Submissions

Queensland Health

Crown Law
Queensland Government

Your ref:
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Department of
Justice and Attorney-General

27 October 2005

Mr David Groth
Secretary
Queensland Public Hospitals Commission of Inquiry
Level 9
Brisbane Magistrates Courts Building
363 George Street
BRISBANE QLD 4000

Dear Mr Groth

Submission on behalf of Queensland Health

I **enclose** Queensland Health's submission to the Commission of Inquiry.

The submission has been drawn on Queensland Health's behalf by Mr Fitzpatrick and Mr Farr both of Counsel and settled by Mr David Boddice SC.

Yours faithfully

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Queensland Public Hospitals *Commission of Inquiry*

Submission of Queensland Health

The following submissions are made on behalf of Queensland Health. They address specifically the terms of reference of the *Queensland Public Hospitals Commission of Inquiry*. Whilst evidence was given to the *Bundaberg Hospital Commission of Inquiry* in relation to systemic issues, these matters were referred to the Forster Review. As Queensland Health made representations to that Review, it is not intended to make submissions in relation to the evidence led in the *Bundaberg Hospital Commission of Inquiry* with respect to systemic issues.

(a) The role and conduct of the Queensland Medical Board in relation to the assessment, registration and monitoring of overseas-trained medical practitioners, with particular reference to Dr Jayant Patel and persons claiming to be overseas-trained medical practitioners.

The registration and assessment of medical practitioners in Queensland is governed by the *Medical Practitioners Registration Act* 2001 ("the Act"). The objects of the Act are to protect the public by ensuring healthcare is delivered by registrants in a professional, safe and competent way, to uphold the standards of practice within the profession, and to maintain public confidence in the profession. [1] These objects are to be achieved mainly by establishing a Medical Board of Queensland ("MBQ"), providing for the registration of persons under the Act, and providing for compliance with the Act to be monitored and enforced. "Profession" means the medical profession. [2]

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1 s7(1)
2 s3

The Act

Relevantly, the Act provides as follows:

- The Board's functions include [3] -

  (a) to assess applications for registration;

  (b) to register persons who satisfy the requirements for registration;

  (c) to monitor, and assess, when the registrants comply with any conditions of registration; and

  (d) to keep a register of, and records relating to, registrants.

- In performing its functions, the Board is to act independently and in the public interest. [4]
- The Board may delegate its powers, but not its powers [5] -

  (a) to decide to register, or refuse to register, an applicant for registration;

  (b) to refuse to renew a renewable registration;

  ...

  (d) to cancel a registration; or

  (e) to impose, or remove, conditions on a registration.

- An application for general registration must be made to the Board. [6]
- A person may obtain special purpose registration to undertake an activity for a purpose (a "**special purpose**") mentioned in, inter alia, section 135. [7] A person is eligible for special purpose registration for a special purpose if the person -

  (a) is fit to practise the profession; and

  (b) is qualified for registration under this subdivision.

- A number of the requirements for application for general registration apply for special purpose registration. [8] Those include the procedural requirements for applications for

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3 s11
4 s12
5 s14
6 s42(1)(a)
7 s131
8 s139(1)

general registration (section 42) and the various considerations for determining whether an applicant for registration is fit to practise the profession under section 45.

- In deciding whether an applicant is fit to practise the profession, [9] the Board may have regard to, inter alia, if the applicant is, or has been, registered under a corresponding law (under Schedule 3: "Corresponding Law" means a law applying, or that applied, in another ..... foreign country that provides, or provided for the same matter as, inter alia, the *Medical Practitioners Registration Act* 2001) and the registration was affected -

  (i) by the imposition of a condition - the nature of the condition and the reason for its imposition; or

  (ii) by its suspension or cancellation - the reason for its suspension of cancellation; or

  (iii) in another way - the way it was affected and the reasons for it being affected.

- The purpose of registration under section 135 is to enable a person to practise the profession in an area the Minister has decided is an area of need for a medical service. It is for the Minister to decide whether there is an area of need for a medical service, [10] that is, whether there are insufficient medical practitioners practising in that part of the State, to provide the service at a level that meets the needs of people living in that part. If the Minister so decides, that there is such area of need, the Minister must give the Board written notice of such.

- A registrant who is registered, under section 135, to practise the profession in a specialty in an area of need, whilst so registered, is taken to also be a specialist registrant in the specialty. [11] Under Schedule 3: "Specialty" means a branch of medicine prescribed under a regulation to be a specialty. Section 6 of the Medical Practitioners Registration Regulation 2002 provides that, for the definition, *Specialty* in Schedule 3 of the Act, a branch of medicine mentioned in Schedule 1, Column 1 is a specialty. "General Surgery" is mentioned in Schedule 1, Column 1.

- The approved form for a Certificate of Special Purpose Registration must provide for the inclusion of -

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9 s45
10 s135(3)
11 s143A

(a) details of the special purpose and activity for which the registrant is registered; and

(b) if the special purpose involves the practise of a specialty, details of the specialty.

Dr Patel

Dr Jayant Mukundray Patel was registered by the MBQ ("MBQ") on 11 February 2003, upon recommendation from the Board's Registration Advisory Committee ("RAC"), as a special purpose registrant to fill an area of need as a SMO-Surgery at Bundaberg Base Hospital ("BBH"). Registration was effective from 1 April 2003 being Dr Patel's commencement date at BBH.

Dr Patel's application was submitted, on his behalf, by Wavelength a reputable Sydney-based recruiting agency.

As part of his Special Purpose - Area of Need - Application for Registration with the Medical Board of Queensland ("MBQ") [12], Dr Patel was required to submit a Certificate of Good Standing from all current registration authorities. In his case, this took the form of a Verification of Licensure with Oregon State. Additionally, he was required to make a Fitness to Practice Declaration to MBQ.

The Oregon State Licensure Verification document dated 17 January 2003 relevantly stated:

> "...
> Standing: Public Order on file. See attached
> Speciality: General surgery
> Limitations: None
> Extensions: None
> ..."

The Public Order inclusion was a reference to the fact that on 1 November 2000, the Board of Medical Examiners for the State of Oregon had made a Stipulated Order - by definition, a disciplinary action - directing that Dr Patel obtain a second surgical opinion (to be documented in the patient charts) prior to undertaking complicated surgical cases, *inter alia*, abdominal - perineal resections, oesophageal surgery, high risk patients with renal failure, and on post-operative patients with more than 2days stay in ICU. Further, on 10 May 2001, the New York State Board for Professional Medical Conduct visited Dr Patel with professional misconduct and

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12 A Certificate of Good Standing is a basic registration requirement of MBQ for special purpose registration: Exhibit 24 "MDG-20"

physician discipline sanctions by ordering the surrender of his licence to practice in New York State. This was based on the making of the stipulated orders in Oregon State.

The terms of the Stipulated Order would have been annexed when the Verification document was delivered by the American Registration Authority to Dr Patel. However, Dr Patel detached those details prior to on-forwarding the Verification to Wavelength for submission to MBQ on his behalf.

It is reasonable inference(in light of the multiple false declarations made as part of Dr Patel's Fitness to Practice Declaration to MBQ referred to below) that this was a deliberate act on Dr Patel's part to deceive both Wavelength, MBQ and ultimately, Queensland Health, his intended employer.

Although the Oregon Licensure Verification was twice provided by Dr Patel to Wavelength, the Wavelength personnel involved failed (on both occasions) to notice that the annexures were missing [13]. On 6 January 2003, Dr Patel's application was submitted by Wavelength to MBQ. Included was the incomplete Licensure Verification and a Declaration by Dr Patel answering the following questions in the negative:

> "3. Have you been registered under the *Medical Practitioners Registration Act* 2001or the *Medical Act* 1939 (repealed) or have you been registered under a corresponding law applying, or that applied, in another ..... foreign country, **and** the registration was effected either by an undertaking, the imposition of a condition, suspension or cancellation, or in any other way?
>
> 4. Has your registration as a **Health Practitioner** ever been cancelled or suspended or is your registration currently cancelled or suspended as a result of disciplinary action in ..... another country?"

Both Declarations were false and a further deliberate deception on Dr Patel's part of MBQ.

Ainslie McMullen, an experienced MBQ staff member, processed Dr Patel's application. On or about 3 February 2003, she completed a MBQ registration check list which signified her having sighted a Certificate of Good Standing in respect of Dr Patel [14].

As registration requirements are not checked again, the results of McMullen's omission to query the incomplete Licensure document was that Dr Patel's application obtained MBQ approval on 3 February 2003 and ultimately, registration by MBQ itself on 11 February 2003.

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13 Bethel : T683/ 35

14 Exhibit 24 "MDG-24"

Conclusions

Having regard to the statutory scheme discussed above, it is MBQ's responsibility to assess the registration, and register, special purpose registrants subject to such conditions as the MBQ considers necessary or desirable for applicant's to competently and safely undertake the desired special purpose activity.

Whilst the Minister decides whether there is an area of need, it is for the MBQ to decide whether an applicant for special purpose registration is sufficiently qualified, that is to say, whether the applicant has a medical qualification and experience the MBQ considers suitable for practising the profession in the area. [15] (The MBQ also decides the applicant's eligibility for special purpose registration). [16]

In practice, it would seem that the MBQ's statutory responsibilities are well understood - on the facts of Dr Patel's own registration, the application and supporting documents were submitted directly by Wavelength to the MBQ on the registrant's behalf, not via Queensland Health.

(b) (i) Any substantive allegations, complaints or concerns relating to the clinical practice and procedures conducted by Dr Patel at the Bundaberg Base Hospital;

During the course of evidence, a number of general substantive allegations were levelled at Dr Patel's clinical practice and procedures at BBH. However, many of these were with the benefit of hindsight, post-dated Dr Patel's departure from BBH in April 2005, [17] and arose following close expert examination of medical records as part of the Inquiry process.

It is relevant, therefore, to concentrate on the matters which had been raised during Dr Patel's tenure at BBH. Chronologically, they were as follows:

01/04/2003	**Dr Patel commences at BBH**
19/05/2003	**P34 - James Phillips (Oesophagectomy)**

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15 s135(2)

16 s131(2)

17 For example, the assessments undertaken by Dr Delacey predominantly related to patients who had complaints, and who were reassessed, following the offer of BBH to provide the benefit of a second opinion to Dr Patel's former patients.

Nurse Hoffman claims to have voiced concerns to Dr Keating two times in mid 2003 concerning this case and Dr Keating accepts she spoke to him once on 30 May 2003 with Nurse Goodman, then Director of Nursing. Dr Keating says Nurse Hoffman mainly complained about personality issues involving Dr Patel and this was accepted by Nurse Hoffman in her evidence. [18] Nurse Hoffman was unable to specifically recall Dr Keating's response. [19] However, Dr Keating says he asked Nurse Hoffman to arrange a meeting with Dr Patel to sort things out. He then followed up with Nurse Goodman later as to how the Dr Patel meeting went and Nurse Goodman reported "well". [20]

Against that background, these circumstances do not give rise to a substantive complaint concerning Dr Patel's clinical practice and procedure at BBH. Further, the issues raised were addressed by the management of BBH.

17/06/2003 **P-18 - James Graves (Oesophagectomy)**

On 18, 19 June 2003, Nurse Hoffman emailed, respectively, Glennis Goodman [21] and Darren Keating [22] with her concerns regarding this patient. Substantively, the emails complained that the surgery done on P18 fell outside the scope of BBH. Previous to Nurse Hoffman's first email to Goodman on 18 June, Dr Joiner met with Dr Keating on 17 June and, in the context of P18's case, queried whether BBH should do oesophagectomies. [23] Dr Joiner also sought the transfer of P18 saying Dr Patel refused it. In response, Dr Keating arranged for Dr Younis, an anaesthetist, to review the patient. Dr Younis reported back that P18 was not in need of immediate transfer. Dr Keating then met with Drs. Patel, Younis and Joiner and it was agreed P18 would remain in BBH ICU for 1-2 days longer under review. [24] When Dr

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18 T44/1-20
19 T46/42
20 Exhibit 448 paragraph 48
21 Exhibit 4 "TH-2"
22 Exhibit 4 "TH-3"
23 T6832/10
24 Exhibit 448 paragraphs 50-51; see also T5018/1-15 (Dr Joiner)

Keating followed up with Dr Younis a couple of days later, he was advised that P18's condition had changed and he would now be transferred to Brisbane as soon as possible.

At or about the same time of Dr Keating's receipts of Nurse Hoffman's 19 June email, the HR Manager at BBH notified Dr Keating that an informal complaint had been made about Dr Patel's behaviour toward an ICU nurse. When Dr Keating received Nurse Hoffman's email (in particular, with its reference to "the behaviour of the surgeon in the ICU" and that "certain very disturbing scenarios have occurred") he thought it related to personality conflicts, as well as the scope of service of BBH ICU. [25]

Subsequently, Dr Keating met with Dr Patel, told him of the ICU nurse's complaints and counselled him about sexual harassment. Dr Patel accepted Dr Keating's counsel. [26]

On 1 July 2003, Dr Keating responded to a phone call from Dr Cook, Mater Hospital, Brisbane. As expressed to Dr Keating, Dr Cook's concern was not so much about Dr Patel's surgical competence but about Bundaberg's incapacity to provide robust ICU follow up. Dr Keating undertook to further investigate and when the Director of ICU, Dr Carter, returned from leave, Dr Keating spoke to him and Dr Patel. Both agreed oesophagectomies could be done at BBH and each said a 72 hour stay in BBH ICU was acceptable. [27]

Dr Keating, still a relative newcomer to Bundaberg, accepted this advice. [28] Having regard to the seniority of Drs. Patel and Carter, it was reasonable for Dr Keating to do so. Further, Dr Carter gave evidence that oesophagectomies had been done at BBH prior to Dr Patel's arrival, as had complex aortic surgery which was almost the equivalent to oesophagectomies in terms of complexity. [29] Dr Joiner's evidence was that he felt the procedures ought not be done in the

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25 Exhibit 448 paragraphs 60-62
26 Ibid
27 Exhibit 448 paragraphs 52-55 & T6832/20 & T6833/1
28 Exhibit 448 paragraph 59
29 T4003/18

absence of the Senior Anaesthestist, Dr Carter. The implication of this evidence is that that, under defined circumstances, they might acceptably be done at BBH. [30] Dr Younis testified that a locum surgeon had done two oesophagectomies previous to P-18's case at BBH. [31]

Against that background, particularly the advice received from Dr Younis, the case of P18 did not give rise to a substantive complaint concerning Dr Patel's clinical practice and procedure at BBH. Again, any issues raised were addressed by management at BBH.

July 2003 **Wound dehiscence**

It was suggested that an increase in the incidents of wound dehiscence at BBH ought to have alerted the Hospital Authorities to Dr Patel's inadequate technical performance as surgeon.

The relevant discussion commences with Gail Aylmer's email re dehiscence on 3 July 2003. [32] Notably, this correspondence was not "Dr Patel specific". On 7 July 2003, Aylmer raised her email at a Leadership and Management Meeting and agreed to present a report. [33] On 9 July 2003 a further discussion of dehiscences were noted in the Minutes. [34] There was a further note that the issue was to be brought forward for further discussion. In Dr Keating's belief, [35] the issue had been openly discussed, researched and resolved satisfactorily. His expectation was that Gail Aylmer would continue to monitor it in her role as Infection Control Co-Ordinator.

Dehiscence was again raised on 14 April 2004 by Di Jenkin and noted in the ASPIC Minutes. [36] The May 2004 ASPIC Minutes [37] records a resolution that dehiscences were to be reported as adverse events. [38]

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30 T5012/50
31 T3781/20
32 Exhibit 59 GA2
33 Exhibit 59 GA3
34 Exhibit 448 "DWK-17"
35 Exhibit 448 paragraphs 67 & 68
36 Exhibit 81
37 Exhibit 65

On 9 June 2004 ASPIC Minutes [39] record discussion concerning the definition of "dehiscence" and on 8 August 2004 DQDSU prepared two reports on wound dehiscences. [40] According to Dr Keating, these reports demonstrate a reduction in the number of dehiscences. Gail Aylmer gave evidence that, as a result of apparently reasonable and convincing explanations from Patel, she reduced significantly the number of dehiscences previously reported to her. [41]

In summary, Dr Keating thought that the dehiscence issue was under control. [42] At no stage prior to Nurse Hoffman's written complaint of 22 October 2004 was he aware of any suggestions that junior doctors were instructed by Dr Patel not to use the word "dehiscence". [43]

In these circumstances, the incidence of dehiscence at BBH, and the circumstances surrounding it, did not give rise to a substantive complaint relating to Dr Patel's clinical practice and procedures.

September 2003 P-39

This patient is the subject of an email [44] from Nurse Hoffman to Nurse Goodman (copied to Dr Keating) in which Nurse Hoffman sets out an alleged agreement [45] between Dr Carter and Dr Patel not to transfer the patient. In addition, Nurse Hoffman raised concerns that there be guidelines about the scope of surgery at BBH, including ICU service and follow-up care. Dr Keating investigated Nurse Hoffman's concerns with both Dr Patel and Dr Carter. He was told it was Dr Carter who suggested the surgery be done in Bundaberg, that Dr Carter thought the patient could be managed there, that each surgeon

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38 Nurse Jenny White acknowledged that, from July 2004, it was resolved dehiscences were to generate Adverse Event Forms: T1234/10-20

39 Exhibit 90

40 Exhibit 64

41 T908/10-20

42 Exhibit 448 paragraph 67

43 Exhibit 448 paragraph 68. The junior doctors disavowed any suggestion that Patel's charts were not full and accurate. See, for example, T2051/35-40 (Athanasiov)

44 Exhibit 4 - "TW-6"

45 When testifying to the Commission, Dr Carter expressly disavowed the making of the alleged agreement with Patel: T3999/25

denied making the agreement [46] which Nurse Hoffman alleged and each said the patient would be transferred, if necessary.

Against that background, these circumstances do not give rise to a substantive complaint relating to the clinical practice and procedures of Dr Patel at BBH.

2004

Dr Miach's Renal Patients

At no stage before commencement of the Bundaberg Hospital Commission of Inquiry was Dr Keating aware that Dr Miach had given instructions that his patients were not to be operated on by Dr Patel. [47]

He was aware of concerns raised by nurses concerning infection control measures in the Renal Unit. [48] He raised the concerns with Dr Patel who denied the claims and took afront at the suggestions. Dr Keating pointed out to Dr Patel he needed to set an example as Director of Surgery.

In late April or early May 2004 Dr Miach spoke to Dr Keating about concerns with the placement of peritoneal dialysis catheters by Dr Patel. These were raised to support the introduction of a catheter access program by Baxter Health. Dr Miach informed Dr Keating that he had problems with other surgeons previously at BBH in inserting the catheters. Dr Keating's understanding was that Dr Miach was not concerned with Dr Patel's general competence but rather his ability to perform this particular procedure. At some time on 15 June 2004 Dr Keating attended a meeting with Dr Miach and the Baxter representatives and received on that date from Dr Miach the dialysis stats. [49] He did not regard the document as suggesting that Dr Patel had a 100% complication rate nor that he had performed all of the procedures listed in the document. After considering the Baxter proposal it was decided to proceed with it. When Dr Patel returned

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46 Exhibit 448 paragraphs 82-86
47 Exhibit 448 paragraph 19 & T6845/35
48 T986
49 Exhibit 69

from leave in July 2004 Dr Keating informed him of the Baxter Program. Dr Keating said that, in part, its introduction was due to concerns about complications with his insertion of the catheters. Dr Patel acknowledged that he had problems with the catheters moving and accepted the proposal to move forward with Baxter.

Dr Miach was unsure when he gave Dr Keating the dialysis stats. [50] He also claimed having distributed them at a clinical forum meeting but acknowledged that Dr Keating did not usually attend these. [51] He said at the time when he gave Dr Keating the stats he did not "think (he) said very much at all" but he acknowledged the primary purpose in giving Dr Keating the audit was to have the Baxter program set in place. [52]

Against this background the actions of Dr Miach did not amount to a substantive complaint relating to Dr Patel's clinical practices or procedures at BBH. The insertion of such catheters required a particular skill, and not all surgeons were able to perform the procedures. [53] The fact that Dr Patel had difficulties did not give rise to a suggestion that he was clinically incompetent.

March 2004 **Letter - Nurse Hoffman to Mr Leck**

Following Goodman's retirement, Nurse Hoffman acted as DDON for one or two weeks in March. Towards the end of this period, Nurse Hoffman reported to Mr Leck with a letter [54] in which she raised some issues regarding Dr Patel. She said the letter was about Dr Patel's "behaviour" and this is borne out on a fair reading of the letter. At the same time, Nurse Hoffman said "*I wanted to see you about this but I don't want you to take it further*". [55] Subsequently, Mr Leck drew the letter to the attention of both Mulligan and Dr Keating. Mulligan later told him she'd spoken to Nurse Hoffman about managing Dr Patel's

50 T294/5
51 T296/25
52 T1630/1-20
53 Exhibit 448 paragraph 209(d)
54 Exhibit 4 "TH-10"
55 Exhibit 463 paragraph 17

behaviour and Dr Keating expressed the opinion that the problem was entirely related to a personality conflict. [56]

Having regard to the terms of the letter and to Nurse Hoffman's request that the letter not be taken further, these circumstances do not give rise to a substantive complaint regarding Dr Patel's clinical practice and procedures at BBH.

14/04/2004 **ASPIC Meeting concerning long-term ventilated patients at BBH**

The Minutes are Annexure "TH-11" to Exhibit 4 and the relevant entry is Item No. 04/04-01. It reads:

> "*ICU: several long term vents for long periods OT budget way over, but overall remains in budget, Director of Anaesthesia/Surgery and NUM of ICU + DMS or DNS need to have a proactive meeting about transferring ventilated patients.*"

As Dr Keating explained in evidence, Nurse Hoffman did not specifically raise at this meeting clinical inadequacies in surgery being carried out by Dr Patel. [57] In her evidence, Nurse Hoffman agreed. [58] Further, during 2004 BBH experiencing difficulties transferring patients to Brisbane because of increased demand for ICU beds resulting from closure of certain services at Rockhampton and Redcliffe-Caboolture. There also were restrictions on night-time transfers due to the refusal of retrieval staff to fly helicopters at night without adequate insurance. In consequence, the overtime hours in Bundaberg ICU increased. Dr, Keating examined statistics provided by Nurse Hoffman [59] and concluded that the demand for ventilation in ICU from all specialties (not just surgical) had increased and applied at least equally to medical patients. That being so, the data did not point to any increase being due to any poor or inadequate clinical practice or procedure by Dr Patel.

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56 Exhibit 463 paragraphs 19-26
57 Exhibit 448 paragraph 123
58 T1387/55
59 Exhibit 448 paragraph 129 & Exhibit 94

Against that background, this letter did not give rise to a substantive complaint regarding Dr Patel's clinical practice or procedures at BBH.

July 2004

P-11 - Desmond Bramich

Desmond Bramich was a 56 year old male injured in consequence of his caravan dislodging from its blocks and crushing him beneath it for 10 minutes.

He was admitted initially to BBH Emergency on 25 July 2004 under Dr Gaffield at which time a right flail chest with multiple rib fractures was diagnosed and a chest drain inserted.

Mr Bramich progressed well and on 26 July was transferred from ICU to surgical ward.

On 27 July at approximately 1:00 pm he collapsed. Dr Boyd, then Dr Gaffield were summonsed and he was immediately transferred to ICU. After that, and for approximately another 12 hours, aggressive attempts to stabilise him were undertaken by a number of clinicians.

An adverse event form [60] documented:

"*ICC drain, no water in underwater seal section*".

Despite that, Nurse Hoffman's documented concerns [61] were, essentially, 3-fold - interference by Dr Patel in the transfer process, lack of co-ordination of care and two surgical teams being involved (P11 was Dr Gaffield's patient), pericardial paracentesis.

Transfer

Dr Ashby opined that Mr Bramich should have been transported to Brisbane when apparently stable, by 26 July. Dr Gaffield, the clinician responsible for any transfer at that time, rejected that opinion. He stated that the patient would not have been accepted for transfer to Brisbane when stable given the extent of the identified injuries. Of

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60 Exhibit 162 Annexure "LR-9"

61 Exhibit 4 "TH-21"

course, once Mr Bramich deteriorated on 27 July, he was always too unstable for transfer out. [62]

Dr Younis was the only witness to corroborate Nurse Hoffman's claim of Patel's interference in the transfer. In evidence, Dr Younis stated he felt "resistance" from Dr Patel to transfer.

Drs. Carter and Boyd (the later was present during almost all of P-11's time in ICU) negated any suggestion of Dr Patel interfering with the retrieval.

Dr Smith, a consultant emergency physician at Royal Women's Hospital, who was involved in the retrieval stated that she did not recall being contacted by anyone at BBH and being asked to defer or cancel the retrieval. If this had occurred, it would ordinarily be documented. [63] There is no other evidence to support the assertion that the retrieval was cancelled or delayed by Dr Patel, or anyone else. [64]

Lack of co-ordination of care

Drs. Boyd, Carter and Younis all state that from 4:30 pm until 6:00 pm, Dr Patel was involved in surgery and not in Mr Bramich's care. Dr Patel became involved at Dr Gaffield's invitation and because Dr Gaffield was involved in other surgery. It seems that the intersection of two different surgical teams gave rise to difficulty. However, the case was, by that stage, an obvious critical emergency,

Pericardiocentesis

Whilst Nurse Hoffman gave a hearsay account of Dr Patel having stabbed the deceased fifty times, no eye witness saw fifty motions and Dr Ashby's testimony was that her findings at post-mortem did not support that account. [65]

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62 T4579

63 Exhibit 423

64 See espec. Exhibit 423: Statement of Dr Sharon Smith and records of clinical care retrieval services which supply no objective support for any interference.

65 Dr Ashby's evidence was that three or four marks consistent with insertions from a pericardial needle were seen; T2713/40

Clinical issues

This case is complex, there being a sudden deterioration in a previously stable patient. Dr Patel only became involved following the rapid deterioration, and at the request of Dr Gaffield. According to Professor Woodruff, Dr Patel has vicarious responsibility as principal clinician caring for the patient but, in reality, it was a team failure to appreciate that the underwater seal drains were not functioning whilst 3 litres of blood accumulated in the patient's chest. [66] Dr Patel's attempt at drainage of the pericardium was reasonable having regard to the rapid deterioration. Further Dr Patel's attempts did not alter the outcome. [67]

Investigation

On 29 July 2004, Dr Keating received a suggestion from Dr Carter that the patient's management be audited and Dr Keating, on 29 July (P11 died 28 July) wrote to Drs. Carter and Patel requesting conduct of a surgical audit. [68]

On 2 August 2004, Sentinel and adverse event forms re the Bramich case were received by Dr Keating. [69]

On 26 August 2004, Dr Keating received Dr Patel's report. [70]

On 13 September 2004, Dr Carter submitted his audit report. [71]

On 14 September 2004, Dr Keating received Dr Gaffield's report. [72] In his report, Dr Gaffield stated "*P11 was far too unstable to consider transfer and was grossly unfit for helicopter transfer.*"

On 27 September 2004, Dr Keating discussed P11 with Dr Younis. Dr Younis was critical of Dr Patel's management. [73]

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66 T4281-1
67 T2712/40-50
68 Exhibit 448 "DWK-39"
69 These forms are attached to Exhibit 163 - Leonie Raven's Statement
70 "DWK-40"
71 "TH-19"
72 "DWK-42"
73 "DWK-44"

On 19 October 2004, Dr Keating discussed P11 case with Dr Brockett, ICU Specialist at Logan. Dr Brockett provided Dr Keating with names of three ICU specialists who could review case.

On 20 October 2004, Peter Leck received oral complaints from Nurse Hoffman (accompanied by Nurse Mulligan) at 3.30 pm.

On 21 October 2004, having reviewed all the material on P11's case, it was apparent to Dr Keating that many factual conflicts were involved. His plan was to meet all personnel on 21 October 2004. Mr Leck requested Dr Keating to delay meetings until Mr Leck told him to proceed. [74] Mr Leck later requested Dr Keating to stop investigating the P11 case altogether, apparently because, at the time of presenting her written complaints to Mr Leck, Nurse Hoffman claimed that some nurses had been to see Dr Keating in the past with Dr Patel issues and were not happy about his investigation or management.

On 22 October 2004, Mr Leck received Nurse Hoffman's written complaint.

On 5 November 2004, Mr Leck met with Dr Keating and told him he intended to arrange an external investigation of Dr Patel. Dr Keating agreed and suggested it is important that review be conducted by someone with regional experience.

In early November to mid December 2004, Mr Leck and Keating enquired at various hospitals for a suitable person to conduct Inquiry. Their endeavours are interrupted by Tilt Train Disaster on 16 November 2004.

On 16 December 2004, Mr Leck forwarded material to Audit and Operational Review Branch, Brisbane, asking for advice in relation to review.

On 17 December 2004, Mr Leck received advice from Audit Branch that, as review involves issues of clinical practice, rather than misconduct, it should be investigated by Dr FitzGerald CHO.

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74 Exhibit 448 paragraph 152

On 17 December 2004, Mr Leck telephoned Dr FitzGerald's office, is told he is about to depart on annual leave but is aware of situation and should be able to assist with review.

21/12/2004 **P-21 Gerard Kemps**

Gerard Kemps was initially admitted to BBH on 6 December 2004 on referral from his GP. His history included an aortic procedure two years previous at BBH which, ultimately, required transfer to ICU at RBH.

Dr Smallberger undertook endoscopy and recommended to the Kemps' that Mr Kemps be transferred to Brisbane. He then referred Mr Kemps to the Department of Surgery, BBH to enlist surgeon support for the transfer. Mr Kemps was seen by Dr Patel who advised Mr Kemps on his options. Mr Kemps elected to be operated on at BBH by way of oesophagectomy. [75]

On 20 December 2004, Dr Patel performed an oesophagectomy on Mr Kemps. At the end of the surgery, notwithstanding that he was made aware by all staff that Mr Kemps was undergoing active internal bleeding, Dr Patel ordered his removal to the ICU.

When Mr Kemps continued to bleed post-operatively, he was returned to theatre by Dr Patel for a laparotomy and, at the same time, a splenectomy.

Mr Kemps continued haemorrhaging and Dr Patel was unable to locate the source of the bleed. Mr Kemps died on 21 December 2004.

Dr Keating first became aware of this case on 21 December 2004 when, via Peter Leck, he received a copy of the night report indicating that Mr Kemps was not expected to survive. Subsequently, Dr Keating spoke to Dr Patel about the case and received an explanation. On checking to see how many oesophagectomies Dr Patel had performed, and the results, Dr Keating resolved to

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[75] T1897/15 (Mrs Kemps)

instruct Dr Patel to cease these procedures, and he did so. [76] Subsequently, at a meeting with Mr Leck and Dr Keating, held 13 January 2005 following Dr Patel's return from annual leave, Dr Patel agreed not to undertake elective surgical cases requiring admission to ICU. [77]

Whilst Professor Woodruff considered the Kemps' case to be the most telling case of all to demonstrate Dr Patel's lack of judgment and motivation in his surgical cases, there is no evidence that Dr Keating ought reasonably to have known that this was so.

Late December 2004/January 2005

P-26

P-26 was 15 years old when, on 23 December 2004, he was involved in a motor cycle accident on a rural property. He sustained a severe laceration to his left groin, a laceration to his femoral vein and massive blood loss. He was airlifted to BBH and arrived in a critical condition. He was immediately transferred to theatre where Dr Patel performed a femoral vein repair and debridement and closure of the wound.

He was transferred to ICU and intubated.

Three hours later he was returned to theatre for left leg compartment syndrome for which Dr Patel effected upper and lower fasciotomies.

P26 was returned to ICU but moved back to theatre 4 hours later where Dr Patel inserted a gortex graft. Reportedly, P26 had good posterior tibial pulse at the end of this procedure.

Since Dr Patel went on leave on 26 December 2004, P-26 was, from that date, under the care of Dr Gaffield.

In the week that followed, P-26 was placed in the surgical ward where he deteriorated.

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76 T6822

77 Exhibit 448 paragraph 264

On 1 January 2005, he was transferred to the RBH, arriving septic and in a critical state.

At the Royal, P-26 was once again taken to theatre where his fasciotomies were extended, his femoral vein re-repaired, and where he underwent a through-knee amputation.

This case came to Dr Keating's attention on 4 January 2005 as a result of his receipt of an email from Dr Rashford. [78] In the email, Dr Rashford expressed concerns at the delay in transferring P-26.

On 5 January 2005, at Mr Leck's request, Dr Keating prepared a brief on this case for submission to Zonal Manager, Dan Bergin. Dr Keating's report [79] recommended a patient with major vascular injury be transferred as soon as the patient's condition is stable. Subsequently, Dr Keating spoke to Drs. Patel and Gaffield and explained that, as a result of his review, any patients undergoing emergency vascular surgery shall be transferred as soon as they were stable.

On 13 January 2005 there was a meeting between Dr Keating, Dr Patel and Mr Leck at which Dr Patel was told of the intended audit by Dr FitzGerald. He replied that he did not intend to renew his contract and agreed, at the Hospital's request, not to undertake elective surgical cases requiring ICU admission.

In his review of P-26's case, Professor Woodruff opined:

(a) The critical time in which to save a leg is 6 hours from time of injury; [80]

(b) The first operation by Dr Patel was life-saving (t/s 4320.50); [81]

(c) The patient could not be transferred from BBH until haemorrhage was controlled and he had been resuscitated; [82]

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78 Exhibit 210 "SJR-1"
79 Exhibit 210 Annexure "SJR-2"
80 T4319/50
81 T4320/50
82 T4320/45

(d) The leg was irretrievably lost by 2.30pm or 3.00pm on admission date to BBH; [83]

(e) There was absolutely no question of getting the patient to the vascular operating theatre of RBH or PA in time to save the leg; [84]

(f) This was a case of mismanagement by Dr Patel (retaining the case at BBH) but not such as caused ultimate harm. The patient would have lost leg anyway but would not have been so sick had he been earlier transferred out; [85]

In contrast to Professor Woodruff, Dr Jason Jenkins opined that, if P-26 had been transferred to Brisbane as soon as he had stopped bleeding, there was a significantly higher probability he would still have his leg. [86]

It is submitted that Professor Woodruff's views ought to be accepted as only he had access to admission records, findings, blood test results etc.

Conclusions

The above summary reveals that no complaint as to Dr Patel's clinical competence was specifically raised with BBH's management until Nurse Hoffman's complaint of 20 October 2004. Prior to that date, issues were raised which, with the benefit of hindsight, gave rise to a concern about Dr Patel's clinical competence. However, they were not raised in that context at the time, and they were all addressed by Dr Keating and Mr Leck in a manner which was appropriate to resolve those issues.

Recalling Professor Woodruff's finding that vicarious liability attached to Dr Patel, it is difficult to see how Mr Bramich's case is one where a substantive concern relating to the clinical practice and procedures utilised by Dr Patel at BBH can be made out. In any event, a review of the case was being undertaken by Dr Keating until Mr Leck decided it was more appropriately dealt with by external review following receipt of Nurse Hoffman's complaint on 20 October 2004.

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83 T4320/55-60
84 T4321/1-4
85 T4321/50
86 Exhibit 254

Mr Kemps' case did raise a clear instance of lack of appropriate clinical judgment on Dr Patel's part in performing a procedure outside the scope of the BBH. However, immediately the case came to light, appropriate action was taken by Dr Keating so as to limit the performance of such procedures by Dr Patel.

P26's case also demonstrates a failure by Dr Patel to effect a prompt transfer of his patient. However, there were other considerations notably, that the patient showed signs of improvement immediately before Dr Patel took annual leave and that the care of the patient was, thereafter, in the hands of another surgeon, Dr Gaffied. Again, as soon as the case came to the attention of Mr Leck and Dr Keating, immediate corrective action was taken.

Finally, once issues of clinical competence were specifically raised by Nurse Hoffman on 20 October 2004, steps were taken to investigate these issues. Ultimately, this resulted in the performance of the clinical audit by Dr FitzGerald. This was an appropriate response, having regard to the information provided to Dr FitzGerald.

Suspension of Dr Patel

Section 89(1) *Public Service Act 1996* empowers an employing authority to suspend an officer from duty should it reasonably believe that officer is liable to discipline and that the proper and efficient management of the officer's department might be prejudiced if the officer is not suspended. A liability to discipline arises where the employing authority is reasonably satisfied that the officer has performed his or her duties carelessly, incompetently, or inefficiently. [87]

Mr Leck acknowledged that, as District Manager, he had power to suspend Dr Patel from BBH. [88] He also appreciated that it was necessary to determine that there were grounds so to do. [89] He thought of suspending Dr Patel after receiving Toni Hoffman's letter on 20 October 2004. [90] However, Mr Leck said that Dr Keating was adamant that the issues were personality based and he had no clinical information to give immediate grounds for action. [91]

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87 *Public Service Act* 1996 s.87(1)(a)
88 T7162/40
89 T7162/67
90 T7163/26
91 T7163/20

As 2005 proceeded, Mr Leck became more concerned about Dr Patel but had no medical qualifications of his own and relied on Dr Keating's judgement [92] accepting it to the point of not feeling it necessary to suspend Dr Patel. [93]

As evidenced by Mr Leck's email - 13 January 2005 to Dr Scott [94] - as late as 13 January 2005, Dr Keating was still advising Mr Leck that the issues were personality-driven.

Dr Keating stated that he was not empowered to suspend Dr Patel, [95] although he acknowledged it was open to him to suggest suspension to Mr Leck, [96] and he did not do so. [97]

Dr Keating acknowledged that, following receipt of Toni Hoffman's written complaint on 22 October 2004, suspension was one of a range of options open to him and Mr Leck. [98] However, he thought it appropriate that an external investigation or review occur. [99] At this stage he had little detail about each individual case and determined that external review was required. [100] As a result of further information obtained following P-21's case, Dr Keating restricted Dr Patel's practice by instructing him, on 10 January 2005, not to perform any further oesophagectomies. [101] Additionally, on 13 January 2005, Dr Keating, in company with Mr Leck, instructed Dr Patel not to undertake any elective surgery requiring ICU. [102] Whilst this action may now be viewed as inadequate, this view is formed only with the benefit of hindsight, and having regard to information which was not then known by Mr Leck or Dr Keating.

Dr FitzGerald's belief was that he had insufficient information to suspend Dr Patel.[103] This view was formed having regard to the conflicting information available to him, including the disparate views of other practitioners as to Dr Patel's competency[104], the conflicting data[105] and the views of the anaesthetists that Dr Patel "*was not the best surgeon neither was he the worst*"[106].

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92 T7164/20
93 T7196/21
94 Exhibit 225 "GF-9"
95 T6847/30 & T7001/7
96 T6847/32
97 T6847/38
98 T7050/17-26
99 T7050/29
100 T7050/33
101 T6878 & 6822
102 T6828
103 T6143/44
104 T6149/20
105 T6161/45; see all T616/25 – 50: 6163/10
106 T6149/30; 6154/20; see also 6119/5

Importantly, Dr FitzGerald took steps to:

(a) Obtain from both Dr Patel and Dr Keating prior to leaving BBH in February 2005, undertakings that Dr Patel would "*undertake only those procedures which are within the scope of the surgical services and relevant support services*" of the hospital and "*to transfer patients more readily to higher level facilities*".[107] It was entirely reasonable for Dr FitzGerald to accept that Dr Patel and Dr Keating would honour those undertakings, particularly as he was informed such an arrangement was already in place[108]. Dr Keating "*would know what those procedures were*"[109]. These undertakings satisfied the principal issues and complaints that had been brought to Dr FitzGerald's attention;

(b) Ensure the MBQ deferred consideration of any registration renewal by Dr Patel. Upon his return to Brisbane following the visit to BBH, Dr FitzGerald, on 16 February 2005, contacted the MBQ to advise that there were possible concerns and to arrange that the MBQ defer consideration of Dr Patel's application for renewal of registration until after the finalisation of his Clinical Audit report[110] and any further investigation [111] Dr FitzGerald knew that Dr Patel was an area of need registrant, that such registration only lasted 12 months and that Dr Patel could not work unless that registration was renewed by the MBQ [112]. Dr FitzGerald had been advised by Mr Leck that Dr Patel's contract expired on 31 March 2005;

(c) Have the MBQ undertake a formal assessment of Dr Patel. On the day he delivered his memorandum to the Director General enclosing the Clinical Audit report, Dr FitzGerald wrote to the MBQ seeking an assessment of Dr Patel's performance. In that letter[113] he stated:

> "*My investigations to date have not been able to determine if Dr Patel's surgical expertise is deficient, however, I am concerned that the judgement exercised by Dr Patel may have fallen significantly below the standard expected. This judgement may be reflective of his decision to undertake such complex procedures in a hospital that does not have the necessary support, and in his*

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107 T6107 – 6108.
108 T3247/40.
109 T6108/25.
110 Exhibit 225, para 67: T6146/25 – 35.
111 T6147/20 – 30.
112 T6147/15 – 30.
113 Exhibit 24, attachment MDG-5.

apparent preparedness to retain patients at the hospital when the clinical condition may warrant transfer to a higher level facility."

Whilst reasonable minds might differ as to the steps to be taken, the steps taken by Dr FitzGerald were reasonable steps, having regard to the information then available to Dr FitzGerald. They addressed the areas of concern by restricting Dr Patel's clinical practise, and arranged for an assessment of Dr Patel.

Dr Buckland relied on Dr FitzGerald's report and conversations he had with Dr FitzGerald to reject any suggestion that he ought, on 24 March 2005, to have suspended Dr Patel from clinical duties. [114] His advice from Dr FitzGerald was that the focus of his reports namely, issues of "out of scope and operation" and "staff disharmony" [115] had been addressed by curtailment of Dr Patel's scope of practice at the Hospital. [116]

There was at all relevant times, insufficient clinical information available to QH to justify lawfully suspending Dr Patel within the meaning of section 89(1) *Public Service Act*. Furthermore, as Dr Patel had agreed to restrict his scope of practice, and to transfer patients more readily, any threat of prejudice to the proper and efficient management of the Department of Surgery at the Hospital had been addressed such that Dr Patel's suspension, under section 89(1) of the Act was not justified.

Against that background, no adverse inference can properly be drawn from a failure to suspend Dr Patel.

Credentialing and clinical privileging

In July 2002, Queensland Health introduced a standard policy of credentialing and privileging[117]. Pursuant to that policy, the responsibility for credentialing and privileging lay with the District Manager. Mr Leck gave evidence that he had delegated this function to Dr Keating.

No effective credentialing and clinical privileging committee was operating at the BBH due to difficulties in obtaining college representation. Attempts were made to overcome these difficulties, including the establishment of a joint committee incorporating Hervey Bay, Maryborough and Bundaberg. This was to minimise the risk of "mate credentialing mate"

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114 T5496/45-50 & T5497/1/2-11
115 T5497/4-5
116 T5561/5
117 Exhibit 279.

thereby increasing the degree of impartiality in the process. That process was subsequently developed into a policy in 2003[118].

Dr Patel was not assessed by the Credentialing and Clinical Privileges Committee. However Mr Leck issued temporary privileges for Dr Patel (and others). This practice was in accord with s.7.3 of Exhibit 279.

The joint Credentialing and Privileging Committee ultimately did assess the credentials and clinical privileges of a number of medical practitioners in late 2004. This did not include the surgical staff.

In his Clinical Audit report, Dr FitzGerald specifically raised the need for an effective credentialing and clinical privileging process to be undertaken at the BBH. By requesting a formal assessment of Dr Patel by the MBQ [119], Dr FitzGerald ensured that an assessment would be undertaken before any re-registration of Dr Patel. The effect of this was that Dr Patel would be unable to practice in Queensland prior to that formal assessment being undertaken. This rendered superfluous any need for Dr FitzGerald to review, or have reviewed, Dr Patel's credentials or clinical privileges. Having regard to the concerns expressed by Dr FitzGerald with respect to Dr Patel's judgment, a formal assessment by the MBQ was the more appropriate procedure in all the circumstances.

Non-publication of Dr FitzGerald's Report

Dr FitzGerald gave evidence that he undertook a clinical audit process focussed on quality improvement not on individual blame[120]. His approach to clinical audits was in accordance with expert views and literature reviews[121]. As a rule, clinical audits are kept confidential. This encourages people to provide information and make complaints for the purposes of the particular clinical audit then being undertaken and for future clinical audits. If a patient or informant is identified from a publicly released clinical audit report, it may discourage patients or informants providing information or making complaints in the future[122].

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118 Exhibit 276.

119 Exhibit 24, attachment MDG-5.

120 T3227/50-3228, T6121/18-28

121 T6121/23-28

122 Paragraph 84 of the statement of Dr Gerard Joseph FitzGerald dated 2 June 2005 (exhibit 225), and T3231/38-39, T3232/4-8, T4227/21-4228/3

In the case of the Bundaberg clinical audit report, Dr FitzGerald gave evidence that it was difficult in the case of a report into a small country town facility, such as Bundaberg, to de-identify the report because everybody knows everybody[123].

Dr Steve Buckland confirmed in evidence that the clinical audit process is an improvement process not a process of blaming individuals, [124] and that it is not usual for clinical audit reports or recommendations to be publicly released[125]. At paragraph 25 of his statement dated 30 August 2005, he stated:

> *"Public release can result in informants and patients being identified (even where carefully de-identified) by the context and the concern by the CHO is that it would make his job harder in future audits as patients and staff may be less willing to voluntarily provide information if there is risk of their identities being disclosed."*

Evidence was also given by Dr John Wakefield about the benefits of a no-blame approach to some investigations in order to promote organisational learning[126].

Whilst the Clinical Audit Report was not disclosed, staff of the BBH were specifically briefed by Dr FitzGerald as to its findings. [127]

Against this background, no adverse inference can properly be drawn relating to the non-publication of the Clinical Audit Report.

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123 T3229/37-43 and T4227/43-45

124 T5505/52-56

125 Paragraph 25 of the statement of Stephen Michael Buckland dated 30 August 2005 (Exhibit 335), T5557/27-31, T5566/40-41

126 Paragraphs 18 to 20 of the statement of John Gregory Wakefield dated 16 August 2005 (Exhibit 290A) and T4520/6 to T4522/55

127 Exhibit 225 paragraph 84 and T4227/17-20

(b) (ii) The employment of Dr Patel by Queensland Health; (iii) The appointment of Dr Patel to the BBH;

Following the resignation of Dr Baker on 28 August 2002, Dr Kees Nydam, then Acting Director of Medical Services, had the task of recruiting a Director of Surgery for the Hospital.

The position was advertised three times in 2002. On the second occasion, the position was advertised with a closing date of 16 September 2002 and there were three applicants. Dr Boris Strekov and Dr Jayasekera proceeded to interview however the third applicant was not considered to have met the selection criteria [128]

The Selection Panel comprising Dr Nydam, Dr Anderson (then in private practice in Bundaberg and a VMO at BBH) and Mr Peter Leck, District Manager, recommended the position be offered to Dr Boris Strekov, who then was a surgeon working at the Mater Hospital, Brisbane. Dr Strekov held the Fellowship of the Australasian College of Surgeons and had worked at numerous QH hospitals. Also short-listed was Dr Jayasekera, a Staff Surgeon at BBH since 14 January 2002 [129]. When Dr Strekov rejected the offer, Dr Nydam elected to continue looking for a Director and "*buy some time by getting some locums*" [130].

Dr Jayasekera was not Dr Nydam's preferred choice as Director of Surgery as he had not performed well at interview and, in private discussions with Dr Nydam, had expressed ambivalence about the job and a preference to relocate closer to Brisbane where his family lived to shorten his commuting time. This was accepted by Dr Jayasekera in his evidence as the reason why Dr Nydam told him he had not got the job [131].

In late 2002, Dr Nydam advertised the Director of Surgery position again with a closing date of 2 December 2002. Dr Jayasekera expressly stated in evidence that he was not interested in re-applying when the job was re-advertised - he was keen to get closer to Brisbane and, in fact, neither Dr Jayasekera nor anyone else applied for the position by 2 December 2002.

Dr Jayasekera's evidence was that he:

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128 T4112/40; 4112/55; 4113/30
129 Exhibit 308
130 T4123/40
131 T5971/10-20

(a) Did not want the position; [132]

(b) Did not feel he could perform it in all of its requirements; [133]

(c) Had no intention of remaining in Bundaberg even if he had been offered the position of Director of Surgery; [134]

(d) Only applied at the urging of others; [135]

(e) Was not interested in re-applying when the position was readvertised. [136]

Mr Leck gave evidence that Dr Nydam expressed the view that Dr Jayasekera was not suitably experienced to undertake the position. [137]

In the meantime, on or about 14 November 2002, BBH established a retainer with Wavelength to recruit a Senior Medical Officer, Surgery, to BBH. The SMO position description [138] supplied to Wavelength stated that the successful SMO candidate would report to the Director of Surgery at BBH. This was at a time when Dr Nydam was re-advertising the position of Director of Surgery.

According to Wavelength's Principal, Dr Bethel, Dr Patel approached Wavelength on its website and in December 2002 he submitted a CV disclosing that he had last worked in the United States at Kaiser Permanente Hospital in September 2001. Dr Bethel was concerned about this lacuna in Dr Patel's employment and followed it up with Dr Patel to be informed by him that Dr Patel, now in his fifties, had decided to take early retirement in the US and was now looking for an opportunity to work overseas as a lifestyle choice.

Dr Patel supplied 6 references to Wavelength and Bethel volunteered to Dr Nydam to undertake reference-checking. Bethel selected two referees who seemed to him to be appropriate - each had worked closely with Dr Patel at the Kaiser Permanente - and each supplied "glowing" references to Bethel. Neither referee said anything to Bethel tending to disclose Dr Patel's disciplinary history in the US. Apart from his referees, Bethel commented on Dr Patel's

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132 T5970/13; T5971/22-30
133 T5971/22-30
134 T5979/1-5981/14
135 T5970/12-22; T5971/31-38
136 T5979-10
137 T7139/55 - 7140/1
138 Exhibit 40

impressive CV including his 1988 Certification by the US Board of Surgery to Practice as a Specialist and Dr Patel's re-Certification (apparently on his own initiative) following completion of specialist exams in 1996. Additionally, Bethel noted that the Kaiser Permanente was a very significant private health provider with a number of centres across several US states. He commented on Dr Patel's apparent continuity of employment with that employer for upwards of 12 years as well as Dr Patel's tenure of a number of academic appointments, including as the Head of the Surgery Residency Program in which he taught young doctors. Bethel was also impressed by the fact that Dr Patel was widely published in credible and internationally recognised peer review journals.

Dr Patel submitted a revised CV in connection with this MBQ Registration Application claiming that he had been employed by Kaiser Permanente until September 2002. [139] Unfortunately, due to the change of personnel from Dr Bethel to Suzy Tawse, the anomalous CVs and, in particular, the obvious inconsistency between the second CV and Dr Patel's claim to Bethel that he had retired, was not picked up. In evidence, Bethel agreed that a reasonable explanation for the submission of a revised CV appeared to be that Wavelength's Suzy Tawse (who was then progressing Dr Patel's registration application through MBQ) suggested to Dr Patel that his non-employment for 12 months or so might be an issue with MBQ.

Dr Bethel referred the references and a record of his reference checks to Dr Nydam who resolved to make an offer to Dr Patel to fill the SMO vacancy in Bundaberg. Dr Bethel accepted that Dr Nydam's instructions to offer Dr Patel the position occurred after Dr Nydam had been supplied with the references and reference checks. [140]

In circumstances where a recruitment agency is employed for the purposes of obtaining a suitable candidate to fill a position, it is not unreasonable that the relevant reference checks be undertaken by that agency particularly where, as here, copies of the references and details of the reference checks are provided to the prospective employer prior to any offer of employment being made. Dr Nydam knew that such checks had been performed by a highly regarded recruitment agency[141]. His acceptance of the results of those reference checks was entirely reasonable in the circumstances, and does not constitute carelessness, inefficiency or incompetence.

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139 Exhibit 46
140 T721/10-31
141 T4137/45.

Dr Jayasekera resigned on 28 December 2002. As the Director of Surgery position failed to produce any applicant, another surgical appointment was needed and Dr James Gaffield was recruited on 9 January 2003. Dr Gaffield was junior to, and less experienced than, Dr Patel. His special interest was plastic surgery and he had no general surgical focus. In light of this, and his practical need for one of these two surgeons to act as Director of Surgery, [142] Dr Nydam appointed Dr Patel Acting Director of Surgery at BBH as evidenced by his instruction to "Georgie, Val" on 9 April 2003 to augment Dr Patel's salary by the payment of a Director's Allowance . [143] Dr Patel was the more senior of the two and was more experienced and did more general surgery[144]. Out of those two, he was the natural choice to undertake the duties of Director of Surgery[145].

As Dr Nydam explained, because Dr Patel looked so impressive on paper, Dr Nydam's strategy was to appoint him for 12 months and then, in the hope that Dr Patel would then have proved himself, the Hospital could try and entice Dr Patel to stay longer. [146] In furtherance of this plan Dr Nydam, on several occasions, attempted to have Dr Patel apply for Australian specialist qualification. In doing so, Nydam was, of course, ignorant that Dr Patel had suppressed his disciplinary history in the US thus making Dr Patel reluctant to seek Australian specialist accreditation in case the true picture should emerge. [147]

It is worthy of note that, at no relevant time, was Nydam referred a copy of Dr Patel's Licensure documents from Oregon.

Air fares

The original Queensland Health letter of offer to Dr Patel [148] dated 24 December 2002 contained a term under the heading "Travel" whereby BBH agreed to pay a one-way economy airfare for Dr Patel and his wife or a business class fare for Dr Patel if travelling alone from the United States to Bundaberg. This letter was silent as to return airfares, although there was a provision as to payment of relocation expenses.

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142 An administrative position carrying a small allowance; T4171/20-40
143 Exhibit 51 Annexure "KN-12"
144 T4126/50.
145 T4126 – 4127.
146 T4129/12-22
147 T4130/10-20
148 Exhibit 51 "KN-9"

Dr Bethel acknowledged a record of a telephone conversation of 20 December 2002 between himself and Dr Nydam in which "relocation expenses" was discussed in relation to Dr Patel. Dr Nydam stated that if Dr Patel was coming for the year, BBH would normally pay return airfares, economy for him and his spouse. If Dr Patel came on his own, Dr Nydam stated his preparedness to upgrade that to business class. Dr Bethel agreed it was likely this information was passed on by him to Dr Patel.

Dr Nydam admitted in evidence that there was no discussion (that is, between Dr Nydam and Dr Patel) when Dr Patel was originally engaged in which he was promised a return airfare home to the United States. [149] However, Dr Nydam said that the usual practice at BBH for locums was that they are repatriated home at the end of their term. [150] At a later stage, Dr Nydam did speak in the corridor with Dr Patel who asked him if he was entitled to a trip home. Dr Nydam replied "Absolutely." [151] Although not recalling the conversation about paying the return air travel of which Dr Bethel made a note, Dr Nydam agreed that he could well have had such conversation and if he did he would have expected it to be passed on to Dr Patel by Dr Bethel. [152]

Dr Nydam did not recall speaking to Peter Leck on this topic but agreed that he may have done and if he had that he would have advised Mr Leck that "*it was my understanding that he was due.*"[153]

During September 2003, Dr Keating sanctioned payment of Dr Patel's first return airfare to the US. He did so in Dr Nydam's absence on leave, after having contacted Wavelength and obtained confirmation that return air travel had been agreed as part of contract negotiations. [154] A memo recording Wavelength's advice existed on file.

In these circumstances, it is reasonable to think that Wavelength, as BBH's appointed agent in about December 2002, did convey an offer on the Hospital's behalf to reimburse to Dr Patel the cost of one return airfare for each contract period. Certainly, Dr Keating acted in good faith when making the enquiry of Wavelength in September 2003, and in reimbursing Dr Patel the airfare for that year. In so doing, Dr Keating set a precedent of which Dr Patel availed himself when seeking to return to the US in the first quarter of 2005.

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149 T4163/10
150 T4162/30-40
151 T4162/30
152 T4168/1-30
153 T4191/15-20
154 Exhibit 448

No adverse findings should be made in relation to the payment of Dr Patel's return airfare.

(b) ~~(iii)~~ (iv) The adequacy of the response by Queensland Health to any complaints received by it concerning Dr Patel; and

Refer to submissions (b)(i) above.

(b) ~~(iv)~~ (v) Whether or not there were any reprisals or threatened reprisals made by any official of Queensland Health against any person who made the complaints referred to in ~~(iii)~~ (iv) above.

Ethical Awareness Seminar (BBH) - 14/10/2004

Nurse Hoffman initially gave evidence that she saw the seminar as being in response to her letter of complaint. [155]

This seminar, sponsored by the Audit and Operational Review Branch of Queensland Health, Brisbane, was part of a program of "rolling out" ethical awareness education programs across 13 districts (including Bundaberg). The seminar was not specific to BBH. The seminar at Bundaberg took place on 14 October 2004 and was pre-arranged some weeks before it actually occurred. [156] In the week in which the Bundaberg presentation took place, 5 similar sessions occurred across the district. Although the presenters called on Mr Leck as a matter of courtesy prior to making their presentation, they received no instructions from him and he made no mention of Dr Patel to them. [157] Mr Tathem specifically denied that his attendance at BBH was responsive to issues concerning Dr Patel. [158]

There was good reason why this should be so:

(a) Nurse Hoffman's letter of complaint was not written until 20 October 2004, some days after the seminar took place. Nurse Hoffman accepted she was mistaken in evidence in

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155 T170/45
156 T3737/15
157 T3738/15-45
158 T3738/45-50

thinking that the seminar occurred post her formal representations, orally and in writing, to the BBH Executive; [159] and

(b) Nurse Hoffman's letter was not tabled in the Parliament until 22 March 2005.

Whilst her then frame of mind may have led Nurse Hoffman to consider that the Ethical Awareness Seminar was retributive, it plainly was not.

(c) Any substantive allegations, complaints or concerns relating to the clinical practice and procedures conducted by other medical practitioners, or persons claiming to be medical practitioners, at the BBH or other Queensland public hospitals raised at the Commission of Inquiry established by *Commissions of Inquiry Order (No. 1)* of 2005.

Lennox Report

A Joint OTD/TRD Support Committee (*'Joint Committee'*) was established [160] in November 2002. One of the aims of the Joint Committee was to consider appropriate mechanisms for the screening and assessment of overseas trained doctors[161]. Members of the Joint Committee included the AMAQ, Queensland Health, the MBQ, the Department of Health and Ageing and the Department of Immigration, Multicultural and Indigenous Affairs[162]. Dr Michael Catchpole, the Principal Medical Adviser was the Queensland Health representative on that committee. Dr Lennox participated in the committee at times when he was Acting Principal Medical Adviser. [163]

At the June 2003 meeting of the Joint Committee, a paper[164] was presented by Dr Lennox for consideration. This paper had previously been tabled at a meeting of the Medical Workforce

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159 At T170/40-50, Nurse Hoffman testified that it was about a month to six weeks after her formal complaint to Leck on 22 October 2004 that three Queensland Health Officers conducted the Ethical Awareness Seminar. Under cross-examination (T1516/18-25) she later accepted that she was mistaken about this order of events and that the seminar pre-dated her complaint to Mr Leck

160 Attachment SMB46 to Exhibit 336

161 Exhibit 55 paragraph 23

162 Exhibit 55 paragraphs 22-24

163 Exhibit 336 paragraph 145

164 Attachment DRL11 to Exhibit 55

Advisory Committee of Queensland[165]. The paper was the subject of ongoing discussion by the Joint Committee and was subsequently redrafted to address issues relating to the management of temporary resident international medical graduates. A new paper entitled *'Medical Jobs@Health, Management of International Medical Graduates'* was tabled at the July meeting of the Joint Committee[166]. This paper became known in the Commission as the Lennox Report.

On 11 August 2003 a meeting took place between Dr Lennox, Dr Toft, President MBQ and Mr Michael Demy-Geroe, Deputy Registrar MBQ[167] at which time the *'appropriateness of Dr Lennox's report'*[168] was considered. It was the view of Dr Toft and Mr Demy-Geroe that this was a draft report and that implementation of the proposals would be a major undertaking and require cooperation of a number of organisations[169]. In evidence, Mr Demy-Geroe stated that, to his mind, the report remained a draft and was never promulgated to a final report[170].

In his statement, Dr Lennox referred to a request by Dr Steve Buckland, then General Manager (Health Services) for a briefing regarding the proposal for integrated management of OTDs[171]. A briefing dated 28 August 2003, prepared by Dr Lennox, outlined the proposal for integrated management of IMGs and the involvement of MBQ to implement the report[172].

Dr Buckland suggests that Dr Lennox *'gave me a briefing dated 28 August 2003 attaching the paper he had prepared for the Committee'*[173] rather than having made an independent request for the briefing. Dr Buckland was unable to recall the status of the report at that stage but stated that *'it was never a QH document as such but a document prepared by Dr Lennox for the committee and subject to agreement by all the members of the committee'*. He further stated *'I do not understand that the agreement of all of the committee members was obtained....'*[174]. In any event, around this time the role of the Centre for Overseas Trained Doctors was being transferred to the Skills Development Centre and it was Dr Buckland's belief that they would work through the issues raised in that report. [175]

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165 Exhibit 55 paragraph 26
166 Exhibit 55 paragraph 27
167 Exhibit 349 paragraph 6
168 Exhibit 349 paragraph 9
169 Paragraph 11 of Exhibit 349; T477/10-20
170 T477/10-15
171 Exhibit 55 paragraph 19
172 Attachment DRL9 to Exhibit 55
173 Exhibit 336 paragraph 150
174 Exhibit 336 paragraph 151
175 T5516/10-15

The letter attached to the briefing[176] appears to have been signed by Dr Buckland, however there is uncertainty about whether it was ever received by the MBQ. Dr Toft has stated that the letter and draft report were never received[177].

It was the belief of Dr Lennox that the report was finalised and that this view was endorsed by Dr Buckland given his decision to write to the MBQ[178]. That was not Dr Buckland's view.

Correspondence was also received from Dr Marsh Godsall, Chair of the Joint Committee advising that the Lennox Report had been considered by a committee of the AMAQ. The letter contained recommendations in relation to additional issues to be incorporated into the report. [179] Mr Demy-Geroe, who was a member of that committee recalls that the report was discussed and that *'people agreed that these are worthy objectives, but whether they could be actually implemented.....was a separate matter'*[180], however *'the proposals were fairly ....resource intensive....'*[181].

Ms Wendy Edmond, the then Minister for Health, first became aware of the Lennox Report in October 2003, after a request from a journalist for a copy of the report[182]. Ms Edmond was informed that the report was a draft working document. In November 2003, Ms Edmond was briefed for the purpose of attending a meeting with the AMAQ. That briefing made reference to the existence of the joint QH/AMAQ working party set up to address matters relating to OTDs[183].

Ms Edmond was of the view that the report was developed for consultation with *'other players'*[184]. In Ms Edmond's opinion, for the report to be considered final, it must contain information regarding the outcomes of consultation. Ms Edmond gave evidence that the report remained a draft until it has been signed off by the appropriate officers. She stated *'I would expect such a report to include statements from the other players on the committee, a summary.....of their ideas...It would also include costings, it would also include whether or not it interacted with Commonwealth legislation...'*[185]

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176 Attachment DRL10 to Exhibit 55
177 Exhibit 349 paragraphs 15-16
178 T915/30-48
179 Exhibit 55 "DRL-13"
180 T477/10-20
181 T478/1-10
182 Exhibit 302 paragraphs 3-4
183 Exhibit 302 paragraphs 3-4
184 T4926/10
185 T4931/2-20

As Ms Edmond stated, *'Maybe it was final from Dr Lennox's point of view but maybe not from an expectation of the department point of view'*[186].

Similarly, Dr Robert Stable, then Director General was not aware of existence of the Lennox Report until being informed on 21 October 2003 that a journalist had sought a copy of the report[187]. In his statement, Dr Stable stated that Dr Lennox's assertion that the report was supported by the AMAQ was an overstatement. He stated *'It seems to me that the AMAQ contemplated at least an appreciable rewriting of Dr Lennox's report before it was considered further'*[188].

Whilst the concepts promulgated in the report were considered to be of value in addressing the problems surrounding OTDs, the report was never publicly released. With the exception of Dr Lennox, the report was not considered to have been finalised. The proposals contained in the report had not been costed by Treasury and it had not been submitted to Queensland Health senior management for approval. It was a report prepared for consideration by the Joint Committee (of which Queensland Health was only one member) and not commissioned by Queensland Health[189]. The report was not adopted by the Joint Committee[190] and the evidence before the Commission of some of the members of the Joint Committee was that it was a working document[191].

There is no proper evidentiary basis to find that the failure to publicly release the Lennox report was other than due to the fact that it was never a final report and was never adopted by the responsible authorities necessary for its implementation.

Vincent Berg

In January 2000 Vincent Berg was appointed to the Townsville General Hospital as a Psychiatric Registrar. At the time of his appointment he held registration from MBQ (refer exhibit 238 MBQ file) and complimentary references which were verified by his employer, Townsville General Hospital. Amongst his other qualifications, Berg claimed to be a fully qualified psychiatrist trained at Voronezh State University, Russia.

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186 T4926/22-24
187 Exhibit 366 paragraph 63
188 Exhibit 366 paragraph 61
189 Transcript 5516/30-32
190 Exhibit 336 paragraph 151
191 See for example T477; attachment DRL10 to Exhibit 55; paragraphs 11 and 14 of Exhibit 349

As a psychiatric registrar, Berg was closely supervised in his work at TGH. That supervision brought to light, at a very early stage, concerns about his style of practice. The result was that Berg was performance-managed at TGH and ultimately, due to continued unsatisfactory performance, failed to have his contract renewed in January 2001.

Subsequent to his departure from TGH, Berg applied to the Australian Medical Council and the Royal Australia and New Zealand College of Psychiatrists for specialist assessment/advanced standing. The College sought to verify his qualifications from Voronezh State University and, in January 2002, was advised that his qualifications were bogus. In January 2002 the College notified MBQ of this advice but MBQ did not notify TGH. The Hospital only discovered this fact co-incidentally in November 2002.

TGH immediately set about identifying the 259 patients who Berg had treated in order to assess their need for follow-up. As an added precaution, TGH devised a media plan in an attempt to identify whether there were other patients out in the community whom Berg had seen (for example, when he was "on-call"). As it was put by Dr John Allan, Director of the Mental Health Service for TGH [192]:

> "*.... I felt very confident that that was the vast majority of the figures. I was really talking about someone he might have seen in the middle of the night and not recorded that on a timesheet or a person who may have shown up at a clinic without an appointment that was seen as an emergency and somehow didn't make the registers, so I thought there were odd occurrences rather than many occurrences.*"

Apart from the 259 identified patients, Dr Allan's guesstimate was that there would be a maximum of maybe 10 others. [193] The audit undertaken demonstrated that only a small number of patients may have required follow up. [194]

Dr Allan and Dr Andrew Johnson, the Director of Medical Services at THG, felt that public disclosure regarding Berg's apparent bogus qualifications was warranted. At a meeting with Drs Allan and Johnson (on an unrelated matter) on 4 December 2002 the proposed disclosure of the Berg issues were raised with Dr Peggy Brown, then Director of the Mental Health Unit. Dr Brown queried whether input had been sought from the Zonal Management Unit and/or the General Manager of Health Services ("GMHS"). On her return to Brisbane, Dr Brown met with

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192 T 3502/3-15
193 T 3052/20
194 Exhibit 376C paragraph 22

Dr Steve Buckland, then GMHS, on 5 December 2002. [195] At that meeting Dr Brown expressed her concern in relation to Dr Johnson's proposal to make a public announcement regarding Berg. She states "*my concerns involved weighing up the potential risks to mental health patients as against the public benefit of such a disclosure.*" [196] Given the audit undertaken at TGH did not suggest any major issues surrounding provision of care by Berg, Dr Brown favoured selected follow up over public disclosure. [197]

Dr Buckland was then called upon to make a decision. He gave evidence that it was one of the most difficult decisions he had to make as a medical practitioner and administrator. [198] Following consultation with Dr Brown, Dr Buckland gave a direction to the TGH District Manager, Ken Whelan, that there was not to be a public disclosure but rather that individuals requiring follow up would be contacted.

Queensland Health had already launched a substantial investigation into the facts of the Berg case. [199] In addition, it reported the matter to the CMC and Queensland Police Service. [200] Berg put up a spirited defence of his credentials. He maintained to MBQ that the Soviets were attacking his credentials as retribution for his refugee status in Australia.[201]

In evidence to the Commission, Dr Buckland explained his rationale for rejecting public disclosure: [202]

> "*... Berg had left more than two years before. He was a Psychiatric Registrar not a Consultant. He was supervised as a Registrar. .... Dr Allan had done a review of patients ... The patients at risk were contacted, and that was happening. The question was only whether or not we talk about the fact of Berg's qualification, not the fact of whether we follow patients up or identified patients at risk ... This is the vexed question. The question therefore remains will you cause greater harm by putting - because .... it is*

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195 Exhibit 376C paragraphs 17-18

196 Exhibit 376C paragraph 20

197 Exhibit 376 paragraphs 21-22

198 Exhibit 336 paragraphs 224-8

199 So much appears from Exhibit 239 - the Q. Health Investigation File on Berg

200 Exhibit 239 contains an email from Ken Whelan dated 9 December 2002 to Michael Shafer (the Director of Audits and Internal Review at QH) recording Buckland's suggestion to Whelan to contact Shafer. In addition, that Exhibit contains a written acknowledgement dated 3 January 2003 from the CMC acknowledging referral of the Berg case, and a further letter from the CMC dated 9 April 2003 recording that the CMC has no further requirements of Queensland Health in the matter

201 full details of this will appear from Exhibit 238 - the MBQ file re Berg and also an Affidavit from the Board's Registrar, Demy-Geroe, tendered to the Commission on 4 August 2005

202 T5525/1-25

a Registrar, and most patients ... wouldn't actually know who the Registrar was that treated them, so if you put it in the public domain or do it in another way, you will have a lot of people who are identified or concerned. They may not approach the service at all. They may actually stop taking the medication. They are all the considerations I went through. ... I equally accept that other people would have made a different decision. I accept that ...".

The then Minister, Ms Edmond, also gave evidence of the sensitivity of the issue of contacting former patients. She related her experience of how, in light of an earlier public airing of sensationalist and lurid publicity regarding mental health patients, she then received, for many months after, reports from persons who said their loved ones refused to go to doctors, refused to take their medication and so on because of that publicity. [203]

Ms Edmond also agreed that, as a Minister, one of the most difficult things she ever had to deal with were mental health issues because of the unpredictability of patient behaviour. [204]

Although not remembering specifically whether she was asked whether or not Queensland Health should go public on the Berg matter, Ms Edmond was firm that her view was that Queensland Health ought not to have gone public. In her view, given that Berg had been gone for nearly two years, it was a reasonable assumption that those patients who were quite ill and under intensive care would have been seen by somebody else. [205]

The then Director General, Professor Stable, agreed that the Berg decision was a difficult one [206] and that it was a reasonable decision at that time not to engage in non-directed publication or media release. [207]

The decision taken to not make public disclosure of the Berg matter was reasonable based on the best interests of his former patients. There is no reasonable basis to assert that the decision was other than one made in good faith, particularly having regard to the views of Dr Brown, the then Chief Psychiatrist and Acting Director of Mental Health.

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203 T4953/30-40
204 T4953/50-60
205 T4956/25
206 T5733/10
207 T5736/50

Cardiology Services

Dr Con Aroney gave evidence that, according to his perception, a series of budgetary cuts were imposed on provision of cardiology services at the Prince Charles Hospital, ("TPCH") which adversely impacted his capacity to clinically treat his patients. Dr Aroney also asserted that TPCH was punished as a consequence of his *'public stance'* on the issues. [208]

In overview, the evidence establishes:

(a) In early 2003, following a submission received from the Princess Alexandra Hospital, ("PAH") in early 2002 seeking to expand its cardiac service, QH made a decision to expand cardiac services at PAH through a transfer of funding and services from TPCH. [209] This was before Dr Aroney went to the media and the press release on 6 January 2004. [210]

(b) The intention of the proposed transfer was to improve the access and timeliness of interventions through managing patients across the service.[211] It was also to make the service at PAH more sustainable, to build up a greater volume of work there, and provide a service more accessible to those living on the southside of Brisbane. [212]

(c) As originally implemented, the transfer involved a redirection of clinical cases from TPCH to PAH with a corresponding transfer of the associated funding to treat those patients. The transfer in activity and funding commenced between April and July 2004. [213] In hindsight, the same result might have been accomplished if TPCH funding had been left undisturbed and the PAH service had simply been allocated new growth funding with redirection of southside patients to PAH. [214]

(d) Although Dr Aroney insisted that the transfer of cases to PAH was rationalised on the basis of a "hidden category 3" waiting list at that hospital, Dr Aroney agreed that it was cardiologists - clinicians - at PAH who were responsible for classifying patients there.[215]

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208 Exhibit 263 page 2
209 Exhibit 301C paragraphs 21 and 23
210 Exhibit 263 page 4
211 Exhibit 301C paragraph 36
212 T6023/10-20
213 Exhibit 301C paragraph 30
214 T6024/30-50
215 T6277/28

He also conceded that he was not in a position to disagree with PAH's claim that they had the capacity to deal with the transferred cases. [216]

(e) Dr Aroney thought "category 3" meant the same thing at both Hospitals. [217] This had also been Dr Cleary's assumption at the time when the transfer from TPCH to PAH was being implemented. [218] In truth, the two Hospitals had, at that time, a different classification system. This contributed to the significant difference in the presentation of waiting list numbers at the two Hospitals. [219]

(f) A Cardiac Procedure Workshop was set up by QH to assist in the development of a common and coordinated approach to waiting list management for cardiology procedures. Dr Aroney conceded that he was not present at that workshop and was unaware which categorization system was ultimately adopted. [220]

(g) Overall, cardiac activity within Queensland Health increased, [221] as did funding to the Cardiology Department at TPCH. [222] Additional funding in the sum of $2.4M was provided to TPCH in the 2004-2005 financial year to undertake additional cardiac surgery. [223] Dr Aroney had no knowledge of these matters. He admitted having never worked at PAH [224] and agreed that he had no knowledge of any overall increase in funding or activity. [225]

(h) Between 2003-2005, the time when TPCH was allegedly being punished, the cardiology department at TPCH had an overall funding increase of $5.5M[226]. There was also an increase in activity across other Queensland Health hospitals[227].

Dr Aroney's assertions of an *'attempted cover-up by Queensland Health of the true circumstances of the death..'* of patients on the cardiology waiting list [228] are without substance. The concerns raised regarding patient deaths on the cardiology waiting list had in fact been the

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216 T6281/38-42
217 T6278/58
218 Exhibit 301C paragraph 41
219 Exhibit 301C paragraph 41
220 T6278/30
221 T6024/55 and Exhibit 301C paragraph 101
222 Exhibit 301C paragraph 99
223 Exhibit 301C paragraph 33
224 T6277/1
225 T6258/25 & 45
226 Exhibit 301C paragraphs 99-100
227 Exhibit 301C paragraph 101-102
228 T6283/1

subject of an independent investigation[229]. Whilst Dr Aroney alleged that Dr Cleary provided incorrect details of the date of death of two patients in an attempt to *'cover up'* the truth, Dr Aroney conceded that *'there may have been an error made, the dates were given to me by staff at the hospital...*'[230].

Dr Aroney's assertion that, during a meeting on 29 September 2004, the cardiologists at TPCH were bullied by Ms Gloria Wallace by threatening to replace them with foreign-trained doctors is also without substance. The minutes of the meeting [231] referred to by Dr Aroney do not record any such threat.

Fraser Coast Health Service District

On 3 November 2003 an article appeared in the Courier Mail headed ASurgeons Lack Qualificationse. The source of the information in that article came from a Dr Blenkin of the Australian Orthopaedic Association.

On 4 November 2003 Dr Hanelt wrote to Dr Blenkin expressing his disappointment that the Australian Orthopaedic Association had not contacted him in an attempt to resolve the issues. Dr Hanelt invited input from the Australian Orthopaedic Association on certain matters.

In early January 2004 the Federal President of the Australian Orthopaedic Association wrote to Dr Hanelt indicating that the Australian Orthopaedic Association would be prepared to send investigators to Hervey Bay to conduct a review of the Orthopaedic Department. Dr Hanelt agreed.

On 16 January 2004 Dr Hanelt, Dr Naidoo and Dr Mullen met and the following issues were discussed:

(a) agreement was reached that formal teaching sessions for the Senior Medical Officers in Orthopaedics must be held regularly;

(b) agreement was reached that formal Morbidity and Mortality Meetings are to commence;

(c) the Australian Orthopaedic Association review is expected to provide some guidance

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229 Exhibit 301C paragraphs 57-66

230 T6283/5-10

231 Prepared by Radford whom Dr Aroney acknowledged to be reliable: T6283/55

as to what that association considers as appropriate training and Quality Assurance activities;

(d) the Australian Orthopaedic Association review is expected to provide guidance for supervision requirements and clinical privilege delineation for the Senior Medical Officers;

(e) the issue of consultant availability was raised. It was accepted that due to the limited number of specialist Orthopaedic Surgeons available, there would be occasions when other hospital medical staff would perform treatment within the bounds of their clinical privileges and that protocols would be developed for obtaining advice from remote specialists where such consultation was required prior to treatment.

This meeting was held because Dr Naidoo and Dr Mullen did not agree upon what would constitute an appropriate degree of supervision of the Senior Medical Officers. The meeting was minuted. [232]

Subsequently, Drs. North and Giblin were appointed as investigators and on 2nd July, 2004 they attended at the Hervey Bay Hospital and conducted a series of half hour interviews with a limited number of staff members and also obtained other documentary information. They conducted no audit of charts and interviewed no patients.

Drs. North and Giblin received further material in the following months.

Delays with the presentation of their report arose as a result of indemnity concerns, but it was finally presented to the Director-General on 6th May, 2005.

The Director-General then forwarded the report to the Chief Health Officer for his advice.

The Chief Health Officer advised the Director-General: [233]

(a) the report should not be published as that would further the impact of any potential defamation;

(b) the interviewers have not sought or been in a position to validate any of the concerns of

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232 Attachment TMH 14 A and B to Exhibit 444

233 Attachment GF32 to Exhibit 225

the hospital staff that had been raised with them;

(c) ordinarily such concerns would require a more formalized investigation;

(d) the investigators= recommendations to cease orthopaedic services at the hospital has significant clinical, legal, industrial and community implications and that alternative solutions to the issues of concern should be first sought;

(e) that certain actions to address the concerns should be taken.

The Director-General sought to meet with Dr North to discuss the report, but Dr North declined to attend such a meeting.

The report was subsequently published under the authority of the Bundaberg Hospital Commission of Inquiry. This resulted in both Dr Mullen and Dr Kwon, the Acting Director of Orthopaedics resigning their positions. Orthopaedic services were subsequently ceased.

The North/Giblin Report was prepared as a result of negotiations between Dr Hanelt and the Australian Orthopaedic Association. Dr Hanelt was hopeful that the review and subsequent report would assist in the proper administration of the Orthopaedic Department.

The report does not purport to contain findings insofar as individual complaints are concerned. Rather, it is a summary of the complaints received. Investigation of those complaints did not occur and the recommendations must be viewed in that light.

The decision to not immediately follow the recommendation to cease all orthopaedic surgical health care activity was reasonable given:

(a) the report was twelve months out of date by the time it was presented;

(b) during that time steps designed to improve the service had been undertaken;

(c) the Acting Director of Orthopaedics had been maintaining proper supervision of the Senior Medical Officers since his appointment in January 2005;

(d) the Acting Director of Orthopaedics had expressed the opinion that patient safety was not an issue whilst he held that position; [234]

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234 Exhibit 336 - paragraph 247

(e) the unvalidated complaints detailed in the report would require investigation, including:

- examination of patient charts;
- conducting full interviews with staff with interviewee's acknowledgment of the accuracy of the recording;
- conduct patient interviews;
- conduct interviews of supervisors from previous workplaces;
- conduct a full audit of Dr Naidoo=s leave history and entitlements;
- make efforts to either confirm or refute hearsay or gossip; and

(f) patient safety was not at risk in the interim due to the changes which had occurred as outlined above.

The administration of the Hervey Bay Hospital acted appropriately and reasonably in arranging for the review to take place.

No criticism should be levelled at any individual or Queensland Health due to the delay in setting up the review process or for the delay in the presentation of the report. The indemnity issues referred to by Dr North in his evidence were in fact not issues of any substance.

In relation to the supervision issue raised in the report, the evidence shows that Dr Hanelt, Dr Krishna, Dr Sharma and Mr Allsop all relied on the opinion of Dr Naidoo as to what was appropriate. That was not an unreasonable approach given Dr Naidoo=s experience in Orthopaedics. The evidence of Dr Wilson [235] tends to support Dr Naidoo=s opinion in relation to Dr Krishna=s clinical skills, decision making ability, preparedness to seek assistance and insight into his own limitations. Similarly, Dr Sharma has been the subject of favourable reports from Dr Mullen and Dr Morgan. [236]

Much evidence has been placed before the Inquiry about the differences between administering a regional or rural hospital and a tertiary city hospital. It is without doubt that those tasked with the job of running a regional hospital have unique and varied problems to overcome on an almost never ending daily basis. It would be inevitable that scrutiny of the practices of any such

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235 T7326

236 Exhibit 503

hospital will find mistakes or areas that can be improved. Any assessment of the evidence in relation to the Hervey Bay Hospital should be made with that consideration in mind.

(d) The appropriateness, adequacy and timeliness of action taken to deal with any of the allegations, complaints or concerns referred to in (a), (b) and (c) above, both:

(i) within the BBH; and

(ii) outside the BBH.

Refer to submissions in (b)(i) above.

(e) In relation to (a) to (d) above, whether there is sufficient evidence to justify:

(i) referral of any matter to the Commissioner of Police Service for investigation or prosecution; or

(ii) action by the Crime and Misconduct Commission in respect of official misconduct or disciplinary matters; or

(iii) the bringing of disciplinary or other proceedings or the taking of other action against or in respect of any other person; or

(iv) amendments to the *Coroner's Act* 2003 in relation to appropriate reporting of deaths caused by or as a result of a health procedure.

In respect of each party represented by Queensland Health, it is submitted that there was insufficient evidence to justify referral of any matter for any of the nominated purposes.

Queensland Health makes no submissions in respect of Term of Reference (e)(iv).

(f) **For the purpose of clarification and the removal of doubt, the phrase "substantive allegations, complaints or concerns relating to the clinical practice and procedures" in (b) & (c) hereof includes allegations, complaints or concerns relating to acts or omissions by current and former employees of Queensland Department of Health which relate to clinical practices or procedures conducted by medical practitioners including acts or omissions relating to waiting lists both for patients referred to specialist outpatient's appointments and for surgical procedures."**

In considering these submissions, Queensland Health respectfully submits that it is relevant for this Commission to have regard to the initiatives introduced by Queensland Health in recent times in an effort to ensure the provision of quality health care throughout the public hospital system.

These measures included:

- The introduction of the measured quality program;
- The application of the service capability framework [237] to all public hospitals. As a result of this initiative, both private and public hospitals will now be subject to this framework which requires hospitals to consider the services that are capable of being performed having regard to the resources available in the hospital.;
- The establishment of the Patient Safety Centre;
- The creation of the Skills Development Centre [238] in the Herston complex of the RBH. This Centre is intended to provide valuable training and other assistance to international medical graduates as well as other graduates;
- The Adverse Event and Sentinel Event System. Whilst evidence led at this Commission suggested that the system was not as effective as it could be, due regard should be given to the evidence led as to the difficulty in having persons within the system accept that reported incidents will be dealt with in a blame free environment. It is to be expected that such a change in the system, which is contrary to the pre-existing culture, will take time to be embraced by persons working within the system.

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237 See generally Dr FitzGerald's evidence T3146/24-28

238 See generally T4645 and 4691