Submissions

Mr Peter LECK

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LAWYERS

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QUEENSLAND PUBLIC HOSPITALS COMMISSION OF INQUIRY

Submissions on behalf of

PETER NICKLIN LECK

DISTRICT MANAGER

BUNDABERG HEALTH SERVICE DISTRICT

sydney
brisbane
adelaide
auckland
melbourne
perth
darwin
newcastle
canberra
hobart
shanghai

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EXECUTIVE SUMMARY

Introduction

It is our submission that any complaints against Mr Leck must be judged against the background of his very substantial responsibilities, inadequate resourcing and oppressive financial accountability and reporting obligations imposed by Queensland Health. It would not be fair to Mr Leck, in judging him, to fail to take into account the daily exigency with which he had to contend and the extent to which this meant that he could not on all occasions at all levels meet all obligations perfectly.

Submission in response to Potential Finding 1(a)

The Commission ought not to make any adverse findings about Mr Leck's alleged failure to address workload complaints in or about 2002 because:

- such a finding is not within the terms of reference;
- a finding in terms of the notice would be so vague as to be unfair;
- any evidentiary criticisms are necessarily subjective;
- they are in any event countered by many favourable comments about Mr Leck's management;
- it is clear on the evidence that Mr Leck's management was inevitably compromised by resourcing problems;
- those who have criticised have often not been in possession of the full picture, especially budgetary issues; and
- there has been no expert management evidence.

Submission in Response to Potential Findings 1(b), (c) and (d)

It was not Mr Leck's responsibility to recruit clinical staff. He was not in fact involved in the recruitment of Dr Patel nor in any of the processes with the Health Department,

Medical Board or Immigration Department required in that recruitment. There is no legal principle nor policy imperative, which obliged him personally to review recruitments and recruitment documents. It would be unrealistic to expect that.

As would be expected, decisions about Dr Patel's promotion, authority and supervision, if any, were taken by the relevant Director of Medical Services and were not something as to which Mr Leck could be expected personally to advert or for which he should be personally responsible.

The proposition that Mr Leck was somehow bound to secure the recruitment of Dr Jayasekera (whose willingness and commitment were at least uncertain) when Dr Strekov declined does not bear scrutiny. It has no legal basis and it depends for its efficacy on hindsight. If Dr Patel had turned out to be a first class surgeon it could not have been credibly contended for.

Submission in response to Potential Findings 1(e), (f), (g), (h) and (i)

In our submission no adverse finding should be made against Mr Leck in relation to the credentialing and privileging matter because:

- the process was unsatisfactory and Mr Leck was trying earnestly to replace it with something more effective.
- his efforts, and those of Dr Keating, were being frustrated by their incapacity to secure College of Surgeons participation.
- this problem was known to Zonal Office and Head Office of Queensland Health and was widespread and was certainly not confined to Bundaberg.
- the evidence regarding what is or ought to be achieved by credentialing and privileging committees is unsatisfactory. It appears that the credentialing was very much dependent upon the Medical Board and the privileging was essentially a paper process.

- the probability is that a credentialing and privileging committee would not have discovered Dr Patel's history and would have granted him general surgery privileges.

Submission in response to Potential Finding 1(j)

If there were errors or "something amiss" with either collection of or the access to clinical data, it is just not reasonable to hold Mr Leck personally responsible. The systems were in place.

Submission in Response to Potential Findings 1(k), 1(l), and 1(m)

The Commission ought not to make any adverse findings about these matters because:

a. In relation to Ms Hoffman's contact with Mr Leck in March 2004:

- neither the document itself nor Ms Hoffman in person raised issues regarding Dr Patel's competence. The focus was his behaviour.
- Ms Hoffman expressly asked Mr Leck not to take any action and endorsed the document accordingly in writing.
- Ms Hoffman at that stage still wanted to work out a working relationship with Dr Patel.
- Mr Leck nonetheless took the precaution of referring the document to the Director of Medical Services and the Director of Nursing for discreet review.

b. No complaint was made to Mr Leck by or on behalf of Geoffrey Smith.

c. In relation to the catheter audit:

- on the evidence, the probability is that the form of the document seen by Mr Leck was the one which referred to Dr Patel in relation to only one of the six entries;

- no one gave this document to Mr Leck in person nor sought to explain what it was or what it meant;
- Dr Miach does not suggest that he informed Mr Leck of his concerns. Dr Keating denies ever knowing of those concerns and therefore could not have informed Mr Leck;
- Mr Leck acted properly in referring the document to Dr Keating.

d. Until October 2004 there was nothing substantial communicated to Mr Leck, which would have alerted him to doubts about Dr Patel's surgical competence.

e. In relation to the contact with Ms Hoffman in October 2004:

- Mr Leck listened carefully to and documented Ms Hoffman's complaint;
- he assured Ms Hoffman that matters would be followed through;
- he caused interviews to be conducted of some of the medical staff;
- despite initial reluctance by the Director of Medical Services he insisted that there was to be an external investigation;
- he made efforts and caused others to be made by the Director of Medical Services to identify suitable persons external to the hospital to carry out the investigation;
- when advised that the Chief Health Officer for Queensland, Dr Fitzgerald, was the appropriate person he followed up with written contact to the Audit and Review Office and by telephone to Dr Fitzgerald's office;
- he became anxious at delay at Dr Fitzgerald's end and followed up with Dr Scott;
- he briefed Dr Fitzgerald all of the material in his possession;
- he gave Dr Fitzgerald full access to hospital records and information and hospital staff.

As to the delay in arranging the review by Dr Fitzgerald, it is not sought to suggest that this simply "does not matter", however, it was undoubtedly correct for Mr Leck to insist on external review. There were no established Queensland Health procedures that enabled Mr Leck to access appropriate external reviewers. For that reason the task of identifying an appropriate person to conduct the review proved difficult and the tilt train interruption could not be helped and did not help. Mr Leck took matters seriously. The delay from 22 October to 17 December 2004 was regrettable, but it was not characterised by complete inaction and Mr Leck did not have independent advice nor the benefit of hindsight as to the urgency that may now be seen as appropriate. As is explained later in these submissions, even as late as December 2004 no-one was suggesting that Dr Patel ought to be suspended. Even the Chief Health Officer did not suggest that once he had investigated.

Submissions in response to Potential findings 1(n) & 1(r)

The Commission should not make any adverse findings on these matters because Mr Leck was not a party to nor aware of the offer made to Dr Patel on 24 December 2004. He was in fact on leave.

Further, the short term re-engagement intended to allow time to find a replacement was reasonable from the point of view of Mr Leck given the advice he was receiving from Dr Fitzgerald and Dr Keating, the fact that Dr Gaffield was likely to leave and the fact that both Dr Fitzgerald and the Medical Board knew of the proposal to re-engage Dr Patel but had not remonstrated.

Submission in response to Potential Findings 1(o) and 1(p)

In our submission, Mr Leck, who did not have clinical or medical training, cannot be criticised for not unilaterally suspending Dr Patel when:

- Although, of course, patient safety is the primary principle, the service to many needy patients would suffer if the decision were wrong.
- Dr Keating thought it not an appropriate course.
- Dr Fitzgerald thought it not an appropriate course.

- Dr Mattiussi gave Mr Leck some reason for comfort that Dr Keating's judgements were right.
- Other doctors were expressing opinions that Dr Patel's skills, if not the best, were not the worst.
- Even if Dr Keating eventually had a change of mind, his communications to Mr Leck appear to have been focused on the "interpersonal conflict matter" and they were in any event made in January 2005 by which time the matter was in Dr Fitzgerald's hands.

Submission in response to Potential Finding 1(q)

We submit that there is no evidence at all that Mr Leck intended to deceive the public or anyone else when wrote to the Bundaberg News Mail. There is no evidence that he did not genuinely hold the opinions expressed in the letter. Accordingly, we submit that there is no basis upon which an adverse finding of this nature could be sustained.

Submission in response to Potential Finding 1(s)

In our submission, the evidence of Drs Nydam and Bethell show that there was a proper contractual basis for authorising the airfare. The fact that Mr Leck advised Dr Fitzgerald and the Medical Board in advance that Dr Patel was leaving the country showed that he was acting properly and innocently. He in any event had the relevant managerial discretion pursuant to then current Queensland Health Department policy to authorise such a reimbursement. In these circumstances, no adverse finding can be made against Mr Leck in respect of this matter.

Submission in response to Potential Adverse Finding 1(t)

If Mr Leck drafted the letter to Dr Patel dated 5 April 2005 the evidence is clear that he did so at the request of the Bundaberg Health Service District Council. It is wrong to say that he approved the letter. As a matter of general principle, there is nothing careless or improper about writing a letter of thanks to a former staff member. At the time the letter was written Mr Leck and members of the Bundaberg Health Service

District Council did not know what is now known about Dr Patel and his fraudulent registration. Mr Leck's conduct should not be assessed with the benefit of hindsight.

Submission in response to Potential Finding 1(u)

In our submission, there is simply evidentiary basis for any adverse finding against Mr Leck in this matter. The evidence of the nurses is inconsistent as between their statements, their evidence in chief and cross-examination and one witness from another.

One cannot even identify from the evidence the precise words or even the substance of Mr Leck's statements which are said to be the basis of this potential adverse finding.

There is no cogent evidence going beyond merely that Mr Leck was upset, or even angry, that he spoke of organisational values, the accountability process which was being applied to Dr Patel, and the need for natural justice and patient confidentiality. The evidence is simply not there that he threatened dismissal.

The raising of the issue of a potential breach of patient confidentiality, and the Code of Conduct, was conceded by the nurses to be a matter of legitimate concern. The leaking of the letter by Nurse Hoffman was a probable breach of the Code and, even if Ms Hoffman had a proper reason for breaching the Code, and even if there was no breach, it is hardly improper or incompetent for Mr Leck to raise the possible breach with his staff so that the important principle of patient confidentiality would be preserved. In fact, given the wide publicity afforded the letter, it would have been remiss if Mr Leck did not seek to reinforce the principle with his staff.

For similar reasons, the email of 7 April 2005, which was sent by Mr Leck only to his immediate superior, was quite proper and appropriate. He was, it was conceded, right to be concerned about the leak. The email, having expressly eschewed any focus on individual responsibility, was nothing more than a suggestion to Mr Bergin that he could consider an education session, which emphasised, in strong terms, the importance of the Code of Conduct and patient confidentiality, and the serious repercussions if there were breaches.

Submission in response to Potential Finding 1(v)

Mr Leck was cognisant of his responsibilities in relation to implementing the Queensland health policies in relation to complaints management and adverse event reporting. He authorised the development of local policies, established the DQDSU to implement and maintain those policies within the constraints of available resources. It is unreasonable to expect that Mr Leck could or should minutely oversee every aspect of the operation of every policy within the Health Service District. For this reason no adverse finding should be made against him if the systems in place were not yet perfect.

Submissions in response to Potential Finding 1(w)

Mr Bramich's case was properly referred initially for internal investigation by Dr Keating and then for external investigation by Dr Fitzgerald.

Mr Mobbs' case was not a sentinel event but was in any event the subject of appropriate communications with "Head Office".

Mr Kemps' case was properly referred by Mr Leck to Dr Keating for enquiry. If it was a sentinel event, he was entitled to expect that Dr Keating, or the treating doctors or nurses would action it accordingly.

Submission in response to Potential Finding 1(x) and 1(y)

The Commission should make no adverse finding against Mr Leck on these matters because:

- There is insufficient evidence of the appropriate kind to determine whether Mr Leck consulted with Dr Keating with sufficient frequency.
- It is not reasonable to expect a District Manager to personally vet documents of the kind referred to.
- In any event the evidence does not disclose that Mr Leck had any knowledge of the existence of these documents.

- It had already been decided in early January 2005 that Dr Patel's services were not to be continued except in the very short term.

Submission in response to Potential Finding 1(z)

Given the ambiguity in the alleged threatening words; the clear possibility of (albeit innocent) predisposition on the part of Dr Jelliffe, the fact that the Commission would have to act upon essentially Dr Jelliffe's interpretation of words and circumstances not intrinsically threatening, the uncertainties in the detail of Dr Jelliffe's evidence and the utter absence of anything in Mr Leck's history or behaviour to suggest that he had in the past threatened anyone in such a situation or would even be capable of descending to such a tactic, the Commission ought not to make any adverse conclusion, observation or recommendation on this matter.

Conclusion

In our submission, adverse findings against Mr Leck of the nature of those listed in Mr Morzone's letter dated 25 October 2005 are not sustainable on the evidence before the Commission. At most, all that can be said against Mr Leck is that, faced with similar circumstances and the benefit of hindsight, some people may have acted differently. That simply demonstrates differences of opinion or judgment, it does not even amount to negligence, much less misconduct of any kind.

BACKGROUND CONTEXT

1. It is our submission that any matter as to which Mr Leck is to be judged or assessed must be seen in proper context. That context includes:

   (a) Mr Leck's own qualifications and experience;

   (b) the nature and scope of his role as District Manager of the Bundaberg Health District;

   (c) the place of Bundaberg Base Hospital and the Bundaberg Health District and the demands upon them;

   (d) the structure systems and culture of Queensland Health;

   (e) available resources.

Personal Qualifications and Experience

2. Mr Leck obtained the degree of Bachelor of Health Administration from the University of New South Wales in 1987 and is an Associate Fellow of the Australian College of Health Service Executives[1]. From November 1986 until early 1991 he was engaged as a management trainee by the Hornsby and Ku-ringi-gai Health Service during which period he acted in various management and administration capacities at a number of public health facilities[2].

3. In 1991 and 1992, Mr Leck relieved Chief Executive Officers and Deputy Chief Executive Officers at Grafton Hospital, Wauchope Hospital and Rylstone Hospital in New South Wales.[3]

4. From November 1992 until June 1998, Mr Leck was first Sector Executive Officer and then District Manager at the Mt Isa Health Service District.[4] From

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1 Statement of Mr Leck Exhibit 463
2 ibid
3 ibid
4 ibid

June 1998 he became District Manager of the Bundaberg Health Service District. He was stood down on full pay from that role on 14 April 2005 and that remains the position.

5. Importantly for many of the matters of interest to the Commission, Mr Leck holds no medical or clinical qualifications. His entire training and experience is in Health Administration and he has at all times been dependent upon medically qualified advisors to assist and guide in decisions and matters pertaining to clinical issues.

Nature and Scope of Role of District Manager

6. Within the Queensland Health System, the District Manager is the person who oversees and monitors all of the public health services provided in the particular district. This involves:

   (a) implementation of corporate policy and strategy;

   (b) development of policies and strategies specific to the health service needs of the local community, within the framework of the corporate objectives;

   (c) management of resources and patient activity within corporate targets;

   (d) development and maintenance of appropriate systems and structures to manage service delivery;

   (e) ensuring that local systems and policies are consistent with corporate guidelines and priorities;

   (f) supervision of the management aspects of the executive team including the Directors of Medical Services, Nursing, Community and Allied Health.[5]

7. Mr Leck's roles and responsibilities were amplified and particularised by reference to a series of Service Agreements into which he was obliged to enter

5 ibid

each year with the Zonal Manager and the General Manager, Health Services.[6] These "agreements" cannot, of course, have any contractual force of themselves (they purport to be "agreements" between co-crown employees). As will be seen, though, as statements of policy and expectation, they were of powerful impact.

Place of Bundaberg Base Hospital and Bundaberg Health Service District

8. The Bundaberg Health Service District included not only the Bundaberg Base Hospital but Childers Hospital, Mt Perry Health Centre and Gin Gin Hospital.[7]

9. In turn, the Bundaberg Health Service District formed part of the Central Zone. It was one of 35 districts across three zones in a multi-layered Queensland Health Department structure.[8]

10. As District Manager, Mr Leck had reporting to him:

    (a) Quality Coordinator;

    (b) Executive Support Officer;

    Bundaberg Base Hospital

    (c) Director of Medical Services;

    (d) Director of Nursing Services;

    (e) Director of Corporate Services;

    (f) Manager Integrated Mental Health Services;

    (g) Director of Community and Allied Health Services;

    Childers Hospital

    (h) Medical Superintendent;

    (i) Director of Nursing.

    Mt Perry Health Centre

    (j) Director of Nursing;

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6 T7120.20-55 & Exhibits 465, 466 & 467

7 Organisational chart attached to Statement of Ms Raven Exhibit 162 & Statement of Mr Leck Exhibit 463 p2

8 See organisational chart attached to Statement of Mr Bergin Exhibit 383

Gin Gin Hospital

(k) Medical Superintendent;

(l) Director of Nursing.[9]

11. The measured quality reports[10] and the Press Ganey material[11] indicate that the relative performance of the Bundaberg Health Service District across the State was of a reasonable and proper standard. The two clinical areas where the measured quality data showed outliers for Bundaberg Base Hospital were in Acute Myocardial Infarction in-hospital mortality and Stroke in-hospital mortality.[12] Those areas (which were not related to surgery or Dr Patel) were promptly addressed.[13]

Queensland Health

12. Mr Leck was required by Queensland Health policy (as was every other District Manager on behalf of his or her District) to enter each year into a "service agreement" with the Zonal Manager and the General Manager, Health Services or the Senior Executive Director, Health Services. He was then judged against the targets in that agreement. (See paragraph 7)

13. These targets included such matters as:

(a) achieving budget integrity;

(b) compliance with asset strategic planning activities;

(c) participating in regional managers coordination networks;

(d) participation in individual project plans to meet Government election commitments; and

(e) improved management of staff absenteeism.

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9 Organisational Chart attached to Statement of Ms Raven Exhibit 162
10 Statement of Mr Collins Exhibit 378 & Exhibit 385
11 Statement of Dr Fitzgerald Exhibit 225 attachment GF17
12 Statement of Mr Bergin Exhibit 383 para 7(c)
13 Statement of Mr Bergin Exhibit 383 attachments 8 & 9

14. The service agreements sought to impose upon Mr Leck a set of principles as to budget performance, funding arrangements and reporting arrangements.[14] These included:

   (a) ***service agreement obligations*** *including operating result, financial position, funding and activity, must be met* ***within the resources available*** *to the Health Service District, Statewide Service and corporate office;*

   (b) ***Health Service District, Statewide Services and Corporate Offices are responsible for their financial performance, financial position and budget performance as appropriately recorded in the Corporate Financial Systems.*** *This performance is closely monitored by zonal management, the Office of the Director General and Government under the Corporate Governance Framework for accountability, service delivery and resource allocation/utilisation services;*

   (c) ***patient activity targets*** *for Health Service Districts and Statewide Services* ***will be established in consultation with Zonal and Health Service District Management as part of the service agreement process;***

   (d) *Health Service Districts, Zonal Management, Statewide Services and Corporate Office are responsible for managing and maintaining the appropriate fulltime equivalent (FTE)/staff profile. The corporate information systems must be updated to accurately reflect the current position for internal and external FTE;*

   (e) *Health Service Districts, Statewide Services and Corporate Office must ensure their* ***costs centre output distributions accurately record the costs of departmental outputs in the corporate systems*** *under the managing for outcomes (FMO) framework and reviewed annually; and*

   (f) ***asset management*** *– capital allocations within the Health Service District budget should be expended in accordance with the Health Service District's asset strategic plan. Additionally, it is Queensland Health policy that expenditure on* ***maintenance and repairs to be between 2.5% and 4%*** *of the total budget for each Health Service district.*

15. The "service agreements" were plainly not legally binding agreements and were not intended to be so. They were, in effect, agreements by one arm of the Queensland Government with another arm of the Queensland Government. They were also replete with the language of policy rather than the language of contract or binding obligations. And, if regarded as a contract, the service

[14] Statement of Mr Bergin Exhibit 383 attachment 7; Exhibits 465,466 & 467; & T7120.10 et seq.

agreement in effect required Mr Leck to provide high quality health care with whatever budget Queensland health decided to allocate to him.

16. Nevertheless, budget integrity was a major Queensland Health focus[15] as was resource management.[16]

17. Mr Leck gave evidence that he was aware of District Managers who had been dismissed from their positions for failure to manage within budget[17] and Mr Leck's Zonal Manager, Mr Begin, conceded there was a perception that District Managers had been dismissed for that reason[18] and that he had informed Mr Leck himself that his (Leck's) job would be at peril if he did not meet budget.[19]

Resources

18. The statement of the former Director-General of Queensland Health, Dr Buckland[20], discloses serious under-funding of Health across the State and a serious shortage of doctors. It points out[21] that hospital expenditure is some 20% less than the Australian average but makes the point that, given the de-centralisation of the state's public hospital services, the expenditure should arguably be greater than the national average.

19. Dr Buckland also describes a State budget review and funding process from which, of course, Mr Leck was utterly remote and in which he had no say. Almost without exception, witnesses who had made generalised complaint (as distinct from matters dealing specifically with Dr Patel) about Mr Leck's management have acknowledged the difficulties under which he laboured by reason of budgetary and resource limitations.

20. There is a sorry, and essentially undisputed picture of Mr Leck, as District Manager, and, for that matter, Dr Keating as Director of Medical Services, each being required to perform a body of work beyond the compass of achievement

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15 T6048-6050 & T7121.22
16 T7121.35
17 T7129.37
18 T6051.10
19 T6051.40
20 Statement of Dr Buckland Exhibit 336
21 Statement of Dr Buckland Exhibit 336 para 78

reasonably to be expected of any one person. Political masters, either unaware or uncaring of the consequences for Queenslanders in the public health system, have, for decades, with recidivistic and unrepentant economic rationalist determination, starved heath budgets and demanded of the senior bureaucracy that they present the result with appropriate "spin". Inevitably, those at the coalface have been left to try to keep "all the balls in the air".

Conclusion

It is our submission that any complaints against Mr Leck must be judged against the background of his very substantial responsibilities, inadequate resourcing and oppressive financial accountability and reporting obligations imposed by Queensland Health. It would not be fair to Mr Leck, in judging him, to fail to take into account the daily exigency with which he had to contend and the extent to which this meant that he could not on all occasions at all levels meet all obligations perfectly.

MANAGEMENT MATTERS

Potential Adverse Finding 1(a)

You failed to take any or any adequate steps in or about 2002 to address workloads of staff in the operating theatre and ICU at the Bundaberg Base Hospital ("the Hospital") despite complaints received from doctors including Drs Baker, Carter, Nankivell and Jelliffe and knowing that the workloads for surgeons and anaesthetists during such period were to high to be safe for patients and too high for the welfare of staff.

21. This notice is far too vague. The notice begs these questions:

    (a) What steps did Mr Leck fail to take?

    (b) What could he have done?

    (c) When specifically? (in or around 2002 is too vague)

    (d) What workloads of which staff were too high and to what extent?

    (e) How many further staff should he have employed, in what disciplines, and with what funds?

22. There are no answers on the evidence to any of these questions. That makes it impossible to deal with the notice.

23. There have been generalised observations/complaints by several witnesses going to Mr Leck's management decisions, skill and style. It has been complained, for example, that he failed to retain staff who in the opinion of the witness ought to have been retained. There has been generalised criticism about insufficient use of Visiting Medical Officers (VMO). Some witnesses have complained that the physical location of Mr Leck and his senior directors in the Hospital was too remote from other activities at the Hospital and that he and the other directors were insufficiently available for feedback and communication.

24. In our submission, the matters in Potential Adverse Finding 1(a) fall into this category of general management decision making and ought not to the subject of any adverse finding against Mr Leck because:

    (a) They are too vague (see above);

(b) They do not fall within the terms of reference. Disagreement with or questioning of a decision whether or not (as an example) to engage a VMO or somehow otherwise to juggle available resources is not a "substantive allegation, complaint or concern relating to the clinical practice and procedures conducted by ... medical practitioners" within term of reference 2(c) either in its original form or as expanded by 2(f);

(c) On no view could these matters fall within items of reference 2(b)(i) to (v) which all relate specifically to Dr Patel. Term of reference 2(d)(i) ties back to 2(a), (b) and (c).

(d) Complaints, observations, judgments of witnesses of this kind are inevitably subjective and ultimately unhelpful to the Commission. For example, the witness Dr Anderson believes a period of "administrative incompetence at Bundaberg Hospital commenced with the teaming up of Mr Leck as District Manager and Dr John Wakefield as Director of Medical Services[22]. Dr Jelliffe, (one of the "complainants" to which this notice refers) on the other hand, saw that same team as running a "very happy ship with staff morale high" and said he "was very happy to be working in that environment"[23]. Dr Jelliffe thought "it was a busy little hospital, it was well organised"[24]. Should those positive remarks be rejected in favour of the negative criticisms, and against what particular standard should all the views be measured? For example, should Mr Leck's management be judged against the performance of the hospital before he arrived or against similar regional hospitals and what is to be measured; patient outcomes, patient throughput, staff morale etc? Or should it be judged on the basis of whether there are more criticisms than positive comments, that is, a popularity contest?

(e) Inevitably the capacity to manage workloads is compromised by inadequate resourcing and the complaints referred to in this notice must be viewed accordingly:

22 T2743.11
23 Statement of Dr Jelliffe Exhibit 437 para 7
24 T6650.35

(i) Dr Woodruff: makes the point that there are deep seated and endemic problems within the health care system. The health system needs more money. There are a number of areas within the system where the quality of services and outcomes would be improved with better resources. Hospital administrators in particular are under pressure to keep costs to budget. Regional areas are at a disadvantage because of the steady progression in the medical profession towards super-specialisation in both training and practice and this is unsustainable in regional and remote areas[25];

(ii) Dr Nankivell: (another of the "complainants" to which this notice refers) *"and so we went above Mr Leck, not out of disrespect to him, but we realised that he did not have the power to fix things. And so having gone above him it then becomes the responsibility of the people above him"*[26];

(iii) Dr Nankivell: *"he's (Leck) set up to fail ... Brisbane has told him to do this and he has resources to do that. Thereby he's set up to fail"*[27];

(iv) Dr Scott: *"they were sandwiched between a whole lot of competing interests"*[28];

(v) Dr Aroney: *"I am cognisant of the fact that the managers of the hospital have to meet budget and that they may be sacked if they fail to do so, and so I understand that they were probably the meat in the sandwich under these considerations."*[29]

(vi) Dr Baker: *(another of the "complaints" to which this notice refers) agreed:*

- in relation to complaint about under resourcing, Dr Mattuissi was engaged to *"look at alternative modules of costing and they did eventually, after a meeting, employ a medical education officer;*[30]
- in respect of his and Dr Carter's complaints *"the summary of Bundaberg Hospital would be not enough staff, not enough resources"*[31] and *"... the issues were lack of funding, lack of staffing"*[32] and *"... You were never told that there wasn't enough money for some of these things?—I was told that we were over budget and*

25 Statement of Dr Woodruff Exhibit 283
26 T3004.10
27 T3005.15
28 T5393.15
29 T3926.25 (referring to The Prince Charles Hospital but of general application)
30 T6351.15
31 T6390.25
32 T6391.1

we didn't have enough money, yes." "That's an explanation, isn't it?—That's an explanation."

(viii) Mr Leck himself: "*Were you in a financial position to try to urge Dr Baker to remain in the district, for instance to attend as a VMO?—We didn't have any additional resources for that but I didn't want to see Dr Baker leave.*

Now, had you the financial capacity to do so, what would you have been obliged to do to keep him in the area, if money were no object?-- he – as I recall, he made a request in relation to certain things that he wanted and Lyn Hawken drafted a letter which I signed, which was a response to him in terms of what we were trying to do to assist him. But we didn't have – the reality is that we didn't have the financial resources to do everything that he wanted done.

Did you make a request up the line or was this an occasion where you knew it would have no positive result?—I remember having a discussion with the zone in relation to it. There were some query about whether a harmonic Scalpel was really needed in Bundaberg for example. I can recall that. But it was a time when we were getting a very clear message that there was just no funding available.[33]

As I recall the discussion from Martin Carter was that there was increasing demand in Bundaberg because of the ageing population and growing population but that resources were going to the metropolitan areas rather than regional areas like Bundaberg.[34]

COMMISSIONER: With these historical budgets, just leaving aside elective surgery for the moment, your budget for year 2 was based on your budget for year 1?—Yes.

Plus or minus?-- Yes, usually perhaps plus – if there was a wage increase, we would get an adjustment for wage increases and at that time there were occasions when we'd get budget reductions for productivity purposes as it was called.

Yes. Well, that's what I was going to ask you. Was there a standard productivity reduction each year on the basis that greater efficiencies would result in a reduced budget?-- Yes, there was. That did stop but I'm not quite sure when it was, that it ceased.

But can you roughly estimate how long it continued, this cutting your budgets for productivity?-- Several years.

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[33] T7183.37-60
[34] T7275.35-40

From when until when?-- Oh, well, it was happening when I was in Mount Isa and it certainly happened when I was in Bundaberg.

I'm more concerned with Bundaberg. Did it cease before you left?-- Yes, it had ceased before I left.

How long before then?-- I think maybe a couple of years but I'm not exactly sure.

I see. What, was there a standard percentage reduction each year for efficiency?—Yes.

And what was it?-- Oh, when you say standard, I think it varied a bit. It was somewhere between one and two per cent of your non-labour budget as I recall.

Thank you. And the labour budget just depended on wage increases?—Yes.

Yes.

MR ANDREWS: You'd have been confronted with, as a part of the complaint about understaffing, complaints about over work by individual clinicians; that is, that they had to work too many on-call hours?-- There had been some complaints about that, yes.

Well, when you say some, the inquiry has heard from a Dr Nankivell and I think his evidence may have even gone so far as to speak of hospitalisation for him for what he attributed to over work?-- I don't recall that but I do recall that he'd raised concerns about his workload on more than one occasion.

Dr Baker was concerned as well about his workload?-- Yes.

Dr Carter, the director of the ICU, was concerned about the workload of the anaesthetists?—Yes.

And these complaints about workload, were they complaints about which you could do nothing?-- Well, we couldn't get additional funding. What we were trying to do was to see what efficiencies we could make in the hospital to be able to reallocate funds. I talked yesterday about the efficiencies in operational services. So some of those things allowed us to internally increase the number of junior medical staff over a period of time and we also increased an anaesthetist's position for similar reasons in the last couple of years.[35]

[35] T7180.18–7181.25

Well, you – because of the budget inadequacy, you were forced to condone unsatisfactory working conditions for your clinicians, weren't you?-- There were staff I was thinking that I thought were working too many hours, yes.

Now, you were forced to condone that because you had very little practical alternative?—Yes.[36]

(f) So inevitably, the question is: if Mr Leck was obliged to retain further surgeons and anaesthetists, where was the money to come from or what other medical services ought to have been sacrificed to enable him to employ more surgeons and anaesthetists?

(g) Witnesses who make criticisms of Mr Leck's management, doubtless doing their best and well intentioned, must necessarily come from their own limited perspective and they are not necessarily in possession of the full picture. As a small example, Dr Baker implied criticism of Mr Leck and Dr Nydam in relation to Dr Nydam's view that some of the comments of Dr Carter and Dr Baker on their departmental self-assessments were inappropriate for inclusion in the District Report. However, Dr Baker conceded that he did not know what the District Report was and could not know what was appropriate or inappropriate for inclusion in it[37]; and

(h) The Commission has heard no expert evidence about management and management techniques for persons in Mr Leck's position with Mr Leck's responsibilities, staff, resources and budget. In our submission, it would not be fair nor sound to draw any adverse conclusions about Mr Leck as a manager generally on the basis of some negative but subjective observations from some witnesses who have no management expertise or knowledge of all the facts, especially available budgets.

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36 T7182.35-40
37 T6388.30-40

Submission in response to Potential Finding 1(a)

The Commission ought not to make any adverse findings about Mr Leck's alleged failure to address workload complaints in or about 2002 because:

- **a finding in terms of the notice would be so vague as to be unfair;**
- **such a finding is not within the terms of reference;**
- **any evidentiary criticisms are necessarily subjective;**
- **they are in any event countered by many favourable comments about Mr Leck's management;**
- **it is clear on the evidence that Mr Leck's management was inevitably compromised by resourcing problems;**
- **those who have criticised have often not been in possession of the full picture, especially budgetary issues; and**
- **there has been no expert management evidence.**

APPOINTMENT OF DR PATEL

Potential Adverse Finding 1(b)

You failed between October and December 2002 to appoint Dr Lakshman Jayasekera to the position of Director of Surgery at the Hospital in circumstances where he had applied for the position, he satisfied all the selection criteria, he was prepared to accept such position and the only other candidate who satisfied those criteria had declined the position.

Potential Adverse Finding 1(c)

You knowingly permitted recruitment and registration of a medical practitioner to enable him to accept employment as a Senior Medical Officer in the surgical department at the Hospital intending that immediately after the commencement of his employment he would be offered promotion to the position of Director of Surgery and knowing that as such he would not be supervised by a general surgeon holding specialist registration and knowing that he did not hold qualification as a general surgeon acceptable for specialist registration and knowing at the time of his recruitment that Dr Jayasekera satisfied all the selection criteria, held specialist registration as a general surgeon and had applied for the position of Director of Surgery.

Potential Adverse Finding 1(d)

Whether because you failed to adequately consult with him or otherwise, you failed to prevent your acting Director of Medical Services Dr Kees Nydam from:

i. **misrepresenting to the Queensland Medical Board the position Dr Patel would occupy and level of supervision to which Dr Patel would be subject and in particular misrepresenting that Dr Patel would occupy the position of Senior Medical Officer in surgery and in that position that he would report to the Director of Surgery at the hospital;**

ii. **misrepresenting to the Department of Immigration in the Form 55 Sponsorship for Temporary Residence in Australia that the position filled by Dr Patel had been advertised a number of times over the past six months, that there had been no Australian applicants and that Dr Patel was suitable with his overseas qualifications when the position of Senior Medical Officer in surgery had not been advertised, there had been an Australian applicant for the advertised position of Director of Surgery and Dr Patel was not suitable for the position of Director of Surgery or the position of Senior Medical Officer in the department of surgery in that he did not have qualifications as a general surgeon acceptable for specialist registration and there was no intention that he be supervised by a person with such specialist qualification;**

iii. **misrepresenting to Queensland Health in the Application for Area of Need Certification that Dr Patel was suitable for registration under the area of need provision of s135 of the Health Practitioners Act 2001 when the position of Senior Medical Officer in surgery had not been advertised, when there had been an Australian applicant for the advertised position of Director of Surgery and when Dr Patel was not suitable for the position of Director of Surgery or the position of Senior Medical Officer in the department of surgery in that he did not have qualifications as a general surgeon acceptable for specialist registration and there was no intention that he be supervised by a person with such specialist qualification.**

25. Dr Nydam, as Acting Director of Medical Services, was responsible for the recruitment of all medical staff at the BBH at the time of Dr Patel's recruitment[38]. This extended to Area of Need[39], Registration, Medical Board

[38] Statement of Dr Nydam Exhibit 51 para 7
[39] Statement of Dr Nydam Exhibit 51 para 23

and Department of Immigration issues where overseas doctors were concerned[40]. This was consistent with practice in other districts[41].

26. On what basis can it be fairly asserted that Mr Leck, a non-clinician, could or should have so intruded upon the duties and activities of the Director of Medical Services as to personally "vet" the formal documents submitted to the Medical Board, the Department of Immigration and Queensland Health? Is it suggested that Mr Leck was obliged to do this for all recruitments? Is it suggested that policy or practice across Queensland Health required him to do so? Is it suggested that other District Managers in fact did this or ought to have done this? The Commission has received no expert evidence as to "best practice" on such matters.

27. It is clear from the evidence of Dr Nydam, and from the evidence of Mr Demy-Geroe of the Medical Board,[42] that Mr Leck had no role in the recruitment of Dr Patel nor in the presentation to the Medical Board of any relevant documentation or information. Nor is there evidence that he ought to have had a role in it.

28. Mr Leck sat with Dr Anderson and Dr Nydam on the Selection Committee for appointment of a Director of Surgery <u>before</u> Dr Patel's recruitment. Of the two eligible candidates, Dr Jayasekera and Dr Strekov, the Committee unanimously chose Dr Strekov[43]. In the result, though, Dr Strekov did not take up the position[44].

29. There is no suggestion that Mr Leck had any role at all in communication with Dr Jayasekera as to whether he would or would not again apply for the position[45].

30. Dr Nydam says that Dr Jayasekera was not really interested in the job[46] and he says that he was not prepared to recommend him for the job[47]. Dr Jayasekera

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40 Statement of Dr Nydam Exhibit 51 para 23
41 T6714-6715
42 T409-496
43 T7311.24
44 T4112-4113
45 T4115-4118
46 T4116
47 T4117

seems to agree that he was persuaded to apply for the job initially, was not really interested in the job, and was in fact willing to take a pay cut to get closer to Brisbane[48]. Dr Jayasekera concedes that Dr Nydam gave him two reasons for not appointing him[49].

31. There is no principle of law or practice nor is there a policy imperative which required Mr Leck to appoint Dr Jayasekera after Dr Strekov declined (even if Dr Jayasekera would have accepted). The Selection Committee was *functus*, and the matter was properly back in Dr Nydam's hands. Mr Leck could not have justified ignoring the recommendations of his Acting DMS to appoint Dr Jayasekera.

32. It is quite unclear what, if anything, is intended by way of criticism of Mr Leck in the reference in Dr Jayasekera's evidence to the Staff Advisory Committee meeting at which, by motion, Management was asked to explain why Dr Jayasekera was not appointed. Given that Dr Jayasekera had had some private discussions with Dr Nydam about that matter, it seems odd that he acquiesced in the passage of this motion. It would also seem surprising to expect that Mr Leck and/or Dr Nydam would or should in, in the presence of other staff, discuss the selection process and any inadequacies Dr Jayasekera might have had in navigating it. Dr Nydam undoubtedly had his reasons.[50]

33. Dr Nydam, and not Mr Leck made the decision to offer Dr Patel the position of Acting Director of Surgery[51]. Dr Nydam's evidence was that he intended that appointment to be in an acting capacity[52].

34. It is not a "given" that there was a bar to appointing Dr Patel as Director of Surgery. There has in fact been debate in the evidence about whether Dr Patel, having been recruited as an SMO could or should properly have been appointed Director of Surgery[53] but, in any event, there is no evidence that Mr Leck knew, adverted to, was informed of or advised about any requirement

48 T5980.50-60
49 T5971.10
50 T4117.10
51 Statement of Dr Nydam Exhibit 51 para 34
52 T4127.20
53 See for example Dr Stable T5718.50-5719.1 and Dr Mattiussi T5604.20

of further training for or supervision of Dr Patel or what his specific qualifications were.

35. Plainly the responsibility for appointment lay with Dr Nydam.

Submission in Response to Potential Findings 1(b), (c) and (d)

It was not Mr Leck's responsibility to recruit clinical staff. He was not in fact involved in the recruitment of Dr Patel nor in any of the processes with the Health Department, Medical Board or Immigration Department required in that recruitment. There is no legal principle nor policy imperative, which obliged him personally to review recruitments and recruitment documents. It would be unrealistic to expect that. As would be expected, decisions about Dr Patel's promotion, authority and supervision, if any, were taken by the relevant Director of Medical Services and were not something as to which Mr Leck could be expected personally to advert or for which he should be personally responsible. The proposition that Mr Leck was somehow bound to secure the recruitment of Dr Jayasekera (whose willingness and commitment were at least uncertain) when Dr Strekov declined does not bear scrutiny. It has no legal basis and depends for its efficacy on hindsight. If Dr Patel had turned out to be a first class surgeon it could not have been credibly contended for.

CREDENTIALING AND PRIVILEGING

Potential Adverse Finding 1(e)

You, as District Manager, were responsible for ensuring that a credentials and clinical privileges committee existed to ensure that all medical practitioners being considered for recruitment to the Bundaberg Health Service District ("the District") had their credentials assessed and their clinical privileges recommended before recruitment and to ensure that all medical practitioners operating within the District have their credentials assessed and their clinical privileges recommended and periodically reviewed.

Potential Adverse Finding 1(f)

You failed to ensure that a credentials and clinical privileges committee existed.

Potential Adverse Finding 1(g)

Due to your failure:

- **i.** **there was no credentials and clinical privileges committee for the District in 2002, 2003 and 2004;**
- **ii.** **the formal qualifications, training, experience and clinical competence of Dr Patel and of numerous other medical practitioners recruited to or operating in the District were not properly assessed by a committee of their peers;**
- **iii.** **the opportunity was lost for such a committee to determine that significant limits had been placed by authorities in the USA on Dr Patel's clinical privileges;**
- **iv.** **an opportunity was lost for such a committee to limit privileges for Dr Patel;**
- **v.** **an opportunity was lost for such a committee to recommend that Dr Patel should not be recruited.**

Potential Adverse Finding 1(h)

You failed to ensure that Dr Patel was assessed by a clinical privileges and credentials committee at the hospital in accordance with the Queensland Health Policy 15801 and Credentials and Privileges Guidelines for Medical Practitioners July 2002.

Potential Adverse Finding 1(i)

In the absence of formal credentialing and privileging, you granted Dr Patel interim clinical privileges which remained current throughout Dr Patel's tenure at the Hospital and which were granted in circumstances where no or no adequate inquiry into Dr Patel's credentials or past clinical practice had been made by you.

36. Mr Leck accepts that there was a Queensland Health Department policy on credentialing and privileging and that, as District Manager, he was responsible for its implementation.

37. He delegated the task to his Director of Medical Services Dr Keating[54] and asked him to make it a clinical governance priority.[55]

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[54] T7149.19 – 25; T7153.11 – 31
[55] T7150.1 - 30

38. There was nothing surprising in this.[56] Dr Keating accepts that he was assigned this responsibility[57] and Mr Leck accepts that Dr Keating, though trying to revive the system, was meeting serious difficulties. Mr Leck sought regular reports and offered to try to help by intervening.[58]

39. Mr Leck felt that the system, as it had operated in the past, had been something of a "rubber stamp"[59] and that participating practitioners had not seen value in it.[60] Mr Leck was trying to achieve something better.

40. It seems clear that the process was frustrated in significant degree by the difficulty in securing College of Surgeons' participation[61] and there is genuine uncertainty about whether that was a prerequisite. It has been suggested that the participation of a representative from the relevant College was a guideline rather than a mandatory provision and yet the Director General himself regarded it as mandatory.[62]

41. It is also clear that the difficulties in securing participation of the College of Surgeons in the process was widespread and well known to Mr Bergin and to Corporate Office.[63]

42. The "anything is better than nothing" solution was mentioned several times in evidence but it is simplistic and there is no reason at all to expect that a committee of that type would have been of any use in relation to Dr Patel. Indeed, when Bundaberg was ultimately able to achieve a fully operational committee for purposes of credentialing and privileging certain categories of practitioners, the process did not even discover the irregularity in Dr Miach's credentials[64] (rather easier, it might be thought, than uncovering Dr Patel's fraud).

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56 T2352.5 Dr Wakefield had regarded it as his responsibility T4555.1 –10 & Dr Hanelt undertook the process for Fraser Coast T6724
57 T7019.40 – 7020.5
58 T7150.20 - 30
59 T7150.35
60 T7151.45
61 T7155.50
62 T5583.10 – 30; Mattiussi T5853.45 & Young T2893.25
63 Statement of Dr Fitzgerald Exhibit 225 attachment GF16
64 T2895.15

43. There is a danger in judging Mr Leck of expecting or presuming too much of the credentialing and privileging process:

(a) as an example, the evidence is quite unconvincing as to the extent to which the credentialing part of the process involves any serious reference checking:

- Dr Young – *We'd just take the selection panel's reference check*[65]
- Dr Cleary - *There is a paper process in which you assess a professional – a doctors credentials. The way to that is the Medical Board website ...*[66]
- Dr Mattiussi – *And you seem to agree with the proposition that that credentialing and privileging procedure, if it had occurred according to policy, may not have uncovered any difficulties with his past registration history in the United States because it's likely that the members of the committee would have relied upon the Medical Board in that regard? ... Yeah, that's correct.*[67]

(b) It is very doubtful that the "privileging" part of the process can be expected to involve any degree of "hands on" review. Dr Cleary says credentialing and privileging is "essentially a paper exercise".[68] Moreover, there are frequent references in the evidence to the College representative participating by telephone or video link.[69] This hardly suggests anything in the nature of close physical review of the candidate's competence or skills.

Dr Young – *Yeah, the Colleges have input into our privileges committee. I leave it up to individual colleges, whether they wish to turn up in person, and some do, or whether they would like to put their advice forward in writing.*[70]

44. What was to be achieved by checking with the referees nominated by Dr Patel? It is reasonable to assume that those who wrote references for Dr Patel, which were then supplied through Dr Bethell at Wavelength, would not likely have resiled from them, either because they knew of the restrictions in New York and

65 T2895.15
66 T4850.15
67 T5881.35
68 T2880.50 & T4556.25
69 T4851.10 - 20
70 T2849.45

Oregon in relation to Dr Patel's scope of practice and dishonestly wrote the references in the first place, or because they did not know of them and would therefore have affirmed their testaments. Indeed, it was Dr Bethell's evidence that he checked some references and received that affirmation.[71]

45. Dr Matiussi has explained that, if Dr Patel had undergone the privileging process, it is likely that he would have been allocated "general surgery" privileges and not been the subject of specific exceptions.[72]

46. In granting interim privileges, Mr Leck acted on Dr Keating's recommendation.[73] It was reasonable of Mr Leck to act on the recommendation of his Director of Medical Services.

47. Mr Leck cannot and does not deny that he had not caused finally to be established a functioning credentialing and privileging process when Dr Patel came on the scene. He was, however, earnestly and for good reason, trying to establish a better system. It is too easy, though, with the benefit of hindsight, to assume that a qualitative process which inevitably, with varying participation, varying information, varying available time and resources etc could ever have been infallible, or is likely to have made a difference.

48. The Australian Council for Safety and Quality in Health Care standard records amongst its principles for credentialing and defining the scope of clinical practice two principles in particular which ring a poignant and pointed note when others speak with retrospective wisdom and disapproval about Mr Leck's and Dr Keating's failures on this matter.

Processes of credentialing and defining the scope of clinical practice are complimented by medical practitioner registration requirements and individual professional responsibilities that protect the community.

There can be no doubt that the community, and Mr Leck along with it, were let down by the Medical Board (theirs was the simplest "credentialing" task of all) and, of course, Dr Patel.

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71 T696.20
72 T5601-5603
73 Statement of Dr Keating Ex 448 para 359

Processes of credentialing *and defining the scope of clinical practice depend for their effectiveness on strong partnerships between health care organizations and professional colleges, associations and societies.*

Again, the community and Mr Leck along with them were let down by the lack of true commitment from the relevant colleges to the strong partnerships that were necessary. This is particularly, disappointing when it is understood that the reason for the Colleges' reluctance to participate related to concerns about their members legal liability and the desire for indemnity in relation to that liability.[74]

49. If frauds such as Dr Patel are to be avoided in the future, that is a matter for a proper body with appropriate resources to make checks with overseas medical organisations.

50. Further, we adopt as accurate and appropriate paragraphs 6 to 13 of the submissions on behalf of Dr Keating.

Submission in response to Potential Findings 1(e), (f), (g), (h) and (i)

In our submission no adverse finding should be made against Mr Leck in relation to the credentialing and privileging matter because:

- **the process was unsatisfactory and Mr Leck was trying earnestly to replace it with something more effective;**
- **his efforts, and those of Dr Keating, were being frustrated by their incapacity to secure College of Surgeons participation;**
- **this problem was known to Zonal Office and Head Office of Queensland Health and was widespread and was certainly not confined to Bundaberg;**
- **the evidence regarding what is or ought to be achieved by credentialing and privileging committees is unsatisfactory. It appears that the credentialing was very much dependent upon the Medical Board and the privileging was essentially a paper process;**
- **the probability is that a credentialing and privileging committee would not have discovered Dr Patel's history and would have granted him general surgery privileges.**

74 Statement of Mr Bergin Exhibit 383 attachments 4 & 5; T6040.10 – 17 & T5583.33 - 49

DATA COLLECTION

Potential Adverse finding 1(j)

You failed to ensure appropriate information was collected and provided to the Director of Medical Services for timely comparison with ACHS data so that any outliers or anomalies were brought to your attention. As a result it was not discovered that the rates of bile duct injury during laparoscopic cholecystectomy at the Bundaberg Hospital for the six month periods from June 2003 to December 2003, January 2004 to June 2004 and June 2004 to December 2004 were significantly higher than the ACHS Clinical Indicator rates for each of the six years from 1998 to 2003.

51. Mr Leck is no more a statistician than he is a clinician. It is too high a standard to require that Mr Leck personally "ensure" appropriate clinical information was collected.

52. Mr Leck was committed to the process of collection of appropriate clinical data[75] but the types of data to be collected and the manner in which it was collected and analysed were matters he necessarily left to others.[76]

53. The clinical governance strategy relevant to this matter was, it is submitted, a reasonable one:

Finally, with respect to data, as part of the clinical governance strategy that there was at the Bundaberg Hospital over the last several years, was it envisaged and intended that the clinical heads of departments would be the ones who would take the responsibility for seeking out specific data relating to their particular areas of practice with a view to assessing its relevance to the safe practice of medicine or surgery in their department? – Yes.

And was the intention behind that, that as the leaders of their departments and being at the coalface and having the expertise, they were the persons best placed to judge the relevance of data? – Yes.

But that system relied on two things, I suggest to you: firstly, the proper data being available to them; do you accept that proposition?—Yes.

And secondly, their honesty in dealing with it? – Yes.77

[75] T2260.50
[76] T7127.30
[77] T7296.5-20.

54. It was reasonable for Mr Leck to expect that those responsible would make proper data available or, if they were unable to do so, would tell him and it was reasonable of him to expect that it would then be dealt with honestly.

55. It is asserted that it was not discovered that rates of bile duct injury were "significantly higher than the ACHS clinical indicator rates". However, the issue of whether that assertion is correct has been put in question.[78]

Submission in response to Potential Finding 1(j)

If there were errors or "something amiss"[79] with either collection of or the access to clinical data, it is just not reasonable to hold Mr Leck personally responsible. The systems were in place.

78 Statement of Mr Johnston Exhibit 492 & Exhibit 498
79 T7295.53.

COMPLAINT INVESTIGATION

Potential Adverse Finding 1(k)

From February 2004 you were aware of complaints about the clinical practices and procedures of Dr Patel and his behaviour, including but not limited to, the following:

i. **in February or March 2004 you received an informal complaint from Ms Toni Hoffman about the insulting behaviour of Dr Patel towards nurses in the ICU, the giving of conflicting orders for medical treatment, Dr Patel's lack of communication with Ms Hoffman as NUM of ICU, Dr Patel's intimidatory conduct, Dr Patel's refusal to transfer patients to Brisbane, the level of care provided by Dr Patel and his performing oesophagectomies;**

ii. **in February 2004 you received a complaint that Dr Patel used a local anaesthetic on Mr Geoffrey Smith to which he was allergic and which was ineffective;**

iii. **an audit provided to you between January and June 2004 showed Dr Patel had either one complication or six in his placement of Tenchkoff catheters and inquiry would have revealed he had six complications being a 100% complication rate;**

iv. **in July 2004 you received sentinel event and adverse incident notifications and a number of complaints from staff about the treatment and death of Mr Desmond Bramich;**

v. **in October 2004 you received an oral and written complaint from Ms Toni Hoffman the substance of which is contained in the written letter dated 22 October 2004 from Ms Hoffman to you (TH37 of Exhibit 4);**

vi. **in October 2004 you received a version of a catheter audit showing that Dr Patel had a 100% complication rate resulting from his placement of six Tenchkoff catheters including two deaths;**

vii. **in October and November 2004 you received corroboration of the complaint of Ms Hoffman from Drs Berens, Risson and Strahan;**

viii. **In January 2005 you received a complaint by Dr Stephen Rashford about the treatment provided to a patient who has been identified before the Commission as P26;**

ix. **on 21 December 2005 you became aware that another patient Mr Kemps had died as a result of Dr Patel having performed another oesophogectomy on 20 December 2004 and in January 2005 you became aware of complaints about this;**

x. **within ASPIC minutes of meetings which were sent to the Leadership and Management Meetings on which you sat it was apparent that the ICU was regularly over budget for costs;**

Potential Adverse Finding 1(l)

While you responded to some of the individual complaints, you failed:

i. **to speak to Dr Carter or Dr Patel about the concerns raised with you by Ms Hoffman concerning Dr Patel and the capacity of ICU in February or March 2004;**

ii. **to speak to Dr Miach to verify and seek further details about the information that he refused to send any of his patients to Dr Patel because he thought he was incompetent;**

iii. **to consider or internally investigate the cumulative significance of the complaints.**

Potential Adverse Finding 1(m)

After receiving the complaint of Ms Hoffman in October 2004, you took an inordinate amount of time to arrange the external review by Dr Fitzgerald or any sort of adequate review of Dr Patel's clinical competence to occur.

External Complaints

56. The usual practice was that patient complaints would be referred to Dr Keating as the Director of Medical Services. This was entirely consistent with Queensland Health policy and practice. Listed under "primary duties and responsibilities" in the position description of the Director of Medical Services is:

"Management, investigation and resolution of patient complaints and also provision of advice regarding appropriate preventative measures".[80]

57. Mr Leck did not receive a complaint as alleged in notice 1k(ii). The patient, Mr Smith, said: [81]

"I got called into his office and may I say now that person who I thought I was talking to was the manager Mr Leck, but it wasn't until this Commission that the – I found out the person I was talking to was Mr Keating over here. He was the person I was talking to."

58. There is no evidence of any external patient complaint about Dr Patel coming to Mr Leck's attention. The only exception is that, in relation to the patient Mr Dalgliesh (P151), Mr Leck asked Dr Keating to undertake inquiry and then subsequently gave feedback to the patient including discussing with the patient the proposal for a further operation.[82]

59. This is not out of accord with reasonable expectation. Ms Raven, Quality Coordinator for the District, in preparing to give her evidence to the Commission, undertook a review of the complaints register and, even then, was able to identify only three complaints relating to Dr Patel. She mentions that it is not uncommon for a complaint to be lodged without identifying the health care provider involved.[83]

60. When Mr Leck explicitly sought information about adverse events involving Dr Patel following his meeting with Ms Hoffman on 20 October 2004, Ms Raven was able to identify only two reports in relation to Dr Patel[84]. Mr Leck, even at

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80 Statement of Dr Keating Exhibit 448 attachment DWK2
81 T2439.18
82 Statement of Dr Keating Exhibit 448 para 318 – 319 & Exhibit 225 attachment GF19
83 Statement of Ms Raven Exhibit 162 para 29
84 Statement of Ms Raven Exhibit 162 para 71

the time of his writing to the Bundaberg News Mail understood that there was only one patient complaint.[85]

Internal Complaints (General)

61. The usual process for making, receiving and dealing with complaints or concerns relating to clinical practices and procedures of hospital medical staff was that the complaint would be sent to Dr Keating directly. He would seek relevant information from the practitioner concerned, medical records, patient and clinical information systems and appropriate hospital policies. Specialist medical advice from a clinical director would also be requested[86].

62. If the complaint related to a medical practitioner's clinical practice and was rated as high risk, information would be gathered for discussion with the District Manager[87]. No such discussion was had by Dr Keating with Mr Leck save as is specifically referred to in this submission.

63. Mr Leck refers to the fact that he located an email from Ms Hoffman to the then Director of Nursing, Glenys Goodman in September 2003.[88] This appears to be attachment TH6 to Exhibit 4. There is no suggestion from Ms Hoffman that she sent the email to Mr Leck nor does that appear on the face of it. There is no evidence as to when or how it ultimately came into Mr Leck's possession nor, in our submission, can there be any suggestion that it was not proper to be left for attention by the Director of Nursing and the Director of Medical Services to whom it was addressed.

64. Ms Aylmer says that, on 7 July 2003, she gave a report to "Leadership and Management" (including Mr Leck), which noted "my initial concerns about wound dehiscence"[89]. The report was the monthly report to Leadership and Management for the month of July. The subject, wound dehiscence, is mentioned as one of six items under the heading "Infection Control" and there is no reference to Dr Patel. In our submission, there was no reason at all for Mr Leck to have been alerted to any particular issues regarding Dr Patel and no

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85 T7305.40-60
86 Statement of Dr Keating Exhibit 448 para 376-377
87 Statement of Dr Keating Exhibit 448 para 378
88 Statement of Mr Leck Exhibit 463 para 13

reason at all that he should not properly have left this clinical matter to the Director of Medical Services and the Director of Nursing. Both Ms Aylmer[90] and Dr Keating[91] have given evidence of the manner with which that subject was dealt. Neither suggests that it was raised with Mr Leck in any way nor that he was or should have been aware that there was any connection to Dr Patel.

65. Mr Leck accepts that a document entitled "Peritoneal Dialysis Catheter Placements – 2003" was left on his desk. No one has given evidence of giving this document to Mr Leck. Certainly there is no evidence that anyone raised any alarms in relation to the document nor even explained to him what it was. The evidence indeed suggests that it underwent changes and did not achieve its final form until October of 2004[92]. No witness has given evidence of giving that document to Mr Leck in October 2004. Mr Leck said that he could no longer recall the precise form of the document he received.[93] However, it cannot have been the final form because Mr Leck says he had a form of the document by June. That document did not show a 100% complication rate by Dr Patel. In fact Dr Patel was only referred to in connection with one of the catheter placements on that form. Even the final form of the document does not on its face disclose a 100% complication rate because it does not explain that there were only 6 placements done. On this subject, Mr Martin says:

> *"I assumed that Dr Patel had been doing these procedures for – for quite some time, I don't know how long, but this was just in relation to this particular six. So I assumed there had been other placements undertaken."*[94]

66. At any rate, Mr Leck acted properly in referring the document to Dr Keating[95].

67. Dr Miach does not suggest that he informed Mr Leck of his concerns regarding Dr Patel's competence with respect to the catheters nor of his decision that Dr Patel should not operate on his patients. Dr Keating denies that he ever

89 Statement of Ms Aylmer Exhibit 59 para 11
90 Statement of Ms Aylmer Exhibit 59 para 12-13
91 Statement of Dr Keating Exhibit 448 para 63-75
92 Statement of Mr Rollings Exhibit 399
93 T7193.5 - 20 & T7223.20 - 25
94 T2020.45
95 Statement of Mr Leck Exhibit 463 para 27-30 & T7193 et seq.

knew of any such decision by Dr Miach[96] and he could not therefore have informed Mr Leck.

68. The Baxter Catheter Program was unremarkable from Mr Leck's point of view and the briefing on the subject to the Zonal Manager which was prepared by Dr Keating for forwarding by Mr Leck is reflective of what Mr Leck was being told about it.[97]

Meeting with Ms Hoffman, March 2004

69. Ms Hoffman gives evidence of a meeting with Mr Leck towards the end of February 2004.[98] Mr Leck believes the meeting was in early to mid-March of that year. He identifies the date by reference to the fact that Ms Hoffman was acting as Director of Nursing at the time. Ms Hoffman was acting in that position from 3 March to 20 March 2005.[99] At that meeting, Ms Hoffman gave to Mr Leck part of a document, which appears as attachment TH10 to Exhibit 4. As Ms Hoffman explained in her evidence, the document at the time consisted only of the part that is bracketed.

70. The document, as it then existed, made no reference to nor complaint about Dr Patel's surgical competence. Rather, it was directed at his attitude and behaviour. Ms Hoffman certainly saw things this way. At that stage, according to her evidence, she still wanted to try to work out some sort of working relationship with Dr Patel.[100]

71. Ms Hoffman made clear in her evidence that she expressly asked Mr Leck not to do anything about the matters then being raised at that stage for the very reason that she wished to try to repair the relationship with Dr Patel.[101] The document itself carries Ms Hoffman's handwritten endorsement *"document handed unofficially to Peter Leck. Asked him not to act upon issue yet"*.

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96 Statement of Dr Keating Exhibit 448 para 191
97 Statement of Dr Keating Exhibit 448 attachment DWK56
98 Statement of Ms Hoffman Exhibit 4 para 49
99 Exhibit 85
100 T88.25
101 T88.10 - 20

72. Though respecting Ms Hoffman's request, Mr Leck nonetheless took the perfectly sensible precaution of confidentially bringing the concern to the attention of the Director of Medical Services and the Director of Nursing for discreet review.[102]

73. Dr Keating and Ms Mulligan dispute that they were told about the March 2004 complaint. Probably not much turns on that dispute because Ms Hoffman herself did not want the complaint progressed and, for that reason, it is unlikely to have assumed any particular significance to either Dr Keating or Ms Mulligan.

ICU Costs

74. Mr Leck quite properly asked Dr Keating to look into this matter and the outcome of his inquiries is set out at paragraphs 124 – 131 of Exhibit 448.

75. So, until 20 October 2004, there was nothing substantiated to alert Mr Leck to doubts about Dr Patel's clinical competence.

Meeting with Ms Hoffman on 20 October 2004 and Letter of 22 October 2004

76. Mr Leck met with Ms Hoffman on 20 October 2004, she explained her concerns to him. Ms Hoffman says Mr Leck was "horrified".[103] He took detailed notes of what Ms Hoffman told him and that record[104], she has agreed, is a "fairly accurate document".[105]

77. The document records Mr Leck's assurance to Ms Hoffman that any issue she raised would be followed through. He asked Ms Hoffman to commit the details to writing and he received the written material on 22 October 2004.[106] Statements from Karen Stumer, Karen Fox, Kay Boison, Karen Jenner and Vivienne Tapiolas were received a few days later on 25 October 2004. Mr Leck, in company with Dr Keating, over the next week interviewed some of those doctors whom Ms Hoffman had identified as sharing her concerns. They

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[102] T7217-7222
[103] Exhibit 88 & T1434.30 et seq.
[104] Exhibit 8
[105] T165.34
[106] Statement of Ms Hoffman Exhibit 4 attachment TH37

were Drs Berens, Strachan and Risson. The notes taken at these meetings appear as exhibits[107].

78. Despite reluctance on the part of Dr Keating, Mr Leck insisted on an external investigation.[108] In the following weeks, inquiries were made of a number of different sources about appropriate persons to conduct the inquiry.[109] Dr Mattiuissi was one of the persons consulted.[110] The tilt train accident interrupted these efforts[111], but on 16 December 2004 Mr Leck made contact with the Audit and Operational Review branch of Queensland Health and this contact marked the instigation of the process of ultimate investigation by Dr Fitzgerald, the Chief Health Officer for Queensland.

79. The evidence shows that:

(a) Mr Leck contacted Rebecca McMahon at Audit and Operational Review Branch on 16 December 2004 by telephone.[112] Mr Leck sent a facsimile on the same day enclosing a copy of Ms Hoffman's letter[113] and Ms McMahon replied next day 17 December 2004 confirming that she had spoken to Mr Michael Schafer and that he had confirmed that the Chief Health Officer, Dr Fitzgerald, "will be able to provide advice as to the manner in which this review should be conducted". That email was copied to Dr Fitzgerald.

(b) Mr Leck then telephoned Dr Fitzgerald's office on 17 December 2004. He was unable to speak to Dr Fitzgerald but was assured that Dr Fitzgerald was aware of the matter and, though going on leave, would take over the conduct of the investigation.[114]

(c) In January, Mr Leck was becoming increasingly concerned that he had not heard further from Dr Fitzgerald and, on 13 January 2005, he sent

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107 Exhibit 281 attachment 2
108 Statement of Mr Leck Exhibit 463 para 52
109 Statement of Mr Leck Exhibit 463 para 53
110 T5868.30
111 Statement of Mr Leck Exhibit 463 para 54
112 T4251.50; T7229 et seq. & Statement of Dr Fitzgerald Exhibit 225 attachment GF8
113 Statement of Dr Fitzgerald Exhibit 225 attachment GF8 &Statement of Mr Leck Exhibit 463 para 55
114 T4252.25-45 & Statement of Mr Leck Exhibit 463 para 57

an email to Dr Scott expressing concern about the need for a swift review process.[115] Dr Scott replied to that email on 20 January 2005 and Mr Leck acknowledged that reply on the same day recording that he had now discussed the matter with Dr Fitzgerald and "progress was being made".[116]

(d) Mr Leck's email to Dr Scott[117] referred to the Shannon Mobbs (P26) matter and Dr Rashford's concerns, nursing staff concerns about "outcomes of patients (including some deaths)" and the fact that Mr Leck's Medical Superintendent "has now expressed some concern". Dr Fitzgerald conceded that the content of the email to Dr Scott was brought to his attention on or about the 20th of January 2005.[118]

(e) On 19 January 2005, Mr Leck then sent to Dr Fitzgerald a comprehensive bundle of material including:

- Ms Hoffman's letter and attachments;
- the notes of the interviews with Drs Strahan, Risson and Berens;
- the file note of the meeting with Ms Mulligan and Ms Hoffman;
- the adverse event report form relating to Mr Bramich, the Sentinel Event Report form relating to Mr Bramich;
- the letters or statements of concern by nurses Hunter (4 January 2005), Law (undated but received on 14 January 2005), Gaddes (undated but received on 14 January 2005), Zwolak (undated but received on 14 January 2005); and
- the Peritoneal Dialysis Catheter Placements document.[119]

115 Statement of Dr Fitzgerald Exhibit 225 & Exhibit 449
116 Exhibit 449 & Statement of Dr Fitzgerald Exhibit 225 attachment GF9
117 Exhibit 449 & Statement of Dr Fitzgerald Exhibit 225 attachment GF9
118 T4253.1-20
119 Exhibit 281

(f) Mr Leck, through Dr Keating and his secretary, ensured a line of service to Dr Fitzgerald and his assistant Mrs Jenkins for the supply of all hospital records and information they might require[120] and facilitated Dr Fitzgerald's interview of all relevant staff.[121]

(g) Mr Leck sought guidance from Dr Fitzgerald as to what he could properly tell Dr Patel about the investigation and what he needed in the way of patient information and other things for the investigation.[122]

Submission in Response to Potential Findings 1(k), 1(l), and 1(m)

The Commission ought not to make any adverse findings about these matters because:

f. In relation to Ms Hoffman's contact with Mr Leck in March 2004:

- **neither the document itself nor Ms Hoffman in person raised issues regarding Dr Patel's competence. The focus was his behaviour.**
- **Ms Hoffman expressly asked Mr Leck not to take any action and endorsed the document accordingly in writing.**
- **Ms Hoffman at that stage still wanted to work out a working relationship with Dr Patel.**
- **Mr Leck nonetheless took the precaution of referring the document to the Director of Medical Services and the Director of Nursing for discreet review.**

g. No complaint was made to Mr Leck by or on behalf of Geoffrey Smith.

h. In relation to the catheter audit:

- **on the evidence, the probability is that the form of the document seen by Mr Leck was the one that referred to Dr Patel in relation to only one of the six entries;**

120 Statement of Dr Fitzgerald Exhibit 225 attachment GF11
121 Statement of Dr Fitzgerald Exhibit 225 attachment GF11 & T7304
122 T4255.10 - 30 & Exhibit 453

- no one gave this document to Mr Leck in person nor sought to explain what it was or what it meant;
- Dr Miach does not suggest that he informed Mr Leck of his concerns. Dr Keating denies ever knowing of those concerns and therefore could not have informed Mr Leck;

i. Until October 2004 there was nothing substantial communicated to Mr Leck, which would have alerted him to doubts about Dr Patel's surgical competence.

j. In relation to the contact with Ms Hoffman in October 2004:

- Mr Leck listened carefully to and documented Ms Hoffman's complaint;
- he assured Ms Hoffman that matters would be followed through;
- he caused interviews to be conducted of some of the medical staff;
- despite initial reluctance by the Director of Medical Services he insisted that there was to be an external investigation;
- he made efforts and caused others to be made by the Director of the Medical Services to identify suitable persons external to the hospital to carry out the investigation;
- when advised that the Chief Health Officer for Queensland, Dr Fitzgerald, was the appropriate person he followed up with written contact to the Audit and Review Office and by telephone to Dr Fitzgerald's office;
- he became anxious at delay at Dr Fitzgerald's end and followed up with Dr Scott;
- he briefed Dr Fitzgerald all of the materials in his possession;
- he gave Dr Fitzgerald full access to hospital records and information and hospital staff.

As to the delay in arranging the review by Dr Fitzgerald, it is not sought to suggest that this simply "does not matter", however, it was undoubtedly correct for Mr Leck to insist on external review. There were no established Queensland

Health procedures that enabled Mr Leck to access appropriate external reviewers. For that reason the task of identifying an appropriate person to conduct the review proved difficult and the tilt train interruption could not be helped and did not help. Mr Leck took matters seriously. The delay from 22 October to 17 December 2004 was regrettable, but it was not characterised by complete inaction and Mr Leck did not have independent advice nor the benefit of hindsight as to the urgency that may now be seen as appropriate. As is explained later in these submissions, even as late as December 2004 no-one was suggesting that Dr Patel ought to be suspended. Even the Chief Health Officer did not suggest that once he had investigated.

REAPPOINTMENT OF DR PATEL

Potential Adverse Finding 1(n)

Despite the matters raising concern about Dr Patel's competence as set out above, by letter dated 24 December 2004, you permitted or allowed Dr Keating to offer to extend Dr Patel's contract from 1 April 2005 to 31 March 2009 contrary to Queensland Health Policy which required a merit process for such a contract, a policy that you ought to have been aware of as District Manager.

Potential Adverse Finding 1(r)

On or about 31 March 2005 you carelessly or improperly offered Dr Patel a further extension of his contract until 31 July 2005.

80. Dr Patel's appointment was due to expire on 31 March 2005. Dr Keating did not consult with Mr Leck before making an offer on 24 December 2004 to Dr Patel to extend his contract from 1 April 2005 to 31 March 2009. Dr Keating does not claim to have done so and it was never put to Mr Leck. The fact is Mr Leck was on leave.[123] He did not return until 4 January[124] and the very next day, or within a few days, Dr Keating informed Mr Leck of his view that Dr Patel's services should not be continued beyond the short term.[125]

81. Mr Leck acquiesced in the proposed short-term re-engagement of Dr Patel from 1 April 2005 to 31 July 2005 to allow time to find a replacement. That was reasonable in the circumstances that:

- neither Dr Fitzgerald nor Dr Keating thought any pre-emptory action in respect of Dr Patel was appropriate;
- Dr Gaffield was likely to leave;[126]
- both Dr Fitzgerald and the Medical Board knew of the proposal to re-engage Dr Patel and neither had remonstrated about that.

123 T7294.25.
124 T7294.32.
125 T6870.40-50.
126 T7302.1

82. It was put to Mr Leck that he was "happy" to re-engage Dr Patel. He resisted that proposition.[127] That is consistent with Dr Buckland's evidence that Mr Leck did not seem interested in re-engaging Dr Patel.[128]

Submissions in response to Potential findings 1(n) & 1(r)

The Commission should not make any adverse findings on these matters because Mr Leck was not a party to nor aware of the offer made to Dr Patel on 24 December 2004. He was in fact on leave.

Further, the short term re-engagement intended to allow time to find a replacement was reasonable from the point of view of Mr Leck given the advice he was receiving from Dr Fitzgerald and Dr Keating, the fact that Dr Gaffield was likely to leave and the fact that both Dr Fitzgerald and the Medical Board knew of the proposal to re-engage Dr Patel but had not remonstrated.

[127] T7214.20.
[128] T5501.50.

SUSPENSION OF DR PATEL

Potential Adverse Finding 1(o)

On or about 4 January 2005 Dr Keating informed you of his concerns about Dr Patel, and in particular that:

- **i.** **Dr Patel overextended himself performing a limited number of certain major sub-speciality operations - oesophagectomies, and thoracic cases when an appropriate level of intensive care support was not available for prolonged periods;**
- **ii.** **Dr Patel had delayed transfer of seriously ill patients to Brisbane;**
- **iii.** **Dr Patel was perceived by staff as arrogant, abrasive and rude;**
- **iv.** **Dr Patel had multiple responsibilities - clinical, administrative, educational and supervisory, which resulted in a potential for fatigue and errors in his judgment;**
- **v.** **the best option was to recruit a new Director of Surgery.**

Potential Adverse Finding 1(p)

Notwithstanding your knowledge of the complaints and concerns referred to above and of the delay in obtaining an external review of his clinical competence, you failed to:

- **i.** **suspend or restrict Dr Patel's interim clinical privileges;**
- **ii.** **restrict his scope of practice or otherwise take steps to limit Dr Patel's clinical duties; and**
- **iii.** **to ensure that Dr Patel was immediately assessed by a clinical privileges and credentials committee.**

83. Mr Leck had no clinical or medical training or knowledge and properly looked to others for advice on clinical matters.[129]

84. Ms Hoffman, when she brought her complaints to Mr Leck in October 2004 did not say that she thought Dr Patel ought to be suspended. Ms Hoffman gave evidence that she brought the matters to Mr Lecks attention so that the care of patients for which she had concerns could be investigated.[130]

> *"...I wasn't asking for anything else but for these patients to be investigated by an independent auditor"*[131]

85. Although Ms Hoffman said that she told Dr Fitzgerald she thought Dr Patel ought to be "stood down"[132] there is no evidence that either she or Dr Fitzgerald ever told Mr Leck that.

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[129] T7120.7 & T6835.50–6836.10
[130] T1475.21 - 41

86. Mr Leck's Director of Medical Services did not consider that it was necessary to suspend Dr Patel.[133] Though the possibility of suspension occurred to Mr Leck, he relied on the opinion of Dr. Keating.[134]

87. In Dr Keating's opinion, there was not sufficient basis to stand Dr Patel aside.[135]

88. The Commission has raised the issue of Mr Leck failing to consult Drs Miach and Carter. Mr Leck explained that at the time he spoke with Drs Strahan, Risson and Berens. He was not himself seeking to conduct a full investigation but seeking threshold corroboration so as to move to the next step of external review.[136] If Dr Miach, on the basis of his own experience with Dr Patel, thought Dr Patel should be suspended, in the interests of patient safety, he should have made that known. Not only did he not make his own reservations about Dr Patel known to Mr Leck, he actually insisted on removal from the minutes of clinical forum meetings his own decision not to use Dr Patel. One of the reasons he gave in cross examination for not making that decision more widely known was that he was not even sure whether, in fact by doing that, he might be "doing (Dr Patel) a disservice".[137]

89. Consultation with Dr Carter is unlikely to have produced any different result. He says:

> *"... Dr Patel on the whole was a reasonable surgeon and there were times when we can look back and say very easily that he stepped outside his limitations, and especially the limitations that were put on him in America, but at the time we did not know that, and I wasn't commenting on his general ability, but merely the nature of the man, because he was always brash and in your face"*[138]

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131 T1475.29
132 T180.7
133 T7196.20
134 T7201.30
135 T6864.20
136 T7195.50 & T6848.34-54
137 T1670.40
138 T4004.55

It was not until after Mr Kemps' case (end of December 2004) that Dr Carter saw the need for any action and then only for limitation on oesophagectomies which in fact occurred.[139]

90. Most importantly of all, Mr Leck had taken the precaution of moving to external review and placing matters in the hands of no less than the Chief Health Officer for Queensland. As the evidence shows:

(a) Dr Fitzgerald, the Chief Health Officer, was "in charge" of the investigation. He accepted that fact and accepted that Mr Leck was relying on him as to what action he should take[140] but it was not Dr Fitzgerald's view that Dr Patel should be suspended.[141]

(b) Not only did Dr Fitzgerald not propose or suggest suspension but nothing in his final report alerted anyone to the need for that.[142] In that respect, incidentally, it should be noted that the form of report finally received by Mr Leck and Dr Keating, did not bear the attachment containing the statistics about complication rates for laparoscopic cholecystectomies.[143] The evidence is that there were various drafts of this report.[144] The statistical information was compiled from sources outside Bundaberg Hospital[145]and there is evidence that it is of limited reliability without further investigation.[146]

(c) Mr Leck did not, in any event, receive the report until only a matter of days before he was stood down.[147]

(d) Mr Leck spoke with Dr. Mattiussi and was comforted that Dr Keating's view about complex surgery had been correct.[148] During Dr Fitzgerald's investigation, he was still being told *"by people who knew (Dr Patel) and observed his surgery"* that Dr Patel was *"not the*

139 T4017.50-60
140 T6145.30
141 T6112-6113; T6115.55; T6117.1-10 & T6143-50
142 T6132
143 T6819.40 & T7125.50-60
144 T6138 and Statement of Mr Wenban Exhibit 495
145 T6144.40
146 Statement of Mr Johnston Exhibit 492 & Letter of Dr Woodruff Exhibit 498
147 T7125.46 & T6105.31
148 T7238.40–7239.30 and T7307 et seq.

best or surgeons but he also wasn't the worst". Dr Fitzgerald says that this same impression emerged from the data that was retrieved.[149] As late as 14 January 2005 some doctors were still writing to Mr Leck and Dr Keating speaking favourably of Dr Patel's skills.[150]

91. Potential Adverse Finding 1(o) erroneously asserts that the matters listed therein (i) – (iv) were conveyed to Mr Leck. The evidence does not support that assertion. If it is suggested that Dr Keating's evidence (for example T6874.1-6875) is sufficient for this purpose, that cannot be so. In no case was Dr Keating asked whether he specifically informed Mr Leck of each of the matters of detail listed in Potential Adverse Findings 1(o) (i) – (iv). It is plainly not enough to refer to a generalised suggestion of informing Mr Leck of his thoughts. Of great significance is that none of these matters were put to Mr Leck by Counsel Assisting or anyone else. The only specific matter which the evidence shows Mr Leck was informed about was Dr Keating's view that Dr Patel's services should not be continued beyond a short period of time *"and I believe that was as much related to the interpersonal conflict situation where I believe that he would be unable to change his behaviour"*.[151]

92. We adopt as accurate and appropriate paragraph 75 of the submissions on behalf of Dr Keating. There is a danger in judging both Mr Leck and Dr Keating with the very substantial benefit of hindsight.

Submission in response to Potential Findings 1(o) and 1(p)

In our submission, Mr Leck, who did not have clinical or medical training, cannot be criticised for not unilaterally suspending Dr Patel when:

- **Although, of course, patient safety is the primary principle, the service to many needy patients would suffer if the decision were wrong.**
- **Dr Keating thought it not an appropriate course.**
- **Dr Fitzgerald thought it not an appropriate course.**
- **Dr Mattiussi gave Mr Leck some reason for comfort that Dr Keating's judgements were right.**

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149 T6118.40-6119.10
150 Statement of Dr Athanasiov Exhibit 142 attachment ARA4

- **Other doctors were expressing opinions that Dr Patel's skills, if not the best, were not the worst.**
- **Even if Dr Keating eventually had a change of mind, his communications to Mr Leck appear to have been focused on the "interpersonal conflict matter" and they were in any event made in January 2005 by which time the matter was in Dr Fitzgerald's hands.**

[151] T6898.50

LETTER TO BUNDABERG NEWS MAIL

Potential adverse finding 1(q)

On or about 28 March 2005 you wrote a letter to the Bundaberg News Mail (Exhibit 473) which was deliberately deceptive in asserting that you had received no advice indicating that the allegations have been substantiated and that a range of systems was in place to monitor patient safety.

93. Mr Leck gave evidence that he understood that it was one of his functions as District Manager to minimise publicity adverse to Queensland Health's interests.[152]

94. He stated that part of the reason he sent the letter to the Bundaberg News Mail was to control the damage from adverse publicity.[153] He also said, however, that *"the intent of the letter was to say that, you know, that I felt that a process of natural justice was important."*[154]

95. It is true that, in the letter Mr Leck states that at the time if writing the letter he had received no advice that the allegations against Dr Patel had been substantiated. He explains this in evidence by saying that he had not received the results of the independent investigation he had commissioned from Dr Fitzgerald. He did not consider the opinions of Drs Berens, Strahan, and Risson, as expressed during his meetings with them as "substantiating" the allegations against Dr Patel.[155]

96. It was put to Mr Leck that the letter involved elements of "spin or snowing the reader" and he denied this.[156] He also categorically denied that the letter was false by omission[157] or that he intended to give the impression that Dr Patel was a safe doctor.[158] Mr Leck's evidence on this point should be accepted. He had no reason to mislead.

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[152] T7203
[153] T7205.41
[154] T7205.50
[155] T7205.30
[156] T7205.46 - 50
[157] T7205.44
[158] T7205.53 – 7206.3

97. Similarly, Mr Leck's evidence that he was referring to the adverse event reporting policy and the collection of clinical indicators when he referred to the "systems in place to monitor patient safety" should also be accepted. There is no basis upon which it could seriously be suggested that the comments were made with anything intention other than a genuine concern to reassure the public. At the time the comments were made, Mr Leck had no reason to think the systems he had put in place were not being properly implemented by staff.

98. He advised his immediate superior, Mr Bergin, by email of his intention to send the letter. It is clear from the tone of the email that Mr Leck was concerned that the content of the letter fairly and truthfully represent the situation.[159] There is no evidence that Mr Bergin advised Mr Leck against sending the letter or otherwise attempted to prevent its publication.

Submission in response to Potential Finding 1(q)

We submit that there is no evidence at all that Mr Leck intended to deceive the public or anyone else when wrote to the Bundaberg News Mail. There is no evidence that he did not genuinely hold the opinions expressed in the letter. Accordingly, we submit that there is no basis upon which an adverse finding of this nature could be sustained.

[159] Exhibit 474

AIRFARE

Potential Adverse finding 1(s)

On or about 1 April 2005 you carelessly or improperly approved payment of Dr Patel's return airfare back to the United States in circumstances where Dr Patel had no contractual entitlement to such payment.

99. Mr Leck did not check Dr Patel's contract but says, from his experience, it was usual that Queensland Health would meet airfares for an overseas trained doctor to return at the end of a contract period.[160] In these circumstances, there was nothing improper or unusual about the request for authorisation. It is to be remembered that Dr Fitzgerald had not yet produced a report and had not given Mr Leck any interim intimation that it would contain any serious adverse findings against Dr Patel. Mr Leck informed both Dr Fitzgerald[161] and the Medical Board[162] in advance that Dr Patel was leaving the country. Neither suggested that Mr Leck could or should do anything to prevent that.

100. Dr Nydam says that, as the person who negotiated the original contract for Dr Patel, he certainly intended that the return airfare be part of his contract and, had he been aware that the contract document sent out by the HR Department did not contain express reference to such an arrangement, he would have amended it accordingly.[163]

101. The evidence of Dr Bethell confirms that Dr Nydam expressly negotiated the return airfare arrangement with Dr Bethell on behalf of Dr Patel[164] and this is confirmed in diary note on Dr Bethell's file of a telephone call between Drs Bethell and Nydam on 20 December 2002.[165]

102. It is wrong in law to suggest that the letter from Ms Rose to Dr Patel[166] constituted the contract of employment. The letter is stated to be a letter of

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160 T7213.40
161 Statement of Dr Fitzgerald Exhibit 225 attachment GF11
162 Statement of Mr Demy-Geroe Exhibit 24 attachment MDG41
163 T4162.28-4163.8
164 T722.20–40 & T4168.1–34
165 Exhibit 50
166 Statement of Dr Nydam Exhibit 51 attachment KN9

offer of employment and records that Dr Patel would be "employed under the terms of the Senior Medical Officers and Resident Medical Officers' Award". The terms set out in the letter only purport to summarise the "major conditions" of the Award. On its face the letter is clearly not intended to comprise the entire terms of the contract.

103. Further, the letter of offer states that transfer and relocation expenses were "subject to negotiation with the District Manager".[167] This is a function that Mr Leck could and clearly did properly delegate to Dr Nydam.[168]

104. Quite apart from the obvious propriety in a contractual sense of meeting the payment, it fell within Mr Leck's managerial discretion.[169]

105. Further, the evidence is clear that Dr Patel had already bought and paid for his return ticket and Mr Leck authorised a reimbursement of those funds.[170] There can be no serious suggestion, then, that by authorising the payment Mr Leck was assisting Dr Patel to "flee" the jurisdiction. Dr Patel would have returned to America in any event.

Submission in response to Potential Finding 1(s)

In our submission, the evidence of Drs Nydam and Bethell show that there was a proper contractual basis for authorising the airfare. The fact that Mr Leck advised Dr Fitzgerald and the Medical Board in advance that Dr Patel was leaving the country showed that he was acting properly and innocently. He in any event had the relevant managerial discretion pursuant to then current Queensland Health Department policy to authorise such a reimbursement. In these circumstances, no adverse finding can be made against Mr Leck in respect of this matter.

167 Statement of Dr Nydam Exhibit 51 attachment KN9
168 Exhibit 50 (diary note of 20 December 2002)
169 T5383.20–5383.60 & T7213.5
170 Statement of Mr Cronin Exhibit 145

LETTER TO DR PATEL DATED 5 APRIL 2005

Potential Adverse finding 1(t)

You carelessly or improperly drafted and approved a letter from the Bundaberg Health Service District to Dr Patel dated 5 April 2005 (Exhibit 284 VC3) expressing thanks to Dr Patel for all his hard work and care provided to the residents of the Bundaberg community.

106. Mr Leck's evidence is that he does not recall being involved in the drafting of this letter but he accepts that he may have been.[171]

107. The decision to write the letter was not Mr Leck's but that of the Bundaberg Health District Council.[172]

108. Although Mr Leck does not remember drafting the letter, his secretary Ms Dooley gave evidence that he did so[173].

109. Mr Chase, though admitting that he signed the letter, at first denied that he ever read it. However, Mr Dooley gave evidence that Mr Chase not only read it but remarked "it is probably not exactly what I would have said, but that will do". Mr Chase eventually accepted this.[174]

110. Mr Chase accepted in cross-examination that the letter as written was not out of accord with the Council's instructions.[175] Neither the Council nor Mr Leck knew at the time of Dr Patel's fraudulent registration. The Council must have known as much as Mr Leck did, namely what was contained in Ms Hoffman's letter and attachments because they were by now public. At a time when those matters were still under investigation, there was nothing wrong with or improper about the Council wanting to express regret about Dr Patel's opportunity for natural justice being overtaken nor about thanking him for his work. Nor was

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171 T7212.38
172 T7212.44–50; Statement of Mr Chase Exhibit 284 para 9; Statement of Ms Dooley Exhibit 287 para 5 & 8 & Exhibit 285A
173 Statement of Ms Dooley Exhibit 287 para 8
174 Statement of Ms Dooley Exhibit 287 para 8
175 T4407.20–30

there anything wrong in Mr Leck implementing the Council's instruction in the circumstances (if he did).[176]

111. The letter was written only to Dr Patel and not to the world at large and could not have been misused by Dr Patel, for example, as a "reference" because it contained mention of the questions being asked in Parliament.

Submission in response to Potential Adverse Finding 1(t)

If Mr Leck drafted the letter to Dr Patel dated 5 April 2005 the evidence is clear that he did so at the request of the Bundaberg Health Service District Council. It is wrong to say that he approved the letter. As a matter of general principle, there is nothing careless or improper about writing a letter of thanks to a former staff member. At the time the letter was written Mr Leck and members of the Bundaberg Health Service District Council did not know what is now known about Dr Patel and his fraudulent registration. Mr Leck's conduct should not be assessed with the benefit of hindsight.

[176] T4399.10–40 & T4407.20-34

RESPONSE TO LEAKING OF INFORMATION

Potential Adverse finding 1(u)

Upon learning of complaints and concerns about Dr Patel's competence being made public, you responded incompetently or improperly:

i. at a meeting of ICU nurses on 23 March 2005 by saying that the leaking of the information raised in Parliament constituted a breach of confidentiality and the Queensland Health Code of Conduct and could result in dismissal; and

ii. by forwarding an email to the Zonal Manager dated 7 April 2005 (Exhibit 477) suggesting that the Audit team come up and "deliver some firm and scary messages".

Mr Leck's Meetings with the Nurses on 23 March 2005

112. The notice of potential adverse finding refers to a meeting of ICU nurses on 23 March 2005. In fact, there were two meetings.[177] One meeting was with ICU staff and a second meeting was with level 3 nurses. The notice refers only to the former (ICU) meeting. For that reason we shall confine our submissions to that meeting except to the extent where it is necessary or appropriate to refer to the second/level 3 nurse meeting. We take it that no adverse finding is contemplated in relation to the second meeting, i.e. the meeting with level 3 nurses.

Hoffman

113. Ms Hoffman says that, at a meeting on 23 March 2005 (the day after the release of the information in her letter to Mr Leck in Parliament) Mr Leck and the Acting Directing of Nursing, Deanne Walls, met with ICU nursing staff.[178] She says in the statement:

(a) *"Peter Leck was visibly furious and angry with us".*

(b) He waved around photocopied documents including *"some sort of document about what happens to people who go outside the Queensland Health Code of Conduct"; "Industrial Relations Manual document which he said outlined that people, who breached*

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177 Statement of Mr Leck Exhibit 463 para 68

confidentiality could get 2 years jail and lose their jobs"; *"some sort of CMC information leaflet"* and *"one of the PowerPoint documents supplied by the Ethical Standards people who gave us the talk in late 2004"*.

(c) Mr Leck said that he had it from *"very high sources"* that the information given to the Member at Parliament had been given to him by a member of the ICU staff and then to the media.

(d) He kept saying he was *"appalled"*.

(e) He said he was appalled that such a senior surgeon of the Hospital could be treated in such a way that denied him natural justice.

(f) It would divide the doctors and nurses, would stop patients coming to the hospital and would erode community confidence in the hospital.

(g) He lectured us about the code of conduct and said there were penalties of imprisonment for whoever took the information to Mr Messenger.

114. Ms Hoffman gave an abridged and not entirely consistent version of this evidence in her evidence in chief[179] and *"they went on to just say that this was the most appalling thing that could ever happen"*.[180] The introduction of the plural pronoun (*"they"*) suggested confusion between what might have been said or done by Mr Leck and what might have been said or done by Ms Walls.

115. In cross examination, Mr Hoffman conceded that Mr Leck had said he was appalled at the lack of natural justice given to Dr Patel and that she (Ms Hoffman) thought *"it may have even been Dianne Walls (SIC) who talked about what the consequences of being found guilty of the CMC could be, which - and then it was said - then it was mentioned, and this may mean gaol time. This could mean gaol time"*.[181]

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178 Statement of Ms Hoffman Exhibit 4 paras 167-171
179 T 185-186
180 T 185.36
181 T 1518.44

116. Commissioner Morris put to Ms Hoffman *"when there was a reference to gaol time and other consequences, you think that was Dianne* (sic) *Walls who said it?"* Her answer was *"I think so"*.[182]

117. Ms Hoffman went on to say:

> *"It was appalling for me, and I may be wrong about some of these little things, and I'll have to concede that because I can't remember exactly. When I gave that evidence, I gave it truthfully and honestly how I felt at the time, what I thought at the time, and, you know, I have had a lot of - there has been a lot of water gone under the bridge since then, and I stand to be corrected on these little things. I may be wrong."*[183]

118. Ms Hoffman conceded that Mr Leck was not present for the whole of the meeting and she was unsure, who (of Mr Leck and Ms Walls) said what and therefore was not in a position to complain that Ms Walls may have said something from which Mr Leck should have dissented.[184]

119. Finally, this exchange occurred:

> *"Commissioner: So, let's make sure we understand it anyway. You can't, with any certainty, attribute to Mr Leck the words that you are explaining* (sic) *about? - the words about jail or losing a job or other consequences. You can't say that Mr Leck used those words? - No.*
>
> *And you can't say he was necessarily in the room when those words were used? - No. He may not have been. He may have already left."*[185]

120. So, on Ms Hoffman's evidence, it is difficult to see what, if anything, Mr Leck said which might be regarded as 'incompetent or improper'.

Aylmer

121. Ms Aylmer was <u>not</u> at the meeting of ICU nurses. She was at the second meeting of Level 3 nurses.[186]

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[182] T 1519.50 - 55
[183] T 1520.12
[184] T 1519 - 21
[185] T 1521.15-26
[186] Statement of Miss Aylmer Exhibit 59 para 46 Note also that Ms Jenner does not note Ms Aylmer as being there (Exhibit 508 para 15)

122. In so far as Mr Leck's conduct at the second meeting might be argued to give some guidance as to the first meeting, Miss Aylmer said in her statement:

"The District Manager Peter Leck attended the meeting and was obviously extremely angry and accusatory in his tone. I was offended by the ease in which he blamed Nursing staff for this leak. He told us that he had heard from a number of reliable sources that nurses were responsible. I resented being accused of such behaviour and felt powerless to be able to defend myself and my peers. I was concerned that if nurses were made the scape goat for this situation, then nurses in the future would be very reluctant to advocate for the patient. I was also very annoyed that the District Manager continued to report to the media that it would be difficult to recruit other doctors now, implying that Bundaberg nursing staff are in the habit of making malicious claims against medical staff, and that he expected that we would act this way again." [187]

123. Ms Aylmer's evidence in chief complained of Mr Leck's *"tone"*, that he was *"very angry and ... he was laying his anger on us"*. As to the second meeting she gave no evidence of the kind given by Ms Hoffman (and largely resiled from) regarding threats of gaol, or dismissal or breaches of the Code of Conduct, or the waving about of documents.

124. In cross examination, Ms Aylmer said of Mr Leck:

"I cannot tell you fully what he said but he did talk about team work and people- he did talk about - again about the source that he had been told by reliable sources. He did say - talk about Dr Patel and his right to justice, and I'm not sure what else he did speak about." [188]

125. Later, Ms Aylmer said *"it was reasonable for him to raise the matters, but it wasn't necessarily reasonable of him to take the tone that he took"*.[189]

126. Ms Aylmer also conceded that, when someone in the group asked whether he intended to *"track down"* the person responsible for the leak he responded *"that's not my priority"*. [190]

127. So, Ms Aylmer's complaint about the second meeting was more about the *"tone"* rather than the content. That hardly assists in assessing the matters the subject of potential adverse finding 1(u).

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187 Statement of Ms Aylmer Exhibit 59 para 46
188 T 1079.36
189 T 1080.15

Pollock

128. Nurse Pollock gave evidence about the second meeting of the level 3 nurses with Mr Leck. She did not attend the first meeting of ICU staff.

129. In relation to the second meeting, to the extent it might be relevant, Ms Pollock's statement[191] makes no reference to Codes of Conduct or to threats of gaol or the like but says Mr Leck was *"visibly angry"*, that he said that the person who released the information *"would be reprimanded"* and that *"reprimanded"* to her meant *"they would lose their job"*.

130. Ms Pollock's evidence in chief was limited to agreeing with counsel assisting that she *"felt"* intimidated after Mr Leck had said that he knew or believed that a nurse was responsible for the leak of confidential information. She agreed with counsel assisting when he put it to her that *"you felt that the nursing staff weren't supported or valued by the executive".* It is hardly relevant or of assistance on this issue to have another nurse say what she felt (subjectively) in relation to another and later meeting.

131. In cross examination, Ms Pollock agreed that *"reprimanded"* does not mean *"dismissal"* [192] and, later, that Mr Leck might not have used the word *"reprimand"* at all.[193] She also agreed that Mr Leck was present for only about a five minute slot.[194] She agreed that Mr Leck used the word *"disappointed"* to describe his feelings, and that he spoke of team work, and that Dr Patel was going through an accountability process, and that fairness in that process being affected by the leak.[195]

132. So, again, in so far as the evidence of the second meeting can be of assistance at all, Ms Pollock's complaint is really not about the content of what Mr Leck said but about his being visibly upset.

133. In the end Ms Pollock said of Mr Leck:

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190 T 1081.10 - 20
191 Statement of Ms Pollock Exhibit 70
192 T 1204.25
193 T 1204.35 - 40
194 T 1205.1 - 10

> *"I feel he had a right to be disappointed, sure, but it was just that he was very upset. He was visibly upset and that was very evident."*[196]

Mears

134. Nurse Mears was at the second meeting, not the first. That is clear from the heading at the bottom of page 2 of her statement and the contents of paragraph 11.[197]

135. As it happens, Ms Mears' evidence demonstrates that nothing Mr Leck said at that second meeting was improper.

Jenner

136. Nurse Jenner was at the first (ICU) meeting. She said:

    (h) the fact that the Hoffman letter had gone to the media was a concern;[198]

    (i) Mr Leck was right to be concerned that the information in that letter had gone into the public domain;[199]

    (j) Mr Leck's raising of the potential breach of patient confidentiality was a matter of legitimate concern;[200]

    (k) she found Mr Leck's conduct *"intimidating"* because:

    - *"we had no idea he was coming (Ms Walls did)";*
    - *"he gave a lecture, and then left";*
    - *she had thought the meeting was going to be about something "completely different"; and*
    - *that was a "surprise".*

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195 T 1205.25 – 1206.10
196 T 1206.10
197 Statement of Ms Mears Exhibit 507
198 T 7389.10
199 T 7389.20
200 T 7393.40

(l) However, she was not fearful, and Mr Leck did not say anything threatening, so there cannot have been any *"intimidation"* in the ordinary sense of the word.[201]

137. In cross-examination Ms Jenner said she thought Mr Leck's *"manner"* was threatening. But that allegation does not appear in her statement, and she did not identify what mannerisms she found to be threatening.

138. Nowhere in her evidence does Ms Jenner say that she or any of the other nurses were threatened with dismissal by Mr Leck.

Mr Leck

139. Mr Leck's own evidence is that, he was *"very collected"* and attended the meetings for only a brief period of time. He spoke in relation to organisational values. His concerns to address at that meeting were natural justice, organisational values in terms of performance accountability and that Dr Patel was going through an accountability process and a concern about breach of confidentiality.[202] He denied holding up documents, denied threatening dismissal, denied speaking of imprisonment, denied referring to the code of conduct and denied suggesting that anyone had *"brought shame upon the ICU"*.[203] A number of these allegations were put to Mr Leck by counsel for the Nursing Union although they have not been the subject of any evidence.

Other Witnesses

140. The following people were at the first (ICU) meeting. Mr Leck, Ms Walls, Ms Hoffman, Ms Jenner, Ms Marks, Ms Stumer, Ms Fox and Ms Tapiolas. Of those 8 people only 3, namely Mr Leck, Ms Hoffman and Ms Jenner, gave evidence on this topic. Ms Fox gave a "supplementary" statement but it does

201 T 7394.30 – 7395.15
202 T 7248.1-60
203 T7249.1 - 50

not address this issue. Ms Walls, Ms Marks, Ms Stumer, and Ms Tapiolas did not give evidence at all. It can be assumed that the Commission did not call evidence from Ms Walls, Ms Marks, Ms Stumer, Ms Fox and Ms Tapiolas because their evidence would not assist.

Summary

141. So, the evidence of Ms Hoffman and Ms Jenner provide no support at all for the proposition that Mr Leck threatened dismissal.

142. And, how can the raising of confidentiality, and the Code of Conduct, be regarded as either incompetent or improper when many of the nurses agreed that it was a matter of legitimate concern?[204]

143. In fact, the leaking of the letter was:

(m) a breach of the Code of Conduct;

(n) a breach of s 62A of the Health Services Act 1991.

144. As to the latter, note that a breach is committed by disclosing, whether directly or indirectly, any information acquired during the employment with Queensland Health if the patient could be identified from the information.

145. The public disclosure of patient treatment and unique UR numbers is within that prohibition. That was the reason Ms Hoffman asked for the patient details to be 'de-identified' before Mr Messenger did anything with them.[205]

146. And, even if that were not the case, it can hardly have been improper or incompetent for Mr Leck to raise the concern about such a potential breach of the important principle of patient confidentiality. That is especially so when the nurses themselves knew and acknowledged that it was a matter of legitimate

[204] See Ms Mears at T 7377.1 and T 7377.30; Ms Jenner at T 7389.20 and T 7393.40; Ms Aylmer at T 1080.12; see also Ms Pollock at T1206.10 (Leck had a right to be disappointed). Ms Hoffman in fact asked Mr Messenger to 'de-identify' patient particulars before he did anything with them. She was plainly disappointed when he failed to do that: see below

[205] Statement of Ms Hoffman Exhibit 4 paras 162 and 164

concern. The nurses were really concerned about other issues (e.g. tone, manner, other issues).

147. No expert or other proper evidence has been adduced to suggest that no reasonable District Manager would raise those apparently legitimate concerns with his staff.

Submission in response to Potential Finding 1(u)(i)

In our submission, there is simply no evidentiary basis for any adverse finding against Mr Leck in this matter. The evidence of the nurses is inconsistent as between their statements, their evidence in chief and cross-examination and one witness from another.

One cannot even identify from the evidence the precise words or even the substance of Mr Leck's statements which are said to be the basis of this potential adverse finding.

There is no cogent evidence going beyond merely that Mr Leck was upset, or even angry, that he spoke of organisational values, the accountability process which was being applied to Dr Patel, and the need for natural justice and patient confidentiality. The evidence is simply not there that he threatened dismissal.

The raising of the issue of a potential breach of patient confidentiality, and the Code of Conduct, was conceded by the nurses to be a matter of legitimate concern. The leaking of the letter by Nurse Hoffman was a probable breach of the Code and, even if Ms Hoffman had a proper reason for breaching the Code, and even if there was no breach, it is hardly improper or incompetent for Mr Leck to raise the possible breach with his staff so that the important principle of patient confidentiality would be preserved. In fact, given the wide publicity afforded the letter,[206] it would have been remiss if Mr Leck did not seek to reinforce the principle with his staff.

206 Note that even Ms Hoffman anticipated that her letter would be altered so that it 'de-identified' patients

Forwarding the Email of 7 April 2005

148. For similar reasons it cannot be incompetent or improper for Mr Leck to raise with his superior the need to reinforce the message that patient confidentiality was important and ought not be breached.

149. The nurses themselves, rightly, considered patient confidentiality to be important and that disclosure of confidential patient information was a serious matter.[207]

150. Indeed the reaction of Nurse Mears and Nurse Jenner to the leaking of the letter is instructive. It is clear that Ms Mears considered the leaking of the letter to be a breach of the Code but, in her opinion, that breach was justified by the exceptional circumstances of this case.[208] Ms Jenner said that the fact that the information about patients had gone to the media was a concern, and Mr Leck was right to be concerned, but she did not think patients were identifiable from the information that the general public had.[209]

151. Even Ms Hoffman recognised that confidential information had been leaked. In her statement Ms Hoffman says:

> *"162. I provided a copy of my complaint to Mr Leck dated 22 October 2004 to him together with the document that I had provided to Mr Leck headed "Issues to do with Ventilated Patients". When I gave those documents to Mr Messenger **I asked him to de-identify the patient particulars contained in those documents before he did anything with them.***
>
> *163. **At no time did I think that Mr Messenger would distribute those documents without de-identifying them, or that he would give copies of them to journalists."***[210] (emphasis added)

152. So, even the nurses themselves saw the leak as a proper concern.

153. The suggestion in the email that the Audit team come up to Bundaberg and *"deliver some firm and scary messages"* does not suggest that the Audit team

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207 T 7377.1 – 30 & T 7385.35
208 T 7377.35
209 T 7389.10 & T 7389.20
210 Statement of Ms Hoffman Exhibit 4 paras 162 &163

were to do anything improper. It is merely robust language designed to secure an education session that emphasised the importance of the Code of Conduct and patient confidentiality, and the serious repercussions if there were breaches.

154. The email[211] should be looked at not only in the context of patient details being leaked into the public domain, but also in the context of the email itself. Mr Bergin asked Mr Leck whether he proposed to investigate the leak. Mr Leck responds as follows:

"Hi Dan,

No not at present. [i.e. he does not propose an investigation into the leak] *I must admit that I'm not entirely sure where to go from here. In the meeting with the staff today the DG advised that we would not have a witchhunt and that we needed to move on from this incident. The Minister said that leaking confidential information including patient details such as UR numbers was unacceptable and that whilst he supports freedom of speech in terms of people raising matters with MP's, he would not tolerate the leaking of such information*

Bottom line is that regardless of whether an investigation is held or not, I don't believe the culprit who leaked this information will be found. While on one hand I would like to send a strong message to the person(s) concerned that they are on very dangerous ground - I am concerned that such an investigation could prove very destructive resulting in nurses and doctors going after one another

Perhaps we have the Audit team come up and deliver some training sessions around the Code of Conduct and deliver some firm and scary messages?

I would welcome your advice especially if the DG's office is expecting action in a particular way.

Peter"

155. There is nothing unreasonable in that response read as a whole and in the context of Mr Bergin's inquiry.

156. Note also that the email was not sent to any person other than the Zonal Manager. It did not go to staff. It was a response to an inquiry by a superior. The suggestion, in the circumstances, was that there <u>not</u> be an investigation

211 Exhibit 477

into the leak but that, instead, there be some training sessions designed to firmly deliver messages on the importance of patient confidentiality. And Mr Leck put it as a question or suggestion. That cannot be improper or incompetent.

157. Mr Bergin was not asked about the email. Mr Leck rejected the suggestion that he intended to have the audit team frighten staff.[212] He, like the nurses, was felt that the leaking of confidential patient information was very serious and he suggested training to deal with it.[213]

158. Indeed, it was not put to Mr Leck that his statement to Mr Bergin was an improper suggestion. Nor was it put to him that to suggest it was incompetent.

159. If the real focus of this notice of possible adverse finding is Mr Leck's use of the words *"firm and scary"* in an internal email then that is facile. This Commission is concerned with weightier issues than whether certain witnesses' writing styles are poor, or clumsy or too robust.

Submission in response to Potential finding 1(u)(ii)

For similar reasons, the email of 7 April 2005, which was sent by Mr Leck only to his immediate superior, was quite proper and appropriate. He was, it was conceded, right to be concerned about the leak. The email, having expressly eschewed any focus on individual responsibility, was nothing more than a suggestion to Mr Bergin that he could consider an education session, which emphasised, in strong terms, the importance of the Code of Conduct and patient confidentiality, and the serious repercussions if there were breaches.

212 T 7211.40; see also T 7264.25
213 T 7211.25 - 45

COMPLAINTS POLICY

Potential Adverse Finding 1(v)

You failed to fulfil your responsibilities and specific accountabilities delineated under the Queensland Health Complaints Management policy and instruction (Exhibit 292) and the Queensland Health Incident Management policy (Exhibit 290A JGW 6) and in particular failed to ensure the overall implementation of those policies at the hospital in that:

i. complaints registered on the complaints register were not all risk rated as required;

ii. outcomes and organisational improvement activity that occurred as a result of adverse events was not fed back to reporters;

iii. despite being aware (e.g., Exhibits 165 and 168 and T2255) of Jennifer Kirby and Leonie Raven complaining about being overworked and unable to keep up with the policy demands for complaints and risk management, you failed to provide further resources or assistance to those persons.

160. Mr Leck established the Bundaberg Health Service District Quality and Decision Support Unit (DQDSU) to address difficulties encountered by staff in accessing information.[214] Consistent with Queensland Health requirements, he had authorised the implementation of appropriate policies for complaints management and incident or adverse event and sentinel event reporting.[215]

161. Mr Leck properly delegated to the staff in DQDSU the task of implementing and maintaining those policies. He enabled Ms Raven to receive training in both complaints management and risk management.[216] There is evidence that clinical staff of the Bundaberg Health Service District were afforded extensive training sessions in relation to adverse event reporting and incident management.[217]

162. Ms Raven gave positive testimony regarding Mr Leck's commitment to patient safely and quality improvement systems:

[214] Statement Ms Kirby Exhibit 169 para 15
[215] Statement Ms Raven Exhibit 162 attachments LTR3, LTR4 & LTR6 & Exhibit 163
[216] Statement Ms Raven Exhibit 162 paras 9 - 28
[217] Statement Dr Keating Exhibit 448 para 384; Statement of Ms Raven Exhibit 162 para 13 & T2278.1

"...certainly one of Peter's passions was in getting something where we could have better understanding of the incidents that were occurring round the hospital."[218]

"...he (Leck) was very proactive in trying to get better systems in place so we could monitor the quality and safety of the care we were providing."[219]

163. Risk rating of complaints was a task for those with clinical understanding[220] and was conducted by Ms Raven, Ms Kirby, Dr Truscott and Dr Keating, all of whom had clinical experience.[221] Ms Raven gave evidence that all adverse events were risk rated but that not all patient complaints were risk rated. She explained that Queensland Health is developing a database that will, in the future facilitate risk rating of complaints.[222] As a manager, Mr Leck could only ensure that systems were in place. There are clearly limits to what he can do to enforce compliance with those systems.

164. Mr Leck was aware of the significant workloads of the staff in DQDSU and attempted to increase staffing levels but budgetary restrictions prevented this.[223] Ms Raven, in her evidence acknowledged Mr Leck's efforts in this respect.[224]

Submission in response to Potential Finding 1(v)

Mr Leck was cognisant of his responsibilities in relation to implementing the Queensland health policies in relation to complaints management and adverse event reporting. He authorised the development of local policies, established the DQDSU to implement and maintain those policies within the constraints of available resources. It is unreasonable to expect that Mr Leck could or should minutely oversee every aspect of the operation of every policy within the Health Service District. For this reason no adverse finding should be made against him if the systems in place were not yet perfect.

[218] T2256.50 - 55
[219] T2257.1 - 5
[220] T2281.17 - 29
[221] T2260.1 - 17
[222] T2282 - 2283
[223] T7174.1 – 7174.10
[224] T2255.49

SENTINEL EVENTS

Potential Adverse finding 1(w)

You carelessly or improperly failed to report the deaths of Mr Bramich or Mr Kemps as sentinel events:

i. to the Director General of Queensland Health through the Risk Management Advisory Committee as required by the Queensland Health Incident Management policy which become effective from 10 June 2004;

ii. (in the case of Mr Bramich) to CZMU and corporate office of Queensland Health as required by the Bundaberg Hospital Sentinel Events and Root Cause Analysis policy effective 1 June 2004;

iii. (in the case of Mr Kemps) to Director General via the Risk Management Advisory Group as required by the Bundaberg Hospital Sentinel Events and In-depth Analysis policy effective 1 November 2004.

165. Some matters which have been put to Mr Leck perhaps imply a suggestion that he was aware of complaints about Dr Patel prior to 20 October 2004.[225] However, this is not the evidence apart from the one patient matter of Mr Dalgleish referred to earlier in these submissions. No complaint was brought to Mr Leck regarding Dr Patel prior to Ms Hoffman doing so in October 2004 and no-one has given evidence asserting that.

166. One gloss on that proposition is that the Desmond Bramich case came to attention in August 2004 via the adverse event report and sentinel event report forms which were both issued in the one matter. Mr Leck's evidence is that he contacted the quality coordinator who expressed the opinion that the matter was not a sentinel event.[226] The evidence appears to be that the new policy requiring referral to Head Office had not yet become generally known and in use.[227]

167. In any event, the Head Office practice was to require local investigation[228] and that is what Mr Leck directed and that is what happened.[229] In due course, when Dr Fitzgerald's appointment was arranged, Mr Leck properly referred the case for inclusion in that investigation. In that was it was properly referred to higher authority for investigation.

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225 T7304.30
226 T7168.27 & Statement of Mr Leck Exhibit 463 para 34
227 Statement of Dr Keating Exhibit 448 paras 156 & 380 -387
228 T7168.20 & T7169.10 - 25
229 Statement of Dr Keating Exhibit 448 paras 132 - 160

168. Mr Leck was asked questions in his evidence about the Shannon Mobbs (P26) case. He became aware of this case upon receipt of Dr Rashford's email[230]. Dr Rashford described the subject of his email as a "sentinel case" but the text of his email did not characterise it as a "sentinel event" as that is understood in the reporting system and did not generate a sentinel event report. Moreover, the matter did not meet any of the actual criteria for a sentinel event as then defined by the policy.[231]

169. It seemed to be suggested in the questions put to Mr Leck[232] that it was convenient for Mr Leck to accept Dr Keating's view that this was not a sentinel event because then it could be somehow "kept from" Head Office. This overlooks the very email which was sent to Mr Leck was copied to Dr John Scott, the Deputy Director General and Mr Bergin, the Zonal Manager.

170. Mr Leck acted properly in causing the matter to be investigated and causing a report to be done to Mr Bergin.

171. When Mr Leck had other occasion to be contacting Dr Scott, Dr Scott's response said that if he, Mr Leck, was making contact regarding the matter raised by Dr Rashford, it was "fine".[233]

172. The death of Mr Kemps on 20 December 2004 was noticed by Mr Leck on review of a night report.[234] He immediately brought it to Dr Keating's attention.[235] In exhibit 448, paragraphs 288 – 299, Dr Keating relates what he did about it, including reporting to the Coroner.

173. Although Mr Leck was aware of his responsibility to notify corporate office of a sentinel event[236]he relied on the clinical staff to notify him of the occurrence of such an event. Mr Leck now concedes that Mr Kemps' death fulfilled the criteria for a sentinel event.[237] However, there is no evidence that Mr Leck considered it to be a sentinel event at the time he first became aware of it. Mr

230 Statement of Dr Scott Exhibit 317 & T7165.30
231 Exhibit 481
232 T7165-7167
233 Statement of Dr Rashford Exhibit 210 attachment SJR2
234 T7171.35
235 T7171.29
236 T7171.47
237 T7171.45

Leck properly brought it to the attention of Dr Keating with the expectation that if it were a sentinel event or the reporting processes were to be initiation, that would be done by Dr Keating, or by the doctors or nurses who were directly involved in the patient's treatment.

Submissions in response to Potential Finding 1(w)

- Mr Bramich's case was properly referred initially for internal investigation by Dr Keating then for external investigation by Dr Fitzgerald.
- Mr Mobbs' case was not a sentinel event but was in any event the subject of appropriate communications with "Head Office".
- Mr Kemps' case was properly referred by Mr Leck to Dr Keating for enquiry. If it was a sentinel event, he was entitled to expect that Dr Keating, or the treating doctors or nurses would action it accordingly.

CONSULTATION WITH DR KEATING

Potential Adverse Finding 1(x)

You limited your consultation with your Director of Medical Services Dr Darren Keating to meetings initially once per week and then once per fortnight in circumstances where consultation between you should have been continual.

Potential Adverse Finding 1(y)

You failed whether because you failed to adequately consult with him or otherwise to prevent your Director of Medical Services Dr Darren Keating from:

i. **in early February 2005 writing to the Medical Board seeking renewal of Dr Patel's registration and an assessment of Dr Patel's performance falsely and grossly misrepresenting and overstating Dr Patel's performance and failing to inform the Medical Board of any of the matters set out above or that a clinical audit was being conducted by the Chief Health Officer into complaints about Dr Patel;**

ii. **on 1 February 2005 knowing that Dr Patel had agreed to continue employment as a Senior Medial Officer in surgery until 31 July 2005 misrepresenting in the Form 55 Application for Sponsorship of Visa for Dr Patel sent to the Department of Immigration and Multicultural Affairs that Dr Patel was to be employed as Director of Surgery at the Hospital for a further four years;**

iii. **making an offer to Dr Patel by letter dated 2 February 2005 (Exhibit 448 DWK 69) of a temporary full time position of locum general surgeon for the period from 1 April 2005 to 31 July 2005 at a daily rate and pursuant to an arrangement that was contrary to Queensland Health policy with respect to the employment of a locum.**

"Continual Consultation"

174. The Concise Oxford dictionary definition of "continual" is "*constantly or frequently occurring*".

175. We do not take it to be suggested that Mr Leck should have been "constantly" consulting with Dr Keating. Both gentlemen were extremely busy.[238] It is clear from the evidence that they worked near each other and would have seen each other every day and doubtless spoke when necessary (and possible).

176. There has been no expert evidence about "best practice" in this matter.

177. Note that the notice here addresses only formal meetings between the two men. They no doubt had other communications verbally, via email, at other meetings, in the corridor etc. They met when necessary. On what basis and

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[238] T7297 - 7299

by what standard can it be suggested that they met formally too infrequently? The allegation was put to neither Mr Leck nor Dr Keating.

178. In any event, this is a managerial decision. Different people will have different management styles. Some might say that Mr Leck consulted frequently; some might say he interfered and failed to give appropriate autonomy. This Commission is ill-equiped by the evidence to be making those sorts of judgments.

Documents

179. As was submitted in relation to Dr Nydham it cannot reasonably be expected of a District Manager that he personally "vet" documents for submission to the Medical Board, Immigration Authorities etc. In relation to this potential adverse finding, however, there is a more fundamental reason why no adverse conclusion can be drawn against Mr Leck. He is not shown to have had any knowledge of the fact that Dr Keating was submitting the documents referred to. It was never put to Mr Leck in evidence that he had any such knowledge.

180. Mr Leck's evidence is that he was on leave when Dr Keating made the offer to Dr Patel. It is not plausible that Mr Leck should have been aware of or expecting that Dr Keating was, in February 2005, making the representations now complained of when in fact the evidence shows that in early January 2005 Dr Keating advised Mr Leck that Dr Patel's services should not be continued save in the very short term pending recruitment of a replacement Director.

Submission in response to Potential Finding 1(x) and 1(y)

The Commission should make no adverse finding against Mr Leck on these matters because:

- **There is insufficient evidence of the appropriate kind to determine whether Mr Leck consulted with Dr Keating with sufficient frequency.**
- **It is not reasonable to expect a District Manager to personally vet documents of the kind referred to.**

- **In any event the evidence does not disclose that Mr Leck had any knowledge of the existence of these documents.**
- **It had already been decided in early January 2005 that Dr Patel's services were not to be continued except in the very short term.**

DR JELLIFFE

Potential Adverse Finding 1(z)

You sought to intimidate a senior staff anaesthetist, Dr Jelliffe, who had complained and cancelled elective surgery due to excessive workload by calling him into your office and asking him to remind you of his current visa status.

181. Dr Jelliffe has made complaint that Mr Leck impliedly threatened him in relation to his visa status following his cancelling elective surgery[239].

182. There had been no previous negativity in the relationship between Dr Jelliffe and Mr Leck[240], Dr Jelliffe accepted that it was perfectly legitimate of Mr Leck to seek an explanation for the cancellation of the surgery list[241] and the appointment was arranged in an appropriately polite way.[242] The words used by Mr Leck to constitute the implied threat were of themselves not intrinsically threatening[243] and they were spoken *"casually and matter of factly"*[244] Dr Jelliffe relies upon unspecified *"body language"*[245] and a *"combination of the circumstance"*[246] and *"gut feeling"*[247] but he says he would prefer not to use the word *"threatening"* at all and would use the word *"focussed"*[248]

183. Dr Jelliffe was reluctant to accept the proposition that he may have been predisposed to find a "threat" where there was none[249]. He said that this was so because he did not go to the meeting in anticipation that Mr Leck would raise the matter of his visa but rather in anticipation that Mr Leck would want to deal with the matter of the cancellation of the surgery. But, referring to Mr Leck's words *"just remind me of your current visa status"* Dr Jelliffe says:

239 T6648 et seq.
240 T6666.55
241 T6667.44
242 T6666.37
243 T6667.53
244 Statement of Dr Jelliffe Exhibit 437 para 21
245 Statement of Dr Jelliffe Exhibit 437 para 23
246 T6668.10
247 T6668.45
248 T6657.9
249 T6668.45-6669.30

"This confirmed my gut feeling when I went to his office that I was to be challenged about my decision and my visa status was going to be raised as a means of my towing (sic) the line and not making such a decision again in the future"[250].

184. Dr Jelliffe was in error as to a large number of the details in his statement and his evidence so as to bring into question general reliability:

(a) he gave evidence that the elective surgery which he cancelled was scheduled for the Easter week but changed that evidence when a document produced to him indicated that he had been on leave for part of that week[251];

(b) his statement asserted that "all" elective surgery was cancelled but his evidence was different[252];

(c) he does not seem to have told Mr Leck that he had consulted with Dr Carter before Dr Carter's departure on leave and it had been agreed that if the pressure became too substantial, the surgery list could be cancelled;

(d) he made assumptions in his evidence in chief about Mr Leck having his (Dr Jelliffe's) personnel file before him at the meeting which assumptions he was not able to sustain in cross-examination[253];

(e) he swears that the contents of attachment 1 to his statement[254], being the article by Mr Thomas, are *"as I inform Mr Thomas about"* however,

- Mr Thomas refers to *"some routine surgery"* but Dr Jelliffe gave a different version;
- Mr Thomas refers to a *"summons"* from the manager but Dr Jelliffe, in his evidence rejected that there was a *"summons"*[255];
- Mr Thomas refers to Dr Jelliffe giving Mr Leck a *"reminder"* about his visa status but Dr Jelliffe says it was *"new information"*[256].

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250 Statement of Dr Jelliffe Exhibit 437 para 21
251 T6664.35
252 T6662.1-30
253 T6667.5-40
254 Statement of Dr Jelliffe Exhibit 437 para 29
255 T6666.41
256 T6672.19

185. In all of the viva voce evidence and all of the exhibits over the whole duration of this commission and its predecessor, not withstanding that there was a high proportion of overseas trained doctors in Queensland Health generally and, relevantly, at Bundaberg Hospital, there is not one other suggestion that Mr Leck has ever raised a doctor's visa status in any improper way or sought to use such a matter improperly to achieve any outcome. There is not the slightest evidence to support any suggestion that this was a technique, practice or disposition of mind of Mr Leck. He rejects it as *"...not something I would do."*[257] Our submission is that the Commissioner's assessment of Mr Leck as a witness and as a person will lead the commission to the same view.

186. In truth, Dr Jelliffe's evidence was to the effect that nothing in Mr Leck's words or conduct was itself threatening but he subjectively *"felt"* or had a *"gut feeling"* of being threatened. That is not evidence at all against Mr Leck.

Submission in response to Potential Finding 1(z)

Given the ambiguity in the alleged threatening words; the clear possibility of (albeit innocent) predisposition on the part of Dr Jelliffe, the fact that the Commission would have to act upon essentially Dr Jelliffe's interpretation of words and circumstances not intrinsically threatening, the uncertainties in the detail of Dr Jelliffe's evidence and the utter absence of anything in Mr Leck's history or behaviour to suggest that he had in the past threatened anyone in such a situation or would even be capable of descending to such a tactic, the Commission ought not to make any adverse conclusion, observation or recommendation on this matter.

[257] T7182.5

CONCLUSION

187. Mr Leck has not been guilty of official misconduct for the reasons set out above.

188. Further, "official misconduct" is defined by section 15 of the Crime and Misconduct Act 2001 as conduct that could, if proved, be

(a) a criminal offence; or

(b) a disciplinary breach providing reasonable grounds for termination the person's services, if the person is or was the holder of an appointment.

189. There is no suggestion of a criminal offence and the breaches alleged are not such as to justify dismissal.

Conclusion

It is our submission that any complaints against Mr Leck must be judged against the background of his very substantial responsibilities, inadequate resourcing and oppressive financial accountability and reporting obligations imposed by Queensland Health. It would not be fair to Mr Leck, in judging him, to fail to take into account the daily exigency with which he had to contend and the extent to which this meant that he could not on all occasions at all levels meet all obligations perfectly.

RESPONSE TO QNU SUBMISSIONS

1. It is proposed to deal only with those submissions of the QNU that are relevant to Mr Leck, and are specific, and are not otherwise dealt with in these submissions.

2. Paragraph 11. As has been made clear earlier in these submissions, the credentialing and privileging process is not a process that would have identified Dr Patel's fraud.

3. Paragraph 12. The submissions do not identify *"the adverse outcomes of patients which Mr Leck had knowledge of"*.

4. Paragraph 14. The prospect of suspending Dr Patel was adverted to by Mr Leck but, for reasons we have explained earlier in these submissions, he did not consider it necessary. Note that Ms Hoffman herself did not call for that step either in October 2004 or later. In fact Ms Hoffman was not asking for anything else other than for the treatment of certain patients to be investigated by an independent auditor.[258]

5. Paragraph 20. There is no suggestion that Mr Leck *"criticised or denigrated"* Ms Hoffman's actions. Mr Leck's legitimate concern was the leaking of confidential patient information. Ms Hoffman herself asked Mr Messenger to keep the patient details confidential. She did not envisage the letter being published *'unedited'*.

6. Paragraph 20. **"The Three Monkeys"**- This is abuse, it is not based on the evidence and does the submission no credit. As regards Mr Leck, the *"detailed written documentation"* in relation to patients is not identified. Nor is the same identified in relation to nursing staff.

7. Paragraph 44. It is erroneous and mischievous for the QNU's counsel to assert that Ms Hoffman merely did not wish the matter to be treated as an official complaint. She asked that it not be acted on. And, as we explain in our submissions, she did that because she still wished to try to sort out the conflict with Dr Patel. And that reinforces the idea that, at that stage at least, the matter at issue was a personality conflict.

8. Paragraph 53. The QNU's submissions do not explain why the failures alleged breached of trust.

9. Paragraph 54. The sentence commencing *"Ms Doherty said ...."* is not an accurate assessment of the evidence. The email from Dr Keating was not expressed as a response to any complaints of Ms Doherty. There is no evidence that it was a response.

10. Paragraph 60. The suggestion that Mr Leck and Dr Keating deliberately disregarded legitimate concerns as to patient safety has no foundation in the evidence. There was certainly no evidence that Mr Leck even appreciated that there were legitimate concerns as to patient safety.

11. Paragraph 61. The letter was plainly not dishonest. Mr Leck was genuinely concerned about natural justice. As has been explained in our submissions and in the submissions on behalf of Dr Keating, one should be careful not to misuse the benefit of hindsight.

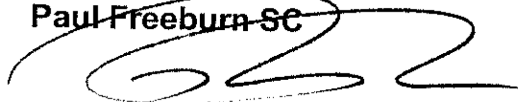
12. Paragraph 62. Here it is asserted that Mr Leck threatened imprisonment and dismissal. The source of that evidence is said to be Ms Hoffman. However, as we explain earlier in these submission, Ms Hoffman resiled from those allegations and certainly thought Ms Walls may have said it and Mr Leck may have left the meeting by then. As to the alleged *"intimidation"* see our earlier submissions.

[258] T1475.29.

13. Paragraph 64. The assertion that Mr Leck had an expectation that Media would contact the nurses is a mistake. It was Ms Hoffman who warned of that possibility. She did that before the meeting started. See paragraph 15 of Ms Jenner's statement. The last sentence is also beyond the evidence. There is no evidence of any express threat. There is no evidence of any acts that might be regarded as intimidatory in the ordinary sense of that word. Mr Leck directed his remarks to breaches of patient confidentiality – a matter conceded to be of legitimate concern.

Dated this 31st day of October 2005

Paul Freeburn SC



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Your Ref:

2 November 2005

The Secretary
Queensland Public Hospitals Commission of Inquiry
PO Box 13147
George Street
BRISBANE QLD 4000

Attention: Mr David Andrews

Dear Mr Andrews,

Submissions in Reply from QNU

We refer to the Submissions in Reply on behalf of the Queensland Nurses Union delivered on 1 November 2005. We hold the view that the Commission should disregard the Submissions entirely on the basis that they do not fall within the category of submissions in response contemplated by the Commissioner in paragraph 5 of his directions of 20 October 2005.

If however, the Commission intends to entertain the submissions we make the following points on behalf of our client:

1. The statement of our client's evidence set out in Paragraph 2(c) of the submissions is simply wrong. Neither our client nor any other witness gave evidence that *"Mr Leck made a determination that the events described in the Sentinel Event form did not constitute a sentinel event."*

In paragraph 34 of his statement (Exhibit 463) Mr Leck says:

"The issues raised in the Adverse Event Report and the Sentinel Event Report caused me concern so I contacted the quality co-ordinator. I was told that this did not constitute a sentinel event within the terms of the specific criteria set out in the Queensland Health Incident Management Policy."

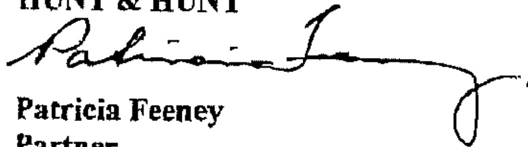
Mr Leck's oral evidence was consistent with his statement:

"My Understanding was that – well, I am not sure whether it was Jane or Leonie had spoken to Darren Keating, who indicated that is also wasn't a sentinel event, and there was specific classifications in corporate policy in relation to sentinel events. "(T7169.2; see also T7167.50 to 7169.50 & 7288.45 –7289.36)

2. The submissions in Part C of the document quote material that is not evidence before the Commission and ought not to be relied upon.

We have sent an electronic copy of this letter to the parties who have been given leave to appear.

Yours faithfully
HUNT & HUNT



Patricia Feeney
Partner

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