State Reporting Bureau

Queensland Government
Department of Justice and Attorney-General

Transcript of Proceedings

MR A J MORRIS QC, Commissioner

SIR LLEW EDWARDS, Deputy Commissioner

MS MARGARET VIDER, Deputy Commissioner

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

IN THE MATTER OF THE COMMISSIONS OF INQUIRY ACT 1950

BUNDABERG HOSPITAL COMMISSION OF INQUIRY

COMMISSIONS OF INQUIRY (No. 1) 2005

BRISBANE

..DATE 09/08/200

..DAY 37

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

THE COMMISSION RESUMED AT 9.34 A.M.

COMMISSIONER: Mr Morzone?

MR MORZONE: Yes, if it please the Commission, the witness for this morning is Dr Younis. I call him to the witness-box.

IFTIKHAR YOUNIS, SWORN AND EXAMINED:

COMMISSIONER: Dr Younis, please make yourself comfortable. Do you have any objection to your evidence going filmed or photographed?-- No.

Thank you.

MR FARR: And I appear for Dr Younis.

COMMISSIONER: Thank you.

MR MORZONE: Your name is Iftikhar Younis?-- Yes, correct.

You are a Senior Medical Officer in the employ of Queensland Health at the Bundaberg Base Hospital?-- Yeah.

You prepared a statement in this matter. Can I ask you to look at this original statement? Is it the statement signed by you?-- It is.

Are the facts contained in the statement true and correct to the best of your knowledge and belief?-- Yes, I believe that.

Are the opinions which you express in there as a medical practitioner opinions which you truly hold?-- Yes.

I tender the statement.

COMMISSIONER: The statement of Dr Younis will be exhibit 258.

ADMITTED AND MARKED "EXHIBIT 258"

MR FARR: Commissioner, after it is marked could it be returned to my learned friend for some photocopying? We have only just signed that statement this morning and it was my copy, so I will need to get a copy to work with.

COMMISSIONER: Sure.

MR MORZONE: Dr Younis, you commenced employment at the

Bundaberg Hospital in September 2002. Prior to that you had been in Pakistan, is that right?-- Yeah, I been in Pakistan, at the same time I had been working as a consultant in anaesthetics in Ministry of Health Malaysia for three years from 1997 to 2000.

And your qualifications in Pakistan were that you studied at the Rawalpindi Medical College?-- Yeah.

Where you obtained your degree in Bachelor of Medicine?-- Yes.

And thereafter you did a Diploma in Anaesthetics from the Post Graduate Medical Institute of Lahore-----?-- Yeah.

-----Punjab University, and you became a member of the College of Surgeons and Physicians in Pakistan?-- Yeah.

And you were a consultant anaesthetist in Pakistan in 1995?-- Yeah, at that time I did my fellowship and after that I became a consultant anaesthetist.

Then you were appointed Assistant Professor and Head of the Anaesthesia Department at the Holy Family Hospital?-- Yeah.

In Rawalpindi?-- True.

Now, I notice from your statements that before you became employed at the Bundaberg Hospital you in fact earlier travelled to Australia for an interview with the relevant College of Anaesthetists, the Australia New Zealand College of Anaesthetists?-- That's true.

How did that come about and why did you do that?-- While I was in Malaysia, I heard that the College of Anaesthetists in Australia were running an overseas-trained specialist program, and they have got opportunities for anaesthetists in Australia. So when I finished my contract for three years in Malaysia, I have to go back to Pakistan to resume my duties because there was a contract between two countries, and then I thought why shouldn't I get international qualification and experience in first world country. So I started doing correspondence with College of anaesthetists. They welcomed my application. It took me six months to do the document paperwork.

You will have to speak slowly because the shorthand reporter takes it all down?-- Ultimately, they invited me for an interview. That was part of assessment process by the College of Anaesthetists on the basis of my Pakistan fellowship, and being a consultant for more than five years. They have got very strict requirements for that. You can only apply for that when you have done your fellowship and after that you have done at least five years of a consultant job in your own country.

Okay?-- So they invited me, I came here for interview and after that interview - seven days after that they give me a

feedback that, "Okay, we are happy you can work in Australia if you get a job, but that would be a supervised sort of training and you will have to complete second part of the Australian fellowship exam, and you have to work at least for 12 months as a clinical performance evaluation program." And then I went back to my country, continued my work as Assistant Professor head of department, and I tried to get a job in Australia and ultimately I managed to get a job as senior medical officer at Bundaberg Base Hospital. And then I got a job offer - I got my registration requirements completed and I came here to work, and Dr Martin Carter who is Australian qualified anaesthetist, he was proposed as my supervisor and I worked for a year under his supervision. I am still doing - for my second part I have completed the requirement of supervised training program and I am going through my second part, that is examination of final fellowship. I prepare my duty paper last week and I am going-----

Your final paper in Sydney?-- My final papers, that's two days examination before I can be eligible to get Australian fellowship.

COMMISSIONER: Dr Younis, there has been a lot of talk in this inquiry about overseas-trained doctors, that I am sure you would understand. On the one hand it is a wonderful thing that when we have a shortage of doctors in Australia we can attract people of your skill and expertise to come here, but it strikes me as a very sad thing that the result is that a country like Pakistan, which is not as wealthy as Australia, is deprived of the services of a doctor of your skill. How do you feel about those issues?-- I think I had - always this thing in my mind if I work in a first world country, because a lot of my colleagues, they go to UK to get UK qualification, they come back to Pakistan, they don't mind staying in UK. So I think I was probably one of the very few doctors who opted to come to Australia. The reason being maybe I was a bit closer to - I worked a bit closer to Australia and in a country which was in between the third world country and a first world country. So I was more inclined to come to Australia and it was - I think everybody has a right to get a better qualification, better experience, and even if I go back to my country now, I feel I am much, much, much better anaesthetist. I can do much good things for my patients over there.

And do you have any intentions about staying in Australia or returning to Pakistan eventually?-- I think if I do my Australian qualification over here and I get a permanent residency, for my kids and for the future of my kids I would love to stay here. I think there is no harm in that.

Yes?-- And I have done 20 years of my services already to my country.

Yes. It does seem surprising, doesn't it, that such a wealthy country as Australia isn't educating enough doctors, with the result that poorer countries are supplying the shortage of doctors in Australia?-- I think everybody has a right to go

to that point, when many start feeling personal satisfaction.

Yes?-- I was not feeling my professional satisfaction while I was working in Pakistan. Just because it was after the thing I was ready, all those skills, I had enough knowledge but I didn't have the opportunity for application of that knowledge, and I was not feeling very much comfortable that I knew a lot, but I am not giving the due benefit to my patient, and I couldn't struggle with that much extent to really change the things over there. I didn't see that maybe in the next 20 years I would be able to make a big change over there, so for my own professional satisfaction I came to work over here.

And please understand, Dr Younis, my questions aren't intended as criticism of your decision to come to Australia. As I said at the outset, when we do have a shortage in Australia it is a wonderful thing that people like you are prepared to come here and assist us with that problem. But in the long-term, it seems to me very important that a wealthy country like Australia should be producing enough doctors, not only for our own needs, but perhaps to help out with poorer countries in the world that don't have enough doctors?-- I think that should be - it should go like that, yes.

Mr Morzone?

MR MORZONE: Thank you, Mr Commissioner. The interview that you had with the Australia and New Zealand College of Anaesthetists, do you recall it and how thorough it was and what the interview involved?-- I think they had already gone through my paperwork, and there were almost four or five people - senior persons, assistant professors and professors, very senior people were there, and then they went through my CV, my professional experience, my professional skills, what I had been doing in Pakistan and Malaysia. It was a good evaluation. It was not basically academic one, but general. Overall it was a good evaluation. I was impressed by the conducting.

Subsequently when you obtained the position as Senior Medical Officer at the Bundaberg Hospital, you obtained Special Purpose Registration from the Medical Board of Queensland?-- Yes.

And did you have another interview with them?-- Yes, before I started working at the Bundaberg Base Hospital, I went for formal interview with the Queensland Medical Board representative over there.

And how did that interview compare with the one from the College of Anaesthetists?-- No, this was - one with the College of Anaesthetists, that was more professional, there was a lot of discussion, there were many people. In this interview there was only one person. There were two or three other candidates like me who were rather very junior fellows, and it was a sort of little bit of description what we were expected to do over there, we were handed over code of conduct as well, but it just maybe 20, 30 minutes - it lasted for 20,

30 minutes for three or four of us over there.

Okay. And during that interview did the Medical Board know you had been to be interviewed by the College of Anaesthetists?-- Yes, I think I mentioned that in my application which was submitted for registration, yes, and in my CV also it was written over there that I had been assessed by the College of Anaesthetists.

D COMMISSIONER VIDER: Under your Special Purpose Registration, doctor, when you obtained it, you obtained it for the position of a Senior Medical Officer?-- Yes.

And you understood that that was the particular registration that you had from the Board?-- Yes, I was very, very clear about that.

And you understood that that position meant that you had to work under supervision?-- Yes.

Thank you.

MR MORZONE: You mentioned - just taking up that supervision, you mention that you were required to work under the supervision of an Australian qualified anaesthetist?-- Yes.

Was that a requirement of the Medical Board's registration or the Australian College?-- That was requirement of the Australian and New Zealand College of Anaesthetists.

Okay. And can you tell us more about that requirement of supervision? For how long was it to last and-----?-- It was initially for 12 months and has to be - I had to work under the supervision unless I do my Australian qualification. I was really prepared for that. I knew I had to learn a lot, coming all the way from third world country to first world country. So I was really mentally prepared for that. I was rather more feeling more safe to work under Australian qualified supervisor.

And what sort of supervision was required? Did Dr Carter have to be present during operations when you were there?-- Yes, initially he was with me for most of the surgeries but when he was satisfied that I am doing well, I am meeting expectation, safe anaesthetist with the patient, and turned out to be a remote sort of supervisor, and it was basically me, that once I felt any problem about patient management, I used to contact him. When he was in his office during daytime, I used to ask him to come with me and give me a hand, and when it was something like after hours, I used to give him a telephone ring and used to seek his advice all the time.

And obviously each year you renew your Special Purpose Registration?-- Yes.

And for the purposes of that, an assessment is done, is that right?-- Yes, because my assessment - a report was used to be given every three months by my supervisor to the College of

Anaesthetists and then after each one year when completed, I renewed - I requested for a renewal of my Queensland Medical Registration Board.

Slow down just a touch?-- They used to ask what progress I have made towards achieving Australian qualification, and then they used to ask for a report from my supervisor as well.

Is this the college or the Medical Board?-- Medical Board, and my supervisor used to provide a report about me, my performance, and at the same time myself has to give them a documentary sort of thing that, look, I am not appearing in this exam this time because I appeared in the exam a few more times before, and I used to provide them the documents every day that I am working towards Australian fellowship exam.

Okay. Now, your renewal for Special Purpose Registration occurred once a year?-- Once a year.

Is that right? You referred before to reporting to the College of Anaesthetists initially at least every three months, is that right?-- Yeah.

How did that occur? Did Dr Carter prepare an assessment?-- Yeah, they have got assessment form from the College of Anaesthetists and he used to put that form assessment, confidentially, of course, after talking to me. It is a big form.

Did that reporting continue on a regular basis?-- Yes.

Through to now?-- Yes.

Has it been every three months through to now?-- Three months or six months, I am not clear about that, but, of course, it has to be there.

Now, you were there when Dr Patel first arrived, that's correct, in March/April?-- Yes, I was working there for about six months when Dr Patel arrived.

When you first met Dr Patel, what was your understanding of his position at the hospital?-- I had a clearcut understanding that he is a Director of Surgery. I was introduced that he is a Director of Surgery.

And do you recall how soon after he started that you were introduced to him as the Director of Surgery?-- Maybe just next day, two, three days, yeah.

Okay. Did you know him at any time as holding any other position other than Director of Surgery?-- No.

Now, in paragraph 7 of your statement, you state that you didn't have a lot of social interaction with Dr Patel?-- Mmm.

And that your impression of Dr Patel was that he was an average surgeon. Can you expand upon that more? What do you

mean by average surgeon?-- I think that statement I made in front of crime protection - the Crime and Misconduct-----

Commission?-- -----Commission, and they were specifically asking me about his professional skills and his calibre, and in that context I made these remarks that he was an average surgeon. I worked with so many surgeons who are even worse than him in my 20 years' career, I work with so many surgeons which were much better than him. But having said that, I still say that this remarks - this assessment should have been gone through as person who is surgeon himself. I being an anaesthetist, I can't comment too much upon his professional skills.

D COMMISSIONER VIDER: Doctor, have you worked with many surgeons in Australia who were worse than Dr Patel?-- No. No, I don't think so, because before that there was a Director of Surgery - local surgeon in Bundaberg Base Hospital and he was doing very well, he was very - I was very comfortable working with him, no problem, and then after four or five months he left Bundaberg Base Hospital and-----

COMMISSIONER: Do you recall his name?-- Sam Baker.

Dr Sam Baker?-- Yeah.

Yes?-- I worked with him as well, yeah.

What about other surgeons at the same time as Patel? Dr Gaffield was, I think, still there, wasn't he?-- Dr Gaffield, yes. He was quite a junior surgeon. Most of the time he was dominated by Dr Patel, being Director of Surgery, and his main interest most of the time had been in plastic surgery, cosmetic surgery. So I think he was not apart from him at all at any time. I categorically say that he was working as a junior surgeon under him.

There has also been mention of a surgeon who assisted with on-call and after-hour work. I think Dr Kingston.

MR MORZONE: Dr Kingston and Dr Anderson as well.

COMMISSIONER: Well-----?-- Dr Pitre Anderson, Dr Kingston, yeah.

Did you work with either of those doctors?-- Yeah, I been working with them as well. They were good, yes, but most of the time they were not doing the major sort of surgeries which Dr Patel was doing, so I can't - I can't actually compare oranges with, you know-----

Yes?-- -----apples here.

Thank you?-- They were doing their own surgeries, limited surgery. Sometimes daycare surgery. They were not involved in the major procedures Dr Patel was daring to do.

MR MORZONE: Okay. Now, you were present when Dr Patel did a

number of different types of surgery, including an oesophagectomy on patient P18, and you refer to that in paragraphs 9 to 14 of your statement. Can I ask you some questions about that?-- Yes, please.

That occurred in June 2003?-- Yep.

And before that operation there'd been an earlier oesophagectomy I think of Mr Phillips, which you have referred to as patient P34 in paragraph 15, is that right?-- Yeah, there are a couple of oesophagectomies done before Mr James Grave, and I was present as anaesthetist assistant with Dr Martin Carter those two before Mr James Grave was operated by Dr Jayant Patel for his oesophagectomy.

Okay. There was one on the 19th of May called Mr Phillips, is that right?-- Yes.

Was there an earlier one than that while you were there?-- As far as I can recall, there was a locum surgeon who did two oesophagectomies before that. First oesophagectomy was done successfully - I think that is his name - I was not the anaesthetist at that time - but the second oesophagectomy was attempted but when they opened - because sometime they only can find out that this patient is inoperable. I think the second oesophagectomy was that sort of operation where they planned to do oesophagectomy and they opened the thorax, the surgeon decided, "No, I am not going to operate on this patient." So it was a planned oesophagectomy but-----

It didn't occur?-- It didn't occur. And after that I was involved with the oesophagectomy as anaesthetist of Mr James Grave.

Now, in paragraph 15 you have stated that you weren't involved in the treatment of Mr Phillips but were you present during the operation, were you? Do you remember?-- No.

No, okay. Can I ask you about Mr Graves then?-- Yeah.

At the time of or before the operation of that patient, do you recall there being any discussion within either the department - or the ICU Department or anywhere else about whether or not those sort of operations should occur?-- No, I don't remember.

Dr Jon Joyner is an anaesthetist as well, is that right?-- Yes.

You mentioned in your statement that Dr Jon Joyner was the specialist anaesthetist on call on the night that the patient was taken to the operating theatre?-- Yeah, that was the third time when he was taken.

The third time?-- The operation he did.

I want to ask you about that operation in a moment but do you recall Dr Joyner raising any concerns with you or anyone else

about these operations?-- No, I can't recall.

Can't recall, okay.

D COMMISSIONER VIDER: Did you raise any concerns with Dr Joyner after the patient had been back the fourth time?-- We had a discussion about that patient because I think on the same morning while he was operated the night before for the third time, I received a telephone call from Dr Darren Keating - because I was on call that day covering ICU and the floor consultant as well - that, "Can you please review this patient independently and let me know whether he is fit enough to stay here in Bundaberg Base Hospital ICU for another 24 hours." Because I was given the impression that there is some sort of dispute, disagreement between the ICU staff and surgeon and Jon Joyner that this patient should be moved as early as possible to Brisbane. Then I had a discussion with Dr Patel, I had a chat with Dr Jon Joyner as well to know what are their concerns, and then we mutually agreed to the point - because Dr Patel was insisting that the surgery what I have done the night before with Jon Joyner, anaesthetised that time, he is definitely going to make a good recovery, and I don't want that this patient to be moved immediately unless we see the results of my last surgery on that patient, and he was still critically ill and he was insisting that we should wait and see for another 24 hours, at least to let me know that what I have done and whether - because he was expecting a drastic improvement in the patient critical condition after that surgery. And I reviewed the patient, I talked with Dr Jon Joyner, and it was a mutual decision that it is written on the chart that we will review that patient after 24 hours, and the same thing I told to Dr Darren Keating after reviewing the patient, that probably there is no harm if we can still keep him for 24 hours and see the results of the surgery and everybody is comfortable.

This is 24 hours after the fourth operation?-- Third operation.

After the third operation?-- Yes.

COMMISSIONER: Did you feel comfortable yourself about arriving at that decision?-- Yes.

As I understand what you told us, Dr Keating very properly asked you to give him an independent view?-- Yes.

Independent from Dr Patel and Dr Joyner, and having spoken to both of those doctors you were satisfied with the patient remaining there until 24 hours-----?-- Yes.

-----was appropriate?-- I didn't mention either - neither to the surgeon nor Dr Joyner that I have been asked by Dr Darren Keating to give my independent - because I didn't feel it fair.

Okay. Thank you.

MR MORZONE: Did Dr Keating - I think you may have mentioned this - but did Dr Keating indicate why he wanted to have an independent-----?-- No, he didn't.

Do an independent assessment?

D COMMISSIONER VIDER: Did you understand, doctor, that the Intensive Care Unit at Bundaberg was a classified level 1 unit and that has certain restrictions?-- Yes, I knew about that, because we didn't have full-time ICU specialist over there, and I also knew that most of the time we were - I and my colleagues were - Senior Medical Officer - were covering both operation theatre and intensive care as a staff specialist, and we were - all the time knew this thing, that is a level 1 ICU.

MR MORZONE: Did you understand from that as well from any protocol or anything else that that level of ICU brought with it certain restrictions about the time period patients should be in ICU?-- Yes, sir. I knew that our ICU gave to - is only there to keep the patient for two or three days, for elective ventilation, and when we feel like this patient is going to hand over on ventilator, he has to be moved in the better ICU with better facilities, and it had been our practice like that, yeah, after assessing - after keeping the patient on ventilatory support for two or three days and not anticipating that this patient is not going to make - make over and he needs ventilating support maybe for some more days, it was to - all of our effort that patient to some better centre.

Okay. Can I ask you about - go back to the operation on patient P18. You were involved in the first operation, were you?-- Yes, I was the anaesthetist.

Was there another anaesthetist with you or was it solely you?-- At that time Dr Martin Carter has gone for some

holidays and he told me about that patient, that we are going to anaesthetise him, and that was a mutual decision between Director of Surgery and Director of Anaesthesia, and I was not involved in decision making, what sort of surgery is to be done in operation theatre at Bundaberg Base Hospital. So I follow the instructions from my head of department, and Dr Patel also talked to me about that patient, that Martin would be away, that - "And you are going to anaesthetise that patient". I went through the patient chart. There was nothing wrong which could hinder me, not to proceed, and it was a planned surgery. The ICU theatre - ICU bed was booked for that patient. So, the first operation went very smooth, the patient was very dramatically stable. I extubated that patient in the operating theatre. I carried that patient to ICU, and he had been practically well for more than 24 hours in ICU and then he either - moved on to the Surgical Ward for ongoing care after having such a major operation.

At the time of or before the first operation occurred, did you have any concerns about anaesthetising the patient or the operation that proceeded personally?-- No, I didn't have any major concern. Because before that there were two oesophagectomies done and maybe less than one - one month time, so I was quite comfortable in anaesthetising that patient.

Are you able to recall how the operation went, the first operation? Were you looking to see what was happening or-----?-- It's a long time now, it's about two years, but what I can say is a patient went smooth as scheduled in due course of time, not a major complication, and I think while I said that I extubated the patient in operation theatre after this major surgery, I mean the patient was - had been - a patient had a smooth operative period and he didn't have any major complication. In immediate post-operative - immediately - immediate post-operative period in operation theatre, that's when I extubated the patient and he was conscious, spontaneously breathing, maintaining his saturation, responsive.

Now, he subsequently developed complications; is that right?-- Yeah, not in the ICU but I think then he moved to - he was moved to the ward he developed some complications.

And what were they? Do you recall?-- I think he was brought into ICU after 48 hours and then he - I was the anaesthetist for the second time as well. At that time it was a wound dehiscence.

An opening of the wound?-- Sort of busted open, wound was opening after surgery.

Okay. Now, you anaesthetised the patient during the second surgery?-- Yes.

And do you recall how that surgery went? What was done, do you remember?-- I think he did a wound - and he tried to do a washing of the abdomen, and then he closed the wound with some

sutures and it was not a very long surgery second time, maybe less than one hour, and again he was moved back to ICU and he was - haemodynamically he was stable up to that time.

Now, how long was this after the first operation did occur?-- I think three days after that.

And is it your recollection that the patient was moved from ICU at that time to the Surgical Ward? Is that your recollection?-- After that, after the second operation, he stayed in ICU all the time.

Okay. Between?-- After the first operation, yeah, he was moved down to Surgical Ward.

Okay. Then he was taken back to for an operation for the third time, which you have mentioned previously?-- Yeah.

And Dr John Joyner was involved in that?-- Yes, he was on call that night.

Were you involved in that as well?-- No.

Okay. And you state in paragraph 12 that the patient had complications, and you said that it was not normal to expect that many complications. Can you expand upon the complications you are referring to there? Is it the wound dehiscence or other complications?-- I think the wound dehiscence because that was the only complication I knew up to that time, and later on when he was operated for the fourth time and I was the anaesthetist, there was another complication, there was leakage of the duodenoileostomy, leakage in the anastomosis that they do, when they join two parts of the gut together.

Okay. So that's a leakage occurring at the site of the oesophagectomy?-- Yes, yes.

Is that right?-- Yes.

Okay. So that complication developing, to your knowledge, was there or present at least on the fourth occasion?-- Fourth occasion.

And by this time, on the fourth occasion, for how long had the patient been in ICU after the second operation?-- Don't to - you said third and fourth operation?

Yes?-- He was there for about 48 hours.

48 hours?-- Yes.

And the review that you referred to by Dr Keating, the review you undertook for Dr Keating-----?-- Yeah.

-----did that occur after the fourth operation?-- No, after the third operation, and then we had - all of us were of the opinion that the patient had to go to tertiary ICU, and we

were trying to make arrangements for that, but before we could - able to get a bed in ICU in Brisbane he developed that fourth - he developed that complication of leakage and then Dr Patel said that, "I can't wait. I have to operate upon him for - to - for that leakage, and I can't wait up to the time we get a bed in ICU in Brisbane." So we took him to the operation theatre, and again it was me that was the anaesthetist for the fourth time.

Okay. Can I ask you a bit more about the between the third and fourth operations?-- Yes.

Did you arrange - seek to arrange for a bed in a tertiary hospital or did someone else seek to do that?-- That was the surgical PHO who was doing that, yes.

Okay. And do you recall attempts being made by the surgical PHO-----?-- Yes.

-----for that to occur?-- Yes.

Do you recall who that was?-- I think that was James Boyd, the surgical - but I may be wrong. I'm not exactly sure about that. And Dr John Joyner also was trying to arrange a bed in ICU-----

Okay?-- -----in Brisbane.

And is it your recollection that one couldn't be found before the fourth operation proceeded?-- Yeah, but at that time the decision had been made. Everybody was happy that this patient should go to ICU but the problem was we were not able to get a bed in ICU, and then he developed that complication and he had to undergo his fourth operation at Bundaberg Base Hospital, in spite of the will that - and the intention that this operation - this patient should have moved on to Brisbane as early as possible.

COMMISSIONER: This is the same patient about whom Dr Keating had earlier asked your advice as to whether the patient was-----?-- Yes.

-----being properly managed at Bundaberg? Did you feel it appropriate to go back to Dr Keating and tell him that despite the decisions to transfer the patient to Brisbane Dr Patel was planning to perform another operation?-- I think was sort of the - the patient, there was no way out and he was of the opinion that, "I can't leave the patient unoperated in ICU unless I get a bed in Brisbane."

Yes. But did you mention your concerns to Dr Keating?-- No. I think he already knew about this thing, because-----

Well, I'm not really asking you to speculate what Dr Keating might have known about, but I think it's important that he did the - took the step of asking your advice. You initially told him that the patient was going to remain in ICU for 24 hours for observation?-- Yes.

When you got to the stage where everyone involved thought the patient had to be moved to Brisbane and then Dr Patel decides to do another operation, I thought maybe that would be the right time to go back to Dr Keating and say, "Well, things have changed and Dr Patel's now planning to do another operation"?-- At that time I was concerned to take the patient to an operation theatre, because now he was very, very critically ill.

Yes?-- And my main concern was to keep the patient alive for the safe anaesthesia for his fourth time. So, yeah, I realise that I would have contacted Dr Darren Keating at that time. Maybe I can't recall that, but I was more involved with the patient care.

Of course, and that was your first priority?-- Other problem with the Base Hospital is the same fellows cover the ICU. They do the operation theatre work as well as the anaesthetist.

Yes?-- So we don't have a lot - large many people so that we can assign the duty. You take care of this patient in ICU. I will take care of the patient in the operation theatre. So, maybe that - at that time Dr Martin Carter was away, so the Director of Anaesthesia was not there. We didn't know who was the boss for the anaesthesia department at that time and you can realise in - a situation at that time.

Look, I am very sympathetic with your situation?-- The patient wasn't ventilated at that time. He was - all the time after the third operation he was on the ventilator, so my main concern was that this patient should not die before he has got this surgery done and he should proceed to the tertiary hospital safe and sound, at least they can take care of him. I think I was successful in that aspect. The patient survived. I managed to send the patient to Brisbane in intact. He survived for more than six months after that in Brisbane in the tertiary ICU.

Dr Younis, again, don't misunderstand me, I'm not criticising you at all?-- Yes.

My difficulty is this. We have had some witnesses say that maybe Dr Keating wasn't quick enough to deal with problems with Dr Patel, but here we have a situation where he asked for your advice, you gave your advice based on the circumstances at the time?-- Yes.

Those circumstances changed. So it's important to know whether Dr Keating was informed of that change of circumstances or whether he was left in the dark, because I am sure you would agree with me that if he was left in the dark-----?-- Yeah, I agree with you.

-----no-one can criticise Dr Keating for the fact that he didn't know what was going on?-- I agree with you, yes. He should have been informed, and since it's a joint team work

between surgeons, surgical PHOs, anaesthetists, ICU staff, and I was of the understanding he was very in the picture at that time.

D COMMISSIONER VIDER: Doctor, can I just ask you to clarify, the first operation was for the oesophagectomy?-- Yes.

The second operation was following the wound dehiscence?-- Yes.

What was the third operation, because the fourth one was the anastomotic leak?-- I know-----

I know the third one is one where you-----?-- I was not the anaesthetist that time, and that operation was done in the middle of the night at some time, 12 o'clock midnight, so I'm not aware of the exact - what was the exact indication for that operation that time.

You are not aware of that?-- No.

The third operation?-- I'm not clear about the third operation.

Yes?

MR MORZONE: Before Dr Keating had asked you to do an independent assessment of the patient, had you been aware that Dr Joyner had arranged for a bed in Brisbane?-- No.

Okay. And did you understand from Dr Keating or anyone else that Dr Patel had not wanted to transfer the patient to Brisbane, notwithstanding Dr Joyner had arranged the bed? Did you understand that or you didn't understand that?-- No.

And that you were not told either of those things by either Dr Keating?-- Yes, no, no.

Or-----?-- I was not told that the bed had been arranged in Brisbane.

Sorry?-- I was not told, aware of that fact that there's already a bed arranged in Brisbane.

Or that Dr Patel had refused to transfer with the bed arranged? This is between this third and fourth operation?-- Yes.

Okay.

D COMMISSIONER VIDER: Doctor, did you say that when the patient was transferred to Brisbane he was in intensive care in Brisbane for six months?-- No, initially he was transferred to the medical hospital in Brisbane and he stayed there for some - I'm not sure about the time duration, but initially he was in ICU and then he was moved to ward and then probably was discharged and later on - I'm not aware of that - how long.

What was his original pathology? Why was the oesophagectomy done in the first place?-- I think there was some carcinoma of the oesophagus, cancer of the oesophagus.

Did you see the patient before the first operation?-- No, I didn't see the patient before first operation, but I was briefed about that patient by my Director of Anaesthesia, because he has assessed the patient himself, and I was briefed by Dr Patel as well.

Were you aware as to whether or not the patient had been informed of other options?-- No.

Like a stint or whatever?-- No. I'm not aware.

MR MORZONE: Were you aware of any decision - clinical opinion, perhaps, is a better way of saying it - either of yourself or others as to the patient's life expectancy before the operation?-- I can't say, no.

Or were you not party to that? Okay. Subsequent to the treatment of P18 - that's Mr Graves - did you have any concerns about the operation that had occurred and the events that had occurred?-- I understand that oesophagectomy is one of the major most surgeries to have got the highest complication rate, but since before that one oesophagectomy was done and it was smooth, the patient had a smooth recovery, there were no medical complications in that, but again it depends from patient to patient. It depends upon the surgical selection of the parent. Some patient might bearing a different pathology, then make a good recovery even with that operation. So I - clearly actually categorise that why this patient is having complication, why that one patient with oesophagectomy before didn't develop any complication, so it varies from patient to patient.

You state in your statement that you can not really comment as to the standard of surgical treatment of this patient?-- Mmm.

Because your role was confined to anaesthetics?-- Yes.

Do I infer from that that you didn't have any concerns about the actual surgical procedure?-- I think as a team work, our responsibility is to look at our own domain, so anaesthesia itself is quite a sensitive issue. So, most of the time being trainee of the College of Anaesthetists I was concentrating on this thing, that I should first prove myself to be a very safe anaesthetist. So I was - most of the time I was of the concern that I should do my best anaesthesia service to my patient, rather than looking at the surgical expertise of other people.

You mentioned earlier that this - the initial decision for the operation to occur was made by people other than you?-- Yes.

Subsequent to the operation, though, did you have some view about whether or not the operation should have occurred?-- I

think just looking at the complications developing, one patient after that major surgery - I didn't raise any concern. Maybe there was something very wrong with the patient himself, so - that was the getting that frequent complications.

COMMISSIONER: Doctor Younis, as I understand it, an oesophagectomy is normally performed on a person who has cancer?-- Yes.

And the purpose of the operation isn't to cure the cancer, the purpose is to improve the patient's quality of life?-- Quality of life, yes.

So, if this patient had an expected two years to live before the operation, he would still have an expected two years to live after the operation, but hopefully it would be a more comfortable two years of life; is that right?-- Yes.

All right. But in this case, given the seriousness of the complications, it sounds as if rather than improving his quality of life it had the opposite effect and that's, I think, why Mr Morzone is asking you whether in retrospect with the benefit of hindsight maybe this wasn't the right sort of operation for this patient?-- Yes, I believe that.

MR MORZONE: Can I ask you about Mr Bramich?-- Yes.

The next one you became involved in is the treatment of Mr Bramich on the day when he collapsed in the Surgical Ward?-- Yes.

I think it was the 27th of - the day he died, is that right, the 27th?-- Yeah, he died on the same day. But I - he was operated on the 28th, morning.

27th of July he died?-- Maybe the 27th or 28th.

Early in the morning of the 28th. You had not been involved in his treatment prior to that time; is that right?-- No, no.

You became involved as, you say, in paragraph 16 when you were called to the ward to assist with the patient and when you arrived Dr Gaffield was there?-- Yes.

Is that right?-- Yes.

In your statement, you have attached a report which you were asked to prepare about that patient after the event and it's a handwritten report attached to the statement?-- Yes.

Okay. And in that - do you remember when you wrote that statement approximately?-- I think that was two or three days after his death.

Okay. In that report on the first page you make mention of when you arrived at the ward reviewing the drainage system of the patient?-- Yes.

Remember that?-- Yes.

Can you explain the purpose of the drainage system - first of all, which drainage system are you referring to? Is it an intercostal-----?-- This is the intercostal drain which is put in the pleural space to drain the fluid collected - most of the time after a transplant of blood product, and at the same time to remove the air that might be causing the tension pneumothorax.

Do you know from a review of the patient's chart when that drain was first put in?-- That was - I think was put it in in the Emergency Department about 24 hours - when the patient arrived in the Emergency Department.

First arrived?-- Yes, after his accident.

Which is the night of the 25th of July, Is that correct?-- Yes.

And you reviewed the drainage system and you found it had stopped working. Is that right?-- Yeah, clinically we assess - when the column in the tube is not moving we say that probably it's not functioning to the desired extent. So I requested them that, "I'm not happy, and either you review or we can put a new intercostal drain."

So you requested the surgeon to insert a new drain?-- Yes.

And did you insert a bigger sized drain?-- We took him to - before that we took him to the ICU and he was really in a critical situation. I said it's better for me to intubate and ventilate this patient, and at the same time, since I gave him some minimum anaesthesia to intubate and ventilate, I requested the surgeon can do the procedure at that time while he was minimally anaesthetised, and they did put a new drain and there was a big gush of fluid and collection from that new drain.

And is that an indication that confirmed that the old drain was not working properly?-- Yes.

And if it was not working properly, is it possible that bleeding that might have been occurring at that time was not being detected?-- Yes.

And are we able to say now for how long that event may have been occurring?-- I think by the time he started draining there was the time - maybe midday of that day, 12 o'clock, because the tube can clot any time so we need to have a good observation of the functioning of the tube in such type of patient who has got a chest trauma that it should be functioning all the time, and that was the time when it blocked, the patient got haemopneumothorax and he started deteriorating critically.

The patient was removed to ICU, and prior to this time do you know whether or not any attempts had been made to arrange for a transfer of the patient to Brisbane?-- No, I don't remember that.

When the patient was taken to ICU, did his condition improve?-- No, he had been haemodynamically very unstable all the time.

Now, you say at about 2 p.m. Dr Gaffield had to leave to go to the operating theatre?-- Yes.

And at that time there was a discussion between - perhaps I should ask this: did you note a discussion having occurred between Drs Gaffield, Carter and yourself-----?-- Yes.

-----concerning whether the patient needed to be transferred?-- You're right.

Did that occur before Dr Gaffield left for theatre?-- Yes.

Okay. And do you remember what the outcome of that discussion was?-- We tried to contact the retrieval team for air retrieval at that time.

Did the three of you - that is Dr Carter, Dr Gaffield and you - agree that a transfer should occur?-- Yes.

And were arrangements made to arrange for the transfer?-- Yes.

Do you recall who made those arrangements?-- That was the surgical PHO, Dr James White.

Now, at this time Dr Patel was not involved in the care of the patient?-- No, he was not in the scene so far.

In your written statement, which again is attached to your statement, you make mention of the discussion about the transfer of the patient to Brisbane at the bottom of the second page?-- Yes.

And you've referred there to the time when you'd sought Dr Carter to come with you to ICU, being about 2.30?-- Yes.

Was that about the time the discussion occurred about transferring the patient to Brisbane?-- I think when I requested Dr Martin Carter to come and give me a hand and then he reviewed the patient, that was the time that we were also of the opinion that this patient should be moved down to Brisbane as early as possible, having - the reason that we don't have the facility to do - if he needed surgery like a thoracotomy at that critical time to arrest the bleeding, we don't have that facility for a prolonged period of post-operative ventilation and the bank of services required for such a major surgery like massive blood transfusion and blood products.

Now, we know from your note that it was about 2.30 that you requested your Director to review the patient?-- Yes.

How soon after that was the decision made that he be transferred?-- I think maybe five or 10 minutes after that, because I went personally to Dr Martin Carter's room. He accompanied me immediately and then we were all of the opinion that he should be moved.

And you refer at the bottom of that page to the surgical PHO communicating with Brisbane hospitals, and a positive response being obtained from the Princess Alexandra Hospital?-- Yes.

Do you recall what time that was after the initial decision to transfer him was made? Was it relatively quick?-- Maybe 3 o'clock.

About 3 o'clock?-- Yes.

You state in paragraph 19 that your main concern was that the patient be stabilised before he was to be transferred to Brisbane?-- Yes.

Is it correct to say that in reaching the decision that he be transferred to Brisbane at that time - that is at 2.30 to 3 o'clock - in your opinion he was able to be transferred? He was stabilised at that time?-- I can categorically say that he was never stabilised haemodynamically in our ICU, but there were some times that he was a bit more responsive to our aggressive, supportive treatment, and normally such type of patients, they behave like that, and we have to accept a degree of instability so that the patient should be moved to a better place. So we were accepting to take that risk.

COMMISSIONER: In your opinion was he sufficiently stable to be medivaced to Brisbane?-- Yes, at one stage definitely. I've written in that notes as well that there was a window period while he was a bit more haemodynamically stable, but when we say 100 per cent, no.

MR MORZONE: I understand.

D COMMISSIONER EDWARDS: Even though at this stage I think you suggested he had impending cardiorespiratory collapse?-- That was immediately when I moved him from ward to the ICU.

Then he stabilised?-- After putting the drain, putting him on ventilatory support, giving him 100 per cent oxygen, that was the window period when he was relatively fit enough to be moved.

Thank you.

MR MORZONE: You make mention then of Dr Carter obtaining a CT scan?-- Yes.

And that being then discussed with Dr Gaffield?-- Yes.

What time was that approximately? Do you remember?-- That, I can say, was roughly about 4 o'clock.

After that time, you state in your statement that Mr Bramich's condition was still not stable and you were not happy with his condition?-- Yes.

Was he still at that time, though, sufficiently stable to be transferred to Brisbane, in your opinion?-- That was the time period when we decided, and he was a bit stable, and then we took him to the - Dr Martin Carter took him to the CT scan and he brought him back. He was reasonably in a haemodynamically stable position, and then at about that time when Dr Martin Carter relieved me, I went for another emergency laparotomy. It was done by Dr Patel. So for the two hour period I was in operation theatre doing an emergency laparotomy, and I came back at 7 p.m. in the ICU after finishing that laparotomy and at that time the patient was close at 7 p.m.-----

COMMISSIONER: Now, the decision by Dr Patel to perform the pericardiocentesis, was that before you went off with Dr Patel for the laparotomy or after you came back?-- No, actually, I did that anaesthesia for Dr Patel for that patient - for the emergency laparotomy, and then I came to ICU and Dr Patel also - he changed his dress and he also came to ICU to see that patient.

You see, I'm just going by what you have in paragraph 21. It says, "My recollection is that Dr Patel then came on to the scene and basically took over the care of the patient. It was about 5 p.m. when Dr Patel decided to attempt to perform a pericardiocentesis." So that would be before the emergency laparotomy rather than after it?-- Maybe that was a problem with my recollection at that time, but basically it was after that laparotomy.

Right?-- At about 7 p.m. when he started - he decided to do a pericardiocentesis on that patient, 7 p.m.

But at some stage - because you had all the arrangements being put in place for the patient to be removed to Brisbane?-- Yes.

At some stage Dr Patel said, "No, he's not going to go to Brisbane. I'm going to treat him here."?-- Yes, that was immediately before it was decided to do a pericardiocentesis, he had a discussion with the patient's relatives that there's no point in moving this patient to Brisbane because he is not stable, and at the same time, the Brisbane people are not going to do any heroic surgery at that critical moment because the CT scan shows pulmonary contusion, and it has to be treated conservatively, not by any surgical intervention.

D COMMISSIONER VIDER: That's what Dr Gaffield told the family?-- No, Dr Patel told the relatives.

Dr Patel told the family?-- Yes, because Dr Gaffield also got involved in some other surgery.

But the CT scan did not indicate the patient needed a pericardiocentesis?-- Yes.

Did it? It didn't indicate that that was necessary?-- No, it didn't indicate that.

COMMISSIONER: Doctor, you have here a situation where three specialists - yourself, Dr Martin Carter, Dr Gaffield - have all decided this is a patient who would be better cared for in Brisbane, you have a bed already available at the PA Hospital, and then Dr Patel says, "No, I'm going to perform an operation on him here in Bundaberg", and it was an operation which you knew wasn't justified by the CT scan. Did that concern you, those circumstances?-- Yes, that did concern me, but I was of the opinion that maybe the benefit of doubt should be given to the patient - the surgeon maybe, in his experience. He says it with the confidence that it is definitely a pericardiocentesis, that I don't feel myself justified to stop him for that procedure because that is a lifesaving procedure, and from my clinical experience I can gather that if it is done for a right indication on a right patient at the right moment, it's a lifesaving procedure, and the results of the procedure are drastic. The patient improves dramatically after that procedure.

You'd previously had the experience with Mr Grave that Dr Darren Keating, as the Director of Medical Services, had become involved in a dispute between different doctors to ensure the right outcome occurred for the patient. Did it occur to you on this occasion that it was another time when it would be worth informing Dr Keating of your concerns so that someone more senior within the hospital could become involved and review the situation and perhaps make a decision?-- I agree with you, but at the same time I was having this thing in my mind that this is purely a decision about the patient's management by the clinical physician, the surgeon, anaesthetist and intensive care specialist, so I didn't know about this policy that once again at that time I should - because that was about 7 p.m. in the evening - that I should involve the Director of Medical Services.

Anyway, whether it occurred to you or not, you didn't do it?-- No, I didn't do it.

And Dr Patel got his way. He overrode the decision of yourself, Dr Carter and Dr Gaffield?-- Yes.

MR MORZONE: Do you recall - are you able to recall when it was that Dr Patel first saw the patient? Was it only after that laparotomy that you were talking about-----?-- Yes.

-----to your knowledge that he first saw him?-- Yes.

We've heard you say that the arrangement for the transfer was made at about 4 p.m. - beg your pardon, about 3 p.m., was it?-- Yes.

Do you know why there was the delay before he was able to be transferred?-- I don't know the exact cause. But I think two or three hours is the expected time, you know. Whenever we

give them a call we - even if we have a bed, it takes two or three hours. That's the normal time.

The Commissioner asked you about the procedure, the pericardiocentesis, and you've referred to that procedure in paragraph 21 of your statement, and am I correct in seeing from your statement that there were actually two attempts at that procedure, one with one needle and one with another needle?-- Yes, yes.

And that they were separated by about 20 minutes?-- Twenty minute period, yes.

And is it possible that different people may have seen the different procedures? That's true? Where did those procedures occur?-- That was done in ICU, and the same person did the procedure, the pericardiocentesis.

You state that in respect of the first procedure you witnessed Dr Patel make at least 10 attempts to get the needle into the correct location to withdraw fluid?-- Yes.

Can you describe how those attempts occurred? What happened?-- The patient was intubated and ventilated. He was on all invasive monitoring parameters, and Dr Patel said, "I'm of great opinion that he has got a pericardial tamponade and I want to do that." So he asked the sister to bring the trolley for that, which includes the needle, and then one of his junior doctors was with him all the time, and then he said, "I want to do that, and I'll just use a sound guided technique. I want do it as an ultrasound guided technique." He was trying to get to the appropriate location. He did make about 10 attempts in front of me, but all the time I was moving up and about, so I can't say that he made more than 10 attempts, because I was taking care of another patient at the same time, trying to make arrangements for shifting of the patient to Brisbane, and taking care of his haemodynamic parameters.

You state that the motion Dr Patel used to insert the needle was a stabbing motion?-- Yes.

What do you mean by that? Can you describe that?-- I think that is a sort of an exaggeration of the medical technical term. It doesn't mean that somebody is carrying a 12 inch knife and making a stab on the patient with full force with a bad intention, but the moment this activity - the procedure is always described like that, that it has to be a stabbing movement, but it has got its own protocol. A patient has to be at a specific position, and then the direction of the needle should be a 45 degree angle. I mean, a stabbing movement - that is described in medical literature like that, but it is not as stabbing is done in practical life.

COMMISSIONER: I think the point, though, is whether it's just a push with the hand or the wrist or whether it's a whole arm movement?-- No, no, it's just a push towards the - getting the pericardial space.

MR MORZONE: Is it an in and out movement, first of all?-- Yes, it is.

And does the needle fully come out when it's pushed back in - or did it on this occasion?-- It does come out, yes.

Completely came out?-- Yes.

And of the 10 attempts you saw, do you know if it went back in to the same hole created by the earlier attempts or-----?-- Yes.

It does?-- But normally after two or three attempts one is - if there is a real indication one is definitely successful in getting into the space, because once there's fluid there, there's at least a space of about five millimetres around the pericardial space around the cardiac cavity. So normally if there's a real indication and the pathology is there, after three, four attempts, every person can definitely aspirate the right amount of fluid.

COMMISSIONER: Doctor, it's easy for any of us to be wise with hindsight, but from what you've told us, there was nothing on the CT scan to suggest that there was a need for this procedure. I would have thought any competent surgeon, after two or three, or at most five attempts, would say, "Well, what I've seen on the CT scan said I didn't need it, I've tried"-----?-- I agree with you. I agree with you.

D COMMISSIONER VIDER: How many actual stab wounds were there on the thorax?-- Very conservatively I can say 10, which I witnessed myself.

COMMISSIONER: But I think you told Mr Morzone that each attempt was through the same hole. So there wouldn't be 10 different holes?-- No, no. You have to bring the needle out and make an attempt again, or sometimes you go through the same needle in different - same site - same injection site and go in different directions.

MR MORZONE: Okay.

D COMMISSIONER EDWARDS: You also say that he withdrew two to five mls of blood?-- Yes.

From your experience, is that indicative that there is in fact blood in the pericardial sack?-- No, no. There has to be around 100 to 250 ml of blood to cause that much of haemodynamic instability.

MR MORZONE: Can I take you back to inserting the needle into the same site, and you said you might go in different directions?-- Yes.

Deputy Commissioner Vider asked you about how many entry sites there might have been on the thorax, the outside of the skin. Do you recall now or not? Did it go back through the same hole each time or was there more than one?-- Because for me

this is even if - it doesn't make much difference whether the needle is out or in. For me it's how many times it perforates - it goes through the heart. So skin won't be a big - skin punctures won't be a big deal for me. But it matters how many times you have gone through the myocardium, you have entered into the pericardial space or not.

D COMMISSIONER VIDER: But doctor, if you're doing this procedure with ultrasound guidance and you've gone 10 times, you wouldn't have a lot of confidence in the operator?-- Yes.

Would you?-- Yes, definitely.

MR MORZONE: And this is the first occasion. He stops then and then a bigger needle is obtained. Is that right?-- Yes.

And then he makes some further attempts with the larger needle. Is that right?-- Yes.

Do you recall how many attempts were made with the larger needle? Were you present then at that-----?-- No. I think at that time when he started attempting with the larger needle - I can't recall myself to be there with the patient, observing that.

In your opinion, do you believe the stabbing actions - you say in paragraph 22 in fact that the stabbing actions would have caused extra distress on the patient. Is that right?-- Yes.

And what do you mean by that, "extra distress"?-- I mean it can itself cause a pericardial tamponade because the blood can come from inside the myocardial cavity and can be collected into the pericardial space. It can injure coronary circulation, major coronary vessels itself, which can cause myocardial ischaemia. The procedure itself is not a very benign procedure.

You state also that you can't be sure about whether or not the procedure contributed adversely to the patient's condition. That's correct, is it?-- Yes, that is correct, because I couldn't clinically assess that at that time because the patient was already so much haemodynamically unstable. So I cannot actually blame that procedure done at that time because he was already going downhill. So I couldn't really appreciate whether that procedure aggravated the happenings.

COMMISSIONER: But it certainly didn't help?-- It didn't help, yes. If it would have helped, actually, there must have been a drastic improvement in the clinical parameters of the patient.

MR MORZONE: After that time, what was the condition of the patient for the remainder of the night?-- He was still on massive doses of inotropic support, that is vasopressin used to bring the bleed pressure up. He was still having 100 per cent oxygen through the ventilator and - but I can say he was in a state of massive haemorrhage, leading to shock.

You state in paragraph 24 that the retrieval team arrived at 9 o'clock that night. I think we've heard some other evidence to suggest it was perhaps about 11 o'clock. Do you recall the time now?-- I think it was about 10 o'clock.

Okay. Between-----?-- Ten o'clock.

Between the time of the pericardiocentesis procedure and 10 o'clock at night, was there a time in that period when the patient remained sufficiently stabilised to be transferred to Brisbane?-- No.

After that time he was not in a condition to be transferred?-- I can still say that that was the time of - the two hour period when he arrived in ICU, got stabilised a bit, until he went to the CT scan, because our CT scan is on the ground floor, and I think nobody will dare to take the patient if he is haemodynamically so unstable to take him to CT scan. That is about a distance of about 10 or 15 minutes, so I think that was the time which would have been available to shift him to ICU, Brisbane.

COMMISSIONER: I think that probably covers everything, doesn't it?

MR MORZONE: I think so.

D COMMISSIONER VIDER: Were you still on duty, doctor, when the retrieval team came from Brisbane?-- Yeah, I was there.

And it was their joint decision not to transfer the patient?-- No, the decision that - the retrieval team doctor talked to the patient's relatives. I was present at that time.

The retrieval team doctor?-- Yeah, and told both pros and cons of moving the patient at that - that critically ill patient, and it was decided, "Okay, we'll do under anaesthetic to make him a bit more haemodynamically stable", but decided to move him to Brisbane, but ultimately, just maybe 10 or 15 minutes before that, he had a cardiac arrest and then he couldn't make that.

MR MORZONE: A couple of little more things, doctor. Dr Boyd refers to an echocardiogram having been undertaken before the pericardiocentesis procedure. Do you remember that occurring?-- No.

And the other thing I should ask you is in your handwritten statement which you prepared after - a couple of days after the incident - correct me if I am wrong, but I don't think it refers anywhere in there to the pericardiocentesis procedure having occurred, is that right?-- Mmm. I - to answer your question, it was done, the pericardiocentesis.

COMMISSIONER: The top of the second last page "decided to do an ultrasound guided pericardiocentesis."

MR MORZONE: Thank you, Mr Commissioner. Yes, I have nothing further, Mr Commissioner.

COMMISSIONER: Thank you, Mr Morzone. We'll take the morning break now, but before I rise there are two things I wanted to canvass. One is there was a report in the Australian newspaper this morning relating to Vincent Berg. If there is a representative here of that newspaper, it would be useful if they could make available to inquiry staff any documentation or other material supporting those issues. I raise that just by way of explanation. This seems to me to be a very clear example of the problem that arises from covering up or not giving publicity to incidents of this nature. What has been revealed in the Australian, if it is true, regarding Berg, would only have come out once the story got into the media, and whilst Queensland Health may have known two years ago that they had a person practising as a psychiatrist in Townsville who wasn't properly qualified, no-one would have known about that man's alleged chequered history if it were not for the diligence and skill of the journalists who have brought those facts to light. So if staff from the Australian could assist in providing that material, it would be of interest to us.

The other thing I wanted to mention concerns you, Ms Feeney. I am told that there is some disagreement about the order of witnesses. Unfortunately, as we're getting towards the end of the inquiry and we have witnesses to call, it is not easy to schedule people to suit everyone's convenience. Mr Andrews, as senior counsel assisting, has the decision as to who is called and when, but if there is a problem I will entertain an appropriate application. As matters stand, I understand that Friday of this week is the only day that is convenient for Dr FitzGerald to come back and for Mr Boddice to be here on his behalf, and therefore it is planned that Dr FitzGerald

will finalise his evidence on Friday. I am not putting you on the spot now but if that is a matter of such concern that you wish to attempt to persuade us that that should not proceed in that way, then I will entertain an appropriate application.

MS FEENEY: Thank you, Commissioner. What time would you like to hear that application? Would it be before Friday morning?

COMMISSIONER: Oh, yes, before Friday morning. I mean, it is pointless getting Dr FitzGerald along here and then send him away again, but this afternoon or tomorrow morning would be fine.

MS FEENEY: Thank you. I will speak to counsel about that.

COMMISSIONER: Thank you. We will now adjourn for 15 minutes.

THE COMMISSION ADJOURNED AT 11.04 A.M.

THE COMMISSION RESUMED AT 11.40 A.M.

IFTIKHAR YOUNIS, CONTINUING:

COMMISSIONER: Can I apologise very sincerely for the delay. There was a matter that the three of us had to deal with together. Sorry, doctor, that you have been held up. Mr Farr, did you have any-----

MR FARR: Just a couple of questions.

EXAMINATION-IN-CHIEF:

MR FARR: Doctor, can I just, so that we have the dates in relation to patient P18, I think you have on a prior occasion supplied relevant dates to those instructing me. Perhaps I could just ask you if you would agree with these dates: that the dates of the four operations that you spoke of to Mr Grave, the 6th of June, 12th of June, 16th of June and 18th of June?-- Yes.

Okay. You spoke to Dr Keating, I understand, on the 17th-----?-- Yes.

-----of June, and he was transferred on the 20th of June?-- Yes.

Those dates all sound correct to you?-- Sure.

Thank you. That's all I have.

COMMISSIONER: Thank you, Mr Farr. That's June 2004, isn't it?

MR FARR: 2003.

COMMISSIONER: 2003.

MR HARPER: I have no questions.

COMMISSIONER: Mr Allen?

MR ALLEN: No, thank you, Commissioner.

COMMISSIONER: Mr Devlin?

MR DEVLIN: Yes, thank you.

CROSS-EXAMINATION:

MR DEVLIN: Dr Younis, my name is Ralph Devlin. I am the barrister representing the Medical Board of Queensland. Just interested in revisiting a couple of details in relation to what happened to Mr Bramich on the 27th of July, and in order to do that, if we could go to your handwritten document, page 3. Firstly, can I ask you this: I am - sorry, I think you said you wrote the handwritten report two or three days later?-- Yeah.

So the sequence of events would have been fairly clear in your mind at that time?-- Yes.

Thank you. At the top of page 3 you say, "I personally talked to Dr Gaffield in OT." See if we can pick up what the time would have been at that point. Do you remember when Dr Gaffield was in OT? He went off at about 3 or 4, you estimate? 3 p.m.?-- 3 p.m.

"He was almost finishing his surgery in OT but he said that he will review the patient after just finishing the case but would be better to arrange a CT Scan before a final decision is made."?-- Yeah.

Now, was the performance of the CT Scan connected in any way with assessing the risks of transferring the patient by air?-- Yes, that was CT of the abdomen.

Yes?-- And we were thinking that he might have got some catastrophic bleeding to any of his abdominal vessel, and if that would have been the case, then doing an emergency

laparotomy which contributes and accedes procedures before he is shifted to any other place, so that is a very, very important decision.

Now, would that be connected with the risk of the patient developing a significant bleed during transfer? Is that what it is about?-- Yes.

Okay. So the CT Scan was done in order to properly assess the risk of transfer to the patient at that point in time?-- Yes.

Now, was there any particular delay to the CT Scan being done and the results available, or was it pretty routine in your mind, in your recollection?-- I think results of that particular - because we don't have a full-time radiologist at the Bundaberg Base Hospital all the time, so we send the CT to a radiologist on call and they send us the report back. But normally since we are immediately concerned with the patient management, surgeon, anaesthetist, ICU staff, they have a good look under available CT and we make opinion before we finally get a report from the radiologist.

So your recollection doesn't tell you that there was any particular delay about being able to get the CT done?-- No.

And then get it assessed?-- No.

Thank you.

D COMMISSIONER VIDER: Mr Devlin, can I just clarify something there then? Doctor, what you are saying is that you only had the CT Scan done so that you could transfer the patient?-- CT of the abdomen, yes. We already had done the CT of the thorax and the results were already there.

But you have got in your statement that the patient's condition was deteriorating?-- Yes.

So you wouldn't have done the CT Scan in any case?-- No, I am saying that the CT of the abdomen - that was justified to rule out any bleeding which has developed later on which was contributing to the haemodynamic stability. If that would be case, then as protocol of resuscitation we would have done an emergency laparotomy to arrest the bleeding in the abdomen itself before we send him to Brisbane for his thoracic injury.

And that's my point?-- Yes.

That CT Scan would have given you a diagnostic tool?-- Yes.

To use your immediate treatment perhaps in Bundaberg?-- Yes.

Thank you.

MR DEVLIN: Thank you. Now, does your memory tell you the time at which the results of the CT - oh, yes, you said in evidence - I will remind you - earlier on that at about 4 p.m. the CT Scan was discussed with Dr Gaffield. With me so far?--

About.

My note of your evidence earlier was that you estimate that at about 4 p.m. the results of the CT Scan was discussed with Dr Gaffield?-- That was I think 5 p.m. I think when the patient came back with the CT Scan.

All right then. After the CT Scan, you went to OT on another matter?-- Yes.

Right?-- Before the CT Scan.

Before-----?-- Because Dr Martin Carter, who is Director of Anaesthesia, he relieve me to go for that laparotomy and he complete the patient to CT Scan.

Thank you. Now, we get, hopefully, a little bit of assistance from a report done by Dr Carter about the way - or the times at which the retrieval was ordered, right. So we will just for the moment accept the accuracy of Dr Carter's notes on this because we don't have the Royal Flying Doctor Service log at this point. Are you with me so far? So just accept for the moment that the request for the transfer was logged at 16:20 hours. So that's 4.20 p.m.?-- Yes.

So that the CT Scan would not have been available then, according to your recollection?-- Yes.

It was available soon after that?-- Yes.

The CT Scan did not indicate that the patient was unsuitable for transfer at that point?-- From that prospect, yes.

Now, Dr Carter says that the flight was dispatched at 7.30 p.m., 19:30 hours?-- Yeah.

If we just accept that for the moment as being right without access to the log from RFDS, you cannot help us with why there was a delay of three hours at that point?-- Yes, I can't.

From 4.20 to 7.30?-- No, I can't help.

Are you familiar enough with the practical issues concerning transfer, however, to this extent: you have said that once the flight is dispatched, the gap of time is about - the elapsed time is about two to three hours. So the team has to be scrambled, the flight has to get into the air, land in Bundaberg and the retrieval team has to get to the airport. So you estimate ordinarily two to three hours, is that - did I understand your evidence correctly?-- No, what I can clarify over here is that is when we intimate to the retrieval team after arranging a bed in ICU in Brisbane or ring hospital in Brisbane.

Yes?-- Normally after that event, we have confirmed bed availability, normally two to three hours they get to the Bundaberg Base Hospital to collect that patient.

Two to three hours?-- Yes.

All right. Well, just accept for the moment that Dr Carter's recollection for his report was that the request was logged at 4.20 but the aircraft was not dispatched until 7.30. You can't assist us with why that would have been?-- No.

You can't assist us, for example, with whether there was anything happening at Bundaberg as opposed to what was happening in Brisbane?-- No.

With the availability of the flight. Does your experience in Bundaberg tell you that sometimes the appropriate aircraft and team are not immediately available?-- Yes.

Because of other pressing duties?-- Yes.

It might be about to land somewhere and has to turn around?-- Yes.

And come out again?-- Yeah.

Righto. So anyway, we don't know. Now, we have got dispatch, according to Dr Carter at 7.30 p.m. but arrival at 11 p.m., 23:00 hours. Your memory tells you more like 10:00 p.m. but again we will get assistance from the log from RFDS, I imagine, but again if there was a delay there you can't assist us as to why that would be?-- No.

Right. Now, let's look at what then unfolded. Your memory is that by the time you came out of the emergency laparotomy, it wasn't a colonoscopy, was it?-- No, it was a laparotomy followed by a colonoscopic. There was - I heard there was a complication with the colonoscopy and since the patient was already - gut was prepared, they decided to proceed further and then-----

COMMISSIONER: There wouldn't normally be anaesthesia for colonoscopy, just sedation?-- No, we do give sedation and anaesthetists are always present for all scopes.

Did you attend the colonoscopy as well?-- No, at that time I was busy in ICU.

Right?-- What happens is after 6 o'clock or 5 o'clock, whoever anaesthetist on call, then he take over all the duties of ICU and theatre, and that's why I think about 6 o'clock Dr Martin Carter, he left the hospital.

MR DEVLIN: Thank you. Going further down your handwritten report, page 3, about six lines from the bottom, "Dr Carter very kindly accompanied the patient to the CT Scan room", which you have just told us, "As I was busy in an emergency laparotomy about 7 p.m. after finishing my anaesthesia, I reviewed the patient in ICU and found his BP again was very low." So by 7 p.m. the patient's condition as you recall had deteriorated?-- Yes.

We know from Dr Carter, if we just accept his times as correct, the retrieval flight started from Brisbane at 7.30 p.m.?-- Uh-huh.

Now, Dr Patel then, you say, also reviewed the patient, carrying on in your report?-- Yes.

So that indicates that the assessment by Dr Patel - are we correct in taking from your handwritten report two to three days after the events that Dr Patel's assessment of the patient occurred at about 7 p.m.?-- Yeah.

Because you have listed the next significant event in your report?-- Yes.

Are you okay with that?-- Yeah.

Okay. He decided to do an ultrasound guided pericardiocentesis in suspicion of a cardiac tamponade, right?-- Yes.

Now, my question about that assessment by Dr Patel: did you at that time have concern that that was not the correct assessment?-- I still say that even any - that CT Scan can still pick that one or two per cent of pericardio-tamponades, and if there is still a doubt in the clinical situation of the patient, the clear - I think the benefit of doubt should still be given to the patient and it is no harm for that procedure is attempted.

Thank you.

COMMISSIONER: What - given that the CT Scan didn't support that diagnosis, what other clinical indicators were there to suggest that that may be a problem?-- He had a chest injury.

Yes?-- He had fracture of the ribs and he was haemodynamically unstable.

MR DEVLIN: Now, as to the attempts that you witnessed then with the instrument, did you have concerns at the time you witnessed those attempts by Dr Patel that they were not appropriately or competently administered?-- I think, as I mentioned, two or three or four attempts. This is a normal thing because there is a lot of variation in different patients' anatomy, and, again, still guided but still partly a blind procedure, and I don't know how many familiar the surgeon was doing it over the ultrasound because I am not expert in doing ultrasound. So there is so many variable contributors to that. So I think they had been inclined to do when - he would have given up the procedure maybe five, six, seven attempts.

Right, so again you really at the time didn't come to any definitive view that what you were watching was indeed incompetent yourself? I am just looking at your own position on it?-- Yes.

Thank you. Go then to your report because there is one more aspect to what Dr Patel then attempted. In your report you say this: "Results of the procedure" - and are they your question marks?-- Yeah.

Do you mean to say that the results of the procedure were unknown to you, or inconclusive, or some other-----?-- That's inconclusive.

Inconclusive. And then you say - you think enough of it to put this in brackets: "(There was two to three ml of blood on one syringe aspiration which immediately clotted later on." What was the significance of putting that observation in your report, please?-- The significance is that the way, by my clinical experience and knowledge, if there is true blood taken out of the pericardial cavity, it doesn't clot. It is important, very entwined. So if the blood clots, it means it has not been taken out of the pericardial cavity.

So in your report you're really flagging that the procedure was really unsuccessful?-- Yes.

And inconclusive?-- Yes.

Thank you.

COMMISSIONER: And perhaps worse than that, that the fact that the blood clotted suggested he may have found the blood may have come from another source such as an artery?-- Yes.

MR DEVLIN: Now, the next part of your report is also important: "He had a detailed" - I take it you mean Dr Patel?-- Yeah.

"Had a detailed discussion with the family and explained the patient's condition and answered their relevant concerns about the patient." Let's just stop there for the moment. Are you reporting what you believe happened or were you present for that conversation?-- I was present, yes.

Was your view at that time that the patient was doing poorly?-- Yes.

Did Dr Patel convey more or less that position with reasonable accuracy to the relatives, do you recall?-- He didn't mention about his pericardiocentesis procedure to the patient.

What about conveying the general condition of Mr Bramich?-- Yeah, the - conveyed the critical position of the patient to the patient's relatives very clearly.

Do you remember anything else he said about the patient's condition apart from that general description?-- No.

Thank you. Let's go on then one more step. "He explained" - I presume again that's Dr Patel - "He explained" - pick that up?-- Yeah.

"To them that we have no plan to shift the patient to Brisbane (no good reason to move him). Diagnosis after CT pulmonary contusion, haemothorax contusion" - I can't pick up the word?-- "Massive".

"Massive", sorry, and, "The patient is also haemodynamically very unstable by that time.", and you have tabulated about 9 p.m.?-- Yeah.

That is an accurate rendering of what Dr Patel then said to Mrs Bramich or to the relatives, as far as you remember it?-- I think he gave a very clear and grave picture of the patient's condition, but he is really very, very sick, and there is everything chance that if we move him at that critical moment he might not make it to the - Brisbane.

Did you concur with that view? Did you agree with that view-----?-- Yes.

-----as it was put to the family?-- Yes.

Thank you. Now, of course, what we know is the flight's in the air?-- Yes.

So, can you help us with the practicalities of what Dr Patel said when you put it against the fact that expensive machinery and a crew, retrieval crew, have already been summonsed and are in the air? Was that a common thing that you'd say, "Well, we're going to retrieve them but we better make sure he's well enough to be retrieved."?-- No. I don't agree with that. Normally it doesn't happen but certainly Dr James Boyd came in after that, that, "I have received a telephonic message from the retrieval team, that they are on their way and they will be soon at Bundaberg Base Hospital."

Right. So, when it was explained in your presence to the relatives by Mr Patel you certainly did not know the retrieval team was in the air; is that right?-- Yes.

It was only just shortly after that that that news at least came to you?-- Yeah.

Righto. So, that at the point where those things were explained to the relatives, you also had the view that all the indications were that it would be unlikely that the patient would physically be able to withstand the transfer?-- Yes.

Okay. And you have noted in your report, if we just go down to about the fifth last handwritten line on that page?-- Yes.

"After about 20 minutes of that detailed discussion", so there

was, as you recalled it two or three days after these events, about 20 minutes of discussion with the family?-- Yes.

Thank you. Then it was Dr Boyd who told you that he'd just received a telephone message that the air retrieval team was on its way?-- Yes.

Then you say, "He", top of page 4, "in my presence conveyed this latest development to the family." I take it that's again a reference to Dr Patel?-- No, that one is a reference to-----

Dr Boyd?-- -----Dr James Boyd.

Dr Boyd. Thank you. At about 11 p.m. the retrieval team doctor had a detailed discussion with the family about the pros and cons of shifting the patient. Firstly, were you present when Dr Boyd advised the family that the retrieval team was on its way or was that just something you heard had happened?-- I'm not sure about that.

Thank you. What about when the retrieval team doctor spoke?-- At that time I was present.

And again when the retrieval team doctor gave the pros and cons of the transfer, I take it you were in agreement with the general information-----?-- Yes.

-----he was handing out?-- Yes.

Did you see it as being still a possible serious risk to Mr Bramich if he were to be air lifted? How were you seeing it by then?-- I think by that time the matter was over to the retrieval team, because they are an expert in that, and if - she particularly took over the charge of the patient from me and from James Boyd, even though we were assisting around the time. I still remember James Boyd put in an intercostal drain to that patient on the other side of the chest, on the left side of the chest.

Thank you?-- So, at that time she was - the retrieval team doctor was playing the main role and we were assisting.

Thank you. And when you say, "It was decided to shift the patient after another aggressive resuscitative effort as per the protocol", what are you referring to there?-- I say after having discussion with the patient's relatives they were of the vision and interest that the patient be - we accept the risks and we still wanted - the patient should be moved to Royal Brisbane - to the Brisbane hospital.

Right. Okay. But what was the aggressive resuscitative effort to be?-- They have got their own protocol because they know what complications can arise during the retrieval and that - putting a chest tube on the other side was a part of that aggressive management. She put some more IV lines. She started on more dosage of vasopressins, and they are more expert in that. They work that their own way.

I understand. I understand. So can we draw from that that the mood from the meeting from the relatives was, "Please, if you can transfer him, please do so"?-- Yes.

And the retrieval doctor, who was now in control of the situation with you assisting-----?-- Yeah.

-----responded along the lines of, "We'll do what we can to retrieve him and get him to Brisbane"?-- True.

Right. Thank you. Now, it was soon after that that unfortunately Mr Bramich arrested?-- Yeah, yeah, arrested and-----

That's all I wanted to ask about that. Now, just a couple of other matters then. Early in your evidence there was a discussion with the Commissioners about your knowledge that the Bundaberg ICU was a level 1 facility and in explaining yourself you said you understood that the ICU did not have a specialist intensivist?-- Yes.

Is that right?-- Yes.

Thank you. That leads me to this question. When you first commenced at Bundaberg Hospital, did you receive appropriate orientation to the level at which the hospital operated, aware it fitted in to the Q Health system as it were, or did you feel you had to learn on the job?-- I think, mmm, basically I learned on the job, bit of description from my Director of Anaesthesia.

Right. Was the learning on the job more to learn from your boss, Dr Carter, little bit by little bit how the Queensland hospital system operated so far as it affected the practice of your speciality?-- Yes.

In retrospect, do you feel that it would have been more helpful to you to receive some formal sessions of orientation, or do you feel that the way you did learn was as effective as it could be?-- I think if there would have been a formal session of orientation that would have been a better way.

What about looking at it this way, do you feel in retrospect that a period of service in a large tertiary hospital in Brisbane would have assisted you before you went to the provinces?-- That would have been a wonderful idea.

Thank you. Thanks very much, doctor.

COMMISSIONER: Thank you, Mr Devlin. Mr Diehm?

CROSS-EXAMINATION:

MR DIEHM: Thank you, Commissioner. My name is Geoffrey Diehm, and I appear for Dr Keating, doctor. I want to start on the evidence you have given concerning oesophagectomies. You mention in paragraph 9 of your statement that prior to Dr Patel performing these operations at the Bundaberg Hospital you had been involved in anaesthetising another patient when a locum surgeon performed an oesophagectomy?-- Yes.

On. Would that surgeon have been a Dr Faint?-- I think so.

And was that a matter of a month or two before Dr Patel's arrival?-- Yes.

Thank you. You also said in your evidence that there was another planned oesophagectomy to be performed by another surgeon but they opened the patient up and the surgeon just decided not to go ahead-----?-- He did.

-----with the procedure?-- I think it was - as far as I remember, it was the same surgeon who did the first oesophagectomy.

All right. Were they fairly close in time?-- Yeah, maybe one or two weeks distance apart.

Thank you. Now, I may have completely misheard your evidence, so forgive me when I ask you this, but did you also say that Dr Baker had performed-----?-- No, no, he didn't. He didn't perform any oesophagectomy.

He didn't?-- No.

Thank you. I did mishear you. With respect to Mr Grave, P18, as you may have referred to as in your statement, with respect to the dealings that you had with Dr Keating, I take it that after you formed your view that you indicated to the Commissioner that you were comfortable with, that this patient could stay for another 24 hours-----?-- Yes.

-----to see how he progressed, you communicated that view to Dr Keating?-- Yes.

And over that next 24 hours did you see the patient again?-- Yes.

And was Dr Keating in contact with you over that time period about the patient's progress?-- No.

Did Dr Keating speak to you again about the patient?-- No.

So I suggest to you that over the next day or so after you related your opinion to Dr Keating that he did keep in contact with you and ask you about the patient's progress. You say

that didn't happen?-- Mmm.

I'm sorry, it's my fault for asking you a negative question?-- How the system worked in Bundaberg Base Hospital is one person is on call, suppose that - they talk to me. He goes to ICU. He had been busy, suppose for all of the night in operation theatre and in ICU, so some time next day he's partly fatigued because a person has worked for more than 24 hours is not safe to proceed.

Yes?-- So, I mean, we don't have a system like that that someone is covering the ICU, next day's someone - that person comes and he covers the ICU, because we don't have a separate staff for ICU and for operation theatre. That's it. That day I was dealing with the patient, then I was asked to do a laparotomy with the patient for two and a half hours. I was blind what is happening with my patient, with Desmond Bramich. So, I'm sorry, that was - that had been working like that in Bundaberg because of huge shortage of the staff.

Because of what, sorry?-- A shortage of the staff.

Shortage of staff?-- We don't have separate staff on the ICU so we're not going to expect that ideal situation where the system runs very smoothly, we have got separate staff on ICU, we have got - and we don't have a full-time PHO or SHO in the ICU to attend the immediate - you know, matters concerning the patient condition. So somebody has to come from operation theatre to liaise with the patient. Things are not ideal at all.

No. Doctor, if I can suggest this to you, that over the time period between when you provided your assessment to Dr Keating-----?-- I don't recall where I was - where I was the next day, whether I was in ICU or I was doing operation theatre, I was - I was away from the hospital, I don't-----

COMMISSIONER: Doctor, I don't think Mr Diehm had finished his question?-- Sorry.

Why don't we wait and hear what the question is before you try and answer it?-- Right.

MR DIEHM: Doctor, what I'm suggesting to you is that over the next one to two days or, to be more precise, between the 17th when you provided your assessment of the patient to Dr Keating and the 20th when the patient was ultimately transferred out, Dr Keating had been kept informed at times about the patient's progress?-- Yes.

Now, that is consistent with your evidence, I think, earlier that you said that as far as you were concerned Dr Keating knew about the patient's-----?-- Yeah, he was aware.

-----progress. Are you unable to say whether you were involved at all in keeping Dr Keating informed of that progress?-- Yes.

So you're not certain as to whether or not you had any discussions with him about it. But the further part of my suggestion to you is that Dr Keating did not know about the fourth operation that was performed. You, I take it, are not in a position to say whether that's right or not?

COMMISSIONER: You can't recall telling Dr Keating about the fourth operation?-- No, I didn't inform him.

No. And you don't know if anyone else did?-- No.

So it's quite possible from your knowledge that Dr Keating was-----?-- Was not.

-----totally unaware of it?-- Yes.

Yes.

MR DIEHM: Thank you. But before I leave that fourth operation, if one were to gain the understanding from the notes that the fourth operation was performed in circumstances where everybody, Dr Patel included, had reached the conclusion that the patient had to be transferred-----?-- Yes.

But that - well, I'm sorry, I will stop there. I will start with that first proposition. Is it right that everybody had reached the conclusion, including Dr Patel, that the patient had to be transferred-----?-- Yes.

-----before the time of that fourth operation?-- Yes.

But that the view was taken that given that there was no bed immediately available, the patient's condition was such that he had to be immediately operated upon to save his life?-- Yes.

Thank you. Now, you say in paragraph 13 of your statement that, "The patient was transferred to Brisbane where he died after a stay there for a couple of months with some complications." Now, I understand that you have clarified that evidence this morning with what you have told us and I gather from what you have told us this morning that you are not particularly certain about what the patient's course was after he went to Brisbane?-- Yes.

But is it right that, as we gather from the balance of paragraph 13, that you did review the patients file prior to giving your statement so that you could understand and offer some evidence about what happened to him?-- Mmm.

Is that right?-- Yes.

Thank you. Doctor, when you looked at the patient file, did you see a note on one of the covers for the file that suggested that the patient died on the 8th of January 2004?-- Yes.

And had the patient returned to Bundaberg Hospital for reviews

approximately every month between September and the date of his death?-- I think I can recall from my memory Dr Patel talking about that patient, that, "Look, that patient survived, and he is some time coming to me for review at Bundaberg Base Hospital."

And do you recall seeing from the file, doctor, that the course that eventually transpired for this was that he developed some secondary cancer in his liver?-- I'm not aware of that.

Can I just ask you to look at this bundle of documents.

COMMISSIONER: Do you wish to have them projected or just shown to the witness?

MR DIEHM: Just shown to the doctor. I will try and deal with these as efficiently as possible, Commissioner. I just ask you to confirm that, in your view, those are extracts from the patient's file dealing with his course from August/September 2003 onwards?-- I think I have to take some time to go through all these notes. This is the first time-----

COMMISSIONER: You are not being asked to go through all of them?-- Yes.

Do you recognise they are the notes? Is that what they appear to be? You can take Mr Diehm's word for it that if that's-----?-- Yes, yes, yes, I can take.

That's what they are.

MR DIEHM: Thank you. Commissioner, I don't have any need to cross-examine the witness about the content of them but I thought it worthwhile for them to go on to the record.

COMMISSIONER: By all means.

MR DIEHM: So I tender them.

COMMISSIONER: Just in case I have fallen asleep and missed something, this is all relates to Mr Grave, is it?

MR DIEHM: Yes, Commissioner.

COMMISSIONER: Exhibit 259 will be an extract from medical file of Mr Grave.

ADMITTED AND MARKED "EXHIBIT 259"

MR DIEHM: Thank you, Commissioner. Doctor, I just wanted to ask you a couple more matters concerning Mr Grave. Mr Farr asked you some questions about particular dates upon which

procedures took place and they were to the effect that the original oesophagectomy was performed on the 6th of June, and that the next operation was performed on the 12th of June, and then the third operation on the 16th of June?-- Yes.

Now, the further matter that I wanted to put to you in terms of the chronology was that the patient during that course was in ICU without ventilation until the 13th of June. Does that accord with your recollection of the-----?-- Yes.

-----course? He was then discharged to the Surgical Ward?-- Yes.

And then he was admitted to the ICU on ventilation on the 15th of June?-- Yes.

Thank you. With respect to Mr Bramich, just a couple of questions. To understand - so that I at least can understand precisely what it is you are saying about the course there, in answer to questions from Mr Devlin you have said that the time which Dr Patel spoke to Mr Bramich's family, you agreed with the view that his condition was such that he wasn't fit for transfer?-- Yes.

I have that right?-- Yes.

And what my question for you is, though, is at the time that Dr Patel became involved in the management of Mr Bramich, was the patient fit for transfer in your opinion at that stage?-- I think that again I say that when he was shifted to ICU and he was intubated ventilated, and so I think that would be a window, roughly a period of two hours from 3.30 p.m. to 5, till he had his CT scan done.

Yes?-- And he was back to ICU from the CT scan from radiology department, which is about two hours.

COMMISSIONER: Dr Younis, that's where things start to get a bit complex, because in your statement you say it was 5 p.m. when Dr Patel decided to perform the pericardiocentesis, but what you have told us this morning is it wasn't at 5 p.m., that Dr Patel then went away and performed another operation, came back at 7 p.m. and did the pericardiocentesis?-- I-----

And by 7 p.m., from what you have said is the window had closed, the patient was then too sick to travel to Brisbane?-- I think maybe some lapse of my memory, but I say it was 7 p.m.

Well, by 7 p.m. you say there's this window of two hours from 3.30?-- Yeah.

So by 7 p.m. the window had well and truly closed?-- Yes.

So by the time Dr Patel came along the patient was too sick to go to Brisbane. Is that what you are saying?-- Yes.

MR DIEHM: Thank you, Commissioner. And was it at that point in time, what you now recollect as 7 o'clock, is that the

first involvement Dr Patel had with Mr Bramich?-- Yes.

Yes, thank you. Now, in your handwritten statement there is something I just want to ask you about again to make sure that I understand just what it is you are saying about the chronology of things, because you have spoken in your evidence about there having been earlier in the afternoon a decision made to transfer Mr Bramich, a decision made conjointly by yourself, Dr Carter and Dr Gaffield. But that's before the CT scan is taken, isn't it?-- Yes, it is, yes.

In your handwritten statement from - following the chronology that's set out at the bottom of the second page, over on to the top of the third page you seem to be saying there that after the CT scan was taken you went and spoke to Dr Gaffield in the operating theatre, and you talk about this at the top of the third page, "Talking to him about this development", which follows on immediately from you talking about the surgical PHO have communicated with Brisbane hospitals and having a positive response from the PA Hospital?-- Yes

So you go to talk to Dr Gaffield about that development and you say, "He was almost finishing his surgery in operating theatre, but he said that he will review the patient after just finishing the case, but it would be better to arrange a CT scan before a final decision is made." So is it right to say that whilst there had been this conjoint view reached between the three specialists, including yourself, that Mr Bramich should be transferred, that wasn't a final decision at that point in time?-- I think when they decided to do a CT abdomen, again it was a view of the surgeon that he might have been bleeding intra-abdominally. That might be a new development which is making him so unstable haemodynamically, and that was basically - CT was to rule out that abdominal catastrophe.

But is the effect of that that whilst - or that what had happened is that there had been a discussion between the three of you, you had reached the view that it looked like it would be in the best interests of the patient for him to be transferred, but that you needed to do some further test - i.e. a CT scan - before you could actually give the go-ahead for that process to happen?-- I think since so far there was not a confirmation of when the retrieval team is arriving, and we were not definitive that - everyone was working for the best interests of the patient, and okay, why not do that investigation. That might be a cause of his haemodynamic instability. And I think that decision was quite justified.

I'm not trying to question anybody's decision or suggest that anyone was doing anything-----?-- We were just trying to avail that time - maybe he had an abdominal catastrophe, and in that case we would have taken him to operation theatre to fix up the problem.

Yes. And had that been the case, that you found such a catastrophe, the patient would have been taken, as you say, to the operating theatre to fix that problem with a view to what happening after that?-- Even then, that would have been a big step and a big achievement. If we would have arrested the bleeding from the abdominal bleeding source there were good chances that he would have responded to our aggressive treatment to stabilise him for that thoracic injury, and in that case there would have been a good prospect to move him to Brisbane to take care of his thoracic injury.

Yes, all right. Thank you, doctor. Thank you, Commissioner. I have nothing further.

COMMISSIONER: Thank you. Ms Feeney?

MS FEENEY: I have nothing.

COMMISSIONER: Any re-examination, Mr Farr?

MR FARR: No, thank you.

COMMISSIONER: Mr Morzone?

MR MORZONE: No, thank you, Commissioner.

COMMISSIONER: Doctor, you're excused from formal attendance. I'd like to thank you, on behalf of the three of us, for taking the time to come down to Brisbane to give your evidence, which I'm sure we'll find very helpful?-- Thank you very much, Mr Commissioner, and the Deputy Commissioners and everybody listening to me. Thank you very much.

Doctor, I know that a couple of times while giving your evidence you may have been a bit apprehensive that people were being critical of you. Please understand that we have no criticism of you, that none of the questions you've been asked were designed to suggest that you have any personal responsibility for any of the tragedies associated with Dr Patel?-- Thank you very much.

Thank you?-- But I can say I did my best for more than two years to give my best services to the people of the Bundaberg Base Hospital regarding anaesthesia and intensive care.

I'm sure you did, doctor?-- Thank you very much. Thank you.

WITNESS EXCUSED

COMMISSIONER: Mr Morzone, do you wish to adjourn now and resume after lunch with - Dr Boyd, is it?

MR MORZONE: It is Dr Boyd, and he's the only other witness for the day, so there would be no-----

COMMISSIONER: Shall we really let our hair down and have a long lunch until 2 o'clock? Would that suit you?

MR MORZONE: Thank you, Mr Commissioner, yes.

COMMISSIONER: Two o'clock it is.

THE COMMISSION ADJOURNED AT 12.34 P.M. TILL 2 P.M.

THE COMMISSION RESUMED AT 2.06 P.M.

COMMISSIONER: Mr Andrews?

MR ANDREWS: I call Dr James Peter Boyd.

JAMES PETER BOYD, ON AFFIRMATION, EXAMINED:

MR FITZPATRICK: If the Commission pleases, I seek leave to appear for Dr Boyd.

COMMISSIONER: Yes.

MR FITZPATRICK: Commissioner Morris, the doctor has expressed a strong preference not to be filmed or to have his evidence audiotaped. He expresses it - he puts it merely on the basis that he's rather a shy person and he feels that he would more comfortably give his evidence if that were not to happen. I've explained to him-----

COMMISSIONER: That's entirely in order. I'm sorry, but there will be no video or audio recordings or photography during the evidence of Dr Boyd.

MR FITZPATRICK: Thank you, Commissioner.

COMMISSIONER: Dr Boyd, obviously we can't insulate you from being photographed as you come and leave the building?-- That's fine.

That's something you'll have to live with, I'm afraid?-- That's fine.

MR ANDREWS: Doctor, you are James Peter Boyd?-- Yes.

You've been kind enough to supply three statements. As I understand it from my copies, you signed one on 17 June 2005 of 35 paragraphs, a short one on 29 June 2005 of 12 paragraphs, and one that the Commissioners probably do not have which was provided today of 71 paragraphs that, from its exhibits, appears to have been signed by you on about 21 July?-- Correct.

COMMISSIONER: You have that almost right, Mr Andrews, except the 71 paragraph one is the only one I've got. It may have been supplied earlier and-----

D COMMISSIONER EDWARDS: It's the only one I've got too.

COMMISSIONER: -----it's back in my chambers.

D COMMISSIONER VIDER: I've got the 71 paragraph one, and the other one I had earlier, the 35 paragraph one.

COMMISSIONER: But in any event, for the moment we'll allocate the exhibit number 260 to all three statements collectively.

MR ANDREWS: Thank you, Commissioner.

COMMISSIONER: Exhibit 260 will comprise the three statements of Dr Boyd.

ADMITTED AND MARKED "EXHIBIT 260"

MR ANDREWS: Doctor, the facts recited in those statements, are they true to the best of your knowledge?-- Correct.

And where you express opinions, are they honestly held by you?-- They are honestly held opinions, but opinions.

Doctor, I'll commence by looking at the statement that's earliest in time, that of 17 June. It seems to me from that statement that by the time you arrived in Bundaberg on 17 January 2004 you'd worked in surgery for about eight years?-- That's including time in Papua New Guinea?

Yes?-- It would be four or five years in Australia - Queensland.

As I take it from your statement, after graduation in 1996 from the University of Papua New Guinea, you were a resident in surgery in PNG and then followed that in PNG with two years as a registrar in surgery?-- Correct.

When you moved to Australia in 2001 you were a senior house officer at the Rockhampton Base Hospital?-- Correct.

And were elevated to the position of principal house officer after three months?-- Correct.

You were a PHO in surgery in Toowoomba, then paragraph 7 says you worked in the Mater Hospital. Whereabouts? Is that in Brisbane or-----?-- Sorry, Mater Brisbane, public.

As a PHO?-- As a PHO in surgery, correct.

When you went to Bundaberg you began as a principal house officer. In one of your - in a document of yours anyway, I think you called yourself an unaccredited registrar?-- Yes.

Can you explain that?-- That essentially means - that's basically the same as a principal house officer. The term "principal house officer" and "registrar" are used interchangeably. Registrar is someone on a recognised surgical training scheme. Principal house officer isn't, but in the capacity as a registrar, if that clarifies that. I'm not sure.

It does, thank you?-- Thank you.

You spent about a year in Bundaberg at the base hospital?-- Correct.

Taking only about six weeks off in the second half of the year when you injured your Achilles tendon?-- Probably more like eight, I think.

In your first six months there you came to work mostly with Dr Patel?-- Correct.

Now, I'm interested to know, with your experience in surgery, whether you were in a position in 2004 to be able to judge whether the surgery you saw Dr Patel perform was as competently performed by him as it should have been. I assume that by the end of your career you will be in an excellent position to judge other surgeons. The point of my question is to determine whether at the time you went to Bundaberg you were sufficiently experienced to be a judge of surgical technique?-- That's difficult to say, but I can only comment on observation in the few years I've worked, and nothing seemed grossly - I use the word "grossly" - different or abnormal. I accepted a variation in practices of different surgeons, and Dr Patel having had 20, 25 years experience, I accepted there could have been some variations in different people, but I didn't, in my opinion, see anything grossly different or what I would have perceived as being wrong or abnormal.

COMMISSIONER: Dr Boyd, some of the witnesses who have given evidence already suggest that Dr Patel failed to clear a good area of vision when he opened the abdomen particularly, so that he wouldn't fold back the organs to give himself a good view of the organ he was working on. What would your comments be about his surgical technique in that regard?-- Can't really comment on that, but the times I've worked with him I didn't perceive we had that problem. We'd often start off with as small an incision as possible, which is generally - a general practice. If difficulties are encountered then you would expand the incision to improve the operative field. I never perceived us to have any - a poor visual view of the organs we were operating on in my, as I say, limited experience.

There's also been a suggestion that he was sometimes a bit rough or, perhaps you might say, brusque in the way in which he treated the internal organs, and it's suggested that may be connected, for example, with the number of times that spleens were damaged during his surgery. Did you make any observations of that nature?-- During my six months with Patel, which was the first six months, I cannot recall us taking out any spleens during bowel surgery. We did quite a bit of bowel surgery during that time. I have heard of some happening after, in the second six months, which - I wasn't there so I can't verify that. But to my memory we did a lot of bowel surgery, but very few spleens were taken out during my term, and I can only speak for the six months-----

Without focusing on spleens particularly, did you notice any difference between his style and that of other surgeons that you've seen, either before or since, with respect to the degree of care he took in handling the internal organs?-- I mean, there is the suggestion he was a bit rough, I've heard, but I never felt he was particularly rough with tissue. There is - in surgery there is a mode of dissection, actually, which involves the use of the hand rather than an instrument.

Sometimes that's perceived as being dangerous or rough, but the rationale behind the use of the hand is that you've got proprioception, which means you can feel what you're doing rather than an instrument that's cutting.

Yes?-- And so he did use a bit of hand dissection, which is rather than cutting with a scalpel or a pair of scissors, and sometimes I could see that looked - would be perceived as being rough, and that could be, I guess, varying opinions that that was rough. But I know it's an accepted form of surgical technique.

D COMMISSIONER EDWARDS: It's also been suggested that he tended to use one layer as a closure of - one layer of sutures as a closure of things, and things like that, and therefore there was possibly a greater incidence of dehiscence. Was that your experience?-- That's no different to most surgeons I've worked with.

Thank you?-- There's what we call a mass closure, which is just one layer closure.

So he pretty well followed the pattern of other surgeons?-- Pretty much. There was no difference in technique from that point of view.

MR ANDREWS: There was a patient who was treated at the Bundaberg Base Hospital called Ian Fleming. You refer to him from paragraph 15 of your first statement?-- Correct.

I gather from paragraph 18 of your statement you can't recall whether Dr Patel assisted you or not?-- By that, he would have been there during the course of the procedure. What tends to happen - part of the procedure I would help out, part he would do. I can't remember which was which. That's what's meant by that relationship.

Do you mean you recall the way you generally proceeded with Dr Patel's assistance, he doing one part and you doing another-----?-- Yes, correct.

-----but you don't recall any particular details about Mr Fleming's surgery?-- Not specific for him to anyone else, the other colonoscopies that we've done that I could remember specifically.

The next patient discussed, P22 - his name remains suppressed - do you have any recollection of that 94 year old man's surgery?-- Yes, I do.

And is it a recollection - is it a good recollection?-- Being 94 and having the disease he had, we knew the likelihood of a bad outcome was very high. In my recollections we - when I say "we", myself assisting Dr Patel - felt we just had to do the best we could with any situation we were in.

I see from paragraph 24 that a perforation occurred during surgery. Is it right to assume that the fecal contamination

occurred because of that perforation?-- Correct, yes.

You say that the perforation would have occurred in any event with a bowel dilated to that extent?-- Correct. That's the reason why we did the colonoscopic depression, was to prevent that from happening acutely.

Doctor, the way the statement reads, it gives to the reader the impression that the fecal contamination was a foregone conclusion, something most likely to happen because it was most likely that there would be a perforation. Is that what you intended to convey?-- Yeah, with the degree of dilatation he had of his intestine, the chance of a perforation was extremely high, yes, in either event. If we did not operate, we felt that was likely to happen, and if we operated, whilst doing the operation, that was still likely to happen.

Now, after that procedure do you recall whether there was any discussion of that case at a Morbidity & Mortality Meeting?

COMMISSIONER: Before you go on, Mr Andrews, my recollection is that when Dr Kariyawasam gave evidence, we concluded that we really didn't have any ongoing concerns about patient P22. I'm really only going from memory and-----

MR DIEHM: That's so, Commissioner.

COMMISSIONER: That is so?

MR DIEHM: That's so.

COMMISSIONER: I think we can probably skip over that patient for the moment.

MR ANDREWS: Thank you, Commissioner.

COMMISSIONER: I'm glad you're on the ball, Mr Diehm.

MR DIEHM: Sometimes, Commissioner.

MR ANDREWS: The patient P99 is discussed from paragraph 30 and following?-- Correct.

Do you recall her case?-- Yes, I do.

That's the patient Linda Parsons. The wound breakdown that required regular visits to the outpatient clinic, was that a breakdown that was to be anticipated?-- There's always - in any form of surgery there's always a risk of that happening. If I remember correctly, she was a little bit on the obese side, and that increases the chance somewhat of that happening. So there was a risk of that happening, but not perceivably - I mean, I can't quote figures, but there would have been a small risk of that happening.

And so the fact that there was a wound breakdown in this patient was not probable, but was a possible outcome?-- Yes, it's possible.

Do you recall whether there was any discussion about this patient at a Morbidity & Mortality Meeting?-- I can't recall exactly. With wound infections we often would list them. Most of the discussions were deaths and other complicated things. Wound infections were often just mentioned, "Six patients had wound infections that required suturing." So it may have been mentioned in that context, but not necessarily specifically.

During your period at the hospital, Morbidity & Mortality Meetings were held about monthly. Is that the case?-- That's correct.

And throughout your 12 months, about how many of them would you have attended?-- I was away for two months, so I probably would have attended eight to 10 perhaps.

And are you able to compare the topics discussed at the meetings at Bundaberg Hospital with topics discussed at meetings at other hospitals?-- They're pretty comparable. It depends on the size of the department to which the - how the meetings work, how many surgeons they had, and that would add a bit more variety. Bundaberg had a small surgical service, but pretty much similar.

And at the meetings attended by Dr Patel, did you say who had the - did anyone control the meetings?-- Would have been Dr Patel as the Director of Surgery.

And at such meetings who directed the discussion? That is, who selected the topics that would be-----?-- Topics would be selected often by the registrars, principal house officers going through the month, any deaths, complications. Cases of interest would be - would type them out on a small list, do a bit of a two or three page presentation, and then the discussions would stem around that.

And do you recall who was the most knowledgeable person during the course of discussions?-- Would have been Dr Patel.

D COMMISSIONER VIDER: Doctor, these officers were principal house officers, not registrars. Is that correct?-- Principal house officers, often called registrars in the context you'd have a consultant on call and you'd have a registrar. The registrar could be - it's often a loosely used term, principal house officer-----

But if it's not loosely used, a registrar denotes that it's a surgeon in training?-- That's right.

Somebody doing a training program?-- Yes.

That wasn't the case in Bundaberg?-- In Bundaberg we'd loosely be called registrars, but we were principal house officers.

But Dr Patel was not accredited with the Royal Australian College of Surgeons to be conducting that sort of surgical training?-- I guess that's correct, because there's no advanced recognised trainee there, yes.

That's correct?-- Yep.

MR ANDREWS: Would you put up on the screen, please, paragraph 12 of Exhibit 106, the statement of P99, Linda Parsons. Dr Boyd, your second statement of the 29th of June discusses Linda Parsons' treatment, and you refer to paragraph 12 of her statement. Do you see it on the screen?-- Paragraph 12 of the patient's statement, is that-----

Yes?-- Yes.

"Ms Parsons observes that her wound completely re-opened." Do you see that?-- Yes.

Do you recall that to be an accurate description of what happened?-- I recall the wound opening up. She used the word "dehiscence", which can imply a total breakdown of the deeper wound. That would amount to, by definition, dehiscence. She had - the deeper layer was not operated on, so it would have been a superficial wound breakdown.

Now, that definition of "dehiscence", is that one that was discussed at the Bundaberg Base Hospital?-- It was discussed from time to time what - we'd often use the term "wound breakdown", "superficial" or a "true dehiscence". "True dehiscence" usually meant there would be intestines and internal organs coming through.

And that, of course, would happen less often?-- Less often, of course, yes.

COMMISSIONER: Is this something that was discussed at Bundaberg, that you wouldn't call it a true dehiscence unless internal organs were showing through?-- That's our perception of the definition, correct.

Is that something that was discussed at Bundaberg?-- Yes, it was.

And who gave you to understand that you shouldn't call something a dehiscence unless internal organs were showing through?-- Patel mentioned that, and that was also my understanding of it as well, true dehiscence.

And when you say it was also your understanding as well, is that your understanding from what Patel told you or from something you were taught at university or you've learned-----?-- From something I've picked up over the years, and from either definitions in - and other surgeons around the place.

MR ANDREWS: In your own statement at paragraph 4, you say that-----

COMMISSIONER: I wonder if you might get Exhibit 90?

MR ANDREWS: You say that this is what you would have aimed to achieve?-- That's correct.

So the opening of the wound is something you would have aimed to achieve, is it?-- Correct. When - when you develop a swelling or collection underneath that causes a lot of pain from the pressure effect, and we would often remove the sutures to relieve the pressure and tension, and in the process the wound would then open up further, and this usually gave relief because you relieve the pressure from fluid that's built up under the wound.

COMMISSIONER: Doctor, we have been provided with a definition of wound dehiscence - and I will read it out to you. Perhaps it is easier to put it on the screen. You see, this is from Exhibit 90. It refers to "separation of the layers of the surgical wound. It may be partial, or only superficial, or complete separation of the layers, and total disruption, complete dehiscence of the abdominal wound usually leads to a evisceration." I take it, from what you said earlier, that you would disagree with that definition, that the only thing that could be called dehiscence, on your view, is what's referred to as a complete dehiscence?-- That's when I use true dehiscence, I guess, would probably correlate with complete dehiscence.

I see. Yes.

MR ANDREWS: May I have paragraph 12 back on the display? Do you recall the treatment of Ms Parsons and this particular partial dehiscence?-- Yes, I do.

Is it correct then that you were anticipating that Ms Parsons' wound would, rather than be healing, that it would, on the occasion of this visit, have not yet healed and that it would need to be re-opened?-- I don't quite understand what-----

Well, the visit - I beg your pardon, the occasion referred to in paragraph 12 of Ms Parsons' statement, do you recall that occasion?-- I recall that occasion, yes.

When you saw Ms Parsons on that day, were you anticipating that she - that her wound would dehisce, or were you anticipating that it would not dehisce, or is it the case you don't remember what you were anticipating?-- With - once she has a bit of swelling underneath and a lot of pain, and we get a bit of seepage coming through the wound, then, yes, we would anticipate that the wound would break down or we would have to remove the sutures to relieve the swelling underneath. So once we see swelling, seepage coming through the dressing, yes, we would anticipate that that would happen.

You had the opportunity, while you were at the hospital, to observe other surgeons?-- Yes, I did work with Dr Gaffield in the second six months and Dr Anderson and Dr Kingston were the other surgeons there.

And so far as wound - I beg your pardon, infection control procedures were concerned, did you see any difference between Dr Patel and the others with whom you worked, either then or elsewhere?-- My recollection of wound infections in Bundaberg were variable, in that we saw there would be stretches of time where there wouldn't be any infections and there would be times we would get a run of infections. I did notice other surgeons did get some degree of wound infection but I never made a tally or statistics or anything to compare.

Were the runs of wound infection ever the subject of discussion at morbidity and mortality meetings?-- Yeah, we would have a segment listing wound infections and wound breakdowns.

Do you recall whether conclusions were ever drawn as to the cause of these wound infections?-- No, we never really came down to any conclusion or cause as to specifics of the wound infections.

And do you recall whether at those meetings there were ever any conclusions drawn as to the cause of wound breakdowns?-- It would be similar to wound infections.

You mean no conclusions were ever drawn?-- No specific conclusions.

Did you yourself observe that there were numerous wound infections associated with Dr Patel's surgery?-- I did notice there were a few wound infections. I also noted that he did quite a lot of operations as well, so.

You assumed he would have more because he did more surgery?-- He did more surgery, and I accepted that would be the case, and he did most of the bowel surgery which comes with higher rates of infection. So I accept that we would be expecting that.

Dr Patel performed several oesophagectomies during your time at the hospital?-- I have heard of that but I was never there present in any of them. This was just anecdotal, what I heard when I got to Bundaberg.

And when you were there, the anecdotal stories you heard were, what, about Dr Patel's oesophagectomies?-- I just heard that some people would say they shouldn't be done here, and that's all I heard. But these were just talk that would go around in circles of the hospital, but I can't make any conclusion, any comment further than that.

COMMISSIONER: Do you recall who you heard that from?-- No, not specifically, no.

All right. Was it only related to oesophagectomies, or did it also include other complex operations, such as Whipples procedures?-- It just revolved around oesophagectomies.

In your own experience, would you regard a Whipples procedure as being of a similar order of magnitude of complexity to an oesophagectomy?-- I wouldn't want to make a comment on that, but, I mean, they are both major operations. It wouldn't be appropriate to compare both, but I know that they fit into - if you want to put major, minor or intermediate, they would both be major cases.

Put it this way: if one of them is too complex to do at a particular hospital, would it necessarily follow that the other is also too complex to do at that hospital?-- Again, I can't say that because I have worked a few other places where they have done Whipples as well, but at the same time I don't recall them doing oesophagectomies. So it would be hard to put both in the same basket, as such.

Thank you.

MR ANDREWS: You did observe Dr Patel to do some operations on the pancreas?-- I do recall one case offhand.

That was complex surgery?-- The circumstances surrounding that involved the patient who was already anaesthetised and it wasn't a planned Whipples, it was meant to be another operation. However, there was a radiological diagnosis of small bowel disease and we found the Whipples - pancreatic disease intraoperatively, and my memory of that was a discussion between the anaesthetist surgeon, that, "We have got this patient anaesthetised already, are we to proceed?", and I think the surgery went ahead after that.

That discussion would have been, what, between the surgeon, Dr Patel, and the anaesthetist?-- Correct.

And Dr Patel would have been asking the surgeon whether it was safe at that stage?-- Sorry, anaesthetist, you mean?

Dr Patel would have been asking the anaesthetist whether it was to proceed?-- Correct, yes.

And that opinion that was sought would have been to do with the efficacy of the anaesthetic that had been administered?-- I think she was an elderly woman, and it was a question of duration of anaesthesia, would she be able to tolerate that, and post-operatively - post-operative care as well.

Do you recall what happened to that patient?-- From memory, she had an excellent outcome. I remember seeing her in the outpatients on one occasion.

Now, how often did Dr Patel perform surgery of a kind that you thought was complex?-- I think that Whipples would have been one I remembered. There was never any oesophagectomies done during my six months, from my observation. Most of them were

varying degrees of bowel surgery, that I can recall, and nothing I'd call complex, from memory.

Well, the Whipples that you saw Dr Patel perform, is that a procedure that you would, in your opinion, regard as appropriate for the Bundaberg Base Hospital?-- If you are just talking Whipples, probably not. This was a slightly different situation, in that the decision had to be made intraoperatively. She was already anaesthetised, she was quite thin, and disease of the pancreas, according to Dr Patel, he felt was easily resectable in the patient and that ended up being the case, as far as I can recall.

COMMISSIONER: Doctor, when they talk about the complexity of surgery and whether Bundaberg is an appropriate place to do it, you would agree that one of the factors is that Bundaberg only had a Level 1 ICU?-- Correct, I understand that the ICU is limited, yes.

And you understood that that meant there were only, I think, two ventilated beds?-- Correct, yes.

And that it was expected that the maximum duration in ICU would be 24 to 48 hours?-- Yes, I understood that to be the case.

All right. One of the reasons then for not doing more complex procedures would be that you would fill up the ICU with those patients and not have spare beds in ICU for emergency cases?-- That's correct.

So in that sense, at least, Whipples and oesophagectomies would both be major, in the sense they are both operations which could be expected to lead to a patient remaining in ICU-----?-- Correct.

-----for longer than those facilities were designed to accommodate?-- Correct, yes.

D COMMISSIONER VIDER: Doctor, can I just make a comment to you? We have had evidence given to us now of a doctor who is seeing a lot of Dr Patel's patients for their follow-up care?-- Okay.

151 patients have so far been seen by that doctor, and he has got quite a comprehensive assessment of some of the complications of Dr Patel's surgery. It might be useful to you to go and have a look at the transcript of that evidence from last Friday, given that you are someone in training or learning surgery, if you like. You might find some of that assessment quite useful to you, now that you had a term in Bundaberg and you had worked with Dr Patel, because the evidence that's been presented here to us is of the fact that Dr Patel did do a lot of surgery. For example, he did a lot of laparoscopic cholecystectomies?-- Correct.

But he also, in that procedure, didn't do an operative cholangiogram?-- That's correct.

And that has contributed to a lot of complications that are now requiring further follow-up surgery. It has also been revealed that Dr Patel was not particularly robust about an accurate preoperative diagnosis, which meant that he didn't always do the correct surgery, or certainly organs removed or resected didn't have a corresponding pathological report to demonstrate the disease that he had said preoperatively the patient had. Are you aware of any of that?-- I can't comment on that, but that's-----

Well, that's been given in evidence now for us and that's an established fact. So from your point of view of where you are at in your career, you might find that evidence of interest to you?-- Yep, I will have a look at that, thank you.

COMMISSIONER: And just following on the Deputy Commissioner's question, other issues were raised by that same surgeon, issues about Dr Patel missing a second cancer or even a primary cancer, so that, for example, when he was removing cancerous growth from a patient's rectum, he found one cancer but missed the one that was further down the rectal passage; or removing a skin cancer, he removed the secondary cancer but didn't identify the primary cancer and remove that. This is all news to you, I take it?-- That's possible. This is all news to me. I can't comment in either way on that.

MR ANDREWS: Doctor, one of the comments made by Deputy Commissioner Vider, because it is jargon I am unfamiliar with, I would like you to correct me if I am wrong, but I thought I heard mention of - was it operative cholangiograms?-- Correct, that's the term used.

And there was a suggestion that Dr Patel did not perform operative cholangiograms, and I thought I saw you acknowledge that you knew that?-- That's correct, and Dr Gaffield also didn't perform operative cholangiograms. And I accept that that may have been the practice in the States, so I couldn't argue bad practice/good practice. I accepted that both of them did it that way, and the rationale given was that operative cholangiograms required radiology services to be teed up, organised, and that involved coordinating with the radiology department, and we did have limited radiology services, and this involved anaesthetic time as well because the patient would be in theatre under anaesthesia, and my understanding was the feeling that it was going to delay - use up a lot of anaesthetic time, and I accepted that that may have been their practice in the States, so it was what I observed in both surgeons.

COMMISSIONER: Doctor, do I take it from what you have just said there was actually a discussion with one or other of the surgeons as to whether or not they should undertake that procedure?-- That's correct. I do recall verbally asking Patel about - because my experience in other hospitals, everyone tended to do cholangiograms-----

And-----?-- -----and-----

From what we have been told, and I would like your comment on this, is that cholangiograms are regarded as best practice amongst Australian surgeons because it can identify potential complications arising from the primary operation?-- I wouldn't be an expert to comment on that but that seems to be what I gather from practice of other Australian surgeons, yes.

And when you spoke to Dr Patel about it, did he tell you that he preferred not to because there was no radiologist available and because it would result in the patient being under anaesthesia for longer than otherwise?-- He - we did discuss this. He mentioned basically the difficulties in getting radiology services, getting angiograms, getting X-rays done, was a bit more involved and needed to be done regularly, and his feeling was that that was going to consume more anaesthetic time, so his option was not to do that.

He didn't suggest to you that, for example, in the United States it is not the practice to have cholangiograms in those cases?-- He never specifically mentioned, it was just my observation, given that both were surgeons trained in the USA.

But certainly from your experience in other Queensland hospitals, your observation was that experienced Australian-trained surgeons invariably used cholangiograms in those cases?-- I would say pretty much nearly all or most, yeah, would be used.

It would be obvious to you that that was a prophylactic step to check that there weren't going to be any complications from the surgery?-- That's correct. That was to image the rest of the bile duct system.

D COMMISSIONER EDWARDS: Also to exclude any calculus or things like that within the bile duct?-- That's correct, yes.

COMMISSIONER: And am I right in thinking that the radiology services, the necessary radiology services were available in Bundaberg, it was just a bit more difficult and time consuming to get them lined up?-- It was a bit of - we didn't have a radiologist on site.

No?-- And variable radiographers, which meant they - there could be substantial delays in getting Image Intensifier to the theatre, getting orientation, getting everything set up, and I think that was - that was the way I believed Dr Patel and Dr Gaffield felt about not doing-----

You mentioned Dr Gaffield, but Dr Patel did the great majority of the abdominal surgery, didn't he?-- That's correct.

So if you had seen Dr Gaffield doing this sort of procedure, it would have been only a very small number of occasions?-- He did do gall bladder surgery. That was probably the area where they equally did surgery, gall bladder. Bowel surgery was often mostly left to Dr Patel.

I am concerned to know, doctor - and I want to give you an opportunity to comment on this - whether it was a case, as one might infer from what you have said of Dr Patel, simply cutting corners and not taking the more careful procedures that are standard amongst Australian-trained surgeons?-- One might perceive that. However, I did see that with Dr Gaffield, so I accepted perhaps they were senior to me, they worked in the States, and I left the issue at that.

Dr Boyd, of course this isn't meant as criticism of you, you are simply here as a witness to tell us what you saw, but you would agree there is at least the appearance of Dr Patel having cut corners?-- Possibly, yes.

MR ANDREWS: The failure to do operative cholangiograms, was that ever a topic raised in a mortality and morbidity meeting?-- It did occur, on odd occasions we would mention it.

Who is "we"?-- The surgical team, Dr Patel, Gaffield, myself, or one of the other PHOs might bring up the issue about doing a cholangiogram.

COMMISSIONER: Doctor, I am sorry to keep interrupting. You do mention in your statement that you sometimes worked with visiting specialists, such as Dr Kingston and Dr Anderson?-- That's correct.

Did you ever discuss this matter with either of them?-- I didn't specifically discuss it with them, no.

Did you see either of them removing gall bladders?-- They didn't do that at the Bundaberg Base Hospital.

All right?-- Dr Anderson, whilst a general surgeon, he did only urology work at the Base Hospital.

And Dr Kingston was mainly on call for emergency surgery?-- He was early on but then he retired from doing that and he did a small elective session, half a day, which I don't recall having gall bladders on.

Okay, thank you.

MR ANDREWS: Doctor, I am trying to understand the mortality and morbidity meetings. If cholangiograms were a topic of discussion at them, do you recall what it was that was concluded about them at the meeting or do you not have a recollection?-- Pretty much what I have said about difficulties with radiology and the fact that it seemed to be his practice, I guess. That was how I left the issue.

That it seemed to be the practice of Dr Patel and so you left it at that?-- And Gaffield.

And you - am I right in thinking that you assumed that was the way of the surgery in the United States of America rather than-----?-- I assumed that was the way he was trained in

doing them.

But it is not something that Dr Patel, nor Dr Gaffield told you; it was your assumption?-- Correct, it is not something they would tell me specifically.

And you as a PHO wouldn't, I suppose, have challenged them to say, "I have seen it done in other places in Australia, that is an operative cholangiogram. Why aren't you doing it, too."?-- That's what I did, and we brought up discussion about difficulty getting radiology, and that's what is done. Once the discussion has been made once, it is inappropriate for me to bring it up a second time as a PHO up there.

When notes were written up in theatre, as I understand your evidence they might have been written either by the PHO or a registrar or even by the surgeon?-- That's correct. Yep.

Now, in paragraph 18 of your statement of the 21st of July you observe that Dr Patel would discuss the patient and the junior doctors would write the clinical notes?-- Yes, that's correct. I have written that somewhere, I think.

Paragraph 18, the second sentence. It's on page 4. And if it's not there, you are looking at the wrong statement?-- Is it-----

I am looking at a statement of 12 pages and 71 paragraphs?-- Oh.

At paragraph 18?-- That's correct, yes.

COMMISSIONER: Mr Andrews, I'm concerned we are going to get confused amongst these three statements. So just to avoid such confusion, what I propose is that the statement of 17 June 2005 of six pages and 35 paragraphs we can call 260A. 260B will be the statement of the 29th of June of three pages and 12 paragraphs. I say this, Mr Andrews, because I must admit I was looking for the wrong statement as well. So the final statement, which I think is undated on my copy but in any event it goes for 12 pages and comprises 71 paragraphs, will be 260C.

MR ANDREWS: Thank you, Commissioner. Looking at paragraph 18 of Exhibit 260C, the second sentence reads that, "Dr Patel would discuss the patient and the junior doctors would write the clinical notes."?-- Yes.

Would the notes be written during Dr Patel's discussion of the patient?-- Any time from there - there afterwards.

I gather from the way you have prepared that statement that a typical event would be that Dr Patel would be discussing the patient and the junior doctors would write the notes during the course of that discussion. Would that be typical?-- There's two aspects here. There's the notes in the operating theatre, which would be done there and then, and ward round notes would be written after ward rounds.

I see.

COMMISSIONER: I think Mr Andrews' question, though, went to the issue of who actually wrote them. So let's go through them one at a time. The operating theatre notes?-- The operating theatre notes would be written by either the Principal House Officer or Dr Patel himself. It would vary between - usually - usual practice would be the Principal House Officer.

And in some cases would both make notes, so Dr Patel might, for example, put in the details of the operation he intended to perform and then the PHO might put in details of any

eventualities that occurred during surgery?-- We rarely got two people writing. It was just the one person.

Okay?-- So I can't recall a situation where the Principal House Officer would write something, Dr Patel would write something. It was usually one or the other.

Right. And who normally made the notes with the ward rounds?-- It's usually the most junior member of the team, which would have been the intern.

MR ANDREWS: And on the ward rounds, that intern would be making the notes as Dr Patel would be discussing the patient?-- Usually after we have finished ward rounds. We would wander off to theatre and the intern would be in the wards looking after things, and that's when they usually do the notes, and that's standard.

COMMISSIONER: Is it standard, then, for the surgeon or the consultant to check the notes and initial them or just make sure that they are accurate?-- Some surgeons would check them, but not all surgeons, in my experience, do that.

And what was Dr Patel's practice?-- Bit of both, I think. He sometimes did, sometimes didn't. I can't say for sure that he would go through everything finely. Sometimes he would. I can't say for sure.

Doctor, why this is of concern, at least to me - I can't speak for anyone else - is that a number of instances have been identified of cases where the notes prepared either by Dr Patel or under his direction would indicate, for example, that the patient was doing well or that the patient was haemodynamically stable, or something like that, but there are strong indications that that wasn't true. For example, there'd be a record of the amount of blood transfused to the patient, which would be quite inconsistent with the assertion that the patient was stable. You understand what I'm driving at?-- I understand what you are saying, yes.

All right. So, obviously we can identify those cases where Dr Patel wrote up his own notes, but in those cases where Dr Patel didn't actually write the notes himself, was it his practice to tell the junior staff what to write?-- Not specifically. Ward rounds and - ward rounds, basically you see patients, see how they are doing. There would be discussion, "Okay, the plan today is to do this, this and this." That would be what's written, how he's doing, output from drains, blood pressure, heart rate, all of that sort of stuff was usually observations that the intern could pick up from the chart.

Well, how, then, are we to explain situations where Dr Patel's notes suggest that the patient is doing well, haemodynamically stable, improving and so on, and yet when you look at other records from the same point in time you have the nursing notes showing that the blood pressure is low, that the temperature is high, that significant quantities of blood are used for

transfusion, those sort of inconsistencies?-- I can't comment on any specifics, but I do know Dr Patel would write most of the notes in intensive care.

Yes?-- That was where he wrote most of the notes, because he - he would start ward rounds probably ahead of us. So he would do his rounds in intensive care, and that's pretty much where he wrote most of the notes, and the ward patients were usually written by the intern or occasionally myself or any of the Principal House Officers.

D COMMISSIONER EDWARDS: What is position relative to nursing notes these days, are they kept separately from the main chart and then collated as the patient leaves hospital?-- Usually written together in the same chart.

Thank you?-- You get medical notes, physiotherapy notes, nursing notes in the same ward chart, yes.

COMMISSIONER: Mr Andrews, might that be a convenient time for a short comfort stop?

MS FEENEY: Commissioner, before we arise, you mentioned before lunch whether my client wished to make an application in relation to witness orders. I have discussed that matter with Mr Ashton. We have made our views clear to Counsel Assisting. We don't intend to push the matter further by way of an application.

COMMISSIONER: All right. Well, you are content, then, to leave that decision to Counsel Assisting and you don't want me to consider it?

MS FEENEY: Yes, thank you, Commissioner.

HIS HONOUR: Thank you.

THE COMMISSION ADJOURNED AT 3.08 P.M.

THE COMMISSION RESUMED AT 3.33 P.M.

JAMES PETER BOYD, CONTINUING EXAMINATION-IN-CHIEF:

COMMISSIONER: Mr Andrew, I envisage you are getting close to dealing with the case of the late Mr Bramich. Given the evidence we have heard this morning, it seems to me that if there's any criticism of Dr Patel it relates only to the form of treatment that was administered in the last hours of Mr Bramich's life. The evidence this stage seems to suggest that whilst Dr Patel may have been quite mistaken in his view that Mr Bramich ought not be transferred to Brisbane, that probably didn't contribute to the death of Mr Bramich.

Now, ultimately we will hear submissions about that and we may be urged to take a different viewpoint, but unless anyone wishes to urge otherwise, I don't think we need to spend a lot of time on the present witness's knowledge of and involvement in that treatment.

MR ANDREWS: I see the logic of what you recommend, Commissioner. It, with respect, accords with my own intended approach. I did when reaching the case of Mr Bramich intend from Dr Boyd simply to put together any pieces of the jigsaw that he may be able to supply that remain unclear.

COMMISSIONER: I appreciate that, thank you.

MR HARPER: Commissioner, I should foreshadow - obviously it is up to Counsel Assisting the line of questioning they seek to pursue - there will be matters regarding the treatment of Mr Bramich which I would like to ask.

COMMISSIONER: Nothing I say will limit you in pursuing those matters if so instructed.

MR HARPER: Thank you.

COMMISSIONER: Thank you, Mr Andrews.

MR ANDREWS: While at the Bundaberg Hospital were aware - according to paragraph 22 of Exhibit 260C you were aware that other units preferred Dr Gaffield to operate on their patients?-- That's correct.

Dr Boyd, I'm interested in your recollection as opposed to what's printed in your statement?-- Can you remind me which paragraph it was?

COMMISSIONER: It's 22 on page 5?-- 22.

MR ANDREWS: I am informing myself, Dr Boyd, from what is written in your statement and rather hoping that you could give me your own independent recollection, unless it is the case that you have forgotten. Now, Dr Boyd, while you were at the Bundaberg Base Hospital, were you aware that there were other units at the hospital that preferred Dr Gaffield should operate on the patients from those units rather than that

Dr Patel should do so?-- That's correct.

Apart from the Renal Unit, what other units preferred Dr Gaffield to operate on their patients?-- As far as I can recall it's only the Renal Unit comes to mind.

And what discussions did you have with others about the fact that the Renal Unit preferred using Dr Gaffield? Were there any discussions you had with other staff at the hospital?-- I could only infer that from the Renal Unit Principal House Officers, who would contact me regarding one of their patients who - requiring surgery, and they would tell me, "Our consultant prefers - asked me to speak to you to speak to Dr Gaffield specifically."

And did you ever ask why the consultant preferred Dr Gaffield?-- I asked why and I was always told there's been some issues, some problems in the past, and I left it at that.

Do you mean none of them ever suggested to you that the problems were with Dr Patel's competence?-- It involved a bit of that, correct, yes.

COMMISSIONER: What else other than competence?-- I was told that there was some dispute between the Renal Unit and Dr Patel. I can't say what precipitated it, what it was from, and all I was told was that there was some issues, some problems, and that's what it was - and that's why they specifically asked Dr Gaffield to do the procedures.

MR ANDREWS: Anastomotic leaks, you recall that there was an issue relating to them?-- Yes, we did have a couple of anastomotic leaks during the time.

Did you ever discuss them at your Morbidity and Mortality Meetings?-- Yes, they did crop up in discussions.

Did anyone ever draw a conclusion as to why you were having anastomotic leaks?-- We accepted that in bowel surgery there's always a chance of anastomotic leak when joining two segments of bowel together, and we accepted that that was a complication. In terms of whether it was a high rate or not, I can't - can't give an opinion about that.

COMMISSIONER: Was it higher than you'd experienced elsewhere?-- I can't give an opinion on that because I felt we did quite - as I say, quite a lot of bowel surgery, and I thought perhaps we would get a bit more anastomotic leaks from that, but I can't correlate numbers of anastomotic leaks with total operations done to give those figures.

MR ANDREWS: You saw Dr Gaffield to have problems with wound infections?-- I did know that every surgeon had some degree of wound infection, correct, yes.

Well, do you mean every surgeon who worked at the Bundaberg Hospital?-- Sorry-----

Or do you know-----?-- Sorry, I will verify that. All other surgeons at Bundaberg, yeah, at the base hospital.

Had problems with wound infections?-- I did know we had one or two with Dr Kingston on one occasion. There was a session where both cases on the one day developed bad wound infections and I remember trying to work out what caused it, what was - what it was created from. We had a bit of discussion with Dr Kingston about that, but we didn't really come to any conclusion about that.

Did you discuss - did you raise it at a Mortality and Morbidity Meeting?-- Yes, that was discussed.

D COMMISSIONER EDWARDS: Was there a procedure by which there was some form of collation relative to the cause of that wound dehiscence - infection?-- I can't say - can't say for sure, because the two cases I remember were two straightforward hernia operations. They both got infected, both done in the same theatre, and that did cause some questions as to why this happened, but I don't think we really came to any full conclusion.

But you would think it fairly rare to have a wound infection in a hernia operation?-- That's correct, yes.

COMMISSIONER: Doctor, in your statement, paragraph 29, you say that you didn't see anything about Dr Patel's infection control practices that gave you cause for concern. We've received evidence from staff at the hospital who say that in substance Dr Patel's septic procedures were very ordinary, but, for example, within the Surgical Ward he would look at a patient, peel back the dressing on the patient's wound with his bare hands, and then move straight on to another patient and repeat that process without washing his hands in between. Did you observe things like that?-- I did notice that - I would say that probably did happen.

Well, why did you say in your statement that there was nothing that gave you cause for concern?-- This was - this - I probably have to clarify, I was referring to operative - the operating theatre, as compared toward rounds and ward patients.

It's also been suggested, for example, he would wear his ward dress out of the - sorry, his surgery clothing out of the surgery and into other nonsterile parts of the hospital. Did you observe that happening?-- That happened, yes.

That would be a cause for concern, wouldn't it?-- But that happened everywhere else as well, and I didn't see that as unique to Bundaberg.

I see.

D COMMISSIONER VIDER: What do you mean that happened everywhere else?-- In other hospitals I have worked, theatre gowns from the operating theatre to the ward - people would

walk out of the theatre into wards and back again in between cases, and I have noticed that happened in other hospitals as well.

Without changing the - their attire?-- Without changing their attire. This is-----

They didn't put an overgown on?-- Sometimes they did.

They didn't put overshoes on?-- Sometimes they did, sometimes they didn't.

D COMMISSIONER EDWARDS: You wouldn't consider that acceptable practice, surely?-- Probably not but I have observed it so I couldn't really say - you know, I have seen it elsewhere. It seems to be done. It doesn't seem to be any different.

COMMISSIONER: Do you recall the person in charge of infection control at the hospital raising concerns and complaints about Dr Patel's hygiene practices?-- I vaguely remember a circular passed around. I can't remember exactly what was said.

MR ANDREWS: Do you recall who the person was who was in charge of infection control at the hospital?-- I haven't specifically spoken with the person, but I did know that it was someone who looked after infection control.

So you wouldn't be able to identify which staff member that was?-- No, I wouldn't.

Do you recall Gail Aylmer, A-Y-L-M-E-R?-- I remember seeing her name on the infectious control circulars and things, yes.

You signed, with several other staff members, a letter of support of the 14th of January 2005. Do you recall that?-- That's correct.

Do you know who the author was?-- I think it was a collaborative effort between five of us with - I think Anthony did most of the writing on that and we all had a look and signed it in conjunction.

Were you in a - I've highlighted a couple of sections from that letter. Were you sufficiently experienced by January of this year to be able to judge whether Dr Patel's management of surgical problems was expert, ordinary or less than reasonable? So I'm asking about your capacity at the moment, not Dr Patel's - your capacity to judge his degree of expertise?-- I'd say reasonable.

And do you retain the opinion that the surgical unit - which I suppose was really a unit of Dr Patel and Dr Gaffield in your time-----?-- Correct, that's right.

-----provided - developed an outstanding service providing quality health care?-- I mean, I'd be reluctant to use absolute terms like "outstanding", but I would say "very good", "reasonable". I'd probably use those sort of words. I wouldn't say "extremely outstanding" or, you know, strong descriptive words of that sort, but-----

COMMISSIONER: Doctor, were you the most senior of the signatories to this letter? Perhaps it can be scrolled up?-- Can I just see the - it would be myself and Dr Kariyawasam, but I think I'd have a few more years experience than him, I think.

Even from what you've told us, for example, in relation to the gallbladder operations, it was obvious to you, wasn't it, that Dr Patel wasn't conducting surgery to the highest and best standards?-- Can't comment on that. I just accepted it as a variation in practice. That's the way I saw it.

Doctor, you'd seen the radiology undertaken at other hospitals and you knew that the surgeons involved in that - in requiring that radiology weren't just doing it to waste money or to waste time. They were doing it because it was in the interests of the patients?-- Understandable, yes.

And Dr Patel wasn't?-- He didn't do that, but I'm only speaking for myself. I can only say the way I saw it. Bundaberg was a smaller hospital. Perhaps the bigger hospitals do it regularly so they have a system in place that they could keep doing it regularly, it ran routinely, and a feeling there, perhaps, was Bundaberg wasn't quite like that.

You see, doctor, I'd be reluctant to be critical of anyone who signed this letter, particularly the younger staff, but with your - I think you said you had eight years' experience in surgery?-- Yes, that's correct, but-----

If we scroll it back down again to where we were before, you'd accept, wouldn't you, that it's not very helpful to say, as you do in the second paragraph on screen, to talk about "his efforts to ensure that his patients received the best care"?-- I would use it in the context of "best care", I felt based on a number of things - he saw his patients regularly, he would come in on weekends. Even when he wasn't on call he would come to see his patients, and he always wanted to be contacted about his patients and their care in the hospital, and I consider that to be good management and care of patients, putting aside technical expertise and decision making. So in that context I thought he gave good service to his patients.

D COMMISSIONER VIDER: But doctor, people go to a surgeon because they want their expertise and their accurate decision making?-- That's correct.

And that was the bit that they all weren't getting?-- As I say, I've got eight years, he's got 25 years. I can't really try and match up that. I could only comment on the personal care, his availability, and the fact he came in at different times. Whenever we had trouble finding people, he was around. That sort of thing was more or less what I was referring to as good care rather than precise technical surgical skills, which I don't feel I be would in a position to comment on.

COMMISSIONER: Doctor, the difficulty is that you did comment on it, you see, as the most senior doctor who signed this letter?-- It is an opinion, but as I say, I can only say from the way I saw it. That's as best I can put it in terms of the technical side of things from what I've said so far.

Doctor, would you agree that in retrospect it probably wasn't a sensible thing to sign a letter that was so generous to Dr Patel?-- I would say probably if we're looking at all the technical side of surgery perhaps not, but I do look at that, and I do also look at, as I said earlier, the care I perceived he gave, the teaching he provided to students, the enthusiasm, availability in the context of this. I put all of that together, and I would have to say the actual technical expertise side is one factor, I accept, but it's the being available, being supportive to junior staff, these all were part of the overall feeling, and that's why this letter was written.

Doctor, let's look at the second sentence on screen. "His coordination has enabled the surgical unit to develop into an outstanding service." Do you know what the surgical unit was like before Dr Patel came along?-- No, I wasn't there.

Well, how then can you talk about it developing into an outstanding service if you don't know whether it was better or worse or the same before Dr Patel came than after?-- I saw that waiting lists were being cut down, procedures were being performed, we had several good outcomes, and I mean I couldn't see anything, as I say, grossly wrong or abnormal, but I certainly saw - during my time there we had - he organised big sessions where we did bouts of colonoscopies to get people off waiting lists, and I thought all that was part of good service, good surgical service.

But none of that adds up to an outstanding service to provide quality health care, does it?-- I guess I was looking at the bigger picture as well, people getting the operations versus individual and excellent technical surgery.

Yes, Mr Andrews?

MR ANDREWS: Doctor, with respect to the patient Desmond Bramich, your statement shows that you were the first to see that he was in difficulty and you called Dr Younis?-- That's correct.

Do you recall who it was who first placed the call to Brisbane to see if the patient could be transferred?-- I can't say for sure who placed the first call, no.

Did you place any calls to Brisbane?-- I did speak, but that was later on down the line. I can't recall exactly when. But I don't think it was the first call made.

When you called, do you recall to which service you placed your call?-- I actually took receiving calls from the other side, from intensive care at PA Hospital to say, "Can we speak to you about this case that's coming down?" So it was from there that I had realised there'd been earlier dialogue.

Did you hear any of the dialogue before that call that you took about transfer?-- Not all the specifics. I do recall there being a problem with getting an ICU bed at the PA, and I do recall information relayed back to me that there was discussion between the intensive care doctors and the thoracic surgeon on call at the PA.

That thoracic surgeon on call was?-- I can't quote a name. As I say, it was relayed back to me that there was discussion with the on-call thoracic surgeon at that time. I never spoke directly with the surgeon.

The thoracic surgeon on call - are you speaking of someone in Bundaberg or at the PA?-- At the PA that is, sorry.

So these conversations occurred before you took a call from the Princess Alexandra Hospital?-- There was quite a few things happening at the same time, so I can't pinpoint which happened first, but I knew all this dialogue had happened, and this was what was relayed back.

And you don't remember who was having the dialogue? Do you recall whether it was Dr Carter, Dr Gaffield, Dr Patel?-- I can't say who made the initial contact. It would possibly have been one of the intensive care doctors. May have been Dr Carter, Dr Younis. I can't say for sure.

Do you recall whether there was a CT scan done?-- Yes, that's correct, there was a CT.

And who - do you recall who it was who advised that there should be a CT scan done?-- Dr Gaffield requested a CT scan be done.

Did you yourself see the results of that scan?-- I did have a look with Dr Gaffield, and I think Dr Patel. May have been a few others there. Martin Carter. There may have been others as well.

Do you recall whether there were any other investigative procedures done with respect to Mr Bramich's chest?-- There was an echo done a bit later on.

There was a what?-- An echo or ultrasound.

And were you watching when that ultrasound was done?-- I was there at the time, yes.

Were you watching a monitor?-- We would have been watching the screen, yes.

And do you recall drawing any conclusions as a result of looking at the CT scan or as a result of looking at the screen during the ultrasound procedure?-- Again that would require a radiologist to make a comment. I can only say from what I saw and what we all thought. We accepted he had a lot of blood in the chest and there was a significant injury to his lung, plus the fractured ribs that we knew about before.

Now, do you recall whether you formed an opinion about whether a pericardiocentesis was warranted?-- That's not really for me to form an opinion whether to do that or not, but I knew that was done.

Do you recall whether there was any discussion among those present about whether a pericardiocentesis was required?-- At the time of the ultrasound it appeared to have a little bit of fluid in the pericardium-----

Is this something that appeared to you or are you talking about a conversation you overheard?-- Oh, this was Dr Patel, myself - I can't remember who else was there. A sonographer would have been there.

COMMISSIONER: Did you look at the CT scan?-- CT and ultrasound, yes.

Did you form the view yourself that there appeared to be fluid in the pericardium?-- That would have been from the ultrasound, not from the-----

Did you form that view?-- We had a discussion with the sonographer. We could see the heart had - appeared to be some fluid there, and I thought certainly it looked like there may be some fluid in the pericardial sack. But as I say, we didn't have - it was just a sonographer, Dr Patel and myself.

MR ANDREWS: Now, did you form the view - doctor, there are several possibilities. One, that you saw something and formed no opinion. There is another possibility that you looked at the echocardiogram as it was being performed-----?-- Correct.

-----and formed an opinion that there was fluid near the heart. There's another possibility that you looked at it and formed an opinion on your own that a pericardiocentesis was required, and there's another possibility that Dr Patel suggested it and you weren't in a position to disagree. Can you understand that they're all possibilities?-- That's correct, yes.

Are you able to say whether any of those reflects the reality of the day?-- I'm not an expert, but I'd have to say I did feel that there may have been some fluid in the pericardium, and I accepted that as my limited opinion on that.

How many times had you seen a pericardiocentesis done before you saw it done by Dr Patel?-- We only learned about it in books. I've probably seen it a couple of times only in Papua New Guinea, but I hadn't seen it done in Australia in my experience around here.

Did you see anything done by Dr Patel which was different from the way you'd seen it done in Papua New Guinea?-- As I said, it didn't strike me as being any different, but that's my limited observation.

Do you recall on how many occasions a needle was inserted into the region of the pericardium?-- I can't recall exactly how many.

Do you recall on how many occasions a needle was inserted into the region of the pericardium when you observed the procedure done in Papua New Guinea?-- I know there used to be several attempts to get it right. That's all I can remember from my Papua New Guinea experience.

Do you recall how many needles were used when Dr Patel performed the procedure?-- I don't quite understand what you mean by how many - as in different needles used or-----

Yes?-- -----how many times he-----

How many different needles. Whether he used one or more than one needle?-- I can't recall exactly that, I'm afraid.

And do you know whether there is any accepted number of occasions when one would insert a needle seeking to release fluid?-- I can't really comment on anything - sorry, I just don't understand your question.

Well, does one do it one time only or does one continue to insert the needle until one strikes fluid?-- I can't say how many times. All I knew - my limited experience in New Guinea, there'd be several goes before they could get it right.

I'd like to discuss the patient P26. Do you recall that young man? He was the 15 year old patient who had a groin injury. Do you recall that patient?-- Yes, yes.

COMMISSIONER: Again, Mr Andrews, you might confine yourself to any new light that can be shone on this sad case.

MR ANDREWS: Thank you, Commissioner. Do you recall how often Dr Gaffield visited the surgical ward in the period that P26 was within that ward?-- I can't recall any specific number of times.

Were there ward rounds done-----?-- There would be ward rounds, yes.

When you give the answer "there would be ward rounds", it suggests to me that you're telling me what the general procedure was-----?-- That's right.

-----rather than what your recollection of that week was?-- There would have been daily ward rounds, correct.

Do you remember whether you went on daily ward rounds with anyone else while that patient was in the surgical ward?-- We would have had our usual ward rounds with - I think Dr Patel was around. We would have done - I think this case had a combined care. I can't remember when each shift Dr Patel was involved do ward rounds, and Dr Gaffield as well, so it would have been both at various points in his care.

D COMMISSIONER VIDER: Doctor, Dr Patel, I understand, left on Boxing Day?-- That's correct, he did leave. I can't remember exactly when, but at some point-----

Did you not have any leave over Christmas? You were around each day in the surgical ward to see this patient?-- During the normal weekdays I think it was, yes.

This patient was transferred to Brisbane on New Year's Day?-- That's possible. I can't say exactly when.

You weren't around at that stage?-- I wasn't around at the time he was transferred.

How many days prior to his transfer - how many days was it before he was transferred when you last saw him? Can you remember?-- Not specifically. There were several days we had been seeing him. I can only guess. I think it may have been the weekend that he was transferred. I can't say for sure, but I knew he was transferred, while I wasn't there at the time. I think that may be a weekend. I can't say for sure. I don't have any dates.

MR ANDREWS: Between Christmas and New Year, do you recall - were you rostered to work?-- That's a difficult question for me to remember exactly.

Do you recall-----?-- I can remember seeing the patient, but in terms of which days, when, I can't give you all the information. I don't remember all of that, sorry.

And you were a PHO in December 2004, weren't you not?-- Yes.

Does that mean that it was your responsibility to attend to ward rounds once each day?-- That's correct.

And do you recall whether you'd do them in the mornings or the afternoons?-- Do them in the mornings, sometimes in the afternoons. It depends. But certainly in the mornings.

And do you recall whether you were rostered to work for seven days straight, longer periods or shorter periods?-- As I say, we worked the usual weekdays. Weekends there's one person on call, and if we're off on the weekends we don't work on the weekends. It would be normal weekdays.

COMMISSIONER: Can you look, please, at paragraph 58 of your statement? This is following the third operation, isn't it? Is that right? Paragraph 58 deals with the point in time after the third operation?-- Yes, yes, that's correct.

You say that in the last sentence of 58, "I remember feeling pulses in his foot." Were the pulses you felt in his foot as strong as in his good foot or weaker or-----?-- Certainly not as strong as the good foot.

Not as strong. Okay. Then you go down further in 62, "When I saw him after surgery the pulse in his foot was not as prominent and his foot seemed a bit cooler." So there was a deterioration between the time immediately after the operation in 58 and the time later on in 62. Is that right?-- That's correct, there were changes there.

There was a deterioration, but then in 63 you say, "He was stable and did not appear to be getting worse." How do you say that?-- That's from his overall - overall wellbeing in terms of haemodynamic parameters, temperature, heart, lungs et cetera. More than just specifically the foot.

Then when we come to 65 you say, "The foot was not ideal", and then you say, "His pulse was weak, but it could be faintly made out in his foot." What point in time are you talking

about there?-- During the gradual subsequent days following the third operation.

What do you mean by his foot not being "ideal"?-- It wasn't comparable to the other foot. It was cooler, had a somewhat mottly appearance and - yeah, basically not the same as the other foot.

And his pulse was still weak in that foot?-- Faintly. There was an argument whether we could make it out or not make it out, I would say faintly, sometimes we couldn't feel it.

So there were times when you couldn't feel a pulse at all?-- That's correct, yes.

And yet it didn't occur to anyone that he should be transferred to Brisbane?-- That was brought up whether he needed to be transferred. Both treating consultants were aware of that.

You say "both treating consultants". Dr Patel had left the country at this stage?-- Dr Gaffield then. I say "both" because there was an early period when Dr Patel was there and Dr Gaffield took over because Patel had left.

D COMMISSIONER VIDER: Doctor, were you aware that there was a purulent discharge from the groin?-- I heard about that later on, yes.

COMMISSIONER: You didn't see that yourself?-- No, I didn't see it specifically myself, no.

D COMMISSIONER VIDER: Did you look at these wounds every day?-- He had fasciotomy wounds which were extensive. It wasn't possible to see them every day because dressings would be done by the nurses at other times. We were often in theatre, so we couldn't be there every day to see the wounds.

D COMMISSIONER EDWARDS: But you could have asked-----?-- We would have asked, "How are the wounds going?"

D COMMISSIONER VIDER: We had evidence that when this patient had been retrieved to the Royal Brisbane Hospital, the odour was so offensive from that groin wound that you could smell it on the other side of the Emergency Department. I'm sure that didn't happen on the way down from Bundaberg to Brisbane?-- That's correct.

So I am just wondering whether or not there was some sort of offensive odour in the surgical ward that must have been developing over that subsequent-----?-- I can only say it would have been building up. It wouldn't have been there the first day, so it would have - I can only suggest it may have started brewing up a couple of days after that until he was transferred.

But you weren't aware of that?-- Not immediately. I heard later on that he did have-----

COMMISSIONER: You weren't aware of it at the time?-- At the time, that's correct, yes.

D COMMISSIONER VIDER: In other words, you didn't smell anything?-- No, I didn't smell-----

COMMISSIONER: Did you see any puss from these wounds?-- He would have had dressings covering up the wounds, so I wouldn't have, and it caused him a lot of pain, given the extensive wounds he had, so we didn't take everything down there and then. It would often be left to later on during the day to take everything down and have a look.

Doctor, I have got no medical background, but it seems to me to be obvious that if the foot doesn't have a pulse, it is going to die. A foot can't survive for eight days without blood flowing through, can it?-- That's correct.

Nothing was being done over that period of eight days to address the fact that the foot was pulseless?-- That's correct, nothing specifically.

Now, I realise that, of course, it wasn't your decision, there was a consultant involved, but nonetheless wasn't it obvious to you, wasn't it screamingly obvious that this patient should have been transferred to Brisbane where he could get proper care?-- Yes, I believe in hindsight perhaps that would have been the best thing to have done.

I am not asking about hindsight, I am asking about at the time you can't find the pulse in the foot. Without a pulse, that foot is going to die - the boy is going to lose his leg, if not his life. Isn't it screamingly obvious that he has to go to Brisbane?-- We could feel higher up pulses. The foot didn't have it. We did bring discussion up at some point, and I think, from what I heard from Dr Gaffield, and possibly Dr Patel, he would possibly lose a toe, he might need some debridement, but the feeling I got was that they had done everything that could be done, and I left that discussion at that. I didn't push the issue any further.

Well, they had done everything that could be done in Bundaberg?-- In Bundaberg, correct.

Yes.

D COMMISSIONER EDWARDS: When you say higher up, you mean

where?-- Oh, the femoral.

Right up in the femoral?-- Up in the groin in the popliteal area. We also feel for warmth and circulation, and it was the foot pulse wasn't very good and it was a bit cold and had the motley colour, but it was - the foot was warmer from below the knee. I can't remember exactly where, but there was a level where we knew there was some circulation getting further, and to us, at the time, it looked like we had this line where there was circulation flowing somewhere between the ankle and the knee, and it looked to be getting warmer further down, and I think on discussion with both the surgeons up there, they thought that was improving, and my feeling that was perhaps the reason why the transfer wasn't organised. That's-----

COMMISSIONER: Doctor, I would really like to know what possible argument there was against transferring him to Brisbane?-- I can't really see any concrete reason why not to transfer him.

D COMMISSIONER VIDER: In that week between Christmas and New Year when you were on duty as the PHO going to the surgical ward, did you ever make the suggestion that you should ring the vascular unit at the Royal Brisbane Hospital and discuss this case with them?-- We did bring that up once or twice.

But you didn't ring them?-- We didn't ring them because it is not our prerogative to do that if there is no instruction from the consultant.

D COMMISSIONER EDWARDS: No instruction from?-- If-----

MR ANDREWS: From the consultant.

WITNESS: If there is no instruction from the consultant to speak to the receiving unit.

D COMMISSIONER EDWARDS: But did you ask the consultant?-- We did bring the discussion up and they said, "No"-----

He said no?-- -----"there is no need to transfer." We would bring that up in rounds, we would ask once, hint at it, and if he said there is no need to transfer-----

COMMISSIONER: And this is Dr Gaffield, is it, saying no?-- This would have been Dr Patel.

But Dr Patel left the day after the operation, as I understand the evidence. He left on-----

D COMMISSIONER VIDER: Boxing Day?-- Dr Patel initially and Dr Gaffield took over his care and Dr Gaffield continued that line of treatment.

Did you ever raise with Dr Gaffield specifically the issue of transferring the patient to Brisbane?-- Yes, it was discussed.

Well, you say it was discussed - you see, I think it is a bit curious, if we look at your statement at the foot of page 11, you say, "Dr Patel felt that he would improve and Dr Gaffield seemed to share the same opinion."?-- Yes.

That makes it sound as if you are just guessing what Dr Gaffield thought about it, you didn't even discuss it with him?-- Well, we could come to the conclusion because there was no specific order to transfer the patient.

That's not the point. Did you ask him?-- We did discuss that should this patient be sent to vascular, should we be doing anything further, and there was no direct answer given, "Yes transfer him".

D COMMISSIONER VIDER: And my question was one step previous to that. Did you ring the Royal Brisbane Hospital and talk to the vascular unit staff there?-- No.

Just to talk to them?-- No, as I say, we'd only do that if the consultant asked us to. We don't do that of our own accord.

All right, so you spoke to Dr Gaffield about transferring the patient?-- Yes.

And there wasn't agreement about that?-- At the point that discussion was raised, yes.

Did you suggest to Dr Gaffield that you might ring and just consult with the vascular unit staff at the Royal Brisbane, just get their opinion of how you were managing the patient?-- Not specifically those words, no.

COMMISSIONER: In any words?-- Once we - I can't recall exact words used but discussion revolved around do we transfer, do we discuss. In my practice, if there is a negative response and they have heard what we have said, it means no. We update the consultants, "This is the situation", I personally don't have a habit of asking the consultant, "Should he be transferred? Should he be transferred?" That often implies harassment and persisting on an argument. I would ask, "This is the situation. Is there anything further we can do? Should we speak to Brisbane? Should we transfer him?", and they wouldn't - his response would have been along the lines, "Let's wait and see", or a non-specific order "transfer" or "speak". It is not my practice to get on the phone and ring without being specifically asked by the consultant.

D COMMISSIONER VIDER: But a foot that was mottled on a 15 year old, very fit person, didn't ring alarm bells to you to say to the consultant, "I have a very huge concern"?-- It did, and the consultants were both aware, so - and they would have seen his foot and everything. So it wasn't my discretion to interrogate them to do it. I left it because my practice is it is a consultant's call; he makes those decisions. If he asked me to, I would. If he doesn't specifically ask me to, I wouldn't.

COMMISSIONER: But, doctor, I am sorry to tax you on this but we really do need to understand it: when Dr Patel left on Boxing Day, he told you that he thought the patient would improve?-- Yes, he felt he would improve.

Yes. The patient didn't improve, did he?-- No.

So there is no point going back and saying, "Dr Patel didn't think he should be transferred to Brisbane." Dr Patel was expecting this patient to improve and he didn't?-- Correct.

So that negated any view Dr Patel might have had about being able to manage the patient in Bundaberg?-- I don't follow.

Any view Dr Patel had about being able to manage the patient in Bundaberg, was dependent on Dr Patel's view that the patient would improve?-- Yep.

The patient didn't improve. So that negates any opinion Dr Patel might have had about managing the patient in Bundaberg?-- That would be correct.

Yes?-- But if - if he has been under Dr Patel's care, he has done the operation. As principal house officers, it is not our duty to go behind the consultant's back and seek opinion. It is just the way practice is done, and if he said not to do it, I wouldn't do it.

D COMMISSIONER EDWARDS: But you also said Dr Gaffield seemed to share the same opinion?-- Yes, he felt that we will watch and see how things go.

COMMISSIONER: You did watch and how you saw things going was the patient was getting worse?-- That's when I think - that weekend I think Dr Gaffield may have been on call and that's when they transferred him.

D COMMISSIONER EDWARDS: And also the orthopaedic surgeon, you say-----?-- Had been-----

-----felt he was going to improve?-- Yes. That was initially, and subsequently after that for a day or two, that's all I can-----

D COMMISSIONER VIDER: It was an orthopaedic registrar who raised concern. He was concerned about the very high white cell count of this patient. Are you aware of that?-- I think that happened at the time he was transferred when I wasn't on duty, so that may have been a weekend. I can only guess that that happened then.

COMMISSIONER: Anything else, Mr Andrews?

MR ANDREWS: Yes, just to establish something. As I understand it, doctor, the young man was injured on Thursday, the 23rd of December, and if it was a Thursday, that would have been a day that you were likely to be rostered on?-- The

day he was injured?

Yes?-- Yes, working, yes.

That would explain why you saw him have his third surgery because you would have been rostered on?-- I - just the third surgery, correct. Not the first or second.

And you would have been rostered on on Friday the 24th of December?-- Normal working days, I can't recall whether I was on call or not, so I would have worked eight to 5 normal working hours on a Friday, yes.

And if things were normal, you wouldn't have been present on Saturday the 25th, nor Sunday the 26th?-- If I wasn't on call, I wouldn't be there.

Now, bearing in mind that Saturday was Christmas Day, are you able to remember whether you were on call last Christmas Day at Bundaberg Hospital?-- No, I can't.

And if things were normal, it would mean that you were absent on Saturday the 25th and on Boxing Day the 26th when Dr Patel left?-- That would have been possible if I wasn't on call, yes, I would have been off on Boxing Day.

And if you weren't on call you would have been - well, you'd have been back to work in any event on Monday the 27th, whether you had been on call that weekend or not?-- That's correct. If it wasn't the public holiday, yes, I would have been.

Now, from Monday the 27th to Friday the 31st, you'd have been doing ward rounds each day in the surgical ward?-- That is correct, doing rounds, yes.

Now, can you tell me would Dr Gaffield have been accompanying you each day, Monday to Friday of that week?-- Yes, he would have.

And would you have stopped at the bed of patient P26 each day and inspected the patient?-- That's correct, yes.

Do you recall whether you and Dr Gaffield had a discussion about whether to transfer the patient that week?-- That would have cropped up during rounds and after rounds, in theatre, other discussions during the course of that week, yes.

That is discussions between you and Dr Gaffield?-- Yes, that's correct.

Would anybody else have been present with you when you and Dr Gaffield did your ward rounds in the week between Monday the 27th and Friday the 31st?-- There would have been a nurse and there may have been an intern, junior house officer, would have been someone with us in the rounds.

Do you remember whether you observed that there was an

elevated white cell count or whether Dr Gaffield did?-- I can't recall specifically who noted.

Do you remember whether either of you observed that the patient was malodorous?-- No, I don't recall observing that.

Do you recall whether you had a mortality and morbidity meeting discussion about this patient?-- I can't recall. That was towards the end of the year. I can't remember whether we had one more mortality meeting after that. I can't recall. That happens once a month and this was towards the end of the year. I can't recall whether we did have one before the end-----

Do you recall ever having a discussion about how it was that an orthopaedic PHO should have seen on Friday evening what you hadn't seen in your ward rounds? Did you ever discuss it with Dr Gaffield?-- These were discussed, yes.

Can you tell me what the outcome of the discussion was?-- Discussions were his foot is much the same, his other indices okay, blood pressure, heart rate, temperature, other things, they are okay, and just continue with dressing changes.

During the ward rounds between Monday the 27th and Friday the 31st, do you recall seeing anyone take the pulse of the patient, that is look for the pulse in the area of the patient's leg or foot?-- We would do that daily.

Do you recall seeing anyone doing it? I am asking about your recollection, not whether it would have happened? Do you remember it?-- I remember doing it myself several times.

Where did you check for pulse?-- Specifically where?

Yes, please.

COMMISSIONER: Where on the patient's body?-- On the foot.

MR ANDREWS: Do you recall any occasion when you did it? Do you know whether you did it five times between Monday and Friday?-- No, I can't.

Or less than five?-- I can't quote numbers or remember exactly. I did know I checked it a couple of times.

COMMISSIONER: And is it the case that sometimes you found a pulse?-- Sometimes I felt there was something and sometimes I couldn't, and that was what I felt was the day-to-day progress of it. It is vaguely there, it is not there. You know, that sort of - that sort of feel.

D COMMISSIONER EDWARDS: Did you record those findings?-- As I say, often during the ward rounds the interns would write the notes. I am not sure whether all that was recorded or not. I can't say specifically.

Don't you think-----?-- But we did bring those discussions

up.

Don't you think that the basic responsibility of a ward intern, whoever it might be, in a situation like this is to record whether they felt a pulse or not?-- Yes, they - they should have recorded it.

D COMMISSIONER VIDER: And, doctor, as I understand it, there was some disagreement about that, it wasn't unanimous that everybody could feel a pulse?-- That's correct, yes.

Some people couldn't feel a pulse at all?-- Some couldn't feel it.

Any day?-- Some thought they could feel it, sometimes they would use a Doppler. "Yes, we can make it out", "No, we can't."

Sometimes they couldn't feel it with the Doppler either?-- That's right, yes.

COMMISSIONER: And-----?-- That's my-----

-----To your understanding, was it inevitable if there was no pulse in the patient's foot, sooner or later he was going to lose that foot?-- That's correct. That was a strong possibility, yes.

And what was then being done to save that patient's foot?-- As I mentioned earlier, all the findings and things, we do daily ward rounds, we inform the on-call consultant - or the consultant at the time, whether it was Patel earlier and then Dr Gaffield, and we tell him, "Look, this is the situation: his foot's - weak pulse, no pulse. It is much the same as it was yesterday. It seems to be the same today.", and we would then bring up the issue should we do anything further. "Okay, let's watch and see", and then continue for that week.

I am not really asking about your conversations with other practitioners. What was actually done to save the patient's foot?-- Just usual, warm blanket, good hydration.

None of that is going to help if there is no pulse, is it?-- The feeling was that-----

Am I right that none of that is going to help if there is no pulse?-- It does, warming up the leg, help to improve circulation, which is what we were hoping to do, but if there is no pulse, yeah, sure, I agree it would mean beyond that there wouldn't be much blood flow.

MR ANDREWS: Doctor, did you take a Doppler with you on your ward rounds?-- Not always, no.

Do you remember whether you took a Doppler with you on your ward rounds in the week between Monday the 27th of December and Friday the 31st?-- There may have been once or twice when a Doppler was used, yes. I can't remember exactly which days

but.

Who would have carried the Doppler?-- Often any one of us would have checked it. I don't remember doing it myself. Sometimes a nurse would have a feel of it, would sort of grab it off and have a look and listen, "Yeah, we can make it out." Other times nurses would do it and tell us, "Oh, we can't get it. We can vaguely make it out." So it was a shared sort of thing.

Do you recall when it was that Dr Keating asked you about wound infections? You refer to this in paragraph 70 of your statement?-- I think that was towards the end of my term in Bundaberg when I was about to leave.

And when did you leave?-- Mid-January, I think it was, 2005.

I have nothing further, Commissioner.

COMMISSIONER: Did Dr Keating ever ask for your comments or input in relation to the patient we have just been talking about, the young man with the leg problem, patient P26?-- No, didn't have any discussions with him about it.

Mr Andrews, can you remind me do we have a heavy schedule tomorrow?

MR ANDREWS: We do. Dr Aroney followed by Dr O'Loughlin.

COMMISSIONER: Right. Mr Fitzpatrick, any further evidence-in-chief?

MR FITZPATRICK: Yes, thank you, Commissioner.

EXAMINATION-IN-CHIEF:

MR FITZPATRICK: Doctor, I just wanted to ask you to reflect back to the time - and I am dealing with patient P26 - when Dr Patel left the country and went on holidays. Is it your evidence that the consultant who was then in charge of that patient was Dr Gaffield?-- That's correct, yes.

And is it also your evidence that in the course of rounds - your doing rounds with Dr Gaffield, there took place a discussion or a number of discussions as to whether P26 should be transferred to Brisbane?-- Yeah, yes, it did crop up in ward rounds and discussions at various times, yes.

All right. Now, are you able to specifically recall one of those discussions had between you and Dr Gaffield? Can you recall sitting there in the witness-box, one of those discussions?-- They were often not necessarily done on ward rounds. Sometimes we would be chatting in theatre between cases, sometimes.

COMMISSIONER: Doesn't matter where the discussion took place. Mr Fitzpatrick wants to know whether you can recall the specifics of any such discussion?-- I can recall several discussions, not necessarily exact words used, but discussions would go along the lines, you know, "This young fellow's foot is still, you know, a bit cool. Sometimes we're getting a pulse, sometimes we're not."

MR FITZPATRICK: All right, can you just stop? Now, who made that comment to whom?-- That would be either myself-----

No, no, not would be, can you recall who made that comment to whom? Which of you, that is you or Dr Gaffield-----?-- I would have made that comment to Dr Gaffield or one of either principal house officers.

COMMISSIONER: Doctor, no-one expects you to remember the precise words of conversations that took place eight months ago, but there is a difference between remembering an actual conversation and just saying what would have happened or what you think might have happened. Mr Fitzpatrick is asking you quite specifically whether you can recall an occasion when these matters were actually discussed with Dr Gaffield. If you can't remember a specific occasion, then please say so?-- I can remember a couple of occasions.

Right, well-----?-- But not the specifics of each one.

Let's deal with them one at a time. The first occasion, do you remember who was it that raised concerns about the patient's foot?-- I do remember Anthony, one of our other doctors up there, he did raise the question raised to Dr Gaffield. I did bring it up once and I think Anthony did bring it up once again to myself and to Dr Gaffield.

MR FITZPATRICK: All right. Now, on the occasion that you mentioned in which Anthony - that's Dr Athanasiov-----?-- Yes, that's correct.

-----raised it, can you remember where the three of you were when that occurred?-- It happened a couple of times. I can't remember specifically where we were, whether it was in ward rounds or after. I can't recall exactly where we were. But I did know it came up a couple of times.

All right. So it was a concern raised by Dr Athanasiov with the consultants?-- With the consultant he raised that.

All right. Can you remember what it was that generated the comment raised by Dr Athanasiov? Can you remember what was it that made him say that?-- Oh, he was saying, "This young fellow, his foot's not good." You know, "We should transfer him. We should ask a vascular opinion, we should do that." He would bring it up with me and say, "Yeah, we probably should" - the consultant would be aware and we wouldn't - it wasn't my personal practice to corner the consultant, tell him "We should do this", "You should do this." We would discuss

that in his presence so that he heard - knew what was going on.

All right. Now, just stop. When Dr Athanasiov raised the matter with Dr Gaffield in the way that you have described, what did Dr Gaffield say in response?-- I think his response was, "Oh, yeah, let's just see how he goes. Maybe we might have to", so obviously he was well aware of it and in his mind-----

COMMISSIONER: No, please-----?-- -----thinking about it.

Don't give us the editorial comments as to what he was aware of?-- Okay.

You are being asked about a conversation. Please do your best to relate to us what was actually said?-- As I said, I can't remember exact words but I remember the gist of the conversation. The gist was-----

All right, what's the gist of what was said?-- The gist was, "We have got this young fellow's foot still the same. We're hoping it will improve. It is not really improving. What do you think? Should we transfer him? Should we try and do something?", and Dr Gaffield's response would often - would be - or was, "Yeah, probably should. Let's watch and see." And that would be pretty much the end of discussion. We wouldn't tell him, "No, we should transfer him." I was unhappy to push that. The next day, subsequently, we would bring it up again, and as far as I recall that was the sequence for that week.

Mr Fitzpatrick, it is entirely a matter for you but I am not inclined to think that this line of inquiry has much value.

MR FITZPATRICK: No, Commissioner, I thought I'd try.

COMMISSIONER: You have made a valiant effort.

MR FITZPATRICK: All right. Tell me just this, doctor: after Dr Patel left to go on holidays, between that time and the time when P26 was ultimately transferred to Brisbane, was P26 occupying an intensive care unit bed in Bundaberg for the whole of that time?-- Not the whole of the time. He was moved to the ward. I can't remember at what point but the last few days before his transfer he was in the ward.

He was in the ward in the last few days before his transfer?-- General Surgical Ward, yes.

I understand. Yes, thank you, doctor. I have nothing further.

COMMISSIONER: Can we just go around the room and have estimates. Mr Harper?

MR HARPER: Probably about 20 minutes, Commissioner.

COMMISSIONER: Mr Allen?

MR ALLEN: Probably not much at all, if anything. So a few minutes, or not.

COMMISSIONER: Mr Devlin?

MR DEVLIN: Commissioner, I would like Dr Boyd to have the progress notes from the 26th of December onwards for him to have a look at his leisure overnight. That would probably shorten what I would like to do on the topic, and otherwise I'd have brief questions, probably about 15 minutes.

COMMISSIONER: Doctor, do you have - were you planning to travel somewhere tonight or you now live in Brisbane, do you?-- Yeah, that's correct, yes.

So are you on duty or is there anything which would prevent you coming back in the morning?-- I would have to check with the Princess Alexandra Hospital, but it's possible, I think, I would be able to return.

Can you please make those inquiries? If you can be back here at 9.30 in the morning, that would be good. If you can't, then Mr Andrews or one of the Inquiry staff will give you a telephone number that you can contact us on so that we can make arrangements for another witness to start at 9.30. Does that suit everyone?

MR HARPER: Yes.

MR FITZPATRICK: Commissioner.

COMMISSIONER: Mr Fitzpatrick?

MR FITZPATRICK: Yes, thank you, Commissioner. I am afraid in my usual quarrelsome way I am going to raise a matter that might bear on the sequence of witnesses for tomorrow.

COMMISSIONER: I have never scene you quarrelsome. I am most intrigued.

MR FITZPATRICK: I will do my best Commissioner. Commissioner, we've been handed this afternoon a statement of doctor, I think, Aroney. I am not sure if the Commissioners have had the advantage of seeing it.

COMMISSIONER: We haven't read it yet.

MR FITZPATRICK: So I can tell you, Commissioners, that it is extensive. It's 47 pages in length. It has, I think, 18 exhibits. From the brief reading that I have made of it, it appears to raise allegations of a most serious kind concerning the delivery of cardiac care at a number of hospitals across the State. As a subsidiary-----

COMMISSIONER: If I can just interrupt you for a moment. Doctor, you are free to go now if you wish?-- Oh.

Unless we hear otherwise, we will see you at 9.30 tomorrow?-- Yes, yes.

Thank you.

WITNESS STOOD DOWN

MR ANDREWS: Commissioner, as a subsidiary matter, it also seems to raise allegations of bullying of the witness by a number of people, which include Dr Scott and Dr Buckland, who, as the Commission may appreciate, don't work any longer for my client and-----

COMMISSIONER: Indeed, it's still not clear to me whether you are acting for them. It may not be clear to you.

MR FITZPATRICK: It's not clear to me either. The point I am trying to make, Commissioners, is that the issue of cardiac care is, so far as I can tell, an entirely new topic. It is one which with the best will in the world it would take a reasonable period of time to come up to speed about. It's not something that has been canvassed-----

COMMISSIONER: I think that's a very fair point.

MR ANDREWS: -----extensively, and Commissioners, I understand that the Commission had important business and that the public hearing time is drawing to a close. But with the best will in the world, even if I had all of these witnesses in the room now ready and willing and available to give me instructions, I couldn't possibly be-----

COMMISSIONER: No, you make a very valid point, despite the querulous and difficult way in which you have expressed it. Mr Andrews, my inclination at the moment, we're going to be a bit behind schedule anyway because of Dr Boyd being held over. Do you see any merit in the witness, Dr Con Aroney, giving his evidence-in-chief tomorrow morning and then postponing cross-examination possibly for a week, for example, to give Mr Fitzpatrick and others the opportunity to take instructions?

MR ANDREWS: I do and especially am concerned to bring him on tomorrow at least because, as I understand it, Dr Aroney is available on Wednesdays only unless some exceptional arrangements are made by him, and Wednesday of next week is a public holiday, which really would then leave only Wednesday of the final week of hearings, so-----

COMMISSIONER: We may have to go out of our way to do something different, such as allowing him to give evidence in the evening as we did with - it seems so long ago - the doctor from the AMA - Dr Molloy, yes, thank you. So we will work out something that that doesn't inconvenience, Mr Fitzpatrick, in any event.

MR FITZPATRICK: Commissioners, I'm hearing what Mr Andrews has said about the doctor's availability. I'm very concerned that if the doctor simply gives his evidence-in-chief and then there is some extensive-----

COMMISSIONER: Delay, yes.

MR FITZPATRICK: That the topics which he covers - and I'm not suggesting for a moment that the material in his statement lacks veracity or anything of that sort-----

COMMISSIONER: Of course.

MR FITZPATRICK: But, Commissioners, I'm very concerned that it will be reported in the press as if it was all entirely true and that any cross-examination will be entirely lost in the public perception. So, in my submission, it is appropriate if it can be arranged in any way that his evidence-in-chief and his cross-examination follow.

So far as I can tell, Commissioners, I would be the only person having representation before the Commission who would be interested, that is, directly in cross-examining him. But I'm not sure about that.

COMMISSIONER: I take the force of your concern. I think, Mr Fitzpatrick, you can probably address that by making the point very clearly and very soundly when Dr Aroney is stood down that Queensland Health hasn't had the opportunity to cross-examine him, and I imagine with the responsible sort of media reporting we have had in these proceedings to date, it will be made clear that the evidence is not yet tested in that way, and I will certainly reinforce that point at the end of his evidence-in-chief. If we do it that way, you are not going to be-----

MR FITZPATRICK: No, no.

COMMISSIONER: -----prejudiced, are you?

MR FITZPATRICK: No, especially if there was that sort of intimation from you, Commissioner.

COMMISSIONER: And just in case I forget, you might remind me

tomorrow-----

MR FITZPATRICK: I will. I will.

COMMISSIONER: -----to do that. Mr Andrews, are you happy with that?

MR ANDREWS: Yes, Commissioner.

COMMISSIONER: So easy to please. Anyone else with any concerns?

MR DEVLIN: Can I just indicate that I have left Dr Boyd with the progress notes directing him to the Boxing Day entry, where he seems to have made one, and asking him to look forward through those notes to the 1st of January, when the patient was transferred out, and can I say that he indicated that he would simply tell his employer that he will be here tomorrow morning at 9.30.

COMMISSIONER: Well, I will leave that between him and his employer. I was concerned he might have clinical duties and I didn't want to interrupt someone's operating list or something like that. But if it's not inconvenient, we will expect to see him at 9.30.

MR DEVLIN: He did indicate his employer was aware that he would be required here.

COMMISSIONER: Splendid. Thank you, ladies and gentlemen. It's been a long day. So, thank you for your assistance and cooperation. We will resume at 9.30 in the morning.

THE COMMISSION ADJOURNED AT 4.54 P.M. TILL 9.30 A.M. THE FOLLOWING DAY