Volume One

Final Submissions

Queensland Public Hospitals

Commission of Inquiry

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Submissions

Mr Michael ALLSOPP

Crown Law
Queensland Government

Department of
Justice and Attorney-General

Your ref:
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26 October 2005

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

Dear Mr Groth

Submissions in response to Notices of Potential Adverse Findings

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

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

Yours faithfully

Peter Dwyer
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for **Crown Solicitor**

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QUEENSLAND PUBLIC HOSPITALS *COMMISSION OF INQUIRY*

SUBMISSION ON BEHALF OF MICHAEL ALLSOPP

Credentialling and privileging process

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Inappropriate supervision and Dr Naidoo's absences

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

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

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

[12] T6781/53

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

General findings regarding the Hervey Bay Hospital

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

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

Submissions

Michael BARNES

State Coroner

QUEENSLAND COURTS

STATE CORONER

Contact name: MAB:DKL

Our reference: 00146

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BY:.....

14 October 2005

The Honourable Geoffrey Davies AO
Commissioner
Queensland Public Hospitals Commission of Inquiry
Level 9
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363 George Street
BRISBANE Qld 4001

Dear Commissioner

Thank you for your letter of 4 October 2005. In accordance with your invitation I **enclose** herewith a submission containing my views about the reporting and investigation of hospital deaths.

Please feel free to contact me if you wish me to clarify or expand upon any of the matters raised in it.

Yours sincerely

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encl

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Queensland Public Hospitals Commission of Inquiry

Submission of Michael Barnes, State Coroner

Introduction

1. This submission contains my views on the appropriateness of the definition which determines whether hospital deaths are reported to a coroner and observations about how such deaths are dealt with by coroners. It also contains suggestions about how those processes might be improved.[1]

2. Although there is some overlap, the challenges encountered by coroners in responding to deaths that occur in a medical setting or are contributed to by suboptimal medical care can be grouped into two categories, namely, issues concerning the reporting of such deaths and the difficulties of investigating them.

Reporting problems

3. The *Coroners Act 2003* by s8(3)(d) requires a death to be reported to a coroner if it *"was not reasonably expected to be the outcome of a health procedure"*. This replaces the requirement of the *Coroners Act 1958* to report deaths that occurred while the deceased was *"under an anaesthetic in the course of a medical, surgical or dental operation."*

4. Presumably, the change was designed to shift the focus from when the death occurred to why the death occurred. It is easy to think of examples in which a death might occur during an operation which would not excite the interest of a coroner whose primary focus is to investigate unnatural, sudden or suspicious deaths; equally the fact that the patient survives the operation only to die a day or so later should not preclude a coroner from considering whether substandard care contributed to the death. However the change of wording, designed to cause the involvement of coroners in cases which suggest that something might have gone wrong, brings with it other problems.

5. For example, whose expectation is it that triggers the obligation to report? When discussing the subsection with doctors I have suggested the test is whether a medical practitioner familiar with the condition of the patient before the procedure that led to the death would feel

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[1] This submission deals only with the circumstances that apply to deaths covered by the *Coroners Act 2003* which applies to deaths which occur or are reported after 30 November 2003. I recognise that some of the deaths being examined by this Inquiry and many of the deaths still being dealt with by coroners occurred before that date.

obliged to warn the patient and his/her family that there was a real and substantial risk of death rather that just the ordinary risk that accompanies, say, every general anaesthetic. The difficulty is determining when the possibility of death becomes so great that it can be said to be a reasonable expectation. I am aware that some hospitals employ risk assessment systems that enable them to express the risk of a fatal outcome in terms of a percentage. I do not consider that approach conclusive for determining of whether a death is reportable.

6. Another problem is establishing with sufficient certainty that the health procedure has caused the death rather than the underlying condition that made it necessary.

7. In respect of both of these issues, in some clear cut cases these questions are easily answered; for example, if a patient presents with a ruptured aortic aneurysm the chances of emergency surgery saving him or her are very slight. Accordingly, during such an operation death would not be "*not reasonably expected*". Rather it would be foreseen that it was unlikely that the patient would be able to be saved and that death was a likely outcome. However as death is certain if the procedure is not undertaken it usually will be. Alternatively, it could also be reasonably concluded that the procedure did not cause the death but rather it was caused by the aneurysm. On both accounts the death would therefore not be reportable. On the other hand, if during a colonoscopy the bowel is perforated and the patient dies of peritonitis, there would be a low expectation of death prior to the procedure being undertaken and little doubt that it was caused by the health procedure. The death is therefore reportable, because it satisfies both elements of the definition.

8. However, while these examples may be fairly easy to categorise, in other cases the delineation may be less obvious. Expectation and causal contribution are not matters that can be easily quantified or calibrated; they are to a large extent subjective and best assessed in a qualitative and relative manner. So that in cases that are less obvious or unambiguous a different assessment may result depending upon who undertakes it.

9. Suggestions that elective surgery that results in death should always be reported because death would never reasonably be an expected outcome, in my view, over simplify the issue. For example, a neonate with congenital heart malformation might not be at risk of immediate death but his life expectancy may be no more than a few years and the intervening quality of life poor. Surgical intervention in some of these cases has better chances of success if undertaken as soon as possible. It is high risk but whether a death in these circumstances is required to be reported depends on an assessment of how likely was a fatal outcome.

10. From one perspective, the person best placed to make that assessment is the person who knows the most about the patient's condition leading up to the death. However, he/she is usually also the person whose performance will be scrutinised if a coroner investigates the death and he/she might therefore not be seen as sufficiently impartial to make an independent judgment on these issues.

11. This potential or apparent conflict of interest is not limited to post operative deaths however. General practitioners treating patients in their surgeries or the patients' homes frequently issue cause of death certificates in accordance with the obligation placed on them by s30 of the *Births, Deaths and Marriages Registration Act 2003* in circumstances where there is no independent check of whether misdiagnosis or inappropriate treatment by the certifying doctor has caused or contributed to the death. It was the abuse of this arrangement that allowed the mass murder committed by Dr Shipman to remain undetected by the English authorities and led to the *Luce Report* commenting that "*there is no reliable mechanism to check that deaths which should be investigated by the coroner are reported to him.*"[2]

12. That report recommend that all deaths be subject to a second certification by a doctor who has not been involved in the treatment of the deceased[3] and the creation of a new post in the coroner's office, filled by a doctor, who would audit death certificates relating to deaths not reported to a coroner to ensure the criteria for reporting deaths were being observed.[4]

13. The Public Inquiry set up to look into how Dr Shipman's murder of 215 of his patients had gone undetected for over 20 years went further and recommended that all deaths be reported to a coroner and that there be both medical coroners and judicial coroners. These recommendations were made in recognition of the difficulty, at the time of death, of effectively separating unexpected deaths that warranted some investigation from expected deaths that do not need any scrutiny.[5]

14. As would be expected, I have been working with stakeholders to review the operations of the relatively recently proclaimed *Coroners Act 2003.* In the course of that process the chief forensic pathologist from Queensland Health Scientific Services made contact with numerous medical superintendents and surgeons and sought their views on whether the wording of s8(3)(d) could be improved. No suggestions

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[2] The Home Office, 2003, *"Death certification and investigation in England, Wales and Northern Ireland"*, The report of the fundamental review, p42
[3] *ibid*, p51
[4] *ibid*, p43
[5] The Shipman Inquiry, 3rd report, "*Death certification and the investigation of deaths by coroners*", chapter 19

were forthcoming. I consider it appropriately describes the deaths that should be reported.

15. In summary, the challenges raised by deaths that occur in a medical setting, so far as their reporting to a coroner is concerned, are determining whether a death is reportable and ensuring that those which do meet the criteria are reported.

16. I have sought to address these issues by taking every opportunity to discuss them with medical practitioners and encouraging them to call me or their local coroner if they are in any doubt.[6] This approach is buttressed by s26(5) of the Act which provides that a doctor must not issue a cause of death certificate if *"the death appears to the doctor to be reportable unless a coroner advises the doctor that the death is not a reportable death"* and s7 of the Coroners Act that makes it a criminal offence not to report those deaths which come within the definition. Notwithstanding, I not infrequently become aware that some hospital doctors do not understand or do not comply with their obligation to report.[7] There is a widespread belief among state and territory coroners and forensic pathologists that these deaths are significantly under reported.

17. I am not aware of any systematic checking or auditing of compliance with the reporting obligations. As a bare minimum I consider that post operative deaths should be at least reviewed by a doctor more senior than those involved in the procedure that preceded the death so that some independence can be introduced into the assessment of whether the death should be reported. That would, however, provide no reassurance in relation to deaths which occur in the home and are certified by the deceased person's regular treating general practitioner.

Difficulties in investigating medical deaths

18. Once a death is reported to a coroner on the basis that it was not an expected outcome of a health procedure, the coroner needs to determine the extent and manner of the investigation of the death.

Which matters warrant investigation?

19. The Coroners Act in s12(2)(b) recognises that not all reportable deaths need to be extensively investigated. That section enables a coroner to authorise a doctor to issue a cause of death certificate even though the

[6] Since my appointment I have made 25 presentations to medical audiences explaining their obligation to report deaths. Those presentations always conclude with my mobile phone number and the advice that I am available to discuss these issues 24 hours a day, seven day a week.

[7] For example, funeral directors occasionally refer to me cause of death certificates indicating that the death has been preceded by trauma and when making presentations to hospitals questions from the audience cite examples of deaths that should have been reported but were not.

death comes within one of the categories of reportable deaths set out in s8.

20. Some uncontroversial examples of the appropriateness of such a course are set out below:-

    a. A deceased person is found naked in his home with copious blood about his person and possessions. It is reported as a suspicious death but family members and the treating GP subsequently notify the reporting police officer that the person suffered from a severe peptic ulcer. That condition (and a number of others) can result in sudden death and the vomiting of a large volume of blood. An inspection of the residence reveals no signs of forced entry or other interference. The coroner authorises the GP to issue a cause of death certificate showing a bleeding peptic ulcer as the cause of death.

    b. An elderly woman living at home falls out of bed and factures the neck of her femur. She under goes surgery to enable it to be pinned. Two weeks later while recuperating in hospital, she dies of pneumonia brought on as a result of the immobility and underlying chronic obstructive airways disease. The death is reportable because it can be traced to the trauma of the fall but little is to be gained by conducting an autopsy and investigating the death. The coroner authorises the medical registrar in the hospital to issue the certificate listing the pneumonia, the COAD and the fractured NOF as the descending causes of death.

21. The provision may also have application in a preoperative setting when the death is an unexpected outcome of a health procedure. For example, an elderly person with chronic heart disease undergoes surgery for a coronary artery bypass and to replace a leaking mitral valve. The surgical team explain to the patient and his family that the operation is highly risky. The patient dies. The death is reportable because it was not reasonably expected but nor was it completely unexpected and there is no basis on which to suspect that any substandard medical practice caused the death.

22. A special form 1A has been created for completion by a doctor who seeks the authorisation of a coroner to issue a cause of death certificate in relation to a reportable death. It requires the doctor to provide information about the circumstances of the death and to submit a draft cause of death certificate for the consideration of the coroner.

23. However the difficulty for the coroner considering such a request is that he/she is reliant on the advice of the treating team that nothing untoward occurred and that no aspects of the death warrant investigation. I seek to augment that advice by discussing questionable cases with one of the forensic pathologists from the John Tonge Centre who are always very obliging. I routinely also discuss the proposed

course of action with the family of the deceased to ensure that they are comfortable with the proposal not to investigate the death.

24. In my view, I and the local coroners need access to a dedicated medical officer to review medical charts and the forms 1A to assist in determining whether a cause of death certificate should be issued without further investigation of the death.

How should medical deaths be investigated by a coroner?

25. Once a death that has occurred in a medical setting has been identified as warranting a coronial investigation, the next challenge for a coroner is determine how that should be undertaken and by whom.

26. Most coronial investigations are undertaken by police officers who have a reasonable level of expertise in investigating matters such as suicides, motor vehicle accidents, homicides and many other matters that frequently come before a coroner. When a death occurs in a more unusual setting that might require an understanding of that esoteric context, specialised investigative bodies undertake the investigation and report to the coroner. For example, inspectors from the Department of Natural Resources and Mines undertake the investigation of mining deaths and officers from Maritime Safety Queensland investigate boating accidents. Aircraft accidents are investigated by officers from the Australian Transport Safety Bureau.

27. There is no doubt that the investigation of deaths that occur in a medical setting are particularly complex and challenging, yet there is no specialist body that regularly investigates such matters on behalf of coroners. These investigations are left to police officers who have to struggle with two main problems. First, they have little or no expertise in isolating the issues that need to be examined and so even identifying the appropriate people to be interviewed and then deciding what to ask them can be difficult. Second, hospitals frequently fail to co-operate with police investigations. From across the state I continue to receive complaints from police and local coroners that doctors and nurses will not provide statements despite repeated requests; indeed on occasions police even have to resort to search warrants to obtain medical files. Hospital administrators seem unable or unwilling to help address the problem.

28. In the past, the medical profession was very reluctant to discuss with patients or their families unexpected negative outcomes of medical procedures for fear of litigation. That reluctance has diminished as medical institutions have recognised their ethical obligation to share information about these incidents with those most affected and realised that full disclosure is more likely to reduce litigation rather than contribute to more and/or bigger civil damages claims.

29. Most, but not all, hospitals have mortality and morbidity committees that examine adverse events that lead to death or an unexpectedly poor outcome. The processes by which these committees operate and the extent to which they disseminate their findings is varied but they demonstrate that clinicians realise that they are best placed to unpack these troubling events. However, they provide little assistance to coroners as the proceedings of such committees are usually cloaked in secrecy and anonymity which make their deliberations difficult to access.

30. In my view, similar expertise needs to be made available to coroners so that the families of patients who die can be properly informed about the death, the public can be assured that these death investigations are reviewed by a tribunal independent from the institution in which the death occurred, and the results of the investigation can be appropriately disseminated so that preventive strategies highlighted by the death become more widely known.

31. Currently, as a result of an arrangments I have put in place with the former chief health officer (CHO), coroners who need to access independent expert medical opinions can approach the CHO to have her nominate such an expert. However those experts can only be provided with medical records and the self serving statements clinicians may have provided as there is no system in place for these witnesses to be effectively interviewed.

32. On occasions I have received reports of investigations undertaken by senior clinicians appointed to act as investigators under the *Health Services Act 1991*. I have found them to be very useful. I understand the department's "sentinel events policy" envisages an investigation being undertaken in relation to all hospital deaths. Consequently, at the conclusion of an inquest I recently undertook, I recommended that the CHO with my assistance develop a policy and process for the independent and expert investigation of all deaths that are not reasonably expected to be an outcome of a health procedure. I also recommended that the reports of such investigations should be made available to the coroner and the family of the patient as soon as possible.[8]

33. The Victorian State Coroner has a more sophisticated system for dealing with such deaths. They are all initially reviewed by a multi-disciplinary team of clinicians who advise coroners whether a death warrants investigation. In the event that he/she accepts the advice of this Clinical Liaison Team that it does need investigation, the team then advises what investigative steps are appropriate and what independent experts might need to provide an opinion in the matter. This information is fed to the police officers undertaking the investigation.

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[8] Findings of the inquest into the death of Katherine Sabadina,@ http://www.justice.qld.gov.au/courts/coroner/findings.htm

Conclusions

34. In my view no changes are needed to the relevant definition of reportable death because the current wording sufficiently describes those deaths which warrant external scrutiny before registration.

35. I consider there needs to be ongoing training provided to all doctors to ensure they remain cognisant of their obligation to report.

36. I recommend that a senior clinician not involved in the treatment of the deceased be required to review each hospital death to determine whether the death should be reported.

37. I consider there should be some systematic auditing of the compliance with the reporting obligation.

38. Coroners need better access to independent medical opinion to assist them determine whether deaths that are referred to them by hospitals are reportable and/or warrant investigation. They also need similar assistance to help them effectively investigate these deaths. There needs to be at least one dedicated medically trained person available to assist with theses issues.

39. I recommend Queensland Health put in place a policy to ensure an investigation is undertaken in relation to each death that occurs in a facility operated by them and that a report of that investigation be provided to the coroner and the family of the deceased.

Michael Barnes
State Coroner
14 October 2005

Submissions

Dr Stephen BUCKLAND

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26 October 2005

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Attention: **Jarrod Cowley-Grimmond**

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Dear Sirs

Dr Buckland

Pursuant to the direction of Commissioner Davies, we **enclose** the submissions of Dr Buckland.

Yours faithfully
MINTER ELLISON

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enclosure

QUEENSLAND PUBLIC HOSPITALS COMMISSION OF INQUIRY

SUBMISSIONS OF DR STEPHEN BUCKLAND

Introduction

1. These submissions concentrate on topics that were the subject of cross-examination of Dr Buckland. They will not repeat at length the evidence of Dr Buckland. For the purpose of these submissions, he relies by way of background on his witness statements, particularly his second statement,[1] which address the role of Director-General[2] ("DG"), the independent role of the Chief Health Officer ("CHO"), the structure of Queensland Health ("QH") and a number of systemic issues[3] which are relevant to the Commission's deliberations.

2. These submissions follow the same order as cross-examination topics. Finally, they shall briefly address the issue of budgets that the Commissioner raised on 17 October 2005.[4]

Dr Buckland's actions in response to Dr Patel and the Bundaberg Base Hospital

3. Dr Buckland acted reasonably in not suspending Dr Patel from duty, suspending him from providing surgical services or otherwise restricting his scope of practice on or after 24 March 2005 for three essential reasons:

   (a) He had received advice from the CHO on 22 March 2005 and again on 24 March 2005 that there was no evidence that Dr Patel's general surgical skills were inappropriate or incompetent and that there was insufficient evidence to take any action against Dr Patel;[5]

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1 Exhibit 336.

2 In particular, reference is made to paragraphs 34 to 45 of Exhibit 336 where Dr Buckland sets out the role of the DG is to *inter alia* deal with strategic issues whilst others were responsible for making decisions within hospitals and within zones. Also the DG was required to deal with large volumes of documents and a large number of issues on a daily basis.

3 Including under-funding of the public health system in a decentralised state (paras 60-100), the demands placed on the public hospital system (paras 165-176), medical workforce shortages (paras 101-105), the adverse consequences of a focus on fiscal management (para 35 and SMB15) and the entrenched economic philosophy that QH was "purchasing" services from hospitals, being a philosophy which focused on throughput and revenue rather than outcomes for the patient and the community (paras 48 and 303).

4 T.7098 ll.30-40.

5 Exhibit 391, page 2. This exhibit is a briefing by the CHO to the Minister dated 22 March 2005 and reflects the oral briefing received by Dr Buckland on that day and subsequently on 24 March 2005.

(b) The content of the CHO's audit report and the memorandum received by Dr Buckland on 24 March 2005, when read in conjunction with the oral briefings or even without them, did not provide sufficient evidence to warrant such action being taken by Dr Buckland; and

(c) By the evening of 24 March 2005, Dr Buckland was aware that Dr Patel was taking sick leave until 31 March 2005 and had indicated he would be resigning.[6]

Oral advice

4. Dr Buckland was first informed about Dr Patel and the fact that the CHO had been undertaking an investigation into general surgery services at the Bundaberg Base Hospital ("BBH") on 22 March 2005.[7]

5. Dr Buckland received an oral briefing from the CHO that day.[8] The CHO briefed the Minister in writing[9] and orally the same day.[10] The CHO acknowledges that the substance of his oral briefings to Dr Buckland and Mr Nuttall on 22 March 2005, and his subsequent oral briefing to Dr Buckland on 24 March 2005, were to the same effect.[11]

6. Dr FitzGerald was of the view at the time that there was "no evidence that [Dr Patel's] general surgical skills are inappropriate or incompetent".[12] In fact he reported comments that the "Director of Surgery has high standards and this has led to some degree of conflict with staff".[13]

7. The CHO did not advise that Dr Patel should be suspended, or, indeed, that there was sufficient evidence at the time to take any particular action against him.[14] Indeed, Dr FitzGerald advised that there was insufficient evidence to take any particular

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6 Exhibit 335, SMB4.
7 Exhibit 335 para 17.
8 Ibid para 20.
9 Exhibit 391.
10 Exhibit 225 para 78; T.6134.
11 T.6134.
12 Exhibit 391 page 2.
13 Exhibit 230 page 11.
14 This is stated in terms in dot point 4 on page 2 of Exhibit 391.

action against him.[15] Dr FitzGerald confirmed in his oral evidence that he did not advise Dr Buckland to suspend Dr Patel or to take any action against him.[16]

8. The CHO maintained this view and reiterated this advice to Dr Buckland at his subsequent oral briefing on the afternoon of 24 March 2005 when the CHO handed Dr Buckland his audit report and memorandum dated 24 March 2005.[17]

9. The oral briefings by the CHO on 22 and 24 March 2005, which were the obvious occasions for the CHO to recommend any immediate action with respect to Dr Patel, did not alert the then Minister or the then Director-General to matters which warranted any particular action being taken against Dr Patel, let alone that he be suspended forthwith. As a result of the CHO's briefings, Dr Buckland:

   (a) was not informed, and had no sense, that there was a major issue with Dr Patel's competence in undertaking general surgery;[18]

   (b) was satisfied that the matter was being adequately dealt with by referral to the MBQ based upon the information that the CHO had conveyed to him at that time;[19]

   (c) was satisfied that appropriate measures had been introduced to limit the scope of surgery being undertaken by Dr Patel;

   (d) anticipated that action would be taken to address the failure of systems noted in the last paragraph of the Memorandum of 24 March 2005.

Clinical Audit Report and Memorandum of 24 March 2005

10. Dr Buckland acted reasonably in not immediately suspending or taking other action against Dr Patel on the basis of the matters raised in the CHO's clinical audit report or memorandum of 24 March 2005.

11. The report highlighted two main concerns raised by staff, namely:[20]

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15 Exhibit 391 page 2.
16 T.6138.
17 T.6138 and T.6143.
18 Exhibit 335 paras 22 and 24. Page 11 of the Confidential Audit Report (Exhibit 230) also contained the assurance that Dr Patel had agreed to undertake only those procedures which were within the scope of the surgical service and relevant support service and had also agreed to transfer patients more readily to higher level facilities.
19 Exhibit 335 para 24.
20 Exhibit 230 page 11.

(a) General surgical procedures which had been undertaken outside the scope of BBH; and

(b) Lack of good working relationships between all staff in the general surgical service.

12. As previously noted, although the report indicated that Dr Patel had undertaken surgery beyond the capacity of the BBH and possibly his own skill and experience and had delayed the transfer of patients to tertiary hospitals, the CHO's report advised that these matters had been addressed.[21]

13. The CHO's report referred to rates of wound infection and wound dehiscence. Appendix 1 to the report in fact showed a wound infection rate of 2.7 at BBH compared to the peer group rate of 2.9. The CHO's view at the time in relation to rates of wound dehiscence was that the data showed that this rate was reducing.[22]

14. The Clinical Audit Report reported statistics about the rates of bile duct injury during laparoscopic cholecystectomy.[23] It was reasonable for Dr Buckland not to take action against Dr Patel on the basis of the bile duct injury statistics contained in the report on the basis of the following:

(a) the CHO's Report, his Memorandum and oral briefings did not highlight matters of particular concern in relation to bile duct injury;

(b) the CHO did not raise any concern about Dr Patel continuing to undertake general surgery after 24 March 2005 or undertaking laparoscopic cholecystectomies;

(c) Dr Buckland depended on the CHO and others to highlight matters of concern warranting suspension or other action;

(d) There could be a number of reasons for the statistical outlier in relation to bile duct injury reported at page 9 of the CHO's report, including patient characteristics and the severity of the conditions being suffered by the patient;[24]

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21 Report page 11 Exhibit 230. The CHO's advice to the Minister was to the same effect: Exhibit 391.

22 Exhibit 391 page 1, third-last dot point on the page.

23 Page 9 of the report. The Memorandum did not specifically refer to these, nor were they raised by the CHO in his oral briefings on 22 and 24 March 2005.

24 Exhibit 492 (Johnston) para 8.

(e) When a statistical outlier is identified, further investigation, for example a review of patient records, needs to be conducted to determine whether the statistical outlier is a cause of concern;[25]

(f) The ACHS indicators are a screening tool to identify clinical areas that may require further detailed review and are not a definitive measure of performance;[26]

(g) Dr Buckland and other persons who understood the appropriate use of ACHS indicators, namely that they identified matters that may require further detailed review, would not reasonably attribute to the statistics on page 9 of the CHO's report the same significance which others might. The evidence is that those statistics did not establish that bile duct injuries were the result of poor surgical practice on Dr Patel's part, despite the statistics' indication of bile duct injury for laparoscopic cholecystectomy procedures being many times the national average.[27] The extent of bile duct injuries, their causes, and any comparison between Dr Patel's performance and the standard to be expected of a surgeon undertaking the procedures that he undertook depended upon an investigation of the facts;

(h) Such an investigation has been undertaken by Dr Woodruff in relation to cases of bile duct injury.[28] His report appears to conclude that Dr Patel only caused one bile duct injury, which Dr Woodruff states was recognized by Dr Patel at the time and was repaired by Dr Patel at the time of injury.

(i) Dr Buckland was entitled to assume that the cases of reported bile duct injury would be investigated by the CHO as part of the audit process;

(j) The statistical outlier in relation to bile duct injury and the CHO's investigation into Dr Patel's clinical skills in connection with laparoscopic cholecystectomy or other procedures were not said by the CHO to be indicative of poor surgical skills or incompetence on the part of Dr Patel: on

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25 Ibid para 7.

26 Ibid paras 9 and 10.

27 The analysis of the tables at page 9 of the CHO's audit report does not necessarily support the proposition that Dr Patel's rate of bile duct injury was 25 times that of his peer group for a period of 18 months. Firstly, the comparison to arrive at the figure of 25 times appears to be a comparison between the June – December 2004 BBH rate with the 2003 ACHS rate, as opposed to a 2004 ACHS rate. Secondly, the figure of 25 times only relates to a comparison of six months of data and not for a period of 18 months.

28 Exhibit 498, in particular the third para of page 2.

the contrary, the CHO maintained that there was insufficient evidence that his surgical skills were inappropriate or incompetent[29];

(k) The statistical outlier in relation to bile duct injury did not, for the reasons noted above, provide a basis for Dr Buckland to independently conclude that Dr Patel had poor surgical skills, and that he should therefore be suspended or restricted from undertaking general surgery.

15. While the memorandum was written more specifically about Dr Patel and was worded more strongly than the clinical audit report, it too did not raise matters that made Dr Buckland's actions unreasonable.

16. The Memorandum of 24 March 2005 referred to a significantly higher surgical complication rate than the peer group rate and referred to Appendix 1 of the Report in that regard. One explanation for the higher complication rate was the reported fact that the Director of Surgery in the past had undertaken types of surgery which, in the CHO's view, were beyond the capability of BBH and possibly beyond Dr Patel's own skills and experience. Although the Clinical Audit Report did not state this in terms as the probable cause of a higher surgical complication rate than the peer group, the CHO's view at the time was that the complications related particularly to the more complex procedures that Dr Patel had previously performed that were beyond the capacity and facilities of BBH.[30] The view that the higher complication rate was due to the fact that Dr Patel in the past had undertaken types of surgery beyond the capability of BBH, and possibly beyond his own skills and experience, was consistent with the report and the CHO's oral briefings, and was supported by the CHO's view that there was no evidence that Dr Patel's surgical skills were inappropriate.

17. That Dr Patel had a significantly higher surgical complication rate than his peer group was a matter of concern, but in itself, was not a sufficient reason to immediately suspend him from duty or to restrict his scope of practice on 24 March 2004. A surgeon may have a higher surgical complication rate than a peer group because of the type of procedures that he or she undertakes. It was also consistent with Dr Patel having previously undertaken types of surgery which, in the CHO's view, were

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29 T.6138, 6143.

30 This is the view expressed by the CHO on 22 March 2005 on the final dot point on page 1 of Exhibit 391.

beyond the capability of BBH and possibly beyond his own skills and experience. The CHO advised that action had been taken to limit the scope of surgery performed by Dr Patel and to ensure that critically ill patients were appropriately referred to higher level hospitals.[31]

18. Although the Memorandum of 24 March 2005 commented in relation to Dr Patel's lack of judgment in undertaking these procedures and also delaying transfer:

(a) the practice of undertaking these procedures and delaying the transfer of patients had been addressed; and

(b) Dr Patel's alleged lack of judgment was to be examined by the MBQ.

In the circumstances, it was understandable, and it is submitted reasonable, for Dr Patel's lack of judgment to be addressed in this manner, rather than for him to be suspended forthwith or action taken to further restrict his scope of practice. Dr Buckland was not advised that any different action was called for.

19. Dr Buckland was advised in the Memorandum of 24 March 2005 that "the Credentials and Clinical Privileges Committee has not appropriately considered or credentialed" Dr Patel. The CHO's report[32] recommended the completion of the implementation of the process of credentialing and privileging.[33] The Memorandum of 24 March 2005 did not indicate that a Credentials and Clinical Privileges Committee had not been convened to consider Dr Patel. It stated that it had "not appropriately considered or credentialed" him. In any case, the CHO did not indicate that, had the Credentials and Clinical Privileges Committee appropriately considered the matter, that they would not have granted Dr Patel the credentials and privileges necessary to enable him to undertake the general surgery which he was practising as at 24 March 2005.

20. The CHO's report, and the Memorandum of 24 March 2005, reported a failure of systems at BBH to respond in a timely or effective manner to concerns raised by staff, some of which were raised over 12 months ago. This shortcoming was to be addressed by way of recommended system improvements and by a specific reminder to the hospital's management about the responsibility to ensure that they responded

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31 This point was made in Exhibit 391, fourth-last dot point on page 1, and also at page 11 of the Confidential Audit Report.

32 Pages 6 and 7 also referred to the need for the process of credentialing to be progressed.

33 Report page 12, strategic recommendation number 1.

appropriately to complaints.[34] This advice concerning a failure to respond in a timely or effective manner to complaints in the past, did not, on the basis of the advice and information available to Dr Buckland on 24 March 2005, make it reasonable for him to suspend Dr Patel from duty or to further restrict his scope of practice.

Dr Patel's cessation of duties

21. Dr Buckland acknowledges that because no action was taken on 24 March 2005 to suspend Dr Patel or to restrict him from continuing to perform procedures at the hospital, Dr Patel might have performed procedures over Easter, 24 March 2005 being Easter Thursday. On the basis of the information and advice that he had at the time, including the absence of any advice that Dr Patel was not fit to undertake general surgery cases, such as road trauma cases, it was understandable and reasonable that Dr Buckland, as Director-General, did not direct that Dr Patel be suspended. Such a course would have exposed road trauma victims and other persons requiring emergency surgery over the Easter period to the risk that BBH would not have the only general surgeon available over the Easter weekend[35] if BBH was not able to find someone to replace him at short notice.

22. By late on 24 March 2005 Dr Buckland understood that Dr Patel had resigned and intended to take sick leave until 31 March 2005.[36] It appears that Dr Patel ceased surgical duties around, if not before, Easter 2005.[37]

23. In summary, the decision not to suspend Dr Patel on 24 March 2005 was a reasonable one in the circumstances, based on the advice and information that Dr Buckland had at the time.

24. Others, with more information about Dr Patel than Dr Buckland had acquired about him between 22 and 24 March 2005, including the CHO, had been assessing and investigating his clinical work for a substantial period and had not taken action during

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34 See the last two sentences of the Memorandum of 24 March 2005; SMB3 to Exhibit 335.

35 Exhibits 474 and 475, the latter being an e-mail from Mr Leck to the Zonal Manager at 1.35pm on 24 March 2005 which reported "There are no general surgeons in Bundaberg (privately or publicly) as from 8.00 this morning (except Dr Patel)". See also attachment SMB4 to Exhibit 335. The advice late on 24 March 2005 was that PHO's would not be able to manage locally any major haemorrhagic event: Exhibit 335 SMB4.

36 Exhibit 335, SMB4.

that time to suspend him or restrict his scope of practice, or recommended such a course. Although Dr Buckland might have suspended Dr Patel on 22 or 24 March 2005 or restricted his scope of practice:

(a) the advice and information available to him did not justify such a course;

(b) such a course would have been at odds with the advice of the CHO who had investigated Dr Patel's clinical performance, who had taken no such steps during his investigations, and who did not support such a course as at 24 March 2005;

(c) no such advice was given by others with a more direct role in the management of BBH, or by the GMHS.

25. In general, and in circumstances where:

(a) the CHO did not recommend action to restrict Dr Patel's scope of practice, let alone recommend that he be suspended;

(b) reported higher surgical complication rates than the peer group were explicable by reference to Dr Patel's past conduct of undertaking types of surgery which were beyond the scope of BBH and possibly beyond his own skills and experience;

(c) Dr Buckland received the assurance that Dr Patel's past conduct in undertaking inappropriate complex procedures and in delaying the transfer of patients to high level facilities had been addressed;

(d) there was no advice that Dr Patel's general surgical skills were inappropriate or that any lack of competence existed that warranted his suspension or restriction on his scope of practice;

(e) the CHO's report and his Memorandum recommended a range of strategic and operational actions to address the failure of systems at the hospital, including failures that had led to a delay in the resolution of matters concerning Dr Patel;[38]

(f) the Memorandum of 24 March 2005 also recommended that the hospital management be specifically reminded of their responsibilities to put systems

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37 As matters transpired it appears that Dr Patel did not work at BBH on the Easter weekend and took sick leave until his contract expired on 31 March 2005. Exhibit 463 para 65, but the precise date upon which he last performed surgical duties is not entirely clear on the evidence.

38 Report page 12.

in place to ensure that they responded appropriately to reasonable clinical quality concerns; and

(g) Dr Patel was to be investigated by the MBQ in respect of his lack of judgment in undertaking procedures that were beyond the scope of BBH and possibly beyond his own skills and experience,[39]

it is submitted that the course of suspending Dr Patel on 24 March 2005, or restricting his scope of practice forthwith, was not supported by the advice and information that was then available to Dr Buckland.

26. At that stage Dr Buckland did not take any step to further investigate Dr Patel's conduct because it was his expectation that:

(a) as part of the usual audit process, the CHO would cross check the findings in his report against clinical files and test the facts upon which the report was based;[40]

(b) Dr Patel had been referred to the MBQ for further investigation.

27. The advice and information available to Dr Buckland as at 24 March 2005 indicated that appropriate steps had been and were being taken in relation to Dr Patel's conduct and in relation to the failure of systems at BBH, as disclosed in the CHO's investigation. The CHO's Report, his Memorandum of 24 March 2005 and his oral briefings on 22 and 24 March 2005 did not make Dr Buckland's failure to suspend Dr Patel from duty that day or to further restrict his scope of practice, or take steps to further investigate Dr Patel, unreasonable in the circumstances.

Advice to the Minister

28. Dr Buckland's briefings to the Minister in respect of Dr Patel over the period from 24 March 2005 to 7 April 2005 were reasonable in all of the circumstances.

29. The CHO reported directly to the Minister.[41] Precisely how and in what format his Confidential Audit Report was conveyed to the Minister's office is uncertain. But Dr Fitzgerald's evidence,[42] the fact that the CHO was asked to directly brief the

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39 The CHO formally referred the matter to the MBQ by letter dated 24 March 2005: Exhibit 225 - GF13.
40 Exhibit 335 para 25.
41 Exhibit 225 attachment GF2 para 5(a); Exhibit 337 para 5; T.6140.
42 T.6141-2.

Minister on this matter[43] and the fact that Minister was directly briefed by the CHO on 22 March 2005 makes it likely that his report was transmitted directly to the Minister's office or "walked in" to the Minister's office by a staff member. That the CHO reported directly to the Minister and would be expected to provide his report to the Minister's office is evidenced by the contents of Exhibit 391, in which the CHO stated that a copy of his draft report was enclosed. The draft report does not appear to have been enclosed with that email. But the direct reporting line to the Minister and the CHO's conduct in reporting directly to the Minister (rather than via the DG), in relation to the Confidential Audit Report makes it likely that the CHO or his staff would have provided a copy of his report to the Minister's office.

30. Mr Nuttall's evidence was that he asked the CHO to make sure that he completed his report as quickly as possible.[44] Mr Nuttall said that he was waiting on the report and "that's why I asked him to complete the report as quickly as he possibly could so I could get a handle on exactly what the situation was at the hospital".[45] The CHO indicated to Mr Nuttall that the report was very near completion and Mr Nuttall says that he asked the CHO to have it made available as soon as he possibly could.[46] Mr Nuttall's evidence was that he understood that the CHO would have given the report both to him and to the Director-General.[47]

31. The fact that Mr Nuttall may not have personally read the report does not mean that the report was not provided to his office prior to 7 April 2005.[48] Mr Nuttall's evidence tends to confirm the probability that a copy of the CHO's report was provided to the Minister's staff in late March or early April 2005. The fact that the Minister was not personally provided with a copy of the report when he attended the 7

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43 T.6140.
44 T.5312.
45 T.5312-5313.
46 T.5314.
47 T.5316, l.40.
48 For example, Mr Nuttall gave evidence that he did not read the material tabled by Mr Messenger MLA in Parliament before meeting with the CHO (T.5314), and the evidence is that Ministers, such as Mr Nuttall, depend upon staff to read the large volume of reports and other materials that are sent to the Minister's office.

April meeting[49] does not contradict the proposition that a copy of the CHO's report had been provided to the Minister's office before that date.[50]

32. The evidence makes it quite probable that a copy of the CHO's report was provided to the Minister's office at about the same time as it was provided to the DG on 24 March 2004, or soon afterwards.[51]

33. Dr Buckland was aware of the CHO's reporting relationship to the Minister and that the CHO had directly briefed the Minister in relation to Dr Patel and the BBH. There was nothing unusual in a senior departmental officer, such as the CHO, communicating directly with the Minister and/or the Minister's staff. Mrs Edmond gave evidence about the flow of communications between the Minister's office and senior members of the Department,[52] and Mr Nuttall gave evidence to like effect.[53] The uncontested evidence is that advice to the Minister was provided, inter alia, by direct access to senior executive and their staff, without being filtered by Dr Buckland.[54]

34. In the circumstances, it is likely that a copy of the CHO's report was provided to the Minister's staff in late March or early April 2005.

35. In the light of the evidence concerning the volume of material which flows into the Minister's office, one would not necessarily expect Mr Nuttall to personally have read the audit report given:

(a) the ordinary course of events;

(b) the fact that he had received written and oral briefings by the CHO on 22 March 2004;

(c) the Minister's staff would be expected to obtain a copy of the report, given that questions had been asked in the House about the CHO's investigation;

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49 T.5316.

50 If, however, this is not the case, then a copy of the report was easily obtainable by the Minister's staff from the CHO, and the DG's office was entitled to assume that the report either had been provided by the CHO to the Minister's office, or that, if it had not been, the Minister's office would have requested it from the CHO.

51 Easter intervened.

52 T.4936 l.10.

53 T.5334 ll.l-15.

54 Exhibit 336 para 37(a)(ii).

(d) the report was not materially different in substance to the CHO's earlier written or oral briefings to the Minister's office.

36. Prior to the visit to Bundaberg on 7 April 2005, Dr Buckland was entitled to assume that the Minister and his staff had been briefed by the CHO both orally and in writing about the CHO's investigation and that, the matter being in the public arena, the Minister's office had access to a copy of the report by the usual means of communication between the Minister's office and senior officers in the department such as the CHO. Dr Buckland had received the CHO's Memorandum of 24 May 2005, and followed that up with a further oral briefing from the CHO which, as previously noted, confirmed the substance of the advice which had been given to Dr Buckland and to the Minister on 22 March 2005. There is no evidence that the Memorandum dated 24 March 2005 was sent by the DG's office to the Minister's office. However, if it had been, and if the Minister's office had raised further questions about its contents either with Dr Buckland or with Dr FitzGerald, then the Minister would have been briefed in the same terms as Dr Buckland was briefed by the CHO on 24 March 2005, following receipt of the Memorandum. That briefing confirmed earlier advice. For the reasons outlined in paragraph 25(a) to (g), it did not recommend the suspension of Dr Patel or other action in relation to him, and indicated that system failures at BBH were being addressed.

37. Prior to the meeting of the hospital on 7 April 2005, Dr Buckland generally briefed the Minister about the matter. That briefing was based upon the information and advice which Dr Buckland had in turn received. There was no basis, at that stage, for Dr Buckland to reject the information, advice and recommendations which had been made to him by the CHO. Dr Buckland's briefing of the Minister was based upon the information and advice which was available to him at the time.

38. Some confusion exists about what was said to the Minister concerning completion of the audit report and completion of the audit process. The fact of the matter is that the audit report was effectively completed in at least a final draft form by 24 March 2005, but that Dr Patel's absence from Australia made it difficult to follow the usual process of consultation with someone who has been adversely named in such a report and it made it difficult to comply with the requirements of natural justice.

39. Prior to 7 April 2005, Dr Buckland anticipated that the audit process would be completed, including the usual audit process of confirmation of data. He expected action to be taken in accordance with the recommendations contained in the March 2005 Confidential Audit Report. He also anticipated the action contemplated by the 24 March 2005 Memorandum would occur, including referral of Dr Patel to the Medical Board. Accordingly, Dr Buckland did not take the view that issues in relation to Dr Patel's conduct at the hospital would not be pursued because of his absence from Australia.

The visit to Bundaberg on 7 April 2005

40. Dr Buckland did not advise the meeting of BBH staff on 7 April 2005 or the Minister that the CHO's audit report could not be completed because Dr Patel had left Australia or because the report contained confidential patient information. Dr Buckland admits that he may have caused confusion amongst staff and the Minister when discussing the completion of the audit process, but at no time did he mean to portray that the audit report could not be completed. There is no evidence that Dr Buckland advised staff or the Minister that the report contained confidential patient information.

41. Lacking a proper appreciation of the true situation at BBH and the underlying causes of staff concerns, the then Minister and the then Director-General visited the hospital and addressed staff on the afternoon of 7 April 2005. Dr Buckland readily acknowledged in his written statement that had he been better informed of issues in relation to Dr Patel before speaking to the staff that day, he would have consulted with the CHO and had a very different approach to the staff meeting.[55] It became clear from the mood of the meeting and the level of frustration and anger verbalised by some staff that there were more significant issues with Dr Patel than the Minister and the Director-General had been briefed.[56]

42. Two related, but distinct, matters need to be addressed:

(a) the Confidential Audit Report of Dr Fitzgerald and requests that its contents be generally communicated;

(b) ongoing processes to address failures identified in the audit report.

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55 Exhibit 335 para 39.

43. As to (a), the report was effectively completed.[57] It was critical of Dr Patel, who had yet to be given the opportunity to respond to adverse findings concerning him. The same issue of principle, namely the need to accord procedural fairness, would have arisen in respect of adverse findings against any other individual, such as a nurse. In attempting to articulate the proposition that no action could be taken against Dr Patel without first affording him an opportunity to respond to the report, Dr Buckland was not defending Dr Patel personally. The issue is one of procedural fairness. As Dr Buckland said in his evidence, "I support the right of anybody to natural justice, not just Dr Patel".[58]

44. Dr Buckland told the meeting of the problems that had been encountered in finalising the audit process because Dr Patel was in the United States and that he had to be accorded natural justice.[59] Dr Buckland did not advise that the report could not be completed because Dr Patel was overseas. There is no satisfactory evidence that Dr Buckland told the meeting or Mr Nuttall that the report could not be completed because it contained confidential patient information.[60]

45. As to (b), the expectation as at 7 April 2005 was that the review process would continue. Dr Keating's evidence is that Dr Buckland told the meeting that some recommendations from an organisational system perspective would be provided to the

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56 Ibid para 33, last sentence.

57 The precise state of the report and the appendix to it as at 7 April 2005 is not entirely clear: see Exhibit 392. Exhibit 495 para 15.

58 T.5567. See also paras 33-34 of Exhibit 335.

59 Exhibit 335 para 33.

60 This allegation was not put to Dr Buckland by Counsel Assisting 5503-5507. It was put to Dr Buckland by Counsel for the QNU and denied by him T.5556 l.50 – 5557 l.1. Mr Nuttall's statement indicates that it was the Minister's Media Advisor who told the media that the report would not be released publicly because, amongst other things, it contained confidential patient information: Exhibit 319, para 99. Mr Nuttall's statement paragraph 100 goes on to say that after speaking with the Director General he was of the opinion that the report should not be publicly released "for the above reasons". Those reasons include the fact that Dr Patel had left the country. Overall, the evidence does not support the conclusion that Dr Buckland cited confidential patient information as a reason why the report should not be released publicly. Mr Nuttall's witness statement para 100 might be interpreted as suggesting that Dr Buckland told Mr Nuttall that the report contained confidential patient information. If it was intended to convey that suggestion, it is in error. Mr Nuttall's oral evidence clarified the matter somewhat, namely that he referred at the meeting to the fact that it was standard practice that clinical audits were not released as a matter of course (T.5319). This was the case, and Mr Nuttall could not recall whether specifically what he was advised by Dr Buckland or Dr FitzGerald about these matters (T.5324, T.5326). The evidence of other persons who attended at the meeting on 7 April 2005 does not suggest that Dr Buckland cited confidential patient information as a basis as to why the report would not be completed or publicly released.

District Manager and the Executive to review and implement.[61] Also, the CHO was instructed by Dr Buckland to request the District Manager to report as to how the recommendations arising from the report were to be implemented.[62] As a result, the CHO requested the District Manager to provide a response and an implementation program for the recommendations arising from the report. The CHO indicated that he would be happy to assist in the preparation of that program.[63] It was Dr Buckland's expectation that this, and other parts of the usual audit process, could and would be undertaken, save that it would be difficult, if not impossible, to give Dr Patel the opportunity to respond to findings in the report in the manner that he would if he was an employee of QH and available to participate in the process.

46. In addressing two distinct issues, namely the general release of the CHO's Confidential Audit Report in circumstances in which Dr Patel had not been afforded an opportunity to respond to adverse findings in it concerning him, and the issue of what would be done to address the issues that the report raised, there was a potential for confusion. This potential was increased in circumstances where these issues were being addressed at a staff meeting, rather than in a more structured discussion. Dr Buckland readily conceded in his witness statement that, in hindsight, he can see that perhaps he caused confusion by the expressions he used at the meeting and by his failure to clearly articulate the difference between the finalisation of the audit report and the finalisation of the audit process.[64] Any confusion that he caused is very unfortunate. However, the contemporaneous documentation and Dr Keating's evidence indicates that the review process was not at an end, that Dr Patel's conduct was being referred to the MBQ and that the failure of systems identified in the audit report were to be addressed.

Events after the meeting on 7 April 2005

47. Upon leaving the staff meeting, Dr Buckland was asked to have a private conversation with Dr Keating. The conversation was brief due to the circumstances. In it

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61 T.6817 ll.40-42.

62 Attachment 13 to the Statement of Mr Bergin (Exhibit 383) which records the DG's request. The DG's request must have pre-dated 7 April 2005 which was the date of the CHO's letter to the District Manager. If, as appears to be the case, the CHO was still finalising his report in late March/early April 2005, this may explain why the letter dated 7 April 2005, which enclosed a copy of the report and requested a report from the District Manager, was not sent until that date.

63 This appears in the same letter to Mr Leck.

64 Exhibit 335 para 34.

Dr Keating disclosed that he had done a Google search on Dr Patel which had shown problems in relation to Dr Patel's registration in the United States.[65] Dr Buckland wanted to check the facts before briefing the Minister.[66] But on the return flight to Brisbane, he told the Minister "There is more to this guy (Patel) than we know, I'll have a look at it".[67] When Dr Buckland arrived home that night, he did a Google search.[68] He telephoned the CHO that same night, reported his findings and told the CHO that he should advise the MBQ as a matter of priority.[69] The next day Dr Buckland advised the Minister of Patel's restricted registration in two states.[70]

48. The revelation of Dr Patel's restricted registration in two American states and the level of frustration and anger displayed at the staff meeting on 7 April 2005 led Dr Buckland to believe that the problem was more extensive than previously thought. He decided that the seriousness of the matter required a comprehensive review of Dr Patel and the Bundaberg Health Service. He recommended the establishment of an investigative team and his recommendation was accepted.[71] The review team included a representative of the College of Surgeons and other individuals who were well-qualified to conduct such a review.

49. The Minister and Dr Buckland requested the CHO to travel to Bundaberg to provide feedback to the staff on the outcome of his investigations.[72] In addition, a large team of individuals from other locations within Queensland Health was despatched to Bundaberg to render assistance to patients of Dr Patel, the community and hospital staff.[73]

Summary – Dr Patel and BBH

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65 Exhibit 335 para 35. Dr Buckland's recollection of the details of the conversation appear at T.5507 ll.10-50. Differing recollections about the precise details disclosed during this brief conversation may not assume great importance, since Dr Buckland proceeded to undertake his own Google search that night.

66 Dr Buckland also recollects that Dr Keating said that he did not want to be identified as the source of the information; Exhibit 335 para 35; confirmed at T.5508 and T.5586-8.

67 Exhibit 335 para 36.

68 Ibid.

69 Ibid para 37.

70 Ibid para 38. Dr Buckland's evidence is that he mentioned the matter to the Minister again, including on an occasion on 12 April 2005 when they were driving in a car together: Exhibit 337 para 16. Although the former Minister may not recall these matters, no contrary version was put to Dr Buckland by the Minister's legal representatives.

71 Exhibit 335 paras 40 and 41.

72 Exhibit 335 para 48.

50. In summary, it is submitted that after 22 March 2005, when Dr Buckland first was informed of allegations in relation to Dr Patel, Dr Buckland acted reasonably on the basis of the information and advice that he received. The information and advice that Dr Buckland received at the time has subsequently been shown during the course of these proceedings to have been inaccurate or misleading. But that does not mean that Dr Buckland should not have acted on the basis of the information and advice that he received. Relevantly, he had not received any advice prior to 22 March 2005 from the CHO, other officers of QH or persons outside QH, such as representatives from the AMA, to suggest that Dr Patel was the subject of investigation, let alone that action should be taken to stop him from operating. On 24 March 2005, he still did not receive advice that action should be taken to stop Dr Patel from operating. It was reasonable for Dr Buckland to rely upon the information and advice provided by the CHO. That information and advice, both oral and in writing, did not recommend that Dr Patel be suspended or that other action be taken against him at that stage.

51. The Minister was briefed directly by the CHO and orally by Dr Buckland prior to the meeting with staff in Bundaberg on 7 April 2005. Dr Buckland's briefing of the Minister reflected the substance of the information and advice that Dr Buckland had received from the CHO.

52. Once Dr Buckland learned on 7 April 2005 that the situation in relation to Dr Patel and BBH was materially different, he took prompt action, namely to recommend the establishment of a well-qualified Review Team. After this time, there was also appropriate support from QH for staff and patients.

Lennox report

53. In August 2003, Dr Lennox wrote a report entitled "Management of International Medical Graduates – proposal for a State-Commonwealth collaboration to formalise and establish to a standard of excellence the management of all international medical graduates in Queensland", referred to in the Commission as the "Lennox report".[74] Dr Lennox wrote his report for the Joint OTD/TRD Committee which was comprised of the AMAQ, Queensland Health, Medical Board of Queensland, Commonwealth Department of Health and Aging and Commonwealth Department of Immigration,

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73 Exhibit 335 para 50.

Multicultural and Indigenous Affairs.[75] Dr Lennox says, "...although the document was written by a Queensland Health employee, the document was prepared for the Joint Committee of which Queensland Health was only one member".[76]

54. The Lennox report was given, by briefing dated 28 August 2003, to Dr Buckland as GMHS to "brief the GMHS on progress on proposal for integrated management of OTDs and to provide a draft invitation to the Medical Board of Queensland to commit to mandating the process".[77] Dr Buckland noted the briefing and signed the letter to the Medical Board of Queensland on 8 September 2003.[78]

55. The Lennox report was apparently considered by a committee of AMAQ and individuals representing various other groups impacted by the proposal in mid September 2003.[79] The AMAQ, by letter dated 12 September 2003, outlined its concerns with the Lennox report and made recommendations of further matters which needed to be incorporated into the report. It was also considered by a sub-committee of the MBQ. The MBQ also had concerns about the practical implications of the proposal.[80]

56. Dr Lennox asserts that it was evident from September 2003 that the proposed integrated management of IMG's was no longer receiving Queensland Health's management support.[81] However, Dr Lennox does not suggest that in or after September 2003 he made amendments to his proposal in response to the AMAQ's concerns, followed up MBQ as to their formal response or put any submission to the GMHS at Queensland Health requiring a decision about the proposal contained in the Lennox report.

57. The Lennox report was not an official Queensland Health document for four reasons: it was not produced for Queensland Health, it required the support of other

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74 Exhibit 55 attachments DRL9 and DRL12.
75 Exhibit 55 paras 24, 27 and 30.
76 Exhibit 55 para 30. T.894.
77 Exhibit 55 attachment DRL9.
78 Exhibit 55 attachments DRL9 and DRL10 and see T.5515. It was never put to Dr Buckland that he did not send the letter attached as DRL10.
79 The letter, which is DRL13 to Exhibit 55, states the meeting took place on 16 September but the letter itself is dated 12 September 2003. Presumably one of these dates is incorrect.
80 T.476-7.
81 Exhibit 55 para 20.

stakeholders but was not fully supported by them[82], it had not been costed by Treasury and it had not been submitted to the QH senior management for approval and therefore had not been approved.[83] The report would not be final, in the sense that it could be considered by the Director-General or Minister for approval, until full consultation with stakeholders had occurred and consensus had been reached and costings had been approved by Treasury and those matters were included in the report. Therefore, the report would certainly not be final until it had been amended as requested by the AMAQ in late September 2003 or, at the very least, amended to reflect the fact that the AMAQ had a number of qualifications to the report.[84]

58. Dr Buckland did not receive a request from Minister Edmond or Premier Beattie to follow up the completion of the Lennox report. It is not reasonable to suggest that a member of the QH executive, including Dr Buckland, should be required to monitor every media statement by the Premier or Minister for Health and take instructions as to action required by them via the media.[85]

59. It was reasonable for Dr Buckland to assume that Dr Lennox would follow through with his report and provide a submission to him which addressed the matters that must be contained in all submissions (as discussed in paragraph 57 above).[86] Given the many responsibilities of the GMHS, the large number of employees under his general management and the existence of other managers in the line of management between Dr Lennox and the GMHS and Dr Buckland's promotion to Acting Director-General on 1 November 2003, it is not reasonable to suggest that Dr Buckland was responsible for ensuring that Dr Lennox completed his report.

60. In circumstances in which the Lennox Report had not been finalised to address the concerns of the AMAQ and the MBQ, its proposals had not been costed and it had not been submitted for approval by QH, no occasion arose for Dr Buckland to approve any proposal that it be published to the general public. No recommendation appears

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82 As to AMAQ, see DRL13 to Exhibit 55, as to MBQ see para 11-13 of Exhibit 349. There is no evidence of the support of the proposal by Commonwealth Departments of Health and Aging or Immigration.

83 Exhibit 336 para 151; Exhibit 366 para 61-62, Edmond (T.4926 to T.4930), Exhibit 349 paras 11-14, Exhibit 55 para 30, DRL13.

84 T.4985.

85 T.5513-4.

86 As Mrs Edmond stated, it was reasonable to assume that all senior public servants, like Dr Lennox, knew that those matters should be addressed in reports: T.4931.

to have been made to Dr Buckland that the report in its then state be released to the general public.

61. The decision to adopt such a report and to publish such a report was one for the Minister of Health.[87]

62. Many of the safety and quality issues about OTD's raised in the Lennox report and earlier versions of the report by Dr Lennox were well known by Queensland Health.[88] In late 2002, Cabinet approved the development of a Skills Development Centre to promote safety and quality in general through the provision of a world class training centre. The board in charge of establishing the Skills Development Centre recognised in mid 2003 that the SDC could play an important role in the training and assessment of OTDs.[89] The Centre for Overseas Trained Doctors ("COTD") was incorporated into the Skills Development Centre in December 2003 and a project was approved for the SDC to establish improved recruitment, assessment and placement processes for OTD's in November 2004.[90] The issues of concern raised by Dr Lennox in the Lennox report were acted upon by QH.

63. Dr Stable and Dr Buckland, and Queensland Health as a whole, have always taken seriously the maintenance of the COTD.[91] Queensland Health did not during 2003 reduce its funding to the COTD or try and close it. The continued operation of the COTD was temporarily threatened in 2003 due to the withdrawal of funding by the Commonwealth government. Queensland Health gave a one-off additional payment to the COTD, on top of its recurrent annual payment, during 2003 to try and meet the shortfall created by the Commonwealth's withdrawal of funding. In November 2003, Queensland Health formally announced that the COTD would be operated by Queensland Health under the auspices of the Skills Development Centre which was to be opened the following year.[92]

Vincent Berg

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87 T.4926, T.5519, T.5725.
88 Exhibit 319 attachment 4. See also Mrs Edmond's evidence at T.4923-4.
89 Exhibit 336 para 143, attachment SMB42, SMB38; Exhibit 366 para 51.
90 Exhibit 336 152, 134; Exhibit 366 paras 51, 53.
91 Exhibit 336 paras 141-144 and 133-134, Exhibit 366 paras 48-53.
92 Attachment SMB43 to Exhibit 336.

64. Dr Buckland's evidence in relation to this matter appears in his second statement.[93] Dr Buckland was not involved in any aspect of Berg's registration or his employment by QH in Townsville as a registrar in psychiatry for the 2000 calendar year. During that time Dr Buckland was Zonal Manager in the Southern Zone. Dr Buckland first became aware of the issue of Berg's qualifications in December 2002, some two years after Berg had left his employment with QH. The issue that Dr Buckland was required to address at that time related to the process of identifying and contacting patients that Berg had seen as a psychiatric registrar.

65. Dr Buckland was called upon to make a difficult clinical and ethical decision which involved assessing competing risks, including the risk of harm to patients that would occur if Berg's lack of qualifications was communicated to vulnerable individuals, particularly through the media.[94] It is not the case that a decision was made not to contact patients. Instead, former patients were identified and contacted where considered appropriate by the local medical service. The ethical and clinical decision that Dr Buckland was asked to make was how the patients were to be contacted and what was to be communicated to them.

66. Dr Buckland describes the decision as perhaps one of the most difficult decisions he had to make as a medical practitioner and an administrator.[95] Dr Buckland readily acknowledged that other people, placed in his position, may have made a different decision when faced with the task of assessing risks and weighing alternative courses of action.[96]

67. In making his decision, Dr Buckland consulted with the then Director of Mental Health, Dr Brown. Dr Brown had been in Townsville in early December 2002 and had discussed the matter with Dr Johnson. She subsequently spoke with Dr Buckland and met with him for between 30 and 60 minutes. Dr Brown's view was that selected follow-up was preferable over public disclosure.[97]

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93 Exhibit 336 paras 207-231.

94 Exhibit 336 paras 224-228.

95 Ibid para 224. The view that the matter involved a difficult clinical and ethical decision was also expressed by the former Minister, Mrs Edmond, who gave evidence concerning her personal experience in dealing with individuals suffering from mental illness. T.4955-6 and T.4965 where Mrs Edmond stated that it was probably "one of the toughest decisions anyone would have to make...".

96 Exhibit 336 para 229.

97 Exhibit 376, Part C, paras 20-22.

68. Dr Buckland was asked under cross-examination about the absence of documentation in relation to this advice. Nothing turns upon the absence of documentation[98] since the evidence of Dr Buckland and the evidence of Dr Brown indicate the advice that he received and the reasons that informed that advice. However, there is no dispute concerning the substance of Dr Brown's opinion, and there is no suggestion that her opinion was other than the genuine and professional opinion of the Director of Mental Health.

69. Issues in relation to Berg were referred to QH Audit and Operational Branch to review and came to the attention of the Queensland Police Service.[99] The Audit Branch referred the matter to the CMC.[100] The MBQ was also seized of the matter.[101]

70. In summary, the decision that Dr Buckland was asked to make about the process to be adopted in December 2002/January 2003 in following up patients who had been seen by Vincent Berg as a psychiatric registrar some two years earlier posed difficult, ethical and clinical issues. The decision that was made by Dr Buckland was one that was open to him on the basis of the advice and information that he received at the time, including the advice of the Director of Mental Health. Although he acted on the basis of advice and discussions that he had with various people about the matter, Dr Buckland accepted in his evidence[102] that the decision rested with him, subject to it being countermanded by the Director General or the Minister. The decision that he made may not have been made by others, faced with the same difficult decision. But the decision was not unreasonable.

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98 Professor Stable (T.5733) stated he did not think a written report was necessary if Dr Buckland had satisfied himself by speaking to psychiatrists.

99 Exhibit 336 para 230.

100 Ibid.

101 Ibid para 231.

102 Exhibit 336 para 223.

Measured Quality

71. This issue emerged on the eve of Dr Buckland's oral evidence and, in the circumstances, could only be briefly addressed in his third statement which was given on the morning he came to give evidence.[103] Dr Buckland was also shown some documents during his oral evidence on 19 September 2005.

72. The history of the Measured Quality program is outlined and documented in statements given by Mr Collins[104] and it is unnecessary to repeat that detail. In short, the Measured Quality program commenced in about 2001 and submissions to the Director-General in relation to it pre-dated Dr Buckland's appointment as GMHS on 29 July 2002. In late 2002, a Cabinet Submission was prepared. A critical event was the Cabinet meeting of 11 November 200, followed by Mr Smith's email of 12 November 2002.[105] QH was required to act in accordance with decisions made by the Cabinet and by Cabinet Ministers concerning the dissemination of MQ reports.

73. Dr Buckland's own opinion concerning the merit of that decision appears to have been shared by other employees of QH. His opinion was that the hospital reports should be available to hospitals to give them feedback.[106] As he explained in his evidence, the issue at hand was to communicate matters to the organisation, namely the hospitals concerned, so that "we can get best value out of it".[107] Dr Buckland recalled discussions within the department following the political decisions made in November 2002 to the effect that QH staff were significantly disappointed because of the need to get benchmarking documents into circulation, the need to involve clinicians and to provide feedback.[108]

74. In March 2003, the Minister was briefed in a written brief prepared by Mr Collins, which was cleared by Dr Cuffe.[109] Dr Buckland was not involved with that briefing[110]

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103 Exhibit 337 paras 24-27.
104 Exhibits 377 and 378.
105 Exhibit 340, Exhibit 377, JEC11.
106 Exhibit 337 para 27.
107 T.5535 ll.1-10.
108 T.5529 ll.30-37.
109 Exhibit 377, JEC13.
110 There is no suggestion that the briefing was cleared by Dr Buckland and the document indicates that it was noted by the Minister after being cleared by Dr Cuffe.

or in the later 6 May 2003 presentation by Mr Collins to the Minister and the then Director-General.[111]

75. Dr Buckland became Acting Director-General on 1 November 2003 and in 2004 Dr Scott, as GMHS, issued new instructions in relation to the dissemination of MQ hospital reports for 2004.[112] These instructions attempted, within the constraints imposed by earlier government decisions, to make hard copies of the hospital reports more accessible to the hospitals.

76. In summary, Dr Buckland, like other QH employees, was obliged to implement Cabinet and Ministerial instructions concerning the dissemination of MQ hospital reports.

Waiting lists

77. The history of the Elective Surgery program and the Waiting List Reduction Strategy has been the subject of substantial evidence and it is unnecessary for the purposes of these submissions to canvass that history.[113] In short, the focus of government policy was to provide specific funding for additional elective surgery. Substantial funds were allocated, from time to time, to reduce elective surgery waiting lists. Considerable evidence has been given to the Commission concerning what have been described as the "anterior lists". It is convenient to briefly address these by way of submission in two respects:

(a) lists maintained locally; and

(b) statewide totals.

78. As to (a), for reasons explained by Dr Scott, Dr Buckland and others, the number of persons on a particular list awaiting an appointment to see a particular type of specialist at an outpatient clinic is relevant information that is accessible to local GPs. But, without more, this information will not inform the GP or the patient how long the person may have to wait for an appointment. This depends upon what Dr Buckland described as a capacity issue which he explained in his evidence.[114] Dr Scott's

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111 Exhibit 377 JEC14.

112 Ibid JEC16. Dr Buckland became Director-General on 29 April 2004.

113 Exhibits 327 and 462 (Zanco), Exhibit 328 (Walker), the oral evidence of Mrs Edmond (T.4873-T.4905, T.4964-5 and T.4972-3) and Dr Scott (T.5249- T.5257).

114 T.5588-9.

evidence was to similar effect.[115] This information is available to local GPs and others who wish to know how long a patient may have to wait for an appointment at a specialist outpatient clinic at a particular hospital for a particular specialty.

79. As to (b), the evidence of Mr Zanco and Mr Walker is that anterior lists were collected and, for a period, manually collated by the Surgical Access Team. However, for reasons explained by them, the data was unreliable.[116] The process of manual collation was a time-consuming exercise and because of the unreliability of the source data the collated information was unreliable.[117] As a result, the time-consuming and costly process of providing monthly summaries was discontinued upon the recommendation of the Surgical Access Team ("SAT"[118]). Dr Buckland gave evidence to the same effect.[119] Given its limited resources, the conclusion was reached that the project team was better spending its time and resources on developing a computerised system to collect reliable data, than on the time-consuming process of manual collation of unreliable data. The reporting of outpatient waiting list data by the hospitals to the SAT did not cease.[120]

80. The existence of anterior lists has been the subject of regular comment and inquiry by Members of Parliament and journalists.[121] The existence of specific outpatient waiting lists and issues in relation to their administration was known to Health Ministers under whom Dr Buckland served.[122] From time to time the total numbers of persons state wide on the anterior lists was included in submissions prepared for Cabinet.[123] For example, in an Information Submission prepared for Cabinet in July 2005, QH advised that approximately 84,000 patients were waiting to be seen by surgical

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115 T.5253-4.

116 Exhibit 326 (Zanco No 1) para 24; Walker evidence T.6203. In respect of initial problems with data, see Exhibit 328 para 55 and T.6180-1.

117 Mr Walker's evidence was that monthly reports could have been publicly disseminated but he would be most concerned about the quality of the data: T.6183.

118 For ease of reference the Surgical Access Team and the Surgical Access Service will each be referred to as SAT.

119 Exhibit 336 para 185.

120 Exhibit 328 para 74.

121 Exhibit 336 para 175, Exhibit 317 (Scott), JGS 17, Mr Nuttall's evidence T.5343-4.

122 Exhibit 336 para 176. The evidence of the relevant Ministers was not to the contrary. For example, Mr Nuttall (Exhibits 320 and 321, T.5343-5) and Mrs Edmond (T.4873-T.4905, T.4964-5 and T.4972-3).

123 Exhibit 328 para 69. See for example, GW22 to GW30 of Exhibit 328.

outpatient specialists of which approximately 60,000 were not booked for a specialist outpatient appointment.[124]

81. It was open, at any time, for the Minister or the Cabinet to request and publish these statewide figures. The department would have been required to collate the collected figures. The figures, so collated, may not have been very reliable for the reasons known to both the department and the Ministers.

82. Ultimately, the public release of reports and information is determined by the Government, not by the department.[125] The Government decided to publish elective surgery waiting figures rather than totals compiled from the anterior lists. This policy pre-dated Dr Buckland's appointment as GMHS and DG, and continued after he ceased to be DG.

Elective surgery and elective surgery targets

83. Dr Buckland was asked some questions about this topic during his oral evidence by Counsel Assisting. The questions touched upon a potentially enormous issue concerning elective surgery, its funding and the processes and rules that have governed these matters over the years. Dr Buckland addressed these matters generally in his second statement.[126] It is unnecessary to repeat the contents of his evidence which was not contested. In brief, the evidence shows a strong policy commitment by the Government to devote specific funding to reducing elective surgery waiting lists. However, the system of funding elective surgery gave rise to significant problems that have been identified by Dr Buckland, including the fact that the process was complicated and did not reflect the actual cost to the hospital of providing these services.[127] This was confirmed by Mr Walker in his evidence.[128] The elective surgery program became more and more rule-bound. The result was a constant tension between the SAT and the doctors in the hospitals. Hospitals were having to subsidise elective surgery from their ordinary funds.[129]

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124 Exhibit 323 page 2.

125 Exhibit 366 para 75; T 5720.

126 Exhibit 336 paras 189-196. A more comprehensive account of the funding and practices relating to elective surgery is given by Mr Zanco in his statement dated 4/10/05 being Exhibit 462.

127 Exhibit 336 para 191.

128 T.6199, T.6204-7.

129 Exhibit 336 para 192. The existence of tension between the SAT and the hospitals is reflected in other evidence: see Bergin T.6015, Exhibit 384, Cuffe T.6580, Exhibit 416 attachment DFM6, Exhibits

This footnote is continued on the next page.

84. After becoming GMHS, Dr Buckland found himself in the middle of an ongoing conflict between the SAT and hospitals over the funding and administration of elective surgery. The evidence shows that he resolved disputes over classification and reclassification processes by adopting new business rules in October 2003.

85. Based on this experience, he learned that clinicians and hospital management who were responsible for managing the delivery of elective surgery needed more input into the processes. The process by which funding to hospitals was turned on and off like a tap was harmful. The evidence is that it provided no certainty upon which services could be planned.[130]

86. After Dr Buckland became Director-General, the funding structure of elective surgery was changed so that elective surgery funding was distributed directly to hospitals as a one line item of recurrent base funding as opposed to a multiple funding program, which was given and taken at the control of the SAT.[131]

87. The old funding structure also created a distinction between surgical procedures and medical procedures. Dr Buckland regarded this as a "perverse driver" which led to poor clinical practice.[132]

88. The funding model which pre-existed Dr Buckland's appointment as GMHS and DG was based upon a purchaser provider model that had been introduced in the mid to late 1990's as part of a philosophy of economic rationalism that dominated health and other government services.[133] The practical consequences of such a model, which enabled the SAT to effectively purchase elective surgery services from hospitals at below cost, was the subject of examination during Mr Walker's evidence.[134]

395, 396, 419 (in particular, reference on page 2 of file note that Dr Margetts considered action by SAS as "bullying"), 429 (in particular, Memo from Fraser Coast HSD dated 3.09.03, email from Toowoomba HSD), Medical Superintendents' Advisory Committee Exhibit 346 Stable ("junior officers who are pushing their own barrow but didn't understand the broader picture...") T.5760.

130 See for example the evidence of Dr Mattiussi T.5876, T.5878-9.

131 Exhibit 336 para 194, SMB59.

132 Exhibit 336 para 195. He elaborated on the nature of this "perverse driver" in his oral evidence. T.5542 and T.5590-1.

133 Exhibit 336 para 48, para 303.

134 T.6204-7.

89. As Director-General, Dr Buckland and others within QH, were concerned at the consequences of hospitals being required to provide elective surgery services at below cost. In August 2004, this issue was highlighted in a Cabinet submission.[135]

90. The elective surgery program and its funding is a complex issue. Government policy specifically funded an elective surgery waiting list reduction strategy and QH developed programs to implement government policy. Through a series of decisions, the Government devoted substantial resources to reducing elective surgery waiting lists. But as Dr Scott's oral evidence explained, even with additional funding, QH did not have the capacity to make inroads into either the category 3 waiting times or the anterior waiting lists.[136] These concerns were stated in the Information Submission to Cabinet about Category 3 patients dated July 2005.[137]

91. Dr Buckland has attempted to address the general issue of waiting lists, including the fact that waiting lists for public hospitals are a result of:

(a) the demand for services in that system;

(b) the fact that the demand is partly the result of the failure of preventative health strategies in the past;

(c) the burden of disease in our communities, particularly amongst socially disadvantaged groups;

(d) under-funding;

(e) the sheer weight of numbers on a system that is not means tested in an era when an increasing number of "middle class" (for want of a better phrase) people turn to the public hospital system in Queensland for health care.[138]

92. Dr Buckland has also addressed specific issues in relation to waiting lists.[139]

93. The policies and practices in relation to waiting lists, elective surgery and its funding pre-dated Dr Buckland's appointment as GMHS and his appointment as DG. During the few years that he occupied those positions, he was required to implement government policy that placed a priority on the reduction of elective surgery waiting

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135 See pages 1 and 8 of GW31 which is attached to Exhibit 328.
136 T.5391-2.
137 Exhibit 323.
138 These matters are addressed at paragraphs 153 to 172 of his second statement, Exhibit 336.

lists. When he became Director-General, Dr Buckland authorised improvements to the system of funding of elective surgery and to remove the "perverse driver" which placed excessive emphasis on elective surgery to the detriment of elective procedures.

Dr Buckland's Involvement in Relation to the Giblin-North Report

94. Dr Giblin and Dr North were each appointed and each was granted an indemnity on 6 May 2004.[140] Each had an unconditional indemnity and the indemnity given upon their appointment was the indemnity that they relied upon in submitting their report in May 2005.

95. The Giblin-North Report recommended the significant step of ceasing all orthopaedic surgical health care activity in the public sector in the Fraser Coast Health Service District. Dr Buckland did not dismiss this as a possibility and, as he made clear in his evidence, he respected the qualifications of the authors of the report.[141] However, he sought to ascertain the currency and content of the evidence upon which such a recommendation was based.

96. Dr Buckland made the reasonable request to meet with Dr Giblin and Dr North to understand the basis for their recommendations and for access to the documents that were relied upon to prepare the report. Dr Buckland's request was reasonable for three reasons.

97. Firstly, the report said nothing about the fact that some 4 months earlier, Dr Kwon, who was an Australian trained orthopaedic surgeon from Sydney and a member of the AOA, had commenced work in the Hervey Bay Hospital as Director of Surgery.[142] It was unclear to Dr Buckland on the face of the report whether the investigators knew that Dr Kwon had replaced Dr Naidoo or had taken that fact into account when making their recommendation.

98. Secondly, the section of the report which contained the recommendation to cease all orthopaedic services, being the "Patient Care" section, was worded in such a way that

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139 Paragraphs 177 to 188 of Exhibit 336 and issues in relation to elective surgery and funding at paragraphs 189 to 196 of Exhibit 336.

140 Exhibit 316 (also is Attachment SMB65 to Exhibit 336).

141 Exhibit 336 para 243; T.5550-1.

142 This fact is acknowledged by Dr North: T.5175-6 and at T.5183-4 "We weren't asked to investigate in May 2005, we were asked to investigate in July 2004."

it was not clear to Dr Buckland whether the recommendation was based on clinical evidence, such as personal observation of operations and validation of allegations by reference to patient records, rather than concerns expressed during interviews.[143]

99. Thirdly, Dr Buckland had not been given any indication from the doctors or others prior to 6 May 2005 that the orthopaedic service at Fraser Coast was in such a state that it required immediate closure.[144] The recommendation did not come at the end of a long history known by Dr Buckland, but rather almost out of the blue.

100. It was reasonable for Dr Buckland to not immediately act on the recommendation to cease all orthopaedic services until such time as he had a better understanding of the currency and content of the evidence upon which the recommendation was made.

101. As Director-General, Dr Buckland was faced with competing advice. He did not have the advantage of the extensive forensic exploration undertaken by this Commission to ascertain the position as at May 2005.[145] He had the Giblin-North Report recommending that the service cease, a recommendation that appeared to be based on an assumption that the service was unchanged from July 2004.

102. The competing view, and the one articulated by the Chief Health Officer, was that the issues of concern raised by the investigators could be addressed in a different way and that the recommendation to shut down the service had "significant clinical, legal, industrial and community implications".[146]

103. Dr Buckland was advised by Dr Fitzgerald and Dr Scott respectively that the methodology adopted by Dr Giblin and Dr North was "an interview and focus group approach to identify issues of concern"[147] and "not on clinical material, either in terms of cases performed by the doctors under consideration or through personal

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143 The report itself did not make this clear, but parts of it indicated that it was based largely on allegations made during interviews. In addition the Report did not identify the persons who made such allegations, such that Dr Buckland was not aware whether the allegations were made by one person or many and whether they were made by persons with relevant experience and knowledge. See pages 27 and 28 of the report, Exhibit 38: "heard that", "stated that", "reported that", "noted".

144 Para 242(e) of Exhibit 336.

145 The state of the service as at May 2005 was not expressly addressed in the Giblin-North Report, which reported their investigations from an inspection in July 2004.

146 Exhibit 336 para 245, SMB 76.

147 Ibid.

observation of the operative procedures and capacity of the doctors involved".[148] He was also advised that they had "not sought or been in a position to validate any of the concerns and ordinarily such concerns would require a more formalised investigation in which evidence is collected and responded to".[149] The principal issues of concern were said to relate to the management and organization of orthopaedic services at Hervey Bay and the information collected in regard to clinical standards was "circumstantial and not validated at this time".[150] Dr Buckland was advised that it would "not be wise to take such dramatic action without first recourse to attempts to seek alternative solutions to the issues of concerns identified in the report. Indeed any such decision would be challengeable on the ground of failure to take due care to seek alternative solutions".[151]

104. Dr Buckland also received advice from Dr Kwon that:

(a) In the short space of time he had been running the Orthopaedics Department at Hervey Bay Hospital, he had done a large amount of work to address the issues apparently raised in the Giblin-North report;

(b) He was fully supervising Doctors Krishna and Sharma; and

(c) The services being provided were safe and patient safety was not at risk.[152]

105. It was also reasonable that action to cease all services wait until Dr Buckland had had the opportunity to understand the currency and content of the evidence on which the recommendation was based given the apparent lack of urgency demonstrated by the doctors themselves. Some ten months had passed since the doctors had visited the Fraser Coast Health Service District. If the circumstances existing at the Hervey Bay Hospital at July 2004 were such that it warranted Dr Buckland shutting down the service without further investigation or consideration, the doctors might have been expected, at the very least, to have advised QH of their views immediately after their inspection. Because this did not occur, it was therefore reasonable for Dr Buckland to assume that the circumstances were not so dire that he could not first enquire into the currency and content of the evidence behind the report.

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148 Exhibit 336, SMB75.
149 Exhibit 336, SMB76.
150 Ibid.
151 Ibid.
152 Exhibit 336 para 247.

106. Given the report's failure to make any comment about the presence of Dr Kwon and the fact that Dr Naidoo had left, and the advice that Dr Buckland had received from Dr Kwon about the state of the services as at May 2005, it was reasonable for Dr Buckland to question the currency of the Giblin-North findings that:[153]

(a) SMO's at the Hervey Bay Hospital were undertaking procedures that were beyond their competence;

(b) SMO's at the Hervey Bay Hospital were undertaking procedures unsupervised in circumstances where they ought reasonably have been supervised;

(c) the Director of Orthopaedics was difficult to contact when on call, had taken excessive leave and frequently cancelled surgery;

(d) the continued operation of the Hervey Bay orthopaedics unit posed a real risk to patients at that hospital.

107. Dr Buckland had reasonable grounds to suspect that those matters were no longer the case as at May 2005. It was therefore reasonable that Dr Buckland did not take immediate action to close the orthopaedic unit. It was also reasonable for Dr Buckland to assume that patients at the hospital were not at risk. It was also reasonable that Dr Buckland did not immediately restrict the scope of practice of the SMO's at Hervey Bay Hospital for two additional reasons. Firstly, it is not the role of the Director-General to determine the scope of services of individual doctors. Secondly, the report did not recommend that the SMO's in question cease doing particular types of surgery. It only recommended that they be supervised at all times in the operating theatre.[154] Dr Buckland had received advice from Dr Kwon that this was now occurring. Dr Buckland did take immediate steps to have the SMO's skills assessed by the Skills Development Centre.[155]

108. The orthopaedic procedures at Hervey Bay Hospital were immediately ceased on the resignation of Dr Kwon, who resigned on 15 May 2005.[156]

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153 Dr Buckland has never questioned the accuracy of what the doctors reported was said to them in July 2004, but rather whether that state of affairs still existed in May 2005: T.5550-1.

154 See pages 18 and 19 of Exhibit 38.

155 See his memorandum to Dr Scott dated 9 May 2005 (being the Monday following the Friday when Dr Buckland first saw the report): attachment SMB74 to Exhibit 336.

156 Attachment SMB84 to Exhibit 336.

109. The evidence upon which Dr Giblin and Dr North relied is a matter that has been explored at some length before the Commission. In May 2005 Dr Buckland sought to ascertain what that evidence was, since it apparently was based upon interviews and had not been validated by a formal investigation. This is not meant to be critical of Dr Giblin and Dr North. As Dr North's evidence indicated,[157] he expected further investigations[158] since his and Dr Giblin's investigations had been of a limited kind.

110. In the circumstances, Dr Buckland acted reasonably in May 2005 in determining whether to immediately act upon the recommendations of the Giblin-North Report to shut down the service. He was entitled to consider competing views from the CHO and request clarification of the evidence which Giblin-North relied upon in making such significant recommendations, including whether account was taken of changes in the service that had occurred in early 2005 upon the appointment of Dr Kwon.

Classification and reclassification of Emergency Presentations and the 30 July 2003 submission by the Surgical Access Team

111. For reasons to be outlined below, the following submissions are made:

The 30 July submission

(a) The SAT's submission dated 30 July 2003 was seriously flawed. It was the unbalanced and untested product of a desktop analysis. It did not disclose, even in a short summary form, the known hospitals' position that there were good practical reasons why hospitals needed to re-classify patients and that re-classification was permitted by the Business Rules.

(b) Contrary to a standing direction, the SAT failed to consult with zones and hospitals before making the submission, which sought approval for an amendment of the Business Rules on the strength of allegations that several hospitals had deliberately engaged in unauthorised reclassification.

(c) Despite these features of the 30 July submission, Dr Buckland treated the submission with interest, worked through its detail in a meeting with members of the SAT on 15 August 2003 and determined a plan of action based upon its contents.

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157 T.5178 and T.5199.

158 of the kind contemplated by the CHO's Memo to the DG. SMB76 to Exhibit 336 or GF32 to Exhibit 225.

Removal of Reference to the Submission from RecFind

(d) Ms Miller, who with Ms Brennan was responsible for the management of documents in the GMHS' office, had a number of concerns about the submission,[159] and was also concerned that registration of the document on RecFind might cause persons to believe that the information contained in it was authorised and validated.[160] As a result she believed that the document should be removed from RecFind until the information contained in it could be validated by the HSDs and zones.[161]

(e) She instructed Ms Brennan to do this.[162] She believes that Dr Buckland endorsed this instruction, but she has no specific recollection of him doing so.[163]

(f) Ms Miller's instruction, if carried out, did not constitute the disposal of a public record within the meaning of s.13 of the *Public Records Act*, 2002 ("the Act").

(g) There is an insufficient evidence to conclude that Dr Buckland breached s.13 of the Act in permitting Ms Miller to remove reference to the document from RecFind.

(h) Removing reference to the document from the RecFind indexing system would not avoid or defeat disclosure of the document under FOI legislation. The original submission was filed and accessible, and an electronic copy of it remained on the computer network.

The allegation that Dr Buckland directed that hard copies of the Submission held by the SAT be destroyed and that it be removed from the Network

(i) No direction was given by Dr Buckland that hard copies of the submission held by the SAT be destroyed and that the document be removed from the Network.

(j) This allegation depends on the evidence of Dr Cuffe concerning his recollection of a phone conversation with Ms Brennan in late August 2003, and also his recollection of a conversation with Dr Buckland in early 2004.

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159 Exhibit 416 para 15
160 Ibid para 18
161 Ibid
162 Ibid para 21
163 Ibid para 19

(k) The allegation is inconsistent with other evidence that commands acceptance.

(l) The suggestion that Dr Buckland directed the destruction of the 30 July 2003 submission is untenable, improbable in the extreme and unsupported by the weight of the evidence. This includes evidence that the document was kept and filed where it should have been kept and filed. It is also inconsistent with his conduct in August 2003 when he "went into bat" for the SAT on the strength of the submission in their follow up with hospitals, as a result of which further documents were generated by the hospitals in relation to allegations of unauthorised reclassification by them.

The dispute between certain members of the SAT and hospitals over classification and reclassification

112. The funding of Elective Surgery and issues in relation to classification and re-classification are addressed in a recent statement of Mr Zanco dated 4 October 2005.[164] Some of the points made by Mr Zanco are:

(a) It took hospitals quite a number of years after the commencement of the elective surgery program in 1995 to understand the complexity and difficulties associated with the program. They sought guidance and training from the SAT, and especially Mr Zanco, to improve their processes to ensure that they managed the waiting list effectively and were appropriately classifying and receiving funding for which they were entitled.[165]

(b) There are many good practical reasons why hospitals may need to re-classify patients originally admitted with an emergency status to an elective status:

(i) the definition of an elective admission for Commonwealth and QHAPDC reporting requirements does not preclude a patient from being classified as elective because they were admitted through the Emergency Department;

(ii) during the professional indemnity crisis in 2002 and 2003, many elective surgery lists were cancelled and cases that would normally have been performed as elective surgery were being performed as emergency surgery as a means of continuing to treat patients despite the industrial action;

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164 Exhibit 462. Mr Zanco was a member of the SAT from July 1998 until January 2005. Before that he was the Manager of Admissions Transfers and Discharge at the RBH.

(iii) patients may be on waiting lists awaiting elective surgery but their condition deteriorates rapidly requiring an emergency admission;

(iv) many minor elective surgery procedures are performed in emergency facilities in regional centres but are not emergency cases;

(v) in hospitals with a high proportion of junior medical staff, the method of safe practice includes junior staff admitting the patients into emergency before review by senior staff and an assessment to schedule the patient for elective surgery;

(vi) if a patient is admitted for a condition unrelated to the reason they are on the elective surgery waiting list, they often have their elective surgery performed while they are in hospital. This may occur due to the inadequacy of support for them at their home, the distance they must travel or because the next available space in the elective surgery list allows them to be treated sooner rather than later;

(vii) in some districts, the Emergency Department acts as a transition lounge or admission portal for patients awaiting elective surgery admission outside normal working hours.[166]

(c) For a significant number of years, some in the SAT have expressed the belief that hospitals have been improperly changing the coding of patient records from emergency to elective surgery to increase their access to elective surgery funding. This belief had been challenged by others in the SAT and others on the ground (eg Medical Superintendents) and was not supported by an independent audit.[167]

(d) The competing view has always been that if hospitals are complying with the Commonwealth and QHAPDC elective surgery definitions, there is nothing improper if the coding for the patient has, at some stage, been re-classified.[168]

113. Mr Zanco also explains that the re-classification argument propounded by some members of the SAT was flawed because it relies on a number of doubtful assumptions, namely:

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165 Exhibit 462 para 22; T.6020.
166 Exhibit 462 para 26.
167 Ibid para 24.
168 Ibid para 25.

(a) that at the commencement of the elective surgery program in 1995/6, hospitals were accurately recording data without the support of better information systems that were introduced years later.[169] It also ignores the fact that hospitals took time to properly understand and apply relevant definitions and that over time SAT provided support and guidance to improve these processes;

(b) that the cost of elective surgery has remained the same since 1995/6;[170]

(c) that data entry errors at hospitals did not occur;[171]

(d) that where elective surgery activity increases, but total surgery does not, it can only be the result of re-classification.[172]

114. The re-classification argument relies upon the flawed assumption that every re-classification does not comply with relevant rules.[173]

115. The re-classification argument propounded by certain members of the SAT was not supported by an independent study undertaken by KPMG in 2002, which identified issues relating to the recording of appropriate admission codes for patients presenting through emergency departments. Unlike the SAT, KPMG reviewed actual clinical files across a sample of hospitals and services within hospitals. It identified a number of patients who were coded as emergency that should have been elective. Its audit highlighted the need for further training and auditing within hospitals. Its conclusion essentially was the opposite of the re-classification argument propounded by some members of the SAT and demonstrated that hospitals were in fact missing out on activity and funding they could claim against the program.[174]

116. As a result, the SAT conducted workshops. The changes in recording practices resulting from these workshops encouraged re-classification. In short, the SAT was encouraging re-classification.[175]

<u>The nature of the 30 July 2003 submission</u>

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169 Ibid para 27.
170 Ibid para 28.
171 Ibid para 29.
172 Ibid para 30. This does not take into account that the mix of services being offered can change in hospitals from year to year, depending on the specialist staff it can attract.
173 Ibid para 31.
174 Ibid para 33.
175 Ibid paras 32 and 34.

117. Viewed against this background, the 30 July 2003 submission prepared by Mr Roberts and cleared by Mr Walker can be said to be seriously flawed. It represented an inadequately researched and blinkered view about re-classification in general. It represented what Dr Cuffe described as an "ideological" point of view.[176] It omitted the position of Mr Zanco about the appropriateness of reclassification, as outlined above, despite stating that he had been consulted in relation to the submission. It also omitted to refer to the fact that the KPMG study was essentially to the opposite effect of the re-classification argument propounded in the submission.

118. It is difficult to accept that the author of the submission, Mr Roberts, or Mr Walker who cleared it, were not aware of the fact that the practice of reclassification by several hospitals, including major hospitals such as the Princess Alexandra Hospital, reflected the kinds of practices outlined by Mr Zanco above, was based upon reasonable interpretation of the then-current business rules[177] and, in the case of many hospitals, had been encouraged by advice to this effect by other members of the SAT. It is very unlikely that Messrs Roberts and Walker did not know the position of other members of the SAT such as Mr Zanco about the legitimacy and appropriateness of reclassification, being the position applied by the hospitals and which had been endorsed in the 2002 KPMG review. Despite this, the 30 July 2003 submission did not:

(a) disclose, even in a short summary form, the hospitals' position that there were good practical reasons why hospitals needed to re-classify patients and that re-classification was permitted by the Business Rules;

(b) consult with zones and hospitals before making the submission to the General Manager Health Services that these hospitals had deliberately engaged in unauthorised reclassification.

119. Although Mr Walker, Mr Roberts and Dr Cuffe sought to deflect these criticisms by stating that the submission was simply about obtaining authority to commence an audit process, and also by focussing upon Nambour Hospital as if it was the only hospital against which allegations of abuse were levelled, the document does not

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176 T.6571.

177 which did not preclude a person who had originally presented for admission at an Emergency Department and who subsequently underwent elective surgery being classified or reclassified as having undergone elective surgery.

support this claim. If the submission had been simply accepted by Dr Buckland and marked by him as "approved", it would have approved the various recommendations made in the submission which included amendment to the Elective Surgery Business Rules to specifically exclude presentations from emergency departments and the approval of financial adjustments to those hospitals shown to be actively re-classifying emergency presentations to elective surgery.[178]

120. The evidence is that there was a standing direction that submissions from the SAT to the GMHS office were to be the subject of consultation with the relevant districts and hospitals and the endorsement of Zonal Managers if the submissions related to funding associated with surgical activity targets and the Business Rules associated with the Elective Surgery Program.[179] The recommendations contained in the 30 July 2003 submission, if approved, would have authorised changes to the Business Rules and also affected the funding of hospitals which were "actively re-classifying". On either basis, the submission should have been the subject of prior consultation in accordance with the standing direction.

121. One possible view is that the authors of the submission did not wish it to be subjected to this process of consultation, preferring to advance their views about reclassification, to make allegations of abuse against several hospitals and, thereby, presumably, to enhance the prospects of having their recommendations approved forthwith by the GMHS. Another view is that the submission, whilst well-intentioned, was unbalanced and the untested product of a desktop analysis.[180] This was the view that Dr Buckland took at the time he received the submission.

Dr Buckland's response to the 30 July 2003 Submission

122. Rather than simply send the 30 July submission back to the SAT on the basis that it was unbalanced and untested and required further work, Dr Buckland met members of

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178 Cuffe (T.6564, T.6570, T.6582), Roberts (T.6438, T.6444-5), Walker (T.6217).

179 Exhibit 426 para 10, T.7108 l.30, 7110 ll.20-25.

180 Although an audit process in relation to certain hospitals, particularly in relation to Nambour Hospital, might have been justified and was, in fact, subsequently approved by Dr Buckland, this does not explain why the authors of the submission did not undertake some simple communications with the hospitals in question or zonal management to obtain at least a preliminary explanation from the hospitals concerning their practices and their justification for reclassification. Perhaps the authors did not do this because they already knew the answer. The alternative is that they abstained from doing so because they did not wish to know the answer. Either way, the submission was unbalanced in its

This footnote is continued on the next page.

the SAT on 15 August 2003. The evidence is that he treated the submission with interest, worked through the detail in relation to the table of hospitals, raised questions in relation to the submission and discussed a plan of action based upon it. Such an approach is inconsistent with someone wishing to bury the document and the issues to which it related.

The filing and retention of the 30 July 2003 submission

123. QH communicated to the Commission the allegation that a direction was received from Dr Buckland that hard copies of the document were to be destroyed and the electronic copy removed from the Queensland Health Network. This allegation, which became a matter of public record on 22 September 2005,[181] was apt to suggest that, if a direction had been given to destroy the document, then the original of the document would have been similarly destroyed. It is unfortunate, to say the least, that before QH conveyed this allegation to the Commission it did not make appropriate investigations concerning the matter. These appear to have post-dated 22 September 2005, whereupon it was established that the submission to the GMHS remained where it might have expected to be found, namely filed in the SAT file in the office of the GMHS.[182] It had not been destroyed. IT analysis also reported that the electronic copy had not been deleted from the Network.[183]

124. The allegation that Dr Buckland, or someone on his behalf, directed that the document be destroyed and that electronic copies of it be removed from the Queensland Health Network will be further addressed below. However, if Dr Buckland wanted the document destroyed, it is odd that he permitted the document to be retained and filed where one would expect it to be. His other conduct was inconsistent with wishing the issue to go away to the extent of directing that the submission be destroyed. He asked the SAT to take up the issue with hospitals. He put his name to letters which "went into bat" for the SAT in their follow up with hospitals.[184] As a result, further

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omission of any reference to the views held by other members of the SAT and the views of hospitals that reclassification was appropriate in certain cases and authorised by the current Business Rules.

181 T.5732.

182 Exhibit 416 para 9

183 See Exhibit 495 paras 21-22, a point acknowledged by Mr Walker when he came to give evidence at T.6197 and T.6222.

184 T.6565 and Exhibit 428.

documents were generated by the hospitals in relation to allegations of unauthorised reclassification by them.

Removal from RecFind

125. Ms Miller says that she recommended that the 30 July submission be removed from RecFind until such time as the information in it could be validated by the HSD's and the zones.[185] Her concern was that a document registered on RecFind is often viewed as authorised and validated.[186]

126. RecFind is an index. It is not a data storage system upon which a document itself is contained.[187] The removal of reference to a document from RecFind did not delete the document from the computer server upon which the document was stored, let alone destroy or dispose of hard or electronic copies of it. Ms Miller's instruction to remove reference to the document from RecFind, if carried out, did not involve destroying or damaging a public record, or part of it, or abandoning, transferring or otherwise disposing of a public record.[188] Ms Miller's instruction, if carried out, did not constitute the disposal of a public record within the meaning of s.13 of the Act.

127. Ms Miller's evidence about what, if anything, Dr Buckland said about removal from RecFind does not involve any recollection of such an instruction, but is based upon a belief about what would have happened.[189]

128. Further, and in the alternative, if Dr Buckland accepted Ms Miller's recommendation that reference to the document be removed from RecFind then it was reasonable for him to act upon her advice about whether the document should be on RecFind until

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185 Exhibit 416 para 18.

186 Ibid.

187 Cuffe (T.6548), Miller (T.6407).

188 See *Public Records Act*, 2002, s.13 and the definition of "disposal" in the Dictionary in Schedule 2 of the Act. Page 8 of the Explanatory Notes states: "For the purposes of this Bill the term 'disposal' refers to the **final** decision concerning the fate of records, including the retention of all or part of a public record, the destruction, deletion, migration or conversion of a public record or part of a public record; or abandoning, transferring, donating or selling a public record or part of a public record" (emphasis added). No final decision was made by Ms Miller, let alone by Dr Buckland, about whether reference to the 30 July 2003 submission would be reinstated on RecFind once there had been consultation with the HSDs and the Zones.

189 Exhibit 416 para 19. This evidence is insufficient to conclude that Dr Buckland gave such an instruction. The evidence is equally consistent with Ms Miller giving the written instruction to Ms Brennan in conformity with her views about whether the submission should be recorded on RecFind, and what she understood to be Dr Buckland's concern that the submission had not been validated by the HSDs and Zones.

such time as the information in it could be validated by HSDs and zones. Dr Buckland relied on others to attend to document management, and he was entitled to accept advice of the kind that Ms Miller says that she gave in relation to the document being registered on RecFind. The practice of removing documents from RecFind[190] was a practice that Dr Buckland was entitled to assume accorded with proper practice and he did not know that it was contrary to any guidelines. Given his limited knowledge at the time about RecFind and document management practices[191], he would have been justified in accepting Ms Miller's advice. In the circumstances, any decision to permit Ms Miller to have reference to the submission removed from RecFind until such time as the information in it could be validated by HSDs and zones, was justifiable on the basis of the advice and information known to him at the time, or should be excused.

129. In the circumstances, there was no contravention by Dr Buckland of s.13 of the Act and it would be inappropriate to refer any alleged conduct by him in permitting reference to the submission to be removed from Recfind for further investigation or prosecution.

130. Any instruction by Ms Miller to remove reference of the document from RecFind, and any permission which Dr Buckland gave to that course, was based upon legitimate and genuine concerns entertained by Ms Miller, rather than some improper motive, and, in all of the circumstances, it would be inappropriate to recommend referral of the matter for further investigation or possible prosecution.

131. Dr Buckland has no specific recollection of the discussions referred to in paragraphs 17 and 18 of Ms Miller's statement.[192] But if those discussions occurred, and if Ms Miller expressed her concern about the reliability of the submission, pending validation by the HSDs and zones, then it was reasonable, in the circumstances, for Dr Buckland to appreciate those concerns. If it be the case that Dr Buckland accepted Ms Miller's advice to have reference to the submission removed from

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190 Exhibit 416 para 20 (Miller); Exhibit 425 para 10 (Brennan)

191 T 7100- 7105. The onerous duties of the GMHS, the volume of material that he was required to process and his reliance on others to attend to document management explains why Dr Buckland was not familiar with practices and guidelines in relation to the use of RecFind.

192 Exhibit 459 para 1.

RecFind until such time as the information in it could be validated by HSDs and zones,[193] then that too was reasonable, given:

(a) the nature of the document and the risk articulated by Ms Miller that its allegations against several hospitals of deliberate abuse of the system by active reclassification might be viewed as authorised and validated;[194]

(b) Dr Buckland's then limited knowledge about RecFind and his reliance on others concerning document management practices.

132. Moreover, removing reference to the document from the RecFind indexing system would not avoid or defeat any application that might be made for it under FOI legislation or other processes for the legitimate disclosure of the document. The evidence is that a request for such a document would have been responded to by various searches and there is no reason to suggest that these searches would not have located the hard copies of the submission or the copies of it which were stored electronically.

133. In summary, the 30 July 2003 submission was at the very least unbalanced and untested, pending consultation with HSDs and zones that should have been undertaken prior to its submission. On one view, it was an attempt to directly lobby the GMHS to authorise changes to the Business Rules. This was apparently the view taken by a meeting of Zonal Managers and Health Services on 27 October 2003.[195] Any decision to remove reference to the document from RecFind pending such time as the information and allegations in it could be validated was based on legitimate concerns held by Ms Miller, and apparently articulated by her to Dr Buckland at the time. Any instruction to remove reference to the document from RecFind did not involve a contravention of s.13 of the Act. Further, if Dr Buckland permitted Ms Miller to give such an instruction, he did not breach the Act. Any such permission was based on advice which was reasonable for him to accept.

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193 As previously noted, Ms Miller's evidence (Exhibit 416 para 19) is to the effect that she believes that such a course was endorsed by Dr Buckland, although she does not have a specific recollection of this occurring. Nor does Dr Buckland, but he does not deny that Ms Miller's instruction may have been endorsed by him: Exhibit 459; T.7106.

194 Pending investigation and consultation with the zones and hospitals, and in circumstances in which the serious allegations against several hospitals had not been properly investigated by even perfunctory inquiries by the SAT into the hospitals' justification for their reclassification practices, it was a reasonable view that the submission's allegation of misconduct by several hospitals should not be given whatever authority might be associated with the submission's registration on RecFind.

The allegation that Dr Buckland directed that hard copies of the Submission be destroyed and that it be removed from the Network

134. This allegation in inherently improbable for the reasons canvassed above.

135. It is also unsupported by the weight of the evidence. The original document was kept, not destroyed.

136. This allegation depends on the evidence of Dr Cuffe concerning his recollection of a phone conversation with Ms Brennan in late August 2003, and also his recollection of a conversation with Dr Buckand in early 2004. For reasons to be developed, Dr Cuffe's recollection is unreliable, and should not be accepted since it is inconsistent with other evidence that commands acceptance.

137. Dr Cuffe does not allege that Dr Buckland gave him the alleged direction.

138. Mr Walker made it clear that Dr Buckland did not direct him to destroy or delete a document.[196] His evidence was hearsay, based upon what Dr Cuffe had told him. Likewise, Mr Roberts says that he has "never heard Steve tell me or mention in my presence that he ordered the removal of that document".[197]

139. Ms Miller's instruction to Ms Brennan, noted on the front of the submission, would have been understood by Ms Brennan to mean that the submission should be removed from RecFind, not that the document itself should be destroyed.[198]

140. Ms Brennan does not recall a direction being given for the document to be destroyed.[199]

141. The evidence is that an order to destroy a document is unprecedented.[200] If Ms Brennan had been asked to destroy all hard and electronic copies of any documents, then presumably she would remember such an exceptional request.

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195 Exhibit 416 para 50.
196 T.6230.
197 T.6434.
198 Exhibit 425 para 10. It is quite possible that Ms Miller's handwritten instruction to Ms Brennan was only written after the meeting on 15 August, 2003, and her statement (Exhibit 416 para 21) is not specific about the point.
199 Ibid para 15.
200 Walker (Exhibit 393 para 10); Cuffe (T.6555); Roberts (Exhibit 417 para 21 and T.6434).

142. Dr Cuffe's recollection of his conversation with Ms Brennan should not be accepted. In light of Ms Brennan's evidence[201], and the improbability that she would not recall such an instruction if one had been given, it seems that Dr Cuffe misunderstood something that was said to him by Ms Brennan.[202]

143. Further, the suggestion that Dr Buckland directed the destruction of the 30 July 2003 submission is untenable, improbable in the extreme and unsupported by the weight of the evidence. The document given to the GMHS was retained, filed in the GMHS office and was the subject of consideration and further action. Dr Buckland went into bat for SAT, based upon the allegations contained in it. Such conduct, which prompted the creation of further documents about the issue of reclassification, is inconsistent with an instruction being issued by Dr Buckland, or by someone on his behalf, that the document be destroyed. The apparent explanation for this misunderstanding is that a direction was given for it to be removed from RecFind. Strong evidence that there was no instruction from Dr Buckland to destroy the document is the fact that the document was kept and filed where it should have been kept and filed.

144. The fact that there was no such instruction by Dr Buckland is supported by the evidence of Ms Miller, and of Ms Brennan. Dr Buckland denied giving any such instruction, and there is no sound reason to reject his evidence.[203]

145. Some very limited support for the proposition that such a direction was given appeared in the witness statements of Mr Walker and Dr Cuffe. However, upon exploration of the issue with Mr Walker in his oral evidence, his position is that the word "destroyed" or "destruct" was not used in the conversation in question, which apparently occurred in early 2004.[204]

146. As to Dr Cuffe, his oral evidence initially was that he did not recall any later conversation with Dr Buckland[205] but later his recollection appeared to improve and

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201 which was received without any request that she be cross examined on her evidence (Exhibit 425 para 15) that she could not recall any such direction being given to her or communicating it to Dr Cuffe.

202 For example, reference by Ms Brennan to the fact that the document had been removed from RecFind may have been misinterpreted by him.

203 T.7112 l.45

204 T.6229-30.

205 T.6556.

he claimed to have a recollection that Dr Buckland stated that "the document that was asked to be destroyed had been seen on the officer's desk, which was the 30th of July submission".[206]

147. Dr Cuffe's evidence in this regard is at odds with the weight of the evidence. His recollection should not be accepted. Dr Cuffe's recollection may be a genuinely-held belief that this was said, but is one based upon reconstruction. The conversation with Dr Buckland apparently happened early in 2004. Several months earlier, hard copies of the 30 July 2003 submission held by the SAT apparently had been destroyed on Dr Cuffe's instructions. A brief conversation between Dr Buckland and Dr Cuffe early in 2004 about an earlier submission on reclassification must have brought to Dr Cuffe's mind the document, copies of which had been destroyed by the Surgical Access Team on Dr Cuffe's instruction. But Dr Buckland did not refer to the document having been destroyed.[207] It had not been, and Dr Buckland did not say that it had. He had no reason to suppose that it had been destroyed. He did not issue an instruction that it be destroyed. Ms Brennan did not receive such an instruction. The process of subconscious reconstruction of conversations long after the event is well-known to the law.[208] Dr Cuffe's recollection is the product of such a reconstruction.

148. Dr Cuffe may have issued a direction to the SAT to destroy their hard copies of the submission because he misunderstood something that was said to him by Ms Brennan. Reference by Ms Brennan to the fact that the document had been removed from RecFind may have been misinterpreted by him. Perhaps he took the view that the

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206 T.6557.

207 T 7113 – 7115; Exhibit 459 para 4.

208 For example McLelland CJ in Eq in *Watson v Foxman* (2000) 49 NSWLR 315 at 318-319 observed:

> "...human memory of what was said in a conversation is fallible for a variety of reasons, and ordinarily the degree of fallibility increases with the passage of time, particularly where disputes or litigation intervene, and the processes of memory are overlaid, often subconsciously, by perceptions of self-interest as well as conscious consideration of what should have been said or could have been said. All too often what is actually remembered is little more than an impression from which plausible details are then, again often subconsciously, constructed. All this is a matter of ordinary human experience
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> Each element of the cause of action must be proved to the reasonable satisfaction of the court, which means that the court "must feel an actual persuasion of its occurrence or existence". Such satisfaction is "not ... attained or established independently of the nature and consequence of the fact or facts to be proved" including the "seriousness of an allegation made, the inherent unlikelihood of an

This footnote is continued on the next page.

document had been discredited, or at least rebutted by responses from the zones and several hospitals which addressed allegations levelled at them. Those responses provided compelling explanations for their practices in relation to reclassification. By early September 2003, Dr Cuffe must have appreciated that the 30 July submission levelled unbalanced, untested and, in most respects, false allegations of abuse against several hospitals and was based upon an interpretation of the Business Rules which the SAT was unable to defend.[209] It is hard to accept that by then, if not sooner, he was not embarrassed by the document.[210] Although Dr Cuffe denied being embarrassed by the document, when regard is had to the comprehensive responses provided by the hospitals and the zones[211] to allegations of unauthorised reclassification, he surely must have been embarrassed by the fact that he permitted such an unbalanced and untested document to be submitted to the GMHS. Therefore, if Dr Cuffe's evidence about not being embarrassed is not accepted, it is distinctly possible that embarrassment over its contents motivated him to direct staff in the SAS to delete hard copies of the document and to remove the document from the Network.[212]

149. In summary, Dr Cuffe's recollection of the detail of his conversation in early 2004 with Dr Buckland is unreliable. It appears to be the product of reconstruction which attributes to the office of GMHS a direction which was not actually given office. The probability is that Dr Cuffe misinterpreted something that was said to him by Ms Brennan. Perhaps something said about the document being deleted from the system (thereby meaning RecFind) was wrongly taken by him as indicating that he should arrange to have the document withdrawn from possible future circulation. A

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occurrence of a given description, or the gravity of the consequences flowing from a particular finding": *Helton v Allen* (1940) 63 CLR 691 at 712." [emphasis added]

209 Hence its lack of response to two specific written requests by Dr Buckland as to whether the Zones' interpretation of the Business Rules and source of referral codes were correct. Exhibits 384, 397.

210 The submission that by then Dr Cuffe must have been embarrassed by the submission is not inconsistent with the fact that Dr Buckland, at an earlier time, and before the hospitals' responses were available, regarded the submission as inadequately researched rather than embarrassing. T.7110 l.31 – T.7111 l.9.

211 The response from Dr Ashby and Dr Wakefield from the PAH (Exhibit 429 Tab A) is an example. The simple, but persuasive, briefing from the Central Zone Exhibit 384 which Messrs Walker and Roberts were unable to answer is another. See generally: Exhibit 429; Exhibit 416 attachment DFM6; Exhibit 396; Exhibit 419.

212 Notably, recent analysis by QH's IT section (Exhibit 495 paras 21 and 22) is that the electronic copy of the document was never removed from the Network.

further and alternative possibility is that he gave the direction because he was embarrassed by the document, and was keen to limit its further circulation.

150. The allegation that was made by Mr Walker, and which was conveyed to the Commission in September 2005 concerning an alleged direction by Dr Buckland concerning the destruction of hard copies of the 30 July submission and the removal of the document from the computer network, was based upon hearsay.[213] It has subsequently been scrutinised and, it is submitted, is unsupported by reliable evidence. It is at odds with evidence that commands acceptance.

151. The allegation should be rejected and no further action taken in relation to it, since the evidence does not support the conclusion that Dr Buckland issued the direction.[214] The evidence certainly does not support such a conclusion having regard to the degree of satisfaction that would need to be attained to be satisfied that such a serious allegation was made out, and the improbability that Dr Buckland would issue such an instruction.[215]

152. In conclusion, although reference to the 30 July submission apparently was removed from RecFind index upon the written instruction of Ms Miller to Ms Brennan, the submission was not destroyed or disposed of. It was retained and filed where it should have been filed. Electronic copies of it also remained on the Network.[216] The weight of the evidence is that neither Dr Buckland, Ms Miller nor Ms Brennan gave an instruction that hard copies of it held by SAT be destroyed and that electronic copies of it be removed from the Network. Hearsay evidence to the effect that such an instruction was given by Dr Buckland appears to have been based upon a misunderstanding. Dr Buckland's conduct in acting upon the submission, actually going in to bat for the SAT on the strength of it, encouraging communications within QH about the issues raised in it and retaining the submission in its proper place within

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213 namely what Mr Walker was told by Dr Cuffe about what he was supposedly told by Ms Brennan.

214 For completeness, it should be noted that no breach of the *Public Records Act*, 2002 occurred in relation to the submission which was retained and filed where it should have been filed, and an electronic copy of it remained on the QH computer network where it was stored. Any disposal by certain members of the SAT team of their own hard copies was not at Dr Buckland's instigation.

215 The observations quoted above of McClelland CJ concerning the satisfaction that must be attained in respect of a serious allegation which is based upon recollection of a conversation are apposite.

216 Exhibit 495 paras 21 and 22.

QH is inconsistent with the conduct of someone who would want the submission destroyed and discussion of the issues canvassed in it stifled.

Budgets and the focus on financial compliance

153. The Commissioner on 17 October 2005 stated[217] that, although not wanting to go into major systemic issues, he had to deal with the budgets imposed on QH by the government and by QH on the various hospitals, and that this should be borne in mind when making submissions.

154. Dr Buckland has addressed these issues in his second statement.

155. The evidence is that the public health system in Queensland has been substantially under-funded.[218] Decisions about the allocation of this inadequate funding are addressed in paragraphs 82-100 of Dr Buckland's second statement.

156. On any reasonable view the funds allocated to public hospitals by government have been inadequate to provide the services demanded of them, and to adequately remunerate staff.

157. The constraints placed on public hospitals and other sections of the public health system by budgets has been a cause of general disaffection amongst staff and pressure on persons responsible for compliance with budgets.

158. These pressures were compounded by an economic philosophy that QH was "purchasing" services from hospitals, being a philosophy which focused on throughput and revenue rather than outcomes for the patient and the community. QH did not initiate this philosophy, and Dr Buckland specifically criticised it when he applied for the position of Director-General on 29 March 2004. But it seems to have been a philosophy that was championed and entrenched by entities outside QH. As Dr Buckland stated:[219]

> "For QH, like many other organizations, the last decade has been one of financial compliance and the culture surrounding economic rationalism. In making that observation, I am not denying the

217 T.7098 ll.30-40.

218 Dr Buckland in Exhibit 336 para 77 pointed to the Productivity Commission's Report on Government Services 2005. The matter has been addressed in the Interim and Final reports of Mr Forster's Review.

219 Exhibit 336 para 23.

> importance of financial compliance and the need for accountability in the use of public money. This is a requirement across all government departments and agencies as a matter of proper corporate governance and to meet the requirements of the *Financial Administration and Audit Act* 1977. But the focus on fiscal management has the potential to lead to lazy decision making at a local level. For example, if a doctor had a good idea it could be dismissed with a simple excuse 'There is no money in the budget for it'."

159. In the mid-late 1990's, Funder, Purchaser/Provider Models were introduced and the Performance Management Unit was established. This was part of the philosophy of economic rationalism that has dominated health and other government services during the last decade. Dr Buckland's evidence was that it has a major focus on linking throughput and revenue. It does not focus on outcomes for the patient or the community.[220]

160. Dr Buckland made no secret of his concern about the focus on throughput and budgets.[221] Based on his lengthy experience in running hospitals, and his relatively brief period as GMHS, Dr Buckland hoped to shift QH's focus on fiscal management. In his application to be Director-General, Dr Buckland wrote:[222]

> "Until recently, Queensland Health has focussed heavily on fiscal management. While this approach has been successful in securing the bottom line, it has suppressed the organisation's ability to respond appropriately to the emerging challenges facing the Queensland health system. This has also resulted in a disaffected workforce, a lack of innovative problem solving, strained relationships with other government agencies and a lack of public confidence in the system's capability."

161. The pressure on District Managers such as Mr Leck over the years to meet budgets has been the subject of evidence. Although the scope for even a Director-General of Health to reduce these pressures is limited, given the system of financial administration which QH is required to apply, during his relatively brief time as

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220 Exhibit 336 para 48.

221 This is not to deny the fact that as GMHS, and in accordance with government priorities to achieve targets for elective surgery funding, Dr Buckland urged that surgical throughput be maintained: Exhibits 398, 428 and 348 (the 2003/04 Business Rules, page 10).

222 Exhibit 336 para 35, SMB 15.

Director-General Dr Buckland supported initiatives that were intended to relieve the financial pressure on hospitals.

162. When he became Director-General, it was difficult for Dr Buckland to understand whether District budget overruns were due to growth pressures or management issues. Districts would carry their deficit into the following financial year. This had two significant effects. It reinforced the focus on budgets for District Management and it impeded the financial planning by QH in trying to understand the causes of budgetary difficulties.[223]

163. In the 2004/05 financial year he retired all District debt and funded the "growth in debt" that occurred during 03/04. This was to allow monitoring of District budgets to determine the cause of any pressures, to be able to address those issues in the 05/06 financial year and to better understand the true impact of growth pressures.[224] For example, if a district had a net debt of $5m at 30 June 2004 and that debt had increased from $3m from the previous financial year (that is, an increase of $2m in the 03/04 financial year), the district's debt of $5m was retired as at 30 June 2004 and the district was funded an additional $2m. This was to ensure that all districts would commence the financial year on an equal basis.[225]

164. As previously noted, hospitals were having to subsidise elective surgery from their ordinary funds. As Director-General Dr Buckland implemented changes to the elective surgery funding structure so that it:

(a) reflects today's costs of performing the surgery;[226]

(b) forms a one line item in base funding;

(c) is managed by districts and zones;[227] and

(d) includes medical procedures.[228]

165. The changes addressed the threat to the budget integrity of hospitals of having to provide elective surgery services at prices less than their actual cost. They reduced the complexities associated with the former system under which the SAT controlled

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223 Exhibit 336 para 75.
224 Ibid paras 76.
225 Ibid para 97.
226 Ibid para 191.
227 Ibid para 194.

funding of elective surgery, and overcame the harmful process by which funding to hospitals was turned on and off like a tap, being a process that provided no certainty upon which services could be planned.[229]

166. Dr Buckland's evidence was that attempts to shift the focus of QH away from fiscal management and on to the delivery of patient care encountered resistance.[230] Such organisational changes can be perceived by individuals and groups as being targeted at them, and devaluing the importance of the work they do.[231]

167. But the greater source of resistance is the entrenched culture of economic rationalism and the mind-set that government departments like Queensland Health are in the business of "purchasing" services. As Dr Buckland statement noted[232] this culture is not confined to health. As his application to be Director-General indicates, and as his evidence confirms, [233]it was a culture that he hoped to change with the support of the QH workforce.

168. Dr Buckland accepts that the Commission does not have Terms of Reference to recommend changes to address these broad systemic issues. However, it is impossible to address the circumstances of the QH workforce, and, in particular the pressures under which hospital administrators were required to operate, without addressing:

(a) the budget constraints on QH in general and on public hospitals in particular; and

(b) the entrenched culture of financial compliance which focuses on throughput and revenue rather than outcomes for the patient and the community.

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228 Ibid para 195.

229 Dr Buckland also worked with Strategic Policy and Finance to develop a 5 year financial forecast to give certainty of funding for new services and to fully cost in the subsequent years the escalating impact of any new initiatives: Exhibit 336 para 74.

230 Ibid para 302.

231 Ibid para 304.

232 Ibid para 303.

233 Ibid.

MinterEllison
LAWYERS

28 October 2005

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BY FACSIMILE

Attention: Jarrod Cowley-Grimmond

Queensland Public Hospitals Commission of Inquiry
Level 9
Brisbane Magistrates Court Building
363 George Street
BRISBANE QLD 4000

Dear Sirs

Dr Buckland

We refer to our client's submissions, which were lodged with the Commission and provided to the other parties.

As you will have noted, our client's submissions address a number of topics, including matters that were not the subject of the Commission's notice of possible adverse findings dated 18 October 2005. The topics were addressed in the same order as topics of cross-examination, and also added a section in relation to the issue of budgets.

As an aid to you in identifying the parts of the submissions that respond to the six matters in respect of which our client was invited to make submissions in relation to possible adverse findings, we provide for your assistance the following references.

Topic 1

Addressed in paragraphs 3 to 27. The specific matters mentioned in subparagraphs (i) to (x) are specifically addressed in the following paragraphs:

(i)	paragraph 16
(ii) and (iii)	paragraphs 16, 17 & 18
(iv)	paragraph 18
(v)	paragraph 19
(vi)	paragraph 20
(vii)	paragraph 14
(viii)	paragraph 13
(ix)	not specifically addressed
(x)	paragraphs 21 to 25

Topic 2

These matter is addressed generally in paragraphs 28 to 39.

The matters addressed in subparagraphs (i) to (vi) are more specifically addressed in the following paragraphs:

(i)	paragraphs 28 to 36
(ii) and (iii)	paragraph 36
(iv)	paragraph 37
(v)	paragraph 38
(vi)	paragraph 39

Topic 3

These matters are addressed under in paragraphs 40 to 49.

Topic 4

These matters are addressed in paragraphs 94 to 110.

Topic 5

These matters are addressed generally in paragraphs 111 to 152. The specific matters raised in subparagraphs (i) to (iii) are addressed in the following paragraphs:

(i)	paragraphs 111, 123 to 124, 134 to 152
(ii)	paragraphs 111, 136, 145 to 152
(iii)	paragraphs 111, 125 to 133
(iv)	paragraphs 111 & 151

Topic 6

This topic is addressed in paragraphs 53 to 63.

We trust that this cross-referencing is of assistance to you.

Yours faithfully

Yours faithfully
MINTER ELLISON

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1 November 2005

BY HAND DELIVERY

RECEIVED
01 NOV 2005
BY:----------

Attention: **Jarrod Cowley-Grimmond**

Queensland Public Hospitals Commission of Inquiry
Level 9
Brisbane Magistrates Court Building
363 George Street
BRISBANE QLD 4000

Dear Sirs

Dr Buckland

Pursuant to the direction of Commissioner Davies, we **enclose** further submissions of Dr Buckland.

Yours faithfully
MINTER ELLISON

Contact: Shane Evans Direct phone: +61 7 3119 6450 Direct fax: +61 7 3119 1450
Email: shane.evans@minterellison.com
Partner responsible: Simon Alroe Direct phone: +61 7 3119 6169
Our reference: SGE SJA 40-4992430

enclosure

QUEENSLAND PUBLIC HOSPITALS COMMISSION OF INQUIRY

SUBMISSIONS OF DR STEPHEN BUCKLAND IN REPLY TO THE SUBMISSIONS ON BEHALF OF THE QCSA AND DR ARONEY

1. The submissions under reply were provided outside the time directed for submissions by the Commission.[1] This submission is limited to replying to their personal attacks on Dr Buckland and will not address the other matters contained in them.

2. The submissions of the QCSA and Dr Aroney make two accusations against Dr Buckland:

   (a) That Dr Buckland behaved aggressively with the effect of intimidating speakers at a meeting of the Cardiac Society on 15 February 2004;[2] and

   (b) That Dr Buckland had a cavalier disregard for accuracy and transparency in relation to cardiac services at Prince Charles Hospital and used dishonesty as a management tool of choice.[3]

3. Neither matter was put to Dr Buckland on the two occasions he gave evidence. In fact, there was no cross examination of Dr Buckland by any party about these matters or about cardiac services at Prince Charles Hospital.

4. If such serious accusations against Dr Buckland were to be made, then fairness dictated that the allegations and any evidence in support of them should have been put to Dr Buckland. They were not.

5. As to the meeting of the Cardiac Society in February 2004 , the evidence of Dr Scott,[4] as to the conduct of the meeting should be accepted. The evidence, including Dr Aroney's oral evidence, does not bear out the assertions made in his final submissions.

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1 Dated 27 October 2005 and received by Dr Buckland's legal representatives on the morning of Friday 28 October 2005. Despite their timing, they do not appear to be in response to any other submissions, such as the submissions of Dr Scott dated 7 October 2005 (circulated 21/10/05) or his submissions dated 26 October 2005 (circulated 26/10/05) .

2 Paragraphs 8 and 13.

3 Paragraphs 16 to 18. The allegation was made in relation to what *The Courier-Mail* reported Dr Buckland as saying in October 2004.

4 Exhibit 317 para 19.16 to 19.17.

6. As to Dr Buckland's conduct in relation to cardiac services at Prince Charles Hospital, there is no evidence that Dr Buckland acted on the basis of advice and information that he knew to be wrong. Whatever the merits of decisions that were made by QH in relation to cardiac services and their funding[5], there is no basis for the unfair submission that accuses Dr Buckland of dishonesty.[6] The preparedness of Dr Aroney to now accuse Dr Buckland of dishonesty in final submissions does him no credit at all.

7. Finally, other evidence in relation to Dr Buckland and Prince Charles Hospital should be mentioned. Dr McNeil gave evidence about a meeting that Dr Buckland attended at Prince Charles Hospital in 2004. Dr McNeil chaired its Medical Advisory Committee. Its members included Dr Darren Walters., a cardiologist at Prince Charles[7]. Dr McNeil's evidence is that Dr Buckland asked at the meeting what Prince Charles needed in terms of cardiac services. The evidence is that additional funding was given.[8] Dr McNeil gave evidence that the people who attended the meeting appreciated Dr Buckland's presence.[9]

> "You know, that occurred on the background of some acrimony that was occurring around cardiac services and it was great that he could come out and talk to us face-to-face. We really appreciated that."

8. This evidence is inconsistent with the submission advanced on behalf of Dr Aroney that Dr Buckland had some kind of set against Prince Charles Hospital and those who provided cardiac services there. There is no reason to doubt the accuracy of Dr McNeil's evidence. There is good reason to disregard the unfounded and unfair accusations made on Dr Aroney's behalf against Dr Buckland.

DATED 31 October 2005.

.....

P.D.T. Applegarth SC

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5 A matter addressed in statements from Dr Cleary (Exhibit 301) and others who were directly concerned with those matters.

6 Paragraph 18 of the submission under reply states "There are many failings of Scott's and Buckland's period of QH management, but the most profound is the dishonesty which became the management tool of choice".

7 Dr Walters was one of the cardiologists who attended the meeting of the Cardiac Society on 15 February 2004

8 T.4755; Exhibit 301C paras 109-110.

9 T.4755 ll.26-30.

Submissions

Bundaberg Hospital Patient Support Group

Please quote these details in your reply

RECEIVED
26 OCT 2005
BY:----------

Carter Capner
Your personal lawyer

OUR REF: IJB:SE: BUN247-01
YOUR REF:
DATE: 26 October 2005

Mr Geoff Davies
Commissioner
Queensland Public Hospitals Commission of Inquiry
PO Box 13147
George Street
BRISBANE QLD 4000

Dear Commissioner

RE: FINAL SUBMISSIONS

Please find enclosed a copy of the **Bundaberg Hospital Patient Support Group** final submissions.

Yours faithfully,
CARTER CAPNER

Carter Capner

Contact Person: Ian Brown
Direct Phone No: 3210 3412

Encl.

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QUEENSLAND PUBLIC HOSPITALS COMMISSION OF INQUIRY

BUNDABERG HOSPITAL PATIENT SUPPORT GROUP – FINAL SUBMISSIONS

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REF: IJB: BUN26901

EXECUTIVE SUMMARY

(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.

1. The Queensland Medical Board failed to discharge its statutory obligations pursuant to the *Medical Practitioners Registration Act*, 2001, to ensure that Patel was both eligible for registration, qualified for registration as a medical practitioner and fit to practice in the profession.

2. Proper investigation of the application should have included careful consideration of all relevant documents, including the Oregon Medical Board "Verification of Licensure" certificate. Had the Medical Board properly investigated the application, the restriction on practice is likely to have been discovered and Patel would not have been registered. In particular, it is difficult to contemplate that Patel would have been registered in circumstances where he had been dishonest on his application to the Queensland Medical Board for registration in the first instance.

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

1. Dr Patel should not have been permitted to conduct surgery, give medical advice or any medical treatment on any patient in Bundaberg (or elsewhere) without having undergone appropriate credentialing and privileging and without having been appropriately qualified. Patel should not have been permitted to supervise, train or otherwise oversee the surgical department or any other medical practitioner without being adequately credentialed and privileged.

2. Dr Patel's surgical skills, clinical judgement and clinical competence were significantly below the standard to be expected of a competent and skilled surgeon.

(b) (ii) The employment of Dr Patel by Queensland Health.

(iii) The appointment of Dr Patel to the Bundaberg Base Hospital.

1. Queensland Health and the Bundaberg Base Hospital failed to adequately investigate Dr Patel's qualifications. The credentialing and privileging procedure was not undertaken. The obligation to "check" Patel's references and qualifications was simply delegated to Wavelength Consulting. The failure to adequately investigate his qualifications resulted in the exposure of patients to a surgeon who lacked appropriate qualifications.

2. Dr Patel should have been supervised after his appointment as a Senior Medical Officer. In the absence of credentialing and privileging, his skills as a surgeon were essentially unknown. Appropriate supervision should have been in place.

3. Patel should never have been appointed to the Director of Surgery position.

4. Dr Patel should have been credentialed and privilege in accordance with the Queensland Health procedures.

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

1. Staff and management at the Bundaberg Base Hospital failed to comply with legislative and policy requirements in respect of the reporting of complaints, adverse events and sentinel events.

2. The complaints system in place at the Bundaberg Base Hospital in April 2003 was inadequate.

3. The conduct of Mr Leck and Dr Keating in respect of the complaints that were made by Toni Hoffman was unsatisfactory.

(b) (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 (iv) above.

1. The Bundaberg Hospital Patient Support Group relies upon the submissions made by the Queensland Nurses Union in respect of these matters.

(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 Bundaberg Base Hospital or other Queensland public hospitals raised at the Commission of Inquiry established by a Commissions of Inquiry Order (No. 1) of 2005.

1. The conduct of Dr Gaffield in the case involving Des Bramich was below the standard to be expected of a competent and skilled surgeon.

(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 Bundaberg Base Hospital; and

(ii) outside the Bundaberg Base Hospital.

1. The failure by the Bundaberg Base Hospital to adequately deal with complaints made by patients is dealt with under Terms of Reference *(b)(iv)* above.

2. The investigation by Dr Fitzgerald failed to adequately identify and respond to the significant concerns that were being expressed by staff. The lack of credentialing and privileging, the failure to adequately check his qualifications and the failure by the Bundaberg Base

Hospital management to adequately manage the complaints and the conduct of Dr Patel were clearly matters that needed urgent attention.

3. The conduct by the management of the hospital and the hierarch of Queensland Health following the disclosure of these matters reflected a culture of "tolerating problems rather than addressing them"[1].

4. The patients are to be compensated in accordance with the package which is not limited by the Scale of General Damages promulgated pursuant to the *Civil Liability Act*, 2003. This arrangement reflects the unsatisfactory state of the law where persons who suffer serious injury are not fairly and justly compensated under the Civil Liability Scale of General Damages.

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1 Woodruff report, page 44.

TABLE OF CONTENTS

BUNDABERG HOSPITAL PATIENT SUPPORT GROUP – FINAL SUBMISSIONS

History

1. The Bundaberg Hospital is situated within the Bundaberg Health Service District. The hospital provides a wide range of general clinical services and some specialty areas including, but not limited to, renal and breast screen. The facility profile indicates that the hospital has 140 available beds with an occupancy rate of 78.3%. The Bundaberg Hospital is 350 kilometres away from its main referral hospitals of Royal Brisbane and Princess Alexandra Hospitals[2].

Employment of Patel

2. Prior to April 2003, several surgeons had occupied the position of Director of Surgery. The position was vacant from early 2002 and filled temporarily. Patel commenced as Director of Surgery in April 2003 and remained at the hospital until April 2005.

3. The Director of Surgery position at the Bundaberg Base Hospital had previously been occupied by Dr Nankivell. Dr Nankivell resigned the position in January 2002. Dr Sam Baker thereafter acted in the position until he resigned on 30 November, 2002. The position of Director had been advertised on two occasions, closing in September, 2002.

4. Dr Jayasekera applied for the position of Director of Surgery in late 2002. Initially, he was not interested in pursuing the position as he wished to obtain employment closer to Brisbane. Despite that, he was encouraged by Dr Kees Nydam to apply for the position and did so.

5. At this time there were only two applicants for the position. One was Dr Jayasekera. The second was a surgeon from Yugoslavia.

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2 Woodruff report, page 11.

6. Dr Jayasekera was interviewed by Mr Leck, Dr Nydam and Dr Pitre Anderson. The position was awarded to the Yugoslavian surgeon, despite the fact that he had never practised in Australia. He ultimately rejected the position.

7. Following that rejection, Dr Anderson raised, at a "sub-committee" meeting the issue as to why the position had not been offered to Dr Jayasekera. No response was received from Mr Leck. Dr Jayasekera was not appointed.

8. The position was again re-advertised.

9. Dr Patel applied for the position in late 2002.

10. John Bethell of Wavelength Consulting states that on 14 November, 2002 his firm received a verbal request from Dr Nydam to find and refer a surgeon for the position of Senior Medical Officer at the hospital. Dr Patel contacted Wavelength Consulting. On 13 December, 2002 Bethell sent him some information about Bundaberg and the hospital. He expressed interest in the role and on the same day sent a copy of his CV.

11. Dr Bethell gave evidence in relation to the following matters relating to Patel's original application:-

    11.1 He had a telephone conversation with Dr Patel, and subsequently sent Dr Patel generic information about Bundaberg and the Bundaberg Base Hospital[3];

    11.2 Dr Patel expressed interest in the position, and forwarded his CV to Wavelength;

    11.3 Patel provided Wavelength with a bundle of references with the application[4];

    11.4 Wavelength forwarded Patel's CV to Dr Nydam;

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3 Paras 7 and 8, Ex 41.
4 See attachment JHB3 T678-679

11.5 Dr Nydam reviewed the CV, and had discussions with Dr Patel by telephone (Nydam paras 15 and 17.);

11.6 On 20 December 2002 Nydam emailed Wavelength confirming proposal to offer Patel employment at the BBH;

11.7 On 20 December 2002 Bethell contacted Drs Feldman and Singh as referees for Patel. These referee checks were consistent with the written references, although there were signs of problems, in that he had problems dealing with other staff, and "*sometimes took on complex cases handed to him by colleagues. He found it hard to say no.*"[5] Notwithstanding this, Dr Bethell in evidence said that "*it certainly seems ambiguous in retrospect, but at the time the whole feeling of the references was that Dr Patel was a very high quality candidate*".

11.8 On 20 December Dr Bethell emailed Nydam and notes the gap in Patel's employment history in his CV:-

> *"One minor issue of concern that I had was that he has not worked for nearly a year. I am not sure if the QMB might have an issue with this."*[6]

11.9 Dr Patel subsequently forwarded a further version of the CV with an amendment that represented that his employment in Oregon was current. This was the version forwarded to the Medical Board. Dr Bethell did not note the false change in the CV by Dr Patel. He gave evidence that he did not compare the two versions until shortly before he gave evidence to the previous Commission in June this year.[7]

11.10 On 24 December 2002 Dr Nydam forwarded an appointment letter to Wavelength. On 29 December 2002 Patel confirmed his acceptance of the position by email to Wavelength;

11.11 Patel was initially to be employed as an SMO.

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5 Refer attachments KN4 and KN5 to ex.51
6 Ex.43
7 T688. Revised CV submitted to MBQ is Ex.45

Patel's process through the Medical Board

12. On 6 January 2003, Patel completed an application for registration with the Queensland Medical Board (QMB). This was forwarded to Wavelength, along with certified copies and original documents in support of his application.

13. On 17 January 2003, Susie Tawse from Wavelength forwarded to the MBQ the relevant applications and accompanying material for Patel's proposed registration.[8] The letter indicated that the "*certificate of good standing*" was to follow.

14. The provision of a letter of good standing was a mandatory requirement for the Medical Board in its determination. It was the subject of a significant amount of correspondence between Dr Patel, Wavelength and the Medical Board. In particular[9]:-

    14.1 It was referred to in the letter from Wavelength of 17 January 2003 as "to follow";

    14.2 17 January 2003 Dr Patel emailed Susie Tawse from Wavelength to advise that the Oregon Board of Medical Examiners would issue a "*verification letter of good standing*", which he would forward through in the following few days.

    14.3 Susie Tawse from Wavelength faxed Ms McMullen of the Medical Board indicating that the application at that stage "*does not include a letter of good standing*".

    14.4 By letter dated 28 January 2003 Ms Tawse from Wavelength forwarded the document described in that letter as "*certificate of good standing*" to the Medical Board.

    14.5 The document, which was forwarded to the Medical Board, was not in fact a "*certificate of good standing*". It was a document titled "*verification of licensure*".

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8 Attachment MDG12 to ex.24

15. Ms Tawse, who was an officer with Wavelength was not called to give evidence, nor did she provide a statement. Ms McMullen from the Medical Board was similarly not called to give evidence, nor did she provide a statement.

16. On 19 January 2003, Patel forwarded to Wavelength the Oregon verification of licensure. This contained a reference to "*public order on file. See attached*". The reference to the public order on file, was a reference to restrictions that had been placed upon Dr Patel's practice in the State of Oregon.

17. Dr Nydam completed and submitted the necessary area of need application to Queensland Health to support Dr Patel's appointment[10]. On 11 February 2003, the QMB approved Dr Patel for registration as a senior medical officer (Demy-Geroe para 38).

18. The QMB issued a letter on 12 February 2003 approving Dr Patel for special purpose registration as a senior medical officer. The letter stated that *"Registration is contingent upon you practising as a Senior Medical Officer in surgery at Bundaberg Base Hospital or any other public hospital authorised by the Medical Superintendent during the period of your registration."*

19. The Medical Board process had involved a review of Dr Patel's application, and supporting documentation. Dr Patel was interviewed by Dr John Waller on behalf of the QMB.

20. Dr Waller did not give evidence at the previous Commission of Inquiry or at this Commission. He has not provided a statement to the previous Commission or to this Commission.

21. One of the central issues for consideration by this Commission is how Dr Patel came to obtain registration as a senior medical officer, notwithstanding the previous disciplinary action that had been taken

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9 See the bundle of correspondence which is ex.50 - *Wavelength Consulting documents relating to Dr Patel*

10 Nydam para 23.

against him in the State of Oregon, and was a matter of public record in that jurisdiction.

22. Patel deliberately took action to hide the information that would have led to his previous history being revealed. Nevertheless, he could not have succeeded in his attempts were it not for the failure on the part of the Medical Board of Queensland, Wavelength Consulting, to perform the necessary checks of Dr Patel and obtain all appropriate information.

23. It is clear that Patel acted dishonestly in the following ways:-

23.1 His CV was changed so as to mask the fact that he had not worked for 12 months prior to his appointment to Bundaberg;

23.2 He failed to disclose to the Medical Board of Queensland the limitations upon his practice imposed by the Oregon Medical Board;

23.3 The "*public order*" referred to in the verification of licensure was not attached.

24. Wavelength Consulting failed to identify the problems with Patel, notwithstanding the following matters which may have highlighted the problems which later became evident:-

24.1 Dr Patel changed his CV between the first time he approached Wavelength, and when he later made application to the Medical Board. This change in the CV masked the fact that he had not been employed for 12 months prior to his appointment at Bundaberg. Wavelength was aware that Dr Patel had not been employed in that period of time and this may have been a matter of concern for the Medical Board;[11]

24.2 The reference checks conducted by Wavelength indicated some level of concern about Dr Patel and his relations with staff. It is acknowledged that, in light of the apparent glowing

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11 Ex 43

references that Dr Patel had attached from late 2001, Wavelength perhaps saw these as relatively minor. Dr Patel had not included any recent written references although Dr Bethell indicated that written references were of use as introductory material only;

24.3 Dr Patel did not have any references from a person who was in a supervisory capacity over him. This again should have been a matter of concern;

24.4 Wavelength failed to identify the reference to the public order on file;

25. The Medical Board of Queensland failed in its obligation to appropriately check Dr Patel's credentials. The Medical Board itself has acknowledged that the failure to discover the disciplinary history of Dr Patel is "*inexcusable*"[12]. The Medical Board did not have a certificate of good standing for Dr Patel, and has acknowledged that the "*verification of licensure*" was known by it not to amount to a clear statement of good standing[13].

26. The review of Dr Patel's application by the Medical Board did not alert it to the reference to "*public order*". The Medical Board had no other formal mechanism for checking on Dr Patel's standing.

27. A personal interview was conducted by the Medical Board with Dr Patel, and his application and accompanying material was reviewed at that interview. The interviewer failed to recognise the problems with Dr Patel's previous registration. The interviewer, Dr Waller, has not given evidence, and so no conclusion can be reached as to whether matters relating to Dr Patel's practice in Oregon were covered in that interview.

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12 Paragraph 44, Statement of Demy-Geroe.
13 Paragraph 46, Statement of Demy-Geroe.

Credentialing and Privileging

28. At the time of Dr Patel's employment at the Bundaberg Base Hospital, Queensland Health had in place a policy to ensure that all medical practitioners within Queensland Health would have their credentials and clinical privileges peer reviewed[14].

29. The policy made the following requirements clear:-

    29.1 All medical practitioners within Queensland Health facilities were required to have their credentials and clinical privileges periodically peer reviewed by a credentials and clinical privileges committee;

    29.2 "Credentials" were the formal qualifications, training, experience and clinical competence of medical practitioner;

    29.3 "Clinical privileges" referred to the range and scope of clinical responsibility that a practitioner may exercise. Clinical privileges may relate to areas of clinical practice, use of facilities or specialised equipment, or the performance of specific operations or procedures[15];

    29.4 The district manager is responsible for ensuring that a process is in place within the district to enable peer review of credentials and clinical privileges;

    29.5 The district manager was responsible for ensuring that all medical practitioners within the district had their credentials and clinical privileges periodically reviewed.

30. The guidelines for medical practitioners allow for a mechanism to exist for the granting of temporary privileges for short-term privileges, without recourse to the full committee[16].

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14 See exhibit 279 *Credentials and Clinical Privileges for Medical Practitioners*, August 2002 and *Credentials and Clinical Privileges Guidelines for Medical Practitioners*, July 2002.

15 Refer particularly to Glossary, Definitions, References section at page 4 of the Policy and further section 2.3 at page 11 of the Guidelines.

16 Section 7.3 at page 11of the guidelines.

31. The guidelines allow for the review of clinical privileges. The guidelines provide as follows:

> *"A review of clinical privileges appropriate when there are indicators of clinical competence such as outdated practices, clinical disinterest or poor outcomes"*[17].

32. Patel did not go through any or any adequate process of checking his credentials and clinical privileges.

33. Were the Queensland Health policy to have been followed, Patel's credentials and privileges should have been checked on at least one of the following times:-

33.1 At the time of his original appointment;

33.2 At the time of his appointment as Director of Surgery;

33.3 At the renewal of his contract in April 2004;

33.4 At any of the times when concerns were raised about the scope of his clinical practice, for example, the appropriateness of Dr Patel performing esophagectomies.

34. The failure to establish a credentials and privileges committee has been attributed to the refusal of the relevant specialist college to nominate a person to sit on that committee. In this regard, it is noted that the policy does not mandate membership from the relevant college. Further, there is evidence that the committee had existed in the past without any membership from the relevant college[18].

Patel is made Director of Surgery

35. When Patel first arrived in Bundaberg the position of Director of Surgery remained vacant. Dr Nydam in his statement states that Patel was along with Dr Gaffield the only two candidates to fill the vacant position. Dr Nydam says that he felt that Patel had the better general surgical experience, and so Patel was offered the position of Acting

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17 Guidelines, pages 11 and 12.
18 See attachment "SPB3" of Statement of Dr Sam Baker (Exhibit 410).

Director of Surgery immediately upon his arrival[19]. There was no other documentation put before the Commission relating to Patel's appointment as Director of Surgery.

36. There was no correspondence to the Medical Board notwithstanding the original advice from the Medical Board in relation to Dr Patel that "*registration is contingent upon you practising as a senior medical officer*".

The first year – April 2003 – April 2004

37. The first sign that Patel may not have been capable of exercising good clinical judgement was the first oesophagectomy performed on James Phillips, Patient P34, on 19 May, 2003. Mr Phillips was at end-stage renal failure, on dialysis and suffering hyper kalemia[20].

38. On 23 April, 2003, an oesophageal biopsy was undertaken. There was poorly differentiated invasive adenocarcinoma associated with Barrett's oesophagus. There was no evidence of metatarsus. Mr Phillips subsequently died on 21 May, 2003.

39. Soon after the death, Glennis Goodman (former DDON) and Toni Hoffman met with Dr Darren Keating. Ms Hoffman raised three specific issues:

    39.1 Dr Patel had allegedly written that the patient was stable when in fact they were on maximum Inotrope therapy and support;

    39.2 Dr Patel was rude, loud and allegedly did not work collaboratively with the ICU medical and nursing staff; and

    39.3 That the ICU in Bundaberg was Level 1 and as such was not capable of providing the level of care that was required to support such surgery.

40. Dr Keating had no recollection about the issue of whether oesophagectomies should be performed at the Bundaberg Base

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19 Statement of Nydam paragraph 35.
20 Woodruff report, page 124.

Hospital being raised on that occasion. He suggested that she should speak to Dr Patel about the reasons for the comment. Dr Keating perceived that Ms Hoffman was more concerned about interpersonal relations between the ICU nurses and Dr Patel. Follow-up by Dr Keating with Ms Goodman indicated that the discussions had gone well.

41. The Woodruff report suggests that this was an appropriate opportunity for intervention for management. A multi-disciplinary meeting, chaired by the DMS, the Director of Surgery, Director of ICU and the Nurse Unit Manager of ICU in attendance would have been an appropriate forum to discuss the issues and document a decision regarding the surgical capability of the Intensive Care Unit. Communication of such a decision or outcomes for the staff that initially raised concerns would have been appropriate.

42. Moreover, this may also have been an appropriate opportunity to have Patel credentialed and privileged. Two of the issues raised by Hoffman, in particular the capability of the Bundaberg ICU in handling a patient such as Mr Phillips following an oesophagectomy, were matters that related directly to credentialing and privileging issues.[21]

43. A short time prior to 1 June, 2003, Peter Dalgleish lodged a complaint about Dr Patel. He complained that a procedure on his ear to remove a skin lesion was performed on the wrong area of his ear[22].

44. Dr Keating asserts that on receipt of the complaint he proceeded to investigate it. He identified that the lateral margin of a skin cancer had only been removed at the surgery. He discussed the patient with Dr Patel who agreed to review him the following week. He further conversed with the patient on 3 June, 2003 to inform him of the arrangements. A second complaint was received from Mr Dalgleish on 11 June, 2003.

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21 Refer paragraph 34 above.

22 Statement of Dr Keating (Exhibit 448), paragraph 318.

45. Peter Leck became aware of the complaint at that stage. Mr Leck thereafter handled the complaint and further surgery was carried out on 22 July, 2003.

46. On 6 June, 2003 Patient P18 was admitted to the Intensive Care Unit in preparation for an oesophagectomy. Around 5 June, 2003 Dr Joiner, Anaesthetist and Ms Hoffman met with Dr Keating to raise concerns about the proposed admission of P18 on or about 6 June, 2003. Dr Patel had indicated that it was proposed that P18 would undergo an oesophagectomy. The surgery envisaged was as complicated as the first oesophagectomy performed on Patient 34 (Phillips).

47. Ms Hoffman and Dr Joiner place the meeting before the admission of Patient P18. Dr Keating suggests the meeting was after that admission[23]. Either way, Patient P18 was the second oesophagectomy performed by Dr Patel.

48. Following the oesophagectomy on 6 June, 2003 both Dr Joiner and Ms Hoffman questioned whether oesophagectomies should be done in the Bundaberg Hospital. Soon after the surgery, Dr Joiner suggested transfer of the patient to Brisbane, but Dr Patel refused. The issue was referred to Dr Keating. He asked the Acting Director of ICU, Dr Younis, to review the patient. Dr Keating reported that Dr Younis indicated the patient could stay in Bundaberg Hospital. Two days later, the patient was transferred to the Mater Hospital, Brisbane, due to complications.

49. On Dr Carter's return, Dr Keating met with him to discuss the concerns raised by Ms Hoffman. Dr Keating said that Ms Hoffman was concerned that the Bundaberg Hospital ICU should only electively ventilate patients for 24 to 48 hours. Dr Carter indicated that this was flexible and could be extended for 3-5 days depending upon the circumstances.

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23 Exhibit 307, paragraphs 4-6 – Statement of Dr Joiner; Statement of Ms Hoffman – Exhibit 4, paragraph 13.

50. Dr Keating states that on 1 July, 2003 he received a message from Dr Peter Cook from the Mater Hospital in Brisbane. Dr Cook had telephoned Mr Leck to discuss P18. Dr Keating contacted Dr Cook who advised that P18's course had been very difficult. Dr Cook expresses concern about this type of operation being performed at Bundaberg Hospital in that the operation required robust intensive care back up. Dr Keating indicated that he would discuss his concerns with the Director of Surgery and Anaesthetics and with the credentials and privileging committee at the hospital.

51. After Dr Carter returned from leave, Dr Keating spoke with both Dr Patel and Dr Carter about the issue of patients and extended ventilation in the ICU. Dr Carter suggested that a period of 72 hours was acceptable before considering transfer of the patient. Both Dr Patel and Dr Carter accepted that transfer should occur if it was required. Both of them were of the opinion that oesophagectomies could be performed at the Bundaberg Hospital[24].

52. Dr Carter however adds that at second aspect of his concern was "patient choice". Dr Carter adds that both oesophagectomy patients appeared to be poor choices by Dr Patel.

53. Dr Keating states that after discussions with Dr Patel and Dr Carter, he concluded that it was appropriate to permit Dr Patel to perform oesophagectomies and that Dr Carter had indicated that the ICU was capable of handling these patients post-operatively.

54. This second episode involving Dr Patel and his performance of complex surgery raised two critical issues.

55. The first issue was a serious question of the capabilities of the Bundaberg Hospital to cover the surgeries such as oesophagectomies and Whipples procedures. There were clearly divergent views as to whether Bundaberg Hospital had the relevant capacity. Dr Joiner, Dr Cook and Ms Hoffman believed that the hospital did not have had the

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24 Exhibit 448, paragraph 55-56.

appropriate capacity. Dr Younis, Dr Carter and Dr Patel considered it did have such a capacity. This was a significant issue that fell squarely within the credentialing and privileging criteria of the hospital.

56. The second significant issue was Dr Patel's judgement in respect of the individual patient. Dr Carter suggested the patients were inappropriate choices for such complex surgery. There was a dispute between Dr Patel and Dr Joiner as to whether Patient P18 should have been transferred. Dr Patel appeared to be performing this surgery without himself considering whether the hospital had the relevant capacity to cope with such surgery.

57. Dr Keating acknowledges he was the "newcomer" to the hospital. So was Dr Patel. As the Woodruff report identifies, a multi-disciplinary meeting to address the concerns raised and decision regarding clinical privileges for Dr Patel in line with the service capability of ICU was clearly called for. Instead, Dr Keating simply chose to accept one view over another in circumstances where he was clearly unqualified to make the decision.

58. On 19 June, 2003 and later in September, 2003, Ms Hoffman again complained about the hospital performing outside its capabilities[25].

59. On 28 October, 2003 Dr Keating received a complaint from Ian Fleming. Dr Keating spoke to Fleming on 30 October, 2003. The version suggested by Mr Fleming should be preferred over that offered by Dr Keating.

60. On 19 June, 2003 and later in September, 2003, Ms Hoffman again complained about the hospital performing outside its capabilities[26].

61. On 28 October, 2003 Dr Keating received a complaint from Ian Fleming. Dr Keating spoke to Fleming on 30 October, 2003

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25 See below and Exhibit 4, TH3 and TH6.
26 See below and Exhibit 4, TH3 and TH6.

62. Dr Keating advised Mr Fleming that he heard that Mr Fleming had lodged a complaint against Dr Patel. Dr Keating stated:

> *"I must tell you that he's a fine surgeon with impeccable credentials and we are lucky to have him here in Bundaberg. I understand you are bleeding internally since the operation, but this can be caused by many factors."*

63. Mr Fleming described four complaints. Those complaints are detailed in his statement and evidence before the Commission. Dr Keating contests that evidence and suggests that the issues as described by Mr Fleming were not discussed. The evidence of Mr Fleming should be preferred over the evidence of Dr Keating.

64. On 21 November, 2003 Patient P198 complained about swelling and bruising of the scrotum following repair of his inguinal hernia. Dr Keating responded to the complaint, providing an explanation, reassurance and offering three options. The options were to attend his local General Practitioner, attend the Emergency Department for immediate review or seek an early review at Dr Patel's outpatient clinic. Dr Keating believes that Mr Dempsey took the last option.

65. Dr Patel was not approached in respect of this complaint.

66. Six days later, on 27 November, 2003, Nurses Gail Alymer and Lyn Pollock complained about wound dehiscence and other complications associated with surgery performed by Dr Patel. Alymer and Pollock were told by Keating that he needed data to support any such complaint.

67. On 6 February, 2004 Dr Keating had been provided with an unsigned and undated complication report through the Director of Nursing, Paddy Martin. Dr Keating replied with the statement "If they want to play with the big boys – bring it on." Dr Keating states that he did not expect those words to be repeated and they were said in the context that if the nursing staff wished to raise these issues, it required data to back-up the concerns. He asked Patty Martin to provide him with that data and expected that it would be provided. He states that he was

not told that there was a 100% complication rate in Dr Patel's performance of this procedure.

68. By February, 2004, Dr Keating had been the recipient of many and diverse complaints about Dr Patel. He was aware that:

68.1 Nurses and other staff were complaining about Dr Patel's competence and the conduct of surgery;

68.2 Dr Miach and nurses from the Renal Unit had concerns about the placement of catheters by Patel;

68.3 Patel had demonstrated, ostensibly, a lack of judgement in patients who he subjected to serious and complicated surgery;

68.4 There had been serious conflict of opinion about the extent to which Bundaberg Hospital ICU could cope with the serious surgery being undertaken by Dr Patel.

69. On any version of events, these various conflicts could not all be attributed to personality conflicts. It was clear that Dr Patel had significant difficulty in determining the full extent of his own capabilities in particular, his capabilities in conjunction with the hospital capacity. In the words of the Woodruff report:

> *"Given that several senior clinicians had expressed concerns regarding the patient outcome from Dr Patel's surgery, consideration could have been given at this stage to obtaining formal external peer review."*

70. Dr Patel's contract was about to be renewed for a second term. It was an appropriate time, given the history, to have him credentialed and privileged. This was never done.

The second year – April 2004 – October 2004

71. On 27 February, 2004, Dr Keating received a complaint from Geoffrey Smith. Mr Smith indicated that he was unhappy about Dr Patel using local anaesthetic to remove a lesion on his shoulder. He had requested general anaesthetic for the procedure as he was fearful that local anaesthetic did not work. Although Dr Patel had persuaded him

to have a local anaesthetic, during the procedure it became clear that the local anaesthetic was not working.

72. Mr Smith was clearly unhappy with Dr Patel's attitude towards him throughout this time. Mr Smith subsequently complained to the Health Rights Commission and was referred back to the hospital. Dr Keating met with Mr Smith and was followed-up with a written apology.

73. Dr Keating suggested Dr Patel was counselled about his manner in such situations. Dr Patel's response was to purportedly accept the criticism.

74. Less than ten days later, Vicki Lester wrote to the hospital seeking travel costs for transfer to Rockhampton Hospital.

75. Ms Lester's complaint was summarised in a note from Dr Keating's secretary[27]:

> *"She then stated that she has been to see Dr P. here and he states that there was nothing there. She has since seen her GP and had another x-ray (January 04). Her GP believes that packing is still there, and was sending her to Rockhampton. I spoke to DMS who advised that PTSS won't be funded as there are two surgeons available at Bundaberg."*

76. The effect of the complaint was that Ms Lester had undergone surgery at the hands of Dr Patel and had returned, concerns that packing had been left in her wound. Dr Patel had advised her that there was no packing in the wound. The patient had returned home, but subsequently believed that there was packing present. She attended upon her General Practitioner. Her General Practitioner undertook an x-ray and concluded that there was in fact packing present and that Dr Patel was obviously wrong. Rather than refer Ms Lester back to the Bundaberg Hospital, the General Practitioner appears to have decided to refer Ms Lester to the Rockhampton Hospital.

77. That action, on one interpretation, could be a significant criticism of Dr Patel. Moreover, the conduct by the General Practitioner is indicative

of a lack of faith in Dr Patel as a surgeon. Nothing further was done in respect of the complaint until 2005.

78. In or about March of 2004, Ms Hoffman provided a portion of her complaints to Mr Leck. The extract of the letter appears at TH10. The complaint by Ms Hoffman clearly identifies several significant issues that require urgent consideration. The issues that require consideration relate to matters associated with the credentialing and privileging of Dr Patel.

79. On 2 July, 2004, a complaint was received in respect of Patient 131. She complained that after a normal screening mammogram, she presented to Dr Patel in July, 2003 with an itchy area around her right nipple. He diagnosed eczema and prescribed a steroid cream. The patient did not attend the follow-up appointment in September. She did present to Dr Gaffield in October, 2003 for a review of another unrelated surgical condition. He reviewed the nipple area and recommended review in three months.

80. At the next review by a surgical principal house officer, the complaint had not resolved. Further investigation revealed Padgett's Disease of the breast. The patient demanded a double mastectomy which was performed. Dr Patel was approached about the issue and advised that the error was based upon a normal mammogram. Dr Keating accepted that explanation.

81. On 2 July, 2004 the ASPIC minutes revealed that the wound dehiscence rates were high. Complaints had been made in respect of Dr Patel's surgery and a possible connection to wound dehiscence rates on previous occasions. Gail Alymer had raised this as an issue as early as mid-2003.

82. Again, the Woodruff report suggests these events should have led to an external peer review of the cases and consideration of restriction of the clinical privileges of Dr Patel.

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[27] Exhibit 448, DWK77.

83. On 2 August, 2004 Ms Hoffman reported the death of Des Bramich as a sentinel event. The sentinel event form had been delivered to Mr Leck, Ms Mulligan and Dr Keating. The allegations of the staff against Dr Patel had included delayed transfer, verbal abuse of Ms Bramich in the ICU and grossly inappropriate attempts at pericardial drainage when the patient had been inextremous[28].

84. Mr Bramich was admitted to the Bundaberg Hospital on 25 July 2004 with serious chest injuries, after a caravan which he was doing work on collapsed on top of him.

85. Mr Bramich was initially admitted to the intensive care unit, but after he stabilised was transferred to the surgical ward.

86. Mr Bramich was diagnosed following x-rays of having broken ribs. It is apparent that Mr Bramich also had a fractured sternum, which did not show up on any of the x-rays or CT scans which were taken.[29]

87. On 28 July 2004 Mr Bramich was returned to the ICU after collapsing and reporting pain and difficulty in breathing.

88. It was subsequently revealed that he had severe into the lung, and that the intercostal catheter which had been placed to drain fluid from his lungs had not been working properly. Dr Woodruff has attributed Mr Bramich's death to a failure on behalf of the team to monitor his health appropriately. He notes that, in the absence of a major arterial injury, which was not revealed in the post-mortem, the only explanation for the death was that the drain had not worked.

89. After Mr Bramich was returned to the ICU, there were attempts to arrange a transfer. There were allegations made that Dr Patel had stopped the transfer so that the patient could be treated in Bundaberg. This does not appear to have been supported by the other doctors who were involved at the time, including Dr Carter.

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28 Woodruff report, page 34-35.
29 Refer evidence of Dr Ashbury

90. It appears that by the stage when a transfer to Brisbane was being considered, the patient's condition was too unstable.

91. The death of Mr Bramich precipitated the complaints by Ms Hoffman. There were two forms filled out in relation to aspects surrounding Mr Bramich's death. The first was an adverse event form relating to the failure of the ICC drain. This was filled out on 28 July 2004. It was submitted by Ms Fox, and reported through Ms Hoffman.

92. Some days later, Ms Hoffman filled out a sentinel event form in relation to the death of Mr Bramich. Mr Bramich's death was also reported to the coroner. A significant concern for the Commission should be the role of Dr Gaffield in the treatment of Mr Bramich.

93. Following the concerns expressed at the death of Mr Bramich, appropriate intervention would have been a multi-disciplinary team review of the circumstances. External peer review of Dr Patel was required. The death of Mr Bramich gave rise to serious concerns about clinical care.

94. On 20 August, 2004 a complaint was received in respect of Patient P127. The complaint form was received by DQDSU on 20 August, 2004. The complaint was in respect of wound dehiscence and was referred to the next surgical Errormed meeting.

95. On 8 October, 2004 Linda Parsons complained to Dr Kees Nydam about the conduct of Dr Patel and Dr Boyd. Details of Ms Parson's complaint are contained her statement and evidence.

96. On 11 October, 2004 Terry Bellamy underwent surgery performed by Dr Patel. The surgery was in respect of a right inguinal hernia. Mr Bellamy gave evidence that he saw Dr Patel for an assessment and he booked him in for surgery on the same day. Dr Patel advised him it was a large hernia and would be basic surgery and he should be back at work within two weeks.

97. After the surgery Dr Patel advised that he had severed the right vas. The discharge summary noted that the right vas was accidentally severed. Dr Patel advised Mr Bellamy that he had a 50/50 chance of having children in the future.

98. Mr Bellamy had serious ongoing pain and impairment of movement. He required further surgery on 3 December, 2004 after an ultrasound showed a build-up of fluid. On 9 December, 2004 he required further surgery which involved an incision and drainage to reduce the scrotal haematoma. He was unable to work for four months.

99. On 6 May, 2005 he saw Dr De Lacy at the Mater Hospital in Bundaberg. On 1 June, 2005 Dr De Lacy was able to perform two procedures and remove the mesh that had been placed by Dr Patel. A new mesh was inserted.

100. Dr Keating and others in administration at the Bundaberg Hospital were unaware of this incident.

101. On 20 October, 2004 Ms Hoffman wrote to Mr Leck. Various statements and a copy of her concerns were emailed to Mr Leck on 22 October, 2004[30]. A copy of this email was forwarded to Dr Keating.

102. On 29 October, 2004 a further adverse event was lodged in respect of Dr Patel. Patient P15 underwent a laparoscopic calycectomy. Surgery was performed by Dr Patel on 26 October, 2004 and is generally recognised as being a straightforward procedure. Following the surgery the patient became "tachycardic, sweaty – abdo. distended".

103. Di Jenkin, a respected and experienced nurse, completed an adverse event report form that was delivered to DQDSU on 29 October, 2004. She specifically raised "surgical technique" as being in question.

104. The complaint was referred to the Errormed Committee. This committee was chaired by Dr Patel.

105. On 20 September, 2004, Marilyn Daisy underwent a left below knee amputation. She was quite unwell at the time and this was a lifesaving procedure[31]. The surgery was conducted by Dr Patel and he was primarily responsible for her management. Because she was, however, a patient with Diabetes and therefore a renal patient, there was some confusion as to the responsibility for the patient's management.

106. Dr Jason Jenkins examined Ms Daisy on 1 November, 2004. In correspondence of 2 November, 2004 to Dr Miach he stated:

> *"I was astounded when I discussed with P52 about when did she have her left below knee amputation and I understand she was quite unwell at the time and this was a lifesaving procedure, but this was performed on 20.09.2004, it is now 01.11.2004 and she still has sutures in her amputation stump some six weeks following the procedure. These sutures were heavily buried within the tissue and very difficult and painful to remove. I find it mind boggling that someone could leave sutures in for this long. It either shows a complete lack of understanding of diabetic disease and how to perform an amputation. I also find it strange that a surgeon that does the surgery has not seen the patient since the operation and to monitor the fact that the patient has an area of necrosis in the amputation stump which will require further debridement. Continued saline dressings are not going to heal this lady's amputation stump".*

107. Dr Miach provided a copy of this correspondence to Dr Keating on 8 November, 2004[32]. Dr Keating spoke to Dr Patel and asked him what happened. Dr Patel acknowledged that there had been a heated debate about who was caring for the patient and that the care had been taken over by Dr Miach. He was unsure as to who was responsible for the follow-up.

108. Dr Patel could not explain why the patient had not been followed-up and reviewed earlier. He acknowledged that it should not have happened but also said that the medical team had not sought a surgical follow-up.

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30 Exhibit 4, Statement of Toni Hoffman, paragraph 125.
31 Report of Dr Jason Jenkins, 2 November, 2004, Exhibit 17.
32 Exhibit 448, paragraph 198.

109. The history of this patient again underscored serious concerns about Dr Patel's clinical judgement and his ongoing relationships within the hospital.

Evidence of Ms Hoffman

110. Ms Hoffman first raised concerns about the scope of surgery performed by Dr Patel at the Bundaberg Hospital in June 2003. On 18 June 2003 she emailed the then Director of Nursing, Glennis Goodman, regarding the patient P18 who had had an oesophagectomy performed by Dr Patel. Further, the next day on 19 June 2003 Ms Hoffman emailed Dr Keating and indicated quite clearly her view that this type of operation should not be performed at the Bundaberg Base Hospital. She specifically stated "*I believe we are working outside our scope of practice, for a level one intensive care unit*".[33]

111. Ms Hoffman became aware in around February 2004 of the directive by Dr Miach that his patients were not to be operated on by Dr Patel.[34]

112. In February 2004 Ms Hoffman, who was acting as director of nursing for a period of three weeks had a meeting with the District Manager Mr Leck and gave him a document headed "*ICU Issues with Ventilated Patients*".[35] According to Ms Hoffman this was essentially the same document as that which she gave to Mr Leck in October that year. It quite clearly raised concerns about the appropriateness of conducting complex procedures at the Bundaberg Hospital. Ms Hoffman indicated that she did not want Mr Leck to act on the information. It contained serious allegations however including the following:-

> "*My concern that the personal beliefs of Dr Patel concerning the types of patients he can care for here, actually endangers the lives of the patients as these patients that would be transferred to Brisbane are not being transferred early enough.*

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33 The emails by Ms Hoffman re patient P18 (Mr Graves) are attachments TH2 and TH3 to exhibit 4

34 Para 48 of exhibit 4

35 Para 50 and attachment TH10 to exhibit 4

A secondary concern of mine is the level of surgery which is performed that should only be performed in a tertiary hospital."

113. Ms Hoffman raised concerns about Dr Patel formally after the death of patient P11 - Mr Bramich. Ms Hoffman completed a sentinel event form. In relation to Mr Bramich Ms Hoffman states (at para 86 and 87) that she attached the earlier document she had prepared about issues with ICU patients to the sentinel event form regarding Mr Bramich.

114. Ms Hoffman asserted that after the death of Mr Bramich, she spoke to Dr Martin Strahan who made inquiries about Dr Patel and concluded that "*there is widespread concern, but no one is willing to stick their neck out yet*".

115. Ms Hoffman met with Mr Leck and Ms Mulligan on 22 October 2004 and formalised her concerns about Dr Patel. She provided Mr Leck with a copy of the document regarding her concerns with ICU patients.

116. The reporting of the sentinel event about Mr Bramich and the meeting between Ms Hoffman and Mr Leck and Ms Mullian on 22 October 2004 led to separate investigations about the clinical practices of Dr Patel. It appears that it became fairly quickly known around the hospital that there was an investigation going on.

117. Ms Hoffman became somewhat frustrated by the apparent lack of progress of these investigations, and went to the local member of parliament, Mr Messenger MP. It was only following Mr Messenger's intervention that the matters of concern about Dr Patel became public.

Kemps and Patient P26

Patient P21 - Gerard Kemp

118. Mr Kemps was born on 19 September 1933 and died on 21 December 2004 after Dr Patel performed an oesophagectomy.

119. Mr Kemps was first seen by Dr Smalberger in December 2004. Dr Smalberger conducted an endoscopy that revealed a large mass at

the gastro-oesophageal junction[36]. A biopsy revealed that the mass was malignant.

120. Dr Smalberger arranged for CT scans of the patients chest and abdomen. The CT scans revealed that the cancer was metastatic, with evidence of enlarged lymph nodes and lesions on the patient's lung (T1962). See also ex.131, which is the report of the CT scan of Mr Kemps.

121. Dr Clamberer stated the following in his statement (at para 5):-

> *"I was firmly of the view that the patient needed to be transferred to Brisbane. I considered that the best further management of the problem was likely to be a combination of the use of a stent (to keep the oesophagus open) and/or radiation and/or chemotherapy."*

122. Dr Smalberger arranged for one of his junior doctors to refer the patient to the Department of Surgery in order to obtain the necessary support for the patient to be transferred to Brisbane.

123. Dr Smalberger was not consulted any further. He states that he was informed later that Dr Patel had carried out an oesophagectomy and that the patient had died.

124. Dr Deter Berens, an anaesthetist at the Bundaberg Hospital gave evidence about the conduct of the operation on Mr Kemps by Dr Patel.[37] Dr Berens concedes in his statement that, as the anaesthetist, it was not possible to watch how the surgery was going. However he describes that during the operation, there was considerable bleeding and that the patient became unstable at times. At paragraph 17 of his statement, Dr Berens describes that after Dr Patel had completed the resection of the oesophagus, which was the second part of the operation, there was still considerable bleeding. He raised the issue with Dr Patel, however Dr Patel indicated that he did not think that the patient needed to be opened up again. He describes that the patient needed transfusions to keep his blood volume and

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36 Statement of Smallberger paragraph 4.
37 Exhibit 128 and T1935.

blood pressure up, and that it was clear that there was a lot of bleeding.

125. Dr Berens describes that Dr Patel went away and did other operations for a period of approximately 4 hours. Mr Kemps was taken back to theatre, and Dr Patel tried to locate the source of the bleeding. Dr Patel was unable to locate the source of the bleeding, and then concluded that there was nothing more that could be done. He completed the operation and sent the patient back to intensive care, where he died 12 hours later.

126. At paragraphs 22 to 24 of his statement, Dr Berens describes having reported his concerns about the treatment of Mr Kemps to Dr Carter, and subsequently Dr Keating. There was discussion about referring the death to the coroner, however it was decided that it was too late to refer the matter to the coroner by the time Dr Berens and Dr Carter had met with Dr Keating, which was on 23 December 2004.[38] The matter was not referred to the coroner, apparently because of concerns that the funeral was about to be held, or had already been held. According to Dr Berens, Dr Keating gave an assurance at that meeting that Dr Patel would not be doing any more oesophagectomies.[39]

Patient P26

127. This patient was a 15 year old boy who had been seriously injured in a motor cycle accident which occurred on 23 December 2004. He suffered life threatening injuries in the groin area. These involved major vascular injury to the femoral vein and femoral artery.

128. The patient underwent three operative procedures, all of which were performed by Dr Patel in the first 24 hours after he was admitted to hospital. The first was a repair of the femoral vein. The femoral vein was ligated. Dr Patel recorded in the clinical notes that the femoral vein had been repaired.

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38 T1942
39 T1956

129. Dr Patel did a further operation to repair the femoral artery. The third operation involved the carrying out of fasciotomies.

130. The patient was not transferred to Brisbane, despite the severity of his injuries, and despite the fact that there was no vascular surgeon available in Bundaberg at the time. (The only vascular surgeon in Bundaberg was Dr Thiele, who was away on holidays). The patient stayed in the Bundaberg Hospital until 1 January 2005 when he was transferred down to Brisbane. By that stage his leg was not salvageable, and he was required to undergo an amputation.

131. There is differing medical opinion as to whether the patient's leg could have been saved had he been transferred earlier. It is submitted that this is not a matter upon which the Commission should make any finding.

132. There appears to be no disagreement that the treatment of the patient was substandard, and in particular, that the patient should have been transferred to Brisbane considerably earlier.

133. The surgery performed by Dr Patel saved the patients life in the first instance. However, it was not a permanent solution, and the patient should have been transferred to Brisbane for specialist vascular surgery. Dr Jenkins describes at paragraph 16 of his statement (which is exhibit 254) that Dr Patel had ligated the femoral vein and the other end of the vein had actually retracted up inside the abdominal cavity and thrombosed. This meant that the blood could not return from the extremities of the limb through the vein.

Contract Renewal and Subsequent Events

134. By 24 December, 2004, Mr Leck had sought assistance from Queensland Health in respect of an investigation into the conduct of Dr Patel. Since the complaint by Toni Hoffman of 22 October, 2004, Dr Keating and Mr Leck had met with Dieter Berens, David Risson and Martin Strahan to discuss complaints about Dr Patel. Serious

concerns were raised in the discussions with those three doctors, although the ultimate conclusions were uncertain.

135. On 5 November, 2004 Mr Leck and Dr Keating meet to discuss an investigation into Dr Patel. Mr Leck considered that it was appropriate to have an external investigation. He subsequently contacted Dr Mark Mattuissi with a view to obtaining appropriate candidates for an investigation.

136. Subsequent investigations during the course of December by Mr Leck led to an arrangement with Dr Gerry Fitzgerald who conducted an investigation into Dr Patel early in the New Year.

137. Following the surgery involving Mr Kemps, Dr Keating offered Dr Patel an extension of his contract from 1 April, 2005 to 31 March, 2009. During the course of that process, he completed form to be delivered to both the Medical Board and the Department of Immigration. These forms indicated that Dr Patel's performance was "better than expected". His emergency skills, procedural skills, teamwork and college were "consistent with his level of experience" and his professional responsibility and teaching was "performance exceptional". Dr Keating made these statements to the relevant authorities, despite the cloud that was looming over the head of Dr Patel at the time. On any version of events, the assertions were simply not correct.

138. In early January, 2005 Dr Keating advises Patel that there are to be no more oesophagectomies performed at the hospital. Further complaints were received from the nurses at that time.

139. By mid-January, 2005 the investigation by Dr Fitzgerald was being organised. On 14 January, 2005 Dr Patel advised that he was not renewing his contract as Director of Surgery.

140. On 20 January, 2005 Dr Keating sought Mr Leck's approval to extend Dr Patel's contract to June/July, 2005. Mr Leck agreed. On 2

February, 2005 Dr Patel was offered the position of temporary full-time Locum, General Surgeon for the period 1 April, 2005 to 31 July, 2005.

141. On 14 and 15 February, 2005 Dr Fitzgerald and Sue Jenkins attended in Bundaberg to undertake their investigations. During the course of that investigation, they were advised that there were no patient complaints against Dr Patel. Dr Keating seeks to explain this omission by stating that he believed Dr Fitzgerald was interested only in "legal claims" not patient complaints. This is clearly inconsistent with the evidence of Dr Fitzgerald.

The Release by Messenger

142. Ms Hoffman gave evidence that, after the announcement by Dr Patel that he had had his contract extended, Ms Hoffman decided to contact Mr Rob Messenger MP, the member for Burnett. Ms Hoffman went to see him on 18 March 2005 and discussed her concerns. She provided Mr Messenger with a copy of the complaint which she had given to Mr Leck in October 2004 headed "*Issues to do with ventilated patients*".[40]

143. Mr Messenger tabled the letter from Ms Hoffman in parliament on 22 March 2005, and further mentioned the matter in parliament on 24 March 2005.

The Meeting of 7 April 2005

144. Mr Nuttall and Mr Buckland attended at the hospital on 7 April 2005 to meet with staff. According to Dr Buckland the purpose of the meeting was "*to fundamentally reassure the staff of [the Minister's] total support for them*".[41] Dr Buckland conceded that "*what came out of that meeting was a very clearly different message and what we found on the ground. I have to say in all honesty when we went in there we did not expect the sort of response that we - that we received, and it*

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40 Paragraphs 160-162, exhibit 4
41 T5504

was very clear then there was a lot more to that than we had briefed."[42]

145. Dr Buckland conceded that he told the meeting that the audit process conducted by Dr Fitzgerald would be difficult to finalise as natural justice had not been afforded to Dr Patel.

Concerns of other Staff at the Bundaberg Hospital

146. There was widespread knowledge within the hospital about the concerns about Dr Patel's surgical practice. Most particularly, there was widespread concern about the conduct of certain operations at the hospital, and there was knowledge that Dr Miach had refused to allow his patients to be treated by Dr Patel.

147. Dr Miach himself gave evidence about his various concerns about Dr Patel and his surgical competence dating back to at least mid 2003. From early 2004 Dr Miach refused to let Dr Patel treat his patients.

148. Numerous staff gave evidence that they had heard about concerns about Dr Patel's surgical practice, and in particular that Dr Miach had refused to let his patients treat them.

149. Dr Berens in his statement (exhibit 1-8) at paragraph 6 says that he "*had some general misgivings about Dr Patel soon after I commenced working with him. I formed the view that, whilst he was quite efficient in certain procedures, his medical knowledge generally was not up to date.*" Further at paragraph 11 he states as follows:-

> "*I was aware that, right from the beginning of my time at the Bundaberg Base Hospital, ICU staff have not been happy with Dr Patel. This has been well known through the hospital. I became aware at some point in 2004 that Dr Miach would not allow Dr Patel to operate on his patients. He did not tell me directly. I heard it on the "grapevine". I was told by Dr Strahan in early 2005 that Dr Strahan would prefer that Dr Patel did not operate on his patients.*"

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42 T5505

150. Dr Strahan gave evidence that he knew in the first half of 2004 about the concerns about Dr Patel's clinical practice. Dr Strahan was aware that Dr Miach did not have a very high opinion of Patel's competence as a surgeon. He was also aware that Dr Miach had given a direction that Dr Patel was not to operate on his patients.[43]

151. Dr Kariyawasam was made aware shortly after he started about the concerns about the high rate of infection and wound dehiscences by Dr Patel.[44] He further stated that he was made aware that Dr Miach was not using Dr Patel for catheter placements, but that he put this down to personality differences between Dr Miach and Dr Patel.[45]

152. Dr Boyd was aware through "*talk in the corridor*" that Dr Miach was refusing to send patients to Dr Patel.[46] He also was aware through "*talk in the corridor*" about the concerns of the ICU about Dr Patel.

153. Dr Carter states that he eventually became concerned about esophagectomies being performed at the hospital after the death of Mr Kemps. He noted that Dr Patel had performed six esophagectomies and five of those patients had died. Dr Carter stated that his review of the literature informed him that 90% of patients should survive at least one year after an esophagectomy.[47]

154. Dr Carter's view remains that Dr Patel was not the worst surgeon which they had had in the hospital.

Training and Support

155. A consistent theme throughout the evidence of staff from the Bundaberg Base Hospital is that the training provided to them in relation to the policies to be observed at the hospital was completely inadequate.

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43 T3279
44 T3109-3110
45 T3110
46 T3878
47 Paragraph 51 of exhibit 265

156. Most tellingly, Dr Keating was provided with no orientation or training when he commenced his employment at the hospital. Dr Keating had no previous experience within the Queensland Health system, and so had presumably little knowledge of the various policies and legislative guidelines that regulate health practice in this State.

157. This experience was consistent with evidence of other witnesses who were previously staff at the hospital.

158. Dr Boyd gave evidence that he had never received any training about the adverse event reporting process.[48]

159. Dr Kariyawasam gave evidence that he received no formal training about referral of matters to the coroner, but relied upon what he had read, and was not able to attend any of the training sessions about adverse event and sentinel event reporting.

160. Dr Anathasiov gave evidence that when he commenced at Bundaberg Hospital he had two mornings of introductory sessions which were general in nature, but could not recall being told about adverse events, sentinel events and the complaints procedure within the hospital.[49]

Adverse Event and Sentinel Event Reporting

161. The Bundaberg Base Hospital had, from at least February 2004, a dedicated and specific policy on reporting of incidents that were of clinical concern. The hospital had a separate unit, the District Quality and Decision Support Unit (DQDSU) which coordinated and recorded the recording of adverse events, and also recorded complaints made to the hospital.

162. The evidence in relation to this policy within the hospital was provided by Leonie Raven[50] and Jennifer Kirby[51].

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48 T3873
49 T2050
50 Exhibit 162
51 Exhibit 169 and Exhibit 170

163. Ms Raven gave evidence about the policy of the Bundaberg Hospital in relation to the reporting and recording of adverse events. In relation to reporting of adverse events, the relevant policy which applied from 1 June 2004 is included as attachment LTR4 to her statement. That policy provided for the reporting of incidents which "*could have, or did lead to unintended and/or unnecessary harm to a person, and/or a complaint, loss or damage*". The purpose of the policy was to ensure that events which did or could have caused harm to a patient were reported so as to prevent their reoccurrence. The focus of the policy was on continuous learning and improvement, rather than investigation of breaches for this purpose of disciplinary or other action.

164. The procedure for reporting and dealing with adverse events is detailed at page 3 of the policy. It requires reporting of the adverse event by the staff member who was involved or discovered the adverse event. Their report is then forwarded to the DQDSU where it is risk rated and dealt with appropriately. The investigation will recommend any changes to the procedure or further training or counselling which may be required. The Bundaberg Hospital policy on adverse event reporting specifically embraced the concept of "*open disclosure*" to patients.[52] This required the hospital to give the patient and/or their family an explanation of what happened, an outline of steps taken to manage the event, an expression of regret, and information about how to make a formal complaint.

165. The hospital also had a policy on the reporting of sentinel events. This policy was consistent with the policy implemented across Queensland Health throughout the State. The original policy was effective from 1 June 2004.[53] The policy was revised, and the revised policy commenced on 1 November 2004.[54]

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52 See page 4 of the Policy
53 See LTR6
54 See LTR7

166. A "*sentinel event*" is described in the policy as "*an incident in which serious harm resulted to a person receiving health care*". In particular the definition of what is a sentinel event reflected the definition provided by the Australian Council for Safety and Quality in Health Care. It is included at page 2 of the policy.

167. When a sentinel event was identified, there was a requirement for immediate notification to the District Manager, the Director of Medical Services or the Director of Nursing. The procedure required a detailed investigation, referred to as a "*Root Cause Analysis*". Again, the policy required open disclosure with the patient and/or their family.

168. The policy was changed in November 2004. Under the revised policy, the District Manager was required to notify the Director General via the Secretariat, Risk Management Advisory Group immediately of any sentinel event notification report.

Requirements of the *Coroners Act 2003*

169. The *Coroners Act 2003* commenced on 1 December 2003.[55] Part 2 of the *Act* imposes the obligation on reporting deaths. In particular s.7 imposes an obligation upon any person who becomes aware of a death that appears to be a "*reportable death*" to immediately report that death to the state coroner.

170. Section 8 of the *Coroners Act 2003* defines "*reportable death*". Section 8(3)(d) provides that:-

> "*A death is a reportable death if:*
>
> *(d) the death was not reasonably expected to be the outcome of a health procedure.*"

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55 See endnotes to *Coroners Act 2003* s.5, and 2003 SL number 296

Terms of Reference

General

The Patient Support Group does not make any specific submission as to findings and/or charges to be laid against particular individuals. This does not mean we do not encourage the Commission to make such findings. Rather, the Patient Support Group puts its faith in the Commission as an independent and impartial body to deliver justice to the patients and their relatives for the conduct of the particular individuals involved.

(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.

171. The Queensland Medical Board failed to discharge its statutory obligations pursuant to the *Medical Practitioners Registration Act*, 2001, to ensure that Patel was both eligible for registration, qualified for registration as a medical practitioner and fit to practice in the profession.

171.1 Patel supplied to the Queensland Medical Board a document entitled "Verification of Licensure" Certificate. The document was issued by the Oregon Board of Medical Examiners. The document included only the first page and omitted an attachment.

171.2 But there was clear reference to the attachment in the body of the document. The body of the document indicates that there

was a *"Public order on file. See attached".* The attachment included a passage:

> *"An amended stipulated order was entered on 12 September 2000. The order restricted licensee from performing surgeries involving the pancreas, liver resections and ileoanal reconstructions."*

171.3 Further investigation into Patel's qualifications would have revealed:

171.3.1 The New York State Board for professional medical conduct disciplined Patel in 1984 for entering patient histories and physicals without examining patients, failing to maintain patient records and harassing a patient for co-operating with the New York Board's investigation. The New York State Board for Professional Medical Conduct ordered a six month license suspension with a stay, three years probation and a fine on each charge;

171.3.2 Further, Patel's license to practice in New York was surrendered due to disciplinary action arising from the September, 2000 proceedings in Oregon. The surrender occurred on 10 May, 2001 and by consent his name was struck from the Roster of Physicians in New York State.

172. Proper investigation of Patel's application should have included careful consideration of all relevant documents, including the Oregon Medical Board "Verification of Licensure" certificate. Had the Medical Board properly investigated the application, the restriction on practice is likely to have been discovered and Patel would not have been registered. In particular, it is difficult to contemplate that Patel would have been registered in circumstances where he had been dishonest on his application to the Queensland Medical Board for registration in the first instance.

172.1 The failure by the Medical Board to discharge its statutory obligations in this instance are particularly significant in the context of the Berg history. The Commission heard evidence that a person named Berg, who was registered and practiced at Townsville as a Psychiatrist, was not so qualified. Berg treated patients and prescribed medication.

172.2 The process of Berg through the Queensland Medical Board and the Board's failure to identify his lack of qualifications (and fraudulent application) should have alerted them to the necessity to carefully check the qualifications of persons seeking registration in Queensland.

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

173. Patel should not have been permitted to conduct surgery on, give medical advice or administer medical treatment to any patient in Bundaberg (or elsewhere) without having undergone appropriate credentialing and privileging and without having been appropriately qualified. Patel should not have been permitted to supervise, train or otherwise oversee the surgical department or any other medical practitioner without being adequately credentialed and privileged.

173.1 Wavelength Consulting failed to carry out adequate checks to determine the full extent of Patel's qualifications and any restrictions on his practice. The records from the Oregon Board of Medical Examiners, included by Patel in his application for employment, clearly indicates that there was a "*Public order on file. See attached*". Wavelength Consulting failed to investigate this matter.

173.2 Additional failures by Wavelength Consulting include the failure to notice the alteration in the CV (acknowledged by Wavelength

as a potential concern for the Medical Board) and the failure to adequately screen the referees.[56]

173.3 The Queensland Medical Board, in failing to adequately investigate the application, also failed in its obligations as described in the preceding paragraph.

173.4 Queensland Health and the Bundaberg Hospital, in failing to adequately investigate Patel's qualifications, also failed in their obligations to the patients.

173.5 It is readily conceded that had Patel's qualifications been adequately investigated, and the true nature of his surgical restrictions revealed, he would not have been employed at the Bundaberg Base Hospital. Had that been the case, he would not have been conducting surgery on any patients whatsoever.

173.6 The Bundaberg Base Hospital and the State of Queensland held out Patel as an adequately qualified and competent General Surgeon. Although he may have been capable of performing some surgical procedures, for the most part, there is serious doubt as to his surgical competence.

173.7 No patient in Queensland should have been operated on nor received medical treatment from Patel. Surgical procedures, advice, medical treatment, supervision and training carried out by him were carried out as a direct consequence of the negligence of Wavelength Consulting, the State of Queensland, the Medical Board and the Bundaberg Base Hospital. Any adverse outcome for a patient, whether a patient can prove it was as a consequence of the *negligent* conduct of Patel or simply as a result of his participation in the treatment, occurred as a consequence of the conduct of the abovementioned parties and the placement of Patel at the hospital.

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56 Refer in general paragraph 24 above.

173.8 No patient could have (or would have) consented to surgery or treatment conducted by Patel had they known the true facts. The risk of an adverse outcome with a practitioner such as Patel must have been significantly higher than the risk a patient would ordinarily face with a reasonably competent and skilled practitioner. The responsibility for any adverse outcome rests with Queensland Health, the Queensland Medical Board, the Bundaberg Base Hospital and Wavelength Consulting as a consequence of the negligent conduct.

173.9 The Patient Support Group does not seek specific findings from the Commission in respect of individual cases. Such findings would require the Commission to descend to detail in circumstances where the medical evidence may not have been fairly tested by reason of access to information by the various medical practitioners and/or the availability of evidence at the particular time that a witness was before the Commission.

173.10 Moreover, the Commission should recognise in a broad way that many patients suffered significantly adverse outcomes as a consequence of the surgical treatment, advice, medical treatment and supervision of Patel. These adverse outcomes would simply have been avoided had Patel not been employed, registered to practise and appointed to the Bundaberg Base Hospital.[57]

173.11 The specific findings in respect of individual patients are recorded in the evidence of Dr's O'Loughlin, Woodruff, De Lacy and Allsopp.

174. Patel's surgical skills, clinical judgement and clinical competence were significantly below the standard to be expected of a competent and skilled surgeon.

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57 See *Chappel v. Hart* (1998) 195 CLR 232.

174.1 The evidence of Dr De Lacy and Dr Woodruff demonstrates that the surgery conducted by Patel was significantly below the standard expected of a competent and skilled surgeon.

174.2 The appointment of Patel, without supervision, placed him in a position whereby the quality of his surgical and clinical skills was difficult to assess. Moreover, the appointment of him as Director of Surgery placed him in a position where he was free to exercise his skills recklessly.

(b) (ii) The employment of Dr Patel by Queensland Health.

(iii) The appointment of Dr Patel to the Bundaberg Base Hospital.

175. Queensland Health and the Bundaberg Base Hospital failed to adequately investigate Patel's qualifications. The credentialing and privileging procedure was not undertaken. The obligation to "check" Patel's references and qualifications was simply delegated to Wavelength Consulting. The failure to adequately investigate his qualifications resulted in the exposure of patients to a practitioner who lacked appropriate qualifications. This consequence can be attributed to cumulative failures by Wavelength Consulting, the Queensland Medical Board, Queensland Health and the Bundaberg Base Hospital.

175.1 Queensland Health and the Bundaberg Base Hospital were prepared to rely on the Medical Board and Wavelength Consulting for the assessment of Patel's credentials. Although reliance, to some extent, was reasonable, the ultimate responsibility must rest with Queensland Health and the Bundaberg Base Hospital for employing Patel in these circumstances.

175.2 Patel should not have been appointed as Senior Medical Officer without supervision.

175.3 Despite the fact that, on the face of it, Patel was an experienced and competent surgeon, it was inappropriate to appoint him to a regional hospital without supervision as a Senior Medical Officer or as Director of Surgery.

175.4 Both Patel and Dr Gaffield's practical skills were unknown. Both should have been subjected to a period of supervision prior to ultimate appointment.

176. Patel should have been supervised after his appointment as a Senior Medical Officer. In the absence of credentialing and privileging, his skills and capacity as a practitioner were essentially unknown. Appropriate supervision should have been in place.

176.1 Patel was appointed as a Senior Medical Officer. His qualifications and his skill as a surgeon and clinician, irrespective of his experience, were relatively unknown.

176.2 In Bundaberg, Patel was exposed to a wide and diverse range of circumstances. As Director of Surgery, he had significant access to patients and was ostensibly entitled to perform complicated procedures and administer and supervise complex medical treatment.

176.3 Patel should have been carefully supervised at all times at the Bundaberg Hospital until such time as an appropriately qualified surgeon was satisfied that he had the skills to continue to operate.

177. Patel should <u>never</u> have been appointed to the Director of Surgery position.

177.1 Patel was appointed to the Director of Surgery position within days of arriving at the Bundaberg Base Hospital. Various explanations have been given as to why that appointment was made. Dr Nydam stated that he considered that it was largely

an "administrative" position. Mr Leck agreed with this assessment.

177.2 Both of these statements ignore the reality that the Director of Surgery had significant administrative control, supervisory responsibility and clinical roles within the hospital. The training and supervision of the junior staff and his position at the "Errormed" meetings meant that he played a pivotal role in the assessment of his own mistakes.

177.3 Moreover, this dismantling of the Otago audit system by Patel was a good example of the significant impact he might have on the clinical auditing and processes at the hospital. The suggestion that his role as Director of Surgery was essentially "administrative" also ignores the fact that he had a significant supervisory role *and was not supervised himself*.

177.4 In November, 2002 the District Manager had, in Dr Jayasekera, a qualified, credentialed and college approved surgeon to take on the position of Director of Surgery. Irrespective of whether he intended to take the position as a permanent place, he should have been appointed to the position.

178. Patel should have been credentialed and privilege in accordance with the Queensland Health procedures.

178.1 The credentialing and privileging procedures at the Bundaberg Base Hospital fell into disarray during the course of 2002. The major concern was the lack of available college representatives to assist in the credentialing and privileging process.[58]

178.2 The net result was that practitioners were undertaking medical procedures without adequate credentialing and privileging. As described in the body of this submission, there were several points during the course of Patel's tenure where he should have

58 Refer to paragraph 34 above.

been credentialed and privileged. The failure to do so was a fundamental error on behalf of the management of the Bundaberg Base Hospital.

178.3 Moreover, Mr Leck was ultimately responsible for credentialing and privileging Patel. As each complaint evolved, particularly those of Ms Hoffman in early 2004, the *only* step that Mr Leck could take (beyond suspension or refusing contract renewal) for Patel was to credential and privilege him. The issues raised by Ms Hoffman were precisely the issues that credentialing and privileging would address: the relevant skills of the doctor in question and the capacity of the hospital to deal with relevant surgical procedures.

178.4 The credentialing and privileging of Patel is likely to have significantly restricted his ability to perform certain surgery.

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

179. Staff and management at the Bundaberg Base Hospital failed to comply with legislative and policy requirements in respect of the reporting of complaints, adverse events and sentinel events.

179.1 There was a failure to adequately deal with the sentinel events. This is exemplified in the cases of Bramich, Kemps and Phillips. There was also a failure to report those deaths in accordance with the obligations under the *Coroner's Act*. None of the deaths of the patients mentioned could have been said to have been "reasonably expected to be the outcome of a health procedure". Each of the deaths should have been reported to the Coroner.

179.2 The reporting system for adverse events was clearly inadequate. For example, Patient 15. The adverse event was reported by Di Jenkin to Dr Keating. Thereafter, Dr Keating referred the matter to the Errormed Committee, chaired by

Patel. Patel regularly sat as Chairperson on meetings that judged or assessed his own conduct.

179.3 Moreover, many adverse events and complaints were simply dealt with on an *ad hoc* basis by Dr Keating and not systematically recorded or collated. Although this has now been remedied to some extent, the reality was that at the time that Dr Fitzgerald came to carry out his audit, the main repository for the complaints relating to Patel was Dr Keating. His failure to disclose the patient complaints meant that Dr Fitzgerald was not aware of them.

180. The complaints, adverse events and sentinel events reporting systems in place at the Bundaberg Base Hospital in April 2003 were inadequate.

180.1 The systems in place at the Bundaberg Base Hospital in April 2003 did not adequately track and lodge complaints.

180.2 The complaints system included a system to monitor complaints by staff (incident reports) and to monitor complaints by the public.

180.3 The complaints and adverse events system as currently in place is adequate, provided that complaints are adequately monitored, tracked and taken seriously.

181. The conduct of Mr Leck and Dr Keating in respect of complaints made by staff and patients was unsatisfactory.

181.1 Ms Hoffman complained on several occasions in respect of various matters related to Dr Patel. Parallel complaints were also being made by other nurses in the Renal Unit and by other doctors.

181.2 An obvious response to the complaint was to have an external review at an early stage. The Woodruff report identifies this as

a sensible and adequate response. Despite the many opportunities that should have been taken to have such a review, Dr Keating and Mr Leck continued to ignore these complaints.

181.3 Had the complaints been taken seriously, it is likely that Patel would have been significantly restrained in the conduct of surgery.

(b) (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 (iv) above.

182. The Bundaberg Hospital Patient Support Group relies upon the submissions made by the Queensland Nurses Union in respect of these matters.

(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 Bundaberg Base Hospital or other Queensland public hospitals raised at the Commission of Inquiry established by a Commissions of Inquiry Order (No. 1) of 2005.

(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 Bundaberg Base Hospital; and

(ii) outside the Bundaberg Base Hospital.

183. The failure by the Bundaberg Base Hospital to adequately deal with complaints made by patients is dealt with under Terms of Reference *(b)(iv)* above.

184. The investigation by Dr Fitzgerald failed to adequately identify and respond to the significant concerns that were being expressed by staff. The lack of credentialing and privileging, the failure to adequately check his qualifications and the failure by the Bundaberg Base Hospital management to adequately manage the complaints and the conduct of Patel were clearly matters that needed urgent attention.

185. The conduct by the management of the hospital and the hierarchy of Queensland Health following the disclosure of these matters reflected a culture of "tolerating problems rather than addressing them"[59].

185.1 Following the disclosure to Mr Messenger of the correspondence from Toni Hoffman in March of 2005, the major focus of the hospital was not the serious allegations against Dr Patel, but the leaking of information. This simply served to further polarise the views in respect of Dr Patel rather than give serious consideration to investigating his qualifications and surgical competence.

185.2 Thereafter, the conduct by Mr Buckland, Mr Nuttall and hospital administration at the meeting of 7 April, 2005 was to further polarise staff and send a clear message that these complaints were not to be investigated and dealt with appropriately, but rather to be simply brushed aside. This approach would not encourage other persons to come forward in the future and make complaints about conduct that they considered to be seriously detrimental to patients.

186. The patients are to be compensated in accordance with the package which is not limited by the Scale of General Damages promulgated pursuant to the *Civil Liability Act*, 2003. This arrangement reflects the unsatisfactory state of the law where persons who suffer serious injury are not fairly and justly compensated under the Civil Liability Scale of General Damages.

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59 Woodruff report, page 44.

186.1 The Civil Liability Scale of General Damages was promulgated by the *Civil Liability Act*, 2003. The Scale of General Damages significantly limits the entitlement of injured persons to claim damages for pain and suffering and loss of amenities and other heads of damage.

186.2 In cases involving medical negligence, where an injury may be of a relatively transient nature, but nonetheless be very significant and painful, are very poorly compensated under the Civil Liability Scale of General Damages.

186.3 The State of Queensland indirectly recognises, by acknowledging that the Scale of General Damages should not apply to these claims, that the Scale of General Damages is fundamentally unfair and unjust. The Scale of General Damages and other restrictions on the right to recover damages imposed by the *Civil Liability Act*, 2003, should be abolished.

DATED this 26th day of October 2005

Carter Capner

CARTER CAPNER

Solicitors for the Bundaberg Hospital Patient Support Group

Submissions

Ms Wendy EDMOND

SUBMISSIONS ON BEHALF OF MRS. WENDY EDMOND

PREAMBLE

1. Mrs. Edmond has received Notice informing her that the Commission is considering whether its report should make adverse findings about her conduct.

2. The Commission is, of course, in a very powerful position. The contents of the report could severely harm Mrs. Edmond's reputation.

3. At the outset, I respectfully remind the Commission that its power to inquire and report is not unlimited. The power is circumscribed by the Terms of Reference.

4. The Terms of Reference clearly do not extend to Mrs. Edmond. Term of Reference (f), the clarification of Term of Reference (c), makes that plain. It follows that the only basis upon which it is thought that Mrs. Edmond could be adversely mentioned in the report is as a corollary of or incidental to adverse findings in respect of persons who do come within the Terms of Reference.

5. Mrs. Edmond is now in retirement. No-one who saw her give evidence before Mr. Morris QC could fail to appreciate that she gave years of industrious and dedicated service to the State.

6. I intend to meet each possible adverse finding in respect of Mrs. Edmond on the merits and urge that no adverse criticism could fairly be made in respect of any of Mrs. Edmond's conduct. However, even if I were unsuccessful in persuading the Commission of this, it remains of critical importance that the Commission only comment adversely in respect of Mrs. Edmond if it is essential to do so within the proper purview of the Terms of Reference. This may involve careful report-writing, but that is part of the Commission's task.

POSSIBLE ADVERSE FINDINGS

The possible adverse findings are dealt with seriatim.

> *"(a) During the period 19 June 1998 to February 2004 when elective surgery waiting lists were published, at your behest as Minister, you took no steps to publicise the specialists' outpatients surgical waiting lists, the outcome being misleading and not reflecting the true nature of surgical waiting time in Queensland public hospitals".*

1. (i) This possible finding is not within the Terms of Reference. This, and all possible adverse findings alleged in respect of Mrs. Edmond, are said to be with respect to Terms of Reference 2(c) and (f).

(ii) Term of Reference (f) is a clarification of Term of Reference (c). Term of Reference (f) pertains to "*current and former employees of the Queensland Department of Health*". Mrs. Edmond was an elected representative and Minister of State.

(iii) This possible finding is a direct allegation against Mrs. Edmond personally: that she took no steps to publicise the anterior waiting lists. It is a potential finding that is not only outside the Terms of Reference, but also it could not conceivably arise as a corollary of or incidental to findings against employees of the Department.

2. (i) The allegation that Mrs. Edmond "*took no steps to publicise*" the anterior lists fails to countenance the full picture disclosed by the evidence.

(ii) Shortly after Mrs. Edmond became Minister, an investigation team was appointed within Queensland Health to assist with management of anterior waiting lists (T4875 L50 – 4883 L10). Mrs. Edmond pointed out in her evidence that collecting data for anterior waiting lists proved far more complex than anyone thought. The data was able to be utilised for problem solving in respect of discrete facilities and the data improved over time (T4877 L40 – 4878 L10). However, the data was never of sufficient quality to enable general publication of anterior waiting lists.

(iii) The allegation that Mrs. Edmond took no steps to publish the anterior lists is ill-founded. The Commission is well aware from the evidence of Mrs. Edmond and, in particular, Mr. Walker, that the data for the anterior lists never reached sufficient quality to permit publication.

(iv) Mr. Walker, who seemed to have been treated by the Commission as a very reliable witness, was repeatedly urged by Counsel Assisting to agree to the proposition that there was no sensible reason not to publish the anterior lists data. Mr. Walker refuted the proposition on no fewer than four occasions (T6181 L1 – 10; L18 – 25; L25 – 32; T6183 L15 - 20), stating:

- that he "*personally would have difficulty in releasing that data …*";

- "*... I would put the rider on it that we need to actually make sure that the data was actually accurate*";

- "*I would suggest that it's*" (surgical waiting list data) "*is much more accurate ...My belief is that that*" (surgical waiting list data) "*is a far more robust data collection than what we're looking at here*";

- "*It could have been*" (disseminated if his "*political masters*" directed him to) "*although once again, I have to say that I would be most concerned about the quality of the data ...*". (emphasis added).

(v) Mr. Walker agreed that a lack of funding stymied improvement of data collection. However, before there is to be any criticism that millions of dollars were not poured into improving this data collection system, priorities for funding must be considered. Everyone agrees that funding was scarce. This Commission is in no position to determine that millions of dollars would have been better spent in this area as opposed to any other area. In addition, Mr. Walker pointed out further difficulties to improving the data collection system at that time. See T6181 L50 – 6182 L35.

(vi) Immediately after Mr. Walker had refuted the proposition by Counsel Assisting that the anterior list data ought to have been published, Counsel Assisting suggested to Mr. Walker that "*Some information is better than no information*". Mr. Walker agreed. One does not know what Counsel Assisting was referring to in this suggestion, nor, more importantly, what Mr. Walker made of the suggestion.

However, clearly, the Commission cannot treat this as some sort of acceptance by Mr. Walker that the anterior list data ought to have been published. Such an acceptance by Mr. Walker would be amazing, he having argued so assiduously as to why the data ought not be published. Further, it would be surprising if Counsel Assisting were advancing the proposition that data, even though it may well be misleading, ought be published to the Public.

It is far more likely that Mr. Walker understood Counsel Assisting's question as relating to the publication of the surgical waiting list.

3. (i) Possible adverse finding (a) further alleges that the outcome of taking no steps to publish the anterior lists was that it was "*misleading and not reflecting the true nature of surgical waiting time in Queensland public hospitals*".

(ii) The allegation does not suggest who might have been misled as to the true nature of surgical waiting time in Queensland public hospitals.

(iii) Term of Reference (f) empowers inquiry into the acts and omissions by current and former employees of the Department "*which relate to clinical practices or procedures conducted by medical practitioners ...including acts or omissions relating to waiting lists ...*".

(iv) Leaving aside my earlier objection that Mrs. Edmond does not fall within this Term of Reference in any event, the Commission's investigation is into acts and omissions which relate to clinical practices or procedures of doctors.

(v) It follows that this allegation of misleading must relate to medical practitioners being misled as to the true nature of the surgical waiting time, and thereby affecting, or potentially affecting, their clinical practices and procedures.

(vi) That this is the correct interpretation of the allegation is fortified by the questioning by Counsel Assisting – see for example T6183 L25 – 32:

> "Q: "*You've no doubt read on the net or perhaps read in the newspapers a number of propositions put to witnesses in these proceedings. You would agree that a referring general practitioner is better armed to advise his or her patient who may have to undergo surgery and needs referral for that purpose?*
>
> *A: Mmm*
>
> Q: *If he or she knows not just the length of the elective surgery waiting list but the length of the anterior lists?*
>
> *A: Yes.*"

(vii) Presumably, this proposition by Counsel Assisting was meant to imply that the publication of anterior lists would assist general practitioners in their practices in advising patients, although, that was not what was raised with the witness.

(viii) With respect to the proposition being put, it is fundamental that every general practitioner would have been well aware that the surgical waiting list did not reflect a patient's waiting time between seeing a general practitioner and having surgery.

(ix) If a patient is on the surgical waiting list, it must mean that the patient has been assessed as needing surgery. That cannot be done until the patient actually sees the Outpatients specialist.

(x) If there is any general practitioner who believed that there was no waiting time to see a specialist, whether at Outpatients or privately, there is something dramatically wrong with that medical practitioner.

(xi) It follows that the allegation that medical practitioners were misled by the publication of the surgical waiting list and the non-publication of anterior list data, is entirely erroneous.

(xii) As a matter of commonsense, all general practitioners have a good idea of the waiting time to see specialists, both at Outpatients and privately, within their area or region. Their general interaction with the specialists concerned, the hospitals and other general practitioners would inevitably keep them informed of waiting times. It is the same for lawyers. Barristers and solicitors involved in litigation are always aware of the waiting time for a trial, in the civil and criminal jurisdictions, in all Courts.

Further, and importantly, general practitioners are obliged to indicate the priority for patients in respect of the elective surgery waiting list. For example, a general practitioner is obliged to indicate if a patient ought be seen by an Outpatients specialist urgently. Interaction between general practitioners and the hospitals and Outpatients specialists is an inevitable part of the prioritising process. The prioritising of patients is, of course, very beneficial, if not essential, but it is one of the many reasons why the anterior lists may change.

(xiii) If, for whatever reason, a general practitioner is uncertain as to the waiting time for a patient to obtain a specialist's Outpatients' appointment, a phone call from the surgery to the hospital or hospitals would immediately cure that problem. See evidence of Dr. Buckland at T5589 L35 – 40:

> "*Q: Do you understand if there is any inhibition on a general practitioner contacting hospital A and hospital B and finding out the raw numbers and the other information they need?*

A: *Not at all. In fact, that happens quite frequently, particularly in regional Queensland. GPs they have a close liaison with the specialists at the hospitals so they tend to know what they are waiting for."*

(emphasis added).

(xiv) It is for the general practitioner to inform the patient how long he/she will wait before appointment and there is absolutely no inhibition from finding out the waiting time.

(xv) Again, as a matter of commonsense, general practitioners often have preferred specialists. A general practitioner may give a patient options as to waiting times in seeing specialists at Outpatients. A general practitioner may advise a patient of a shorter waiting time to be seen at hospital A, but that hospital B has the preferred specialist.

"(b) Your press release of 11 November 1999 headed 'Health Minister says opposition campaign to discredit the waiting lists data is desperate and dishonest', in light of the previous press release of 3 (sic) July 1998 entitled 'Health Minister lifts the Lid on Waiting Lists' and a further press release of 16 October 1998 entitled 'Labour Plan reveals Hidden Waiting Lists', was misleading in not reflecting the true nature of surgical waiting time in Queensland public hospitals."

1. (i) This possible finding is not within the Terms of Reference.

(ii) Term of Reference (f) is a clarification of Term of Reference (c). Term of Reference (f) pertains to "*current and former employees of the Queensland Department of Health*". Mrs Edmond was an elected representative and Minister of State.

(iii) This possible adverse finding is a direct allegation against Mrs. Edmond personally. It is a potential finding that is not only outside the Terms of Reference, but also it could not conceivably arise as a corollary of or incidental to findings against employees of the Department.

2. (i) The allegation that the press release of 11 November 1999, in light of the earlier press releases, is misleading and not reflecting the true nature of surgical waiting time in Queensland public hospitals, is ill-founded and must result from a misunderstanding of the contents of the press releases.

(ii) The press release of 30 July 1998 announced the publication of the elective surgical waiting lists.

It must be understood that when Mrs. Edmond became Minister the whole focus – political, public and media – was on surgical waiting lists (T4903 L10). Mrs. Edmond initiated the publication of these surgical waiting lists.

The press release of 30 July 1998 also referred to the untold story of patients waiting for specialist Outpatient appointments and the concern that surgical waiting lists did not represent the whole picture.

The press release publicly revealed the existence of substantial numbers of patients without appointments.

The press release in no way suggested that it was intended to publish the anterior lists.

(iii) The press release of 16 October 1998 highlighted the untold story of the waiting lists to get an appointment with a specialist at Outpatients and, further, emphasized that the data collected so far showed roughly the same number of people waiting to see a specialist as patients on the surgical waiting lists.

The press release in no way suggested that it was intended to publish the anterior waiting lists.

This press release <u>again</u> emphasized the existence of anterior waiting lists:

> "*Patients referred to public hospitals by their doctors have to wait to be allocated appointments to see a specialist at an outpatient clinics. The specialist assesses the patient and it is only then that the patient is placed on a hospital elective surgery waiting list.*"

This press release made it perfectly clear that tackling the anterior waiting lists was part of the overall strategy in dealing with surgical waiting times.

This is precisely what was done. The anterior lists data was collected and used for problem-solving in respect of the various health facilities.

(iv) The press release of 11 November 1999 was in response to an attack by the Opposition that the surgical waiting lists that were published were dishonest because they did not include the anterior lists.

The surgical waiting lists never purported to include the anterior lists. Further, and most importantly, the media, the Opposition and the Public at large must have known, and certainly ought to have known, that the surgical waiting lists did not include anterior lists. The press releases of 30 July 1998 and 16 October 1998 made it abundantly clear that the anterior lists were not part of the surgical waiting lists.

Importantly, this press release of 11 November 1999 again made it patently clear that people waiting for specialists' Outpatient appointments were not included in the surgical waiting lists:

> "*The pathetic attempts of the Opposition to claim that specialists' Outpatient appointment waiting times would provide the 'real picture' of elective surgery waiting times shows a complete misunderstanding of the hospital system.*
>
> *People waiting for specialists' Outpatient appointments do not necessarily need surgery.*"

It is impossible to read this press release as indicating anything other than that there is a waiting time to get to see specialists at Outpatients and, therefore, necessarily, a waiting time before being placed on the surgical waiting list.

(v) The relevant evidence by Mrs. Edmond on this point is as follows:

> "*Q:* *It is correct to say that by this press release (11 November 1999) you were dismissing the claim – as it transpires, it came from the Opposition – that specialists' Outpatient appointment waiting times would provide the real picture of elective surgery waiting times?*
>
> *A:* *No.*
>
> *Q:* *You were dismissing that?*
>
> *A:* *No, I was dismissing the claim – if you will excuse me, I was dismissing the claim that the waiting lists that we were publishing were dishonest because they didn't include them, and I would say that here and now, that they were exactly the same, they were not dishonest, they - never pretended to include the Outpatient appointments.*" (emphasis added).

(vi) Not only did the surgical waiting lists never pretend to include patients waiting for specialist Outpatients appointments, each of the press releases referred to, including that of 11 November 1999, made that patently obvious. The allegation against Mrs. Edmond is demonstrably wrong.

"(c) With respect to the measured quality programme developed by Queensland Health directed to improvement of patients' safety in medical standards, following a presentation by Mr. Justin Collins of Queensland Health on 13 August 2002, in which you were informed that use and dissemination of hospital reports was proposed to be left to District Managers, you directed that the measured quality programme hospital reports be taken to Cabinet for noting."

It is further alleged in paragraph (e) that as a result of this direction Mrs. Edmond *knew or believed that the measured quality hospital reports would not or may not be available to the Public, and further that access by hospital staff thereto would be delayed, and use thereof restricted in a manner deleterious to the effective implementation of the policy.*

It is further alleged that the direction in paragraph (c) and the outcome in paragraph (e), *were contrary to the public interest.*

1. (i) These possible findings are not within the Terms of Reference.

(ii) Term of Reference (f) is a clarification of Term of Reference (c). Term of Reference (f) pertains to "*current and former employees of the Queensland Department of Health*". Mrs Edmond was an elected representative and Minister of State.

(iii) These possible findings are direct allegations against Mrs. Edmond personally. They are potential findings that are not only outside the Terms of Reference, but also they could not conceivably arise as the corollary of or incidental to findings against employees of the Department.

2. (i) Possible adverse finding (c) states that in the presentation of 13 August 2002, Mrs. Edmond was "*informed that use and dissemination of hospital reports was proposed to be left to District Managers*".

The allegations go on to say:

(A) Mrs. Edmond directed that the measured quality programme hospital reports be taken to Cabinet for noting (possible adverse finding (c));

(B) As a result of that direction Mrs. Edmond knew or believed that the measured quality reports would not or may not be available to the Public (possible adverse finding (e));

(C) And further, that access by hospital staff thereto would be delayed (possible adverse finding (e));

(D) And use thereof restricted in a manner deleterious to the effective implementation of the policy (possible adverse finding (e));

(E) The direction in (c) and the outcome in (e), were contrary to the public interest (possible adverse finding (f)).

(ii) Mrs. Edmond's allegedly being informed on 13 August 2002 that the use and dissemination of hospital reports was proposed to be left to District Managers, is the factual premise for the further allegations in (c), (e) and (f) of the Notice.

(iii) To give any sense of significance to allegations (A) and (B) above, the factual premise in (c) must be meant to convey that Mrs. Edmond was informed that the use and dissemination of hospital reports, <u>including to the Public</u>, was proposed to be left to District Managers.

If that is the factual premise alleged, it is entirely inaccurate. There was no proposal by Mr. Collins to Mrs. Edmond that the District Managers determine whether the hospital reports be disseminated to the Public. The proposal by Mr. Collins at the presentation was that a decision needed to be made whether to leave dissemination of the reports to the Public to District Managers or to leave it only to FOI applications.
See Exhibit JEC 30 Handout 8 "*Issues*" and T5915 L40 – 5916 L30. See also T5920 L45 – 5921 L42.

The author of the Notice seems to have confused what Mr. Collins and his team "*considered*", as opposed to the proposal advanced to Mrs. Edmond. See paragraph 9 of Mr. Collins' second Statement.

(iv) It seems likely, given the Cabinet Submission in November 2002 (Exhibit JEC 9) that in the presentation on 13 August 2002 Mrs. Edmond was informed that use and dissemination of hospital reports to key staff was proposed to be left to District Managers.

(v) It follows that the implication that Mrs. Edmond directed that the hospital reports be taken to Cabinet because she was informed that use and dissemination of hospital reports was proposed to be left to District Managers, is entirely ill-founded.

(vi) That Mrs. Edmond knew that taking the hospital reports (or, for that matter any document, including the draft Public report) to Cabinet may result in their not being available to the Public, cannot be a basis for an adverse finding against Mrs. Edmond. The allegation is meaningless. Ministers are obliged to report to Cabinet. By way of example: "... *Every three months I had to provide to Cabinet a report on how we were going on waiting lists and other matters on a regular basis ...*". (Mrs. Edmond at T4883 L55). Of course, notwithstanding that the data in respect of the surgical waiting list was taken to Cabinet for its consideration, the surgical waiting lists continued to be released to the Public.

The fact that Mrs. Edmond had expressed concern in relation to publication of the hospital reports is unsurprising. One has only to look at the concerns expressed in the expert literature in relation to the potential for the media to misuse this type of material to understand Mrs. Edmond's concerns. Mrs. Edmond's expression of concern does not make illegitimate the taking of the hospital reports to Cabinet. Quite the contrary, concerns in publication would be one of the matters to be considered by Cabinet.

Mr. Collins and his team had such concern that the media would misuse the contents of the hospital reports if they received them that he and his team devised media plans.

The expert literature relied upon and referred to by Mr. Collins set out the fundamental criticisms of programmes of this type, including, that "*the media would misuse* them" (the data). The literature stated that such arguments were not sustainable "*if public disclosure is introduced properly.*" See article by Marshall and Brook. (emphasis added).

Dr. Cuffe, a witness who seemed to be regarded as reliable by the Commission, gave evidence as follows:

"*Q:* *Is it correct or incorrect that prior to the Minister making that decision, that your knowledge no-one from Queensland Health suggested to the Minister, or any of her staff that the MQP report or draft reports be taken to Cabinet?*

A: *Not to my recollection. The presentation was given. Minister Edmond seemed quite, you know, excited or enthralled about what the outcome was, and suggested that she would like to take it to Cabinet to inform Cabinet colleagues about the work that had been done.*" (T6538 L5 – 15).

At T6539 L8:

"*Q:* *Was that*" (submitting the MQP and reports to Cabinet) "*a matter of some concern to you?*

A: *It was a concern that whilst it was legitimate for the Minister to take the reports to Cabinet to inform Cabinet, once having done so the potential outcomes of what might happen to those reports was a matter for Cabinet and the Cabinet's choice ...*". (emphasis added).

(vii) In relation to allegation (E) above, with respect, this Commission is in no position to properly allege that the taking of these reports to Cabinet was not in the public interest. By what benchmark does the Commission purport to judge which major new initiative (as this was) is appropriate or not appropriate for Ministers to take to Cabinet?

The measured quality programme was a major new initiative, not only for the Queensland Government, but within Australia. It must be understood that Mrs. Edmond was entirely supportive of this programme throughout. (T6558 L20). Mrs. Edmond wanted the programme introduced and for it to be a success. There is an obvious incongruity in the attack being made upon her in the Notice. Mrs. Edmond is, potentially, being criticized in respect of the implementation of a programme which she did not have to introduce but wanted to introduce in an attempt to improve health care in this State.

It being such a major new initiative, as a matter of commonsense, it would be an obvious matter to go to Cabinet. Further, Cabinet would not be expected to judge the value of the programme and determine whether to continue with the programme, let alone

understand what the programme entailed, without reviewing the contents of the hospital reports.

If the object was to prevent the hospital reports from being available publicly, there was no need to have the reports physically taken to Cabinet, nor "*To inform Cabinet of the content*" of the hospital reports. See Exhibit JEC 9.

(viii) The allegations set out in (C) and (D) above are demonstrably wrong.

Mrs. Edmond would have had no reason to believe that Cabinet would restrict dissemination of the hospital reports, as Cabinet did.

Mrs. Edmonds' Cabinet Submission dated 7 November 2002 relevantly proposed:

> "*The 60 measured quality hospital reports will be released to each of the relevant District Managers and Zonal Managers within Queensland Health for dissemination and action where necessary.*" See Exhibit JEC 9. (emphasis added).

"(d) Further with respect to the measured quality programme, following a Ministerial briefing to you dated 10 March 2003, and a presentation to you by Mr. Collins on 10 May 2003, in each of which you were informed of the deleterious effect which the Cabinet restriction of 12 November 2002 had on the use of the measured quality hospital reports, you directed the phrase (sic) two reports be taken to Cabinet for noting and failed to include the aforesaid deleterious effect in the Cabinet submissions."

It is further alleged in paragraph (e) that as a result of this direction Mrs. Edmond *knew or believed that the measured quality hospital reports would not or may not be available to the Public, and further that access by hospital staff thereto would be delayed, and use thereof restricted in a manner deleterious to the effective implementation of the policy.*

It is further alleged that the direction in paragraph (c) and the outcome in paragraph (e), *were contrary to the public interest.*

1. (i) These possible findings are not within the Terms of Reference.

(ii) Term of Reference (f) is a clarification of Term of Reference (c). Term of Reference (f) pertains to "*current and former employees of the Queensland Department of Health*". Mrs. Edmond was an elected representative and Minister of State.

(iii) These possible findings are direct allegations against Mrs. Edmond personally. They are potential findings that are not only outside the Terms of Reference, but also they could not conceivably arise as the corollary of or incidental to findings against employees of the Department.

2. (i) The factual premise for these allegations is inaccurate.

(ii) The Ministerial briefing dated 10 March 2003 contained, relevantly, the following:

> "*Due to the restricted distribution of the measured quality hospital reports (District Managers only), difficulty may be encountered in the dissemination of the results within the hospital environment. This may impact on the usefulness of the hospital reports and limit the engagement of traditions and Managers to whom change is to be delivered.*" (emphasis added).
>
> The Ministerial briefing contained no information that there had been a deleterious effect on the use of the hospital reports. The author of the Notice has exaggerated the language of the Ministerial briefing in a manner adverse to Mrs. Edmond.

(iii) Nonetheless, the Minister's briefing of 10 March 2003 did raise the possibility of difficulties due to the restricted distribution of the reports.

(iv) However, what followed the briefing of 10 March 2003 was that Mr. Collins and his team travelled to give a presentation to each selected hospital.

Mr. Collins notes in his first Statement that his research "*revealed that direct communication, that is, face to face oral communication, of findings was more effective than simply delivering written reports to the hospital.* (emphasis added).

The first Statement of Mr. Collins continues:

> "*... As a result, MQS project officers travelled to each selected HSD to present and report to the executive and nominated key staff (generally the District Manager/s and key clinicians and management) the findings of the hospital report/s for their HSD. During this presentation, MQS project officers explained the content of the*

reports, the results and the context around the indicated development and the indicators which have been identified for each hospital as being significant, otherwise known as 'outlier indicators'. Generally the presentation is done in conjunction with representatives from the Zonal Management Unit." (emphasis added).

(v) After those face to face presentations to the hospitals, Mr. Collins provided a presentation to Mrs. Edmond on 10 May 2003.

The presentation is reflected in the written words in Exhibit JEC 14.

The section of the presentation entitled "*Strategy developed*" contains the relevant information passed to Mrs. Edmond during this presentation.

It points out the measures taken to accommodate the restriction on distribution of the hospital reports, namely, the presentations to the hospitals as described in (iv) above. Mr. Collins actually refers to what he needed to do "*To obtain the serious attention of clinicians and managers*" in the absence of physically distributing the reports. Nothing said there suggests other than an ability by Mr. Collins and his team to obtain the serious attention of the relevant personnel.

The presentation goes on to identify the manner in which security of the hospital reports has been managed.

The presentation then reports that attendees have varied from "*as little as the District Executive to the involvement of nearly twenty staff with majority being clinicians across the areas of medicine, surgery and O & G*".

It speaks of the "*eagerness*" to benchmark with peer groups. (emphasis added)

It speaks of the smaller hospitals "*enthusiastically*" greeting the data and the opportunity to compare their performance but that they raise concerns over the ability to action due to limited resources. (emphasis added).

The only negativity referred to in the presentation is as follows:

"*Some negativity has been expressed about the restriction on the distribution as nearly all have shown a great eagerness to discuss with staff further about ways to*

improve or identify reasons for good performance in particular areas (so as to share with peers)." (emphasis added).

There was no suggestion in the presentation that the negativity was widespread or significant. In context, it is no more than an expression of inconvenience. However, most importantly, the presentation contains absolutely no suggestion that the restriction on the distribution of the hospital reports was having any deleterious impact. There is absolutely no suggestion in the presentation that those who expressed negativity about the restriction on distribution of the reports were also claiming that it had a deleterious effect on the use of the reports.

The presentation goes on to inform Mrs. Edmond the explanation given by Mr. Collins and his team in respect of the restricted distribution.

It then speaks about "*a lot of hospitals expressing great delight in receiving data back in a useful way* ...". (emphasis added).

The presentation to Mrs. Edmond concludes by informing her "*Good first step but need to go beyond the Inpatient services*". (emphasis added).

(vi) A mere perusal of the presentation in Exhibit JEC 14 discloses an up-beat, optimistic and "*good first step*" introduction of the programme.

(vii) For the author of the Notice to interpret the content of the presentation of 10 May 2003 in such a way as to allege as the factual premise: "*you were informed of the deleterious effect which the Cabinet restriction of 12 November 2002 had on the use of the measured quality hospital reports ...* ", is staggering.

(viii) The factual premise for the allegations clearly does not exist and it follows that the allegations fail.

(ix) If these allegations are meant to include a criticism, isolated from the factual premise, merely because Mrs. Edmond directed phase 2 reports to Cabinet, the submissions above at page 11 and the relevant parts of the submissions under (vi) are relied upon. Further, directing phase 2 reports to Cabinet would be the natural consequence of this major new initiative still under consideration by Cabinet. It should not be overlooked that the public report still had not been released at that time.

The allegations against Cabinet that it acted contrary to the public interest relate to:

a. The decision not to publish the anterior waiting lists; and

b. The decision to restrict distribution of the hospital reports in the measured quality programme.

a. (i) This potential finding is not within the Terms of Reference for the reasons advanced above.

(ii) Relevant parts of the submissions above, particularly at pp.2 – 9 inclusive, are relied upon.

(iii) In light of Mr. Walker's evidence, it would not have been in the public interest, and Cabinet would have been deserving of criticism, if it had decided to publish data which the Department and the Minister and therefore, presumably, Cabinet, knew to be of insufficient quality for publication. Cabinet would have been responsible for having published misleading data.

(iv) With respect, this potential adverse finding is contrary to the evidence.

b. (i) This potential finding is not within the Terms of Reference for the reasons advanced above.

(ii) Relevant parts of the submissions above, particularly the submissions at p.12 referring to Mrs. Edmond's support for the programme, and p.13 (viii) referring to Mrs. Edmond's submission to Cabinet dated 7 November 2002, are relied upon. Further, the Premier's letter to the Commission dated 20 September 2005, particularly at p.2 L18 – 30, is relied upon.

(iii) In any event, there must be serious doubt that the restriction in dissemination of the hospital reports adversely affected the implementation of the programme to any significant extent, if at all, let alone to an extent contrary to the public interest.

(iv) Given Mr. Collins' evidence, the most effective implementation of the programme involved face to face communication – it was "*more effective than simply delivering written reports to the hospital*". It follows that anything short of face to face oral

communications by MQS project officers with the key personnel of the hospitals, would be deleterious to the effective implementation of the programme.

(v) With respect, this potential adverse finding would be contrary to the evidence.

T.D. MARTIN SC
Chambers
26 October 2005

FURTHER SUBMISSIONS ON BEHALF OF MRS. WENDY EDMOND

RE: SUBMISSIONS ON BEHALF OF QUEENSLAND CLINICIAN SCIENTISTS' ASSOCIATION AND DR. CON ARONEY

1. At paragraph 47 of the QCSA Submission, the following appears:

> "*Further, Mrs. Edmond did not explain what staff it was in what office who fell about laughing when 'they read that in the paper', given that she had retired the year before, a point she made repeatedly in her evidence*".

2. Counsel for the QCSA elected not to seek any clarification of the evidence.

3. The staff referred to was, as Mrs. Edmond stated in her evidence, the staff in her office. Should anyone be in any doubt, it was her Ministerial staff.

4. In case it is thought that there is an incongruity in Mrs. Edmond's evidence because it refers to her staff laughing at the bullying allegation in the paper, the reference was to an allegation of bullying made against Dr. Scott and published in "*The Courier Mail*" in about January 2004, before Mrs. Edmond retired.

T.D. MARTIN SC
Counsel on behalf of Mrs. Edmond
31 October 2005

Submissions

Ms Dale ERWIN-JONES

Crown Law
Queensland Government

Your ref:
Our ref: CS5/HEA027/5744/DZP
Contact: Peter Dwyer
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Department of
Justice and Attorney-General

26 October 2005

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

Dear Mr Groth

Submissions in response to Notices of Potential Adverse Findings

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

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

Yours faithfully

Peter Dwyer
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QUEENSLAND PUBLIC HOSPITALS *COMMISSION OF INQUIRY*

SUBMISSIONS ON BEHALF OF DALE ERWIN-JONES

1. The evidence of Ms Erwin-Jones appears at:

   (a) Exhibit 329 – Statement of Dale Erwin-Jones – paragraph 49;

   (b) Transcript - T5416/16 – 5418/23; 5426/30 – 5429/20; 5432/20 – 5433/20.

2. The evidence of Dr Sean Mullen appears at:

   (a) Exhibit 330 – Statement of Dr Sean Mullen – paragraphs 37 – 39;

   (b) Transcript - T5469/1 – 5471/25; 5805/10 – 5819/55.

3. The evidence of Mr Michael Allsopp appears at:

   (a) Exhibit 456 – Statement of Michael Allsopp – paragraph 4.66;

   (b) Transcript - T7081/1-52; 7082/11-25.

Surgery cancellation

4. Whilst it is correct to say that Ms Erwin-Jones did not **"consult with Dr Mullen or any of the other doctors involved in that surgery"** the evidence clearly shows that the opinion of a relevant doctor was in fact taken into account by her. She was advised by the senior nurse on duty that:

   > **"The anaesthetist had already advised that we shouldn't perform the case because the patient had a chest infection and he believed that the patient should be treated for that chest infection and booked scheduled for Monday."**[1]

5. Ms Erwin-Jones was therefore provided with unambiguous information to the effect that the anaesthetist on duty was of the opinion that it was contrary to the patient's safety for the procedure to be performed that day.

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[1] T5416/44 – 5417/45.

6. No evidence has been placed before the Inquiry that Dr Mullen provided any reasons to the nurse on duty to support the scheduling of the operation on the Saturday.

7. Against that background, Ms Erwin-Jones had information that supported entirely the scheduling of the operation on Monday as opposed to Saturday.

8. Further, Mr Allsopp, the District Manager, was contacted by Ms Erwin-Jones prior to her confirming the duty nurse's decision to not book the procedure for that day. According to Mr Allsopp she provided all relevant information to him and requested his assistance. Mr Allsopp stated that he in fact was the person who confirmed the duty nurse's decision[2]. Ms Erwin-Jones made no mention in her evidence of having such a conversation with Mr Allsopp - apparently having forgotten that it occurred.

9. Given that Dr Mullen had not presented clinical reasons for the timing of the surgery (or at least there is no evidence of that having occurred), this cannot be said to be a situation where Ms Erwin-Jones substituted her own judgment for the clinical judgment of Dr Mullen. She did no more than act upon reliable information provided to her by a senior nurse which originated from the anaesthetist on duty.

10. Evidence has been placed before the Inquiry which proves that the issue of Dr Mullen wishing to perform elective surgery during weekend emergency hours has been the subject of consideration on prior occasions. In the Minutes of two meetings of the Surgical Services Management Advisory Committee (9 December 2002 and 12 March 2004)[3], the following passages appear:-

(a) Minutes of 9th October 2002, paragraph 4.2:

> **"Morgan spoke of the problems with Sean Mullen's doing elective surgery on the weekends. This includes physio cover ...."**

(b) Minutes of 12th March 2004, paragraph 5.4:

> **"Liz Willmott voiced concerns that theatre staff have been called in after hours for cases that could have waited until emergency theatre session. This is resulting in significant overtime for nursing staff as it creates**

[2] T7081/49.
[3] Exhibit 502.

problems with fatigue leave and paying staff double time."

The Minutes reveal that Ms Erwin-Jones was present at both of these meetings.

11. Given that Ms Erwin-Jones was not on duty at the time of this incident, it is unreasonable to expect her to chase after Dr Mullen who was on duty. She was quite entitled to reasonably expect Dr Mullen to contact her if he disagreed with the decision to book the surgery for Monday. She would also be entitled to expect Dr Mullen to contact the anaesthetist on duty to further discuss any clinical disagreement that may have existed between them.

12. Dr Mullen did contact the person who had confirmed the decision to not book the procedure for that Saturday - Mr Allsopp. He discussed with Mr Allsopp his clinical reasons for wishing to perform the surgery that day and provided Mr Allsopp with the name of another anaesthetist who had seen or could see and review the patient. Mr Allsopp took advantage of that information and subsequently spoke to the other anaesthetist before approving the surgery to take place on the Sunday morning. This enabled hospital staff to arrange a reserve emergency team in case another emergency patient arrived at the hospital during the procedure in question.

13. There is no evidential basis to find that Ms Erwin-Jones' conduct compromised the safety of a patient. Ms Erwin-Jones stated in evidence that **"we would never stop a doctor operating if he said it needs to be done"**[4]. Furthermore, insufficient evidence exists to support the contention that that decision had the potential to result in an adverse outcome and resulted in a real risk to the safety of the patient. The only evidence on this point comes from Dr Mullen[5]:

> **"Q: And is it best practice to treat such persons within 72 hours of the fracture?**
>
> **A: 48 - certainly - 48 hours in most of the recent evidence based medicine, 48 hours seems to be the ideal situation, provided there's not a really good contra indication. As I say, we looked at that issue and found there wasn't a contra indication."**

[4] T5427/33.
[5] P5470 L25.

Even Dr Mullen uses such terms as **"<u>most</u> of the recent evidence based medicine"** and **"<u>seems</u> to be the ideal situation"**. He was not asked during his evidence to offer an opinion as to the risk which delaying the surgery might pose.

Conclusions

14. Having regard to all of the evidence, there is no basis to find that Ms Erwin-Jones acted carelessly or incompetently or has been guilty of misconduct. Ms Erwin-Jones gave due consideration to the issue at hand, acted upon the information provided, and sought approval from the District Manager.

15. The making of adverse findings and recommendations against a person has serious consequences, particularly where the potential recipient of the findings is to be the subject of criticism in the context of carrying out workplace duties below an acceptable standard. Here, the evidence establishes that Ms Erwin-Jones performed her duties conscientiously, and in good faith, with the issue of patient safety in the forefront of her mind. In those circumstances, no adverse findings or recommendations should be made against her.

Submissions

Dr Gerard FITZGERALD

Crown Law
Queensland Government

Department of
Justice and Attorney-General

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26 October 2005

Mr David Groth
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Level 9
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BRISBANE Q 4000

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Yours faithfully

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QUEENSLAND PUBLIC HOSPITALS *COMMISSION OF INQUIRY*

SUBMISSIONS ON BEHALF OF DR GERARD FITZGERALD

1. The evidence of Dr FitzGerald appears at:

   (a) Exhibits 225, 226, 227 – Statements of Dr FitzGerald;

   (b) Exhibit 225, Attachment GF14: Memorandum to Director General dated 24 March 2005, enclosing Clinical Audit Report;

   (c) Exhibit 230: Clinical Audit Report;

   (d) Transcript: T4195 – 4266; 6094- 6168.

2. At all material times, Dr FitzGerald held the position of Chief Health Officer.

3. The Chief Health Officer's office was first contacted on 17 December 2004 following a referral by the Audit Branch, Queensland Health, of material that had been forwarded to it by Mr Leck, District Manager for Bundaberg Health Service District regarding complaints concerning Dr Patel. Dr FitzGerald was commencing annual leave, and did not return to his office until mid January 2005.

4. On 17 January 2005, Dr FitzGerald spoke to Mr Leck concerning the matter. Subsequently, on 19 January 2005, Mr Leck forwarded a bundle of material to Dr FitzGerald.[1] At that time, Mr Leck advised that Dr Patel did not intend to renew his contract when it expired on 31 March 2005. It was not obvious from a perusal of that material that Dr Patel was "*a dangerously incompetent surgeon*"[2].

5. Dr FitzGerald determined that further inquiries would be necessary before any opinion of clinical standards could be offered.[3] He advised Mr Leck that his review would take the form of a "clinical audit" and would not be an investigation into any individual.[4]

6. On 14 and 15 February 2005, Dr FitzGerald and his assistant, Ms Jenkins, attended the Bundaberg Base Hospital to interview staff and collect further information. Prior

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[1] Exhibit 225, Annexure GF10.
[2] T3205/45.
[3] Exhibit 225, para 48.
[4] Exhibit 225, para 61.

to their attendance at the hospital, Ms Jenkins had requested various documentation be provided to them.

7. During the interviews, staff members were advised that Dr FitzGerald was collecting personal impressions of issues of concern and not evidence for any particular disciplinary or other process.[5] This process is consistent with the nature and intent of a clinical audit, which is "*intended to be non-judgmental or non-threatening to ensure that people do participate in the clinical audit*"[6]. This process is viewed by experts in the field and by literature to be the way to exact system improvement and improve the quality of health care[7].

8. The principle issues of concern raised with Dr FitzGerald during his visit to the hospital were that Dr Patel was conducting surgical procedures which were not within the reasonable scope of practice of the hospital and that patients were being retained at the hospital when they would be better cared for in a larger hospital.[8]

9. Prior to leaving Bundaberg, Dr FitzGerald obtained assurances from Dr Patel and Dr Keating, the Director of Medical Services, that Dr Patel would not in the future conduct surgical procedures which were not within the reasonable scope of practice of the hospital and would transfer patients more readily to higher level facilities.[9] Indeed, Dr FitzGerald was told that this arrangement was already in place.[10] Dr FitzGerald derived confidence from Dr Keating that these arrangements would be honoured.[11]

10. Upon his return to Brisbane, Dr FitzGerald, on 16 February 2005, spoke to Mr O'Dempsey, from the Medical Board, in relation to Dr Patel. Dr FitzGerald was advised that Dr Patel's registration was due for renewal, and it was agreed the Registration Advisory Committee would defer consideration of Dr Patel's current application for renewal of registration until after the finalisation of his clinical audit report[12] and any further investigation.[13] Dr FitzGerald knew that Dr Patel was an

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[5] Exhibit 225, para 63.
[6] T3214/25.
[7] T6121/25.
[8] Exhibit 225, para 65.
[9] T3210/25.
[10] T3247/40.
[11] T6143/25.
[12] Exhibit 225, para 67: T6146/25 – 35.
[13] T6147/20 – 30.

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 Medical Board.[14]

11. Thereafter, Dr FitzGerald began to compile his report. This process was delayed by the need to obtain further data. On 22 March 2005, Dr FitzGerald was contacted by the Minister's office following allegations being raised in the Queensland Parliament. Dr FitzGerald met with the Minister and advised him that the significant issue regarding the competency of Dr Patel appeared to relate to his preparedness to take on cases which were beyond the capacity of the Bundaberg Hospital and possibly beyond his personal capacity.[15] He also advised the Minister that his report was nearly complete.[16] At the time of that meeting, Dr FitzGerald was still awaiting some statistical data.[17]

12. On 24 March 2005, Dr FitzGerald completed his report and supplied it undercover of a Memorandum to the Director General.[18]

13. At the time of provision of his report, and earlier, Dr FitzGerald was of the opinion that there was insufficient evidence to take any particular action against any individual, and that to suspend anyone would be unjust and inappropriate[19]. However, Dr FitzGerald referred his concerns about Dr Patel to the Medical Board of Queensland on the same day he completed his report, namely, 24 March 2004.[20] He did so knowing his earlier approach to Mr O'Dempsey had resulted in a deferral of consideration of any application to renew Dr Patel's registration which expired on 31 March 2005.

14. On 29 March 2005, Dr FitzGerald was advised by Mr Leck that Dr Patel was on sick leave and was intending to leave the country.[21]

15. In assessing Dr FitzGerald's actions in relation to the concerns raised with respect to Dr Patel, it is important to have regard to the information available <u>at that time</u> rather than the substantial body of information now available in relation to Dr Patel's clinical conduct. If regard is had only to the information available at that time,

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[14] T6147/15 – 30.
[15] T6136/45 – 49.
[16] T6141/41.
[17] T6134/40.
[18] Exhibit 225 – Attachment GF14; Exhibit 230.
[19] T6138/40 – 50.
[20] Exhibit 225, GF13.
[21] T6107/25.

Dr FitzGerald's actions were reasonable in all the circumstances. To find otherwise involves a consideration of Dr FitzGerald's actions with the benefit of hindsight, having regard to the information now available concerning Dr Patel's clinical competence, including information about his conduct in the United States of America.

16. Dr FitzGerald repeatedly emphasized that his clinical audit and subsequent report were conducted and prepared for the purposes of examination of, and recommendations in relation to, systems and associated issues.[22] This process was adopted in order to obtain the full cooperation of staff, such cooperation being forthcoming in a blame free environment intended to look at systems and structures rather than make judgement about individuals.[23] The importance of such an approach was emphasised by Professor Woodruff[24], Dr Wakefield[25] and Dr Buckland.[26]

17. Against that background, it would be unreasonable and unfair to make adverse findings against Dr FitzGerald in relation to the content of his Clinical Audit report. Such criticisms only arise if the report is viewed as something which it was not intended to be. That would entail extending the report beyond the scope which was foreshadowed by Dr FitzGerald to staff at the commencement of his interviews at Bundaberg.

18. Further, it is illusory to read the report in isolation of the accompanying Memorandum to the Director General. That Memorandum enclosed the Clinical Audit Report. Plainly, that Memorandum was designed to address issues which related to the individual.[27] This is consistent with Dr FitzGerald having performed what he intended, namely a clinical audit, but having appropriately raised issues of clinical concern relating to an individual which had arisen in the course of that clinical audit.

19. The Memorandum enclosing the report specifically bought to the attention of the Director-General all relevant issues that Dr FitzGerald had discovered relating to both systemic issues and the individual. There is no evidence before the inquiry to suggest

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[22] T6111/18: 6113/35: 6115/8 – 35: 6122/6: 6126/41.
[23] T6113/40: 6115/25-35.
[24] T4332 – 4334.
[25] T4522/50.
[26] T5505/50.
[27] T6113/40.

that Dr FitzGerald should not have reasonably expected that the contents of the Memorandum would be considered and acted upon appropriately.[28]

20. As Dr FitzGerald said, the Memorandum and audit report "*were intended to be complimentary and for different purposes*".[29] The Memorandum was intended to raise issues "*about the standard and quality of medical services ... concerning Dr Patel*".[30] The information set out in the accompanying Memorandum resulted in the Director General being explicitly advised of Dr FitzGerald's concerns on the issues concerning Dr Patel's clinical competence and judgement.

21. Dr FitzGerald's actions were also reasonable having regard to:

(a) The fact that Dr FitzGerald was told by Dr Keating and Mr Leck that there were no patient complaints.[31] Whilst Dr Keating initially disputed that there had been any question about patient complaints, he subsequently accepted that such a request had been made[32], although he did not accept that they were told there were no complaints, asserting they were told that there were minor complaints that had been resolved. [33] Significantly, Mr Leck accepted that Dr FitzGerald and Ms Jenkins asked about patient satisfaction and patient complaints.[34] Whilst Mr Leck could not recall that the answer given was that there weren't any patient complaints, he accepted that prior to that interview he had looked through the most recent volume of complaints files and hadn't located anything which related to Dr Patel and that he may have indicated that to Dr FitzGerald and Ms Jenkins[35];

(b) The conflicting information Dr FitzGerald was receiving in Bundaberg. Dr FitzGerald received "*disparate views about Dr Patel on the issue of competency, practical competency and surgery*"[36]. He was told that Dr Patel "*was not the best of surgeons but he also was not the worst*" by people "*who knew him and observed his surgery*"[37]. Importantly, these views were

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[28] T6132/30.
[29] T6115/45.
[30] T6132/20.
[31] T6150/20.
[32] T7027/60.
[33] T7028/20.
[34] T7305/40.
[35] T7305/45.
[36] T6149/20.
[37] T6119/5.

proffered by anaesthetists who, in Dr FitzGerald's experience "*are usually most observant of people's surgical skills*"[38];

(c) The undertaking he obtained from both Dr Patel and Dr Keating prior to leaving Bundaberg Base Hospital 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*"[39]. It was entirely reasonable for Dr FitzGerald to accept that Dr Patel and Dr Keating would honour those undertakings. He was informed such an arrangement was already in place.[40] Further, Dr Keating "*would know what those procedures were*"[41], and Dr FitzGerald reasonably believed such undertakings would satisfy any concerns regarding issues of patient safety as the principal issues and complaints that had been brought to his attention related to the matters the subject of the undertakings;

(d) The steps Dr FitzGerald took, upon his return to Brisbane following the visit to Bundaberg Base Hospital, to advise the Medical Board that there were possible concerns and to arrange that Dr Patel's registration not be renewed until all issues had been finalised. Dr FitzGerald knew that Dr Patel, being an area of need Registrant, would not be able to continue working beyond his registration period, namely 31 March 2005, without being further registered by the Board.[42] Against that background, Dr FitzGerald's concession that, as at 24 March 2005, he knew Dr Patel could carry out "*tens if not hundreds of operations*"[43] whilst awaiting the finalisation of a Medical Board investigation must necessarily be incorrect. Likewise, his agreement with the suggestion that it was his belief up until 29 March 2005 that Dr Patel "*may well continue to operate as a surgeon at Bundaberg Hospital until at least the end of June 2005*" [44] must necessarily be incorrect. Dr FitzGerald was told, when he spoke to Mr O'Dempsey on 16 February 2005, that Dr Patel's registration was coming up for renewal, and Dr FitzGerald had arranged for any consideration

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[38] T6149/30; see also T6154/20.
[39] T6107 - 6108.
[40] T3247/40.
[41] T6108/25
[42] T6147/15 – 30.
[43] T6118/1 – 11.
[44] T6159/40.

of that renewal to be deferred pending completion of his report and other investigations. Dr FitzGerald had earlier been told by Mr Leck that Dr Patel's contract expired on 31 March 2005. Accordingly, Dr Patel had one week left before his registration expired and he could not work beyond that date;

(e) The notification Dr FitzGerald gave the Medical Board of his concerns by letter dated 24 March 2005 [45]. This was the day he delivered his Memorandum to the Director General enclosing the Clinical Audit report. That letter specifically sought an assessment of Dr Patel's performance by the Medical Board . Significantly, it 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 apparent preparedness to retain patients at the hospital when their clinical condition may warrant transfer to a higher level facility."*

Dr FitzGerald believed that the Medical Board would then conduct an investigation into Dr Patel. This is not an unreasonable approach given that Dr FitzGerald knew that Dr Patel's registration was about to expire, and, further, the complaints regarding Dr Patel were now public knowledge and Dr FitzGerald had notified the Director General and the Medical Board of his concerns.

22. The steps taken by Dr FitzGerald to ensure a formal assessment of Dr Patel would be undertaken by the Medical Board, rendered superfluous any need for him to review or have reviewed Dr Patel's credentials or clinical privileges. Indeed, the concerns expressed by Dr FitzGerald with respect to Dr Patel's judgement meant that a formal assessment by the Medical Board was the more appropriate procedure in all the circumstances, particularly where Dr FitzGerald knew that Dr Patel's registration was about to expire and he would be unable to work at Bundaberg Base Hospital or elsewhere without first having his registration renewed by the Medical Board.

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[45] Exhibit 24, attachment MDG5.

23. The criticism of Dr FitzGerald's actions, given the apparently high complication rate of Dr Patel arising from the performance of laparoscopic cholecystectomies must be viewed against Dr FitzGerald's evidence that the data relevant to this issue was unreliable. Dr FitzGerald was not comfortable with that sort of data as it is coded by somebody else, and it is necessary to know more details about the particular cases.[46] In fact, Dr FitzGerald did not have confidence in it[47]. Further, the other available data was showing a much different and mixed position.[48]

24. Due regard must be given to a medical practitioner's view of the reliability of such data, particularly where, as here, Dr FitzGerald is not alone in relation to concerns as to the reliability of such data. Both Mr Johnston [49] and Professor Woodruff [50] comment on the need for further investigation before relying on such data. Indeed Professor Woodruff's most recent review of this issue, whilst yet to be fully completed, would seem to prove that the data was spectacularly inaccurate[51] and that Dr Patel's complication rate was consistent with the national average. Further, data drawn from other hospitals by Dr FitzGerald showed these hospitals "*were up and down across the parameters and some of them were much more*".[52]

25. Dr FitzGerald's concern as to the reliability of the data was noted in his letter to the Medical Board on 24 March 2005[53]. In that letter, Dr FitzGerald said:

> "*There is evidence that the outcomes of those complex operations (namely oesophagectomies), were relatively poor, with at least two of the patients dying in the immediate post-operative period. In addition, data produced during the audit demonstrated a significantly higher rate of complications than the peer group average, however, we have not been able to exclude the impact of differential severity on this complication rate.*"

26. Having regard to Dr FitzGerald's view that it would have been unfair to act on such data, given its unreliability, Dr FitzGerald's conclusion that there was "*insufficient evidence at this time to take any particular action against any individual and to*

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[46] T6116/25 – 50.
[47] T6163/10.
[48] T6161/45.
[49] Exhibit 492, paragraphs 7 – 9.
[50] Exhibit 498.
[51] Exhibit 498.
[52] T6119/5.
[53] Exhibit 24, attachment MDG5.

suspend anyone would be unfair and unjust"[54] was reasonably open. Further, his conduct in notifying the Director General and the Medical Board of Queensland as to his concerns was entirely appropriate and adequate in all the circumstances, having regard to his knowledge that Dr Patel soon would not be able to work due to the cessation of his registration on 31 March 2005.

27. Against that background, it is unreasonable to criticise the briefing note Dr FitzGerald gave to the Minister.[55] It factually detailed Dr FitzGerald's views, including noting that the Hospital had taken action to limit "*the scope of surgery performed by this surgeon and to ensure that critically ill patients are appropriately referred to higher level hospitals*", and that Dr FitzGerald had recommended the matter be referred to the Medical Board for attention.

28. The fact Dr FitzGerald received additional data after that briefing note was prepared did not render that briefing note inappropriate, inadequate or misleading. Dr FitzGerald did not consider the data reliable, and had no confidence in it. It did not alter his conclusions as expressed in that briefing note, or as expressed in the Memorandum enclosing the Clinical Audit report. Accordingly, there was no reason for Dr FitzGerald to provide a further briefing to the Minister.

29. It is also unreasonable to criticise Dr FitzGerald for failing to provide the Minister and Mr Leck with a copy of his audit report. Dr FitzGerald believed, reasonably, that the Director General would provide a copy to the Minister and subsequently to Mr Leck. By this time Dr FitzGerald knew the Minister was aware of the Clinical Audit undertaken by him and the matter was subject of public debate which, appropriately, was a matter for the Director General and the Minister.

30. In the case of Mr Leck, there was obviously a sound basis for Dr FitzGerald's belief because the report was ultimately provided to Mr Leck on 7 April 2005 "*at the request of the Director General*"[56]. It is unsurprising that at the time of provision of that report to Mr Leck, a copy of the accompanying Memorandum to the Director General was not supplied to Mr Leck. By that time, Dr Patel had left Bundaberg Base Hospital and the concerns raised in the memorandum in relation to Dr Patel were no

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[54] T6138/45.
[55] Exhibit 391.
[56] T6105/55.

longer an issue as he was not working at the hospital.[57]. It was the matters canvassed in the Clinical Audit report that then needed addressing by Mr Leck and the management of Bundaberg Base Hospital.

31. There is no proper evidentiary basis to find that Dr FitzGerald performed his duties other than in a conscientious manner and in good faith.

32. To make adverse findings and/or recommendations against an individual who has performed his duties conscientiously and in good faith is a serious step, and should only occur where there is strong and compelling evidence that the individual's conduct fell well short of errors of judgement, and amounted to incompetence.

33. A proper consideration of the information available to Dr FitzGerald as at the date of completion of his Clinical Audit report could not reasonably justify a finding of incompetence. Whilst reasonable minds may differ as to the steps that may have been taken, it is not open to conclude that Dr FitzGerald's chosen course of action was one no reasonable person, acting competently, could reach on information then available to that person. That being so, no adverse findings or recommendations ought to be made against Dr FitzGerald in respect of this matter.

[57] T6146/15.

Submissions

Dr Bruce FLEGG

DR BRUCE FLEGG MBBS, ASIA, MP

STATE MEMBER FOR MOGGILL

26 October 2005

Queensland Public Hospitals Commission of Inquiry
PO Box 13147
GEORGE STREET QLD 4003

SUBMISSION TO THE QUEENSLAND PUBLIC HOSPITALS COMMISSION OF INQUIRY

I refer the Commission to my submission to the Bundaberg Hospital Commission of Inquiry led by Mr Anthony Morris QC.

I wish to make only two major points.

Firstly, all of the events surrounding the appointment and work of Dr Jayant Patel relate to systemic issues affecting the entire State. Some of these I addressed in Parliament prior to the appointment of the commissions of Inquiry. The systemic failures issues that exist relate to:

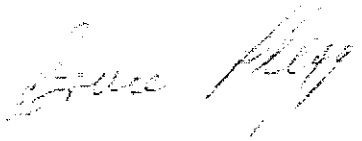
- The appointment of untested overseas trained doctors
- The elevation by 'deeming' of non-qualified doctors to be specialists
- The failure to supervise untested doctors
- The bullying of professional staff who raise concerns about the care of their patients
- The covering up of mistakes and errors by administrators and recent health ministers
- The emphasis on administrators delivering budget compliance not good patient care
- Misrepresentation of waiting times
- The failure of recent Health Ministers to properly administer the health department, and to advocate corrective measures.
- The failure of the present government to spend appropriate resources on health care
- The undue emphasis placed by the present government on having a budget surplus at the expense of the sick and injured

These are systemic problems and numerous staff and patients have come forward from a range of other Health Districts with the similar issues to the ones raised directly by the Patel scandal. It would be wrong to focus on Bundaberg as opposed to the health system more generally.

The Second matter concerns the meeting between five staff unions and the Premier in Bundaberg. (The minutes of this meeting dated 6 October 2000 were forwarded to the Commission by Email on 31 May 2005). The union representatives alerted the Premier to the potential for disaster in Bundaberg and the extremely dysfunctional health district. The meeting resulted in the reappointment of Mr Leck then on "gardening" leave. This unprecedented warning by five hospital staff unions was of such seriousness that the Premier personally travelled to Bundaberg to handle the crisis. Prompt action on this warning may have prevented the subsequent events with Doctor Patel. Unfortunately, the problems in Bundaberg were ignored.

Thank you for considering this submission which is supplementary to that which I made to Commissioner Morris.

Yours faithfully



Dr Bruce FLEGG MBBS, ASIA MP
Member for Moggill

Enclosure

Submissions

Dr James GAFFIELD

FAX TRANSMISSION

AMA QUEENSLAND

TO:	Jarrod Cowley Grimmond		
FAX:	3109 9151		
FROM:	Colleen Smyth		
PAGES:	Cover + 3		
DATE:	24 October 2005	**TIME:**	10.00am
SUBJECT:	Dr James Gaffield		

☐[P21] **Urgent** ☐ **For Review** ☐ **Please Comment** ☐ **Please Reply**

Please find herewith a letter from Dr James Gaffield in response to your correspondence of 14 October 2005.

There was difficulty transmitting this via fax on Friday, but the Secretary to the Inquiry should have been received a copy via email.

Please call me on (07) 3872 2268 if there are any difficulties.

Kind regards

Colleen Smyth
Senior Policy Officer

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21 October 2005

Mr Cowley Grimmond
Principal Lawyer
Queensland Public Hospitals Commission of Inquiry
PO Box 13147
George Street Qld 4003

Dear Mr Cowley-Grimmond

Thank you for your letter dated 14 October 2005 addressed to Hall Payne Solicitors, which I received on 18 October 2005.

I have attempted to respond to the main areas I feel need further deliberation by the Commission before making the general or adverse findings under consideration. I believe some of the proposed findings are untrue or the testimony on which they are based is misleading. It is possible to prepare a more detailed response, if the Commission wishes me to, but to do so I would need to seek an extension.

Alternatively, I feel these matters are dealt with adequately in my testimony to the Bundaberg Hospital Commission of Inquiry on Day 45, 19 August 2005. It may be useful for the Commission to refer to this transcript.

The comments that I wish to make on the findings under consideration by the Commission follow, and are numbered as per your letter:

1(d) Patient 26 (P26) did show some signs of clinical improvement during his hospital stay in Bundaberg. To say that he showed no significant signs of clinical improvement is untrue. It would be more appropriate to say he did not show dramatic improvement, but certainly did show some signs of improvement prior to his deterioration in his final time in Bundaberg. He improved in terms of the colour of his leg (less apparent ischemic tissue), and the swelling (reduced). Please refer to my testimony at pp4584 – 4585.

1(f) The patient had a normal white cell count on 28 December, not one that had "increased to an extent that it should have been clear to those caring for him that he was septic.". His white cell count was 10 on 28 December, 10 on 29 December, and rose to 17 on 30 December. A white cell count of 10 is within normal limits. As detailed in my earlier testimony, it was two days later that P26's white cell count rose to a level that indicated he was possibly becoming septic. When Dr Woodruff's testimony from the Bundaberg Hospital Commission of Inquiry is read I think it is clear he meant to say P26 was "clearly septic" on 30 December when he actually stated 28 December:

"...and I would like to draw the Commission's attention to the white cell count, and you'll see that on the - around the 29th of December, it's remained roughly normal from the 26th through to the 29th, but it's grossly abnormal on the 30th, it's risen from 10 to 18 and then goes on to 19 and a half on the 31st. And if one looks also at the nutrafills (sic) or the reactive white cells in the bloodstream, they're becoming elevated on the 28th. So this patient is becoming septic, clearly septic around the 28th, and should not have been allowed to get into that state."

Day 42, 18 August 2005, p 4922

2(a) Obviously, looking at this case retrospectively is quite different to prospectively, as I was forced to do. There was nothing in his clinical presentation to suggest that he needed to be transferred to Brisbane, nor were there clinical guidelines made available to me to suggest that this was the case (i.e. any guidelines from Queensland Health, Medical Board, or the Bundaberg Base Hospital). At the time, I didn't transfer the patient to Brisbane earlier due to Dr Patel's reassurance that the patient's injuries had been fixed appropriately and that there was no reason for concern that he may develop complications or not have undergone appropriate initial surgical management. I transferred P26 to Brisbane when I discovered this not be the case (i.e. when he clinically deteriorated).

2(b) With regard to P26's urine pathology test of 29 December 2004, it is easy to create some particular significance of this test in hindsight, however I maintain that this should not be so, and moreover reject that my action or inaction as a result of it is of any particular relevance, as:

- I was on holidays at the time the urine analysis in question was conducted and was not aware of its existence;
- I do not think it is reasonable to suggest that it is standard practice for a doctor covering someone else's patients to read through every single portion of the patients' charts before providing advice or treatment to them. Rather, it is common to take a briefing from his treating doctor, as I did so in the case of Dr Patel with regard to P26; and
- In any case, had I reviewed the test I would have concluded that the patient had muscle necrosis, which would be expected after a period of transient ischaemia to the leg. It is commonly used to assess the need to prevent renal failure (the muscle products clog up the kidneys and cause acute renal failure). If the level is high, measures to protect the kidneys need to be instituted. Dr Patel had told me that the patient initially had renal failure, but that it had cleared with appropriate treatment. This can be shown in his subsequent normal kidney function tests (blood tests). It did not require ongoing monitoring since the kidney problem had ceased. The test, theoretically, could be used to measure ongoing muscle death, but I don't think this was why it had been ordered by Patel, merely that it was used to judge the need for renal function monitoring. If one thinks that there is ongoing tissue ischaemia (eg, from faulty vascular repair, as was the case here), the appropriate pathway is either to re-

explore the vascular repair or perform imaging (ultrasound) to look at the vascular repair, not to follow the trend on this urine test.

2(c) I believe the statement that I "failed on 30 December 2004 to identify the patient's increasing white blood cell count in his pathology test dated 30 December 2004" is untrue. I noticed P26's increasing white cell count on 30 December 2004 and I considered potential sources of infection and took measures to resolve them. These measures included removing of the central intravenous line, taking urine and blood cultures, and examining the wound.

These are the major areas I feel it necessary to comment on in the time available.

Yours sincerely

James Gaffield

Dr James Gaffield

10.

Submissions

Dr Terry HANELT

James A. McDougall

Barrister-at-Law

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26 November 2005

Delivery

Private & Confidential

The Secretary
David Groth
Queensland Public Hospitals
Commission of Inquiry
Level 9
Brisbane Magistrates Court
363 George Street
Brisbane Q 4000

Dear Mr Groth

Re: Doctor Terry Hanelt

Enclosed herewith please find submissions on behalf of Dr Terry Hanelt.

With Compliments

J McDougall
Chambers

encl.

QUEENSLAND PUBLIC HOSPITALS COMMISSION OF ENQUIRY

Submissions on Behalf of Dr Terry Hanelt

1. It is easy to overlook the circumstances which gave rise to the interest of this Commission of Inquiry into the Fraser Coast District Orthopaedic Department. The North/Giblin Report did not come about as a result of any whistleblower's claims or as a result of gross mismanagement of patient care. It came about because Dr Hanelt sought the assistance of the AOA to resolve a dispute between Dr Mullen and his Director of Orthopaedics, which Dr Hanelt considered should be resolved in the interests of patient care. To now turn on Dr Hanelt based upon the scandalous content of the North/Giblin Report would be a gross injustice. The incidental exposure of faults inherent in the system of supply of hospital care in rural areas is considered healthy and it is appropriate that be dealt with by this Commission. Those faults are universal and the likes of Dr Hanelt with his long term devotion to rural medicine should be supported, not vilified.

2. In the course of this Commission there has been a tendency by witnesses, counsel assisting and the Commission itself to overlook or at least not have regard to the vastly different resources (facilities and medical staff) available to rural hospitals compared to the large tertiary hospitals. This was readily apparent in the approach adopted by the authors of the North/Giblin Report, by Dr Mullen and in the artificial distinction that has been drawn between orthopedic trauma surgery and so called elective surgery.

3. There has been no criticism of the SMOs performing trauma surgery (see para 2(b) of the list of potential adverse findings) as there can be no such criticism. That would lead to the SMOs being prevented from carrying out such surgery. That in turn would lead to a situation where most rural hospitals would simply shut down as in every discipline there are generally no specialists available to supervise and in many cases the specialist is plane journey away. If reliance was placed on specialists in obstetrics no babies would be born outside metropolitan areas.

4. The overwhelming evidence is that it is extremely difficult if not impossible to attract specialists in sufficient numbers to rural Queensland. QH is forced to rely on SMOs in all areas of need to fill the gap where required. The public demands their local hospital be open to meet community needs. The situation at the Hervey Bay was no different to most other rural or provincial communities except that it was better resourced than many.

5. The situation in Hervey Bay was vastly different from that which was revealed in Bundaberg. There have been reviews of patient's charts by independent specialists, reviews of patient complaints arising out of calls to an advertised hotline and review of a small number of patients by Dr Mullen. These reviews have revealed a very small number of adverse outcomes beyond what could reasonably be expected from orthopedic surgery - trauma or elective. Approximately 6-8 of these related to the care of the SMOs and only 3-4 of these arose out of alleged inappropriate procedural decisions by the SMOs. One of these (the so called "exploded" femur)

was explained very carefully and plausibly by Dr Krishna and his evidence has been reviewed by Dr Wilson and is left unchallenged.

6. This is an extraordinarily good outcome bearing in mind that there were about 5000 (average 1100pa.) orthopaedic admissions over the period under review. It is submitted that this is a result that would compare very favorably with the results of any tertiary hospital orthopaedic department staffed by any number of full time specialists and VMOs.

7. To single Dr Hanelt out for criticism is extremely unfair, unjust and unsupported by the evidence. The individual criticisms contained in the Notice of Possible Adverse Findings will be answered in detail below. Dr Hanelt is an extremely competent manager and a dedicated clinician who brings a wealth of experience to the management of the Fraser Coast Health District. He is a Fellow of the Australian College of Rural and Remote Medicine. He has made a career out of service in rural and remote hospitals as Medical Superintendent. He has maintained his clinical work doing shifts in Accident and Emergency and in relieving posts. He is not just a bureaucrat, as that term has been pejoratively used. He is a doctor who is clearly dedicated to his job and to the people of the Fraser Coast. He has continued to work as well as possible with the resources given to him in difficult circumstances and with difficult personalities. He is not the person to be made a scapegoat for a system that has many obvious and sometimes insurmountable shortcomings. He is exactly the sort of doctor Queensland Health and the people of Queensland desperately need.

8. **The Accusers.**

8.1 **Dr Mullen**

8.1.1 An analysis of Dr Mullen's evidence suggests his complaint was not with Dr Hanelt or indeed the hospital. It was about Dr Naidoo. There was open animosity and a history between them arising perhaps out of the period when Dr Mullen was Dr Naidoo's registrar. (Krishna- Statement para: 23)

8.1.2 Dr Mullen's criticisms of Dr Hanelt set out in his statement did not stand up to cross examination at all. He resiled from the allegation of bullying and aggression. He resiled from the suggestion that Dr Hanelt was not receptive of his complaints. (T. 5811 and following)

8.1.3 His reasons for withdrawing his services in 2002 were not supported by the contemporary documents. His reasons for allegedly refusing to sign the memorandum of the meeting of 16.01.04 (he would not sign it as it did not reflect the truth) came to nothing when it was revealed that not only had he signed it but he had amended it more than once. (T.5461,5466,5839)

8.1.4 Dr Mullen's testimony is conflicting regarding supervision of the SMOs.(T. 5836,5460 and 5454 in contrast to what he said at T.5839)

8.1.5 Dr Mullen's opinion as to what the SMOs could and couldn't do without supervision was not supported by Dr Wilson who was in a much better position to form an opinion about Dr Krishna and was not entirely

supported by Dr Crawford. Dr Naidoo was a more experienced orthopaedic surgeon than Dr Mullen and he disagreed with him. Dr Naidoo's professional ability has never been questioned in this Inquiry except by Dr Mullen and Dr Naidoo responded with a very plausible explanation of the reasons for his treatment in the Green case. Drs North and Giblin were in no position to offer any opinion at all for the reasons set out below. Dr David Morgan was complimentary of the ability of Dr Sharma in a letter tendered to the Commission.

8.1.6 Dr Mullen was critical of Drs Krishna and Sharma's performance of the so called "exploded" femur surgery. This criticism is without any foundation in fact. The "exploded" fracture was no more than the displacing of an undisplaced butterfly fracture that occurred when inserting the nail and was an anticipated risk of the surgery. The use of the retrograde nail was appropriate (T.7344). Dr Mullen was not even present for this surgery as he arrived after 5.30pm and performed the ankle surgery. This casts a degree of suspicion over all of Dr Mullen's evidence as being less than frank.

8.2 The North/Giblin Report

8.2.1 This document is by any measure a scandalous document and would not be admitted into evidence in any proper court. Dr North's oral evidence was equally flawed.

- The report and oral evidence reveals that no proper investigation was carried out.
- The investigators, for no valid reason, only attended at the hospitals for less than a full day.
- They conducted no audit of charts.
- They interviewed no patients.
- They only interviewed a very limited number of staff.
- They did not record interviews.
- They did not release their notes.
- They relied entirely on hearsay and innuendo and gossip.
- The alleged lack of cooperation in the production of documents proved to be entirely false.
- They made unsubstantiated scandalous allegations about Dr Naidoo's alleged relations with a prosthetics supplier which were never put to Dr Naidoo in the witness box. No attempt was made by the investigators to support this scurrilous allegation.
- They made unsubstantiated allegations about Dr Naidoo's terms of contract which were never put to him in evidence and which could have been resolved with a single phone call to the Human Resources Department
- The suggestion that they asked Dr Krishna clinical questions upon which they based their so called assessment of him was denied by Dr Krishna. Dr Krishna had no reason to deny this unless it was untrue. Dr Sharma also denies it in his statement.

- The Report suggests no one had a good word to say about the SMOs. This cannot be so. For example, Dr Mullen was full of praise for Dr Sharma and said he told the authors of this. (T.5460, 5780,5811,5812)
- The allegation that all of the nursing staff was critical of Drs Krishna and Sharma is false as they did not interview all or even a fraction of the nursing staff. Nurse Erwin-Jones was said by Dr North to be the source of this but she denies she said any such thing.
- The "sinister" innuendo about the unavailability of Nurse Winston was false and Dr North was later revealed as being quite untruthful about this witness. Nurse Winston's statement tendered on the last day puts an end to the false allegation that they did not speak to her and were prevented from doing so for "sinister" reasons. This exposes the whole of this evidence as being seriously tainted and calls into question the motives of the authors.
- The insistence by Dr North that the investigation was instigated by Dr Mullen flies in the face of the evidence that it was Dr Hanelt who sought the assistance of the AOA.
- If the investigators seriously held their views about patient safety, then why delay release of the report for 11 months? To say there were indemnity issues holding things up beggars belief. They could at any time have intimated their concerns in private.
- The Report is heavily criticised by Dr Hanelt, Drs Sharma and Krishna, by Mr Allsopp and by nurse Erwin-Jones. They are very critical of its accuracy in reporting what is recorded as their statements.

- The evidence of Dr Wilson completely contradicts the scathing assessment of Dr Krishna' skills and commitment (T.7345-7346).
- In an unresponsive answer during cross-examination by Mr Farr, Dr North, quite contumeliously it is submitted, offered up gossip about an alleged affair between a member of the nursing staff and the District Manager. This was never later put to either party to allow them to respond. This behavior by Dr North exemplifies the approach he took to this whole affair. The manner of giving evidence by Dr North seemed contemptuous of the whole process and displayed arrogance and a casual regard for the truth.
- The Report failed to address its terms of reference and was of no assistance to Dr Hanelt. It has done a great disservice to the people of the Fraser Coast. At a time when solutions were being sought it offered nothing.

8.2.2 This Report should be wholly rejected by the Commission.

Detailed Response to the Notice of Potential Adverse Findings

9. **Possible adverse findings:**

   a. **With respect to Term of Reference 2(c) that, as the Director of Medical Services at the Fraser Coast Health Service District, you:**

      (i) **failed to implement the Queensland Health policy on credentialing and clinical privileging within the Fraser Coast**

Health Service District or any alternative process to have medical practitioners in the Orthopaedic department credentialed and privileged. That failure resulted in Dr Krishna and Dr Sharma ("the Senior Medical Officers") performing orthopaedic surgery and orthopaedic clinics in circumstances where they had not been properly credentialed or privileged;

9.1 **Response**

9.1.1 The following responses are based on evidence contained in Paras 66, 67 and 109 of Dr Hanelts statement and inT.6721 and following:

9.1.2 The Queensland Health (QH) policy "Guidelines for Rural Medical Practitioners" lists hospitals for which the Credentials and Clinical Privileges process is to be determined by the Rural Committee for Clinical Privileges. This policy is still in effect to this date and the policy lists Hervey Bay and Maryborough Hospitals as included within that framework. It was last published on the Queensland Health Intranet on 14/01/2003.

9.1.3 This Policy was published at a date later than the overarching QH Policy document 15801 which sets out the principal that all medical practitioners using QH facilities require Clinical Privileges. This Policy was created on 12/09/2002.

9.1.4 Dr Krishna commenced in the District on 22/07/2002. On 10/01/2003 Dr Hanelt recommended to the District Manager that Dr Krishna be granted Interim Privileges in Trauma Orthopaedics and minor elective orthopaedic surgery whilst awaiting processing of formal privileges by the Rural

Committee. This 5½ month period was a reasonable time for assessment of Dr Krishna's skills by the Director of Orthopaedics to allow an informed recommendation in relation to Clinical Privileges. This recommendation, which was done in the form of a draft letter (correspondence is attached by way of tender.) to be signed by the District Manager, clearly articulates that at that stage Dr Hanelt was recommending Interim Clinical Privileges in accordance with QH policy and was also attempting to have the Clinical Privileges process conducted by the Rural Committee in line with QH policy in that the letter states the Privileges are Interim and in force until the Rural Committee formally grants privileges.

9.1.5 Interim privileges were also recommended to the District Manager in respect to Drs Sean Mullen, Morgan Naidoo, Veruthaslam Padayachey and Jim Khursandi in the same manner.

9.1.6 Dr Sharma commenced duties with the District on 6/03/2003. Interim privileges recommendation was not made in respect to Dr Sharma until 2/07/2004. This was an oversight that came to light when the Review of Orthopaedic Services was performed at that time. In any event the same process would appear to have been followed although not pursuant to a letter requesting same.

9.1.7 Thus four of the five doctors providing dedicated orthopaedic services within the District had Clinical Privileges recommended to the District Manager in accordance with QH policy soon after the new policy was

introduced and in the case of the fifth doctor, Dr Sharma, the requirement was overlooked.

9.1.8 These recommendations which resulted in letters outlining the Clinical Privileges were signed by the District Manager and forwarded to all these doctors. Copies of the signed letters for Dr Krishna and Dr Sharma have been located and are produced.

9.1.9 The QH policy does not state the duration of Interim Clinical Privileges and as such all medical staff within the orthopaedic department who are required to hold Clinical Privileges have current Clinical Privileges.

9.1.10 At some stage after the recommendation in relation to Clinical Privileges for Dr Krishna, Dr Hanelt was advised by the Rural Clinical Privileges Committee that the Fraser Coast Health Service District Medical Staff would not be processed by that Committee.

9.1.11 After discussion with superiors within QH the Directive was given to convene a District Committee. Despite this Directive the QH policy remains that both Hervey Bay and Maryborough Hospital medical staff are to have the Clinical Privilege process performed by the Rural Committee.

9.1.12 After the Directive was received, establishing a Clinical Privileges Committee that complies with QH policy has not been possible in some specialities, due to lack of College participation.

9.1.13 An alternate process was commenced to try to overcome this situation as best as could be done. This was by combining with Bundaberg Health Service District to get a sufficient number of senior clinicians to be able to manage the process in a reasonable manner.

9.1.14 Medical staff employed in specialities in which nominees were received have had their credentials assessed and Clinical Privileges recommended by the combined District Committee.

9.1.15 The Royal Australasian College of Surgeons (RACS) and the Australian Orthopaedic Association (AOA) failed to provide nominees. The District has recently been able to obtain a RACS representative through the Queensland Branch after the request was again rejected by the Federal Branch. The Queensland Branch of the AOA has failed to respond to two letters requesting representatives since endeavours to set up a local Clinical Privileges Committee commenced. A further letter was sent to the Federal Chair of the AOA who has recently supplied three nominees. These nominees were Dr Sean Mullen, Dr John North and Dr Greg Gillett. The determining of Clinical Privileges SMO's who are not specialists, but work in a specialised clinical area remains a problem.

9.1.16 The Colleges will only be involved in the process for specialists, deemed specialists and medical practitioners who hold overseas specialist qualifications not recognised in Australia and who are undergoing a period of assessment under oversight. In relation to these two latter groups the Colleges nominate any restrictions that should be applied to these practitioners Clinical Privileges relating to their Credentials and nominate the College requirements for supervision.

9.1.17 There are Joint Consultative Committees (JCC's) set up between some of the Specialist Colleges and the Royal Australian College of General Practitioners (RACGP) and the Australian College of Rural and Remote

Medicine (ACRRM). These (JCC's) work well in relation to determination of Clinical Privileges for General Practitioners (GP's) performing operative obstetrics and Anaesthetic services. There are delineated mechanisms for determining Clinical Privileges and requirements to maintain these Privileges. This is not the case so far as orthopaedics is concerned.

9.1.18 This leaves the option (in accordance with QH Policy) of getting College representative input from the RACGP or the ACRRM for non-specialist medical staff working in a discipline specific position at an advanced procedural level.

9.1.19 Neither of these Colleges is well suited for assisting in the determination of Clinical Privileges for non-specialist SMO's working in these positions. These Colleges are suited to assisting with the determination of Clinical Privileges for General Practitioners who provide limited specific procedural services.

9.1.20 Had the Clinical Privileges for Drs Sharma and Krishna been determined under the current policy guidelines using the RACGP or the ACRRM, it is highly probable that they would have had their Clinical Privileges granted in line with the recommendation of the Scope of Practice as determined by their direct supervisor, Dr Naidoo. Apart from the concerns of Dr Mullen, there would have been no evidence not to grant such privileges. Dr Mullen's concerns were not based on the actual skills of the SMOs, but usual practice in a tertiary hospital. This is unlikely to be more persuasive than Dr Naidoo's opinion.

9.1.21 This process was too flawed to be of value and would be ignoring the issue rather than addressing the issue of appropriate determination of privileges. A Scope of Practice determination with the basing of recommendation of Interim Clinical Privileges in line with this determination was considered a better process until a more formal process could be developed.

9.1.22 The Scope of Practice was determined by the Director of Orthopaedics once clinical ability of Dr Krishna and Dr Sharma had been determined. It now appears that this process may not have been done in a reasonable manner but Dr Hanelt was unaware of this factor until evidence was presented to the Commission to that effect.

9.1.23 This Scope of Practice was requested when the SMOs commenced and was required to be reduced to a document in preparation for the formal Credentials and Privileges process. This document was only provided in writing after a formal request in writing was provided to the Director of Orthopaedics.

9.1.24 In a meeting with the two Orthopaedic Surgeons providing services at Hervey Bay Hospital on 16.01.2005, the problem of how to get an independent and unbiased assessment of the clinical ability of the SMOs was discussed. It was agreed that the AOA was asked as part of the Terms of Reference for the Orthopaedic Service Review to provide some framework for assessment of Credentials to make the process meaningful, transparent and accountable.

9.1.25 This Term of Reference was not covered by the North/Giblin report.

9.1.26 In any event the evidence of Dr Wilson is generally supportive of the opinion Dr Naidoo held of Dr Krishna's clinical skills as contained in the Scope of Practice. Dr Wilson's evidence is the best on this point. He was the specialist best able to form an opinion about Dr Krishna's skills and insight as his supervising specialist at Toowoomba. He generally agrees with Dr Naidoo. Taken at its lowest, Dr Wilson's evidence serves as an example of the differing opinions of specialists about non-specialist's skills. In addition Dr Wilson totally disagreed with the opinions expressed in the North/Giblin report about Dr Krishna. (T.) As Dr Hanelt had no reason to question Dr Naidoo's clinical judgement it was not just reasonable for him to accept Dr Naidoo's opinion on these matters, he was really obliged to. Who else could he ask? There does not appear to be any evidence based criticism of Dr Sharma's performance and very little evidence based criticism of Dr Krishna. Having regard to the fact that there were on average 1100 orthopaedic admissions to the hospital per annum (T.6794) there is very little evidence of poor outcomes beyond the what would normally be expected from a large tertiary hospital which this was not.

9.1.27 There is no criticism of the SMO's performance of orthopaedic trauma surgery. The exigencies of the situation the District found itself in left no alternative but to trust that surgery to the SMOs. It was a trust that was justified if one looks closely at the evidence of Dr Crawford and the clinical evidence of Dr Mullen as opposed to the speculation, hearsay and innuendo of the North/Giblin document.

9.1.28 In summary, the QH policies in relation to Clinical Privileges are in contradiction; some of the Colleges are less than co-operative in the process. There is no robust mechanism for the process in relation to non-specialists. Dr Hanelt, as is shown in the emails attached hereto by way of tender, attempted to set up an appropriate system in conjunction with Bunderberg Hospital at least as early as 12.03.03. Clinical Privileges were recommended on an Interim basis whilst attempting to develop a suitable mechanism; there was a delay in relation to Dr Sharma's Privileges due to an oversight. There was agreement between Dr Naidoo, Dr Mullen and Dr Hanelt on 16.01.2004 that the AOA would be asked to provide input on a suitable mechanism for determining the Credentials of the SMOs and subsequently formal Clinical Privileges. There are still problems in seeing how an appropriate mechanism can be developed for Clinical Privileges for doctors such as Dr Sharma and Dr Krishna without a QH wide approach to develop suitable mechanisms due to the unwillingness of the Colleges/AOA to participate to date. Dr Hanelt did everything reasonable to ensure Interim Clinical Privileges and attempt to develop an appropriate mechanism for determining formal Privileges.

9.1.29 To assist in the process for Clinical Privileges in the future Dr Hanelt suggests: –

9.1.30 QH needs to review the policies in relation to Credentials/Clinical Privileges to eliminate inconsistencies between different policies and between policies and verbal instructions provided.

9.1.31 QH needs to review the Policy in relation to Clinical Privileges for SMOs who are neither registered as specialists and are not GP's and for specialities where the Colleges fail to nominate a representative.

9.1.32 A suitable option may be for each Zone to have a senior clinician in each discipline who undertakes this responsibility for non-specialist SMOs and for specialists where there is a lack of College participation.

9.1.33 This should be combined with the establishment of supra-nummary positions (funded by the employing District) in teaching hospitals where SMOs can undergo periods of assessment to determine clinical ability independent of the employing District. This process would remove the potential for bias based on the need of the Districts Director or that service.

9.1.34 These supra-nummary positions would also be of benefit in assessment of registered specialists where there was some question raised in relation to clinical competence where the District does not have the ability to provide appropriate assessment. Ideally this is a College responsibility but the Colleges have a poor history in relation to this aspect and current mechanisms are deficient with the only exception to Dr Hanelt's knowledge being the College of Obstetricians and Gynaecologists which has a fairly well developed assessment process in place.

10. **Between July 2003 and August 2004, allowed Dr Krishna and Dr Sharma to perform elective orthopaedic procedures without providing either with an appropriate level of supervision or consultant support;**

10.1 **Response**

10.1.1 The response below is based on evidence contained in paras: 67,72-74 of Dr Hanelts statement and T.6732,6736,6745 and 6757.

10.1.2 The procedures performed by Dr Sharma and Dr Krishna were of the type that the Director of Orthopaedics had determined they were competent to perform with the assessed degree of supervision/support.

10.1.3 Contrary opinion in relation to the degree of supervision requirement was provided by Dr Mullen.

10.1.4 The assessment by Dr Naidoo is largely supported by Dr Wilson who is in a strong position to assess Dr Krishna.

10.1.5 This contrary opinion was viewed in relation to several facts –

a. Dr Naidoo was vastly more experienced than Dr Mullen.

b. Dr Naidoo had far more direct contact with both Dr Sharma and Dr Krishna and was in a better position to make judgement of clinical ability.

c. Dr Mullen continued to delegate surgical procedures to be performed by Dr Sharma and Dr Krishna without providing supervision in a situation where he knew no other supervision was being provided for the procedure

d. Dr Mullen had done his training in teaching hospitals where there were always specialists available and did not seem able to properly understand or recognise alternate models of care. Many non-specialist medical practitioners provide a range of elective surgical procedures throughout non-teaching hospitals and some teaching hospitals without

direct supervision or in many cases with no supervision. Dr Mullen did after some time agree this was widespread practice and accept this as a necessity. This is documented by his signature to the memorandum from the meeting on 16/01/2004.

10.1.5 There was no current standard that applied to the supervision requirements for non-specialists performing procedures and as such Dr Hanelt was not in a situation of being able to accurately assess or determine the level of supervision required for these two rather unique doctors within QH. It appeared reasonable to follow the model he had observed in the multiple hospitals in QH in which he had worked during his career. This model was the assessment of supervision requirements of the senior clinician to whom the non-specialist reported on a clinical basis.

10.1.6 The North/Giblin Report had as a Term of Reference to provide guidance as to appropriate supervisory requirements in a situation of difference of opinion and incongruous behaviour by Dr Mullen. This demonstrated a desire to get independent opinion to assist in determining appropriate supervision requirements.

10.1.7 The Medical Board has now developed guidelines in relation to supervision requirements for Special Purpose Registrants that will assist Directors of Medical Services in ensuring supervision in line with the expectations of the Boards and community standards and Dr Hanelt would welcome the provision of some guidance in this aspect for the future.

11. **Allowed the Senior Medical Officers to be placed 'on call' in circumstances where there was inadequate consultant support available to provide an appropriate level of supervision;**

11.1 **Response**

11.1.1 This response is based on evidence contained in paras: 46(iii), 60, 72(ii) and 74 of Dr Hanelts statement.

11.1.2 The matters raised in response to 1(b) apply to this possible finding as well as the following factors relating to provision of an on-call service.

11.1.3 It was not possible to have a specialist orthopaedic surgeon on-call at all times with the number of specialists available in the District.

11.1.4 The offer of Dr Mullen to do a 1 in 2 on-call was conditional of Dr Naidoo also doing a 1 in 2 on-call. As that condition could not be met, the offer from Dr Mullen could not be implemented.

11.1.5 Even if this condition could have been met and a 1 in 2 specialist on-call service had been implemented this would not have functioned during periods of leave for either specialist.

11.1.6 With an inability to provide a specialist on-call at all times, the only option available is to have differential levels of on-call service.

11.1.7 When a specialist is on-call then that service is provided.

11.1.8 When a specialist is unavailable someone must be on-call for patients presenting with orthopaedic conditions.

a. The Medical Officer on-call for patients presenting with orthopaedic conditions when a specialist is unavailable could be the Surgical

Department Medical Officer or an Emergency Department Medical Officer if orthopaedic non-specialist SMOs were not to be utilised.

b. Using a Surgical or Emergency Department Medical Officer would be using a Medical Officer with less Orthopaedic knowledge and skill that the Orthopaedic SMOs and would result in a service less able to meet patients needs. This was the model in place prior to employment of the Orthopaedic SMOs and was quite unsatisfactory with concerns relating to inadequate assessment and management of some orthopaedic patients.

11.1.9 The alternative option of having no Medical Officer providing orthopaedic advice/assistance to a junior doctor from the Emergency Department and that junior doctor contacting a hospital such as the RBH or PAH would also be less suitable due to the limited ability in orthopaedic patient assessment of the junior doctor in the Emergency Department.

11.1.10 Throughout QH provincial and rural hospitals, having SMOs being on-call without local consultant supervision is common practice and is accepted as the norm. Acting in a manner widely accepted within QH as the normal practice should not be deemed inappropriate practice by an individual. If the practice is inappropriate then it must be applied to all Queensland Health facilities, both public and private.

12. **In the 'area of need' application for Dr Krishna and Dr Sharma, provided information that suggested that both doctors would have consultant supervision "24 hours per day/ 7 days per week" in circumstances where, due**

to consultants being on leave or unavailable or off duty, the level of supervision was likely to be significantly lower;

12.1 **Response**

12.1.1 The response below is based on evidence at T.6715-6721 and para:104 of Dr Hanelts statement.

12.1.2 The Area of Need forms completed for the Medical Board were filled in with the intent to portray the supervision in an accurate manner.

12.1.3 Further details of other Forms 1 produced by the Medical Board provide a more complete picture. In addition, prior to requiring a proforma "Performance Report" for application of renewal of registration under the "Area of Need" category a free form report was required. The required forms were completed in what was Dr Hanelt's belief to be the Medical Board requirements and it clearly articulated the specialist support level in terminology that is understood by other practitioners and Dr Hanelt believes, by practitioners on the Medical Board

12.1.4 The guidelines for registration in the Area of Need lack specificity in the requirements for provision of information. More explicit details of the supervision requirements would have been met, as has been done since the application forms were altered to make it more clear what information the Medical Board required.

12.1.5 In relation to information supplied to the Medical Board about supervision for Dr Krishna the information varied with the annual applications. Phrases used included –

- "Orthopaedics – Provide management of wide range of conditions with minimal supervision. Supervision available – Director of Orthopaedics (full-time) 2 x VMO's. Consultant advice available – Normal working hours + weekday nights. Not all weekends on site but remotely always."
- "Orthopaedics – Experience and procedural ability in the area of orthopaedics and ortho trauma operative skills. Supervision available – 3 x consultants. Consultant advice available – Available 24 hrs a day."
- "Supervision available – Supervision by a Staff Specialist "business hours" and as necessary after hours."

12.1.6 The forms submitted showed to varying degrees that the position required orthopaedic operative skills; the ability to manage a wide variety of orthopaedic conditions; that this work was required with minimal supervision; and that consultant advice was only available remotely at times.

12.1.7 Supervision available as necessary after hours is considered as accurate as the scope of practice was limited to that in which Dr Krishna had been assessed by the Director of Orthopaedics to be competent to perform independently. It was intended that no procedures be performed if supervision had been deemed necessary and that supervision was not available.

12.1.8 The supervision during business hours may, in hindsight, have been worded more explicitly to reflect that during times of leave by the Director

of Orthopaedics supervision was limited to times when a VMO was available. It is submitted that this would not have changed the registration granted by the Medical Board as the Board was aware from the same documentation that after hours Dr Krishna worked without direct supervision being available and did not impose any restriction in relation to this activity.

12.1.9 In a report to the Medical Board on 17.04.2003 Dr Hanelt stated "Dr Krishna has very good insight into his ability and limitations and does not attempt to independently manage any patients that would better be managed by a specialist Orthopaedic Surgeon." This clearly demonstrates that the Board was advised Dr Krishna was independently managing some orthopaedic patients and certainly did not indicate supervision at all times.

12.1.10 The registration category approved special purpose activity and conditions imposed by the Medical Board for Dr Krishna did not vary in response to these applications that indicated Dr Krishna was performing a range of operative orthopaedics and that this was not done with constant supervision. There were no restrictions imposed by the Medical Board in relation to limitation of practice or supervision requirements.

12.1.11 The documentation completed in relation to Dr Sharma was very similar to that of Dr Krishna and the same registration categories and requirements were applied by the Board.

12.1.12 It was usual for the Medical Board to impose supervision requirements irrespective of the information provided if supervision was felt necessary.

12.1.13 SMOs are employed in that capacity due to their ability to work as basically independent practitioners. If this ability was not present employment was at the level of Principal House Officer or lower. Employment and registration as a SMO inherently indicates that the Registrant would be performing at a high level of responsibility.

12.1.14 It is unreasonable to expect a Director of Medical Services to know the exact information required by the Medical Board when there was limited documentation in relation to the requirements and correspondence to the Board received no responses.

13. **Failed to take steps to ensure that either Dr Naidoo or another registered orthopaedic surgeon was able to supervise or be contacted to assist the Senior Medical Officers in circumstances where you were aware:**

a. Dr Naidoo was difficult to contact on occasions when he should have been able to be contacted;

b. The Senior Medical Officers had on occasions, called Dr Naidoo for assistance, and he had not been available;

c. **Dr Naidoo was absent from the hospital for extended periods.**

13.1 Response

13.1.1 The response below is based on paras: 62-63 of Dr Hanelts affidavit.

13.1.2 Dr Hanelt relied on Dr Naidoo. He was aware of the need to provide supervision for the SMOs having regard to their assessed scope of practice, clinical privileges and the availability of supervisors. He was also

aware of Dr Mullen's view. However, he accepted the assessment of his Director of Orthpaedics as he was obliged to do until he had good reason not to. It is grossly unfair to judge Dr Hanelt's actions with the benefit of hindsight. The relationship between Dr Hanelt and his Director of Orthopaedics would have been quite untenable if he was to overrule the Director without apparent good reason. As things turned out Dr Hanelt took the very serious step of seeking to have the dispute between Drs Mullen and Naidoo resolved by inviting the AOA to nominate investigators.

13.1.3 Supervision was required if the SMOs were to perform a procedure for which their assessment required that they must only perform that procedure with supervision. Dr Wilson gives strong evidence of Dr Krishna's insight as to his capabilities.

13.1.4 There was an arrangement that the SMOs were to contact alternate sites on occasion when neither the Director of Orthopaedics nor a VMO was available. In cases where the patient's condition required management beyond the scope of the SMO then transfer for care or admission with care provision when a specialist was available were the normal options available. They were capable of making this decision. T.6798, 6734, 6748 refers to recruitment of additional orthopaedic staff. Steps were taken to try to obtain additional specialist services in orthopaedics within the District to cover periods of leave. This was done by attempting to recruit additional specialist staff, both on a permanent basis and on a locum basis.

13.1.5 The attempt to recruit these additional staff was to allow for the provision of a specialist level service during absence of the Director rather than a non-specialist SMO level service during these absences.

13.1.6 Recruitment efforts were significant including advertising, contact with recruitment companies and direct mail outs to every registered orthopaedic specialist in Australia and New Zealand.

13.1.7 Recruitment was unsuccessful except for the period from January 2005 when a locum was recruited.

13.1.8 When additional specialist supervision was not available the service level was reduced to the best that could be provided with the available staff. Patient care was not compromised. To remove Dr Sharma and Dr Krishna from orthopaedics during periods of unavailability of the Director would have resulted in staff with less expertise being obliged to provide an orthopaedic service.

14. **With respect to general findings that the Inquiry intends to make with respect to the Hervey Bay Hospital:**

(ii) Dr Naidoo was unable to be contacted when he was on call, and on duty within the Fraser Coast Health Service District;

14.1 Response

14.1.1 The response below is based on paras: 61-62 of Dr Hanelts statement and paras: 1(a), 1(b-c) of the supplementary statement and T.6730.

14.1.2 Dr Hanelt was aware of such claims from time to time, but was unable to confirm this as on the occasions this was brought to his attention at the time, he was able to establish contact.

14.1.3 On several of these occasions Dr Hanelt confirmed Dr Naidoo's physical location (eg scrubbed in the operating theatre or in transit between hospitals and seeing him after his arrival).

14.1.4 There were obviously occasions about which Dr Hanelt was unaware. This was not surprising as Dr Hanelt was responsible for a large medical staff between the two hospitals.

15. **Dr Naidoo was, on occasion, in Brisbane when he should have been on duty at the Hervey Bay Hospital;**

15.1 **Response**

15.1.1 The response below is based on evidence at T. 6730, 6739 and 6740.

15.1.2 Dr Hanelt was aware of some times when Dr Naidoo reported sick from Brisbane when he was rostered for duty.

15.1.3 He was also aware of some times when Dr Naidoo would depart early to travel to Brisbane. This flexibility was allowed for all staff in return for overtime that had been worked but not claimed and is normal practice within QH. (Time off in lieu.)

15.1.4 Dr Hanelt is now aware from the telephone call audits and fuel docket audits that there are occasions when calls were made from locations and fuel was obtained at locations not consistent with Dr Naidoo's work roster and leave claims, assuming he had possession of his car and phone at such

times as was a requirement. There has been no opportunity to seek an explanation of these apparent discrepancies since they became known, as Dr Naidoo has been absent on sick leave since these apparent discrepancies were noted. In any event Dr Hanelt did not have access to these documents prior to this inquiry because of privacy issues. This information was within the province of Human Resources.

15.1.5 The QH payroll system is counterproductive to monitoring staff attendance as reporting is by exception. That is to say if one works normal rostered hours or fails to notify the pay office of any variation one is paid for normal rostered hours. No regular time sheets are submitted through Medical Administration so policing attendance is difficult. This does not create difficulties where staff are in the same location as their supervisor. This is dysfunctional for medical staff as all are rostered to work over multiple locations over two hospital campuses and staff are often not seen by Medical Administration for significant periods.

15.1.6 The problem with the monitoring of attendance has been discussed with various levels within QH without any provision of advice as to suitable mechanism. Dr Hanelt has been unable to find or formulate a mechanism to date that would not be onerous to Medical Administration and staff and produce a feeling of apparent mistrust of staff.

15. **Dr Naidoo authorised Drs Krishna and Sharma to perform certain orthopaedic procedures without:**

a. an appropriate level of supervision or consultant support;

b. observing either Dr Naidoo or Dr Krishna performing those procedures;

c. reviewing patient outcomes following procedures performed by Drs Krishna and Sharma;

d. otherwise satisfying himself of Drs Krishna and Sharma's competence to perform those procedures instead relying on Dr Krishna and Dr Sharma to advise him of their respective levels of competence with respect to orthopaedic surgeries;

16.1 Response

16.1.1 The response below is based on evidence contained in paras: 22, 96-97 of Dr Hanelts statement and at T.6716, 6728, 6733, 6736 and 6745.

16.1.2 The supervision requirements should depend on clinical competence. Lack of an Australian specialist qualification does not preclude competence.

16.1.3 The available evidence to date indicates this may be correct in relation to some of the procedures in so much that the process of assessment of operative skills appears to have been deficient. Dr Hanelt was not aware of this until the Commission evidence was heard.

16.1.4 The second point is recognised and acknowledged. It occurs with all medical staff in relation to their Director and certain procedures. It is submitted that it is not always necessary to observe each and every procedure performed by a staff member as the same skills and abilities applying to some procedures are identical or to a lesser degree, applicable to other procedures. (T.) However Dr Hanelt concedes that the level of observation performed by Dr Naidoo in determining the clinical skills of Dr Sharma and Dr Krishna, as revealed in evidence, is not what Dr Hanelt expected to be the case when he relied on Dr Naidoo's assessment.

16.1.5 Reviewing patient outcomes is referred to at T.6729 to 6730 and 6802.

16.1.6 Dr Hanelt concedes there was a deficiency in that longer term clinical audits were not performed regularly. This problem was related primarily

to lack of suitable tools for data entry and analysis and lack of staff to perform this function had the tools been available. Data was collected but was not collated or analysed. This was a system fault rather than an individual fault. The District and QH failed to provide the resources. This has since been rectified.

16.1.7 The assessment process to determine competencies for Dr Krishna and Dr Sharma as revealed is less than what Dr Hanelt expected from Dr Naidoo.

17. Dr Krishna and Dr Sharma performed procedures that may have been beyond their competence;

17.1 **Response**

17.1.1 The response below is based on evidence at T.6726-6727 and 6735.

17.1.2 There is evidence of some adverse outcomes. However these outcomes are recognised complications of the surgery that was performed.

17.1.3 At T.6726 and 6727 the issue of the e-mail stating the SMOs could book cases that they were happy to do during the absence of Dr Naidoo is raised. Dr Hanelt concedes this was worded poorly and open to misinterpretation. The intent was that they would book cases within their level of competence and not anything except joint replacements as was suggest in the Commission.

17.1.4 Use of the term "happily manage" is in the context of meaning-'within their scope of competence' and again does not mean they are doing things that they are not competent to perform.

17.1.5 Dr Sharma or Dr Krishna may have performed procedures which they were confident to perform but in which they required further training to increase their skill levels.

17.1.6 Without a proper audit of the incidences of adverse outcomes or an independent assessment of their clinical competence, Dr Hanelt no longer accepts the assessment of Dr Naidoo, especially in light of the manner in which this assessment was performed as revealed by the evidence before the Commission. Nevertheless there was significant evidence that the work of Drs Krishna and Sharma was in the main reasonable and within their level of competence.

18. **The lack of supervision in the orthopaedic department at the Hervey Bay Hospital resulted in patient safety being placed at risk;**

18.1 **Response**

18.1.1 The response set out below is based on paras: 57, 58, 98, and 105 of the statement and in evidence at T. 6736

18.1.2 To the extent that adverse outcomes occurred in a small number of cases, this may be correct, although some of the evidence is unclear as to whether the adverse outcomes were due to lack of supervision or were simply complications which could occur in the best of hands. This statement also has to be balanced against the competing risks to patient safety of no service being provided at all, or simply by junior doctors in an Emergency Department.

18.1.3 The lack of adequate skill assessment of the SMOs by Dr Naidoo means that there was the potential for safety to be compromised. There is very little evidence that it was.

18.1.4 This proposition ignores the fact that the SMOs were capable of determining the safe level their own abilities and that they could and did seek advice elsewhere within the system and could and did in fact refer patients on. This meant the level of service available at Fraser Coast was compromised but not patient safety.

19. **The Senior Medical Officers were routinely placed on duty after hours in circumstances where they had inadequate consultant supervision.**

19.1 Response

19.1.1 See 1(c) above, as well as below.

19.1.2 This is only accurate if the scope of practice/Clinical Privileges were assessed inaccurately.

19.1.3 A system whereby practitioners act within their level of competence and arrange alternate care for patients who have conditions beyond their level of skill is congruous with the available level of supervision.

19.1.4 Since the withdrawal of services by specialist orthopaedic surgeons at Hervey Bay Hospital, patients still present with orthopaedic conditions. These patients must still receive treatment. This treatment is at a GP type level now with less expertise than was previously available from the SMOs. This has necessitated increased referrals to other centres. Lack of available beds at alternate facilities has caused treatment delays that in some cases are associated with increased risk of adverse patient outcomes.

20. **And you are invited to make written submissions regarding the following possible adverse recommendation:**

With respect to term of reference 2(e) that as a result of any or all of the potential findings in paragraph 1 and 2 above, the Director-General of Queensland Health consider whether you should be disciplined under s.87 (1) (a) and (b) of the Public Service Act 1996 on the grounds that you may have

performed your duties carelessly, incompetently, inefficiently, or are guilty of misconduct.

20.1 **Response**

20.1.1 Dr Hanelt has performed his duties to the best of his ability and at a high standard.

20.1.2 Failure to complete some components of his duties results from difficulties resulting from inconsistent policy, lack of co-operation by other necessary participants and the magnitude of his workload.

20.1.3 The QH policies having conflicting requirements hindered compliance with of the Clinical Privileges policy – one policy states they must go through the Rural Clinical Privileges group which was unable to provide that service.

20.1.4 The lack of co-operation by certain Colleges/Associations hindered the performance of the Clinical Privileges process.

20.1.5 Attempts were made to comply with the Policy as closely as possible with the recommendation of Interim Clinical Privileges whilst determining a suitable model that would be functional.

20.1.6 Reliance and trust was placed in certain individuals to perform their duties in a reasonable manner. Without delegation and reliance on others there would be serious limitations on what could be achieved by Dr Hanelt personally performing every task.

20.1.7 Dr Hanelt works significant amounts of unpaid overtime in an attempt to fulfil the range of duties assigned to his position. Even with this dedication it is not possible to achieve all that is required of the position.

20.1.8 Dr Hanelt's workload during the period of interest included responsibility for the following -

- All Medical Staff issues.
- Processing Registration and Immigration.
- All Allied Health Staff except Community Health Staff.
- Pharmacy.
- Medical Imaging.

- Rostering of Medical Staff for the Emergency Department.
- Allocation of junior staff to clinical placements.
- Organising coverage for emergent leave.
- Medico-legal matters.
- Clinical Complaints.
- Resolution of staff complaints.
- Recruitment of staff – medical and allied health.
- Head of Surgical Services Management Advisory Group.
- Strategic management of Elective Surgery target achievement.
- Liaison with private practitioners, Emergency Services and the media.
- Executive functions including: Weekly Executive Meetings, Monthly Surgical MAG meetings, District Health Council meetings (monthly), Monthly MSAC, District Quality meetings (fortnightly), Heads of Departments meetings (monthly), Division of General Practitioners Meetings (as required).
- Instituting relevant new policy and legislative requirements including necessary staff education.
- Provision of direct Clinical care.
- Medical Education.
- Orientation of new medical staff.
- Patient Travel Subsidy Scheme.
- Monitoring budgets.
- Performance appraisal of 65 staff.

20.1.9 During the period of his employment within the District Dr Hanelt's responsibilities have had a huge increase with no additional support until January 2004 other than one support officer. The District went from one secondary level facility and one primary care facility to two secondary service level hospitals. In 1994 the District employed 24 full-time doctors. The District now employs just over 60 full-time doctors. The Allied Health staff also doubled from about 20 to about 40 full-time staff. This is a massive workload increase and was impossible to manage adequately.

Since the start of 2004 and especially during 2005 several changes have occurred that have diminished this workload. These include –

- Appointment of a Deputy (January 2004).
- Allied Health staff transferred to Community Health (Early 2005).
- Temporary appointment of HRM support for medical recruitment (August 2005).
- Temporary appointment of a Clinical Governance assistant (July 2005).
- Temporary appointment of a Morbidity & Mortality administrative assistant (Mid 2004).
- Temporary appointment of an A/Director of Emergency Medicine (June 2005).
- Devolution of medical officer clinical attachment determinations to the Director of Clinical Training (June 2005).

20.1.10 These changes have the potential to reduce the workload to the degree that it is possible to perform the required duties for the position.

20.1.11 Dr Hanelt's history of continuous service to QH since 1983 demonstrates commitment to that organisation.

20.1.12 During that period there have been no concerns raised about Dr Hanelt in relation to having performed his duties carelessly, incompetently, inefficiently, or being guilty of misconduct.

J A McDOUGALL

Counsel for Dr T Hanelt

From: Terry Hanelt
To: Nydam, Kees
Date: 12/03/2003 4:39 pm
Subject: Clinical Privileges

Kees,
I have made a couple of changes (highlighted). See what you think. I went through the latest guidelines (July 2002)
I have also attached a list of our staff that need clinical privileges (a couple yet to start) I have also marked the ones that I think would be good as college reps Can you compile a similar list with recommendations and I will write to the Colleges with our suggestions and seeking their input Please also let me know of any other specialities you have that we do not have such as Dermatology so these do not get overlooked
Once we are happy with the Policy, we can meet with Dr Paddy and finalicy the actual procedure for the process.
Terry H

From: Terry Hanelt
To: Keating, Darren
Date: 7/05/2003 3 25 pm
Subject: Fwd: Clinical Privileges.

Darren,
This has some priority.
If the clinicians do not have clinical privileges formalised, they could be denied indemnity by QH
Could you please have a look at the attached and give me a ring if you wish to discuss any aspects
Maybe next Thursday when we meet about the Renal stuff we could touch on this issue as well.
Terry H

Dr Terry Hanelt
Director of Medical Services
Fraser Coast Health Service District
PO Box 592,
Hervey Bay Qld. 4655.
Ph 07 41206859
Fax 07 41206799
e-mail Terry_Hanelt@health.qld gov.au

From: Vinod Gopalan
To: Hanelt, Terry; Keating, Darren
Date: 15/07/2004 2:25pm
Subject: credentialling

Dear All

Just an update into whats happening. I have contacted the college of surgeons in Victoria who refereed me to the college branch in QLD. following my discussuions with them, they informed me that they had been swamped with applications from other area health services. Importantly they had a new chairman now and at this stage they are unable to suggest a suitable candidate as there are problemsd including indemnity of the college representative for any fallout from the review. I got a call yesterday from the college informing me that they were now awaiting advice from the college headquaters in Melbourne. I will keep you posted, however I think we should get together and review our own staff applications Can you provide me with a number of suitable dates?

Regards

vinod gopalan

From: Terry Hanelt
To: Gopalan, Vinod, Keating, Darren
Date: 6/09/2004 4.35 pm
Subject: Re: credentailling

Vin,
You have access to my calender so you can check as needed Also need both Districts Directors of O&G involved.
Terry H

>>> Vinod Gopalan 09/06/04 02.22pm >>>

Dear All

The RANZCOG have got back to me They have informed me that Dr Adam Bush from Gladstone is available to credential our o+g specialists. Can you provide me with some dates when you are free so I can organise a formal reveiw?

Regards

vinod gopalan

From: Darren Keating
To: Vinod Gopalan
Date: 7/09/2004 8 53 am
Subject: Re credentailling

Hi Vin

Do you want to do this via teleconf or in person ? I'm on leave 23/9 - 9/10 inc.

R/Darren

>>> Terry Hanelt Monday, 6 September 2004 16 35 49 >>>

Vin,
You have access to my calender so you can check as needed Also need both Districts Directors of O&G involved.
Terry H

>>> Vinod Gopalan 09/06/04 02:22pm >>>

Dear All

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Regards

vinod gopalan

CC: Terry Hanelt

From: Vinod Gopalan
To: Darren Keating
Date: 9/09/2004 9:27 am
Subject: Re. credentailling

Dear Darren

I'm not sure. Does Dr. Bush need to come down from Gladstone? Also can you tell me the name of the director of o+g in Bundaberg Terry tells me we need to have the directors of both sites involved also. I will then sned out an email requesting suitable dates and tee that up with Dr. Bush.

Regards

vin

>>> Darren Keating 09/07/04 08 53am >>>

Hi Vin

Do you want to do this via teleconf or in person ? I'm on leave 23/9 - 9/10 inc

R/Darren

>>> Terry Hanelt Monday, 6 September 2004 16:35 49 >>>

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Terry H

>>> Vinod Gopalan 09/06/04 02 22pm >>>

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Regards

vinod gopalan

Queensland Government
Queensland Health

Fraser Coast Health Service District.

Enquiries to: Mr Mike Allsopp
District Manager
Telephone: (07) 41206666
Facsimile: (07) 41206799
Email: Mike_Allsopp@health.qld.gov.au
File Number:
Our Ref.:
Your Ref.:

Dr. D. Krishna
Hervey Bay Hospital
Hervey Bay. Qld. 4655.

Dear Dr Krishna,

The formal process of obtaining Credentials and the granting of Clinical Privileges will be undertaken in the Fraser Coast Health Service District in the near future. Until this process is completed, interim privileges have been granted on the recommendation of the Director of Medical Services. These privileges will lapse when the formal process is completed.

As per the advice of the Director of Medical Services, I hereby confer privileges in Trauma Orthopaedics and minor elective Orthopaedics for the hospitals within the Fraser Coast Health Service District.

The Clinical Privileges are valid until the formal Clinical Privileging process is completed and you are notified of the outcome of that process, unless terminated or suspended prior to that time.

Should you wish to appeal this decision, the process is outlined in Section 9 of the document "Credentials and Clinical Privileges Guidelines for Rural Medical Practitioners — July 2002".

Yours sincerely,

..... / /
Mr Mike Allsopp
District Manager
Fraser Coast Health Service District

Hervey Bay Office
Hervey Bay Hospital
Cnr Nissen St and Urraween Rd
HERVEY BAY Q 4655
Phone 07 41206666 Fax 07 41206799
E-mail: Mike_Allsopp@health.qld.gov.au

Hervey Bay Postal
Hervey Bay Hospital
PO Box 592
HERVEY BAY Q 4655

Maryborough Office
Maryborough Hospital
185 Walker Street,
MARYBOROUGH. Q. 4650.
Phone 07 41238425. Fax 07 41231606.
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Queensland Government

Queensland Health

FRASER COAST HEALTH SERVICE DISTRICT

Enquiries to: Mike Allsopp
Telephone: (07) 4123 8425
Facsimile: (07) 4123 8447
Our Ref:

Dr D Krishna
Hervey Bay Hospital
Hervey Bay Qld 4655

Dear Dr Krishna

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Yours sincerely

Mike Allsopp
District Manager
Fraser Coast Health Service District
13 January 2003

Submissions

Dr Suzanne HUXLEY

Crown Law
Queensland Government

Department of
Justice and Attorney-General

Your ref:
Our ref: CS5/HEA027/5744/DZP
Contact: Peter Dwyer
Direct ph: 3239 6169
Direct fax: 3224 7431

26 October 2005

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

Dear Mr Groth

Submissions in response to Notices of Potential Adverse Findings

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

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

Yours faithfully

Peter Dwyer
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encl

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QUEENSLAND PUBLIC HOSPITALS *COMMISSION OF INQUIRY*

SUBMISSIONS ON BEHALF OF DR SUZANNE HUXLEY

1. The evidence relevant to Dr Huxley appears at:

   (a) Exhibit 58 – Statement of Dr Huxley;

   (b) Transcript: T937/18 – 961/60.

Area of Need applications

2. Dr Huxley has held the position of Principal Medical Advisor since September 2003.[1]

3. As Principal Medical Advisor, Dr Huxley held a Ministerial delegation under which it was her responsibility to manage the process of certification of area of need application forms.[2] Dr Huxley was one of three people afforded this Ministerial Delegation.[3]

4. On the assessment of areas of need, Dr Huxley gave evidence that:

> "*...for the public sector, the applications that we receive, are for junior and senior positions and each of those applications is assessed on its merit. The reality at the moment is that the workforce shortage is so great that in my time in the position which has been fulltime since October, 2003, we haven't rejected an area of need application for the public sector.*[4]

5. She later agreed:

> *So in summary, a short form explanation is that the whole of Queensland is potentially capable of being an area of need, that each application is a separate application considered on it is merits..... Yes.*"[5]

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[1] Exhibit 58, Attachment SMH – 1
[2] Exhibit 58, para 3
[3] T957/20
[4] T938/57
[5] T939/10

6. Dr Huxley stated:

   (a) When an application for area of need classification is made by a regional hospital, the delegates assume that the hospital administration has gone through the process of trying to recruit an Australian practitioner[6];

   (b) she applied her mind to the issues raised by s.135 (3) of the *Medical Practitioners Registration Act* 2001 by taking into account the fact that the workforce shortages are so great that she can only assume that the medical superintendents are doing their job and advertising the position[7].

7. In evidence, Dr Huxley identified a deficiency in the area of need process, that being the failure to request proof of an inability to fill a public sector vacancy before approving the application.[8] She detailed the steps which had been undertaken to overcome that deficiency, resulting in the Health Service Districts now being required to document that an assessment of the overseas trained Doctor, including reference checks, has been undertaken.[9]

8. Against that background, it would be unreasonable and unfair to criticise Dr Huxley in the performance of her duties. She performed those duties conscientiously, and in good faith, having regard to the available resources. The fact that she performed her duties conscientiously is confirmed by her identification of pertinent deficiencies in the processes, and the instigation of appropriate changes to correct those deficiencies, prior to giving evidence before the Inquiry.

9. Further, it would be unreasonable and unfair to make any adverse findings against Dr Huxley in relation to the process adopted between her appointment to this position and the implementation of the aforementioned amended protocol. There was, at all relevant times, an acknowledged medical workforce shortage in Queensland. Dr Huxley was uniquely positioned to understand and appreciate its extent. She relied on that knowledge, in combination with a reasonable assumption that hospital administrators act honestly and with integrity when advising her of their inability to obtain an Australian trained Doctor to fill a position. This was a reasonable approach in the circumstances.

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[6] T957/58
[7] T959/25-32; 959/51; 960/18 – 26.
[8] Exhibit 58, para 14.
[9] Exhibit 58, para 17; T939/55 – 940/10.

Use of Ministerial policy

10. Dr Huxley stated that the workload of her unit has been so great since she started in her position that she and her staff have been unable to devote the substantial period of time that would be required for the purposes of preparing a new policy.[10] No evidence to the contrary was placed before the Commission.

11. Against that background, it would be unreasonable and unfair to make an adverse finding against Dr Huxley in relation to her use of the pre-existing policy. This is not an instance of an employee performing her duties in an ignorant or incompetent manner. It is an example of an employee undertaking her duties, with due recognition of statutory and/or policy requirements, to the best of her ability having regard to her onerous workload and the resources available to her.

Renewal of Area of Need certification

12. The above submissions are relevant to, and relied upon, in relation to this issue.

13. During Dr Huxley's evidence, the following exchange occurred:

> "DEPUTY COMMISSIONER EDWARDS: *Dr Huxley, is the area of need, once it is filled by, say, an overseas Doctor, the appointment is made in that position as an area of need for 6 months, 12 months and a review done as to how many applicant may be around at that time, or is it a permanent – they could stay there for five years in that hospital?...They would stay there, yes, we wouldn't put someone out of a job. If we have given an individual area of need status we would not say after a year, 'sorry, you have to move on'. If they leave that position then that would be reviewed if someone else came in, and the position should be advertised.*
>
> COMMISSIONER: *I'm sorry, Dr Huxley. It seems to me that defeats the whole purpose of the legislation. When Parliament allowed for these areas of need, the whole idea was that it would be temporary for 12 months and every 12 months Queensland Health would ascertain afresh whether it still remains an area of need. What you seem to be telling us is that Queensland Health*

[10] T942/54 – 943/49.

totally ignores Parliament's intention and would allow something to go on as an area of need for 20 years if that's how long the Doctor wanted to stay there?...at the moment, yes, that's the case, and again, as I said, its likely through all this that it will be assessed. One of the issues that we have is that under the Medical Act, after four years someone should progress to either general or specialist registration. Up until recently that wasn't enforced. So it was very difficult – for example, you could give someone an area of need, renew it each year for four years, and at that time they should have progressed to general or specialist registration, and would not require area of need".[11]

14. Later, Dr Huxley was asked:

> *"Dr Huxley, just taking you back to one point that you made there briefly, you said that if an area of need certification is approved for a 12 month period then the following year, assuming the area of certification is the same, it would be simply rubberstamped; that's correct?...We would check to make sure that the information was correct, but generally, yes.*
>
> *You said you wouldn't pull up the first years to check it? ...No – we have a database. So we would check the information that we have on our database, but as I said, if we are approving an SMO we would not put any extra information in it. Its an SMO provision or a specialist or JHO position, for example.*
>
> *So when you say you wouldn't pull up the information you wouldn't pull up the original application?...No.*[12]"

15. The effect of Dr Huxley's evidence on this point is that if the administrator of an individual hospital which employs an area of need Doctor seeks to renew that certification, Dr Huxley would accept that the area of need requirements had not changed from the previous year, refer to the data that was gathered from the original application, and then renew the certification.

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[11] T942/21 – 50.
[12] T951/50 – 952/10

16. Paragraph 2.5.16 of Exhibit 58 is also relevant. That paragraph suggests that it was Departmental policy to assume that rural and remote locations automatically qualify as area of need until the contrary is shown. Such an approach, by Queensland Health, involved common sense and a minimum amount of red tape. This is commendable, having regard to the medical workforce needs of rural and remote locations.

Conclusions

17. The evidence does not support a finding that Dr Huxley failed to perform her duties appropriately. Even if the Commission is of the view that the approach that has been adopted was lacking, such a finding should not involve any adverse comment about, or finding against, Dr Huxley. It should be an observation as to the system in which Dr Huxley was required to perform her duties.

12.

Submissions

Dr Darren KEATING

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BY:----------

28 October 2005

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

Dear Mr Groth,

DR D W KEATING

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

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

Yours faithfully,

David Watt

Enc(1)

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

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

Paragraphs 1(a) and 1(b)

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

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

WRITTEN SUBMISSIONS

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

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

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

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

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

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

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

7. The policy relevantly provided –

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

5.1 General principles

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

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

5.3 Variable membership

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Paragraph 1(c) (iv)

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

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

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

Paragraph 1(c) (vi)

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

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

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

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

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

Paragraph 1(c) (vii)

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

Paragraph 1(c) (viii)

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

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

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

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

Paragraph 1(c) (ix)

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

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46 1061.40.
47 986.30 to 987.05.
48 1988.50.

Paragraph 1(c) (x)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Paragraph 1(c) (xi)

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

Paragraph 1(c) (xii)

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

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[70] 7005.20.
[71] Ex. 317 JGS12.

Paragraph 1(c) (xiii)

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

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

Paragraph 1(c) (xiv)

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

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

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

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

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

Paragraph 1(c)(xv)

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

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

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

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

Paragraph 1(c) (xvi)

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

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

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

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

Paragraph 1(c) (xvii)

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

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

Paragraph 1(c) (xviii)

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

Paragraph 1(c) (xix)

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

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

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

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

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

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

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

[91] Ex. 155.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Paragraph 1(d)

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

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

Paragraph 1(e)

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

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

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

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[97] Ex. 24.

Paragraph 1(f)

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

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

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

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

Paragraph 1(g) (i)

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

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

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

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[101] Ex. 102.

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

Paragraph 1(g) (ii)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Paragraph 1 (l)

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

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

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

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

Paragraph 1 (m)

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

Paragraph 1 (n)

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

Paragraph 1(o)

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

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

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

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

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

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

Paragraph 1(p)

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

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

Paragraph 1 (q)

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

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

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

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

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

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

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

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

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

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

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

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

Paragraph 1(r)

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

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

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

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

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

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

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

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

Paragraph 1(s)

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

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

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

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

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

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

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

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

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

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

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

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

Potential Recommendations

Section 137 of the *Criminal Code* (Cth)

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

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

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

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

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[158] *MacKenzie v. The Queen* (1996) 190 CLR 348 in particular at 356 per Dawson and Toohey JJ, and at 372 to 374 per Gaudron, Gummow and Kirby JJ, and to *R. v. O'Connor* (1980-1) 146 CLR 64.
[159] Contrast (1) (c) – see s.137(1a) and s.6.2.
[160] 7064.10.

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

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

Paragraph 2(b)

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

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

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

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

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

[161] Ex. 448 P26 of exhibits.

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

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

Paragraph 2(c) Referral to the CMC

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

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

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

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

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

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

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Our ref: DW:250796
Your ref:

1 November 2005

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

Dear Mr Groth,

DR D W KEATING

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

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

Yours faithfully,

David Watt

Enc(1)

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

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

***Coroner's Act* 2003**

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

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

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

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[1] Exhibit 448 para. 299.

Flower & Hart
Solicitors
Level 19, NAB House
255 Adelaide Street
BRISBANE QLD 4000

Telephone: 3233 1233
Facsimile: 3229 4555

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

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

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

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

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

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

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

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

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

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

Mr Graves

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

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

Submission by Medical Board

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

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

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

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

Patient Support Group Submissions

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

G W Diehm
Counsel for Dr Keating

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

13.

Submissions

Mr David KERSLAKE

17 October 2005

Mr D Kerslake
Health Rights Commissioner
Health Rights Commission
Level 19 288 Edward Street
BRISBANE QLD 4000

Dear Mr Kerslake

This morning I reminded counsel appearing before the Commission that, arising out of concerns about complaints which had been made against certain medical practitioners and the way in which those complaints have been handled or the failure to deal with them in a timely fashion, I might be obliged to consider the system or systems providing for the investigation of complaints against medical practitioners and this, in turn, might impinge upon the way in which complaints against other health professionals and nurses should be handled. I indicated that that consideration might result in my making recommendations with respect to amendment or repeal of provisions in legislation relating to the handling of complaints against such persons as well as with respect to appropriate administrative structures for that purpose.

Consequently I invited the parties to make submissions on any of those matters. I mentioned specifically that they might be of interest to QHealth, the Medical Board and the Nurses Union, and I also indicated that I did not intend to restrict submissions on those questions to those parties only.

As any such consideration may affect your Commission and its legislative and administrative structure, I invite you also to make such submissions as you consider appropriate upon those issues.

The submissions of the parties, other than you, are, as you may know, required to be made to the Commission by close of business on 21 October 2005. However, as your representative has not been present during most of the hearing of this Inquiry, I am prepared to extend that time to you until the close of business on 28 October 2005. As in the case of the other parties, those submissions must be in writing.

Yours sincerely

Hon Geoffrey Davies AO
Commissioner

Commissioner
Hon Geoffrey Davies AO

Counsel Assisting
David Andrews SC
Richard Douglas SC
Errol Morzone
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Secretary
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28 October 2005

The Hon Geoffrey Davies AO
Commissioner
Queensland Public Hospitals Commission of Inquiry
Level 9
363 George Street
BRISBANE QLD 4000

Our reference: 12352/80026643

Dear Mr Davies

Submission - Health Rights Commission

We refer to your letter of 17 October 2005 to the Health Rights Commissioner, Mr David Kerslake.

We and our client thank you for the opportunity to comment upon the matters you have raised from the perspective of the Health Rights Commission, and respectfully enclose the following submissions on behalf of our client for your consideration.

Yours faithfully

Ross Perrett, Partner
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Enclosure

Submission by the Health Rights Commission

Queensland Public Hospitals Commission of Inquiry

28 October 2005

Table of contents

1. Introduction

This submission is provided in response to the Commissioner's letter of 17 October 2005 to the Health Rights Commissioner whereby the Commissioner observed:

- that he might be obliged to consider the system or systems providing for the investigation of complaints against medical practitioners;
- that such consideration might impinge upon the way in which complaints against other professionals and nurses should be handled and might result in recommendations with respect to provisions in legislation relating to the handling of complaints against such persons, as well as with respect to appropriate administrative structures for that purpose; and
- that the Health Rights Commissioner be invited to make such submissions as he considers appropriate upon those issues.

The evidence which underpins the following submissions is the statement of Mr Kerslake dated 19 September 2005 (exhibit 354) and the original submission by the Health Rights Commission to the Bundaberg Base Hospital Commission of Inquiry dated 19 May 2005 (attachment "DK1" to exhibit 354).

2. Own motion powers

Consideration should be given to strengthening the Health Rights Commission's ("HRC") independent role by empowering the Health Rights Commissioner to investigate public interest issues of his "own motion".

A significant limitation on the existing powers of the Health Rights Commissioner is that he can only respond to complaints actually received. Even if he becomes aware of apparently serious health issues by means such as media reports, the Commissioner has no power to intervene in the absence of a complaint, notwithstanding the matter reported may raise important issues of public interest, significant systemic issues or serious concerns about a practitioner's competence.

A related concern is that there have been occasions where the HRC has received a complaint against a health service provider and, in the course of its enquiries, became concerned about the care provided by a different provider. The HRC has been limited in its ability to deal with the additional matters in the absence of a complaint made under the HRC Act.

This places a significant limitation upon the Commissioner's ability to act unilaterally in the public interest.

It is respectfully submitted that the HRC's robustness as an independent body would be reinforced and the protection of the public interest greatly strengthened by affording the Commissioner his or her "*own motion*" powers in circumstances where there appears to be an immediate risk to the health or safety of a user of a health service, or where the Commissioner is satisfied that the public interest otherwise so requires.

The requirement for such a power appears to have been recognised, to some extent, in the final report of the Queensland Health Systems Review (hereinafter referred to as the "Forster Report") which provides for a Commission (described in that report as the "Health Commission") whose functions include a power to "*investigate on its own initiative and where necessary report on systemic failures within the State's public and private health facilities*". However it is respectfully submitted that this power should be extended beyond "*systemic failures*", and should encompass the broader circumstances described in this submission.

3. Power to conduct investigations against individual registrants

Under it's existing legislation, the HRC is only empowered to conduct formal investigations of complaints against *non-registered providers*, that is, organisations such as hospitals, hostels or nursing homes, and a small number of alternate therapists who are not required to be registered.

By virtue of amendments introduced by the *Health Practitioners (Professional Standards) Act* 1999, the HRC is prevented from investigating complaints against individual registrants (such as medical practitioners and nurses). In the case of individual registrants, the HRC retains the power to *assess or conciliate* complaints, but following the legislative amendments referred to above, only registration boards have the power to formally *investigate* complaints against individual registered providers. This restriction, which is unique to Queensland, is one example whereby the existing Queensland legislation provides less flexibility than is the case in other States. All other States and Territories Health Commissions may, if they deem it appropriate, conduct formal investigations into *any of the complaints received.*

Another example of such inflexibility is Section 83 of the HRC Act which provides that a HRC officer who is a conciliator must not be involved at all in the investigation of health service complaints. The Australian Capital Territory and Northern Territory Acts place no restrictions upon conciliators also being involved in investigations. Under the New South Wales legislation an officer may not investigate and conciliate the same complaint if to do so

might interfere with the conciliation process. In Western Australia, the legislation permits officers to both conciliate and investigate cases provided that they do not do so for the same complaint.

It is respectfully submitted that it would be in the public interest for the HRC's power of investigation to be reinstated. There are two primary reasons for this submission.

Firstly, such a change would facilitate the comprehensive review of complaints that raise multiple issues, that is, matters pertaining to an individual registrant's actions as well as the effectiveness of broader health systems or procedures. Such cases are by no means unusual. Take the example of a complaint concerning shortcomings in respect of hospital procedures, a treating doctor and an attending nurse. Under the current legislation, three separate investigations would be required. The HRC has no power to investigate the actions of the individual registrants - that power is vested solely in the relevant registration bodies. The registration bodies have no power to review the conduct of the hospital and possible systemic deficiencies - that power resides in the HRC. The inefficiencies, delays and potential for distress and frustration on behalf of complainants inherent in such a process are self-evident.

Secondly, whilst the HRC currently has the power to conduct an initial assessment of all complaints (whether against individuals or organisations), it is limited in its ability to do so by the absence of any power to compel individual registrants to participate in its processes. The HRC Act provides that, having commenced assessment of a complaint, the HRC must *invite* the health provider to respond. Although most providers choose to cooperate, some simply refuse. In the event that a non-registered provider declines to participate, the HRC is able to use its formal investigative powers to ensure that it can obtain relevant information. However, where an individual registrant declines to participate, the HRC is powerless to take the matter further and the only available avenue is to refer the matter to the relevant registration body, which does have such power. If, however, that registration body deems that the complaint is not sufficiently serious to warrant its attention, the complainant would effectively be denied the capacity to have their concerns independently reviewed. Even if the registration body accepts the referral, its role is limited to reviewing the outcome of the investigation in the context of considering possible disciplinary action against the registrant. It has no power to recommend a remedy for the complainant even if it considered such an outcome was warranted.

The HRC respectfully submits that Queensland should be brought into line with all other Australian States and Territories and that it be vested with the power to investigate *any* health complaint where it deems such action appropriate, subject perhaps to a requirement that before commencing an investigation of an individual registrant, the HRC should first consult with the

relevant registration body. Further, it is respectfully submitted that the HRC should have power to refer a matter to a registration body following investigation with a recommendation for disciplinary action. Whilst disciplinary bodies may retain the capacity to conduct their own investigations, there should be no requirement for them to do so if they consider that the outcome of the HRC's investigation provides a sufficient basis for disciplinary action.

4. Compulsory provision of information at the assessment stage

Under the existing legislation, health service providers (registered or otherwise) have no obligation to provide information to the HRC at the assessment stage. As noted in submission no. 3 above, a power to compel the production of information exists in respect of non-registered providers where a complaint is investigated.

However, speedy and satisfactory resolution of health service complaints is to be encouraged in the public interest, and for that reason, the HRC endeavours to address and finalise a large proportion of complaints received in assessment or conciliation, leaving formal powers of investigation to be exercised in the more serious cases, or in circumstances of a particularly recalcitrant provider. However, the capacity to speedily and satisfactorily address complaints would be enhanced if the HRC was empowered at the assessment stage to compel a health provider to furnish information relevant to the complaint.

In practice, the circumstances in which such a power would need to be exercised are likely to be limited. Experience of other regulatory bodies would suggest that the existence of such a power will be sufficient to secure the cooperation of most providers in supplying information in response to a complaint. It is nevertheless respectfully submitted that the existence of such a power would enhance the HRC's ability to deal with complaints in a comprehensive and timely manner.

5. Obligation to advise complainants of their right of independent review/development of a statewide complaints database

Best practice in complaints management requires recognition by consumers of their health rights, including their right to access an independent complaints review body. It is respectfully submitted that the public awareness of this right would be enhanced through health service providers generally, or at least Queensland Health having an obligation, when responding to complaints at the local health service level, to advise complainants of their right if dissatisfied to seek further review from the HRC.

Best practice also requires that where serious action is warranted, the need for such action is identified promptly, and that information gathered through past experience is used to inform improvements to the quality of health services and to reduce adverse incidents. An important initiative to address these objectives is the development of a statewide complaints database which would record details of all complaints, adverse events and incident reports in relation to the provision of healthcare by Queensland Health. Queensland Health should be charged with collating, analysing and disseminating such data in order to identify systemic issues and facilitate systems improvement. The Health Rights Commission should be responsible for cross referencing Queensland Health's data with complaints made directly to the HRC and other independent complaints bodies and for monitoring health outcomes and trends. The database should include data relating to those complaints which are resolved at the local level. This would ensure that the successful local resolution of individual complaints does not obscure more disturbing patterns of conduct.

The Forster Report recommends the development of such a complaints database. The HRC endorses that recommendation subject to the observations noted above.

6. Concentration of patient complaints management and resolution at the local health service level

Health consumers are entitled to expect that their complaints will be addressed at a local level by people who are committed to understanding their concerns and to resolving them in a fair and effective way. The HRC respectfully submits that you cannot have a quality health system in the absence of a culture that welcomes complaints and values feedback, and it is a matter of concern that at the time when such a large number of complaints began to materialise, there was no patient liaison officer in place at Bundaberg Base Hospital. Patients are more likely to complain if they feel that their concerns will be taken seriously and that the effort of making a complaint has some realistic chance of making a difference, and staff members are likewise unlikely to come forward if they feel their concerns will be trivialised.

The Forster Report recommends a complaints model that provides first for local resolution, with escalation to an independent complaints body if the complaint is not resolved in 30 days. The HRC agrees that the timely resolution of complaints will be facilitated by improving the quality of complaints management and resolution within Queensland Health at the local health service level with the support of appropriately trained and experienced patient complaints officers. However, the HRC respectfully submits that attempted resolution of the complaint at the local health service level should not be mandatory. Circumstances can be readily envisaged where it is self-evident that attempted resolution at the local level will be futile (eg a

sexual misconduct complaint), and under this model, the HRC should retain a discretion, in the public interest, to receive complaints directly, or to take over the management of a complaint at any time. Providing the HRC with access to the proposed complaints database would further facilitate this capacity.

The HRC strongly endorses the recommendation of the Forster Report that local resolution be facilitated by the principles of *open disclosure* and that the consistent application of such principles will make a major contribution to the fair and timely resolution of complaints.

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1 November 2005

The Secretary
Queensland Public Hospitals Commission of Inquiry
Level 9
Brisbane Magistrates Court Building
363 George Street
BRISBANE QLD 4000

Our reference: 12352/80026643

Dear Sir

Health Rights Commission

We refer to the letter dated 31 October 2005 by Messrs Gilshenan & Luton, solicitors for the Medical Board of Queensland ("MBQ") to the Commission of Inquiry in reply to the submission of the Health Rights Commissioner dated 28 October 2005. On behalf of our client, we wish to make reference to one matter.

The MBQ submission in reply suggests that there is an inconsistency between the HRC's submission no. 2 (power to conduct investigations against individual registrants) and the evidence of the Health Rights Commissioner (Mr Kerslake). This suggestion is, with due respect, contrary to the evidence.

In its original submission of 19 May 2005 (attachment "DK1" to exhibit 354) the HRC referred to the removal in 2000 of its power to investigate complaints against individual registrants, the impact of this legislative amendment upon the HRC's ability to deal with complaints, and the possibility of the need for legislative review in the area of investigations (attachment "DK1", pages 10-11 and 18).

This issue is also specifically addressed in the HRC's Annual Report to the Minister for Health for 2003/04 (attachment "DK5" to exhibit 354, pages 8-9) in which problems associated with the inability of the HRC to investigate individual registrants are highlighted, and the return to the HRC of its former power to investigate individual registrants identified as a possible solution to these problems.

The reservation as to the New South Wales Health Care Complaints Commission model referred to by Mr Kerslake in the passage of evidence cited by the MBQ in its submission of 31 October 2005 is clearly a reservation as to the incompatibility between the undertaking by the HRC of its existing role, and the exercise by it of a prosecutorial role through the undertaking of disciplinary action, and is not, as suggested by the MBQ in its reply, evidence as to a dichotomy between the HRC's existing role and that of an investigator.

That Mr Kerslake's reservation related to the exercise by the HRC of a prosecutorial (and not to an investigative) function is clear from the passage of evidence immediately following that cited by the MBQ in its reply (transcript page 5645 lines 38-45). Mr Kerslake there refers to perceptions as to the level of cooperation from health providers in New South Wales being lower than the level of cooperation enjoyed in Queensland or in other States. New South Wales is the only Australian State in which health commissions undertake a prosecutorial function, whereas all Australian States, other than Queensland, exercise an investigative power in respect of registered providers.

There is no dichotomy between the HRC's role as an investigator and its role as a conciliator in that, pursuant to its existing powers, the HRC undertakes both such roles (investigation and conciliation) in respect of non-registered providers without there being any suggestion (or evidence) of incompatibility in the exercise of those functions.

Yours faithfully

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14.

Submissions

Dr Damodaran KRISHNA

Crown Law
Queensland Government

Department of
Justice and Attorney-General

Your ref:
Our ref: CS5/HEA027/5744/DZP
Contact: Peter Dwyer
Direct ph: 3239 6169
Direct fax: 3224 7431

26 October 2005

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

Dear Mr Groth

Submissions in response to Notices of Potential Adverse Findings

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

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

Yours faithfully

Peter Dwyer
Principal Lawyer
for **Crown Solicitor**

encl

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QUEENSLAND PUBLIC HOSPITALS *COMMISSION OF INQUIRY*

SUBMISSIONS ON BEHALF OF DR DAMODARAN KRISHNA

P449

1. The evidence of Dr Krishna appears at:

   Transcript: T6482/51 – 6489/29; 6515/12 – 6517/26.

2. The evidence of Dr Mullen appears at:

   (a) Exhibit 330 – Statement of Dr Mullen, paragraphs 23 – 26;

   (b) Transcript: T5764/55 – 5768/50.

3. The evidence of Dr Sharma appears at:

   Transcript: T5697/20 – 5698/50.

4. The evidence of Dr Wilson appears at:

   Transcript: T7343/48 – 7345/5.

5. Dr Krishna gave evidence that he had performed this procedure on two or three previous occasions[1].

6. There is no evidence upon which the Commission could rely to find that Dr Krishna's experience caused any adverse outcome for the patient. Whilst Dr Mullen did speak of the retrograde nail causing a further fracture, Dr Krishna explained that, in fact, was not the case and that the nail merely emphasized the pre-existing fracture at that site[2].

7. The scope of practice document prepared by Dr Naidoo for Dr Krishna [3]was prepared some time after this particular procedure. In those circumstances, Dr Krishna did no more than undertake a procedure which he has performed at least twice previously (presumably with success) at a time when no restrictions had been placed upon him to do otherwise.

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[1] T6485/40; 6486/2 - 7; 6488/44 – 6489/2.
[2] T6483/30 – 6484/46.
[3] Annexure 6 to Exhibit 424.

8. It would appear that the patient made an uneventful recovery from the surgery[4]. Dr Mullen's criticism of the use of a retrograde nail was answered by Dr Krishna when he spoke of features in the fracture of which Dr Mullen had no apparent knowledge[5]. Additionally, Dr Wilson gave evidence that the choice of a retrograde nail was a reasonable one in the circumstances. There is no basis, therefore, to find that the procedure was beyond Dr Krishna's skill or competence.

9. That being so, there is no sufficient evidentiary basis to make adverse findings against Dr Krishna in respect of this patient.

P442

10. The evidence of Dr Krishna appears at: Transcript: T6501/29-54; 6520/25-40.

11. The evidence of Dr Crawford appears at:

    (a) Exhibit 404 – Statement of Dr Crawford paragraph 14;

    (b) Exhibit 405 – report of Dr Crawford;

    (c) Transcript: T6297/50 – 6300/30: 6318/7 – 18.

12. It is conceded that this patient suffered a poor outcome as a result of an error of judgment of Dr Krishna.

P435

13. The evidence of Dr Krishna appears at:

    Transcript: T6489/30 – 6494/25: 6517/30 – 6518/8.

14. The evidence of Dr Mullen appears at:

    (a) Exhibit 330 – Statement of Dr Mullen, paragraph 33;

    (b) Transcript: T5773/50 – 5776/55; 5790/16 – 5799/26

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[4] P6516 L30 - 6517 L26.
[5] P6487 L20 - P6488 L6.

15. The evidence of Dr Mullen in relation to this patient is that alternative treatments to that which were performed would have resulted in a better clinical outcome for the patient. It is not intended to submit to the contrary.

16. What is relevant however is the evidence that Dr Krishna gave of Dr Naidoo's involvement (or lack of involvement) in this case. Dr Krishna stated in evidence:-

    (a) That Dr Naidoo consulted with this patient at the time of her initial presentation to the hospital and recommended the procedure which Dr Krishna subsequently carried out[6]; and

    (b) That Dr Naidoo did not supervise this procedure despite being asked by Dr Krishna to do so on two separate occasions - before surgery and during surgery[7].

17. The effect of Dr Krishna's uncontradicted evidence was that he performed a procedure authorised by Dr Naidoo, unsuccessfully sought assistance from Dr Naidoo before commencing the procedure (in fact, Dr Naidoo at this time directed him to undertake the procedure) and sought further assistance, again unsuccessfully, during the procedure.

18. In these circumstances, no adverse finding could reasonably be made against Dr Krishna in relation to this patient.

P436

19. The evidence of Dr Krishna appears at: Transcript: T6494/29 – 6498/10; 6518/10 – 6519/12.

20. The evidence of Dr Mullen appears at:

    (a) Exhibit 330 – Statement of Dr Mullen, paragraph 34;

    (b) Transcript: T5776/55 – 5779/8; 5799/38 – 5804/10.

21. A factual dispute exists between the opinions of Drs Mullen and Krishna as to the type of fracture sustained by the patient. Dr Mullen spoke of it being a subtrochanteric fracture

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[6] T6490/14 - 6492/20; 6494/7-12.
[7] T6492/30 – 6493/16; 6494/3-25

whereas in Dr Krishna's opinion it was an intertrochanteric fracture[8]. The evidence from both doctors was that the fixation device which was used would have been correct if the fracture was in fact intertrochanteric.

22. Dr Mullen acknowledged that this was a fracture (irrespective of its type) that is notorious for not uniting or not uniting correctly[9].

23. Whilst it is correct to say that Dr Krishna performed this procedure without supervision and without calling for assistance or supervision, the type of fracture is not clear on the evidence. It is therefore impossible to determine that an inappropriate procedure was performed. Dr Mullen made no criticism of the surgical skill of Dr Krishna in the procedure he carried out - his criticism was of the decision-making process[10].

24. In circumstances where the evidence offers two different opinions as to the type of fracture, the Commission is in no position to accept one over the other. Whilst it is acknowledged that Dr Mullen is the more senior of the two doctors, that fact must be balanced against the evidence that Dr Krishna saw not only the original x-rays, but also the break itself during surgery.

25. Against that background, it would be unfair to make an adverse finding against Dr Krishna. Such findings can have serious adverse effects for witnesses, both personally and professionally as well as having an adverse effect on members of their family. This is a matter which can be further investigated (i.e. a close study of all x-rays and tomograph results) by the appropriate body, if it is considered necessary, without any adverse finding being made by the Commission.

Transfers

26. No adverse finding should be made against Dr Krishna having regard to:

(a) Dr Krishna had not been provided with a defined scope of practice until 2004;

(b) Dr Krishna was in a difficult situation of being beholden to the Area of Need certification and thus, at least, having the perception that if he did not perform as

[8] T6496/30.
[9] T5799/55 - 5800/1.
[10] T5804/3-10.

required, he could lose that position; and

(c) His line manager had expressed confidence in both his clinical skills and decision-making ability.

27. Any criticism of Dr Krishna's transfer practices is more appropriately directed to the system rather than to the individual. Dr Krishna was placed in a difficult situation, and conducted himself to the best of his ability.

Procedures outside scope and skill

28. There is no sufficient evidentiary basis to find Dr Krishna performed procedures outside his scope of practice, or own level of skill and experience. The most that can be said is that Dr Krishna was left by Dr Naidoo to determine his own scope of practice prior to the preparation of such a document by Dr Naidoo in 2004. After such document was prepared, there is no evidence that Dr Krishna operated outside the parameters of its contents. Furthermore, Dr Mullen stated on a number of occasions that his criticisms were not of Dr Krishna's surgical skills, rather they were of the lack of supervision being offered to Dr Krishna.

29. Accordingly, no adverse finding should be made against Dr Krishna in respect of this issue.

Level of care

30. There is no sufficient evidentiary basis to find Dr Krishna provided a level of care below that expected of a qualified Orthopaedic Surgeon. In fact, evidence to the contrary was given by Dr Crawford:

> **"With respect to that group of poor outcomes in the balance of 35, is it your opinion that you are unable, from the examination you had, to conclude whether the surgery was performed with reasonable care or to a lesser standard? - - All the evidence I saw was that it was performed with reasonable care."** [11]

31. There is no evidence to show that Dr Krishna provided anything less than the appropriate

[11] T6297/12-20.

level of care to the best of his abilities.

32. Accordingly, no adverse finding should be made against Dr Krishna in respect of this issue.

15.

Submissions

Mr Peter LECK

Hunt & Hunt
LAWYERS

Commissions of Inquiry Act (1950)

QUEENSLAND PUBLIC HOSPITALS COMMISSION OF INQUIRY

Submissions on behalf of

PETER NICKLIN LECK

DISTRICT MANAGER

BUNDABERG HEALTH SERVICE DISTRICT

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EXECUTIVE SUMMARY

Introduction

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

Submission in response to Potential Finding 1(a)

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

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

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

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

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

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

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

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

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

- the process was unsatisfactory and Mr Leck was trying earnestly to replace it with something more effective.

- his efforts, and those of Dr Keating, were being frustrated by their incapacity to secure College of Surgeons participation.

- this problem was known to Zonal Office and Head Office of Queensland Health and was widespread and was certainly not confined to Bundaberg.

- the evidence regarding what is or ought to be achieved by credentialing and privileging committees is unsatisfactory. It appears that the credentialing was very much dependent upon the Medical Board and the privileging was essentially a paper process.

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

Submission in response to Potential Finding 1(j)

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

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

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

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

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

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

c. In relation to the catheter audit:

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

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

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

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

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

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

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

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

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

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

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

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

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

Submission in response to Potential Finding 1(q)

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

Submission in response to Potential Finding 1(s)

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

Submission in response to Potential Adverse Finding 1(t)

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

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

Submission in response to Potential Finding 1(u)

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

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

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

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

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

Submission in response to Potential Finding 1(v)

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

Submissions in response to Potential Finding 1(w)

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

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

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

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

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

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

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

Submission in response to Potential Finding 1(z)

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

Conclusion

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

BACKGROUND CONTEXT

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

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

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

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

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

   (e) available resources.

Personal Qualifications and Experience

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

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

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

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

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

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

Nature and Scope of Role of District Manager

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

   (a) implementation of corporate policy and strategy;

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

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

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

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

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

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

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5 ibid

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

Place of Bundaberg Base Hospital and Bundaberg Health Service District

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

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

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

(a) Quality Coordinator;

(b) Executive Support Officer;

Bundaberg Base Hospital

(c) Director of Medical Services;

(d) Director of Nursing Services;

(e) Director of Corporate Services;

(f) Manager Integrated Mental Health Services;

(g) Director of Community and Allied Health Services;

Childers Hospital

(h) Medical Superintendent;

(i) Director of Nursing.

Mt Perry Health Centre

(j) Director of Nursing;

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

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

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

Gin Gin Hospital

(k) Medical Superintendent;

(l) Director of Nursing.[9]

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

Queensland Health

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

13. These targets included such matters as:

(a) achieving budget integrity;

(b) compliance with asset strategic planning activities;

(c) participating in regional managers coordination networks;

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

(e) improved management of staff absenteeism.

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

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

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

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

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

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

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

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

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

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

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

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

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

Resources

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

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

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

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

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

Conclusion

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

MANAGEMENT MATTERS

Potential Adverse Finding 1(a)

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

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

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

    (b) What could he have done?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- in relation to complaint about under resourcing, Dr Mattuissi was engaged to *"look at alternative modules of costing and they did eventually, after a meeting, employ a medical education officer;*[30]

- in respect of his and Dr Carter's complaints *"the summary of Bundaberg Hospital would be not enough staff, not enough resources"*[31] and *"... the issues were lack of funding, lack of staffing"*[32] and *"... You were never told that there wasn't enough money for some of these things?—I was told that we were over budget and*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Yes.

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

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

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

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

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

35 T7180.18–7181.25

> *Well, you – because of the budget inadequacy, you were forced to condone unsatisfactory working conditions for your clinicians, weren't you?-- There were staff I was thinking that I thought were working too many hours, yes.*
>
> *Now, you were forced to condone that because you had very little practical alternative?—Yes.*[36]

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

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

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

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

Submission in response to Potential Finding 1(a)

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

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

APPOINTMENT OF DR PATEL

Potential Adverse Finding 1(b)

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

Potential Adverse Finding 1(c)

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

Potential Adverse Finding 1(d)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CREDENTIALING AND PRIVILEGING

Potential Adverse Finding 1(e)

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

Potential Adverse Finding 1(f)

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

Potential Adverse Finding 1(g)

Due to your failure:

i. **there was no credentials and clinical privileges committee for the District in 2002, 2003 and 2004;**

ii. **the formal qualifications, training, experience and clinical competence of Dr Patel and of numerous other medical practitioners recruited to or operating in the District were not properly assessed by a committee of their peers;**

iii. **the opportunity was lost for such a committee to determine that significant limits had been placed by authorities in the USA on Dr Patel's clinical privileges;**

iv. **an opportunity was lost for such a committee to limit privileges for Dr Patel;**

v. **an opportunity was lost for such a committee to recommend that Dr Patel should not be recruited.**

Potential Adverse Finding 1(h)

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

Potential Adverse Finding 1(i)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Submission in response to Potential Findings 1(e), (f), (g), (h) and (i)
In our submission no adverse finding should be made against Mr Leck in relation to the credentialing and privileging matter because:

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

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

DATA COLLECTION

Potential Adverse finding 1(j)

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

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

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

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

> *Finally, with respect to data, as part of the clinical governance strategy that there was at the Bundaberg Hospital over the last several years, was it envisaged and intended that the clinical heads of departments would be the ones who would take the responsibility for seeking out specific data relating to their particular areas of practice with a view to assessing its relevance to the safe practice of medicine or surgery in their department? – Yes.*
>
> *And was the intention behind that, that as the leaders of their departments and being at the coalface and having the expertise, they were the persons best placed to judge the relevance of data? – Yes.*
>
> *But that system relied on two things, I suggest to you: firstly, the proper data being available to them; do you accept that proposition?—Yes.*
>
> *And secondly, their honesty in dealing with it? – Yes.*77

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

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

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

Submission in response to Potential Finding 1(j)

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

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

COMPLAINT INVESTIGATION

Potential Adverse Finding 1(k)

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

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

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

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

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

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

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

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

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

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

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

Potential Adverse Finding 1(l)

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

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

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

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

Potential Adverse Finding 1(m)

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

External Complaints

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

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

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

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

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

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

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

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

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

Internal Complaints (General)

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

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

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

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

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

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

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

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

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

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

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

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

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

Meeting with Ms Hoffman, March 2004

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

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

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

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

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

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

ICU Costs

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

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

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

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

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

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

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

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

79. The evidence shows that:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

h. In relation to the catheter audit:

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

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

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

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

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

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

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

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

REAPPOINTMENT OF DR PATEL

Potential Adverse Finding 1(n)

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

Potential Adverse Finding 1(r)

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

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

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

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

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

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

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

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

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

127 T7214.20.
128 T5501.50.

SUSPENSION OF DR PATEL

Potential Adverse Finding 1(o)

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

i. **Dr Patel overextended himself performing a limited number of certain major sub-speciality operations - oesophagectomies, and thoracic cases when an appropriate level of intensive care support was not available for prolonged periods;**

ii. **Dr Patel had delayed transfer of seriously ill patients to Brisbane;**

iii. **Dr Patel was perceived by staff as arrogant, abrasive and rude;**

iv. **Dr Patel had multiple responsibilities - clinical, administrative, educational and supervisory, which resulted in a potential for fatigue and errors in his judgment;**

v. **the best option was to recruit a new Director of Surgery.**

Potential Adverse Finding 1(p)

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

i. **suspend or restrict Dr Patel's interim clinical privileges;**

ii. **restrict his scope of practice or otherwise take steps to limit Dr Patel's clinical duties; and**

iii. **to ensure that Dr Patel was immediately assessed by a clinical privileges and credentials committee.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

LETTER TO BUNDABERG NEWS MAIL

Potential adverse finding 1(q)

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

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

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

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

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

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

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

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

Submission in response to Potential Finding 1(q)

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

[159] Exhibit 474

AIRFARE

Potential Adverse finding 1(s)

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

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

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

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

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

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

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

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

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

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

Submission in response to Potential Finding 1(s)

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

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

LETTER TO DR PATEL DATED 5 APRIL 2005

Potential Adverse finding 1(t)

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

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

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

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

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

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

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

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

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

Submission in response to Potential Adverse Finding 1(t)

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

176 T4399.10–40 & T4407.20-34

RESPONSE TO LEAKING OF INFORMATION

Potential Adverse finding 1(u)

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

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

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

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

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

Hoffman

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

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

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

177 Statement of Mr Leck Exhibit 463 para 68

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

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

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

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

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

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

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

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

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

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

117. Ms Hoffman went on to say:

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

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

119. Finally, this exchange occurred:

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

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

Aylmer

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

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

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

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

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

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

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

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

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

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

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

Pollock

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

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

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

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

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

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

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

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

Mears

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

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

Jenner

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

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

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

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

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

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

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

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

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

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

Mr Leck

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

Other Witnesses

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

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

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

Summary

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

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

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

(m) a breach of the Code of Conduct;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Forwarding the Email of 7 April 2005

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

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

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

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

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

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

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

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

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

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

"Hi Dan,

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

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

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

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

Peter"

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

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

211 Exhibit 477

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

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

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

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

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

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

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

COMPLAINTS POLICY

Potential Adverse Finding 1(v)

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

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

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

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

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

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

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

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

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

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

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

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

Submission in response to Potential Finding 1(v)

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

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

SENTINEL EVENTS

Potential Adverse finding 1(w)

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

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

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

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

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

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

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

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

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

169. It seemed to be suggested in the questions put to Mr Leck[232] that it was convenient for Mr Leck to accept Dr Keating's view that this was not a sentinel event because then it could be somehow "kept from" Head Office. This overlooks the very email which was sent to Mr Leck was copied to Dr John Scott, the Deputy Director General and Mr Bergin, the Zonal Manager.

170. Mr Leck acted properly in causing the matter to be investigated and causing a report to be done to Mr Bergin.

171. When Mr Leck had other occasion to be contacting Dr Scott, Dr Scott's response said that if he, Mr Leck, was making contact regarding the matter raised by Dr Rashford, it was "fine".[233]

172. The death of Mr Kemps on 20 December 2004 was noticed by Mr Leck on review of a night report.[234] He immediately brought it to Dr Keating's attention.[235] In exhibit 448, paragraphs 288 – 299, Dr Keating relates what he did about it, including reporting to the Coroner.

173. Although Mr Leck was aware of his responsibility to notify corporate office of a sentinel event[236]he relied on the clinical staff to notify him of the occurrence of such an event. Mr Leck now concedes that Mr Kemps' death fulfilled the criteria for a sentinel event.[237] However, there is no evidence that Mr Leck considered it to be a sentinel event at the time he first became aware of it. Mr

230 Statement of Dr Scott Exhibit 317 & T7165.30
231 Exhibit 481
232 T7165-7167
233 Statement of Dr Rashford Exhibit 210 attachment SJR2
234 T7171.35
235 T7171.29
236 T7171.47
237 T7171.45

Leck properly brought it to the attention of Dr Keating with the expectation that if it were a sentinel event or the reporting processes were to be initiation, that would be done by Dr Keating, or by the doctors or nurses who were directly involved in the patient's treatment.

Submissions in response to Potential Finding 1(w)

- Mr Bramich's case was properly referred initially for internal investigation by Dr Keating then for external investigation by Dr Fitzgerald.
- Mr Mobbs' case was not a sentinel event but was in any event the subject of appropriate communications with "Head Office".
- Mr Kemps' case was properly referred by Mr Leck to Dr Keating for enquiry. If it was a sentinel event, he was entitled to expect that Dr Keating, or the treating doctors or nurses would action it accordingly.

CONSULTATION WITH DR KEATING

Potential Adverse Finding 1(x)

You limited your consultation with your Director of Medical Services Dr Darren Keating to meetings initially once per week and then once per fortnight in circumstances where consultation between you should have been continual.

Potential Adverse Finding 1(y)

You failed whether because you failed to adequately consult with him or otherwise to prevent your Director of Medical Services Dr Darren Keating from:

i. **in early February 2005 writing to the Medical Board seeking renewal of Dr Patel's registration and an assessment of Dr Patel's performance falsely and grossly misrepresenting and overstating Dr Patel's performance and failing to inform the Medical Board of any of the matters set out above or that a clinical audit was being conducted by the Chief Health Officer into complaints about Dr Patel;**

ii. **on 1 February 2005 knowing that Dr Patel had agreed to continue employment as a Senior Medial Officer in surgery until 31 July 2005 misrepresenting in the Form 55 Application for Sponsorship of Visa for Dr Patel sent to the Department of Immigration and Multicultural Affairs that Dr Patel was to be employed as Director of Surgery at the Hospital for a further four years;**

iii. **making an offer to Dr Patel by letter dated 2 February 2005 (Exhibit 448 DWK 69) of a temporary full time position of locum general surgeon for the period from 1 April 2005 to 31 July 2005 at a daily rate and pursuant to an arrangement that was contrary to Queensland Health policy with respect to the employment of a locum.**

"Continual Consultation"

174. The Concise Oxford dictionary definition of "continual" is "*constantly or frequently occurring*".

175. We do not take it to be suggested that Mr Leck should have been "constantly" consulting with Dr Keating. Both gentlemen were extremely busy.[238] It is clear from the evidence that they worked near each other and would have seen each other every day and doubtless spoke when necessary (and possible).

176. There has been no expert evidence about "best practice" in this matter.

177. Note that the notice here addresses only formal meetings between the two men. They no doubt had other communications verbally, via email, at other meetings, in the corridor etc. They met when necessary. On what basis and

238 T7297 - 7299

by what standard can it be suggested that they met formally too infrequently? The allegation was put to neither Mr Leck nor Dr Keating.

178. In any event, this is a managerial decision. Different people will have different management styles. Some might say that Mr Leck consulted frequently; some might say he interfered and failed to give appropriate autonomy. This Commission is ill-equiped by the evidence to be making those sorts of judgments.

Documents

179. As was submitted in relation to Dr Nydham it cannot reasonably be expected of a District Manager that he personally "vet" documents for submission to the Medical Board, Immigration Authorities etc. In relation to this potential adverse finding, however, there is a more fundamental reason why no adverse conclusion can be drawn against Mr Leck. He is not shown to have had any knowledge of the fact that Dr Keating was submitting the documents referred to. It was never put to Mr Leck in evidence that he had any such knowledge.

180. Mr Leck's evidence is that he was on leave when Dr Keating made the offer to Dr Patel. It is not plausible that Mr Leck should have been aware of or expecting that Dr Keating was, in February 2005, making the representations now complained of when in fact the evidence shows that in early January 2005 Dr Keating advised Mr Leck that Dr Patel's services should not be continued save in the very short term pending recruitment of a replacement Director.

Submission in response to Potential Finding 1(x) and 1(y)

The Commission should make no adverse finding against Mr Leck on these matters because:

- **There is insufficient evidence of the appropriate kind to determine whether Mr Leck consulted with Dr Keating with sufficient frequency.**
- **It is not reasonable to expect a District Manager to personally vet documents of the kind referred to.**

- **In any event the evidence does not disclose that Mr Leck had any knowledge of the existence of these documents.**

- **It had already been decided in early January 2005 that Dr Patel's services were not to be continued except in the very short term.**

DR JELLIFFE

Potential Adverse Finding 1(z)

You sought to intimidate a senior staff anaesthetist, Dr Jelliffe, who had complained and cancelled elective surgery due to excessive workload by calling him into your office and asking him to remind you of his current visa status.

181. Dr Jelliffe has made complaint that Mr Leck impliedly threatened him in relation to his visa status following his cancelling elective surgery[239].

182. There had been no previous negativity in the relationship between Dr Jelliffe and Mr Leck[240], Dr Jelliffe accepted that it was perfectly legitimate of Mr Leck to seek an explanation for the cancellation of the surgery list[241] and the appointment was arranged in an appropriately polite way.[242] The words used by Mr Leck to constitute the implied threat were of themselves not intrinsically threatening[243] and they were spoken *"casually and matter of factly"*[244] Dr Jelliffe relies upon unspecified *"body language"*[245] and a *"combination of the circumstance"*[246] and *"gut feeling"*[247] but he says he would prefer not to use the word *"threatening"* at all and would use the word *"focussed"*[248]

183. Dr Jelliffe was reluctant to accept the proposition that he may have been predisposed to find a "threat" where there was none[249]. He said that this was so because he did not go to the meeting in anticipation that Mr Leck would raise the matter of his visa but rather in anticipation that Mr Leck would want to deal with the matter of the cancellation of the surgery. But, referring to Mr Leck's words *"just remind me of your current visa status"* Dr Jelliffe says:

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239 T6648 et seq.
240 T6666.55
241 T6667.44
242 T6666.37
243 T6667.53
244 Statement of Dr Jelliffe Exhibit 437 para 21
245 Statement of Dr Jelliffe Exhibit 437 para 23
246 T6668.10
247 T6668.45
248 T6657.9
249 T6668.45-6669.30

"This confirmed my gut feeling when I went to his office that I was to be challenged about my decision and my visa status was going to be raised as a means of my towing (sic) the line and not making such a decision again in the future"[250].

184. Dr Jelliffe was in error as to a large number of the details in his statement and his evidence so as to bring into question general reliability:

(a) he gave evidence that the elective surgery which he cancelled was scheduled for the Easter week but changed that evidence when a document produced to him indicated that he had been on leave for part of that week[251];

(b) his statement asserted that "all" elective surgery was cancelled but his evidence was different[252];

(c) he does not seem to have told Mr Leck that he had consulted with Dr Carter before Dr Carter's departure on leave and it had been agreed that if the pressure became too substantial, the surgery list could be cancelled;

(d) he made assumptions in his evidence in chief about Mr Leck having his (Dr Jelliffe's) personnel file before him at the meeting which assumptions he was not able to sustain in cross-examination[253];

(e) he swears that the contents of attachment 1 to his statement[254], being the article by Mr Thomas, are *"as I inform Mr Thomas about"* however,

- Mr Thomas refers to *"some routine surgery"* but Dr Jelliffe gave a different version;
- Mr Thomas refers to a *"summons"* from the manager but Dr Jelliffe, in his evidence rejected that there was a *"summons"*[255];
- Mr Thomas refers to Dr Jelliffe giving Mr Leck a *"reminder"* about his visa status but Dr Jelliffe says it was *"new information"*[256].

250 Statement of Dr Jelliffe Exhibit 437 para 21
251 T6664.35
252 T6662.1-30
253 T6667.5-40
254 Statement of Dr Jelliffe Exhibit 437 para 29
255 T6666.41
256 T6672.19

185. In all of the viva voce evidence and all of the exhibits over the whole duration of this commission and its predecessor, not withstanding that there was a high proportion of overseas trained doctors in Queensland Health generally and, relevantly, at Bundaberg Hospital, there is not one other suggestion that Mr Leck has ever raised a doctor's visa status in any improper way or sought to use such a matter improperly to achieve any outcome. There is not the slightest evidence to support any suggestion that this was a technique, practice or disposition of mind of Mr Leck. He rejects it as *"...not something I would do."*[257] Our submission is that the Commissioner's assessment of Mr Leck as a witness and as a person will lead the commission to the same view.

186. In truth, Dr Jelliffe's evidence was to the effect that nothing in Mr Leck's words or conduct was itself threatening but he subjectively *"felt"* or had a *"gut feeling"* of being threatened. That is not evidence at all against Mr Leck.

Submission in response to Potential Finding 1(z)

Given the ambiguity in the alleged threatening words; the clear possibility of (albeit innocent) predisposition on the part of Dr Jelliffe, the fact that the Commission would have to act upon essentially Dr Jelliffe's interpretation of words and circumstances not intrinsically threatening, the uncertainties in the detail of Dr Jelliffe's evidence and the utter absence of anything in Mr Leck's history or behaviour to suggest that he had in the past threatened anyone in such a situation or would even be capable of descending to such a tactic, the Commission ought not to make any adverse conclusion, observation or recommendation on this matter.

257 T7182.5

CONCLUSION

187. Mr Leck has not been guilty of official misconduct for the reasons set out above.

188. Further, "official misconduct" is defined by section 15 of the Crime and Misconduct Act 2001 as conduct that could, if proved, be

(a) a criminal offence; or

(b) a disciplinary breach providing reasonable grounds for termination the person's services, if the person is or was the holder of an appointment.

189. There is no suggestion of a criminal offence and the breaches alleged are not such as to justify dismissal.

Conclusion

It is our submission that any complaints against Mr Leck must be judged against the background of his very substantial responsibilities, inadequate resourcing and oppressive financial accountability and reporting obligations imposed by Queensland Health. It would not be fair to Mr Leck, in judging him, to fail to take into account the daily exigency with which he had to contend and the extent to which this meant that he could not on all occasions at all levels meet all obligations perfectly.

RESPONSE TO QNU SUBMISSIONS

1. It is proposed to deal only with those submissions of the QNU that are relevant to Mr Leck, and are specific, and are not otherwise dealt with in these submissions.

2. Paragraph 11. As has been made clear earlier in these submissions, the credentialing and privileging process is not a process that would have identified Dr Patel's fraud.

3. Paragraph 12. The submissions do not identify *"the adverse outcomes of patients which Mr Leck had knowledge of".*

4. Paragraph 14. The prospect of suspending Dr Patel was adverted to by Mr Leck but, for reasons we have explained earlier in these submissions, he did not consider it necessary. Note that Ms Hoffman herself did not call for that step either in October 2004 or later. In fact Ms Hoffman was not asking for anything else other than for the treatment of certain patients to be investigated by an independent auditor.[258]

5. Paragraph 20. There is no suggestion that Mr Leck *"criticised or denigrated"* Ms Hoffman's actions. Mr Leck's legitimate concern was the leaking of confidential patient information. Ms Hoffman herself asked Mr Messenger to keep the patient details confidential. She did not envisage the letter being published *'unedited'.*

6. Paragraph 20. **"The Three Monkeys"**- This is abuse, it is not based on the evidence and does the submission no credit. As regards Mr Leck, the *"detailed written documentation"* in relation to patients is not identified. Nor is the same identified in relation to nursing staff.

7. Paragraph 44. It is erroneous and mischievous for the QNU's counsel to assert that Ms Hoffman merely did not wish the matter to be treated as an official complaint. She asked that it not be acted on. And, as we explain in our submissions, she did that because she still wished to try to sort out the conflict with Dr Patel. And that reinforces the idea that, at that stage at least, the matter at issue was a personality conflict.

8. Paragraph 53. The QNU's submissions do not explain why the failures alleged breached of trust.

9. Paragraph 54. The sentence commencing *"Ms Doherty said ...."* is not an accurate assessment of the evidence. The email from Dr Keating was not expressed as a response to any complaints of Ms Doherty. There is no evidence that it was a response.

10. Paragraph 60. The suggestion that Mr Leck and Dr Keating deliberately disregarded legitimate concerns as to patient safety has no foundation in the evidence. There was certainly no evidence that Mr Leck even appreciated that there were legitimate concerns as to patient safety.

11. Paragraph 61. The letter was plainly not dishonest. Mr Leck was genuinely concerned about natural justice. As has been explained in our submissions and in the submissions on behalf of Dr Keating, one should be careful not to misuse the benefit of hindsight.

12. Paragraph 62. Here it is asserted that Mr Leck threatened imprisonment and dismissal. The source of that evidence is said to be Ms Hoffman. However, as we explain earlier in these submission, Ms Hoffman resiled from those allegations and certainly thought Ms Walls may have said it and Mr Leck may have left the meeting by then. As to the alleged *"intimidation"* see our earlier submissions.

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258 T1475.29.

13. Paragraph 64. The assertion that Mr Leck had an expectation that Media would contact the nurses is a mistake. It was Ms Hoffman who warned of that possibility. She did that before the meeting started. See paragraph 15 of Ms Jenner's statement. The last sentence is also beyond the evidence. There is no evidence of any express threat. There is no evidence of any acts that might be regarded as intimidatory in the ordinary sense of that word. Mr Leck directed his remarks to breaches of patient confidentiality – a matter conceded to be of legitimate concern.

Dated this 31st day of October 2005

per: R Walton.

Paul Freeburn SC

Ron Ashton
Counsel for Mr Leck

Hunt & Hunt
LAWYERS

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Your Ref:

2 November 2005

The Secretary
Queensland Public Hospitals Commission of Inquiry
PO Box 13147
George Street
BRISBANE QLD 4000

Attention: Mr David Andrews

Dear Mr Andrews,

Submissions in Reply from QNU

We refer to the Submissions in Reply on behalf of the Queensland Nurses Union delivered on 1 November 2005. We hold the view that the Commission should disregard the Submissions entirely on the basis that they do not fall within the category of submissions in response contemplated by the Commissioner in paragraph 5 of his directions of 20 October 2005.

If however, the Commission intends to entertain the submissions we make the following points on behalf of our client:

1. The statement of our client's evidence set out in Paragraph 2(c) of the submissions is simply wrong. Neither our client nor any other witness gave evidence that *"Mr Leck made a determination that the events described in the Sentinel Event form did not constitute a sentinel event."*

In paragraph 34 of his statement (Exhibit 463) Mr Leck says:

"The issues raised in the Adverse Event Report and the Sentinel Event Report caused me concern so I contacted the quality co-ordinator. I was told that this did not constitute a sentinel event within the terms of the specific criteria set out in the Queensland Health Incident Management Policy."

Mr Leck's oral evidence was consistent with his statement:

"My Understanding was that – well, I am not sure whether it was Jane or Leonie had spoken to Darren Keating, who indicated that is also wasn't a sentinel event, and there was specific classifications in corporate policy in relation to sentinel events." (T7169.2; see also T7167.50 to 7169.50 & 7288.45 –7289.36)

2. The submissions in Part C of the document quote material that is not evidence before the Commission and ought not to be relied upon.

We have sent an electronic copy of this letter to the parties who have been given leave to appear.

Yours faithfully
HUNT & HUNT

Patricia Feeney
Partner

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