Transcript of Proceedings

THE HONOURABLE G DAVIES AO, Commissioner

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

IN THE MATTER OF THE COMMISSIONS OF INQUIRY ACT 1950

COMMISSIONS OF INQUIRY ORDER (No. 2) 2005

QUEENSLAND PUBLIC HOSPITALS COMMISSION OF INQUIRY

BRISBANE

..DATE 05/10/2005

..DAY 18

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

THE COMMISSION RESUMED AT 10.01 A.M.

COMMISSIONER: Yes.

MR PERRY: Commissioner may I make application for leave to appear?

COMMISSIONER: Yes. Who for?

MR PERRY: Dr Naidoo, who is on tomorrow, but this witness this morning may be a witness of interest in that regard.

COMMISSIONER: Yes.

MR PERRY: I am instructed by Deacons.

COMMISSIONER: All right.

MR PERRY: Thank you.

COMMISSIONER: Mr Devlin?

MR DEVLIN: Commissioner-----

COMMISSIONER: I am sorry, have you got something first?

MR FITZPATRICK: Commissioner, we apply for leave to appear for Dr Krishna.

COMMISSIONER: All right.

MR FITZPATRICK: And, Commissioner, I am instructed on the doctor's behalf to seek an order from you that he not be filmed, photographed, nor that any audio tape be made of his evidence. His two younger children, he instructs, have suffered at school in consequence of publicity that's attached to the publication of the Giblin North report.

COMMISSIONER: Yes.

MR FITZPATRICK: And whilst he understands that there will be a certain amount of that through the necessity of giving evidence, he feels the situation would be exacerbated if he were filmed.

COMMISSIONER: You mean a public video or audio report?

MR FITZPATRICK: That is so, Commissioner. He understands-----

COMMISSIONER: Public transcript but no audio recorded.

MR FITZPATRICK: He understands the need for an official transcript, Commissioner.

COMMISSIONER: Yes. Does anyone have any objection to that? All right, I will make such order.

MR FITZPATRICK: Thank you, Commissioner.

COMMISSIONER: Yes, Mr Devlin?

MR DEVLIN: Commissioner, I seek your leave to tender into the record a number of documents going to about three or four disparate topics.

COMMISSIONER: Yes.

MR DEVLIN: We sent word to Mr Groth last evening of our intention to apply for such leave.

COMMISSIONER: Yes.

MR DEVLIN: The first is a further affidavit of Michael Stephen Demy-Geroe, a deputy registrar of the Medical Board of Queensland, which brings up to the current moment the terms of exhibit 136, which was the Board's letter of the 22nd of June 2005 relating to the current arrangements, particularly in relation to supervision of international medical graduates being granted provisional registration in Queensland. In particular, it encloses now or attaches the Board's formulated policy on supervision which provides for four separate levels of supervision of medical practitioners.

COMMISSIONER: Yes.

MR DEVLIN: So I formally tender that.

COMMISSIONER: Thank you.

MR DEVLIN: Seek leave to.

COMMISSIONER: That will be Exhibit 420.

ADMITTED AND MARKED "EXHIBIT 420"

COMMISSIONER: These witnesses are available if anyone wants to ask questions, I presume?

MR DEVLIN: That's so.

COMMISSIONER: Thank you.

MR DEVLIN: The next, Commissioner, is the police statement of Ainslie McMullen. In preparing written submissions to you about various aspects relating to the Terms of Reference, it became clear to us that there was something of a gap, somewhat unintentionally, in the evidence. We act for Ms McMullen and Ms McMullen was the assessment officer who originally assessed

Dr Patel's application. Ms McMullen has given her consent for the tender of the police statement, so I formally seek leave to tender that.

COMMISSIONER: Yes, Exhibit 421.

ADMITTED AND MARKED "EXHIBIT 421"

MR DEVLIN: Next, with the assistance of Q Health, there have been documents assembled which relate to the particular patient Mr Bramich, P11, relating specifically to the issue of the availability of the aircraft for transfer from Bundaberg to Brisbane on the critical day. With the assistance of Q Health we have assembled documents relating, firstly, from the Royal Flying Doctor Service which will address, as far as possible, the availability of the plane and any delays ordered from Bundaberg. So far the material does not reveal any such order or countermanding of the flight from Bundaberg, but the RFDS records such as they are, I seek to tender those.

COMMISSIONER: Thank you. They will be Exhibit 422.

ADMITTED AND MARKED "EXHIBIT 422"

MR DEVLIN: Might I say, the purpose of putting these on the public record is so that the Board can make detailed submissions to you about this particular case.

COMMISSIONER: Yes.

MR DEVLIN: The last bunch of documents are documents from the coordination centre, the Q Health Coordination Centre, and, as I understand it, these documents are annexed to a statement of Dr Smith, which is with the Commission, but we seek to put them on the public record since this particular case of Mr Bramich has received a lot of attention.

COMMISSIONER: I thought you said they are on the record annexed to a statement which has been tendered.

MR DEVLIN: No, it hasn't been tendered, it has been supplied. So I formally tender them into the record so the Board can make submissions upon them.

COMMISSIONER: They will be Exhibit 423.

ADMITTED AND MARKED "EXHIBIT 423"

MR DEVLIN: That's all I have.

COMMISSIONER: Just before you sit down, though, Mr Devlin, there is one matter which I should raise with you now, for a couple of reasons, and it concerns the original registration of Dr Patel by the Board.

MR DEVLIN: Yes.

COMMISSIONER: It was registration SMO surgery.

MR DEVLIN: Yes.

COMMISSIONER: And there is a question that occurs to me as to whether that had the legal effect of his being registered as a deemed specialist. I don't want you to necessarily answer that concern I have, but let me explain it to you. 143A(2) says that a person, in effect, when registered "is registered as a deemed specialist if he is registered to practise the profession in a specialty". On the assumption that surgery is a specialty, it seems to me, on a superficial reading of the section, the correct construction of it is, and the correct construction of that document is that Dr Patel was registered by your client as a specialist surgeon.

MR DEVLIN: Commissioner, the Board will address that in as much detail as it can and it will do it sooner rather than later.

COMMISSIONER: Well, you don't have to do it sooner. You can do it in your submissions at the end. But it seemed to me that it may have concern for you, both in your address and also as to any question of liability of the Board, and I thought I should raise it with you now in case you are advised further in relation to matters relating to liability.

MR DEVLIN: Yes, thank you.

COMMISSIONER: Mr Andrews?

MR ANDREWS: I call Dr Krishna.

COMMISSIONER: I don't think we're filming. Excuse me, cameraman, we are not filming. I presume the sound - is the sound still going outside? Thank you.

DAMODARAN KRISHNA, SWORN AND EXAMINED:

MR ANDREWS: Good morning, doctor, would you tell the inquiry your full name, please?-- My full name is Damodaran Krishna.

Doctor, have you signed a statement dated the 28th day of July 2005?-- Yes, sir.

Do you have a copy of it with you?-- Yes.

Doctor, are the facts recited in that statement true and correct to the best of your knowledge?-- Yes.

Are the opinions that you give in that statement, opinions you honestly hold?-- Yes.

I tender that 12 page statement with annexures, Commissioner.

COMMISSIONER: That will be 424.

ADMITTED AND MARKED "EXHIBIT 424"

MR ANDREWS: You are still a senior medical officer working in the orthopaedics department at the Hervey Bay Hospital, is that correct?-- At the moment, no.

What is your current occupation, doctor?-- At the moment I am doing supervised practice as required by the Medical Board to get my general registration.

And where do you perform that supervised practice?-- I am actually - at the moment I finished that supervised practice. I was performing there for the past six months at the Hervey Bay Hospital.

I see. And in what areas were you being supervised?-- In general medicine and accident and emergency.

You graduated with a Diploma in Orthopaedics in 1995, which was awarded in Fiji by the Australian Orthopaedic Association, is that correct?-- No, it was awarded in August by the Australian Orthopaedic Association.

Thank you. In Fiji you were registered as a specialist in orthopaedics?-- Yes.

That was in 1998?-- Yes.

You began your work in the orthopaedics department at the Hervey Bay Hospital on the 20th of July 2002 as a senior medical officer?-- That's correct.

Doctor, who recruited you to that position?-- This post was advertised while I was still employed in another hospital in Queensland Health - yeah, in Queensland. I applied for this post and I was recruited by the hospital.

Were you approached by Dr Naidoo?-- No, actually, I have never seen Dr Naidoo before, but I talked to him when I wanted to - when I got - applied for this post, I talked to him by phone.

Now, when you commenced on the 20th of July 2002, according to your statement, Dr Naidoo - am I correct in thinking he was then on bereavement leave?-- I can't remember.

How long after your commencement on the 20th of July did you actually attend at the hospital to commence work?-- I think that was the date I started work.

Thank you. Were you seeing patients in your - or giving them clinical care immediately, or did your commencement at work involve something else for a time?-- Initially, Dr Naidoo was with me all the time for first week. He took me around Hervey Bay Hospital, showed me around the wards, the operating theatre. Then he took me around to Maryborough and then showed me the normal things which I was required to do, the clinics and the ward work, and then used to be with me all the time. I can't remember for how long. And then eventually I started doing the normal work as given to me by Dr Naidoo.

When you were receiving your orientation by Dr Naidoo of the Hervey Bay Hospital, the Maryborough Hospital, and being - having explained to you the work you would be doing, were you performing clinical services at that stage?-- Yes.

How long was it until Dr Naidoo allowed you to perform services where he was not present?-- You mean present in the operating theatre?

Yes?-- I can't remember.

Did Dr Naidoo - were you credentialed by anyone, by any committee?-- No.

Were you privileged by any committee?-- When I arrived, the hospital gave me a surgical privileges letter which was a one-page couple of paragraphs only. Basically only thing it said was I was allowed to do - I was privileged to do trauma and minor elective cases only.

I see. Did you ever inquire what was meant by minor elective cases?-- I talked to Dr Naidoo and he did mention to me minor elective cases would mean very simple things like arthroscopies, carpel tunnel syndromes and bunion surgeries, which I had done before, and also had exposure to when I was working at another hospital in Queensland.

Were you given a list - I see that within your statement, at annexure DK6, there is a list of several pages which is headed "Orthopaedic Surgical Services - Dr Krishna, scope of service", and it sets out on three pages an orthopaedic trauma list, and on two pages, an elective orthopaedic surgery list?-- Yes.

Now, the one that appears within your statement at annexure DK6 is dated the 1st day of January 2004. Were you given an earlier one?-- Not in this much detail. Like I said, we were given an earlier one, which was not this descriptive. It was

- just basically mentioned that I was allowed to do trauma cases within my scope and minor elective cases.

And who was to determine what those minor elective cases were?-- Actually, it was myself to determine.

And who was to determine what the trauma cases were?-- Again, it was my responsibility to do whatever trauma cases I was comfortable with.

Now, the list DK6 - allow me to put it on the screen for you - at least the first page of it - you recognise that as the first page of your annexure DK6?-- Yes.

Did you have any discussion with any person at the hospital before you received that document - that is about what the contents of the document would be?-- Dr Naidoo discussed with us after he had given it to us, and asked if there was anything we were not too uncomfortable with, which we are uncomfortable with.

"Anything which we were uncomfortable with", do you mean-----?-- Myself.

-----"anything which I was uncomfortable with"?-- Yeah.

COMMISSIONER: When you say "we", were you given one at the same time as Dr Sharma, do you think?-- Yes, sir.

I see.

MR ANDREWS: So it was - am I right in thinking it was not until Dr Sharma had been employed that you received a document like this?-- Yes.

COMMISSIONER: Well, not until 1st of January 2004?-- Yes.

Is that right? When did Dr Sharma come?-- Earlier than the 1st of January 2004.

COMMISSIONER: Yes.

WITNESS: 2003.

MR ANDREWS: Yes, during 2003 are the dates within my memory at the moment.

COMMISSIONER: I see.

MR ANDREWS: What conversation did you have with Dr Naidoo when receiving this list?-- Well, the only thing I remember telling him that in one of the - this is the trauma one, but I did mention about on the elective list where he mentioned about acetabular fracture, which I said-----

A-C-E-T-A-B-U-L-A-R fracture?-- Yeah.

Would you identify it on the elective orthopaedic list? I

suspect it is lower down on the page. Perhaps it is on the second page. Would you mind putting the first page back again?-- Possibly-----

COMMISSIONER: Can't see it at all.

MR ANDREWS: Can you-----

WITNESS: Some more.

MR ANDREWS: But it is an acetabular fracture that you recall discussing, is it?-- Yeah, the-----

Would that not be on the trauma list?-- Trauma list, yes.

In the circumstances, would you please put up the second page of the trauma list. Towards the top of the page do you see "acetabulum fracture, simple and complex"?-- Yes.

Did you discuss one of those with Dr Naidoo?-- Yeah. Dr Naidoo's answer was, "We don't do any pelvic trauma in Hervey Bay Hospital. All the pelvic trauma patients go to Brisbane." But he did mention if we had a simple fracture, dislocation of the hip joint where we have to reduce very gently, if there was a nerve involvement if we had to open and reduce it, then there was a small fracture which just needed fixation by a simple screw, we could do that. That's what he meant by simple fracture.

And he felt you could do that independently; that is without his supervision?-- Yes.

Tell me, how many of those had he observed you to perform before he authorised you to perform it independently?-- None.

I see. Would you look, please, at the first page of the orthopaedic trauma list? I am thinking of the column where you have been certified to perform things independently, doctor?-- Uh-huh.

The compound fracture dislocations, which is the third item from the top, do you - were you observed to attend to any of those by Dr Naidoo before being certified to perform those independently?-- Yes.

And the fractured clavicle, do you recall whether you were observed to attend to fractured clavicles by Dr Naidoo?-- Yes.

Before being certified to perform independently?-- Yes.

How many?-- One.

And the ACJ dislocation?-- Dr Naidoo hasn't seen me doing any and I haven't done any in Hervey Bay.

The fracture of the proximal humerus?-- I am not sure whether Naidoo has seen me but I have done a few in Hervey Bay.

Thank you. The fracture of the shaft of the humerus?-- Yes, I have done a few and Dr Naidoo has seen me doing one.

The compound fracture involving a compound scrub and external fixateur?-- Yes, he hasn't seen me actually performing the operation, but he has seen the patient post-op, which I had done independently.

And was this before or after you were certified?-- Before.

If you can't remember whether it was before or after, I would appreciate you saying so?-- No, definitely before.

Open reduction and internal fixation of the - it says "medical epicondyle". Does it mean - should it be "medial"?-- "Medial epicondyle.

Do you recall whether Dr Patel had seen you perform that procedure before receiving this certification?-- I can't remember any Dr Patel.

Dr - I beg your pardon, Dr Naidoo. Feel free to correct me every time I make that mistake?-- I am not sure whether Naidoo has seen me doing this or not but I have done while he was around in the hospital.

The next item, lateral condyle?-- Again, I can't remember if Dr Naidoo has seen me doing this but I remember doing one case.

Radius head?-- I have done a few of them. Not sure whether Naidoo was around or not.

Thank you. Supracondylar?-- Yes, again, I can't say whether Naidoo has seen me.

Is it reasonable for me to conclude that Dr Naidoo certified you as being capable of performing many of these orthopaedic trauma tasks independently, not as a result of having seen you perform them but as a result of the faith he placed in you?-- No, I disagree. I think he must have based his assessment on the post-op outcomes because even if he has not seen me operating, he has seen the patient in the ward post-op and also he must have taken into consideration my employment in other hospital in Queensland.

The next item of interest is ulnar/radius/ulnar and radius, open reduction internal fixation. Do you recall whether Dr Naidoo observed you to perform this procedure before certifying you?-- Again I can't remember Naidoo actually present in the theatre or at any time assisting me doing this case, but I've done a lot of those procedures.

The colles fracture and distal radius fracture?-- Very, very common operation. Definitely there'd be always at least one patient in the ward, so Naidoo has seen a lot of those post-op.

So he'll have seen them post-op, but is it quite possible he will not have seen you perform the procedure?-- Oh, he might have just crossed the room while I was doing it.

And - well, to treat the same problem with an external fixateur, he'll have seen that post-op?-- Yes.

Compound fractures, external scrub and external fixateur. Would you have been observed to be performing surgery by Dr Naidoo before certification?-- Yes, one of the cases he was actually with me, helping me with this external fixateur.

The lunate/peri lunate fracture dislocation?-- Very uncommon injury. I've done one and he has seen the post-op. He was very happy with that.

And the next item is the same problem but with open reduction and internal fixation. Do you see that the first was closed reduction and percutaneous K wires?-- I haven't done any open reduction peri lunate-----

And the final item, scaphoid, open reduction internal fixation and bone graft?-- I've done a few, and I think the one Dr Naidoo assisted me was after this, which was a difficult one and he assisted me. It was after this report, I think, from my memory.

Thank you. On the next page under the heading of "Metacarpals"?-- Yes, I've done quite a bit of - lot of them, and Naidoo has seen post-op x-rays and this is a very simple operation and Naidoo never assisted me in this one.

Phalanges?-- Again the same, like the other one.

Pelvic ring disruptions with external fixateur?-- This is the one Naidoo assisted me, and I did most of it. He was just helping me, and he was happy with me.

So he was supervising?-- Oh, yes.

Was this before or after you were certified as being able to perform it independently?-- This was well before. I think this was in 2000. I think so.

Closed fracture/dislocation with a closed reduction?-- This - I'm not sure whether Naidoo's seen me, but he's always - I've

done a lot of those and he's seen all the post-op x-rays and doing ward rounds.

Compound fracture/dislocation with compound scrub?-- Yes.

The same? Is that-----?-- Same.

You're not sure whether he's seen you perform it, but he will have seen post-op and post-op x-rays?-- Yes.

Subcapital fracture of the femur where the operation is cannulated hip screws?-- Yes, I've done a lot of those and never called Naidoo or - he would never come around.

So - well, you said you've never called Naidoo, and I think you said "who'd never come around". They're two different statements?-- It's a very simple operation.

I see?-- Very, very simple.

So Dr Naidoo, do you mean, has never observed you perform this simple operation?-- No.

Subcapital fracture of the femur where the operation - it seems to be there are three alternatives or more described. I can't say that I understand them. Monopolar, monoblock, hemi arthroplasty, Austin Moore and Thompson's?-- Yes.

Are they three different things or-----?-- They're probably describing the same type of procedures, but they are different companies which makes the prosthesis, like Austin Moore or Thompson's. Can be called a monoblock. It's just one piece.

I see?-- Again, I've done a lot of those.

Has Dr Naidoo observed you perform any of them?-- I think he helped me with one case. I can't remember whether it was before or after this report.

High subtrochanteric fracture. Has Dr Naidoo observed you perform that procedure?-- Yes. Yes, several times.

Well, the procedure is called DHS, what does that stand for?-- Dynamic hip screw. Very common operation.

Femoral shaft fracture simple involving a locked intramedullary nailing?-- Yes.

Has Dr Naidoo observed you perform it?-- Yes.

The supracondylar intercondylar fracture simple. Again, has Dr Naidoo seen you perform it before certifying you?-- I actually assisted Dr Naidoo in one of these, and I did most of the operating part. He was there to supervise me, and again I can't remember whether this was before the report - before this report or after, but I have definitely done a lot of these procedures, and again, Naidoo has seen these patients in the ward.

But he's seen you perform it only once?-- Yes.

The compound femoral fracture?-- I can't remember him seeing me perform this, but again these patients would be in the ward for at least a week, and Naidoo has always seen them post-op.

And tibial plateau fracture simple, open reduction internal fixation/bone graft?-- Yes, I have helped Naidoo one or two times, and I have done without supervision one or two times.

On the third page, tibial shaft fracture simple, locked intramedullary nail. Has Dr Naidoo seen you perform that before certifying?-- Excuse me, can I have it on the screen?

Oh, certainly. Would you put up the third page, please? On the bottom right-hand corner of the page it should have the code ending in 74. That's the page. Do you see the second item, tibial shaft fracture simple, locked intramedullary nail? Has Dr Naidoo observed you perform that before certifying you?-- Yes.

How many times?-- At least two times.

The distal tibial fracture simple?-- Yes.

How many times?-- I would be guessing, but I'm sure he's seen me at least one or two times.

Would you look now at the elective orthopaedic surgery list which is, I think, the next page. The first item, rotator cuff tendonitis/rupture simple?-- He hasn't observed me, but I have done one case only.

The fourth item, the pronunciation of which I don't remember, D-U-P-U-Y-T-R-E-N contracture?-- Dupuytren.

Thank you. Has he ever observed you perform an excision and Z-plasty?-- I would say no, but he has seen the patients post-op.

The excision of the ganglion/bursa/Baker's cyst?-- It's a very, very simple procedure, and I can't remember Dr Naidoo actually assisting me or supervising me with this.

Wrist arthropathy?-- Can you scroll up?

Certainly?-- Yes.

An arthrodesis for a wrist arthropathy?-- Yes, I've done two cases in Hervey Bay and Naidoo was around when I was doing the first one. He didn't actually assist me, but he was in the theatre.

Fracture non-unions, bone graft, the next item?-- Yes. This was my first operation when I came to Hervey Bay.

Do you recall whether you were observed by Dr Naidoo?-- Yeah, he was in the theatre.

The metatarsal osteotomy with - it says IF?-- Oh, yes. Yes, he has seen me do this procedure.

How many times?-- Couple of times.

About?-- Couple of times.

MTPJ arthrodesis. Did he see you perform such an arthrodesis before certifying you?-- Yes, I think he's seen me once.

And the PIPJ arthrodesis for hammer toes?-- I can't remember Dr Naidoo seeing me doing this. I have done just a few of these operations at Hervey Bay.

Subtalar osteoarthritis/arthropathy?-- I have done - I have not done any operation of this sort in Hervey Bay.

Thank you, doctor. When you started work as an SMO in orthopaedics at Hervey Bay, you were registered as an SMO for an Area of Need; is that the case?-- Yes.

Now, that, in practice, meant that you were obliged to work at Hervey Bay and Maryborough and were unable to work anywhere else. That is, your registration wouldn't have permitted you to work outside of those two hospitals?-- Yes, that's correct.

That meant - and you were there with your family?-- Yes.

That effectively meant that if the conditions were unpleasant, you didn't have any practical opportunity to leave, did you? You were obliged to take whatever the conditions were at the hospital?-- I don't think that's true. I could have left Hervey Bay Hospital and asked - and seek job at another hospital if the hospital was happy to employ me. I might not have got the same post, but they could have employed me as a PHO.

I see. So you mean you might have become attractive to another hospital by seeking a job with a lower classification than SMO?-- No, what I meant was I might not have got the job as SMO because these jobs are - if it's not available - like the bigger hospitals, the jobs are not available.

I see. PHOs are paid less than SMOs; is that correct?-- Yes.

The workload at this hospital, you say, was largely carried by the SMOs. Do you mean the workload in the orthopaedics department?-- Yes.

Now, there was a full-time staff specialist in orthopaedics, Dr Naidoo. Why do you say that the workload - at paragraph 19 of your statement - was largely carried by the SMOs, bearing in mind that Dr Naidoo was a full-time employee?-- Okay. We - talking about myself, I didn't do any arthroplasties. By

that I mean total joint replacements, which are big operations and which was just probably just 20 per cent of the workload. Most of the workload was either minor elective cases, plus 50 per cent of the work was trauma, and SMOs did most of the trauma cases.

What was Dr Naidoo doing when the SMOs were doing the trauma cases?-- Dr Naidoo would be in the hospital. He'd be either doing his clinics, or if he's - if he has got a list in the theatre, he'll be operating in another theatre.

COMMISSIONER: We've heard from other witnesses that Dr Naidoo was away a lot. Was that your recollection?-- Yes, Dr Naidoo had been away on some planned leave, and also a few times unplanned leaves. We believe - we're told that he was sick.

But for whatever reason, he was away quite a lot?-- I would like - he was away quite a lot, yes.

During the time you were there, what percentage of the time would he have been actually on the hospital premises?-- Sorry, I couldn't-----

During the whole of the time you were there, about how much of that time was he on the hospital premises? Would it have been half that time, a quarter of that time or what?-- Oh, he would be present about - I think in the year he would be away for at least two months.

Thank you.

MR ANDREWS: Well, in 2004, for example, when Dr Naidoo was working, he would work Monday to Friday approximately. Is that the case?-- Yes.

But not at weekends?-- Occasionally sometimes once in four weeks or once in six weeks he'll do one weekend.

And in 2004 were - are you able to remember in particular that year to be able to compare it, for instance, with 2003? Do you know whether Dr Naidoo took more or less leave in one year rather than another?-- I can't really recall, but I think it was 2004 when Naidoo was sick. So that would be the reason why he got more leave in 2004. That's from my memories.

Well, has Dr Naidoo been sick, or at least on leave for most of 2005?-- Yes, he took leave towards the end of January.

And has been on leave most of the time since the end of January?-- Yes.

Well, in 2004 did he have at least 14 weeks of leave?-- I can't remember.

Does 14 weeks of leave seem about right? That's nearly four months?-- It's about three months.

Thank you. You're quite right. In 2003 was Dr Naidoo away on leave for something of a similar amount of time as to 2004?-- I wouldn't be able to comment on the exact number of weeks he was on leave.

Were there occasions when Dr Naidoo was not on leave where you were unable to contact him when you wanted to?-- I can't remember any situation like that.

At paragraph 22 of your statement you observe that Dr Naidoo held Mortality & Morbidity Meetings once a week?-- Every Tuesday.

That's, of course, unless he was on leave?-- Yes.

And are you able to say what quality of meeting it was?-- Well, I think it was very good.

You say he was available on the floor during fracture clinics which were done solely by the SMOs?-- Almost all the time, except on Friday afternoons.

How many - were fracture clinics held how often? Daily?-- Except for Tuesday. Except for Tuesdays, yes.

Do you mean Dr Naidoo would attend the fracture clinic on a Friday?-- No, Friday - we had fracture clinic the whole day on Friday. In the morning session he'd be around. In the afternoon he won't be in the fracture clinic.

All right. So Monday, Wednesday, Thursday and Friday afternoon-----?-- No, Friday mornings.

Monday, Wednesday and Thursday there would be fracture clinics?-- Yes.

And Dr Naidoo would not attend them?-- He will be in the fracture clinic doing his own clinics. He will do a new patient clinic, arthroplasty clinic, or on a Friday morning he'll do a hand clinic, and while we are doing - one of us will be doing a fracture clinic.

You say that Dr Mullen often commended Dr Sharma and you for looking after his patients, but said that you would not be accredited because there was no supervision?-- Yes.

Was that a matter of disappointment for you, that there would be no accreditation because there was no supervision?-- Yes.

Were you being accredited for supervision by Dr Naidoo?-- Sorry, I - can you repeat that?

Were you being accredited for supervision by Dr Naidoo?-- I wasn't employed as a specialist, so I believe Dr Naidoo's responsibility was to supervise non-specialists.

I'd like to understand why you'd have been disappointed that you were not being accredited for supervision by Dr Mullen.

Can you explain that?-- Well, Dr Mullen could not supervise us because he was only doing orthopaedics once a week, and when he was on call, we're not on call, and the other thing was we are two SMOs. One at that stage was Dr Naidoo, and Dr Sharma was with Dr Mullen. That would mean if Dr Mullen was doing a case in theatre, Dr Sharma would go and assist him, and with Dr Sean Mullen's patients post-operatively in the ward. So he will contact Sean Mullen more often and assist Sean Mullen.

Were you disappointed when Dr Mullen told you you would not be accredited because there was no supervision?-- Yes.

What would have been the advantage to you if there had been supervision?-- Well, number one-----

MR PERRY: I object to that.

COMMISSIONER: Why, Mr Perry?

MR PERRY: The problem is this is what Mullen told him.

COMMISSIONER: Beg your pardon?

MR PERRY: This is what Mullen told this doctor. I don't think this doctor yet has been asked whether there was supervision, or what level of supervision rather than simply an assumption that there was insufficient -----

COMMISSIONER: I think it was pretty clear there was no supervision by Dr Mullen. That seems to be pretty clear.

MR PERRY: As long as it's confined in that respect, I have nothing to say about it. Thank you.

COMMISSIONER: Yes, Mr Andrews? Keep going.

MR ANDREWS: What would - what did you regard as the advantage that you would have had if Dr Mullen had accredited you for his supervision?-- There would be a lot of advantage. Number one, if I had applied for any training post, with Dr Sean Mullen's reference, it would be a very strong point for me.

But Dr Naidoo was there as a full-time staff specialist. How could you have had any advantage from Dr Mullen that you couldn't have obtained from Dr Naidoo's supervision?-- For example, for the advanced training post you need nine referees, so if we - any we obtain, the better.

I understand. Dr Khursandi I see you've met once in three years?-- Yes.

At paragraph 25 you say that Dr Mullen was always very critical of Dr Naidoo's lack of supervision. Did Dr Mullen say these things to you?-- Yes.

Did you disagree with him? Did you agree with him that you had a lack of supervision from Dr Naidoo?-- Well, if he was away, he can't supervise. I think that Dr Mullen's issue at that time, every time we talk to him we say, "Oh, Dr Naidoo is on leave", he get pretty upset. He said, "How come he's on leave?", and, "How come he's entitled to so much leave?", so that would be his argument.

Well, didn't he ever express to you that he was upset that you were being left unsupervised?-- Yes.

The fact that you were being left unsupervised had an effect on the quality of care that would be given to the patients?-- All the time we - we operated within our scope of practice so we - we tried to do safe practice all the time.

Do you mean you operated within the scope of your practice that had been set out in the document supplied to you by Dr Naidoo?-- Yes.

Doctor, I suggest to you that Dr Naidoo was too generous in the number of procedures that he listed for you to perform without supervision. Do you understand my proposition?-- Yes.

COMMISSIONER: What do you say to that?-- I won't entirely agree with that. I think Dr Naidoo based my assessment on me doing these cases which he has seen and also from the references I received when I applied for the post while I was employed in another hospital in Queensland.

You felt confident in doing all the procedures unsupervised that he had certified on those two lists that you could perform unsupervised?-- Oh, well, most of them, yes.

Most of them, but not all of them?-- Not all of them.

You would have been happier with more supervision, wouldn't you?-- Yes, sir.

MR ANDREWS: You observe in paragraph 26 that you received only good reports from Doctors Naidoo and Hanelt. I will put one of those up on the monitor. This seems to be an assessment by Dr Hanelt. You will see it on the monitor in a moment. Do you see that your clinical knowledge is shown to be better than expected, your clinical skills consistent with level of experience, your clinical judgment and decision-making performance better than expected, your procedural skills better than expected. They're reasonably flattering comments, aren't they?-- Should have been better, go one up.

COMMISSIONER: It is unfair to ask this witness these questions, isn't it?

MR ANDREWS: Would you look at the second page of the document, please. The assessor is shown to be Dr Terry Hanelt and dates the assessment as the 30th of November 2004?-- Yes.

Can you say why it was that Dr Naidoo was not your assessor?-- Actually, this - both of them assessed me. This was for the general registration. That was the time I passed my Australian Medical Council examination and then because before-----

COMMISSIONER: No, keep going?-- Before that I was employed with - as an Area of Need registration. So because I passed my AMC, I applied for general registration and for this you need certificate from two supervisors. One of them was Dr Naidoo and the other one was Terry Hanelt.

COMMISSIONER: And Dr Hanelt observed you performing these various surgical procedures?-- Never.

No.

MR ANDREWS: Now, I'll put up on the monitor, Doctor, page 19 of the North/Giblin report which has some unflattering things said about you that I want to give you the opportunity to comment upon?-- Thank you.

Do you see the portion that I have marked with yellow highlighter?-- Yes.

The second sentence suggests that a number of clinical scenarios were put to you. Do you recall that that occurred?-- I must tell you I totally disagree with Dr North and Dr Giblin when they put this report-----

And you set out a number of the reasons for your disagreement very comprehensively in your own statement but I'm interested in this particular issue. Did Dr North or Dr Giblin give you a number of clinical scenarios to comment upon?-- No. Excuse me, Commissioner, can I explain what they asked me?

COMMISSIONER: Yes, yes?-- We were - we were talking about supervision in the clinics. Dr Giblin asked me, he said, "Do you have" - "Does Dr Naidoo do the fracture clinic?" I said, "No, we do the fracture clinics on our own." Then Dr Giblin said, "What about if you have a supracondylar fracture?" That's in the clinic. So in the clinic we don't see any acute cases, they're all follow-up cases, all - or if the patient is fit to come to a clinic, they're not emergencies, there is no problems at all. So I said, "No, we manage our supracondylar fractures before and there was no problem." Then Dr Giblin said, "What if open fracture?" I said, "If it was open fracture, it would be in the accident/emergency and we would go and see the patient straight away in accident and emergency, not in the clinic." Then he said - I said, "We

clear the open fractures appropriately", obviously considering the neurovascular status and the soft tissue injury, and I never thought this was a - this was an exam thing. I thought what they wanted to do - whether I was supervised or not, I think that's what the issue. So that's what they asked me and I still don't understand why they think they try to test my knowledge or something like that.

Thank you.

MR ANDREWS: Would you move further down the page, please, to reveal the next section. They report that you said you did not believe you needed further training in orthopaedics. Did you say that to them?-- Absolutely false.

Did you or do you believe that you needed further training in orthopaedics?-- Definitely, yes.

And is the best way to get that training to be supervised by a specialist such as Dr Naidoo?-- Yes.

You weren't receiving that level of supervision from Dr Naidoo at the time, were you?-- I think the level of supervision which the Australian Orthopaedic Association recommends for accreditation was not provided.

COMMISSIONER: And you would have been happier yourself if you had have had greater supervision. You would have felt more confident in what you were doing if you had more supervision?-- Definitely, yes.

MR ANDREWS: Even when Dr Naidoo was present at the hospital, that is not on leave, the degree of supervision that he was able to provide you was not sufficient for the Australian Orthopaedic Association accreditation, was it?-- I think before I answer that I will just clarify. I think that supervision is a very, very broad aspect. Can range from consultant actually scrub in with you, operating with you, holding your hands or just staying in the theatre or it can be just sitting within the theatre - operating rooms or it can be away at home contactable by phone and can reach you. So there's a lot of levels of supervision.

And what level of supervision were you getting from Dr Naidoo?-- When - when he was at work he was always around the hospital. He will be either in Hervey Bay or occasionally in Maryborough Hospital but Maryborough Hospital is only 30 minutes away. So, he was - he was around all the time.

How often did you discuss with him before commencing surgery the procedure that you were about to undertake?-- If I'm - if that procedure was within my scope of practice, I won't discuss with him.

COMMISSIONER: You wouldn't?-- I won't.

Wouldn't.

MR ANDREWS: And if it wasn't in your scope of practice, it meant that you couldn't perform it anyway because you had to perform with supervision?-- Definitely, yes.

And the supervision that was - did you understand that if you were required to have supervision to perform surgery, it meant Dr Naidoo or Dr Mullen was to be in the theatre with you?-- Yes.

You will see that Doctors North and Giblin recommended that no surgical treatment be undertaken by you unsupervised. You see that recommendation?-- Yes.

Since that report became public, your orthopaedic surgical treatments, have they all been supervised?-- When this report was published I was not doing orthopaedics.

Did you say that you should receive specialists registration in Australia because of the work you were doing and because of the training you'd had in Fiji?-- I never say that. If I - if I thought, I would have applied long time ago because I was in Australia probably five years now. I never applied.

At paragraph 39 you say, "It's sad to mention that sometimes orthopaedic SMOs are called without an emergency medical officer having assessed and documented the finding in the chart", and you talk about a "treat the X-ray attitude". Can you explain - perhaps you can look at paragraph 39?-- Yes, I know what that means. What I mean is like, for example, if we have a 80-year-old lady who had a little trip in a bathroom and injured her right wrist, obviously she will have the fracture and there will be a big deformity, a lot of swelling and a lot of pain. What I meant by that was that was an obvious injury. But the - the I think it is the job of the accident/emergency doctor to make sure - find out what's the cause of that injury, whether she simply tripped, which would be the simple case, or she had a major bleed in the - intracranial bleed and she collapsed and she had this injury. I think - if it is just simple colles fracture but if we - if we left it to orthopaedics and we don't examine - take a good history and actually don't examine for intracranial haemorrhage, then she could die once we put her to sleep. So my reason for putting that was if we missed it in the first place in accident/emergency, then it will get missed while doing the orthopaedic because orthopaedic is a very specialised field and, mostly, gross examination is not done.

Did you bring that to the attention of hospital administrators or Dr Naidoo?-- Yes, several times.

To whom did you raise this issue?-- I raised this once - several times with Dr Naidoo and at - once I had an argument with one of the SMOs in A&E and I arranged for the Director of Medical Services-----

Who is that person?-- His name is Dr Vinod Gopalan, G-O-P-A-L-A-N.

COMMISSIONER: Mr Andrews, is this a convenient time?

MR ANDREWS: Yes, thanks, Commissioner.

THE COMMISSION ADJOURNED AT 11.17 A.M.

THE COMMISSION RESUMED AT 11.34 A.M.

DAMODARAN KRISHNA, CONTINUING EXAMINATION-IN-CHIEF:

MR ANDREWS: Doctor, you say at paragraph 53 of your statement or you did on the 28th of July say that you were looking forward to providing a high level of orthopaedic health services in the district with orthopaedic specialists providing supervision. Is that something that wasn't happening before, orthopaedic specialists providing supervision?-- Probably what I meant was that more supervision.

Did you work with Dr Kwon during 2005?-- Yes.

Dr Kwon started some time late in January; is that correct?-- Yes.

Do you recall Dr Kwon's level of supervision was considerably more intense than Dr Naidoo's level of supervision when Dr Naidoo was about?-- Dr Kwon's level of supervision was 100 per cent. We never had a similar level of supervision with him before in my life.

I see. I see?-- He'd be present for any case. Even - even if he was not assisting, he was sitting in the theatre, but he liked to see all the cases and he would like us to tell him about any case which we admitted which did need surgery, we must tell him. The reason he gave was he said he just graduated last year and he wanted to - and he doesn't know us and he wanted to start with a clean slate.

And did he maintain degree of 100 per cent supervision throughout his whole time - throughout the whole time that you and he were there?-- Yes. Only once - one weekend after I think five weekends he had to go to Sydney to visit his family. He left on a Friday, come back on a Sunday afternoon.

Doctor, I'm now going to ask you to consider the elective surgery scope of practice that you had. The thing about elective surgery is that you had a choice about whether to retain it or to refer the elective surgery patient elsewhere; isn't that the case?-- Yes.

And if in any doubt about whether you had the skills to perform the elective surgery, do you agree it would have been appropriate to refer the patient elsewhere?-- Or to - yes.

Or to Dr Naidoo if he were present?-- Or Dr Mullens, if he was present.

Yes. Now, do you remember - well, I suggest to you you spoke with Dr Mullen about your concerns with the lack of supervision you were receiving at the Hervey Bay Hospital?-- Again, I can't remember exact dates but once in a while we'll meet Sean Mullen in the - outside theatre or sometime in the ward if he comes to see one of his prior patients and he will raise concerns that Naidoo is on leave and we will also agree with him and we say that's something beyond our control.

So you yourself told him that you were uncomfortable with the amount of time you were left unsupervised?-- Well, I actually didn't start the conversation. I would - I would virtually agree with if Sean mentioned it.

And you were agreeing honestly, weren't you?-- Yes.

Now, did you take your concerns about the lack of supervision to Dr Hanelt?-- No.

Did you take them to Dr Naidoo?-- He was the one who supposed to provide supervision so I can't take it to him.

COMMISSIONER: No, you wouldn't take it to him, I can understand that.

MR ANDREWS: Why didn't you take them to Dr Hanelt?-- Well, we thought our job is temporary and if Naidoo is not providing a service, we believed Dr Hanelt was the one authorising his leave because going on planned leave, so if he was sick, which is beyond anybody's control, but if he's going on a planned leave and leaving two SMOs unsupervised, which the administrators, Dr Hanelt would have known, and we couldn't complain because they employed us and they expect us to continue to perform this - our duties as per privileges.

I would like now to discuss some of the patients you are alleged to have treated where some of the outcomes are said to have been less satisfactory than they'd have been had you been supervised. Now, you no doubt have seen the statement of Dr Mullen?-- Yes.

Which lists a number of patients?-- Yes.

I ask that this excerpt of paragraphs 23 to 25 of Dr Mullen's statement be put on the monitor. This was Dr Mullen's recollection of an occasion in 2003. Subsequent investigations suggest that the patient may be a person called P449 and that there was a procedure performed on about the 9th of April 2003?-- Yes.

Now, have you considered whether you recall a patient involved in a motorbike accident who received a fractured femur in his right leg where you and Dr Sharma were the persons in theatre?-- Yes.

Do you recall such a case?-- Yes.

As Dr Mullen recalled it, you had been instructed by Dr Naidoo to perform the surgery and he wasn't present for the surgery?-- No, I didn't contact Dr Naidoo.

You did not contact him?-- No.

Why is that?-- Because I was capable of performing this procedure.

Now, Dr Mullen says that the case started at about 1.30 p.m., the patient had lost a lot of blood and the femur had subsequently significantly fractured during a procedure where a nail had to be inserted into it?-- Incorrect.

Which is the portion which is incorrect?-- The timing. The patient arrived in the operating theatre at half past 1 and by the time the patient was - we started operating was half past 2. Before the patient is anaesthetised we have to put in a special table, get the X-rays, make sure we get the X-rays properly, whatever views you wanted, before we actually prep the patient. So we didn't start operating - we started operating, according to the theatre notes, half past 2.

But otherwise it's correct that Dr Mullen is right in thinking that the femur fractured during the theatre where a nail had to be inserted into it?-- I was coming to that, sorry. This patient is a young male who has got a high velocity injury in a very hard bone. The femur is the biggest bone in the body and very hard in a young man and you can't expect to have a straight transverse simple fracture. There will always be a lot of combination. What he actually - what actually happened was while inserting the nail, the undisplaced butterfly fragment has displaced. So in the view of the anaesthetists, they thought this a new fracture which has broken off. It's actually undisplaced butterfly fragment. So that we didn't create a fracture, we just made it more obvious.

And how is it that you are sure that there was an undisplaced butterfly fracture?-- In the X-rays.

Were the X-rays performed before or after the procedure?-- Always - always before the operation you examine X-rays.

Is it the case that Dr Sharma was not the surgeon but scrubbed for the case while you performed it?-- Yes.

COMMISSIONER: So if it were just an undisplaced fragment, that would appear as a fairly minor fracture, wouldn't it?-- No, the - it was a comminuted fracture, meaning multiple fragments. The main shaft of the femur was displaced but in the proximal part of the shaft there was an undisplaced fracture also. That's what we call a butterfly fragment.

I understand that. It was a fragment, though?-- Yes.

Right. Doesn't seem consistent with what Dr Mullen observed, that there was a significant fracture. Would you call a displacement of a butterfly fragment a significant fracture?-- The reason I would not call it because the fracture is already present.

All right?-- It wasn't displaced, but putting in the nail displaced the fragment.

There was a fractured femur, but the point is, really, that what Dr Mullen thought he observed was that there was a substantial fracture or a significant fracture at the point where the nail went in. Now, you say that was an undisplaced fragment at that point?-- Yes.

Is that correct?-- Yes.

It just doesn't seem to me at the moment to be consistent. In other words, what Dr Mullen observed looked - looks to me to be, as a layperson, to be substantially more than the displacement of a fragment?-- I think - which I will answer later on, I thought, I will do it now - probably Dr Mullen didn't see the original X-rays because he missed another fracture, and hence the reason for me doing the antegrade nail, which he has totally missed and he has never mentioned, and he has criticised for me to doing a retrograde nail instead of an antegrade nail without - I believe he hasn't seen the original X-rays.

All right.

MR ANDREWS: Is it correct that the nurse in charge of theatre called Dr Hanelt to see if assistance could be obtained?-- What happened behind the scenes, I don't know. We are concerned with the patient, and nurse, if they thought there was something - some problem happening in theatre and if they have tried to call somebody, I can't-----

COMMISSIONER: But you didn't call Dr Mullen in?-- No, no,

no.

MR ANDREWS: Do you mean - well, was Sister Liz Wilmont likely to have been the nurse in charge of theatre on that occasion?-- She used to be the sister in charge, still a nurse sometimes in charge. I can't remember whether she was the one that day. I can't really remember.

Now, is the nurse in charge of theatre actually present in theatre during surgical procedures?-- Yes.

When Dr - well, did you speak with Dr Hanelt before Dr Mullen arrived?-- We were surprised to see Dr Mullen in the change room.

Did you speak to Dr Hanelt before Dr Mullen arrived?-- No.

So you were unaware that Dr Hanelt was looking for Dr Mullen and asking him to come to theatre?-- Not aware.

Dr Mullen arrived some time after 5.30. Isn't that correct?-- I can't remember the time but it would be - I thought it was 5 or just before 5, but I am not sure.

This was a day when Dr Naidoo was not on leave. Isn't that correct?-- I believe so.

You believe that he was not on leave?-- No.

Did you ever inquire where Dr Naidoo was?-- You mean before the operation or-----

Yes?-- No.

You didn't attempt - or did you attempt to contact Dr Naidoo to tell him that this was a procedure you intended to perform?-- No.

And why not?-- Because I have done this procedure before and I was capable of doing that.

I'll put on the screen some things that Dr Mullen recalls about that day and ask you to comment. This is from the transcript at 5766, and you will see that Dr Mullen is describing his recollections with respect to the patient who appears in paragraphs 23 to 26 of Dr Mullen's statement. Now, Dr Mullen was being asked to comment on, to begin with, things that Dr Sharma recalled from that day. Do you recall that the patient had other injuries and that Dr Mullen took over the management of the other injuries when he came into theatre?-- Yes.

Were you aware that Dr Sharma was concerned about the lack of supervision for the procedures done on this patient this day?-- Dr Sharma has never seen a retrograde nail done, so that's why I was assisting him.

Were you aware that Dr Sharma was concerned at the lack of

supervision for that day?-- No.

How many retrograde nails had you done before this procedure?-- About three.

Had you done any of them in Australia?-- Yes, all in Australia.

Would you move further down the page, please? Is it correct that there had been concerns about the patient's blood loss?-- We were never told about that.

COMMISSIONER: You weren't concerned about it?-- No, because the patient was not bleeding at all. This was putting in the nail is a closed procedure. We don't open the fracture sites, so there is no bleeding.

All right?-- But they - excuse me, but they bleed when they break the bone. They lose about a litre of blood from the femur itself.

Right?-- But it is all inside the body.

MR ANDREWS: Please display page 5767. Is it correct that the patient had a fractured ankle?-- Yes.

Is it correct that because of the extended period of time that the patient had been anaesthetised and, as I understand it, the patient would have been anaesthetised from about, what, one o'clock?-- Half past one. From half past one.

Half past one, because of the extended period of time he had been anaesthetised and because of the blood loss, it was appropriate to fix the fractured ankle as quickly as possible?-- I will answer like this: it is up to the anaesthetist to decide whether a patient is fit to continue with the surgery any longer or not. I have seen patients being anaesthetised for 10 hours. But in any case, completing the operation in the shortest time possible would be the best.

Do you remember the anaesthetist was concerned about the temperature and general condition of the patient?-- No.

Do you agree that the device used in this particular case was a newer device which requires greater skill to place?-- I came to know about this retrograde nail in 2001 when I was working in another hospital. I don't know how long before this was but I believe it has been there for a long time.

So you disagree that it was a newer device?-- Yes.

Do you have an opinion about whether it requires greater skill to place this nail?-- Yes.

Does it?-- It is - it is a - if I compare with an antegrade nail, which is putting the nail from the top, putting from the bottom is retrograde, it would be about - much, much easier putting from the top.

COMMISSIONER: So it is more difficult to put in this nail?-- From the bottom, yes.

Yes, thank you.

MR ANDREWS: Do you agree that it is a procedure which needs the assistance of another person because there is no external support to hold the patient in place?-- Yes, we had two other people.

COMMISSIONER: Who was that?-- Dr Sharma and Dr Hugh McGregor was a PHO.

I see, and he was in the operating theatre at the time?-- Yes. Later on when we finished, when myself and Dr Sharma finished, when Dr Mullen took over the case, Dr Hugh McGregor assisted Dr Mullen to finish off the operation.

May I see further down the page, please? Is it correct that the - that retrograde femoral nails are designed for fractures at the very end of the femur bone near the knee?-- Yes.

Is it correct that this fracture was more up towards the mid-part of the leg?-- Not only. He also had a fracture very close to the knee joint.

COMMISSIONER: That's the one you just spoken of which was a fragment - a displaced fragment?-- No.

Not that?-- No.

All right?-- It had two fractures, one fracture was the obvious one, with a displaced one which was between the upper third and the middle third of the femur, and there was an undisplaced fracture within four centimetres of the knee joint which was undisplaced. The reason I took the nail - did the nail - did the harder operation, which I believe was a correct operation, because if I had done from the top there was a danger of or likelihood of converting the undisplaced fracture to a displaced fracture. Also we could have caused a fracture going into the knee joint. That would have caused a lot more problems.

Do you agree with Dr Mullen that this fracture was more up towards the mid-part of the leg?-- I think I have just said he had two fractures.

Was there a fracture up towards the mid-part of the leg?-- Yes.

Do you agree that it is difficult to do those fractures with a retrograde femoral nail?-- If-----

Is that a matter about which you have any experience? Do you know whether it is or is not difficult to do those fractures with a retrograde femoral nail?-- It would be hard.

Do you agree that using a retrograde femoral nail with a fracture towards the mid-part of the leg makes it more likely that there will be an intraoperative fracture?-- Yes. That would be a wrong selection. If that was a fracture in isolation, the retrograde nail would be a wrong selection, definitely.

Do you agree that for this particular procedure, you ought to have been supervised by Dr Naidoo, or another orthopaedic specialist because of the limited experience that you had had to this time?-- It is always comfortable if there is somebody around but I didn't ask for Dr Naidoo's help in this situation.

COMMISSIONER: Why not?-- Because I thought I was comfortable in doing this case.

All right.

MR ANDREWS: Was this - well, as femoral shaft fractures go, was this a simple one or a complex one?-- this Particular case?

Yes?-- It was a complex fracture.

Would you look, please, at your scope of practice document from - I think it is part of your annexure 6. At this particular page from the orthopaedic trauma section, do you see femoral shaft fracture complex requiring - would you display that part, thank you? Femoral shaft fracture complex requiring retrograde nailing is shown to be a procedure you are to perform with supervision, that you are not entitled to perform independently, according to the scope of service that was provided for you by Dr Naidoo?-- Yes, in 2004.

Why did you fail to call for Dr Naidoo's assistance?-- This operation was done in 2003.

I see. So does that mean that until you received your scope of service document in 2004, there were - you didn't regard yourself as being limited by - limited to any particular procedures?-- There was no clear definition.

COMMISSIONER: But didn't you think it was unreasonable that you should be doing this operation without supervision? Didn't that occur to you?-- After doing a couple of this procedure, I thought it wasn't really unreasonable.

You thought it was perfectly okay if you had done a couple of them?-- Yes.

All right.

MR ANDREWS: And the couple you had done, they were unsupervised ones, weren't they?-- Yes. I did with another PHO - we are all the same level - at another hospital.

Were they simple or complex, the two you had done before?--

Can't remember if it was actual segmental fracture or one fracture, can't remember.

Hugh Mackenzie, was that the name of the person assisting you?-- Hugh McGregor.

Had Hugh ever done any of them before?-- Oh, no, no, he was a junior person.

So you were the experienced one in the theatre?-- Out of the three, yes.

Dr Sharma never having done one before?-- Yes.

I suggest to you that it would have been appropriate for you, and you should have called for Dr Naidoo's assistance with this complex procedure you had so little experience with?-- Well, now-----

Surely you agree?-- Now I know that Naidoo has asked us to do this procedure with supervision, that's what we will do now.

Well, when you got the document that said do it with supervision some time in 2004, didn't you go to Dr Naidoo and say, "I have done these before. You don't have to supervise me."?-- Well, he was a director, we left - we didn't want to influence his judgment, we didn't want him to - force him to give us extra privileges. We left all the decision on him.

I would like to discuss now a patient P435.
P435. Dr Mullen, in his statement at paragraph 33, described P435 as "a lady who had a non-union of the distal tibial leg fracture who could be looking at amputation in the future whose care was delayed for six months after surgery even though the fracture had not healed." Now, do you recall that particular case?-- Yes.

Would you please put some of these notes with respect to P435 on the screen, from the transcript at page 5774 from the evidence of Dr Mullen? Do you recall that this was an operation on the 11th of January 2005 where you were the surgeon assisted by Dr-----?-- Gamini.

Gamini?-- That's correct.

It was a case of a very comminuted distal fibula?-- Yes.

Would you proceed down the page, please? The patient tendered a report to the Health Rights Commission complaining that she was told the procedure was cancelled because the plate wasn't available and the surgeon, being you, was away on sick leave or stress leave, or wasn't available at the time. Do you remember there was a week in January where you were ill and unable to perform this surgery?-- Yes.

Now, as I understand it, Dr Naidoo was not on leave in January 2005?-- Yes.

You say that as if you agree with me that he was not on leave?-- Yeah, definitely not on leave.

Why would this procedure not have been performed by Dr Naidoo or someone else when you were ill?-- This patient was admitted on the 4th of January. As - because of the fracture, I ordered a new plate, which is not kept in the south - in the south in the hospital because it is an expensive plate and it is a new plate, so we get it on loan from the company Synthes.

Do you mean because there was no plate there the procedure couldn't be done by someone else?

COMMISSIONER: You are being asked why Dr Naidoo couldn't-----?-- The patient was booked on the 6th and the plate was available. I don't know why Dr Naidoo didn't do it, but he has written in the charts why he didn't want to do it.

MR ANDREWS: I see?-- On the 6th he has written in the chart why he didn't want to do it.

Thank you. Would you-----

COMMISSIONER: Sorry, what was written in the charts?-- It is written in the chart.

That, what-----?-- On the 6th-----

That he did not want to do it?

MR ANDREWS: I think the witness's evidence is that in the charts there is an explanation for why Dr Naidoo didn't perform the procedure but the witness doesn't - I infer the witness doesn't recall it and I am-----

COMMISSIONER: And doesn't know why.

WITNESS: I know why. Do you want me to-----

MR ANDREWS: Would you please put, from the patient's chart, the entry for the 6th of January? That's the right-hand page shown in blue.

WITNESS: That's Dr Naidoo's writing.

MR ANDREWS: Are you able to read it?-- Yes. It says "History noted comminuted closed fracture distal fibula and tibia. Requires ORIF", which means internal - open reduction internal fixation, "and was scheduled for OT by DKRI", that's me, "today but he is away sick. Inform patient that there is an elderly patient with neck or femur fracture NOF which needs to take"-----

"Priority"?-- -----"priority today. And due to staff shortages, her surgery will be scheduled for Tuesday on the 11th of January. Patient and husband understands the position. Collects 40 milligrams of Clexane - subcutaneous.

While that note says 6 January '04, can you tell from the note below it, which is 6/1/5, and from your own recollections, that this is with respect to events that occurred in 2005?-- From the notes?

Yes. Do you see below the blue shaded section there is another note?-- Yeah.

In the left-hand margin it says "6/1/5"?-- Yes, "NSG". That's the nursing note.

Yes. It was 2005 that this occurred, was it not?-- Yes - oh, yes, sorry, I didn't pick up that part.

That document can be returned now, and I'd like the transcript to go back on the monitor. Now, do you agree that it was apparent from this patient's x-rays that she had a very badly damaged fracture of the tibia which extended the whole way down into the joint surface, and a nasty fracture of the fibula, in many pieces?-- Yes.

Did you - you used an open procedure-----?-- Yes.

-----for this patient? Do you disagree with Dr Mullen's opinion that it's better not to open the fracture widely to place large plates in it, particularly given that there was a delay of a week and there was swelling at that time?-- It's controversial. I can't really say whether Sean is correct or Dr Naidoo is correct, because Naidoo approved open reduction internal fixation and Sean-----

COMMISSIONER: Had Dr Naidoo seen this patient?-- Yes, on the 6th. That's his writing.

MR ANDREWS: And are you able - do you disagree with Dr Mullen's opinion that in the circumstances it would have been better to do a different technique, that is to use frames or nails to achieve the fixation without having to widely open the fracture and expose it to the environment with its swelling?-- With Dr Mullen's experience - he's a very experienced specialist consultant. In his hands I think putting in a frame would be good, but I've never done that, and I've got no experience with it.

Did you consult - did Dr Naidoo supervise you when you performed the procedure on this patient?-- No.

Did he consult with you?-- I called him. He didn't come.

Why did you call him?-- I called him on the day of surgery. I told him because she's got a lot of swelling, it might be a very difficult situation, and he talked to me by phone and he said, "Open, if there's any problem, let me know." When I opened up, the fibula fracture was more comminuted than we expected in the x-ray, because x-ray's are just a two-dimensional picture. When we open up we see three-dimensional bone. So it was more comminuted. I was seeking assistance and he did not come.

Did you make it clear to him that you would have preferred him to be present?-- Twice.

Did he explain why he would not come?-- No. He said, "You are SMO, you should be able to do this."

COMMISSIONER: Did he say where he was?-- I think he was in his room. He was still in his residence-----

In Brisbane?-- No, no, no. He stays in one of the motels close to the hospital.

But he stayed in Brisbane quite a lot. He lived actually in Brisbane, didn't he?-- No, that day he was definitely in his motel.

All right.

MR ANDREWS: How is it that you know he was definitely in his motel? Presumably you phoned him on his mobile?-- No, we got him on his freeset. The freeset doesn't catch if he's in Brisbane, and - sorry, and he did come back - come to the hospital just after we finished the procedure. So he couldn't have been in Brisbane.

May I see the bottom of the page, please? Thank you. So you'd agree with Dr Mullen that there ought to have been an orthopaedic specialist supervising you for that procedure?-- Yes, because I asked for it.

In her post-operative care she developed infections?-- Yes.

Do you recall that? Do you disagree with Dr Mullen that earlier aggressive treatment of those infections may well have prevented recurrent infections?-- Well, any infection - can I explain further?

Yes?-- Any infection, the more aggressive treatment you give, the better it will be for the patient. I think she had pretty aggressive treatment in the form of high dose antibiotics and elevation, which was all supervised by one of the specialists orthopaedic surgeons.

I see.

COMMISSIONER: Who was that? Dr Naidoo?-- No, Dr Ming.

MR ANDREWS: Dr Kwon didn't come until the end of January, isn't that the case?-- Yes, but this infection developed about two or three weeks post-op.

You will see Dr Mullen's preferred course of treatment on this next page of the transcript at about line 8. "My treatment would have been to put an external frame on the injury immediately to avoid damaging the soft tissues." You don't disagree with that-----?-- No.

-----as the preferred treatment, do you?-- That would be the best in Dr Mullen's hands.

The risk of infection would have been far less with that treatment, is that - you don't disagree with Dr Mullen, do you? That the risk would have been less?-- I don't know what he's comparing with. Is he comparing with the open reduction internal fixation or any other form of-----

COMMISSIONER: Less than what was done.

MR ANDREWS: Less than - yes - what was done?-- I can't really agree with this.

Do you mean you disagree or you don't have an opinion?-- Don't have an opinion.

Without an orthopaedic surgeon to supervise, Dr Mullen's opinion is the patient should have been transferred to another unit where supervision was available. You don't disagree with him in the circumstances, do you?-- I disagree, because this person was - Dr Naidoo had seen the patient and he had authorised the planned surgical procedure. The only problem is Dr Naidoo didn't come when he was called.

Would you move further towards the bottom of the page, please?

COMMISSIONER: But wasn't your solution then to say, "I won't perform this operation unless you come."?-- The patient was already in the anaesthetic bay and given anaesthesia, and Naidoo was just across the road.

And wouldn't come?-- He said, "Open up and then see first", and then let him know. When I opened up, I had a problem. Even then he didn't come.

You rang him again?-- I rang him again. Even then he didn't come, so I couldn't have left it.

All right.

MR ANDREWS: Is there more with this? Please turn the page. Is there more? Thank you. Next I'd like to discuss a patient P436, described by Dr Mullen at paragraph 34 as a man who had an unstable fractured hip, a case which Dr Mullen believes you performed without the supervision of Dr Naidoo in 2004, and it may be from records that if it was P436, that it was on 26 March 2004?-- Yes.

Would you please put the transcript of Dr Mullen's evidence starting at page 5,777 on the monitor? Do you agree with Dr Mullen's opinion that for this procedure there should have been supervision of the procedure from surgery through to follow-up?-- No.

You don't disagree?-- I disagree.

I see. Do you recall this was an injury that was more than the normal injury which occurs when a person falls and breaks a hip in that this was a higher velocity injury because the man fell four feet from a boat ladder, and the man was himself very heavy, being 107 kilograms?-- Yes.

And that this was a subtrochanteric fracture?-- No.

Was it a fracture at the point where the hip bone meets the thigh bone?-- Yes.

Is that a dangerous area because it's very difficult to get a fixation there?-- It's an unstable situation.

Does that mean it's very difficult to get proper fixation there?-- No.

Do you agree that where this patient's fracture was, you often find fixation failure occurring?-- Yes.

Do you agree that there are different techniques designed to deal with this problem?-- Yes.

Did you discuss any of them with Dr Naidoo?-- No.

Do you agree this fracture was also comminuted?-- Yes.

Do you agree that this was a case where it was obvious the fracture was going to be far more difficult to fix than a simple fractured hip that you might find in an elderly person who falls in a nursing home?-- Yes.

Do you agree that the type of fixation used was very inadequate because there were only four screw holes in the plate to fix the bone to the shaft?-- No.

What experience do you have with performing this procedure?-- A lot.

COMMISSIONER: In Australia or in Fiji?-- Both. With this system, a lot in Australia.

MR ANDREWS: But do you mean with the system of using a plate with four screw holes?-- Yes, a lot.

And what experience do you have with the other fixation systems?-- I've used all the other systems also.

Do you agree that it would have been preferable to use a plate with between eight and 12 holes on the femoral shaft to get good strength on the bone?-- Absolutely not.

Do you agree that there are techniques available that don't require plating such as a nailing procedure?-- Yes.

Have you ever performed those?-- Yes.

For this kind of fracture?-- No.

Would you turn the page, please? So you disagree with Dr Mullen's opinion that it would have been better for this particular big man, with his high velocity fracture, to have used a very long plate which has a different type of screw into the ball of the femur to give better fixation?-- I agree with that with a different system. That's a different system than I used. That's called DCS.

COMMISSIONER: But do you agree that that would have been a better thing to do?-- Probably no.

Probably no?-- No.

All right.

MR ANDREWS: Another alternative suggested by Dr Mullen was to use a big, long nail that goes into the canal of the bone which can give more stability and designed for this particular situation? Do you know of that procedure?-- Yes, it's called intramedullary nailing. In this situation I wouldn't have performed it because I couldn't have. He's a very, very heavy man and a lot of soft tissue. I couldn't have done that procedure, and in my experience this would have been very difficult because multi-fragmented fracture.

Are you aware of literature dealing with the effect on healing when one chooses the two types of devices that you rejected?-- The reason I rejected-----

COMMISSIONER: No, no, you're asked did you - listen to the specific question that's asked and answer that.

MR ANDREWS: Are you aware of literature that shows the incidents of healing to be lower when you use the devices Dr Mullen prefers?-- Can you rephrase that?

Are you aware of literature which reveals that the - that healing is better when you use the devices Dr Mullen prefers?-- Yes.

Well, why didn't you use one of them?-- Because this was not a subtrochanteric fracture. It was an intertrochanteric fracture.

Are you aware that this - of what's happened with this particular patient since?-- I don't know what happened now, but I know until I was following up until 6th of June.

Are you aware that the patient has in fact had a six hour joint reconstructive surgery since?-- Well, after reading Dr Mullen's transcript I came to know that, but this is one of the complications of this fracture.

Now, Dr Mullen observes that the patient was seen by you on about 11 June 2004?-- Yes.

And that by that time he'd complained of groin pain in May, in the Accident & Emergency Department?-- Yes.

That was a symptom which ought to have caused you to have him x-rayed?-- Yes. He was admitted on the 7th of May.

May I see the next page, please? Did you have him x-rayed?-- Yes.

I suggest to you that during the post-operative phase of monitoring this patient, it would have been better if the monitoring had been supervised by an orthopaedic specialist, if your monitoring of the patient had been supervised by an orthopaedic specialist?-- I would answer like this: whenever I was looking after him, the three times I've seen him

post-operatively, I was happy with his progress.

COMMISSIONER: Did he tell you on a number of occasions in that post-operative period of nine months that he had severe pain and couldn't bear weight on his hip?-- He told me initially, but immediate post-op period, and then when I saw him on the 7th when he was admitted - actually admitted with deep venous thrombosis, he was feeling better and his x-ray looked fine. He was - the fracture was healing. There was signs of a lot of callus formation, and when I saw him on the 6th of June he was fully mobile with very minimal pain, feeling very comfortable. He was mobilising with just a walking stick. At that stage I discharged him from the clinic to be followed up by his local doctor.

MR ANDREWS: You didn't consider that these - that there were signs that he was not healing?-- At that stage, no.

Did you consider the potential that he may not have been healing and that it may have been important to consider that because you could have performed a bone graft or some other procedure to encourage him to heal?-- I considered that. That's why I asked the patient to continue monitoring, going to see his GP for three reasons. The three reasons why I discharged him was, number one, because he was very comfortable and he was able to weight bear. Number two was his x-rays on the 7th of the 5th showed a lot of callus formation, which is new bone, and there was a lot of signs of healings, and the fracture had stabilised. I was very happy with that, and number three, because he was diagnosed with deep venous thrombosis and he was commenced on Warfarin, which is an anticoagulant which has to be monitored every week, the dose - he has to have blood tests almost every week, and for that he had to go and see his GP, and I said, "Go and see your GP if you're concerned with your hip. The GP can give us a call, then we'll see you." Otherwise I thought it would be too much for him going to see the GP almost every week or every second week and then coming and seeing us also.

So, doctor, you didn't ask any specialist to assist you when monitoring this patient on his returns to the hospital?-- He was discharged on the 6th.

Yes. Before his discharge on the 6th, how many - I beg your pardon. Had the patient been an inpatient from the time of his surgery?-- Yes.

Until the 6th of which month?-- I have to check the-----

Can you go back to the prior page, please?-- He had developed infection post-op, so he was admitted for close to three weeks immediate post-op, I think, from memories.

So he was discharged from - I beg your pardon, he became an outpatient after three weeks. Is that your recollection?-- Yes.

And he returned to the hospital-----?-- On the 7th of the 5th with-----

And on that occasion did you consider - I beg your pardon - did you ask an orthopaedic specialist to assist you in assessing the patient?-- No. He was admitted in the ward. I can't remember whether Dr Naidoo was around at that time or not. I can't remember. If he was around, he would have seen the x-rays and the patient, but I can't remember.

I'll consider now a patient P445. Do you happen to recall this patient? I suspect, without reading all of these notes which relate to her-----?-- Yes.

-----that she may be a patient who had two procedures performed by you, one successfully and one with complications?-- Yes.

Would you look, please, at this, which appears to relate to a procedure performed on about the 27th of August 2003. You were the surgeon, and on this patient - on this elderly patient, you performed a bunionectomy and arthrodesis of the left - on the left and a first MTPJ?-- Yes.

Is that correct? Do you understand that that led to a satisfactory result?-- The patient was very happy with this.

Did you then perform a second procedure to her right foot on the 27th of July 2004, about a year later?-- Yes.

Unsupervised?-- Yes.

Would you look, please, at this orthopaedic Discharge Summary. It shows Dr Naidoo to be the consultant. Is that - did Dr Naidoo play any part whatsoever in the - by way of supervision?-- No.

COMMISSIONER: Did you ever ask for supervision for either of these operations?-- No.

MR ANDREWS: Dr Crawford says of this patient in the transcript at page 6,307, further down the page, that she didn't have enough of an angle when the procedure was performed on the right, and has had ongoing difficulty walking because of it. Now, the failure to have enough angle is a matter of judgment when setting the patient after the procedure?-- Yes.

Is that the case? I suggest to you that it is less likely that there will be complications of the kind this patient suffered if there is supervision by an orthopaedic specialist. Do you agree?-- I disagree.

Can you tell me, is there another document that follows? This is a procedure that Dr Naidoo certified you, according to your scope of practice, as being able to perform without supervision, isn't it?-- Yes.

Are you aware that there are other orthopaedic specialists who hold a different opinion that a person who is not an orthopaedic specialist ought either to be supervised or ought to have been seen to have performed these procedures successfully several times before being allowed to perform them unsupervised?-- If that's the opinion of other orthopaedic specialists, majority of them, I'll agree with them.

COMMISSIONER: Sorry, you say you agree with that?-- Yes.

MR ANDREWS: I think it was qualified by if it's the opinion of a majority of them.

COMMISSIONER: Oh, I see. Oh, right. But it didn't occur to you that you required supervision?-- The reason being, sir, because I had done this procedure before.

Mmm?-- In fact, in the same patient, doing exactly the same procedure.

I understand, on the other foot?-- She was very happy. I have the opinion that the - during the recovery period she must have lost some degree of extension.

MR ANDREWS: Well, please, look at Exhibit 408, which contains two medical reports which each relate to this patient. Towards the bottom of the page does the report set out the degree of extension which the patient has after the second procedure, that is the one on the right?-- Yes.

About five degrees of extension?-- Yeah, that's what Dr Crawford mentioned.

COMMISSIONER: You don't disagree with that?-- No.

MR ANDREWS: And that's a poor result?-- Yes.

Would you show the next report, please. It seems that the patient had a revision of the IP joint fusion and while the word "extension" doesn't appear to be used in this report, does that reveal whether or not there has been an improved result?-- Yes.

Does the zero to 20 degrees of movement of the - in the IP joint mean zero to 20 degrees of extension?-- Yes.

You performed a procedure on p444 in September 2003?-- Yes.

Which was to some extent similar?-- Similar procedure, yes.

And like the second procedure done to P445, it had

complications?-- Yes.

Would you look, please, at the first of these documents which I'll put on the monitor. Is that the operation report showing you to be the surgeon who operated on P444 on the 3rd of September 2003 performing on the left a bunionectomy and fusion MTPJ?-- Yes.

You were unsupervised?-- Yes.

May I see the next document, please. Do you see the third paragraph marked in yellow showing the degree of extension?-- Yes.

And is it suggesting a poor result?-- We will expect to get about 25 - 20, 25 degrees. This is 15, so probably a bit less than what we expect.

COMMISSIONER: Well, do you agree that's an unsatisfactory result?-- If the patient is symptomatic, yes.

MR ANDREWS: It does - well, the report shows what ongoing problems this patient had but you're probably aware of them in any event, aren't you?-- Yes.

She was definitely symptomatic?-- Yes, that's why she came.

May I see the next document, please, that being the transcript at page 5773. If the toe fusion is fused in the wrong position, it allows for very poor function of the foot. You would agree with that?-- Yes.

It takes a fair amount of experience to get it right, you'd agree with that?-- Yes.

You wouldn't regard yourself in 2003 as being the equivalent of a senior training registrar under supervision, would you, because you were indeed not under supervision?-- Oh, yes, yeah, because of the supervision thing - we did have supervision-----

COURT REPORTER: I'm sorry, can you repeat that?-- Where the senior registrar under supervision is more advantageous.

COMMISSIONER: But you don't agree that you should have had supervision for that operation?-- Well, I have done this before and it was within my scope and I was happy to perform without supervision.

Thank you.

MR ANDREWS: May I see the next page, please. Are you in any position to agree or disagree with the evidence that an orthopaedic surgeon would generally get a better result than you had?-- I'm not an orthopaedic specialist. Definitely an orthopaedic specialist would do a better result and probably less complication.

But did you advise P444 of that opinion?-- Yes.

Are you saying that you told her she'd probably get a better result if she went to an orthopaedic surgeon?-- Sorry, not - not that, but I advised her on the complications.

You failed to tell her of your opinion that she would probably get a better result with fewer complications if she went to an orthopaedic surgeon?-- I didn't tell her.

COMMISSIONER: Doctor, this was a similar operation to the one you'd performed on P445?-- Yes.

Bad results in both. Unsatisfactory results in both?-- Yeah, two out of three bad results.

MR ANDREWS: There was no reason why you couldn't have referred her instead, for instance, to Dr Naidoo or why you couldn't have asked Dr Naidoo to supervise?-- The reason being there was a lot of other cases which I have done similar operation, no problems at all.

Are there any other pages that come with - I think there is one. This is from the statement of Dr Crawford. Do you accept the opinion of Dr Crawford that there were technical shortcomings in your work with respect to the patient P444?-- I agree.

Thank you. I'd ask you now to look at and consider the patient P442 . Does that show you to have been the surgeon who performed a correction of the lesser toes on P442 on the 28th of January 2004?-- Yes.

As I recall it, there is some criticism of the incision or, indeed, there is more than that. May I see the next document, please. This was elective foot surgery. It was unsupervised?-- Yes.

Did you consider calling for supervision?-- No.

Do you agree the patient required corrective surgery subsequently?-- Yes.

Do you agree that you performed the surgery in an inappropriate fashion? You're allowed, if you like, to ask me to show you the remaining documents?-- What I want to say is the outcome was not what I expected. I didn't expect to - him to develop fusion of the second and the fourth toes-----

COMMISSIONER: No, no, that's not the question you're being asked?-- Oh.

MR ANDREWS: Do you agree that you performed the surgery in an inappropriate fashion?-- Yes.

In the circumstances, I will move to the patient P446.

COMMISSIONER: Yes.

MR ANDREWS: Doctor, this is a patient who was, according to the operation note, operated on by Dr Naidoo and assisted by you?-- Yes.

It seems that there were two procedures, one on the 24th of May 2004, open reduction and internal fixation of a fracture of the tibial plateau on the left, and then on the next page on the 2nd of June, the operation was an EUA. Can you say what that is?-- Examination under anaesthesia.

And screw fixation of the tibial plateau on the left?-- Yes

Is it fair to say that Dr Naidoo was in charge of the processes here and is responsible for the outcome whether it be good or bad?-- Yes.

Can you show me what is on the next page so I can be reminded of. I have no further questions with respect to this patient. Commissioner, is this a convenient time?

COMMISSIONER: Oh, yes, certainly. I will adjourn.

MR DEVLIN: Commissioner, can I hand up to you some evidence references relevant to the matter that you raised earlier. That may assist you in relation to section 143A.

COMMISSIONER: It occurred to me also, Mr Devlin, that a similar question might arise with respect to other doctors not just Dr Patel, and it might be Dr Krishna, Dr Sharma. I don't know what the legislation says but if, for example, Dr Krishna is registered as SMO orthopaedics, then the same problem might arise for your client, and the same might arise for a number of other doctors who are mentioned during the course of this inquiry.

MR DEVLIN: Yes, I'll be endeavouring to meet your concern, Commissioner. Those evidence references may assist you in your deliberations at this stage anyway.

COMMISSIONER: Yes. Of course, it doesn't matter, I suppose, what the members of the board thought.

MR DEVLIN: Well, it is also a question of what communications the registrant received immediately upon registration and I suppose there are a range of factors that-----

COMMISSIONER: Well, I mean, if he registered these people as specialists, he stands or falls on that, doesn't he? Well, the board does.

MR DEVLIN: Well, the evidence is to the effect that that was not what was considered was being done but I expect I'll-----

COMMISSIONER: I just wonder whether that might be all a greater negligence on the part of the board, ought to consider - I'm not saying that's the case. I just don't know at the moment.

MR DEVLIN: I'll endeavour to assist you with that, Commissioner, in the long term.

COMMISSIONER: Thank you.

MR DEVLIN: Can I also tender as part of the last exhibit Exhibit 143 the statement of Dr Sharon Smith. That's the co-ordinator centre records.

COMMISSIONER: So that's part of exhibit - Queensland Health, record, is it?

MR DEVLIN: Sorry, 423, sorry.

COMMISSIONER: 423. Okay.

MR DEVLIN: The exhibit attached to the back of that statement is not as clear as the one I handed up separately. We must have got a first generation copy.

COMMISSIONER: The statement by Sharon Smith will be part of Exhibit 423.

MR DEVLIN: Thank you.

COMMISSIONER: I now adjourn.

THE COMMISSION ADJOURNED AT 1.02 P.M. TILL 2.30 P.M.

THE COMMISSION RESUMED AT 2.31 P.M.

DAMODARAN KRISHNA, CONTINUING:

COMMISSIONER: Just before we continue, Mr Andrews, can I just raise something with you, Mr Devlin, because I don't want there to be a misunderstanding about the point I raised with you this morning, because as I understand the evidence you tendered to me just before lunch, what it shows is what the Board thought it was doing when it registered doctors and I don't see that as having any relevance to the question I raised with you.

The question I raised with you has two aspects: the first is what, on the proper construction of 143A(2), is the effect of certificates of registration issued by your Board. The second is if the effect of certificates, on the proper construction of 143A, is that doctors were registered as specialists who should not have been registered as specialists, that was a negligent act or omission by your client. And that might depend, for example, on whether it was because your client didn't read 143A(2), or misread it, or whatever.

MR DEVLIN: Or whether the registration happened under section 135.

COMMISSIONER: No registration - all registrations happens under 135. It is the effect of registration 135 that 143A(2) deals with. That's as I understand the proper construction of the Act.

MR DEVLIN: Yes. No, I understood, with respect, Commissioner, what you were saying this morning. I was just pulling up evidence references which might assist, but if they don't assist I will certainly-----

COMMISSIONER: I don't think it does.

MR DEVLIN: I will certainly address the matter of construction which you have raised.

COMMISSIONER: Yes.

MR DEVLIN: Legal construction.

COMMISSIONER: Two aspects: (1) the construction, and (2) whether that construction, if that possible view I put to you is correct, ought to have been perceived by a Board properly reading its own registration.

Yes, Mr Andrews?

MR ANDREWS: I have no further examination.

COMMISSIONER: Thank you. Do we have an agreed order? Yes, Mr Allen.

CROSS-EXAMINATION:

MR ALLEN: Dr Krishna, John Allen for the Queensland Nurses' Union. I really only want to deal with one relatively minor aspect of your statement, and that's at paragraph 36 of your statement when you refer to the issue of ward rounds and the presence of nurses during those rounds. Now, in your statement you raise a concern as to the lack of frequency of participation of the nurse unit manager in the surgical ward in ward rounds. Are you referring to a period before the end of last year or are you referring to a situation which continued into this year?-- End of last year.

End of last year, okay. There was a difference in relation to how ward rounds proceeded after Dr Kwon started at the hospital, is that correct?-- Yes.

And is it the case that you yourself were involved in orthopaedic ward rounds this year, or was that only last year?-- Both.

Both?-- Both the years, yes.

Because I understood some of your evidence this morning to be that you basically ceased orthopaedic duties some time this year and were performing medical duties?-- After the - yes.

When was that?-- In end of March - 21st of March.

Okay. Now, is it the case - and I am dealing with the situation last year, firstly - that there would be two types of rounds in the surgical unit of a morning?-- Yes.

So there would be a surgical team that was undertaking a ward round?-- Yes.

And there would be an orthopaedic team that was undertaking a ward round?-- Yes, that's correct.

And last year you would have been a member of the orthopaedic team taking a ward round?-- Yes.

And was it often the case that both teams would start their ward rounds at the same time?-- Yes, I agree.

And it is the case, of course, that the nurse unit manager in that situation could not be with both teams at the same time?-- Yes.

And is it the case that the surgical team would have the larger number of patients to see in the ward?-- Not all the

time.

But mostly?-- Most of the time, yes.

And was it mostly the case that the nurse unit manager of the ward would accompany the surgical team on their round rather than the orthopaedic team?-- I am not sure whether the nurse unit manager was attending the surgical rounds or not when she was not present with the orthopaedic rounds.

And you didn't notice whether the nurse unit manager was with the surgical team conducting a round at the same time?-- No.

So you can't say either way?-- Yeah, I can't.

All right. Is it the case that when the orthopaedic team would arrive on the ward, the nurse unit manager would go through the orthopaedic patients on their list with the orthopaedic team and inform them of any changes that might have occurred during the night or any other specific concerns?-- It did happen once and a while.

And is it the case that the nurse unit manager would sometimes join the orthopaedic team to address the concerns regarding a particular patient when the orthopaedic team had reached that patient?-- Yes.

And are you aware that Dr Naidoo was aware of the problem with the overlapping surgical team and orthopaedic team rounds and that twice a week he would do a round with the orthopaedic team at a later time?-- Yes.

Did you notice - and you have said that there were changes in how the ward rounds were conducted after Dr Kwon joined the hospital. Did they include the fact that he would - he introduced changes as to how notes were made in the patients' charts?-- No.

I suggest that before Dr Kwon was at the hospital, it was quite often the practice that the orthopaedic team would not make notes in the patients' charts at the time the patient was reviewed?-- Disagree.

That the resident medical officer accompanying you on the rounds would simply make notes on a separate piece of paper which would then later be translated into the patients' notes?-- Not always.

Not always? Was that a common occurrence, though?-- No, it depended on which resident medical officer is with orthopaedics. There was a situation once - involved only one particular resident medical officer. He would prefer to write in a separate page and go and sit down with the charts and write everything in the charts, whereas most of the others in the hospital preferred to write straight away in the charts.

Wasn't there a problem with that type of approach by an RMO that there would be a period of time then between the ward

round and, say, a physiotherapist or other health professional seeing the patient when those notes weren't appearing in the chart?-- As soon as we finished the ward rounds, the RMO will straight away go and write in the charts, so I don't think there would be delay, but the RMO would be present in the ward, I believe, all the time, and if the physiotherapist or occupational therapist had some concern, they could have got in touch with the resident medical officer.

It created some, to use your words, communication defects with regard to patient management plans?-- Yes.

Now, why would the practice vary according to the particular preference of the RMO if that RMO was under your direction?-- When I wrote that piece of statement, I was actually referring to the situation when we didn't have any RMOs.

In your statement you say - well, you refer to an allegation that the nursing staff on the ward, including the unit manager, would almost never participate in ward rounds. You then say, "This resulted in communication defects with regard to patient management plans and resulted in medical officers being blamed for lack of communication." Were you referring there to a situation where there were defects with regard to patient management plans because a resident medical officer or other doctor hadn't made the proper records in the notes?-- Could be possible.

All right. Now, surely the resident medical officer is under your direction?-- Yes.

You should enforce a system, if you feel it appropriate, that the resident medical officer make the notes at the time? Why would you simply leave it to the preference of the particular RMO how they recorded their notes?-- I didn't see any problem if the RMO recorded it in a paper and straight away went down and sat with the charts and recorded everything in the charts. I didn't see any problem with that.

How can you suggest that these communication defects with regard to patient management plans could be as a result of the non-participation of the nurses in the round?-- Because nurses are looking after patients, sometimes four patients or sometimes two patients, if they are more sick, and if we had one nurse, like, for example, a nurse unit manager, or one of her delegates who would go around with us doing a ward round so they can record the new changes regarding all the patients, and then later on communicate with the respective nurses regarding each.

But shouldn't the resident medical officer, or in their absence yourself, be recording the changes in the patients' notes at the time of the round?-- Yeah, should, but I didn't think there was a big problem if it was recorded immediately after the ward round.

All right. I take it that you are not suggesting that nursing staff were sitting around reading magazines during the ward

rounds?-- No, definitely not.

Definitely not. They were busy performing their duties?-- Of course, yeah.

So, what, does your criticism basically come down to the fact that there wasn't time for either the nurse unit manager or some other nurse to accompany both teams when they were doing their simultaneous rounds?-- I would think that would be right. The only thing - my concern was there wasn't a plan, like in - if there was a plan formed by the nurse unit manager saying all rounds should be - should have one nurse delegate or herself accompanying. There wasn't any rule as such. So we would ask one of the nurses, "Can you accompany?", and she say, "Would you hold on for a while? I am sponging this patient and then I will come down." So we - most of the time because we had other duties to perform we had only certain amount of time to finish the ward round.

Likewise-----?-- Nurses-----

-----because nurses had other duties to perform, sometimes the availability of nurse and doctor did not always coincide?-- Definitely, yes.

Okay. Did the way that you would review patients on rounds change after Dr Kwon joined the hospital?-- No.

In that there was greater attention given to checking wounds?-- It was done all the time.

Greater attention given to seeing whether patients could mobilise?-- That wasn't a new thing, it was done all the time.

And greater attention given to filling in documentation, such as fluid balance charts, observation charts, et cetera?-- It was done all the time.

Thank you, doctor.

COMMISSIONER: Thank you. Mr Devlin?

CROSS-EXAMINATION:

MR DEVLIN: My name is Ralph Devlin. I represent the Medical Board of Queensland, doctor. Did you see yourself as Dr Naidoo's registrar?-- No. I saw myself as a senior medical officer, which is one level off a registrar level.

Thank you. Looking at your scope of practice, are you able to estimate how many procedures of the various kinds that you were authorised to do by that scope of practice, whether

before or after it was created - can you estimate how many procedures you have performed between July 2002 and the present day?-- Yeah, I have done 550 procedures.

550?-- Yes.

Thank you. Now, in relation to the general topic of supervision - just correct me if I'm wrong - you seem to have given different aspects of what you understand to be supervision, so I will just go through them one by one and you can correct me if I'm wrong. First of all, there were occasions when Dr Naidoo did observe you in the process of a procedure?-- Yes.

Secondly, Dr Naidoo, so far as you are concerned, was in a position to assess postoperatively the outcomes for your patients?-- Yes, that's correct.

In terms of the postoperative assessment that you were aware of from Dr Naidoo, did he ever raise with you any complaints or concerns about your procedures that you performed unsupervised in terms of anyone being present for them?-- Yes, I can remember a few times there is a small comment, he would say, "I would have put this screw a little bit longer", or he say, "I would have put one more screw", things like that.

What was your response to those sorts of comments by Dr Naidoo on the occasions he made them?-- I took it as a learning process.

A learning process?-- Yes, and said words - and Dr Naidoo would say, "This is the latest in the journal", and sometimes, if he remembers, he will give me a journal article to go and read.

Very well. So those things happened from time to time, did they?-- Yes.

Thank you. Now, you also seem to say in your evidence that you felt that Dr Naidoo was in a position to assess your general level of competence, your general level of surgical competence?-- Yes.

First of all, was he in a position, from ward rounds with your patients, to form that assessment so far as you were concerned?-- Yes.

In orthopaedic clinic, did you say that on occasions Dr Naidoo directed to you patients and then was in a position to know what became of those patients and what their outcomes were?-- Yes.

Did you also make mention of Dr Naidoo being aware, so far as you were concerned, of the referees who you brought with you, as it were, to this job?-- Yes.

Who are some of those referees that you had in mind, doctor?--

They were all from my previous employment.

Where?-- In Toowoomba Base Hospital.

Toowoomba?-- Yeah.

And were they specialist orthopods?-- Oh, yes, yeah.

So far as you were concerned, were they specialist orthopods of some eminence, some standing?-- Oh, yes, very, very experienced and they do very well.

So far as you were concerned, did they speak well of you?-- As far as I know they - in fact, didn't want to release me.

They didn't want to release you?-- Yes.

Do you say Dr Naidoo was aware of such things?-- Yes.

How was he aware of such things?-- Once, the Director of Orthopaedics in Toowoomba, he told me - he said he had a talk with Dr Naidoo and he said, "I told him I want to retain you."

I see?-- So.

Thank you. Who was that Director of Orthopaedics in Toowoomba?-- Dr Bob Ivers.

Thank you. You mentioned that you and Dr Sharma would do trauma cases?-- Yes.

You mentioned in evidence that at the same time Dr Naidoo might be performing clinic or doing his own list?-- Yes.

Remember saying that?-- Yes.

Well, was Dr Naidoo available for your assistance if you needed his advice in those situations?-- Yes.

For example, if he was busy with his own list, were there occasions on which he was prepared to come and give you advice, or be available to you?-- Yes.

We'll come to the one where you say he did not come-----?-- Yeah.

-----that specific case, but I am going to ask you were there other occasions where he did not come when you asked for his assistance when he was doing his own list?-- I can't remember of any situation.

When he was doing his clinic, whilst you were doing trauma cases, was he available to you in that circumstance?-- Yes.

Were there occasions when he did not make himself available to you when you requested it whilst doing a trauma case?-- No.

Now, I have taken you through some of the different types of

supervision. Is that right? Is that how you see it?-- Yes.

Are there any other classifications where you would say, by way of some form of supervision, Dr Naidoo had some view of your capabilities? Are there any other aspects to that relationship that I haven't already gone through with you?-- I am not sure whether you mentioned by phone, if he is somewhere else he can - I can talk to him by phone and get advice. If he is happy he can give me advice regarding what to do in that particular situation in that moment.

Right. Were there situations though where you badly needed that advice and he was not contactable by phone?-- I can't remember any situation.

If you lived in a situation or practised in a situation where without sufficient level of supervision you were not going to expect to be accredited as a specialist, why did you stay in Hervey Bay? Can you explain that?-- The reason I stayed in Hervey Bay, because there was a permanent job and I've - I've discussed my chances of getting into the training program while I was in Toowoomba Base Hospital and I contacted Dr John North, I wrote to him and he replied - he said the chance of getting into the training program is almost negligible.

Was there an explanation why?-- He said, "Because of your qualification."

Being Fijian qualifications, is that what-----?-- Yes.

-----you understood by that?-- Yes. And so I was looking for a permanent job, because being an SMO would be not a specialist position in orthopaedics. Of course, I will never become a specialist, but I will continue doing orthopaedics.

Yes, go on?-- And when I was in Toowoomba, I was given examples of people doing this kind of job and there were people in Ipswich and people - there was somebody in Cairns doing similar kind of job. So, in fact, it was Dr Robert Ivers who said this will be good for me as a career path, "if you can't get into the training program."

It would be for you to go to Hervey Bay?-- Yes.

That was Dr Robert Ivers' view, was it?-- Yeah, if I wanted to stay in doing orthopaedics.

Well, why wasn't staying in Toowoomba an option?-- Because Toowoomba's job was principal house officer job which is not a permanent job, it is temporary job.

Yes?-- So even though Dr Ivers was very supportive, he advised me that he will continue employing me, but because of our Area of Need situation, if I had not passed this exam probably Medical Board would not register me after four years in the Area of Need.

I see?-- Then-----

So can I summarise that and you can tell me if I have got it right: you went from Toowoomba where you say you were well regarded by Dr Ivers and others?-- Yes.

To Hervey Bay firstly on a promotion?-- Yes.

Secondly into a position which you regarded as having more long-term security?-- Yes.

Although the hope of having supervision at such a level as to gain ultimately accreditation, that was not a hope that was held out to you in any way?-- Yes.

Does that sum it up?-- Yes.

And do you have a young family?-- Yes.

Does settling in the particular district for a longer period of time in a more permanent position, is that something that's attractive to you in your family life?-- Exactly, yes.

More so than if you had stayed in Toowoomba where you say you were well regarded?-- Yes.

Thank you. Now, you spoke about Dr Hanelt and he having completed an assessment for you on the 30th of November 2004. Did you mean to say that at that point you had passed your AMC exam and this was an assessment as a general practitioner, is that what you were saying?-- Yes.

That's how you understood it?-- Yes.

Now, I want to just explore with you your understanding of the means of knowledge of Dr Hanelt as to your competencies, in his position as Director of Medical Services and in yours as an SMO. What are the means by which, so far as you see it, Dr Hanelt could have assessed - could have been in a proper position to assess your skills?-- He would send reports from Dr Naidoo every year where he apply for renewal of registration.

So firstly let's go through them. Firstly, at least once in a year Dr Naidoo would report on you for the purposes of renewal of your Special Purpose Registration?-- Yes.

And that - you say Dr Hanelt would know something of that?-- That's right.

Anything else?-- Nothing in writing, no.

Well, what other means of knowledge did he have?-- Probably-----

So far as you were concerned?-- I thought he had oral reports from - regarding all the staff, he was Director of Medical Services so I don't know which method did he use.

COMMISSIONER: But he wouldn't have had any other reports about you, though, did he? The only report about you would have come from Dr Naidoo?-- Yes.

MR DEVLIN: Thank you. From your experience, was Dr Hanelt a hands-on Director of Medical Services?-- I think he was very good.

COMMISSIONER: He didn't ever observe you performing any surgery. You told us that?-- No, he didn't.

MR DEVLIN: Was he present around the hospital whilst you were working, as opposed to observing you?-- Oh, he was at work all the time.

He didn't stay in his office all the time? What was his style of work, so far as you observed it?-- He used to work in his office and if there is a shortage in accident and emergency, he will go work in accident emergency, and I think he had a special interest in obstetrics and gynaecology. Sometimes if there was shortages he would go and do their clinics.

So he was active around the hospital but not particularly in your area; is that what you are saying?-- No, never in orthopaedics.

One other aspect of being able to seek advice - I think we heard from Dr Sharma in his evidence that he felt he could make contact with other orthopaedic specialists if he had a query. I think he mentioned contacting Brisbane if he felt the need to do so. What was your experience in that regard? Did you have enough contacts within the general practice of orthopaedics to seek other peoples assistance and advice as and when you needed it?-- Yes, all the time.

COMMISSIONER: Did you ever do that?-- Yes.

Whose advice did you seek?-- Oh, we would ring the-----

No, no, you. Whose advice did you seek?-- Sorry, I couldn't-----

Whose advice did you seek? Not what other people might have done?-- Advice about the patient?

Yeah, about a patient?-- Yes, I called Royal Brisbane and asked for the orthopaedic registrar on call.

Yes?-- And if the orthopaedic registrar on call is senior enough, if he makes a decision, then he will advise me or sometimes - there has been a couple of times he will say, "Okay, send in the x-rays", or send in the - e-mail the x-rays and he will talk to his consultant and get back to us, and they always came back to us.

MR DEVLIN: Can you estimate on how many occasions since your arrival in July 2002 you availed yourself of that assistance when you needed it?-- I would be guessing, but I would think it would be well over 15 to 20 times.

Thank you. Did you have recourse back to the orthopaedics department of Toowoomba, because that's where you'd come from? Did you ever contact people you knew in orthopaedics there?-- Yes, I knew them, and I actually talked to one of the consultants who was working with me as a PHO. He is a consultant now, so I talked to him a few times.

And where was he based when you spoke to him? Still Toowoomba, or somewhere else?-- Toowoomba Base Hospital, yes.

Any other areas that you got assistance from when you needed it apart from Brisbane and Toowoomba?-- Oh, if it was a spinal case we'll ring PA Hospital. That's where all the spinal cases will go.

Can you estimate how many times you've done that since July 2002?-- A couple of times. We don't have too many spinal cases in Hervey Bay.

As an international medical graduate, now having been in Australia since what year?-- 2000.

2000, have you had, whilst working in Hervey Bay, a sense of isolation, or have you felt that you can speak to other

colleagues in other places?-- Yeah, I think I can speak to other colleagues in other places, and I tend to know more and more people.

When you first started as an international medical graduate in Toowoomba, did you have that sense of isolation, or were you oriented sufficiently well in Toowoomba to suit your purposes?-- In Toowoomba the situation was different. There was 100 per cent supervision. There were consultants all the time, and any new case we see, we have to tell the consultant.

Very well?-- So that was a different situation in Toowoomba.

Thank you. Now, can I just go to a couple of specifics then as quickly as we can. Firstly, there are two matters in relation to Mr P449 I'd like to draw your attention to, and they'll go up on the screen. Firstly there's the times of the operations, and secondly, some post-operative assessments. If you look on the chart there, the shaded parts in blue should give us the story about times?-- Mmm hmm.

Does that accord with your general recollection, what's recorded there?-- Yes.

Now, we have a finish time for the - sorry, we'll start again. We have a start time. Would that be the time into the OR, 1340?-- No, 1424.

I beg your pardon, 1424, thank you, surgery start. We have 1845, 6.45 p.m., surgery finish?-- Yep.

By your standards, against your experience, was that a long period for the patient to be in surgery?-- No.

When do you believe Dr Mullen took over the next part of the surgery?-- It would be after five.

So you had carriage of the patient from roughly 2.30 to just after 5 p.m.?-- Yes.

When Dr Mullen arrived, was that a complete surprise to you?-- Yes.

Did you feel that he was unnecessarily taking over the patient?-- Well, we couldn't complain because he was a consultant, and he was a consultant on call after five, and it was, if I can remember, almost five, or just after five. So what Dr Mullen told us - we met him in the change room. He said, oh, he was around in Accident & Emergency just before going home and he found out there's a trauma case. He said he will take over. That's what he told us, and we didn't know that somebody has called him.

Well, I want you to be as frank as you can be about this. By the time Dr Mullen got there, did you feel you were in difficulty with the procedures that you were carrying out on this patient?-- The femur was finished.

Weren't there other things to be done, though?-- There's an ankle fracture.

You say just an ankle fracture; was it a complex one or a simple one?-- Probably moderate.

Moderate? Somewhere in the middle?-- Yeah.

Well, I'm asking you to be frank about it. Did you feel that you were out of your depth at the point where Dr Mullen joined the operation?

COMMISSIONER: He already said he thought he was quite capable of performing that procedure.

MR DEVLIN: Thank you. Did you defer to Dr Mullen's seniority when he came along to assist? Did you recognise his seniority? Is that the way you saw it?-- No, we were very happy because we had been in theatre for three hours - close to three hours, and after five Dr Mullen was on call, so he came to help. He said, "I'll take over", because he was on call, so we happily-----

Accepted the assistance?-- Accepted the assistance. We were happy with that.

And did you then play a role in the post-operative follow-up of Mr P449?-- Yes.

I'll just show you the next document from the file then, and the only other document I wanted to show you. This seems to be a letter, 21 August 2003, giving the history of Mr P449 post-operatively. First of all it shows the admission details, 9 April, transfer from Maryborough Hospital. It shows the diagnosis and treatment there?-- Mmm hmm.

So far that's all accurate, correct?-- Yes.

Then it says, "By way of subsequent treatment he remained in Hervey Bay Hospital until 15 April, was transferred to Maryborough on 15 April until fit for discharge." Now, he was reviewed in the orthopaedic clinic on 2 May, and it was said that healing was progressing without problems. Do you know if you did that review?-- The first review was done by Dr Sharma. I'm not sure whether this was the first review.

It then recites that he failed to attend for review a month later in orthopaedic clinic. Do you know anything about that?-- I can remember from the charts that it's written there - there's nothing written, so I believe he failed to attend.

Righto. He was then reviewed, however, in the June, and at this time the femur - that's what you operated on, correct?-- Yes.

And the ankle fracture were healing well, but the radial head fracture had malunion?-- Yes.

Had you operated on the radial head fracture?-- No, we handed over the care after the femur to Dr Mullen, and after finishing the ankle, Dr Mullen decided that he will treat the radial head fracture conservatively, without operating.

Very well. Then the patient was booked for removal of a screw from the ankle. Did you perform that procedure?-- No, Dr Sharma performed it.

And was that a routine step in his recovery?-- Yes.

And excision of the left radial head, was that a routine step in his recovery?-- Because of the malunion, yes.

Because of the malunion. And then those procedures were performed on 24 June, discharged on the 25th of June; is that right?-- Yes.

Okay. That's as much as we seem to know about his post-operative recovery. Do you know any more than what's revealed in this letter?-- I think I also reviewed him four months post-operatively, and at that time he was fully mobilising, full weight bearing, and we didn't see him after that.

Thank you. Can we go now quickly to P435. There is a note at page 205 of the chart. I'll put it up on the screen. It's shaded in blue, I think. There it is. Is that in your printing?-- No.

Do you know who the author of it is, or was?-- It has to be one of the nurses, because nurses fill this form.

Yes. Is it true in what it conveys? "No surgical assistant available despite requests from Dr Krishna."?-- It's true.

Now, did you authorise the placing of that note on the chart yourself?-- No.

A nurse took it on herself to record it for posterity?-- Yes.

This is a specific instance where you say that despite your requests, Dr Naidoo did not come until just after the procedure had finished; Is that correct?-- Yes.

Did that occur on other occasions?-- No.

Are you aware of any note like this one being on any other patient file?-- No.

Thank you. There's one other aspect to that, and it's at page 155. We see this type of document on a number of occasions. If we can focus on that, the document recites, under the name of the patient, that the consultant was Dr Naidoo, and that you were the SMO. Did he consult with you on this patient at

any time?-- No. All the patients admitted would be under Dr Naidoo.

Yes?-- Or Dr Sean Mullen if he's on call.

So that was a standard notation no matter what the level of consultation in each case?-- Yes.

Thank you. If I can move on now to P436, you seemed to strongly disagree with the view that this was a subtrochanteric fracture. You strongly - seem to strongly express the opinion that it was an intratrochanteric fracture?-- Yes.

Can you please explain so we can understand what the difference is, firstly?-- Okay. The definition of a subtrochanteric fracture is the fracture line extending beyond the lesser trochanter. We have the greater trochanter and lesser trochanter.

This is within what part of the body? The hip, is it?-- Yeah, the thigh bone.

The-----?-- The thigh bone. That's on the top of the thigh bone, the femur.

And why is the location of the fracture important, in your thinking, in this case?-- If it is a subtrochanteric fracture the chances of non-union is very high.

The chances of-----?-- Non-union.

Non-union, yes?-- And implant failure is very high because of the muscle imbalances.

And what if it's an intra - am I saying that right? Intratrochanteric?-- Yes.

Intratrochanteric?-- After fixation can have - achieve good stabilisation.

Now, do we resolve this difference of opinion by looking at x-rays if we can? Is that the way we resolve that difference of opinion?-- Yes.

And in your experience, is that a difference of opinion which can occur in this part of the body?-- Yes.

I see. You also seem to strongly suggest that the treatment of the fracture to the femoral shaft by an apparatus requiring eight to 12 screw holes would not have been appropriate in your view?-- Yes.

Do I understand you correctly?-- Yes.

Why?-- Because the instability and the fracture was not in the shaft.

Not in the shaft?-- It was all above the lesser trochanter.

It was above the lesser trochanter?-- Lesser trochanter. So putting extra 10 screws below in a perfectly normal bone would not make any difference to the instability which is right on the top.

Does your opinion about the eight to 12 screw hole apparatus turn on your opinion - or depend upon your opinion that the fracture was in the intratrochanteric location?-- Yes.

If the fracture was in the subtrochanteric area, then would that treatment have been suitable?-- Absolutely.

Right. Turning now to P445, you - I took a quick note of what you said, and this is my note of it. She could have lost some degree of extension in the recovery period. That's what I understood you to say. My question is this: is it your opinion, or is it your experience, that a degree of extension can be lost in the post-operative period regardless of how good the surgery was?-- Yes.

Is that your opinion and is that your experience?-- Yes.

Thank you. In relation to P444, you seemed to indicate that you had done a number of other bunionectomies?-- Yes.

And MTPJ-----?-- Fusion.

-----fusions, which you say were successful?-- Yes.

How many others do you say you had done up to this point?-- At least 10 in Hervey Bay.

You, however, I think, agreed there were some shortcomings in her treatment?-- Yes.

What do you say they were?-- As per Dr Crawford's assessments, she had only 15 degrees of extension. Normally for good outcome, as far as mobility goes, we need about at least 20 to 25 degrees of extension.

Well, that's seems to me to be discussing an outcome, with respect. Were you agreeing also that there were some shortcomings in the way it was treated, or are you really talking about the outcome not being what you would have wished?-- Yes, the outcome.

The latter?-- Yes.

Where there was an outcome that was not as you would have wished with P444, for example, was such a matter discussed at the Morbidity & Mortality Meetings which you say were held weekly?-- We had - Dr Naidoo had a form of audit where he would put a form which we had to fill for all the patients which we think had some degree of complication or unfavourable outcome, even if it was a very minor one. So if

she had come to the clinic, if she had complained, then we would have recorded it in that form, and that would have gone in our audit.

COMMISSIONER: Can I take you back to your previous answer. You agreed, as I understood it, with Mr Andrews, that in the case of P444 there were some technical shortcomings in your operative procedure. That's what you said?-- That's what-----

Do you want to change at that view now?-- That's what Dr Crawford said.

No, no, but you agreed with that. You were asked whether you agreed with that, and I thought you said you did?-- I think I probably might have misunderstood. I agreed to the final outcome there are some shortcomings.

So you don't agree there were some technical shortcomings in the way you performed that operation?-- Yes.

Yes, you do agree, or don't?-- Don't agree.

You don't agree. All right, thank you.

MR DEVLIN: You, in relation to P442 , agreed with a question which suggested that you had performed the operation in an inappropriate fashion?-- Yes.

What did you mean when you agreed to that?-- This patient had callosities underneath the second and fourth toes, and I did a partial excision of the metatarsal head, and - which I didn't think will fuse, and if that two bones had not fused he would have been very comfortable. Just because it's fused, the weight has been transferred to either two metatarsals which has caused the problem and then required a re-operation.

Do you accept that that was an error on your part?-- I would say yes. If I had done partial excision - I should have done the whole lot, done the all four instead of just doing two.

Thank you. You mentioned the general process of filling out forms when there was a suboptimal outcome. Did those forms routinely get discussed at the Morbidity & Mortality Meeting? Is that what you're saying?-- What will happen with this form - the plan was we'll - we'll do the audit every three months and these complications should come in the audit.

Yes?-- And then discuss it.

So were they discussed more as a general trend rather than concentrating on the specific case? Is that what you're saying?-- Sometimes if that patient required a re-operation then it would be discussed as a specific case.

If the patient required a re-operation you would descend to the detail of what led to the re-operation?-- Yes.

Is that what you're saying? In these meetings?-- Yes.

And I think you've already said that as far as you were concerned, the meetings were held regularly and fulfilled a positive function, did they, in your view?-- No, the Mortality & Morbidity Meeting we had once in a week on every Tuesday. It won't be discussed in that meeting. It will be discussed quarterly-----

I understand that, but these meetings generally were effective, in your view?-- Yes.

To assist you in your practice?-- Yes.

Thank you. I have nothing further, Commissioner.

COMMISSIONER: Thank you. Mr McDougall?

MR HARPER: I just have one matter arising out of that line of questioning, if that's okay.

COMMISSIONER: Yes, certainly.

CROSS-EXAMINATION:

MR HARPER: Doctor, my name is Justin Harper. I appear on behalf of the Bundaberg patients. Just in relation to those last matters you were talking about with the forms, were those titled "Adverse Incident" forms?-- Yes.

Can I ask, the process which you went through when you filled them out, was there an investigation which would go on when an adverse incident form was completed?-- No.

No? Can I ask, where there was a patient who had an adverse incident and one of these forms was filled out, was the patient - relevant patient contacted to advise them of it?-- No.

Were you aware that at the time the Queensland Health policy required that the patients be contacted and informed about those adverse incident forms?-- I was not aware of that.

When you were employed at the hospital, did you receive any training about the process for filling out those forms?-- Sorry, can I go one step - these forms were designed by Dr Naidoo.

All right?-- I don't think it was a Queensland Health form. It was just designed by Dr Naidoo which was written - the patient's name and the procedure the patient had and the complication, just for internal audit. It wasn't a Queensland Health form.

Okay. Were they recorded in any place, do you know?-- It would be all - after filling in it would all be given to Dr Naidoo and he would keep it and he will - and then - the plan was to have three-monthly Mortality & Morbidity Meetings, which wasn't really frequent. We only had it twice.

Okay. Now, you mentioned these were forms which Dr Naidoo designed. Were they a specific form or was it just something you filled out from time to time? Was it a - sorry, I'll explain again. Was it a dedicated form which was pre-printed?-- Yes.

But it was not an official Queensland Health form?-- Yes.

Right. Yes, it was not - it was-----?-- Yes.

It was not a Queensland Health form?-- Yes.

And you don't know if those forms were filled out and recorded in any place other than with Dr Naidoo?-- Yeah, I don't know.

Okay. Thank you, doctor.

COMMISSIONER: Just before you go on, Mr McDougall, did I understand you to say just now that the Morbidity & Mortality Meetings were only held twice?-- Yes, the quarterly-----

But they were only held twice in the whole time you were there?-- Yes.

Thank you. Mr McDougall?

CROSS-EXAMINATION:

MR McDOUGALL: Dr Krishna, my name is James McDougall. I represent Dr Hanelt. Did they have ward meetings once a week where cases were discussed?-- Yes.

And is this the sort of meeting that you've just been referring to in your evidence?-- Yes.

So where the Commissioner says Morbidity & Mortality Meetings are held - were only held twice, were you referring to something different to these weekly meetings?-- Yes, the ones I've just answered to the Commissioner was this is a quarterly meeting where the whole admissions and a lot more things will be discussed.

I see. That was a quarterly meeting?-- Quarterly meeting.

Now, you were asked some questions this morning by my learned friend counsel assisting about your scope of practice prepared by Dr Naidoo. That is, one for traumatic surgery and one for elective surgery. Do you recall seeing those documents on the

screen?-- Yes.

Now, the one for traumatic surgery would describe, would it not, most of the traumas that would come through a busy hospital anywhere so far as orthopaedics are concerned?-- Yes.

Most of those - most of the traumas that you would see would be included on that list?-- Yes.

And that would be the same, for example, in Toowoomba, at the Toowoomba Base Hospital where you worked?-- Probably more busy in Toowoomba.

Busier in Toowoomba than here?-- Yes.

You also worked at the St Andrew's Hospital in Toowoomba, did you not?-- No.

You were - you got a reference from Dr Y K Punn?-- Yep.

Was he the PHO who has now become a consultant?-- No, no, when I went - he was actually the Director of Orthopaedics before I came to Toowoomba, then he became a VMO.

I see. So he was based at St Andrew's Hospital, was he?-- Yes.

He wrote a reference for you and said that he found you to be competent to look after general orthopaedic traumas. By "general orthopaedic traumas", are they the same matters that would appear on the list that you were shown this morning as orthopaedic traumas?-- Yes.

It's the case, I think you said in your evidence earlier, that you had 100 per cent supervision in Toowoomba; is that right?-- Yes.

That was by Dr Punn and by Dr Ivers?-- There were seven VMOs, so depending on who was on call.

So at one time or another the VMOs, that is visiting medical officers, who were orthopaedic surgeons, because that was your area of practice, and Dr Ivers and Dr Punn would have seen you perform and supervised you in the performance of most of the surgery that appears on that list of traumatic surgery that we saw this morning?-- Yes.

COMMISSIONER: Is that right? Most of that surgery on that list?-- They would have seen me doing almost all the operations.

Almost all the operations on the traumatic surgery list?-- Yes.

All right, thank you.

MR McDOUGALL: And they would have supervised during the performance of those surgeries?-- Yes.

Dr Ivers wrote a reference for you and said, "He's quite capable of performing most of the acute trauma which comes through a busy hospital." Is the acute trauma that Dr Ivers is referring to, doctor, the same matters that appear on the list of traumatic orthopaedic incidents that you saw this morning?-- Yes.

And did Dr Ivers normally supervise you in the performance of that surgery?-- A couple of times.

You worked at - you started at Toowoomba in 2000, did you not? December 2000?-- Yes.

And you stayed there until May 2002?-- Yes.

I'm sorry, you started at Hervey Bay in May 2002?-- July.

I'm sorry, July 2002. So did you work full-time from December 2000 up to July 2002?-- Yes.

Did you have any time off?-- Yes. In between - a couple of times. We're entitled four weeks' leave a year, so.

So you simply had your annual leave?-- Yes.

And were you on-call on weekends?-- Yes.

At the hospitals?-- What-----

At the hospital?-- Sorry, one in three on-call.

One in three. Now, if I could just come to your training in orthopaedics in Fiji. In paragraph 8 of your statement you say that, "I graduated with a Diploma in Orthopaedics (Australian Orthopaedics Association)." Do you mean by that you were trained in this Diploma in Orthopaedics by the Australian Orthopaedics Association?-- Yes.

They weren't - it wasn't only Australian specialists that did the training as I understand it?-- 90 per cent would be Australian but we-----

Do you know what the purpose of your training was by the Australian Orthopaedics Association? What did they hope to achieve by training you?-- I think the - it was to help the Asia-Pacific region and training was - because they couldn't get all the people - they couldn't fund to get all the people in Australia to get a full fellowship so they trained - they went to the - their country, respective countries, and trained. This program was also conducted in Papua New Guinea and I think also in Thailand.

Your training was specifically designed, was it not, to allow you to perform orthopaedic trauma surgery in your country?-- Yes.

And did you in fact perform orthopaedic trauma surgery in your country after you had completed this diploma?-- Yes.

And the orthopaedic trauma surgery that you performed in Fiji, that included most of the things that were on the list that we have talked about this morning?-- Yes.

Did you find yourself in a situation in Fiji where you had to perform that surgery without supervision?-- Yes.

All right. Now, how long - for what period of time did you perform the surgery - did you perform traumatic orthopaedic surgery in Fiji before coming to Australia? Was it from 1995?-- Yes.

And do you think that training and the work you performed in Fiji over that period of five years served you well when you came to Australia?-- I think so.

Just to clear up my understanding of your evidence this morning in one small respect, as I understand your evidence it's the case, is it not, regardless of whether or not Dr Naidoo had ticked the traumatic surgery list or the elective surgery list as being surgery you could perform supervised or unsupervised, you would make a decision yourself, would you not, as to whether or not you were comfortable to perform the surgery?-- Yes.

And if you were not comfortable to perform the surgery, you would not perform it?-- Yes.

Or you would seek assistance from someone to-----?-- Yes.

-----help with the surgery?-- Yes. I agree.

Was that always your practice from when you started at Hervey Bay?-- Yes.

Just one other question. The Commissioner asked you some questions about how Dr Hanelt might be able to assess you and you talked about him assessing you for your general medical registration with the Medical Board; is that right?-- Yes.

It was the case, wasn't it, that Dr Hanelt arranged for you to work in different areas of the hospital outside orthopaedics in order for you to gain your general medical registration, did he not?-- Yes.

And he to some extent oversaw that, made sure that you got the experience that you needed in order to get general medical registration?-- Yes. He's actually one of the supervisors.

I have nothing further, thank you, Commissioner.

COMMISSIONER: Thank you. Mr Perry.

MR PERRY: Commissioner, I won't be in a position to conclude cross-examination about the P435 matters. I have to take instructions from Dr Naidoo-----

COMMISSIONER: Sorry, won't be able to finish cross-examination about what?

MR PERRY: About the P435 case. That's the lady where there was this conversation, Dr Krishna says. I can take it so far. If it is of assistance, I would have no problem with concluding it by telephone if that is easier to be done rather than keeping this man in Brisbane.

COMMISSIONER: It is a great pity, isn't it, because it is not as if these matters haven't come to light long, long before now.

MR PERRY: This one hasn't. It is about his assertion, the assertion that he contacted Dr Naidoo and was rebuffed. That's what I'm talking about, just that aspect of it.

COMMISSIONER: I see. I see. I thought it had but you say it hasn't.

MR PERRY: Certainly not in his statement. Certainly nothing we have been made aware of I must say. If it has arisen somewhere else, I can tell you my side is not aware of it.

COMMISSIONER: All right. Well, go on.

CROSS-EXAMINATION:

MR PERRY: My name is Perry. I act for Dr Naidoo. Mr McDougall here just asked you about the decision-making process that you would engage in, that is with respect to whether or not you felt comfortable about undertaking any particular operation?-- Yes

Right. Turn your mind to that. It was your practice, wasn't it, to treat that decision-making process with prudence and caution?-- Yes.

That is, it was your understanding that what was expected of you by your superiors at Hervey Bay was that you should do just that, that is, always err on the side of prudence and caution in determining whether or not to undertake any particular operation unsupervised?-- Yes.

And that was your understanding because that was made clear to you by Dr Naidoo?-- Yes.

You will recall-----

COMMISSIONER: Excuse me, what did Dr Naidoo say to you about that?-- In general?

Well, in particular or in general. Tell me any conversation you had with Dr Naidoo about that and what he said to you?-- Oh, when I started he said we'll be doing calls in the weekends or in the afternoon - after hours.

Mmm?-- And we'll be on our own and if there's any patients, any situation arise where you have difficulty in managing, don't hesitate to ring Royal Brisbane or any other referral centre.

Right. So that's what he said?-- Yes.

And that's all he said?-- Yes.

All right. Thank you.

MR PERRY: And from that, you - your practice was thereafter that if you considered there was any potential risk requiring supervision or contact, that is what you would do?-- Yes.

And it was only in cases where you satisfied yourself that there was no such potential for risk that you would undertake these procedures unsupervised?-- Yes.

Thank you. Mr Andrews spoke to you this morning about complaints made to you by Dr Mullen concerning a lack of available supervision. Do you remember that?-- Yes.

And he discussed with you a circumstance in which you in broad terms agree with Dr Mullen's view?-- Yes.

That complaint by Mullen and your agreement with it though arose only in the context of Dr Naidoo being absent on leave or otherwise absent from the hospital, particularly during '03 and '04?-- Yes.

That is, when Mullen complained to you about supervision, it was only in a limited context, that is arising because of Naidoo's unavailability?-- Yes.

And when the Commissioner in that context said to you that you would have been happy, I think, or content to have supervision, your agreement with that proposition is again in the same context - namely, that because Naidoo was simply unavailable, that is not at Hervey Bay at all, that there was this dearth of supervision?-- Yes.

And similarly where there was a question raised with you by Mr Andrews and, indeed, the Commissioner about concerns raised by you about this lack of supervision, it was asked of you by Mr Andrews whether you raised your concerns with Dr Naidoo; do you recall that?-- Yes.

And I think the Commissioner said, "Well, you wouldn't raise it with him of course." But your concerns arose only in the context of Naidoo being absent in fact from the hospital. So you could not raise it with him unless or until he returned?-- Yes.

Did you raise your concerns with the amount of leave that Dr Naidoo was approved to have with Hanelt?-- No.

In terms of the P435 matter, Mr Devlin here showed you an excerpt from a clinical note on which there is a record placed not by you but perhaps by one of the nursing staff?-- Yes.

That note refers to an inability to obtain a surgical assistant despite requests by you and I think you said to Mr Devlin that that is a true description of the position as you recall it?-- Yes.

A surgical assistant though would not be an accurate description of Naidoo; it would be a description of someone working under you?-- No, it should have been surgical consultation or supervision.

So whoever the notetaker or writer was, they didn't seem to

refer to your superior but, rather, to someone - some different category of person.

COMMISSIONER: But you meant to refer to your superior?-- Yes.

MR PERRY: Well, can I ask you about that. I think you said to Mr Devlin-----

COMMISSIONER: He already said that.

MR PERRY: Excuse me, sir, if I may. You said to Mr Devlin you didn't authorise that person to write the note?-- No.

No-one asked you before they wrote the note whether they got it right?-- No.

No. So when you say that you meant it to refer to that, what you mean to say is that whatever the note says, your concern was not the absence of a surgical assistant but the absence of your superior?-- Yes.

Thank you. I think that fairly - more fairly describes the position. That's as far as I can take it until there is a conference with Naidoo this evening and that will be my final area of cross-examination. What would be most convenient, to do it by telephone?

COMMISSIONER: We will see at the end of the day. We have got Mr Fitzpatrick to ask some questions so we will see how it goes at the end of the day.

MR PERRY: I won't be able to do it by 4.30, you understand that. Naidoo doesn't get into my instructing solicitors until 6 this evening.

COMMISSIONER: No, no, I understand that. Yes, Mr Fitzpatrick.

MR FITZPATRICK: Thank you, Commissioner.

RE-EXAMINATION:

MR FITZPATRICK: Doctor, would you look, please, at annexure DK6 to your statement?-- Yes.

You will see that the tables to which Mr Andrews took you earlier before lunch and which bear, amongst other things, ticks and so on are preceded by what looks to be a letter from Dr Naidoo to somebody?-- Yes.

What relationship does the letter from Dr Naidoo bear, if it bears any relationship at all, to the tables?-- I think, basically, this letter says that - how Dr Naidoo came to the conclusion that I am capable of doing what is ticked.

I see. Do you know to whom the letter was given by Dr Naidoo?-- We - we are told that one of this - the whole letter would be kept in our file and that it would be given to the District Manager and Terry Hanelt.

I see. Would you look, please, at the second paragraph of Dr Naidoo's letter?-- Yes.

Are the facts set out in it true?-- Yes.

So, just so we understand, is it the case that so far as the elective surgery work that you did in Toowoomba, you did that at all times under consultant supervision; is that so?-- Yes.

But that of the emergency cases that you did in Toowoomba, 90 per cent of those you did without consultant supervision?-- Can I - can I add in to that? With that, I think Dr Naidoo meant the consultant was not actually present in the theatre but let me clarify, we're supervised by the consultant all the time. So the consultant was available by phone and you operate in theatre within 20 to 30 minutes if you needed.

I see?-- So-----

All right. Well, is it true as paragraph 2 says that the range of procedures for which you were privileged in Toowoomba is similar to those for which you were privileged at the Fraser Coast Health Service District? In other words, was there a commonality of privileges - of procedures between the two hospital facilities?-- Yes.

Now, so far as the tables which bear ticks that form part of annexure 6 to your statement, is it the case that those documents were created by Dr Naidoo without any input from you at all?-- Absolutely no input.

The privileges were afforded you were entirely Dr Naidoo's decision?-- Yes.

Yes, thank you. The next matter that I had was do you remember being asked - do you remember telling Mr Devlin from the Medical Board that for those cases - for those operations which you did unsupervised, Dr Naidoo made post-operative assessments of your work? Do you remember giving that evidence?-- Yes.

In what circumstances did he do that? Was there a set procedure in which he did it?-- He would do ward rounds once a week almost every time but sometimes twice a week. And then-----

Yes?-- Then he will see post-op cases. If he had missed any case, that will be discussed during the weekly morbidity and mortality meeting.

When was that held?-- Every Tuesday.

When?-- Where?

When, between what times?-- Oh, he will start the ward round at 9 o'clock on a Tuesday. It depends on how many patients we have. Sometimes takes one hour, sometimes take two hours to finish the ward round. After the ward round is finished the conference room was booked for us until 1 o'clock.

And in the conference room, what occurred?-- In the conference room we would present to him all the cases which was admitted for the past one week.

And how did you do that?-- We made - we kept all the charts and the relevant X-rays of all the patients and we - we go one by one.

And, what, he'd make comments?-- Yes.

Including of the sort that you were telling one of my learned friends in the back row, that he wouldn't have done it in that particular way, and so on?-- Yes.

On occasions?-- Yes.

All right. Now, you were asked about how - you were - you said that in non-spinal cases you were told to consult in a case of doubt with the orthopaedic registrar at the Royal Brisbane Hospital, Dr Naidoo told you that I think?-- Yes.

Did you also have occasion when you were working at Hervey Bay to transfer or evacuate orthopaedic cases to the Royal Brisbane Hospital?-- It happened several times but we always got in touch with our consultant first. Most of the time he will come and he will transfer the patient, he'll make arrangements himself, but some obvious cases like a spinal trauma patient with a fracture which was not dealt with in Toowoomba to be sent to the spinal unit. After we have discussed the case, the consultant would authorise us to transfer the patient.

You said that spinal cases weren't dealt with in Toowoomba. Did you mean in Hervey Bay?-- I thought you were asking about Toowoomba.

No, as I understand your evidence, when you were in Hervey Bay you received an instruction from Dr Naidoo that in cases of doubt for non-spinal cases, you were to consult the orthopaedic registrar at the Royal Brisbane?-- Yes.

Is that your evidence?-- Yes.

All right. Did you also by the same process transfer or evacuate patients from the orthopaedic department at Hervey Bay to the Royal Brisbane?-- Yes

You did?-- Yes.

And what were those cases?-- They'd be mostly pelvic traumas

and spinal injuries.

Is that because those cases weren't dealt with at Hervey Bay?-- Yes.

Can I ask you to recall the surgery that you did on the patient P442?-- Yes.

Was the surgery that you did on P442 surgery which you had been privileged by Dr Naidoo to do unsupervised?-- Yes.

Yes, thank you, Commissioner. That's all I have, thank you.

COMMISSIONER: Thank you. Mr Andrews.

RE-EXAMINATION:

MR ANDREWS: Mr Fitzpatrick was just asking you questions and one of the answers you gave to him was that there was a commonality of the privileges that you were given in the Fraser Coast Health Services District with the privileges that you had been given at Toowoomba?-- There was nothing such as privileges in Toowoomba.

So there was nothing such as privileges at Toowoomba?-- Yes.

COMMISSIONER: Because you had to do everything supervised?-- Yes.

MR ANDREWS: Did you-----

MR FITZPATRICK: Commissioner, forgive me, as I understood the evidence, the witness agreed there was a commonality between the procedures undertaken at both hospitals.

COMMISSIONER: I thought you said privileges.

MR FITZPATRICK: I might be mistaken, Commissioner. The transcript will tell us.

COMMISSIONER: Anyway, we've sorted it out now.

MR ANDREWS: The procedures that you performed at Toowoomba, every single one of them was supervised by a consultant?-- Yes.

The procedures that you performed at Hervey Bay were mostly not supervised by a consultant?-- Yes.

I have nothing further, Commissioner.

COMMISSIONER: Do you want to make any submissions about what should happen now about Dr Krishna? Perhaps we should first of all ask - were you intending to go back to Hervey Bay this

afternoon or tonight?-- Yes, sir.

And you came down this morning, did you?-- I came yesterday.

Well, it is a bit of problem. You have heard that we do need you back tomorrow to give evidence. Is it more convenient for you to come back - to go to Hervey Bay and come back here or to stay here?

MR PERRY: Or stay up there, Commissioner, if you are minded to take telephone evidence.

COMMISSIONER: Well, that's one solution. We can hear your evidence by telephone?-- That would be better.

All right, we might do. Unless anyone has any objection to that?

MR ANDREWS: No, Commissioner, and it is only I think Mr Perry who would be inconvenienced by that and he helpfully suggested-----

MR PERRY: I suggested it, so I don't have a problem with it.

COMMISSIONER: All right.

MR ANDREWS: May Dr Krishna be excused on the condition that he remains contactable so that perhaps tomorrow he can be called-----

COMMISSIONER: We will need you to give evidence tomorrow, probably tomorrow morning, Dr Krishna, but you can do that from Hervey Bay Hospital by telephone. Subject to that you're excused from further attendance.

MR PERRY: There may be one document he will require and there maybe one copy up there-----

COMMISSIONER: If not, you can fax it to Hervey Bay.

MR PERRY: It will be just that one page that Mr Devlin took him to-----

COMMISSIONER: Why don't you make sure it gets faxed to Hervey Bay before he proceeds tomorrow.

MR PERRY: Thank you. We can do that.

COMMISSIONER: Thank you, Doctor, you're excused.

WITNESS STOOD DOWN

COMMISSIONER: Mr Douglas.

MR DOUGLAS: Just some administration whilst Mr Applegarth comes, Commissioner.

COMMISSIONER: Is he not here?

MR DOUGLAS: No, but he is coming. I have telephoned him. I don't think we have tendered Ms Brennan's statement. I tender that. It is a statement of Cheryl Evelyn Brennan.

COMMISSIONER: That will be Exhibit 425.

ADMITTED AND MARKED "EXHIBIT 425"

COMMISSIONER: Do I have that?

MR DOUGLAS: The Commission does, yes. Mr Applegarth is here now so I can proceed with Dr Cuffe. I call Glenn Phillip Cuffe.

COMMISSIONER: Yes.

GLENN PHILLIP CUFFE, SWORN AND EXAMINED:

MR DOUGLAS: Is your full name Glenn Phillip Cuffe?-- That's correct.

And you reside at an address known to the Commission of Inquiry?-- That's correct.

Thank you. You are an employee of Queensland Health?-- Yes.

Your current position is Director Analysis and Evaluation Unit Innovation Branch, Innovation and Workplace Reform Directorate?-- That's correct.

These are very lengthy titles, Dr Cuffe?-- I believe they'll all change pending the current restructure.

Thank you. I'm sorry, I was being facetious?-- Yes.

You have been employed with Queensland Health since 29th of June 1975?-- That's correct.

And you've held your current position since July 2004?-- That's correct.

Prior to taking up your current position, your title was Manager Procurement Strategy Unit?-- That's correct.

And you've held that position from 1999?-- That's correct.

In broad terms, Dr Cuffe, what role did you perform when you were undertaking that position as Manager Procurement Strategy Unit within Queensland Health?-- That particular unit comprised five teams which included a pricing strategy team which was primarily concerned with the costs of services as they were delivered by Queensland Health. There was a clinical strategy team which developed clinical policies and other procedures, for example, the Service Capability Framework which has had some mention in the Commission. There is the quality strategy team which was responsible or had the oversight for quality improvement and enhancement program which was a number of projects funded under a Commonwealth government initiative in the Australian Health Care agreement which went from '98 through to 2003 but continues on today, and the surgical access service which is responsible for the government's waiting list reduction strategy.

Dr Cuffe, are you a medical doctor?-- No, I'm not, PhD.

In the discipline of management?-- Psychology.

Psychology, thank you?-- My initial training is a psychologist and I worked until '75 to '91 as a psychologist and moved into the head office in 1991.

Thank you. Dr Cuffe, at the request of this Commission, you have prepared a statement and also an addendum to that statement dealing with some other issues too?-- That's correct.

Your statement is dated the 2nd of October 2005. I can arm you with a copy if you wish?-- Yes, I have a copy here.

You have signed it?-- Yes, it is the 2nd of October 1975 and the subsequent schedule of answers to questions as of today, the 5th October.

The content of your statement, which is dated the 2nd of October 2005, is true and correct to the best of your knowledge and ability?-- That's correct.

I tender that document.

COMMISSIONER: That will be Exhibit 426.

ADMITTED AND MARKED "EXHIBIT 426"

MR DOUGLAS: Can I turn to the supplement? That's a document headed "Answers of Dr Glenn Phillip Cuffe to schedule to questions"?-- Yes.

And you have signed that document?-- Yes, I have signed that document today, the 5th of October.

Thank you. Is the content of that supplement true and correct to the best of your knowledge and ability?-- Yes, it is.

Thank you. I tender that document.

COMMISSIONER: Can that be part of 426?

MR DOUGLAS: It could be. It is probably best to make it-----

COMMISSIONER: Separate.

MR DOUGLAS: -----separate.

COMMISSIONER: All right, 427.

ADMITTED AND MARKED "EXHIBIT 427"

MR DOUGLAS: Could I deal with the supplement first, Dr Cuffe, if that's not inconvenient to you?-- As you wish.

Thank you. You recite in that document that you know Mr Justin Collins?-- Yes, I do.

As you probably realise, but I can remind you, Mr Collins has already given evidence to this Commission?-- Yes, I am aware of that.

Thank you. You know Mr Collins to be, and to have been for some years, the measured quality programme manager?-- That's correct.

Thank you. In the supplement, you speak of, from question 2,

a presentation which was made on the 13th of August 2002 by Mr Collins and during which you were present?-- Yes, I was present at that presentation.

Thank you. Is it correct to say that the persons present at that at least numbered you and Mr Collins and also Minister Edmond and also Director-General Stable?-- Yes, and others.

Thank you. Were the others, not to put too fine a point on it, inferior staff to those which I have just mentioned?-- The - well, one wouldn't have been. Ms Edmond's - Minister Edmond's senior policy advisor.

Who was that?-- Mr Bruce Pickard was there and he is a staffer from the Minister's office. The other people who were there was Ms Helen Little, who was the senior departmental liaison officer, which is a senior officer's position. That's a position that is basically the interface between the Minister's office and the department. Mr Collins, myself. A media and communications officer, Susan Rejall. It is an unusual spelling, Canadian lady, and a Ms Lisa Crawford, who was a media and communications officer attached to the quality improvement enhancement program. She was the media person overseeing the whole program.

Do you have a recollection as to how this presentation came to be?-- The presentation was suggested to Mr Collins and myself by the two sponsors of that program. At that time it was the Dr John Youngman, who was the General Manager of Health Services, and Dr David Filby, who was the deputy Director-General, policy and outcomes at the time who were the two sponsors that oversaw the program, and they - as the program was - you know, was getting to the conclusion of phase 1, he made the suggestion that we should brief both the Director-General and the Minister on where things were up to, and what the outcomes of those investigations were.

Is it correct to say that prior to that presentation on the 13th of August 2002, that the measured quality program, as it was intended by Queensland Health to move forward, had already been promulgated or finalised?-- Could you just clarify that, if you would, please.

I do. I might be able to do it another way. In question 2C in your answer thereto in the supplement-----?-- Yes.

-----you refer to your recollection that there was a draft media plan which raised the issue for the potential of hospitals to be asked about hospital reports?-- Correct. I mean, the individual hospital reports at that stage had been finalised, per se, and there was a draft of the public report, which was intended for public dissemination available. So it hadn't reached entire closure, but it was sufficiently advanced that it was deemed time by the sponsors that the most senior management of the department and the Minister should be appraised of where we were up to, what the findings were.

You say further in your answer to that question 2C this - and

I will read it into the record: "During the presentation, the Minister made the decision that the draft of the public MQP report, and the individual hospital reports were to be submitted to cabinet." Do you see that?-- Yes, yes, that's correct.

Is it correct or incorrect that prior to the Minister making that decision, that to your knowledge no-one from Queensland Health suggested to the Minister, or any of her staff that the MQP report or draft reports be taken to cabinet?-- Not to my recollection. The presentation was given. Minister Edmond seemed quite, you know, excited or enthralled about what the outcome was, and suggested that she would like to take it to cabinet to inform cabinet colleagues about the work that had been done.

Do you recall whether or not at that meeting of 13th of August 2002 anyone present expressed concern about media attention being given to the content of the hospital reports?-- No, I don't recall any particular conversation relating to the hospital reports or, indeed, the public report.

Do you say you can't recall now whether or not any comment was made about that issue of media attention being given to the hospital reports?-- There was - from the best of my recollection there was no comment made in relation to the - you know, media issues, although we had a media officer present who gave a brief presentation on what was intended, and, in fact, one of the outcomes was that Lisa Crawford was to work with the media and communication section and the ministerial media advisors around the media and communication strategy that would follow. Primarily it was about the public report, not the hospital reports.

You say in your answer to the same question that following the presentation you did have a discussion with Mr Collins and also Ms Crawford, the Queensland Health media officer, about the Minister's decision to take the information to cabinet and the implication that that would have insofar as an FOI exemption was concerned?-- That's correct.

That was a matter which, even prior to the meeting, you were alive to as an issue?-- I was aware that if a decision was made to take the item to cabinet, then the implications of potential FOI exemption would be invoked but there was no mention made of it at that meeting. But following the meeting I had a conversation with Mr Collins and Ms Crawford, that after the Minister had determined that she would take the items - the reports to cabinet, that the flow-on effect would be that the FOI exemptions could potentially be invoked, and that if people required access to the hospital reports after that, then they would need to make the appropriate applications to cabinet in order to seek a release of those documents.

In your answer to the next subquestion of question 2, you-----?-- Is that point D, if I could clarify?

Yes. You purport to answer in the affirmative, that is you answer yes to the suggestion that you were of the view - you shared it with Mr Collins - that submitting the measured quality data and reports to cabinet, as I understand it, would effectively kill the measured quality program?-- That's correct.

Was that a matter of some concern to you?-- It was a concern that whilst it was legitimate for the Minister to take the reports to cabinet to inform cabinet, once having done so the potential outcomes of what might happen to those reports was a matter for cabinet and the cabinet's choice, and that could potentially have ranged from simply noting the report, which would mean we could have released it, right through the spectrum that cabinet may have decided, for its own reasons, to put a complete embargo on everything being released, in which case the substantial amount of work that had been done was largely, you know, to bear no fruition in terms of the long-term aims of the program, which was to engage clinicians and managers and others to enhance safety and get organisational change.

You had, as a public servant, served Minister Nuttall as Minister, in your then current position, since 1999?-- Minister Edmond.

Ms Edmond?-- Yes, not Mr Nuttall.

I am sorry, I meant Ms Edmond?-- That's correct, yes.

I will start again. You had served, by 2003, Minister Edmond since 1999?-- That's correct.

What would you say to the suggestion that when you were dealing with Ms Edmond in respect of this issue on 13th August 2002, that she would not have been alive to the consequence that the FOI exemption would have been invoked in respect of these measured quality documents in the event that they were taken to cabinet?-- That would be a question I would surmise for Ms Edmond, but, I mean, the Minister, I would imagine, was - you know, she had been in cabinet for a long time and would have been more than au fait with the ramifications of cabinet processes, much more au fait than I would have been.

And, yet, as you expressed, you were quite well aware of it?-- I was well aware that, as, I guess, a student of history would note when cabinet documents are released after 50 years of embargo, that certain things come to light in the public domain that may surprise us all, from time to time.

Thank you. In your answer to question 4, you refer to a briefing which was prepared by Mr Collins to the Minister in March 2003?-- Yes, correct.

You have obviously read that briefing before giving evidence-----?-- Yes, I have.

-----to this Commission. In fact, as you say in your

statement, you read it prior to it being furnished to the Minister in March 2003?-- Yes.

To utilise the language of the department, it was cleared by you?-- Correct.

Can you explain to the Commissioner, according to your experience, what is involved in a person undertaking the role of clearing a briefing to a Minister?-- Clearing the briefing means that you have read and understood the components of that briefing and are prepared to send it on through the correspondence chain to the relevant party.

COMMISSIONER: And you approve it?-- Sorry, Commissioner?

And you approve it?-- And you approve it, yes. You approve- you are the last point of releasing that particular document.

It really becomes your document from that point on?-- From that point on you accept the accountability.

Yes.

MR DOUGLAS: And suffice it to say as part of that process, if you are clearing it, the document has been drafted by one of your inferior officers?-- Yes, in that case, yeah, Justin was reporting to me and the line manager.

I will put the document on the overhead, if I may. There is only one portion of it that I wish to show you. Do you have a copy of it with you? It is exhibited to part of the statement?-- Yes, I think I have a copy of it.

Could the last page be placed on the visualiser, Commissioner. The visualiser is in front of you-----?-- Yes, yes, I have it there.

-----to assist you. Do you see a heading on the last page "key issues"?-- Yes.

And underneath that there is a paragraph which reads: "Due to the restricted distribution of the measured quality reports (district managers only) difficulty may be encountered in the dissemination of the results within the hospital environment. This may impact on the usefulness of the hospital reports and limit the engagement of clinicians and managers to whom change is to be delivered."?-- That's correct.

That was a view that you had in March 2003?-- That's correct.

Did you think it important that that view, drafted by Mr Collins and adopted by you, be expressed to the Minister?-- I did.

Why did you think it important that it be so expressed?-- It - the restrictions that had been placed on the distribution of the report, in my mind and in Mr Collins' mind was going to make it difficult to get a full dissemination of the

information contained in those reports to all the clinicians, managers in the various hospitals because of the - which is actually contained on the first page - the structure of the access arrangements which we had set up, quite limited, in our understanding or in our view, the capacity to really, if I could say, get this out there to the clinicians and managers in the hospitals so they could, you know, work on the issues that had been highlighted.

COMMISSIONER: So it severely limited the effectiveness of the process?-- It did, Commissioner, in our view, and we raised that issue with the - in the briefing to the Minister.

Okay.

MR DOUGLAS: When you speak of restrictions or restriction - I am not too sure whether it was singular or plural that you mentioned - what was the restriction of which you speak?-- If I could just refer to the first page of that document?

Yes?-- Do you have it there?

Yes?-- Scroll down - I will just locate mine - sorry, the second page, my apologies.

Scroll to the second page, please?-- Yes. Further down, thank you. Right towards the bottom, I think you will find it there. Okay. The last paragraph as well we're talking about. So we had received a subsequent email from Brad Smith after the phase 1 reports had gone to cabinet, about the distribution issues and the subsequent formal advice that had come from cabinet was that cabinet noted it and that we were to work with the Minister to arrange the distribution methods for it, and with the sponsors, what we came up with was a system where there were to be no hard copies provided to the district managers or any district clinician staff, but we found out through the Queensland Health electronic publishing service, they had a capacity to provide a soft copy, if you like, on the network, which they could read only. They were unable to print from that document unless they were - how should I say - almost program designers of the Windows or Word environment. There was a very subtle way around it, which it could be done if you are very adept at it, but by and large I guess most people wouldn't have had that level.

COMMISSIONER: You wouldn't expect too much people in provincial hospitals to be familiar with it?-- No, Commissioner, I agree. So essentially what these people had, they had the document available to them, they had individual pass words so they couldn't read the reports of another hospital, they could read only, they couldn't print, they couldn't email it to any other member of staff in their hospital, and the only effective way they could deal with it was so, if you like, get a huddle around their screen of their relevant clinicians, managers, whoever they wished and read it, you know, in the presence of those persons in their office and-----

MR DOUGLAS: Do you consider that that approach, in your experience, would conduce to attract the serious attention of clinicians within the hospital environment?-- No, it didn't. In fact we copped considerable criticism over that from both clinicians and district managers, and Mr Collins, who actually went out with members of his team to talk people through the results - it was virtually the opening line of those visits, considerable criticism over the way we actually set this up.

Before you go on, those field trips by Mr Collins, can I suggest to you that they were undertaken subsequent to this-----?-- System.

-----ministerial briefing of March 2003?-- That's correct, for the phase 1 reports.

Thank you. And can I suggest, if you can recall, that they were undertaken within a month or so of this ministerial briefing?-- Yes, that's for the phase 2 reports, he went out and - with the team, because the process was the data came in and was analysed, went through the appropriate statistical techniques, the outliers - and they were both good and bad performances - were identified, because some hospitals obviously had done very well in certain areas, and if there was a lesson to be learned that could have been passed on to other hospitals that were not performing as well, then that was an important part of it. For others, where issues had been flagged or highlighted, Mr Collins, in his trips to the various hospitals, it was a strategy to say, "Look, there appears to be an issue here. Dig here. Can you go away and find out what those issues are and then report back on what - if you've found anything. Is it really an artifact of data or something else, or is there a true story here?"

Mr Collins has told the Commissioner that subsequent to his field trips in May of 2003 - so about two months after this ministerial briefing - he attended another presentation to the Minister and the Director-General of the phase 2 hospital reports. Do you recall that?-- I think there was another briefing in May, yes.

And you were in attendance at that?-- Yes, I think I was. I'd just have to check my diary, but I can - yes.

Do you recall at that presentation whether Mr Collins repeated the constraints about which you've told the Commissioner in his presentation to the Minister and the Director-General? If you don't recall, please say so?-- No, look, I don't have an accurate recall of that, I'm sorry.

It would have been Mr Collins who was making the presentation?-- Yes, it was, yes.

You would be there as his superior?-- Yes.

You spoke earlier of a constraint or restriction imposed by Cabinet. Could I ask you to look at this document on the visualiser, please? That is an e-mail from Brad Smith to,

among other persons, you, of 12 November 2002?-- That's correct.

Is that the instruction from Mr Smith expressed on behalf of the Department of the Premier and Cabinet to which you were making reference earlier in your evidence?-- Yes.

Thank you. That's Exhibit 340, Commissioner. That can be returned to me, please. You know that the phase 2 hospital reports were sent to Cabinet in June 2003?-- Yes, I believe that to be so.

And they would have gone to Cabinet under the hand of the then Minister, Minister Edmund?-- That's correct.

Thank you. Can I take you back now, please, to your first statement, or your statement that you've made dated 5th October? I should say 2nd October?-- Yes, I have that.

A number of questions about that. The submission of the 30th of July 2003 was something which was, in effect, conveyed by you as a clearing officer to Dr Buckland, the General Manager Health Services?-- That's correct.

You say in paragraph 10 of your statement, on the second page, last paragraph, that a then extant direction relating to submissions and briefings did not apply to all submissions and briefs originating from the SAS?-- That was my understanding, yes.

You say in the last sentence, and I quote, "I did not understand the direction to apply to submissions such as the 30th July 2003 submission."?-- That's correct.

Why do you say that?-- I say that because my understanding was that the direction was that if we were to provide information in relation to activity targets, in which targets were set in terms of the number of separations the districts, or facilities - hospitals within districts would have to deliver each year, we would have to negotiate those with the zonal management units. If it was in relation to funding for surgical procedures then we would require the district management units to - sorry, the zonal management units to sign off on that that they agreed that that was the appropriate funding level, or in relation to the business rules which described about how the whole pools of money could be dealt with and so on, then we were - we again required signatures of the zonal managers to say that they agreed with this - the rules about how the program would be run. But if there was other correspondence in which, you know, for example, a routine HRM issue or an issue which the team wished to bring to Dr Buckland's attention because of a significant concern that they may have had, and there may have not been agreement with the zonal management units, then that was a legitimate thing for us to do.

What is an HRM issue?-- Human resource management. If it was a particular staffing issue or something of that nature - and

that wasn't common, but should there have been an issue such as that - for example, if we had a project and we required the employment of an additional officer to undertake a particular project, then I didn't have the delegation to sign off on that and I would have to put that to the various people occupying the position of General Manager Health Services, which included Dr Buckland's predecessor, Dr Youngman, and his successor, Dr Scott, so they could sign off on that. So the notion that everything had to go to the zones, that's not my understanding.

It was suggested by a witness in these proceedings before the Commission that a submission such as that of the 30th of July 2003 was a document properly characterised as a draft submission which retained that character pending approval or disapproval by Dr Buckland in his capacity as General Manager Health Services. What do you say to that proposition?-- If it was a draft submission it would have been a draft submission to me and by-----

COMMISSIONER: It sounds like something from Alice in Wonderland?-- Yes. I mean, once I had been comfortable with the submission and sent it off, it had a status from our unit in its own right, and would be presented to the General Manager Health Services. If he thought that we were headed down the wrong track it would be quite easy for him to simply write on the submission, "approved" or "not approved", you know, "I agree" or "I disagree" or, "Go away and do some more work on it" et cetera. So no, I don't accept the draft issue then.

Can I put this to you then: when it's a submission made by Mr Roberts - who was his line manager?-- Mr Walker, Gary Walker.

Mr Walker, at that point it's a submission by Mr Roberts. When it's signed off by Mr Walker, it then becomes a submission by him?-- Yes, that's correct.

When it's signed off by you, it becomes a submission by you?-- Mmm, yes, in that sense of the word.

And when it's signed off by the Director-General, it becomes his document?-- Yes, he agrees, or accepts the accountability if there's a decision contained therein.

Yes?-- Yes.

So never at any stage is it a draft submission by anyone?-- No, no, I don't believe so. A draft submission would be something - for example, if it came up and it contained some error or the English expression or sentence construction was tortured prose that would challenge anyone, then, you know, you would make changes to it, send it back to be done. But finally, once those particular changes had been achieved and it was sent off under signature, as that one was, it was - Gary Walker's initials, I believe, were on that, my signature was on it, it headed off to the General Manager Health

Services and that was our submission to the General Manager Health Services.

I understand that, but even in the case you've just instanced, then it becomes a submission?-- Yes.

It may be a submission which is inaccurate and has to be amended?-- Still as it is.

Yes, and it then becomes an amended submission?-- I mean, it may well be the case, Commissioner, that had you had something totally wrong, the officer who you were sending to would send it back to you and say, "Look, you've got this wrong" or, "It's not approved. Do it again." The thing that - you know, it may have contained errors, contemporaneous facts that were incorrect. It becomes part of the public record and then you put the new submission up which may address those issues and get it right, and that sits on the same file. So-----

Of course it does?-- Yes.

All right. Thank you.

MR DOUGLAS: Commissioner, I've got a number of other matters to deal with, and some of them I shouldn't rush, to be fair, in particular to Dr Buckland. It's probably best, if it's not inconvenient to the witness, if he comes back tomorrow.

COMMISSIONER: I think it would be better if we finish this witness before we get Dr Krishna back, so maybe we can arrange for Dr Krishna - you can give some estimate, perhaps overnight, as to how long you think you'll be with this witness and the next one.

MR DOUGLAS: I suspect I'll be another 15 to 20 minutes.

COMMISSIONER: And then there will be some cross-examination.

MR DOUGLAS: About an hour perhaps.

COMMISSIONER: We could probably say to Dr Krishna that we'd get him on the phone at 11.30.

MR DOUGLAS: Yes.

COMMISSIONER: Does that sound right?

MR DOUGLAS: Between 11 and 11.30.

COMMISSIONER: 11.15 then.

MR DOUGLAS: All right. Thank you. Let's stick with your original estimate, 11.30.

COMMISSIONER: All right.

MR DOUGLAS: Thank you.

COMMISSIONER: Adjourn.

THE COMMISSION ADJOURNED AT 4.33 P.M. TILL 10 A.M. THE FOLLOWING DAY