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IN THE MATTER OF THE COMMISSIONS OF INQUIRY ACT 1950

BUNDABERG HOSPITAL COMMISSION OF INQUIRY

COMMISSIONS OF INQUIRY (No. 1) 2005

BRISBANE

..DATE 10/08/200

..DAY 38

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THE COMMISSION RESUMED AT 9.31 A.M.

COMMISSIONER: Mr Andrews, are we continuing with Dr Boyd?

MR ANDREWS: Yes, Commissioner.

COMMISSIONER: I will just remind the cameramen and photographers that there's to be no filming or photography of Dr Boyd's evidence.

MR ANDREWS: Commissioner, I am aware that - I see that Dr Boyd's counsel isn't here.

COMMISSIONER: Yes.

MR ANDREWS: I wouldn't ask the doctor to be examined-----

COMMISSIONER: Dr Boyd, take a seat and make yourself comfortable, but we won't begin until your counsel are here.

DR BOYD: Thank you.

COMMISSIONER: Mr Andrews, I realise that Mr O'Loughlin, I know he's not giving evidence till this afternoon, but I seem only to have his second statement, not his first. Perhaps you can make arrangements to-----

MR ANDREWS: My hearing was interfered by something in the background.

COMMISSIONER: I only have Dr O'Loughlin's second statement, not his first one.

D COMMISSIONER EDWARDS: I just have the statement on the 11th of July.

COMMISSIONER: Yes.

MR ALLEN: Commissioner, it has been admitted as Exhibit 173.

COMMISSIONER: Yes, I'm sorry. I had forgotten that. Thank you, Mr Allen.

Morning, Mr Devlin.

MR DEVLIN: Morning.

COMMISSIONER: Mr Diehm.

MR DIEHM: Commissioners.

COMMISSIONER: I have been very nervous with all the reports in papers about Magistrates getting into trouble for not starting punctually.

MR DIEHM: You're concerned possibly by the clocks in the

building which are wrong, Commissioner.

COMMISSIONER: It could be that. Mr Fitzpatrick, good morning.

MR FITZPATRICK: I apologise for my lateness.

COMMISSIONER: Not at all, Mr Fitzpatrick. I was going to say for the benefit of the public and press that I think what a lot of people don't realise is that what goes on in this room is really only the tip of the iceberg for the work involved in conducting an inquiry, not only for us here - in fact perhaps it's less for us - but for counsel there are many hours before and after the hearing of work and we have been running at a fairly stagnant pace anyway, so it's not surprising that people are running late.

Mr Fitzpatrick, I'm pleased you are here, though, because there's something I feel I ought to say about Dr Boyd's evidence. It's simply on any view of the evidence Dr Boyd was not primarily responsible for the care of the patients concerned. However, given that he held the position of a Principal House Officer, which is a relatively senior position, and had eight years experience in surgery, it does concern me that on the evidence as it presently stands we may have to give consideration as to whether recommendations should be made having regard to the standard of care provided, particularly to patient P26, and I'm not limiting it to that. It certainly gives me no pleasure to say that, but as the evidence stands there are grounds for concern that the patient's care was suboptimal, not only with respect to the care provided by Dr Patel.

I just wonder whether you wish to have the opportunity to discuss that situation with Dr Boyd before his evidence continues and consider whether, for example, there's any further evidence-in-chief you'd like to adduce.

MR FITZPATRICK: Perhaps if I could have a short opportunity to do that, Commissioner?

COMMISSIONER: Yes.

MR FITZPATRICK: I'm sorry for causing further inconvenience, but I'm grateful of the opportunity to do that.

COMMISSIONER: Yes. And please understand no final conclusions have been reached at all. My primary concern at this stage is that a relatively young doctor may be exposed to necessary criticism, and I would hate to do that unless he had every opportunity to defend himself against those - that possible criticism.

MR FITZPATRICK: Thank you, Commissioner.

COMMISSIONER: Mr Andrews, is that - do you wish to say anything about-----

MR ANDREWS: No, Commissioner.

COMMISSIONER: We might stand down and, Mr Fitzpatrick, you might get a message to us when you are ready to proceed. We will be back, shall we say, at 10 to 10 unless we hear otherwise.

MR FITZPATRICK: Thank you, Commissioner.

COMMISSIONER: Thank you.

THE COMMISSION ADJOURNED AT 9.36 A.M.

THE COMMISSION RESUMED AT 10.10 A.M.

COMMISSIONER: Mr Fitzpatrick?

MR FITZPATRICK: Thank you, Commissioners. Commissioners, I have taken the opportunity to speak with Dr Boyd. Commissioners, the doctor doesn't feel at this stage that it would be fruitful to embark on further evidence-in-chief.

COMMISSIONER: Yes.

MR FITZPATRICK: He is content to be subjected to further cross-examination, including by my learned friend Mr Devlin and others. He will - and he wishes to emphasise that he will endeavour to answer the questions to the best of his ability, but he isn't privy, for instance, to details of his working arrangements over Christmas and documents that might support or not those matters.

So, Commissioners, if it's suitable to the Commission, we were proposing that we proceed on that basis. If at the end of the cross-examination there are matters which either the Commission doesn't feel have been satisfactorily addressed or that clearly should be addressed by way of accessing documents - work history and so on-----

COMMISSIONER: Yes.

MR FITZPATRICK: -----then I was proposing to seek leave to put in a supplementary statement on notice to everyone to-----

COMMISSIONER: Yes.

MR FITZPATRICK: -----deal with those matters.

COMMISSIONER: Thank you, Mr Fitzpatrick. I'm very grateful for that explanation. I'm also very grateful that Dr Boyd has the benefit of your voice and assistance, and so that there's no misunderstanding, I do want to make it very clear that I expressed concern this morning only in the interests of Dr Boyd should it be considered necessary to address potential areas of concern.

I shouldn't want anyone to think that I, or the Commission generally is singling out Dr Boyd. I'm acutely conscious of the fact that he was working under the guidance of his superiors, and it may well, at the end of the day, be quite clear that Dr Boyd did discharge his duty of care by drawing problems to the attention of his superiors, and any responsibility from that point onwards belongs to those who failed to take heed of what Dr Boyd brought to their attention.

I'm also very conscious of the difficulties that a relatively junior doctor in the surgery department would be under when working as, in effect, a subordinate to people like Dr Patel

based on the evidence we've heard of Dr Patel's performance in surgery, and I think I can fairly say that none of us would wish to jump to any adverse conclusions against a subordinate when he was simply working under the supervision and authority of a superior like Dr Patel.

So my comments this morning were not intended in any way to suggest that we are singling out or identifying Dr Boyd as a potential target for criticism. We simply felt it was responsible to draw attention to the fact that there may be scope for criticism, and that Dr Boyd should have the opportunity, in fairness to him, to answer that criticism if he were able to do so.

MR FITZPATRICK: Thank you, Commissioner.

COMMISSIONER: It goes no further than that. Dr Boyd, can we ask you to come back to the witness box, and I'll remind the cameramen that this evidence is not to be filmed or photographed, or the subject of audio recording.

JAMES PETER BOYD, CONTINUING:

COMMISSIONER: Thank you, Dr Boyd. May I apologise to you personally for raising that?-- That's fine.

I hope you understand that it was as much in your interests as anything else that I did raise that issue?-- That's fine, Commissioner.

Thank you, Mr Harper.

CROSS-EXAMINATION:

MR HARPER: Dr Boyd, my name is Justin Harper and I appear on behalf of the Bundaberg patients generally, and in particular Mrs Bramich and the mother of patient P26. Can I ask you, you spoke at length yesterday about the process for transfers, particularly as they related to Mr Bramich and patient P26 and the discussions around that. Could I take you back one step further and ask you about in your experience, both within Bundaberg and elsewhere, what are the sorts of considerations which would be taken into account when determining whether to transfer a patient?-- In - determining whether to transfer patients depended on several factors, time delays in available retrieval, availability of beds at tertiary hospitals, and this is often - hasn't been spoken of, but often there's a lot of discussion and arguments about accepting transfers, and it's not a simple matter of deciding, "This patient needs to be transferred", put them on a plane, send them to Brisbane.

It doesn't work like that. It often involves a lot of phone calls, and sometimes we have to argue with receiving hospitals who often say, "We don't have beds. We don't have beds", and we say, "What are we supposed to do?" So we're often faced with that scenario in transferring patients. The other problem - the other problem I encounter in transferring patients, everyone is quick to say transfer, but there's often a lot of time delay and still treatment needs to be done during this time delay. These are quite important considerations in transferring patients, and it's not often a decision made lightly. In order to transfer a patient who has been operated on, irrespective of my opinion or any junior's opinion, it really is the consultant's call whether the patient gets transferred or not, and that's pretty much my experience with transfers.

COMMISSIONER: And Dr Boyd, am I right in thinking perhaps the most important consideration is - or one of the most important is whether the patient is sufficiently stable to be able to-----?-- Absolutely.

-----be transferred?-- And that's an important consideration as well. In that situation, if the patient is unstable, it would be deemed quite irresponsible to attempt to transfer someone in that situation, and sometimes that would go against a transfer, if someone was critically unstable.

D COMMISSIONER EDWARDS: Dr Boyd, could I just ask you for clarification, when you want to transfer, is it easy to find somebody in the major hospitals to whom you can speak? Do you know of a set position in the hospital who is responsible for accepting patients such as this or do you have to ring up, get delayed on the switch, find a great difficulty in finding a particular person, and should that be looked at and refined?-- I think it probably might require looking at. It varies. Sometimes it's pretty straightforward. Sometimes I've found myself in situations ringing up several hospitals to try and find an ICU bed to transfer a patient, and this can take two or three hours ringing around, phone calls, meanwhile you have the patient still there. You can't tell them anything. Are we going to transfer or are we not? Because you have the situation where there's no beds, no available - particularly intensive care beds in any of the hospitals. I've been in one or two situations where patients have gone to Redcliffe and then information comes back there is no beds and two hours later, "We do have a bed." So communication does get mixed up along the way. Beds, no beds. So these are often quite - some of the difficulties in transferring patients.

COMMISSIONER: Doctor, we've heard evidence from Dr Rashford and the retrieval operation that he conducts, and the impression I had from his evidence is that at times he's working almost as a bed brokerage service, looking around for beds to supply. Have you had occasion to work with him and telephone him and say, "We've got an urgent retrieval. Can you find us a bed?"?-- I don't recall specifically speaking with him, but I can't remember names of people I would have spoken with.

You'd agree that it's much more efficient to have a central service like that now provided by Dr Rashford's outfit which handles not only the retrieval, but finding a hospital for the patient to be transferred to with the appropriate bed and other resources and facilities?-- I think an absolutely excellent system to have something like that in place.

MR HARPER: Back to those factors which you weigh up in determining whether to transfer, would it be correct to say that in the case of a major trauma, one of the factors which should be considered is obviously the significance of that trauma and the significance of the injuries?-- Correct.

And the types of possible complications which may flow from the nature of the injuries which have been sustained and the nature of the trauma?-- Correct.

And an assessment would need to be made as well then of the capacity of the hospital to provide the appropriate specialist care or otherwise for that type of injury?-- That's correct.

And particularly whether that specialist care could provide the necessary further treatment and operative procedures which would be a possible or likely flow-on from those types of injuries?-- That's possible. However, I might add that sometimes the initial assessment may be made to keep a patient. That can change from time to time as well.

Could I go then specifically to Mr Bramich. Now, if my recollection is correct, the injury occurred on the evening of the 24th and you first saw him on the 26th - sorry, the 23rd perhaps?-- That would seem about right, yes.

Now, when you first saw him, you mention at paragraph 38 of statement which is Exhibit 206C - you said you remember discussing it with Dr Gaffield, "and I recall that we discussed the fact that he was stable and he could be managed in Bundaberg."?-- I remember that. I'm just looking for it on the statement at the moment.

Okay. That's at paragraph 38 of your statement?-- Yes, that's correct.

Now, can I ask you, did that discussion revolve around those general factors which you've referred to as being considered when a transfer of a patient is being considered?-- Yes, all general factors are considered in that regard. It's also professionally what's appropriate to be transferred as well. If a unit or hospital feels they're able to deal with a case then they may choose to treat. Sometimes we may ask an opinion, and often they would say, "Look, there's no need to transfer at this stage. You can manage the patient up there." Sometimes we get that discussion.

I'll ask you specifically on that, in the case of Mr Bramich, was to your knowledge there a discussion with anyone in Brisbane about whether this patient needed to be

transferred?-- There was no discussion from - as far as I know, from his initial admission to the time he had the acute problem.

Okay. Now, can I ask in that discussion you had with Dr Gaffield, was there discussion about the fact that this was a significant and serious chest injury?-- Yes, that's correct. It was understood.

And was there discussion then to the effect that it would need, most likely, some assessment and possible treatment by a specialist thoracic surgeon?-- Not necessarily. We see a lot of chest injuries regularly, all the time, and not all get referred to thoracic surgeons.

Would you accept, though, that where it is a serious and significant trauma, some sort of opinion from a thoracic surgeon would be prudent?-- That would be correct in certain situations, yes.

It would be fair to accept that the circumstances relating to Mr Bramich in which a caravan lay on his chest for a period of 10 minutes was a significant chest trauma?-- That was a significant chest trauma, yes.

To repeat, to your knowledge there was no discussion with a specialist thoracic surgeon about-----?-- Not as far as I can recall.

And there was no serious discussion about the need to transfer him down to Brisbane for that assessment?-- There was no specific discussion up to that point.

Would you accept, even in hindsight, that that may have been an appropriate course of action for the hospital to take?-- It's hard to say. It's easy to look back and say we could have, but we see a lot of chest injuries all the time. It's quite a common injury. We see multiple fractured ribs, and a very small percentage would get sent to a thoracic unit, and having worked at the Princess Alexandra currently, they are often managed by a general surgical team and not necessarily a thoracic team.

Can I ask you - I'll continue on Mr Bramich, but off the subject of transfers. I'll just deal with it very briefly. In the follow-up to Mr Bramich's death you are aware that there was an investigation, a coronial inquiry?-- Yes, I was.

And you were interviewed in relation to that coronial inquiry?-- Yes, that's correct.

Were you contacted - were you aware that there was a Sentinel Event Form filled out in relation to the death of Mr Bramich?-- I can't recall that, no.

You're aware, though, of the nature of a Sentinel Event Form?-- No, you might need to -----

You're not aware of a Sentinel Event Form?-- Adverse event? Sentinel-----.

Adverse event, Sentinel Event Forms?-- I can't recall to my memory.

So you were never provided any training within the Bundaberg Hospital about adverse events reporting?-- I knew of forms available to fill in for adverse events. They were available, and if you felt there was a need to report one, you'd use that form.

But you never received any training in your induction at the hospital?-- No specific training about the adverse form itself, no.

Otherwise in your history of employment within Queensland Health have you ever had any training formally about reporting adverse events?-- No specific training on that, just what you pick up on the job.

Back to Mr Bramich again, were you ever contacted by Dr Keating about an investigation into the sentinel event reporting about the death of Mr Bramich?-- Come to think of it now, there was a hospital investigation and I did submit a report to that, yes.

Can I ask, in those investigations, was there any substantial focus on the first two to three days of Mr Bramich's care?-- I don't think there was that much focus paid to that period of time.

So there wasn't any critical analysis of whether a transfer in those first two to three days would have been appropriate?-- I don't believe that was brought up, no.

D COMMISSIONER VIDER: Was Mr Bramich's case discussed at a Morbidity & Mortality Committee?-- I think it was in one of the subsequent meetings we would have had. I can't remember exactly when.

And was that discussion robust? Did you go through that to evaluate the clinical care that had been given to Mr Bramich?-- Yes, we did review aspects of his care, but I guess primarily our focus was on that initial - well, not initial, but the period where he deteriorated, and probably in some discussion around the whole case. I can't recall specifics, but I do remember we had a discussion on that case, yes.

MR HARPER: You don't recall if that focused on the treatment in those initial two to three days?-- I can't recall specifically, no.

Okay. Can I just ask, you work at the PA Hospital now?-- That's correct.

Which section of the PA do you work at?-- Currently general

surgery.

Okay. Can I take you on now to patient P26? If you go to around about paragraph 60 and onwards of your statement - the main statement which is Exhibit 260C. It's at about page 11. Again your evidence from yesterday was that you weren't present for the first operation?-- That's correct.

But you were there between the - was it between the second and third operation you were there?-- I was there for the third operation.

I'll go back again to those factors you referred to earlier about transfers. Was there any discussion with Dr Patel about the need to transfer patient P26 in that first period, that first 24 hours?-- From his initial injury up until the third operation he had, I had little to do with that, so I can't say from that period.

Right?-- Following that, having had an operation done, Dr Patel felt the problem had been dealt with at the time so there was no specific mention of a transfer following that 24-hour period from the third operation to the next day.

So there was no assessment done according to those factors about the availability of a bed, the stability of the patient, the severity of the injury and the nature of the injury?-- Not as far as I can recall in the first 24 hours, no.

So there was no discussion that this patient had suffered a quite severe vascular injury and may require treatment at some stage by a vascular surgeon?-- I don't recall any specific discussion during that period, no.

It sounds though, am I right in assuming, that the vascular surgery was, in Dr Patel's opinion, well within his capabilities?-- I can't speak from him, but I would say he possibly felt it was within his capacity to deal with that injury.

Clearly it's a logical consequence from the fact that we have a serious vascular injury, Dr Patel performs the surgery and there's not even any discussion about the need to get a vascular surgeon in?-- Sorry, what's your question?

You would agree that that's a logical conclusion then, that Dr Patel - perhaps I am asking you to surmise his views - but Dr Patel-----?-- I don't quite get what you are asking me to-----

I won't take it any further. Can I take you to your statement exhibit 260B? And it relates to the patient Linda Parsons - and at this point I should say to you that I also have instructions to act on behalf of Mrs Parsons, so there are matters that I will need to put to you about her account. I understand from your evidence yesterday, my recollection was that you accept that Mrs Parsons' wound had opened up?-- That's correct, yes.

But the difference about whether it was completely dehisced or not completely dehisced seems to be about the specific medical terminology for what a complete dehiscence is?-- Correct, yeah.

Okay. You accept that you saw her on that first day - I can't recall the date offhand?-- I can't, but, yes, I do remember seeing her.

And that you gave a direction that the wound should be packed?-- The wound should be packed, yeah. It is a form of dressing.

And then Mrs Parsons came back the next day and her wound was sutured again?-- I can't recall whether it was the next day or the day after, but somewhere in that time-frame.

Okay. Can I take you now to paragraph 7 of that statement?-- Sorry, which-----

Paragraph 7 of the statement which is exhibit 260B?-- B. Okay, yes.

Okay? Now, you acknowledge there that in the second sentence, "She" - that's Mrs Parsons - "did have tears." You then say, "More from anxiety and fear."?-- That's correct.

Now, that is your interpretation of what the source of those tears was, isn't it?-- I said that because she had those before coming, before we did anything. She was-----

You accept, though, she was crying during the operation?-- I believe she was, yeah.

She was. Do you accept that it is possible that the reason she was crying was that the local anaesthetic wasn't in fact working?-- It is hard to say because she was crying before I even started, so I can't make any fixed opinion on that.

But you concede she was obviously in some distress while this was being-----?-- She was in distress because she obviously had a swelling underneath and needed a dressing.

You mentioned - you then continue on and you say that you had

"at least two other nurses to hold her hand and comfort her"?-- That's correct.

Were there more than two nurses there?-- I can recall one nurse helping me.

Right?-- And one holding her hand and comforting, yes.

But there may have been another there?-- I can't recall.

Right. Would it normally be necessary to have more than two nurses to comfort someone in that circumstance?-- One nurse to comfort and one to help me.

All right. Just in a normal circumstance of inserting stitches where a local anaesthetic is working perfectly well?-- No, we did that with anxious patient, and that is what I assessed the situation to be, and it is often difficult in someone who is anxious to know is it pain, is it anxiety? So that's why that was done.

Would you accept, if I suggested to you that those nurses in the room, that one of them had their hands down on her applying some level of pressure?-- I did not notice that, no.

Would you accept, though, that there was - one of the nurses was down near her feet?-- I can't recall that specifically, no.

Right, okay. Is it possible that what happened in this case was that you inserted a local anaesthetic but that the wound was in fact red and inflamed?-- Sorry?

Sorry, do you accept that the wound was red and inflamed when you were stitching it?-- The wound had a breakdown but it did not have the true redness of cellulitis surrounding it. It would have had a bit of redness around the wound, yes, which we often see following surgery as well, or low grade infection, it is hard to say, but she did not have, to my recollection, a full blown cellulitis with it, which is infection of the surrounding area.

You are aware, though, if you try and inject local anaesthetic into an inflamed or infected area, there is a possibility that that won't - that the local anaesthetic won't work?-- It is a possibility it doesn't work but it sometimes does work.

Is it possible that that's what happened in this circumstance?-- It is possible, yes.

Now, I would like to ask you some general questions about the hospital in general and the culture of it - and I preface it by saying I am not implying any criticism of you when I ask these questions - your general interactions at the hospital, you discuss matters openly with the other doctors?-- You mean which other doctors? In the department?

Any of the other doctors. Generally the culture of the

hospital?-- Yes, I would say yes.

It is a normal work environment and you discuss matters, professional and personal matters?-- Yeah, with my colleagues.

Yes?-- Other principal house officers in other departments, colleagues of surgery department, yeah.

And with the nurses as well? And with the nurses-----?-- That's correct, yes.

-----you have discussions?-- Yep.

And there is the normal, as in every workplace, the sort of hallway gossip and that sort of thing?-- That happens everywhere, yes.

In the context of those, can I ask when were you first made aware that other people at least had concerns about Dr Patel's clinical competence?-- I can't recall specifically when I was made aware of it, no.

Right. Do you remember that you were made aware of it, though, before it all hit the media?-- I heard - I can't remember exactly what I heard. I heard little bits here and there but I didn't think it sounded significant at the time to hit me.

COMMISSIONER: You were aware, for example, that the renal unit refused to send patients to Dr Patel?-- Yes, I was aware of that, yes.

MR HARPER: How were you made aware of it?

COMMISSIONER: And that Dr Keating had already asked you for your input on infection rates and matters of that nature?-- That was discussed towards the end of the year, before I left, in a meeting we had to see how the year went.

D COMMISSIONER VIDER: And if the comments were being made about Dr Patel's clinical competence as a surgeon, what was your reaction to those comments when they were made to you?-- I didn't hear any specific comments saying, "Oh, he is a poor surgeon. He is this, he is that." We hear a lot of things. I just ignore it.

Okay?-- Because we hear so much here and there, anyone says anything. I have learnt to take in what's relevant and a lot of stuff I just ignore.

MR HARPER: Okay. Can I ask - and you answered some of these questions yesterday about the renal unit - did you - just going back to my notes, you answered Mr Andrews - he asked you about whether you were aware that the issues that the renal unit had were about - whether it was about an issue of competence, and you said, "It involved a bit of that." Can I ask - I might just take you back to that. So we're discussing

here-----?-- Yep.

-----the renal unit refusing to send patients to Dr Patel?-- Yes.

Can I ask you again who else mentioned that to you?-- This is, again, talk in the corridor.

Right?-- From other colleagues who work in the renal unit and others around the hospital-----

Okay?-- -----at junior house officer, principal house officer level.

Do you remember any specific discussions with them?-- It was all vague, a bit of talk here and there, nothing I can specifically talk about, but just the gist of what was said, yeah.

Did you ever raise it with Dr Patel?-- He was aware of it himself.

Did you ever raise it with him?-- No, I didn't, no.

How do you know that he was aware of it?-- He would say he doesn't get along well with the renal unit, and I was aware, and that's it, that's where I left it.

Did he say not only does he not get on well with the renal unit, but that the renal unit won't send patients to him?-- That I can't recall whether he mentioned it or not, but I knew that myself because I was told that they didn't want patients referred to him, yes.

Did you think it a bit odd-----?-- Which-----

Did you think that it was a bit odd that the renal unit weren't sending patients to Dr Patel?-- I did think it was odd but I have noticed that happens as well in other places, too, some people have a specific surgeon that they refer to and choose and choose not to see someone else. I know that that does happen.

But it was - but would you accept it is a little bit more when the Director of Medicine won't send any patients to the Director of Surgery?-- It is still the same thing. They are still consultants in different capacities and that still does happen.

D COMMISSIONER VIDER: Were you aware that there was an audit of the placement of the Tenckhoff catheters that was the substance-----?-- Of?

-----of Dr Miach's-----?-- I wasn't aware of an audit.

You weren't aware there was actual evidence that had been presented?-- I can't recall anything specific, no.

COMMISSIONER: Have you any experience at any other hospital where the deterioration in professional relationships had got to the point where the Director of Medicine refused to send his patients to the Director of Surgery?-- I have experienced that in other hospitals, yes.

You have?-- Not necessarily directors, but high up.

MR HARPER: Can I take you to paragraph 68 of that statement number C - the letter C? You say, "I know that there was some complaints from the ICU about Dr Patel but I was not involved in that." Can I ask is that something which you know at the time of making this statement or is it something which you knew previously when you were employed at the Bundaberg Hospital?-- Oh, I heard about it some time while I was up in Bundaberg.

Okay. Did you - were you asked - did you know what the nature of those concerns were?-- Not specifically. Again, it was just talk around the corridor here and there. I shut my ears after a lot of stuff.

You were aware, weren't you, that part of it was about Dr Patel performing oesophagectomies?-- That happened - from what I heard, that happened the year before I got there.

Okay?-- And may have been once or twice, and that was it.

So would it be fair for me to assert that - or for the Commission to find that it was relatively well-known around the hospital that there were some concerns about Dr Patel's clinical competence?-- It is hard to say that because everyone else has opinions about everyone else, and if you listen to every bit of talk that goes on in the corridors, you would find that there would be complaints about absolutely everyone.

Just one final thing, in response to some questions yesterday you talked about that it is not your responsibility to question a consultant?-- That's correct, after having - that was in the context of having brought up the issue once or twice, not to bring it up again. That was in that context.

Is that common, in your experience within Queensland Health, that under no circumstances, effectively, can you-----?-- No, it is not - I think that's been misinterpreted. Perhaps I might clarify. If - the situation which I made that comment, if you ask a consultant, "Should we transfer? Should we do this?" once, and he says, "Oh, maybe not", and you bring it up a second time, after that you don't keep hassling and say, "Should we transfer? Should we transfer?" That's the context in which I used that.

Say, for example, in either the case of Mr Bramich or patient P26, though, would it have been normal for you or someone else in your position to have perhaps rung down to Brisbane before you even spoke to your own consultant?-- No, I wouldn't do that, no.

You wouldn't do that?-- No.

Why is that?-- Because the patient had an operation and I have to respect the consultant I work under, but I would suggest, can put forward, but I wouldn't go on my own accord to do that, no. I might informally talk to my friends or colleagues but that's an informal discussion between friends.

Okay, I have nothing further, Commissioner. Thank you.

COMMISSIONER: Thank you, Mr Harper. Mr Allen?

MR ALLEN: I am content to follow my learned friend Mr Devlin and then consider whether I have any questions.

COMMISSIONER: That sounds sensible. Mr Devlin?

MR DEVLIN: Thank you.

CROSS-EXAMINATION:

MR DEVLIN: Doctor, Ralph Devlin. I represent the Medical Board of Queensland. I want to focus on the two patients Mr Bramich and the young lad P26. Firstly, I want to show you this document in relation to Mr Bramich.

COMMISSIONER: Do you want that displayed, Mr Devlin?

MR DEVLIN: Yes, please. There are a couple of aspects I would like to go to. Perhaps the witness could have one as well, sorry. Is that a report you did for the Coroner or for the hospital? Firstly, does it bear your signature?-- Yes, that's my signature, that's correct.

And just see what the heading says, if that can be scrolled down a bit? "Report on issues regarding the care of Desmond Bramich". Do you recall whether you did this report for the Coroner or for the hospital?-- I can't recall which one was which, I am afraid. Both were similar.

The document is undated. If Mr Bramich passed away early on the 28th of July, are you able to say - able to estimate or recall how long after the events of the 27th of July you completed this statement?-- I remember submitting a statement during the time I had injured my leg and I was away from hospital, which I think was in October/November.

So quite some time after the events?-- Some time after - I can't remember whether it was the second or thirst - but I remember writing the statement around that time-frame.

Is it a true statement? Is it a true statement?-- What I wrote?

Yes, what's on that document?-- Yes - this one here?

Yes?-- What I wrote?

Yes?-- To the best of my knowledge, yes.

Right. In the second sentence you say, "I was involved in the 11 hours of resuscitation with Dr Younis, ICU consultant, and also present at the postmortem. If Mr Bramich passed away at about midnight on the 27th/28th July, do we take it that you had contact with the patient almost continually through the day of the 27th of July from about 1 p.m.?-- Pretty much a good part of that period, yes.

Did any other medical practitioner have as much contact with Mr Bramich as you did through that period?-- Several people involved, it was all team work. Dr Younis was involved, Dr Carter was involved at some point, Dr Patel, Dr Gaffield.

Yes, I understand that. My question was really directed to the continuity of your contact with the patient and, therefore, your ability to witness the various discussions that went on through the day. For example, were you called away to any long operation in OT?-- No, I never left for any operation. I would have perhaps gone to the ward to do some things here and there but can't specifically tell you what - how much time I was out.

During that 11 hours can you describe the continuity of your contact with the patient then? Was it sporadic or was it fairly consistent contact through that 11 hours?-- Sorry, what do you mean by sporadic? Continuous?

Well, were you in and out doing lots and lots of other things or are you conscious that you were-----?-- I don't normally - during the time I would have been in the operating theatre assisting Dr Gaffield, that would have been the normal course of action, but because of the seriousness of the situation, I didn't go to the operating theatre so my focus was on attending to this patient.

Attending to Mr Bramich?-- Bramich.

Thank you, thank you. Into the second paragraph, third line you say, "He was under the care of Dr Gaffield as the in-charge consultant with an opinion from Dr Patel." Does that accurately describe the situation?-- That is correct.

Now, the next sentence says, "It seems that there is some misconception that there was no intention to transfer this patient or there was a significant delay." I want you to listen very carefully: did Dr Patel override the transfer at any time to your knowledge?-- No, he did not.

Now, we have heard that you were a signatory to a letter supporting Dr Patel. Have you in any way slanted this report, having been created some months later, to support Dr Patel, or

is this an accurate account?-- This is an accurate account. I wouldn't do that.

Well, you say that the surgical unit's decision to transfer was made after 1600 hours. That's at the top of the third paragraph?-- That's correct.

Do you see that?-- That's correct.

After - sorry, following a CT Scan to delineate his injuries?-- Correct.

You say that is the truthful position?-- The surgical unit. And I will have to clarify that was Dr Gaffield's decision-----

Very well?-- -----by surgical unit, as compared to the intensive care unit.

I see?-- That's why I used the ward "surgical" there.

Righto, thank you. Go to the third sentence in that paragraph. You say that the delay in transfer was occasioned by the fact that there were no beds available in the IC unit at PA?-- That's correct. I heard that indirectly.

In the succeeding or the last-----

COMMISSIONER: Sorry, Mr Devlin. You say you heard that indirectly. From whom did you hear that?-- I can't remember - I can't recall specifically who. There was a lot of people involved, few phone calls, nurses and I think there may have been someone - a junior in intensive care. I can't recall specifically who may have taken a few calls. So there were several people taking calls back and forth. So I can't tell you exactly who.

MR DEVLIN: Going to the second last paragraph, you say, "Further discussions were made with the PA Hospital following a further deterioration in the patient status. A bed was finally available only after a retrieval team had already been dispatched."?-- Correct.

Now, we know from a report by Dr Carter that the request time was 4.20 p.m. and the dispatch time was 7.30 p.m. Does that assist you at all, when I give you those times, that we for the moment have to accept?-- I will accept them, yes.

Yes. Does that assist you though - what I really want to ask you is this: would it be unusual that a retrieval team was already in the air before a bed was made available?-- It was a little unusual, but in the context of when these things happen, there were several phone calls. They would say, "There is no bed", "now there is a bed", "the retrieval team is coming", "it is not". There were several discussions back and forth and I remember us telling the patient's - Mr Bramich's spouse or wife, family that they don't have a bed, now they do. We were saying several things during the

course of the night.

Very well. In the last paragraph you refer to his "deterioration and unstable clinical state"?-- Correct.

You expressed the opinion that it "would have been extremely difficult to manage him on transfer"?-- That's correct.

So overall when you were called upon to report, you took the view that the delay was about the availability of a bed and you certainly do not acknowledge in this report that Dr Patel overrode any earlier transfer?-- He may have said things, but Dr Gaffield, as far as I recall, was the consultant and I do hear - I do remember Dr Patel telling - saying it is Dr Gaffield's call.

Do you say that Dr Gaffield remained in charge of his patient so far as you could see?-- He did remain in charge and Dr Patel was consulted to help in difficult situations, and that's been the practice up in Bundaberg.

COMMISSIONER: Dr Boyd, you just told us that you recall Dr Patel saying it was Dr Gaffield's call?-- That's correct.

Can you give us the context in which that discussion took place?-- Oh, that means if the patient needs to be transferred or not, that's Dr Gaffield's call.

I understand what the comment means?-- Okay.

But let's put it in context. Was there a discussion about transferring the patient?-- I think it stemmed from a discussion about transfer, what to do next, yeah.

And when did that discussion take place?-- Sorry, I can't recall exactly when. Everything was blurred during that time.

Well, at 4 p.m. a decision was made to transfer the patient, according to your recollection?-- Four to five. It was after the CT Scan, yes.

All right. So this discussion would have been earlier in the day, is that right?-- Would have been around that time, just - just-----

Well-----?-- -----before.

Was this discussion at the time of the decision to transfer the patient or was it at an earlier time when a decision was made not to transfer the patient?-- Sorry, I just got a bit lost there.

Let's start again. You tell us you recall Dr Patel saying the words that it was Dr Gaffield's call. You recall that?-- Yeah.

Now, that could only have come up in a situation where there was a discussion about transferring the patient?-- That's right, yes.

Right. So, there were different views being expressed at some point in time and Dr Patel put in his view, Dr Gaffield put in his view, and at the end of that discussion Dr Patel said, "Well, Dr Gaffield, it's your call."?-- That's correct, yes.

Now, was that at the stage when a decision was made to transfer the patient to Brisbane, that discussion, or was it at an earlier time during the day?-- It would have been - it would have been leading up to that decision.

All right. And the views expressed by Dr Patel during that discussion, were they views in favour of or against transferring the patient?-- I can't recall specifically. He may have said some things in the background, but I can't recall specifically whether he said he should have been transferred, not to transfer. No, I can't.

Can you confirm this: the very fact that you remember Dr Patel saying to Dr Gaffield, "It's your call."-----?-- That's correct.

-----suggests - to me anyway - that Dr Patel and Dr Gaffield had a difference of opinion and the way of resolving that difference of opinion was for Dr Patel to say, "Well, Dr Gaffield, it's your call." Is that how it happened?-- That's possible, yes.

Yes. And would that difference of opinion - and that difference of opinion related to the question of transferring the patient?-- Yes.

Do you recall a situation where Dr Gaffield had one view and Dr Patel had a different view with regard to transferring the patient?-- I didn't notice any immediate clash, if you like, of opinions.

It wouldn't have to be as much as a clash, but as you already agree, the very fact that Dr Patel says, "It's your call.", suggests that they had different viewpoints?-- Possibly, yeah.

All right. Do you recall what those viewpoints were? Was it Gaffield in favour of transferring, Patel against, or was it Gaffield against transferring and Patel in favour, or can't you remember?-- I do remember Gaffield actually - prior - because before the CT scan there was the issue of transfer.

Yes?-- And I remember a point Dr Gaffield saying, "We can't just transfer the patient, we need to know what's going on.", so that's when we wanted a CT scan, and it may have been some time during that discussion - and there was a point where both were in agreement, "We can't just bundle the patient off and transfer him. As surgeons we need to" - I'm speaking on behalf of - as the discussion I heard. And part of the discussion stemmed around that they needed to get more information first rather than just transfer. That's when the CT scan was ordered, and looking at the CT scans and I think subsequent to that during that discussion it was probably when

this happened.

Dr Boyd, is it fair to say that your recollection of the discussions took place, the order in which they took place and the time at which they took place is really very vague?-- That's correct. Everything happened suddenly, and while one thing was happening something happened - else was happening on the side. We were getting bits of information here, there, so it's very - it's not easy to put things in an immediate sequence.

So if, for example, there was a witness - I am not saying this is the case - but if there is a witness who said, "I've got a very clear recollection that there was talk about the patient being transferred to Brisbane and Dr Patel said, 'No, you are not transferring my patient to Brisbane.'", you couldn't dispute someone who has a clear recollection of events?-- I couldn't dispute that if someone heard that, yep.

Thank you. I'm sorry.

D COMMISSIONER VIDER: Dr Boyd, looking at that statement, that paragraph - that's the top paragraph that we're looking at on the screen - where it says, "The thoracic surgeon at PA was notified via their intensive care team."-----?-- That's correct.

-----who notified the thoracic surgeon at PA?-- The intensive care unit at the PA.

Is it a correct observation then to say that there was not unity over the management of this patient between the surgical team at Bundaberg Base Hospital and the ICU staff at Bundaberg Base Hospital?-- I'd have to say there was a lot of things happening and coordination and everything, it was difficult to get good unity, correct.

All that being the case, that there was a lot of things happening-----?-- That's correct.

-----I'm talking about the clinical decision making - was there harmony or disagreement or a difference of opinion between the ICU staff and the surgical staff?-- That did fluctuate from time to time. There was at one point, "Yes, transfer may be - not right now, is unstable", so that - I felt that it did fluctuate during the course. There were times where they seemed to be in agreement, there were times when they were in disagreement.

Would you agree that where you have got a patient whose condition is very unstable following these sorts of injuries, that those sort of differences need to be sorted out fairly quickly so that all of you can remain focused on the patient's care?-- That's correct. Everyone was - is working, I think, in the unit, were busy actually giving blood units and actually with the patient for a good part, which meant we couldn't be on the telephone. Others were on the telephone, so there was a lot of things happening, someone doing this,

someone doing that, and coordination wasn't less than ideal.

But it does seem to me that while you are all busy doing things, and I understand that, you have also got two points of disagreement, one team's saying transfer him and the other team saying, no, we keep him a bit long?-- No, the other team's saying, "Let's try and find out exactly what's going on here first."

That's what I mean?-- Yeah, and then we might the - there was some disagreement, yes.

Thank you.

COMMISSIONER: Can we scroll down the document up to bit to see the preceding paragraph. You say in that paragraph - you talk about some misconception that there was no intention to transfer. The need for transfer, in fact, seemed to have been instigated by others, not from the surgical team. So, who was it who instigated the proposal to transfer?-- I can't say with certainty. I can only say that we got feedback from PA Hospital that - about the patient, so obviously from then I know there's been some discussion.

That was obviously earlier than 4 o'clock than the surgical - 4.30, whatever it was - earlier than the surgical team's direction to transfer?-- Yes.

Do you know when during the day that proposal-----?-- No, I can't.

-----was made?-- I can't remember the exact times.

I see. And you say you found that to be inappropriate and discourteous to the surgical team?-- Yes.

Who are you suggesting committed this discourtesy?-- I'm not suggesting - I don't know who did, but is usually courteous that, in my experience, when there is a surgical trauma situation the surgical team speaks with the surgical team to the receiving hospital.

What's the source of the information in those last two sentences of that paragraph that it was instigated by others, not from the surgical team without consultation, which you found to be inappropriate and a discourtesy. Where does all that information come from?-- That comes from me getting phone calls from the PA asking about the patient, "What's happening up there?", all that sort of stuff.

Was that earlier than 4 p.m.?-- I can't recall exactly, no.

Well, it would have to be, wouldn't it, because according to your evidence-----?-- It would seem that, yes, before.

-----it was before the surgical team had decided to transfer the patient?-- Yes, that would be correct, yes.

All right. So, is that a correct statement of your knowledge, that at an earlier time on the day prior to the surgical team's decision to transfer the patient someone else within the hospital, whether it was a medical team or an ICU team or whatever, but someone else had been in contact with the PA trying to arrange a transfer of the patient?-- Yeah, that would be correct.

Yes. But that proposal was not actioned until after 4 p.m. when the surgical team decided that they would go along with the idea of transferring the patient?-- Yeah. That would seem correct, yes.

Yes. Thank you, Mr Devlin, for clarifying that up.

MR DEVLIN: I tender that document.

COMMISSIONER: Yes. Dr Boyd's report on issues regarding the care of Desmond Bramich will be Exhibit 261.

ADMITTED AND MARKED "EXHIBIT 261"

MR DEVLIN: I want to take you now to the patient chart for P26, please. You have had a chance to look at that chart overnight?-- Yes

I have directed your attention particularly to entries on and from Boxing Day, the 26th of December. I want to step you through these as quickly as I can and I want you to tell us if you are able to nominate whether you were present for a particular ward round or not. Do you have a page - I am not sure I can give you a number, but at the top is the date 26th of December '04?-- Correct.

"Review with Dr" - it looks like Robinson?-- Robinson, yes.

Did you sign that entry?-- Yeah, that's my signature.

There were other later entries on that day. It's Boxing Day. Are you able to give us any time? The earlier entry by Dr Patel is at 8.15 a.m., and then the next entry is yours?-- That would have been - I think some time between there and lunch. That's-----

Right. You have noted, "No change in management at this stage. Foot warm to ankle." What are the next words, please? "Same bluish tinge mottled appearance?-- Mottled appearance, yeah, distal and dorsal.

Distal and dorsal. Thank you. Now, we see various - did you make further notes on the 26th of December, the bottom half of that page, or is that someone else?-- No, I don't think I made any further notes here.

When you did ward rounds did you adopt the practice of reading the nursing notes at the time of the round?-- Sometimes we did often get a verbal with the nurse because they would say this and this happened.

Right. Thank you. Well, the next entry, middle of that entry, whoever made it says, "Circulation to left leg remains poor. Warmth, ankle, heal. Cool mottled foot." Is that Dr Patella reports no change when viewed?-- I think so, yes.

"Serious ooze plus plus"?-- "Serous" not serious.

Serous. Thank you. Over the next page, 26th of December, 18.30 hours. Is that your entry?-- Doesn't look like mine, no.

27th of December, 6.55 hours, appears to be a nursing note?-- That would look to be correct, yes.

Now, the 27th of December is a Monday and this looks to be the Surgical Ward round, Boyd/Dobinson ?-- That's correct.

Who was Dobinson?-- Dobinson was the intern working with the unit at the time.

Hazel Dobinson?-- Hazel Dobinson, correct.

Who wrote the entry?-- That would be her writing.

Is there any reason to doubt its accuracy?-- No reason to doubt that, no.

The entry says, "Remains stable.", and then under the heading, "Not", "palpable dorsalis pedis"?-- Correct.

What's that?-- That's to the artery on the - the top surface of the foot.

Does that suggest that there was a pulse or that there wasn't?-- If it's palpable it suggests there is a pulse, yes.

"Post-tibialis but not found using Doppler. Clinically improving." Can you help us with what that means or any recollection you have?-- I can just go by what's meant by what's here.

So you have no recollection of the actual ward round on the 27th of December last year?-- I can't remember specific days ward rounds, no.

Well, then, interpret it as best you can, please?-- From these notes "palpable dorsalis pedis and posterior tibialis", infers that both pulses in the foot were felt but not found on the Doppler, meaning the Doppler was not about to pick it up.

And when a note like "clinically improving" is put in the notes by an intern, is it likely that you and she have agreed

on that observation?-- Yeah, that's likely.

In relation to the left leg then, we have got, "Swollen oblique tight", and then, "Dressings taken down", is it, "for review of fasciotomy sites"?-- That's correct.

"Wounds gaping wide"?-- Correct.

Does that suggest anything beyond the words that are there to suggest whether the leg was, as far as you observed and Dobinson observed, in a good state or a bad state?-- Oh, that implies that - that just implies everything's okay. The fasciotomy wounds are open and - as it should be, and there's nothing there to - of note-----

Right?-- -----to require any specific mention.

Thank you. In the next nursing note, on the next page, done by Registered Nurse Mullins, about the fourth line - we're still on the 27th of December - about the first - fourth line we have got "pulse S", in a circle, can't get the next word, "with Doppler". Can you interpret that at all?-- Pulse - might look to be - it might look to be popliteal but I can't-----

Popliteal?-- Popliteal. That's the one up in the knee, but that wouldn't seem - wouldn't seem to make sense. It could be referring to------

Is there any note there, nursing note since the writing is fairly legible, that suggests that a pulse was found in the left foot?-- I'm not sure what the "W" stands for here, so I - "dorsalis and tibia" - "dorsalis and tibialis palpable". So, yes the pulses were there.

You have used those terms earlier?-- That's right.

The nursing notes suggests that the pulse was palpable?-- That's correct.

We go to a fairly late hour then, down at 22.40 hours, still on the 27th of December?-- Yes.

We have got the words "Nursing" - is it "supervised by medical team and Dr Gaffield"?-- Seen by.

Seen by. Thank you. Something "obs"?-- "Circulation obs".

Right. "Attended by doctors. Good pulse around ankle"?-- "Faint at lower".

"Faint at lower part of foot"?-- "Foot", yeah.

"Foot top remains cool and motley"?-- Yes.

"Large leakage from dressings". So that suggests a visit by the medical team and Dr Gaffield at 10.40 p.m. on the 27th of December. Is that the way to interpret that?-- Not

necessarily. Sometimes the note may be written there but the references may have been made to the early part of the day.

On the 27th of December are you able to say whether or not you were a member of the team that visited that patient with Dr Gaffield?-- I would have to say yes, I was. I can't specifically recall, but if my name's put up on the front, yes, then I would have been present.

Thank you. Let's go to the 28th of December. We have a Surgical Ward round?-- Yes.

Are you able to say whether or not on Tuesday, the 28th of December, you participated in the Surgical Ward round?-- It's hard to say with certainty.

What else would you have been doing if you weren't doing a ward round?-- It's possible having clinics, operating theatre sessions. It's possible, but I can't say whether I was there or not.

There's a reference to "multiple transfusions" in the little entry in the middle of that entry, "multiple transfusion. HB", something, "yesterday"?-- 83 or 87.

What does that suggest to you?-- That suggests he'd lost a lot of blood. "Multiple transfusion" could be an entry from what he had previously and "HB yesterday 83", so just what the level of - his haemoglobin levels are.

Is that a good or a bad level? Is the patient doing reasonably well or not?-- In a young, fit, healthy person that's an acceptable level, yeah.

Thank you. The multiple transfusions might have been an historical description?-- That's possible. Sometimes we get notes like this, yes.

Thank you. Now, we go to the entry about the left leg, still on the surgical round of Tuesday the 28th of December. "Mottling appearance" - on the next page, doctor?-- Yes, I have got it.

"Mottling appearance", something else there, "decreasing". "Mottling appearance decreasing. Patient has increasing sensation of pain in foot". The word "pulses", with a tick, question", mobility of foot". Have I interpreted that correctly?-- That's right.

"Sensation and pain", so, my friend says, Mr Allen. "Patient has increased sensation"?-- "Sensation and pain", yes.

"And pain", so that at least shows that the leg was checked at that ward round?-- That's correct.

And it would appear that Dr Dobinson has signed off on that entry?-- That's correct.

That's the AD#0008?-- That's right.

What's the #0008?-- That's a pager number. So if someone wants to get hold of you, you page 0008.

Thank you. We have got a nursing note, 28th of December, by Nurse Mullins. We can skim over that perhaps. Another one by Nurse Nichol. Another one by Nurse Mitchell. Takes us on to the 29th of December, which is the Wednesday. We have a Surgical Ward round noted. Again, are you able to say whether or not you participated in the ward round of Wednesday, 29th December?-- Again, I can't say with absolute certainty, but there's a good chance I would have been there.

Over the page, do you see that the ward round is again noted by Dr Dobinson, the intern?-- That's correct.

In the middle of - the second entry on that following page we have "foot - left foot improving. Decreasing mottling. Pulses by Doppler", tick?-- Yes.

"Still unable to move foot"?-- Correct.

In relation to dressings, because we have received evidence that this lad was in a distressed state in terms of the condition of his leg when he arrived in Brisbane, "Dressing today lunch time with Dr Gaffield". Is that how we're to interpret that?-- Yep.

What does that mean to you?-- Lunchtime today - that would mean the plan was to do the dressings around lunchtime when Dr Gaffield would be around, because it was difficult to do dressing changes in the morning, there was just wasn't enough time.

Then the next entry about, "Consideration of a splint to keep the foot at 90 degrees"?-- Yeah, that would be right.

And we later see there is splint from physiotherapy. We will come to that. Then down the bottom the entry is, "Physio resplint. Have reviewed this a.m. and likely too painful as yet to have splint on. Will monitor over next few days, re swelling and foot position". Get that right?-- Yep.

Next entry, 29th of December, still on the Wednesday, we have, "Physiotherapy coming in. Too painful for splinting."; correct?-- That would be the gist of it, yes.

Right. Just trying to move through this pretty carefully. 29th of December down the bottom of the page, at 22.50 hours, by the look of it, 10.50 p.m., "Nursing unable to obtain pulse on upper foot with Dopplers". Correct?-- That's what is written, yes.

Couple lines down, "Cool on foot. Cold toes. Leg elevated. Dressings intact." Correct?-- Yes.

"Large haemoserous ooze from femoral wound site"?-- Yes.

Does that suggest after so many days after an operation that things are problematic?-- The groin area's always a difficult area, always particularly prone to serous discharge, and from a nursing point of view it's a difficult area to clean, mobilise, so, yes, we did. And I think in some of the notes he developed a bit of a pressure sore between the scrotum and the fold. It was always a difficult area to clean.

Right?-- That's explained in that context.

That's a nursing note we have just seen. Over the page, 4.40 a.m. on the 30th, which is now the Thursday, fourth line down we have got here, "Change is noted. Large ooze from leg wound". What's the next word? Can you pick that up?-- "Continues".

"Continues". Right. Sorry, "No change is noted." Sorry, there's a word "no". That changes the sense of it. "No changes noted." "Large ooze from leg wound continues." That seems to be a reference to the fasciotomies?-- That's correct, yes.

Can you remember whether or not you adverted to such things as this?-- Sorry?

Can you remember whether or not you noted such things as this yourself?-- As the - with regard inspecting-----

Yes?-- -----fasciotomies?

Yes?-- We - we did look at them but - is that what you are getting at?

Yes?-- When we reviewed the patient-----

Yes, yes?-- -----it wasn't always possible in the morning because, from memory, he had a lot of pain and we needed to give him a bit of pain relief first and take time taking the dressings, so it was not always possible that we were always there to see it, so-----

COMMISSIONER: But the ooze from the leg wound wouldn't have been easy to mess with?-- Sorry?

The ooze from the leg wound, the notes refer to a large ooze. That's right, isn't it, Mr Devlin, a large ooze from the leg wound?

MR DEVLIN: Yes, from the fasciotomies. I'm sorry, I don't have a copy to put up on the screen.

COMMISSIONER: You wouldn't have missed that very easily, would you?-- No, no. This is the fasciotomy wound, which is an open wound.

Yes.

MR DEVLIN: 6.30 a.m. on the 30th, you see another little note within the nursing note by Registered Nurse Mitchell, "Temp elevated at 39 degrees". Does that suggest a problem developing?-- Yes, that would.

I think it's one of the first entries we see on an abnormal temperature. I am going to take you to one other part of the chart at which you haven't looked at yet, but the last of that note by Nurse Mitchell is, "Advised to wait until ward round for review." See that? That's at 6.30 a.m.?-- That's right.

"Surgical Ward round on Thursday, the 30th of December". Again you are not able to recall whether or not you were present?-- That's hard to say from this.

Again, Dr Dobinson, the intern, has done the entry?-- Correct.

Correct? And we see under the heading, "Surgical Ward Round. Decreased swelling in leg. Leg elevated". What does "good UO" mean?-- I think that's good urine output.

"Good", sorry, "urine output". Thank you. "Febrile", is it, "this a.m."?-- That's correct.

"Temperature elevated", something, "p.m. every evening"?-- "Every p.m.", or something like that, yes.

Okay. What does that entry suggest to you about how the patient's going?-- I mean, we at this point - we were aware he had very extensive fasciotomy wounds and these were open to the air, so there was always a possibility of that being colonised with bacteria, being a very extensive open wound, yes.

Sorry, so a high temperature would be indicative of that, perhaps?-- Could - likely possibility of that being a problem and having to see where it's coming from. That would be the-----

Right. Thank you. Under the heading, "Foot.", we have got "Improving. Decrease in mottling", down the bottom of the page?-- Yes.

Do we see anywhere where there's been an attempt to feel for the pulse again on this particular ward round? Is there anything noted there that you would like to draw our attention to?-- I guess there's a special note there, "Increased sensation", which from memory, he had very poor sensation and he was starting to gain sensation. So that was considered an improvement.

30th of December '04 is the physiotherapy entry. Was it your practice to have regard to physiotherapy entries on the chart whenever you looked?-- Sorry?

At the bottom of the next page sorry?-- Yes.

One entry there is, "Foot appears a better colour with improved sensation to light touch. Active movement noted to foot ankle, though the attempt to move causes pain." And then it appears that the - right at the bottom page, "Leg and foot checked. Three hours post application of splint to check for any pressure areas", over the page. So, if you have looked at that, what would that suggest to you, if physiotherapy's there applying a splint and making those comments?-- That would suggest that he's doing okay if they are happy to put on a splint. The swelling's reducing and they are picking up sensation.

Right. But we've got a nursing note then, 30th of December '04, 1530 hours. We've got a couple of references to "oozing plus plus", we've got "groin area oozing plus plus plus". What does that suggest to you?-- There's ongoing fluid seepage from - I'm not sure where they - must be from the fasciotomy site. I can't say from these notes here.

So would that suggest still a real possibility of infection?-- Certainly. With an open wound there's always, as I said, the possibility of being colonised by bacteria and causing infection, yes.

The last note by what appears to be Registered Nurse Mullins, however, is, "Swelling decreasing. Left foot less mottled." Is that right? Against the word "addit" - A-D-D-I-T - for "additional". See that? Just above the date 30/12/04, 1535 hours?-- "Swelling decreased" - yes, yes, okay. I've got it.

So there's a mixed message coming from at least the nursing notes at this point. Possible infection, but swelling's decreasing in the left foot and less mottling?-- Not necessarily. Infection is a separate issue to blood flow in the limb, so it would seem from this note that blood flow to the limb was okay and the next problem was fasciotomy wounds, which were a likely source of infection. So it would suggest he's improving in one area, not so much in the other.

Then we've got a note from Dr Dobinson five minutes later on the same day, "Patient continues to have temperature to 38 degrees and tachycardia, but" - and can you interpret the rest?-- That would be - mean a normal white cell count.

Normal white cell count "till today"?-- "Till today".

Can I just show you the pathology results covering the span of days, and I've marked the white cell count. Does that tell us that on the 30th and 31st of December the white cell count started to give an abnormal reading?-- That's correct.

How abnormal?-- It started climbing up.

How abnormal? Is that - are we looking at a serious situation?-- Oh, it's showing an infective inflammatory process going on, yes, but it implies that there's either an infective or inflammatory process. That's what that means.

They're for the dates up to 31 December, aren't they?-- That's correct.

The readings, though - just keep that one. The readings are within tolerances until the 30th and 31st of December. Do you agree? Sorry, I mean on that sheet?-- Oh, yes. Up to that, reasonable, 10.5 on the 29th, on the 30th 17.8, and the 31st 19, yes.

So they jumped on the 30th and 31st of December?-- That's correct, yes.

If you go back then historically, the white cell count in the other document in your right hand shows normal?-- Normal, that's correct, yes.

Righto. So we've got a young patient coping until the 30th of December, at least on the objective figures?-- That's correct.

Is that a fair comment?-- That would be a fair comment, yes.

Can I have those back then? I won't be much longer. Over on the next page - again you don't know whether you were present with Dobinson on Thursday, the 30th of December?-- No, I can't say with any certainty.

Over on the next line - next page, though, down near the bottom, "Take out central line." What's that about?-- A central line is an intravenous line that would have been put in in intensive care for fluid resuscitation, fluid management, IV antibiotics.

IV antibiotics?-- If required. That would be what the central line would be for, and that would have been most likely from his time in intensive care.

Can you suggest a reason, from your experience, why an IV line which is used to apply antibiotics would be taken out at this point?-- At this point with a temperature, you've got to look at all possible sources and folk eye of infection, and a central line is a foreign lumen inside the body, and one would tend to take that out because it can get colonised on the tip and be a source of infection. So at this point in time we're looking as to what are causes-----

All the possibilities?-- Yes, all the possibilities.

D COMMISSIONER VIDER: But if you removed that central line, did you put in another one?-- I can't say, but that would be the case. If he needed one, he would get a small peripheral line.

COMMISSIONER: That should be the case, but there's nothing to indicate that happened?-- Putting an IV cannula is not necessarily written down. I can't say with any certainty whether it was done or not, but if he required it for antibiotics he would have got one, yes.

D COMMISSIONER VIDER: You would expect the insertion of a central line to be noted in the chart, would you not?-- That would have been in the intensive care notes, which may have been early on. So that would be in the notes somewhere, yes.

I'm talking about the central line. If you took that one out, you'd put another one in, because you wouldn't discontinue the antibiotics, would you?-- No, no. If you took out the central line you would either replace it or put a peripheral line in, but you'd still have an intravenous line to give the antibiotics. It's not stopping the antibiotics. That's

removing a source of foreign body that's likely to be a source of infection.

I understand that. Would it be likely, though, that you'd put a peripheral line in for antibiotics where you've got an increasing white cell count and other symptoms indicating infection? Would you think it likely that you'd put a peripheral line in for antibiotics rather than another central line?-- You would. That's common practice to use, and that - you can buy a bit of time if he needs a bit more, and one or two days later you might put a central line in. So that's done.

MR DEVLIN: About five lines down on a page beginning - I think I need you to turn a couple of pages, but it begins - perhaps just the next one, the 30th of December '04, 2240, "Nursing" up the top. The fifth line, does that show the insertion of another line in the right arm? About the fifth line?-- Yeah, "IVT commenced right arm."

Would that be what you're just referring to with Ms Vider?-- That's correct, yes.

What does the next entry mean, "Febrile to 39 degrees."?-- 39.3 degrees.

39.3 degrees. "Now afebrile", is that right?-- Yes. I could only guess that it means it was 39 earlier on in the day. At that point in time it may have gone down.

You read it as being the temperature is going up and down a bit?-- It could mean that, yes.

Let's go to - this is a nursing note, but I think we've got here 31 December, 7.25 a.m.. The last five entries there before we get to the 31st of December, New Year's Eve. "Leg oozing and groin plus plus. Pads changed intermittently. No dorsal" - it seems to read "pedial pulse present"?-- Dorsalis pedis.

"But posterior tibial pulse audible." So no foot pulse is detected at that point. Correct?-- On one of the pulses, because there's two foot pulses. The posterior one is detected here. The anterior one isn't.

"Left foot remains extremely swollen and mottly. Cold to touch and tender."?-- Correct.

Then that's the last entry before the ward round of Friday, 31 December. Again you don't know whether you were there or not?-- It's - yeah, it's hard to say. I may have been there in the morning Friday, if I was off the weekend.

Is there any way to check that against any other records apart from tipping the hospital upside down to see what else you were doing?-- Probably would be hard to verify that. I can't see any other way of-----

Right. Now, it seems the first entry is, "Bloods from yesterday."

D COMMISSIONER EDWARDS: Could I ask, Mr Devlin, that ward round was a routine ward round or a visiting medical officer's ward round, or what kind of ward round are you referring to?-- On this date here?

Yes?-- The 31st.

The one Mr Devlin is asking you about. Is it your ward round-----?-- On the 31st? Is this the-----

COMMISSIONER: Yes, the 31st. The Friday.

D COMMISSIONER EDWARDS: The 31st?-- It's hard to say because the intern's notes - sometimes she was write my name, the consultant's name, someone's name. So it's often difficult, but someone would have been around. It's hard to gauge that from the notes. I can't say with any certainty.

Does it appear that it was the intern doing that ward round?

MR DEVLIN: If you go over the page, witness, you will see the signature again?-- Yes, I see that signature. There's a note saying, "Discuss with Dr Risson x-ray report." I can't say with any degree of certainty. The fact that she said "discussed" here, it may have mean - it's hard to say whether there was anyone else there or not. I can't say with certainty, no.

D COMMISSIONER VIDER: Doctor, given that you were the PHO and the other doctor named in that record is an intern-----?-- Yes.

-----would you not have gone every day to see this 15 year old boy?-- Pretty much, yes, but as I say-----

Not pretty much. You either would have seen that boy every day - I mean, this would have certainly been of clinical concern to you?-- Yes, yes.

So would you not have gone to see him every day?-- I would have, yes.

Have you seen fasciotomies done before for compartment syndrome?-- I have seen it done before, yes.

So you had something in your mind clinically to compare this with?-- That's correct, yes.

And you were quite happy yourself with this clinical progress as it's charted in the record?-- Yes, it seemed to be going okay, yes.

D COMMISSIONER EDWARDS: Could I - sorry to interrupt?-- That's all right.

Could I ask you then, is that advice that you gave Ms Vider as a result of your feeling one of the pulses, the colour of the foot? Not necessarily the swelling, but the basic, important clinical signs of circulation?-- His sensation was coming back according to the notes, and that's a good thing as well in assessing circulation.

So we could say that the advice that you felt that you could give us is on the 31st of December there was hope for that leg, and it appeared that there was going to be a successful outcome?-- Yes. We'd be thinking possibly maybe or maybe not. It's a balancing act in the situation here, and with sensations coming back, having one pulse present, the other not, again you think - you know, you weigh up situations accordingly, but nothing to suggest he's made a significant sudden change.

Thank you.

COMMISSIONER: Doctor, I'm sorry, just from that answer, it follows that on the 31st the leg was at risk. It may or may not survive. Is that right?-- Sorry, can-----

On the 31st the clinical indicators suggested that the patient may or may not lose that leg?-- Yes, he was - I guess the word we use is he was hanging in there, yes.

And that was the same on the Thursday, the day before, the 30th?-- According to the notes and things, yes, memory.

The same on the Wednesday, the 29th?-- That would presume to be the along the same pattern.

The same on the Tuesday, the 28th?-- Yes.

Can you explain why the patient would be kept in Bundaberg when this 15 year old boy was at risk of losing his leg? Not suddenly on the Friday or suddenly on the Saturday, but he'd been there for a week and was still at risk of losing his leg?-- I mean, now in looking at the notes there was - as far as I can see there was no definite period of time where there was a sudden deterioration. There was a pattern of a slow - foot being cold, weak pulse, we can feel the pulse, that sort of pattern over subsequent days. So there was no distinct timeframe where the foot was warm, you could feel a pulse now, you can't totally at all. There was no distinct change in that pattern.

D COMMISSIONER VIDER: But repeatedly in the records there's a description of that foot that says it's mottled?-- Mottled, yes.

This is a very fit 15 year old?-- Yes.

Did you not have concerns about the increasing ischaemic condition?-- It would have been - had concerns about the mottly appearance.

Not you would have been. This is what you were seeing?-- Yes.

You would have had a right foot that looked very good?-- Yes.

A left foot that looked very mottled?-- Yes.

Now, that mottling really didn't change. It might have gone up and down a bit-----?-- Possible.

-----but it remained mottled?-- That's correct.

Did you not have concern-----?-- Yes, we did.

-----about the circulation?-- Yes, we did, but we take it in context of everything else as well, pulses, doppler, sensation, other factors as well.

I'm looking at it in the context of everything else as well. This is a 15 year old, very fit boy-----?-- Yes.

-----and he has got symptoms that he's presenting to you that would indicate the outcomes one would expect from doing those fasciotomies perhaps weren't achieving their clinical purpose. Would you agree with that?-- From memory, his leg was extremely swollen, and when the fasciotomy was done there was a huge gap. That implies that there was a lot of tension underneath. So it's hard to say that the fasciotomy would not have been justified, so I cannot say that the fasciotomy was not justified on those terms.

No, that's not what I'm saying. I'm saying the fasciotomies were justified, but I'm saying you did the fasciotomies in an attempt to improve circulation to the leg?-- That's right.

But you've got a situation now where you've got clinical signs that that's not really happening?-- There's some signs there, yes.

Was that not of concern to you?-- That would have been of concern, yes.

No, not it not would have been-----?-- It is of concern, yes.

-----was it of concern to you?-- Yes.

COMMISSIONER: Do you remember seeing this patient and being worried?-- Yes, we were worried from the whole time he came in. He poured blood from his groin, nearly died. We were always worried about his condition from there on.

I'm talking the post-operative period when he was lying in a hospital bed in Bundaberg for a week with all of the clinical indicators that Mr Devlin has taken you through one by one-----?-- Yes.

-----showing that there was no improvement, that this patient a week later was still at risk of losing his leg?-- There was

always that risk, but there were sensations which were not present which were starting to come up, and the mottling was always there from the beginning. So there were some indices that suggested that he wasn't deteriorating and some suggesting, with sensation coming back, that there may have been some improvement.

Doctor, on a slightly different subject, Mr Devlin drew to your attention the removal of the central line, and you indicated that that should have been replaced with an alternative source of antibiotics, either by a different central line or a peripheral line?-- Sorry, an alternative source of IV access.

IV access?-- Yes.

But for the purpose of providing antibiotics?-- Antibiotics, IV fluids, whatever the indication was, yes.

This patient had a massive open wound on his leg from the fasciotomies?-- That's right.

He had increasing indications of high temperatures, including regular high temperatures at night. Is that right?-- Yes.

He had an elevated white cell count on the 30th and the 31st of December?-- That's correct.

In those circumstances, would I be right in thinking that it would have been gross negligence not to provide an alternative source of intravenous antibiotics after the removal of the central line? That would have been gross negligence.

D COMMISSIONER EDWARDS: Commissioner, he did tell us that he inserted a new IV line at 2240 that day?-- That's correct. That's what the entry says.

He did tell us. The point that we're all trying to make is was that adequate, or should a central line go back in?-- It depends on what the indication is. A peripheral line is usually adequate for antibiotics. If - once you take out a central line, you're then left with the option of putting one in the other side. If that gets infected you lose your central line access. So in the circumstances, a common practice is to use IV access for - peripheral IV line for one or two days and then put a central line in after that. So it often happens, and I've seen that in intensive care as well in many places. You take out the central line and use a peripheral line.

I'm not an experienced doctor these days - and that may be a good thing - but I find the most concerning factor in this case is not so much whether the IV line and so forth - that seems to be covered, but what I'm having great difficulty with is the possible absence of a pulse from about the 29th, if I remember rightly the nurse's note, at 10.50 p.m. on the 29th that there was difficulty with a pulse and nothing really was done relative to highly specialised care - vascular care from

the 29th to - we're now up to the 31st at 7.25 a.m. in the morning. That is a real concern, and would you agree with that?-- Yes, that would be a concern, yes.

COMMISSIONER: Yes, Mr Devlin?

MR DEVLIN: Thank you. I'll try and move quickly through the balance of these notes, Dr Boyd. Firstly, can I ask for my blood results back, please, before we forget? Maybe I've got them back?-- I think you've got them back.

I have got them back. Thank you. Down the bottom of the next page, just before Dr Dobinson's signature, is "Continue IV fluids. Keep splint on. Elevate the leg. Dressing" something "daily". Would that be "dressing leg daily"?-- Yeah, that would be what that's referring to.

"Review with Dr Gaffield today." Fair enough?-- Yes.

Just go back up that page, "Today IV fluids running 24-hour basis" - no?-- That's the rate, so one litre over 24 hours.

Thank you. "Eating increased (family brought in food)"?-- Yes.

"Foot in splint. About the same. Leg appears less swollen."?-- Yes.

All the way through we're seeing some negative indicators and then-----?-- Some positives.

-----some positives. Let's go over the page then. I'm sorry, I wanted to ask you about Dr Risson. It says, "Discussed with Dr Risson" - what's "XR report"?-- X-ray report.

So Dr Risson's the orthopaedic registrar?-- He is the orthopaedic registrar who also worked in general surgery. We have one orthopaedic registrar, two general, and both cover general and orthopaedics afterhours and on the weekends.

Would you accept that this appears to be the first reference to Dr Risson?-- That's correct, yes.

In the notes that you've reviewed overnight?-- Yes.

The 31st of December over the page, physiotherapy notes, nursing notes then, 31st of December. Then we go to surgery. "Dobinson, 31st of December. Discussed with Dr Gaffield re spiking temperatures and increased white cell count. To do BCs when temperatures spike."?-- "BC", blood cultures.

Blood culture. "May need to go back to OT if temperatures continue for cleaning of wound."?-- Correct.

Okay. Do you recall speaking at all to the boy's mother?-- I do recall speaking with her several times during-----

In this period? In this period after Dr Patel departed?-- Yes, I do recall speaking several times. I can't remember when exactly.

Do those recollections spread - stem to whether other medical practitioners were present for those discussions with the boy's mother?-- Can't recall that.

Did the boy's mother ever plead with you or suggest a transfer to Brisbane?-- That discussion did come up, yes.

Did the mother exhibit great concern that a transfer should be done? Or was it simply a discussion of the prospect? How do you recall it?-- It was a discussion of the prospect. She didn't come across, "Look, doctor, I'm very, very unhappy. He should be transferred." It wasn't in that context. It was a general discussion about transfer to Brisbane or so-----

COMMISSIONER: Do you recall her saying something along the lines that money wasn't a problem, that they wanted the best care for their son, and if he had to go to Brisbane they'd find the money?-- That's possible in the context, but no, I can't say specifically. But in the gist of it, yes.

MR DEVLIN: Did those conversations with the boy's mother alert you to the prospect that perhaps he should be transferred to Brisbane?-- We were always - it was always in the back of our mind, yes, from the beginning.

D COMMISSIONER VIDER: Mr Devlin, did you just read out there an entry that said "may need to go back to the operating theatre"?

MR DEVLIN: Yes, "if temperatures continue for cleaning of wound".

D COMMISSIONER VIDER: That would indicate to me that there was a fair degree of support for the notion that you would be keeping the boy in Bundaberg?-- Yes, if he was to go to theatre, that would be - that would have been the intent.

So I find it a bit hard to say that you were contemplating all along that this boy may need to go to Brisbane?-- It was always in the back of our minds.

Well, it certainly wasn't in the forefront of your mind when you've got down here an entry that says you may need to go back to the operating theatre?-- With the temperatures, he - I can only infer from what would have been meant here - because I think this is at this point - from the 31st, I think, checking dates, was the weekend. I wasn't working during that period of time.

The 31st, Mr Devlin has said, was the Friday. Is that correct, Mr Devlin?

MR DEVLIN: Correct.

WITNESS: Friday. So I would have been off perhaps the afternoon. I can't remember. Sometimes we have early afternoons. Dr Risson would have been - that's why his note appeared. But from this-----

D COMMISSIONER VIDER: It's not Dr Risson that's saying "may need to go back to the operating theatre", is it? Is that specifically Dr Risson?-- That's the intern of the unit who represents Dr Gaffield, and if Dr Risson was on call, he would be the principal house officer.

I understand that.

MR DEVLIN: Going-----

WITNESS: Sorry, I might add, by going to the OT, the context in which this is meant - he's got extensive wounds and dressings, and that was probably for a dressing change, which sometimes is difficult in the ward, and sometimes to do a dressing change you'd have to take them to the main operating theatre. That would be what that was for, dressing and wound care, which is sometimes difficult in the ward.

D COMMISSIONER VIDER: I understand that.

MR DEVLIN: We're on the last page and a bit of the relevant notes, Dr Boyd. The nursing note of 31 December '04 at 10.25 p.m. suggests a temperature of 37.2. "All hygiene cares attended. Intravenous" something "given. IVTO8/24. Commenced on Endone to good effect. Large volume of haemogenic ooze"-----?-- That's correct.

-----"from the groin." What are the obs they're describing there? Something "obs remain the same"? Anyway, importantly, "Left foot mottled in colour. Toes are cool to touch. Lower half of foot is warm. Patient states sensation to left foot remains numb. Unable to move toes." Is that right?-- That's correct.

Then we seem to have an entry for the 31st of December '04, that being a nursing note. It appears to be "midnight", would that be right? M-I-D-N?-- No, that's Risson, I think that might be.

Oh, yes, so it is. Okay. "Review films." That would be the x-rays that Dr Risson ordered?-- Yes, that's right.

"And discuss with Dr Dobinson"?-- Probably - it wouldn't be Dobinson. It would be Robinson.

We've got a Robinson as well?-- Robinson.

What's that person's name?-- Neil Robinson. He's the orthopaedic surgeon up there.

"Left" - can you interpret?-- "Left acetabulum non-displaced." The squiggle before that refers to a fracture, so fractured acetabulum.

Spell that word?-- A-C-E-T-A-B-U-L-U-M.

What's that?-- That's the hip.

Thank you. And so that's an entry by Dr Risson?-- Yes.

Then on 1 January, 6.45 a.m., a nursing note from somebody called Crossart or Gossart. Would that be right?-- I don't often know the surnames.

"Pain plus plus on slightest movement", then further down she notes the - he or she notes, "Right foot tender, purple, posterior tibial pulse present. Obs stable. Left lower leg the same. Very offensive smelling."?-- That's correct.

We're in a bit of trouble, aren't we?-- It looks that way, yes.

Ward round, Dr Gaffield, on New Year's Day. "Temperature settled this a.m.." What does "P110" mean?-- Probably the pulse at 110 per minute.

Right?-- -----per minute.

"Peripheral" - sorry-----?-- "Pulse".

How do you say that word?-- Popliteal pulse.

"Weak palpable foot pulses." PT palpable, what's that?-- Posterior tibial, I would presume. They have got "foot" there.

And "OP", "DP". "Not palpable with Doppler"? What's that-----

COMMISSIONER: Dorsal, is it?-- Dorsal is there, yes.

MR DEVLIN: Thank you. "Cool toes, blistering foot. Dorsum"-----?-- Yes.

-----"mottling dorsolateral left foot discussed with Dr Gaffield for discussion re RBH transfer"?-- That's right.

Correct? Thank you. One of the themes of your evidence seems to be that you suggested transfer on one or two occasions but you did not consider it your place to continue to raise that issue?-- That's correct, given that three consultants already had been involved in this case, yes.

Those three consultants being Dr-----?-- Dr Patel, Dr Robinson and Dr Gaffield.

Thank you, I have nothing further.

COMMISSIONER: Mr Allen, do you have any questions?

MR ALLEN: Just briefly, thank you, Commissioner.

CROSS-EXAMINATION:

MR ALLEN: Dr Boyd, you mentioned yesterday that you understood that Dr Patel and Dr Gaffield would not undertake intraoperative cholangiograms?-- Correct, yes.

And you said that you understood that was because of the perceived need for arranging radiology services?-- And it may have been part of the practice not to do it. I can't say for sure, but.

Okay. But as far as any reasons which might have influenced such a practice, it would be the type of burden involved in arranging radiology?-- That's correct, yes.

And you said also that it would consume more anaesthetic time?-- That's correct.

Would the - does the cholangiogram occur in the operating theatre?-- Yes, it does.

During the major procedure?-- It does. It occurs intraoperatively, yes, during.

When you say it would consume more anaesthetic time, it would also consume more theatre time?-- Absolutely.

So if one was to undertake that step, the best practice procedure of performing a cholangiogram, it would mean necessarily that such procedures would be longer?-- Certainly, yes.

And do you believe that one of the factors influencing the practice of not undertaking cholangiograms was that there was a reluctance to slow down the throughput of patients through theatre?-- Certainly, and it is also practice anaesthesia is given for an appropriate length of time, and it is never wise to keep anaesthesia going. So also from that point of view as well. If it is going to take one hour to do it, that's almost, one would argue, an extra one hour which shouldn't really be added to the case.

COMMISSIONER: But, doctor, a lap choly isn't a long operation, is it? How long would an ordinary lap choly take?-- 60 to 90 minutes.

All right?-- Somewhere around there.

How much longer would it take to do the cholangiogram?-- Depending. If it is difficult organising radiology, radiographers with limited experience, if they are tied up, that could even take an hour to get all of that organised.

But if it was organised in advance, as one would expect it would be, how long would it take to do the cholangiogram?-- It is hard to quote. It depends on what the practice is at the hospital. A hospital that's running that regularly would do that far more efficiently than one that isn't.

Right. How long would it ordinarily take if you had the right people there to do it?-- I can't really say.

Five minutes? 10 minutes? Half an hour?-- It wouldn't be five minutes. It would be probably of the order of 20 minutes or 30 minutes, something to that effect, because you have got to wheel in the machine, you have got to get - it is connected, you take a few check X-rays, check again. That could take up to half an hour quite easily.

MR ALLEN: And any competent anaesthetist and surgeon could take into account the time involved in performing a cholangiogram and structure the procedure so that there was no increased risk to patient safety?-- Sorry, I am a bit lost. Was it a question or-----

Well, you are not suggesting the performance of a

cholangiogram, because of the additional anaesthetic time, would cause an unacceptable risk to the patient safety?-- The - sorry, I am just having trouble-----

I am trying to fathom your comment that one of the reasons why one would not perform this procedure would be because it would increase the length of time of the patient under anaesthesia?-- That's correct, yes.

If the practice was to routinely perform cholangiograms-----?-- Correct.

-----and appropriate arrangements were made on the part of the surgeon, the anaesthetist and the radiology, that procedure could be carried out without any unnecessary risk to patient safety?-- It could be, yes.

And it would produce the added benefit to patient safety of detecting a possible side-effect from the lap choly?-- Yes, that's possible.

That is why it is considered best practice to undertake such an intraoperative procedure?-- Yeah, it would be.

Okay. So let's get down to the real reasons then why it seems it didn't occur. You have agreed that it would lengthen the overall procedure?-- That's correct.

So, therefore, it would reduce the number of patients who could go through the operating theatre during any particular session or list?-- That's correct.

Do you think that one of the factors that influenced Dr Patel and Dr Gaffield in not undertaking such a procedure was the pressure to put patients through and reduce waiting lists?-- That would be a possibility, yes.

That would be likely, wouldn't it?-- Likely, yes.

Because Dr Patel would speak as to the fact that he was of great value to the hospital. That's so?-- Yeah, he did say that quite a few times, that's correct.

He would bring in money for the hospital and reduce the waiting list?-- That's correct, I have heard him say that a few times, yes.

And he prided himself upon that, didn't he?-- Yes.

And you have spoken about how you would have these blitzes in certain procedures?-- Yes, blitz - colonoscopies and things where we try to do a whole day list on these procedures, yes.

And I think you said yesterday, when being asked about a letter that you signed, that you saw one of his positive attributes as a surgeon was that he was very industrious and reduced waiting lists?-- Correct, yes.

Have you had the benefit of reading the evidence of Dr Jason Jenkins or Dr Ray, vascular surgeons, in relation to their views regarding the treatment of patient P26?-- No, I haven't had a chance to read it.

Okay. Look, do you think it might be perhaps of benefit if you were to avail yourself of that, just to get their views?-- Absolutely. I wouldn't mind having a look, certainly.

Yes. Thank you.

COMMISSIONER: Thank you, Mr Allen. Mr Diehm?

MR DIEHM: Yes, just briefly, Commissioner.

COMMISSIONER: Yes.

CROSS-EXAMINATION:

MR DIEHM: I am Geoffrey Diehm, counsel for Dr Keating, Dr Boyd. I just want to ask you about paragraph 70 of your statement, that is exhibit 260C. That's the one in which you say that you can remember Dr Keating asking you about wound infections?-- That's correct.

Was that a conversation that was part of an exit interview towards the completion of your time at the Bundaberg Hospital?-- Yeah, that was an informal meeting with him to see how I enjoyed my term there.

Yes?-- And if what I felt about Dr Patel, the hospital, was anything I was unhappy with, just an informal matter and that's when it was raised.

Did he ask you about - in this context about discussion about wound infections, about your sense of any difference in the rate of infections or the incidence of infections at the Bundaberg Hospital versus the other hospitals where you had worked at - I think it was Toowoomba and Rockhampton?-- Yes, I guess he was trying to ascertain that, yes.

I am sorry?-- I guess he would have been trying to ascertain whether there was any significant difference.

All right. And you told him, did you not, that in your observation there wasn't any difference?-- All I could say is there was no strikingly obvious difference.

Thank you. That's all I have, thank you.

COMMISSIONER: Thank you, Mr Diehm. Ms Feeney?

MS FEENEY: Nothing, thank you, Commissioner.

COMMISSIONER: Any re-examination?

MR FITZPATRICK: Just a couple of things, Commissioner.

RE-EXAMINATION:

MR FITZPATRICK: Dr Boyd, can I ask you, please, to consider the part of the notes pertaining to patient P26 in which it was resolved as part of his care plan to take out the central line. Do you have those - that part of the notes available to you? I think it bears a note or a label at the bottom right-hand corner which says "QHB", and then there is a number which is "00135"?-- Yes, got that.

Do you have that?-- Yes.

Now, do those notes evidence the fact that on the 30th of December last year, at some stage after half past two or so in the afternoon, a plan was resolved to take out the central line in P26's case?-- That's right.

Can you tell us, please, doctor, what was the function of the central line in the care of that patient?-- It would be for antibiotics and fluids.

Antibiotics and fluids, all right?-- May I just point out where it says "IV line", that squiggle means change on the notes.

And what's the significance of that?-- Oh, it just means to change it rather than take it out and leave it be. I think that was raised earlier. That's all I was just pointing out.

All right. But am I right in interpreting that the part of the note which appears in the bottom paragraph of the page to which I have directed you as recording that there was a plan to take out the central line?-- That's correct, yes.

In the case of this patient, that is remove it?-- That's correct.

And am I also right, if I direct you to the last line of that paragraph, which contains the words "CONT.IVABS", that it was also part of the management of the patient to continue with intravenous antibiotics?-- Correct.

All right. Would you turn, please, to the next page which is numbered 00136. Do you have that?-- Yes.

There is a note by the nursing staff, apparently, which opens with the words "care as care path"?-- That's correct.

"As per care path"?-- That's right.

Is it reasonable to infer from that note that the plan, documented plan for P26, has been put into effect or is being put into effect?-- The care path there often refers to nursing notes where they have a standard protocol in certain patients, so it could be referring to standard procedure or practice, or it may refer to that, I can't say. But that would possibly refer to if, for example, someone has a prostate operation, an operation, there would be a care path the nurses would use day 1, day 2, day 3, day 4. It could be referring to that or it could be referring to the implementation of the medical notes.

Well, does it help you to look two lines down in the note for the - in the nursing note where these words appear - to me it looks like C - "VC or CLC removed"?-- CVL. I take that as central venous line.

The central line?-- Yeah.

So that records that in fact the line was removed?-- Removed and the tip.

And the tip was sent for a culture?-- Correct.

And does that reflect your earlier evidence that the tip might have been a source of infection?-- That's correct, that's always a possibility.

All right. Now, Mr Devlin asked you overnight to review the notes for P26 from, I think, the 26th of December onwards?-- That's right.

Did you do that?-- I had a look at the notes here, yes.

Can you find anywhere in them, or were you able to find anywhere in them an express note that the central line was restored in the case of P26, that is replaced?

COMMISSIONER: Did you find such a note, or didn't you?-- I can't say I found it, no.

No.

D COMMISSIONER VIDER: Who puts central lines in in Bundaberg?-- The anaesthetist.

MR FITZPATRICK: Is there anything in the notes - if, in fact the plan that P26's intravenous antibiotics were to be continued, as had been ordered, I suppose, on the 30th of December 2004, could that have been done only by a central line?-- That could be done by peripheral line.

A peripheral line?-- Peripheral line, yes.

Can you see anything in the notes which evidences that that was done?-- The next line "IVT commenced right arm".

D COMMISSIONER VIDER: That doesn't necessarily say it has got

antibiotics in it. That's intravenous therapy?-- Intravenous therapy. So that implies an IV line.

Was established?-- Was established.

But it doesn't tell you it is an IV line with antibiotics in it?-- No, it doesn't tell us from this, no.

MR FITZPATRICK: Is there any other note which clarifies that issue that you have been able to find?-- That he was given antibiotics or-----

Yes?-- In order to ascertain it I would have to look at the drug sheet.

I see. Do you have that available to you?-- It could possibly be - I don't think I will find it that quickly.

Did you say you don't think you will find it that quickly?-- I don't think I will find it quickly.

COMMISSIONER: I was going to have the morning break after Dr Boyd finishes evidence. I apologise to Dr Aroney that he has been waiting for so long but we might have the break now. Can I mention a couple of things in relation to Dr Aroney's evidence though? One issue is that Deputy Commissioner Vider, as is well-known, practises at Holy Spirit Northside where she has the position Director of Mission. That's also the hospital at which Dr Aroney practises now exclusively. In those circumstances, the Deputy Commissioner feels that there would be at least an appearance of conflict and she is therefore going to excuse herself for the duration of Dr Aroney's evidence.

The second thing I was going to say is that Dr Aroney has very helpfully provided us with an extremely detailed statement. I have suggested to Mr Andrews that there is no need to follow the usual practice of taking a witness step-by-step through the evidence. A lot of it speaks for itself and we can probably confine ourselves to the key issues. The third thing is, as I indicated yesterday afternoon, is that certainly the case of Queensland Health, and any other party who wishes to postpone cross-examination, will have the opportunity to do that, and I will emphasise to the press and media that the evidence given by Dr Aroney is as yet untested, at least on behalf of Queensland Health.

The fourth thing I was going to mention is that Dr Aroney's statement, which I have had the opportunity to read, does refer to a number of what could be regarded as missing documents. For example, in paragraph 32 he refers to a report that was commissioned by Queensland Health but was never provided. In paragraph 59 he refers to angiograph and defibrillator waiting lists which have been suppressed. Those sort of documents, I don't imagine for a moment, Mr Fitzpatrick, that you will have them available immediately, but since those issues have been raised by Dr Aroney, I think we should have the opportunity to see the documents in due

course.

MR FITZPATRICK: Of course, Commissioner.

COMMISSIONER: Well, we will adjourn now for 15 minutes. I apologise again to Dr Aroney for keeping him waiting.

THE COMMISSION ADJOURNED AT 12.20 P.M.

THE COMMISSION RESUMED AT 12.39 P.M.

JAMES PETER BOYD, CONTINUING RE-EXAMINATION:

COMMISSIONER: I'm sorry, we keep catching people unawares. Thank you, Mr Fitzpatrick.

MR FITZPATRICK: Dr Boyd, do you remember being asked just before the Commission adjourned about whether there were documents available to you that might assist you to determine whether or not the central line or an equivalent was reinstated in the case of patient P26? Do you remember that?-- That's correct, yes.

Would you look, please, at this document? Commissioner, could I have it brought up-----

COMMISSIONER: Yes, of course?-- Upside down.

I think it's upside-down actually.

MR FITZPATRICK: Doctor, can you just - do you have that-----?-- Yes.

-----document available to you on the monitor?-- Yep. The-----

What is it, please?-- The section 1 is - needs to go that way - sorry, the other way. Bit further. Bit further. Bit more, thanks.

Perhaps if the whole word "medications" could be displayed?-- Basically - and up, up a bit. Up. Okay. Yeah, that will be about right there. Thanks.

What is that document?-- This is a medication chart and it shows on this one here Keflor, which is an antibiotic, was given during the course of the dates which are above - I can't see on this screen - just above that. Bit further. Yeah, and then the dates the antibiotics were given.

Now, how does that help in throwing light on what was done about P26's central line or the reinstatement of it or an equivalent?-- That would mean that he had continuous antibiotics, which meant that if he - the central line was removed he would have had a peripheral line put in to give the antibiotics intravenously.

Now, you have seen that you are not able on the screen to read the dates. Commissioners, can the witness actually see the-----

COMMISSIONER: Yes. I think they can now be seen at the top?-- I'm seeing them now, yes.

I just wonder whether we can focus out a little bit so we can have the dates plus the whole of the box relating to Keflor - no, the other way-----?-- Bit more.

-----on the same page. Yes, that's perfect?-- That's great, thanks.

MR FITZPATRICK: Now, doctor, can you look at the document and explain, please, your reasoning?-- If you look at the document it's "Keflor", which is an antibiotic, and it's got "IV", which means that's given intravenously, and it's been given for the dates - you can make out 25, 26 up to 31 on 12 at the top, and even the 1st, which meant that he was given intravenous antibiotics for the full duration of that period.

COMMISSIONER: It looks like he might have missed out at midday on the 31st, would that be right, because there's no-----?-- That's possible, yes, yes. There's a missed-----

D COMMISSIONER VIDER: Why is there a line through those signatures from the evening of the 31st?-- That would - that means it's been stopped.

That's right?-- And changed to another antibiotic, which is also on one of the forms here as well, and that's Timentin. I forgot-----

If it was ceased, why has it got signatures down to say that the dose has been given?-- That line?

Yes, the vertical line I am talking about.

COMMISSIONER: Or diagonal.

D COMMISSIONER VIDER: Diagonal?-- Diagonal.

It would have been - ceased up to the 1st and at 12 p.m., that point?-- The last dose would have been at 6 in the morning on the 1st.

COMMISSIONER: Thank you, Mr Fitzpatrick.

MR FITZPATRICK: I will tender that document, if the Commissioners please.

COMMISSIONER: Yes. The medication chart for patient P26 will be Exhibit 262.

ADMITTED AND MARKED "EXHIBIT 262"

MR FITZPATRICK: Now, Dr Boyd, on the topic of transfers, transferring patients, when you went first to work for Queensland Health in regional areas, were you given

instructions, practical or otherwise, in how to go about arranging a patient transfer?-- Most of it we learnt on the job, and in many hospitals I found it was always - had to be an order from the consultant to organise a transfer.

All right. And were you in the - as a registrar, was it your responsibility to organise the transfer on the part of your consultant?-- That's correct.

I see. And in doing that, you would speak with the transferring hospital?-- I'd speak with the receiving hospital and the unit to which the transfer's being made.

And in the course of that were you asked whether the transfer had the sanction of your consultant?-- Sometimes we would. Not always. If I did ring to make a transfer it often implied that it was initiated from the consultant.

D COMMISSIONER VIDER: Would you compile the Discharge Summary that accompanied the patient, or whatever you call it, the clinical history that was to go?-- Clinical history, the letter, sometimes, sometimes someone else does it. It varies but, yeah, usually - usually I would be doing it, yeah.

MR FITZPATRICK: Now, Dr Boyd, when you went - in the 12 months you worked at the Bundaberg Hospital, you were Dr Patel's registrar and also Dr Gaffield's registrar; is that so?-- That's correct.

And did you work for those consultants consecutively or ecumenically; in other words, did you have a certain period of time as Dr Patel's registrar, and a certain period of time as Dr Gaffield's, or what was the situation?-- First six months with Dr Patel, second six months with Dr Gaffield.

Yes. And-----

COMMISSIONER: Sorry, Mr Fitzpatrick, you weren't in fact a registrar, though, were you?-- Principal House Officer.

MR FITZPATRICK: Principal - I'm sorry, Commissioner, that's my terminology?-- We are often called registrars, but, yes.

COMMISSIONER: Registrar has a technical meaning?-- By definition, I agree.

Yes?-- Yep.

MR FITZPATRICK: Now, when you were at Bundaberg, under either of those consultants were you called upon to organise transfers for patients?-- Yes.

And did that include when you were under Dr Patel?-- That's correct, that would have included that, yes.

And also when you were under Dr Gaffield?-- Yes.

In your experience, was Dr Patel more or less reluctant to

initiate a transfer of one of his patients than other consultants?-- Dr Patel would have often been less - less reluctant to transfer.

COMMISSIONER: Less reluctant?-- Less reluctant in some cases. However, cases relating to the head and neck, ear nose, throat, any neurosurgical cases were transferred automatically.

Sorry, you say he's less reluctant?-- Less reluctant in some cases - particularly abdominal cases where he felt confident to deal with, he was less likely to refer.

So he would be more reluctant, he'd have a greater degree of reluctance to transfer those patients?-- Yes, the ones he felt confident with, but in other specialties that he had little to do with, especially ear, nose, throat, he would transfer them.

We all tend to get confused with the double negatives. He was more willing to transfer thoracic patients, he was less willing to transfer abdominal patients. Is that a fair summary?-- Yeah, yeah.

MR FITZPATRICK: Could you discern any reason for that?-- That's - in an area he felt he was comfortable in dealing and confident in dealing with, he would not transfer. Anything he felt out of his scope of practice then he would transfer.

I see. Now, when Mr Bramich's case arose in the hospital, to which of the consultants were you attached?-- At that time I was with Dr Gaffield.

All right. And is that the reason why you of the other available doctors attended Mr Bramich for the 11 hours-----?-- That's correct.

-----before he was transferred?-- That's correct.

You did so as Dr Gaffield's PHO?-- Correct.

And in Exhibit 261, which I think was your letter or report following Mr Bramich's case - do you remember that document? Do you remember being shown that document this morning?-- Yes, yeah, I have got it here.

All right. You express or you record your concern at - what I think you express as discourtesy to the surgical unit-----?-- Correct.

-----in the transfer of Mr Bramich?-- That's correct.

When you attended Mr Bramich, did you do so in - as a patient of the Surgical Word or of some other ward?-- He was a patient in the Surgical Ward at the time this happened and he was - during that, the start of that 11 hour period I have written he was a patient in the Surgical Ward. That's when I called Dr Younis, who's the intensive care consultant. He

came, helped, helped - we sort of managed it - managed Desmond Bramich together and got him transferred to ICU soon after that.

I see. So, as Dr Gaffield's PHO, was it your expectation that if anyone was asked to arrange the transfer of Mr Bramich it would be you by your consultant?-- That's correct.

So, of the two - are we to take it that Dr Gaffield at no stage instructed you to arrange the transfer of Mr Bramich?-- That's correct.

So, assuming that someone else had initiated Mr Bramich's transfer, someone else in the hospital, who might that have been?-- It would be speculative but it would either have been from intensive care treating doctors or nursing staff. That would be the two possible sources that this would have been started from.

At one point in answer to Commissioner Morris you relayed a comment which I think you said was made to you by Dr Gaffield to the effect that we can't just transfer the patient, we need to - I think that in the event a CT scan was done?-- Yes.

And you then went on to say that somebody was wanting to bundle the patient off?-- That's referring to the fact that there'd been talk of transferring and everything else happened without it being initiated from Dr Gaffield.

I see. Yes, that's all I have, Commissioner.

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

MR ANDREWS: No, Commissioner.

COMMISSIONER: Thank you. Doctor, one thing that I did want to ask you about. We have heard evidence from the mother of patient P26, and my memory is that she recalled an occasion, probably about the Wednesday of the week that her son was in the Surgical Ward, she spoke to you and said that she wanted her son to have a vascular surgeon. Do you recall her approaching you about that?-- I do remember some discussion about that. I can't remember exactly when, but, yes.

And you said to her something to the effect that vascular surgery had already been performed by Dr Patel?-- Could be - yeah, that's correct.

She asked you whether there was another vascular surgeon available or whether there was a vascular surgeon available in Bundaberg?-- I can't recall that specific question, but possible.

To your knowledge was there a vascular surgeon available in Bundaberg at the time?-- There was a Dr Thiele, who I knew as a vascular surgeon. I think he had - to my knowledge had left or something, something of that note, but I can't say with certainty.

Left in the sense of being on holidays or what do you mean?-- On holidays or no longer practising. He did a public session in the early part of the year. In this second half, I don't recall specifically what happened to him, but he was only in private practice.

All right. Did you tell the patient's mother that there wasn't a vascular surgeon in Bundaberg?-- If I - I can't recall whether I made that comment. If I did it would have been that he was away at the time.

I see. And did you explain that the only way in which she could get a vascular surgeon would be if her son went to Brisbane?-- Yes.

And was it in that context that she said that money wasn't a problem, they'd find the money to send the son to Brisbane if that would ensure the best possible care?-- That's correct.

All right?-- And-----

Well, in those circumstances, why would the son not be transferred to Brisbane?-- Again, as I mentioned earlier, it's - we work under - there were three consultants involved and the decision to transfer comes from them.

But, doctor, the consultants can't override the boy's guardian. His mother wants him to get the best possible care and in this case that involved the vascular surgeon in Brisbane?-- She did bring up that discussion and I remember us having a discussion. I can't remember the exact words. If it was put to me that, "I want this patient to go to Brisbane.", that would have been taken in a different context. If she said, "Could it be - could it be a good idea.", and after discussion telling her the situation and the issue was accepted by her, then I wouldn't pursue.

Which was it, doctor?-- The former.

Sorry? I don't what want there to be any confusion about this. What was her - tell us now how best you recall the conversation?-- As far as I can recall, we had a discussion about transfer and I told her to the effect he's had three operations, the third one, vascular procedure, and there was thrombose clot evacuated and the feeling was that this was going to get better, and after discussion she accepted it at that, and as far as I can recall didn't bring the matter up again on - insisting, "I want the patient to be seen by a vascular surgeon."

Doctor, if the conversation occurred, say, on the Wednesday, which would have been, I think, the 28th of December, there would have been no basis for telling the mother that you had any degree of confidence that the patient was getting better?-- Looking at what we went through earlier, there was some indices responding favourably and some less favourably.

Exactly. So you couldn't confidently tell the mother that the patient was getting better?-- I'm not exactly confident of that.

Not with any degree of confidence, as you say you had indicators going both ways?-- Some indicators were a sensation, as I mentioned earlier, coming back, was a positive indicator. The mottling was always there to start with, and the sensation coming back was perhaps a new thing which was a positive thing.

Mr Fitzpatrick, anything arising out of that?

MR FITZPATRICK: No, thank you, Commissioner.

COMMISSIONER: Mr Andrews?

MR ANDREWS: No, Commissioner.

COMMISSIONER: Doctor, you're excused from further attendance. Thank you?-- Thank you.

WITNESS EXCUSED

COMMISSIONER: Mr Andrews?

MR ANDREWS: Commissioner, Dr Aroney's timetable is such that he can make himself available until 2.30.

COMMISSIONER: Yes.

MR ANDREWS: Dr O'Loughlin's evidence is such that probably for Dr Aroney, I should finish by about 2.30 in any event.

COMMISSIONER: We'll do our best, Mr Andrews. Dr Aroney, would you please come forward? Just for the record, Deputy Commissioner Vider is leaving the bench at this time.

CONSTANTINE NICHOLAS ARONEY, SWORN AND EXAMINED:

COMMISSIONER: Dr Aroney, please make yourself comfortable. Do you have any objection to your evidence being video-recorded, filmed, photographed or audio-recorded?-- That's fine.

Thank you.

MS KELLY: Commissioner, I should remind you, I act for Dr Aroney.

COMMISSIONER: Yes, thank you, Ms Kelly. I haven't seen you for so long. It's a pleasure to have you back.

MR ANDREWS: Dr Aroney, have you prepared a statement of evidence of 47 pages with annexures?-- Yes, I have.

My version is unsigned. Do you have a signed one with you?-- My barrister has a signed version, or I'm prepared to sign it if you'd like.

There is no need. Are the facts recited in it true to the best of your knowledge?-- Yes, they are.

And are the opinions you express in it opinions you honestly hold?-- Yes, I do.

I tender Dr Aroney's statement. I am correct, am I, doctor, in thinking that it has with it 16 exhibits, marked CA1 to CA16 respectively?-- Yes.

Within your statement in Exhibit CA2, at least in my copy, at the end of CA2 there is a patient key. Have you created a key which identifies the names of patients referred to within your statement by otherwise numerical designations PT1 to PT22?-- Yes, I have.

COMMISSIONER: The statement of Associate Professor Aroney other than the patient key will be Exhibit 263.

ADMITTED AND MARKED "EXHIBIT 263"

COMMISSIONER: I'll ask that the patient key be separated out and we'll make that Exhibit 264, and that will be a confidential exhibit.

ADMITTED AND MARKED "EXHIBIT 264"

MR ANDREWS: I have a loose leaf of that patient key which I can tender.

COMMISSIONER: So do I, Mr Andrews.

MR ANDREWS: Thank you, Commissioner. Doctor, I concede that looking at your curriculum vitae, which seems to run to about 20 odd pages, some of your memberships I'm not familiar with the significance of, but it does seem that in your particular specialty, which relates to cardiac matters, some of these memberships may be relevant. You are a Fellow of the Royal Australasian College of Physicians, an affiliate member of the American College of Cardiology, a member of the Cardiac Society of Australia and New Zealand, and this year you became a Foundation Fellow of the Cardiac Society of Australia and New Zealand?-- Yes.

COMMISSIONER: I wonder if you can tell me - and I hope you will forgive my ignorance in that regard - you describe yourself as an interventional and consultant cardiologist. I would have thought a cardiologist is ordinarily something different from a cardiac surgeon. Is that right?-- That's correct. A cardiologist is trained as a physician.

Yes?-- And primarily trained in general medicine, and then subspecialises in cardiology.

Yes?-- So we all begin as clinicians, diagnosticians using medical therapies, and then in cardiology we train in all aspects of cardiology, which is diagnosis and therapeutics.

Yes?-- And then interventional cardiology is a subspecialty above that where patients are treated with interventional techniques such as balloon angioplasty, stenting, ASD closure and so forth. That's an additional subspecialty after that where keyhole surgery is performed for heart attack and angina, for instance.

But do you perform that surgery yourself or does someone else actually undertake the surgery?-- Yes, we perform it ourselves.

Right. So although you're, as it were, trained as a physician rather than a surgeon, you do practise surgery in these interventional aspects?-- That's correct. I perform approximately five or 600 angiograms per year and approximately two to 300 angioplasties a year, and about 50 or so other procedures, closures of ASDs and balloon valvuloplasties per year.

Just purely to gratify my curiosity, is this the only specialisation where a person with their background as a physician also performs surgery, or are there other physicians who become surgical interventionists?-- Gastroenterologists, for instance, also perform endoscopies, which is considered a type of surgical procedure.

Yes, except by Queensland Health, of course. Yes, Mr Andrews?

MR ANDREWS: Doctor, you were Director of Cardiac Services at the Holy Spirit Northside Hospital - you still are. You were the Senior Staff Cardiologist and Clinical Director of the Coronary Care Unit at the Prince Charles Hospital at Chermside from 2001 to 2005 half-time, and for the 10 years before that full-time?-- That's correct.

You resigned in 2005, and your statement sets out your reasons for doing so. I notice that after resignation, paragraph 58 shows me that you made an offer to continue performing on a voluntary basis three cardiac operating procedures which you had pioneered in Queensland. You say it was intended to benefit both patients and other clinicians until such time as those clinicians became accustomed to the procedures. What were those three procedures?-- The three procedures are balloon - mitral valvuloplasty, which I first performed in Brisbane in 1990, the first case. I've performed approximately 300 cases since that time, and we've had no deaths as a result of a pure mitral valvuloplasty procedure. The other - the second procedure is closure of atrial septal defect, or hole in the heart, and I again performed the first case here in Brisbane in around '96, and have been performing - since that time have performed over 100, and the third procedure is that of alcohol septal ablation, which - we performed the first Australian case in 2000 and continue to do so. Now, I have been involved with another doctor at the hospital and he has had less experience in these than I, and I've - we've been working together whilst I was at Prince Charles Hospital, and so I preferred to continue to assist him with those cases because of my greater experience, but he has become adept in these and is now an excellent clinician. But I still had offered my services to assist him in difficult cases.

What do you mean that the management at the Prince Charles Hospital effectively refused your offer, treating it as a request for privileges rather than an offer of voluntary service?-- I received a letter from the Medical Superintendent stating that I would not be credentialled to appear to do these procedures at the hospital unless arrangements had been made aforehand with the medical administration, and this was obviously going to be difficult. Some of these cases come up as very difficult during the middle of the case, and so - and I was happy to come across and do them, as I have in fact done in the past several years, but this offer was refused.

COMMISSIONER: Doctor, my understanding is that credentialling is a process of ensuring that a surgeon or other specialist is competent and qualified to perform procedures at a hospital. Is it your evidence that the management at the Prince Charles used the credentialling process - perhaps I should say abused the credentialling process to treat it as a way of keeping you out of the hospital, even though there was no doubts about your competence or qualifications?-- I assume that is the case.

It wouldn't have been difficult for them to check your credentials since you'd been working there for 10 years?-- Not at all, Commissioner.

MR ANDREWS: Doctor, I won't ask you to repeat in testimony the evidence which you have in your statement - which in summary is of increasing concerns by you and other cardiologists from 2002 about the ability to treat those who needed your care in public hospitals because of access block and other matters - but I will take you to paragraph 7 of your statement to ask you about your attempts to bring these matters to the attention of the hospital administrators?-- I think it's true to say that over a period of several years we had met with administration at the Prince Charles Hospital about problems, particularly with bed access block - that is, obtaining beds for acute patient transfers from regional hospitals such as Bundaberg - about restrictions in beds which were physically present but were closed for financial reasons in the Coronary Care Unit where I was director, and in restrictions in performing procedures, and on all of these occasions we were met with a brick wall of financial constraint.

And you're not in a position, are you, to determine whether the administrators were themselves the victims of tight budgets or whether they were limiting cardiac care irresponsibly?-- No, I'm not in a position to know where these decisions were being made. I'm cognisant of the fact that the managers at the hospital have to meet budget and that they may be sacked if they fail to do so, and so I understand that they were probably the meat in the sandwich under these considerations.

Now, you do, at paragraph 7, suggest that it was difficult for the clinicians to meet with the administrators to express their concerns. Is that still your opinion about public hospitals?-- It certainly was the conditions at that time, and until I left the hospital. Very difficult to have one-on-one type meetings. The administrators very rarely would actually walk into the hospital itself. They would have to - you would have to meet them in the administration block, whereas the problems, of course, which arise are much more easily demonstrated in the hospital itself, and this was a rare event, that they would venture into the hospital to discuss these issues.

COMMISSIONER: Doctor, in paragraph 7 you refer to the occasion when yourself and the Director of the Cardiac Catheter Lab at the PCH scheduled a meeting with the Director of Medical Services, Michael Cleary. Can you outline for me the circumstances of that incident?-- Yes, we'd made this appointment at least a week before to raise a lot of these issues about bed access, about patient deaths that had been occurring because of bed access block, and we'd taken off the morning session to - at least two to three hours so that we could meet with the Medical Superintendent, and we were told that other arrangements had been made, he could not meet with

us. We were actually kept waiting for over an hour and a half, and after two hours we left. We had further work to be done.

Did you ever get any explanation of what it was that was so important that the Director of Medical Services couldn't speak to his senior cardiologist?-- I think that the explanation which was offered was that he was talking to patients' relatives and that he could not speak to us at the same time.

D COMMISSIONER EDWARDS: In that same paragraph you say about the numerous complaints made by cardiologists over a two year period. These mainly related to facilities of staff or - could you just in very short words give us what you meant by that?-- The problems that arose on a consistent basis were doctors ringing up from regional hospitals such as Bundaberg and Nambour and Caboolture with ill patients who required urgent transfer, and we couldn't have a bed for these patients within a short period of time. The national guidelines say that these patients should really come down within 48 hours, and we'd had increasing number of patients waiting for over a week. In fact one of the articles - one of the addenda shows that increasing number waiting for greater than a week, and some of these patients died. Our registrars at the hospital field these telephone calls. They have desperate doctors on one end of the telephone line, and our registrars are the meat in the sandwich because there's no beds to house them in, and they come to me and I've got - I can't shift patients out. So we're in a continual state of frustration. We have the ability to operate on these people, but the bed access was restricted, and then later in 2003 they actually limited our ability to operate. They actually told us we couldn't even operate.

Even though there would have been spare session time?-- That's correct. They actually put a moratorium on using stents, for instance. So these were the type of problems that we were faced with.

Thank you.

MR ANDREWS: Doctor, at paragraph 8-----

COMMISSIONER: I'm sorry, Mr Andrews, I have trouble even understanding that proposition. When you say there's a moratorium on using stents, if you've got - does that mean that if you've reached your limit for the year, you've got your 100 or 150 or however many is allowed, and I roll up with a cardiac problem which is best treated with a stent, you have to say to me, "Look, sorry, you just can't have that treatment."?-- Yes. In December 2003 - in fact what really caused the crisis for us to go to the press was an edict given by the management of the hospital. Included in that edict was that stents could not be implanted except in emergency cases. Now, this is bread and butter treatment of coronary artery disease in our hospital. It's what I mainly do, it's what several of my colleagues mainly do, and this was prohibited because of financial reasons. We'd written to the Premier,

we'd had no adequate response. We'd spoken to the administration - and this was, of course, their edict. They weren't going to back down. And my colleagues came to me in early January and said, "This is untenable. Our patients can't have this sort of cutback and we have to go public", and they asked me to go public, and we released these issues, along with several deaths that occurred because of these types of bed access problems, to the press in early January 2004.

Doctor, I'm afraid I'm right out of my depth, but I need to understand these things, so I hope you'll forgive me for asking what may be silly questions, but my understanding was that the procedure of using a stent often prevents the need for much more serious surgical intervention at a later point in time. So even if one viewed it as a matter of pure economic rationalism, using a stent is actually a more economic way of dealing with patients than waiting until they have, for example, a heart attack and need bypass surgery?-- Yes, that is certainly correct. The other issue is that before a stent is put in we do an angiogram, and then in most of these cases we proceed on immediately at the time of the angiogram and put the stent in. What we were being told is, "Do the angiogram, discharge the patient and bring them back on another occasion to have the stent implanted", which is totally against best practice and a major retrograde step, and that's what we were being told to do, and we felt this was totally untenable.

And what possible merit is there in doing that, apart from the fact that the patient goes away and joins another waiting list to come back on another occasion?-- I'm afraid the logic of the hospital management and the Health Department is not evident to me in this decision making, and this was very common. Other things that happened in December of that year is that they closed the outpatients down for a month during that period which we thought was totally untenable. We had severe patients with heart failure who needed to be seen on a weekly basis and our heart failure doctor said that these patients would suffer greatly, but this went ahead and there was closure of outpatients, and there's a five to seven month wait for patients - new patients - and follow-up patients even longer - in the Outpatients Department. So this was another aspect which we felt was untenable. But it went ahead.

And, doctor, again would I be right in thinking that there are treatable and relatively simple problems - perhaps angina or arrhythmia or something like that - which, if dealt with at outpatients, not only produce a far better result for the patient, but will actually save Queensland Health money in the long run because that patient won't have to have more serious operative treatment later down the track?-- Oh, that's absolutely correct. The tragedy, of course, too is that many patients waiting for outpatients have very serious conditions. It's often hard for general practitioners to tell how serious they are until they have further investigations performed, and so we have patients with potentially life-threatening illnesses waiting for five, six, seven months for basic cardiac investigations.

So in a sense Mr Andrews makes a very valid point that the hospital management were subject to budget constraints, and they're not necessarily to be blamed for the fact that they had to operate within budget, but from what you are telling us, even if you're under a budgetary constraint, it makes economic as well as medical sense to allow things like stents and outpatients because that saves the health system money in the long run?-- Yes, I believe so, and the constraints that were put against us were both economically incorrect in many cases, and logically incorrect, because they would probably end up costing the hospital more money in the long run. If a patient, for instance, who is waiting for an angiogram has a major heart attack, they end up with chronic heart failure for the rest of their lives, they're on life-long treatment, life-long recurrent admissions to hospital, and expensive cardiac defibrillators are often used which cost upwards of $20,000 or more. So the cost of missing out one heart attack is a huge cost to the community.

D COMMISSIONER EDWARDS: Why was the ward closed for one month? Did you say the ward was closed?

COMMISSIONER: Outpatients.

D COMMISSIONER EDWARDS: The outpatients?-- The Outpatients Department at the hospital was closed for Christmas period. This had occurred for several years.

Just closed?-- It was closed for budgetary reasons, and the doctors were told they would take holidays during this period, that this was holiday period and we should all take our holidays at that time. Not everybody wished to take holidays at that time, but that was what we were told.

So you don't get sick in December?-- That's correct. You won't get into an Outpatient Department.

COMMISSIONER: Doctor, obviously you have contact and discussions and social interaction and so on with your colleagues from other medical disciplines. Is what you're telling us unique to cardiac or is it endemic across all sorts of areas of medicine?-- I'm sure it's endemic across all areas of medicine. I've spoken with my colleagues from all other specialties and these problems are across the face of medicine. Of course I can only speak to cardiology and to my own patients, and unfortunately when a cardiac patient waits an inordinate time the results are often tragic. But as you point out, the problems are endemic, and if you spoke to any specialist working in the public system across this state I'm sure you'd have the same answer.

Mr Andrews, I think we better take a lunch break because we've got a busy - or a very full afternoon. I again apologise to Dr Aroney that it's been such a mixed-up day, but would it suit everyone if we have a reasonably short break and come back at about 10 past two or so?

MR FITZPATRICK: Yes, Commissioner.

COMMISSIONER: Doctor, you will be right then until three?-- I'm right until 3.30 or quarter to four.

Splendid. Ten past two.

THE COMMISSION ADJOURNED AT 1.25 P.M. TILL 2.10 P.M.

THE COMMISSION RESUMED AT 2.14 P.M.

CONSTANTINE NICHOLAS ARONEY, CONTINUING EXAMINATION-IN-CHIEF:

COMMISSIONER: Please be seated. Thank you, Mr Andrews.

MR ANDREWS: Dr Aroney, at paragraph 8 you give an example which seems to be an exceptional example about the use of stents at the Prince Charles Hospital, but an example in which one of the administrators at the time, a Ms Podbury, threatened to dismiss your catheter lab director for determining to use a stent. Now, as I understand it from that paragraph, the stent was to be implanted in a private patient and it would have been fully funded. What possible economic or other motive would Ms Podbury have had for being perturbed by the threat to implant a stent?-- You would have to ask Ms Podbury this directly, but my supposition is that these stents are drug-eluting stents were not then available to public patients, and there was seen to be an equity issue with implantation of these newer better stents in private patients and them not being available to the public. So I presume that that was the reasoning behind it.

COMMISSIONER: Doctor, would my reaction be an exaggeration if I were to say that this is political correctness gone mad and if you can't give first rate treatment to all your patients, equity means you have got to give substandard treatment even to the private patients?-- That's correct. That's how we saw it at the time, and our cath lab director was very close, we believe, to being dismissed and we had to put a petition out amongst all the hospital staff, which was signed by many people, which we believe saved his position.

MR ANDREWS: Well, I would like to explore that a little. To be fair to Ms Podbury, you say she threatened to dismiss your catheter lab director. Did you hear the threat?-- It was the understanding of all the staff that he faced code of conduct violation and that he could be dismissed and, hence, the petition.

I see. He is now the director of the entire cardiology program?-- That's correct.

His dismissal, no doubt, would have been a tragic loss to the public system?-- It would have been catastrophic.

You speak of other - at paragraph 9, two other examples of what you say are common instances of - well, a clash between administrators and the clinicians?-- Yes, these examples involved our senior paediatric cardiac surgeon, Dr Pong, who has been at the hospital for many years. I think over 30 years.

You call him the most experienced paediatric cardiologist in

the State?-- Cardiac surgeon.

Cardiac surgeon in the State?-- That's correct. And it was his view in both of these cases that he required a ventricular assist device to be available. In the first case, he was in the midst of operating on a critical ill child when he called for this to be available and in the middle of the operation, that request was initially denied by the hospital administration, he had to use a paediatric cardiologist to go to the administration on his behalf, because he was operating, to try and get the device if it was required, and, finally, later in the evening it was finally agreed to, but not without much dislocation to the operating staff who were very concerned that they may need the device. At the end of the day, fortunately, the child survived and didn't need the device. The second case was a case which he wished to operate on and wished to have the device made available and it would - and, again, was not made available for his use, and delayed the surgery on this critically ill child for I think a couple of weeks until finally it was agreed that it would be made available. In both of these cases, the surgeon felt that the administration put major obstacles up to appropriate clinical management and he was also threatened with a code of conduct violation by the hospital manager.

With respect to the child patient 2, whose instance you describe on page 11, you say that the administration did agree to a VAD being available but then further delayed surgery by insisting that a second one be made available from interstate in case the first one malfunctioned?-- Yes.

Now, does this mean that the surgery was scheduled but not commenced and then was forced to be postponed for a couple of weeks?-- Yes, it is my understanding that that further delayed the surgery.

And was it - is it consistent with reasonable clinical concern for the insistence to be made that there should be two devices present during the surgery, two VADs?-- In my view, I think that was unnecessary and a further obstacle to appropriate management.

COMMISSIONER: Doctor, whilst I don't for a moment question your veracity, it comes across as almost a fairytale story that when you tell us that the bureaucrats initially say, "You can't do this operation if you have got any VADs", and then when you break through on that, they say, "You can only go ahead now if you have got two VADs." The happy medium of having one just wasn't acceptable?-- The logic of Queensland Health is something that I fail to grip even today.

Are these - are VADs - again, please forgive my ignorance - are these devices that are inserted in the patient or are they machines used in the theatre?-- They are used in the theatre. They can also be used for a time in the intensive care unit following theatre to support the circulation.

If one of these machines was available, would it then cost

anything to have it on call, as it were, for the operation?-- It certainly is a cost to use the device. There are consumables involved and there is, I believe, a considerable cost in their use.

Right. So that was the issue. It was the cost of the consumables?-- I believe it was, yes.

You have got a machine there that is capable of doing the job but the bureaucrats say you can't use it because it costs too much to supply the consumables?-- Yes.

D COMMISSIONER EDWARDS: Why buy the machine then?-- The surgeons consider these machines should be required and are a necessary accompaniment for this surgery.

If the machine is approved by health departments, surely they should approve ongoing operational costs of it?-- I agree with you.

COMMISSIONER: Yes, I think Sir Llew meant why would the administration agree to fund the purchase of the machine unless they are going to agree to fund the consumables necessary to operate it?-- Yes.

MR ANDREWS: At paragraph 10 you speak about the alteration by Ms Podbury, the hospital manager, "alteration of the management structure of the cardiac program." What was its structure before Ms Podbury altered it in 2003? You say it was led by a practising cardiologist or cardiac surgeon?-- That's correct.

Now, that leadership, did that involve the power to make budgetary decisions?-- Yes, it did. The cardiologist or cardiac surgeon was a chair of a committee - cardiac committee which made the budgetary decisions. The Chairman had the final say, as it were. That was changed to a triumvirate of the cardiac surgeon, senior administrative nurse, and a business manager, and this was a change that was made and this led to a very unworldly management decision process which led to significant delays, and under the auspices of this triumvirate, there were major cutbacks in hospital committee. For example, our anti-smoking clinic was shut down, the rehab - rehabilitation clinic was cut back, preventative programmes, which Queensland Health has been espousing lately but which were removed, the anti-smoking clinic totally removed.

MR ANDREWS: Doctor, I am unable to tell whether they were cutbacks justified because of the priority of some other costs that were met by the budget. I am interested to begin with in understanding the structure. Until 2003 would it have been the case that the practising clinician who led the cardiac program would have been advised of his or her budget for a period and given the discretion as to how to allocate it?-- That's my understanding.

And then after 2003's change, that discretion had to be exercised by a committee of three persons?-- Yes.

COMMISSIONER: And amongst that committee was the doctor who would have been the sole decision-maker previously, a business manager and you say an administrative nurse. So this isn't a practising clinician. In a sense, therefore - I keep getting into trouble for using the word "bureaucracy" as a pejorative term, but the bureaucrats had a majority on the committee?-- Yes, that's true.

MR ANDREWS: At paragraph 12 you speak of cuts in funds. Now-----

COMMISSIONER: Sorry, Mr Andrews, just before you move on to that paragraph 10, we heard I think for the first time earlier this week from - who was it - I think it was Dr Jenkins was telling us about the situation at the Royal Brisbane Hospital in vascular surgery where you have a non-clinician in charge of the vascular surgery section or department unit. Now we're being told about a similar thing at the cardiology area of Prince Charles. Do you know from your experience whether there is anywhere else in the world outside Queensland Health where you have functional specialist units within major tertiary hospitals run by people other than practising clinicians?-- I am not aware of such a structure.

And presumably you are familiar at least with the way in which cardiac units are operated both in Australia and overseas?-- Yes, I am.

Sorry, Mr Andrews you were taking us to paragraph 12.

MR ANDREWS: Yes, Commissioner. You say that plans were made in 2003 to reduce cardiac services at the Prince Charles Hospital, including a reduction in 300 open heart operations. Do you mean that the annual number of open heart operations had been 300 and it was proposed to reduce that to something less, or do you mean that 300 operations were taken from the list?-- 300 were removed from the list.

I see.

COMMISSIONER: Doctor, nobody has an open heart operation unless they need it pretty desperately?-- That's correct.

How can you possibly, at a stroke of a pen, say, "This year we're going to do 300 fewer operations."?-- The reasoning given for this is that the money was required south of the river, the Princess Alexandra Hospital, and we have no doubt that the money was required there. The Princess Alexandra has been severely under funded for many years and was very urgently in need of extra funding. But to remove this number from the north side of the river to take to the south is a little like shifting the deck chairs on the Titanic. During this period, the administration was well aware that there had been a doubling of referrals from regional hospitals to the Prince Charles Hospital, and those numbers I have listed in the lists there, the September quarter 2002, there were 46 referrals for acute coronary syndromes to the hospital and

that was 93 in 2003, and in the face of this doubling in demand, which we faced every day, these cutbacks were then put to us.

Can you tell us the extent of the cutback? If - how many open heart operations would you do annually before you take away the 300?-- There is approximately - of the bypass operations, about two and a half thousand. I don't know the exact number. So it is - the Prince Charles has been the largest provider of cardiac services in Queensland for many years, and so this - this is why these numbers are so great. But this represented a significant cutback.

Something like an eighth of the standard annual turnover was wiped off?-- Yes, that's correct.

D COMMISSIONER EDWARDS: Not allowing for any normal increase in year?-- That's right, and no increase; in fact decrease.

COMMISSIONER: And, doctor, on that subject, given both the increasing Queensland population and the ageing Queensland population, I assume that the demand for this sort of surgery is rising all the time?-- It is indeed, and also the guidelines for treating a heart attack and acute coronary syndromes have been more aggressive, so more people are now brought into hospitals, treated and have angiograms, stents and open heart operation. This is how we treat these patients. Typically a patient has a small heart attack, for instance in Nambour. The risk is they will go and have a major heart attack unless they are transferred within a few days to Prince Charles or Royal Brisbane, for instance. They are transferred, they will have an angiogram, and then they will guarantee to have a stent straight away, go home within a day or two or to have bypass surgery within a few days, and that's how the management goes. So this was a cutback of 300 open heart operations, for example, bypass, but along with that there was a cutback of 500 angiograms and 90 angioplasty stent procedures to go along with it.

And, again, how would that compare as a percentage of the annual turnover? Would 500 angiograms be 10 per cent or five per cent?-- It is the order of three and a half thousand or so angiograms. So 500 is quite a reduction.

Yes?-- And the angioplasty, something in the order of about 7 or 800. So about 10 per cent reduction.

Yes.

MR ANDREWS: Doctor, at paragraph 12 I see that the concern that that caused to you because of this first round of cuts in 2003 was a concern shared by other staff members, so you met with Mr Bergin who then was, what, the zonal manager?-- Yes, correct.

Now, I see that you told Mr Bergin that the Cardiac Society would hold him accountable for the anticipated deaths, and he quite - well, not surprisingly reacted angrily to that

statement?-- Yes. This was-----

But he said that the Cardiac Society shouldn't have been present at the meeting. Is that the case?-- Yes. He-----

COMMISSIONER: Didn't the zone manager know that you worked in his hospital?-- No, he did not. The meeting was a meeting of staff - cardiology staff and other staff - in fact, staff from all parts of the hospital, and there were 12 presentations given by all members of the staff on how deleterious this would be to the hospital and to the patients of the northern region. Very compelling presentations. There - at the conclusion I gave - well, Mr Bergin said this would go ahead regardless, and that's when I spoke up and said I was representing the Cardiac Society and the Cardiac Society would hold him responsible for deaths that might accrue from these cuts. As you pointed out, he reacted and said the Cardiac Society shouldn't have been invited. It was then the Chairman of the meeting told him that I in fact was the Director of the Coronary Care Unit and a member of the Cardiac Society and that's why I was speaking out. But Mr Bergin said the cuts would go ahead regardless, and, indeed, they did.

MR ANDREWS: Did Mr Bergin explain to you why it was that in spite of the arguments put up to him, that those arguments had to be rejected and that the cuts had to proceed? Did you have an explanation?-- The only explanation that's been offered is that the funding was required at the Princess Alexandra Hospital.

Did Mr Bergin say who made that decision?-- It was made by - well, it was assumed it was made by Queensland Health.

Should I deduce from that that you do not recall Mr Bergin to have said whose decision it was?-- I am not sure whose exact decision this was.

D COMMISSIONER EDWARDS: Did you get the impression that the increased activity at PAH would be in coronary care or cardiac facilities, or was it going back into general funds?-- No, it was certainly going to an increase in surgery and that has, in fact, happened.

COMMISSIONER: Coronary surgery?-- Yes.

Yes?-- I think all forms of open heart surgery, including coronary surgery, and, indeed, that's happened and they had to put more surgeons on at the PA. So rightly so, PA is now doing more cases, but PA was doing, you know, a fraction of what it should have been doing. So deservedly needed the funds, but we felt they should not have been removed from a hospital that was actually already underservicing its community.

And already had the technology and the staff expertise to provide those services?-- Yes.

MR ANDREWS: We will move to "write to the Premier". Then

eventually on 5th of January - I see from paragraph 22 of your statement you issued a press release?-- Yes. I was asked - we had meetings at the end of 2003 and early 2004. The problems with the second round of cuts, which meant that we couldn't put stents into patients unless you were in emergency. That was really the telling point. And the other cardiology staff at the hospital at a meeting asked me to present this publicly. As we had had no response from Queensland Health on our submission, there had been a submission from the cardiac program for an increase in cases, and these cutbacks had occurred. And I had written to the Premier in December and had a response from Mr Mackenroth that things would be looked into. But nothing had happened and come early - the first week in January, we were told that these cuts and stent angioplasty would be stopped, and it was felt that this was totally untenable so we issued a press release. I spoke to The Courier-Mail and told them what had happened, that these cutbacks were resulting in patients' deaths, that three patients had died recently as a result of inadequate resources, and that this was inappropriate and needed to be - we needed to be funded.

COMMISSIONER: Doctor, I just want to - we've skipped over a few paragraphs, which is fine because they speak for themselves, but if I can just take you back for a moment to paragraph 14, you refer to a meeting with the Director-General. Was that Dr Stable or Dr Buckland?-- That was Dr Stable.

All right, and with regional directors in June 2003, and you say that, "Ms Podbury walked out of the meeting when a photograph of closed cardiac beds at Prince Charles Hospital was shown." Just explain to us what the context was of that walkout?-- The - firstly, the meeting with myself - there was two meetings I think in that paragraph. The first meeting was a community cabinet meeting that Ms Edmond, the Health Minister was at, along with Dr Stable, Podbury and Bergin. And I went along to that meeting because I wanted a direct line to the Health Minister and the Director-General as to what was happening.

Yes?-- So that was my meeting with Dr Stable and the Health Minister and I informed them of what was happening and that these cutbacks would result in patient deaths, and that, in fact, rather than cutbacks, we needed an urgent increase in activity. They promised that they would look into it, and nothing further transpired as far as that goes. We had - I had no response to that meeting, the only attempt I had to approach the main powers, the Health Minister. The second meeting was a meeting on Queensland Day where a cardiac presentation was given at the Prince Charles Hospital detailing the lack of activity and underresourcing that was occurring. During a powerpoint presentation by one of my colleagues, he flashed up a photograph of one of the coronary care beds, which had been closed because of financial constraints and had a whole lot of material over the bed so the bed could not be used. Clearly an embarrassing photograph, and when this was shown during the powerpoint

presentation, the hospital manager walked out of the meeting.

Mr Andrews?

MR ANDREWS: Is it not possible that Ms Podbury simply had another engagement, or was this - or did she indicate her emotional state by something when she walked out?-- You would have to ask her that.

Now, after your press release on 5 January, three days later an employee of Queensland Health, Dr John Scott, telephoned you to request an urgent meeting, and I gather he told you it was to discuss the problems you raised in your press release?-- Yes, and I thought after this telephone call, which was a very cordial one, that at last we had got through to the senior bureaucracy Queensland Health and that there may be some improvement. So I gladly agreed to meet in my own private rooms. I at the last moment invited one of my cardiology colleagues to attend. I don't think that I told Dr Scott that he was coming. Dr Scott came along with Mr Bergin, the zonal director. The meeting, I can describe, began as basically a verbal attack upon me. That's how I certainly felt at the time. The first words after we exchanged handshakes with him was that he said my letter to the Premier was offensive to Queensland Health and personally offensive to him. He then went on to say that-----

COMMISSIONER: I didn't see any mention of Dr Scott in the letter?-- No, there was no mention of Dr Scott in the letter. This is the first time I had ever met Dr Scott.

What was personally offensive about it to him? Just that you were bagging Queensland Health?-- Yes - well, I presume so. I was bagging the system.

Yes?-- He then went on to say that the deaths which I had raised in my letter were cheap shots. I reacted to say that I didn't feel that deaths were cheap shots at all and that these were our patients who were dying and that we were very frustrated at not getting them in and that he shouldn't refer to them as cheap shots. He then went on to say, "We're going to investigate the deaths.", and I said, "Please do so as they require investigation, and further deaths will occur, will also require further investigating." And I told him that as the Chairman of the local Cardiac Society, that I would continue to advocate for our patients who were dying and that we would monitor all upcoming deaths if nothing were done. During the course of the discussion, he then went on to say, "If you come after us with more shots, we'll come after you." I was very taken aback at all of this, I must say. There was some further discussion between Dr Scott and the other cardiologist Dr Galbraith at the time. I felt that further discussion with Dr Scott about these issues was almost going to be pointless and, as I say, I was rather shocked with this barrage. So nothing useful, as far as I am concerned, came out of the meeting. In fact, I felt that, after the meeting, this was a case of bullying, that he had come along merely to intimidate me, to prevent me from speaking out about this

further. I felt this was totally inappropriate and that the best recourse was for me to go public, which I did the next day, and released a press release to that effect.

MR ANDREWS: During the same conversation, you discussed with him high risk acute coronary syndromes and the topic of whether they should be treated with stents and not surgery. Dr Scott mentioned to you that he'd had advice from another cardiac specialist that they should be treated with surgery rather than stents. That's the case, isn't it?-- That's what Dr Scott said.

And did you explain to Dr Scott your own point of view, which was the reverse?-- Yes. I told Dr Scott that what he was saying was completely incorrect, that he'd obviously not read the national guidelines for treating acute coronary syndromes. I made him aware that I was a national author of the national guidelines. I am sure he hadn't read them or he wouldn't have made such an incorrect statement. In fact, there is no great competition between the cardiac surgeons and cardiologists about these patients. Some patients, very appropriately, will have cardiac surgery if they have severe multi-vessel disease, and others with single or double vessel disease will have stenting. So, we work together rather than competitively in these cases.

COMMISSIONER: Doctor, I appreciate there are some areas of medicine where the highest and best qualified experts sometimes disagree on appropriate procedure, but was the point of view that Dr Scott put to you one that you think would be entertained by any competent cardiac expert?-- Definitely not. It was a totally inappropriate response and I was surprised that a senior person controlling the funding at Queensland Health could make such a proposition.

Do you believe that Dr Scott was telling you the truth when he said he had been told this by a cardiac surgeon?-- Yes, I believe he probably had. I think he probably had information from a more senior surgeon who possibly hadn't been working for some time. I'm not sure who it was.

I see?-- But I think he probably had been given some advice and that he'd really got it quite wrong.

Yes.

MR ANDREWS: Doctor, I won't ask you to take us through the next letter you wrote to the Premier on the 25th of January. I will move to the meeting you had on the 15th of February. It was a meeting like this one called at the request of Queensland Health, and the participants included almost all the senior cardiologists who worked in public hospitals. But also at the meeting was Dr Buckland, then the assistant Director-General.

COMMISSIONER: I think Acting?-- Acting.

MR ANDREWS: Or Acting Director-General. You say that at that meeting Dr Buckland's first comments were to interject?-- Yes.

Was there any - was it a time when questions from the floor

were anticipated?-- No, indeed it was not. The meeting began - the meeting was - we were asked to have the meeting by Queensland Health. Dr Scott had called me and said he wanted a meeting of the membership of the Cardiac Society. We called it on a Sunday, and so all of these cardiologists from Southeast Queensland gave up their Sunday to attend the meeting - I have listed all of them in the statement - on very good faith that things would be looked at sympathetically again by Queensland Health, and Buckland and Scott represented Queensland Health. I made some introductory remarks. I then introduced the first speaker. There were to be, I think, six or seven speakers from all the major disciplines and the - representing the major hospitals. The first speaker spoke of the acute coronary syndromes and after about two minutes of talking Dr Buckland stood up and interjected very aggressively, mentioned a profanity, and stated that what had been said by this speaker was Prince Charles-centric and the information was irrelevant. We could only take that this statement was again an intimidatory interjection in order to inhibit that speaker and further speakers and, indeed, I am sure it did, because everyone was very taken aback by this interjection, and the following speakers, I think, probably became much more circumspect in what they were saying.

Well, is it possible that Dr Buckland's interjection was to make the point that cardiac services were being offered by Queensland Health in places other than the Prince Charles Hospital and the speaker was ignoring that fact?-- We certainly didn't see it that way. The presentation was extremely balanced and just spoke of the inadequacies and the difficulties in transferring patients with acute coronary syndromes.

At paragraph 31 you speak of the discussion at the meeting about the lack of publication of waiting lists for coronary angiograms and cardiac defibrillators. What do you mean where you say that Doctors Scott and Buckland would not accept that these should be published? Did they say so?-- Yes, they did.

Did they say why they shouldn't be published?-- They said that these were not surgical procedures and, therefore, were not in the same class, for instance, as coronary bypass surgery. We made the point that, in fact, most people waiting for procedures, in fact, die on the list for the coronary angiogram, which is the diagnostic procedure to determine how severe it is. Once you have the coronary angiogram you then may be placed on the bypass surgical list but with the knowledge that the patient's got very severe disease most severe ones will be done quickly, so that most of the deaths - in fact, about 1.5 per cent of people waiting on the list for a coronary angiogram will die waiting on that list and most of the deaths that occur on cardiac waiting lists occur on that list. Hence, I feel and I think most members of the Cardiac Society feel that these lists are very important, should not be allowed to blow out to the extent that they have, and the length of these lists should be published so that the public are aware of this. Similarly, for cardiac

defibrillators, these are patients who are at risk of dropping dead and any lengthy wait beyond 30 days is a considerable impost on these patients and, indeed, several of the deaths considered later are patients dying on these lists, and although not open heart surgery, again we felt that these lists should be published, so - that a duration of wait is a public interest disclosure and should be made available, and the - and Buckland's got - said that they wouldn't do this, they wouldn't publish these lists.

COMMISSIONER: Did they give any clinical or other explanation for not revealing them or was it just, "We don't class that as surgery, therefore, we are not going to give it out."?-- The other excuse that was given at the presentation was that if they publish these lists they would have to publish every type of list, including patients waiting for methadone treatment and so forth. So, this - this was the reasoning given to us.

Doctor, we have already heard evidence from specialists in other fields, particularly general surgery and subspecialisations of general surgery, and they make a very similar point about procedures such as endoscopies and colonoscopies which are very important in a prophylactic sense as an early detection of potential disease which may prevent more serious surgery being needed at a later point in time. Am I to take it that we're in an analogous situation here, that these are procedures which if performed in a timely fashion will not only have a better outcome for the patient, but will have a better economic outcome for Queensland Health?-- This is exactly correct, and the analogy is consider close to that of endoscopy.

Right. It would be your strong recommendation that any competent and transparent system of reporting waiting lists should include not things like patients waiting for methadone, which I can't see as having any analogy at all, but any procedure which is of a diagnostic or prophylactic nature in order to detect a disease or to determine the need for therapy?-- Indeed. I agree with that entirely, particularly if the delay may lead to the patient's death or heart attack, and included in the waits should be the five to seven month wait in a cardiac outpatient department where we have very sick people waiting for long periods who sometimes don't reach their cardiac outpatient appointment.

That's yet another point that's been made to us, that really there's not one waiting list but three. A patient might think that they're on the waiting list when they are referred by a GP to see a specialist, but in fact it's one waiting list to see the specialist, it's a second waiting list to have a diagnostic procedure, and the third waiting list to have surgery if it's determined that that's appropriate?-- Yes.

And your evidence is that people often die on the first and second waiting lists before their names even reach the third?-- That's correct, and those waiting lists are not publicised.

What would be the current length - I suppose you are out of the public system at the moment. Do you have any idea what the length of waiting lists would be - we will call it waiting list 1 to see a specialist in cardiology at a public hospital?-- I believe the outpatient waiting lists are still of the order of six months.

And then there's waiting list 2 to get a diagnostic procedure, such as an angiogram. How long is that likely to take?-- Whilst I was there it was the order of three - three to four months, sometimes longer, and it would depend on which hospital you were referred to.

And then after that you would be classed as getting on a waiting list for surgery, assuming that surgery was indicated?-- That's correct.

And you would be classed either as category 1, 2 or 3?-- Yes.

Right. But on category 1, theoretically the operation should happen within 30 days?-- Yes.

But from what you have told us, that may be 12 months plus 30 days after you have been referred by the GP?-- That's correct.

D COMMISSIONER EDWARDS: Commissioner, could I ask Dr Aroney, therefore that leads to your statement in 31 where you say that, "It was carried unanimously that all cardiologists had - at Queensland had the worst coronary outcome."?-- Yes. That's a national statistic that Queensland has the worst coronary heart disease outcomes and mortality of any of the major States.

Would it be fair to say that - that, you mean, is not so much cardiac disease but outcomes of people who have disease and can't get treatment within a reasonable period of time?-- I think that's an additional point. The national statistics reflect simply the coronary heart mortality rate in general.

Mortality rate?-- That's correct.

MR ANDREWS: Doctor, after the meeting of the 15th of February 2004, did you make notes of what had been concluded at that meeting, and do they - are they annexure CA8?-- Yes, I made notes immediately after the meeting.

Doctor, may I direct your attention to the monitor before you. Did you at the meeting say that information in relation to waiting lists and deaths beyond the categorised waiting times should appear on the Queensland Health public intranet website, and then did the following conversation ensue, that is the conversation appearing on the monitor?-- Yes, that's correct. These are the minutes of the meeting. We had a secretary at the meeting who took minutes and then these have been printed up subsequent to the meeting.

D COMMISSIONER EDWARDS: Dr Walter's position at that stage

was?-- Dr Walters was the director of the Catheter Laboratory at the Prince Charles Hospital.

Thank you.

MR ANDREWS: Now, Dr Scott seems to have concluded that they may have A look at the publication of cardiology waiting lists. Did anything ever ensue as a result of that?

COMMISSIONER: I'm not sure that that's a fair question, Mr Andrews. According to this, Dr Scott said they'd look at that if it was done in the context of looking at waiting lists for everything else, such as methadone treatment.

MR ANDREWS: Yes, Commissioner.

COMMISSIONER: Is that as far as it went, to your recollection?-- It is, yes.

In any event, to answer Mr Andrews' question, was there ever any progress towards releasing these waiting lists?-- No, there's been no progress.

MR ANDREWS: There were more funding cuts in September and as a result there was a staff meeting on the 24th of September, which is described at paragraph 39 of your statement. Now, in that meeting the manager at the time of the Prince Charles Hospital, Ms Gloria Wallace, the replacement for Ms Podbury, told you that a decision had been made and the cutbacks had to be performed by the staff or Queensland Health would step in and do it directly, if necessary she had a list of foreign doctors who were prepared to take your positions. Is that an accurate recollection of the - of something said by Miss Wallace at the time?-- Yes, it is. These are - this is my exact recollection. There were also minutes taken at the meeting by Dr Radford, which I have sighted - I don't have a copy of them - but they corroborate everything which I have written here. The meeting was told that there would be major cutbacks. We were doing approximately 80 cases in the cath lab per week before that meeting and we were told the cutback would be to 57, a 23 patient a week cutback. This, we thought, was absolutely outrageous. This came on top of all the previous cutbacks which had already occurred. It came on top of the 36 page submission, which we'd only tendered a month before which Queensland Health had asked us to prepare where we ask for greater funding, and instead of greater funding and in the face of all the problems which we already outlined of increasing demand and a doubling in demand at our hospital, which the administration was well aware of, they then put this final serve cutback to us, a cut of 23 patients per week. At the time I told Ms Wallace that I thought this was totally unconscionable, that this would lead to a steep increase in deaths and this not be allowed to occur and was she representing us in the Health Department and what representations had she made. She said she had made representations there, but the decision had come to her. So, I presume she was a meat in the sandwich. But what - come as it may, this was what we were told. She did tell us that she

had a list of foreign doctors, I think from South Africa, who were prepared to come in, cardiologists, if we weren't prepared to work on this. I told her that bringing foreign graduates into the country was not really a good solution for this problem, that there were many experienced cardiologists just sitting at the staff table, some that had been there for 30 or 40 years, and that these couldn't be replaced easily with foreign doctors. You can't buy commitment like that, someone who's worked at a hospital for 30 years. You can't purchase that and yet we were told that foreign doctors were available to take our positions, and this lack of accountability to our patients really was a thing that hurt me most about what had happened in Queensland Health, that there really was no human face to Queensland Health and that we were faced with a massive cut which would lead to further deaths, and I knew at that point we had to go public again and - because this was a response and, indeed, we went public again with the deaths that had occurred over the interim period before the previous revelations.

And, doctor, it seems that the number of cases was reduced to 57 per week; is that correct?-- That's correct.

And one sees in CA11 that there was a memorandum to Ms Gloria Wallace, the district manager, from Dr Darren Walters relating to that and it was dated the 28th of September 2004. I won't put it up on the screen, but you in the next month, that is in October, issued a press release and you were quoted on radio and television, and by the 15th of October Dr Scott went on to an ABC program and was asked about your statements; is that correct?-- That's correct.

And one seep at CA13 - I will put that on the screen. This is a transcript of what Dr Scott said to Kirrin McKechnie during a program, and on the - in the last-----

COMMISSIONER: Do we know what program this is? Is it Statewide?-- Stateline.

Stateline?-- Yes, ABC Stateline.

MR ANDREWS: Kirrin McKechnie, in the second last paragraph on the page, asks, "Have you reduced the number of services, cardiology procedures, at the Prince Charles Hospital from 80 to 57?", and Dr Scott said, "No.", among other things. Now, it seems that you'd been quoted before that date as saying there had been such a reduction?-- Yes.

And is it the case that the week after Dr Scott's interview, in CA14, on the 18th of October in a district manager's update - on the second page of your Exhibit CA14 - the district manager observed, "I, therefore, simply make the following points: cardiology is funded for approximately 57 intervention procedures per week, excluding ASD closures and valvuloplasty."?-- Mmm.

COMMISSIONER: I wonder if we can have the page taken up to

the top for the moment. All right. We have got the first statement by Kirrin McKechnie attributing to you the statement that, "By international standards Queensland has only one third of the number of cardiologists that it should have. Is that true?" And Dr Scott replies, "We don't believe that it's true to the level that he's describing it." Doctor, according to your knowledge and belief, was that response from Dr Scott an accurate response?-- No, it was not and, in fact, Queensland Health asked us in our submission to look at the appropriate ratios and numbers of cardiologists in Queensland in our 36 page submission - I think it's CA2 which you may have - and according to international guidelines Queensland should have per capita three times the number of cardiologists in the public system that we currently have. There were at that time 25 full-time equivalent cardiologists in Queensland. By entire national standards and the UK Taskforce there should be 75. Dr Scott was in receipt of that. It was written directly to him. It has the UK Taskforce recommendations in it, and so he was well aware that Queensland has a third the number of public cardiologists in the system that it should have.

Two paragraphs further down Dr Scott says the words, "We really feel that the services that we are delivering at the moment are not putting any Queensland lives in jeopardy." In your professional opinion, was that a truthful statement by Dr Scott?-- No, definitely was not.

And had you provided evidence to Dr Scott indicating the falsity of that statement?-- Yes. In fact, our 36 page submission again shows severe underservicing, inappropriate waits, patients not being treated according to appropriate national guidelines.

And specific deaths resulting from that?-- He was well aware of the deaths, and three of the deaths were investigated in February of that year. I'm yet to receive the results of that internal health inquiry, and he was well aware that a further - further deaths had occurred during that year, which I - which I detailed shortly thereafter.

D COMMISSIONER EDWARDS: Do you know who did that inquiry?-- It was an internal Queensland Health inquiry. I cannot recall the two persons who ran the inquiry. We have never received a report into those deaths, never been released.

COMMISSIONER: Mr Fitzpatrick, are you able-----

MR FITZPATRICK: Those documents are being obtained, Commissioner.

COMMISSIONER: Thank you. And then further down Dr Scott says that, "The disappointing aspect of this debate is that we seem to be accused of cost cutting and reducing services and I can't see why we would want to do that. In fact, what we're doing is looking to increase services across Queensland and, of course, what that means is services and resources are going to hospitals other than Prince Charles, and perhaps that's

part of the reason why we're having this debate." But according to what you say, it wasn't simply that services and resources were going to hospitals other than Prince Charles, they were actually being taken away from Prince Charles; is that right?-- That's correct, that's correct. And, in fact, our submission was very clear that the underservicing was State-wide, there's severe problems throughout all of the major hospitals in Queensland.

Mr Andrews?

MR ANDREWS: At paragraph 47 you say you were repeatedly attacked in the media by health minister Gordon Nuttall. Can you be more specific?-- Most of the-----

If it's in the media, I suppose it's something that can be found by one of the services that produces transcripts of media statements?-- Yeah, I mean, the attacks were made mainly on radio and in Parliament. As far as a radio transcript goes, I unfortunately don't have those, but he attacked me on several occasions on different radio programs that I'm aware of.

COMMISSIONER: Dr Aroney, do I take it that you don't particularly blame Dr Nuttall - sorry, Mr Nuttall for that? Because he's not a doctor, he wouldn't know what the facts are and - beyond what he's told by his departmental officers?-- I agree with you. I think the Minister was very poorly advised by his senior bureaucrats. I recognise that Mr Nuttall is not a doctor, had no knowledge of cardiology issues, but I - and I am sure that the main fault here lies in the senior bureaucracy.

Yes.

MR ANDREWS: After making these statements, do you believe or did something happen which led you to believe that perhaps the Prince Charles Hospital was being punished as a result of things that you had said?-- It was the feeling that with the third round of cuts, down to 57 per week, that this was such an illogical and untenable position that Queensland Health had taken, that the reasons for this could only be that the hospital was being punished because of the stand I'd made on these cardiac issues. It was - it's certainly something I have no absolute proof of. However, there's some indirect evidence towards this. Firstly, when we asked Ms Wallace at that meeting in September did she think the hospital was being bullied, her advice to us is that the cardiology program at Prince Charles was poorly looked upon by Queensland Health and, secondly, that we, the cardiology program, should show more political savvy. To me, that implies that we were being targeted because we were politically incorrect in our behaviour .

Secondly, there'd been public disclosures by Mr - by Dr Buckland targeting the Prince Charles Hospital, and I've got an example of that about the defibrillators.

Yes?-- And of course by Dr Scott, which you've alluded to.

You were reduced to 57 procedures a week. Did that change on - did something change on the 1st of January 2005 where suddenly you were no longer subject to the same strictures that had been applied for three months?-- Yes, the 57 cases a week lasted for about three months. During that time there was a huge escalation in problems in trying to get patients done, and I believe - and I've listed 11 patients who I believe died as a result of these cutbacks. Now, at the end of this terrible cutback period, Queensland Health realised - or at least the hospital realised that funding is contingent upon activity, and if the activity of the cardiac program was going to remain low, that their funding would be greatly reduced for the following year. And so the hospital was suddenly told to increase from 57 and to perform overtime to get our activity up to a level where funding would be then appropriate, and that is indeed what happened, and those restrictions were removed in January purely on funding reasons back to where they were. And, of course, during this terrible three month period we had this problem with deaths, and I've mentioned those deaths are ones that we've found at least which occurred during this period.

Doctor, a different topic. At the Gold Coast Hospital there has been significant money invested to provide cardiac care. Is that the case?-- That's correct. The one major response that Queensland Health has made to actually increase activity overall is to fund a cardiac catheter lab at the Gold Coast Hospital.

You've been concerned that there was insufficient attention to the credentialling of the clinicians who operated that lab?-- Well, there's two issues. The first issue is that it was - a precipitate decision was made to embark not just on diagnostic angiography in that lab, but to very quickly embark into interventional or coronary angioplasty, which carries a much higher risk, in the knowledge that the Gold Coast Hospital doesn't have immediate surgical back-up which the Prince Charles and the PA, for instance, have. So to embark upon an interventional program immediately is a dangerous thing to do, and I was asked for some advice, and others have been asked for advice about this.

Your recommendation was that those who would participate in the interventional program at the Gold Coast should first have a significant period of supervised training. Is that the case?-- If they weren't credentialled as experienced and active interventional cardiologists, that that would be appropriate, and certainly if the interventionalists have not been very active, had a very low volume, and therefore credentialling is very important under these circumstances, particularly with an interventional program.

COMMISSIONER: Do I take it again that you're not being critical of the clinicians involved, your criticism is directed to the system and the decision making which resulted in clinicians who do not have a lot of recent active experience being put in this position?-- That's true. The clinicians there are actually working in the best interests of the patients.

Yes?-- From my knowledge of them, they're very committed and hope to provide a very good service, which I'm sure in due course will happen. But I think that the planning of the interventional program at that hospital has been very poor.

I raise that particularly because the Inquiry has received a very detailed submission from Professor Laurie Howes relating to the bullying which he's experienced. I assume he's one of the clinicians that you refer to as being dedicated to the patients?-- Yes, although he is not one of the interventional cardiologists who I've mentioned.

MR ANDREWS: Doctor, paragraph 60 is the last topic I wish to take you to. You estimate that there are ongoing weekly deaths or heart attacks in Queensland - am I right in thinking that over about the last 20 weeks you're estimating that there have been 20 to 60-----?-- Yes, my estimates-----

-----In the central region? That's Prince Charles Hospital and Royal Brisbane Hospital?-- That's correct.

And are these deaths because of the waiting lists?-- Yes, these are my best estimates of deaths of patients waiting in all sections, outpatient delays, bed access delays, of which I've listed the - in the patient key, inadequate application of guidelines, so - a recent publication was published in the Medical Journal of Australia this year showing that only - that 40 per cent of patients who should have been referred for coronary angiography early on did not receive this in Queensland public hospitals. This means that those 40 per cent were very severely undertreated and could well have perished. So for all of these reasons, my estimates are that roughly between 300 and 550 patients per year are dying because of inadequate provision of cardiac services in this state.

D COMMISSIONER EDWARDS: You say that's a conservative estimate as well?-- I believe it is.

COMMISSIONER: Doctor, at the end of your statement you include a number of pages headed "Recommendations". Can I take you particularly to page 46. You talk on page 46 about the removal of multiple layers of bureaucracy. We've received recently, in a submission from another source, some figures that indicate that Queensland Health employs about 63,000 people, that of those, about 1100 are doctors and about 13,000 are nurses, so - and that figure of 13,000 for nurses includes both nurses who practise as clinicians and those who are involved in administration. So even if you treat all of those 13,000 as active clinicians, only about one-fifth of those

63,000 employees are actually involved in treating patients. Are those statistics consistent with your dealings with Queensland Health and the administration within Queensland Health?-- Unfortunately they are. There seems to be a proliferation of bureaucracy, non-service delivery personnel in the hospital at the expense of particularly experienced nurses. We've lost a lot of our good nurses often due to desperation. During the three month period when we were shut down to 57 cases per week, we actually lost experienced cath lab nurses from the hospital because they weren't required, and these nurses take six to 12 months to train up to become experienced and safe. So due to this very inappropriate bureaucratic bungling, we're losing quality staff at the expense of bureaucratic staff.

Doctor, the next point you make on page 46 is consideration of return to hospital boards and clinician led management of service provision. I assume you would accept, as I think most people do, that there are things that are done much more efficiently at a statewide level, and that could be anything from buying stores for hospitals to audit systems and accounting packages and that sort of thing. So you're not saying that Queensland should be broken up into 37 or however many separate provinces that run their own show?-- No, I guess what I'm suggesting is possibly a return to what we had some years ago. When the hospital board system was in place we had community representation on the hospital boards.

Yes?-- And these sorts of patient problems would not have been tolerated if there was a community person making these decisions, and so we need to return to that sort of involvement by the people in the conduct of Queensland Health, because the people have been excluded, and this is a result.

During your time at Prince Charles, did you have any interaction at all with - what's it called, Mr Andrews - the Divisional Council - District Council.

MR ANDREWS: District Council.

COMMISSIONER: District Council?-- The only involvement with - you mean Mr Bergin's District Council?

Apparently there's a District Council of community representatives?-- No, I have had no involvement. I haven't been asked to be involved with those representatives.

The next point you make is clinician led management of service provision. At a very minimum, would you argue that any operational unit such as a cardiac unit or a surgical unit or a gynaecology unit should be headed by a practising clinician?-- Definitely.

There's also been the suggestion raised that one of the problems with the present overall structure is that once you get above that level to what used to be traditionally called a medical superintendent and a nursing superintendent and above, there is no-one to whom particularly junior medical staff and

junior nursing staff can look to as a figurehead, as a mentor, as a source of guidance in relation to clinical issues, someone in a position to discuss and resolve clinical problems within the hospital. Do you see some merit in having, within each hospital structure, someone, whether they're described as a superintendent or a chief of staff or chairman - or whatever term you use - who is a practising or retired clinician who has that mentor role?-- Yes, and I can hark back to the days of the medical superintendent at Prince Charles many years ago, Kevin Kennedy, who just had such a role.

Yes?-- That the senior clinicians respected, provided a very important role model for clinicians in general, and I agree this would be an excellent improvement.

You refer further down to Code of Conduct threats. You yourself have recorded the instances where you've been the subject of these sorts of threats and what you refer to as bullying. Do I take it from the way you've given your evidence, doctor - being frank about it - that you have a reasonably thick hide, and the slings and arrows haven't hurt you too much, but your real concern is other people within the system have been and are intimidated?-- Yes, that's true. I personally haven't felt too physically intimidated, and my main reasons, I think, at the end of the day for resigning from the hospital was that I may be doing further damage to the hospital itself because of my stance. So I felt that acutely. Others at the hospital clearly, although feeling very strongly as well as I do, were, I think - clearly had been at the hospital for 20, 30 years and were not used to speaking out and bringing these subjects to the public fore. So I felt I had to do this, and I was in a position to do so, but - yes.

The next point you mention is about whistleblower protection being inadequate. One of the things that strikes me as coming out of your statement, which dovetails with what we've heard from so many other places, is that it's only once you talk to The Courier-Mail that anyone takes you seriously. You can go through all the right channels, even to the point of raising matters at community cabinet meetings, speaking to the Minister, speaking to the senior departmental people, but it's only when you get to The Courier-Mail that it counts. Is the sort of improvement or enhancement to whistleblower protection that you have in mind the sort that allows a person, at least in a last resort, when they've gone through other channels, to go to the press or to their local member of parliament and raise these concerns?-- Yes, there certainly has to be more provision for this. I don't think the whistleblower protection is adequate at all for protecting the vast majority of people who wish to speak up. I think the only people who can speak up are people who do get a public viewing, people who have - are higher in the hierarchy of the hospital. As Director of the Coronary Care Unit and Chairman of the Cardiac Society I could speak in this hat. In fact when I spoke it was as Chairman of the Cardiac Society. If I'd spoken merely as an employee, then I assume I could have been sacked immediately. So one has to have a hat outside of the hospital

in order to really speak up publicly, and certainly people - the vast majority of junior doctors and nurses couldn't think of speaking up in this manner. They would be immediately ostracised or discharged if they spoke up publicly. So there are major deficiencies in this whistleblower act.

The next recommendation you offer us relates to waiting lists, and you make the point that waiting lists should include procedures like coronary angiography and defibrillators and outpatient delays. Obviously, doctor, you're speaking from a cardiac viewpoint in saying this, but consistent with the recommendations you make, would that extend to all procedures of a diagnostic or prophylactic nature such as the - what's the word - the endoscopy and the colonoscopies that we talked about earlier?-- Yes, I'm sure this is what should be done, that all of these procedures should be listed, I think not only for public disclosure, but for general practitioners who wish to determine how long their patients will be waiting for these procedures, so that they can look at who to refer to and that they can come up with appropriate referrals for patients. At the moment patients are uncertain how long they will wait and which hospital they should go to.

If for no other reason than so that when a patient of relatively modest means without private insurance who sees their GP can be told, "Your options are to go to the PA or the Royal and have your colonoscopy in nine months, or to St Andrew's and have it done in 48 hours." It at least gives people that level of choice?-- That's correct.

MR ANDREWS: Commissioner, Dr Aroney has clinical obligations and he gave us until 3.30.

COMMISSIONER: He did indeed. Ms Kelly, did you have any further evidence-in-chief?

MS KELLY: Yes, I do, but I won't finish it in time for Dr Aroney to make his patient list.

COMMISSIONER: Doctor, I'll ask you to stand down now, but I'll also ask you to liaise with counsel assisting - I think Mr Atkinson might be the easiest point of contact - so that we can find a time that is most convenient for you. We can't be too flexible, I'm afraid, but if the best thing is to come back in the evening, for example, we should be able to accommodate you?-- Thank you.

MR ANDREWS: 4 p.m. on Tuesday, Commissioner. The time has already been advised by Dr Aroney and-----

COMMISSIONER: This coming Tuesday?

MR ANDREWS: Yes.

COMMISSIONER: Excellent. Look forward to seeing you then, doctor.

WITNESS STOOD DOWN

MR ANDREWS: It allows everyone to sleep in on the public holiday the next day.

COMMISSIONER: Of course, yes. I'd forgotten it. Mr Andrews, of course before we get on we have to get Deputy Commissioner Vider back, so we might take a 10 minute break and then resume with Dr O'Loughlin?

MR ANDREWS: Dr O'Loughlin, who is here.

COMMISSIONER: Before we rise, I just want to make the point again, as I made earlier, that with the evidence we've heard from Dr Aroney, it's very important in reporting that evidence to note that it hasn't yet been subjected to any cross-examination or challenge. That's of some importance where it involves criticism of Queensland Health, but it's of particular importance where individuals are named and, arguably, criticised, and I have in mind particularly. Dr Buckland, Dr Scott and others who haven't had a chance to have their version put to Dr Aroney, and any report should reflect the fact that evidence is at this stage untested.

MS KELLY: Commissioner, may I say, before you rise, in relation to that, I've asked Mr Fitzpatrick if he could - prior to cross-examining Dr Aroney, if he could clarify for us exactly for whom he is acting in relation to the instructions which-----

COMMISSIONER: Thank you, Ms Kelly. I take the force of what you say, but one of the things which has made this difficult Inquiry easier is we've had the support and assistance of counsel, both Mr Farr and Mr Fitzpatrick who are here at the moment, and Mr Boddice who is not here at the moment. We appreciate that they are in a difficult position because their instructions initially came from Dr Buckland as Director General, and there have been changes there. I am sure that Mr Boddice is doing his best to resolve that situation, and I could feel confident it will be resolved before Dr Aroney returns on Tuesday of next week.

MR FITZPATRICK: Certainly, Commissioner.

MS KELLY: Commissioner, in case I was misunderstood, my concern didn't arise out of an invalidity of those instructions, but more to the point of making sure that Dr Scott in particular had an opportunity to test Dr Aroney's evidence.

COMMISSIONER: Of course.

MS KELLY: Thank you.

COMMISSIONER: Thank you. We will stand down for 10 minutes.

THE COMMISSION ADJOURNED AT 3.35 P.M.

THE COMMISSION RESUMED AT 3.56 P.M.

COMMISSIONER: Mr Atkinson?

MR ATKINSON: Good afternoon, Commissioner. I call Barry Stephen O'Loughlin. Commissioners, I have put sworn statements before each of you.

COMMISSIONER: Thank you, yes.

BARRY STEPHEN O'LOUGHLIN, SWORN AND EXAMINED:

COMMISSIONER: Dr O'Loughlin, please make yourself comfortable. Do you have any objection to your evidence being filmed or photographed?-- No, Commissioner.

Thank you.

MR ATKINSON: Witness, your name is Barry Stephen O'Loughlin?-- It is.

And you are the Director of Surgery at the Royal Brisbane Hospital?-- I am.

You have been a Fellow of the Royal Australasian College of Surgeons since 1984?-- I have.

And in the past you have been a senior lecturer in surgery at the University of Queensland?-- That's correct.

Dr O'Loughlin, you provided two statements to the Commission of Inquiry?-- That's correct.

Can I show you the first one? Dr O'Loughlin, is that a statement you provided the Commission in relation to a patient called Ian Rodney Vowles?-- That's correct, Mr Atkinson.

For the record, of course, that's exhibit 173.

COMMISSIONER: Yes.

MR ATKINSON: Dr O'Loughlin, can I also show you this statement? Is that your signature at the bottom of that statement?-- It is.

And is that a statement that you signed and adopted today?-- It is, yes.

And it is a statement which addresses more generic issues about patients that you have seen who were formerly patients of Dr Patel?-- That's correct.

Are the contents of that statement still true and correct to the best of your knowledge?-- They are.

Commissioner, I tender that statement.

COMMISSIONER: Just in the hope that this will reduce confusion rather than increase it, we might give that the number 173A so that the two statements of Dr O'Loughlin are dealt with together.

MR ATKINSON: Thank you.

ADMITTED AND MARKED "EXHIBIT 173A"

MR ATKINSON: Doctor, what I propose to do is walk you through your statement relatively swiftly and then make it available to others for cross-examination. You have seen 42 former patients of Dr Patel's pursuant to an arrangement between Queensland Health and the Royal Brisbane, is that right?-- That's correct.

And you mention that there are other doctors such as George Hopkins who have also seen some of Dr Patel's former patients?-- That's correct, yes.

Now, you say there is 42, and that's pursuant to that arrangement, but have you seen patients formerly of Dr Patel's through other avenues?-- I may have seen one or two during the course of my normal work, referrals down at various times from Bundaberg.

Can I take you to paragraph 5? You mention that of the 42, almost all were unhappy. I mean, obviously they only came to you if they sought, at the very least, reassurance?-- Yes, that's right.

Is there anything clinically significant about the fact they were unhappy?-- Well, of the 42, 14 of the patients sought further information about the treatment that they'd received, an explanation of what had been done. They wanted me to go through the clinical record and discuss the findings. Some of the patients had concerns that they may not have had the relevant organ removed, et cetera. So I was able to do that. And there was usually an examination involved, and I hope that in the case of those 14 that they were reassured that things had been done reasonably.

It is fair to say, I understand, from speaking with you, that you divide 42 patients into three groups?-- That's right.

The first group is the group of 14?-- That's right.

On the other extreme are a group of seven who required remedial surgery?-- That's correct.

And in the middle there is a majority?-- That's correct, yes.

With the 14, you say that you hope they went away reassured?-- Yes.

When you say you hope that, do you mean to say that, in effect, you agree with the clinical decisions that were made by Dr Patel, at least on the record?-- Yes, I do, yeah.

And that would include that at least for those 14 you thought that the patients were offered appropriate options before whatever path was taken, was taken?-- Well, often - in most cases there was only one option that was reasonable and I agreed with the option that was offered. It was usually an operation.

Right. Now, as I say, on the other extreme are the group of seven to whom you refer in paragraph 5?-- Yeah.

And they needed remedial surgery?-- Yeah, these patients had obvious problems that were ongoing and the - my recommendation was that they had - that they had surgery, that they needed further surgery.

COMMISSIONER: Doctor, you described the range as satisfactory to disastrous?-- That's right.

How many would you put in the disastrous category?-- Well, certainly one patient I would put in the disastrous category, a further four patients that I have referred to specifically in my statement, I would regard those outcomes as most unsatisfactory.

Yes. Just in general terms, I guess 42 is a fairly small audit sample?-- Yes.

But given that a sixth of the patients you saw required some sort of remedial treatment, seven out of 42, that would strike me as a very high figure for a general surgeon, if that's a fair representation of the total number of patients?-- Well, it would seem that way, but, as has been pointed out, these were a select group of patients. They were patients who felt that they had a concern or a problem. I understand that, you know, Dr Patel operated on a very large number of patients and I have not had the opportunity to see those people.

Yes.

MR ATKINSON: So-----

D COMMISSIONER VIDER: Doctor, can I just ask you, of the 14 patients, did I understand you to say that they only sought and required an explanation, or did some of them seek an explanation but they may go on and have further surgery elsewhere?-- No, Deputy Commissioner, I don't believe so. I hoped that I had - mainly they had concerns in relation to what exactly has been done and I hope that I was able to

reassure them. Whether I did in fact, I can't say.

No, I misunderstood you, thank you.

MR ATKINSON: Commissioner, I should say that this statement hasn't been deidentified at this stage.

COMMISSIONER: Yes.

MR ATKINSON: And perhaps if the comments you made in relation to Dr de Lacy's evidence could apply, that the names be suppressed.

COMMISSIONER: Yes, I will remind press and media of the general ruling I gave earlier, which I will specifically apply to Dr O'Loughlin's statement, that patient names are not to be used in any press or media reporting unless either the name has been already released from suppression by the Commission of Inquiry or the reporter has the prior permission of the patient or the patient's family.

MR ATKINSON: Thank you. Doctor, to return to the group of seven, there are four patients who you identify and discuss at the end of your evidence, and I understand there is those four, plus there is one more who you say clearly received a very poor standard of care?-- That's correct.

Right. And then there is two more in the group of seven. Obviously you did remedial surgery. What can you say about the standard of care that they received?-- I am sorry, you have lost me there.

You say there is seven who needed remedial surgery?-- Yes.

You identify four in the statement. You spoke about a fifth one in answer to a question from the Commissioner?-- Uh-huh.

That means there is still two more who took remedial surgery?-- Yes.

And I am wondering what you can say about the standard of care that they received?-- I think in both cases the standard of care was reasonable.

All right, okay. And then there is this third group, the middle group, and what can you say about them?-- That - well, the middle group, about approximately 20 patients had undergone surgery and had a range of symptoms and complaints, and I felt, as a consequence of my consultation with them, that they required further investigation. This may include something like an endoscopy, or a colonoscopy, or an X-ray of one form or another, an ultrasound perhaps, a CT Scan, and then following on that these patients required further review.

Doctor, in the course of your statement you speak at a number of places about thematic issues, about big picture issues in relation to Dr Patel's care. You first do that at paragraph 8. "It seems that Dr Patel may have had a tendency to not

always examine patients and to not be thorough in terms of assessment and consideration of options for treatment." Can you explain that a bit further?-- Well, I formed the impression that on a number of occasions, certainly according to the record and as a result of my discussions with the patients, that Dr Patel sometimes did not certainly personally examine the patient in a way which I would regard as being necessary. Such things as not doing a rectal examination, for example, in someone who presented with rectal bleeding. That sort of patient on occasions would simply - was simply sent off for a colonoscopy, you know, without an examination and I would regard that as a serious omission.

And then you say, in the second part of that sentence, that he wasn't always thorough, from what you could see, in terms of consideration of options for treatment?-- Yes, I think that, you know, there are considerations or presentations which are not clearcut, and not infrequently it is more reasonable to seek other opinions from colleagues, consider other non-invasive treatments. There is little evidence that I could find that that happened. Generally an operation was recommended.

All right. So he had a bias, if you like, towards surgery, from what you can see?-- That's - that's what I felt, although, once again, I saw 42 patients who, you know, who were a selected cohort of people and almost all of them had had an operation.

Sure. Well, we understand you are confining yourself to the 42 but from those 42 you see a bias towards surgery rather than non-invasive treatments?-- Yeah.

And can you say whether that bias or that proactivity, if you like, is a characteristic that is shared by good surgeons?-- No.

It is not?-- It is not.

And why not? Don't surgeons have a bias for surgery?-- Well, surgeons - surgeons certainly - surgeons like performing surgery. It is, to a large extent, a technical exercise and it is true that surgeons enjoy the technical side of surgery. But operative surgery is only part of the practice of surgery and what is equally as important is clinical judgment, and on occasions it is far better not to operate than to operate. And that sort of judgment comes only with the right sort of training and experience, and I think also a sense that patients put their trust in you and, as I have said, somewhere in one of my statements surgery is not a benign undertaking even in the best hands.

Sure. Do I glean from what you say that whilst you see that this propensity towards surgery could be a failing, it is more forgivable, it is more understandable in a young surgeon?-- Yeah, young surgeons tend to be more aggressive in terms of intervention, but, you know, when you have been around long enough and, you know, you have seen complications as a result

of surgery, you tend to get - you tend to become more conservative and not to rush into operative surgery.

And Dr Patel is someone you classify as old enough to know that?-- I would agree with that.

Doctor, in the second part of paragraph 8 you speak about something curious, I guess, all by itself, which is that what you don't see in perusing Dr Patel's records, I understand, is evidence of him writing or conferring with other specialists?-- That's correct.

And that's unusual?-- Yes, it is.

How so?-- Well, the practice of medicine is a multidisciplinary exercise and much is to be gained by seeking other opinions, particularly in relation to abdominal complaints. Other specialty groups who are interested in that area include gastroenterologists, gynaecologists, urologists. These are all sort of specialists in those particular areas, and it is not only desirable but it is mandatory, you know, that all the expertise available is made use of.

And you would expect, I guess, to see more evidence of that from a practitioner in a major regional hospital?-- Yes, I would, yeah.

And then you mention that another thing you found unusual is that where you are, as a Director of Surgery at the RBH, that you had no contact with the Director of Surgery at the Bundaberg Base during his term there?-- That's correct.

And that compares differently with your relationships with Anderson and Nankivell?-- That's right. I had regular contact with both Dr Anderson and Dr Nankivell when they were working at the Bundaberg Base Hospital as Directors of Surgery, and I am also - I also know most of the other Directors of Surgery around the - certainly around the State, really, but, you know, particularly in the central zone, which has, you know, links with Royal Brisbane Hospital.

Is that a function of their office or a function of the fact that you grew up at Brisbane and went to the same universities?-- Well, it is a bit of both. Certainly in some respects it relates to where you have done your surgical training. So if - you know, if you pass through a surgical training program at the Royal Brisbane Hospital and you then end up in Nambour as the Director of Surgery - and that's the case, that case exists as we speak - then obviously you have got strong links with the surgeons and other specialists who work at the Royal Brisbane Hospital and the communication tends to continue. That doesn't always - that's not essential, though, and I would point out that Rockhampton recently has appointed a new Director of Surgery. He has not gone through any training program in Queensland. I understand he was trained in New Zealand, but in contradistinction to Dr Patel, he made contact with me, and both by telephone and email, and when he was next in Brisbane I invited him to come

to the Royal Brisbane where he met a number of the staff, and, so, you know, already we have - we have a line of communication there.

Doctor, just to continue with the big picture issues, at paragraph 10 you speak about concerns you have for the judgment, knowledge and technical abilities of Dr Patel. And you talk about the fact that he was perhaps too interventionist?-- Yes.

COMMISSIONER: Can you explain - you say that you had the impression his intervention was fairly aggressive. Are you speaking there about aggression in the sense of deciding to perform surgery rather than not perform surgery, or aggression in the way in which the surgery was performed?-- No - well, certainly I can't comment - I never - I never had the opportunity of seeing Dr Patel operate.

Yes?-- But, I mean, aggressive in terms of recommending surgery and proceeding to surgery.

Well, I accept that, but when you say you never saw him operate, you have seen the consequences of his operating, and, for example, removing a bowel when a more cautious approach would be a colonoscopy and perhaps removing a polyp?-- Mmm.

I guess that's a sense of aggression as well, taking the more aggressive approach to surgery?-- Yes.

MR ATKINSON: Doctor, in paragraph 11 you make the point, that you discussed just before, that surgery is not a benign undertaking?-- Yes.

It is a tough exercise and any practising surgeon has complications?-- That's correct.

Can you tell me whether this is right: I understand when surgeons are viewing this whole inquiry about Patel, they think, "Look, any one of these complications, we have all had it at one time or another." Is that a fair comment?-- Well, certainly there is - you know, there is the view that there but for the grace of God go I in relation to complications that are seen-----

But if you can?-- -----or encountered. Sorry, I have lost my train of thought.

I was going to move you to this point if I can: every surgeon has a complication, but even just looking at this 42, even looking at one patient like Ian Vowles or Nelson Cox?-- Yeah.

You are seeing a number of complications?-- That's correct, yeah.

And that causes alarm bells to ring for you?-- Yes, it does, yeah.

All right. In-----?-- If I can just enlarge a bit on what I

have said, the practice of surgery, you know is not a benign undertaking, and, you know, there are ways in which surgeons try to minimise the risk of complications, which is one of the very major downsides of practising surgery. And in spite of the best intentions and, you know, the best technical skills, patients will get complications. And the risk of complications is greater if surgery is done in an emergency situation where there is no time to prepare the patient or where an infection or disease process is well established. But also complications tend to occur to a greater degree in elderly patients, or patients who have got what we would call comorbidities or other medical problems like cardiac disease and respiratory disease, hypertension, obesity - and all these things I believe are on the increase - and, you know, doing abdominal surgery, for example, in an emergency situation, in a patient of that nature, complications are not infrequent.

No, but you are seeing not just one complication but admittedly over this selected group of 42 you are seeing a lot of complications?-- I am, and I would say the majority of the patients that I saw were not emergency patients, they were done in the elective setting.

And your view, of course, is that complications in elective surgery, adverse outcomes and particularly the iatrogenic outcomes are less acceptable than they are for emergency surgery?-- That's right, yeah.

COMMISSIONER: Doctor, I assume there are, if you like, benchmarks for a lot of these complications? Like, if you have one wound dehiscence in every 500 patients, you wouldn't worry too much, but if it is one in every 50, then you would start to think there may be a problem?-- That's correct, Commissioner, yes. There are such benchmarks, yeah.

MR ATKINSON: And some of the ones you have chosen in your statement, to take Nelson Cox as an example, each of these patients seem to show not one complication but a series of complications?-- That's correct.

Nelson Cox, you mentioned in paragraph 15, there is difficulty in entering the abdominal cavity. Then in the same paragraph you mention that the gall bladder was inadvertently opened?-- Yes.

Then in paragraph 16 you mention that a haematoma developed?-- Yes.

In paragraph 19 you mention evidence of internal bleeding?-- Yes.

And in paragraph 20 you have got drains filling - sorry, and, of course, "Dr Patel has sewn up the patient while there are still drains filling"?-- Yes. Yes, so each one of these complications is something that you might see in the practice of a competent surgeon, but here we have a sequence of four or five complications occurring in the same patient at the same time, and this is unusual. This would be unusual.

And then in paragraph 21 there is a further complication, the incisional hernia?-- Yes, this is the final indignity, I suppose, that ultimately when the patient is largely recovered, he is left with a painful hernia.

And what-----

COMMISSIONER: Doctor, if this operation had been performed by your registrar, would I be right in thinking you would be suggesting the registrar think of a career somewhere other than surgery?-- Well, yes, I would have to agree with that, Commissioner.

D COMMISSIONER VIDER: And whilst anyone can have complications, doctor, would you think it a bit unusual if you had taken someone to theatre with a preoperative diagnosis of a lap choly and you have taken that patient back to theatre three times within 48 hours, would you think that was unusual?-- Yes, I would, yeah.

MR ATKINSON: And to be fair, doctor, that's a point you make, isn't it, in paragraph 23A?-- Yes, it is.

Now, in paragraph 24, you deal with a different patient. Again, the first complication or the first cause for concern is set out in paragraph 25. You are not convinced that was the right way to approach the abdominal cavity, is that right?-- Well, my understanding, from the operative notes here, is that this particular means of accessing the abdominal cavity was taken in order to avoid an injury to the bowel. So in spite of that, the bowel was injured.

Not enough clearance was allowed?-- That's right.

You mention in paragraph 26, of course, that somehow inadvertently the bowel has been nicked. Then in paragraph 27 you speak about a complete wound dehiscence?-- That's right.

Is that something that can happen reasonably regularly to good surgeons?-- Not reasonably regularly. It can happen very occasionally to a competent surgeon and it usually relates to patient factors, including malnutrition in the presence of, say, a disseminated cancer where there is - where there are problems with wound healing.

Right?-- But it ought to be a rare event, a completely dehiscenced abdomen.

Doctor, in paragraph 30 you say something startling, which is that those two cases make you wonder whether Dr Patel is proficient in laparoscopic surgery?-- Yes. It's only two cases, but in both cases there was - there were significant and serious complications and I am aware of a third case, patient, that I have - that I have not seen personally, I am aware of the third case, where the patient was transferred down to the Royal Brisbane Hospital with a bile duct injury at the time of the laparoscopic cholecystectomy performed by Dr Patel, and these cases suggest to me that he's not the most proficient laparoscopic surgeon around.

And that's not a small failing - sorry, Commissioner, that's not a small failing in a general surgeon? I mean, that's a big part of your work?-- That's a major part of our work.

COMMISSIONER: Indeed, I was going to ask lap cholies are pretty much bread and butter operations these days, aren't they?-- That's right, Commissioner. It would be amongst the most common operation performed.

And it's the sort of thing that you would regularly trust a registrar to perform under your supervision and even without being physically present in the operating theatre?-- Yeah, although I would say - I would say that although it's commonly performed, it is technically a challenging procedure, and that is why training in laparoscopic surgery is so important, because the - you know, the consequences of doing laparoscopic - a laparoscopic cholecystectomy poorly can be - the risk can be incredibly high.

And for all of those reasons you mention, because they are quite frequently done, because they are technically challenging and because the risks involved are significant if they are poorly performed, a lap choly is a good litmus test for a surgeon's competence, that if Patel can't do a competent lap choly, you start to worry?-- I think that's a good - that is a very good point, yep.

MR ATKINSON: And in any case laparoscopic surgery is done often right outside and apart from a cholecystectomy; is that right?-- Absolutely, yes.

Because it just means the patient can heal quicker and you can have a better turnover in hospital?-- Yeah, it's a minimally invasive technique which avoids a large abdominal incision and that allows patients to recover quickly, more - quickly, leave hospital earlier. A laparoscopic cholecystectomy normally would expect not to be in hospital for more than 24 hours. Some patients can be done as day cases.

Doctor, in paragraph 31 you start dealing with a different patient?-- Could I just make at point?

I'm sorry, yes?-- In relation to an incisional hernia through

the type of incision in the case of - can I use the name?

Yes?-- Mr Cox, the subcostal incision that was made eventually in the case of Mr Cox, that is a wound that is very rarely associated with an incisional hernia, just by nature of the anatomy. Incisional hernias attend to occur more in the midline type abdominal wounds. This is an oblique wound here and incisional hernias in that sort of wound are extremely rare, and if they do occur it usually relates to a technical failure in sewing the wound, sewing the wound together.

COMMISSIONER: Just for the record, because these things have to be recorded, you were indicating an oblique line moving down from the centre, I guess along the line underneath the rib cage?-- That's correct, yes.

Yes.

MR ATKINSON: Now, in paragraph 31 you deal with a different patient. You make the point, doctor, in paragraph 36 that she also had a complete wound dehiscence post-operatively?-- Yes.

And she also had a stormy and prolonged post-operative course, but your main concern with this patient, I understand, is that she wasn't adequately assessed?-- That's correct.

After the operation she had a heart attack?-- That's right.

And one of the problems, I understand you to say, is that she wasn't properly assessed, she had the wrong operation, but after the heart attack she couldn't really have another operation because she wasn't up for it, she wasn't fit for it?-- That's right. Well, she didn't have the best operation, the operation that would be best advised for that condition. She then sustained a heart attack in the post-operative period and that then renders her at significant risk of - you know, a further cardiac event were she to be subjected to another major operation after that.

D COMMISSIONER VIDER: Mrs Connors, she went to see Dr Patel on the schedule for surgery in March 2004. You saw her in 2005. What's her psychological state like?-- She was very depressed and upset by what had happened, as was her family.

COMMISSIONER: And, doctor, I don't want to overdramatise this, you say that she's now unfit for optimum treatment for her ovarian cancer. Is that likely to prove fatal?-- It's outside my area of expertise, Commissioner.

Yes. Well, to put it in another way, if she had had appropriate assessment and the ideal operation in the first instance, there's a reasonable prospect that her cancer would have been nipped in the bud?-- Yes, that's correct.

Now she doesn't have that chance?-- She has a chance, but, as I say, she hasn't had the most appropriate operation by the most appropriate surgeon.

Yes. And, indeed, it was - even the inappropriate operation seems to have been badly performed in the sense that it led to wound dehiscence?-- That's correct.

Would that have any linkage with the fact that she suffered a heart attack or is that unrelated?-- There may be - there may be a linkage, if her - if her wound was not healing correctly and she was unwell. That may have - that may have caused systemic changes which contributed to the heart attack. It's possible.

MR ATKINSON: Doctor, from paragraph 40 you deal with a fourth patient, and then in paragraph 46 you set out the issues that concern you about that patient's care?-- Yes.

The main ones - I guess, they're two. The first is there wasn't enough evidence - there wasn't enough weighing up of options prior to taking the surgical route?-- That's correct.

And second of all, the surgery was - at least looking at the outcome, seems to have been performed poorly?-- That would be my view.

Doctor, the specific ones - and there's five there counting Mr Vowles of course. Can I take you back - you spoke about the 20 and some of them will need follow-up in the middle group. Can you answer this question, is it true or false to say that the majority of the patients you saw received a standard of care which is less than what you'd expect from a reasonably competent surgeon?-- The majority - I think I would agree that around half of the patients that I saw received a standard of care that I - that was less than I would expect from a competent surgeon.

And there's perhaps an even easier way to judge Dr Patel, would you let him operate on you?-- No.

That's the evidence-in-chief.

COMMISSIONER: Mr Farr?

MR FARR: I should-----

COMMISSIONER: Sorry.

D COMMISSIONER EDWARDS: Can I ask you, doctor, what system do you have in place at the Royal Brisbane Hospital that would detect a higher complication rate than is normally acceptable and, secondly, do such processes exist as you know in most hospital - major hospitals in the regional centres of Queensland?-- The systems in place at Royal Brisbane Hospital are several. Primarily there is a clinical audit system in place. Each department of surgery has a database where information is gathered on a prospective basis and entered in relation to all patients who are admitted and have operations, and complications are identified and these are then presented at a - in a regular forum. This happens in all the specialities that I'm aware of at Royal Brisbane Hospital, and

attendance is thought to be important, and although we have a high proportion of visiting surgeons at Royal Brisbane Hospital the majority of them will attend these meetings when they are - whenever they can, and it's most of the time. Most of them will set aside time to ensure that they do get to the Morbidity and Mortality meetings. All the complications are discussed and it's - it's possible, you know, to pick up trends in doing that, and as a group we sometimes modify the way in which we practise, you know, on account of a pattern emerging. That's one way in which it - which it occurs. The other way, which is perhaps not so specific, is that medical records also record complications and on review of the medical record after the patient has been discharged - and it's - most of the departmental directors or the divisional directors will receive from medical records a breakdown of complications, but unfortunately because of the descriptors and the coding used it's not as - surgeons don't find it as friendly as the audit system that I have talked about, the clinical audit system that I have talked about.

COMMISSIONER: I think Sir Llew also asked you about regional areas. Do you have knowledge of similar systems outside Brisbane?-- Yeah, well, I think in most of the provincial hospitals there is - there would be something similar, certainly in the departments of general surgery. You are not going to have many subspeciality departments anyway, but, you know, it's an important part of - you know, of ongoing quality control in surgery, and any surgeon who's a fellow of the Royal Australasian College of Surgeons will - would need to take part in some sort of clinical audit for reaccreditation purposes, and whether - as a training program in surgery it's actually a mandatory requirement for a hospital to have - to have a clinical audit system in place. Unfortunately Bundaberg had a training post in general surgery but lost it on account of the surgeons who - Dr Anderson, Dr Nankivell, Baker - who were able to provide that training moving on from the system. So they lost their - they lost their training post at - that we worked hard to establish.

D COMMISSIONER EDWARDS: And that would have then perhaps interfered with the normal audit processes such as a Morbidity and Mortality committees to which you refer?-- It more than likely did.

Thank you.

COMMISSIONER: Mr Farr?

WITNESS: The other thing, Deputy Commissioner, is that there are clinical indicators, and these are indicators that are agreed upon by the College of Surgeons and the ACHS, Australian Council of Health Services. These very - and these are collected as well by - certainly by large hospitals, like the Royal Brisbane Hospital. There aren't many of those clinical indicators, but things like anastomosis leak rate after low anterior section, you know, haemorrhage after prostatotomy are a couple that come to mind.

COMMISSIONER: Unplanned returns?-- Yes, unplanned returns to theater. Most big hospitals also will collect some data in relation to wound infection, you know, although that - the collecting of that information and the interpretation is fraught with - you know, problems in that many patients have a wound infection after they go home from hospital and not whilst they are in hospital

Mr Farr?

MR FARR: I don't have any questions thank you but I should announce my appearance on behalf of Dr-----

COMMISSIONER: Thank you. Ladies and gentlemen, I would like, if possible, to not to have to bring Dr O'Loughlin Back. Do we think it's possible to finish his evidence this afternoon?

MR DEVLIN: I will be very brief.

MR HARPER: I will be very brief.

MR ALLEN: I won't add any time.

MR DIEHM: I don't have anything either.

MS FEENEY: I have nothing, Commissioner.

COMMISSIONER: Thank you.

CROSS-EXAMINATION:

MR HARPER: My name is Justin Harper. I appear on behalf of the Bundaberg patients. Could I take you to paragraph 5 of your statement. In the last - second last sentence of that, at page 2, you say, "In my view a smaller proportion of the patients that I saw received suboptimal care from Dr Patel." That term "suboptimal", would it be reasonable to replace for that "less than competent professional care"?-- Yes.

Thank you. Could I take you then to paragraph 7, and again the second last sentence there says - talks about the conduct of cholangiograms and you say, "However, there is also a reasonable body of opinion that suggests that routine cholangiograms may not be necessary." Could I ask you to turn your mind specifically to the situation in terms of Australian surgical practice. Would that statement hold specifically for Australian surgical practice; that is, is there a reasonable body of opinion within Australia, among Australian registered surgeons, that a routine cholangiogram may not be necessary in those circumstances?-- That would be - that would be less likely in a cohort of Australian surgeons.

Thank you.

COMMISSIONER: Doctor, can I ask it the other way around?-- Mmm.

Is the routine performance of cholangiograms regarded in Australia as best practice in the case of laparoscopic cholecystectomies?-- Well, I would regard it as such, but it's a topic that's the subject of considerable debate, and it's an ongoing debate and a never-ending debate, and when I - when I refer to routine cholangiograms, I mean a cholangiogram that's performed on every occasion or certainly that's attempted on every occasion, and I would regard that personally as best practice. However, there is a group of surgeons and there is a body of evidence in the literature that suggests that cholangiograms done on a selective basis - now, I don't mean never doing a cholangiograms, I mean doing a select - doing cholangiograms selectively on the basis of the patient's presentation, the biochemical investigations, and the radiology that's been done.

Certainly there's no body of opinion that supports the abandonment of cholangiograms generally?-- That's the point I would like to make, that not doing cholangiograms ever I would regard as being less than an acceptable standard of care.

And, doctor, the body of opinion that favours selective rather than universal cholangiograms, is that because it's considered unnecessary or because there there's considered to be some actual disadvantage to the patient?-- Both. Both of those things.

You see, we have heard suggestions that one reason Dr Patel may have had for not undertaking cholangiograms was the delay and the added time the patient, therefore, spent under anaesthetic. Is that one of the arguments supported by the selective party rather than the universal party?-- No, I don't think - I don't think the time spent performing the cholangiograms would be regarded as a valid reason not to - not to do them or not to recommend them, but certainly it follows that if you - if you only occasionally do an operative cholangiogram, then when the time comes for you to do it it's obviously going to take you longer to do it because you are not doing it all the time and you may not - you may not do it as well.

We have also heard it suggested that one of the arguments in Dr Patel's case against cholangiograms was the fact that there were no dedicated radiology services at the Bundaberg Base Hospital and, therefore, there was some added fuss in getting radiological services available. Nonetheless, is it the practice to undertake cholangiograms with lap cholies in other provincial hospitals around Queensland where there are no dedicated radiological services?-- Well, you certainly - you certainly need radiological assistance to do a cholangiogram.

Yes?-- But - there is no doubt about it, but I don't believe it's terribly sophisticated.

Yes?-- And I believe in most provincial centres it would be - it would be available.

Yes. So, the difficulty in lining up the technician or the radiological service you wouldn't see as a compelling argument for not doing it in Bundaberg-----?-- No.

-----where you would do it in Brisbane?-- Absolutely not. If you have got an orthopaedic service, for example, you know, you are going to have a reasonable radiological service to back that up and - so, no, I wouldn't see that as a valid objection.

Thank you. Sorry-----?-- The reason for - you know, the debate that rages - well, it doesn't rage, but the debate that's had is that cholangiograms are - may protect against bile duct injury, which is the most sort of feared and serious complication of a cholecystectomy, not just laparoscopic but open cholecystectomy in days gone by. But, in fact, the performance of cholangiograms won't necessarily prevent a bile duct injury, but it may - it may reduce the severity of the bile duct injury. I mean - and the critical part of a cholecystectomy is the anatomical dissection, defining the structures accurately, identifying the structures and dividing the right structures. That's the critical part and that's why - that's why I would take the view that I would not be critical of a surgeon who did cholangiograms selectively who was technically adept and skilled in identifying, doing the dissection.

Thank you.

MR HARPER: Just to expand upon that, you mentioned that there is a theory that the conduct of a cholangiogram would protect against bile duct injury. That is disputed by some surgeons. Is that the situation?-- Yeah, that's right, because to do the - to do a cholangiograms you have to make a cut-----

Yes?-- -----in a duct. Now, if you - if you misidentify the right duct or the correct duct, then by definition you have - you have caused a bile duct injury to do the cholangiogram.

Okay. So that is in fact a downside to it, that it can have-----?-- Yeah.

That it can cause that subsequent injury?-- That's right.

So that's the downside?-- That's right. If you don't - if you don't do the dissection accurately and you fail to identify the appropriate duct, then the performance of the cholangiogram may in fact cause a bile duct injury.

Could I suggest that that is not about the proper conduct of a cholangiogram and a complication which arises from it, but is, in fact, about that on occasions when a cholangiogram is attempted it is not done successfully?-- Yes, that's - I'd agree with that.

Okay. So, then is it fair to say that that is the only downside to the conduct of a cholangiogram is that the surgeon performing it may on occasion make a mistake and do some damage?-- Could you put that to me again?

Is it fair to say that the main downside of the conduct of a cholangiogram is that the surgeon performing that cholangiogram may on occasion make a mistake and do some collateral damage?-- Yes.

So can I go back to the debate then that's had. Is it fair to say that in Australia it is a relatively small proportion of the surgical community who would not routinely conduct a cholangiogram?-- Routinely?

Yes?-- Look, I couldn't say what the proportion would be. Certainly in Queensland the proportion would be low.

Okay?-- Because we are trained in - we tend to be trained in a way which favours routine cholangiography.

Would it be fair for me to describe then that in fact what you describe as a reasonable body of opinion is not really a body of opinion about the conduct of a cholangiogram, but it is the practice of some surgeons that they don't conduct it.

COMMISSIONER: I think the doctor's, in effect, answered that by saying there is actually a body of opinion that says it's preferable to be selective.

WITNESS: Well, that it's equally efficacious to be selective.

MR HARPER: Okay. I won't proceed any further with that. Could I take you then to paragraph 29, and it's just a point of clarification. In 29A you say, "Normally" - half-way down - "Normally the incision should be placed well away from any previous incisions. This is the sort of mistake that happens occasionally and can be made by a reasonably competent surgeon." Just to clarify, is it true that you're not suggesting there that - what you're alerting to there is competent surgeons as such make mistakes?-- Yes.

And competent surgeons occasionally fall below reasonably competent professional practice in a particular incident?-- No, I'm not suggesting that. I'm suggesting that competent surgeons occasionally make a mistake, and in this particular instance an injury to the bowel occurs because of the way - the placement of the incision.

But is it fair to say that were the reasonably competent surgeon acting appropriately, they would not make that sort of mistake?-- Well, I don't think you can say that because it happens in spite of competence. If the bowel, for example, is adherent to the abdominal wall in an area where one might not expect it to be adherent, there may be an inadvertent injury to the bowel wall.

Thank you, doctor.

COMMISSIONER: Thank you, Mr Harper. Mr Allen?

MR ALLEN: No, thank you, Commissioner.

COMMISSIONER: Mr Devlin?

CROSS-EXAMINATION:

MR DEVLIN: Dr O'Loughlin, Ralph Devlin for the Medical Board of Queensland. Firstly in respect of the 40 odd patients that you have seen, do I take it that in each and every case you've had the benefit of the patient charts?-- Yes, I have, Mr Devlin.

Thank you. And secondly, about wound dehiscence, in your experience have you encountered definitional differences of opinion amongst competent colleagues about what amounts to a wound dehiscence and what amounts to something less than that?-- Well, I would think that most surgeons would recognise a superficial wound dehiscence - this is in relation to the abdomen - and a deep or complete wound dehiscence where the fascia gives way as well.

So what gives way in terms of a superficial wound dehiscence?-- It's usually the skin and the subcutaneous layer of fat.

In your experience, have you encountered differences of opinion as to whether it's truly - sorry, the first word you used was-----?-- Superficial.

Superficial. In your experience have you encountered differences of professional opinion about whether it was superficial or the more fundamental wound breakdown?-- Well, on occasions it may be difficult to distinguish clinically. Is that what you mean?

Well, I suppose I'm getting at whether you've encountered, in your long experience, the difficulty, for example, of classifying something - some incident as a true fundamental wound dehiscence as opposed to a superficial one? Your reaction suggests you haven't really encountered that at all, that it's relatively easy to determine the difference between the two?-- Yes.

Am I right there?

COMMISSIONER: Or that perhaps it's unnecessary to make such a distinction. They're all called dehiscences, and it's just a question of how deep or superficial the dehiscence is?-- Yes. I mean, if you see an incisional hernia at a stage remote from the operation, then clearly there has been a complete dehiscence of the fascial layer. But in the early stages, you know, in the first week or two after surgery, when there is a separation of the tissues, it's sometimes difficult to know whether in fact a deeper layer is still intact. Sometimes it's quite obvious because all layers give way and the bowel eviscerates. So, you know, clearly that's a very easy clinical diagnosis to make. But there are variations on that. For example, the skin is intact and the deeper layer is dehisced or there is a complete dehiscence, but the bowel

doesn't eviscerate.

MR DEVLIN: Yes. So there are permutations and combinations within the very idea or phenomenon of wound dehiscence?-- That's right.

On a scale of seriousness?-- Yes.

Are you able to assist us as to how - as to whether any - there's any need to properly define wound dehiscence across that span of event or whether it's simply classified as wound dehiscence for the purpose of the hospital's statistics? Do you follow me?-- Well, yes, there is some importance. There would be some importance in trying to distinguish because the complete dehiscence, or the dehiscence of the fascial layer, is a much more serious problem and may require either an immediate return to theatre or repair of an incisional hernia further down the track. So, you know, if you're getting a lot of these then there are - there would be cause for concern because there may be some technical difficulties, some technical problems if that's occurring frequently. Superficial wound dehiscence, on the other hand, is more likely associated with infection in the wound or other matters like simply removing the sutures too early in a body part where there's a fair amount of tension on the wound. For example, on the back. If you remove the sutures too early the wound will invariably dehisce and separate, but it's not of such consequence.

In a hospital setting in detecting negative trends, are you somewhat reliant upon the accurate collection of data?-- Very much so.

And is that collection of data something participated in by all levels of staff in a team setting?-- To a large extent, yes.

Thank you.

COMMISSIONER: Thank you, Mr Devlin. Mr Diehm?

MR DIEHM: I have nothing.

MS FEENEY: No, thank you, Commissioner.

COMMISSIONER: Mr Farr?

MR FARR: No.

COMMISSIONER: Mr Atkinson?

MR ATKINSON: No. Perhaps if the statement could make its way up to the Bench.

COMMISSIONER: Yes, indeed. We've already indicated the exhibit number. Dr O'Loughlin, I've had a number of occasions recently to comment on how humbling it is for those of us who have the difficult job to do here to have the benefit of such

skill and experience and wisdom as that which you obviously possess. We couldn't do our job unless people like you were prepared to come forward and give us the benefit of your assistance. We are deeply grateful to you for that assistance, and you are formally excused from further attendance. Thank you again for your time?-- Thank you, Commissioner.

WITNESS EXCUSED

COMMISSIONER: Mr Atkinson, tomorrow, what time?

MR ATKINSON: We have Dr Carter in the morning. He's coming down especially from Bundaberg.

COMMISSIONER: Yes.

MR ATKINSON: He is the Director of Anaesthetics, of course, so 9.30 would be good.

COMMISSIONER: 9.30? Do you know what time he's arriving?

MR ATKINSON: No, actually Ms Gallagher and Mr Tait are acting for Dr Carter. I think he is on the early flight, and otherwise there's a later flight that still gets him in at 8.40.

COMMISSIONER: We will assume it's 9.30, and if he's running late then we'll put up with that.

MR ATKINSON: Thank you, Commissioner.

COMMISSIONER: 9.30 in the morning. Thanks, ladies and gentlemen.

THE COMMISSION ADJOURNED AT 4.59 P.M. TILL 9.30 A.M. THE FOLLOWING DAY