

Chapter One – Report summary

The origin of this Inquiry

- 1.1 This Commission of Inquiry arose out of complaints relating to Dr Jayant Patel at Bundaberg Base Hospital in 2004 and early 2005. These complaints, and other concerns expressed about Dr Patel's judgment, competence and care, and the failure of Bundaberg Base Hospital's administrators, and later officers of Queensland Health, to address those complaints and concerns, have been one of the main focuses of this Inquiry.
- 1.2 Those complaints and concerns might never have been made public or been properly addressed if it had not been for the efforts of three people. The first and most important of these was Ms Toni Hoffman. It was her courage and persistence which, in the face of inaction and even resistance, brought the scandalous conduct of Dr Patel to light. I say more about Ms Hoffman's contribution in Chapter Three at paragraphs 3.324 to 3.331 and 3.432.
- 1.3 The second was Mr Rob Messenger MP. Had he not raised Ms Hoffman's complaints in Parliament it may be that there would never have been a public inquiry into them. I mention his contribution further in Chapter Three at paragraphs 3.370 to 3.373 and 3.432.
- 1.4 And the third was Mr Hedley Thomas of *The Courier-Mail*. His investigative skill, persistence and undoubted authority as a respected journalist ensured that public notice and government action was taken notwithstanding the apparent reluctance of hospital administrators and officers of Queensland Health to take appropriate action or to permit the matter to be exposed. It was he who first publicly revealed Dr Patel's discreditable past in the United States. I say more about his contribution also at paragraphs 3.402 and 3.433.

Bundaberg Base Hospital: Chapter Three

Area of Need Registration and Bundaberg Base Hospital before 2003

- 1.5 A short history of Bundaberg Base Hospital up to the appointment of Dr Patel in April 2003 and an analysis of the evidence with respect to Dr Patel's appalling conduct and its consequences, is discussed in Chapter Three. That is preceded in Chapter Two by a discussion of base hospitals and the recruitment of doctors, in particular that of overseas trained doctors, about which I make some critical findings and recommendations in Chapter Six.
- 1.6 The history of Bundaberg Base Hospital up to April 2003, which I discuss at paragraphs 3.1 to 3.65 is revealing. It shows a gradual deterioration of what was

once an efficient, safe hospital providing reasonable care to one which was inefficient, unsafe and incapable of providing reasonable care. In retrospect, it is perhaps unsurprising that into that environment Dr Patel should come.

*Dr Patel's registration and appointment at Bundaberg Base Hospital 2003:
Paragraphs 3.66 to 3.138*

- 1.7 Dr Patel was registered by the Medical Board of Queensland under the area of need scheme¹ as a senior medical officer in surgery at Bundaberg Base Hospital on 11 February 2003. As the Act required, his registration was for a period of one year. He was appointed as Director of Surgery by Dr Nydam, the Acting Director of Medical Services at Bundaberg Base Hospital.
- 1.8 This registration and appointment occurred through a chapter of negligent mistakes by the Medical Board and by administrators at Bundaberg Base Hospital. The Medical Board negligently failed to properly check Dr Patel's paper credentials and to make any assessment of whether he had the qualifications and experience for practising surgery in Bundaberg. And Dr Nydam, and later, Dr Keating negligently failed to have any assessment made of his skill or competence by a committee of peers called a Credentialing and Privileging Committee.

Registration

- 1.9 He came to be registered because of a negligent omission by the Medical Board to advert to a notation on Dr Patel's Certificate of Licensure from Oregon, United States of America which, if pursued, would have revealed a restriction imposed on him, as a disciplinary measure, from performing certain types of surgery in Oregon; a negligent failure by the Board to make independent inquiries about Dr Patel's past practice in the United States which would probably also have revealed that he had surrendered his licence to practise in New York in consequence of disciplinary proceedings against him there and that he had been unemployed for over a year; and a negligent failure by the Medical Board to assess, or to have assessed, his qualification and experience suitable for practising as a Senior Medical Officer performing general surgery at the hospital as required of s135(2) of the *Medical Practitioners Registration Act 2001*. I make findings against and recommendations with respect to the Medical Board at paragraphs 6.116 to 6.134.

Appointment

- 1.10 He came to be employed at Bundaberg Base Hospital without any assessment being made of his clinical skill and competence. This should have been done by that hospital, as a condition of his appointment, by a process of credentialing and privileging, pursuant to a policy and guidelines of Queensland Health which had been in force since 2002. This failure was due to the negligence of Dr Nydam,

¹ *Medical Practitioners Registration Act 2001*, s 135

then Acting Director of Medical Services of Bundaberg Base Hospital. Dr Nydam also caused Dr Patel, who had been registered and appointed as a Senior Medical Officer, a position which would ordinarily be supervised, to be appointed as Director of Surgery, a position ordinarily occupied by a registered specialist surgeon, where he was subject neither to supervision nor even peer assessment. By doing it in this way, Dr Nydam avoided the need, he thought, to convene an appointment committee. I make findings against Dr Nydam at paragraph 3.426.

- 1.11 About a fortnight after Dr Patel commenced work at the Base, Dr Keating replaced Dr Nydam as Director of Medical Services there. In breach of his duty to do so, and knowing that Dr Patel's skill and competence had not been assessed before he commenced employment at the Hospital, Dr Keating failed at any time between April 2003, when he was appointed, and when he left in 2005 to have that skill and competence assessed by an appropriate credentialing and privileging committee. This was notwithstanding that the Policy and Guidelines required that his employment was conditional on that being done, and that, in the meantime, Dr Patel's registration was renewed and his employment extended. I make findings and recommendations against Dr Keating in respect of this and other matters at paragraphs 3.427 and 3.428.

Dr Patel's conduct at Bundaberg Base Hospital 2003-2005: Paragraphs 3.415 to 3.420

- 1.12 In the period during which he performed surgery at Bundaberg Base Hospital, from April 2003 until early 2005, Dr Patel performed a large number of operations. The results of an examination of a comprehensive sample of his operations and aftercare was the subject of evidence by three respected general surgeons, Drs de Lacy and O'Loughlin, both of whom examined and performed corrective surgery on a number of Dr Patel's former patients, and Dr Woodruff who conducted a comprehensive survey of Dr Patel's work by examining hospital records.
- 1.13 Dr De Lacy said that Dr Patel's conduct as a surgeon was deficient in four main respects, namely:
- (a) His assessment of a presenting patient was inadequate;
 - (b) His surgery techniques were defective;
 - (c) His post operative management was poor, and
 - (d) His follow up was inadequate.

He concluded by saying that Dr Patel's results were not ten times worse than one would expect; they were one hundred times worse.

- 1.14 Dr O'Loughlin observed shortcomings in Dr Patel's judgment, knowledge and technical ability. When asked whether he would permit Dr Patel to operate on him, he said 'No'.

- 1.15 Dr Woodruff found that there were 13 deaths in which an unacceptable level of care on the part of Dr Patel contributed to the adverse outcome; and there were a further 4 deaths in which an unacceptable level of care by Dr Patel may have contributed to the outcome. He found, in addition, 31 surviving patients where Dr Patel's poor level of care contributed to or may have contributed to an adverse outcome. He said that he had no hesitation in saying that Dr Patel's performance was incompetent, and that this performance was far worse than average, or what one might expect by chance.

Complaints about Dr Patel and his avoidance of scrutiny: Paragraphs 3.181 to 3.282

- 1.16 In his 24 months at Bundaberg Base Hospital, staff or patients made over 20 complaints about Dr Patel. Those complaints commenced with a procedure he performed six weeks after he commenced at the Hospital and continued until he ceased working there. All of the patients' complaints were verified by the examinations of the above specialist surgeons. Whilst the complaints varied in their seriousness and the formality with which they were made, some of them were extremely grave. Dr Keating and Mr Leck persistently ignored or downplayed the seriousness of these complaints. Dr Keating, for instance, was keen to describe them as 'personality conflicts'. In some cases their conduct was obstructive or antagonistic to complainants. On the whole their actions and inaction were unresponsive and discouraged complaint. Nevertheless, despite the fact that Dr Patel also, in a number of ways, avoided scrutiny of his conduct, complaints continued.
- 1.17 Dr Patel's avoidance of scrutiny of his conduct was contributed to by the position to which he was appointed, Director of Surgery, and the manner in which that occurred, referred to above. By this means, Dr Nydam managed to circumvent the more difficult route of seeking deemed specialist registration under s.135, having the consequence stated in s143A, which would have required assessment by the Royal Australasian College of Surgeons. The result was that Dr Patel was not supervised and, given the size of the Hospital, he had no peers at the Hospital who could assess his clinical skill and competence in the course of their work.

*The failure of Mr Leck and Dr Keating to properly investigate these complaints:
Paragraphs 3.306 to 3.359*

- 1.18 Notwithstanding the isolation from scrutiny that Dr Patel was able to achieve, it may now seem astonishing that the number and seriousness of the complaints against him did not cause either Dr Keating or Mr Leck to institute some thorough independent investigation of his conduct, at the latest by the end of October 2004. But their failure in this respect becomes less surprising, although no less reprehensible, when it is seen how they saw their role of running the Hospital, and where their priorities lay.
- 1.19 In the first place, both saw themselves as running a business of providing hospital services. They were not solely at fault in this for that is how Queensland

Health officers also saw their role. Indeed, the terminology used was that Queensland Health was 'purchasing medical services' from the hospitals and that patients were 'consumers' of these services. The hospital budget was fixed on an historical basis, that is based on that of the previous year, with an additional incentive payment based on elective surgery throughput. Up until quite recent times it also provided for a small percentage reduction from the historically fixed budget on the assumption that improved efficiencies would enable that to be achieved. In other words the budget was fixed as if the hospital was running a business of selling goods or services. Patient care and safety was not a relevant factor.

- 1.20 There was a strong incentive to Mr Leck, and consequently to Dr Keating, to maintain that budget. Mr Leck said that District Managers had been sacked for exceeding budget. And because achievement of the elective surgery target was necessary to obtain maximum funding for the following year, there was considerable pressure on both of them to achieve that target.
- 1.21 In this respect Dr Patel was a considerable asset. He was very industrious and, no doubt also partly because of his careless surgery, and lack of proper after care, maintained a high throughput of general surgery. Without him, the hospital would not have been able to achieve its elective surgery target. Mr Leck's and Dr Keating's greater concern with maintaining their elective surgery target than with patient care or safety is reflected in a great deal of the evidence.
- 1.22 Secondly, Dr Keating and Mr Leck were also both more concerned with procedures than with substance; what the purpose of those procedures were. Nowhere is this better reflected than in Dr Keating's attempts, together with Dr Hanelt at Hervey Bay Hospital, over more than a year, to obtain specialist college representation on credentialing and privileging committees, whilst ignoring the urgent need to have Dr Patel and others properly credentialed and privileged. Whilst seeking to achieve what he thought was the ideal system of credentialing and privileging committees in what he mistakenly thought was the required system, Dr Keating failed to realise the essential purpose of credentialing and privileging; to assess the clinical skill and competence of a doctor to perform the task for which he or she is to be employed, before commencing work.
- 1.23 And thirdly, the complaints system at the Hospital was grossly inadequate; and neither Dr Keating nor Mr Leck seemed to appreciate, or they chose to ignore, the significance of the accumulation of complaints, some of them quite serious about Dr Patel, which built up over the period of his working at Bundaberg Base Hospital..
- 1.24 It was a gross dereliction of duty by each of Mr Leck and Dr Keating not to have investigated the complaints against Dr Patel, at the latest, by October 2004, when they met with Ms Toni Hoffman about her written complaint.

- 1.25 I make serious findings and recommendations in respect of conduct, including conduct which, on the evidence before me appears to constitute criminal offences, against Dr Patel. These are at paragraphs 3.424 and 3.425.

Conclusions with respect to Bundaberg Base Hospital

- 1.26 Four factors, in my opinion, contributed to Dr Patel's sustained path of injury and death at Bundaberg Base Hospital. They were:

(i) *The Hospital Budget.*

The Hospital budget contributed in two ways. The first was that, although a Director of Surgery is ordinarily, and should be, a registered specialist surgeon, a surgeon who had Australian specialist qualifications would have probably required an offer of salary and conditions more generous than Queensland Health would have permitted the Hospital to offer; and so also would an overseas trained specialist surgeon who would have been able to satisfy the Royal Australasian College of Surgeons that his qualifications and experience were sufficient for them to recommend that he be granted deemed specialist registration. It is unlikely that the Hospital would ever have obtained the money to pay this. The second aspect was the focus, dictated by the budget, upon elective surgery throughput. Dr Patel made himself so valuable in that respect that the administrators were plainly reluctant to offend him, let alone investigate him.

(ii) *The failure to check his background*

Both the Medical Board and Queensland Health failed to check the credentials which he submitted. Had that been done, his discreditable past would probably have been revealed.

(iii) *The failure to have him credentialed and privileged*

At no stage did Mr Leck or Dr Keating have Dr Patel's skill and competence assessed by a committee of his peers under Queensland Health Policy and Guidelines. That should have been done before he commenced to see or operate upon patients at the Hospital, and again before he was reemployed a year later.

(iv) *The failure of any adequate complaint system to operate*

As explained earlier, this failure was caused, in part, by the budget system and the focus of both Dr Keating and Mr Leck upon the maintenance of the elective surgery target, but it is hard to believe that, if Dr Keating had been constantly confronted with the accumulating number and seriousness of complaints, as he should have been under any proper system, he would not have felt obliged to act.

- 1.27 In retrospect it is, perhaps, unsurprising that these causes of Dr Patel's appointment and continued course of conduct causing death and serious injury,

emerged as a cause of problems in other hospitals, which were, in whole or in part, the subject of evidence before this Commission.

Hervey Bay Hospital: Chapter Four

1.28 The examination of Hervey Bay Hospital was primarily concerned with the absence of adequate supervision of two Fijian trained doctors, registered under the area of need provision of the *Medical Practitioners Registration Act 2001*, in the orthopaedic department at the Hospital. This meant that they were unsupervised whilst performing operations in orthopaedic surgery which were beyond their respective levels of competence, with consequent serious risk to patient safety, and in some cases, with unfortunate results.

The need for and failure to provide supervision of the Senior Medical Officers

1.29 Both Drs Krishna and Sharma had had experience performing orthopaedic surgery in Fiji. Dr Krishna had also had some experience of performing orthopaedic surgery, under close supervision, at Toowoomba Hospital. Both were, at all relevant times, registered as Senior Medical Officers under the area of need provision. Their registration in each case, lasted for a year but was, in each case, renewed.

1.30 The application to the Medical Board from Dr Hanelt, the Director of Medical Services at Hervey Bay Hospital for the registration of each, indicated, in each case, that they would be supervised. However, no condition with respect to supervision was imposed by the Medical Board upon their registration, as it could have been.

1.31 The uniform view of all specialist orthopaedic surgeons who gave evidence was that Dr Krishna and Dr Sharma required supervision when performing orthopaedic surgery. The extent of which that supervision was required gave rise to some differences of opinion but it was unnecessary to resolve those. None was provided.

1.32 There was never any real prospect that Dr Krishna or Dr Sharma would be properly supervised at Hervey Bay Hospital because there was only ever one specialist orthopaedic surgeon, Dr Naidoo, at that Hospital. In addition, as it turned out, he was absent from that Hospital frequently, and some times for long periods of time. The Commission was unable to investigate fully the legitimacy of all of the absences of Dr Naidoo and has made a recommendation for further investigation of those. That recommendation is at paragraph 4.238.

Complaints about lack of supervision and their rejection

1.33 Dr Mullen, a registered orthopaedic surgeon in private practice at Hervey Bay, and a Visiting Medical Officer at the Hospital, complained frequently to Dr Hanelt, the Director of Medical Services, about the failure of Dr Krishna and Dr Sharma to receive supervision. His complaints were either rejected or ignored. He eventually took his complaints to the Australian Orthopaedic Association, whose efforts resulted in the appointment of Dr North and Dr Giblin to investigate,

referred to below. Dr Mullen also gave evidence of unfortunate consequences of one of these doctors operating without supervision.

- 1.34 Complaints were also made by nurses about Dr Naidoo's absences and the lack of adequate supervision of operations conducted by these Senior Medical Officers. Their complaints were similarly dismissed or ignored by Dr Hanelt and Mr Allsopp.

The failure to credential and privilege either Senior Medical Officer

- 1.35 In addition, Dr Krishna and Dr Sharma were employed and commenced service at Hervey Bay Hospital without having their skills and competence assessed by a committee of peers, a credentialing and privileging committee. Indeed, no such committee ever existed at any relevant time at Hervey Bay Hospital. Dr Hanelt, like Dr Keating, was preoccupied over this period with drawing up a local policy and obtaining representation from specialist colleges on all credentialing and privileging committees, both unnecessary requirements. Like Dr Keating, Dr Hanelt, whilst drawing up a local policy for that purpose and then seeking to implement that policy in the way I have indicated, lost sight of the purpose of credentialing and privileging; to ensure a safe, adequate provision of hospital care. Consequently, Dr Hanelt failed to provide any means of assessment of the skill or competence of either doctor before he commenced work at the Hospital or, for that matter, at any later time.

There was never a safe, adequate orthopaedic service at Hervey Bay Hospital

- 1.36 Qualified and experienced orthopaedic surgeons were unanimous in saying that the provision of a safe, adequate orthopaedic service at Hervey Bay would have required the employment of four specialist orthopaedic surgeons. From the time of inception of an orthopaedic service at Hervey Bay, in 1997, until it was terminated in 2005, that was never the case. Consequently, Hervey Bay Hospital was never able to provide and consequently never provided a safe, adequate orthopaedic service. Its orthopaedic service was, for that reason, closed down in consequence of the North Giblin Report. Dr North and Dr Giblin were nominees of the Australian Orthopaedic Association.
- 1.37 No doubt it was because of budget constraints that the orthopaedic unit at Hervey Bay Hospital was, from the start, so inadequately staffed by orthopaedic surgeons, that it was an inadequate and unsafe service. Dr Krishna and Dr Sharma, who both required supervision in performing a substantial number of orthopaedic operations, were nevertheless expected by Mr Allsopp and Dr Hanelt to perform orthopaedic surgery unsupervised with only very few restrictions. Thus the main cause of the inadequacy and lack of safety of the orthopaedic service at Hervey Bay Hospital, which, after its investigation by Dr North and Dr Giblin, was closed down, was the failure to adequately resource it. There was never any attempt, at any time, to provide Hervey Bay Hospital with a full complement of four orthopaedic surgeons necessary to provide an adequate and safe service.

Conclusion with respect to Hervey Bay Hospital

1.38 The reasons for the risks which were taken and the injury caused to patients at Hervey Bay bear a remarkable similarity to the causes of the much more damaging consequences at Bundaberg Base Hospital. They were:

- (i) Insufficient funding to provide a safe, adequate service;
- (ii) A failure of the Medical Board to impose, as a condition of the registration of each of Dr Krishna and Dr Sharma that he be supervised;
- (iii) The failure to assess the clinical skill and competence of either Dr Krishna or Dr Sharma as should have been done by a credentialing and privileging committee;
- (iv) A failure to provide supervision to Dr Krishna and Dr Sharma; and
- (v) A failure to investigate and act on complaints by Dr Mullen an independent orthopaedic surgeon and nurses at the Hospital about the inadequacy of supervision of Dr Krishna and Dr Sharma.

Findings and recommendations against Dr Hanelt and Mr Allsopp

1.39 I have made findings and recommendations against Dr Hanelt and Mr Allsopp. These recommendations are at paragraphs 4.240 to 4.247.

Townsville Hospital, Charters Towers Hospital, Rockhampton Hospital and the Prince Charles Hospital

1.40 Because of limitations on my terms of reference the Commission was able to examine only limited aspects of the services provided by each of those hospitals. Nevertheless, these limited examinations were revealing of common problems, and, in the case of Townsville Hospital, an indication of some solutions.

Townsville Hospital: Chapter Five - Part A

1.41 The Townsville Hospital is a tertiary referral hospital. It has 425 beds and is the largest provincial hospital in Australia. It provides a comprehensive range of services comparable to the major Brisbane hospitals such as Royal Brisbane and the Princess Alexandra. Two of its systems are worth noting.

1.42 The first of these is that its management structure and manner of budget distribution is different from other public hospitals, or at least, other provincial public hospitals. In both respects there is greater involvement and control by clinicians. In the Institute of Surgery, for example, which is what the Department of Surgery is called, the Clinical Director, a practising surgeon, and the Operations Director, a nurse, between them control the surgery budget. And they have power to spend a substantial amount of money without reference to the District Executive. Consequently, the kind of problem which arose in Bundaberg, of surgeons having to seek District Manager's permission to replace rusty surgical instruments, does not happen. Moreover the budget of each Institute is negotiated each year between the Townsville Executive and the Clinical and Operations Directors of each Institute. Unlike in other hospitals, or at

least other provincial hospitals, in Townsville the role of the Executive is one of supporting clinicians, and advocating their case for budget to Corporate Office, rather than, as it appears to be elsewhere, a 'them and us' approach to the clinicians. Unsurprisingly, this refreshing approach to budget by the Executive seems to be neither understood nor welcomed by Corporate Office. But it has managed to achieve what I think is essential, an appropriate balance between clinicians and administrators in fixing and advocating for budgets. I discuss this approach in more detail at 5.14 to 5.25.

- 1.43 The second is its approach to the assessment and integration of overseas trained doctors. All overseas trained doctors employed in hospitals in the Northern Zone are first required to spend time working in the Townsville Hospital. Although it is not called this, this is, in effect, a probationary period during which the doctor is closely supervised by experienced doctors who can monitor and assess whether he or she has the qualifications and experience to work in the position to which that doctor is to be appointed. It also gives that doctor an opportunity to see how the Queensland health system works during a period of close supervision, and to meet the specialists from whom he or she may later need to seek advice. I have expressed the view in Chapter Six that although s135(3) requires the Medical Board to make an assessment of such a doctor's suitability to practise in a designated area of need before registering that doctor, there is no process by which that is done. But at least something is done about this in the Northern Zone before that doctor is permitted to operate unsupervised or with minimal supervision, albeit after registration rather than before it. I express the opinion in Chapter Six that a similar process should be adopted before registration pursuant to s135 whereby all overseas trained doctors who would otherwise be qualified for registration pursuant to s135 must first be conditionally registered and serve a probationary period of registration in a tertiary hospital.

Vincent Berg

- 1.44 The other main focus of the Commission's inquiry at Townsville Hospital was with respect to Vincent Victor Berg who was employed as a Resident Medical Officer at Townsville Mental Health Unit between January 2000 and January 2001. He claimed to have post-graduate qualification in psychiatry from the Voronezh State University in the former USSR, now the Russian Federation. It seems probable now that that claim is false, and that the documents which he produced to the Medical Board to obtain registration were forged.
- 1.45 Two aspects of Mr Berg's registration and practice at Townsville Hospital were the principal areas of inquiry by this Commission. They were how he came to be registered by the Medical Board, and why no investigation of his fraudulent conduct was carried out.
- 1.46 It was not until some six months after he had left the Townsville Hospital that these forgeries were first discovered. Curiously, Berg contributed to the

discovery by applying for specialist registration in Australia. As part of the process of assessment for that purpose the College of Psychiatrists took steps to verify the authenticity of Berg's qualifications. They did what might have been thought necessary for the Medical Board to have done before Mr Berg was first registered; they wrote to Voronezh State University who told them that that University did not produce the degree in psychiatry which Mr Berg claimed to have and, when they saw the documents which Mr Berg had produced, described them as very rough forgeries.

- 1.47 It is unlikely, when it registered Mr Berg, that the Medical Board had any knowledge of Voronezh State University or the quality of the degree which it produced, if any. Yet it made no inquiry from that University, or from anywhere else, other than Mr Berg, about the authenticity or quality of his credentials. It accepted the documents produced by Mr Berg, at their face value, and registered him.
- 1.48 This registration bears a striking similarity to the registration of Dr Patel in the omission to make the necessary inquiries by the Medical Board. In both cases, as I have shown, inquiries from a source independent of the applicant would have revealed, in the case of Patel, that he had been suspended for malpractice and, in the case of Berg, that his qualifications were fraudulent. I discuss those negligent omissions and a solution to them in Chapter Six.
- 1.49 The probable falsity of Berg's qualification was discovered by the College of Psychiatrists in or about September 2001. The College informed the Medical Board of this on 16 October 2001. Notwithstanding that, the Board, astonishingly, provided Berg with a certificate of good standing on 10 January 2002 with an added notation that 'the Board has not been able to verify the qualification on which Dr Berg's registration was granted.' Apparently on the basis of this, Berg applied for and was granted provisional registration by the Medical Board of Western Australia. However, that Board soon discovered, from the College of Psychiatrists, the doubts about the veracity of Berg's claimed qualifications and cancelled his registration on 28 February 2002.
- 1.50 The Medical Board did not notify either Queensland Health or the Townsville Hospital of what it had been told by the College of Psychiatrists. The Hospital found out about this, by accident, when one of its employees went to a meeting of the College of Psychiatrists. This was in or about December 2002. The Hospital then expressed immediate concern to Corporate Office about the need to contact Berg's former patients and to take other action against Berg, who had indicated to the Medical Board of Western Australia that he intended to return to Queensland. Both disclosure to former patients of Mr Berg, that his credentials appeared to be false, and referral to the Crime and Misconduct Commission or the Police by the hospital, were prohibited by Dr Buckland.
- 1.51 The first decision may have been justified. The second was plainly without justification. The matter should have been immediately referred to Police

because it was plain that there appeared to be a prima facie case of the commission by Berg of a number of criminal offences.

- 1.52 Dr Buckland's reasons, on 23 January 2003, for his failure to involve the Police, that the Medical Board refused to acknowledge that Berg was not registrable, did not make sense. Dr Buckland knew that there was prima facie evidence that Berg's so called qualifications were forgeries.
- 1.53 The circumstances relating to this matter, together with Dr Buckland's earlier decision not to permit former patients of Berg to be informed that Berg's qualifications might be forgeries, and Dr Buckland's decisions not to investigate Dr Patel's conduct in Bundaberg and, apparently, the complaints about the orthopaedic service at Hervey Bay, together lead me to think that Dr Buckland's concern about the possibility of adverse publicity to Queensland Health and the Government was a major factor in his decision not to permit any further investigation, by the Crime and Misconduct Commission or by Police, of Mr Berg.
- 1.54 I refer to the Commissioner of the Police Service for further investigation the question whether Vincent Victor Berg committed a number of offences. This is at 5.158.

Charters Towers Hospital: Chapter Five - Part B

- 1.55 Dr Maree was appointed as Medical Superintendent of Charters Towers Hospital in the middle of 2000. He was a South African trained doctor who claimed considerable experience in obstetrics and that he also had experience in anaesthetics.
- 1.56 He was granted conditional registration by the Medical Board under s17C(1)(d) of the *Medical Act 1939*, the predecessor of and in similar terms to s135. As in the cases of Dr Patel in Bundaberg and Dr Krishna and Dr Sharma in Hervey Bay the Medical Board made no independent assessment in order to satisfy itself that Dr Maree had suitable qualifications and experience to practise as a Medical Superintendent in Charters Towers.
- 1.57 Also, as the Coroner found in this case, as with Dr Patel's appointment in Bundaberg, Dr Maree's appointment was made in breach of appropriate policies concerning appointment on merit. And as with the cases of Drs Patel, Krishna, Sharma and Berg, Dr Maree was not subjected to any process of assessment of his clinical skill and competence by a peer committee.
- 1.58 Dr Maree was negligent in applying an anaesthetic to a patient on 17 December 2000 as a result of which she died.
- 1.59 This gave rise to a coronial inquiry which made a number of findings against Dr Maree. But the concern of the Commission here was these defects in the process of his appointment, and a failure by the Medical Board to investigate Dr Maree's conduct which resulted in death.

- 1.60 There seems little doubt that Dr Maree was unsuitable to perform the work ordinarily required of a Medical Superintendent at Charters Towers Hospital including, as it turned out, anaesthetics in which he claimed some expertise. And, like the other cases I have examined, it seems at least likely that, if the proper processes of registration, employment and credentialing and privileging had been applied, this would have been discovered before the tragedy occurred.
- 1.61 Dr Maree did not renew his registration and returned to South Africa. Nevertheless, there were complaints made against him which the Board could have investigated for the purpose of making recommendations. It was partly because Dr Maree had not renewed registration and returned to South Africa, and partly because it had a large number of other investigations to deal with, that the Board took no further action against Dr Maree. The Coroner found that it was wrong not to continue to investigate and prosecute him. I agree with that.

Rockhampton Hospital: Chapter Five - Part C

- 1.62 A review team produced a report, the Miller Report, on the Emergency Department at the Rockhampton Hospital in June 2004. It identified serious problems in the operations and staffing of that department. One serious problem in that department, a common one in other hospitals, was that Senior Medical Officers were employed to do the work which specialists in emergency medicine should have been performing. Secondly, it was substantially understaffed. And finally, and most importantly, it seems as if the Hospital, instead of employing its most competent doctors in the Emergency Department, was using it as the Hospital's 'dumping ground' for underperforming doctors.
- 1.63 The Miller Report made a number of recommendations, none of which, it seems, were ever adopted. However, partly in response to the recommendations, the Hospital employed Dr William Kelley, an American trained specialist in emergency medicine. He arrived at Rockhampton Hospital in March 2005 about nine months after the Miller Report. He noted that little progress had been made in implementing the recommendations of the Miller Report. The staffing of the emergency department remained inadequate and he felt that patient safety was being compromised. There continued to be poor utilisation of information technology, which he considered essential to the safe and efficient operation of an emergency department. He was also concerned that there were no radiologists at the Hospital, as radiological support was essential to the practice of emergency medicine.
- 1.64 Dr Kelley offered to contact senior doctors in other places in the world to join Rockhampton Hospital Emergency Department. However, his offer was rejected as was a further approach when it was made known that there were two such doctors in the United States willing to come and work in Rockhampton.
- 1.65 Dr Kelley recommended that, rather than employ a large number of junior doctors in the Emergency Department, as was the case, the Hospital should reallocate its funds so as to employ senior doctors. Again, this suggestion was not taken up.

The Hospital remained with an inadequate number of doctors in the Emergency Department of inadequate seniority and training, mostly appointed on an area of need basis.

Cardiac care at Prince Charles Hospital: Chapter Five - Part D

A substantial shortage of funds

- 1.66 The main and continuing problem for the provision of cardiac services at Prince Charles Hospital was a substantial shortage in funding. That had been the position for some time but more so since 2000 because of an Australia wide acceptance of the need for earlier intervention in heart disease. The waiting list for such services was large and growing.
- 1.67 Despite warnings by cardiologists of this and requests for additional funding, Queensland Health failed to respond. Dr Aroney, then a Senior Staff Cardiologist, met with management on a number of occasions, including with the Director-General, Dr Stable between 2001 and 2003 to no avail.

A transfer of funding to Princess Alexandra Hospital

- 1.68 In 2003 the decision was made by Dr Buckland, the General Manager of Health Services, to transfer cardiac procedures, 300 surgical procedures, 500 angiograms, and 96 angioplasty stent procedures, and consequently the funds to be allocated for those procedures, from Prince Charles Hospital to Princess Alexandra Hospital. This decision was made contrary to the advice given by cardiologists at the Prince Charles Hospital, and it appears mainly on the basis of advice given to him by administrators. This was despite evidence of a substantial increase in demand for inter-hospital transfers to the cardiology unit at Prince Charles Hospital, causing a major imbalance between demand and capacity in that hospital.
- 1.69 There were, it seems, at least three disadvantages, for patient care, in that transfer. The first was that, notwithstanding the substantial increase in demand for services at Prince Charles Hospital, the transfer resulted in a substantial transfer of funds from Prince Charles Hospital to Princess Alexandra Hospital. The second was that it was not at all clear that the patients who were transferred in fact ended up going to Princess Alexandra Hospital. And the third was that, although it was thought by administrators that Princess Alexandra Hospital had a very small urgent waiting list, it appears, as Dr Aroney said, that this was not the reality, but rather the result of the adoption by that Hospital of a method of calculation of urgency of need for care which was different from that adopted by other hospitals. I am satisfied that, in reality, there was a cutback in funding to cardiac services at Prince Charles Hospital, notwithstanding the urgent need for an increase in funding, even if most of the above patients were, in fact transferred to Princess Alexandra Hospital.

- 1.70 The sensible and fair solution to the problem, one which would have, to some extent, relieved the chronic backlog in provision of cardiac care at Prince Charles, would have been to transfer the above patient procedures to Princess Alexandra Hospital, but to have provided additional funding to that Hospital for that purpose, rather than, as occurred, to transfer it from Prince Charles. But that would have required an increase in total funding of cardiac care and that was plainly not the intention of Queensland Health and, in fairness to its officers, perhaps beyond its capacity to provide it.

Retribution against those who complained

- 1.71 Whilst the administrators at Prince Charles Hospital and those at Queensland Health plainly resented the complaints about under funding by Dr Aroney and others, but did little about it, it does seem to be the case that there were at least implied threats of retribution. An example of this was Ms Wallace's implication that the cardiologists could all be replaced by foreign doctors.
- 1.72 In early 2005 Dr Aroney resigned. He offered to continue as an honorary Visiting Cardiologist with catheter laboratory credentialing to assist where required in difficult cardiac interventional cases, but his offer was refused. There was no sensible reason for refusing it. It seems likely that this refusal was, at least partly, motivated by the resentment to which I have referred.

Common problems, common causes: Chapter Six

- 1.73 As I think already appears from what I have said so far, this examination of the above hospitals revealed a number of common problems, which together resulted in inadequate, even unsafe health care, in some cases with disastrous results. It is, perhaps, unsurprising, that these problems, common to a number of hospitals, also had common causes. It therefore became clear that, unless all of those causes are removed, or their effects substantially diminished, a serious risk of inadequate and unsafe health care in public hospitals will remain. Those problems, their causes, and some remedies are discussed in Chapter Six.
- 1.74 The first of these was an inadequate budget defectively administered. In a number of cases, for example, in Bundaberg, Hervey Bay, Townsville, Charters Towers and Rockhampton inadequate budgets resulted either in doctors being appointed to hospitals who should never have been appointed, or in doctors being put in positions beyond their level of competence. In both kinds of cases, the decisions to appoint were made because the hospital budget did not permit the hospital to make an offer generous enough to attract an appropriate applicant; and where the applicant appointed was plainly in need of supervision, the hospital budget did not permit that supervision to be provided. In some cases, Bundaberg and Charters Towers being examples, this led to disastrous consequences; in all others there was a serious risk of harm and, in some, actual harm. At Prince Charles Hospital it resulted in unacceptable delays in urgent cardiac care. There were also serious defects in the way in which budgets were

allocated and administered. The allocation of elective surgery budgets placed too much emphasis on attaining target numbers, and too little on patient care; and the excessive control exercised by administrators, because of budget constraints, and a culture of economic rationalism, led to poor decisions about patient care. This problem, its causes and some possible solutions are discussed in Part B of Chapter Six.

- 1.75 The second was a defective system of special purpose registration for areas of need. The idea of special purpose registration for areas of need was a reasonable one. But it has been abused, rather than used. In many cases, registration was granted under s.135 when neither of its pre-requisites had been satisfied. The Minister's delegate and the Medical Board were both negligent in the performance of their respective duties under that section. Their failures also contributed to harmful consequences. These defects, their consequences, and the remedy, are discussed in Part C of Chapter Six.
- 1.76 The third was an absence of credentialing and privileging. In none of the relevant cases at Bundaberg, Hervey Bay, Townsville, Charters Towers or Rockhampton were the relevant doctors credentialed or privileged. This was astonishing for two reasons. The first was that the obligation to do so, and the manner of doing so, was clear and simple. Even though Mr Berg in Townsville, and Dr Maree in Charters Towers were appointed before the Queensland Health Guidelines came into effect in 2002, there were requirements in much the same terms before then. And the second and more important reason why this failure was astonishing was that it was so obviously vital for patient safety to have a doctor's skill and competence adequately assessed before he commenced work. There was no excuse for not doing it. This is discussed in Part D of Chapter Six.
- 1.77 The fourth problem was a failure to monitor the performance of doctors, including to record and properly investigate complaints. There were no regular meetings to monitor clinical performances and no adequate recording of complaints in Bundaberg. Moreover, complaints were discouraged by management. The same was true of Hervey Bay. Nor was there any adequate investigation of complaints at either place. To take Bundaberg as an example, there were more than 20 complaints against Dr Patel, in a little under 2 years, yet that fact was not recorded anywhere. Consequently, there was no way in which an accumulation of complaints, some very serious, could be seen to require investigation. Had there been any such system, Dr Patel's conduct would have been investigated properly long before it was. Much of this also applies to Hervey Bay. When one comes to making a complaint outside the Hospital, the array of bodies to which a complaint can be made, and the appropriate body in any case, is confusing, and the overlap in their powers leads to delay and frustration. And finally, those who do complain need greater protection against retribution than they now have. These problems and their consequences, and some general suggestions about what should be done, are discussed in Part E of Chapter Six.

1.78 And the fifth problem was a tendency of administrators to ignore or suppress criticism. Bringing to light these and other problems in the public hospital system was made very much more difficult by a culture of concealment of practices or conduct which, if brought to light, might be embarrassing to Queensland Health or the Government. This culture started at the top with successive governments misusing the *Freedom of Information Act* to enable potentially embarrassing information to be concealed from the public. Unsurprisingly, Queensland Health adopted a similar approach, and because inadequate budgets meant that there would be inadequate health care, there was quite a lot to conceal. I make findings and recommendations in this respect against Cabinets in successive Governments, against former Minister Edmond and Minister Nuttall, against Dr Buckland and against Dr FitzGerald. Again unsurprisingly, the same approach was adopted by administrators in public hospitals, and this, in turn, led to threats of retribution to those who saw it as their duty to complain about inadequate health care. I make findings and recommendations against Mr Leck and Dr Keating in Bundaberg and against Mr Allsopp and Dr Hanelt in Hervey Bay. These problems and their solution are discussed in Part F of Chapter Six.

Amendment to the Coroner's Act: Chapter Seven

1.79 As I mention in Chapter Three, thirteen people died in Bundaberg after an unacceptable level of care by Dr Patel. Extraordinarily, only two of these deaths were reported to the Coroner under the *Coroner's Act* 2003, which required reporting in any case in which death was not a reasonably expected outcome of a health procedure. It seems likely that none of these deaths were reasonably expected outcomes of the relevant procedure.

1.80 Defects in the provision of the *Coroner's Act* permitted Dr Patel to circumvent its provisions by imposing on junior doctors to certify cause of death, in each case falsely, but on Dr Patel's expressed opinion and instructions. Such defects would also have permitted circumvention of these provisions by Dr Patel if he himself had falsely certified the cause of death in each of those cases.

1.81 It therefore became necessary to recommend amendments to the *Coroner's Act*, and to its administration which would prevent this from occurring. I do that in Chapter Seven.

Conclusion: Chapter Eight

1.82 I then make some concluding remarks which are unnecessary to repeat here.