Submissions

Mr Michael ALLSOPP

Crown Law
Queensland Government

Department of
Justice and Attorney-General

Your ref:
Our ref: CS5/HEA027/5744/DZP
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Mr David Groth
Secretary
Queensland Public Hospitals Commission of Inquiry
Level 9
Brisbane Magistrates Courts Building
363 George Street
BRISBANE Q 4000

Dear Mr Groth

Submissions in response to Notices of Potential Adverse Findings

I **enclose** submissions on behalf of Drs Fitzgerald, Nydam, Krishna and Huxley, Ms Erwin-Jones, Mr Allsopp and Ms Miller in response to Notices of Potential Adverse Findings (or, as the case may be, Notices of Potential Adverse Findings and Recommendations) given to each of those individuals.

The submissions were drawn by Mr Farr of counsel and settled by Mr Boddice SC.

Yours faithfully

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QUEENSLAND PUBLIC HOSPITALS *COMMISSION OF INQUIRY*

SUBMISSION ON BEHALF OF MICHAEL ALLSOPP

Credentialling and privileging process

1. The evidence from Mr Allsopp relevant to this issue appears at:

   Transcript - T7076/48 - 7079/41; 7084/16-23; 7090/1-30.

2. The evidence from Dr Hanelt relevant to this issue appears at:

   (a) Exhibit 444 - Statement of Dr Hanelt - Paragraphs 66 and 67;

   (b) Transcript - T6716/58 - 6716/6; 6721/30 - 6726/20; 6766/2 - 6770/40; 6781/17 - 6785/50.

3. In the mid-1990's a Credentialling Clinical Privileging Committee existed in the Fraser Coast Health Service District under previous Queensland Health Policy. In approximately 2001, that policy changed and was then changed again in 2002 [1].

4. In July, 2002 Queensland Health introduced a standard policy of credentialling and privileging [2]. Pursuant to that policy, the responsibility for credentialling and privileging lay with the District Manager.

5. Mr Allsopp delegated his responsibility for this issue to the Director of Medical Services, Dr Hanelt [3].

6. Mr Allsopp was aware that the 2002 policy did not have a time frame attached to it. He was also aware that Dr Hanelt had a large workload. He did not consider that Dr Hanelt was in any way or at any time derelict in his duty in failing to set up a credentialling and privileging committee [4].

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[1] T6721/38 - 6722/5
[2] Exhibit 279
[3] T7077/14
[4] T7077/28

7. Dr Hanelt gave evidence that due to the non-cooperation of the Colleges and the fact that the Fraser Coast District had only two specialists in the orthopaedic discipline, negotiations between Dr Hanelt and the Director of Medical Services at Bundaberg occurred with a view to amalgamating both districts for credentialling and privileging purposes [5].

8. These negotiations were designed to establish a system whereby Maryborough, Hervey Bay and Bundaberg Hospitals were incorporated into the one process. This was to minimise the risk of **"mate credentialling mate"** [6], thereby increasing the degree of impartiality in the process. That process has subsequently developed into a policy in 2003 [7].

9. Formal credentialling of Drs Sharma, Krishna and others did not occur due to the difficulties outlined above. Dr Hanelt stated in evidence that with the benefit of hindsight, it should have been done **"contrary to the policy"** [8].

10. Mr Allsopp had understood that temporary privileges had been issued by Dr Hanelt in accordance with Section 7.3 of Exhibit 279 [9]. Although the evidence shows that he was mistaken in that regard, it was not an unreasonable assumption to make in the circumstances.

11. Dr Hanelt gave evidence that he requested and relied upon his Director of Orthopaedics, Dr Naidoo, to provide an assessment of the clinical competencies of Drs Krishna and Sharma. He said that Dr Naidoo was asked to **"assess these guys and determine what they were competent to perform and to provide that documentation which could**

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[5] T6723/39 - 6724/55; T6766/2 - 46; T6781/16 - 6782/42
[6] T4139/36; 6724/1
[7] Exhibit 276
[8] T6724/20
[9] T7078/8-53

then go to the privileging committee as part of their credentials" [10].

12. Dr Hanelt had understood that the scope of practice of Drs Krishna and Sharma would then be restricted to that which Dr Naidoo considered them competent to perform [11].

13. Therefore, whilst a formal credentialling and privileging process was not established, there was demonstrable good reason for that omission. Furthermore, attempts were being made to establish an independent and impartial process that accorded with departmental policy. Those attempts even extended to delegating this specific task to the Deputy Director of Medical Services for the Fraser Coast District in January 2004 [12].

14. Having regard to all of the above, there is no sufficient evidentiary basis to find that Mr Allsopp acted carelessly, incompetently or inefficiently or that he is guilty of misconduct (i.e. disgraceful or improper conduct in an official capacity: s.87(2)(a) of the *Public Service Act 1996*) in relation to this issue.

Inappropriate supervision and Dr Naidoo's absences

15. The evidence of Mr Allsopp relevant to these issues appears at:
    (a) Exhibit 456 - Statement - Paragraphs 4.25 and 4.26; 4.38
    (b) Transcript T7076/3-10; 7082/54 - 7083/42; 7084/35-45; 7085/35-43; 7086/1-10.

16. The evidence of Dr Hanelt relevant to these issues appears at:
    (a) Exhibit 444 - Statement - Paragraphs 32; 37(iii); 61; 62(i), (ii), (iii), (iv), (v), 72(i), (ii); 74(i), (ii), (iii), (iv), (v);
    (b) Transcript T6715/48; 6716/10-55; 6717/10 - 6718/13; 6718/50 - 6720/60; 6728/32-60; 6732/40; 6735/55; 6736/43; 6738/19; 6742/48; 6753/35; 6760/5-40; 6766/58 - 6767/16.

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[10] T6766/48 - 6767/7
[11] T6767/12

[12] T6781/53

17. The evidence of Dr Naidoo relevant to these issues appears at:

(a) Exhibit 431 - Statement - Paragraphs 2.29 - 2.32; 4.1 - 4.24;

(b) Transcript T6590/25 - 6591/2; 6591/43 - 6594/2; 6597/19; 6622/3-20; 6623/36 - 6624/22; 6630/22-45; 6635/30-45; 6680/3-50; 6705/45.

18. The evidence of Dr Krishna relevant to these issues appears at:

(a) Exhibit 424 - Statement - Paragraphs 22, 23, 25, 35, 50;

(b) Transcript T6475/42-60; 6477/2-45; 6479/15-50; 6481/32-52; 6482/9-42; 6528/5-42.

19. The evidence of Dr Sharma relevant to these issues appears at:

(a) Exhibit 357 - Statement - Paragraphs 26, 27, 31, 32, 33, 34;

(b) Transcript T5673/42 - 5675/10; 5683/5-40; 5694/15-60; 5696/45 - 5697/15.

20. Mr Allsopp gave evidence that his understanding was that a disagreement existed between Dr Naidoo and Dr Mullen as to what would constitute an appropriate level of supervision for Drs Krishna and Sharma [13].

21. Mr Allsopp further believed that Drs Krishna and Sharma had been provided with a scope of practice and that there were some procedures that they could perform independently, some procedures that they could perform with supervision and some procedures that they could not do at all [14]. His further understanding was that when Dr Naidoo was absent, the procedures which fell in the latter two categories would be transferred to another hospital[15] or alternatively deferred [16].

22. All witnesses acknowledged that due to manpower shortages, supervision of the Senior

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[13] T7076/2
[14] T7082/52
[15] T7083/1
[16] T7086/10

Medical Officers at the Hervey Bay Hospital could not be as intensive as a larger regional hospital (i.e. Toowoomba) or at tertiary hospitals in Brisbane. That is not to say however, that the level of supervision provided was necessarily inappropriate.

23. The evidence reveals that the principal complaint with the level of supervision arose as a result of Dr Naidoo's many absences. In that regard, Mr Allsopp had reasonably understood that the system in place (as referred to in paragraph 21 above) adequately dealt with such issues.

24. Mr Allsopp is not a clinician and must necessarily rely on the advice of the clinicians below him. It would be unreasonable to expect Mr Allsopp to disregard the opinions of his Director of Orthopaedics and his Director of Medical Services in relation to this clinical issue.

25. Furthermore, his request for a review to be conducted by members of the Australian Orthopaedic Association in relation to, inter alia, this issue, is demonstrative of a careful and competent hospital administrator. The fact that the report took as long as it did for presentation was through no fault of any administrator at the Hervey Bay Hospital.

26. The evidence therefore does not support a finding that Mr Allsopp acted carelessly, incompetently or inefficiently or that he is guilty of misconduct.

General findings regarding the Hervey Bay Hospital

27. No evidence is before the Inquiry which suggests that Mr Allsopp had any knowledge of the issues raised in paragraph 2(a); 2(b); 2(c)(ii), (iii), (iv); 2(d) and 2(e) of the Notice.

28. With respect to paragraph 2(c)(i) and 2(f) of the Notice, the submissions as outlined in paragraphs 15 - 27 above are applicable.