

Medical Services, who, it might have been thought, because of his medical qualifications, would have understood the need for peer assessment of medical practitioners before they commenced work in a hospital. In each of the cases of Dr Nydam and Dr Keating in Bundaberg, and Dr Hanelt in Hervey Bay, his failure to implement that process was a gross dereliction of duty.

The remedy

6.200 As appears from what I have already said, it is and was at all times simple to apply Queensland Health guidelines which are clear and comprehensive. In applying them four matters should be borne in mind. They are:

- (1) That the process is one of independent peer assessment; consequently an assessment by a group of independent peers is more important than compliance with the letter of the policy or guidelines;
- (2) That whilst college participation in the process is of advantage, it is not essential;
- (3) That it must be applied before the applicant commences to work in hospital;
- (4) That privileges may be limited by the committee, and that, for an area of need applicant, a period of supervised practice may be first required.

Part E – Inadequate monitoring of performance and investigating complaints: inadequate protection for complainants

6.201 Every year in Australia there are a huge number of adverse outcomes which are 'iatrogenic' in origin: that is, the poor outcome for the patient is caused by the health care provider rather than the underlying condition. It is conservatively estimated that around 4,500 preventable deaths occur in hospitals each year as a result of mistakes and inappropriate procedures.¹⁶⁴ Against that background, it is, of course, vitally important that any health care organisation implement early warning systems to identify, and remedy, poor care. Moreover, it is important to acknowledge that the ultimate aim of any health system should be the creation of an environment predisposed to preventing, rather than reacting to, poor care.

¹⁶⁴ Australian Government Productivity Commissioner Annual Report 2003-2004 page 14. I say conservatively because there have been other studies to suggest that the figure may be more than three time higher than this: David Ranson, *How Efficient? How Effective? The Coroners Role in Medical Treatment related Deaths* (1998) 23 *Alternative law Journal* 284 at 285

To this end, I set out a range of measures aimed at maintaining clinical standards that came to the attention of this Commission.

Maintaining Standards

6.202 There are a number of measures aimed at maintaining clinical standards in hospitals, namely:

- Credentialing and privileging;
- Clinical audit and peer review, including morbidity and mortality meetings;
- The Service Capability Framework;
- The use of College accredited training posts;
- A 'critical mass' of appropriately experienced peers;
- Safe working hours for staff;
- Continuing medical education; and
- Complaints and incident management systems.

6.203 I briefly summarise these measures below and their role in maintaining standards.

6.204 I set out in detail the role played by complaint and incident management systems and their inadequacies as they presently exist below. It suffices at this point to refer to Queensland Health's recognition of complaints and incident management systems as quality control measures, as demonstrated in its own policy:¹⁶⁵

Queensland Health recognises that consumer feedback, both positive and negative, is essential in order to provide quality health care services that meet consumer needs...

Using information gained from consumer complaints enhances organisational performance. Service improvement results from both handling complaints at the individual level and from the collation and analysis of aggregated complaint data...

The following complaints management performance standards must be met by all Queensland Health services.

- 1) Consumer feedback is actively encouraged and promoted.
- 2) Consumer and staff rights are upheld throughout the complaint management process.
- 3) Local process are implemented to support best practice in complaint handling.

¹⁶⁵ Exhibit 292

- 4) Complaints information is integrated into organisational improvement activities.

6.205 Whilst a good deal of attention has been devoted to complaints and incident management systems those systems should not be the sole focus for improvement in the future. Their success depends heavily on a human element. People have to be willing to bring their concerns forward, and people are by nature unwilling to complain. Further, complaints systems tend to be focused on eradicating inadequate treatment, rather than striving for excellence in clinical standards. Moreover, they tend to be reactive in that something has to go wrong or at least appear to go wrong before the system is invoked. Other measures for maintaining standards, such as audit, accredited training posts, and critical mass of doctors, are essential because they provide other means of checking the standard of clinical services. When they are working they provide objective indicia against which persons with concerns can confirm their concerns and overcome some of the hesitancy they may have to complaining. Further, those persons charged with responding to complaints are more likely to respond more swiftly if they have such indicia against which they can measure those complaints.

Credentialing and privileging

6.206 As I have set out elsewhere, the fact that a person holds medical qualifications does not automatically entitle them to practise medicine in Queensland public hospitals. In accordance with best practice, Queensland Health policy demands that before a doctor commences providing clinical services they must first be subject to a process of credentialing and privileging. The process involves assessment of a doctor's credentials, skills, and competence in the context of the clinical capabilities of the hospital in which they are to work with a view to determining their scope of practice at the hospital. I have outlined above the sound reasons which underlie this policy.¹⁶⁶

6.207 Under Queensland Health policy the credentialing and privileging process can be invoked in respect of its doctors in three instances, being:¹⁶⁷

- a) When a doctor is first employed by Queensland Health and before they commence performing procedures;
- b) Periodically, every three years a doctor is employed by Queensland Health; and

¹⁶⁶ See Chapter Three – Dr Patel's employment at the Bundaberg Base Hospital – Application of the credentialing and privileging process to Dr Patel

¹⁶⁷ See Chapter Three – Dr Patel's employment at the Bundaberg Base Hospital – Application of the credentialing and privileging process to Dr Patel

- c) On an ad hoc basis when matters are referred to the credentials and privileges committee by officers such as the Director of Medical Services.

6.208 Had the policy been faithfully implemented in Bundaberg, there is a good chance Dr Patel's history and shortcomings would have been identified. This is for two reasons. Firstly, if the process had been carried out rigorously, (as seems possible for reasons identified in Chapter Three) they may have had serious doubts about Dr Patel's history. Secondly, if the process had been in place, then when complaints had been received, such as the complaint from Dr Cook about the performance of oesophagectomies at the Base, they could have been referred to a credentials and privileges committee for a surgeon's opinion.

Clinical audit, peer review and morbidity and mortality meetings

- 6.209 A consistent theme from many witnesses was that adverse trends in Dr Patel's performance would have been identified more swiftly if he had been subject to a functioning and effective clinical audit system, including a process of peer review such as morbidity and mortality meetings.¹⁶⁸
- 6.210 Clinical audit involves comparison of actual clinical performance with accepted standards of what that performance should be.¹⁶⁹ The Royal Australasian College of Surgeons identifies three essential elements of clinical audit, being collection and measurement of data on clinical activities and outcomes; analysis and comparison of that data using standards, performance indicators and outcome parameters; and peer review of that data and analysis.¹⁷⁰ Clinical audit can involve collection and analysis of a range of data, including 30 day mortality and morbidity,¹⁷¹ length of hospital stay, unplanned readmission or re-operation rates, and patient satisfaction.¹⁷² It was suggested in evidence by Dr Carter that data from audits conducted by individual departments within a hospital should be reported to the hospital Executive so that, in effect, the right hand of the hospital knows what the left hand is doing.¹⁷³ Dr Woodruff said that all doctors should be periodically assessed, and he drew comparison with the measures adopted by the aviation industry.¹⁷⁴ Regular audit of such doctors' practices might form a critical part of that process. There is a great deal of benefit in documenting data from audits, or even as suggested by one witness, computerising that data so as

¹⁶⁸ See in particular evidence of Drs de Lacy, Woodruff, Young, Strahan, Nankivell, Fitzgerald - T3263, T2873, T3622-3, T4328, T4440; see also concerns expressed by Dr Risson about the abandonment of the Otago audit system in Bundaberg – Exhibit 448, DWK63

¹⁶⁹ *A Guide by the Royal Australasian College of Surgeons – Surgical Audit and Peer Review 2005*, viewed at www.surgeons.org on 11 November 2005 p3

¹⁷⁰ *A Guide by the Royal Australasian College of Surgeons – Surgical Audit and Peer Review 2005*, viewed at www.surgeons.org on 11 November 2005 p3

¹⁷¹ The monthly peer review of morbidities and mortalities is discussed in more detail below

¹⁷² *A Guide by the Royal Australasian College of Surgeons – Surgical Audit and Peer Review 2005*, viewed at www.surgeons.org on 11 November 2005 p7

¹⁷³ T3985 (Dr Carter)

¹⁷⁴ Exhibit 283 para 35 and 36

to streamline the process of accessing data for the purpose of assessing doctors' performances.

- 6.211 Audit serves the purposes of identifying ways of improving the quality of care provided to patients and assisting in the continuing education of clinicians.¹⁷⁵ The most important purpose that clinical audit serves, in the context of this Commission, is that it provides a sense of perspective and places a doctor's deaths and complications in a meaningful context.

I mean, longitudinal data. I'll give you a simple example. Supposing at our next month's meeting at my hospital someone presents a wound dehiscence, which we've been talking about in the inquiry. What does that mean? Absolutely nothing. You will only know the meaning if you analyse that doctor's data over a period of time, because over the years everybody will get every complication, if you know what I'm trying to say. I mean, we all get complications. That's part of being a surgeon. What you have to do is look for a percentage because...we know what the acceptable, if you like, benchmarks are for, say, a wound dehiscence.¹⁷⁶

- 6.212 Morbidity and mortality meetings should comprise an aspect of peer review as part of the clinical audit process. They are held monthly by each clinical department in a hospital such as surgery.¹⁷⁷ Deaths and significant illnesses are presented, usually by junior doctors, and then discussed and analysed by the attendees openly in a non-judgmental way with the aim of improving the service for the future.¹⁷⁸ Cases are selected by the Chair of the meeting or the person they delegate that responsibility to.¹⁷⁹ Ideally, they should be attended by all clinical staff, not just the doctors.¹⁸⁰ It was Dr Woodruff's view that Directors of Medical Services should attend all morbidity and mortality meetings that occur in a hospital.¹⁸¹ Anyone can attend the meetings, including doctors from outside the hospital and Visiting Medical Officers.¹⁸² If the meetings are to be part of the clinical audit process then they should be documented.¹⁸³ Dr Woodruff testified that where a death involves multiple departments then all those departments should attend the meeting.¹⁸⁴
- 6.213 In order to achieve their aim, discussions at these meetings are frank and open, and sometimes robust.¹⁸⁵ Patients' cases are brought forward and attendees suggest other approaches to the treatment of those patients than were in fact

¹⁷⁵ *A Guide by the Royal Australasian College of Surgeons – Surgical Audit and Peer Review 2005*, viewed at www.surgeons.org on 11 November 2005 p3

¹⁷⁶ T2984 (Dr Nankivell)

¹⁷⁷ Exhibit 283 para 33

¹⁷⁸ T3620 (Dr de Lacy)

¹⁷⁹ *A Guide by the Royal Australasian College of Surgeons – Surgical Audit and Peer Review 2005*, viewed at www.surgeons.org on 11 November 2005 p14

¹⁸⁰ Exhibit 283 para 33

¹⁸¹ Exhibit 283 para 33

¹⁸² T3620 line 1 (Dr de Lacy)

¹⁸³ *A Guide by the Royal Australasian College of Surgeons – Surgical Audit and Peer Review 2005*, viewed at www.surgeons.org on 11 November 2005 page 11; Exhibit 283 para 33

¹⁸⁴ Exhibit 283 para 33

¹⁸⁵ T3620 (Dr de Lacy)

adopted.¹⁸⁶ Topics of discussion at the meetings might include wound infection and dehiscence rates¹⁸⁷ and rates of anastomotic leak.¹⁸⁸

- 6.214 It is essential for vibrant morbidity and mortality meetings that doctors be encouraged as much as possible to attend and actively participate. Doctors will often face difficulty in attending because they have running operating lists. Morbidity and mortality meetings should be 'quarantined' so that no other business interrupts them.¹⁸⁹ Consideration should be given to setting aside a specific part of day which is wholly devoted to morbidity and mortality.¹⁹⁰ Further, it is desirable that doctors frankly and honestly discuss their patient deaths and adverse outcomes.¹⁹¹
- 6.215 It is important that morbidity and mortality meetings and other forms of audit should not be confused with complaints and incident management systems. They are complementary and not mutually exclusive. Dr Jeannette Young, Executive Director of Medical Services of the Princess Alexandra Hospital, testified that properly functioning morbidity and mortality meetings often uncover particular issues with doctors' competence which are usually raised with her by those present.¹⁹² Further, morbidity and mortality meetings can provide a transparent forum for review of decisions about reporting incidents, such as decisions about reporting deaths to the Coroner.¹⁹³ Documented audit and peer review uncovers problems and provides people with the opportunity to test the validity of concerns they hold. Moreover, the process provides a means of communicating concerns about clinicians throughout a hospital. If the process is documented and attended by the Director of Medical Services that officer is in a better informed position to assess complaints brought to his or her attention and how to act in response.
- 6.216 Similarly, audit and peer review can potentially provide invaluable data for the process of periodic review of clinical credentials and privileges.
- 6.217 For reasons set out above, the clinical audit/morbidity and mortality system in Bundaberg failed during Dr Patel's period there. Rather than being frank and robust discussions aimed at improving the quality of service, they were subverted by Dr Patel so that they were conducted as teaching sessions where he could demonstrate his medical knowledge to the junior students.¹⁹⁴ I am

¹⁸⁶ Exhibit 283 para 33, T3620 (Dr de Lacy)

¹⁸⁷ T3840 (Dr Boyd)

¹⁸⁸ T3833 (Dr Boyd)

¹⁸⁹ Exhibit 283 para 33

¹⁹⁰ T2984 (Dr Nankivell), T3962 (Dr O'Loughlin)

¹⁹¹ Exhibit 283 para 33

¹⁹² Presumably, the issues are initially canvassed with the doctor concerned and then raised with that doctor's superiors if the problems persist - T2847 (Dr Young)

¹⁹³ T3628 (Dr de Lacy), T5164-T5165 (Dr North)

¹⁹⁴ Dr de Lacy said the only resemblance the meetings bore to morbidity and mortality meetings was they shared the same name and that was all. He commented that the complications he subsequently saw during his review were not presented at the meetings – T3620

satisfied that had there been an effective process of clinical audit operating at Bundaberg at the relevant time it is more than likely that the following would have been uncovered and verified:

- 1) That Dr Patel's rates of complications and deaths were significantly higher than is to be expected from a reasonably competent general surgeon;
- 2) That the quality of care rendered by Dr Patel in individual cases was so inadequate that it would have been reasonable to seriously doubt his competence generally,¹⁹⁵ and
- 3) That the judgment he brought to treatment was seriously impaired.

6.218 The experience of Bundaberg shows that the process of audit and morbidity and mortality meetings relies on independence and transparency for its success. As much as possible there must be independent monitoring of collection and presentation of data. Dr Jeannette Young, for example, gave evidence that the Princess Alexandra Hospital takes steps to ensure that data on deaths and complications is collected and monitored independently of the doctors involved.¹⁹⁶ Most importantly, it is the role of the Director of Medical Services to oversee the whole process and ensure it is transparent and operating as it should.¹⁹⁷

6.219 Clinical audit and peer review is not only designed to discover rogues and underperformers. The process is an invaluable clinical tool that helps identify systemic issues affecting patient care. Where patterns or trends emerge, that can provide impetus for doctors to modify their practice.¹⁹⁸ For example, audit can identify problems with the use of a particular treatment in particular patients. On that basis practice can be altered to address that and improve service.

6.220 Further, clinical audit and peer review should not be seen as a check on the quality of care of only overseas trained doctors such as Dr Patel. Dr Woodruff testified that he knew of a couple of occasions when the performances of well regarded Fellows of the College dropped below an acceptable level requiring remedial action to be taken to correct them.¹⁹⁹ Dips in a competent surgeon's performance can happen for a number of reasons, including change of environment, age related loss of motor skills or dementia, and illnesses or

¹⁹⁵ Particularly pertinent in this context are the cases that Dr O'Loughlin reviewed that led him to question Dr Patel's proficiency at performing laparoscopic surgery and therefore question his competence as a general surgeon. I particularly note the case where Dr O'Loughlin said that if one of his registrars had rendered the same level of care rendered by Dr Patel in that case, he would probably suggest to that registrar that they consider a career other than surgery.

¹⁹⁶ T2848-9 (Dr Young)

¹⁹⁷ Exhibit 283 para 33

¹⁹⁸ T3967 (Dr O'Loughlin), T5132 (Dr North)

¹⁹⁹ T4337 (Dr Woodruff)

injuries.²⁰⁰ When such dips occur clinical audit provides an essential element of the systems that identify them so that remedial action can be taken.²⁰¹

- 6.221 I am of the opinion that all hospitals should have an effective clinical audit system. As a minimum this system should include monthly audit of all mortalities and significant morbidities.

Service Capability Framework

- 6.222 Not all hospitals are created equal. Some hospitals have access to more staff, expertise, infrastructure and facilities than others. There is an obvious distinction, for example, between tertiary referral hospitals and Base hospitals. The effect of this is that some hospitals have the capability to provide certain services safely whilst others do not. In this context, Queensland Health has developed a policy framework aimed at marking out the boundaries that limit the services that its hospitals can provide.
- 6.223 Prior to July 2004, there existed separate policy regimes for defining the limitations of health services that may be provided in public and private hospitals. The *Guide to the Role Delineation of Health Services* applied to public hospitals whilst *Guidelines for Clinical Services in Private Health Facilities* applied to private hospitals. For uniformity between the public and private sector a single policy applying to both sectors was released in July 2004 known as the Service Capability Framework.²⁰²
- 6.224 The Service Capability Framework is designed to 'outline the minimum support services, staffing, safety standards and other requirements required in both public and private health facilities to ensure safe and appropriately supported clinical services'.²⁰³ The framework rates each health facility's ability to deliver a range of clinical services according to a number of factors, including service complexity, patient characteristics, and support service availability and capability. A rating of either primary, Level 1, Level 2, Level 3, or Super-Specialist is then attributed to each service.²⁰⁴ The framework serves two purposes, namely to aid in planning of health services and to provide a broad framework for setting out the minimum knowledge, skills and services that should be available to a facility in order to safely provide a service.²⁰⁵ For example, the document is designed to ensure that hospitals are not performing surgery at a level of complexity beyond their capabilities.²⁰⁶ The framework

²⁰⁰ T4337 (Dr Woodruff); *A Guide by the Royal Australasian College of Surgeons – Surgical Audit and Peer Review 2005*, viewed at www.surgeons.org on 11 November 2005 page 21

²⁰¹ T2847 (Dr Young)

²⁰² Exhibit 231; T3147 and T3224 (Dr FitzGerald)

²⁰³ Exhibit 231 *Service Capability Framework* p(iii)

²⁰⁴ Exhibit 231 *Service Capability Framework* p8

²⁰⁵ Exhibit 231 *Service Capability Framework* pp2 and 3, T3343-4

²⁰⁶ T3221 (Dr FitzGerald)

should form an integral part of the credentialing process so that privileges are awarded to doctors according to the facilities available to the hospitals in which they practise.²⁰⁷

- 6.225 Bundaberg is an example of a situation where the absence of clearly defined boundaries rendered the Base vulnerable to a doctor who would perform procedures clearly beyond the capabilities of that hospital (oesophagectomies and whipples procedures). So is Hervey Bay where complex elective orthopaedic surgery should never have taken place.

Critical mass of appropriately experienced peers

- 6.226 As I have set out elsewhere in this report, Dr Patel operated in ‘splendid isolation’ from his peers and thereby avoided a level of oversight which could have revealed his inadequacies as a surgeon sooner.²⁰⁸ In large measure this was the result of the fact that the Base at the relevant time had on staff only two surgeons – Drs Patel and Gaffield, that Dr Patel was the Director of Surgery, and that Dr Gaffield had significantly less experience in general surgery. The only other doctors in the surgery department were very junior and were not in a position to assess Dr Patel’s work.
- 6.227 Hospitals should aim to engage a ‘critical mass’ of doctors. By maintaining a breadth of expertise within a hospital, no one doctor can become isolated, either by choice or accidentally, and thereby arbitrarily determine what is adequate care. Moreover, it seems that staffing shortages are threatening public health services’ abilities to meet demand, particularly in rural and regional areas where for reasons discussed above public hospitals struggle to recruit a critical mass of staff specialists.
- 6.228 I deal in more detail with the challenges facing rural and regional hospitals below. However, at this point it is convenient to set out a proposal that might go some way to addressing the practical difficulties public hospitals face in trying to develop critical mass.
- 6.229 Dr Woodruff proposed a strategy he described as ‘hub and spoke’. In essence, he proposed that all regional hospitals (spokes) be attached to tertiary referral hospitals (hubs). Hubs can contribute expertise and resources to spokes’ credentialing, audit, training, assessment and other processes. The use of technology such as teleconferencing and video link can aid in this process.²⁰⁹ Drs Woodruff and O’Loughlin both noted that Dr Patel seemed to practise in isolation and, in particular, did not confer with his colleagues in the tertiary

²⁰⁷ T3244 (Dr FitzGerald)

²⁰⁸ See Chapter Three – “Splendid Isolation”

²⁰⁹ Exhibit 283 para 32

referral hospitals.²¹⁰ Dr Woodruff inferred that Dr Patel, and many other overseas trained doctors, lacked the clinical networks developed with their colleagues after years of training and practice in Australia.²¹¹

6.230 Aiding overseas trained doctors to develop those networks is essential in the Queensland Health system which increasingly relies on them; first, because, as Dr O'Loughlin said, medicine is a multidisciplinary exercise and the best care is provided when doctors can draw on as much expertise as possible; and secondly, because the Queensland public hospital system is one where the vast bulk of resources and funding is concentrated in the tertiary referral hospitals. In a sense there needs to be a symbiosis between those hospitals and the rural and regional hospitals to improve the care provided in the regions.²¹²

Accredited training posts

6.231 I have identified elsewhere in this report the benefits which College accreditation for training of registrars bring to hospitals. In summary, those benefits are:²¹³

- (a) Higher level of competence of staff;
- (b) Registrars contribute to the breadth of expertise available for the process of informal audit of staff;
- (c) Because registrars possess a higher degree of competence than more junior doctors they take some of the pressure off those doctors and the senior doctors;
- (d) Potential for retention of Fellows following completion of registrars' specialty training;
- (e) A continuing culture of professional development amongst medical staff; and
- (f) The existence of a collegiate educational culture within hospitals which is an incentive for recruitment of specialists, including Visiting Medical Officers.

6.232 Further, increasing the number of accredited training posts is necessary so that the increased numbers of graduates from medical schools in Queensland are not lost.²¹⁴ The good work in overcoming the shortage of doctors in this state by increasing the intake of medical students will effectively be undone if those graduates cannot find training positions.

²¹⁰ See Chapter Three – Competency of Dr Patel

²¹¹ T4291 and T4338 (Dr Woodruff)

²¹² I note the efforts of Townsville in this regard. See Chapter Five and in particular reference to the assistance Townsville Hospital provides for credentialing and privileging in smaller hospitals in the Northern Zone

²¹³ See Chapter Three – History of the Hospital and Chapter Five – Rockhampton Hospital; see also T1824

²¹⁴ See the discussion in Chapter Two on steps taken to increase the number of places for medical students

Safe working hours

- 6.233 A consistent theme that ran throughout the evidence before this Commission was the impact of unsafe working hours on clinical standards and patient safety.
- 6.234 Drs Nankivell, Baker, Jelliffe and others consistently gave evidence that they were required to work impossible hours at the Base.²¹⁵ Both Drs Jelliffe and Nankivell gave evidence that the effect on a doctor's ability to provide medical care who is suffering from tiredness is similar to a doctor who is under the influence of alcohol.²¹⁶ In particular, Dr Jelliffe referred to studies that have shown the ability of a doctor who has been working for ten consecutive hours is impaired to an extent equivalent to a doctor whose blood alcohol level is 0.05, and the effect gets worse as the number of hours rises.²¹⁷ Doctors at the Base were regularly required to work well over ten consecutive hours at a time.²¹⁸
- 6.235 Not only do safe working hours enhance patient safety, they are conducive to the retention of quality staff. I am satisfied that the diaspora of 'wounded soldiers' from the Bundaberg Base Hospital was in part precipitated by the work loads to which they were subject. Dr Jelliffe recalled the condition of Dr Nankivell at the time he left the Base following a period in which the only other staff surgeon there, Dr Baker, had been away on leave:²¹⁹
- He had been broken on the wheel at the hospital. He looked grey and old. He was...doing a one-in-one (on call roster). He really had no choice. I think he had to leave for his health. You can't keep up that sort of punishing roster.
- 6.236 That Bundaberg lost a Fellow of the College of the calibre of Dr Nankivell is a tragedy, given what eventually transpired there. When he turned to the Medical Board for direction on safe working hours he was informed that it was not the Board's role to define safe working hours, and that he should instead consult with the Australian Medical Association, his employer (Queensland Health) or the Department of Industrial Relations.²²⁰ I do not doubt the Board's assertion in that regard. However, unfortunately for Dr Nankivell, he is not a member of the Australian Medical Association.²²¹

Continuing medical education

- 6.237 Fellows of the relevant Colleges are subject to obligations that they must engage in continuing medical education, re-accreditation courses and other educational and quality assurance activities.²²² This process of continuing education adds to

²¹⁵ See Chapter Three

²¹⁶ T2971 (Dr Nankivell); T6656 (Dr Jelliffe)

²¹⁷ T6656 (Dr Jelliffe)

²¹⁸ See Chapter Three

²¹⁹ T6652 (Dr Jelliffe)

²²⁰ Exhibit 215

²²¹ T3003 (Dr Nankivell)

²²² See Chapter Three – The Competency of Dr Patel; T776

the quality of delivery of medical care through the ongoing maintenance of clinicians' currency of practice and competency.

Rural and regional challenges

6.238 Largely because of isolation and lack of resources, rural and regional hospitals face substantial challenges in implementing measures aimed at maintaining clinical standards, namely:

- (a) Difficulties in funding, attracting and retaining a critical mass of doctors, which means:
 - As in Bundaberg, the morbidity and mortality process is vulnerable to subversion because there are insufficient doctors involved in the process to ensure that it is independent and transparent;
 - Rural and regional hospitals do not have sufficient doctors to ensure their doctors are not overworked; and
 - Because of insufficient staff rural and regional hospitals struggle to meet the demands for services placed upon them;
- (b) Difficulties in gaining accreditation for College training posts; and
- (c) Difficulties in attracting training registrars, because of isolation and the obvious disparities between the tertiary hospitals and regional hospitals in terms of the variety of expertise that can be devoted to the educational experience.

6.239 Potentially, if the model for the delivery of public health services is not adapted to accommodate these peculiar challenges, a two-tiered health system in Queensland may perpetuate. That is, a system where the quality of care delivered in the cities is superior to the quality of care delivered in the regions.

6.240 I do not accept that the challenges facing rural and regional hospitals should inevitably lead to a two-tiered health system. Standards in rural and regional hospitals should be made a priority.

6.241 The principal step that must be taken is that rural and regional public hospitals must engage the private sector. The experience of Bundaberg provides a particularly salient illustration of the following statement:

The public and private systems may be able to run in parallel in the metropolitan areas, but in provincial areas, for health services to be optimised it has to be done jointly between the private and the public sector because that's the way in which you will have the broadest range of clinical services available.²²³

6.242 The best means of engaging the private sector is through increased use of Visiting Medical Officers. I do not suggest that either Staff Specialists or Visiting Medical Officers are necessarily superior to the other. Each serves a particular

²²³ T1826 (Dr Thiele)

purpose.²²⁴ However, it is vital that rural and regional hospitals draw on the private sector by way of Visiting Medical Officers. Bundaberg had a wealth of surgical experience in the private sector during Dr Patel's tenure as Director of Surgery at the Base. That experience could be an invaluable resource to draw on to ensure patient safety. I say this for the following reasons:

- Visiting Medical Officers with Staff Specialists could provide the necessary critical mass of expertise to ensure the effectiveness of the audit and peer review process;
- Offering more Visiting Medical Officer positions to new specialists rural and regional hospitals can increase the depth of talent available in their areas;²²⁵
- Visiting Medical Officers supplement the staff available to public hospitals so as to ensure Staff Specialists are not overworked;²²⁶
- Visiting Medical Officers increase staff available to rural and regional hospitals to meet demand for their services; and
- Visiting Medical Officers help provide the level of supervision required for College training accreditation.²²⁷

6.243 With respect to morbidity and mortality meetings more generally, rural and regional hospitals should consider the following steps so as to ensure the process is vibrant, effective, independent and transparent:

- a) Involving outsiders; outsiders chair the meetings;²²⁸ indeed, perhaps chairs can rotate on a monthly basis;²²⁹
- b) Holding multidisciplinary meetings between general practitioners and other specialist disciplines;²³⁰
- c) Holding meetings which combine doctors from a number of districts, for example Bundaberg and the Fraser Coast;²³¹ and
- d) Involving outsider doctors from metropolitan areas in morbidity and mortality meetings through regular visits and the use of teleconferencing facilities, online chat groups or discussion forums.²³²

6.244 To an extent the ability of rural and regional hospitals to secure College accreditation for training depends on the resources available to them. For

²²⁴ T2856 (Dr Young)

²²⁵ The option of becoming a Visiting Medical Officer is quite attractive to new private specialists. It provides them with a base income while they establish their private practice - T1826 (Dr Thiele)

²²⁶ Dr Nankivell testified that the presence of a few Visiting Medical Officers at the Base during his time there would have made his roster acceptable - T2935

²²⁷ Chapter Three – History of the Hospital

²²⁸ T3622-T3623 (Dr de Lacy)

²²⁹ *A Guide by the Royal Australasian College of Surgeons – Surgical Audit and Peer Review 2005*, viewed at www.surgeons.org on 11 November 2005 p12

²³⁰ T4560

²³¹ T4560; *A Guide by the Royal Australasian College of Surgeons – Surgical Audit and Peer Review 2005*, viewed at www.surgeons.org on 11 November 2005 p12

²³² *A Guide by the Royal Australasian College of Surgeons – Surgical Audit and Peer Review 2005*, viewed at www.surgeons.org on 11 November 2005 p12

example, one of the essential requirements imposed by the Royal Australasian College of Surgeons for accreditation is that registrars be supervised by one of its fellows.²³³ However, many of the measures required for accreditation, such as safe working hours, risk management, credentialing, audit and peer review,²³⁴ represent measures aimed at maintaining standards and ensuring patient safety. Hospitals should be implementing these measures in any event, quite apart from the aim to gain accreditation.

- 6.245 In addition to accreditation, hospitals should strive to attract trainees, which as I have said elsewhere require an environment where those trainees can be assured of an attractive educational experience. Measures such as regular weekly clinical meetings, visits from Brisbane specialists, teaching ward rounds, and regular educational presentations all contribute to this experience.²³⁵

Recommendations

- 6.246 All hospitals must have effective clinical audit systems. As a minimum these systems should include monthly audit of all mortalities and significant morbidities. Hospitals must ensure that their clinical audit systems are independent and transparent. Whilst it is not my function to determine what steps they should employ to ensure this, rural and regional hospitals in particular, should consider the measures aimed at that purpose that I have outlined above and others.
- 6.247 Rural and regional hospitals must engage the private sector as much as possible, such as by the use of Visiting Medical Officers.
- 6.248 All primary referral hospitals should aim to gain accredited training status with the relevant Colleges. Adequate resources and funding should be allocated to those hospitals for this purpose. Steps should be taken to encourage trainees to fill training posts.

Complaints and incidents management

- 6.249 In the course of his evidence before the Commission, Dr Molloy, the President of the Australian Medical Association, acknowledged complaints against doctors – even if they take the form of litigious claims - can be an important tool in

²³³ *Accreditation of Hospitals and Posts for Surgical Training: Process and Criteria for Accreditation*, viewed at www.surgeons.org on 11 November 2005 p4

²³⁴ *Accreditation of Hospitals and Posts for Surgical Training: Process and Criteria for Accreditation*, viewed at www.surgeons.org on 11 November 2005

²³⁵ See Chapter Three – History of the Hospital

maintaining professional standards.²³⁶ Dr Nydam from Bundaberg Base Hospital gave evidence that, even when he was the Assistant Director of Medical Services, he would personally prepare medico-legal reports for lawyers because it presented a ‘fantastic opportunity for clinical audit...as an educator, I need to work out where things can be improved, and writing these letters, after a consideration of clinical notes, provided a very, very fertile ground...’²³⁷ The importance of recording, and acting upon, complaints was further emphasised in evidence when it was realised that, of the many complaints received during Dr Patel’s term, almost all of them were subsequently vindicated by Drs de Lacy, O’Loughlin or Woodruff.²³⁸

- 6.250 Those matters above underline what is perhaps self evident. However, many Queenslanders are reticent to make complaints. When they do, it will often be a very good indicator that they have received poor care or, at the very least, that there has been poor communication. This will be all the more so where complaints are made by medical staff because, first, there is no reason to suspect any over-readiness on their part to make complaints about colleagues²³⁹ and, secondly, they will have a technical understanding of treatment which is rarely available to patients and relatives.
- 6.251 An organisation which welcomes and addresses complaints frankly is likely to achieve more just outcomes, and it is likely in turn to minimise litigation. Furthermore, if the organisation responds properly to complaints, it is likely to function at a much higher level in the future. For those reasons, the issues addressed in this chapter are critical to confidence and clinical standards in our public hospitals.

The multiple avenues for complaints about medical treatment

- 6.252 If a patient, a patient’s relative or a member of staff wishes to complain about treatment received, or to raise an issue about conditions, in a public hospital there are various authorities to whom they might turn. The choice of the appropriate authority can be difficult and confusing, and it is perhaps complicated further by the fact that, at times, the complaint might be received by more than one body. The complaint could be made:
- a) Within the public hospital to an appropriate employee of Queensland Health;
 - b) If the complaint is to be about a medical practitioner, to the Medical Board of Queensland;

²³⁶ T770, T800 (Dr Molloy)

²³⁷ T4108 (Dr Nydam)

²³⁸ See Chapter Three

²³⁹ On the contrary it has been that doctors may tend not to make complaints about the performance of a colleague: eg Shipman Inquiry 3rd Report Chapter 11 available at www.the-shipman-inquiry.org.uk/thirdreport.asp

- c) If the complaint is to be about a nurse, to the Queensland Nursing Council;
- d) If the complaint is to be about an allied health worker, such as a physiotherapist or an occupational therapist, to the relevant registration board. Queensland has twelve other boards²⁴⁰ Each board is established under an Act with the function of registering, suspending or cancelling the registration of practitioners of any kind of health service.
- e) If the matter involves suspected official misconduct, for instance a sexual assault by a medical practitioner, a nurse or an allied health worker employed by Queensland Health, to the Crime and Misconduct Commission;
- f) If the complaint is to be about administrative action, to the Ombudsman;²⁴¹
- g) If the matter involves an unexpected death whilst in hospital, to the Coroner;²⁴²
- h) To the Health Rights Commissioner if the complaint is about the service of any provider of a health service whether the provider be a doctor, nurse or allied health worker;
- i) By litigation or the threat of it.

6.253 People wishing to choose where to take a complaint are faced with further complexity. They will find that different bodies have different investigative powers and remedial powers and that those powers may be curtailed as certain circumstances arise in the course of the investigation.²⁴³

6.254 To demonstrate deficiencies and inefficiency of the current health complaints system in Queensland and the consequential frustration for complainants, I set out some of the history from a recent case study performed by the Ombudsman²⁴⁴ which details the investigation of a complaint made to him. I will refer to it in the chapter as the 'Ombudsman's case study'.

6.255 The Ombudsman's case study is particularly apt to illustrate the complex and confusing nature of the health complaints system in Queensland. The complainants wished to complain about the tragic death of their child at a regional Queensland Hospital on 7 January 2002. The father is a Medical Practitioner, a senior official in Queensland Health and had a good understanding of the relevant systems for making complaints. Few members of

²⁴⁰ The various Registration Boards are in schedule 2 of the *Health Rights Commission Act 1991* and are Chiropractors Board of Queensland; Dental Board of Queensland; Dental Technicians and Dental Prosthetists Board of Queensland; Medical Board of Queensland; Medical Radiation Technologists Board of Queensland; Occupational Therapists Board of Queensland; Optometrists Board of Queensland; Osteopaths Board of Queensland; Pharmacists Board of Queensland; Physiotherapists Board of Queensland; Podiatrists Board of Queensland; Psychologists Board of Queensland; Queensland Nursing Council; Speech Pathologists Board of Queensland.

²⁴¹ see *Ombudsman Act 2001*

²⁴² *Coroners Act 2003* s7

²⁴³ The Health Rights Commission, for instance, cannot continue with an investigation where the complaint is the subject of litigation. Bodies such as the Queensland Nursing Council may choose to defer investigations where a coronial inquest is expected

²⁴⁴ Referred to in the Submission of Ombudsman dated August 2005 (Volume 3 Submissions No 26)

the public would have the advantages which these parents had in selecting the appropriate bodies to whom to make their complaints and in describing the issues for the complaint. Despite the advantages which they had, the fragmented health complaints system in Queensland meant that there were no less than seven separate inquiries into aspects of an adverse incident. There were inquiries by the State Coroner, the Health Rights Commissioner, the Medical Board of Queensland, the Queensland Nursing Council, the Crime and Misconduct Commission and the Queensland Ombudsman. When the Ombudsman made a submission in August this year, it seems that more than 3 years after the parents made their first complaints, some aspects of the process were still incomplete.

6.256 The Ombudsman's case study reveals:

(a) As for Queensland Health:

- On 11 January 2002, the Executive Director of Medical Services of the relevant Health Service District provided a Preliminary Investigation about the incident to Queensland Health's corporate office, concluding that the treatment provided was reasonable;
- In about March/April 2002, the doctor and his wife lodged complaints with Queensland Health, the Health Rights Commission, the Medical Board of Queensland, and the Queensland Nursing Council concerning treatment provided at the hospital;
- They also raised concerns about a 'Preliminary Investigation Report' prepared by the Executive Director of Medical Services for the relevant district;
- Indeed, they sent a 21 page letter to Queensland Health, seeking a full investigation;
- A senior executive within Queensland Health advised that, given that the Health Rights Commission, the Medical Board, the Queensland Nursing Council, and the State Coroner were likely to conduct their own investigations, Queensland Health would postpone its inquiries;
- In December 2003, after the doctor and his wife drew attention to their still unresolved concerns, another senior executive within Queensland Health commissioned a neurologist to review the circumstances the subject of the complaint;
- The neurologist's report was presented to Queensland Health in June 2004;
- The couple maintain that they have not been informed, subsequently, of the actions taken by Queensland Health in respect of the neurologist's findings and recommendations.

- (b) As for the Health Rights Commission:
- It informed the couple on 10 May 2002 that their complaint had been accepted for assessment and indicated that, in its view, the complaint raised four key issues;
 - On 8 August 2002, the Health Rights Commission indicated that it would investigate the first and fourth issues but, because the second and third concerned nurses and doctors, the Commission had a statutory obligation to consult with the Queensland Nursing Council and the Medical Board respectively to determine whether each of those bodies would accept the complaint for further action;
 - The Queensland Nursing Council and the Medical Board agreed subsequently to investigate the second and third issues;
 - The Health Rights Commission made inquiries of the relevant District Manager about the first and fourth issues, but whilst there was initially co-operation, a challenge was then made to the Commission's jurisdiction on the fourth issue. After seeking advice from Crown Law, the Health Rights Commission decided it did not have jurisdiction because, as the allegation concerned the Preliminary Investigation Report, it did not relate to an administrative service directly related to a health service. It informed the couple accordingly on 16 July 2003;
 - On 4 September 2003, the Health Rights Commission delivered a report but it did not make any recommendations;
 - The couple were unhappy about certain aspects of the report and the Commission agreed to conduct a review. That review was not published until 28 June 2004. It found that there were a number of systemic issues that needed to be addressed at the regional hospital: it made recommendations accordingly.
- (c) As for the Medical Board:
- it received a complaint on 10 April 2002 and a referral from the Health Rights Commission on 7 August 2002;
 - The Board appointed an investigator from the Office of the Health Practitioner Registration Boards on 27 August 2002;
 - After repeated complaints about delay, the Office of the Health Practitioner Registration Boards appointed an external investigator on 24 June 2003;
 - The Office of the Health Practitioner Registration Boards provided a copy of the investigator's report to the couple on 20 January 2004;

- The Office of the Health Practitioner Registration Boards referred the matter to the Health Practitioners Tribunal and, on 8 November 2004, certain disciplinary action was taken against a doctor.
- (d) As for the Queensland Nurses Council:
- It received a copy of the complaint on 11 April 2002 and it received the referral from the Health Rights Commission in August 2002;
 - The Council agreed to investigate the complaint about one nurse;
 - The investigator completed her report in July 2004;
 - Subsequently, the Queensland Nurses Council sought legal advice and as a result decided not to proceed against a nurse;
 - It is still unclear, nearly 18 months after the completion of the investigators report, whether disciplinary action is to be taken against the first nurse.

On 24 December 2003, the couple referred the matter to the Ombudsman. The Ombudsman has indicated that he is concerned that there were four separate investigations, by four different agencies, acting under different legislation, and that there were considerable delays and dissatisfaction that accompanied the process.

6.257 One can see that there is some scope for adopting a more centralised approach to managing complaints in this State. Before considering that option, I address in turn below, several of the avenues currently available for making complaints.

Complaints made within a public hospital

Overview

6.258 As already indicated, there were a range of systems through which problems and issues can be reported, detected and analysed in the hospital environment:

- 1) Complaint processes;
- 2) Incident reporting;
- 3) Risk Management;
- 4) Clinical governance committees; and
- 5) Clinical audits and peer review.

To better understand why Dr Patel was able to practise for so long, despite his incompetence, it is necessary to consider what went wrong with those systems. I have already shown how the last of these failed at Bundaberg. So also did the complaints processes, incident reporting and risk management. Their failure shows that having an adequate policy is not sufficient.

6.259 There were three Queensland Health policies applying statewide which, in various versions, applied during the period of Dr Patel's employment for the management of complaints and incidents raised by patients and staff. If properly implemented and followed at Bundaberg, they should have been useful for picking up surgical incompetence. They were:

- (a) the Complaints Management Policy.²⁴⁵ This policy was effective from 31 August 2002 and governs the management of complaints made by or on behalf of patients;
- (b) the Integrated Risk Management Policy. Two versions of this policy existed during the relevant period. It prescribes how staff should respond to risks which arise in the hospital. The earlier version effective from February 2002 was replaced by another version²⁴⁶ in June 2004; and
- (c) the Incident Management Policy²⁴⁷ which governed treatment of clinical issues raised by hospital staff and was effective from June 2004.

6.260 In addition to these Queensland Health policies, the Bundaberg Base Hospital developed local policies which also dealt with practical application of the matters the subject of the Queensland Health policies.

6.261 The following chronology details when the relevant Queensland Health and Bundaberg policies relating to patient and staff complaints and risk analysis were introduced:

Feb 2002	Queensland Health Integrated Risk Management Policy ²⁴⁸
May 2002 ²⁴⁹	Bundaberg Complaints Management System ²⁵⁰
July 2002	Queensland Health Complaints Management Policy ²⁵¹
Dec 2002	Bundaberg Risk Management Process ²⁵²
Feb 2004 ²⁵³	Bundaberg Adverse Events Management Policy ²⁵⁴
June 2004	Queensland Health Integrated Risk Management Policy (replaced policy of February 2002) ²⁵⁵
June 2004	Queensland Health Incident Management Policy ²⁵⁶

²⁴⁵ Exhibit 292

²⁴⁶ Exhibit 293

²⁴⁷ Exhibit 290A JGW6 Statement Wakefield

²⁴⁸ Exhibit 293

²⁴⁹ Exhibit 162 para 11 Statement Raven

²⁵⁰ Exhibit 162 LTR2 Statement Raven

²⁵¹ Exhibit 292

²⁵² Exhibit 162 LTR3 Statement Raven

²⁵³ Exhibit 162 para 21 Statement Raven

²⁵⁴ Exhibit 162 LTR4 Statement Raven

²⁵⁵ Exhibit 293

June 2004	Bundaberg Sentinel Events and Root Cause Analysis Policy ²⁵⁷
Nov 2004	Bundaberg Incident Management – Clinical and Non-Clinical (replaced Bundaberg Adverse Events Management Policy) ²⁵⁸
Nov 2004	Bundaberg Incident Analysis Policy ²⁵⁹
Nov 2004	Bundaberg Sentinel Events and In-depth Analysis Policy (replaced Bundaberg Sentinel Events and Root Cause Analysis Policy) ²⁶⁰
Nov 2004	Bundaberg Risk Management Process (replaced Bundaberg Risk Management Process issued in December 2002) ²⁶¹

Complaints Management Policy

6.262 The Queensland Health Complaints Management Policy²⁶² governs how Queensland Health should deal with complaints by or on behalf of patients. This policy should have been used at the Bundaberg Base Hospital for recording and analysing patient complaints. Patients are referred to by Queensland Health in the policy as ‘consumers’. The policy does not apply to staff complaints.²⁶³ When staff had clinical issues to raise they were dealt with under a different policy, namely the Incident Management Policy.

6.263 It was observed in the Queensland Health Systems Review, Final Report,²⁶⁴ that the ‘policy reflects contemporary best practice’. The Queensland Ombudsman reported to the Director-General of Queensland Health in March 2004 that the policy ‘compares very favourably to those in most other departments and meets nearly all the criteria for good complaints management’.²⁶⁵ However, each of those compliments was based upon the policy but not upon its implementation. The Queensland Health Systems Review, Final Report observed that implementation of the policy throughout the state had been poor. The Ombudsman in March 2004 recommended that Queensland Health improve the awareness of its staff of the patient complaints management system.

6.264 The Queensland Health Complaints Management Policy relevantly provides:

- Health care consumers have the right to receive feedback and have complaints heard and acted upon;²⁶⁶

²⁵⁶ Exhibit 290A JGW6 Statement Wakefield

²⁵⁷ Exhibit 162 LTR6 Statement Raven

²⁵⁸ Exhibit 162 LTR7 Statement Raven

²⁵⁹ Exhibit 162 LTR7 Statement Raven

²⁶⁰ Exhibit 162 LTR7 Statement Raven

²⁶¹ Exhibit 162 LTR7 Statement Raven

²⁶² Exhibit 292

²⁶³ Exhibit 292: Scope and Application

²⁶⁴ Queensland Health Systems Review, Final Report p189 (www.healthreview.com.au)

²⁶⁵ Queensland Ombudsman submission to the Bundaberg Hospital Commission of Inquiry August 2005 page 43

²⁶⁶ Exhibit 292: Policy Statement

- Information from the complaints management process is used to improve quality and safety in health care;²⁶⁷
- All complaints are to be assessed in a manner that reflects the seriousness of the complaint, in categories that can be applied to the risk management framework ie. negligible, minor, moderate, major or extreme;²⁶⁸
- Complaints rated as moderate, major or extreme will be referred to the Complaints Coordinator for action, the Complaints Coordinator will inform the District Manager of major or extreme complaints and the District Manager will inform the General Manager, Health Service of extreme complaints;²⁶⁹
- Staff are encouraged to resolve minor complaints at the point of service; if this is not achieved the matter should be referred to the Complaint Coordinator who will arrange referral to the district executive. An investigator should undertake an in-depth and or root cause analysis of complaint matters;²⁷⁰
- All parties involved in a complaint are advised of the outcome of the complaint;²⁷¹
- Local processes should be put in place to support best practice in complaint handling;²⁷²
- Organisation wide improvements should result from both aggregated and individual complaint information;²⁷³ and
- A complaints management procedure and register will be in place in each District.²⁷⁴

6.265 From May 2002 a local policy also applied In the Bundaberg Health Service District. Relevantly, the Bundaberg Complaints Management System²⁷⁵ provided:

- Complaints that cannot be resolved at the point of service should be referred to the relevant Executive Director;

²⁶⁷ Exhibit 292: Policy Statement

²⁶⁸ Exhibit 292: Seriousness Categories

²⁶⁹ Exhibit 292: Reporting

²⁷⁰ Exhibit 292: Appendix 1 Complaint Handling Model

²⁷¹ Exhibit 292: Appendix 2 Performance Standards and Criteria

²⁷² Exhibit 292: Appendix 2 Performance Standards and Criteria

²⁷³ Exhibit 292: Appendix 2 Performance Standards and Criteria

²⁷⁴ Exhibit 292: Instruction, Implementation Process

²⁷⁵ Exhibit 162 LTR2 Statement Raven

- The investigation should be coordinated by the line manager or executive member and all quality improvement activities are to be registered with the Quality Management Unit and Improving Performance Committee;
- When the complaint is resolved all relevant documents are to be sent to the Complaints Coordinator for inclusion on the Complaints Register; and
- The Complaints Coordinator will provide a bimonthly report to the Leadership and Management Committee.²⁷⁶

Incident Management Policy

6.266 The Queensland Health Incident Management Policy²⁷⁷ covers all incidents, clinical and non-clinical, defined in the policy as ‘an event including adverse incident or circumstances which could have, or did lead to unintended and/or unnecessary harm to a person or the organisation, and/or a complaint, loss or damage’.²⁷⁸ Events with a very high and extreme risk rating and sentinel events must be reported to the District Manager, State Manager and relevant Corporate Office Branch Executive. All incidents must be reported on an incident report form and each district is to maintain a comprehensive register.²⁷⁹

The Queensland Health Incident Management policy is supplemented by three local policies In the Bundaberg Health Service District:

- Incident Management Policy;²⁸⁰
- Incident Analysis Policy;²⁸¹ and
- Sentinel Events and In-depth Analysis Policy.²⁸²

Integrated Risk Management Policy

6.267 The Queensland Health Integrated Risk Management Policy²⁸³ focuses on establishing an organisational philosophy and culture that ensures risk management is an integral part of decision making activities. This policy also applied during the period of Dr Patel’s employment. The Policy provides an ‘Integrated Risk Management Analysis Matrix’ for the risk rating of incidents. The Policy details specific requirements for reporting risks, including:

²⁷⁶ Exhibit 162 LTR2 Statement Raven

²⁷⁷ Exhibit 290A JGW6 Statement Wakefield

²⁷⁸ Exhibit 290A JGW6 Statement Wakefield: Incident Categories

²⁷⁹ Exhibit 290A JGW6 Statement Wakefield: Reporting and Recording

²⁸⁰ Exhibit 162 LTR7 Statement Raven. This policy was issued in November 2004 replacing the Adverse Events Management Policy Exhibit 162 LTR4 Statement Raven

²⁸¹ Exhibit 162 LTR7 Statement Raven

²⁸² Exhibit 162 LTR7 Statement Raven. This policy was issued in November 2004 replacing the Sentinel Events and Root Cause Analysis Policy Exhibit 162 LTR6 Statement of Raven

²⁸³ Exhibit 293

- Each district will report very high and extreme risks to their appropriate line management; and
- Each district will provide to the Risk Management Coordinator, a quarterly download of the Risk Register and details of risks that have a rating of very high or extreme.

6.268 The Queensland Health Integrated Risk Management Policy sets out principles and leaves much of the practical detail to local policy, the Bundaberg Risk Management Process.²⁸⁴ The local policy which applied throughout Dr Patel's employment requires that risks are systematically identified in each Clinical Service Forum. The Improving Performance Committee is to maintain a Central Risk Register. The Improving Performance Committee may delegate responsibility for the treatment of risks to the relevant committee. The Risk Register must be provided to the Queensland Health Integrated Risk Management Coordinator on a quarterly basis.

What went wrong in Bundaberg?

6.269 Throughout the course of the Commission it became apparent that there had been a steady stream of complaints and clinically significant incidents involving Dr Patel which commenced shortly after his arrival in Bundaberg. There were informal concerns. There were formal ones, by which I mean occasions where patients or staff filled in forms referring to clinical incidents relating to Dr Patel or formally brought issues relating to Dr Patel to the attention of the executive or a committee. If one excludes Dr Patel's holidays, his activities resulted in about one formal patient complaint or formal staff report for each month he actually worked. Despite this, the cumulative significance of the informal and the formal complaints and reports went either undetected or unaddressed for almost two years. A number of factors contributed to this:

- Many adverse incidents which occurred were not made the subject of a complaint nor of an incident report;
- Many complaints and incidents which were formalised were not dealt with as they should have been if the policies had been complied with;
- There was inadequate investigation of complaints;
- There was inadequate risk rating and referral;
- There was inadequate response and resolution;
- There was inadequate management and use of data; and

²⁸⁴ Risk Management Process (December 2002) and Risk Management Process (November 2004) Exhibit 162 LTR3 and LTR7 Statement Raven

- Implementation of systems was hindered by inadequate money, staff and time.

Many adverse incidents were not made the subject of a complaint nor of an incident report

6.270 In the two year period of Dr Patel's employment at the Bundaberg Hospital there were 22²⁸⁵ incidents or issues that were formally reported in one form or another. They can be broken down as follows:

- 7 patient complaints;
- 7 incidents reported to a member of the executive (with no formal incident report form);
- 3 incidents reported with an Incident Report only;
- 2 reported to a member of the executive and an Incident Report was completed;
- 1 incident reported to a member of the executive and a committee;
- 1 incident reported to a committee only;
- 1 incident reported by a patient complaint, Incident Report and to a member of the executive.

6.271 When the issues surrounding Dr Patel came to light, Queensland Health arranged reviews for patients who had received treatment from Dr Patel. The review conducted by Dr Peter Woodruff involved a review of charts but not of patients. It was not a random selection of charts. Dr Woodruff was confined to reviewing charts of a particular kind. The terms of reference for the cases which were to be reviewed by Dr Woodruff was relatively general. The team appointed on 18 April 2005 were to 'review the clinical cases of Dr Patel where there has been an identified adverse outcome, or where issues related to his clinical practice have been raised'.²⁸⁶

6.272 One would expect that the reviewers ought to have been able to identify those cases from the two registers that should have been established pursuant to the Queensland Health Complaints Management and Incident Management policies. They were the Complaints Register which recorded complaints made by and on behalf of patients²⁸⁷ and the Adverse Event Register which recorded incidents raised by staff.²⁸⁸

²⁸⁵ See discussion in Chapter Three: Dr Patel Works at the Base

²⁸⁶ Exhibit 102 p20

²⁸⁷ Exhibit 166

²⁸⁸ Exhibit 167

- 6.273 When one bears in mind the extraordinary findings of Dr de Lacy,²⁸⁹ Dr O'Loughlin²⁹⁰ and Dr Woodruff,²⁹¹ as to the number of procedures performed incompetently by Dr Patel with adverse results, one would expect both registers to be filled with the name Patel.
- 6.274 When the Quality Coordinator was first asked to identify complaints and incidents about Dr Patel, a review of the Complaints and Adverse Incidents registers revealed only three complaints²⁹² and five adverse events.²⁹³ There were in fact other entries on each register which related to Dr Patel that were not picked up because the medical practitioner's name was not, as a rule, put on the registers.
- 6.275 In the months after the Patel issue became public, the Quality Coordinator at the Base was able to find another five records of adverse events relating to Dr Patel's care that had been reported by staff. The extra five had not appeared on the register because they occurred before the Adverse Events Register was commenced in February 2004.²⁹⁴
- 6.276 The failure of the Base to record the names of the medical practitioners about whose treatment complaints were made or issues were raised, is explained by a desire to promote better reporting by promoting the notion of a blame free culture. It did not promote adequate reporting. Reporting was lamentable. The failure to record Dr Patel's name must have helped to conceal his dangerous incompetence.
- 6.277 Dr Woodruff did not content himself with an investigation of the three patients whose complaints identified Dr Patel on the Complaints Register and the five patients about whom entries appeared on the Adverse Events Register. Dr Woodruff was forced to look wider. He chose to look at the patients who died, those who were transferred to other institutions and at those identified as having adverse outcomes which were brought to the attention of the Review Team.²⁹⁵
- 6.278 Dr Woodruff gave evidence that, of the patients' charts he reviewed, 22²⁹⁶ showed to him that Dr Patel contributed to an adverse outcome and a further 24²⁹⁷ showed that Dr Patel may have contributed to an adverse outcome. Of the 46 adverse outcomes identified by Dr Woodruff, only seven appear on the

²⁸⁹ Para 3.416 herein

²⁹⁰ Para 3.417 herein

²⁹¹ Para 3.418 herein

²⁹² Exhibit 162 para 29

²⁹³ Exhibit 162 para 33

²⁹⁴ Exhibit 162 paras 54-60

²⁹⁵ Exhibit 102 p47

²⁹⁶ Exhibit 102, p120-125

²⁹⁷ Exhibit 102, p126-130

Adverse Events Register²⁹⁸ and only six appear on the Complaints Register^{299 300}.

- 6.279 With respect to patient complaints, it is probably the case that many would not have been aware that their problems were the result of clinical deficiencies. Many would have assumed, or may have been informed, that any ongoing problems were normal or to be expected, hence no complaint was made.
- 6.280 The reasons why incidents were not more frequently reported by clinical staff are not so easily explained. Under the Queensland Health Incident Management Policy, which came into effect in June 2004, all incidents must be reported.³⁰¹ For the purposes of the policy, the term incident is defined as 'an event including adverse incident or circumstances which could have, or did lead to unintended and/or unnecessary harm to a person ..., and/or a complaint, loss or damage'.³⁰² The local policies, one of which was in operation from February 2004³⁰³ had similar reporting requirements.
- 6.281 It is worth reiterating. The doctors and nurses at the Base were obliged by the policies in effect from February 2004 to report even incidents which could have led to unintended harm to a patient. It obviously was not honored by staff or sufficiently encouraged by the executive.

Unhealthy culture for staff to complain and report incidents

- 6.282 For any complaints systems to function properly it is vital that people are willing to come forward and 'speak up' about concerns that they have.
- 6.283 Whilst Toni Hoffmann campaigned (quite consistently and courageously) over quite some time to bring her concerns about Dr Patel's practices to light, many other staff at the Base were less than forthcoming in their concerns. A significant number of reportable incidents occurred in Bundaberg but were not reported.
- 6.284 In the aftermath of the Bramich incident, Dr Strahan indicated to Ms Hoffmann that there were a number of other people who had concerns about Dr Patel but were not willing to 'stick their necks out'.³⁰⁴ Whilst Dr Miach communicated his concerns about Dr Patel's incompetence in the insertion of catheters, he did not tell his line superiors, Dr Keating or Mr Leck that he had given instructions that his patients were not to be touched by Dr Patel. Indeed, he asked that Ms

²⁹⁸ Exhibit 167

²⁹⁹ Exhibit 166

³⁰⁰ These figures are with respect to the surgery or adverse outcomes referred to by Dr Woodruff. Instances where the patient appears on the register for a distinct adverse event (eg. a fall or system error) have not been included. The register was checked for complaints made prior to April 2005

³⁰¹ Exhibit 290A JGW6 Statement Wakefield: Reporting and Recording

³⁰² Exhibit 290A JGW6 Statement Wakefield: Incident categories

³⁰³ Exhibit 162 LTR4 Statement Raven

³⁰⁴ T1490 (Ms Hoffman)

Pollock not minute that direction at an ASPIC meeting.³⁰⁵ There are a number of reasons for staff reluctance to report safety issues.

- 6.285 First, some would have felt unwilling to tell of their concerns and effectively challenge Dr Patel, who was known to intimidate staff and effect some retribution upon those who challenged him. Consistent with this impression was the collective understanding propagated among the staff who worked with Dr Patel that because Dr Patel generated a large amount of revenue for the hospital by his capacity to perform elective surgery he had the unwavering support of management. Dr Strahan testified that he and others felt that if they complained against Dr Patel they would not only be challenging him, they would be challenging management.³⁰⁶
- 6.286 Secondly, Dr Strahan testified that the reason why he and others were less willing to come forward was that they did not believe that the information they had available to them was sufficient to warrant challenging Dr Patel. He effectively said that whilst, to an individual, information did not seem to justify a complaint, that information comprised a larger picture that was beyond any individual's knowledge. Had that information been combined so that the gravity of the situation was known to all those who held the separate pieces of it then he said that more people might have been willing to come forward.³⁰⁷
- 6.287 Thirdly, people who had concerns could only be confident about those things within their expertise and would be less willing to challenge Dr Patel on matters outside it. This problem is multiplied by the increased level of specialisation which characterises modern medical practice. The effect of this is that a specialist may not be willing or able to suggest incompetence in another practitioner who practises outside the specialist's scope of expertise. An eminent nephrologist, for example, may be less willing to claim that a surgeon is incompetent because surgery is not within his expertise nor within the expertise of the hospital's executive who would have to consider the claim.
- 6.288 Fourthly, because Dr Patel was the only general surgeon at the Base, (Dr Gaffield was a plastic surgeon whose general surgical experience was not so extensive as Dr Patel's), there was effectively no-one there observing Dr Patel's work, who could identify failings in Dr Patel as a surgeon with any confidence or significant credibility. Patients are often unable to identify inadequate care and for that reason are more likely to accept than challenge it by way of complaint. Further, a patient's credibility with those to whom they complain is hampered by limited or non-existent clinical knowledge.

³⁰⁵ Exhibit 70 para 21

³⁰⁶ T3282 (Dr Strahan)

³⁰⁷ T3282-3 (Dr Strahan)

- 6.289 Fifthly, the process of formally complaining is quite alien to most people, including clinicians.³⁰⁸
- 6.290 Sixthly, there were some, it seems, who were tired of complaining with no result and because of 'complaint fatigue' were unwilling to complain again.³⁰⁹
- 6.291 The Queensland Health Review team which went to Bundaberg reported³¹⁰ that numerous staff at Bundaberg reported barriers to reporting clinical incidents and summarised those barriers as follows:
- Little point reporting as nothing changed;
 - Leadership not actively encouraging reporting for 'learning';
 - Lack of feedback of outcome to reporting person/unit;
 - Culture of blame and history of punitive approach to reporter;
 - Fear of reprisal;
 - Seen as nursing business; and
 - Multiple forms.
- 6.292 By the time Dr Patel began work at the Base in 2003, the relationship between clinical staff and administrators was marked by a dysfunctional approach to complaints about clinical standards. Management was accustomed to rejecting legitimate demands because management had inadequate funds. Management was accustomed to providing an unsatisfactory service to patients about which the clinicians continued to complain. The inadequate budgets were a constant problem for the District Manager.
- 6.293 There had been some quite vehement earlier complaints about staff working unsafe hours and the need for more staff and equipment. Dr Nankivell and Dr Baker, each surgeons, had complained about their workloads. Dr Jeliffe and Dr Carter, Anaesthetists, had complained about the workloads for anaesthetic staff. When Dr Baker resigned in 2002 he said that he did not wish to continue to provide a third world surgical service. Dr Jeliffe had cancelled elective surgery during the Easter period in 2002 because he was concerned about the risks to patient safety caused by his workload. Dr Nankivell was hospitalised for exhaustion.
- 6.294 The District Manager, Mr Leck, thought that there were staff working too many hours but felt that he had to condone this because he had little practical alternative. He believed that the recommendations of Australian Colleges as to proper numbers of specialists were universally ignored in Queensland Health.³¹¹

³⁰⁸ T3268-T3269 (Dr Strahan)

³⁰⁹ T3283; T4006 (Dr Strahan)

³¹⁰ Exhibit 102 p80

³¹¹ T7187 line 49 (Mr Leck)

- 6.295 If a complaint or a suggestion required further funds, it was likely to lead to nothing but frustration. That frustration could be increased by lack of feed back. A sensible request by a clinician might have to pass through several layers of administration before a decision could be made on the request and it might take several months before the original clinician received an answer. If the request was rejected, it was possible that the clinician would be left wondering as to why it was rejected. Dr Thiele, who had been a Director of Medical Services at the Base, regarded it as 'a fundamental system failure'.³¹²
- 6.296 A general concern was expressed that a complaint about another clinician would result in reprisal or retribution.³¹³ Evidence was given of actual or perceived threats by administrators to suppress complaints. Dr Miach, Staff Physician, formed the impression that he was being threatened by the Director of Medical Services. When the Patel issue arose in the media Dr Keating came to Dr Miach's office, which was most unusual, and observed 'you know what goes around comes around'. Prior to the Patel controversy Dr Jelliffe, then a Staff Anaesthetist, was uncharacteristically summoned to the office of Mr Leck, District Manager. It was after Dr Jelliffe had cancelled elective surgery during the Easter period out of his concern for patient safety caused by the working hours for which he would be rostered. He interpreted the interview as threatening when Mr Leck asked him about the status of his visa.
- 6.297 Dr Nankivell gave evidence that 'the feeling amongst all nurses is that if you complain you'll be sacked or discriminated against', and said that nurses were terrified of the Code of Conduct.
- 6.298 It was alarming that, even after an independent internal investigation had been undertaken by Dr FitzGerald in February 2005 and it was clear to Mr Leck that legitimate concerns had been raised about Dr Patel's clinical competence, he considered taking an adversarial approach to those staff who had felt they had had no alternative but to raise their concerns with their local member. On 7 April 2005 he wrote to the Zonal Manager '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?'

Lack of response to complaints:

Dr Miach's experience

- 6.299 Dr Miach, the Director of Medicine at the Bundaberg Hospital and an eminent physician and nephrologist, found management unresponsive to his serious concerns.

³¹² T1835 line 25 (Dr Thiele)

³¹³ T2251 line 25 (Ms Raven), Exhibit 102 p80

- 6.300 Shortly after Dr Keating's arrival at the hospital, he changed the system of on-call rostering without any staff consultation. Dr Miach advised Dr Keating that the rostering of the most junior staff to the Accident and Emergency Department after hours, instead of the most senior, was bad practice.³¹⁴ Dr FitzGerald whose expertise included emergency medicine confirmed in evidence that Dr Miach's concerns were appropriate.³¹⁵ The bad practice was maintained.
- 6.301 Another incident concerning Dr Miach was the creation of the catheter audit which so damned Dr Patel's competence in surgery to place peritoneal catheters and, arguably, his judgment in performing the procedure. I have referred to the efforts to bring this information forcefully to Dr Keating's attention in Chapter Three. Dr Keating's failure to question the significance of the catheter audit and his failure to become involved with the nurses' concerns about the complications must have left Dr Miach and the nurses perplexed.
- 6.302 Dr Miach also raised issues about vascular access in the hospital with Dr Keating. He wrote a letter to Dr Keating with an example of a young patient who had suffered immensely because vascular access was not performed locally and he was too ill to travel to Brisbane. He suggested that Dr Thiele, a vascular surgeon in town with a long association with the Base, be engaged as a Visiting Medical Officer to perform vascular access locally. Dr Miach received no response to that letter and had to take up the matter with the Zonal Manager.³¹⁶

Oesophagectomy complaints

- 6.303 The circumstances of the first two oesophagectomies performed by Dr Patel at the Base led to a conflict of evidence as to what notice was given to Dr Keating of concerns by Ms Hoffman, Dr Joiner and Dr Cook. Some matters remain beyond doubt. Dr Joiner advised Dr Keating that the Base was not doing sufficient oesophagectomies to maintain competency. This was correct. Dr Joiner advised that the Intensive Care Unit did not have the necessary resources for post-operative support. This, too, was correct. Ms Hoffman wrote by e-mail on 19 June 2003 that she had continuing concern over the lack of sufficient Intensive Care Unit backup to care for a patient who has undergone such extensive surgery. Dr Cook, the most senior intensivist at the Mater Hospital in Brisbane wrote to Dr Keating and spoke to him by telephone because of his concern that a surgeon at the Base would be embarking on such a complicated operation as an oesophagectomy. Dr Keating did not return to Dr Cook to inform him that he was prepared to permit such procedures to continue to be performed at the hospital nor did he respond to the email from Ms Hoffman. The decision by Dr Keating to allow the procedures to continue in the

³¹⁴ Exhibit 21 para 110

³¹⁵ T3158 (Dr FitzGerald)

³¹⁶ Exhibit 21 para 119-126

future was plainly inconsistent with the requirement to apply risk management practices.³¹⁷

- 6.304 It took two more oesophagectomies to close this chapter. It ended with the inappropriate and unnecessary oesophagectomy performed upon Mr Kemp which killed him in December 2004. The circumstances of the incident and the staff concerns raised appear in Chapter Three. The anaesthetist, Dr Berens, brought to Dr Keating his and the theatre staff's concerns about Dr Patel's conduct. Dr Berens was so concerned he expressed the view that perhaps the matter should be referred to the Coroner.
- 6.305 None of the staff involved with Dr Patel during the surgery, nor Dr Carter to whom Dr Berens first went, nor Dr Keating filled in the 'Adverse Event Report Form' consistent with the Adverse Events Management Policy requirements at Bundaberg since February 2004. It meant the event was not sent to the District Quality and Decision Support Unit for registering and risk rating. More significantly, Mr Kemp's death from elective surgery was a 'Sentinel Event' under the Sentinel Events and In-depth Analysis policy because it was an unexpected death. That policy required that the incident be given special treatment. Mr Keating was required to report it to Mr Leck immediately. Mr Leck learned of it immediately. Mr Leck was required to notify the Director-General of Queensland Health immediately. A team independent of the incident were to analyse it within 7 days. A root cause analysis investigation tool was to be used. There was no notice to the Director-General, nor an investigation. Within a month, Mr Leck and Dr Keating extracted a promise from Dr Patel that he would not carry out any further oesophagectomies at the Base.

Reported complaints and incidents not dealt with under the policy framework

- 6.306 Of the 22 incidents or issues that were reported, 15 of those were complaints or issues raised by staff. Of that 15, nine were reported informally, without the use of an Accident/Incident Report or as it was later known, an Adverse Event Report Form.
- 6.307 It meant that nine incidents reported to the executive in this informal way were not dealt with under the policy framework.³¹⁸ The effect of this is that:
- Incidents were not risk rated according to the severity of consequences and likelihood of reoccurrence;
 - Potential or actual incidents with a very high or extreme risk rating were not reported to the District Manager;

³¹⁷ As required at the time by the Risk Management Process Exhibit 162 LTR3 and the Queensland Health Integrated Risk Management Policy Exhibit 293

³¹⁸ Incident Management Policy, Exhibit 293; Adverse Events Management Policy, Exhibit 162 LTR4 Statement Raven; Incident Management Clinical and Non-Clinical Exhibit 162 LTR7 Statement Raven

- Incidents were not recorded on the Adverse Events Register, meaning that trends could not be picked up and this data would not be included in the quarterly trends reports provided to various committees;
- Incidents were not investigated under the comprehensive requirements of the policy,
- Corrective action plans and reports were not produced;
- Feedback about actions taken was not provided to those involved in the incident;
- Risks were not reported on the local Risk Register.

6.308 Similarly, there are examples where patient concerns became known to the executive; however, because they were not the subject of a formal complaint they were not dealt with under the policy framework.

6.309 Recall the case of Ms Lester,³¹⁹ who applied for a travel subsidy to avoid Dr Patel. The patient had seen Dr Patel on an earlier occasion to have packings from a previous procedure removed. The experience had been particularly traumatic as the procedure took place before the anaesthetic had taken effect.³²⁰ After experiencing ongoing pain, the patient sought the opinion of a different doctor. An ultrasound revealed that a foreign body was still within her.³²¹

6.310 Despite what appears to be gross carelessness on the part of Dr Patel, Dr Keating gave evidence that he did not consider it necessary to investigate the clinical aspects of this incident³²² and merely put it down to a difference of opinion between doctors.³²³ The matter was considered purely as a travel application.³²⁴

6.311 There was no record of a complaint, no record of an adverse incident, no risk assessment, no investigation of the treatment that led to the foreign body being missed. This was less than 10 days after Dr Keating counselled Dr Patel about his attitude to Mr Smith and failure to anaesthetise adequately. Ms Lester raised this same issue.

6.312 The policies support the idea that issues are addressed even if they are not raised as complaints. The Queensland Health Complaints Management Policy defines a complaint as 'any expression of dissatisfaction or concern, by or on behalf of a consumer...'. The Queensland Health Incident Management Policy

³¹⁹ Paras 3.253 - 3.255 herein

³²⁰ Exhibit 176 para 14 Statement Lester

³²¹ Exhibit 176 para 16 Statement Lester

³²² T6954 line 35 (Dr Keating)

³²³ T6955 line 17 (Dr Keating)

³²⁴ T6954 line 50 (Dr Keating)

provides that incidents can be identified in many ways, including from patient complaints.

Non-Compliance with the Complaints Management Policy

- 6.313 The Queensland Health Complaints Management Policy affirms and supports the right of patients to feedback and to have complaints heard and acted upon. The implementation of the complaints management process strives for consumer satisfaction in the way the complaint is handled, and to provide reliable and accurate information which is used to improve quality and safety in health care.³²⁵
- 6.314 A review of the Complaints Register for the period July 2002 to April 2005 paints a superficially positive picture of complaints management at the Bundaberg Hospital. During this period 675 complaints were registered, 533 were resolved within 28 days and all but four eventually resolved.
- 6.315 However, a closer analysis of individual cases paints a different picture. The Commission heard evidence that complaints were not always thoroughly investigated and resolved to the satisfaction of the patient. Further, there is evidence of disparities between the patient's recollections and perceptions and the Hospital's records of the complaint outcome.

The Fleming complaint

- 6.316 Mr Fleming's relevant medical history is more fully set out in Chapter Three. Five months after surgery by Dr Patel Mr Fleming was extremely concerned about his health because of pain and internal bleeding and was concerned about delays in having the hospital investigate it. He complained by telephone and a staff member filled in for him a Complaint Registration Form.³²⁶ The staff member chose not to classify the complaint as about 'treatment' or 'professional conduct' but as about 'access to service'. And so, when the complaint could so easily have been categorised as one raising an issue about whether the original treatment was adequate, it was categorised, instead, as a concern about delay – delay in obtaining an investigation to determine the need for remedial treatment from the hospital. When the complaint appeared on the Complaints Register³²⁷ a reader of the document would have assumed that Mr Fleming's major concern was about obtaining access to a specialist. The register gave the impression that the complaint was 'resolved' in two days by 'explanation given'. If it had been classified as a complaint about treatment it would have been more difficult to classify it as 'resolved' and to close the book on it. It would have required a consideration of the adequacy of the initial treatment and a consideration of the

³²⁵ Exhibit 292 QH Complaints Management Policy: Policy Statement

³²⁶ Exhibit 114 IGF3

³²⁷ Exhibit 166

accuracy of the patient's belief that he had internal bleeding and the need for remedial treatment. The complaint was classified as resolved two or three weeks before Mr Fleming was able to see the specialist he was so desperate to have review him.

The Smith complaint

- 6.317 On 27 February 2004 Geoff Smith made a oral complaint to Dr Keating regarding the treatment he received from Dr Patel.³²⁸ Mr Smith had a melanoma on his shoulder. Mr Smith advised Dr Patel that local anaesthetic was not effective for him and questioned him regarding alternatives. Dr Patel dismissed Mr Smith's concerns and proceeded to excise the melanoma without anaesthetising him properly.
- 6.318 Dr Keating met with Mr Smith to discuss the complaint. Dr Keating then met with Dr Patel and explained to him that the patient's complaint appeared to be legitimate and the attitude displayed to Mr Smith seemed to be inappropriate.³²⁹ After the meeting Dr Keating sent a letter to Mr Smith in which he apologised for the distress and unhappiness that had been experienced and advised that Dr Patel had given an undertaking to review his interactions with patients in such circumstances.³³⁰
- 6.319 An alert was also placed on the cover of Mr Smith's medical file stating 'local anaesthetics alone are ineffective alternative methods of pain relief are required'.³³¹
- 6.320 The complaint was registered on the Complaints Register as a 'Treatment' issue that was resolved within 12 days. The resolution is noted as 'explanation given'.³³²

P131 complaint

- 6.321 On 2 July 2004 P131 made a telephone complaint about Dr Patel which was referred to Dr Keating.³³³ P131 complained that she had attended at BreastScreen complaining of an itchy nipple. BreastScreen wrote to Dr Patel requesting that a biopsy be performed to exclude Paget's disease. When she presented for the biopsy on 1 July 2003 she was informed by Dr Patel that she only had eczema and was given cortisone cream.
- 6.322 In October 2003, she was attending the hospital for another matter and informed staff that she still had the itchy nipple and that the cream Dr Patel had given her

³²⁸ Exhibit 174 Statement Smith

³²⁹ T6953 line 20-30 (Dr Keating)

³³⁰ Exhibit 174 GS1 Statement Smith

³³¹ Exhibit 190, there is some contention as to when this alert was placed on the file see T2679-2681 (Mr Smith)

³³² Exhibit 166

³³³ Exhibit 225 GR19 Statement Fitzgerald

had not worked.³³⁴ She was referred to Dr Gaffield for review who recommended that she undergo a punch biopsy.³³⁵ P131 underwent the biopsy in March 2004, some eight months after the first scheduled biopsy that never took place. The biopsy revealed the she did in fact have Paget's disease. The patient elected to undergo a bilateral mastectomy.³³⁶

6.323 On receiving the complaint, Dr Keating took this up with Dr Patel. Dr Patel advised that he intended to review the patient after three months and if there was no improvement a biopsy would be conducted then. He explained that Paget's disease and Eczema are very hard to differentiate. Dr Patel claims that the patient did not return for her review appointment on 23 September 2003.³³⁷ It appears that the patient was not aware of a review appointment.

6.324 Dr Keating accepted Dr Patel's explanation and responded to P131 that:

Eczema and Paget's Disease (early cancer) can be very hard to differentiate and based upon your normal breast examination and mammogram, conservative treatment was begun with a review due in three months. This course of management was appropriate; unfortunately a lack of thoroughness at initial review appointment prolonged the time until definitive diagnosis and treatment in 2004.³³⁸

6.325 The complaint was registered on the Complaints Register as a 'Treatment' issue that was resolved within 31 days. The resolution is noted as 'explanation given'.³³⁹ The complaint was not given a seriousness category or risk rated.

What should have happened under the Complaints Management Policy

6.326 Under the statewide Complaints Management Policy³⁴⁰ any moderate, major, extreme and unresolved complaints are to be referred to the Complaints Coordinator. The Complaints Coordinator is to review resolved complaints and ensure comprehensive assessment or investigation of moderate, major, extreme and unresolved complaints. Under the Bundaberg policy, members of the health service executive are responsible for coordinating the investigation of a complaint in their area of authority.

6.327 In the examples above, the complaints were made directly to Dr Keating or referred to him. He attempted to resolve issues before referring them to the Complaints Coordinator.

6.328 Once the complaints were received by the Complaints Coordinator, the complaint information was put into the Complaints Register. The complaints

³³⁴ Exhibit 294 para 52 Statement Gaffield

³³⁵ Exhibit 294 para 54 Statement Gaffield

³³⁶ Exhibit 294 para 60 Statement Gaffield

³³⁷ Exhibit 225 GR19 Statement Fitzgerald

³³⁸ Exhibit 225 GR19 Statement Fitzgerald

³³⁹ Exhibit 166

³⁴⁰ Exhibit 292

were not classed according to seriousness. The complaints of Ms Lester (a foreign body left within her), Mr Fleming (continued internal bleeding and wound infection), P131 (failure to perform a biopsy to exclude Paget's disease leading to a double mastectomy) and possibly Mr Smith's (failure to give anaesthetic) should have been classed, at least, as moderate and should have been referred for investigation. None of the complaint examples received a comprehensive assessment or investigation as required by the Policy.

6.329 The Policy requires an in-depth and/or root cause analysis of complaint matter. The Policy defines investigation as:

A systematic process of collecting relevant evidence, followed by an assessment of the evidence that leads to a logical and reasonable determination or conclusion. Investigations are undertaken when a decision needs to be made and the material/evidence before the decision maker is insufficient and/or needing clarification and/or only an allegation which needs a response or collection of further evidence from another party/parties and/or conflicting and cannot be reasonably assessed without further evidence.

6.330 The Policy sets out the following responsibilities of investigators:

- Investigating complaints objectively, fairly, confidentially and in a timely manner;
- Establishing the facts associated with a complaint;
- Compiling a report on the investigation findings;
- Forwarding reports to the person who appointed them to conduct the investigation; and
- Ensuring the principles of natural justice and procedural fairness are upheld throughout the investigative process.

6.331 In each of the complaint examples, with the exception of Lester, Dr Keating discussed the incident with Dr Patel. Dr Patel's comments were accepted for the Fleming and P131 complaints and no further medical opinion was sought. With respect to the Smith complaint, Dr Keating advised Dr Patel that the complaint seemed to be legitimate and the attitude displayed to Mr Smith seemed to be inappropriate. The issues raised by Ms Lester were not investigated at all.

6.332 Dr Keating's inquiries fall significantly short of the investigation process described in the policy. At the very least, he should have sought a medical opinion from a doctor independent of the event and talked with staff who may have first hand knowledge of an incident.

6.333 With respect to the four examples, there were no investigations to establish the facts associated with the complaint. For example, Mr Fleming advised Dr Keating that there was a dispute between Dr Patel and the nurses about the treatment of his wound. It would have been a simple exercise to talk to the nurses involved.

- 6.334 Also of concern is Dr Keating's willingness to accept Dr Patel's explanations. The complaints of Mr Fleming, Mr Smith and Ms Lester occurred in relatively close succession. Dr Keating investigated Mr Fleming's complaint in October 2003. In February 2004, Dr Keating counselled Dr Patel with respect to Ms Smith's complaint. Less than one week later, Ms Lester's problems became known to Dr Keating. All three complaints involved allegations of a failure by Dr Patel to anaesthetise properly and a callous disregard for the patient. In light of the emerging pattern, one might think it essential to conduct investigations beyond obtaining Dr Patel's opinion.
- 6.335 The Policy requires that a report be compiled on the investigation findings and sent to the person who requested the investigation. In each of the four examples, no comprehensive report was produced.
- 6.336 The District Manager has a responsibility to ensure that all patient complaints with a seriousness category of Extreme are reported to the General Manager, Health Services.³⁴¹ In Bundaberg from February 2003 complaints were not categorised and, presumably, then could not be reported to the General Manager, Health Services.
- 6.337 The District Manager is also responsible for ensuring that concerns arising from complaints that relate to the health, competence or conduct of a registered professional are referred to the appropriate registration body.³⁴² This did not occur with complaints about Dr Patel.
- 6.338 Under the Bundaberg policy, following the investigation of a complaint, the line manager should identify the cause of the complaint, isolate contributing factors and identify opportunities for improvement that prevent the circumstances of the complaint recurring. All quality improvement activities should then have been referred to the Quality Management Unit and the Improving Performance Committee.³⁴³ It is not clear from the evidence or the minutes of the Improving Performance Committee whether this ever occurred.

Non-compliance with the Incident Management Policy

- 6.339 In addition to the patient complaints about Dr Patel, there was also a steady stream of concerns expressed by staff within Queensland Health. As discussed above, many were reported informally and were not dealt with under policy requirements. Of those that were reported through an Adverse Incident Form or a Sentinel Event Report Form, the policy was not strictly complied with.

³⁴¹ Exhibit 292: Compliance and Responsibilities

³⁴² Exhibit 292: Compliance and Responsibilities

³⁴³ Exhibit 162 LTR2 Statement Raven

Desmond Bramich (A Sentinel Event³⁴⁴)

6.340 Mr Bramich was admitted to the Bundaberg Hospital on 25 July 2004 suffering an injury to the chest after being trapped under a caravan. Mr Bramich appeared to stabilise but then deteriorated suddenly, he passed away on 28 July 2004. This matter is more fully discussed in Chapter Three.

6.341 Dr Keating received a number of staff complaints with respect to the care of Mr Bramich:

- Dr Carter approached Dr Keating shortly after the death of Mr Bramich suggesting that the management of the patient be audited;³⁴⁵
- Karen Fox, a registered nurse in the Intensive Care Unit lodged an Adverse Event Report Form reporting an absence of water in the underwater seal drainage unit. The unit is used to drain fluid or air from the lungs;³⁴⁶ and
- Ms Hoffman lodged a Sentinel Event Report Form. The form was accompanied by a two page letter detailing the problems the Intensive Care Unit was having with Dr Patel.³⁴⁷

Dr Keating received the Adverse Event Report Form and the Sentinel Event Report Form on 2 August 2004.³⁴⁸

6.342 Dr Keating undertook the following activities in response to the complaints:

- On 29 July 2004, he wrote to Dr Carter and Dr Patel requesting an audit of the total management of Mr Bramich within two weeks;
- On 26 August 2004, he received Dr Patel's report;³⁴⁹
- On 31 August 2004, he obtained a copy of the autopsy report from the Coroner;
- On 13 September 2004, he received Dr Carter's report;³⁵⁰
- On 14 September 2004, he received a report from Dr Gaffield;³⁵¹
- On 25 October 2004, he received a report from Dr Carter to be provided to the Coroner;³⁵²
- On 27 September 2004, he received advice from Dr Younis who was critical of Dr Patel's management;³⁵³

³⁴⁴ A sentinel event is an event that signals that something serious or sentinel has occurred and warrants in depth investigation – Exhibit 290A JGW6 Statement Wakefield

³⁴⁵ Exhibit 448 para 133 Statement Keating

³⁴⁶ Exhibit 162 LTR9 Statement Raven

³⁴⁷ Exhibit 162 LTR9 Statement Raven

³⁴⁸ Exhibit 448 para 135 Statement Keating

³⁴⁹ Dr Patel's report appears at Exhibit 448 DWK40 Statement Keating

³⁵⁰ Dr Carter's report appears at Exhibit 448 TH19 Statement Hoffman

³⁵¹ Dr Gaffield's report appears at Exhibit 448 DWK42 Statement Keating

³⁵² Dr Carter's report for the Coroner appears at Exhibit 448 DWK43 Statement Keating

³⁵³ File note of Dr Younis's advice appears at Exhibit 448 DWK44 Statement Keating

- On 19 October 2004 he discussed the case with Dr Rodd Brockett, an intensive care specialist at Logan Hospital and obtained the names of three intensive care specialists who could review the case;³⁵⁴
 - He provided Dr Patel with a copy of Ms Hoffman's Sentinel Event Report Form and statement and requested him to respond;
 - Dr Patel responded to Ms Hoffman's report and statement;³⁵⁵
 - He reviewed the medical records and various reports;³⁵⁶ and
 - He kept Ms Mulligan and Mr Leck informed of the investigation.³⁵⁷
- 6.343 On 20 October 2004, Ms Hoffman met with Ms Mulligan to raise issues of Dr Patel's clinical competence. Later that day, there was a meeting between Mr Leck, Ms Mulligan and Ms Hoffman in which these issues were discussed further. Ms Hoffman advised that a number of nursing staff had been to see Dr Keating with issues regarding Dr Patel and were not happy with the way he had investigated or managed the complaints. Mr Leck requested Dr Keating to stop investigating the Bramich case.³⁵⁸
- 6.344 After the meeting, Ms Hoffman documented her concerns in a letter to Mr Leck dated 22 October 2004.³⁵⁹ The letter was provided to Ms Mulligan and Dr Keating.³⁶⁰
- 6.345 In order to corroborate the allegations, Mr Leck and Dr Keating met with some of the doctors named by Ms Hoffman. After this Mr Leck concluded that there were some clinical issues in relation to Dr Patel that needed investigation.³⁶¹
- 6.346 On 5 November 2004, Mr Leck met with Dr Keating to discuss what action should be taken in relation to Dr Patel. Mr Leck gave evidence that Dr Keating was reluctant to agree to a review because he considered that the allegations related to a personality conflict and lacked substance.³⁶²
- 6.347 Mr Leck and Dr Keating began to make enquires at various hospitals to find a suitable person to conduct the enquiry. On 16 December 2004, Mr Leck contacted the Audit and Operational Review Branch for advice about the review.³⁶³ They advised that he should contact Dr Gerry FitzGerald, the Chief Health Officer.³⁶⁴
- 6.348 On 17 December 2004, Mr Leck contacted Dr FitzGerald's office and was advised that Dr FitzGerald was about to depart for annual leave but was aware

³⁵⁴ File note of Dr Brockett's advice appears at Exhibit 448 DWK45 Statement Keating

³⁵⁵ Dr Patel's response appears at Exhibit 448 DWK46 Statement Keating

³⁵⁶ File note of Dr Keating's investigations appears at Exhibit 448 DWK47 Statement Keating

³⁵⁷ Exhibit 448 Statement Keating

³⁵⁸ Exhibit 463 paras 42-47 Statement Leck

³⁵⁹ Exhibit 4 TH37 Statement Hoffman

³⁶⁰ Exhibit 463 para 48 Statement Leck

³⁶¹ Exhibit 463 para 51 Statement Leck

³⁶² Exhibit 463 para 52 Statement Leck

³⁶³ Exhibit 463 para 55 Statement Leck

³⁶⁴ Exhibit 463 para 56 Statement Leck

of the situation and could assist with the review. Dr FitzGerald and Mr Leck did not talk until 17 January 2005 when he returned.³⁶⁵

- 6.349 On 14 February 2005, some six months after Ms Hoffman submitted the Sentinel Event Report Form, Dr FitzGerald came to Bundaberg to interview the relevant staff.³⁶⁶
- 6.350 Having not received any feedback from Dr FitzGerald or management regarding the outcomes of investigations into Dr Patel, Ms Hoffman was somewhat comforted by the fact that Dr Patel's contract was due to expire in early 2005. When Dr Patel announced that his contract had been extended Ms Hoffman decided that she needed to do something desperate. On 18 March 2005, Ms Hoffman took her concerns to Rob Messenger, the Member for Burnett.
- 6.351 As at March 2005, Ms Hoffman had received no feedback regarding the outcomes of investigations into the sentinel event report she had lodged in August 2004.

What should have happened under the Incident Management Policy

- 6.352 The adverse and sentinel events with respect to Mr Bramich were reported in August 2004. At this time the Bundaberg Health Service District had a local Adverse Events Management Policy³⁶⁷ and a Sentinel Events and Root Cause Analysis Policy.³⁶⁸ The Queensland Health Incident Management Policy³⁶⁹ was issued on 10 June 2004. The policies of the Bundaberg Health Service District were reviewed in light of the new statewide policy and revised policies³⁷⁰ were issued in November 2004.
- 6.353 The timing of the policies is relevant because under the Queensland Health policy, sentinel events must be reported to the Director-General. This was not a requirement under the earlier policies of the Bundaberg Health Service District. The earlier Bundaberg policy requires the immediate handling of the event including, liaison and notification of the Central Zone Management Unit and Corporate Office Queensland Health.³⁷¹
- 6.354 All District Managers were informed of the new policy by memorandum from the Deputy Director-General dated 30 June 2004.³⁷² The memorandum states that all sentinel events are to be reported to the Director-General immediately.

³⁶⁵ Exhibit 463 para 57-62 Statement Leck

³⁶⁶ Exhibit 463 para 63 Statement Leck

³⁶⁷ Exhibit 162 LTR4 Statement Raven

³⁶⁸ Exhibit 162 LTR6 Statement Raven

³⁶⁹ Exhibit 290A JGW6 Statement Wakefield

³⁷⁰ Exhibit 162 LTR7 Statement Raven

³⁷¹ Exhibit 162 LTR6 Statement Raven

³⁷² Exhibit 448 DWK49 Statement Keating

- 6.355 The Queensland Health Incident Management Policy³⁷³ describes a sentinel event as an event that signals that something serious or sentinel has occurred and warrants in depth investigation. The policy provides a list of certain incidents that are deemed to be sentinel events. The list is not stated to be exhaustive. Under the policy an unexpected death of a patient is deemed to be a sentinel event.
- 6.356 The Policy sets out an Incident Management Model³⁷⁴ with nine elements:
- Prevention
 - Incident Identification
 - Classification/prioritisation
 - Reporting and recording
 - Patient and staff care/management
 - Analysis/investigation
 - Action
 - Feedback
 - Communication
- 6.357 Incidents should be prioritised according to their risk rating. The policy provides a Risk Matrix which assists in categorising the seriousness of adverse events. The event should be risk rated by the person who reports the event and again during the investigation phase. There is no evidence that the sentinel event was ever risk rated.³⁷⁵
- 6.358 The Policy requires that the line manager must report all sentinel events to the District Manager. The District Manager must report all sentinel events to the Director-General.³⁷⁶
- 6.359 One month after Ms Hoffman lodged the Sentinel Event Report Form, she heard that it had been downgraded, that it was deemed not to be a sentinel event.³⁷⁷
- 6.360 Leonie Raven, the Quality Coordinator, gave evidence that Ms Hoffman contacted her around October 2004 enquiring as to the status of the sentinel event. Ms Raven could not locate the report on the Adverse Incidents Register and contacted Dr Keating to see if he was aware of the sentinel event. Dr Keating advised that he was and that an analysis of the event had been undertaken. Ms Raven was of the understanding that Dr Keating would report back to the clinicians involved. Ms Raven stated that she believed the sentinel

³⁷³ Exhibit 290A JGW6 Statement Wakefield

³⁷⁴ Exhibit 290A JGW6 Statement Wakefield: Incident Management Model p6

³⁷⁵ Exhibit 290A JGW6 Statement Wakefield: Prevention p6

³⁷⁶ Exhibit 290A JGW6 Statement Wakefield: Reporting and Recording p8

³⁷⁷ Exhibit 4 para 89 Statement Hoffman

event was actioned appropriately and in accordance with the Hospital policy which was current at the time; it was not downgraded. The reason it did not appear on the Register was purely an administrative error.³⁷⁸

- 6.361 Dr Keating gave evidence that at no stage was Mr Bramich's death downgraded or deemed by him not to be a sentinel event.³⁷⁹ However, he did not believe the incident had to be reported to the Director-General because, although it occurred after the introduction of the Queensland Health policy, which requires that all sentinel events are reported to the Director-General, it occurred prior to the implementation of that policy in Bundaberg.³⁸⁰ I do not accept this argument.
- 6.362 Mr Leck gave evidence that he receives copies of Sentinel Event Report Forms because he is required to send a copy to corporate office within a certain timeframe. When he received Ms Hoffman's Sentinel Event Report Form, he said that he contacted the Quality Coordinator and was told that this case did not constitute a sentinel event within the terms of the specific criteria set out in the Queensland Health Incident Management Policy. On this advice, Mr Leck did not report the sentinel event to corporate office.³⁸¹
- 6.363 Each District Manager was supposed to maintain a comprehensive register of all reported incidents in their accountability area. In Bundaberg, the Adverse Incidents Register is maintained by the District Quality and Decision Support Unit.
- 6.364 Due to an administrative error, the sentinel event was never recorded on the Adverse Incidents Register. Of particular concern is that this was brought to the attention of Ms Raven, the Quality Coordinator from the District Quality and Decision Support Unit in October 2004 and the Register provided to the Commission which includes entries up to May 2005 still has no record of the sentinel event reported by Ms Hoffman.
- 6.365 Under the Queensland Health policy, the investigation of sentinel events involves the following mandatory requirements:³⁸²
- Use of a team independent of the incident;
 - Analysis, commencing seven working days after the incident;
 - The root cause analysis tool must be used;
 - Teams should be commissioned by the District Manager;
 - At least one member of the team must be trained in using the root cause analysis tool and process; and

³⁷⁸ Exhibit 162 para 37-39 Statement Raven

³⁷⁹ Exhibit 448 para 157 Statement Keating

³⁸⁰ Exhibit 448 para 159 Statement Keating

³⁸¹ Exhibit 463 paras 33-35 Statement Leck

³⁸² Exhibit 290A JGW6 Statement Wakefield: Incident Analysis/Investigation p10

- A report must be provided to the District Manager within 45 days of commencement of investigation.
- 6.366 Unfortunately, Dr Keating was still operating under the less stringent investigation requirements of the outdated Bundaberg policy³⁸³ and none of the above requirements, with the possible exception of the second requirement, were met.
- 6.367 The Bundaberg Sentinel Events and Root Cause Analysis Policy essentially requires that an investigation be undertaken by a team headed by one of the executives, a root cause analysis to be conducted and a report sent to the Leadership and Management Committee.
- 6.368 The investigation even fell short of the less stringent requirements of this Policy. In the three month period from the date of the sentinel event until the investigation was stopped to focus on wider issues, none of the requirements were met.
- 6.369 Actions are identified through investigating the underlying causes of incidents and are to be documented in a report to the District Manager. The District Manager is to nominate a person, unit or committee to receive investigation reports and authorises and resources this entity to implement actions.³⁸⁴ This did not occur.

General observations with respect to application of complaints and incident management policies

- 6.370 The policy framework for managing complaints and adverse incidents in Queensland Health and the Bundaberg Hospital appears to be adequate with one exception. The requirement of the local policy in Bundaberg that a form be filled in to raise an issue is problematic. The obligation to investigate an issue should not be made dependent upon a complaint in writing. Having an adequate policy solves only part of the problem. The downfall is in the implementation. The effectiveness of the policy framework has been seriously undermined by a number of non-compliant practices that appear to have occurred frequently.

Failure to seek independent medical opinion

- 6.371 A fundamental problem with investigations into complaints about Dr Patel was that the investigation usually consisted only of reference back to Dr Patel and acceptance of his opinion or explanation. With respect to issues of clinical competence, an independent medical opinion should always be obtained.

³⁸³ Exhibit 448 para 159 Statement Keating

³⁸⁴ Exhibit 290A JGW6 Statement Wakefield: Action p11

Failure to check accuracy and corroborate statements

6.372 Another deficiency in the investigation of complaints was a failure to check the accuracy of and corroborate statements. This occurred even in circumstances where it would have been a relatively simple exercise to check facts.

Failure to undertake root cause analysis

6.373 Where patient complaints are classed as moderate and above, they should receive a comprehensive assessment or investigation. The Investigator is required to undertake an in-depth and/or root cause analysis.³⁸⁵ This did not occur at the Bundaberg Hospital because no one was trained in this process. Dr Keating gave evidence that he was not trained in root cause analysis, nor to his knowledge was any other staff member at Bundaberg Hospital.³⁸⁶

Inadequate risk rating and referral of complaints

6.374 The Queensland Health Complaints Management Policy requires that all complaints are categorised in a manner that reflects the seriousness of the complaint. This process enables complaints data to then be applied to the risk management framework³⁸⁷ and for moderate, major, extreme and unresolved complaints to be referred for a comprehensive assessment or investigation.³⁸⁸ The Bundaberg Complaints Management System³⁸⁹ does not have a requirement that complaints be risk rated.

6.375 The Bundaberg Hospital Complaints Register³⁹⁰ includes fields for both seriousness category and level of risk. A review of the Register for the period July 2002 to May 2005 reveals that, for the 675 complaints registered, 613 were not risk rated and 610 were not given a seriousness category. After January 2003, no complaints were risk rated.

6.376 Ms Raven gave evidence that she identified the level of risk of complaints for a period, purely on speculation but stopped doing this in January 2003.³⁹¹ The fact that complaints were not being risk rated means that they may not have been referred for assessment and investigation in accordance with the policy and the complaints data could not be applied to the risk management framework.

³⁸⁵ Exhibit 292: Appendix 1 Complaint Handling Model

³⁸⁶ Exhibit 448 para 154 Statement Keating

³⁸⁷ Exhibit 292: Seriousness Categories p3

³⁸⁸ Exhibit 292: Appendix 1 Complaints Handling Model p4

³⁸⁹ Exhibit 162 LTR2 Statement Raven

³⁹⁰ Exhibit 166

³⁹¹ T2282 line 53 – T2283 line 2 (Ms Raven)

Inadequate risk rating and referral of incidents

- 6.377 It is also a requirement of the Queensland Health Incident Management Policy that incidents are assessed according to the level of risk.³⁹² Incidents identified as a very high or extreme risk should be reported to the appropriate line manager and District Manager.³⁹³
- 6.378 It appears that, for a period at the Bundaberg Hospital, incidents were not being risk rated nor subsequently referred accurately. Ms Raven gave evidence that there was some discontent surrounding the practice of risk rating ever since the system was introduced. The nurse unit manager and the clinicians who were filling out incident forms felt that they should be risk rating the incident.³⁹⁴ In an email to Mr Leck dated 14 September 2004, Ms Raven wrote that she was not rating anything above medium while there was an unresolved question over whether she should be making those sorts of judgments or decisions. The effect of this was that matters were not being referred to the relevant executive officer for investigation.

Inadequate response

- 6.379 One of the reasons why staff were hesitant to raise issues and report events was the perception that nothing would be done. The perception was reinforced when there was a lack of feedback about a complaint or report. Ms Raven gave evidence that following the implementation of the Adverse Events Management Policy in February 2004, it had been the intention of the District Quality and Decision Support Unit to provide feedback to staff who were reporting adverse events. Due to resourcing issues feedback ceased.³⁹⁵ A fundamental tenet of the policy was ignored.

Inadequate Management and use of data

- 6.380 Complaints and adverse incidents data can potentially serve as a valuable tool for quality improvement and risk management. It is apparent, however, that the data that was being captured during Dr Patel's period at the Hospital was of little value in this respect. Many of the incidents that were reported were not recorded on the registers. For those that were recorded on the registers, it was in insufficient detail to highlight that there was a problem.
- 6.381 It is a requirement under both the Complaints Management Policy³⁹⁶ and the Incident Management Policy³⁹⁷ that each District maintain a comprehensive register of complaints and incident data.

³⁹² Exhibit 290A JGW6 Statement Wakefield: Classification Prioritisation p7

³⁹³ Exhibit 290A JGW6 Statement Wakefield: Reporting and Recording p8

³⁹⁴ T2279-2280 (Ms Raven)

³⁹⁵ Exhibit 162 para 25 Statement Raven

³⁹⁶ Exhibit 292: Instruction, Implementation Process, p7

- 6.382 In Bundaberg, a Complaints Register³⁹⁸ was maintained from July 2002 and an Adverse Events Register³⁹⁹ was maintained from February 2004.
- 6.383 The Commission heard evidence from Ms Raven, the Quality Coordinator, that the data on the registers is useful to identify where complaints are coming from, how complaints are received and what complaints are about.⁴⁰⁰ Trends reports were provided to the District Manager and various quality improvement teams and committees.⁴⁰¹
- 6.384 As discussed above, an initial examination of the registers revealed only three complaints and five adverse incidents with respect to Dr Patel's treatment. We now know that 22 incidents or issues were reported in one form or another about Dr Patel. Each of these incidents or complaints should have been readily identifiable from the registers.
- 6.385 One of the reasons why it was difficult to quickly identify all of the incidents involving Dr Patel is that there is no field on either the Adverse Events Register of the Complaints Register to enter the name of the clinician or staff member involved in the incident. Ms Raven's response to this was that the Hospital was trying to introduce a blame free culture.⁴⁰² The problem with this is, that where a surgeon is consistently causing bad patient outcomes, it will not necessarily be picked up through the data registers.
- 6.386 Mr Leck gave evidence that, at the time of Ms Hoffman's complaint in October 2004, there was no information that he had received from the trend information from adverse events that indicated that there was a problem. Mr Leck agreed that if there were serious problems he would expect those sources to have alerted him.⁴⁰³
- 6.387 Another shortfall of the data is that it fails to identify clinical issues in sufficient detail. If this had occurred, it is possible that a number of trends would have been identified with respect to Dr Patel. These included:
- increase in wound infections and dehiscence;
 - inadvertent nicking of organs during surgery;
 - increased complaints about failure to anaesthetise; and
 - increased readmission and corrective surgery.

Implementation of systems was hindered by lack of resources

- 6.388 For complaints handling to operate effectively, those who are responsible must be given sufficient time to devote to it. One of the problems for Bundaberg was

³⁹⁷ Exhibit 290A JGW6 Statement Wakefield: Reporting Requirements – local p9

³⁹⁸ Exhibit 166

³⁹⁹ Exhibit 167

⁴⁰⁰ T2289 line 3-12 (Ms Raven)

⁴⁰¹ T2248 20-30 (Ms Raven)

⁴⁰² T2302 line17 – T2303 line 4 (Ms Raven)

⁴⁰³ T7288 line 20-44 (Mr Leck)

that the responsibilities created in 2002 for the hypothetical Complaints Coordinator were added to an officer's other numerous responsibilities. The role of complaints management fell to the Quality Coordinator, who already had other significant duties including preparation of the ACHS accreditation and maintaining and updating Hospital policies and procedures.⁴⁰⁴

6.389 In a large district like the Bundaberg Health Service District, a Complaints Coordinator who has responsibility for resolving complaints in a thorough and timely manner, should be free from other administrative tasks. It would be consistent with the recent recommendation in the Queensland Health Systems Review, Final Report.⁴⁰⁵ Queensland Health's Initial Submission to the Commission stated that the Bundaberg Health Service District has no dedicated Complaint Coordinator. The role of the Complaints Coordinator would need to be promoted in the hospital. I have not heard sufficient evidence to recommend the number of days which the Complaint Coordinator should have to attempt to resolve the complaint locally before referring the matter to the 'one stop shop' which I recommend later in this chapter. Nor have I heard sufficient evidence to recommend the exceptional cases which ought to be referred immediately by the Complaint Coordinator to the 'one stop shop'.

Other systems to capture clinical issues

Clinical governance committees

6.390 The Bundaberg Health Service District also had a clinical governance committee structure through which clinical safety and quality issues could be addressed.⁴⁰⁶ At the risk of over-simplifying, various committees throughout the hospital had a responsibility for discussing issues concerned with patient safety, analysing them, suggesting solutions and referring them to the appropriate person or committee to take action.

6.391 A review of the clinical governance committee structure in the Bundaberg Health Service District in April 2005 revealed over twenty one committees.⁴⁰⁷ The responsibility for clinical safety and quality issues was shared by a number of committees that were to report directly to the Leadership and Management Committee. A number of sub-committees were to also play a role in considering clinical safety and quality.

6.392 During the review of clinical services in April 2005, staff reported that there were too many committees, significant overlap in functions and potential for issues to

⁴⁰⁴ Exhibit 162 para 8 Statement Raven

⁴⁰⁵ Queensland Health Systems Review, Final Report p191 (www.healthreview.com.au)

⁴⁰⁶ Exhibit 102 para 3.4.4

⁴⁰⁷ Exhibit 102, Appendix F. The committee structure has been reviewed since this time resulting in a reduction of major committees

fall through the cracks. Staff reported that, when safety and quality issues were raised, there was rarely any feedback. It was also evident, from reviewing committee minutes, that there was little evidence of any outcomes or decisions made.⁴⁰⁸

Performance management

- 6.393 There was no formal performance management process in place for medical staff at the Base.⁴⁰⁹ Accordingly, no person with the skills to assess Dr Patel was ever called upon to manage or assess him. As I have discussed earlier, the Medical Board of Queensland required an annual assessment from the Hospital, when medical practitioners were registered under the area of need process. The Medical Board of Queensland did not monitor the registrant's performance throughout the year of their registration. However, if an application was made to renew that registration, the Medical Board of Queensland would call upon the employer to certify to a number of performance criteria based upon the registrant's service during the preceding year. Dr Keating, as the Director of Medical Services at the Base, provided such certifications towards the end of Dr Patel's first and second years of service at the Base. Dr Keating did not have qualifications to equip him to assess Dr Patel's skills as a general surgeon by watching Dr Patel's performance. Dr Keating did not watch Dr Patel perform surgery. Dr Keating did not have other general surgeons on his staff or as Visiting Medical Officers during Dr Patel's employment. It meant that he could not have the benefit of the opinion of another general surgeon about Dr Patel's skills.
- 6.394 It has been remarked earlier in this report that Dr Patel was able to practise in splendid isolation. The opportunities to observe and correct his mistakes, which would have existed in a busy metropolitan hospital with numerous general surgeons, did not exist.
- 6.395 Because of this, the importance of adequately recording and investigating complaints and clinical incidents arising as a result of general surgery was all the more acute.

The Health Rights Commission

- 6.396 Aside from complaining directly within the public hospital to Queensland Health, the most popular avenue for complaints is probably to the Health Rights Commission. The Health Rights Commission which accepts complaints about health services provided anywhere within Queensland, in both the public and private health sectors receives approximately 4,500 complaints and enquiries

⁴⁰⁸ Exhibit 102 para 3.4.4

⁴⁰⁹ Exhibit 102 para 3.4.9 (a)

each year.⁴¹⁰ In 2004 the Health Rights Commission's reception received approximately 11,500 telephone enquiries⁴¹¹ although not all became formal complaints.

6.397 The Health Rights Commission is an independent statutory body established under the *Health Rights Commission Act 1991* ('*Health Rights Commission Act*'). At present it has a staff of 26 full time equivalents, and an annual budget of \$3million.

6.398 The statutory functions of the Health Rights Commission are set out in the *Health Rights Commission Act* at s10 which provides:

10 Commissioner's functions

The functions of the commissioner are:

- (a) to identify and review issues arising out of health service complaints;
- (b) to suggest ways of improving health services and of preserving and increasing health rights; and
- (c) to provide information, education and advice in relation to;
 - (i) health rights and responsibilities; and
 - (ii) procedures for resolving health service complaints; and
- (d) to receive, assess and resolve health service complaints; and
- (e) to encourage and assist users to resolve health service complaints directly with providers; and
- (f) to assist providers to develop procedures to effectively resolve health service complaints; and
- (g) to conciliate or investigate health service complaints; and
- (h) to inquire into any matter relating to health services at the Minister's request; and
- (i) to advise and report to the Minister on any matter relating to health services or the administration of this Act; and
- (j) to provide advice to the council; and
- (k) to provide information, advice and reports to registration boards; and
- (l) to perform functions and exercise powers conferred on the commissioner under any Act.

6.399 The main roles of the Health Rights Commissioner are to impartially review and resolve complaints about health services; make suggestions for improvements to health systems and practices by utilising the feedback provided through an analysis of complaints; and to work with health service providers to help them to improve their own complaints management processes. Registration bodies are also required to forward their investigation reports to the Commissioner.

⁴¹⁰ Exhibit 354 para 26

⁴¹¹ Exhibit 354 para 26

- 6.400 Pursuant to ss31 and 32 of the *Health Rights Commission Act*, the Minister may give the Commissioner a written direction to investigate a particular matter or to conduct an Inquiry. However, this Ministerial power is rarely exercised.
- 6.401 Approximately 11,000 complaints have been received by the Health Rights Commission since its inception in 1991 concerning health services in Queensland. Just over 45 % of these complaints have resulted in outcomes that the Health Rights Commissioner has described as favourable or satisfactory to the complainant. The resolutions might include an apology or acknowledgment that a health service should have been performed better; access to treatment that had been unreasonably denied; a remedial procedure; refund of fees; an *ex gratia* payment; or financial settlement of a claim for medical negligence.
- 6.402 The Health Rights Commissioner may not take action on a complaint if the patient has commenced a civil proceeding for redress for the matter of the complaint and a court has begun to hear the matter. A patient who wishes to complain the Health Rights Commissioner is not obliged to forfeit the right to commence a civil proceeding. Presumably, if a patient complains and participates in a conciliation arranged by the Health Rights Commissioner it will be a matter considered by the patient and any other party to the conciliation whether a term of a settlement agreement will be an agreement to compromise civil proceedings.
- 6.403 The Commissioner regarded it as a significant limitation on his powers that he can only respond to complaints the Commissioner actually receives. Even if the Commissioner becomes aware of apparently serious health issues by means such as media reports, the Commissioner has no power to intervene unless the Commissioner actually receives a complaint from someone involved with the particular health service – for example, a patient or a member of staff at the health service concerned. The Commissioner has no power to investigate health care issues of the Commissioner's own initiative, even though the matter may involve important issues of public interest, significant systemic issues or serious concerns about a practitioner's competence.
- 6.404 There are two further significant practical limitations on the Commissioner's powers. Though the Commissioner may have assessed the matter about which a complaint was made, though he may understand the facts thoroughly and though the parties may be before him, the Commissioner cannot adjudicate on the complaint. He cannot determine whether a complaint is unreasonable or justified. He cannot order a restriction or a condition on the right of practice of the doctor, nurse or allied health professional whose conduct led to the complaint.
- 6.405 Section 57 of the *Health Rights Commission Act* provides the types of complaints which may be made to the Commissioner. Among the various types of complaints provided for in s57 the following would allow for complaints

relating to Dr Patel's actions and the hospital's failure to take timely action.

Complaints:

- that a provider has acted unreasonably in the way of providing a health service for a user;
- that a provider has acted unreasonably in providing a health service for a user;
- that a registered provider acted in a way that would provide a ground for disciplinary action against the provider under the Health Practitioners (Professional Standards) Act 1999;⁴¹²
- that a public body that provides a health service has acted unreasonably by:-
 - not properly investigating; or
 - not taking proper action in relation to:

a complaint made to the body by a user about a provider's action of a kind mentioned above.

6.406 It follows that a complaint about Dr Patel's decision to perform complex surgery or his manner of performing surgery would each be appropriate for referral to the Health Rights Commission. A complaint that he was unfit for registration would not.

6.407 The Health Rights Commission is not responsible for matters relating to the registration of individual health providers. Decisions as to whether a medical practitioner is entitled to be or to remain registered in Queensland are for the Medical Board of Queensland. The *Health Rights Commission Act* recognises this fact by requiring the Commissioner, in specified circumstances, to refer certain health services complaints to the appropriate registered provider's registration board.⁴¹³ In relation to the issue of registration and monitoring of overseas trained medical practitioners, the Health Rights Commission has no role, nor any powers, and absent a complaint, no responsibility in respect of their ongoing assessment and monitoring.

6.408 Section 71 of the *Health Rights Commission Act* provides that, before accepting a health service complaint for action, the Commissioner must first be satisfied that the complainant has made a reasonable attempt to resolve the matter with the health service provider⁴¹⁴, unless it is clearly impracticable to do so.⁴¹⁵ Three telephone enquiries were received by the Health Rights Commission from patients of Dr Patel. In each case the patients were referred to the Bundaberg

⁴¹² The Commission's interaction with registration boards is discussed in more detail below. While there are some synergies between the respective bodies, there are also areas where the statutory responsibilities of the Health Rights Commission and registration boards are quite distinct.

⁴¹³ See s68 of the *Health Rights Commission Act 1991*

⁴¹⁴ This is discussed in s71(2)(a) of the *Health Rights Commission Act 1991*

⁴¹⁵ Instances where the Commissioner would generally regard it as impracticable include where allegations are made of serious breaches of professional conduct (such as sexual misconduct), or where there is a clear evidence of a threat to public safety. The Commission's policy is also to accept complaints in the first instance where the complainant may, for language or cultural reasons, find it difficult to take up their concerns with the provider on their own behalf.

Base Hospital and advised of their right to come back to the Health Rights Commission if they wanted to take the matter further. Presumably these three referrals were to satisfy s71(1)(a) of the *Health Rights Commission Act*.

- 6.409 Before accepting a complaint for statutory action, the Commissioner is required to consult the provider's registration board about the complaint.⁴¹⁶ The Health Rights Commission must not take any action with respect to the complaint until the relevant registration board provides comments, advises that it does not intend to comment, or a specified period of time has passed.⁴¹⁷
- 6.410 Section 77 of the *Health Rights Commission Act* provides that if the Commissioner receives a health service complaint about a registered provider, believes that the provider poses an imminent threat to public safety and therefore, considers that immediate suspension of the provider's registration may be necessary, the Commissioner must then immediately refer the complaint to the provider's registration board.
- 6.411 Some clinical staff at Bundaberg Base Hospital had become concerned about Dr Patel well before issues relating to his competence became public. No complaints were received by the Health Rights Commission directly from clinical staff. It would have been open to the Health Rights Commissioner to accept such complaints had they been made. Section 59 of the *Health Rights Commission Act* provides that a 'health service complaint' may be made to the 'Commissioner' by a person other than the *user* of the health service or the user's representative, if it is considered by the Commissioner to be in the public interest to do so. The effect of s59(1)(d) is that a staff member of a public hospital wishing to make a complaint to the Health Rights Commissioner has no right to do so. However, if the Commissioner considers that the public interest requires that the staff member make the complaint then the Commissioner will accept it. Accordingly, if Ms Hoffman in her capacity as a Nurse Unit Manager had chosen in October 2004 to report her concerns to the Health Rights Commission she would have had no certainty that the Health Rights Commission would have acted on the complaint. The first hurdle for her would have been to persuade the Commissioner that the public interest required that she be permitted to make her complaint. If Ms Hoffman had tried to do so, it is reasonable to conclude that her complaint would have been rejected and that she would have been referred to the Medical Board of Queensland as this is in effect what happened to Mr Messenger MP.
- 6.412 When Mr Messenger MP contacted the Health Rights Commission on 23 March 2004 raising Ms Hoffman's concerns about Dr Patel, the Health Rights

⁴¹⁶ s71(3) *Health Rights Commission Act 1991*

⁴¹⁷ s71(6) *Health Rights Commission Act 1991*

Commissioner's recommendation to Mr Messenger was that the Medical Board was the most appropriate body to investigate the concerns.⁴¹⁸

- 6.413 If a staff member of the Bundaberg Base Hospital had persuaded the Commissioner that there was a public interest requirement that the complaint be accepted, the end result may well have been a time consuming assessment process and conciliation with little or no benefit for the staff member or the public.
- 6.414 The *Health Rights Commission Act* essentially follows the so-called conciliation approach to complaints resolution that has been adopted by all States and Territories other than in New South Wales. The Health Rights Commission strives to work cooperatively with all parties to a complaint and wherever possible to help preserve the relationship between them. This contrasts with the more prosecutorial approach to complaints resolution that is reflected in the NSW complaints system, whereby the Health Care Complaints Commission, in addition to its other functions, retains a prosecutorial role.
- 6.415 It should be noted that the Commissioner has no power to compel parties to respond to a complaint or to provide information during assessment. The Commissioner may invite a response or may request information from the provider against whom the complaint was made, or request advice from a practitioner who subsequently treated (or provided a second opinion to) the complainant.⁴¹⁹
- 6.416 Where the information obtained in assessment supports a claim for compensation or some other significant remedy, the matter would quite likely be moved into conciliation, enabling the complaint to be explored further in a privileged and confidential setting. Under the *Health Rights Commission Act*, the parties can reach a legally binding settlement. Of the complaints conciliated, 21 per cent resulted in an agreement that compensation be paid to the complainant.
- 6.417 For a complaint against a registered provider such as Dr Patel, the only further action that is open to the Commissioner following assessment is to try to resolve the complaint by conciliation, if the Commissioner considers that it can be resolved in that way,⁴²⁰ or to refer the matter to the provider's registration board. The Commissioner's power to conduct investigations of individual registrants, was removed by the *Health Practitioners (Professional Standards) Act 1999*.

⁴¹⁸ Exhibit 354 para 48, Statement Kerslake

⁴¹⁹ A 'third party'

⁴²⁰ *Health Rights Commission Act 1991* s71(4)

Only a registration board has the power to formally investigate issues relating to a registered provider.⁴²¹

- 6.418 For a complaint against an individual such as Dr Patel, the actions available to the Commissioner are limited to assessing the complaint, conciliating it or referring it to the provider's registration board.⁴²² The Health Rights Commissioner, Mr Kerslake, explained that, as Commissioner he had no power to punish or sanction.⁴²³ While the Commissioner had power to assess all complaints, he did not have power to investigate a complaint about Dr Patel but did have power to investigate a complaint about Bundaberg Base Hospital.⁴²⁴
- 6.419 Where the Commissioner and a registration board agree that a matter should be referred to the registration board, the Commissioner must generally defer conciliating the complaint until the registration board completes its own investigation.⁴²⁵
- 6.420 The Health Rights Commissioner may not take action on a health service complaint if the matter of complaint arose more than a year before the complaint was made to the Commissioner.⁴²⁶ Such a limitation could affect the treatment by the Health Rights Commissioner of a complaint by a concerned person such as Ms Hoffman if the complaint were based upon a series of clinical misadventures which commenced more than a year before the complaint was made. This is noteworthy because it is similar to the situation which arose in respect of Dr Patel. Ms Hoffman wrote to the District Manager on 22 October 2004⁴²⁷ listing a number of matters of concern to her extending back as far as June 2003.
- 6.421 In summary, while the Health Rights Commissioner performs many useful functions, he was not empowered to provide a practical solution in a case like Patel's where a member of hospital staff held the opinion that several patients had been harmed by a medical practitioner who was likely to harm further patients. No single patient was likely to be aware of the numerous complaints relating to Dr Patel. No patient was likely to complain to the Commissioner of more than an isolated event. A patient's complaint may have led to a conciliation about the patient's individual concern. A member of staff was in a better position to perceive that Dr Patel had harmed several patients and was likely to continue to do so. But a member of staff had no right to force the

⁴²¹ The Commissioner's sole power to require the provision of information falls within the category of 'non-registered' providers (such as a hospital), when undertaking a formal investigation under Part 7 of the Act

⁴²² This can result in quite convoluted with overlapping processes and enquiries in certain circumstances, such as where a complaint is made about a health service performed by an individual doctor in a hospital setting

⁴²³ T5633 line 15 (Kerslake)

⁴²⁴ T5634 line 13 (Kerslake)

⁴²⁵ *Health Rights Commission Act 1991* s75

⁴²⁶ *Health Rights Commission Act 1991* s79(5)

⁴²⁷ Exhibit 4 TH37

Health Rights Commissioner to accept the complaint unless the Commissioner could be persuaded that it was in the public interest. If the Commissioner accepted the complaint, the Commissioner had no power to investigate Dr Patel, no power to sanction Dr Patel and no power to terminate his registration. The Commissioner's power was to conciliate. The most practical thing the Health Rights Commissioner could do if a staff member raised allegations that a medical practitioner had caused harm to numerous patients was to refer the matter to the Medical Board of Queensland. If the Health Rights Commissioner heard of the issue in the media or from a person who was not making a complaint, the Commissioner had no power to act.

Health Rights Commission's response to Bundaberg complaints

- 6.422 As at March 2005 the name of Dr Patel had attracted no significance, nor any level of recognition within Health Rights Commission. A review of the Health Rights Commission's complaints and enquiries database indicated to the Health Rights Commissioner that during the two year period from 1 April 2003 to 31 March 2005, the Health Rights Commission had received six written complaints concerning the provision of health services at Bundaberg Base Hospital. This was not a high level of complaints for that period of time from a provider of the size of Bundaberg Base Hospital. None of these complaints concerned services provided by Dr Patel. There were three telephone enquiries about Bundaberg Base Hospital received over the same period where Dr Patel was named as the treating doctor. In each instance the callers were happy to take their concerns up directly with Bundaberg Base Hospital. The Health Rights Commission advised them of their right to come back to the Health Rights Commission if they wished to take the matter further but none did so prior to April 2005.
- 6.423 On 23 March 2005 the Health Rights Commission received a copy of Mr Rob Messenger MP's letter to the Minister for Health dated 22 March 2005 raising concerns about Dr Patel. Following receipt of this letter the Commissioner spoke with Mr Messenger's office to advise that as the letter primarily raised competency issues concerning a registrant, the Medical Board was the most appropriate body to investigate the concerns, and the Commissioner would confirm with the Medical Board that it would be addressing the matter.
- 6.424 On 8 April 2005 *The Courier-Mail* newspaper reported that the Chief Health Officer of Queensland Health had carried out an investigation into the competency of a surgeon at the Bundaberg Base Hospital who had been linked to the death of at least 14 patients and that the surgeon in question had since 'fled the country'. Upon it becoming apparent that there would be a larger number of complaints and a broader range of issues to be addressed, the Commissioner contacted Mr Messenger and advised that the Health Rights Commission would clearly need to be involved in the assessment and investigation of the complaints, and asked that he refer any additional matters of

which he became aware to the Health Rights Commission. Mr Messenger continued to do this.

- 6.425 The Health Rights Commission sent a senior officer to Bundaberg to liaise with potential complainants and the Health Rights Commission Complaints Manager attended Bundaberg for this purpose for the week of 18 April - 22 April 2005. Over 70 formal complaints or enquiries were received in the course of that week. A priority in this initial period was to ensure that patients in need of medical treatment could receive it. The Commissioner engaged in liaison with Queensland Health. The Health Rights Commission agreed a protocol with Queensland Health that it would advise patients seen by its liaison officers in Bundaberg of their right to complain to the Health Rights Commission, and that the Health Rights Commission would inform complainants who were potentially in need of treatment of the opportunity to make contact with a Queensland Health liaison officer. While in Bundaberg the Health Rights Commission's Complaints Manager arranged for the urgent review of some complainants' immediate health needs. The Health Rights Commission did not initially refer its complaints about Dr Patel to the Medical Board as the Medical Board advised that Dr Patel's registration had expired and they had declined to renew his registration.
- 6.426 As at 5 August 2005, the number of formal complaints received by Health Rights Commission concerning health services provided by Bundaberg Base Hospital had grown to 97 and the Health Rights Commission had notified the Medical Board of Queensland of these complaints and was keeping the Medical Board informed of developments.
- 6.427 Although no formal findings had been reached by the time the Commissioner gave evidence, assessment of these complaints by the Health Rights Commission was well advanced. The Commissioner advised in oral evidence on 20 September 2005 that he had appointed an independent expert to assist with this process being a surgeon from Melbourne, Dr Allsop. A considerable number of cases had already been reviewed, which reviews had identified a range of significant inadequacies in the standard of care provided to patients of Dr Patel. It was then impractical to call Dr Allsop. The results of the reviews were to be made available to the Medical Board of Queensland to assist in its deliberations. The Health Rights Commission had put in place arrangements with Queensland Health to facilitate the prompt assessment, and where appropriate, resolution of these complaints, including the payment of compensation.

6.428 The Health Rights Commission also has an investigative function,⁴²⁸ although that function is limited.⁴²⁹ Mr Kerslake described the Health Rights Commission's investigative functions as invoked:

where a complaint raises serious systemic issues that might warrant detailed examination or result in formal recommendations for change.⁴³⁰

In this ability to investigate systemic issues the Health Rights Commission has the advantage over the Medical Board which has no equivalent investigative power. Yet, if there emerged an obvious need to investigate a doctor, the Health Rights Commissioner would be unable to investigate but the Medical Board could. The Health Rights Commission may use its powers to investigate only:

- A complaint about a health service provider such as a hospital or nursing home;
- An unsuccessful conciliation; or
- A complaint where the Commissioner has elected to end a conciliation.⁴³¹

It could not investigate an individual practitioner such as Dr Patel.

6.429 Through the Australian Health Care Agreements ('the Agreements') the provision of health funding by the Commonwealth is conditional in part on all States and Territories maintaining independent health complaints commissions. Under the Agreements, each of these bodies must:

- be independent of the State's Hospitals and the State's Department of Health;
- be given powers that would enable it to investigate, conciliate and/or adjudicate upon complaints received by it; and
- be given the power to recommend improvements in the delivery of public hospital services.

In the agreements between the Commonwealth and Queensland and the Commonwealth and New South Wales, it is agreed that the:

Powers of the complaints body will not interfere with or override the operation of registration boards or disciplinary boards...and that the exercise of powers by the complaints body will not affect the rights that a person may have under common law or statute law.⁴³²

6.430 The Health Rights Commissioner, Mr Kerslake perceived benefits in keeping the conciliation function of the Health Rights Commission separate from the professional standards and disciplinary function of the Medical Board of Queensland. Mr Kerslake's opinion was that the disciplinary function of the

⁴²⁸ *Health Rights Commission Act 1991 Part 7*

⁴²⁹ *Health Rights Commission Act 1991 s95*

⁴³⁰ Exhibit 354 para 21

⁴³¹ *Health Rights Commission Act 1991 s95*

⁴³² See schedule D clause 6 of the Australian Health Care Agreement between the Commonwealth of Australia and the State of Queensland 2003-2008 and of the Australian Health Care Agreement between the Commonwealth of Australia and New South Wales 2003-2008

Medical Board did not 'fit readily together' with the Health Rights Commissions functions of resolution of complaints and recommending systemic improvement of the health sector.⁴³³ Mr Kerlake considered that the New South Wales Health Care Complaints Commission, which performs all three functions, receives significantly less cooperation from the health service providers than is received by the Queensland Health Rights Commission.

The Medical Board of Queensland

6.431 The Medical Board of Queensland is established by the *Medical Practitioners Registration Act 2001*. The objects of that Act are:

- To protect the public by ensuring health care is delivered by registrants in a professional, safe and competent way; and
- To uphold the standards of practice in the profession; and
- To maintain public confidence in the profession.⁴³⁴

6.432 In the year 2003/2004 the Medical Board received 232 complaints,⁴³⁵ including 128 complaints from patients or persons acting on behalf of patients. In that year the Health Rights Commission referred 21 complaints to the Medical Board.⁴³⁶ Of those 232 complaints the Medical Board referred 74 complaints to the Health Rights Commission.⁴³⁷ A further 34 complaints were investigated by the Medical Board, some of which resulted in disciplinary action.⁴³⁸

6.433 The Medical Board may investigate complaints it receives,⁴³⁹ or a complaint referred to it by the Minister⁴⁴⁰ or the Health Rights Commission.⁴⁴¹ The Medical Board may also conduct an investigation on its own motion.⁴⁴² This is an advantage that the Health Rights Commission does not have for it must wait to receive a complaint and then its power is generally limited to assessment but not investigation.

6.434 When the Medical Board of Queensland determines to investigate a complaint it appoints an investigator from the Office of the Health Practitioner Registration Boards to carry out the investigation. On occasion the Medical Board uses a panel of external investigators to conduct investigations.⁴⁴³

⁴³³ T5645 line 4- line 45 (Dr Kerlake)

⁴³⁴ *Medical Practitioners Registration Act 2001* s7

⁴³⁵ See Medical Board Annual Report available at:

<http://www.medicalboard.qld.gov.au/Publications/Publications.htm>

⁴³⁶ Medical Board Annual Report 2003/04 p11

⁴³⁷ Medical Board Annual Report 2003/04 p12

⁴³⁸ Medical Board Annual Report 2003/04 p12

⁴³⁹ *Health Practitioners (Professional Standards) Act 1999* s62(d)

⁴⁴⁰ *Health Practitioners (Professional Standards) Act 1999* s62(a) & (b)

⁴⁴¹ *Health Practitioners (Professional Standards) Act 1999* s62(c)

⁴⁴² *Health Practitioners (Professional Standards) Act 1999* s62(f)

⁴⁴³ Medical Board Annual Report 2003/04 p12

6.435 The Medical Board has broad powers when conducting its investigation into a doctor including:

- the power to require a person to provide information, attend before the investigator and answer questions, and to produce documents;⁴⁴⁴
- the power to enter and search premises and seize evidence;⁴⁴⁵
- the power to require a medical practitioner to attend a health assessment.⁴⁴⁶

6.436 If the investigation is related to a complaint, then during the investigation the Medical Board must also keep the Health Rights Commission informed about the progress of that investigation.⁴⁴⁷ It must also send a copy of its report to the Health Rights Commission.⁴⁴⁸ The Health Rights Commission may, within 14 days or such further times as may be agreed by the Medical Board, comment on the report.⁴⁴⁹

6.437 The *Health Practitioners (Professional Standards) Act 1999* sets out the functions of various boards established under Health Practitioners Registration Acts. It applies to the Medical Board of Queensland. The *Health Practitioners (Professional Standards) Act 1999* provides at Section 11:

11 Boards' functions under this Act

A board's functions under this Act are the following:

- (a) to receive complaints about its registrants and, if appropriate, refer the complaints to the commissioner;
- (b) to consult and cooperate with the commissioner in investigating and disciplining its registrants and in relation to complaints about impaired registrants;
- (c) to immediately suspend, or impose conditions on, the registration of its registrants if the registrants pose an imminent threat to the wellbeing of vulnerable persons;
- (d) to conduct investigations, whether because of complaints or on its own initiative, about the conduct and practice of its registrants;
- (e) to deal with disciplinary matters relating to its registrants that can be satisfactorily addressed through advising, cautioning and reprimanding;
- (f) to bring disciplinary proceedings relating to its registrants before panels or the tribunal;
- (g) to implement orders of panels or the tribunal relating to the board's registrants;
- (h) to establish health assessment committees to assess the health of registrants who may be impaired and make decisions about impaired registrants;

⁴⁴⁴ *Health Practitioners (Professional Standards) Act 1999* s78

⁴⁴⁵ *Health Practitioners (Professional Standards) Act 1999* Pt 5 div 5 subdiv 2,3 & 4

⁴⁴⁶ *Health Practitioners (Professional Standards) Act 1999* div 5 subdiv 7

⁴⁴⁷ *Health Practitioners (Professional Standards) Act 1999* s116(2)

⁴⁴⁸ *Health Practitioners (Professional Standards) Act 1999* s116(3) & (4)

⁴⁴⁹ *Health Practitioners (Professional Standards) Act 1999* s116(5)

- (i) to monitor its registrants' compliance with conditions imposed or other disciplinary action taken, or undertakings entered into, under this Act;
- (j) to cancel or suspend, or impose conditions on, its registrants' registration as a result of action taken under a foreign law;
- (k) to consult and cooperate with other boards, foreign regulatory authorities and other relevant entities about the investigation and disciplining of its registrants and the management of its registrants who are impaired;
- (l) to exercise other functions given to the board under this Act.

6.438 The *Health Practitioners (Professional Standards) Act 1999* establishes the Health Practitioners Tribunal.⁴⁵⁰ That tribunal may hear disciplinary matters relating to medical practitioners and other health service providers.⁴⁵¹

6.439 Complaints to the Medical Board must be in writing,⁴⁵² and may be made by a patient, an entity acting on behalf of a patient, another registrant, which includes registered medical practitioners, nurses and allied health workers, the Director-General of Queensland Health, the Minister for Health, or a foreign regulatory authority.⁴⁵³

6.440 The way the Medical Board may deal with a complaint about a doctor depends on the person who makes the complaint. Complaints by and on behalf of a patient are dealt with differently from complaints from any other entity. If a doctor or nurse complains to the Medical Board of Queensland about a registered doctor and the complainant is not representing a patient then the Medical Board would deal with the complaint under the protocol in Section 53 of the *Health Practitioners (Professional Standards) Act 1999*. It provides so far as is relevant:

53 Action by board on receipt of complaint made or referred by another entity, or complaint commissioner not authorised to receive

(1) This section applies if:

- (a) a registrant's board receives a complaint about the registrant from an entity, other than a user of a service provided by the registrant or an entity acting on behalf of the user; or
- (b) a complaint about a registrant is referred to the registrant's board by the commissioner under the *Health Rights Commission Act 1991*; or
- (c) a registrant's board receives a complaint about the registrant and
 - (i) the complaint is about a matter that happened before 1 July 1991; and
 - (ii) the complainant was aware of the matter before 1 July 1991.⁴⁵⁴

⁴⁵⁰ *Health Practitioners (Professional Standards) Act 1999* Pt2 div4

⁴⁵¹ *Health Practitioners (Professional Standards) Act 1999* s30

⁴⁵² *Health Practitioners (Professional Standards) Act 1999* s49

⁴⁵³ *Health Practitioners (Professional Standards) Act 1999* s47

⁴⁵⁴ See the *Health Rights Commission Act 1991*, s149

- (2) After considering the complaint, the board must decide to do 1 of the following:
- (a) under the immediate suspension part, to suspend, or impose conditions on, the registrant's registration;
 - (b) investigate the complaint under the investigation part;
 - (c) start disciplinary proceedings under the disciplinary proceedings part;
 - (d) deal with it under the impairment part; 14 See the *Health Rights Commission Act 1991*, section 149 (Transitional for *Health Rights Commission Act 1991* (Act No. 88 of 1991)).
 - (e) deal with the complaint under the inspection part or the health practitioner registration Act under which the board is established and, if appropriate, start proceedings to prosecute the registrant under this Act or the health practitioner registration Act;
 - (f) refer the complaint to another entity that has the function or power under an Act of the State, the Commonwealth or another State to deal with the matter;
 - (g) reject the complaint under section 54.

6.441 But if instead, a complaint is from or on behalf of a patient about a medical practitioner, the Medical Board is obliged to refer that complaint to the Health Rights Commission⁴⁵⁵ unless, certain conditions exist. They are set out in sub-section 51(2) of the *Health Practitioners (Professional Standards) Act 1999*. This is seen from sub section 51(1) and (2):

51 Action by board on receipt of complaint

(1) This section applies if a registrant's board receives a complaint about the registrant from a user of a service provided by the registrant or an entity acting on behalf of the user.

(2) The board must refer it to the commissioner unless:

- (a) following consultation between the board and the commissioner, the board and the commissioner agree it is in the public interest for the board to do 1 of the following:
 - (i). *keep the complaint for investigation under the investigation part;*
 - (ii). *keep the complaint and start disciplinary proceedings under the disciplinary proceedings part;*
 - (iii). *keep the complaint and deal with it under the impairment part;*
 - (iv). *keep the complaint and deal with it under the inspection part or the health practitioner registration Act under which the board is established and, if appropriate, start proceedings to prosecute the registrant under this Act or the health practitioner registration Act;*
 - (v). *refer the complaint to another entity that has the function or power under an Act of the State, the Commonwealth or another State to deal with the matter; or*
- (b) the board keeps the complaint under a standing arrangement entered into between the board and the commissioner and deals with it in a way mentioned in paragraph (a); or
- (c) the board, under the immediate suspension part, suspends, or imposes conditions on, the registrant's registration; or

⁴⁵⁵ *Health Practitioners (Professional Standards) Act 1999* s51(2)

- (d) the complaint is about a matter that happened before 1 July 1991 and the complainant was aware of the matter before 1 July 1991.⁴⁵⁶

6.442 Once the Medical Board has referred a complaint to the Health Rights Commission, then the Medical Board may take no further action with respect to the complaint, unless the Health Rights Commission chooses to refer it back to the Medical Board.⁴⁵⁷

6.443 Unlike the Health Rights Commission, the Medical Board also has the power to immediately suspend a registrant, or to impose conditions on the doctor's registration.⁴⁵⁸ This power is given to the Medical Board to effectively respond to threats posed by medical practitioners to the well being of vulnerable persons. In theory, the Medical Board was empowered in October 2004 to receive Ms Hoffman's complaints about Dr Patel and to take action if Ms Hoffman had chosen to complain to the Medical Board.

6.444 If Ms Hoffman had complained about Dr Patel and had done so on her own behalf and not on behalf of a patient, the Medical Board would have had power to suspend Dr Patel immediately or to impose conditions on his registration. But before doing so the Medical Board would have been obliged to form a reasonable belief about two matters. These appear in s59 of the *Health Practitioners (Professional Standards) Act 1999* which provides, so far as is relevant:

59 Immediate suspension or imposition of conditions on registration

- (1) This section applies if a registrant's board reasonably believes at any time, whether on the basis of a complaint or otherwise, that—
 - (a) the registrant poses an imminent threat to the wellbeing of vulnerable persons; and
 - (b) immediate action to suspend, or impose conditions on, the registrant's registration is necessary to protect the vulnerable persons.
- (2) The board may decide to suspend, or impose conditions on, the registrant's registration.
- (3) However, in making its decision under subsection (2), the board must take the action the board considers is the least onerous necessary to protect the vulnerable persons.

6.445 Where a nurse or a doctor complains to the Medical Board of Queensland about a doctor in a way that suggests that patients may be in danger, the Medical Board is faced with two practical choices. Suspend immediately⁴⁵⁹ and then

⁴⁵⁶ The *Health Rights Commission Act 1991*, section 149, provides that the Act does not authorise a complaint to be made to the commissioner about a health service provided before the commencement of the section, if the complaint relates to a matter arising more than 1 year before the commencement and the complainant was aware of the matter of the complaint more than 1 year before the commencement. Section 149 commenced on 1 July 1992.

⁴⁵⁷ *Health Practitioners (Professional Standards) Act 1999* s52

⁴⁵⁸ *Health Practitioners (Professional Standards) Act 1999* Pt 4

⁴⁵⁹ *Health Practitioners (Professional Standards) Act 1999* s53(2)(a)

investigate the doctor⁴⁶⁰ or postpone the decision about suspension and investigate first.⁴⁶¹

- 6.446 The Medical Board can make the choice to immediately suspend a doctor on condition that it has first reasonably formed the belief that the doctor poses an imminent threat to the well being of patients and secondly that immediate action to suspend is necessary to protect them. Dr FitzGerald was a member of the Medical Board at the time he investigated, for Queensland Health, the complaints relating to Dr Patel. Dr FitzGerald did not choose to recommend to Queensland Health either suspension or the imposition of conditions upon Dr Patel's employment. Dr FitzGerald did write to the Medical Board.⁴⁶²

I wish to formally bring to your attention and seek assessment of the performance of Dr Jayant Patel...My investigations to date have not been able to determine if Dr Patel's surgical expertise is deficient, however, I am concerned that the judgment exercised by Dr Patel may have fallen significantly below the standard expected...I would be grateful for the Board's consideration in this matter.

This was not a recommendation from Dr FitzGerald to suspend Dr Patel. It is probable the Medical Board would not have formed the beliefs necessary to suspend Dr Patel if its members had acted on the basis of that letter to the Medical Board 24 March 2005. If Ms Hoffman had made her complaints to the Medical Board by providing it with a copy of her letter to Mr Leck of 22 October 2004⁴⁶³ would the material in it have permitted the Medical Board to reasonably believe that Dr Patel posed an imminent threat to patients? Possibly, at the very least, the letter would have justified the Medical Board in arranging an urgent and prompt investigation to determine the imminence and extent of any threat to patients and whether suspension of Dr Patel or a less onerous⁴⁶⁴ condition was required to protect patients.

- 6.447 Would a complaint to the Medical Board in October 2004 have led to any practical result? In practice it would have been dependent upon the Medical Board's investigators' case backlog and priorities as to whether the Medical Board would have taken any practical action in a timely way. Mr O'Dempsey on behalf of the Medical Board referred to Section 59 of the *Health Practitioners (Professional Standards) Act 1999* and the way it has been interpreted⁴⁶⁵ writing that:⁴⁶⁶

The threshold was a high one for applying section 59 *Health Practitioners (Professional Standards) Act* for a suspension in terms of evidence of 'immediacy of the threat' ... I believe this provision in its current form is inconsistent with one of the

⁴⁶⁰ *Health Practitioners (Professional Standards) Act 1999* s59(4)(a)

⁴⁶¹ *Health Practitioners (Professional Standards) Act 1999* s53(2)(b)

⁴⁶² Exhibit 225 GF13 Letter Dr FitzGerald to Mr Jim O'Dempsey of 24 March 2005

⁴⁶³ Exhibit 4 TH37

⁴⁶⁴ The Health Practitioners Tribunal in *Thurling v the Medical Board of Queensland* [2002] QHPT 004 held that the Medical Board when applying its power under section 59 of the *Health Practitioners (Professional Standards) Act 1999* should determine the least onerous action necessary to protect vulnerable persons from the imminent threat.

⁴⁶⁵ *Thurling OP.CIT.*

⁴⁶⁶ Exhibit 28 para 41

overall objects of the legislation which is the protection of the public by ensuring health care is delivered by registrants in a professional, safe and competent way...

It seems clear from that evidence that the approach from the Medical Board, since the Health Practitioners Tribunal's decision of 2002, has been to require more evidence of danger to the patients before acting to suspend than Mr O'Dempsey regards as appropriate for protection of the public.

- 6.448 It is appropriate that there should be concern for the rights of a doctor or an allied health professional who is accused of endangering patients. This is especially so if the accusation cannot be tested until there has been a thorough investigation of the facts. However, it is undesirable if the concern for the doctor or allied health professional causes the relevant authority to allow a real risk to patients to continue until a thorough investigation has taken place, or worse, until the evidence is tested in a contested hearing. Under the *Nursing Act 1992* there is a provision to allow for the immediate suspension of a nurse's registration or enrolment prior to an investigation. It creates a lower threshold for suspension than the one which appears in Section 59 of the *Health Practitioners (Professional Standards) Act 1999*. The *Nursing Act* relevantly provides:

67 Immediate suspension of registration or enrolment by council

(1) If the council is satisfied that the ability of a nurse to continue to practise nursing is seriously impaired to such an extent that a patient's health or safety could be at risk, whether because of the state of the nurse's condition or the nurse's conduct or practice, the council may by written notice given to the nurse suspend the nurse's registration or enrolment.

- 6.449 The Medical Board of Queensland had determined to investigate the complaint in the Ombudsman's case study on the 27 August 2002. At that time the Medical Board had a backlog of 295 investigations being about 50 for each of its 6 investigators. Eventually, the Medical Board referred the investigation to an external investigator 10 months after the Medical Board first determined to appoint an investigator. The investigation then took 6 months. The Medical Board found evidence to conclude that the doctors' management constituted unsatisfactory professional conduct. The Medical Board then referred the matter to the Health Practitioners Tribunal. Ten months later the Tribunal accepted a guilty plea from the doctor concerned and imposed sanctions upon his registration. So much emerges from the Ombudsman's case study. It reveals also that the period between complaint to the Medical Board and discipline of the doctor by the Tribunal was two years and seven months. It seems unlikely that a complaint made to the Medical Board in October 2004 would have led to limitations being placed upon Dr Patel's clinical practice before his departure in April 2005. Indeed, the facts of the Ombudsman's case study tend to suggest it is reasonable to expect to wait six months for investigation and a further ten

months for a Tribunal hearing. If the case study can be relied upon as a rough guide, even acting upon the assumption that the investigation would be complete in six months after the complaint⁴⁶⁷ and assuming that it then takes a further ten months for a tribunal hearing as it did in the case study, Dr Patel may well have been practising until April 2005 before the investigation was complete and the investigator informed the Medical Board. If the Medical Board failed to suspend Dr Patel until the evidence was tested in the Tribunal then Dr Patel may have practised until February 2006 before the Tribunal made a finding and determination as to whether conditions should have been imposed upon his registration.

Disciplinary action by the Medical Board

6.450 The Medical Board may start disciplinary action against a medical practitioner in four ways. It may take disciplinary proceedings itself⁴⁶⁸ or establish a disciplinary committee to conduct the proceeding.⁴⁶⁹ It may refer the matter for hearing by a professional conduct review panel.⁴⁷⁰ The role of professional conduct review panels is to conduct hearings of routine disciplinary matters in an informal and collaborative manner.⁴⁷¹ Under Part 6, division 5 of the *Health Practitioners (Professional Standards) Act 1999*, a professional conduct review panel has substantial powers and may refer appropriate matters to the Health Practitioners Tribunal if the matter may provide ground for suspending or cancelling a doctor's registration. Fourthly it may refer the matter for hearing before the Health Practitioners Tribunal.⁴⁷²

6.451 There are a number of grounds for disciplinary action against a medical practitioner including:

- Unsatisfactory professional conduct;⁴⁷³
- Failure to comply with a condition of registration.⁴⁷⁴

6.452 Once proceedings have commenced the Medical Board has extensive powers including the power to:

- Conduct hearings;⁴⁷⁵
- Summon witnesses to provide evidence or produce documents;⁴⁷⁶
- Inspect documents or other things;⁴⁷⁷
- Hold persons in contempt of the Medical Board.⁴⁷⁸

⁴⁶⁷ Instead of the 21 months in the Ombudsman's case study

⁴⁶⁸ *Health Practitioners (Professional Standards) Act 1999* s126(1)(a)

⁴⁶⁹ *Health Practitioners (Professional Standards) Act 1999* s126(1)(a)

⁴⁷⁰ *Health Practitioners (Professional Standards) Act 1999* s126(1)(b)

⁴⁷¹ See the Explanatory Notes, *Health Practitioners (Professional Standards) Bill 1999*

⁴⁷² *Health Practitioners (Professional Standards) Act 1999* s126(1)(b)

⁴⁷³ *Health Practitioners (Professional Standards) Act 1999* s124(1)(a)

⁴⁷⁴ *Health Practitioner (Professional Standards) Act 1999* s124(1)(b)

⁴⁷⁵ *Health Practitioners (Professional Standards) Act 1999* s137

⁴⁷⁶ *Health Practitioners (Professional Standards) Act 1999* s143

⁴⁷⁷ *Health Practitioners (Professional Standards) Act 1999* s148

- 6.453 The Health Rights Commission may intervene in proceedings before the Medical Board if it so chooses.⁴⁷⁹
- 6.454 The Health Practitioners Tribunal, established by s.26 of the *Health Practitioners (Professional Standards) Act* 1999, is comprised of the judges of the District Court. The Tribunal's functions include:
- The hearing of disciplinary matters referred to it by health practitioner boards;⁴⁸⁰
 - The hearing of appeals from decisions of health practitioner boards.⁴⁸¹
- 6.455 The Health Rights Commission may choose to intervene in any disciplinary proceedings before the Tribunal.⁴⁸²
- 6.456 The tribunal has broad powers to hear disciplinary matters including power to:
- Conduct public hearings;⁴⁸³
 - Suppress the name of the registrant to whom the disciplinary proceeding relates;⁴⁸⁴
 - Summon witnesses to give evidence or produce documents;⁴⁸⁵
 - Punish for contempt of the tribunal.⁴⁸⁶
- 6.457 The Tribunal has broad powers if it decides to discipline. They vary from a caution to imposing conditions upon registration to cancelling registration and declaring that the doctor must never be registered by the Medical Board of Queensland.⁴⁸⁷
- 6.458 The Medical Board first learned of concerns relating to the clinical practice of Dr Patel at the Bundaberg Base Hospital on 15 February 2005. Mr O'Dempsey met with two representatives of the Queensland Nurses' Union who indicated that their members were concerned about Dr Patel and had been interviewed by Dr FitzGerald. The Medical Board of Queensland did not receive a formal complaint about Dr Patel. Mr O'Dempsey spoke with Dr FitzGerald, ascertained that Dr FitzGerald was finalising a report and that there may have been recommendations or information about Dr Patel to be included in that report and asked Dr FitzGerald to inform the Medical Board's Registration Advisory Committee before the end of May 2005 so that it could consider whether to recommend conditions upon Dr Patel's registration. This was practical in the opinion of Mr O'Dempsey because conditions upon registration would be more easily imposed under the *Medical Practitioner's Registration Act* than under the *Health Practitioners (Professional Standards) Act*.⁴⁸⁸ This is consistent with the

⁴⁷⁸ *Health Practitioners (Professional Standards) Act* 1999 s163

⁴⁷⁹ *Health Practitioners (Professional Standards) Act* 1999 s153(1)

⁴⁸⁰ *Health Practitioners (Professional Standards) Act* 1999 s30

⁴⁸¹ *Health Practitioner (Professional Standards) Act* 1999 s30(2)

⁴⁸² *Health Rights Commission Act* 1991 s130

⁴⁸³ *Health Practitioners (Professional Standards) Act* 1999 s220

⁴⁸⁴ *Health Practitioners (Professional Standards) Act* 1999 s223

⁴⁸⁵ *Health Practitioners (Professional Standards) Act* 1999 s229

⁴⁸⁶ *Health Practitioners (Professional Standards) Act* 1999 s239

⁴⁸⁷ *Health Practitioners (Professional Standards) Act* 1999 s241

⁴⁸⁸ Exhibit 28 para 31

effect of the interpretation of s59 of the *Health Practitioners (Professional Standards) Act 1999*⁴⁸⁹ which has led the Medical Board to the view that before suspending or imposing conditions upon a doctor it was obliged to find evidence to meet a high threshold of proof of 'immediacy of the threat' and that it should determine the least onerous action to protect the patient.⁴⁹⁰

- 6.459 A consequence of the Medical Board's concern for the quality of evidence required to satisfy s59 of the *Health Practitioners (Professional Standards) Act 1999* is that it is more attractive to the Medical Board to allow an Area of Need registrant such as Dr Patel to continue practicing without conditions or suspension until the expiration of the doctor's year of registration and to consider imposing conditions when the doctor applies for a further year's registration. This cannot be in the best interests of patients.

The Queensland Nursing Council

- 6.460 Complaints against the nursing profession are referred to the Queensland Nursing Council.⁴⁹¹ The Queensland Nursing Council has, as one of its functions, the investigation of complaints against members of the nursing profession⁴⁹². In 2003/04 the Queensland Nursing Council received a total of 177 complaints against nurses.⁴⁹³
- 6.461 The Queensland Nursing Council may accept⁴⁹⁴ complaints about a nurse or midwife from any entity.⁴⁹⁵
- 6.462 If the complaint is from a patient, then before the Queensland Nursing Council can investigate a complaint it must first refer the complaint to the Health Rights Commission.⁴⁹⁶ If the complaint is from someone other than a patient then the Queensland Nursing Council may retain and investigate the complaint.⁴⁹⁷
- 6.463 The Queensland Nursing Council has broad powers to investigate complaints and may also immediately suspend a nurse if satisfied that there is a risk to patient safety.⁴⁹⁸
- 6.464 During the investigation, the Queensland Nursing Council is obliged to keep the Health Rights Commissioner informed on the progress of the investigation,⁴⁹⁹

⁴⁸⁹ See *Thurling v the Medical Board of Queensland* [2002] QHPT 004

⁴⁹⁰ Exhibit 28 para 41

⁴⁹¹ Established by the *Nursing Act 1992* s6

⁴⁹² *Nursing Act 1992* s7(g)

⁴⁹³ Queensland Nursing Council, Annual Report 2003 – 2004

⁴⁹⁴ regarding the acceptance of complaints see *Nursing Act 1992* s102A

⁴⁹⁵ *Nursing Act 1992* s102

⁴⁹⁶ *Nursing Act 1992* s102A, although in some circumstances, following consultation with the Health Rights Commissioner, the Queensland Nursing Council may retain the complaint for investigation if that is in the public interest, or in other case: see *Nursing Act 1992* s102A(2)

⁴⁹⁷ *Nursing Act 1992* s102A

⁴⁹⁸ *Nursing Act 1992* s67

⁴⁹⁹ However the council is only obliged to keep the Commissioner informed of the progress of the investigation if the Health Rights Commissioner asks to be kept informed

and is also required to provide to the Health Rights Commission the final report about the investigation.⁵⁰⁰

- 6.465 If satisfied that there are grounds for disciplinary action,⁵⁰¹ then the Queensland Nursing Council may refer the charge to the Nursing Tribunal.⁵⁰²
- 6.466 The Nursing Tribunal is an independent tribunal⁵⁰³ established under the *Nursing Act* 1992. It has no relationship with the Health Practitioners Tribunal established under the *Health Practitioners (Professional Standards) Act* 1999.⁵⁰⁴ It has broad powers and its function is to hear disciplinary charges with respect to nurses, make findings, and take appropriate action in response to disciplinary charges.⁵⁰⁵
- 6.467 The Ombudsman's case study reveals that the complaint about a registered nurse which was made to the Queensland Nursing Council was not immediately investigated by the Council. The investigation was delayed for three and a half months while the Health Rights Commission assessed the complaints, sought submissions and consulted with the Council. The Council accepted the complaint for investigation after that delay. The Council's investigation into the complaint against that registered nurse took a further fourteen months. Despite finding that there were concerns regarding the nurse's competence, the Queensland Nursing Council resolved to await an inquiry by the Coroner to determine what action should be taken. Three years and three months after complaining to the Queensland Nursing Council the complainants were still waiting to learn what disciplinary action, if any, would be taken against the nurse.

Queensland Ombudsman⁵⁰⁶

- 6.468 The Ombudsman can investigate administrative actions of an agency,⁵⁰⁷ including Queensland agencies that provide health services, deal with complaints about the provision of health services, and regulate the health service professions. The Ombudsman can investigate the administrative actions of the Health Rights Commissioner, the Medical Board of Queensland, Queensland Health and the Queensland Nursing Council.

⁵⁰⁰ *Nursing Act* 1992 s103A(2)

⁵⁰¹ *Nursing Act* 1992 s104A

⁵⁰² *Nursing Act* 1992 s104

⁵⁰³ The Nursing Tribunal is established under the *Nursing Act* 1992 Pt 5 Div 1

⁵⁰⁴ The Health Practitioners Tribunal hears matters concerning health practitioners other than nurses

⁵⁰⁵ The actions that the Tribunal can take are contained in the *Nursing Act* 1992 s116

⁵⁰⁶ The Queensland Ombudsman helpfully provided to me a copy of his submission of August 2005 to the Bundaberg Hospital Commission of Inquiry. I have relied upon the submission to describe the role of the Queensland Ombudsman so far as it relates to dealing with complaints about the Health Service and particularly for a case study done by the Queensland Ombudsman of a health related complaint. The case study illustrates well some unsatisfactory consequences which arise from Queensland's system which allots to different authorities different responsibilities for dealing with health complaints.

⁵⁰⁷ As defined in ss8 and 9 of the *Ombudsman Act* 2001

- 6.469 The Ombudsman is expected to liaise with other complaints entities to avoid inappropriate duplication of investigative activity⁵⁰⁸ and would not ordinarily accept an initial complaint about the provision of a health service if the complaint more appropriately fell within the jurisdiction of the Health Rights Commission, the Medical Board of Queensland (or another registration board), or the Queensland Nursing Council.
- 6.470 In most cases, the Ombudsman will not accept a complaint unless the complainant has tried to resolve it with the agency which is the subject of the complaint.
- 6.471 In the 2004/2005 financial year, the Ombudsman's Office received 339 health related complaints. Of those:.
- 156 related to Queensland Health;
 - 50 related to the Health Rights Commission;
 - 33 related to a registration board or the Queensland Nursing Council.
- 6.472 In accordance with the Ombudsman's normal practice in relation to Queensland Health complaints, many of the 256 complaints received (126) were referred to Queensland Health for internal review, while an additional 37 complaints were referred to the Health Rights Commission or to the relevant registration board.
- 6.473 The Ombudsman received no complaints about medical services at Bundaberg Base Hospital or about maladministration by health agencies in dealing with complaints about medical services at Bundaberg Base Hospital.

Recommendations for complaints management

Health Systems Review recommendation for complaints management

- 6.474 The final report of the Queensland Health Systems Review⁵⁰⁹ (the Forster Report) recommends changes to the current system of complaints management within Queensland Health.⁵¹⁰
- 6.475 Some key features of the Forster Report's proposed complaints model are:
- A complaints model be adopted that provides for local resolutions first whilst requiring escalation to an independent complaints body, a Health Commission if the complaint is not resolved in 30 days;⁵¹¹
 - the proposed Health Commission would have powers to investigate

⁵⁰⁸ *Ombudsman Act 2001* s15

⁵⁰⁹ *Queensland Health Systems Review, Final Report, September 2005*

⁵¹⁰ *Queensland Health Systems Review, Final Report, September 2005* p190-192

⁵¹¹ *Queensland Health Systems Review, Final Report, recommendation 9.16* at p196

the complaints;⁵¹²

- There should be better coordination of the work of the Health Rights Commission, the Medical Board of Queensland and the other Health Practitioner registration boards, the Crime and Misconduct Commission, the State Coroner and the Queensland Ombudsman;⁵¹³
- A separate and short review needs to be undertaken of the legislation and working arrangements between those external bodies to determine how their work can be better coordinated;⁵¹⁴
- The proposed Health Commission could assume within its functions the role of the current Health Rights Commission;⁵¹⁵
- The proposed Health Commission would adjudicate complaints in a timely way.⁵¹⁶

6.476 The Forster Report did not explain what powers should be given to the proposed Health Commission as part of its role as an adjudicator of complaints. It was not obvious from the report whether the Health Commission would be 'one stop shop' with power to discipline or power to impose conditions upon the right to practice of doctors, nurses or allied health professionals.

Ombudsman's proposals for a new health complaints system

6.477 The submission of the Queensland Ombudsman⁵¹⁷ set out a comprehensive outline of features for a proposed new health complaints system.⁵¹⁸ The Queensland Ombudsman's office initiated a project in March 2003 called the Complaints Management Project and provided a report to the Director-General of Queensland Health on 8 March 2004 concluding that the Queensland Health system of complaint management 'compares very favourably to those in most other departments and meets nearly all the criteria for good complaints management.' However, the Ombudsman's office had recommendations for improvement then. That office has considered the matter since and in particular in light of the experience of the Bundaberg Base Hospital and has set out a comprehensive outline of the health complaints system which the Ombudsman proposes.

6.478 Some features of the Ombudsman's submission relating to a new health complaints system differ from the features I have extracted from the Forster

⁵¹² *Queensland Health Systems Review*, Final Report, p190

⁵¹³ *Queensland Health Systems Review*, Final Report, p198

⁵¹⁴ *Queensland Health Systems Review*, Final Report, recommendation 9.22 p198

⁵¹⁵ *Queensland Health Systems Review*, Final Report, p199

⁵¹⁶ *Queensland Health Systems Review*, Final Report, p191

⁵¹⁷ Submission to Bundaberg Hospital Commission of Inquiry, August 2005, which was resubmitted to this Inquiry

⁵¹⁸ Ombudsman's submission at Section 5.4

Report. The Ombudsman's recommendations included the following features not apparent among the Forster Report's recommendations:

- A new and independent body which could provide complainants with a 'one stop shop' in that it would have jurisdiction to deal with all aspects of complaints in relation to both registered and non-registered providers of health services in both public and private sectors with power to assess and coercive powers to investigate.⁵¹⁹ The Medical Board and the other registration boards would no longer conduct investigations of complaints about their own registrants, except by arrangement with the new body;
- Generally before the new body would accept a complaint the complainant would be required to demonstrate that the complainant had attempted to resolve the matter with the health service provider. In this respect the recommendation of the Ombudsman is somewhat similar to the recommendation of the Forster Report. However, the Ombudsman adds significant practical exceptions:

There should be exceptions to this, for example where there is an immediate risk to the health or safety of a user or consumers, or where a complaint is made by a staff member of the relevant HSP who is fearful of reprisal.⁵²⁰

6.479 On the basis of the evidence and submissions received I am not in a position to recommend, in any detailed way the indicia of a better system. Some deficiencies are obvious. By dividing the jurisdiction to deal with complaints between numerous bodies there is a confusion for the complainants as to which is the best authority or the appropriate one for a practical resolution. Complaints often pass from one body to another and back again with consequential delays. The transfer of matters from one authority to another is dispiriting for complainants. From the Ombudsman's case study, it emerged that the Medical Board and the Nursing Council had no statutory power to investigate the matter for the first few months after receiving the complaints while the Health Rights Commissioner was assessing them. During the same months, while the Health Rights Commissioner was empowered to assess, he lacked the Medical Board's and Nursing Council's powers to investigate and had no power to adjudicate. The same case study reveals that for the next ten months, the backlog of Medical Board investigations prevented an investigation. When the investigation was assigned by the Medical Board to an external investigator it took six months to complete. In total, the time between complaint to the Medical Board and the

⁵¹⁹ Ombudsman's submission to the Bundaberg Hospital Commission of Inquiry August 2005 p74

⁵²⁰ Ombudsman's submission to the Bundaberg Hospital Commission of Inquiry August 2005 p77

disciplining of the doctor about whom the complaint was made was two years and eight months. When, in August of this year, the Ombudsman submitted the case study three years and four months had elapsed since the complaint to the Queensland Nursing Council. The complainants then were still waiting to learn what disciplinary action, if any, would be taken against the registered nurse about whom they first complained.

- 6.480 There are obvious advantages in having one independent body which could act upon complaints from patients and health practitioners or on its own initiative with the powers to assess and to investigate doctors, nurses, allied health professionals, private hospitals and public hospitals and which had the power to conciliate but also to adjudicate, discipline and suspend in cases where there exists a real risk to patients.
- 6.481 On the basis of the complaints made by Ms Hoffman in October 2004 some authority independent of Queensland Health ought to have existed with sufficient investigators to verify in no more than thirty days whether there existed a real risk that patients were in imminent danger and with the willingness and the power to suspend Dr Patel. If necessary, the suspension could be followed by a subsequent, more thorough, prompt investigation into whether the suspension was justified and whether it should continue. Fairness to a doctor or nurse suspended could be offered with a right to appeal and provisions such as those appearing in s92 of the *Public Service Act* 1996. That section provides so far as relevant:

92 Effect of suspension from duty

- (1) An officer suspended from duty under this part is entitled to full remuneration for the period for which the officer is suspended, unless the employing authority otherwise decides.
- (2) If the officer is suspended without full remuneration, the authority cancels the officer's suspension and the officer resumes duty, then, unless the authority otherwise decides, the officer is entitled to be paid the prescribed remuneration to which the officer would have been entitled apart from the suspension, less any amount earned by the officer from additional employment undertaken during the suspension period.

Complaint by litigation

- 6.482 Some significant claims against doctors, nurses and allied health professionals are made without notice to the Health Rights Commissioner or to the relevant registration board. This commission received a copy of an extract from a foreign newspaper that asserted that Dr Patel had been made the subject of several medical malpractice suits in the United States and that those suits had been settled without trial and without public record.

- 6.483 It is common for insurers to require of their insured that the insurer be notified by their insured if a claim for professional negligence is made against them. It would be useful if the insurer of a doctor, nurse or allied health professional gave notice of receipt of claims for professional negligence against its client and, upon resolution of the claim, details of the resolution. Legislation to compel this should be considered. The appropriate body to whom such notice should be given by the insurer is the body which has power to suspend or impose conditions upon the practise of the doctor, nurse or allied health professional, whether that body be the relevant registration board or the proposed 'one stop shop'.
- 6.484 In summary, it seems to me that serious consideration should be given to legislation to oblige insurers to report notice of claims for negligence against health practitioners and to creating a body which:
- Is a 'one stop shop' independent of Queensland Health and the registration boards having sole power to act upon complaints from or on behalf of patients or issues raised by health practitioners or upon notice of claims notified to insurers of health practitioners;
 - Has power to investigate, conciliate and adjudicate;
 - Has the power, where there is a real risk to a patient's health or safety from acts or omissions of a doctor, nurse or allied health professional, to immediately suspend or impose conditions on the doctor, nurse or allied health professional. Patient safety should have a higher priority than fairness to the practitioner. A sensible compromise for the practitioner would be a preliminary assessment of the reality of the risk to patients and, if a suspension or the imposition of a condition upon practise were to be ordered, it would be followed by a prompt investigation into whether the suspension or condition was justified and whether it should continue, a right of appeal, and a fair approach to remuneration for the practitioner for the period of suspension.

Whistleblower protection and reform

- 6.485 The people of Queensland owe a great deal to Ms Toni Hoffman, whose decision to speak to her local member of Parliament about her concerns regarding the activities of Dr Patel and the apparent threat he represented, led to his exposure and this Inquiry. Without her taking that step, the extent of Dr Patel's actions may yet remain unknown. As shown in Chapter Three above, that was not the first time that she had complained about Dr Patel.

6.486 Whether Ms Hoffman realised it or not, her disclosure to Mr Messenger MP was not protected by the *Whistleblowers Protection Act* 1994.⁵²¹ The fact that Ms Hoffman had to reveal her concerns to Mr Messenger MP, to have those concerns dealt with, and that her disclosure was not protected, reveals the failure of the current system of protecting whistleblowers.

The present system of Whistleblower protection

6.487 When introduced in 1994, Queensland's *Whistleblowers Protection Act* was the first of its kind in Australia and indeed one of the first in the common law world.⁵²² Whistleblower protection is an attempt to encourage people to speak out against corruption and poor practices without fear of reprisal as a result of speaking out. The *Whistleblowers Protection Act* recognises and attempt to achieve a balance of competing interests such as:

- The public interest in the exposure, investigation and correction of illegal, improper or dangerous conduct;
- The interests of the whistleblower in being protected from retaliation or reprisal and in ensuring that appropriate action is taken regarding the disclosure;
- The interests of persons against whom false allegations are made, particularly the damage to reputations and the expense and stress of investigations;
- The interests in the organisation affected by the disclosure in ensuring its operations are not disrupted and also in preventing disruptive behavior in the workplace; and
- The need to ensure that whistleblower protection has appropriate safeguards to protect against abuse.⁵²³

6.488 In attempting to strike a balance between these competing considerations the *Whistleblowers Protection Act* permits specified persons to make disclosures to particular entities about specified conduct. As the system presently stands, public officers are entitled to make public interest disclosures afforded the protections in the *Whistleblowers Protection Act* provided that disclosure is to a public sector entity about conduct that amounts to:⁵²⁴

⁵²¹ Under Part 4 Division 2 of the *Whistleblowers Protection Act* 1994, in order to attract the protections of the Act public interest disclosures must be made to a public sector entity. A public sector entity is defined in Schedule 5, section 2 of the Act. That definition does not include disclosures to a member of the legislative assembly.

⁵²² See: 'Three Whistleblower Protection Models: A comparative analysis of Whistleblower Legislation in Australia, the United States and the United Kingdom' a report of the Public Service Commission of Canada available at: www.psc-cfp.gc.ca/research

⁵²³ These points are drawn from the Ombudsman's submissions

⁵²⁴ For the source of this information see the Ombudsman's submission to the Bundaberg Hospital Commission of Inquiry, see also: Sections 15, 16, 17, 18, 19, and 26 *Whistleblowers Protection Act* 1994

- Official Misconduct;
- Maladministration that adversely affects anybody's interests in a substantial and specific way;
- Negligent or improper management involving a substantial waste of public funds; or
- A substantial and specific danger to public health or safety or to the environment.⁵²⁵

6.489 Apart from public officers⁵²⁶ any person⁵²⁷ may make a public interest disclosure about:

- A substantial and specific danger to the health or safety of a person with a disability
- An offence under certain legislation that is or would be a substantial and specific danger to the environment
- A reprisal taken against anybody for making a public interest disclosure

6.490 There are two significant limitations to this system. Firstly, disclosures must be made to an 'appropriate entity'. Secondly, only public officers are permitted to make disclosures about official misconduct, maladministration, waste of public funds, or threats to public health.

Disclosures to an 'appropriate entity'

6.491 Section 26 of the *Whistleblowers Protection Act* provides:

26 Every public sector entity is an appropriate entity for certain things

- (1) Any public sector entity is an appropriate entity to receive a public interest disclosure—
 - (a) *about its own conduct or the conduct of any of its officers; or*
 - (b) *made to it about anything it has a power to investigate or remedy; or*
 - (c) *made to it by anybody who is entitled to make the public interest disclosure and honestly believes it is an appropriate entity to receive the disclosure under paragraph (a) or (b); or*
 - (d) *referred to it by another public sector entity under section 28.4.*
- (2) Subsection (1)(c) does not permit a public sector entity to receive a public interest disclosure if, apart from this section, it would not be able to receive the disclosure because of division 4, 5 or 6.5.

⁵²⁵ Clearly Ms Hoffman's complaint would fall into this category, however her disclosure to Mr Messenger MP was not a disclosure to a 'public sector entity' as defined by the Act.

⁵²⁶ A public officer is an officer of a public sector entity see Schedule 6, *Whistleblowers Protection Act 1994*

⁵²⁷ as opposed to a public officer

- (3) If a person makes a public interest disclosure to an appropriate entity, the person may also make a public interest disclosure to the entity about a reprisal taken against the person for making the disclosure

6.492 The term ‘appropriate entity’ is defined in the *Whistleblowers Protections Act* 1994 as including bodies such as:

- a committee of the Legislative Assembly;
- the Parliamentary Service;
- a court or tribunal;
- the administrative office of a court or tribunal;
- the Executive Council;
- *a department*;
- a commission, authority, office, corporation or instrumentality established under an Act or under State or local government authorisation for a public, State or local government purpose.

6.493 Section 26 of the *Whistleblowers Protection Act* has the effect that, as far as Queensland Health is concerned, under that section an appropriate entity to receive a public interest disclosure about Queensland Health is itself.⁵²⁸

6.494 There was considerable evidence before this Commission about staff of Queensland Health having little or no faith in Queensland Health in dealing with complaints. In an organisation that actively conceals information and uses Cabinet confidentiality provisions to avoid Freedom of Information laws, it seems unlikely that public interest disclosures by employees would be dealt with any differently.

6.495 In any event, Ms Hoffman’s complaint to Mr Leck would amount to a public interest disclosure⁵²⁹ to an appropriate entity under the *Whistleblowers Protection Act*.⁵³⁰ However, Ms Hoffman did not consider that the actions taken by Queensland Health were appropriate to her complaint.

Limitations of persons and entities to whom a protected disclosure can be made

6.496 Noticeably a member of Parliament is not an ‘authorised entity’ to whom a public interest disclosure can be made under the *Whistleblowers Protection Act*.

⁵²⁸ s26(1) of the *Whistleblowers Protection Act* 1994 states that a public sector entity is the appropriate entity to receive a public interest disclosure about its own conduct or the conduct of any of its officers

⁵²⁹ concerning a threat to the health and safety of patients at the Bundaberg Hospital

⁵³⁰ Queensland health is an appropriate entity to receive a disclosure about the conduct of one of its own officers.

- 6.497 Furthermore, a disclosure to a journalist or a member of the media attracts no protection under the *Whistleblowers Protection Act*. During the course of this Commission of Inquiry, there was at least one instance of a report being provided to *The Courier-Mail* newspaper.⁵³¹ How that document came into the possession of the *The Courier-Mail* before being disclosed to the Commission was not investigated. However, needless to say that disclosure was afforded no protection under the *Whistleblowers Protection Act*.
- 6.498 The findings made in respect of Bundaberg, Rockhampton, and Queensland Health show that Ms Hoffman had no choice but to complain to her local member of Parliament, and that another person felt the need to disclose a confidential report regarding the Rockhampton Emergency Department should be provided to *The Courier-Mail*, in my opinion demonstrates that the protection to whistleblowers in the Queensland public sector needs reform.

Limitations on who can make a protected complaint

- 6.499 As set out in paragraph 6.488 and 6.489 above, it is not just any person who can make a public interest disclosure about maladministration or a threat to public safety. Patients, or their family members, are unable to gain the protections of the *Whistleblowers Protections Act* should they wish to make a public interest disclosure. The categories of persons permitted to make protected disclosures needs expansion.

Lack of central oversight of public interest disclosures

- 6.500 As submitted by the Ombudsman, another failure of the current system is the lack of a central body charged with overseeing and managing public interest disclosures. Under the present system, the Office of Public Service, Merit and Equity is responsible for administering the *Whistleblowers Protection Act*.⁵³² That office has no role in overseeing public interest disclosures, each department being required to develop its own policy and procedures for managing public interest disclosures.⁵³³
- 6.501 Queensland Health has developed a document titled 'Policy and Procedures for the Management of Public Interest Disclosures' that sets out the processes to be used in managing public interest disclosures under the *Whistleblowers Protections Act*.
- 6.502 Broadly, the procedures in place at Queensland Health are as follows:

⁵³¹ Exhibit 129: Rockhampton Emergency Department Review, which was 'leaked' to *The Courier-Mail* prior to being disclosed to the Commission of Inquiry

⁵³² See Administrative Arrangements Order (No 2) of 2005 available at:
http://www.premiers.qld.gov.au/library/pdf/admin_arrangements2_05.pdf

⁵³³ See Ombudsman's submission August 2005

- Public interest disclosures must be brought to the attention of the Director-General to determine appropriate management and investigation of the disclosure.
- The Director-General is also charged with considering the risk of reprisals and with taking steps to ensure that an employee who makes a public interest disclosure is not disadvantaged as a result of making the disclosure.
- The Audit and Operational Review Branch of Queensland Health is obliged to record the public interest disclosure and also record the action taken. This information is collected for publication in the department's annual report.

6.503 At present there is no single body charged with overseeing public interest disclosures within the Queensland Public Sector (save where that public interest disclosure involves official misconduct⁵³⁴). In my opinion this is a serious shortcoming. As the facts revealed in this Inquiry show, it was futile to expect Queensland Health to manage public interest disclosures about itself with no external oversight.⁵³⁵

6.504 The Queensland Ombudsman has provided a helpful submission to the Commission, in which he recommends changes to enhance the protection of whistleblowers in the public sector. The Ombudsman makes the following recommendations regarding changes to the current whistleblowers protection system.

6.505 Firstly the Ombudsman recommends that his office be given a supervisory role over public interest disclosures made under the *Whistleblowers Protection Act* 1994⁵³⁶. That role would be similar to the role which the Crime and Misconduct Commission has in overseeing and investigating complaints about official misconduct. The Ombudsman recommends a model where:

agencies would have an obligation to refer to the ombudsman all public interest disclosures that involve serious maladministration but do not amount to official misconduct.⁵³⁷

6.506 The Ombudsman takes the view that the phrase 'serious maladministration' includes such things as conduct that would amount to a danger to the health and safety of the public or the environment and also negligent or improper management affecting public funds.⁵³⁸

6.507 The Ombudsman recommends that public interest disclosure regarding official misconduct should remain subject to the present arrangements of referral to, and oversight by, the Crime and Misconduct Commission.

⁵³⁴ in that case the complaint must be dealt with in accordance with the *Crime and Misconduct Act* 2001 which obliges notification of the Crime and Misconduct Commission

⁵³⁵ the same can be said for any public sector body

⁵³⁷ See Ombudsmans Submission to the Bundaberg Hospital Commission of Inquiry, August 2004

⁵³⁸ See the *Queensland Ombudsman, Annual Report 2004/2005*

6.508 I adopt those recommendations.

Proposals for reform

6.509 I recommend the following changes to the *Whistleblowers Protection Act 1994*:

Central oversight of public interest disclosures

6.510 Firstly I recommend that the Queensland Ombudsman be given an oversight role with respect to all public interest disclosures save those involving official misconduct. I recommend a system similar to that involving Official Misconduct where all public interest disclosures must be referred to the Ombudsman who may then either investigate the disclosure itself, or refer it back to the relevant department for investigation, subject to monitoring by the Ombudsman.

Increase the class of persons who may make a public interest disclosure

6.511 Secondly, I recommend that the categories of persons who may make a public interest disclosure protected by the *Whistleblowers Protection Act* be expanded in cases involving danger to public health and safety, and negligent or improper management of public funds, to include any person or body.

Expansion of bodies to whom a complaint may be made

6.512 Finally, I recommend a scale of persons or bodies to whom a complaint may be made. Effectively a whistleblower ought to be able to escalate his or her complaint in the event that there is no satisfactory action taken with respect to it. The scale should be as follows:

- (a) A whistleblower should first complain to the relevant department – or public sector entity under Schedule 5 of the *Whistleblowers Protection Act* – subject to the Ombudsman’s monitoring role discussed above. The *Whistleblowers Protection Act* must also provide strict time limits to investigate and resolve the disclosure. A time of 30 days would be appropriate.
- (b) If the matter is not then resolved within the time, to the satisfaction of the Ombudsman, the whistleblower ought to be able to make a public interest disclosure to a member of Parliament.⁵³⁹
- (c) If disclosure to a member of Parliament does not result in resolution, to the satisfaction of the ombudsman, within a further 30 days, then the whistleblower should be entitled to make a further public interest disclosure to a member of the media.

⁵³⁹ It should not be restricted to a local member of Parliament, but should be any member of Parliament, for example an Opposition spokesperson on the relevant matter.