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Submissions

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28 October 2005

Mr David Groth
Secretary
Queensland Public Hospitals Commission of Inquiry
PO Box 13147
George Street
BRISBANE QLD 4003

Dear Mr Groth,

DR D W KEATING

We ***enclose*** Dr Keating's submissions.

A copy of the submissions has been provided by email to all parties given leave to appear before the inquiry.

Yours faithfully,

David Watt

Enc(1)

WRITTEN SUBMISSIONS ON BEHALF OF DR DARREN KEATING IN RESPONSE TO LETTER DATED 21 OCTOBER 2005 FROM QUEENSLAND PUBLIC HOSPITALS COMMISSION OF INQUIRY

The following submissions are made in response to the items identified in the letter from Mr Cowley-Grimmond dated 21 October 2005 "Notice of Potential Adverse Findings and Recommendations".

Paragraphs 1(a) and 1(b)

1. It is accepted that Dr Keating did not ensure at any time during the concurrence of his and Dr Patel's employment at the Bundaberg Hospital that Dr Patel was assessed by a Clinical Privileges and Credentials Committee at the hospital. It is also accepted that in June 2003, Peter Leck granted Dr Patel interim clinical privileges based on advice from Dr Keating. It is accepted that those interim privileges remained current throughout Dr Patel's tenure at the hospital, subject to the limitation imposed in early January 2005 that Dr Patel was not to perform any elective surgery likely to require ICU care post operatively (which included oesophagectomies, which were themselves excluded in late December 2004).

2. With respect, it is wrong to say that the granting of interim privileges was made in circumstances where no inquiry into Dr Patel's credentials or past clinical practice had been made by Dr Keating, or, to his knowledge, by any other person.

WRITTEN SUBMISSIONS

Filed on behalf of Dr Darren Keating in response to letter dated 21 October 2005 from Queensland Public Hospitals Commission of Inquiry

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3. Dr Keating gave evidence as to what matters he took into account in recommending interim privileges for Dr Patel.[1] Whilst that did not involve any verification of the information provided, it did amount to an inquiry into his credentials and past clinical practice. Furthermore, Dr Keating assumed that Dr Patel's credentials and past clinical practice had been investigated as part of his appointment process.[2] That assumption was an entirely reasonable one. It would have been extraordinary for Dr Keating to consider other than that Dr Patel would have been employed by Queensland Health as the Director of Surgery at Bundaberg Hospital (and these were the facts which Dr Keating was presented with, even if they amount to a gloss on the true position) without such investigations having been undertaken.

4. Whilst the matters conceded above might be concluded by the Commissioner in his report, with respect, they ought not be cast in a fashion that is critical of Dr Keating.

5. By the time of Dr Keating's arrival at the Bundaberg Hospital the credentialing and privileges process had long been in abeyance.[3] A decision had been taken prior to Dr Keating's arrival to amalgamate the process by joining together with the Fraser Coast District.[4] Dr Keating set about finalising the policy to reflect that decision, and from an early time thereafter Dr Keating set about seeing to arrangements for the necessary members on the committees, in particular, the nominees from the colleges. Fraser Coast offered to take up that responsibility,[5] and unfortunately there appears to have been some delay in their pursuit of it.[6] The delay was

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1 7044.30.
2 7044.55.
3 4136.30.
4 4139.25 - 4140.40.
5 Ex. 448 para. 354 - 6.
6 DWK79 of Ex. 448.

probably inconsequential, because, as was discovered when contact was sought to be made (and as appears from Dr Hanelt's evidence to have been known by him even before Dr Keating's involvement)[7] the colleges were not prepared to make the nominations required.[8] That continued to be the source of frustration in obtaining the necessary membership for the committee.

6. It is submitted that the terms of the policy[9] mandatorily required a nomination from the College of Surgeons for the credentialing and privileging of surgeons. Not only is that a fair interpretation of the policy document, but it seems to have been accepted by virtually every witness from within Queensland Health[10] that this was the case, so that, even if another construction is to be favoured by lawyers, Dr Keating cannot be criticised for a layman's understanding consistent with the prevailing view of his peers and superiors.

7. The policy relevantly provided –

"*5. Membership of credentials and clinical privileges committee*

5.1 General principles

- *There should be a core membership of practitioners constant for all applications considered. Additional members should be invited as required, depending on the size and complexity of the facility, with representation from relevant professional and other bodies as dictated by the principle of peer representation . ...*
- *The district manager will decide on the categories of variable membership of the committee. ...*
- *Members of the credentials and clinical privileges committee should be chosen so as to ensure that recommendations are based on adequate knowledge of the requirements of the position and are free from bias in relation to any applicant. ...*

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7 6723.40.
8 DWK79 of Ex. 448
9 Ex. 279.
10 Hanelt 6724.20; Buckland 5583.20; Mattiussi 5853.50.

5.3 Variable membership

The actual composition of the committee will vary depending on the discipline of the applicant(s) under consideration and the type of facility involved, but should include, in addition to the core membership, a representative from the following where appropriate:

- *Relevant clinical/professional college. ...*

The respective colleges and professional associations will nominate a representative to the committee...."

8. The existence of this barrier to achieving credentialing and privileging was common knowledge amongst medical superintendents,[11] and was known by the Director-General as early as late 2003 early 2004.[12] Despite that knowledge, nothing useful or practical seems to have been done by Head Office to overcome the impasse,[13] and even by June of 2005 it seems the impasse continued to exist.[14]

9. It is noteworthy that 6 months after Dr Keating ceased in active duty at the Bundaberg Hospital, credentialing and privileging by a Credentials and Privileges Committee appears still not to have been undertaken for the specialities that had not already been completed.[15] Similarly, despite all the controversy concerning Dr Patel, the Fraser Coast appears not to have achieved credentialing and privileging by a committee for its surgeons.[16] With all the imperatives there have been in that time, it is difficult to criticise Dr Keating in that context.

10. The emails annexed to Dr Keating's statement,[17] aside from reflecting the problems with respect to obtaining a college nominee, shows some of the serious imperfections in the existing

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11 Ex. 448 para. 358; 5585.10.
12 5584.45.
13 5585.20 - .35.
14 JGS6 Ex. 317.
15 Ex. 497, Statement of Monica Seth, P1 of 'MS1'.
16 6782.10 - .30.
17 DWK79.

policy. A far better system, one might suggest, would be to have a central credentialing and privileging committee within Queensland Health that regularly and routinely looks at the credentials and privileges for each of the doctors throughout its hospitals in Queensland, assessing them in consultation with the Director of Medical Services, and perhaps the relevant clinical head within each hospital. The current system is clearly very cumbersome in terms of organisation, and explains some of the difficulties that were experienced.

11. Dr Keating had been charged with some responsibility towards getting the credentialing and privileging system up and running in Bundaberg. It is wrong to suggest that he had been delegated the total responsibility by Mr Leck.[18] Dr Keating reported his progress and, importantly, his lack of progress, to Mr Leck on a regular basis.[19] If what he was doing was to be unacceptable to Queensland Health, and in turn to the public, then he should have been directed to do something else. In the absence of that, the expectation clearly for him was to continue with the course that he was following. It appears that that expectation was also held by the Director-General[20] (though obviously without knowledge of the specific circumstances being considered here).

12. In the meantime, Dr Keating recommended the granting of interim privileges, which is what the policy expects to be done. His decision to recommend interim privileges for Dr Patel of the kind that were recommended was based on no less information than what a very experienced Director of Medical Services would have considered reasonable to base such a decision upon.[21]

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[18] 7291.15.
[19] 7293.20 - 7292.20.
[20] 5585.35.
[21] 6784.55 - 6785.30.

13. Finally, it needs to be acknowledged, it is submitted, that it is likely that the subjecting of Dr Patel to a formal credentials and privileges process would have made little if any difference to outcomes. The practice of such committees it seems was, in terms of credentials, to accept the assessment of the Medical Board of Queensland as to the credentials, and to simply grant privileges in a general way, and in the instance of Dr Patel, in a way which would likely have simply been "general surgery".[22] Whilst Dr Thiele gave evidence that had he been involved, his particular knowledge of the American training system would have meant he would have understood some limitations in terms of Dr Patel's training,[23] that would not be a proper basis for any adverse finding against Dr Keating, because the involvement of Dr Thiele on such a committee, with his peculiar knowledge, would have been merely a fortuitous event, and not a likely outcome of a process carried out otherwise in full discharge of the terms of the Queensland Health Policy.

Paragraph 1(c)(i) and (iii)

14. The patient described in 1(c)(i) would seem to be Annette Webb, and there is some duplication (and confusion then) in 1(c)(iii). Dr Patel was not the subject of this complaint.[24] Dr Patel's involvement in her case was to write an opinion reviewing the treatment the patient had received and about which she complained. Dr Carter gave evidence confirming that Ms Webb was not operated on by Dr Patel. If the Commission has any doubt about the matter, with respect, an examination of the patient's file would confirm it.

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22 5854.30 - 5855.20.
23 1844.20.
24 3996.40; Ex. 448, para. 317.

Paragraph 1(c)(ii) and (v) - 2003 Oesophagectomies

15. Between the evidence of Dr Joiner, Ms Hoffman and Dr Keating there is some conflict as to the timing of, and the number of, conversations about this particular subject matter. Dr Keating accepts that it matters little as to whether there were one, two or three such conversations, or whether they occurred in early June or mid June, for instance. Dr Keating accepts that there were issues that were brought to his attention about oesophagectomies.

16. A number of observations however need to be made. The first is that the issue was not about "Dr Patel performing oesophagectomies at the hospital" but rather about oesophagectomies being performed at the hospital. There were issues raised by Ms Hoffman about Dr Patel personally, in particular the manner in which he treated nurses and the way in which he spoke to them, and also the way in which he had described the patient Phillips as being "stable". Dr Keating explained his perspective concerning that last comment in oral evidence. As to the interpersonal issues, Dr Keating pursued a discussion with Dr Patel, and put in place arrangements which he hoped might go someway towards resolving the interpersonal issues that were developing between Dr Patel and ICU staff. It was reported back to him that those processes had been satisfactorily undertaken.[25]

17. It is said in the notice that "Mr Graves subsequently died". Whilst Mr Graves had a "stormy" post-operative recovery period, he ultimately was discharged home.[26] There is no evidence to show that Dr Keating would have known that Mr Graves died as a result of oesophagectomy, and indeed Exhibit 89 from the hospital records gives a different impression altogether.

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[25] Ex. 448 para. 48.
[26] Ex. 89.

Whilst Dr Woodruff attributed this patient's death to Dr Patel, with respect, the causal link was tenuous, and entirely speculative.[27]

18. The other aspect of the issues raised by Ms Hoffman and Dr Joiner was one and the same raised by Dr Cook. That was, the capacity of Bundaberg Hospital, because of the limitations on its ICU, in managing the necessary post-operative care for patients who have undergone procedures as complex as an oesophagectomy.

19. It needs to be emphasised that whilst Dr Cook did harbour some concerns about the skill of the surgeon, those concerns were not expressed to Dr Keating.[28]

20. With these issues raised, Dr Keating undertook the course of consulting the Director of Surgery and the Director of Anaesthetics and ICU. Each of them were of the view that it was in order for that procedure to be performed at Bundaberg.[29] Dr Carter corroborated this in evidence.[30]

21. Dr Cook regarded the course of speaking to the Director of Surgery, and the Director of Anaesthetics and ICU, about the issue he had raised as being an appropriate course.[31]

22. Viewed objectively, Dr Keating was a newcomer to Queensland Health and its hospitals. On his arrival at the hospital he found already appointed Dr Patel as the Director of Surgery. One must consider the position from Dr Keating's perspective. Dr Patel was a man who put himself out as being an experienced general surgeon with many years of practice in America.

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27 4635.50 - 4637.10.
28 Ex. 448 para. 53; 3139.30.
29 Ex. 448 para. 55.
30 4063.40 - 4064.05.
31 3139.20.

On all accounts he had the physical appearance consistent with that, in that he looked the age, and spoke that way. He carried himself confidently. He had been deemed suitable by Dr Keating's predecessors to be appointed to the position of Director of Surgery. It is entirely reasonable, it is submitted, for Dr Keating, in those circumstances, to have placed trust in the judgment of Dr Patel with respect to such clinical issues.

23. More importantly, the issue being raised was predominantly an issue of the capacity of the ICU. Dr Carter was the Director of the ICU. He was a British trained, Australian qualified, experienced Anaesthetist and Director of ICU.[32] He had been established in the position for quite some time. Again, it was perfectly reasonable for Dr Keating to accept the advice of Dr Carter that it was in order for these patients to be managed.

24. Regrettably, and surprisingly, Queensland Health did not have in place at this time a clinical framework which defined in clear terms the range of surgery that might be performed at different hospitals. It subsequently attempted to introduce such a system,[33] though it was not due for final implementation until the middle of this year. Even so, it has been subjected to criticism for being too vague.[34]

25. The context of oesophagectomies being performed at the Bundaberg Hospital needs to be understood. There is a risk that it might be thought that it was only Dr Patel who might have pursued such an operation there.

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[32] Ex. 265.
[33] Ex. 102 P87.
[34] Ex. 102 P89.

26. Oesophagectomies and Whipple's procedures had been performed at the Bundaberg Hospital in past years, including by Dr Anderson,[35] and including during the time of Dr Joiner.[36] In March of 2004, a surgeon by the name of Dr Feint performed such a procedure at the hospital.[37] That patient apparently had a successful outcome.[38] It can also be seen from Exhibit 89 that that patient would have been an inpatient at the Bundaberg Hospital at the time of Dr Patel's commencement, and up until very shortly prior to Dr Keating's commencement. There had been another attempted by Dr Feint earlier.[39]

27. Dr Carter gave evidence that in his experience, at the Darwin Hospital, which he said was a similar sized hospital to Bundaberg, operations such as oesophagectomies were performed.[40]

28. In all of these circumstances, with respect, Dr Keating should not be criticised for his decision to allow such procedures to continue at the hospital, even though he later came to accept they should not.

Paragraph 1(c) (iv)

29. It is accepted that a complaint was made by Mr Dalgleish. It appears from the contents of the complaint itself that Mr Dalgleish[41] had experienced unsuccessful treatment of this lesion on a number of occasions from his general practitioner prior to attending Bundaberg Hospital. It appears from Dr Keating's review of the patient records that the lateral margin of the lesion only was removed, leaving some affected area behind. Anyone with any experience of skin

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35 2762.40 - 2763.15.
36 5035.45.
37 Ex. 89.
38 5035.55.
39 3812.10 - .25.
40 Ex. 265 para. 39.
41 Ex. 225 GF 19.

cancer removals knows that that is something which happens not infrequently, and is one of the reasons for pathology always being undertaken. The complaint was otherwise, apparently, able to be satisfactorily resolved.

Paragraph 1(c) (vi)

30. Ms Aylmer's evidence in Exhibit 59, in particular at paragraphs 11, 12 and 13, is tempered substantially by the contents of contemporaneous emails sent by her, in order being Exhibit 198 and Exhibit 60. Exhibit 198 was received only by Ms Kennedy, because it was retracted by Ms Aylmer, apparently when the information available to her was able to be updated as she did in Exhibit 60 i.e. it would seem that when she had further information she retracted the earlier information to give the most updated information possible.[42]

31. In any event, the emails show the proper context of what was occurring.[43] They demonstrate that Ms Aylmer was not pressured by Dr Patel to accept more favourable interpretations, and that Ms Aylmer felt free and comfortable in undertaking the analysis she was undertaking. Indeed, it seems that in the majority of cases she arrived at an independent opinion with respect to the reasons for problems with wound dehiscence. They demonstrate that her view, after her investigation, was that in the majority cases there was no question of clinical competence on the part of any practitioner, and that even in those where there were technique problems, the explanations for them were "very reasonable".

32. Exhibit 60 in itself shows the nature of the communication which Dr Keating received and in itself, it is submitted, demonstrates why that issue as raised would not have given cause for

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42 See the passage at 2727.30 - 2730.50.
43 Ibid.

any specific concern about Dr Patel for Dr Keating. Exhibit 198 more clearly demonstrates the environment and attitudes of people prevailing at the time, giving a startlingly different picture than that represented in Exhibit 59. Indeed, if Exhibit 198 does properly represent the attitude prevailing at the time, the matter would appear to be nothing other than a clinical issue properly explained and understood, in a mature environment involving co-operation and reasonable conduct on the part of all concerned, and with a satisfactory resolution.

Paragraph 1(c) (vii)

33. Dr Keating's evidence concerning Mr Fleming is contained in his statement at paragraphs 320 to 329. The notification of complaint form, including the handwritten notes made on it by Dr Keating (as initialled by him),[44] demonstrates that the complaint that was brought to Dr Keating's attention was primarily about concerns in the delay in getting in to see a surgeon for the underlying disease. There is incidentally a mention of wound infection, but there is nothing exceptional about the occurrence of a wound infection in a patient having the sort of medical treatment that Mr Fleming had.

Paragraph 1(c) (viii)

34. There are two aspects to the issue concerning Ms Pollock and Ms Aylmer's complaints. Firstly, insufficient attention to proper hygiene is a common problem amongst doctors and, on occasion, nurses.[45] There is an ideal standard, and there is the standard that is commonly observed. It would seem that medical practitioners and nurses alike, being people, sometimes take shortcuts with respect to the issue of hygiene. That does not make it acceptable, but in a

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[44] They are to be distinguished from the notes made by others.
[45] 1062.20.

practical sense, one has to have proper regard to those human weaknesses. Ms Aylmer's evidence was clear that Dr Keating was genuinely supportive of her attempts to improve hygiene standards around the hospital, including with respect to the concerns that she raised regarding Dr Patel.[46]

35. As to the specific incident complained of arising in the Renal Unit, Dr Keating took the matter up with Dr Patel, who vehemently denied the claims. In Dr Keating's understanding Dr Patel refused himself to attend in the Renal Unit any longer, and other doctors from the Surgical Department took over that responsibility. Again, looking at the matter fairly, it would be difficult for Dr Keating to know that Dr Patel was in fact guilty of some serious wrongdoing in this particular instance. His actions demonstrated that he was extremely offended by the allegations. Dr Keating, quite properly,[47] asked if there was any data to support a suggestion there were poor hygiene practices being engaged in, but none was provided.

Paragraph 1(c) (ix)

36. Dr Keating's evidence on this topic appears at paragraphs 180 to 182 of his statement. The impression Dr Keating had from Dr Smalberger's attendance upon him was that the primary concern was one of interpersonal relationships, and in particular, Dr Patel not treating him with an appropriate degree of respect. Dr Keating's impression was that there had been a difference of professional opinion, but he was not left with an impression that there was some serious and fundamental incompetence on the part of Dr Patel in the interaction. Dr Smalberger did not try to leave him with that impression.[48]

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46 1061.40.
47 986.30 to 987.05.
48 1988.50.

Paragraph 1(c) (x)

37. The Catheter Audit document was not provided to Dr Keating between February 2004 and May of 2004. The first time any such document was provided to Dr Keating was on 15 June 2004,[49] and that was the document in the form of Exhibit 69. Dr Keating has noted on it in handwriting his receipt of it and the date. It did not demonstrate a 100 percent complication rate for the placement of Tenckhoff Catheters.

38. There is no evidence from anybody that the document was provided to Dr Keating between February and May. Dr Miach was on leave for that period, and thought that it was likely that he gave the document to Dr Keating after his return from leave.[50] That would be consistent with Dr Keating receiving it as he had noted on 15 June, though of course it was not then in the form of Exhibit 18 as claimed by Dr Miach.

39. No document was provided to Mr Martin when issues of complications with catheter placements was raised with him.[51] Mr Martin specifically asked for data, having had that request from Dr Keating, and none was provided to him.

40. There is evidence which has since been received by the Commission which shows that Exhibit 18 had not been created by the end of March 2004.[52] On the evidence then of those responsible for its creation,[53] which was to the effect that it had been created in the form of Exhibit 18 by or before February, that evidence must be rejected. Ms Druce, the proper author of the document, conceded that the reason for Dr Keating receiving a copy of Exhibit 69 in

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49 Ex. 448 paras. 210 & 211.
50 294.05.
51 Ex. 139 para. 25.
52 Ex. 399.
53 Ex. 70 para. 28.

June of 2004 could very well be because that was the version of the document that was available then, and that Exhibit 18 did not come into existence until October of 2004, when that document was given to Dr Keating.[54]

41. As to the significance of the distinction, it says several things. The fact that no finalised document was prepared until October 2004, despite a specific request for data when initial concerns were raised, suggests that there was no desire on the part of those raising the issue to pursue the matter further.

42. When the issue was raised again with Dr Keating, being in June of 2004, it was in the context where Dr Miach was seeking approval to set up the Baxter programme.[55] The matter was not raised with Dr Keating in a way to suggest that there was any issue with respect to the competence of Dr Patel per se. Dr Miach raised with Dr Keating that he had had troubles in having this procedure done over a longer period of time than the time of Dr Patel's stay.

43. The document then provided only nominated Dr Patel as the surgeon in one of the cases mentioned on it, despite there being provision for that to be done. That there was presumably some uncertainty as to whether Dr Patel was the surgeon on the part of the author creating the document in itself raises questions about the context in which and the purpose for which it was created.

44. Exhibit 69 does not have the notation at the bottom of the sheet "x6 Peritoneal Dialysis Catheter Placed 2003".

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[54] 1133.30.
[55] Ex. 448 PP41 - 44.

45. Furthermore, if the abovementioned notation as it appears on Exhibit 18 is meant to designate that there were only 6 such placements performed in 2003 (and it is submitted that the words are ambiguous enough that that conclusion would not automatically be reached) it would be wrong. As DWK55 to Dr Keating's statement (p.132) shows, in the period from 1 July 2003 to 30 June 2004 there were 8 patients who had a total of 11 placements. There is evidence of only 1 patient having a placement at the Bundaberg Hospital after Dr Patel ceased performing this procedure (being the one referred to in the evidence of Ms Pollock where the procedure was performed by a Nephrologist and a Gynaecologist),[56] but no evidence of any others, and indeed the reason for the introduction of the Baxter programme was because there was not anybody else to perform the surgery.[57] Ms Druce was adamant Dr Patel had been the only surgeon performing these procedures in the period covered by the audit.[58] Any performed in the year ending 30 June 2004, apart from that one, were presumably then performed before the end of December 2003.

46. Dr Miach told Dr Keating that he had difficulty with other surgeons performing this procedure as well.[59] Dr Jayasekera was a surgeon who had experienced complications in performing this procedure at Bundaberg.[60] He would have put it that it was only a small proportion of a very large number of procedures that he performed there, though the statistics contained in DWK55 would suggest that there were not that many procedures being performed on an annual basis at Bundaberg. This submission is made with not the slightest criticism of Dr Jayasekera at all. Dr Miach's own evidence was that it was a procedure that a lot of general surgeons would

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56 1160.40.
57 Ex. 21 para. 83.
58 1131.10.
59 Ex. 448 para. 204.
60 5977.40.

decline to do.[61] It was seemingly better the province of a Vascular surgeon. Hence the desire to have the procedure by Dr Thiele at the Private Hospital.

47. Mr Leck's initial assertion that he had seen the Catheter Audit document naming Dr Patel as the surgeon in all cases prior to June of 2004 was abandoned by him in the sense that he said that he now could not say whether it was Exhibit 18 or Exhibit 69 that he saw. He maintained though that he did see the document around the time of the commencement of the Baxter programme.[62] He could not though place what he meant by the commencement of the Baxter programme.[63] It can be seen that in mid June 2004 the Baxter programme was nothing more than a proposal. The documents in DWK56 (p.133 and following) to the statement of Dr Keating show that Mr Leck cleared a briefing to the Zonal Manager about the Baxter programme on the 20 September 2004. Dr Keating's recollection was that Mr Leck approached him with the Catheter Audit document after the time of Ms Hoffman's complaint.[64] It is submitted that that is likely, and that Mr Leck is in error in suggesting that the commencement of the Baxter programme was sometime by or before June of 2004. It is only by reference to that event that he is able to date when it was that he saw the document.

48. The document having been received by Dr Keating, in the context of events in October of 2004, was included in the documents briefed to Dr Fitzgerald.[65]

49. As to what the document should have conveyed, whilst it raised an issue, it did not on any reasonable view of it portray such a dramatic effect as has been suggested by some. Dr Miach

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61 292.10.
62 7299.20 - .30.
63 7299.40 - .50.
64 Ex. 448 para. 221.
65 Ex. 281.

himself said that there were others (presumably doctors) who had told him that 6 patients with this range of complications for this procedure was not enough to demonstrate incompetence.[66] Whilst Dr Miach claimed that it was enough for him, that was contradicted by his own actions.[67] Despite his attempt to explain away the inconsistency,[68] the clear impression left from this very experienced Nephrologist is that he was a doctor who was very careful in considering the skills as he could appraise them of a surgeon to whom he would refer patients;[69] that he was involved in the management and care of each of these individual patients, and was the doctor who referred them to Patel in each case for the procedure, and that he, by virtue of what must have been the course of the review of each of these patients by himself at the varying times, by the time he referred the sixth patient to Dr Patel, knew of the complications in the first four (chronologically) of the patients, and possibly even the fifth. He was still prepared to refer the sixth patient to Dr Patel. This was despite his earlier acceptance that there was no magic in the number being 6 instead of 5 or even 4.

50. As non-medical people it is open for us to assume a significance to certain events but to those with experience in the practice of medicine no such significance would necessarily attach. This is consistent with Dr Fitzgerald's clear knowledge of not only the document, but Dr Miach's specific concerns as related to him in an interview in Bundaberg, with Dr Fitzgerald not attaching any particular significance to the outcome.

51. In all of those circumstances it is very much unfair to attach criticism to Dr Keating for not seeing some greater significance in the Catheter Audit document than Dr Fitzgerald did.

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66 1641.10.
67 1633.30 - 1638.01.
68 1640.50.
69 267.50; 271.10.

Paragraph 1(c) (xi)

52. Dr Keating did not become aware of the complaint by Ms Hoffman made to Mr Leck in March of 2004.[70] His account in that respect is corroborated by Mr Leck's email to Dr Scott in April of 2005[71] which made it clear that Mr Leck was not prepared to take Ms Hoffman's complaints any further unless she was prepared to make them formally. Contrary to his evidence before the Commission that he copied documents and put them into folders for bring-up with each of Dr Keating and Ms Mulligan, he told Dr Scott that he had simply destroyed the document. Mr Leck also claims that he spoke to Mrs Mulligan about the issue, though Mrs Mulligan apparently disputes that.

Paragraph 1(c) (xii)

53. It is accepted that in March of 2004 Dr Keating was made aware of a complaint by Mr Geoffrey Smith that Dr Patel had performed a minor excision from Mr Smith's shoulder in circumstances where Mr Smith was not subjectively sufficiently anesthetised. There is and was nothing to suggest that the level of anaesthesia employed by Dr Patel would not have ordinarily been sufficient. The issue was one where the patient fitted into a small group of people for whom ordinary local anaesthetic was not adequate, so as that he needed another approach. The problem with Dr Patel in this instance was not one of competence with respect to determining a level of anaesthetic, but rather of communication with his patient. Its relevance to the overall context will be addressed subsequently.

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70 7005.20.
71 Ex. 317 JGS12.

Paragraph 1(c) (xiii)

54. It is accepted that in April of 2004 an issue was raised at the ASPIC meeting about wound dehiscence, and that Dr Keating was present at that meeting. It is important however to appreciate the chronology and outcomes of those investigations.

55. Firstly, the outcome of the investigation carried out was such that there was an agreed definition of wound dehiscence. Secondly, the investigation revealed that there had in fact been a decrease in the incidence of wound dehiscence from the previous year.[72] Finally, it was resolved with some determination that any future incidences of wound dehiscence would be documented in an adverse event form so as that it could be properly noted and investigated.[73] Thereafter there was only one adverse event form for a wound dehiscence.[74] Objectively, to a person in Dr Keating's position, this could appear to be nothing more than a concern raised anecdotally, which when investigated appeared not to be as serious as was feared, and indeed to represent an improvement in clinical performance, and where the incidence of it going forward thereafter appeared to be even less.

Paragraph 1(c) (xiv)

56. As to Dr Keating becoming aware of complaints from Ms Hoffman from April 2004 concerning the long term ventilation in the ICU, it is accepted that this was a topic of discussion at a number of the ASPIC meetings subsequent to April 2004. The evidence demonstrates that in 2004 there were difficulties in transferring patients to Brisbane for a variety of reasons, including increased demand for ICU beds because of closure of other

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72 Ex. 64.
73 The course of this appears from the minutes in Ex. 65; see also Ex. 90; Ex. 81; Ex. 448 paras. 69 - 73.
74 Ex. 448 para. 73.

services in other hospitals, and restrictions on night time transfers.[75] There were a variety of other reasons unconnected with Patel.[76]

57. The evidence also established that the increase in demand was not solely from surgical patients, but was evenly matched by increased demand from medical patients.[77]

58. Further, as Dr Keating's analysis after Dr Patel left the hospital demonstrated, Dr Patel's patients who required ventilation in ICU for more than 24 hours averaged one a month in his time at Bundaberg, and only one-third of those was elective surgery patients i.e. one every 3 months.[78]

Paragraph 1(c)(xv)

59. Dr Keating dealt with an application for travel subsidy by Ms Lester in April of 2004. Ms Lester had, on her complaint, seen Dr Patel who expressed the view that there was no packing left in her wound. She had seen a general practitioner who thought to the contrary. The general practitioner clearly thought it appropriate to refer the patient to another surgeon, and seemingly chose to do so by referring her to Rockhampton.[79]

60. There could on no view of it be said to have been sufficient information on that basis for Dr Keating to suppose any wrongdoing on the part of Dr Patel. There was a difference of opinion, based on different information, between a general practitioner on the one part and Dr Patel on the other part. Dr Keating's focus, quite appropriately, was upon seeing the

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75 Ex. 448 para. 124.
76 Ex. 265 para. 29 et seq; 4035.10 - 4036.20; 4072.45 - 4075.10.
77 Ex. 448 para. 129; Ex. 94.
78 Ex. 448 para. 131 and DWK38A.
79 Ex. 448 paras. 334 - 5; DWK77.

patient obtain a further opinion, and when alerted to her not wanting to see Dr Patel, noted, quite pertinently, that there was another surgeon at Bundaberg whom she could see. Indeed, given that that general surgeon had a particular interest in plastic surgery, and given the nature of the complaint, that would seem to be entirely appropriate. It could only have been if after seeing Dr Gaffield that there was some confirmation that Dr Patel had missed something that he ought not to have missed that Dr Keating could have had any reason to think adversely of Dr Patel out of the circumstances of that patient's complaint.

Paragraph 1(c) (xvi)

61. As to the patient Mr Bramich, much time in the inquiry has been spent examining the circumstances of his death. What is abundantly clear is that there is a complex and broad range of factual disputes amongst the witnesses as to what factors were responsible for his death. Even the Pathologist, Dr Ashby,[80] and Dr Woodruff[81] had different opinions in that respect. On all of the evidence Dr Keating took the concerns regarding the management of this patient seriously.[82] He pursued his investigation of the matter over several months, but unfortunately was hampered in part by delay on the part of clinicians with respect to providing information that he had requested. His plan was to gather all of the relevant information, convene a multi-disciplinary team, and review the case. He was doing all of that in the knowledge that it was a Coroner's case as well.

62. As Dr Keating described in paragraph 160 of his statement, the issues which emerged to him concerning Dr Patel as a result of his investigation, incomplete as it was, concerned the

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80 2709.35 (he should have been transferred long before Dr Patel's involvement).
81 4280.20 (a team failure re the drain - 4280.50).
82 Ex. 448 paras. 132 - 160.

multiple unsuccessful attempts at pericardiocentesis, his apparent failure to clearly establish himself as the clinician in charge after Dr Gaffield departed, and his communication problems with relatives and nursing staff. Dr Keating of course did not have the advantage of conducting an investigation in the way the Commission does. Even with the advantages the Commission enjoys, determining who said what at what time, and to what effect, is not an easy task in a case as complicated as this. On the tentative conclusions that Dr Keating had reached at that point in time, whilst one would think that there were issues to be further pursued with Dr Patel, it would be difficult to identify out of them a reason for taking any action against him. On different views of what occurred others had greater degrees of responsibility for the outcome, and there is no suggestion (and nor ought there be) that any particular disciplinary action or constraint of clinical privileges should have been exercised for those persons.

Paragraph 1(c) (xvii)

63. With respect to Marilyn Daisy, and the letter from Dr Jenkins dated 2 November 2004,[83] Dr Jenkins of course new very little of the facts surrounding the care of that patient. That was never more abundantly clear than when Dr Jenkins effectively disowned the criticism that he raised in that letter when he gave oral evidence before the Commission.[84] As it appeared to Dr Keating, there had been some confusion with respect to the management of the patient because she was a surgical patient being cared for in the Renal Ward.[85] However, it appears that the problems with the patient were largely driven by her own choice to discharge herself against medical advice.[86]

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83 Ex. 17.
84 3696.30.
85 Ex. 448 paras. 194 - 9.
86 Ex. 448 para 200; Exs. 100 & 101.

Paragraph 1(c) (xviii)

64. It is accepted of course that Dr Carter and Dr Berens did speak to Dr Keating about the patient Mr Kemps. Dr Keating was already aware of this patient, and had spoken to Dr Patel about him. He had received an explanation for the death of the patient that did not of itself suggest any error on the part of Dr Patel.[87] Dr Carter and Dr Berens had some different concerns, and Dr Keating supported them, including by providing them with advice, to make a complaint to the Coroner if their concern about the clinical issues was sufficient to warrant it. The decision to not refer the case to the Coroner was one which Drs Carter and Berens independently made.[88] Dr Keating was in a different position to those doctors because he had received an explanation for the death from Dr Patel, and he had not had the clinical involvement that the medical staff from Anaesthetics and ICU had.

Paragraph 1(c) (xix)

65. Whilst it is true that Dr Keating received a complaint by Dr Rashford in January 2005 concerning the care of P26, the complaint was not about the surgical treatment the patient had received, but rather was a complaint about a delay in transferring him to Brisbane.[89] Dr Keating investigated that matter within the time constraints he perceived he had, realised that there was substance to the complaint that the patient had not been transferred early enough, and directed the relevant staff to ensure that in future patients such as this one were transferred as soon as they were stable, which was the appropriate direction.[90] The criticism concerning delay in transferring the patient was in fact one which more substantially applied to

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87 Ex. 448 para. 289.
88 4072.40; 1955.40 - 1956.10.
89 Ex. 210 SJR 2.
90 Ex. 210 SJR 2.

practitioners other than Dr Patel, given that he went on leave on the morning of the 26 December[91] but the patient was not transferred until 1 January.

Dr Keating's consideration of the matters set out in paragraph 1(c)

66. Dr Keating responded to every one of the matters referred to above, or at least was aware of them being responded to (for example, the complaints regarding wound dehiscence raised at the ASPIC meeting Dr Keating knew were being dealt with by the committee, and saw the outcome of that. Similarly with respect to the issues raised by Ms Aylmer in July of 2003 with respect to wound dehiscence - Dr Keating was aware that those matters had been able to be resolved by Ms Aylmer pursuing her enquiries under the guidance of Dr Keating). The only matters referred to in paragraph 1(c) that were not attended to by or to the knowledge of Dr Keating were the ones which either did not happen or were not brought to his attention. The details of those matters have been set out above.

67. It is suggested then that Dr Keating failed to consider the cumulative significance of those matters. That is not so. The last of those matters occurred in January 2005, and very shortly after becoming aware of it Dr Keating did consider the cumulative effect of the significant matters that were in his mind, which resulted in him generating the two documents being DWK66 and DWK67.

68. The review of the cumulative effect of what was in Dr Keating's recollection of significant events during Dr Patel's time nevertheless resulted in a conclusion in his mind that Dr Patel was still a capable enough surgeon to warrant him continuing to perform surgery at the

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[91] Ex. 155.

Bundaberg Hospital, though limitations needed to be placed upon the scope of surgery, in the form of there being no elective surgery likely to require post-operative ICU care. In the longer term he was unsuited to being Director of Surgery.

69. If Dr Keating had considered the cumulative effect of the other episodes, assuming that he had remembered them all when sitting at his desk in late November 2004, it is submitted that there is every reason to suppose that he would reasonably have not taken any different course.

70. Looking at the matters cumulatively, one starts with the issue about the oesophagectomies. Whilst concerns have been expressed by Ms Hoffman, Dr Joiner and Dr Cook, the critical question in their concerns was the issue of ICU capacity. Dr Keating had spoken to Dr Carter, who appears to be readily accepted as a competent and experienced Director of Anaesthetics and ICU, (and would have appeared that way to Dr Keating), that the ICU could manage the care of those patients. It is unreasonable, with respect, to think that Dr Keating should not have accepted and acted upon that advice.

71. As to wound dehiscence, it appeared to be a problem that was diminishing in the time of service of Dr Patel, on the information reported to Dr Keating. As to hygiene, those matters were not unique to Dr Patel, it was something that needed to be worked upon with many practitioners. Dr Patel had had a difference of opinion with Dr Smalberger, but there could be nothing usual about disagreements in the workplace. Dr Patel had had some problems with the placement of Tenckhoff Catheters, but so had his predecessors. The information provided to Dr Keating was limited in its detail and, it seems, unreliable. Dr Patel had explained his problem as being due to a difference in these catheters to others he had worked with, and importantly was no longer performing those procedures. Dr Patel had displayed some

personal weaknesses with regard to his dealings with Ms Hoffman, Mr Smith, Dr Smalberger and the family of Mr Bramich. The personal weaknesses could be seen as demonstrating insensitivity, arrogance and rudeness. Such qualities are hardly novel for professional persons including doctors. Everyone one of us will have heard multiple complaints about doctors and other professionals (and indeed other people) behaving that way frequently in the past. It is not by any means an indicator of professional incompetence, undesirable as those attributes may be. One would have expected the complaint of Ms Lester to be unlikely to come to mind given that it was an issue predominately about whether her second opinion be obtained in Rockhampton or Bundaberg.

72. In the case of Ms Daisy, it would not have appeared, objectively, to Dr Keating that Dr Patel had any personal responsibility for the stitches remaining insitu.

73. In addition to that, as of late October 2004, Dr Keating would have had in his mind that there was to be an external review by someone more experienced and capable than he to assess Dr Patel's strengths and weaknesses. Therefore, where it says on p.4 of your letter at the conclusion of paragraph 1(c) that Dr Keating "failed to take any action, or any appropriate action, to investigate those complaints ..." there is no substance to that suggestion.

74. Again, to the suggestion that Dr Keating should have considered that these matters amounted to an indictment of Dr Patel's surgical skills and judgment, it is difficult to see how that can be, when the Chief Health Officer of Queensland Health conducted his own investigation, having access to documents[92] and to the staff involved in making the respective complaints,[93]

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92 Ex. 281.
93 GF11 of Ex. 225.

and reached a conclusion that it was in order for Dr Patel to continue to practice surgery at the Bundaberg Hospital subject only to the same limitations that Dr Keating had already recommended be imposed. The suggestion has been made through cross-examination at the Commission that that may have been as a result of information being held back from Dr Fitzgerald. The suggestion is refuted. Even if it be right that Dr Keating did not tell Dr Fitzgerald that there have been some minor patient complaints that had been resolved, it cannot for one moment be suggested that out of the matters listed in paragraph 1(c) it was the lack of knowledge of the complaint of Mr Dalgleish, Mr Smith, Mr Fleming and Ms Lester that caused Dr Fitzgerald to not make a more substantial recommendation. Dr Fitzgerald was aware of the issue about oesophagectomies, including Mr Kemps, he was aware of the complaints concerning hygiene habits, infection rates, dehiscence rates, overuse of the ICU, the Catheter Audit, the case of Mr Bramich and quite probably the case of Ms Daisy (given he had spoken to Dr Miach). He had access to all of the relevant staff members[94]. He had the summaries of the meetings with Drs. Strahan, Risson and Berens, the complaint of Ms Hoffman, and the written complaints of the other nurses.[95] He had assessed all records he had identified as relevant before coming to Bundaberg, extensively.[96]

75. The one thing Dr Fitzgerald did not have was the same thing that Dr Keating did not have. It is something that this Commission has had. It is the one thing that can be said in all probability, from a historical point of view, to have been catalyst for this Commission even occurring. That thing is the past history from the United States of Dr Patel. It is with that knowledge that all of these other matters are viewed differently. The effect of that knowledge

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94 Ibid.
95 Ex. 281.
96 See the correspondence in GF11 of Ex. 225.

is then enhanced by the evidence of the likes of Dr de Lacy, Dr O'Loughlin and others who have reviewed patients and found complications that were not even being complained of by patients until the substantial media exposure of the issues concerning Dr Patel's qualifications to practice.

76. That extra information adds a substantial hindsight bias to an analysis of the significance of these other various events. That is not to say that the complaints of Ms Hoffman were not in the end justified. She has been vindicated in terms of the concerns that she raised. On her ventilating those concerns a plan was put in place for those matters to be investigated. It was slower than it ought to be, and in the end, inadequate in its outcome, but those things were not the fault of Dr Keating.

Paragraph 1(d)

77. The offer to extend Dr Patel's employment contract on 25 November 2003 is said to have been made notwithstanding Dr Keating's knowledge of the matters referred to in paragraphs 1(a) to (c). Of course, the preponderance of the matters raised therein occurred after the offer to extend the employment contract. The major one which had occurred beforehand was the concerns expressed about oesophagectomies, but as has already been submitted, Dr Keating had a sound basis and advice from Dr Carter in proceeding to permit the performance of that procedure at Bundaberg. The issue raised by Mr Fleming with Dr Keating was one about access to surgical services, in that he was concerned about the delay in getting to see a specialist. The wound dehiscence issue raised by Ms Aylmer had, on all appearances, been satisfactorily resolved.

78. The reference to paragraphs 1(a) and (b) seems to be a reference to offering to extend Dr Patel's employment contract when Dr Keating knew that Dr Patel had not been assessed by a Credentials and Privileges Committee at the Bundaberg Base Hospital. If Dr Patel's contract was not to be extended, any new surgeon whose services were to be obtained (including to perform emergency surgery) would also not be credentialed and privileged, as the same barrier would exist for that surgeon as it did for Dr Patel. In any event, as of November 2003, on the evidence provided by Dr Keating, and in particular from the chronology of exhibits in DWK79, Dr Keating would have no reason to think that credentialing and privileging was something that would be delayed inordinately.

Paragraph 1(e)

79. It is accepted that on 1 December 2003 Dr Keating did, in writing to the Medical Board of Queensland, assess Dr Patel's performance as "excellent", and otherwise endorsed his performance as being, in general terms, of a high standard.

80. It is suggested that that might be inappropriate, given Dr Keating's knowledge of the matters referred to in paragraph 1(c) above. The submissions above as to the chronology in response to paragraph 1(d) of your letter apply equally here.

81. It is then said that Dr Keating "failed to advise the Medical Board that Dr Patel was employed as the Director of Surgery". That is not true. (See paragraph 49 of the statement of Mr Demy-Geroe,[97] and Exhibit MDG33 thereto which includes several documents in which Dr Patel is described as the Director of Surgery).

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[97] Ex. 24.

Paragraph 1(f)

82. Dr Keating did offer on 24 December 2004 to extend Dr Patel's contract from 1 April 2005 to 31 March 2009. Dr Keating continued to hold the view at that time that Dr Patel was a surgeon with sufficient skills to conduct surgery at the Bundaberg Base Hospital into the future. He was aware of the ongoing investigation, but was of the opinion (quite rightly) that if that investigation produced a result that meant that Dr Patel's surgical practices should be curtailed or ceased altogether that the entering into of a contract of that kind would not effect that position.[98] Dr Keating was under pressure at the time because if Dr Patel's contract was to be renewed, for whatever term that was to be, it needed to be dealt with urgently, because of the delay that would be involved in having the necessary paperwork attended to by Queensland Health, the Department of Immigration and the Medical Board.[99] The perception at that time was that a 4 year visa could be obtained if there was a 4 year contract.[100] Again, the willingness to enter into such a contract was a product of the difficulties in paperwork with overseas trained doctors if the process had to be repeated for shorter periods of time, as had been the case in the past, and the continued belief that Dr Patel had adequate skills to continue to perform surgery at Bundaberg.

83. It is accepted that Queensland Health policy required a merit review before such a contract could be entered into, but Dr Keating was unaware of that policy. It is suggested in the letter that Dr Keating ought to have been aware of that policy as Director of Medical Services, but there is no evidence that establishes how Dr Keating should have been aware of that policy.

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98 Ex. 448 para. 260.
99 Ibid.
100 7043.

All we know is that Dr Mattiussi was aware of it, but of course he is a very experienced and long standing administrator as a Director of Medical Services and District Manager. The Woodruff report notes,[101] Dr Keating was an interstate transferee, and he was given no induction or orientation to Queensland Health's policies. He was left to find these things out for himself. There should in those circumstances be no criticism of him for failing to be aware of that distinction.

Paragraph 1(g) (i)

84. This part of your letter says that notwithstanding Dr Keating's knowledge of the complaints referred to in 1(a) to (c) (which presumably is meant to read just paragraph 1(c)) Dr Keating failed to suspend Dr Patel's interim clinical privileges, restrict his scope of practice, or otherwise take steps to limit his clinical duties with the exception that in January 2005 did he direct him to refrain from undertaking oesophagectomies and other procedure requiring extensive post-operative ICU care.

85. The primary difficulty with that proposition is that some of the matters referred to did not happen until immediately before Dr Keating did take the steps described therein to limit Dr Patel's clinical duties. In particular, two of the most significant clinical matters raised were the episodes concerning Mr Kemps and P26.

86. It is difficult to see how Dr Keating should be expected to have taken some such step based on his knowledge if the events that he is said to know of had not yet occurred.

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[101] Ex. 102.

87. Again, for the reasons that have already been described above, if one takes the episodes concerning Mr Kemps and P26 out of the list of complaints from paragraph 1(c), and properly analyses and considers the earlier mentioned matters, it is submitted that it was not unreasonable for Dr Keating, to the extent he was able to bring all of those matters to mind, to not suspend Dr Patel's interim clinical privileges or restrict his scope of practice etc. prior to the time that he did place a restriction.

Paragraph 1(g) (ii)

88. It is said that notwithstanding Dr Keating's knowledge of the complaints referred to in paragraph 1(c) he failed to ensure that Dr Patel was assessed by a Credentials and Clinical Privileges Committee.

89. As p.288 of the exhibits to Dr Keating's statement shows, on 7 January 2005 he pursued yet again the question about a representative for the Clinical Privileges Committee for assessing surgeons. The problem with getting nominees persisted, as it has done long since Dr Keating's cessation of work at Bundaberg. In any event, Dr Keating knew at that time that there was to be a review of Dr Patel's practice by Dr Fitzgerald, which he was entitled to assume would be far more extensive than any review by a Clinical Privileges Committee.

Paragraphs 1(h), (i), (j) and (k)

90. Dr Keating did read Ms Hoffman's complaint of 22 October 2004 on or about 25 October 2004.

91. Dr Keating did not convey to Dr Patel the details of the allegations made in Ms Hoffman's letter because he was directed by Mr Leck not to do so.[102] Dr Keating in fact desired to do so, but Mr Leck was insistent on his view.

92. Dr Keating did not repeatedly advise Mr Leck that his view was that Ms Hoffman's complaint was unjustified and purely personality driven. Dr Keating did believe that there were significant personality issues involved in the complaint, but was also of the view that there were clinical issues that needed to be investigated.[103] Mr Leck himself said in cross-examination that Dr Keating did not say to him at any stage with respect to the October complaint that it was purely personality driven.[104]

93. As to the suggestion that Dr Keating's decisions and conduct in relation to Dr Patel after he became aware of Ms Hoffman's complaint in October 2004 were unduly influenced by an unrelenting and irrational desire to maintain surgical services at the hospital, and also meet elective surgery targets in order to maintain a flow of funds to the hospital under the Elective Surgery Programme, it is submitted that there is no evidence to justify that proposition. Clearly the Bundaberg Hospital needed to have a general surgeon available to perform surgery. There was an expectation from Queensland Health and the public no doubt that Bundaberg Hospital would provide surgical services, both elective and emergency. It may be taken that Dr Keating desired, in a professional sense, for surgical services at the hospital to be maintained – that was one of the tasks that he, together with others was charged with. It is also right no doubt to say that Dr Keating, and others, were concerned to endeavour to meet

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[102] 7302.20 - .40.
[103] 7005.45.
[104] 7286.20 - .30.

elective surgery targets because of the system of funding for hospitals. But it is the proposition that Dr Keating would allow Dr Patel to continue to operate in circumstances where he expected that to expose patients to unnecessary risks with respect to the performance of that surgery that is without foundation.

94. There is no direct evidence for the conclusion. An inference would have to be drawn. For the inference to be drawn there would have to be, logically as well as legally, a basis for supposing that it is more probable than not that that was the reason for Dr Keating taking the decisions he took.

95. Another prospect emerges. That prospect is that Dr Keating was a new Director of Medical Services, not having served in such a position before. The position was a difficult one – reflected in the fact that the position had not been able to be filled for several years. He was new to Queensland Health, and was unfamiliar with its policies, procedures and practices.[105] He was given no induction, training or orientation whatsoever,[106] and was simply expected to start duties. He came into a hospital which was dysfunctional in many respects. It was dysfunctional in that the clinical governance system had collapsed entirely.[107] There had not been credentialing and privileging for quite some time. There was no service capability framework in place. The system with respect to committees for reviewing and managing patients' safety and outcomes, and the delivery of services, was in disarray. Audit systems are poorly utilised, particularly in the case of surgery.

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[105] Ex. 102 P 44.
[106] Ex. 448, para. 5.
[107] 7297.55 to 7298.10.

96. From a personnel point of view, there has been a long history of difficulties.[108] As early as 1998 the then Director of Medical Services, Dr Thiele, who had at an earlier time been very successful in the position, and popular, with a strong following amongst the local medical practitioners, had given up the position because of the culture that was emerging within Queensland Health. Dr Wakefield came in subsequently, and himself had some considerable conflict with medical practitioners who were unhappy with aspects of his management. (No criticism is made of Dr Wakefield, or for that matter Dr Thiele.) In Dr Wakefield's time there are still some good aspects of the management of the delivery of medical services at the hospital, but after his departure those aspects fall away. There are still scars from his time in amongst the local medical profession.

97. In Dr Keating, an outsider, not a specialist, and a novice Director of Medical Services was appointed.

98. Prior to his arrival the Director of Surgery position had been vacant for some time. There was considerable discontent around that vacancy.[109] Bundaberg had had several years of difficulties in attracting adequate numbers of surgeons to the hospital, and its stocks had reached their lowest ebb prior to the arrival of Dr Patel. Expectations with respect to the delivery of services were not being met – this extends beyond mere financial rewards, and includes simply whether or not the local population were getting the services that they expected.

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[108] See the evidence of Drs. Anderson, Nankivell, Baker, Thielle and Wakefield.
[109] i.e. concerning Dr Jayasekera.

99. Likely to be contributing to the atmosphere in the hospital, it cannot be overlooked that there had been great discontent surrounding the treatment (whether justified or not is irrelevant) of Dr Anderson and Dr Stumer. In particular, there seems to have been considerable discontent about an action of suspension taken against Dr Stumer over clinical issues.[110]

100. Some of these cultural issues may (and only may) explain some of the attitudes that Dr Miach expressed, (in a way which suggested he held them at the material times) about Dr Keating.[111] There was nothing rational about those criticisms – they were prejudiced and vile criticisms. That attitude reflects in a practical sense in the failure of Dr Miach to ever inform Dr Keating of his decision to not allow Dr Patel to operate upon his patients.[112] It is reflected in Dr Miach's decision to ask that that sort of information not be minuted in committee meetings even though it had been discussed.[113] It is reflected in Dr Miach's decision to ignore a direction, soundly based and justified on evidence provided, to Dr Miach with respect to the peritonitis protocol.[114]

101. When Dr Keating commenced at the Bundaberg Base Hospital he found employed as the Director of Surgery at the hospital Dr Patel. Dr Patel claimed to be very experienced as a surgeon, with many years of training and practice in the United States. He carries himself with a very strong air of confidence (understandably interpreted as being arrogant, brash). Dr Patel was hard working and applied himself to the needs of the hospital. He appeared not only efficient in terms of his own work, but effective in terms of organising the hospital surgery

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[110] Anderson 2743 - 4.
[111] 1595 - 1597.10.
[112] Ex. 448 para. 119.
[113] Ex. 70 para. 21.
[114] Ex. 97; 1597.15 - 1598.

programme. He was ostensibly popular with the medical students under him,[115] and indeed was able to impress the University of Queensland panel (Dr Keating of course was one of the three, but the other two panel members supported Dr Patel) in obtaining the appointment to the teaching position.[116] He had an impressive resume[117] – this was acknowledged by the Medical Board not only in registering him, but in oral evidence.[118] Even when Dr Miach snuck into Dr Keating's office to check Dr Patel's resume, he found it to be "in order", which could fairly in the circumstances be meant to say "bullet proof".[119]

102. Thereafter, there was conflict between Dr Patel and other members of staff, but in the context where Dr Patel is this loud, brash and arrogant American surgeon. A lot of people entrenched in Australian culture would find that difficult to deal with, and in that context, personality conflict would be expected.

103. There had been some complaints about Dr Patel's treatment of patients, but complaints about surgeons are, like complaints about surgeons' personalities, not novel and peculiar to Dr Patel.

104. It is important to look at the data there is regarding complaints and incidents that was collected at Bundaberg over this time period.[120] It can be seen when regard is had to that that the complaints there were about Dr Patel were hardly excessive in number. Another thing to take into account is the number of patients that Dr Patel consulted and operated on. Based on the numbers suggested in the Woodruff report (1457 inpatients),[121] the percentage of patient

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115 See e.g. Ex. 142 paras 4 & 5.
116 Ex. 448 para. 29.
117 MDG19 to Ex. 24.
118 435.1.
119 342.10.
120 Exs. 166 & 167.
121 Ex. 102 P47.

complaints brought to Dr Keating's attention by patients of Dr Patel was, expressed as a very small percentage. Regard has to be had to the positive feedback Dr Keating received concerning Dr Patel, and to the lack of complaint. Criticisms suggest that relying on a lack of complaint is reactive management, but Dr Keating was entitled to have regard to the fact that other surgeons and anaesthetists and the like were not voicing complaints to him about Dr Patel's general competence. All of this goes to creating a picture, for the person in the shoes of Dr Keating, as to the true nature of the problem. He was also in a position which was too demanding for one person to handle.[122] That overload was without the extra burden of a collapsed clinical governance system.[123]

105. In that context, one possibility that might be contemplated is whether Dr Keating's decisions and conduct in relation to Dr Patel were unduly influenced by an unrelenting and irrational desire to maintain surgical services, or simply involved him making wrong decisions about the issues that presented before him. That in other words, on information presented to him, he made certain choices, but either it can be seen now, with the benefit of other information and retrospect, that those decisions were wrong, or even that another person in Dr Keating's position may have made a different decision. Either way, the simpler and only available answer available on the evidence is that Dr Keating was simply wrong, and wrong because of an error of judgment, rather than because of some hypothetical and speculative motive.

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[122] Dr Thiele 1822.10; 6785.35 - .50.
[123] Leck 7298.40 - .60.

106. The email which is exhibited to the statement of Ms Doherty[124] is noted. As the cross-examination[125] of her demonstrated (despite her ultimate evasiveness) the document did not put patient safety second to weighted separations.

Paragraph 1 (l)

107. It is true that Dr Keating met with Mr Leck on the one part and Drs Berens, Risson and Strahan between 29 October and 5 November 2004. It is true that the views expressed by them provided some corroboration for the complaints of Ms Hoffman, and did not contradict per se her allegations. However, what is summarised in the letter is not in all respects accurate. Statements of summary that are included in the letter at times represent a different picture because of their truncation, or their lack of qualification compared to what appears in the summaries in DWK62 to 64.

108. The other aspect that is important that is not noted in the summary provided in the letter are the positive things that were said about Dr Patel. In particular, Dr Berens' comment that he believed that he could continue to work with Dr Patel into the future, Dr Strahan's observation that most specialists in regional centres, including himself, had delayed too long in transferring patients to tertiary hospitals, and Dr Berens' comments that Dr Patel's manual skills were very good.

109. It is also important to note that Dr Strahan was wrong about the Whipple's procedure – the patient did not have Whipple's procedure, and the patient did not die.[126]

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[124] Ex. 509.
[125] 7402.
[126] 3723.50; 3285.35.

Paragraph 1 (m)

110. Dr Keating supported Mr Leck's decision to pursue an external review, and did not tell him that the complaint was purely personality driven. Dr Keating maintained the view at the time that there were personality issues, and was concerned that they be addressed.[127] That was a perfectly reasonable thing to do. There had been a plan in place prior to Ms Hoffman's complaint which Dr Keating expected to be fulfilled to attempt to address those issues. Mr Leck decided at the time of determining that there be an external review that those matters not be pursued further at that time. Dr Keating thought they should be.

Paragraph 1 (n)

111. Dr Keating did not direct Dr Patel, or advise Mr Leck to direct Dr Patel, to refrain from providing further surgical services between 5 November 2004 and late December 2004/early January 2005. He did not do so because in his judgment at that time there was no need to do that. Whilst there were issues to be investigated, Dr Keating did not believe the evidence at that time to warrant that action. He also had an expectation, entirely reasonable, that the review would take place within a matter of weeks, and not the months that it ended up taking.[128] To form a judgment like that is not a dereliction of duty, even if the judgment was wrong.

Paragraph 1(o)

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[127] 7287 - 7288.15; 6844.50.
[128] 6864.50.

112. It is true that Dr Keating created a document between about 5 and 10 January 2005 setting out a number of things, including consistent concerns that had to that date come to his notice including the four matters set out therein.[129]

113. With respect to the second item, that Dr Patel had delayed transfer of serious ill patients to Brisbane, it is submitted that again regard should be had to Dr Strahan's comment to Dr Keating and Mr Leck that most specialists in regional areas, including himself, had been guilty of that.

114. It is further submitted that the third item, that Dr Patel was perceived by staff as arrogant, abrasive and rude, while from a human resources management issue might be undesirable, is not unique in any professional setting, and hardly a basis for taking action against the doctor, other than at most some remedial action to try to have him change his ways.

115. As to him having multiple responsibilities that might result in a potential for fatigue and errors in judgment, Dr Nankivell gave evidence of the same concerns for surgeons going back years. There is no suggestion that could or should be made that Dr Nankivell and others like him should have some disciplinary action or restriction of their duties. All that is open is to try to relieve their burden if possible.

116. That left the only matter being identified by Dr Keating in that list of consistent concerns as being the performing of surgery that might be beyond the Bundaberg Hospital's capacity to support, and he had by that time taken steps to prevent that happening again.[130]

Paragraph 1(p)

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[129] Ex. 448 exhibits at P187.
[130] Ex. 448 paras. 263 - 4.

117. Dr Keating did make an offer of temporary fulltime position of Locum General Surgeon on 2 February 2005 for the period from 1 April 2005 to 31 July 2005.[131] It was made despite his knowledge of the matters acknowledged herein, and was done because his opinion remained that, subject to the limitations on the scope of surgery to be performed because of the capacity of Bundaberg Hospital to support it, Dr Keating was of the view that Dr Patel was a good surgeon. It is accepted that the position offered was contrary to Queensland Health practice, but only in the sense that where a surgeon was to be employed as a Locum on a daily rate, they were to be employed under the Award, except if they offered their services through a service company. The offer of employment purported to offer a daily rate as a Locum when Patel had no company.[132] In that respect the earlier submissions with respect to the earlier offer of employment breaching Queensland Health Policy are restated.

Paragraph 1 (q)

118. Dr Keating submits that his assessment of Dr Patel's performance in the document submitted to the Medical Board in early February 2005 were not a "knowingly false, gross misrepresentation and overstatement of Dr Patel's performance in many respects". Dr Keating remained of the view that Dr Patel was an average to good surgeon.[133] Whether he be right or wrong about that (and subsequent events have clearly demonstrated that his assessment was wrong) is beside the point. The contemporaneous and detailed documents being DWK66 and DWK67 show that he still saw quite a number of redeeming features as far as Dr Patel was

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131 Ex. 448 P192 of exhibits.
132 4571.40 - 4572.30.
133 6820.10.

concerned. He regarded him as a capable enough surgeon to warrant his continued employment at the Bundaberg Hospital.

119. Dr Keating has accepted that he overrated Dr Patel in that assessment. In terms of the document with the ticks in the boxes, he has accepted that he ought to have marked down some of those assessments given the views that he had formed about Dr Patel. He has accepted that he held a lesser opinion of Dr Patel than what he represented when he filled out the form. But that does not mean that he thought so lowly of Dr Patel as to make his assessment a gross misrepresentation and overstatement. That would be so if he held Dr Patel in the opinion that he and others have since the discovery of his history overseas, and the revelations of the further medical evidence in this inquiry. Whilst others would have held Dr Patel in a lower opinion than what Dr Keating did, it remained that his assessment was of an average to good surgeon, whose continued employment would not jeopardise patients unreasonably.[134] An average to good surgeon, subject to some of the criticisms identified in Dr Keating's memoranda, would be marked somewhat lower, but not so much lower as to make this statement a gross misrepresentation.

120. As to the knowingly false aspect, Dr Keating has given evidence that he was under considerable time pressures at the time of completing these documents.[135] That would be understandable as all of the evidence indicates that the job for the Director of Medical Services was one which was beyond the ready capabilities of one person, even when they were not burdened by the additional problem of the complete failure of the clinical governance systems prior to their arrival.

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[134] 7052.01.
[135] Ex. 448 para. 274.

121. On a closer examination of the document it can be seen that the assessment on the page headed "Area of Need Position Description" at p.207 of the exhibits to Dr Keating's statement is utterly identical in terms of the words used in the column next to "Surgical" to the document used the previous year and exhibited at p.14 to the exhibits.

122. He was not conscious he was overrating Dr Patel at the time[136] even though, had he reflected more, he would have realised he was overstating his opinion. There is a difference between a person recording in a document a description of an opinion as being that person's opinion when, if pressed to reflect more closely on their views, they would move the grading to some degree, compared to a situation where a person consciously and deliberately misstates their opinion with the intention to mislead the recipient. Hence, just because a person says something is that person's opinion, when on closer scrutiny, and in less haste, their opinion is moderately different[137] than that, does not mean that the person has knowingly and falsely misstated their opinion. They may have, but it also may have been done inadvertently.

123. To test which of those propositions is more likely here, one would have to say what did Dr Keating have to gain. The matter by then, he knew, was in the hands of Dr Fitzgerald, the Chief Health Officer, with a view to there being an external review of Dr Patel's competence. Dr Keating must have known that Dr Fitzgerald would be accessing a whole range of information critical to Dr Patel, including the details of all of the crucial allegations. Indeed by that time, much of that information had already been provided to Dr Fitzgerald.[138]

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136 7050.55.
137 Compare 7056.05.
138 Ex. 281.

124. In that circumstance it defies logic that Dr Keating would think that there would be any useful purpose gained in his misleading the Medical Board as to his assessment of Dr Patel's performance. If he was concerned that an objective examination might reveal that Dr Patel was not fit to practice as a surgeon at the Bundaberg Hospital, he would have been unlikely to think for one moment that that would not be discovered by the external review.

125. In hindsight, it would have been preferable for Dr Keating to inform the Medical Board of the pending review by the Chief Health Officer. Again, it can hardly be thought that that was omitted due to ill motive. If the review by the Chief Health Officer was to produce an adverse outcome for Dr Patel that was relevant to the Medical Board, then, as was the case, the Medical Board could and would be told.

Paragraph 1(r)

126. It is not true that when Dr Keating signed the Form 55 Application for Sponsorship of Visa for Dr Patel concerning a 4 year visa application he knew that Dr Patel had agreed to continue employment as a Senior Medical Officer in Surgery until 31 July 2005. The evidence shows that both the offer[139] and acceptance[140] of that contract post date the letter to the Immigration Department.[141] There had been some discussions though.[142]

127. Furthermore, insofar as the document represented that Dr Patel had agreed with the hospital to a 4 year Contract of Employment, that was due to a clerical error.[143] Dr Keating explained that the history of his beliefs were that up until December of 2004 he understood the new changes

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[139] Ex. 448 P192 of exhibits (2/2/05).
[140] Ibid P196 (7/2/05).
[141] Ibid P211 (1/2/05).
[142] Ex. 448 para. 268.
[143] 6913.05.

to the Immigration rules meant that to have a 4 year visa one must have a 4 year contract. He had come to understand from information provided to him by staff that the prior understanding was wrong, and that a maximum 4 year visa could be obtained, without there being a corresponding contract period.[144] The Visa Application was quite apparently a document based upon the previous contract offered.[145] That is apparent not only from the 4 year term referred to in the Visa Application, but also by the terms of the contract as described in the Visa Application. The rate of pay described in Answer 13 on p.216 of the exhibits to Dr Keating's statement shows a salary package that was the amount under the earlier contract offer, not under the contract for the 3 month period.[146] At item 7 the position is described as Director of Surgery.

128. Dr Keating explained in his evidence, which was not controverted, that the documents for these applications were prepared by staff in his office, and presented to him with sticky labels designating the places for his signature to be signed.[147] The documents he signed he did so without reading their contents, relying on his staff, who prepared many of these documents, to have them right. Unfortunately, and probably because of the multiple changes in understanding as well as changes in proposed contract arrangements that were being floated, a clerical error has resulted in that the document has been filled out with incorrect information as to the employment arrangements. It is clear that the document[148] is not completed in Dr Keating's handwriting, bar for his signature. Nor does it call for him to certify anything –

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144 7042.50 - 7043.10.
145 Ex. 448 P219 of exhibits.
146 Ibid P192 of exhibits.
147 7064.10.
148 Ex. 457 (D).

his signature is nothing more than an undertaking by the sponsor as to future matters. He no more certified as to the truth of the contract details than did the other signatories.

129. In these circumstances, Dr Keating's explanation for the error in the documentation should be accepted.

Paragraph 1(s)

130. It is true that on 14 February 2005 Dr Keating told Dr Fitzgerald that Dr Patel was an average to good surgeon. It would be an unfair criticism to say that Dr Keating did not volunteer any of the information regarding any of the matters referred to at paragraphs 1(a) to (o) in the letter of Mr Cowley-Grimmond.

131. Firstly, paragraphs 1(a) and (b) deal with Dr Patel not being credentialed and privileged. Dr Fitzgerald was aware of that.[149]

132. It is true that Dr Keating did not tell Dr Fitzgerald about the patient Annette Webb, but her treatment had nothing to do with Dr Patel.

133. Dr Fitzgerald was perfectly aware of the concerns, and the history of them, concerning oesophagectomies being performed at the hospital. He was aware of that at the least because he was provided with Ms Hoffman's complaint at the outset of the referral to him.[150] They were discussed with Dr Keating as well.[151]

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[149] 4236.10 - .40.
[150] Ex. 281.
[151] 4234.35; 4235.15.

134. Dr Fitzgerald was aware about concerns regarding infection rates, and wound dehiscence rates.[152] Dr Fitzgerald was aware of concerns about Tenckhoff Catheter placements, and had been provided with a copy of the audit document.[153] Dr Fitzgerald was aware of issues and particulars relating thereto of concerns about Dr Patel's reluctance to transfer patients who ought to be transferred.[154]

135. By Exhibit 281 it can be seen Dr Fitzgerald was aware of issues with respect to long term ventilation patients in the ICU. Dr Fitzgerald was well aware of the concerns regarding the management of Mr Bramich.

136. Dr Fitzgerald was aware of the issue concerning P26 – the patient's U.R. number[155] is one of the ones for which the file was requested by Sue Jenkins.[156]

137. Dr Fitzgerald was aware of these matters because the information had been, prior to that meeting, to the knowledge of Dr Keating, provided to Dr Fitzgerald. Dr Fitzgerald's office had prior to that meeting made contact with the Bundaberg Hospital, through the good offices of the executive, requesting to speak to a range of relevant persons all of whom had the actual knowledge of the matters pertaining to these relevant complaints.[157]

138. The suggestion therefore that Dr Keating was involved in some conscious withholding of information from Dr Fitzgerald has to be rejected. There is disagreement between Dr Keating and Dr Fitzgerald as to whether the fact that there had been some more minor patient

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[152] Ex. 281.
[153] Ex. 281.
[154] Ibid.
[155] 038213.
[156] Email contained in GF11 TO Ex. 225.
[157] GF11 to Ex. 225.

complaints that had been resolved was mentioned. It is submitted that there is no logical reason why Dr Keating would have deliberately concealed those matters from Dr Fitzgerald. In the overall scheme of things they must have appeared to him to be relatively minor matters when compared to the bigger issue items, well able to be substantiated to the extent they could be on their own merits, by the witnesses whom Dr Keating knew Dr Fitzgerald would be speaking to.

Potential Recommendations

Section 137 of the *Criminal Code* (Cth)

139. In response to paragraph 1(r) above submissions have already been made about the factual matters that might be involved in a charge under this section.

140. By way of further submission the following is said:-

(a) it would be necessary for the prosecution to show that not only did Dr Keating know the matters contained in the document to be false, but that he was conscious of it at the time.[158] The elements of the offence, in s.137(1) (a) and (b) are not "absolute liability",[159] - so intent remains an issue. There is no evidence that Dr Keating knew what the contents of the document were – there is only evidence that he did not;[160]

(b) the falsity must be as to a material particular. On the information before the Commission it would appear that even if the visa was granted, it would cease to

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[158] *MacKenzie v. The Queen* (1996) 190 CLR 348 in particular at 356 per Dawson and Toohey JJ, and at 372 to 374 per Gaudron, Gummow and Kirby JJ, and to *R. v. O'Connor* (1980-1) 146 CLR 64.

[159] Contrast (1) (c) – see s.137(1a) and s.6.2.

[160] 7064.10.

operate on Dr Patel's employment at the Bundaberg Hospital terminating, by whatever means.[161] In that circumstance, it can hardly be said that a description of the period of the Contract of Employment is a material particular;

(c) to make out the charge under s.137 (1) it is necessary for it to be shown that ss.4 or 5, as may be applicable, has been proved. There is no evidence of those matters, and indeed, on the face of Exhibit 457 it was not.

Paragraph 2(b)

Section 273 of the *Medical Practitioner's Registration Act* 2001

141. Submissions have already been made about the factual matters underlying the issues which this potential recommendation presumably canvasses. They are the submissions in response to paragraph 1(q).

142. The version of s.273 that applies is the one as set out in Reprint 1C i.e. unaffected by the amendments in the *Medical Practitioners Registration Amendment Act* 2005.

143. The first thing to note about the section is that it is not an offence under it to fail to give information which if given would be material.

144. Most significantly, and for similar reasons as submitted earlier,[162] it would need to be demonstrated that Dr Keating was conscious of the falsehood at the time he provided the information and that he intended therefore to provide false and misleading information in a

[161] Ex. 448 P26 of exhibits.

[162] See footnote 158. The minority judgment of Cussen J in *R. v. Lowe* [1917] VLR 155 at 162 approved of by Dawson and Toohey JJ in *MacKenzie* at 356 is particularly instructive given the facts of that case.

material particular. The evidence does not justify that conclusion on any view of it. The most that can be said is that Dr Keating, had he reflected more carefully upon his views, would have marked Dr Patel harder than what he did.

Paragraph 2(c) Referral to the CMC

145. It is submitted there should be no referral to the CMC to prosecute for official misconduct because:-

(a) for the reasons already submitted, Dr Keating has not committed a criminal offence;

(b) Dr Keating has not engaged in conduct within the meaning of s.14 (b) of the *Crime and Misconduct Act* 2001 in that the mere making of mistakes in the performance of one's work, or, perhaps better described, errors in judgment, does not establish dishonesty or partiality in the performance of the person's functions or the exercise of the person's powers within the meaning of the Act, and nor is it a breach of the trust placed in the person as the holder of the appointment. For it to satisfy those things it would have to be apparent that there was some improper motive behind the making of the errors, and that has not been established.

Paragraph 2(d) – Referral to the Director-General of Queensland Health for Discipline Under s.87 of the *Public Service Act* 1996

146. Again, it is submitted that the making of errors in judgments, or wrong decisions, in the course of employment is not a basis for disciplinary action under s.87. It is submitted that Dr Keating did not perform his duties carelessly or incompetently. He performed his duties in an

environment where there was little support for him, and where he, like many others, was deceived by Dr Patel.

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Our ref: DW:250796
Your ref:

1 November 2005

Mr David Groth
Secretary
Queensland Public Hospitals Commission of Inquiry
PO Box 13147
George Street
BRISBANE QLD 4003

Dear Mr Groth,

DR D W KEATING

We ***enclose*** Dr Keating's supplementary submissions.

A copy of the submissions has been provided by email to all parties given leave to appear before the inquiry.

Yours faithfully,

David Watt

Enc(1)

SUPPLEMENTARY WRITTEN SUBMISSION ON BEHALF OF DR DARREN KEATING IN RESPONSE TO SUBMISSIONS FROM OTHER PARTIES

1. This written submission is in response to those written submissions served upon Dr Keating's solicitors to date. It does not attempt to respond seriatim to every submission made that might be adverse to Dr Keating's interests. Rather, it seeks to identify substantive submissions made against Dr Keating on matters upon which submissions have not already been advanced on behalf of Dr Keating. If a finding or recommendation was to be made against Dr Keating on a matter not the subject of the Commission's correspondence to Dr Keating, and not dealt with in this written submission, Dr Keating does not waive his right to notice of the potential for such finding or recommendation being made.

***Coroner's Act* 2003**

2. It is submitted in paragraph 59 of the QNU's submissions that there ought be some consideration for referral to the CMC or to the Commissioner of the Police Service concerning the obligations under s.7 of the *Coroner's Act* 2003 regarding the death of Mr Kemps.

3. Such a referral should not be made for the following reasons.

4. Firstly, Dr Keating did refer Mr Kemps' death to the Coroner.[1]

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[1] Exhibit 448 para. 299.

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Level 19, NAB House
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5. Dr Keating did not earlier refer Mr Kemps' death to the Coroner because, on the information he had been provided by the treating surgeon, it was not, in his view, a reportable death.[2]

6. Regard should be had to s.8 (3) of the *Coroner's Act* 2003. It would seem that the sub-paragraph (d) is the relevant provision. The question in determining whether Dr Keating was guilty of a breach of s.7 (2) would involve a determination that he did not believe that death was "not reasonably expected to be the outcome of a health procedure".

7. It is unlikely that the section means that any death arising out of a health procedure in which there is even the slightest chance of death eventuating is not required to be reported to the Coroner. That is an unlikely construction, given that death might be conceivably possible out of virtually any health procedure at all.

8. On the other hand, it is unlikely that the section was intended to exclude the obligation to report a death arising out of a health procedure unless the death was thought to be the inevitable outcome of the health procedure, because it would mean that deaths would only become not reportable where the procedure was performed with the clear understanding that the only outcome would be death i.e. death was the intended outcome. That would be perverse.

9. It is submitted that the likely intended operation of the section is such as to require a death as the outcome of a health procedure to be reported to the Coroner where the occurrence of the death is "surprising" in the sense that it could not have been reasonably expected as an outcome of the procedure. If a procedure carried with it a 10% chance of death, then it can be

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2 Exhibit 448 paras. 289 and 295; T.7007.50.

said that death from the procedure is reasonably expected, even if in the majority of cases it will not happen. The death is not "unexpected".

10. Even if that interpretation is to be rejected, there is no evidence that Dr Keating regarded the death as being a reportable one, and therefore no evidence to sustain a conviction under the section.

11. Dr Keating, contrary to the QNU's submission, did give advice to Drs Carter and Berens with respect to the reportability of deaths to the Coroner, and there has been no suggestion that the advice he gave was wrong or misleading. Those doctors then exercised their own judgment and decided not to report the death to the Coroner. Having learned of Dr Patel's prior history in the United States, the circumstances took on a different complexion, and the death became one that was likely to fall within s. 8 (3) (c).

12. It is not submitted that Dr Berens or Dr Carter should be the subject of an adverse finding or recommendation with respect to their role concerning the non-reporting of the death to the Coroner. However, the submission by the QNU that no recommendation should be made against those doctors, but one should be made against Dr Keating, is a curious one. It might be otherwise had Dr Keating misled those doctors, or if those doctors were junior and impressionable, or if Dr Keating exercised undue influence over them. None of those matters pertain, and a prosecution against Dr Keating but not against Drs Berens and Carter would take some explaining by the prosecuting authority.

Mr Graves

13. In paragraph 37 of the QNU submission criticism is levelled at Dr Keating that when Dr Keating was approached by Dr Joiner during the post-operative stay of Mr Graves Dr Keating "mollified" Dr Patel by permitting a compromise of the care of the patient contrary to "sound clinically based arguments for transfer", and supported only by "unreasoned but adamant refusal on the part of Dr Patel".

14. The submission overlooks the uncontroverted evidence that what Dr Keating did, when confronted with this conflicting opinion, was to obtain a second opinion from an Anaesthetist, Dr Younis. It was based on Dr Younis' advice that the patient was not immediately transferred, but rather permitted to be kept for a further short period at the Bundaberg Hospital[3].

Submission by Medical Board

15. On page 10 of Part B of the submissions of the Medical Board of Queensland it is said, in effect, that Dr Keating ought to have known that he should inform the Medical Board of issues concerning Dr Patel's clinical practice because he knew, as demonstrated by his experience in the Qereshi matter, that such matters might be advised to the Medical Board.

16. With respect, it is not surprising that it "did not occur" to Dr Keating to inform the Medical Board of such matters, instead thinking that it was at that stage an internal matter for Queensland Health, given Dr Keating's experience in the Qureshi matter. There Dr Keating raised the issues with the Medical Board, and there was an apparent lack of activity by the

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[3] Ex. 448 paras. 50 & 51; 3782 - 3783.

Board in response thereto. Dr Keating subsequently was advised that the matter should be dealt with internally by Queensland Health.[4] Whilst Dr Keating has not given evidence of a consciousness of that history in his dealing with the Patel matter, in the circumstances, it would be understandable if there was a subconscious response to think that these were matters to be dealt with in the first instance internally by Queensland Health.[5]

Patient Support Group Submissions

17. In paragraph 67 of the submissions on behalf of the Patient Support Group it is said that Patrick Martin gave Dr Keating a document demonstrating problems with Catheter placements in February of 2004. Mr Martin's evidence does not support such a conclusion. [6]

G W Diehm
Counsel for Dr Keating

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4 Ex. 448 para. 107.
5 7019.15.
6 Ex. 139 para. 25.