, are rolled up into what we call a diagnosis related group and they use a similar sort of resource consumption. So it's a classification system of the types of patients that we're treating. So there's different classifications for in-patients, out-patients, emergency.

Then there is the further category of data which is clinical benchmarking?-- Mmm-hmm.

I guess that comes back to Deputy Commissioner Vider's question; that would be a clinical indicator of some sort?-- Certainly, yep.

And that strikes me as being inappropriate for someone to be reporting to the Director of Corporate Services. I would have thought the clinical benchmarking was something that either the Director of Medical Services or someone in the clinical field anyway would need to know about?-- Certainly when we implemented the system I was reporting directly to the Director of Medical Services. We had a merger of three separate little units into one unit to develop this information shop, which became what was known as the DQDSU, in 2001. Originally I was reporting to the Director of Medical Services and as part of the merger, I was changed to reporting to the Director of Corporate Services.

D COMMISSIONER VIDER: Can you give me an example then of what sort of clinical indicators you collect?-- You mean in terms of the ACHS clinical-----

Yes?-- There's a whole range of them. So you were talking about do we monitor the returns to theatre, do we monitor the returns to ICU; yes, we do-----

I'm actually asking you, in your role, which ones you collect?-- Oh, I'd have to - I mean, off the top of my head I can't remember them all. There's quite a suite of them. There's some gastro ones. We collect ones for total joint replacements. There's a whole range of ACHS indicators and I don't have them all off the top of my head.

When you collect those, what do you do with them?-- They're reported to the ACHS on a six-monthly basis. So we generally run most of them on a six-monthly basis. We do the collection on a six-monthly basis. So I actually run the reports for a lot of those that collects the raw data. Some of those then need to go back to the clinician-----

Yes?-- -----to be evaluated about whether they meet the criteria or not because it will select whether you - one of them is for bleeding with gastroscopies and whether they'd had a transfusion within 24 hours. Well, I can't tell that from an electronic information system. I can say, "Here's the group of patients that meet the minimum of that criteria. You need to tell me whether they meet that 24 hours." So some of them go back to the clinicians to be evaluated before they're submitted. Then when the ACHS report comes back-----

Yes?-- -----they come back into - the report will come back into the District Manager and then into the Quality Manager. That is then disseminated out through the executive council and clinical service forums for - there's the report back in your comparison to other facilities.

So that's the management of the clinical data-----?-- Uh-huh.

-----maintaining its clinical focus?-- Mmm-hmm.

For example, if you're looking at pulmonary embolism or whatever else it might be, it comes to you. Do you put the data together for the committees?-- Some of the data, yes. Yes.

And then it goes back to the committee, and then it could come back to you as the central hearing house that will send them off to ACHS?-- To ACHS.

Or whichever national benchmarking it's going for?-- Because as you know with the ACHS, there is a national software application that you have to enter so that will come back to your unit, all the data, and get submitted and sent off in one batch.

That's part of what you do?-- That's part of the role of the unit, yes.

Of your role?-- I do some of it, yes.

Do you make any other applications based on what we've just been reading about the financial/casemix/clinical benchmarking data? Do you extrapolate any of that information and use it in that financial/casemix - I'm looking at things like, given that you've talked about the costing, clinical costing. Are you the one that does the analysis on length of stay for example, which increases costs, where you've got length of stay related to complications?-- Yes.

Does that come out of your-----?-- It does - it does come out of this, yes.

-----system report?-- So routinely, on a monthly basis, that would be one of the casemix reports that we would send out. That is, all the in-patient departments would receive probably a top 20 DRG report which tells you, "This is your high volume cases that are going through and this is the length of stay compared to the state average length of stay." So that information then becomes useful for the clinicians to say, "Well, which of these groups of patients are we outside the length of stay? Do we need to look at their clinical pathways and their care?"

Yes. From that scenario, was it possible to pick up any of the Dr Patel saga whereby we've got complications that are outside the scope of the original reason for admission?-- Unless the - no, in terms of the routine monthly reporting that goes out, it's not - very seldom will say Dr X, Dr Patel, Dr This, Dr That. It will be, "Here's everybody's." If there had been - if somebody had said to me, "Could you break that down further to tell me who the actual surgeons are", then that's possible, but the onus is really not for me to make those judgments. But if somebody asks me for that, is it

possible, yes.

No, but the flags were there, were they, to let you know that somebody - that you had X number of cases that were outside the normal clinical case load or benchmarking. For example, you would have length of stays that were longer for certain diagnosis?-- Mmm. I guess the difficulty - I know there has been lot of discussion about oesophagectomies here. The difficulty is that in terms of the high volume of information that went out, we were not doing a great deal of oesophagectomies. I mean, two or three wouldn't flag in a surgical ward that that's a high volume of cases that we need to have a look at.

What about lap cholies?-- Lap cholies, and certainly I think we will probably get to that, but Dr Patel was quite interested in lap cholies and did some change in practice to those, so we had certainly looked at monitoring some lap cholies. Did anyone come and flag that, you know, we might have some complications or issues, I can't - I don't recall that.

MR ANDREWS: How do you collect the data, your monthly data, relating to clinical matters? Do people send it to you or-----?-- No, what happens around the whole hospital, like many organisations, I think, now that have become so electronic, there are a lot of different information systems. So if you order a pathology test, then you're going to have something recorded in the pathology module that, you know, Joe Bloggs had a full blood count on this day. If you go to radiology, if the patient goes to radiology and has an X-ray, then in the radiology module information system there is radiology information. That-----

Let me give you an example. For instance, within your statement you've exhibited some reports that were produced when people were concerned about wound dehiscence?-- Mmm-hmm.

How does the data relating, for example, to wound dehiscence find its way to DQDSU?-- Okay. A patient on discharge from hospital will have a chart - will be sent to the clinical coding department. They will sit there and go through the whole medical record and assign procedure and diagnosis codes. So that's the IC10 codes, the international classification of diseases. That then is obviously going into a software application. On a weekly basis within our department we extract out of all these information systems that I've been talking about, including the one that the clinical code is written to, we extract all that information and put it into what we call the transition database. It is at that point that we start having the different information systems start talking to each other. So in terms of wound dehiscence, what happened was that has been clinically coded in the - by the coder and from the medical record. I then look-----

It is recorded with IC10 classifications?-- Yes.

Now, I see that the Transition 2 Database is first mentioned

in your statement about paragraph 8 and that's the same paragraph where you talk about a changing of things that occurred in mid-2001. For how long has the hospital been using the Transition 2 Database?-- In 1999 I was taken off line for six months to learn how to manage the system, to feed the beast. We have been using it since 2000.

And for how long have the clinical coders been using the IC10 code?-- IC10 classification.

Or classification?-- For as long as I can remember.

Thank you. Perhaps 10 minutes ago, in answer to another question, you, and I'm paraphrasing, suggested that people were starting or were now more and more using the data that you were able to provide from DQDSU, that is the clinical data, which left for us here the possibility that you're implying a few years ago they weren't using it and now they are tending to use your data more and more. Was that the correct inference for me to draw?-- It is. A few years ago I think we had quite primitive data that was of value to - to staff. What the transition database did was, because it was actually going to now make these information systems talk to each other and they wanted to know more than just one thing about a patient, we now had an opportunity to put these systems together and give more complex information or more detailed information about the patient care.

And would a clinician in 2005 asking you for data relating to the Bundaberg Hospital be likely to get more reliable results than the data from 2003?-- I don't think it's more reliable. I think the information that we've been pulling through has been much the same for quite some years. There is ongoing data quality issues. The more they use the information, the more we interrogate it and evaluate it, but that information has been available since - for 2003. So if you're asking if we can compare information from 2005 to 2003, yes, we can.

Well, one of your e-mails, Exhibit 164, from July 2003 contained your expression of concern that a Carolyn Kennedy was not classifying incidents in a way that was, well, intelligible to a person called Allan. Now, is it the case-----?-- That is - that information that I'm referring to there was in an Excel spreadsheet. It was not in any sort of sophisticated information system. What you were asking me previously was about the clinical benchmarking system. That - that incident that I'm talking about there is not information that's coming out of the clinical benchmarking system.

But is it information that finds its way into the clinical benchmarking system?-- No.

The clinical benchmarking system of course is only as accurate as the information that gets fed into it?-- True.

Is the quality of data that you're collecting improving?-- I think it is.

And has it improved to any significant extent since 2003?-- Parts of it have, yes.

Now, for instance, again, with respect to wound dehiscence?-- Mmm-hmm.

A person seeking to gather data in respect of wound dehiscence in 2003, are they at any - is it easier for them to do so in 2005 than it was in 2003; that is, to gather reliable data?-- There would be no difference. That - that source of information has remained unchanged.

Within your statement at paragraph 35 you deal with the June 2004 issue of wound dehiscence and you show a report that DQDSU provided, which is JK5. Now, my version of JK5 seems to be in three pages. Is yours also? I will have it put up on the screen. Could I have returned to me the document that's been considered. Would you put up the first page of my version, please. Ms Kirby, is that what you have as the first page of your JK5?-- Yes.

Good. Now, regrettably, all the questions I wish to ask you seem to be at the bottom of the page in pencil and I can't see them just at the moment. Yes, this is a problem.

COMMISSIONER: Mr Andrews, why don't we have your copy returned to you and have my copy on the screen. Bring that with you.

MR ANDREWS: If one looks at that first page, it's not headed "Wound Dehiscence"; it's headed instead "Patients with Diagnosis of Disruption of Operation Wound"?-- That's right.

But the next two pages in the report that was sent are each headed "Wound Dehiscence". What's the difference?-- What's the difference, the T81.3-----

T81.3 I see is a code in the principal diagnosis column?-- That's right.

In the first page?-- That's right. So it includes - and that's a short description there, that ICD short description. That's what I was talking about, the international classification of diseases. So under T81.3-----

Which appears four times in that column?-- That's right. That includes - the title of it is Disruption of the Operation Wound and it's - in the book it's not elsewhere classified but it includes dehiscence and rupture of wound operation. So in - what actually happened was that Di Jenkin spoke to one of our staff about wound dehiscence. She asked if we would send some details about these particular patients. We corresponded back and forth over a period of time to try and get exactly what it was that she needed. So you'll find that some of - at some point we've gone to the coding and said - she's asked if it's coded and if there's an electronic way of collecting that and we said it will come under the T83.1 code, which is disruption of operation, and then as time has gone on we've

referred to that as wound dehiscence in further reports for her.

I see. So when you sent these three pages in 2004, were they to indicate to the reader that from the first page there were four incidents of wound dehiscence, each coded T81.3, and were the next two pages said to be two separate and different episodes of wound dehiscence?-- What I was trying to show there was that during the time when the conversation was being undertaken with Di Jenkin about wound dehiscence, there was a range of reports going back and forth between Di Jenkin and the unit. This had been a first report that had gone out and then I had - and I had received a copy of it and I e-mailed her myself and said, you know, "Di, do you want some additional information, not just - not just this? There's a whole range of other things that you might be interested in." She's corresponded back and said, "Yes, I would like that additional information." So then we've started to build a bit more of a profile about the patients for her that she wanted.

Good. Well, that first page, would that have been immediately apparent to Di Jenkin that the T81.3 codes were the wound dehiscence codes?-- Yes.

And the next two pages, they're obvious because they're headed with the wounds "wound dehiscence" so they each would - ought to have been coded T81.3?-- Yes.

But they weren't, were they?-- I can't - I can't see the selection criteria on that actually.

Well, actually the third of the three pages does seem to have amongst its various codes at the bottom T81.41-----?-- Mmm.

-----wound infection following a procedure. Is that different from T81.3?-- Yes, it's - it's another code.

But it doesn't have a code T81.3?-- No, and I think this was what we were trying to determine with Di is that we had sent her this initial report and then she started saying could you run a report with the additional and she actually started specifying what the counter numbers were going to be so then she could see what the coding was that we were - what the patients were coded as.

Now, for instance, the one which is the third of the pages in Exhibit JK5 headed "Wound Dehiscence" and it's the one that shows the diagnosis code the T81.41, amongst others. Now, do you-----

COMMISSIONER: But that one doesn't have a surgery date or a surgeon.

MR ANDREWS: No. It does have an admission date and the discharge date, however, and it could possibly be to do with the fact that I'm looking at the DRG in description?-- This could be a re-admission because that's a post-operative and post-traumatic impression so there may not have been a surgery date or surgery during that particular admission.

So if the person had surgery prior to the 30th of May but the wound, for instance, dehisced and returned it wouldn't include again the day of surgery?-- Not in this report, no.

COMMISSIONER: Well, if you go back to the previous page on that occasion we are given the name of a surgeon, at least initials FAI. I assume that's the name of the surgeon, not the insurance company, but that would be the surgeon who attended to the repair of the wound dehiscence rather than the surgeon who conducted the surgery which resulted in the wound dehiscence?-- That's actually the surgeon there that's listed for the fibreoptic colonoscopy.

Yes. Well, is that the surgeon whose surgery gave rise to the wound dehiscence?-- No, not necessarily. That's the surgeon that provided the procedure fibreoptic colonoscopy.

Well, in other words, if Di Jenkins or anyone else is wanting

to get data about wound dehiscences identified by a surgeon this database wouldn't have been of any assistance at all?-- I disagree with that. I guess what I'm trying to show here is that while - when the wound dehiscence issue came up with Di Jenkin we were having a lot of discussion back and forth about the information that she required and how she wanted that presented.

MR ANDREWS: So that I understand it take it one page at a time?-- Mmm.

But start with the first, the one that has a dozen or so different discharge dates. Now, when Di Jenkins asked you for data relating to wound dehiscences you supplied her with this document. Does every entry on that document respond to her request, that is, did you select or someone in your department select these dozen or so entries because of Di's request?-- Yes, so we have selected for a particular date range. We have then said that the selection has to have a T81.3 code on discharge.

But you-----?-- We have to say that they've - sorry.

But you've included four with T81.3 codes and a number of others with other various codes?-- That report at that stage is only showing one of the codes. I mean, a patient can come in - these ICD-10 codes, they can have multitudes of these codes so in the selection we have said that all these patients actually in the coding have been flagged as having the T81.3. This is the first one that's in the list.

I see.

COMMISSIONER: So we have got the first one here. You've got someone who is in hospital for 42 days six weeks. The principal diagnosis was K45.0 which might be something totally unrelated to wound dehiscence?-- That's right.

But if you are going to put the details of that patient you will find a T81.3 somewhere-----?-- Absolutely.

-----in that patient's records?-- Yes. So in the selection we have made the selection - to run the report we have said you must have a T81.3 code.

MR ANDREWS: I see. Now, your computer will have found those for you?-- Absolutely.

You wouldn't manually have been obliged to?-- No.

D COMMISSIONER VIDER: My question then would be we have had evidence put before us that the documentation wasn't always complete where you would have been from the record able to find evidence of wound dehiscence. All of these 13 cases from the 1st of the 1st 2003 to the 30th of the 4th 2004 have been drawn straight from the record?-- Absolutely.

All right, with no other need to go and trace anything else?--

No.

No other indicator?-- That's just straight from clinical coding.

COMMISSIONER: Mr Andrews, maybe you can tell us where this evidence is taking us. We know that Patel's wound dehiscences weren't picked up by the system. Are we trying to demonstrate it could have if it had been used properly or-----

MR ANDREWS: Commissioner, upon reading these documents I come to a different construction of them. One that suggested that wound dehiscences when requested weren't easily retrieved by the system and that the system missed many cases. I'm now starting to appreciate the significance of this document and see that these 13 cases upon this document are, in fact, each wound dehiscence cases and that there aren't simply four.

COMMISSIONER: The system - I don't know whether it's the best system in the world or the worst system in the word, but it didn't do any good so what's the point of spending a lot of time going through it all?

MR ANDREWS: Indeed, if that's all this would demonstrate there is no point. I did perhaps optimistically think that this might demonstrate that the system doesn't properly reveal wound dehiscences even when they are requested, but Miss Kirby's evidence is making me change my mind. It does appear from the evidence we have just heard that the system will at least retrieve recorded cases of wound dehiscence if they've been passed on to the DQDSU.

COMMISSIONER: Am I right in thinking these are all of the wound dehiscences for the relevant period at the Bundaberg Hospital?-- During that - no, not the entire hospital. This was from the surgical ward.

And there's nothing on this covering form to tell us which surgeon is involved or-----?-- Not at that point, no.

Is there at any point?-- Do I know what surgeons, yes.

How do you find that out?-- I just drop the field in surgeon into the report.

But doesn't that tell us then from the other documents we saw a moment ago doesn't it tell us which surgeons were detailed to repair the dehiscence rather than which surgeon may have caused it?-- At the point of this report this was just one of the first reports that we did with Di-----

Am I right? Does it only tell you who was detailed to fix up the dehiscence?-- No, it wasn't.

Well, these two sheets we have got one doesn't list a surgeon, the other lists a surgeon who, as I understand it, was responsible for repairing the dehiscence. Put it this way, if Di Jenkin comes into your office and says I want a list of all

wound dehiscences for which Jayant Patel was responsible where he was the surgeon nothing that you've shown us so far suggests that you can produce that data. Could we do that?-- I can produce that data and I think, Commissioner Morris, I actually have supplied some of that information to the Commission already-----

Well-----?-- -----through Queensland Health. It's not in my statement here, but there's a whole range of reports that we have - I've obviously been running for the last month or so in preparation.

I don't know why we are going through this, you see?-- If a clinician like Di Jenkin had come to me and said just for Dr Patel, "I want to know how many wound dehiscences he has.", if the question is can I provide that information, yes, I can.

That information as you mentioned to the Deputy Commissioner is as reliable or unreliable as the information that was inputted into the system to produce this database?-- Absolutely.

And if, for example, Dr Patel doesn't record his dehiscences or quibbles over whether it's defined as a dehiscence or something else it just doesn't find its way into the system?-- No, I disagree with that. Dr Patel is not - a clinical coder who is sitting there going through the whole medical record is not just looking for what Dr Patel writes, so if a nurse writes that there's a wound dehiscence or there's a wound breakdown, if a doctor - another doctor writes that down then it will be detected by and picked up by the clinical coder. It doesn't require Dr Patel on his own just to omit that information and, therefore, just because Dr Patel omits it then it's not recorded.

The evidence that we have received suggests that when nurses started to identify things as wound dehiscence Dr Patel got to them and said, "No, you can't call that a dehiscence because it's not a dehiscence. You should go away and read the literature. It's not a dehiscence.", so it is written down by the nurse as something quite different and, therefore, it doesn't get into your system as a dehiscence?-- I think when you are looking at the data it identifies that there are 13 patients and I think you have found testimony that they have found it and they have found wound dehiscences, maybe one or two; that the information was getting recorded in the information systems and it was obviously recorded in the medical record because we can't get it out of the medical record and into this system unless it's written there, so somebody was writing it there.

And how did this system then help to deal with the problem? Was there metaphorically an alarm bell that rang and said we have got an excessive number of dehiscences. This should be brought to the attention of the Director of Surgery or the Director of Medical Services or something else? Did that happen?-- I'm fairly sure that's the testimony that you will be hearing. There's some-----

This is your system. Did you bring it to someone's attention?-- Di Jenkin was dealing with this issue and it was getting dealt with through the ASPIC meeting. I ran some reports for - at Dr Patel's request saying, okay, we'd like to repair the wound dehiscence rates compared to the - to the total amount of surgery so that we can have a rate of which I provided that and I - it is my understanding that that was discussed at the ASPIC meeting. In addition to that it's easy to switch that record round and identify which particular surgeons and I also provided that to the Director of Medical Services.

Sorry, I am getting mystified by this. As I understand what you are telling us now all of this depends on Di Jenkin twigging to the fact that there was some problem with wound dehiscence and going to you, getting the data in relation to that. It is not a system that warns the hospital administration or anyone else of ongoing problems?-- Oh, do you mean are there flags in the system that says ding-a-ling, ding-a-ling, we have got something that you need to look at? No, it's not. No. People need to be asking and looking for the information.

D COMMISSIONER EDWARDS: So you don't really collate, for example, a number of wound infections that occur in Bundaberg Hospital following laparotomies as an example?-- There is a report that I do provide to the Infection Control Coordinator which tells her wound infections relating to particular procedures.

And she could take out, therefore, the number of infection processes to which are referred in laparotomies?-- Yes.

She would have to do that?-- It's - we - the report that I'm referring to can actually group these are all the patients that had a laparotomy. Of these these are the ones that had a wound breakdown or wound infection. It is possible.

Does that flag to the system that there was a problem or summing up to say there may be a problem?-- The system is not there - it doesn't flag to the system. It's meant to flag to clinicians when they are looking for that information. When they are reviewing the clinical practice and the clinical care that is employed a system doesn't do that. The computer doesn't do that. The clinicians themselves do that.

Can't you programe the computer to do that?-- Not this one.

So why collect the information?-- To effect change clinicians are the ones that know what clinical care that is to be provided. Computers don't sit there making those decisions for them.

No, but people do?-- People do; that's right.

I'm asking you doesn't somebody recognise it from the computer information that is available that there's a problem?-- Well,

I would hope so.

But hoping is not what I'm asking you. Does it or does it not?-- It will depend on the clinician and the person that is actually looking at that information. I can't draw that conclusion for you. I can provide that information to them. They can draw their own conclusions and make their own clinical judgments on that.

COMMISSIONER: In essence, is it a case where you have got to know the right question to ask? If you are Di Jenkin and you worked out that there's a problem with wound dehiscence and you can solve this database you might get a body of useful information, but unless you've thought of the right question to ask the system just doesn't tell you anything?-- That's right and, I mean, that was really one of the roles that I had by attending a lot of these clinical service forums and a whole range of committees was that I was to be - and I was there to help them work through those issues, so in terms of this particular one there was a lot of correspondence and a lot of phone calls and a lot of visits back and forth between our unit and the surgical ward that Di was working on.

Mr Andrews, we'll take the afternoon break. It may be that we're leading somewhere useful, and I will trust you entirely, but it doesn't seem that this is taking us very far at the moment.

THE COMMISSION ADJOURNED AT 3.18 P.M.

THE COMMISSION RESUMED AT 3.28 P.M.

JENNIFER KIRBY, CONTINUING EXAMINATION-IN-CHIEF:

MR ANDREWS: Ms Kirby, please look at JK6. It is a copy of a report that was developed comparing wound dehiscence rates over two years?-- Yes.

I notice it starts with July. Would I be right in thinking that's July 2002?-- Yes.

That is the first page of JK6?-- Yes.

Running down to June 2003?-- Yes.

On the same page?-- Yes.

There is nothing in there for March 2003 by way of wound dehiscence. You will see it is zero for that month?-- Yes.

When I look at JK5, the second page of it, which is the document headed "wound dehiscence", it shows a wound dehiscence for a person admitted on the 25th of March, discharged on the 25th, and yet that person doesn't appear in the annual dehiscence indicator. Can you explain that?-- Just from the JK5, can you just tell me which patient it is again?

JK5, it is the second page. You will see that it relates to a patient admitted on the 25th of March and discharged on the 25th of March, same day. Have you located that entry? When I look at JK6, I find nothing for March 2003 to indicate that there was an instance of wound dehiscence. Are you able to explain its absence?-- You will also see that in the wound dehiscence - can I just - have I got the-----

That looks to me like the-----?-- JK5, second page?

Yes?-- Yep. That's the one you were referring to? Why is that not in the other?

Well, if it has an admission date 25th of March it is. It was hard for me to see from here?-- It is-----

Why is it not within JK6?-- -----because in the JK6 we have actually specified there what all the abdominal operations are that we're selecting for, and it would - that admission there was for a colonoscopy. So it didn't meet the criteria of the abdominal operations that were reported in the second report.

I see. Thank you. Now, at paragraph 20 of your statement, it is ambiguous as to who prepares the measured quality reports. Is it you?-- Sorry, what paragraph was that?

Paragraph 20. You're responsible for coordinating the collection of data and reviewing the data quality for the measured quality reports. But you go on to say "the reports provided by the measured quality team at QH"?-- That's right. So initially when the measured quality team in Queensland Health were looking at what the indicators were that they were going to report on, we actually were asked to validate whether at a local level when we ran those same reports, whether we were getting the same information. So initially I coordinated a collection of data before the report is written to see that we've - we are collecting that we have got this information in the system, and then Queensland Health actually extract the data.

And write the report?-- Corporately.

Thank you. You monitor the district's elective surgery activity to see whether it is complying with its target?-- Yes.

Can you - and fortunately we have got the advantage of your supplementary statement which tells us something about weight separations - but can you tell me has the hospital been meeting its target over the last three years?-- Not every year. I have to go back and check exactly, but not every year. We haven't always met target.

There is some evidence that Dr Patel was particularly productive as a surgeon. He was quick and keen to perform surgery. Are you able to say whether during Dr Patel's time you were able to see any statistical change with respect to elective surgery targets?-- Certainly. Dr Patel's contribution to the elective surgery target while he was there, across from 2003 onwards, contributed to about 17 to 20 per cent of the total elective surgery that was put through. As a Director of Surgery he was also responsible for the theatre management group who were looking at theatre lists, and theatre utilisation, and theatre productivity. So he was involved in looking at processes to improve that. He contributed, in terms of changed some practices within the theatre, in terms-----

I was more interested to know whether or not there was more surgery done while Dr Patel was there, more elective surgery in particular?-- There was more - more surgery done while he was there. Not because it was Dr Patel that was there but certainly during his tenure there was more-----

Well, when you monitor elective surgery targets, would I be right in thinking you're the person to whom I should turn if I wish to determine whether the targets have been met or whether they have been exceeded?-- Yes.

Do you keep lists of the amount of surgery performed by a surgeon or does your department keep lists only of the amount of elective surgery done?-- No, we can monitor both. I mean, when we're monitoring it to report to Queensland Health Central Zone, we report total surgery, but we're also able to

report on what specialties are doing that surgery and what-----

Are you able to say whether Dr Patel was, as some evidence suggests, a very productive surgeon, in the sense that he did more elective surgery, or perhaps more weighted separations than the typical surgeon?-- I can't really say that. We only have two - I mean, we have two surgeons there that work full-time, so - we're just comparing one to the other. As I said to you, Dr Patel's contribution was about 20 per cent of the total elective surgery. 20 per cent.

D COMMISSIONER VIDER: With two surgeons?-- There is two surgeons in general surgery. So contributing to elective surgery targets would be general surgery, urology, gynaecology, so other specialties were also - orthopaedics - also were contributing to the overall elective surgery target. Dr Patel certainly wasn't doing it on his own.

What proportion, then, of the surgery was contributed to by the other general surgeon?-- I would have to go back and have a look.

MR ANDREWS: And there is evidence that Dr Patel boasted at one stage that he'd earned the hospital $500,000, or thereabouts. Are you able to say whether he was accurate with his figures?-- I would suggest he was very inaccurate with that claim. I hadn't heard that claim until, obviously, all this blew up.

Where would one go to determine the accuracy or inaccuracy of his figures?-- Me.

And you haven't looked it up?-- In terms of whether he made $500,000 for the organisation?

Yes?-- No, he hasn't made $500,000.

Are you able to say what he made for the organisation by way of contribution to elective surgery targets, or election targets, or otherwise?-- Not here and now. I mean, I would have to go and look it up. I don't have that off the top of my head.

You have said that surgeons don't set the elective surgery lists?-- I beg your pardon?

By your supplementary statement, exhibit 170, you discuss theatre lists?-- Yes.

You have explained that those lists aren't in any way based on financial incentive to the hospital?-- That's right.

That they are in fact prepared by the coordinator - the elective surgery coordinator?-- Yes.

Indeed, they are prepared weeks in advance?-- The first drafts of them are, yes.

Now, we've heard evidence of complaints by the Nurse Unit Manager in the ICU, that in 2003 in ICU there were problems which emerged when elective surgery was scheduled for Fridays of a kind likely to result in the need to roster on extra staff in ICU at weekends?-- Yes.

And that this was a problem that arose because Dr Patel was keen to perform such surgery on Fridays. Is it your understanding that the Director of Surgery was not in a position to influence the elective surgery lists in that way?-- That's right. The - he would certainly be involved in the discussion. On a weekly basis - and every week this occurs - the Director of Anaesthetics and Intensive Care, so the person who is in charge of intensive care, that's Dr Carter, the Nurse Unit Manager of theatre, the elective surgery coordinator, and the Director of Surgery, as a minimum those people, we meet on a weekly basis to review theatre lists.

Do you meet with them ever?-- Not in my current role, no.

That suggests to me that you used to meet with them in some other role. Have you met with them since 2003?-- No.

Where you say in your statement, that is the short one at paragraph 16, that "these lists are formulated several weeks in advance of the planned surgery and are not formulated in any way based on financial incentive to the hospital - at least not in my experience", what experience are you relying upon?-- I was the elective surgery coordinator.

How long ago?-- I finished that in 2000 when I started in the clinical benchmarking.

Thank you. Weighted separations seems to be a name for explaining that complicated surgery might attract funding of more than $2,500. Am I oversimplifying?-- The weighted separation that is assigned is to give a numeric value about the complexity of care. So one weighted separation is the equivalent financially to $2,500. So if you were to come into hospital and have your ingrown toenail removed, you would have a weight in of .1 or .2, some small weight. If you came into a hospital and had a total hip replacement and had lots of complications and comorbidities, you might have a weighting of 6 or 7.

Is it because the surgery was complicated, or the surgery was complicated and the stay thereafter was long?-- Both.

Yes. So when it comes to the complicated surgery of an oesophagectomy, one would have - if the stay was just a couple of days for one oesophagectomy and was a couple of weeks for another, would the weighted separation for the longer stay be greater?-- There is - the weighted separation remains the same. It is not - yes. The length of time that you're there and the formula that's calculated for financial reimbursement, there is a formula with that depending on the length of stay.

Do you happen to know what the weighted separation is for an oesophagectomy?-- Not off the top of my head, no.

D COMMISSIONER VIDER: Just for clarification, if, therefore, a hip replacement had a weighting of 6, you would get 15,000 for that procedure?-- Yes.

MR ANDREWS: Weighted separations - well, the greater the number of weighted separations done by elective surgery would mean the greater the amount of funding the hospital receives?-- Yes.

And does the hospital generally seek to be - to increase its funding from year to year by increasing its elective surgery targets?-- Not necessarily. When we discuss the elective surgery target, we really have to take into consideration medical staffing, what sort of availability we're going to have for anaesthetists, what sort of availability we're going to have with the surgeons available.

Are the elective surgery targets annual?-- Yes.

Are they based on calendar or financial years?-- Financial years.

The elective surgery target for the financial Year 1 July 2004 to 30 June 2005, would it have been greater than the target for the year-----?-- Previously.

-----before?-- We - the general - one part of it would have been much the same as the previous year. However, there was an election and some - as part of that, the election commitment to the community was that there would be more additional elective surgery funding made available to hospitals. Bundaberg Hospital looked at our waiting list and said, "Have we got any particular groups of patients that have been waiting a long time?", and generally that's total joint replacements that are waiting longer than we would like. "Have we got the availability of a theatre, nursing staff, anaesthetic staff, and perhaps an orthopaedic surgeon that might be able to do some additional work over and above?" At that time we did have. We had a South African orthopaedic surgeon that we knew was arriving, or had arrived, so we did put our hands up to say that we probably have some capacity to do some additional elective surgery work in orthopaedics. And we would bid for that, that we had capacity. So we have had, on occasion, where our elective surgery target have gone down because we haven't met it the previous year.

Were you ever asked to prepare the weighted separations statistics for Dr Patel?-- In what way? His elective surgery?

Yes?-- I - in terms of the elective surgery component, I did provide to the elective surgery coordinator - she had a breakdown of the elective surgery, that activity that was done by surgeons. So she would have known what Dr Patel was

contributing.

And when were you asked to do that?-- That's actually a routine report that we provide on a monthly basis.

So you'd have known monthly Dr Patel's contribution to weighted separations in elective surgery?-- We could have.

As would anyone who spoke with the elective surgery coordinator?-- Anyone that wanted to know could have found that out, yes.

D COMMISSIONER VIDER: In preparation for the budget-----?-- Yes.

-----of the district, do you have any involvement with that, in gathering data to put in that would become part of the submissions? Where I am going with that is is the budget based on X amount of money that's going to be necessary for maintaining a theatre?-- Yes.

And dealing with X number of elective surgery cases?-- Yes.

And then is it separated out so that you then have additional revenue that's based on these separated weightings?-- Yes.

Is that how it works, so that you know what you're doing?-- Yes. That - on an annual basis the cost - you know, the Nurse Unit Manager would be having discussions with the finance manager, finance team, and the Director about budget build-up and she would definitely be taking into consideration the throughput of activity that had been done previously and what was intended for the next. So on many occasions I would be asked to provide information to go with that.

MR ANDREWS: You're a member of the ASPIC committee?-- Yes, I am.

But you don't attend its meetings very often?-- Not last year I didn't, no.

Why was that?-- There was several reasons last year. I was actually seconded to undertake the ISAP project for the district.

There was also a refusal by you in 2003 to attend because of attitudes displayed by other members. Explain that for me, please?-- The ASPIC committee is a large group of people. There are some fairly strong personalities. I had attended that meeting on numerous occasions previously.

What was it about their behaviour that caused you to write that you didn't wish to attend it?-- There had been some ongoing frustrations. I corresponded previously about things - we had talked about cancellation rates for surgery. So this is the surgical - this is the ASPIC group, so they're looking at the continuum of care of surgical patients and how we get them in and out of the hospital, and the cancellations of

patients for surgery, which is a terrible frustration for the patients, let alone for anybody working in the hospital, but mostly for the patients. We - that topic had been raised, and the group at the time, and one particular individual, felt that it wasn't appropriate for anyone at the ASPIC meeting to go and tell the patient that they - that surgery had been cancelled, that ultimately the CEO of the organisation, who was the District Manager, he controlled the budget and the bed numbers, so he should tell them individually. This was the sort of discussion that was going on in these ASPIC forums that I found incredibly frustrating, when we were there as managers ourselves - albeit we were middle managers, but we had a responsibility to look at processes that were in place that were affecting these cancellations, and that sort of, you know, banter really wasn't helpful. So the email that you are referring to, at the time I wasn't attending but I had a proxy that was attending on my behalf. She came back from that meeting completely distraught. I had several people from the ASPIC meeting who had been in attendance at that meeting come and apologise to her about the poor behaviour.

Did anyone ever complain about the quality of the data that was being produced by DQDSU to those meetings?-- No, it wasn't necessarily - no, it wasn't about the data. It was about their ability to function in a committee, keep focussed.

You say at paragraph 45 that it became untenable for you, that is at DQDSU, to acknowledge all the incident reports that were coming into the unit. But was it not one of the ambitions of the incident reporting scheme that every report would be acknowledged - not just acknowledged, but that the follow-up results would be communicated?-- Certainly when - when we first talked about implementing the adverse event system, there was the - the intent was for every adverse event, the person would get a nice letter of acknowledgement telling them when we had received it, it had been risk rated, and what we'd done with it. And when I say what we'd done with it, if it had been risk rated as low or medium, it was going to be trended, and if it was a high or above, that it was going to be analysed.

Is that a responsibility of the DQDSU now, to fulfil that ambition?-- No, it is not.

Whose responsibility is it now?-- We don't provide that feedback to them because-----

I wondered whose responsibility it is?-- The feedback to the person that's reporting it? Oftentimes now it is actually the costs - the cost centre management, whoever the department head manager is, because they sign off that form and let them know what the actions and outcomes were as they report it. I mean, often these forms come through with actions and prevention strategies already documented on them.

I have no further questions, Commissioner.

COMMISSIONER: Thank you, Mr Andrews. Does anyone have any

questions?

MR FITZPATRICK: I have just a couple of things.

COMMISSIONER: Thank you, Mr Fitzpatrick.

EXAMINATION-IN-CHIEF:

MR FITZPATRICK: Ms Kirby, can I ask you to focus, please, on your supplementary statement? Can you just clarify some things related to your work history? Do I understand your evidence to be that since when you - I am sorry, I withdraw that. That when you were the Elective Surgery Coordinator at the hospital, you were responsible for formulating the draft theatre lists, is that so?-- Yes.

And that since you ceased to be the Elective Surgery Coordinator at the hospital, you have ceased also to have responsibility for formulating the draft lists?-- Yes, that responsibility remains with Elective Surgery Coordinator.

Yes. Do you know - and if you don't know, you should say so - whether the mechanism whereby the theatre lists are formulated at the hospital remains the same as it was when you were the elective surgery coordinator there?-- To my knowledge that system, process remains unchanged.

All right?-- In addition to - I mean, I mentioned earlier that there were four people that routinely see that on a weekly basis. When we're going through winter and peak periods of admissions and bed blockages, those sorts of things, there are a whole lot of additional staff that are actually involved, like the bed manager also gets involved and - so there is essentially the four people that review those lists, but it does expand when the need arises to include other individuals.

Yes?-- And as far as I am aware those - that review still occurs today.

Yes, I see. So do we understand it to be the case on your evidence that no one person has command, if I can use that term, of the composition of the draft and, indeed, the ultimate theatre lists?-- No, that's right, it is discussed amongst a whole group of people.

All right. Is it also the case, though, that in your current job description as manager of the Quality and Decision Support Unit, that you do have responsibility for the hospital's performance of its elective surgery targets?-- Targets, yes.

All right.

D COMMISSIONER VIDER: Just before we move off that, how

frequently would it be necessary to contact a patient to postpone their surgery, someone on the elective surgery list?-- We would probably have on a weekly basis patients that we have to contact and reschedule for some reason or another. One of the flags that's on the waiting list module is the amount of times patients have been cancelled, and we have certainly got some policies in place of our cancellations so that we don't have repeatedly the same people being cancelled over and over.

But for the list that's published, say, for this week?-- Mmm-hmm.

Would patients be cancelled or have to be re-scheduled on a daily basis?-- Not necessarily on a daily basis, but certainly on a weekly basis I would expect that there would be some re-scheduling of patients for whatever reason. It may be that we've re-scheduled them because there's, you know, been a road trauma in and we've got all the theatres running with emergency cases or something.

Mmm.

MR FITZPATRICK: Thank you Commissioner.

Miss Kirby, you mentioned - you were asked by my learned friend Mr Andrews about the hospital's performance under its targets and you said that sometimes in some years the hospital has not been able to meet its targets. A couple of things: why would the hospital not be able to meet its targets?-- We're a provincial hospital so if you have a surgeon or an anaesthetist that leaves town and goes into private practice or moves to another town, then we're suddenly without the staff, that can be one of the reasons that we don't meet target. There's a whole range of reasons why we may not reach a target.

I see, so that if the person who was - had the capability of discharging the surgical procedures at the hospital left, then there's, until you get a replacement there's no-one there to do it?-- Absolutely. I mean, just very recently we had one of our anaesthetists had an accident and hurt his arm and was not able to give anaesthetics for a period of time while he was on leave and that can affect our elective surgery throughput.

Is that also a detriment to the hospital, financial or otherwise if it's not meeting its targets?-- If we don't meet our targets, then we're not going to receive the allocated funding, we're required to meet our targets to receive that funding, so there would be a budget adjustment.

All right?-- Or we would renegotiate targets.

I see. And have you been a party to the re-negotiation of the target as part of your management of this unit?-- Certainly I've been involved in a lot of the projections about how many weeks have we got until the end of the financial year and what do we - what do the projections normally entail, so I'd be involved in these projections, but ultimately the re-negotiation of the target is a discussion that occurs with the Director of Medical Service and the District Manager and the relevant zonal staff.

I see, so your role will be to provide to them the current position as regards the targets and the data and so on?-- As much up-to-date information as we can about what we've done so far and in terms of reaching our targets.

I understand. Yes, thank you Commissioners, that's all that I have.

COMMISSIONER: Thank you. I did want to follow something up, so before you sit down, you might wish to ask some supplementary questions. It relates to the targets that you've been asked about for elective surgery. Given what we've been told about the way in which weighted separations operate, am I right in understanding that the outcome for the patient isn't a factor in determining whether the payment is received?-- No.

So to use an example, and I apologise to Mrs Kemps for continuing to use her late husband as an example, but in the case of Mr Kemps being a man of advanced years and in a serious condition already with his cancer, and given that the proposed operation was a very complicated one, an oesophagectomy, that would, I assume, have quite a high weighted separation; would that be right?-- Yes, it would.

So it would be worth a lot of money to the hospital; is that right?-- Yes, I mean, a high weight multiplied by $2,500 tells you what the remuneration on it is.

All right. And it then doesn't matter, as far as the remuneration is concerned, whether or not Mr Kemps survives the operation?-- Well, that's not - no, the deciding factor is not on whether the patient survives the operation or not, no.

Indeed, on one view, the hospital saves money because it then doesn't have to provide a bed or ongoing treatment for the payment?-- Alternatively, quite a considerable amount of resources could have been spent on actually trying to save Mr Kemps' life.

Yes, but they wouldn't have been spent in Bundaberg?-- The resources you mean?

Yes, the alternatives, as I understand them, were either Mr Kemps would be sent to Brisbane for palliative care or instead of that, Dr Patel decided to keep him in Bundaberg?-- I was just referring to the fact that if the patient has had the oesophagectomy, then resources would have been spent on providing that surgery.

Well, is it an exaggeration to say that there was a financial incentive for Dr Patel to perform surgery on very ill patients, particularly very complicated surgery, to bring in remuneration for the hospital and it was a bonus for the hospital if the patient didn't survive?-- More often than not in terms of remuneration, the more complex the care that's provided, the more it actually costs us.

Yes?-- So it's likely that even though that's the way the separation and that's the remuneration we would have received, that's not to say that it didn't cost us a lot more than that.

But if you had a very cynical surgeon, and I'm not for the moment saying that Dr Patel was one, if you had a very cynical surgeon, he would see an attraction in operating on patients who were very ill and unlikely to survive and particularly to perform very complicated operations on them because that would bring in more revenue for the hospital?-- No, it's been my experience that more often than not, that based on the remuneration is the way the weighted separation, but that doesn't mean that that's how much it actually cost us to deliver that care, so the financial benefit generally with surgeons when they're looking at things is that patients that often will have minor ops that don't even need to stay overnight, they have considerable weighted operation separations on them and yet, it may not cost us as much as the weighted separation and the remuneration we're going to receive to actually deliver that care, so the efficiency is actually in putting through those less complicated cases because we can get a lot more of those through than a patient with complex care, so the benefit is more often than not multiple patients with less complex care than doing one patient with complex care.

Well, if you recall my question though, you answered it based on your experience and no doubt what you say is how the system is intended to operate?-- Sure.

But what I was suggesting to you is if you have a particularly cynical doctor, which may or may not be Dr Patel, there is an actual incentive for him to find a patient who is on death's door, perform a particularly complex operation on that patient, earn a lot of money for the hospital and, as I say, it's icing on the cake if the patient then doesn't survive the operation and therefore the hospital doesn't provide a bed and post operative care to that patient; that's right, isn't it?-- Potentially that's possible.

Yes. Mr Fitzpatrick?

MR FITZPATRICK: Thank you, Commissioner.

Miss Kirby, is the hospital paid on a procedural basis, that is, is it paid per procedure?-- No, no.

So this budget that you've been talking about, is it set in advance of a particular financial year?-- Yes, it's - at the beginning of the financial year we have a target of X amount of weighted separation and that weighted separation target doesn't tell us which procedures we have to do and what weighted separations we're going to get, is that your question?

Yes. And so if in the course of the financial year the hospital encounters a raft of complex surgical procedures, how do you know? Is that then taken into account in budget considerations, do you know?-- Routinely, I mean, we talk about oesophagectomy patients and we didn't do that many oesophagectomy patients, but routinely the complex care that

we're providing to patients is generally things like total hip replacements with complications of comorbidity, so we know that we can probably have an allocation of, you know, 40 or 50 of those complex cases that we can manage through the year.

I see. And what about-----?-- But I'm not sure I understand your question?

Well, let's approach it in this way: what about if during the course of the financial year the hospital does a hundred of those procedures, how is that then factored into the budget and when? Is it the next year does it report that it's in fact done double the number of complex weighted separations and is the budget for the next year greater accordingly?-- If that's what we're going to do, yes, it's taken into consideration for the next year, yes.

And if that's what you've in fact done?-- If that's what we've done and that's the complexity of the care that we're delivering, then it will be taken into account the following year when we're doing ledger build-ups.

I see. Yes, thank you Commissioners.

COMMISSIONER: Mr Fitzpatrick? Mr Allen?

MR ALLEN: Thank you, Commissioner.

CROSS-EXAMINATION:

MR ALLEN: Do I understand that you were a member of the theatre management group even after you finished that role in 2000 you referred to?-- No, theatre management group as it currently stands is, no, it doesn't include me.

Okay. All right. Are you able to say from what knowledge you have of these issues in relation to waiting lists, whether there was an imperative expressed in February this year that the hospital's behind target with weighted separations?-- Oh, definitely during our heads of department meetings there would be an update to all staff as to where we would be heading with elective surgery activity, so it didn't determine theatre lists but people were aware throughout the organisation about whether we were meeting elective surgery targets, yes.

From an e-mail that we have, which is Exhibit 72, it would certainly result in the Director of Medical Services indicating that if there was to be any cancellations on the elective surgery lists, that they had to be discussed with Dr Patel and others first?-- Sure.

Because there was this concern that the hospital was to meet its elective surgery target before the end of the last financial year; is that so?-- There - I'm not really sure I

understand the question?

There was a concern in the first half of this year that the hospital had to meet its elective surgery target?-- Oh, yes.

Okay. Now, can you - are you able to say what impact it would have had upon the hospital being able to achieve that target if, for example, Dr Patel had been suspended from surgery in, say, October last year?-- If he'd have been stood - it would have been dependent who his replacement was.

So it would have depended upon being able to find a replacement?-- Yes, yes.

And whether they were prepared to undertake procedures of the same complexity as Dr Patel?-- They wouldn't necessarily - I mean, they needed to do procedures from the patients that were on our waiting list, so which are very generic, you know, hernias, lap cholies, I mean, there's not a great range there, so, yeah, if Dr Patel had been stood down, then his general surgery lists would have either needed to be re-allocated to another general surgeon or to offer to other specialties.

So it could have had a significant impact upon the hospital's ability to meet those elective surgery targets?-- It's possible, yes.

Now, you indicate in your statement that yourself and Dr Keating were responsible for the education of staff in relation to adverse event reporting?-- Yes.

And you've annexed to your statement some Powerpoint presentation slides as JK9?-- Yes.

They don't seem to include any specific information as to who can or should fill out an adverse event form?-- No, those are just slides so they're prompts for me and Darren Keating when we were doing them as we talked through them.

What information was given to staff as to who could or should fill out an adverse event form?-- At the time every staff member that attended got a copy of the actual presentation, they got a copy of the policy I'm fairly sure, but there's incident management guidelines and they were supplied with those as well.

All right.

COMMISSIONER: But I think Mr Allen's focussing on the question where an adverse event has occurred?-- Mmm-hmm.

Who should be reporting it? Obviously, the person who was directly involved in the matter should report it, so if it's surgery, the surgeon should report it, maybe other people in the operating theatre should report it; what about people who get wind of it further down the track?-- The information that we provided to people was anybody could fill in an adverse event form. We really just wanted people to start filling

them in, so this was very early days with it and during that training we were much more advocating it doesn't matter who fills it in, so long as somebody fills it in.

But surely you want someone who actually knew what happened rather than filling in forms based on second or third or fourth-hand hearsay?-- Well, they had to provide some information with that. I mean, we were asked by staff about whether they could submit them anonymously and we indicated to them, yes, you could submit them anonymously, so if you were aware of something and you wanted to report something, then yes, you could do that.

And was any distinction drawn between executive staff, clinical staff, other staff within the hospital?-- No, no. When I did that training, it - I gave - we did sessions that were open to everyone and we did specific sessions where we went to the medical services meeting, the surgical services, we did a specific session for the executive staff where we delivered these at a time that was suitable to them because they hadn't been able to come to the general sessions so everybody was told - well, as many people as we could get to was how the adverse event form could be filled in.

So to take an extreme example, if one of the catering staff happen to be bringing a tray of food to a patient's bed and saw the patient falling out of bed, even the catering staff could hand in such a form?-- It's possible, Mmm.

Similarly, if it came to the attention of one of the executive staff that a clinical - that an adverse event or a sentinel event had occurred, they would be entitled to fill in such a form?-- There's no exclusions.

Yes.

MR ALLEN: So you wouldn't agree with the proposition that adverse event forms were only to be filled in by clinical staff?-- The actual adverse event form, if you have a look at it, has got adverse events that may occur to staff members as well, so there's a column for staff and there's a column for patients, so it's possible that other people can fill out adverse event forms.

And adverse events in relation to patients, they could be filled out by persons other than clinical staff?-- Unlikely, but it's possible.

All right. Well, do you have any specific recollection as to what you told staff as to whether they should be filling out forms in relation to, say, an incident which occurred not in their presence but perhaps they heard about afterwards?-- I don't recall having those conversations, about incidents that they'd heard about on the grapevine, no.

D COMMISSIONER VIDER: Can I just ask you: you said that staff could fill out forms anonymously. If an anonymously presented form comes across the unit - comes to the unit, how could you

do a further investigation if you don't know who generated the form?-- It doesn't have to be - anonymous as in the person that is sending it in, you know, doesn't have to sign who they are, but they do need to provide sufficient information that we could go back and have a look at that incident and ask some questions about that incident.

Yes?-- Yes. So anonymous in terms of signing it off.

MR ALLEN: Do I understand from your evidence that somewhere in the records of the hospital or Queensland Health there would be monthly reports to the District Manager and Director of Medical Services on the hospital's progress and meeting elective surgery targets?-- Yes, it did.

Reports prepared by yourself?-- Yes.

And also there'd be fortnightly reports during 2004 of the meeting of the additional elective surgery election commitment activity?-- Yes, that was the central zonal unit manager required us to report on a fortnightly basis.

Did I understand you to say to my learned friend Mr Andrews that at one stage you did provide to the Director of Medical Services a report in relation to wound dehiscence identifying a particular surgeon?-- Yes.

Okay, when was that?-- I can't recall the date.

When was it in relation to the discussion that you referred to in your evidence regarding wound dehiscence?-- It would be after, it would be after the report had been done from Jayant Patel where he wanted to know what the rate was compared to, you know, by identifying the groups of operations, so it would have been after that point, because it's actually, the report is that same report but I've just switched it around so that where I'd previously suppressed who the surgeons were, it shows who.

COMMISSIONER: Well, the document JK5 attached to your statement, "The Incidents of Patients with Diagnosis of Disruption of Wound Operation T80, 1.3" is for the period from the 1st of January 2003 to the 30 April 2004?-- Yes.

So I assume that that was generated sometime shortly after the 30th of April 2004; would that be right?-- I'd have to say so. It doesn't have a date on that, so I'm not sure.

Do you see under the confidentiality statement or in that box it has "Data as at 14/12/2004"?-- Mmm-hmm.

Does that indicate when it was generated?-- That would normally tell you when the data was generated, but for the purposes of submitting to here as part of my statement, I've gone back into the system and printed that report out and it will have automatically, it may have, you know, repopulated there, I can't be sure of what that date is.

It's fair to say though that if, for example, you were doing the exercise in June or July or August, you would have consulted the data up to the end of the previous month or up to the most recent data available?-- Up until the end of coding, yes.

So the fact that you took out the data to the end of April would suggest that this was probably done during the month of May, wouldn't it?-- I've taken it to the 30th of April which means it was probably done in July.

Probably done in July?-- Because of when the coding finishes.

Is that because it's done at-----?-- Retrospectively, and it's done six weeks after the end of the month, it must be completed six weeks after the end of the month the discharges so that-----

And given then that you would probably have done this in July, when would you probably have been in a position to provide a sort of a final print-out of it to the executive?-- This particular report was done, like you say, around July, the discussion was going, still going on at ASPIC and I think it wasn't until October that it came off the agenda, I think Dr Patel had been on leave and he came about June/July to ask me about additional information, so it would have been about then so that I did the second report.

MR ALLEN: But was it another version of JK5?-- No.

With the doctor's name included?-- No, JK6.

JK6?-- Yes, where it's got "July, August, September", I've run that report and switched that to show who the principal surgeon was.

I see. And just to work out when you would have done that then, in your statement you say it was after Dr Patel came back from leave that you provided that. Now, obviously you didn't provide this, the same document that is JK6 because it's got "Data up until June 2005", hasn't it, or at least May 2005?-- There's three reports there.

Yes?-- Two financial years and then year-to-date.

So only part of that would have been produced at the time that Dr Patel spoke to you?-- The first two years.

The first two years?-- Yeah, we had two full years and then we had part of a year.

Okay, so up to June 2004 or perhaps a few months after that as well?-- I can't recollect exactly, I'd have to go back and have a look to see how much of the fiscal year 2005 data he had.

But another copy of JK6 but including the surgeon's identity was prepared by you and supplied by Dr Keating - to Dr Keating

at some stage?-- Yes.

So would that have been sometime in the second half of 2004?-- Yes.

You don't recall when?-- No, not really.

Okay. And did you keep a copy of that document?-- I do have a copy of that document, yes.

Do you have one with you?-- No, not in this folder, no.

All right. Did it identify any other surgeons apart from Dr Patel?-- Yes, that had wound dehiscence?

Yes?-- Yes.

Are you able to say what sort of percentage involved other doctors as compared to Dr Patel?-- No, I'd have to - not off the top of my head, I'd have to go back and have a look, but I know there were other surgeons because even in the information that I was putting together for Di Jenkin, it wasn't just in relation to Dr Patel, I mean, we knew that those patients included one, two, three, four, five, six other doctors, five other doctors including Dr Patel.

In relation to what period?-- The report "Patients with Diagnosis of Disruption of Operation Wound, 1/1/2003 to 30/4/2004", there was six surgeons that were identified.

Okay. There has been a document which has been prepared in relation to wound dehiscence which includes, for instance, in relation to one patient it will have two doctors names, Dr Patel and Dr so and so; are you referring to other doctors in that context or are you referring to other doctors without any involvement of Dr Patel?-- I'm not sure which report you're referring to?

COMMISSIONER: It doesn't matter which he's referring to?-- Mmm.

The question is whether the - when you say there was six other doctors involved?-- Mmm.

Whether they were six other doctors involved in operations performed by Dr Patel?-- No.

Or six other doctors in doing their own operation without the involvement of Dr Patel?-- That's right.

MR ALLEN: And you'd have those reports if you were asked to supply?-- Yes.

Thank you.

COMMISSIONER: Thank you Mr Allen. Mr MacSporran?

MR MACSPORRAN: I have nothing, thank you.

COMMISSIONER: Miss McMillan?

MS McMILLAN: No thank you.

MS FEENEY: No thank you.

COMMISSIONER: Thank you. Any questions? Any re-examination, Mr Fitzpatrick?

MR FITZPATRICK: No thank you, Commissioner Morris.

COMMISSIONER: Mr Andrews?

MR ANDREWS: No. May Miss Kirby be excused?

COMMISSIONER: Yes, thank you so much for your attendance, Miss Kirby, you're excused from further attendance and we appreciate you coming along to give us your evidence?-- Thank you.

WITNESS EXCUSED

COMMISSIONER: Gentlemen, I see it's almost 4.30. There are a few things I'd like to deal with. The first relates to the proceedings in the Supreme Court. I'm probably the last to know what's going on there, but I thought it would be useful to pass on what information I have.

I'm told that the directions hearing this morning was delayed due to a bomb scare in the Law Courts building. All of us with the exception of Mr MacSporran have an alibi because we were here. In any event, McPherson J, the Senior Judge Administrator of the Supreme Court heard the directions hearing and has given directions with a view to the matter being heard on the 2nd, 3rd and 4th of August.

A solicitor from the Crown law office attended on behalf of myself and the two Deputy Commissioners to inform the Court that we did not wish to take any active part in the proceedings and that we would simply abide the Court's decision. I understand that Mr Sofronoff QC, the Solicitor General of Queensland, has been briefed by the Attorney-General to defend the application on behalf of the Attorney-General. Mr Andrews, do you have anything to add to that?

MR ANDREWS: Only this, Commissioner: you referred to McPherson J when you intended to refer to Moynihan J.

COMMISSIONER: I did indeed intend to refer to Moynihan J, thank you for that, and I'm not sure from the information that I've received whether Moynihan J will be hearing the matter in August or whether a judge has yet been allocated?

MR ANDREWS: I heard nothing as to the judge to hear the matter.

COMMISSIONER: Okay. That's one matter.

A second matter concerns correspondence I have received indirectly from the Leader of the Opposition. When I say indirectly, apparently a number of journalists have been speaking to the secretary who in the course of the day are awaiting response to this letter. I still haven't seen the original but someone from the media helpfully provided us with a copy so I could respond to it. In essence, the Leader of the Opposition wishes to know whether it is proposed to call Mr Nuttall, the Minister for Health, before the inquiry to give evidence in relation to a matter which took place before a parliamentary committee last week.

There are a couple of things I want to say about that. Three things I want to say about that. The first is that, as everyone here is aware from the circumstances in which Mr Messenger gave his evidence, we are precluded from investigating what goes on within parliament or parliamentary committees so it would certainly not be the case that we would be investigating the rights or wrongs of what went on before that parliamentary committee last week.

The second thing that I want to say is that I have been informed that Mr Nuttall, quite some time ago, volunteered to come before the inquiry and give evidence regarding his knowledge concerning areas of need, overseas trained doctors and related matters and I think we would welcome any evidence that the Minister wishes to give in that regard. So I anticipate at some stage we will be hearing from Mr Nuttall.

The third thing is that as matters stand, I don't see that there is anything in our Terms of Reference which requires us to or even invites us to make a judgment as to whether Mr Nuttall found out about things or whether he was told things by Mr Scott or Mr Buckland or anyone else. I just am inclined to think that that debate is quite outside our Terms of Reference, but if anyone wishes to canvass those issues when Mr Nuttall comes to give evidence or, indeed, when Dr Scott or Dr Buckland is giving evidence, counsel are entitled to ask the questions and if there is an objection, I'll rule at that stage as to whether or not it's within our Terms of Reference. Again, Mr Andrews, is there anything I need to raise further in that regard?

MR ANDREWS: No, Commissioner.

COMMISSIONER: Thank you.

Moving on to another subject, we began to have a number of press inquiries concerning the fact that staff of the Commission are undertaking investigations in Townsville. I can confirm that some matters have come to our attention in Townsville and staff of the Commission are following up on those matters. It's not appropriate at this stage to disclose what those matters are. Obviously they're still under investigation. Depending on the outcome of those investigations, it may be that we'll need to go to Townsville to take evidence there; it may be that witnesses from Townsville will be called to Brisbane to give evidence in

Brisbane. It would be premature to speculate on any of those possibilities at this stage.

The only thing I want to make clear in response to the media inquiries which we have received is that it's not a matter of expanding the Terms of Reference of the Commission of Inquiry. Our Terms of Reference remain as they stand. Any issues that arise in Townsville or Rockhampton or Charter Towers or Cairns or Mount Isa or anywhere else are of interest to us only to the extent that they touch upon the existing Terms of Reference rather than going to create new areas. If I can put things in the vernacular, we have got enough on our plate at the moment without asking the Governor-in-Council to expand our Terms of Reference to involve issues beyond those which are presently covered.

Moving on to again something entirely different, Mr Andrews, there's a document that you indicated to me earlier you were minded to tender. What's the situation with that?

MR ANDREWS: Commissioner, I have to hand a letter written by the, it seems to be, Acting Manager Investigations Audit and Operational Review Unit of Queensland Health to Mr Mark Dockwra, Executive Legal Officer, Complaints Services Misconduct Division of the Crime and Misconduct Commission, dated the 16th of June 2005. I propose to tender it tomorrow morning so that I can give the legal representatives for Mr Leck, Dr Keating and a Mr, I think, Terry Flemming an opportunity to see it because it does raise allegations, if not evidence, which seems to be against the interests of those persons. Thus, those legal representatives will have an opportunity tomorrow at least, if they wish, to put their clients' versions to the Commission.

COMMISSIONER: Thank you, Mr Andrews. Moving on again to something else, Mr Fitzpatrick, I see that you're without the benefit of either of your learned leaders at the moment. You might recall that, I think it was on Wednesday of last week, I asked Mr Boddice to ascertain whether there are any more of these secret reports hidden away in the cells at Charlotte Street like the Rockhampton report Mr Thomas discovered and reported last Wednesday. Can you inform us how progress is going towards locating any further such reports?

MR FITZPATRICK: Commissioners, Mr Boddice has met - conveyed immediately your comments to our client in Brisbane. He has met with them today for a complete update in relation to that and the many other matters which are before the Commission. He will be here this evening and I would expect that he will be able to inform the Commission in full about those matters tomorrow morning if that's sufficient, Commissioner Morris.

COMMISSIONER: Yes, yes, I appreciate that. Thank you for that. Is there anything else that anyone wishes to raise this afternoon, otherwise we will adjourn till 9.30 tomorrow morning. Nothing further?

MR ANDREWS: Nothing further, thank you, Commissioner.

COMMISSIONER: Thank you, Mr Andrews. 9.30 tomorrow.

THE COMMISSION ADJOURNED AT 4.36 P.M. TILL 9.30 A.M. THE FOLLOWING DAY