

Volume Two

Final Submissions

Queensland Public Hospitals

Commission of Inquiry

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Submissions

Medical Board of Queensland

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Our Ref: PDM:01.0690886
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28 October 2005

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Dear Mr Cowley Grimmond

Medical Board of Queensland and Dr Jayant Patel – Commission of Inquiry No 2 of 2005

We refer to your letter dated 27 October 2005 relating to 2 further matters in respect of which you advised that there may be other potential adverse findings available to the Commission concerning our client.

Our response on these 2 matters appears hereunder. Separate letters will deal with the submissions of the Patients and the Health Rights Commissioner.

1. DR IZAK MAREE

We previously referred briefly to the matter of Dr Maree's service as Medical Superintendent of Charters Towers Hospital, at **Part "B" Submissions, paragraph 1.7**. We also annexed as Appendix "B" what we thought to be the relevant findings of the State Coroner delivered on 24 August 2005. Our submission was that the Coroner's findings exposed the difficulties facing IMG's in small regional hospitals.

As a consequence of receiving your letter dated 27 October 2005, we will deal specifically with those findings of the Coroner which may reflect in some way upon the Medical Board and its processes. Your letter does not draw attention to any particular aspect of the Coroner's findings, however, we will endeavour to extract those statements which might bear upon the potential adverse findings you have in mind.

1.1 Registration Issues

At page 26 of his findings, the Coroner said as follows:

"Because he had secured a position with Queensland Health the Medical Board granted Dr Maree conditional registration. All that it required of him was proof that he had such qualifications as would entitle him to registration and to be satisfied that he complied with the provisions of the Medical Act 1939. The Board satisfied itself of these matters by having Dr Maree interviewed by a senior doctor from the Townsville Hospital who then wrote to the Board certifying that Dr Maree met these conditions for registration. It seems this process did not involve any assessment of Dr Maree's suitability for the position he was about to fill nor any review of his level of competence."

Discussion

We repeat and rely upon our general submissions contained in **Part "A" Submissions dated 26 October 2005, in particular at pages Part A 1-7.**

The Commission of Inquiry has the Board's file in relation to the registration of Dr Maree.

The Board's file shows that the decision to register Dr Maree had already been made by the Board, utilising the process described by Dr Cohn and summarised in our Submissions Part "A" at pages 5 and 6.

The interview was conducted by a delegate of the Board for the purposes explained by Mr Demy-Geroe at paragraph 40 of his statement, Exhibit 24, and Exhibit "MDG28".

The interview did not constitute the Board's entire process for registration pursuant to S.18 Medical Act 1939.

1.2 Investigation issues

At page 28 of his findings, the Coroner outlined that Dr Maree tendered his resignation effective from 17 April 2001. On 27 November 2001, the Board resolved to discontinue its investigation. The Coroner referred to the evidence of the Chair of the Medical Board, Dr Erica Mary Cohn, in which she said that:

"...the decision not to advise the home country of the doctor involved of the concerns about him was consistent with the Board's practise at the time but that now such advice would be given to any country in which it was thought the doctor in question might seek to practise".

The Coroner also referred to Dr Cohn's evidence that the Board's decision was based on the following factors:

- Dr Maree had left the country;
- The Board had a large number of investigations to deal with at the time;
- The Board was waiting for other inquiries such as *"this inquest"* to be completed before taking action, to avoid parallel inquiries.

Next, the Coroner referred to a submission put to him by the Solicitors for the Board, in which it was argued that:

"No good purpose would have been served by the Board taking further action in this case as the most the Board could have done was to de-register Dr Maree and that

had already happened as a result of his resignation. Further, they (the Solicitors) suggest that no disciplinary prosecution in the Health Practitioners Tribunal would have been likely to succeed in the absence of evidence of criminal negligence and as I have found such evidence is not available in connection with the death of Ms Sabandina (sic), a disciplinary charge based on allegations of poor practise standards would not have succeeded. I shall respond to these submissions shortly."

In the balance of his findings, the Coroner made the following observations (at page 31 of his findings):

"In my view that (the Board's decision to take no further action in relation to the report of Drs Johnson and Farlow) was an inappropriate response to the serious allegations contained in the report. The functions of a coronial inquiry are not co-terminous with the Board's responsibility to uphold the standards of practise within the health professions and to maintain public confidence. For example, in this case, there were 11 allegations of professional misconduct raised against Dr Maree and only one of those was the subject of this inquest. Nor is it appropriate for the Board to postpone taking action until other authorities that may consider some aspects of a practitioner's performance have done so. In my view, the Board should act as quickly as possible to determine matters within its special area of responsibility. ...it is inappropriate for it to forbear from doing its duty in this regard merely because some other body may take some action or the practitioner whose conduct is in question leaves the State.

I recommend the Medical Board of Queensland consider and determine the allegations made against Dr Maree and investigated by Drs Johnson and Farlow. Its findings in relation to those matters should be published in a form that makes them readily accessible to those who might want to be informed of Dr Maree's past performance."

Discussion

We refer you to our previous **Submissions, Part "A", pages 35 – 36**, in which similar issues were dealt with in the context of the Board's handling of complaints in relation to Dr Malcolm Stumer.

We again submit that these issues were not canvassed to any extent in the conduct of the Commission proceedings. The Commission itself did not pursue this issue in its hearing. The matter was raised briefly with Mr Demy-Geroe in cross-examination by one of the parties¹. Though the Coroner's findings post-dated Mr Demy-Geroe's evidence, he was not recalled for further examination on the Maree issues; nor was Dr Cohn. It is impracticable for the Board to attempt to call fresh evidence or seek any other documents in relation to the matter. Until receipt of your letter dated 27 October 2005, the Board was addressing the matter of Dr Maree as being a typical example of the difficulties confronted by overseas trained doctors when placed in areas of responsibility by QHealth.

By recourse to the Board's file on Dr Maree, it can be seen that at least the public interest of Queenslanders was protected at an early stage of the investigation by the departure of Dr Maree from Queensland. This was undoubtedly an important consideration in the Board's decision.

The unchallenged evidence of Mr O'Dempsey was that after commencing duties as Executive Officer on 4 March 2002, proactive steps to alleviate the backlog of complaints were instituted. The Board's decision in relation to Dr Maree predated the arrival of Mr O'Dempsey and predated the efforts of the Board to get its own house in order. Since 2002, the "dysfunction" candidly referred to

¹ T481-482



by the Board in its Part "A" Submissions, pages 35- 36, have been addressed to the point where the annual rate of "carry over" of investigations in progress has fallen by over 40%.

If the matters of concern to the Commission of Inquiry had been addressed to Mr O'Dempsey, or Mr Demy-Geroe, or Dr Cohn when these witnesses were in the witness box, or if any one of the three witnesses had been sought for recall after the Coroner's findings and prior to the close down of the public evidence heard in the Inquiry, the Commission would have received evidence that by mid 2004 the Board had changed its general policy on such matters. Since that time, the Board has proceeded with a general policy to complete investigations and/or disciplinary action, even in circumstances where previously registered practitioners have left the jurisdiction.

In support of the above submission, we can only point to the statements made by our Counsel, Mr Devlin, on 5 July 2005², when at the Bundaberg Sitzings of the Commission of Inquiry he announced that an investigator had been appointed by the Board to investigate matters relating to the clinical practise of Dr Patel which had been raised in the Commission evidence to that time. The then-Commissioner, Mr Morris, approved of that step being taken by the Board. Further, in a letter dated 7 September 2005³ to the current Commission, which was primarily concerned with a construction of the second Commission's first Terms of Reference, the Solicitors for the Board clearly flagged that it was wishing to proceed to possible disciplinary action against Dr Patel in the near future.

It is regrettable that the concerns about the Board's previous decisions in relation to Drs Stumer and Maree were not raised with the Board's legal representatives at a time when further evidence could have been adduced on the topic, and the Board's witnesses had an opportunity to explain the Board's position in full. This is particularly so in light of the handing down of the decision of the Coroner on 24 August 2005 well before the closure of evidence in Commission of Inquiry No 2.

No adverse finding is warranted in these circumstances.

2. DR QURESHI

The Board has made detailed submissions about Dr Qureshi at **Submissions Part "B" dated 26 October 2005, pages 18 – 20.**

We refer in particular to **page 19** of those Submissions, in which a detailed chronology sets out the steps taken between 22 October 2003, when Dr Keating first lodged a complaint to the Medical Board, and 11 March 2004 when the Board Complaints Co-Ordinator advised Dr Keating that an investigator would be appointed. Some relevant dates upon which proper action was taken, are set out again as follows:

- 22.10.03 - Dr Keating advised the Medical Board Complaints Unit about a second complaint against Dr Qureshi, also referring to the first complaint, and advising that Dr Keating had already arranged for Dr Qureshi to be chaperoned during his clinical practise.
- 17.11.03 - Medical Board advice to Dr Keating that his complaint would be considered at the next meeting of the Board.
- 09.12.03 - After receiving a further complaint from staff, Dr Keating interviewed the patient and then interviewed Dr Qureshi, who denied the allegations.
- 11.12.03 - Dr Keating again wrote to the Medical Board Complaints Unit advising of a further incident and advising that Dr Qureshi has a chaperone and that

² T1909

³ Exhibit "A", Commission of Inquiry No 2 of 2005



administrative action had begun under the Queensland Health Code of Conduct.

- 18.12.03 - facsimile Medical Board Complaints Assessment Co-Ordinator to Dr Keating requesting further information concerning the various complaints which had flowed in over the previous 2 months.
- 24.12.03 - Dr Keating wrote to the Medical Board Complaints Assessment Co-Ordinator supplying further information as requested.
- 24.02.04 - Medical Board reviewed the complaint material and noted that an investigator had been directed to investigate. (The assessment by the Board therefore took 2 months)

The Board's complaint files on Dr Qureshi, which are in the possession of the Commission, reveal that in the 4 months during which Dr Keating's complaints were under assessment by the Medical Board Complaints Unit, the following additional official activity had occurred, to the knowledge of the Board's employees, and ultimately the Board:

- On 11 December 2003, Dr Keating advised the Medical Board Complaints Unit that administrative action had begun under the Queensland Health Code of Conduct.
- On 29 January 2004, the QHealth internal auditor had referred Dr Keating's complaints to the CMC.
- In late January or early February 2004, the Crime & Misconduct Commission had referred the allegations of misconduct to the Queensland Police Service for investigation. QPS advised that prior to interviewing Dr Qureshi he fled the jurisdiction. A Warrant was issued for Qureshi's arrest and a "passenger alert" had been instituted with Australian Immigration and with Interpol.

It is strongly submitted that any perception of "*unreasonable and excessive*" delay is unfounded when the events between 22 October 2003 and 11 March 2004 are subjected to close scrutiny.

First, it is clear that over a period of time further complaints about Dr Qureshi flowed in through Dr Keating to the Board's Complaints Unit. Assessment of the full range of complaints occurred between 24 December 2003 and 24 February 2004.

Secondly, it is apparent that, to the Board's knowledge, Dr Qureshi was placed immediately under a requirement for a chaperone, in the conduct of any further clinical work at Bundaberg Base Hospital. The public interest was immediately served by that initiative of Dr Keating.

Thirdly, it is apparent that an internal QHealth investigation had been instituted.

Fourthly, it is apparent that the CMC became involved, which led in turn to a QPS investigation, which led in turn to advice that Qureshi had fled the country.

Fifthly, it is apparent that, to the Board's knowledge, an Arrest Warrant was brought into existence, together with an international "passenger alert".

Sixthly, pursuant to S.124(1)(i) *Health Practitioners (Professional Standards) Act 1999*, a conviction for an indictable offence gives grounds for disciplinary action before the Health Practitioners Tribunal without the need for an investigation. Sexual offences are ordinarily indictable offences.

The Medical Board of Queensland would be failing in its duty if it did not prioritise the more urgent investigations within its purview.

We refer you to S.12 *Financial Management Standard 1997*, which states *inter alia*:

12. Responsibilities of accountable officers and statutory bodies

- (1) *Under the Act, each accountable officer and statutory body is assigned various functions.*
- (2) *As part of the functions, every accountable officer and statutory body must manage the agency efficiently, effectively and economically, including, for example, by developing and implementing systems to ensure the appropriate use of, accountability for and safeguarding of, public resources."*

In the context of the facts set out above, to prioritise the investigation of an absent practitioner, no longer registered in the State of Queensland, subject to possible police charges, and subject to the execution of an Arrest Warrant if found somewhere in the world in the near future, would have been a waste of resources.

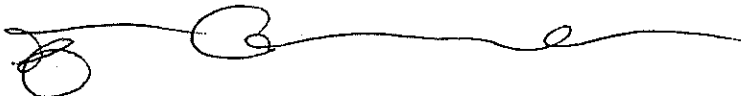
It is submitted that an adverse finding of "*unreasonable and excessive*" delay in relation to the assessment period of 22 October 2003 and 11 March 2004 is unwarranted due to the unfolding and dynamic nature of the complaints to be investigated. It is apparent that the assessment phase was an active one.

It is submitted that a finding of "*unreasonable and excessive*" delay in relation to the six month possible period of delay set out in the Board's letter of 11 March 2004 is also unwarranted because:

- The period of six months was but an estimate, given as a courtesy by the Board to the complainant, Dr Keating;
- The falling backlog of cases was an historical reality, but was proactively being dealt with; and
- The estimate of time should be understood as evidence of an appropriate allocation of resources by the Board and its employees to undoubtedly more urgent cases.

No adverse finding is warranted in the light of the circumstances raised above.

Yours faithfully
GILSHENAN & LUTON



Paul McCowan
Partner

Partner: Paul McCowan

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1 November 2005

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Dear Mr Cowley Grimmond

Submissions from Wavelength Pty Ltd

We refer to paragraph 7.5 of the Submission made on behalf of Wavelength Pty Ltd wherein it was submitted:

"It is a function of the Medical Board of Queensland, pursuant to Section 11 of the Medical Practitioners Registration Act 2001, to assess applications for registration".

If such an assertion was made in support of any submission to the effect that the Board would have had a legal obligation to "assess" Dr Patel then such assertion cannot be sustained as a matter of law.

The reference to the term "registration" in S 11 is in fact defined in Schedule 3 to the *Medical Practitioners Registration Act 2001* as meaning "means registration under part 3". Special purpose (area of need registration) is not "registration under part 3".

In any event the function as outlined in S11 is clearly applicable to assessment of "applications" and does not in any way import into the section any duty upon the Board to "assess" applicants for registration under Part 3. The Board repeats and relies upon its Submissions as contained in pages 1 – 7 of Part A of the Submissions to this Inquiry.

Yours faithfully
GILSHENAN & LUTON

A handwritten signature in black ink, appearing to be "Paul McCowan", is written over a horizontal line.

Paul McCowan
Partner

Partner: Paul McCowan

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Dear Mr Cowley Grimmond

Response on behalf of Medical Board of Queensland Re Submissions on behalf of Dr Hanelt

We refer to paragraph 12.1.14 of the Submissions made on behalf of Dr Hanelt wherein it has been submitted:

"It is unreasonable to expect a director of medical services to know the exact information required by the Medical Board when there was limited documentation in relation to the requirements and correspondence to the Board received no responses".

An examination of the files of Drs Krishna and Sahrma as well as the transcript of evidence has not revealed any evidence of correspondence to the Board which either called for any response or sought any advice or direction from the Board in this context. Further it would appear that the question of documentation which may be required by the Medical Board as to supervision was neither posited nor tested in evidence by Dr Hanelt.

In light of the above we submit that there cannot be any adverse inference against the Board in respect of paragraph 12.1.14 of the submissions on behalf of Dr Hanelt.

Yours faithfully
GILSHENAN & LUTON

A handwritten signature in black ink, appearing to be 'Paul McCowan', written over a horizontal line.

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Dear Mr Cowley Grimmond

Response of the Medical Board of Queensland to Submissions made on behalf of Mr Leck

At Paragraph 81 of the Submission on behalf of Mr Leck it is noted:

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

.....

- *Both Dr Fitzgerald and the Medical Board knew of the proposal to re-engage Dr Patel and neither had remonstrated about that."*

We submit that there is no evidence that the Medical Board of Queensland knew of the substance of the proposal to re-engage Dr Patel at the time Dr Patel was still employed at Bundaberg.

There is evidence that the Board would consider "whether it was necessary to recommend that the Board impose conditions upon Dr Patel's registration" in the context of an application for renewal of registration in the course of a discussion between Dr Fitzgerald and Mr O'Dempsey referred to at Paragraph 31 of the Statement of Mr O'Dempsey (**Exhibit 28**)(see also T472 lines 42-60 – **evidence of Mr Demy-Geroe**).

Further the file note of the conversation between Duncan Hill (Registration Officer) and Mr Leck on 30 March 2005 reflects that there was inquiry on behalf of the Board as to "confirmation of the conditions to be imposed by the District onto Dr Patel's employment." (**attachment MDG-40 to Statement of Mr Demy-Geroe - Exhibit 24 and see also evidence at T7213-7214**)

The Board therefore rejects any possible inference that it supported or gave any tacit approval of any actions by Mr Leck in respect of the *"proposed short term re-engagement of Dr Patel"*.

Yours faithfully
GILSHENAN & LUTON

A handwritten signature in black ink, appearing to be 'Paul McCowan', written over a horizontal line.

Paul McCowan
Partner

SUBMISSIONS OF
THE MEDICAL BOARD OF QUEENSLAND

**IN THE MATTER OF THE COMMISSIONS OF
INQUIRY ACT 1950**

**QUEENSLAND PUBLIC HOSPITALS COMMISSION
OF INQUIRY
NO. 2 OF 2005**

**Submissions from
THE MEDICAL BOARD OF QUEENSLAND**

SUBMISSIONS OF THE MEDICAL BOARD OF QUEENSLAND TO
INQUIRY No. 2 OF 2005

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**PART A – DETAILED RESPONSE OF THE MEDICAL BOARD OF QUEENSLAND TO
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REFERENCE**

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IN RELATION TO THE ASSESSMENT, REGISTRATION AND
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WITH PARTICULAR REFERENCE TO DR JAYANT PATEL AND
PERSONS CLAIMING TO BE OVERSEAS-TRAINED MEDICAL
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- 1.2 Dr Jayant PATEL (Bundaberg Base Hospital)
- 1.3 Vincent Victor BERG (Townsville Base Hospital)
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- 1.5 Dr Thamara Ranjika MUNASINGHE (Townsville Base Hospital)
- 1.6 Dr Tariq Salman QURESHI (Bundaberg Base Hospital)
- 1.7 Dr Isak MAREE (Townsville District/Charters Towers Hospital)
- 1.8 Dr Dinesh SHARMA (Hervey Bay Hospital)
- 1.9 Dr Damodaran KRISHNA (Hervey Bay Hospital)
- 1.10 Dr Morgan NAIDOO (Hervey Bay Hospital)
- 1.11 Dr Anatole KOTLOVSKY (Bundaberg Base Hospital)
- 1.12 Dr Keith MUIR (Nambour Hospital)

- (d) **THE APPROPRIATENESS, ADEQUACY, AND TIMELINESS OF action** taken to deal with any of the allegations, complaints or concerns referred to in (a), (b) and (c) above;

- (i) **within the Bundaberg Base Hospital**

Zone Manager – Dan Bergin

An overview of the evidence as to why no complaint was made to the Medical Board until February/March 2005.

THE APPROPRIATENESS, ADEQUACY, AND TIMELINESS of action taken to deal with any of the allegations, complaints or concerns referred to in (a), (b) and (c) above;

- (ii) **outside the Bundaberg Base Hospital**

Evidence of James O'Dempsey

Evidence of Dr Gerry Fitzgerald

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TO PART A
DETAILS RESPONSE OF THE MEDICAL BOARD OF QUEENSLAND TO
"NOTICE OF POTENTIAL ADVERSE FINDINGS AND RECOMMENDATIONS"
DATED 14 OCTOBER 2005

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PART A
DETAILED RESPONSE OF THE MEDICAL BOARD OF QUEENSLAND TO "NOTICE OF
POTENTIAL ADVERSE FINDINGS AND RECOMMENDATIONS"
DATED 14 OCTOBER 2005.

Introduction

The response of the Medical Board of Queensland ("the Board") to the "Notice of potential adverse findings and recommendations" ("the notice") is contained in this document which is "Part A" of a three part submission. "Part B" will deal with matters of interest to the Board which arise in relation to the Terms of Reference, other than clinical cases and issues of potential unsatisfactory professional conduct by registrant medical practitioners. The latter will be dealt with specifically in "Part C".

It should be noted that the changes to processes which have been adopted by the Board since the matters giving rise to Commission of Inquiry Number 1 of 2005 were always, as will be demonstrated, part of a broad range of process change which had been sought and worked toward by the Board for a long period of time. Because of the interests of key stakeholders who might be affected by any proposed changes to processes involving applications for area of need registrations of overseas trained doctors ("OTD's" or "IMG") the Board's ability to implement change was only likely to have been evolutionary. However as events have unfolded, the face of intense public interest generated in the Patel case has made and indeed enabled this process of change to be revolutionary. The recent changes thus implemented by the Board should be seen in this context.

The Commission did not itself lead any specific formal evidence of processes as adopted by other Australian medical registration boards in the handling of registration of OTD's. Thus there is no evidence that the Board was operating other than in accordance with appropriate national standards. However as will be submitted herein, there is a clear body of evidence demonstrating that the Board was in fact a leading participant in national reforms aimed at tackling the unique problems posed by the registration of OTD's in an area of need.

The Board submits with respect to each paragraph of the notice outlined as follows:

1. *With respect to Term of Reference 2(a), it is noted that the Board is charged, pursuant to Section 135 of the Medical Practitioners' Registration Act 2001 with the function of considering whether an applicant for special purpose registration in an area of need ("an area of need applicant") has a qualification and experience suitable for practising medicine in a given area. The Commission may find that:*

(a) The Board failed to test the clinical skills and knowledge of area of need applicants.

The Board submits that any such proposed finding could not be sustained on the evidence nor be made out as a matter of law. An examination of the scheme of the *Medical Practitioners Registration Act 2001* ("MPRA" or "Registration Act") reveals that the primary role of the Board in processing applications for registration is dedicated to the registration of those who have met the Australian Qualification Standard.¹ Such persons may then seek employment as medical practitioners wherever in this state a willing employer wishes to so appoint them if the registrant chooses not to establish his/her own private practice.

However, in the case of OTD's the process is inverted. OTD's will be attracted to a position in an area of need as a result of an employer seeking an area of need declaration, recruiting for that position then offering a position of employment. The Board is then faced with the role of considering the application for special purpose registration based upon the qualifications and experience "the board considers suitable for practising the profession in the area."² The Board is therefore not charged with any mandatory obligation to "test the clinical skills and knowledge" of an area of need applicant.

Thus the primary responsibility for matching the clinical skills of an area of need applicant with the position description of the area of need position as certified by the employer rests, in the case of Queensland Public Hospitals, with Queensland Health ("QHealth") during the recruitment and selection process. To effect registration the Board is then charged with the obligation to ensure that the applicant has the requisite qualifications and experience "suitable for practising the profession in the area." This obligation upon the Board requires the exercise of discretion upon facts which are subjective in each case.

But for the instance of Patel's registration which involved fraud, and Berg's application involving suspected fraud, there is otherwise no evidence of the Board failing to discharge its discretionary obligations to ensure that an applicant for Special Purpose registration had the requisite qualifications and experience "suitable for practising the profession in the area" as certified.

The assessment process for OTD's and inherent difficulties in assessing OTD's should also be understood in the context of two fundamental models of assessment whether "time based" or "competency based". Close regard should also be given to the national approach to this problem over at least the period of the last decade.

¹ See especially Ss 43 - 45

² S 135(2) MPRA

The evidence of **Dr Mark Waters**³, himself a senior staff member of QHealth, contains an argument for competency based assessment of applicants to be implemented in the future rather than "time based assessment" as currently adopted. The draft report of Dr Lennox⁴ also makes reference to this issue. Clearly, this new approach to assessment requires a significant shift in the thinking of a broad range of stakeholders and appropriate funding. The Australian Health Ministers Advisory Council (AHMAC) had already rejected a package of similar initiatives proposed to them by the Australian Medical Council ("AMC") in this context to be dealt with in more detail shortly.

To the present, the model for assessment of OTD's throughout Australia has been the "time-based assessment" model. Such a model (of assessing clinical skills and knowledge) involves the assessment of the applicant's CV and referees. This was performed by QHealth, a Recruitment consultant and the Medical Board, acting in combination at the relevant times under examination in this Commission of Inquiry. It accords with a national approach for uniform assessment. It is a matter for government to implement and fund significant changes to a competency-based assessment model. This will require the allocation of significant resources and is not a matter for apportioning blame to any party who has followed the current and accepted time-based model of assessment since at least 1996. See in particular the evidence of **Mr James O'Dempsey**, Executive Officer of the Board as submitted to the Bundaberg Hospital Commission of Inquiry.⁵

The Board was a party to the development of this submission to AHMAC through its membership of the AMC and the AMC's Standing Advisory Committee (The "Joint Medical Boards Advisory Committee"). The evidence of Mr O'Dempsey on these points remains uncontested. The initiatives for improvement that were supported by the Board were rejected at a national level in 1996. However they have since been gradually progressed by the Board. The Commission is urged to have particular reference to **Mr O'Dempsey's** evidence in particular (**Exhibit 28 attachment "JPO-18"**) which contains a paper entitled "DEVELOPMENT OF ASSESSMENT PROCESSES FOR OVERSEAS-TRAINED DOCTORS, INCLUDING AREA OF NEED SPECIALISTS" DATED 17 MAY 2005. This paper traces the historical background of the national approach to assessment and registration of OTD's.

See also **paragraph 58** of **Mr O'Dempsey's** statement, **Exhibit 28**, wherein he stated:

"58. *The MBQ is developing the necessary changes to enhance the assessment of overseas-trained medical practitioners whilst at the same time not making revolutionary changes which would directly impact on the supply of medical practitioners to the workforce in Queensland. Broadly these initiatives are:*

³ T4646

⁴ Exhibit 55, Statement of LENNOX

⁵ See Paragraphs 58-61

Exhibits "JPO-18" paragraphs 18 & 19 and "JPO-19" to the Statement of O'Dempsey, Exhibit 28;

- Since May 2004 the Board implemented a policy, developed in the preceding year, which required all overseas qualified medical practitioners seeking special purpose registration to sit and pass the International English Language Test. This ensures they have the necessary language skills for medical practice.
- Since February 2004 the Board has been developing a policy on the 'Requirements of Supervised Practice.'
- From July 2006 a national computer administered screening examination will be implemented for all special purpose registrants. The Board has always intended to utilise this screening examination for area of need registrants.
- With the introduction of the national screening examination, the online primary source verification of all qualifications will commence. Negotiations for this service are currently underway with the US Education Commission for Foreign Medical graduates".

See also paragraph 61 wherein Mr O'Dempsey stated:

"61. A specific document demonstrating the historical background to the problems of area of need registration is evidenced in a 1996 report by the Australian Medical Council to the Australian Health Minister's Advisory Council dealing with a structured system for area of need registration. Annexed hereto and marked "JPO-19" is a true copy of that report. A recent forum on the assessment of temporary resident doctors for general practice hosted by Department of Health and Ageing on 20 April 2005 deals with the issues of a national approach to the assessment of temporary resident doctors. A background paper titled 'Assessment of Temporary Resident Overseas-trained General Practitioners' was published by the Department for that forum. Annexed hereto and marked "JPO-20" is a true copy of this document. The Registrars/CEO's sub-group of the Joint Medical Boards Advisory Committee of the Australian Medical Council produced a position paper for the forum. Annexed hereto and marked "JPO-21" is a true copy of that document. The report on remedial actions which I prepared for the Board's consideration, and which was subsequently presented to the Minister was based directly on the position paper produced by the Registrars/CEO's".

Dr Gerry Fitzgerald gave evidence⁶ that the AMC was currently working on a "screening knowledge-based test" which could be applied in an overseas country prior to the individual medical practitioner coming to Australia. It is submitted that, in light of the in-progress nationally-based initiative to introduce a knowledge based screening test for OTD's, the Board should not be

⁶ T3182 lines 37-40 and T3184 lines 9-13

the subject of an adverse finding in circumstances where it has applied the current national standard and has, for some time, according to Dr Fitzgerald, been part of the AMC initiative to improve that standard.⁷

Mr O'Dempsey also referred to this national initiative in his evidence⁸. He also explained that a medical practitioner migrating to practice permanently in Australia (not on an "area of need" registration) is required to do the AMC examination for competency to the Australian Standard. He said in evidence⁹ that the AMC is not resourced to provide examinations for area of need applicants, and he warned that an examination does not equal performance ability but is only an indicator of competence and safety. He said¹⁰:

"Performance is what happens when you get in clinical practise, and it is having effective supervision. I agree on having examination processes, not to the detail of having to do the AMC exam, but screening safety examination, but having that effective apprenticeship style of supervision that has generally been available in the past to those that are coming up through the system".

This opinion evidence from **Mr O'Dempsey** remains unchallenged. He also gave comprehensive evidence of international initiatives currently in progress with the International Association of Medical Regulatory Authorities ("IAMRA") to address this issue.¹¹

Dr Mary Cohn current Chair of the Board stated¹² that the Board relies upon the Registration Advisory Committee ("RAC") monthly Report in order to make the final decision about the registration of an area of need Applicant. She said:-

"The RAC (which is a sub-committee of the Board) relies upon a more detailed examination of the suitability of each applicant for registration. The RAC relies on the OHPRB Registration Staff Officer/s to assess the eligibility of special purpose applications for "general registration" or "area of need" by checking the submitted documentation and ticking off a checklist.

In evidence, **Dr Cohn** described the RAC as a "very hard-working Committee".¹³ Dr Cohn explained that, with the assistance of Board staff, the RAC put forward its recommendations to the Board, with only matters which were not straight forward matters for registration being given an asterisk in the Board papers. She explained that the asterixed matters were then subject to full

⁷ T3181 lines 53-55

⁸ T505 lines 20-25

⁹ T668 lines 40-60

¹⁰ T668 line 58

¹¹ T534,535

¹² Statement of Dr Mary Cohn Exhibit 33, paragraph 12

¹³ T542

Board discussion. She estimated that at Board meetings, between 5 and 14 applicants would be the subject of full Board discussion and the straight forward matters approved by the RAC would be approved as a matter of course.¹⁴ Dr Cohn said that, in her experience on the Board since 1998, the asterisk matters were always the subject of robust discussion at Board level. Dr Cohn had her attention drawn to the statistics set out in Mr O'Dempsey's statement, Exhibit 28, at paragraph 62, wherein refusals of registration varied from 18 in 2002/03 to 45 in 2004/March 2005. Dr Cohn said:-

"...it reflects the ability of the members of the RAC to be able to look more closely and more carefully at the – matching the job description with the relevant experience and qualifications of the applicant."¹⁵

Dr Cohn explained in evidence¹⁶ that at the end of each RAC meeting – which can take between 3 and 4 hours the members collectively discuss the applications for registration which appear to be problematical:

"...everybody at RAC level would have looked at the problems first before they – and that may be solved at that level, but if it is not, then it will go to the full Board."

In Dr Cohn's experience, the Board's business is spread equally between the taking of the RAC recommendations, practitioner health assessment matters and practitioner complaint matters.

Dr Cohn's evidence is, in summary, that the Board's processes for assessing qualifications and experience of OTD's, through the RAC, are rigorous and thorough. The RAC and the Board did not act as a rubber stamp.

Dr Waters told the Commission¹⁷ that in June 2004 QHealth took over the Centre for International Medical Graduates ("IMG's") from the University of Queensland and it has been subsumed into the Skills Development Centre, which opened in September 2004. Dr Waters said that there had been consultation with the Medical Board concerning the Skills Development Centre assessing IMG's as to their skill levels and their training needs. Arrangements had also been made with the Medical Board for each IMG to consent to the information arising from training and assessment to be given

¹⁴ T543

¹⁵ T544

¹⁶ T546

¹⁷ T4693, 4694

to medical superintendents and to the Board for the further assessment of IMG's. Dr Waters expanded upon these processes when questioned by Junior Counsel for the Medical Board¹⁸.

Dr David Molloy, then President of AMAQ, also endorsed the initiatives currently under way to assess IMG's at the Skills Development Centre¹⁹. The only reservation Dr Molloy had was as to the funding model proposed by QHealth, i.e. as to the future funding commitment to this initiative by government.

Dr Molloy also made the following observation during his evidence, specifically in the area of assessment of clinical competence of specialists²⁰:

"...the Medical Board is not in a position to be an arbitrator of clinical competence in terms of the nuances of standards of specialists and their fitness to practise within the range of a speciality. That would be much better decided by the College in consultation with the Medical Board".

No finding adverse to the Board is warranted or justified on the evidence, or as a matter of law, in respect of paragraph 1 (a) of the notice. On the contrary, the Board's adherence to applicable national standards for assessing of clinical skills and knowledge of area of need applicants for special purpose registration should be acknowledged. Further the Board's proactive participation in initiatives for improvement of assessment of OTD's, involving the Skills Assessment Centre, the AMC and IAMRA, all, pre-dating this Inquiry, ought to be acknowledged.

1(b) - The Commission may find that:

(b) The Board failed to determine (at least prior to May 2004) the English language proficiency of area of need applicants.

The Board submits that any proposed adverse finding concerning the English language testing of area of need special purpose applicants for registration cannot be sustained on the evidence.

Mr Demy-Geroe gave unchallenged evidence²¹ that prior to formalised English language proficiency testing in May 2004, there was an interview process in place, one of the purposes of which was to assess whether a person had an adequate command of the English language. The Medical Board discontinued the interview process in December 2004. Most importantly the Board led the nation in implementing an objective English language test for OTD's.²²

¹⁸ T4695, 4696

¹⁹ T831, 832

²⁰ T780 lines 49-55

²¹ T420 lines 30-50

²² T423 lines 25-50

Mr Demy-Geroe also said²³:

"...we simply didn't have very many substantiated cases of doctors who couldn't communicate at all – who couldn't communicate to any acceptable level".

It is therefore submitted that the unchallenged evidence before the Commission is that, until May 2004, the interview of OTD's was properly considered to be a sufficient means of assessing English language skills, in light of the fact that according to the unchallenged evidence of **Mr Demy-Geroe**, the number of substantiated cases of doctors who could not communicate was very low. In May 2004, well before this Inquiry, the Board significantly improved its method of English language assessment. The Board submits that this was a significant initiative because language skills testing moved from being a subjective process to being an objective one as a pro-active initiative of the Board.

In light of the matters detailed, an adverse finding such as that posited in Paragraph 1(b) is not warranted and is contrary to the evidence. The Board's initiative in leading the nation in this area ought to be acknowledged.

1(c) - The Commission may find that:

- (c) *The Board failed, as a matter of routine, to satisfy itself as to the level of supervision an applicant would receive, when such a step might be critical to a consideration of suitability.***

As submitted above it is the primary responsibility of the employer, relevantly QHealth, to satisfy itself that the OTD is selected for an "area of need" position which is commensurate to the OTD's skill level and seniority of position as to whether there will be an appropriate level of supervision intended within the hospital. The Board is entitled to expect that appropriate consideration was given by QHealth to the question of supervision of the OTD when a responsible and senior officer from QHealth selects a candidate and then seeks certification of the "area of need" position in order to appoint that particular candidate.

In the case of **Dr Patel**, the evidence demonstrates that if a suitably qualified Director of Surgery was in place at Bundaberg Base Hospital at the relevant time, **Patel** as an SMO (Surgery) would, have, *prima facie*, received appropriate supervision from that Director. On the face of the certification of "area of need", the Board was entitled to expect an appropriate level of supervision was intended by the Hospital in the Board's consideration of **Patel's** suitability for "area of need" registration in that position. See in particular the evidence of **Dr Mark Mattiussi**²⁴.

²³ T421

²⁴ T 5627-5629

The Board was also generally entitled to expect a high level of supervision of OTD's within QHealth. It is not within the functions²⁵ of the Board to dictate to any Public Hospital as to how it was to structure its management and utilization of resources.²⁶ Furthermore QHealth was at the relevant time of Patel's appointment, subject to a Public Service Commissioner directive number 18/97²⁷ issued pursuant to S 34 of the Public Service Act 1996 which requires:

Directive:

- (a) *In order to achieve continuous improvement of performance in the delivery of services as detailed in Part 3 of the Public Service Act 1996, Chief Executives shall implement a performance management system.*
- (b) *To achieve the principles of work performance and personal conduct, detailed in Section 25 of the Public Service Act 1996, employees shall actively participate in departmental performance management strategies.*
- (c) *Performance management systems should be linked to strategic plans and be directed toward the achievement of organisational goals and objectives.*
- (d) *Performance management may be applied to the achievement of both individual and team performance objectives.*
- (e) *A performance management system shall include, at a minimum, the following strategies:*
 - *A performance appraisal and development strategy.*
 - *A strategy for acknowledging high levels of performance.*
 - *A strategy for the improvement of unsatisfactory performance.*
 - *A strategy for managing disciplinary action". (emphasis added)*

This directive is highly relevant to the question of management and supervision within QHealth.

Good examples of close supervision can be seen in the following Board files, which have been supplied to the Commission and which are referred to in detail in Part B of the Medical Board's general submissions:

- 1.3 Vincent Berg

²⁵ See s,11 *Medical Practitioners Registration Act 2001*

²⁶ Affidavit of O'Dempsey, Exhibit 461, especially paragraphs 3-5

²⁷ The full text of the directive is annexed hereto and marked "Annexure 1"

- 1.4 Dr Vitomir Zepinic
- 1.5 Dr Thamara Munasinghe
- 1.9 Dr Domodaran Krishna (at Toowoomba Hospital) (see statement of Dr Anthony Wilder Ex 482 and T7334)
- 1.11 Dr Anatole Kotlovski

In the latter case, it is apparent from the Board's file that the OTD received close supervision at Royal Brisbane Hospital from eminent surgeons, although during his two-month locum period at Bundaberg Base Hospital ("BBH") in February 2002, there was a lack of supervision, the reason for which was not ultimately explored in evidence.

In his statement,²⁸ Dr Kotlovsky, at paragraphs 21-36, said that he did have supervision from Drs. Nydam and Jayasekera, but that the latter had expressed resentment at having to provide supervision without remuneration. Though these statements have not been able to be put to Jayasekera, and should not be used as a basis for any adverse finding against Jayasekera, the statement demonstrates two important aspects of the supervision issue:-

1. QHealth supervision can break down without the Board becoming aware of it; and
2. The excellent references provided by Dr Kotlovsky bear eloquent testimony to the level of supervision he received at RBH and PA Hospital.

The evidence reveals possibly unsatisfactory instances of supervision of 2 OTD's apart from Dr Patel, these being Drs Sharma & Krishna. However, in the assessment of their suitability for the position, the Board was presented with information by the employer, QHealth, that they would be supervised by the Director of Orthopaedics, Dr Naidoo. See in particular for example Exhibits 360 and 361, wherein the Board was advised that a prima facie appropriate person, Dr Naidoo, was the supervisor of the OTD. The fact that possibly unsatisfactory supervision resulted from Dr Naidoo's many authorised absences in the period 2003 – 2005 is not due to any act or omission by the Board, nor is it a matter of which the Board could have become aware, unless an appropriate complaint was received from some party. Although Dr Mullen said he had such complaints about Drs Sharma and Krishna, he chose not to address those complaints about supervision to the Board.

As Mr Demy-Geroe, Deputy Registrar of the Board, explained in evidence under examination from Senior Counsel Assisting²⁹:

²⁸ Exhibit 484

²⁹ T492 - 493

"I think in the hospital structure generally one expects that there is supervision at all levels ...

Q: The employer didn't specify supervision available, in that respect, was that Form 1 deficient or is that how they are regularly left?

A: I think in the case of hospitals they are sometimes left like that and at that time that wouldn't have raised any concerns because, again, as I have indicated, there was an expectation that hospital's are a supervised environment..."

Mr Demy-Geroe agreed with Senior Counsel Assisting that it would be feasible for annual re-registration applications to require the applicant to obtain from the employer a certificate as to the degree of supervision that the certifier has exercised³⁰. Mr Demy-Geroe's Affidavit,³¹ demonstrates that current requirements for supervision are much improved and are evidence of the Board's ability in the circumstances to progress revolutionary change as mentioned above.

No adverse finding is warranted. The Board's recent initiatives in strengthening supervision requirements ought to be acknowledged.

1(d) - The Commission may find that:

(d) The Board failed, in particular, to require that the applicant identify the person who was to provide any supervision in order to assist in considering the applicant's suitability for practise.

With respect, the adverse finding posited in (1)(d) of the Notice misconceives the person upon whom the requirement rested at the time of the events under investigation. At the relevant time, the Board required the employer to specify the supervision available. The applicant for registration was not required to certify as to supervision available.

The employer, QHealth, by nominating the position by way of its position description and by nominating the applicant, by way of his qualifications as a medical practitioner, for special purpose ("area of need") registration, in effect identified to the Board that the supervisor or supervisors would be the medical staff senior to the OTD in the particular hospital structure. For example, if the OTD was nominated for registration as an "SMO-Surgery", then the Board was entitled to take the view that the staff specialists and generalists senior to the SMO would be his/her supervisor/s. Before the Commission even contemplates making an adverse finding as posited in 1(d), it is urged that the Commission examine carefully **Exhibits 360 and 361**, as well as the relevant Exhibits from the Affidavit of **Mr O'Dempsey Exhibit 461**: see in particular **Exhibit 361**, the "Form 1", where the employer, not the applicant, is required to certify as to:

³⁰ T493

³¹ Exhibit 420

"Supervision available"

"Consultant advice available"

See **Exhibit 360**, where upon re-registration, the Assessment Form imposed obligations upon the employer as follows:

- *"assessment form must be completed by the clinical supervisor or mentor nominated on the Area of Need Certificate or training program approved by the Board.*
- *The clinical supervisor or mentor must currently hold General, Specialist or Special Purpose Section 138 registration with the Board.*
- *The assessor is to attach a brief explanation as to how the supervision or monitoring was undertaken".*

The Board's improved processes (as detailed in Ex 420 – Supplementary Affidavit of **Mr Michael Demy-Geroe**) spells out the exhaustive processes which have been adopted.

In fairness to the Board the ability to have sought timely legislative amendment, as for example the increase in penalties for false or fraudulent applications for registration, would not have realistically been available but for the high degree of public attention created by the Commissions of Inquiry. The Board's ability to affect change in registration processes when considering potential interests of all other relevant stakeholders should be seen in this light rather than as an opportunistic and reactive approach. An example of this is evidence from the Board's recommended change to the law as detailed in the Affidavit of **Mr O'Dempsey, Exhibit 28: JPO-14, Paragraph 13**. However, it took the interim report of the Bundaberg Hospital Commission of Inquiry – for legislative change to take place.

The Board submits that this issue should be considered as against practices existing at the relevant time, without the benefit of hindsight. An adverse finding would be misconceived and not based on the evidence.

1(e)- The Commission may find that:

- (e) *The Board failed to make inquiries of referees nominated by the applicant into the applicant's suitability for a position.*

As submitted above the primary responsibility for making inquiries of referees nominated by applicants for special purpose "area of need" registration, lies with QHealth which has the task of matching "area of need" applicants to "area of need" position descriptions within the public hospital system. QHealth is in the best position to know the requirements of the position description.

The obligation for reference checking for the filling of a job position is clearly one which sits with an employer. Reference checking necessarily involves the job applicant giving consent either expressly or impliedly to a prospective employer or agent to contact any nominated referee and canvass confidential information about the candidate pertaining to the position.

In the case of a recruitment agency being used for the recruitment of a doctor to fill the position ultimately filled by Dr Patel it is submitted that there was an implied contractual obligation upon **Wavelength Consulting** to QHealth to diligently carry out appropriate reference checks upon Dr Patel. The express terms of the contract of agency between QHealth and Wavelength Consulting are in evidence.³²

Whilst the contract is silent on the specific duty of **Wavelength Consulting** to carry out the reference checks it is clearly implied that **Wavelength Consulting** was under a duty to carry out those checks. First neither QHealth nor Dr Nydam carried out any reference checks on Dr Patel. Secondly they were in fact (at least in respect of 2 referees) carried out by **Wavelength Consulting** which suggests a duty on the part of **Wavelength Consulting**. Thirdly and most importantly paragraph 9.2 of the contract of agency between **Wavelength Consulting** and QHealth provides under the heading

"Warranties and Limitations of Wavelength Liability

9.2 Wavelength will refer Candidates to the client on the basis of the information provided to it by the Candidate. Wavelength will use reasonable endeavours to establish accuracy of information provided by the Candidate, however the Client must make and rely upon its own enquiries will (sic) regard to matters the Client considers relevant in determining to engage the Candidate."

The Board was as it turns out justified in having an expectation that the reference checks had been diligently carried out either by QHealth or the recruitment agency as would normally be expected to be the case.

³² see attachment to statement of Dr Nydam Ex 51 – KN8) which is the contract of agency. These conditions post date those contained in the document in evidence - exhibit 42

Indeed, **Dr Nydam** said in evidence³³ that, because **Patel** was seen by him as a locum, a fact not known to the Board, the ordinary selection processes for permanent employees were bypassed for selection of a temporary employee. The requirements for selection processes in public service appointments (other than temporary employees) are contained in Public Service Commissioner Directive (01/04) of 5 April 2004 which is annexed hereto and marked "Annexure 2".

The Board has always relied, and is entitled to rely, on Public Sector employers, meeting their legal obligation under the *Public Service Act* and any Directives issued pursuant to that Act, in regard to the processes of recruitment and selection of candidates for a position, including appropriate reference checking. In any event, the referees were "*glowing*" according to **Dr Bethell**. In fact, **Dr Bethell** said in evidence that when he returned to the two referees, one said he did not know of the Oregon orders and the other declined to speak to him about it.³⁴

Dr John Bethell³⁵ said in evidence that he had made contact directly with the two referees cited by **Dr Patel** in the course of seeking employment as an OTD through **Wavelength Recruiting**. The third referee did not work with **Patel**, so was not spoken to. The references were "glowing".

Mr Demy-Geroe³⁶ also gave evidence about the practise of contacting referees of applicants for special purpose "*area of need*" registration.

The Commission is asked to note the frank and full disclosures made by the Board to **Minister Nuttall** in a Memorandum dated 13 April 2005.³⁷ This Memorandum followed a detailed investigation by **Mr Demy-Geroe** of the circumstances of the registration of **Patel**.

There is no other evidence in relation to any other "*area of need*" applicant, to the effect that inquiries of referees nominated by the applicant were not made by the Board or by the Recruitment Agency involved, or by QHealth, in the process of assessing the applicant's suitability for a position.

The Commission has not received any evidence that there was a systemic failure by the Board to make inquiries of referees, or to see that they were made.

The Commission received evidence that **Dr Kees Nydam** and **Mr Demy-Geroe** had the belief that, from their previous experience, **Wavelength Consulting** were a superior service and reputable.³⁸

³³ T4120

³⁴ T705

³⁵ T680, 681, 696, 704, 705, 761-762

³⁶ T426,486

³⁷ Exhibit "MDG-3" to the Statement of Mr Demy-Geroe, Exhibit 24.

³⁸ T4137 and Statement of Mr Demy-Geroe Exhibit 24 – "MDG-3" (paragraph 2.3)

Dr Nydham, for his part, attempted to explain his own reasons for not performing referee checks, and he may be correct as a matter of law.³⁹

In all of the above circumstances, it is submitted that a finding adverse to the Board is not warranted on the evidence, because the evidence is that full inquiries with referees were made by Wavelength, in the case of Patel, and no other evidence of systemic failure has been presented.

1(f) - The Commission may find that:

- (f) *The Board failed to make inquiries of the applicant's last known employer to assist in the consideration of the applicant's suitability for a position.*

Dr Bethell of Wavelength Consulting gave evidence⁴⁰ that he made direct contact with Dr Patel's referees, at least one of whom worked at the Kaiser Permanente Hospital at Portland, Oregon with Patel, once or twice a week over 10 years. That is the best that can be said of the checking that was done. If the checking had included the last known employer – the administrators of Kaiser Permanente – there is a higher likelihood, though not a guarantee, that Patel's apparent fraud would have been discovered.

Directive 01/04 was issued for the Public Sector in April 2004. Therefore, as at December 2002, there was no legal requirement for QHealth to check with the former employer as part of the recruitment and selection process. It is hardly fair to criticise the Board itself for failing to make inquiries with the last known employer in circumstances where:

- (a) there was no legal obligation upon QHealth or the Board to do so; and
- (b) if there was a practical obligation, then it rested with QHealth in the first instance; and
- (c) As Mr Demy-Geroe said in evidence, the sheer numbers of applications for area of need registration made it impractical for the Board staff to check with the previous employer; and
- (d) There has always been the risk that, for their own purposes, employers may choose not to disclose some prior negative history; and
- (e) The Board's current requirement to receive original Certificates of Good Standing direct from the issuing authority is a more reliable safeguard.

If the Government, as at December 2002 had not thought to mandate the requirement posited in paragraph 1(f) (until April 2004), the Board should not be criticised for this failure.

³⁹ T4138

⁴⁰ T696

The Board submits that the Commission should note the evidence of **Dr Kees Nydam**⁴¹ to the effect that it had crossed his mind "*quite early in the piece*" that if **Dr Patel** was as skilled and experienced as he claimed, it was unusual that he would take a position in Australia for a substantially reduced remuneration package. **Dr Nydam** conceded in evidence that this was an "*error of judgment*" and that he had made a further error when he took Patel's explanation for this decision at face value:

"His (Patel's) explanation was he had worked hard, he had earned a lot of money, and now it was time to give something back".

It should also be taken into account that **Dr Bethell** was misled when a 12 month gap in **Patel's** employment was dealt with by Patel dishonestly amending his *curriculum vitae*, and forwarding a second misleading CV to QHealth.⁴² This dishonesty was not exposed by **Dr Bethell** or QHealth by way of taking up inquiries directly with the previous employer. The fact that QHealth ultimately presented the "new CV" to the Board as a component of Patel's application highlights the "*inverted process*" for registration of OTD's previously referred to. It also highlights QHealth's primary practical, if not legal, obligation.

In all of the above circumstances, the Board does not accept that it had a duty to make inquiries of **Dr Patel's** last known employer. Such a duty now rests with the prospective employer, QHealth, only after April 2004, and only if the recruitment and selection process is not for a casual position such as a locum position.

1(g) - The Commission may find that:

- (g) The Board failed to conduct internet searches to ascertain whether any disciplinary proceedings had been brought against an applicant.**

Mr O'Dempsey outlined in his statement⁴³ that internet checks are by no means a reliable method for the validation of the records of overseas trained medical practitioners, or of any registrant who has practised overseas at any time in his or her career. **Mr O'Dempsey** cited a number of reasons for this inherent unreliability:

- Overseas jurisdictions do not always post registration data relating to its registrants on the internet; and
- Overseas jurisdictions do not always record on the internet whether any conditions of practice have been imposed; and

⁴¹ T4137

⁴² T717

⁴³ Exhibit 28 paragraphs 42 and 43

- Even if such information were to be posted, there is the possibility that it is out of date or erroneous.

Mr O'Dempsey's evidence is unchallenged, and supported by the unchallenged evidence of Mr Demy-Geroe, who spoke of the time-consuming and potentially inaccurate nature of such searches. He also made the valid⁴⁴ point that many internet entries are in a foreign language and also that there are inherently irrelevant pieces of information which can come back from an internet search⁴⁵.

The Commission should note the unchallenged evidence contained in Mr O'Dempsey's statement Exhibit "JPO-13" in Exhibit 28: Summarised herein it indicates that in April 2005, 6232 internet entries for Queensland OTD's registered at that time revealed no irregularities and numerous references to persons other than the OTD, but with identical names.

It is submitted that an adverse finding in relation to the failure to conduct internet searches should not be made in light of the unchallenged evidence as set out above, and in light of the fact that in the period 1 July 2002 to March 2005, a total of approximately 8,876 applications for "area of need" registration were approved by the Board⁴⁶.

1(h) & (i) Commission may find that:

- (h) The Board adopted a practise of accepting certificates of good standing, and copies of other certificates or qualifications, from applicants rather than from the issuing bodies, being a practise which permitted fraud.**
- (i) The Board failed to require that an applicant arrange for a certificate of good standing to be supplied from each jurisdiction in which the applicant had practised.**

At the time of the registration of Dr Patel, and until recently, certificates of good standing were not obtained from the issuing bodies, and certificates were not required from each jurisdiction in which the applicant had practised.

It should be noted that Dr Bethell of Wavelength said in his witness statement⁴⁷ that although Dr Patel originally faxed his Verification of Licensure, he subsequently sent the original of the document.

See also the evidence of Mr O'Dempsey on this issue.⁴⁸

⁴⁴ T456 and T458-459

⁴⁵ T459 line 40 where for example a disciplinary matter involving a polo club might be irrelevantly found

⁴⁶ Statement of O'Dempsey, Exhibit 28 Paragraph 62

⁴⁷ Exhibit 41, paragraph 17

The Board does not accept that it had a duty to accept Certificates of Good Standing directly from the issuing bodies, nor does it accept that it had a duty to arrange for a Certificate of Good Standing to be supplied from each jurisdiction in which the Applicant had practised. It does acknowledge that, in the context of **Patel**, who was acting apparently fraudulently in his dealings with **Wavelength Consulting**, his fraud would have been detected if the above procedures had been carried out.

The Board concedes that it is a better procedure to receive COG's directly from the issuing authority. It is to the Board's credit that, in the course of this Inquiry, it has instituted tighter procedures to minimise this risk of fraud. It is also to the Board's credit that, in its Memorandum dated 13 April 2005⁴⁸, it frankly identified this issue to the Minister and a full public acknowledgement and apology from the Board followed in the public media.

If an adverse finding is to be made about the Board's procedures, as a matter of fairness, the Board's swift response and handling of the problem when the issues became known should also be acknowledged.

1(j) - The Commission may find that:

- (j) The Board did not otherwise carry out adequate inquiries to ensure that applicants would be sufficiently competent to fill any proposed position.**

Precisely the way in which the Board failed to "otherwise" carry out adequate inquiries to ensure the competence of "area of need" applicants, is not specified, nor is the Board aware of any other evidence about any other inquiry that the Board could have made in order to determine competence of "an area of need" applicant in respect of the matters under inquiry.

In the absence of any further particularity, the Board is unable to make any further submissions. Therefore an adverse finding in terms of this paragraph of the notice is unsustainable.

1(k) - The Commission may find that:

- (k) The Board failed to implement any system for monitoring the performance of area of need applicants during the term of their registration, whether by the imposition of conditions or otherwise.**

The Board submits that it is not correct to suggest that there was no system for monitoring area of need applicants. That system consisted of the following:

⁴⁸ T502 - L25-30, 503

⁴⁹ Exhibit "MDG-3" to statement of Demy-Geroe, Exhibit 24

- Employer notification that supervision was available⁵⁰
- Instructions to employers in the renewal "Assessment Form"⁵¹
- Complaints mechanism provided pursuant to the *Health Practitioners (Professional Standards) Act 1999*⁵²
- Board's periodic follow-up of OTD's efforts to seek Australian Specialist College accreditation⁵³.
- In addition the Board was entitled to expect an appropriate level of supervision within QHealth. In this regard QH has legal obligations pursuant to Directive 18/97 issued under S 34 of the *Public Service Act 1996*.

The proper credentialing and privileging of **Dr Patel** before or after his arrival in Bundaberg was also a matter for QHealth. The Medical Board was entitled to rely upon the proper implementation by QHealth of the Queensland Health Policy Statement on credentialing and privileging⁵⁴.

The Commission has received no evidence to suggest any further method for monitoring of OTD's with special purpose registration in an "*area of need*", over and above the provision of the credentialing and privileging process, the provision of appropriate supervision, and the framework set out above.

The Board was also entitled to rely upon the existence, within QHealth, of a system for identifying and reporting "*sentinel events*" and "*adverse incidents*". This provided a further internal mechanism for monitoring of IMG's by QHealth.

The Board's file on **Dr Tariq Qureshi** demonstrates the speed with which the BBH notified the Board of suspected sexual misconduct by **Dr Qureshi**. This is eloquent testimony to the monitoring system at work as for that matter are the files relating to Berg, Zepinic and Munasinghe. These are examples of usual and expected monitoring procedures at work.

Upon the substance of any adverse report of an OTD being made out, there would then be evidence upon which the Board would be able to reassess the registration of the OTD, or impose conditions upon registration. The Commission has received no evidence to suggest that the Board is guilty of a failure to implement some additional system for monitoring the performance of "*area of need*" special purpose applicants for registration during the term of their registration. The Board is unaware of any evidence upon which an adverse finding in this regard could be based.

⁵⁰ See for example Exhibit 361

⁵¹ See for example Exhibit 360, three "dot points" referred to above.

⁵² See Board's Submissions PART A, Section 1.6 re Dr Qureshi.

⁵³ See evidence of Dr Younis, T3779

⁵⁴ Exhibit 279

1(l) - The Commission may find that:

(l) The Board failed to ensure that it has adequate resources to appropriately process the area of need applications that came before it

There is no evidence to suggest that the Board's handling of and processing of area of need applications was in any way systemically deficient. Thus there can be no inference that the resources as dedicated were inadequate to deal with area of need applications in any financial year. In fact in all of the evidence before the Commission the highest any suggestion comes to full utilisation of resources was with reference to the peaks of timing when area of need registrations are at their highest⁵⁵.

On a general note funding of the Board is a matter for government through the fees established in the *Medical Practitioners Registration Regulation 2001*. It is through the fees set by government that the Board receives the overwhelming majority of its funding to implement the functions under both the *MRA* and the *Health Practitioners (Professional Standards) Act 1999*.

The Board identified that further resources were necessary to implement its reforms to processing applications for special purpose registration. A recommendation in this regard was made to **Minister Nuttall**. The statement of **Mr O'Dempsey Exhibit 28: JPO-14, Attachment A, Paragraph 12**, refers.

The statement of **Mr O'Dempsey (Exhibit 28)** paragraphs 5-7 describes the legislative relationship between the Office of Health Practitioner Registration Boards (OHPRB) and the Medical Board. It annexes the annual reports of the Office of Health Practitioner Registration Boards for the period 2002 to 2004 (JPO 2- JPO 5). Of particular importance is an extract from the OHPRB report to the year ended 2004 which is publicly available and annexed hereto and marked "Annexure 3". In these reports to government issues of resourcing are shown to have been regularly addressed as detailed below:

- JPO 3 – pages 4 and 5 demonstrate that the schedule to the service agreements was reviewed and modified to ensure appropriate billing of staff time to each board; apportionment of non-salary costs was directly linked to staff usage by each board; and cross-subsidisation between the boards was minimised.

⁵⁵ At the beginning of each calendar year - evidence of Demy-Geroe T417 – Lines 1-10

- JPO 3 – page 13 reports that an investment policy developed by the office had been approved by each board and that this policy would result in increased interest revenue for all boards.
- JPO 3 – page 13 reports that recurrent costs of the office and each board had been reviewed and from this review, changes had been implemented resulting in significant recurrent cost savings.
- JPO 4 – page 6 reports that the establishment of a renewals and restorations business processing centre had resulted in a reduction in salary costs equal to the equivalent of 1.4 full time casual positions.
- JPO 4 – page 10 reports that based on a cost benefit analysis for use of external investigators the Board established a panel of contract investigators through a competitive tendering process to clear the backlog of investigations.
- JPO 4 – page 17 reports that a review of the financial management infrastructure had been undertaken and details the changes to be implemented to enhance financial management and corporate governance. In addition, the report details a further initiative of implementing Board specific merchant facilities which in part ensured that Board interest revenue would increase.
- Annexure 3 – page 6 reports that a jointly funded project for review of registration processes had been established in partnership with the integrated service delivery unit of the Department of Innovation and Information Economy.
- Annexure 3 – Page 16 reports that an objective to be achieved in the following year was *"to inform, negotiate and implement a realistic policy for fees established under the regulations of each registration act"*.
- Annexure 3 – Page 19 reports that the quality improvement in the financial management and reporting framework had been fully implemented, resulting in a more effective use of staff resources and enhanced corporate governance. A report has also provided that a model enabling 5 year financial projections had been developed and fully implemented. It was further reported that the model enhanced corporate governance and enabled each board to:

- Consider their medium to long term financial projection in both the development and approval of the annual budget;
 - Incorporate a simple, cost effective and regular budget review process; and
 - Model the cost of proposed initiatives to informed decision making.
- JPO 5 – Page 10 reports on progress for the development of a submission to the Minister for a change in government policy on fees established under the regulations of each registration act. It is further reported that the office has continued to progress relevant fee increases consistent with the current government policy.
- JPO 6 is a copy of a submission made to all boards which has been subsequently approved. It documents the outcomes of the registration review project and, in particular, paragraph 17 advises that a net savings of \$2,382,348.00 would be generated over 10 years should the boards implement the outcomes of the project.
- Paragraph 19.2 of JPO-6 also documents that funding of \$1,250,000.00 on an interest free repayable basis for the development of proprietary software was being sought from Queensland Health as the current income arrangement for the boards and the reserves available limited the possibility of boards investing such an amount in any one financial year.

Funding of the Board is ultimately a matter for Government. In the Reports to Government of the OHPRB from the years 2002 – 2004 (Publicly available on the OHPRB website), issues of funding of the functions of the Office can be shown to have been regularly addressed.

It is also noted that a specific grant was sought in respect of funding research into the issue of safe working hours for doctors.⁵⁶ Thus the Board was, particularly from the year 2002 onwards, acutely aware of its funding and resourcing needs and pro-active in addressing those needs. The Board submits therefore that there is a clear body of evidence to suggest that any such proposed adverse finding is not sustainable nor justified on the evidence.

1 (m) The Commission may find that “the Board failed to comply with good practise, the National Policy document entitled Assessment Process for Area of Need Applicants (see Exhibit 36), or the legislative intent of Section 135 and 143A of the Act, in that:

⁵⁶ Exhibit 229 (a request for funding is made in respect of this important study)

- (i) *Where an application would result in the applicant becoming a deemed specialist, it should only be approved following consultation with the relevant College and pursuant to such conditions as the College might recommend;*
- (ii) *Section 135 and 143A, when read together, provided that, where the Board registered an applicant "to practise the profession in a specialty in an area of need", the applicant was deemed to be a specialist;*
- (iii) *The Board regularly registered applicants to practise in positions such as a "Senior Medical Officer in Orthopaedics" or a "Principal House Officer in Obstetrics and Gynaecology";*
- (iv) *The effect of such registration was that the applicant, by operation of Section 143A, became a deemed specialist.*
- (v) *Where it so acted, the Board failed to consult with the relevant College either adequately or at all.*

The Board rejects the suggestion that any registrant, through area of need special purpose registration, in any circumstance was improperly processed such that he/she became a "deemed specialist" under S 143A of the MPRA.

There can be no doubt that the conduct of the Board in considering registration of in an area of need under special purpose S135 registration per se in circumstances where the registration certificate will read such as "Senior Medical Officer in Orthopaedics" or "Principal House Officer in Obstetrics and Gynaecology" does not have the effect by operation of Section 143A of deeming that applicant to be a specialist.

Neither Sections 135 nor 143A of the Registration Act have yet been the subject of judicial construction.

It is submitted that an analysis of the operation of each of Sections 135 and 143A will demonstrate that the Board's processes as evidenced in the Affidavit of **Mr O'Dempsey - Exhibit 461** result in the proper registration of registrants as intended and provided under the relevant law.

- (a) Ministerial decision as to "area of need" is a condition precedent to special purpose registration.

For S135 to be invoked requires a ministerial decision as to there being an "area of need for a medical service in a particular area of the State."

S143A of the Registration Act did not have an equivalent provision in the former *Medical Act* nor in the Registration Act as it was originally enacted. The provision of Section 143A was inserted into the Registration Act prior to the commencement of the operative provisions of that Act in 2002⁵⁷. It is submitted that the amendments made to the Registration Act prior to commencement were primarily driven by a need to enable Queensland to conform to a proposed national scheme for the assessment of overseas trained specialists seeking registration to practise in an area of need. The Minister advised the House in the second reading speech:

(b) The amendment to insert Section 143A

"The Bill contains amendments to the Medical Practitioners Registration Act 2001. The amendments are necessary to facilitate a proposed national scheme for the assessment of overseas trained specialists seeking registration to practise in an area of need. Under the scheme, overseas trained specialists who are granted special purpose registration by the Medical Board of Queensland to practise in an area of need would be subject to periodic assessment by the relevant specialist college. The scheme envisages that the Board will change the conditions of registration if the results of a college's assessment indicate this action is necessary. However, the current provisions of the Act only allow the Board to change the conditions of registration on renewal of registration, which could be up to one year after a College's assessment. The Bill overcomes this difficulty by enabling the conditions on special purpose registration to be changed during the term of registration if this is necessary for the registrant to practise safely and competently. The Bill also provides that area of – need – specialists, who have special purpose registration, are deemed to also have specialist registration. Deemed specialist registration will be necessary for appointment to public sector specialist positions and for specialist recognition under the Health Insurance Act 1973"

It can thus be seen that the amendment by adding Section 143A facilitated the appointment of area of need special purpose registrants to public sector specialist positions and the securing of specialist recognition of these persons for the purposes of the Commonwealths Health Insurance Act 1973. That Commonwealth Act provides for the payment of specified benefits for the provision of medical including specialty services by approved providers.

(c) The scope of Section 135 – "Medical Service"

⁵⁷ *Medical Practitioners Registration Act 2001*, Act No. 7 of 2001, date of assent 11 May 2001 Sections 1-2 commenced on date of assent. Sch.2, AMDT 1 of the *Health Practitioners (Professional Standards) Act 1999* commenced 12 May 2002 (automatic commencement under the *Acts Interpretation Act 1954*, Section 15DA(2)(AMDT could not be given effect) (remaining provisions commenced 1 March 2002)(2002 SLNo.30)

"It is submitted that Section 135 of the Registration Act is not directed just to the registration of those people who will provide specialist services in an area of need. The language employed in ss.135(1), 135(3) and 135(4) is "area of need for a medical service". The term "medical service" is not expressly defined in the Registration Act and neither is the term "specialist medical service". The term "professional service" is expressly defined – "professional service means a medical service, including a specialist medical service"⁵⁸

It is submitted that a "specialist medical service" is a subset of a "medical service". This is implied in the definition of "professional service". It is also explicit in the Act's definition of "speciality" – speciality means a branch of medicine prescribed under a regulation to be a specialty⁵⁹

(d) The effect of s.139(2)

A conclusion that special purpose registration, including special purpose registration under s135 is not confined to the practise of a specialty is consistent with the use of the conditional tense in s139(2) of the Registration Act with respect to the details for the inclusion of which a special purpose registration certificate must provide:

"(2) The approved form for a certificate of special purpose registration or certificate of provisional special purpose registration must also provide for the inclusion of –

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

(b) if the special purpose involves the practise of a specialty, details of the specialty" (emphasis added)"

It is submitted that there is nothing in the Minister's second reading speech to suggest that all practitioners registered under s.135 were to be deemed specialists under 143A. Neither the second reading speech, nor the construction of the scheme of the legislation, can justify this conclusion.

It therefore follows that it is not legitimate to construe the statement in s143A(1) as to the application of s143A as an indication that s135 is confined in its operation to the special purpose registration of a person "to practise the profession in a specialty". It sits equally comfortably with the language of s.143A(1) to construe it as applicable only to those

⁵⁸ Definition, S8 and Schedule 3 "dictionary", Registration Act

⁵⁹ Ibid. As to what a "specialty", Section 6 of the *Medical Practitioners Registration Regulation 2002* provides 6 specialties – Act, Sh.3, Definition "specialty"
For the definition "specialty" in Schedule 3 of the Act, a branch of medicine mentioned in Schedule 1, Column is a specialty.

particular s135 special purpose registrants whom the Board has registered to practise the profession in a specialty in an area of need. Those whom it has registered under s135 just to practise the profession and without reference to so doing in a specialty fall outside the deeming regime for which s143A makes provision.

Thus, special purpose registration under s135 does not, on the true construction of the Registration Act, automatically engage the deemed specialist registration for which s143A makes provision. It will be necessary to consider further what is meant by the words "*to practise the profession in a specialty*" in s143A when considering whether the Registration Act may have the consequence that those special purpose registrants whose position is in a specialty area of medicine are nonetheless deemed to be specialist registrants by that section.

(e) The need for a "*medical service*" is the core of the ministerial decision.

What informs the making of a ministerial "*area of need*" decision is not geography per se but rather a need for a medical service in a particular locality. That service, for the reasons given, may or may not be a specialist medical service. In notifying his decision to the Board in conformity with s135(4), the Minister must notify both the area and the associated medical service need in that area. The notification of all that information is necessary for the Board to be able to conform to the requirements imposed on it by s139(2) of the Registration Act in relation to the details that must appear on a special purpose registration certificate.

It is submitted that as a matter of language, the words "*in orthopaedics*" and "*in obstetrics and gynaecology*", each read in isolation, refer just to a branch of medicine. As used by the Board, these words form part of a position description (which is developed and approved by Queensland Health) and are descriptive of the branches of medicine in which the special purpose registrant is to practise in one or other of the nominated offices – eg. JHO, PHO or SMO etc.

(f) The descriptors of the "*area of need*" position

The nominated offices have a long standing meaning in the medical profession and, through the usage of those descriptors, in the broader community.⁶⁰ "*Medical*", when employed adjectivally with "*officer*" to create the term "*medical officer*" yields nothing more than a term meaning "*a doctor appointed by a company or public authority to attend to matters relating to health*". The term has never carried the connotation that the holder of such an office, so described, is a medical specialist. As a matter of ordinary language, the

⁶⁰ Refer to Affidavit of James Patrick O'Dempsey paragraph 3

adding of a reference to a specialty field to each of these nominated officers does nothing more than indicate the branch of medicine in which the medical officer or, as the case may be, the house officer is to be employed.

(g) Further observations upon the scheme of the Act – the effect of ss.143A(4) and (5)

S143A clearly is intended to have the consequence that a person registered for that particular special purpose will be deemed to be a specialist registrant. The occasion for the insertion of that section prior to the commencement of the amendment act, as revealed in the secondary materials referred to above, makes it abundantly clear that this was Parliament's intention. The section bears the explicit stamp of that intention in the exemptions found in ss.143A(4) and 143A(5) from the ordinary specialist resident registration pathways in the Registration Act. These subsections deal with exemption from formal requirements for specialist registration and other formal requirements of registration. These are designed to engage with the national scheme for overseas recruitment and specialist college advice to which the Minister referred in her second reading speech.

(h) Conclusion

It is submitted that it would be inconsistent with the evident scheme of ss135, 139(2) and 143A of the Registration Act to construe the words "*to practise the profession in a specialty in an area of need*" as having the effect that any reference on a special purpose registration certificate to a branch of medicine in which a junior practitioner will practise means that that practitioner is deemed to be a specialist.

It is therefore submitted that the Commission will upon a careful analysis of the provisions and the detailed submissions above, determine that there can be no criticism of the Board's conduct in relation to its processing of the special purpose (area of need) applications for registration and the basis upon which the Board processes applications for deemed specialist registration where it is clearly appropriate to do so pursuant to s.143A of the *Medical Practitioners Registration Act*.

The Board rejects any suggestion that it failed to comply with its obligations. The process of consultation with the relevant College is well known and accepted by the Board (see paragraphs 31-37 and 39) in the Affidavit of **Mr O'Dempsey – Exhibit 461** wherein the Board has followed a rigorous and patently distinct procedure in dealing with an application for "*deemed*" specialist registration. Clearly the process followed to affect a "*deemed*" specialist registration in an area of need was in accord with the national pathway and in reliance upon College assessment.

It is submitted that a registrant who is registered pursuant to Section 135 does not attract "*deemed*" specialist registration where he/she is simply being placed in a position within a particular

department of a hospital. (See description of positions within various departments of hospitals – Paragraph 3 Affidavit of Mr O'Dempsey - Exhibit 461).

The Board in its correspondence confirming the fact of registration to any special purpose (area of need) registrant reiterated in the correspondence to the registrant that he/she was *"not registered as a specialist"*.

The Board, whenever dealing with an application for *"deemed"* specialist registration would consult the relevant College (Paragraph 33 Affidavit Mr O'Dempsey). It must be pointed out that this process is initiated through the College by the relevant employer in accordance with the nationally agreed protocol.

The Board had no reason or obligation to consult with any of the relevant Colleges in respect of any of the special purpose (area of need) applications for registration other than bona fide applications for *"deemed"* specialist registration.

2 - With respect to Term of Reference 2 (a) and with respect to the Board's assessment, registration and monitoring of Dr Jayant Patel, the Commission may find that:

- (a) Dr Patel acted fraudulently in completing his application for registration in that he falsely maintained that his registration in other jurisdictions had not been cancelled, suspended, or subject to an undertaking of a condition when the same was not true;
- (b) Dr Patel's application for registration included a document entitled Verification of Licensure from the State of Oregon Board of Medical Examiners which containing a notation:

"Standing: Public Order on File See Attached."

The Public Order was not attached but the Board, by its staff, failed to note that omission or to make enquiries into the terms of the said Public Order. If the Public Order had been obtained and perused, it would have revealed that Dr Patel had been restricted from performing surgeries involving the pancreas, liver resections, and ileoanal reconstructions, and it may have led to the application being rejected or approved subject to stringent conditions.

- (c) As a result of the Board's failure as described in above, Dr Patel's fraudulent conduct was not revealed.

Exhibit 421 is the duly certified Police statement of the original assessor of Patel's application, **Ms Ainslee McMullen**. She was at that time an employee of the Board, and the Board's most "experienced and reliable registrations officer at that time".⁶¹

In her Police statement dated 27 June 2005⁶², Ms McMullen said:-

"On the original checklist, there is a section which asks, "under investigation or conditions/undertakings in place" with the options of either circling "yes", "no", or "N/A". To this question I have circled "No". This response is based to (sic) the fact that I did not observe any reference to any investigation, condition, undertaking or disciplinary action on any of the documents supplied by PATEL.

From my experience, a Certificate of Good Standing ("CoGS") is either granted or not. The "Verification of Licensure" as supplied by PATEL was taken by me to be the equivalent of a CoGS. I can't recall observing anything untoward on PATEL's "Verification of Licensure" that warranted me performing further inquiries. In PATEL's application form, there are also questions concerning his "Fitness to Practice". In this area, the applicant makes declarations including the status of their registration overseas and whether it has been the subject to (sic) any undertaking or the imposition of a condition, suspension or cancellation or in any other way. There is also a declaration concerning whether their registration as a Medical Practitioner had been cancelled or suspended. To both these questions, PATEL has crossed the boxes marked "No".

These factors made me believe that Patel's application and "Verification of Licensure" were legitimate. If PATEL had ticked any of the boxes "yes", I would have made the appropriate enquiries and passed on the information to the RAC for their consideration. Had I been aware of the previous disciplinary history of PATEL, I would have brought (sic) it to the attention of the RAC for their further investigation and consideration."

In his Memorandum dated 13 April 2005⁶³, a Memorandum which was forwarded to **Minister Nuttall** upon the instruction of the Board, the Deputy Registrar of the Board frankly stated⁶⁴:-

⁶¹ Memorandum of Michael Demy-Geroe, Exhibit "MSD-3", paragraph 5.3 – part of Exhibit 24

⁶² paragraphs 13-16 of Exhibit 421

⁶³ Demy-Geroe's Exhibit "MSD-3"

⁶⁴ paragraphs 5.1-5.7

- "5.1 *Patel clearly set out to deceive the Board in the response he gave in his initial application for registration regarding his past disciplinary history, and also in his subsequent renewal applications. The conclusion is also inescapable that the attachment to the verification certificate from Oregon, which detailed Dr Patel's disciplinary history, had purposely been removed and withheld by him when the document was given to the recruitment agency for submission to the Board.*
- 5.2 *Dr Patel's omission to disclose his past to the recruitment agency and his employer reveals similar deceptive conduct.*
- 5.3 *It is undeniable however that had a thorough check been made of the verification of licensure document, and the notation queried, Dr Patel's registration is unlikely to have been approved, at least in an unsupervised setting. The oversight, while inexcusable, nonetheless might be regarded within the context of its occurrence. The officer who processed Dr Patel's application is not currently employed by the Office and was in fact the Medical Team's most experienced and reliable registrations officer at that time. All officers engaged in processing are routinely reminded of the importance of checking documentation for authenticity and any irregularities, as the Registration Advisory Committee could not be expected to undertake this responsibility. The Committee concentrates its efforts on the suitability of an applicant to engage in the special purpose activity the subject of the application, and does this through considering the particular skills and experiences disclosed in the curriculum vitae and the Forms 1 and 2 compared to the specification of the area of need vacancy. Certificates of Good Standing and copies of other certificates of qualification are expected to have been passed as acceptable by the Office in accordance with the Board's policies and guidelines, in the preliminary processing stage, and are generally not revisited at the decision making stage.*
- 5.4 *Some issues surrounding the Oregon certificate are also worthy of comment. Certificates of Good Standing are a traditional assurance tool used by registration authorities to assist in considering the fitness to practise of an applicant for registration. They follow a similar format in most jurisdictions internationally and contain a clear statement that the registrant is in good standing and not subject to disciplinary action or investigation. Conventional certificates of good standing are most commonly still passed directly between registration authorities. It is sufficient therefore to give such documents only a cursory review as the heading "good standing" and the certification provide the information required.*

- 5.5 *United States medical registration authorities however generally do not issue certificates of good standing in the customary format. The verification certificate more commonly issued by US registration boards is a status report or statement of details from the register usually with no specific comment or certification. They often are given directly to the registrant and require more careful scrutiny as details can more easily be overlooked. Comments on the registrant's standing such as "Public Order on file – see attached" may not be as meaningful or conspicuous to processing officers as the absence of a certificate of good standing would be in other cases, **although as already mentioned, the absence of an attachment should have, at the least, prompted some questions.***
- 5.6 *Another factor which might explain, as much as is possible, how such an oversight could occur is the sheer volume of registration activities with which registration officers must deal during the December-February peak period. Dr Patel's application was initiated in mid January with the receipt of an area of need certification, on 17 January 2003, and the form of application with supporting documents three days later. During January 2003 a total of 233 area of need special purpose applications were approved, and 104 were approved during February 2003. At that time area of need applications were prepared for the decision making stage by 1.4 FTE A03 level officers. Registration officers must deal with constant pressure from agencies, applicants and employers seeking to expedite applications, and this adds to the substantial workload in peak periods. Constant interruption and distraction from the task at hand obviously is conducive to errors occurring.*
- 5.7 *It is my view that a combination of circumstances coincided in this case with unfortunate consequences. These were firstly, the intention of the applicant to mount a deception; secondly the nature of the American certificate which tended to obscure the vital information within the document's format and through use of unfamiliar terminology; thirdly, the oversight by the processing officer; and lastly, the workload pressures under which registration staff were functioning at the material time."* (emphasis added)

In his evidence before the Commission of Inquiry, **Mr Demy-Geroe** said that the words "see attached" ought to have prompted some concerns and ought to have been pursued.⁶⁵ **Mr Demy-Geroe** did point out however, that the abovementioned endorsement is potentially at odds with two other endorsements on the face of the "Verification of Licensure" namely:-

"Limitations – none"; and

"Extensions – none".

Mr Demy-Geroe said:-

"...the description 'standing – public order on file without the further comment "see attached – public order on file" is really quite meaningless, in our experience. Could mean any number of things. If it does relate to a persons disciplinary situation in that jurisdiction, then the limitation, as you have observed, would appear to be conflicting with that."

Mr Demy-Geroe said as a result of the Patel incident, Certificates of Good Standing emanating from the United States were re-examined and it was discovered that these entires were *"fairly typical"*. He therefore frankly acknowledged that the assessor ought to have picked up the words *"see attached"* and enquired further.

Mr Demy-Geroe doubted that QHealth would have seen the *"Verification of Licensure"* but said that the recruiting company also should have noted it and seemed to have missed it.

The Board has always acknowledged its error and the public apology made is a matter of record.⁶⁶

Dr Bethell from **Wavelength** similarly acknowledged that the endorsement on the *"Verification of Licensure"* should have been followed up. It is a relevant circumstance, however, that Patel made two false answers on his Application in order to deflect further inquiry. Further, having been encouraged by both **Dr Kees Nydam** and **Dr Darren Keating** to seek specialist registration through the AMC – where closer scrutiny of his qualifications may well have revealed the fraud – **Patel** did no more than enter into the earliest phases of that process, even though he was employed at Bundaberg for a continuous period of approximately 23 months.⁶⁷ **Patel** did not want to be discovered and succeed in this endeavour, partly as a result of the Board's employee being duped by his, fraudulent behaviour.

In over 8,000 approvals since Patel's, only the approval of Berg in 1999 – predating Patel's – has emerged as having been potentially induced by fraud.

Any adverse finding pursuant to paragraph 2 of the Commission's Notice should acknowledge the combination of factors which led to the error, as set out by **Mr Demy-Geroe** in his Memorandum.

3 - The Commission may find that "with respect to Term of Reference 2(a) and the Medical Board's role in monitoring and managing complaints about medical practitioners generally, the Commission may find that:

⁶⁶ T 540 L 8 - 20

⁶⁷ see Exhibit 274 – Nydam's email to Patel dated 25 February 2003/see Keating's evidence, T6831

(a) ***The Medical Board failed to publicised (sic) and promote its investigatory and disciplinary role with respect to medical practitioners;***

No evidence has been adduced to the effect that the Medical Board failed to promote its investigatory and disciplinary role. On the contrary, there is clear, compelling and unchallenged evidence that the Board had widely publicised and promoted its investigatory and disciplinary role with respect to medical practitioners.

The Board has its own dedicated website which complies with the obligations of public publication of matters it is required to published pursuant to its governing legislation. See in particular T521 line 30 evidence of **Mr O'Dempsey**. See also paragraph 21 of the Statement of **Mr O'Dempsey (Exhibit 28)** as well as **Exhibit 32** wherein a number of newspaper articles concerning the Board in its disciplinary role are identified. **Mr O'Dempsey's** contribution to public discussion in the media is evidenced in the articles referred to in Exhibit 32. It should also be borne in mind that the Health Rights Commission has a leading role in publicising its complaint handling process in respect of users of health services and that also the administration of QHealth has its own responsibility to develop and implement its own complaint handling processes.

In addition, it is a common theme throughout the evidence of witnesses at the Inquiry particularly within the medical profession that the Board is the appropriate complaints handling body in relation to complaints against medical practitioners. To this extent see evidence of **Dr Anderson** T2771 - line 58.

Evidence of **Ms Aylmer** T1027-T1028 – line 10. In this reference Ms Aylmer refers to an apparent long standing knowledge of complainants being able to refer complaint to the Medical Board and/or Health Rights Commission.

Dr Cleary at T4851 – line 35-48.

Nurse Gaddes was familiar with the Board's handling of impaired medical practitioners and was obviously aware of the Board's regulatory role T2117- line 50-55.

Nurse Jenkins' discussion as to referral of matter to the Medical Board T3717 – Lines 25-35.

Dr Johnson at T3368 - line 30-35 indicated it was *"when there are issues of clinical concern my normal practise to contact the Medical Board"*.

See **Dr Johnson** further at T3403 – line 20 and further at T3421 – lines 45-55, and T3422 – lines 15-25.

Dr Keating clearly knew of the role of the Medical Board in investigating and disciplining medical practitioners T6886 – line 50.

See also the evidence of **Dr Molloy** T598 at lines 10-20 where he stated:

"so for example, if they knew a colleague – and, you know. I have personally experienced this and seen it at closer hand – was taking – was drug addicted, I think they would almost always take that problem to the Medical Board because I think the Medical Board has a very good track record of handling that".

Q: And further question or perhaps sexual misconduct or things of that kind?

A: Exactly, that's right".

Dr Nankivell wrote a complaint to the Board about an issue he had T2974 – lines 10-20.

Dr North in respect of concerns over orthopaedic care offered in the Fraser Coast region was aware that those matters might be referred to the Medical Board for investigation: see T5156 – lines 1-10.

Ms Raven was aware of the availability of the Medical Board to receive complaints: see T2362 – lines 30-40.

Mr Smith, a patient of the hospital was aware of the process of complaining to the Medical Board of Queensland – see Statement of Mr G L Smith paragraph 20 and evidence of Mr Smith T2438 – lines 40-55 (albeit it would appear this complaint had been made to the Health Rights Commission).

Dr Strahan gave evidence of intimate knowledge of the Board's processes in a particular case T3311 – lines 22-42.

Dr Young gave unequivocal evidence as to the types of matters where a complaint could be taken to the Board: see T2849 – T2850 and T2888 – lines 18-33.

Also it should be noted that the **Queensland Nurses Union** knew of the processes involved (Paragraph 30 - Affidavit of **Mr O'Dempsey Exhibit 28**) in particular where the Queensland Nurses Union representatives came to meet Mr O'Dempsey in relation to a Gold Coast based doctor who was subject of a written complaint by the Union on behalf of a number of its members. It is submitted that the body responsible for representing most of the nurses within Queensland Health clearly knew the processes for a complaint to the Board.

The Health Rights Commission also is an integral part of the complaints awareness process and has a legislative obligation to fulfil in notifying the Board of any formal complaint before referring the complainant back to the hospital.

It would be unfair to the Board, and contrary to the evidence, for the Commission to find that the Board failed to publicise and promote its investigatory and disciplinary role. The Commission could well find that the prevailing culture within the QHealth hospital system was to deal with complaints of a clinical nature as an internal matter. Such findings, if made, do not and cannot convert into a finding adverse to the Board and would be in the teeth of a substantial body of evidence to the contrary.

Not one witness criticised a lack of resolve in the Board to investigate and prosecute medical practitioners where appropriate, nor did one witness criticise the Board's lack of profile in the community as a regulatory body acting in the public interest.

(b) *The Medical Board did not manage the investigation into the clinical practise of Dr [REDACTED] in a timely and efficient manner;*

The Board submits that the Commission has not afforded the Board an appropriate opportunity in the conduct of the Commission proceedings to address the issues concerning Dr [REDACTED] as it did not feature in any of the Commission evidence apart from a brief reference to it after initially having been brought to the attention of the Bundaberg Hospital Commission of Inquiry in Paragraph 49 of the Statement of Mr O'Dempsey (Exhibit 28). There was no proper opportunity to cross-examine any relevant witnesses in relation to the matter. It is now impracticable for the Board to attempt to call evidence or seek the issuance of subpoenas as to production of certain records from QHealth. Those records would evidence the fact that Dr [REDACTED] had been the subject of certain conditions of clinical practice as imposed by QHealth as a result of clinical issues coming to light, including the one subject of the complaint.

The Board's file clearly shows that the public interest was protected at an early stage of the investigation by clinical matters being addressed by QHealth, whilst an admittedly protracted and complex investigation proceeded.

There is also a non publication order in relation to the name of Dr [REDACTED] and the Board was led to believe in the conduct of the proceeding, in the Bundaberg Hospital Commission of Inquiry, that the Commission did not intend pursuing the issue of Dr [REDACTED]

There is clear unchallenged evidence of the enormous backlog of investigations which existed when Mr O'Dempsey commenced duties as Executive Officer on 4 March 2002. Pro-active management has alleviated the backlog of Complaints (T519 – line 40.) This clearance of the backlog has been verified by Mr Kerslake, Health Rights Commissioner at T5668 – lines 5-10. Further reference to Exhibits "JPO-3" to "JPO-5" to O'Dempsey's statement, Exhibit 28 reveals that the Stumer investigation was being conducted at a time when the Board's investigation

processes were dysfunctional. Since 2002, that dysfunction has been fully addressed. In the period 2002 to 2005 the "carry over" of investigations in progress has fallen over 40%.

4 - The Commission may find "With respect to the registration and monitoring of Vincent Berg in circumstances where:

- (a) the Medical Board had information that the Royal Australian and New Zealand College of Psychiatrists ("the College") had been unable to verify the authenticity of Vincent Berg's claimed qualifications from the Voronezh State University;**
- (b) the Medical Board had in its possession copies of correspondence from the Voronezh State University to the College in which it advised that:**
 - (i) having reviewed the qualifications provided by Vincent Berg they appeared to be "crude forgeries"; and**
 - (ii) at the relevant time it did not offer the course that Vincent Berg claimed to have completed;**
- (c) Vincent Berg had been employed by the Townsville Mental Health Service for 12 months and had administered psychiatric treatment to numerous patients during that time;**

the Medical Board took no step to advise Queensland Health that there was real reason to suspect that Vincent Berg held no psychiatric qualifications.

The Board first became aware of the forgery allegation relating to Berg's claimed Russian medical qualifications on 19 October 2001. On that date, the Board received a letter from the Royal Australian and New Zealand College of Psychiatrists ('RANZCP') to the AMC in which Berg's qualifications from a Russian University were said to be false.

At this time Berg had already ceased as a registrant in Queensland or any other State of Australia.

Berg, however, chose to vigorously defend himself in letters to the AMC dated 30 October 2001 and 11 November 2001. The Board considered that it was not in a position to verify or disprove Berg's claimed qualifications. The Board's dilemma was compounded in that another government agency, the Commonwealth Department of Immigration, had accepted Berg's status as a Refugee. It appears that Berg's claimed status of a Russian Medical Practitioner had been a factor in his successful application to the Department of Immigration.

It is important to note that at the time the Board received the advice of the possible forgery, Berg was not a registrant in Queensland. He was not known to be a registrant in any other Australian jurisdiction.

It is submitted that the Board cannot be criticised for taking its initial view that Berg's qualifications were unable to be verified, rather than taking the more stringent view that they were false. Undoubtedly several factors influenced the Board's position as at late 2001:

- Berg had taken the step of seeking specialist registration through the AMC. A person who held demonstrably false qualifications may well not have taken such a step; and
- In two spirited and detailed defences, in direct response to the allegation of forgery, Berg claimed Refugee status and claimed that the assertion by the Russian University was yet another attempt to persecute him; and
- The Board's file showed that Berg had the support of a number of psychiatrists, both in Sydney and in Townsville, who spoke well of his clinical skills. This at least indicated the likelihood that he was duly qualified.

It should be kept in mind that if Berg is shown to be a skilful fraudster, then he has also managed to hoodwink the Department of Immigration, which conferred Refugee status upon him, at least partly, it seems, upon the strength of his claimed qualification as a specialist medical practitioner.

The Board has frankly acknowledged its regret that the Townsville Health Service District was not notified of the difficulties with Berg's registration until Dr Toft's letter dated 28 February 2003. The failure to notify occurred against the background that the Board, during 2002, held the view that the qualifications could not be verified one way or the other, and that he had departed Queensland, to the Board's knowledge.

In all of the circumstances, the Berg incident should be seen as unique. See in particular the evidence of **Dr John Allan**.⁶⁸

"Q: To sum up then, would it be fair to say that in Berg's case you confronted a somewhat unusual set of circumstances?"

A: Correct

Q: You had a fellow that showed some medical knowledge, is that right?"

⁶⁸ p3500 l.17 to p3501 l.10

A: Yes

Q: *Some psychology based knowledge?*

A: Yes

COMMISSIONER: *Or psychiatry?*

A: *Something or other. Yes.*

Q: *Quite personable at times?*

A: Yes

Q: *Claiming to have been persecuted by nefarious unknown people in his country of origin?*

A: Yes

Q: *Even claiming to have been a clergyman at some point?*

A: *Yep*

Q: *Is that right? And another one that – where you aware of this – that on coming to Australia he changed his name?*

A: *Yes, I was aware of that. That was part of the persecution story*

Q: *Yes. So he volunteered that to you?*

A: *Well, his documents were in a different name. He had various documents from the Department of Immigration showing this claim and he said that that was their advice.*

Q: *Yes. He, it appears, did get refugee status with Australian authorities?*

A: *Yes, that's true*

Q: Did he speak to you about claims based on international law that as a refugee he was entitled to have his qualifications looked at afresh rather than the authorities going back to the country of origin because of alleged persecution? Did he ever raise that with you?

A: That's what he told me about contact with Russia.

Q: So it was an incredible grab bag of issues that this man presented with?

A: Yes

Q: And unique in your experience, one would hope?

A: I would hope not to meet it again.

Q: But unique in your experience?

A: Yes

Q: And, therefore, even as an experienced clinician, very difficult to unravel?

A: Yes, it was. It was very difficult to unravel."

The Board's failure to notify Townsville in October 2001 is regrettable. Berg had left the jurisdiction. He had been employed in a training position but had never practised psychiatry in Townsville without supervision. The status of his qualifications, for some time, were viewed by the Board as "unverifiable" rather than "false". These factors undoubtedly obscured the immediate need to advise Townsville Hospital of the October 2001 correspondence.

Therefore any adverse finding in relation to the Board's handling of the Berg matter should be made against the context of all relevant facts.

5 – "With respect to terms of reference 2(a) and (3) the Commission may make recommendations as to the future legislative and administrative structures for the registration of medical practitioners and the investigation and determination of complaints against medical practitioners, other health practitioners, and nurses including but not limited to amendment or repeal of provisions of the *Medical Practitioners Registration Act*,

the Health Practitioners (Professional Standards) Act; the Health Rights Commission Act, and the Nursing Act.

It is submitted that the legislative framework with which the Medical Board of Queensland is constituted and by which it operates does not need substantive amendment on account of the matters dealt with in the Terms of Reference of this Commission of Inquiry 2(a) and (3).

The evidence of Mr O'Dempsey clearly sets out the pro-active conduct of the Office of Health Practitioner Registration Boards in its administrative and support functions for the Medical Board. His evidence also provides an informed observation as to the effectiveness of the operation of the legislation to date which has been subject thus far to one external review.⁶⁹ Such an observation which was unchallenged would indicate that there is no basis for repeal of any of the governing legislation. However the Board submits that there are some amendments which, if recommended and adopted would assist the Board in carrying out its functions more effectively in the public interest. These amendments should be proposed to the Minister as one set of amendments.⁷⁰

Mr O'Dempsey referred to the benefits in delegating the role of decision making in relation to registration decisions. The Board does not have the discretion to delegate such decisions. If a delegation is made then that would engender a *"more definitive approach in defining policy and procedure which applies for the accountable officers or the delegate to actually make the decision"*.⁷¹

Mr O'Dempsey also noted the limitations of Sections 47⁷² and 59 (**Exhibit 28 paragraph 31**) of the *Health Practitioners (Professional Standards) Act 1999*. These provisions relate to who may make a complaint against a medical practitioner and the limited power of the Board to suspend or impose conditions on registration in the public interest.

The issue of mandatory reporting was also canvassed.⁷³ The Board submits that mandatory reporting to a responsible authority of a complaint made and received within QHealth should be the subject of favourable recommendation.

Also where someone complains to the Board and is referred to the Health Rights Commission and the file is subsequently closed by the Health Rights Commission because it does not meet the threshold for investigation, then the Board should be the appropriate authority to finalise the

⁶⁹ Statement of O'Dempsey 19-20 and 66

⁷⁰ T533 L1-20

⁷¹ T499-500 L50

⁷² T522 L20

⁷³ T662 L1

complaint if necessary. See the discussion of this and related issues by Mr O'Dempsey in evidence.⁷⁴

It is submitted that area of need registrations should be able to be influenced by the imposition of standard conditions (which are not subject to an appeal) at the time of registration. The issues are canvassed in further detail in the evidence of Mr O'Dempsey.⁷⁵

It is submitted that the role of the Board as prosecutor should not be altered since the Health Practitioners Tribunal is an independent body appropriate to deal with the more serious disciplinary matters. See the evidence of Mr O'Dempsey dealing with the matters.⁷⁶

It is submitted that the *Health Practitioners (Professional Standards) Act 1999* be amended to include a non-adversarial process for competence assessment modelled on Part 7 of that Act.⁷⁷

The Commission should consider recommending that directive 1/04 issued pursuant to Section 34 of the *Public Service Act 1996* be applied to all special purpose registrants being employed by QHealth notwithstanding their status as locums or temporary employees.

The legislation should be tightened in relation to practitioners describing areas of practice they undertake when they could be mistaken as holding themselves out as specialists.⁷⁸

The Commission may wish to consider recommending the mandating of clinical assessment by the Skills Development Centre of QHealth and that the assessment be available to the Board in its registration determination. Should such a recommendation be made the issue of appropriate funding of the assessment must be concomitant to such process.

It is submitted that there is certainly no evidence of any systemic failure or neglect which would warrant any substantial change to the Board. In fact it is submitted that the Board has carried out its functions in an appropriate manner. However in order for the Board to be seen to be totally independent of government it is submitted that some recommended change could be made to its appointment processes.

Rather than have all positions made by Governor in Council⁷⁹ it is submitted that the Board should be enabled to set position descriptions and actively recruit and appoint persons to those positions.

The Board should also be enabled to set appropriate levels of remuneration to ensure retention of membership of the highest calibre. The issues involved in this regard were the subject of evidence

⁷⁴ T529 L1-15

⁷⁵ T532 L25-39

⁷⁶ T655 L10-60; T656; T657 L1-25

⁷⁷ T632 L1-40; T634 L1-25

⁷⁸ T627 L1-20

⁷⁹ See Ss 15 – 19 MPRA as to provisions for appointment of Board members

from Dr Cohn and Mr O'Dempsey.⁸⁰ It is submitted that such changes would need to be made through legislative amendment.

On the matter of funding the Medical Board, the Commission may consider recommending upon two key issues. First, to assist in funding the Board in its reforms introduced for the processing of applications for special purpose registration, that it recommend the amendment of the MPRA to increase the application fee and to introduce an appropriate application fee for renewal of registration.⁸¹ Second, that the Government review its current policy for setting statutory fees which are the primary source of funding the functions of the Board.⁸²

It is submitted that any amendments to the legislation should be directed to improvements in process where there is an identified need based upon reliable evidence in support thereof.

⁸⁰ T 546 L 50-60; T547 L 1- 50; T533 L 1 - 20

⁸¹ Exhibit 28: "JPO-14", Attachment A, Paragraph 12

⁸² Exhibit 28: "JPO-5", Page 10



QUEENSLAND GOVERNMENT



Office of the Public Service

DIRECTIVE

(refer Section 34 of the *Public Service Act 1996*)No: **18/97**Supersedes: PSM
Standards 2, 4, 6 & 10**1. TITLE: Performance Management****2. PURPOSE:** To specify the requirements for the implementation of performance management systems.**3. LEGISLATIVE PROVISIONS:** Sections 23(b), 25, 51(2)(g), 51(2)(h) and Part 6 of the *Public Service Act 1996*.**4. EFFECTIVE DATE:** 18 July, 1997**5. DIRECTIVE:**(a) In order to achieve continuous improvement of performance in the delivery of services as detailed in Part 3 of the *Public Service Act 1996*, Chief Executives shall implement a performance management system.(b) To achieve the principles of work performance and personal conduct, detailed in Section 25 of the *Public Service Act 1996*, employees shall actively participate in departmental performance management strategies.

(c) Performance management systems should be linked to strategic plans and be directed toward the achievement of organisational goals and objectives.

(d) Performance management may be applied to the achievement of both individual and team performance objectives.

(e) A performance management system shall include, at a minimum, the following strategies:

- A performance appraisal and development strategy.
- A strategy for acknowledging high levels of performance.
- A strategy for the improvement of unsatisfactory performance.
- A strategy for managing disciplinary action¹.

6. APPLICATION:

Public Service Employees

7. NON APPLICATION: Chief Executive Officers.**8. APPEALS**

Appeals will be subject to the provisions of Directives issued by the Office of the Public Service.

¹ Chief Executives should ensure that, where applicable, the requirements of the *Workplace Relations Act 1997* are met and that the principles of natural justice are followed in accordance with Section 90 of the *Public Service Act 1996*.



Office of the Public Service Commissioner

Supersedes:

01/03

01/03

DIRECTIVE
(refer Section 34 of the Public Service Act 1996)

1. **TITLE:** Recruitment and Selection

2. **PURPOSE:**

To specify the requirements applying to the recruitment and selection of public service employees.

3. **LEGISLATIVE PROVISION:**

Public Service Act 1996 - Sections 24, 33, 34, 51, 77, 78.

4. **APPLICATION:**

(a) This Directive applies to -

- (i) public service officers, including Senior Executive and Senior Officers¹, unless otherwise stated;
- (ii) temporary employees engaged under section 113 of the *Public Service Act 1996*, unless otherwise stated; and
- (iii) general employees engaged under section 112 of the *Public Service Act 1996*, unless otherwise stated.

(b) This Directive does not apply to the recruitment and selection of chief executive officers.

(c) This Directive does not apply to the recruitment and selection of casual employees.

5. **EFFECTIVE DATE:** 5 April 2004

¹ In addition to this Directive, the recruitment and selection of Senior Executive Officers and Senior Officers is also subject to rulings issued by the Public Service Commissioner.

6. DIRECTIVE:

6.1 Selection to be based on merit

- (a) The selection of an eligible person for appointment or secondment as a public service employee must be based on merit alone, as defined in section 78 of the *Public Service Act 1996*, unless otherwise specified in the *Public Service Act*, this Directive, or any other Directive
- (b) Exemptions to appointment on merit are contained in sections 6.12 to 6.16 of this Directive.

6.2 Job descriptions

- (a) A job description must be used for each vacancy detailing as a minimum –
 - purpose of the role;
 - duties and outcomes; and
 - the basis against which the relative merits of applicants are to be assessed.
- (b) In addition, the job description must include where applicable, a statement about –
 - (i) any pre-employment history checking requirements that may be undertaken, and
 - (ii) any probationary period to which the appointment may be subject.
- (c) "Mandatory" qualifications can be included in a job description only when it is essential for the occupant of that role to hold such qualifications in order to comply with an Award provision, or to satisfy legal, accreditation or registration requirements.

6.3 Job evaluation

- (a) Where relevant to the award structure, each job must be evaluated utilising a job evaluation methodology approved by the Public Service Commissioner to determine the relative worth of each job.
- (b) Unless otherwise approved, the job evaluation methodology to be utilised as "approved by the Public Service Commissioner" is the Queensland Public Sector Job Evaluation Management System (JEMS).

6.4 Job vacancies to be advertised in the *Gazette*

- (a) Subject to the provisions of section 77 of the *Public Service Act*, this Directive and other Directives, job vacancies must be advertised as widely as practicable to ensure a competitive pool of applicants for consideration.
- (b) Vacancies for public service officer roles must be advertised in the *Gazette* and on the *Queensland Government Jobs Online* website. As a minimum, vacancies must be advertised for a period of two calendar weeks exclusive of public holidays
- (c) The notification is to include:
 - a vacancy reference number;
 - a job title;
 - the name of the agency;
 - the centre at which the appointee is to be located;
 - the remuneration applicable;
 - the applicable classification level;
 - the closing date and time for receipt of applications;
 - the address to which applications should be forwarded;
 - the type of vacancy - tenured, temporary, full-time, part-time or contract; and
 - any other relevant information.

- (d) There is no need to advertise the following vacancies in the *Gazette* and *Queensland Government Jobs Online*:
- (i) designated to be in a Ministerial office;
 - (ii) subject to an industrial determination by which the salaries, duties and designation of the job are modified;
 - (iii) at a base-grade level²;
 - (iv) to be filled in compliance with a progressional scheme or other scheme contained in an award, certified agreement, industrial agreement or determination made under section 149 of the *Industrial Relations Act 1999*;
 - (v) to be filled under a progressional scheme or other scheme subject to an agreement between the relevant industrial organisation of employees and the chief executive and approved by the Public Service Commissioner;
 - (vi) to be filled on a temporary basis where the period will not exceed 12 months;
 - (vii) to be filled on secondment or transfer at level only;
 - (viii) to be filled on secondment to a higher level where the period will not exceed 12 months;
 - (ix) to be filled by the promotion of an officer who has been redeployed within 1 year before the promotion and the promotion is to a classification level that is not higher than the officer's substantive classification level immediately before their redeployment;
 - (x) to the office of a Chief Executive under Part 5, Division 2 of the *Public Service Act*;
 - (xi) a vacancy which has been previously advertised and an appointment made but has subsequently become vacant within a period of three (3) months from the initial date of notification of appointment in the *Gazette*;
 - (xii) to be filled in accordance with sections 6.13 to 6.16 of this Directive.

6.5 Recurring and identical vacancies

- (a) A job advertisement for a vacancy (other than a senior officer or senior executive), may include a note that applications remain current for up to 12 months after initial advertisement where identical and recurring vacancies are expected to become available in this time and re-advertising is determined to be unlikely to vary the quality of the existing applicant pool.
- (b) As a minimum, recurring and identical vacancies must share the same job description, including classification level and geographic region.
- (c) Applications received during the period but after the initial closing date must be assessed for consideration of future vacancies.

6.6 Selection tools

- (a) Selection tools are to be clearly relevant to the responsibilities and requirements of the role and the skills required to competently perform it
- (b) Selection tools must be reliable, valid and culturally appropriate, fair, unbiased and cost-effective to the filling of the vacancy concerned.
- (c) A pool of preferred applicants may be created by applying one selection technique, which must be transparent and reviewable.
- (d) At least one further selection technique and a referee check must be used to determine the preferred applicant from that pool. Over reliance on information obtained from any one selection tool is to be avoided.
- (e) Selection tools include, but are not restricted to: short listing based on information provided in applications, curricula vitae, resumes and written statements from applicants; structured interviews; standardised achievement, aptitude and ability tests; role plays; job simulations; work samples; work performance and job knowledge tests; in-tray exercises; group assessment exercises and activities, and case study presentations.
- (f) Referee checks are to be used for confirmation and verification of an applicant's claims. In this regard they may be used as a moderation assessment tool by a selection panel, however referee checks must not be scored separately as a selection tool.

6.7 Referee checking

- (a) Referee checking must be undertaken for at least the preferred applicant.
- (b) Referee checking includes seeking employment related information about an applicant from present or past supervisors and other people with a direct knowledge of the applicant's work behaviour or performance. Referee checks are also used to explore, clarify and verify information provided by the applicant in their application or at an interview
- (c) Referees are obliged to disclose all information known to them that is relevant to the responsibilities and duties of the advertised vacancy.
- (d) Applicants must be given an opportunity to respond to any unfavourable or adverse referee comments and any such response must be taken into consideration when evaluating the merit of the applicant.
- (e) Referees must be advised of the panel's duty to disclose unfavourable or adverse comments to applicants.

6.8 Selection committees

- (a) A selection committee for job vacancies at the AO8 level and below must contain a minimum of two people and is collectively responsible for:
 - (i) understanding the requirements of the vacancy
 - (ii) understanding the principles of employment equity, anti-discrimination and natural justice and the relevant legislative requirements including this Directive,
 - (iii) having the skills necessary to conduct an objective, valid and fair assessment of each applicant's merit using an appropriate combination of selection tools;
 - (iv) using selection methods that provide for transparent, effective, and bias free decision making;

- (v) conducting an objective, valid and fair assessment of suitability where a registered deployee³ or a surplus Departmental employee has applied for an advertised vacancy at their substantive classification level or below prior to considering other applicants in accordance with the provisions of relevant Directives and/or guidelines;
- (vi) making a selection recommendation to the chief executive or delegate that is capable of withstanding independent scrutiny and assessment, and
- (vii) ensuring there is no conflict of interest, real or apparent arising from the selection decision.

6.9 Pre-employment checks

- (a) Pre-employment checks of preferred applicants may include checking of criminal history, identity or previous discipline history.
- (b) Pre-employment checks of preferred applicants may be done only in accordance with legislative provisions or Directives issued by the Public Service Commissioner.

6.10 Post selection feedback

- (a) All applicants are to be offered a timely opportunity to receive factual, constructive and sensitively conveyed feedback about the selection process from a member of the selection committee.
- (b) Feedback can be provided either verbally or in writing at the discretion of the selection committee member.
- (c) The feedback given is to be based on an accurate and unbiased summary of the reasons for selection or non-selection in terms of the applicant's strengths and areas for improvement against the role-related assessment criteria and gaps identified in comparison with the selected applicant.

6.11 Documentation of decisions

- (a) Documentation of a selection decision must clearly explain the decision making process and be in a form that allows it to be reviewed.
- (b) Selection documents must be maintained for a minimum period of twelve (12) months from the date of gazettal of the appointment.
- (c) Confidentiality of selection documentation is to be maintained.

6.12 Exemptions to appointment on merit

- (a) It is not mandatory that appointments to the following jobs be based on merit.
 - (i) a job that is designated to be in a Ministerial office;
 - (ii) a secondment or transfer at the same classification level;
 - (iii) a job to be filled by the promotion of a registered deployee or a surplus Departmental employee within one year of the deployee being redeployed to a lower classification level, and the promotion is to a classification level that is not higher than the deployee's substantive classification level immediately before their redeployment;
 - (iv) a job that has had its salary, duties and designation modified by an award, certified agreement or industrial agreement;

³ A "registered deployee" is a surplus employee who has been registered with the Office of the Public Service Commissioner
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- (v) a job under a progressional scheme or other scheme contained in an award, certified agreement, industrial agreement or determination made under section 149 of the *Industrial Relations Act 1999*;
 - (vi) a secondment to a higher classification level where the period is not to exceed 12 months;
 - (vii) a temporary engagement where the period is not to exceed 12 months; and
 - (viii) a job, promotion, appointment or circumstance as defined in sections 6.13, 6.14, 6.15 and 6.16 of this Directive.
- (b) Paragraph (a) (iii) does not apply to senior executive or senior officer roles.
 - (c) The application of an "exemption to appointment on merit" scheme for a group of jobs under a proposed progressional scheme is subject to an agreement between the relevant industrial organisation of employees and the chief executive and the Public Service Commissioner or the chief executive of the Department of Industrial Relations

6.13 Promotion following job evaluation resulting in a higher classification level.

- (a) This section does not apply to senior officer or senior executive roles.
- (b) A chief executive may decide to apply "exemption to appointment on open merit" to the promotion of a substantive occupant of a job that is evaluated at a higher classification level where all of the following conditions are met:
 - (i) the substantive occupant is a public service officer who was selected for appointment on open merit to the job in accordance with sections 77(1) and 78 of the *Public Service Act*, and the provisions of this Directive or any Directive that applied to appointments at the time the appointment was made; or
 - (ii) the substantive occupant is a tenured general employee selected for employment in the job on open merit in accordance with section 78 of the *Public Service Act*, and the provisions of this Directive or any Directive that applied to such appointments at the time of employment; or
 - (iii) the substantive occupant is a public service officer who was transferred at level to the job, and had been selected for appointment on open merit to the classification level in accordance with the sections 77(1) and 78 of the *Public Service Act*, and the provisions of this Directive or any Directive that applied to appointments at the time the transfer was made; or
 - (iv) the substantive occupant is a tenured general employee who was transferred at level to the job, and had been selected for employment on open merit to the classification level in accordance with the section 78 of the *Public Service Act*, and the provisions of this Directive or any Directive that applied to appointments at the time the transfer was made; and
 - (v) the substantive occupant has undertaken the job in question for a continuous period⁴ of two years or more, during which time the cumulative effect of incremental changes is such that the duties, functions and responsibilities of the job are now assessed as having changed substantially and the employee concerned has been objectively assessed as meeting the agreed performance objectives of the higher classification level that now applies to the job in question; and

⁴ A continuous period includes paid or unpaid leave. However, unpaid leave periods greater than three (3) months do not form part of the continuous period of two years.

- (iv) the promotion supports and facilitates the development of necessary organisational capabilities and achievement of agency business outcomes
- (c) The date of effect of the promotion shall be no earlier than the date of approval of the reclassification.
- (d) An officer who is promoted to a higher classification level in accordance with this section is not eligible for a further promotion under the provisions of this section in the event that the job in question is again evaluated at a higher classification level.
- (e) A tenured general employee who is employed at a higher classification level in accordance with this section is not eligible for further employment under the provisions of this section in the event that the job in question is again evaluated at a higher classification level.
- (f) Notice of any promotion of an officer made in accordance with this section is to be published in the *Gazette*.
- (g) Chief executives are to keep a record of the number, type and classification level of appointments that are made in accordance with this section each financial year. For audit and reporting purposes, these records are to be retained for at least twelve (12) months from the date of approval of promotion

6.14 Promotion following secondment to a higher classification level.

- (a) This section does not apply to senior officer or senior executive roles.
- (b) A chief executive may decide to apply "exemption to appointment on open merit" to promote a public service officer following secondment to a higher classification level⁵, where all of the following conditions are met:
 - (i) the current occupant is a public service officer who was selected for the secondment on open merit to the job in accordance with sections 77(1) and 78 of the *Public Service Act*, and the provisions of this Directive or any Directive that applied to appointments at the time the appointment was made; and
 - (ii) the officer has assumed the full duties and responsibilities of the job in question for a continuous period of two years⁶ or more and has been objectively assessed as meeting the agreed performance objectives of the higher classification level; and
 - (iii) the promotion supports and facilitates the development of necessary organisational capabilities and achievement of agency business outcomes; and
 - (iv) ongoing budgetary provision is available
- (c) Notice of any appointment made in accordance with this section is to be published in the *Gazette*.
- (d) Chief executives are to keep a record of the number, type and classification level of appointments that are made in accordance with this section each financial year. For audit and reporting purposes, these records are to be retained for at least twelve (12) months from the date of approval of promotion

⁵ For the purposes of this section of the Directive, 'secondment' may be taken to include the performance of higher duties

⁶ See previous footnote specifying two year period.

6.15 Appointment of a temporary employee to tenured status at level and appointment of a trainee to tenured base-grade employee status.

- (a) A chief executive may appoint a temporary employee⁷ to tenured status at level, or a trainee⁸ to base-grade in the following circumstances:
- (i) the employee was selected for appointment on open merit⁹ to the job in accordance with sections 77(1) and 78 of the *Public Service Act*, and the provisions of this Directive or any Directive that applied to appointments at the time the appointment was made; and
 - (ii) the employee concerned has been engaged in the job in question for a continuous period of two years¹⁰ (this period of time does not apply to base-grade employees or trainees); and
 - (iii) the employee concerned has been objectively assessed as satisfactorily meeting all of the agreed performance objectives of the role; and
 - (iv) existing registered deployees and surplus Departmental employees have been provided with an opportunity to express an interest in positions (other than base grade positions) in accordance with provisions contained in Directives and guidelines about deployment and redeployment; and
 - (v) the appointment supports and facilitates the development of necessary organisational capabilities and achievement of agency business outcomes; and
 - (vi) there is the likelihood of continuing work being available for the temporary employee or trainee; and
 - (vii) ongoing budgetary provision is available.
- (b) The appointment of a trainee may occur immediately following successful completion of the traineeship to ensure continuity of service.
- (c) Where it is considered that more than one person may meet the requirements of a position to which a permanent appointment is intended, the chief executive officer may give consideration to a closed merit selection process.
- (d) Chief executives are to keep a record of the number, type and classification level of appointments that are made in accordance with this section each financial year. For audit and reporting purposes, these records are to be retained for at least twelve (12) months from the date of approval of promotion.

6.16 A group of jobs that are subject to an agreed closed merit scheme

- (a) A closed merit scheme refers to a merit selection exercise where the applicant pool for a group of vacancies is restricted through limited advertising or notification to a certain group or groups of existing staff in an agency or from within a number of agencies
- (b) A chief executive may consider implementing a closed merit scheme under this section to minimise potential displacement of existing tenured public service employees and/or to minimise, as far as is possible any disruption to the workforce that may result from:

⁷ Requirements concerning the employment of temporary employees are detailed in other Directives and guidelines and are to be referred to in conjunction with the application of this Directive.

⁸ Trainee means a person defined as such in the *Training and Employment Act 2000* or any successor legislation

⁹ Open merit includes base grade administrative employees engaged under the provisions of SOA 200 or any successor SOA or selection activities conducted in accordance with the provisions of section 78 of the *Public Service Act* and trainees engaged in accordance with trainee provisions.

¹⁰ See previous footnote specifying two year period.

- an approved organisational restructure; or
 - machinery of government changes
- (c) All proposals for closed merit schemes must be agreed to by the chief executive and the relevant industrial organisation of employees and have the approval of the Public Service Commissioner or the chief executive of the Department of Industrial Relations.
- (d) Documentation of closed merit schemes agreed to must clearly explain the decision making process, and be in a form that is capable of withstanding independent scrutiny and assessment
- (e) For audit and reporting purposes, documentation is to be retained for at least twelve (12) months from the expiry date of the relevant appeal period applying to the last appointment made under the scheme.
- (f) There is no requirement to consider existing registered deployees or surplus departmental employees as part of a closed merit scheme where such consideration would result in the displacement of other tenured employees.
- (g) Closed merit schemes that consider temporary employees will not be approved unless an opportunity has been given for surplus departmental employees and registered deployees to be considered on suitability grounds in the first instance.

6.17 Exemption

The Public Service Commissioner may exempt specific jobs or categories of jobs or agencies from specific parts of this Directive.

6.18 Transition

If a position had been advertised, but recruitment and selection action had not been finished, under the Directive superseded by this Directive, namely —

- 01/03 Recruitment and Selection

the action may be finished under that Directive as if it had not been repealed.

Foreword from the Executive Officer

The Honourable Gordon Nuttall MP
Minister for Health
Member for Sandgate
Parliament House
BRISBANE QLD 4000

Dear Minister

The Office of Health Practitioner Registration Boards is pleased to present its fifth Annual Report. As part of its accountability and, consistent with its commitment to the Boards, this Report details the achievements of the Office over the past year and specifies the objectives to be achieved in 2004-2005.

In the year under report, the Office has delivered on the majority of the goals that were documented in the *Annual Report 2002-2003* and a summary in regard to these is provided on pages 4 and 5 of the Report. Of particular note is implementation of the recommendations of the Complaints and Health Assessment and Monitoring Review Project and the commencement of a project to review registration procedures.

The achievements of the Office in the year under report have been made possible by the support and contribution of the Boards and of the staff of the Office. I am appreciative of the support of the Boards and for the efforts of all staff.

It is therefore with a commitment to continuous improvement in the quality of Office services that I provide this *Annual Report 2003-2004* to you.

Jim O'Dempsey
EXECUTIVE OFFICER

Purpose and Responsibilities

The Office of Health Practitioner Registration Boards ('the Office') was established under s. 7, *Health Practitioner Registration Boards (Administration) Act 1999* ('the Act') on 7 February 2000. As an independent statutory body, the Office is responsible under s.8 of the Act to provide the administrative and operational support necessary or convenient to help each of the 13 Health Practitioner Registration Boards ('the Boards') to perform their functions.

Consistent with its legislative responsibilities the Office's purpose, as stated in its *Strategic Plan 2004-2008*, is to provide quality services which enable the Health Practitioner Registration Boards in regulating the professions to: (a) promote and protect the public interest; (b) uphold the standards of practice within the professions; and (c) maintain public confidence in the professions.

In assisting the Boards to meet these objectives the Office provides administrative and operational support through six key services as follows: (a) registration; (b) Board meeting support; (c) complaints management; (d) health assessment and monitoring; (e) professional advice and support; and (f) corporate support.

Constitution of the Office

The Office is constituted under s. 7(2) of the Act and consists of the Executive Officer and staff of the Office. Appendix 1 details the organizational structure of the Office and staff as at 30 June 2004.

The Executive Officer, for the purposes of the *Financial Administration and Audit Act 1997*, is the Chairperson of the Office and is responsible for its efficient and effective administration and operation.

In discharging the role, the Executive Officer's responsibilities include:

- The management of the Office including financial management.
- The negotiation of Service Agreements with each of the Boards.
- The implementation of Service Agreements.
- Providing training for Board members on their appointment about their role and the legislative scheme.

The Executive Officer may also perform other functions given to or conferred on the Executive Officer under another Act, including, for example, any Act in the legislative scheme.

Clients of the Office

The Office has a wide range of clients to whom it provides services. The primary clients of the Office are the Boards and their registrants. The 13 Boards to which the Office provides services and the legislation they administer are as detailed in Appendix 2.

In addition to the Boards, the Office provides services to other clients who include:

- The general public, whose health care interests are the reason for the establishment and ongoing operations of the Boards.
- The Minister for Health, for whom the Office regularly provides advice on the operations of the legislative scheme.
- The Director-General and officers of Queensland Health for whom the Office provides advice on the operations of the legislative scheme.
- The Health Rights Commission, through consultation and reporting arrangements, on the management and investigation of complaints about the conduct, competence and health of registrants.
- Health practitioner registration authorities in other states, territories and countries through the exchange of information on the good standing of registrants and policy and practice issues.
- The state and national branches of the various professional associations of health practitioners through the provision of advice.
- Academic institutions whose programs of education prepare graduates eligible to apply for registration in Queensland.
- National councils and organizations established to progress consistent approaches to the regulation of the various health professions.
- The Health Insurance Commission, private health insurance companies and employers which seek details of the registration status of health practitioners.

Ministerial Directions

Section 32, *Health Practitioner Registration Boards (Administration) Act 1999* requires the Office to include in its Annual Report copies of all ministerial directions given to the Executive Officer under s.9(1), s.25(1), s.29(3) or s.38(3) during the financial year. During the year under report the Office received no such directions from the Minister.

Highlights: 2003 - 2004

The period under report has been characterized by a continued focus on implementation of quality improvements and enhancement of client service. Progress and outcomes relevant to each of the Office's key service areas are detailed in the following sections of the Annual Report. The highlights for this half year are summarized below:

- The *Service Agreement 2003-2006* implemented from 1 July 2003.
- Project planning completed for business process review of registration procedures. Project commenced in February 2004 and the final report is due to be completed in September 2004.
- Board meeting support service change proposal considered and endorsed by each Board.
- Recommendations from the Complaints and Health Assessment and Monitoring Review Project considered by each Board and implementation of approved recommendations progressed.
- The corporate identity of each board has been reviewed and a design house contracted to provide long term print design and management services
- Review of use of panel of external investigators demonstrates the strategy has been successful. The Medical Board has agreed to its continued use and all the remaining Boards have endorsed the strategy for future use of the panel.
- Recommendations from the Siggins Miller Review have been fully implemented.
- Project Officer appointed to develop discussion paper on recency of practice. Discussion paper will be placed before Boards for consideration from July 2004 prior to Cabinet approval being sought for its release to stakeholders.
- Review required under section 33 *Health Practitioners Registration Boards (Administration) Act 1999* completed.
- Corporate Governance and Risk Management Strategy developed and implemented.
- Human Resource Management Policy and Procedure Manual implemented including the development and implementation of a Human Resource Management Delegations Manual.
- Diagnostic audit of current safety management systems at the Office undertaken, report considered by senior management and implementation of approved recommendations commenced.
- Staff Development and Training Plan fully implemented.
- Communication Standards and Structure fully implemented.
- Financial Management Practice Manual fully implemented.

- Quality improvements in the financial management and reporting framework fully implemented.
- Internal audit function fully implemented.
- Functional analysis and specification of Version 1 of the Professional Standards Information System completed and design phase commenced.
- Systems hardware plan developed and implemented to enhance system capacity, performance and redundancy.
- On-line services implementation strategy developed and implemented.
- Approved recommendations from the Records Management Evaluation Project implemented.

Service Agreements

The new *Service Agreement 2003-2006* commenced from 1 July 2003. Upon commencement, the number of service areas was decreased from nine to six as follows: (a) Records Management Services and Freedom of Information Services have been included as sub-services of Corporate Support Services; (b) the Statutory Compliance Service has been included as a sub-service within all six primary services; and (c) the Planning and Reporting Service has been included as a sub-service of the Professional Advice and Support Service.

Statistical Data

Appendix 3 -

Table 1 details funds provided to the Office under the Service Agreements for the prospective year and includes a comparison for the 2002-2003 reporting periods.

Registration Services

This service manages all processes associated with application for, and renewal of, registration in accordance with the relevant legislative provisions and the policies of the relevant Board. The service ensures that: (a) initial applications for registration are processed; (b) registrations are renewed annually; (c) all other registration activities such as restorations, and special purpose and conditional registrations are completed; (d) enquiries from applicants for registration and registrants are processed; (e) registers are maintained in accordance with the legislation; and (f) Boards are kept informed of all matters relating to registration services.

This report identifies the objective stated in the *Operational Plan 2003-2004*, the activities undertaken to meet this objective and outcomes achieved.

Objective: To implement the approved recommendations from the Registration Review Project.

During the period from September to October 2003, negotiations were undertaken with the Integrated Service Delivery Unit ('ISDU') of the Department of Innovation and Information Economy, Sport and Recreation. The negotiations were successful in establishing a partnership with the ISDU for a jointly funded project to undertake a full review of the registration processes utilizing the Access Queensland Business Review Methodology.

The project mandate was completed following staff workshops in November 2003 and the objectives detailed in that mandate are to:

- (a) Develop a registration policy and procedure manual which supports consistent application of the provisions in each Board's registration Act.
- (b) Develop a registration delegation manual consistent with the requirements of the relevant provision in each Board's registration Act.
- (c) Establish customer-focused registration processes that are efficient and effective.
- (d) Establish the ability for registrants to apply and to maintain their registration through multiple channels, including on-line.
- (e) Inform the further development of the Registration Information System.
- (f) Inform whether registration process redevelopment requires organizational structural change.

The Project Steering Committee is constituted by Mr O'Dempsey, Mr Connell (Deputy Registrar), Mr Demy-Geroe (Deputy Registrar) and Mr Woolley (ISDU). A full time Project Team was also appointed and is constituted by Mr Posner, Ms Ramsay, Ms Portier and Ms Davey. In addition, ISDU has seconded to the Office, at no cost, Ms Newman who facilitates the Project Team in their use of the Business Process Review methodology.

A Project Plan was completed with the project commencing in February 2004 for completion by May 2004. This completion date was extended to September 2004 primarily because: (a) the scope of the project was revised to include renewal and restoration of registration processes; and (b) the discovery phase of the project identified a total in excess of 130 procedures being utilized for the fourteen key registration processes.

At the time of this report, the Current State Baseline is well advanced and the Service Vision Concept is being completed. When documentation for these two phases of the project has been endorsed by the Steering Committee, the Project Team will complete the detailed design for future registration processing and a service business case. When the service business case has been completed a proposal for change will be prepared for consideration by all thirteen Boards prior to the development of an implementation strategy. It is important to note that a number of prominent issues identified in the Current State Baseline will be addressed in the implementation strategy. These are as follows:

- (a) The Registration Information System: does not meet all legislative requirements; lacks standard business rules governing data entry; contains irrelevant and unnecessary fields of information; does not provide management information reporting; and functions as a repository of information rather than a management information system.

- (b) The processes for registration: are convoluted; require multiple handling of primary documentation; are not supported by professionally designed application forms; and are not supported by documented policies and procedures.
- (c) The current organizational structure does not support the goals for quality registration service provision.

Given these factors, the discovery phase of the project has highlighted many opportunities to improve the delivery of registration services to clients. This includes the implementation of: significantly simplified and generic processes; a reliable registration and renewals management information system; a less silo based organizational structure; and improved accessibility to services through various channels. These initiatives will significantly improve the efficiency and effectiveness of the registration services provided to clients by the Office. They will also give staff the opportunity to develop new knowledge and skills.

In addition to establishing the above noted project, significant development work has been undertaken in designing standard registration management information reports. The initial design for these reports has been reviewed by the Deputy and Assistant Registrars. This review has identified a number of minor modifications and Information Technology staff are currently progressing these changes. It is expected that the standard management information reports will be commenced in the next reporting period.

Strategic Objectives 2004-2005

The forward operations in relation to this key service area have been reviewed. On the basis of that review, the objectives to be achieved in 2004-2005 are:

- To implement the approved Plan from the Business Process Review of Registration Services.
- To develop and implement a strategy for monitoring compliance with conditions imposed under the registration Acts.
- To jointly develop and implement standard processes for dealing with breaches of the registration Acts.
- To develop and implement an information kit for new medical registrants.
- To progress the AHMAC Working Party initiative for enhancements in mutual recognition.

Statistical Data:

Appendix 3 - Table 2 details the number of registrants per Board as at 30 June 2004 and includes comparative data from previous years.

Appendix 3 - Table 3 details the number of registrations approved in the period under report.

Board Meeting Support Services

This service provides administrative support for Board and Board Committee meetings, including actions arising from decisions at meetings. The service ensures: (a) preparation of agendas and minutes for meetings of the Boards and, where required, their Committees; and the Combined Meetings of Board Chairpersons; (b) attendance and taking of minutes at Board meetings and, where required, Committee meetings; and (c) preparation of Board correspondence and newsletters.

This report identifies the objective stated in the *Operational Plan 2003-2004*, the activities undertaken to meet the objective and outcomes achieved.

Objective: To develop and implement a service change proposal based on the evaluation report completed in June 2003.

In February 2003 a survey of the members of each of the Boards was undertaken to evaluate the secretariat services and processes utilized by the Office in providing Board meeting support services. The results of the survey demonstrated that all Boards were generally satisfied with the service provided.

While generally satisfied, each Board raised a number of issues to be addressed and provided data to inform new service standards. Submissions addressing these matters were considered by each Board in the first quarter of 2004 and the recommendations made in such submissions were approved by all Boards and subsequently implemented.

Strategic Objectives 2004-2005

The forward operations in relation to this key service area have been reviewed. On the basis of that review, there have been no objectives identified for the 2004-2005 reporting period.

Statistical Data

Appendix 3 - Table 4 details the number and type of meetings serviced by the Office in the period under report.

Complaints Management Services

This service manages all processes associated with complaints made about the conduct of registrants. These processes include: (a) receipt and documentation of complaints; (b) management of investigations and any subsequent disciplinary proceedings; (c) monitoring compliance with conditions and undertakings; (d) management of competence assessments; (e) obtaining formal opinions from, and instructing, solicitors acting for the Boards; and (f) development of education programs for practitioners on ethics and standards of practice.

This report identifies the objectives stated in the *Operational Plan 2003-2004*, the activities undertaken to meet these objectives and outcomes achieved.

Objective: To implement the approved recommendations from the Complaints and Health Assessment and Monitoring Review Project.

During the year under report all Boards considered the Project Report and made decisions in regard to the recommendations ensuing from the review. The Office has progressed the approved recommendations and, in this regard:

- (a) A Delegations Manual for the *Health Practitioners (Professional Standards) Act 1999* was completed, approved by all Boards and implemented.
- (b) Terms of Reference for the Complaints Committees of the Medical, Dental and Psychologists Boards were completed, approved by each Board and implemented.
- (c) Following a competitive tendering process, Inovoke was appointed to develop the Corporate Style Manual and provide long term print design and management services to the Boards. The Chairperson of each Board, or their delegate, have met with Inovoke to brief on the design/redesign of Board logos. At the time of this report, three Boards were yet to finalise their logos. When these are finalized, the Corporate Style Manual will be completed and Inovoke will progress the design and layout of the professional standards policy, information leaflets and the complaints pro forma recommended from the Review.
- (d) A matrix and procedure for the assessment of complaints has been completed and implemented.
- (e) The review of Complaints Unit pro formas (notices, letters, authorizations, etc.) has been commenced and will be progressively completed by 30 June 2005.

Objective: To review the administrative procedures of the Complaints Unit.

During the year under report an initial meeting was held to commence the review, the primary focus of which was the: (a) development of administrative procedures for the complaints assessment process; and (b) review of administrative procedures for telephone inquiries made to the Unit.

The review of these administrative procedures has been completed and the outcomes implemented in the period under report. The review of the remaining procedures will be progressively undertaken at regular meetings of the Unit's administrative staff and the outcomes implemented.

Objective: To review the outcomes of using a panel of external investigators.

During the year under report a review of the panel of contract investigators was prepared for the Medical Board. This panel was established as one component of a three-fold strategy directed toward reducing both the backlog of investigations and the 'turnaround' time for investigations. The review found that:

- (a) One hundred cases had been allocated to the panel during the period from January 2003 to September 2003.
- (b) As at 25 November 2003, 55 investigations had been substantially completed and the remaining 45 investigations were due for completion to the draft report stage by 28 February 2004.

- (c) Of the 30 investigation reports considered by the Medical Board, the average completion time (from allocation to consideration by the Complaints Advisory Committee) had been approximately 5 months.
- (d) The costs of the completed investigations were within the budget parameters and it was estimated that the full cost for completion of the 100 allocated cases would be approximately \$2,500 above budget.

Given these findings, the Medical Board approved the allocation of an additional 25 cases to the panel both in February and April 2004. In addition, each of the Boards, in considering the Budget Proposal 2004-2005, approved inclusion of an expenditure item for external investigators. The inclusion of such expenditure in the budget will enable all Boards to access the panel of external investigators should this be deemed necessary by the Board to ensure that a future backlog of investigations does not occur.

Objective: To implement Version 1 of the Professional Standards Information System.

During the year under report, the Functional Analysis and Specification for Version 1 of the Professional Standards Information System has been completed and the development phase commenced. Further information in regard to this project is provided in the Information Technology Services section of this report.

Strategic Objectives 2004-2005

The forward operations in relation to this key service area have been reviewed. On the basis of that review, the objectives to be achieved in 2004-2005 are:

- To finalise implementation of the approved recommendations from the Complaints and HAM Review Project as follows: (a) final drafting, design and printing of policy, information sheets and complaints brochure; (b) develop expert witness register; and (c) complete all required templates.
- To implement Version 1 of the Professional Standards Module.
- To finalise the review of administrative procedures and protocols.
- To improve our processes and co-operation through effective communication with related organisations.
- To review the role and responsibilities of investigators.
- To develop and implement processes and protocols (including an information package) for Board level disciplinary hearings.
- To develop and implement a strategy for monitoring compliance with undertakings, conditions, and suspensions initiated under the *Health Practitioners (Professional Standards) Act 1999*.
- To develop and progressively implement a stakeholder education strategy.

- To finalise the reduction of the investigation backlog and to establish an ongoing strategy for management of future caseloads.

Statistical Data

- Appendix 3 - Table 5 details the number of investigations as at 1 July 2003, the number of complaints received during the period under report, the number of investigations commenced during the period under report, the number of investigations completed during the period under report and the number of investigations continuing as at 30 June 2004.
- Appendix 3 - Table 6 details the change in outstanding investigations in percentage terms from 1 July 2002 to 1 July 2004. It should be noted that the three fold strategy to reduce the investigation backlog has been effective. In this regard the number of outstanding investigations as at 1 July 2004 has been reduced by 35.6% when compared to those outstanding as at 1 July 2002. This significant trend is expected to continue.

Health Assessment and Monitoring Services

This service manages all processes dealing with impaired registrants in accordance with Part 7, *Health Practitioners (Professional Standards) Act 1999* ('the Act'). Part 7 of the Act provides the authority for all Boards to manage impaired registrants through a non punitive approach to illness management and to reduce the incidence of concealment of impairment by registrants. Such management includes assessment, monitoring and supervision of impaired registrants. The service ensures: (a) compliance with legislative requirements; (b) protection of the public through appropriate management of registrants who have illnesses that can potentially impact on their ability to practise safely; and (c) assistance to registrants whose career is threatened by illness.

This report identifies the objectives stated in the *Operational Plan 2003-2004*, the activities undertaken to meet these objectives and outcomes achieved.

Objective: To implement the approved recommendations from the Complaints and Health Assessment and Monitoring Review Project.

During the year under report all Boards have considered the Project Report and made decisions in regard to the recommendations ensuing from the review. The Office has progressed the approved recommendations and, in this regard:

- (a) A Delegations Manual for the *Health Practitioners (Professional Standards) Act 1999* was completed, approved by all Boards and implemented.
- (b) Terms of Reference for the Health Assessment and Monitoring Committees of the Medical, Dental and Psychologists Boards were completed, approved by each Board and implemented.
- (c) Following a competitive tendering process, Inovoke was appointed to develop the Corporate Style Manual and provide long term print design and management services to the Boards. The Chairperson of each Board, or their delegate, have met with Inovoke to brief on the design/redesign of Board logos. At the time of this report, three Boards were yet to finalise

their logos. When these are finalized, the Corporate Style Manual will be completed and Invoque will progress the design and layout of the brochures for the Health Assessment and Monitoring Unit.

- (d) The review of the Health Assessment and Monitoring Unit pro formas (notices, letters, authorizations, etc.) has been completed.

Objective: To implement the plan approved by Cabinet to progress the outcomes of the Siggins Miller Review.

During the year under report the Health Assessment and Monitoring Unit has implemented the Cabinet approved recommendations ensuing from the Siggins Miller Review. This has included:

- (a) Negotiating a Memorandum of Understanding between the Medical Board of Queensland and the Crime and Misconduct Commission ('CMC'). A first draft of the Memorandum is being prepared by the CMC and is expected to be received by the Office by August 2004. On its receipt the Office will convene a meeting with the CMC and Queensland Health (Drugs of Dependence Unit and Audit Branch) with the objective of developing a standard Memorandum of Understanding between the Board(s), the CMC and the above noted Units of Queensland Health.
- (b) A workshop for psychiatrists and psychologists (who specialize in neuropsychology) was conducted in November 2003 to inform these specialist groups about the Health Assessment and Monitoring Unit's role and responsibilities. A future workshop, to be held in north Queensland, is currently being planned to enable psychiatrists and psychologists from that region to attend on a cost effective basis.
- (c) The Office corresponded with the Health Insurance Commission to raise the issue of whether the use of pethidine in doctor's bags should be reviewed. The response received was in the negative.
- (d) The Office sought advice from Crown Law about whether the Boards could delegate their power to modify an existing undertaking. The response received was in the negative and the matter has now been referred to the Legislative Projects Unit, Queensland Health, to progress an amendment to the legislation to enable such delegation.

A final report detailing information on the actions taken to implement the above noted matters will be prepared for the consideration of all Boards when the Memorandum of Understanding with the CMC and Queensland Health has been finalized.

Objective: To implement Version 1 of the Professional Standards Information System.

During the year under report, the Functional Analysis and Specification for Version 1 of the Professional Standards Information System has been completed and the development phase commenced. Further information in regard to this project is provided in the Information Technology Services section of this report.

Strategic Objectives 2004-2005

The forward operations in relation to this key service area have been reviewed. On the basis of that

review, the objectives to be achieved in 2004-2005 are:

- To finalise implementation of the approved recommendations from the Complaints and HAM Review Project as follows: (a) final drafting, design and printing of policy, information sheets and HAM brochures; and (b) negotiating and implementing legislative amendments.
- To implement Version 1 of the Professional Standards Module.
- To develop and progressively implement a stakeholder education strategy.
- To enhance administrative procedures and protocols.

Statistical Data

There were a total of 42 new referrals to the service during the period under report, while 33 practitioners were discharged from the program. In addition, 7 investigations were conducted during the period one of which was with the panel of external investigators. Three of these were carried over from 2001-2002 and one was commenced during 2002-2003. Of the seven investigations, five were concluded during the period under report and two remain ongoing. In relation to the latter of these, both investigations are due for completion in the first quarter 2004-2005.

It should be noted that since 2002 the Unit has cleared 16 of the 18 outstanding investigations and has the resources and capacity to investigate any practitioner on the HAM Program who is not complying with the program requirements.

Professional Advice and Support Services

This service utilizes professional knowledge and expertise to provide high level advice and support on matters related to the Board's functions under relevant legislation. Among the services provided by the Office are: (a) advising the Boards on their obligations under statutes and government guidelines; (b) assisting the Boards in negotiating amendments to primary and subordinate legislation; (c) organizing seminars and attending conferences on behalf of the Boards; and (d) representing the Boards in various forums within Queensland, nationally and internationally.

This report identifies the objectives stated in the *Operational Plan 2003-2004*, the activities undertaken to meet the objectives and outcomes achieved.

Objective: To develop a policy position on 'Recency of Practice'.

During the year under report, a project officer was recruited with the appointment commencing in August 2003. The project officer, in consultation with the Executive Officer, has drafted a project plan and a discussion paper. A submission will be made to each Board in July and August 2004 in regard to progressing this project through consultation with stakeholders. Subject to Cabinet approval of the discussion paper, consultation is expected to commence with stakeholders in October to define recency of practice for the purposes of the renewal of registration provisions in each of the registration Acts. Implementation of recency of practice requirements will not commence until they are defined in

the registration Regulations and, at this stage, recency of practice as a requirement for renewal of registration is not expected to commence until May 2006 at the earliest.

Objective: To co-ordinate submissions to the review required under s.33, *Health Practitioner Registration Boards (Administration) Act 1999*.

During the year under report, the Office provided a range of documentation to the Legislative Projects Unit, Queensland Health, to inform the review and co-ordinated meetings between the Chairperson of each Board and the contracted review officer, Mr Gil Brooks. In addition, the Executive Officer and Senior Managers met with Mr Brooks in contributing to the review process.

The review was completed in the period under report and subsequently considered by the Minister for Health who tabled the report in Parliament in April 2004. The formal findings of the review were that:

The effectiveness and responsiveness of the HPRB Office established by the Act have resulted in improved administrative and operational support for the Health Practitioner Registration Boards in Queensland.

The operational and support issues identified in the HPRA Review have been substantially addressed, and the identified benefits from adopting this approach have also been substantially achieved.

No requirements for legislative changes to the Act were identified as a result of the review, and there is no pressure from key stakeholders to modify the Act or the current administration and operational support model.

After a reconsideration of the relative merits of alternative means of providing administrative and operational support to the Boards, it is considered that the approach adopted in the Act remains the most relevant to the Queensland environment.

There is no requirement to make any legislative change in relation to the reporting relationship of the Executive Officer, including the proposed performance review arrangements for the position.

The administrative and operational support arrangements established under the Act should be maintained.

While the Office was pleased with the outcome noted above, it submitted during the review that there were provisions in the registration Acts and the *Health Practitioners (Professional Standards) Act 1999* which impacted on the efficiency of the administrative and operational services it provided to both the Boards and their clients. In acknowledging that a review of those Acts was outside the scope of this project the Office, in consultation with the Chairperson of each Board and each Board's legal advisors, has progressed this issue by identifying all such provisions and, through a workshop of senior staff, developed a proposal for change. A submission seeking each Board's support of such changes is currently under development and will be placed before each Board for consideration from October 2004.

Objective: To assist Boards with the development of 'Codes of Practice' for Registrants.

During the year under report, the Executive Officer provided comments on a number of drafts of the guidelines for developing Codes of Practice as prepared by the Legislative Projects Unit, Queensland

Health. The guidelines were completed by the Legislative Project Unit during the period under report and subsequently submitted to, and approved by, the Minister. The guidelines are currently being considered by each Board and the Office will await each Board's decision in terms of any assistance they require to progress development of a Code of Practice.

Objective: To redevelop the structure and content of the Annual Reports of the Boards and the Office.

This objective was not progressed during the period under report as there were a number of significant competing workloads. The objective will be progressed in 2005-2006.

Objective: To develop for Board consideration a communication infrastructure to achieve strategic priorities.

During the year under report, the Office progressed a number of prerequisite objectives prior to developing a submission to the Boards in regard to a communication infrastructure. There are two primary prerequisite objectives, being: (a) the development/redevelopment of the corporate images of the Boards and preparation of the Corporate Style Manual; and (b) the development and implementation of an integrated world wide website for the Boards and the Office.

Both these objectives have been substantially achieved and will be completed in the next reporting period.

Objective: To co-ordinate Board specific corporate governance and risk analysis and to undertake Office corporate governance and risk analysis.

During the year under report, the Corporate Governance and Risk Management Strategy was developed and implemented. The implementation strategy is comprised of four specific initiatives. These are as follows:

- (a) Governance and Risk Management Self-Assessment: The Office has undertaken a self-assessment of governance and risk management utilizing the program developed by the Queensland Audit Office. The findings of this self-assessment have been implemented.
- (b) Internal Audit Assessment: The internal auditor will, in early 2005, assess the Office through the *Framework of Organisational Characteristic Questionnaire*.
- (c) Risk Management Policy: The policy has been developed in the period under report and was approved by the Executive Officer in October 2003. A risk assessment workshop was conducted in November 2003 and a risk management plan is currently nearing completion. Upon its completion, the plan will be implemented and monitored.
- (d) Board Self-Assessment: During the period under report the Office, in consultation with JAQ Pty Ltd, developed a governance self-assessment tool for use by the Boards. A submission in relation to the self-assessment was placed before all Boards (with the exception of the Medical Board which undertook the self-assessment in June/July 2003) in late 2003. In considering the submission, all Boards agreed to undertake the self-assessment and to fund the cost for setting up the web-based questionnaire, analysis of Board specific responses and preparation of Board specific reports. The report of this self-assessment has been completed and each Board will consider its results by October 2004.

Strategic Objectives 2004-2005

The forward operations in relation to this key service area have been reviewed. On the basis of that review, the objectives to be achieved in 2004-2005 are:

- To finalise development of a policy position on 'Recency of Practice' and prepare an implementation strategy.
- To finalise development of an integrated communication strategy for all Boards specifically addressing newsletters and the release of standards/guidelines developed or adopted by the Boards.
- To assist the Boards in implementing any requirements identified from the Board governance self-assessment.
- To inform, negotiate and implement amendments to the *Health Practitioners (Professional Standards) Act 1999* and the registration Acts.
- To inform, negotiate and implement a realistic policy for fees established under the Regulations of each registration Act.
- To schedule and undertake reviews of service standard measures.
- To commence a review of services to ensure they are accessible to all ethnic communities.
- To continue to develop and implement strategies to improve the work environment and enhance intra Office communication.

Corporate Support Services

This service manages all corporate support services of the Office and the Boards including: (a) human resource management; (b) financial management; (c) information technology; (d) records management; and (e) freedom of information processes. In addition to the matters detailed under each sub-service, corporate support services has: (a) developed and implemented policies on corporate cards, purchasing and Qantas Club membership; (b) managed the negotiations and co-ordinated the design for refurbishment of the Office; (c) implemented accumulated time arrangements for the organization; and (d) reviewed the position descriptions for all positions within corporate services and re-designated nine positions.

Human Resource Management Services

This sub-service provides all human resource management services to enable the Office to deliver its services to Boards and their clients. This report identifies the objectives stated in the *Operational Plan 2003-2004*, the activities undertaken to meet these objectives and outcomes achieved.

Objective: To implement the Human Resource Management Policy and Procedure Manual.

The project to develop the Human Resource Management Policy and Procedure Manual was completed in August 2003 and the Manual has been fully implemented during the period under report. Implementation has included staff training workshops which have been conducted for one hour at each of the monthly half day Office closures. In addition, the Office has developed and implemented a Human Resource Management Delegations Manual.

The Executive Officer and senior management also considered, in July 2003, the report of the diagnostic audit of Office workplace health and safety. To progress all corrective actions recommended by the auditor, an interim Workplace Health and Safety Committee was established in August 2003. This Committee met on a number of occasions during the period under report and in November 2003 provided the Executive Officer with a framework and timetable for implementation of the workplace health and safety strategy. A Workplace Health and Safety Committee was constituted in February 2004 and that Committee is now responsible for implementing the strategy.

Objective: To implement the Staff Development and Training Plan.

The Staff Development and Training Plan was approved by the Executive Officer in August 2003. This Plan articulated the direction, priorities and strategies that the Office would pursue during 2003-2004 and was consistent with the priorities detailed in the *Strategic Plan 2003-2007*. During the period under report, staff development and training activities undertaken have included the following:

- | | |
|--|--|
| ▪ Gathering evidence (investigations) | ▪ Briefing experts (investigations) |
| ▪ Code of Conduct training | ▪ Organisational communication |
| ▪ Leadership & Innovation | ▪ Recruitment & Selection |
| ▪ Equal Employment Opportunity | ▪ Induction |
| ▪ Powerpoint Presentations | ▪ Preparing an Investigation Report |
| ▪ Job Analysis & Job Evaluation | ▪ Preparing and Presenting the Case (Investigations) |
| ▪ Basic Computer Skills | ▪ Dealing with Difficult People & Situations |
| ▪ Professional Telephone and Enquiry Skills | ▪ Situational Leadership Training |
| ▪ Introduction to Public Sector Financial Management | ▪ Polished Presentations |
| ▪ Internal Controls & Risk Management (Tooher Gale & Associates) | ▪ Writing for the Public Sector – Current Conventions, Machinery of Government & Email Etiquette |
| ▪ Financial Management Framework and Managing Budgets & Cost Centres | ▪ Write Smart Departmental Correspondence |

Objective: To implement the approved Communication Standards and Structure.

In July 2003 the draft Communication and Client Service Standards were reviewed by all staff at a workshop. Amendments suggested by staff and agreed by management were subsequently incorporated in the Standards, which were approved by the Executive Officer in September 2003. The Standards reflect the Office's commitment to professional and effective communication in the provision of service to our clients. In this regard the Office aims for excellence in client service by: (a) providing professional, inclusive and informative advice; (b) responding promptly to client needs; (c) being courteous, professional and respectful in our communication; and (d) operating efficiently and effectively.

The Standards, which are detailed below, apply within the Office and between the Office and the Boards, their registrants and any others with whom staff of the Office do business. All staff share the responsibility for achieving the Standards and to assist them in this, the Office has provided monthly All of Staff communication workshops during the period under report.

Standard 1 Staff of the Office are responsible to the Executive Officer in provision of services to our client Boards.

- Standard 2* The Office through senior management consults with staff and the Boards in the development and provision of services.
- Standard 3* Staff of the Office respond promptly to all written and verbal enquiries from clients.
- Standard 4* The communication style in verbal, non-verbal contact and by indirect means such as letters, reports and submissions, portrays an image of the Office as a professional organization.
- Standard 5* The privacy of clients and staff is assured.
- Standard 6* Information strategies and techniques are used to provide accurate and complete information.
- Standard 7* All communication demonstrates respect for persons.
- Standard 8* The Office, through its staff, undertakes all its activities in an equitable, efficient and cost-effective manner.

The above noted Standards are supported by a series of individual and organizational model practice statements. In future years the Office's achievement against these standards will be measured through key performance indicator data sourced from our clients.

Strategic Objectives 2004-2005

The forward operations in relation to this key sub-service area have been reviewed. On the basis of that review, the objectives to be achieved in 2004-2005 are:

- To develop a procedure manual for each position in the Corporate Services Unit.
- To review and enhance the induction policy and procedures (with a specific focus on induction in each Unit).
- To refine and re-focus staff development and training.

Financial Management Services

This sub-service includes provision of all financial management services to the Boards to ensure compliance with relevant statutory financial management requirements. The sub-service includes: (a) revenue, accounts receivable and reconciliation; (b) expenditure and accounts payable; (c) administration of payroll; (d) maintenance of assets register; (e) administration of taxation compliance; (f) financial system development and maintenance; and (g) budget preparation and statutory reporting.

This report identifies the objectives stated in the *Operational Plan 2003-2004*, the activities undertaken to meet these objectives and outcomes achieved.

Objective: To implement the Financial Management Practice Manual.

During the year under report the Financial Management Practice Manual has been fully implemented. Such implementation has included staff training, as detailed in the Staff Training and Development objective, and the development of all required policy, procedures and registers including:

- | | |
|--|---|
| ▪ Release of Information to Third Parties Policy | ▪ Travel Policy – Board Members |
| ▪ Salary Overpayments Policy | ▪ Travel Bookings Information Sheet |
| ▪ Investment Policy | ▪ Travel Warrant Form – Information Sheet |

- Payments – General Policy
- Systems Appraisals Policy
- Fringe Benefits Tax Policy
- Record of Bank Accounts
- Register of Merchant Facility Arrangements
- Reproduction of Financial Records Policy
- Register of Reproduced Financial Records
- Movement of Reproduced Financial Records Register
- Processing Refunds Policy
- Travel Policy (OHPRB)
- Travel Reimbursement/Acquittal Form – Information Sheet
- Procedural Guide to Preparing Annual Financial Reports
- Imprest Advance Accounts Policy
- Register of Accountable Advances
- Register of Accountable Forms
- Register of Legal Documents
- Register of Leases
- Tax Invoice Checklist
- Gift Policy
- Risk Management Policy
- Use of Taxis Policy
- Assets Policy
- Use of Office Motor Vehicles Policy and Guidelines
- Electronic Funds Transfer Policy

Objective: To implement quality improvements in the financial management and reporting framework.

The quality improvements in the financial management and reporting framework have been fully implemented during the year under report. This implementation has achieved the expected outcomes, being as follows: (a) a more effective use of staff resources that were previously consumed by the complex financial management infrastructure; and (b) enhanced corporate governance through the provision of timely, accurate and clear financial management reports.

Objective: To fully implement the internal audit function for compliance and quality outcomes in financial management.

The internal audit function has been fully implemented during the period under report consistent with the *Internal Audit Charter June 2003*, *Internal Audit Strategic Plan 2003-2007*, and *Internal Audit Operational Plan 2003-2004*.

Objective: To develop and implement five year financial modeling.

The model enabling five year financial budget projections has been developed and fully implemented during the year under report. This model significantly enhances corporate governance as it enables the Office and each Board to: (a) consider their medium to long term financial projection in both the development and approval of the annual budget; (b) incorporate a simple, cost effective and regular budget review process during the course of each financial year; and (c) model the cost of proposed initiatives to inform the decision-making process.

Consultancies

Section 95(1)(eb), *Financial Management Standard 1997* requires every public sector agency to include in its Annual Report, information about the agency's expenditure on consultancies. During the year under report, the Office expended the following amounts on consultants:

▪ Management	-
▪ Human resource management	\$2,850
▪ Information technology	-
▪ Finance/accounting	\$31,850
▪ Professional/technical	\$8,302

Strategic Objectives 2004-2005

The forward operations in relation to this key sub-service area have been reviewed. On the basis of that review, the objectives to be achieved in 2004-2005 are:

- To evaluate the internal audit function including the need to establish an internal audit committee.
- To develop and implement financial systems appraisals.
- To implement all requirements of the International Financial Reporting Standards.
- To evaluate the five year financial modelling and its integration with the budget.

Audited Financial Statements

Appendix 4 - Reproduces the Audited Financial Statements 2003-2004.

Information Technology Services

This sub-service develops and maintains technological resources to enable the Office to deliver its services to the Boards and their clients. This report identifies the objectives stated in the *Operational Plan 2003-2004*, the activities undertaken to meet these objectives and outcomes achieved.

Objective: To implement information system best practice in terms of government standards and guidelines.

During the period under report an implementation strategy outlining the start to finish process required was completed. Implementation of this strategy commenced in 2004 and as at 30 June 2004, a range of best practice initiatives have been implemented, as follows:

- (a) Board and Office website maintenance: changes are now implemented via a managed process that includes content authorization by a registration team supervisor or manager and archiving of all pages and files (older versions of files are kept for historical purposes).
- (b) Creation and maintenance of staff user accounts: team supervisors or managers are now required to formally request access to the Office's network resources for their staff. The significant advantage of this initiative is that temporary staff are now automatically deleted from the system when their tenure has expired and, as such, security has been enhanced.
- (c) The recording and maintenance of information technology assets has been streamlined through the adoption of new forms and a new procedure.
- (d) Constant updating of information security processes in terms of industry standards.

Progression of the balance of initiatives from the Best Practice Implementation Strategy was deferred in May 2004 due to the Office's upgrade of its server products. The balance of information technology tools and the training in their use will be acquired early in the next reporting period.

Objective: To implement Version 1 of the professional standards information system.

During the year under report progress has been achieved in the development for implementation of Version 1 of the professional standards information system. Information Technology staff have worked

closely with staff of the Complaints Unit and the Health Assessment and Monitoring Unit to define the requirements of the system and detailed these in a Functional Analysis and Specification document.

The Functional Analysis and Specification is the basis of the development phase which commenced in November 2003 and was expected to be completed in June 2004. However, following successful negotiation with the Queensland Nursing Council, the Office entered into a Memorandum of Understanding for joint development of Version 1. Such joint development was expected to reduce both the development time and cost. While it was expected that Version 1 would be implemented from May 2004, a number of delays ensued due to project staff absences and turnover. It is now expected that implementation will occur from November 2004, at which time the module will be populated with all data available from 1 July 2004. This will ensure the availability of management information reports on the required financial year basis.

Objective: To implement and further develop the Information Systems Policy and Procedure Manual.

During the year under report the Information Systems Policy and Procedure Manual has been fully implemented and amended where changes to the environment have occurred. In addition, six further policies have been developed and implemented. These are as follows:

- Use of Electronic Communications
- Information Security
- Disaster Recovery
- IT Cost Benefit Justification
- Information Technology Asset Management
- Acceptable Use of Electronic Information and Communication Systems

Objective: To develop and implement a systems hardware plan which enhances capacity, performance, physical and logical separation, fault tolerance and disaster recovery.

During the year under report a systems hardware plan has been developed and implemented. As at 30 June 2004 the objectives of the plan have been fully achieved. As a result, the Office is now utilizing the latest technology with the most up to date and secure operating software.

Objective: To ensure proprietary software enhances productivity and client services.

During the year under report no further action has been initiated in relation to redevelopment of the Registration Information System ('REGIS'). A prerequisite to such redevelopment is completion of the registration review project. As such, redevelopment of REGIS will be incorporated in the implementation strategy ensuing from the registration review project.

Objective: To develop and implement a project for an integrated world wide web site for the Boards and the Office.

During the year under report, the On-line Services Implementation Strategy was developed and implemented. This strategy is anchored in the full redevelopment of the websites of each Board and the Office with such redevelopment meeting the following business objectives: (a) enhancing and promoting the identity and functions of the Boards; (b) raising public confidence in the Boards through quality information provision; (c) offering contemporary on-line services to the Boards' separate customer groups; and (d) creating administrative cost savings.

The implementation strategy is comprised of three broad phases. These are as follows:

- Establishing a core focus group to determine an effective design for the new websites. This group will be constituted by individuals representing the Assistant Registrars, Administration Officers (Registration), the HAM and Complaints Units, and senior managers.
- Finalising the Corporate Style Guide which will, in relation to this strategy, provide the style foundation for each of the websites.
- Developing options for the new websites at the completion of the design phase.

The core focus group has been established and the design phase commenced from October 2003. The websites are currently being populated with text and, following such, a further submission will be made to each Board to seek approval of the preferred option prior to commencing the website development phase. It is expected that this submission will be made in the next reporting period subject to all Boards having approved their corporate logos.

Objective: To enhance organizational ownership of information systems.

During the year under report future users of Version 1 of the professional standards information system have directly informed the functional analysis, specification and development of the system. It is planned to assess user acceptance of the completed system to inform how best to meet this objective on an ongoing basis.

In addition to this initiative, staff ownership of information systems has been enhanced through: (a) integration of the information technology induction into the corporate induction process; (b) the creation of a series of simple information sheets covering 'how to' aspects of the users' information technology environment; (c) the continued development and support of a User Reference Group; and (d) improved communication to staff at All of Staff meetings.

Strategic Objectives 2004-2005

The forward operations in relation to this key sub-service area have been reviewed. On the basis of that review, the objectives to be achieved in 2004-2005 are:

- To implement the approved recommendations relating to REGIS from the Business Process Review of registration services.
- To establish a portal server to enable delivery of on-line corporate services.
- To develop and implement policy and procedures for archiving of electronic documents.
- To evaluate the telephone system and propose costed options for enhancement of client service.
- To continue implementation of the Project for an integrated website for the Boards and the Office.

Records Management Services

This sub-service manages all records on behalf of the Office and the Boards to ensure: (a) efficient access to stored information; (b) storage and release of information is consistent with relevant legislative requirements; and (c) records are accurately, contemporaneously and completely

maintained. This report identifies the objective stated in the *Operational Plan 2003-2004*, the activities undertaken to meet this objective and outcomes achieved.

Objective: To implement the approved recommendations from the Records Management Evaluation Project.

During the year under report implementation has commenced for the approved recommendations from the Records Management Evaluation Project, as follows:

- (a) Timelines have been established for completion of action on all recommendations.
- (b) All actions required to be completed by June 2004 are substantially complete. In this regard: the retention schedule has been reviewed and submitted to State Archives for approval; identification of unrecorded business files for incorporation into the business filing system has commenced; and the business files of all Boards have been culled so that only relevant files remain on site.
- (c) All records management policies and procedures have been reviewed, updated and implemented.

In addition, the Office completed development of a draft Strategic Records Implementation Plan as required under *Information Standard 40*. This Plan was submitted to State Archives in October 2003, subsequently approved and implementation is ongoing.

Objective: To review the role, responsibilities and organization of information management.

During the year under report, the Executive Officer convened a meeting of the Corporate Services Manager, the Information Technology Co-ordinator and Information Co-ordinator to scope the review process. The meeting agreed to the scope of the review. However, due to staff secondments the review will not be further progressed until the 2005 reporting period.

Strategic Objectives 2004-2005

The forward operations in relation to this key sub-service area have been reviewed. On the basis of that review, the objectives to be achieved in 2004-2005 are:

- To finalise implementation of the approved recommendations from the records management evaluation project.
- To finalise the review of the role, responsibilities and organisation of information management.

Freedom of Information Services

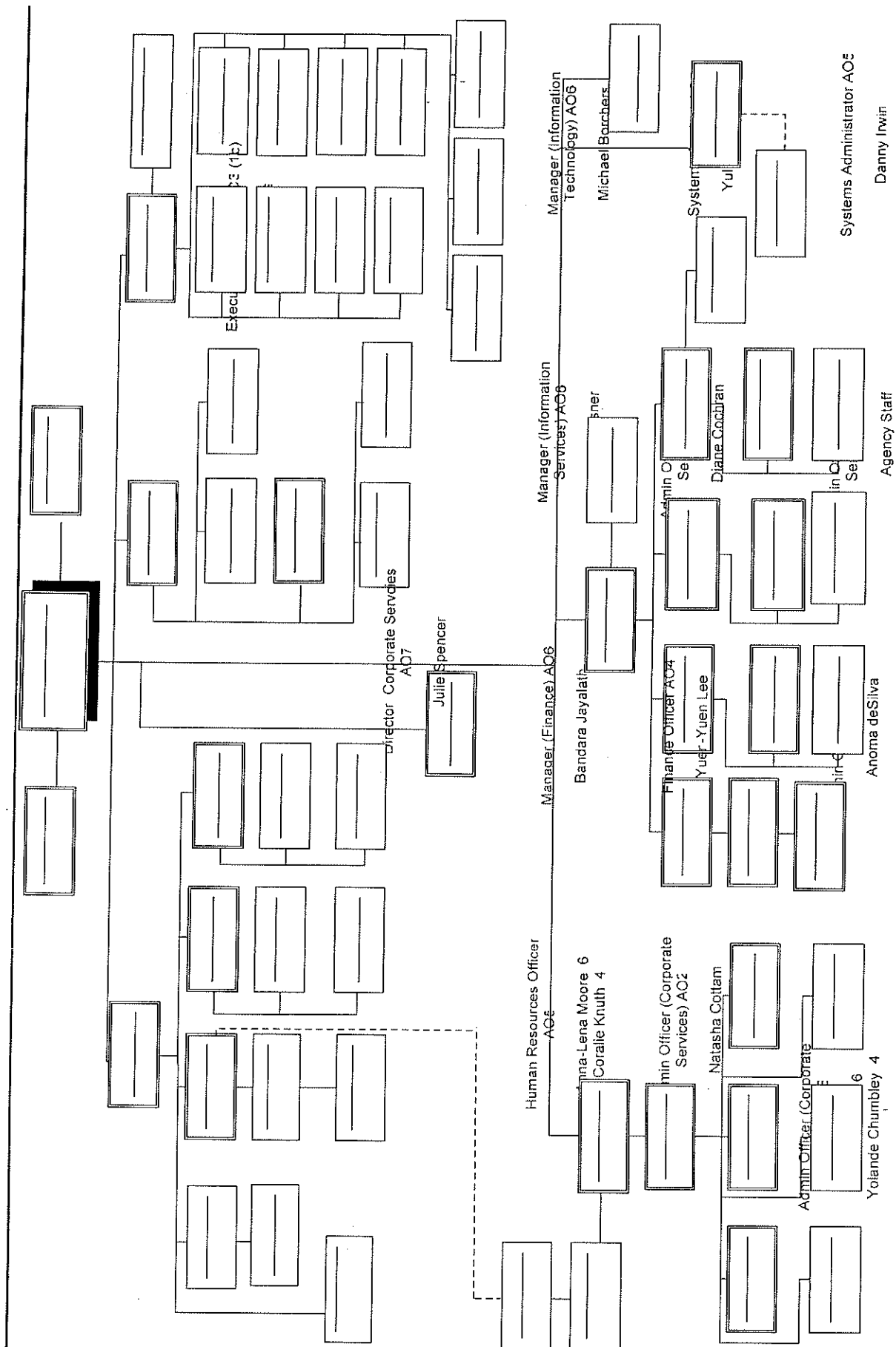
This sub-service manages all processes required under the *Freedom of Information Act 1992* to ensure each Board and the Office meet their obligations and responsibilities under that legislation.

During the period under report, the Office processed 45 applications on behalf of the Boards. In processing such applications, 5837 documents were reviewed for decision-making purposes. Of the 45 applications processed, 34 were made to the Medical Board, one was made to the Chiropractors Board, one was made to the Optometrists Board, two were made to the Dental Board, two were made to the Physiotherapists Board and five were made to the Psychologists Board. Of the 5837 documents reviewed, 5360 documents were either partially or fully disclosed to the applicant.

Five applicants applied for internal review of the access decision to the Office during the period under report. Two applications for external review, including one for amendments to information, were made to the Information Commissioner during this period. At the beginning of the year there were four external review applications awaiting the Information Commissioner's decision. During the period the Information Commissioner finalized five external review applications, thus leaving an outstanding balance of one external review application still under consideration at the end of June.

Executive (

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**Boards to Which the Office Provided Services
in the Period 1 July 2003 – 30 June 2004**

BoardLegislation

Chiropractors Board

Chiropractors Registration Act 2001

Dental Board

Dental Practitioners Registration Act 2001

Dental Technicians and Dental Prosthetists Board

Dental Technicians and Dental Prosthetists Registration Act 2001

Medical Board

Medical Practitioners Registration Act 2001

Medical Radiation Technologists Board

Medical Radiation Technologists Registration Act 2001

Occupational Therapists Board

Occupational Therapists Registration Act 2001

Optometrists Board

Optometrists Registration Act 2001

Osteopaths Board

Osteopaths Registration Act 2001

Pharmacists Board

Pharmacists Registration Act 2001

Physiotherapists Board

Physiotherapists Registration Act 2001

Podiatrists Board

Podiatrists Registration Act 2001

Psychologists Board

Psychologists Registration Act 2001

Speech Pathologists Board

Speech Pathologists Registration Act 2001

Table 1: Funds Provided by the Boards Under the Service Agreements 2002-2003; 2003-2004; 2004-2005

Board	<u>Service Agreement Funding 2002-2003</u>	<u>Service Agreement Funding 2003-2004</u>	<u>Service Agreement Funding 2004-2005</u>
Chiropractors	69928	89002	82853
Dentists	369324	438146	450054
Dental Technicians and Dental Prosthetists	62712	78576	81669
Medical	2401104	2698826	2908127
Medical Radiation Technologists	212300	218716	228712
Occupational Therapists	101476	97626	99170
Optometrists	68912	68508	71827
Osteopaths	37648	36386	29630
Pharmacists	397684	379406	441598
Physiotherapists	215564	168046	176013
Podiatrists	48960	41224	40594
Psychologists	550692	629080	671740
Speech Pathologists	114560	107036	102880
TOTAL	4650864	5050578	5384867

Table 2: Number of Registrants as at 30 June 2001, 2002, 2003 and 2004

Register	<u>2001</u>	<u>2002</u>	<u>2003</u>	<u>2004</u>
Chiropractors*	-	550	568	615
Chiropractors and Osteopaths*	575	-	-	-
Dentists	1970	2017	2141	2282
Dental Specialists	212	226	235	257
Dental Technicians	626	658	684	709
Dental Prosthetists	146	142	143	144
Medical Practitioners**	8081	8231	8512	8696
Medical Practitioners and Specialists**	3635	3931	4023	4216
Radiation Therapists***	-	-	207	232
Medical Imaging Technologists***	-	-	1350	1505
Nuclear Medicine Technologists***	-	-	64	91
Occupational Therapists	1315	1429	1545	1695
Optometrists	695	726	776	824
Osteopaths*	-	86	80	83
Pharmacists	3456	3590	3712	3893
Physiotherapists	2678	2809	2908	3104
Podiatrists	300	324	343	374
Psychologists	2854	3073	3302	3579
Speech Pathologists	814	837	862	940
TOTAL	27357	28629	31455	33239

* The Chiropractors and Osteopaths Board ceased to exist on 30 April 2002 and two separate Boards, being the Chiropractors Board and the Osteopaths Board, were created on the commencement of their respective registration Acts on 1 May 2002.

** In previous years Medical Specialists who were also registered as Medical Practitioners were included in both categories and, as such, the total number of registrants was overstated. The figures for 2000, 2001 and 2002 have been amended to ensure the total in each category is correct.

*** The Medical Radiation Technologists Board, which was constituted on 12 May 2002, had no registrants as at 30 June 2002 as the Register for the three professions was in its initial development stages.

Table 3: New Registrations Approved in the Period 1 July 2003 – 30 June 2004

Register	Trans-Tasman Mutual Recognition	Mutual Recognition (Australia)	Non Mutual Recognition	Total
Chiropractors	-	45	31	76
Dentists	18	99	118	235
Dental Specialists	1	5	7	13
Dental Technicians	-	8	52	60
Dental Prosthetists	-	-	1	1
Medical Practitioners and Specialists	-	436	2942	3378
Medical Imaging Technologists	7	11	214	232
Nuclear Medicine Technologists	-	-	25	25
Radiation Therapists	1	1	32	34
Occupational Therapists	7	16	166	189
Optometrists	5	36	32	73
Osteopaths	-	7	6	13
Pharmacists	8	142	188	338
Physiotherapists	20	104	156	280
Podiatrists	-	15	27	42
Psychologists	2	64	330	396
Speech Pathologists**	-	-	88	88
TOTAL	69	989	4415	5473

* The medical profession is excluded from the legislation for Trans-Tasman Mutual Recognition.

** Mutual recognition and Trans-Tasman Mutual Recognition are currently not applicable as there is no registration of speech pathologists in other Australian States/Territories or in New Zealand.

**Table 4: Number and Type of Meetings Serviced by the Office In the Period
1 July 2003 – 30 June 2004**

Board	<u>Ordinary Board Meetings</u>	<u>Special Board Meetings</u>	<u>Committee Meetings</u>	<u>Disciplinary Proceedings by Board/Board Committees</u>	<u>Total</u>
Chiropractors	12	-	-	-	12
Dental	11	-	60	-	71
Dental Technicians & Dental Prosthetists	8	-	7	-	15
Medical	22	1	64	4	91
Medical Radiation Technologists	13	-	7	-	20
Occupational Therapists	11	5	4	-	20
Optometrists	9	-	-	-	9
Osteopaths	4	-	-	-	4
Pharmacists	9	-	1	3	13
Physiotherapists	10	-	10	1	21
Podiatrists	6	-	-	-	6
Psychologists	12	-	32	3	47
Speech Pathologists	8	-	-	-	8
TOTAL	135	6	185	11	337

Table 5: Complaints* and Investigations pursuant to *Health Practitioners (Professional Standards) Act 1999* as at 30 June 2004

Board	Number of Investigations as at 1/7/03	Number of Complaints* Received to 30/06/04	Number of Investigations Commenced to 30/06/04	Number of Investigations Completed to 30/06/04	Number of Investigations as at 30/06/04
Chiropractors	5	13	2	3	4
Dental**	19	33	5	18	6
Dental Technicians and Dental Prosthetists	1	6	-	-	1
Medical***	233	232	37	95	****175
Medical Radiation Technologists	-	-	-	-	-
Occupational Therapists	-	2	1	1	-
Optometrists	-	1	-	-	-
Osteopaths	-	-	1	-	1
Pharmacists	11	50	30	34	7
Physiotherapists	-	4	2	2	-
Podiatrists	4	1	-	1	3
Psychologists*****	18	45	13	11	20
Speech Pathologists	-	-	-	-	-
TOTAL	291	388	91	165	217

- * Complaints: for the purposes of this table, the data includes complaints as well as other information received. This is because a Board can determine to investigate a matter on the basis of information received which is not in the form of a complaint.
- ** Dental Board: The number of open investigations as at 1 July 2003 was reported as 18. However, it has been identified that a further investigation should have been considered open at that time as the 14 day statutory period for the Health Rights Commissioner to comment on the Investigation Report did not expire prior to 30 June 2003.
- *** Medical Board: This data includes three matters under the *Medical Act 1939* (now finalized) and 5 matters under the *Medical Practitioners Registration Act 2001*, four of which were finalized in the year under report.
- **** Medical Board: As at 30 June 2004 the Panel of External Investigators had completed 41 investigations and completed to draft report stage a further 43 investigations. Sixty three investigations remain ongoing and a further 13 investigations are yet to be referred to the Panel.
- ***** Psychologists Board: During the period under report, the Board reviewed an investigation and effectively reopened it subject to legal advice on the matter. Until the matter is finally considered, it has not been included in the data.

Other Investigations

In addition to the above noted data, the Health Assessment and Monitoring Unit completed five investigations in 2003-2004. The Complaints Unit also completed eight investigations about alleged breaches of the various registration Acts. In this regard, three investigations were completed for the Chiropractors Board, two investigations were completed for the Dental Technicians and Dental Prosthetists Board, one investigation was completed for the Occupational Therapists Board and two investigations were completed for the Osteopaths Board.

Disciplinary Actions

In addition to the above noted data, the Complaints Unit has managed a significant workload in disciplinary actions as follows:

Chiropractors Board: Two Board level disciplinary matters.

Dental Board: One Health Practitioners Tribunal ('HPT') disciplinary matter.

Dental Technicians and Dental Prosthetists Board: One Board level and one HPT disciplinary matter.

Medical Board: 20 Board level, eight Professional Conduct Review Panel ('PCRP') and 40 HPT disciplinary matters.

Physiotherapists Board: One Board level and one HPT disciplinary matter.

Podiatrists Board: One Board level disciplinary matter.

Psychologists Board: 12 Board level; one PCRP and nine HPT disciplinary matters.

Table 6: Comparison of Outstanding Investigations 1 July 2002-1 July 2004

Board	<u>Number of Investigations as at 1/7/02</u>	<u>Number of Investigations as at 1/7/03</u>	<u>Number of Investigations as at 1/7/04</u>	<u>% Change 1/7/02 – 1/7/04</u>
Chiropractors	14	5	4	↓ 71.4%
Dental	27	19	6	↓ 77.8%
Dental Technicians and Dental Prosthetists	4	1	1	↓ 75.8%
Medical	237	233	175	↓ 26.0%
Medical Radiation Technologists	-	-	-	-
Occupational Therapists	-	-	-	-
Optometrists	-	-	-	-
Osteopaths	-	-	1	↑ 100.0%
Pharmacists	28	11	7	↓ 75.0%
Physiotherapists	1	-	-	↓ 100.0%
Podiatrists	5	4	3	↓ 40.0%
Psychologists	20	18	20	-
Speech Pathologists	1	-	-	↓ 100%
TOTAL	337	291	217	↓ 35.6%

Section 30, *Health Practitioner Registration Boards (Administration) Act 1999* establishes that the Office is a statutory body within the meaning of the *Financial Administration and Audit Act 1977*.

Section 46J, *Financial Administration and Audit Act 1977* requires the Office as a statutory body to include in its Annual Report a copy of the Annual Financial Statements which have been audited by the Auditor-General.

A copy of the Audited Annual Financial Statements is included as an insert in this Appendix to meet the requirements as detailed above.

The Audited Annual Financial Statements are constituted by:

- Statement of Financial Performance for the year ended 30 June 2004
- Statement of Financial Position as at 30 June 2004
- Statement of Cash Flows for the year ended 30 June 2004
- Certificate of Office of Health Practitioner Registration Boards
- Independent Audit Report

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SUBMISSIONS BY THE MEDICAL BOARD OF QUEENSLAND

PART B - AS TO THE "REGISTRATION MATTERS" REFERRED TO IN THE TERMS OF REFERENCE

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

1.1 Preamble

These submissions attempt to summarise all of the instances where the assessment, registration and monitoring of International Medical Graduates have come to the notice of the Inquiry. These submissions should be read against the background that the Medical Board of Queensland approves up to 3400 applications annually.¹

1.2 Dr Jayant PATEL (BUNDABERG BASE HOSPITAL)

(a) Assessment and Registration of Dr Patel -

Suspected fraudulent acts

Dr Jayant Patel ("Patel") apparently procured his registration in Queensland as a medical practitioner by false and fraudulent means. The attached chronology² demonstrates the way in which the Board's assessors and the Registration Advisory Committee ("RAC") were misled. Patel has chosen not to explain his acts and omissions to the Commission of Inquiry.

Exhibit 421 is the duly certified police statement of the original assessor of Patel's application within the Medical Board of Queensland, **Ms Ainslie McMullen**. Paragraphs 13-16 of Ms McMullen's police statement clearly show that she was not put on inquiry by the form of Patel's "*Verification of Licensure*", because of Patel's false answers. His registration was apparently procured by unconditional fraud, in the absence of any explanation from him.

Dr Kees Nydam³ gave some further limited evidence about the circumstances of Patel's application for registration. Dr Nydam was the Acting Director of Medical Services at the Bundaberg Base Hospital ("BBH") at the time of Patel's registration. Dr Nydam said that after a couple of unsuccessful attempts to fill the position of Director of Surgery at BBH, the selection committee elected to re-advertise the position in late 2002. In fact, the advertisement was for a "*Senior Medical Officer – Surgery*". Dr Nydam explained⁴ that the position of Senior Medical Officer :

"...is a grade that includes Senior Medical Officer non specialist and Senior Medical Officer specialist..."

¹ See statement of O'Dempsey, Exhibit 28, paragraph 62

² See Attachment "A"

³ Dr Nydam's Statements are exhibit 51 and 51A. Evidence T4111 *et seq*

⁴ T4118

Dr Nydam drew the distinction between a large tertiary hospital in which a Director of Surgery would spend a lot of time teaching, and the regional hospitals where there may be two full time surgical staff and one of those is "the unlucky bunny" who ends up in the position of Director of Surgery, as it were, by default.⁵

The then- Director General of Health, **Prof. Robert STABLE**, conceded that it was a reality in the regional hospitals, but said the Director should be a specialist.⁶

It is a relevant circumstance, also, that the Industrial Award for "Senior Medical Officer" applies to all levels of Medical Officer from Superintendent down to the position above Registrar. The Industrial Award also did not make the distinction between specialist and non-specialist S.M.O's – see the evidence of **Dr Mark MATTIUSSI**.⁷

Dr Nydam also made the point that Patel filled a locum position as Director of Surgery:

*"...In my mind Dr Patel was employed, was engaged as a locum, temporary post...there are certain roles for permanent staff. For reasons of pragmatism those rules haven't got the same degree of stringency for locum staff. I believe that there has been a clouding of this issue when it comes to Patel...In the way that evidence has been presented....if I employ a locum, I don't need someone to be a Fellow of any college."*⁸

Professor Stable said in evidence that he did not agree with this approach.⁹

Dr Mattiussi also did not agree¹⁰

Dr Nydam made the point that, for example, in the six years he had been associated with BBH, there had been Directors of Anaesthetics who were not members of the Australian College of Anaesthetists.

Dr Nydam conceded in evidence¹¹ that the Medical Board would be given the impression by the paperwork submitted for registration that Patel, as a Senior Medical Officer, would have been under the direct supervision of a Director of Surgery, whereas, Patel was appointed as a locum to the position of Director of Surgery and therefore was not subject to any direct supervision. Dr Nydam stated that this was a typical situation which developed throughout the regional hospitals of Queensland. He said he welcomed the Inquiry's exposure of this unsatisfactory situation.

The following exchange¹², adequately encapsulates an unsatisfactory situation:

⁵ T4119

⁶ T5755

⁷ T5888, 5889

⁸ T4120

⁹ T5755

¹⁰ T5596, 5597 and T5628

¹¹ T4121

¹² T4124

"Q...and let me cut to the chase, you know, without being rude, it looks as if you are getting this SMO in, you are running him through the Medical Board as an SMO, but looks like he is going to be the head of the surgical department because it is a pretty easy headcount, he is it?"

A: I guess he is it for the period of the locum period. My experience with overseas surgeons previously at the Bundaberg Base Hospital was that we were able to get surgeons whose level of work was of a very very high quality.

Q: Doctor, but under his registration, he was not eligible for appointment to that position?

A: He wasn't appointed that, as I understand it. As I understand it, that is a position description for a permanent employee.

Q: and that was a position description that was presented to the Medical Board against which his Special Purpose Registration was granted?

A: Ok. I accept that and that was in error.."

Dr Nydam accepted¹³ that if Patel's application had gone before the Medical Board for the position of Director of Surgery, the Board might well have insisted on either a period of supervision or a closer look at his background and qualifications. Dr Nydam conceded that the Medical Board was not given the full facts. He described the confluence of events as "tragic".

It should be noted that Dr Nydam conceded that there were no concurrent attempts to attract a permanent Director of Surgery whilst Patel occupied the "locum" position.¹⁴

Needless to say, Dr Nydam did not realise Patel had made false statements to the Medical Board. He said that, on paper, Patel was an impressive candidate.

Dr Nydam also conceded¹⁵ that, as a general proposition, his strategy was to call Patel a locum for the first 12 months in the hope that Patel would ultimately hold the position of Director of Surgery permanently, and that there was no intent to find a permanent Director of Surgery in the interim. In his own defence, Dr Nydam cited the case of Dr Wakefield, who came from South Africa and occupied the position of Director of Anaesthetics and Director of Intensive Care at BBH. During the time he worked at BBH, Dr Wakefield obtained the appropriate Australian Specialist qualifications and credentials. Dr Wakefield is now a highly valued member of the staff at one of the major tertiary hospitals in Brisbane. In Dr Nydam's mind, there were many such precedents for proceeding in the way he did in relation to Patel. In further support of Dr Nydam's position, on 25 February 2003, before Patel commenced duty at BBH, Dr Nydam, in an email to Patel, urged him to seek specialist registration in Australia¹⁶.

Professor Stable regarded this way of proceeding to be an unacceptable practice.¹⁷

¹³ T4126

¹⁴ T4128

¹⁵ T4129

¹⁶ Exhibit 274 (see also T4132 lines 25-35)

¹⁷ T5756

Dr Nydam also conceded¹⁸ that once Patel arrived and was given the locum position of Director of Surgery, he did not revert to the Medical Board to advise it of the change of position due to "oversight".

Dr Nydam also conceded that the way in which Patel was appointed effectively avoided a more formal Appointments Committee process by which the specialist position of Director of Surgery might ordinarily be appointed, ie, by the establishment of a Committee which included a member of the Australian College of Surgeons and a person from Q Health Head Office who would form the Committee, together with local people, to effect the specialist appointment.¹⁹

It is submitted that **exhibit 274** – Dr Nydam's email to Patel dated 25 February 2003, in which he encouraged Patel to seek specialist registration – is a significant document for the reason that Patel did not act in accordance with that communication. If Patel had sought specialist registration from the Australian College of Surgeons, no doubt his conditions on practise imposed upon him in the state of Oregon, and his other registration history in the state of New York, would have come to light.

Dr Nydam said in evidence²⁰ that it had crossed his mind "*quite early in the piece*" that if Patel was as skilled and experienced as he claimed, it was unusual that he would take a position in Australia for a substantially reduced remuneration package. Dr Nydam said that this was an "*error of judgement*" and that he made a further error when he took Patel's explanation for this decision at face value:

"His (Patel's) explanation was that he had worked hard, he had earned a lot of money, and now it was time to give something back. Now, I have long taken the view that people who work in Public Health are either missionaries or idiots, and I thought that he was a missionary. That was an error of judgement."

It is also relevant that Dr Nydam had had previous experience with the recruitment agency Wavelength and had found them to be "*pretty superior*"²¹. He had previously been particularly happy with staff members who had been obtained through Wavelength.

Dr Nydam's perception about the process of assessment and registration of Patel is worthy of note. He said in evidence²²:

"I think one of the problems in retrospect was that there were three bodies all hoping that the other person was doing the work. I was hoping that the checks would have been done by Wavelength, Wavelength were hoping that the checks were being done by the Medical Registration Board. I was hoping, they were hoping that I would, and I think – yeah, there is a

¹⁸ T4133

¹⁹ T4133

²⁰ T4137

²¹ T4137

²² T4138

mismatch of what the expectations of each of the other party (sic) were. That's a part of the tragedy".

The Commission has heard evidence from Dr Bethell (Wavelength) and from Mr Demy-Geroe (Medical Board) that the recruitment agency conducted an assessment of Patel as a potential applicant for registration, including making direct contact with various referees, all of whom spoke highly of Patel. It was Patel's own dishonesty which prevented further inquiry by the assessor employed by the Medical Board, Ms McMullen. Dr Nydam's perception is therefore somewhat overly critical of the Recruitment Agency/Medical Board process as it applied to Patel's application for registration.

Dr Mark Mattuissi, a co author of the June 2005 review into Bundaberg Hospital, said in evidence ²³ that non-specialists can in some cases be employed as Directors in hospitals, however where the Director was the clinical and not solely the administrative leader in the hospital, that clinical leader should be a registered specialist in that clinical field. Dr Mattuissi saw the central issue as being whether there was adequate supervision available to a non-specialist Director. Where there was no such supervision, the situation was unacceptable. ²⁴

Dr Mattuissi also said that, even if Patel was employed as a locum, no matter how short-term, he should have been credentialed and privileged. ²⁵

Dr Mattuissi also said that from his general experience in the Logan District, the question of appropriate supervision of International Medical Graduates had received increased attention. ²⁶

He was aware of the Board's recent initiatives on this issue. Dr Mattuissi saw the new arrangements as a mechanism to ensure that the supervisor him/herself was appropriately qualified.

In the context of Hervey Bay, **Dr Terry Hanelt** said²⁷:

"...we have several of our directors who are international medical graduates and none of those have taken on a director's position until the College was satisfied that they should either get a full specialist recognition or deemed specialist recognition, so they've all gone through the College process prior to appointment...I honestly don't think I would be appointing somebody as director until they had been through that."

Dr Darren Keating "inherited" Patel as his Director of Surgery when he started as Director of Medical Services in April 2003.

²³ T5627

²⁴ T5628

²⁵ T5628

²⁶ T5629

²⁷ T6768

Soon after Dr Keating arrived at Bundaberg, he exhorted Patel to seek registration as a Specialist, but said that he was advised by Patel that he was awaiting some further information from the United States.²⁸

Preventative measures initiated by the Board, in relation to Assessment and Registration

Measures have been put in place which, it is submitted, are sufficient to prevent the recurrence of the combination of events which led to an incorrect initial assessment of Patel by all relevant parties, and which in turn led to his registration. In a letter to the Commission of Inquiry dated 22 June 2005, from Solicitors representing the Medical Board of Queensland²⁹, the Commission was advised, *inter alia*, that the following steps had been put in place:

1. Applicants must advise whether they have attempted any medical qualifying examinations, and, if so, the result.
2. Applicants are asked to provide a summary of their experience including any time undertaking an observership in an Australian or New Zealand Health Care Facility.
3. The Applicant is asked to consent to any assessment reports from such an observership to be obtained by the Board.
4. Along with the questions in relation to fitness to practise, the Applicant is asked whether he/she has undertaken bridging programs which are designed to prepare candidates for practise within Australia. The Applicant is now asked to consent to further communications between the Board and other individuals or entities.
5. Applicants are required to provide a complete Curriculum Vitae in standard form. This is to provide consistency in the presentation of each Curriculum Vitae of each Applicant.
6. There is now a Special Purpose Employer Form. The employer must certify that it has assessed the Applicant and believes the Applicant satisfies the qualifications and experience needed for the position the Applicant is proposed to occupy. There is also a requirement that verbal reference checks are conducted. Mandatory questions to be asked of referees are supplied to employers and are attached to the Form.
7. There must also be a clinical supervisor appointed for each Applicant. The clinical supervisor undertakes to provide the Board with any adverse reports identified. The supervisor is also required to assess the applicant at the conclusion of his/her registration.

The effect of all of these measures is to ensure that employers take responsibility for the employment of applicants and advise the Board when a potential problem is identified.

²⁸ T6831

²⁹ Exhibit 136

The further affidavit of Michael DEMY-GEROE, Deputy Registrar of the Board, gives a current picture concerning supervision requirements of the Board.³⁰

An indication of the stringency of the current Board requirements for supervision, is to be found in the evidence of Dr Danesh Sharma³¹. Dr Sharma, employed at Hervey Bay Hospital as a Surgical SMO, described how supervision was not required of him when he first obtained registration in an area of need, but that it was now required of him by the Board after he had acquired some two further years' experience in hospital practice.³²

The Board respectfully submits that Dr Sharma's evidence can be taken as supporting the Board's letter and Mr Demy-Geroe's latest affidavit, as to the extent to which the requirement for supervision of International Medical Graduates has intensified at a practical level. The fact that Dr Sharma, for his part, does not consider the supervision requirements to be warranted is not a matter adverse to the Board.

Similarly, the evidence of **Dr Terry Hanelt**, Director of Medicine at Hervey Bay Hospital, supports the proposition that current supervision requirements of IMG's are now more comprehensively defined into four separate categories.³³

Further suggested preventative measures

In his evidence, **Dr Mark Waters** argued for a more robust recruiting process which should be centralised '*into at least hubs or maybe just one database for the entire State*', and which ensures that the recruiter conducts personal interviews with International Medical Graduates³⁴. Dr Waters argued for a greater effort to integrate IMGs and their families into the communities they have been employed to serve and to provide such additional training as they may need to become an effective part of the Queensland Health workforce.

Dr Waters spoke about the Q Health Skills Development Centre which is designed to support the introduction of competency based assessment rather than, as Dr Waters put it, '*time based*' assessment³⁵.

'What I would argue that the Australian community may want or the Queensland community may want is some assurance that when you have done your five years (training and exams) you are actually competent at the procedures that you do...'

'I think we can go to a situation where we can give people an assurance that we can test the competencies of the actual procedure'.

Dr Waters said that a more intensive process of assessment and credentialing IMGs could be performed by the Skills Development Centre. Dr Waters pointed out the additional advantage that the Health District employing the IMG would not be placed in a position of

³⁰ Affidavit of Demy-Geroe, Exhibit 420

³¹ T5677

³² T5677

³³ T6716

³⁴ T4641

³⁵ T4646

conflict by also credentialing the registrant³⁶. Dr Nydam expressed similar concerns in his evidence³⁷. Dr Hanelt also referred the need for independent, and not locally-based, credentialling.³⁸

Specifically in the context of the assessment and registration of Patel, it is submitted that Patel's fraud would have been discovered by the processes currently in place, as described in Exhibits 136 and 420. The current procedures allow for more rigorous assessment before registration is granted. The increased requirement for supervision as set out in Exhibits 136 and 420, will also ensure that IMGs are monitored more closely, and the Skills Development Centre may well have a more prominent role to play in both assessment and monitoring in the future.

It is respectfully submitted that the evidence relating to the experiences of Drs. Sharma and Krishna at Hervey Bay Hospital eloquently supports these existing and suggested reforms.

(b) Monitoring of Dr PATEL after Registration;

It is assumed, for the purposes of the Board's submissions that the issue of "monitoring" Patel relates to the period after his registration and initial employment at Bundaberg.

Credentialling and Privileging of Dr PATEL

The proper credentialling and privileging of Dr Patel before or after his arrival in Bundaberg is, it is respectfully submitted, a matter primarily for Q Health. From the perspective of the Medical Board of Queensland, it can be identified firstly that a preliminary process of checking the International credentials of Patel was conducted by Wavelength Consulting. As pointed out earlier in these submissions, Dr Bethell gave evidence that he made contact with individual referees before Patel was referred to the Medical Board. The failure to properly credential Patel at "*recruitment level*" and at "*Board assessment level*" was due primarily to Patel's apparent fraudulent acts, as referred to earlier in these submissions.

Exhibit 279 is the Queensland Health Policy Statement on credentialling and privileging. The Policy states that Q Health District Managers are responsible for ensuring that the credentialling and privileging process occurs periodically. That is not a process which, at the relevant time, involved the Medical Board in the relevant sense.

It is submitted that the Medical Board was entitled to rely upon the existence of this Q Health Policy after the Board's initial assessment that each Applicant for Registration who was certified for area of need had credentials which were appropriate to the position description and appropriate for registration as a Medical Practitioner in Queensland.

Dr Mark Mattiussi said in evidence³⁹ that those responsible in Q Health would place a certain reliance upon the fact that the Medical Board had seen fit to register the practitioner on making certain checks of that practitioner. Dr Mattiussi conceded, however, that reliance upon Wavelength or Medical Board processes is only part of that process and does not

³⁶ T4654

³⁷ T4138 *et seq* and T4187

³⁸ T (Hanelt)

³⁹ T5855

amount to completion of the credentialling process in terms of the Q Health policy.⁴⁰ Again, it is submitted that if those responsible in Q Health relied upon the recruitment and registration processes for an indication that Patel was suitably credentialled, then they were erroneously relying upon a process which was tainted by Patel's own fraud.

Supervision of Dr PATEL

As a consequence of PATEL being employed almost immediately as Director of Surgery at BBH, he was not placed in any form of effective supervision. It is submitted that the "supervision" by Dr Darren Keating, was nominal only, for the purpose of Patel's re-registration in late 2003. If Patel had been in fact employed as "SMO-Surgery" at BBH, then the BBH Director of Surgery would ordinarily have been the appropriate supervisor.

After Dr Keating's arrival, Patel's first contract was due to expire in March 2004. By a letter dated 25 November 2003, Keating offered to extend Patel's contract from 1 April 2004 to 30 March 2005.

By a letter dated 1 December 2003 Keating advised the Medical Board of the extension of Patel's contract. Queensland Health had already renewed Patel's area of need certification on 21 November 2003 describing Patel as "Director of Surgery – SMO". Dr Keating's statement, paragraphs 37-40 set out the basis upon which Keating felt he was able to provide the certificate of the "clinical supervisor" dated 2 December 2003, which was required for the Medical Board assessment form for re-registration of Patel in an area of need. None of the factors outlined by Dr Keating included direct supervision of Patel's clinical competencies. Dr Keating concluded at paragraph 40 of his statement:

"as Dr Patel was in the position of Director of Surgery when I started at Bundaberg Hospital, it did not occur to me that there was any need for supervision of Dr Patel."

The best Dr Keating could do was to suggest that "peer" supervision or oversight – from Dr Gaffield, the VMO's and anaesthetists – would amount to a sufficient check on Patel's clinical skills.⁴¹ This does not meet the Board's legitimate expectations.

Thus, the Board's expectation that a Senior Medical Officer who was a generalist, and not a specialist, surgeon would ordinarily be supervised by a specialist surgeon in the hospital context was not met.

Exhibits "DWK-12" and "DWK-13" demonstrate that, to Dr Keating's knowledge, Dr Patel was only in the earliest stages of applying for specialist registration as at 5 August 2003.

During the calendar year 2004, however, concerns about Dr Patel's surgical competence began to come to the notice of Dr Keating. These various concerns were canvassed at length with Dr Keating by Counsel Assisting, Mr Douglas SC. Against the background of these concerns, on 31 January 2005, Dr Keating wrote again to the Medical Board advising that the Bundaberg Health Service District had extended Patel's contract to 31 March 2009. Once again, Dr Keating signed the assessment form as Patel's "Clinical Supervisor" as at 2

⁴⁰ T5884

⁴¹ T6824

February 2005.⁴² Counsel Assisting challenged Dr Keating as to the glowing assessments which Keating included in the forms which went to the Medical Board on this occasion.⁴³ Dr Keating ultimately conceded that, against the background of the range of concerns expressed to him during the latter half of 2004, his assessments of Patel were "overrated". Dr Keating attempted to explain himself as follows⁴⁴:

"what I do believe is I have overstated it and that I was looking at a large period of time. There were an isolated number of situations which had been provided but there had also been a large number of patients he had looked for and cared for, multiple situations Dr Patel had been involved in, and I was trying to give a fair and accurate reflection of the totality of work he did."

Dr Keating nevertheless conceded that he overrated Patel's abilities, but did not concede the suggestion that the documents were a "tissue of lies".

Later, the following exchange occurred:⁴⁵

"Q: I suggest to you sensibly and honestly, if you are acting in accordance with those attributes (of transparency) you would have included that information (that an audit review was being conducted into Patel by the Chief Health Officer) to the Medical Board?"

A: As I said, I could have provided that information. I didn't provide that information. I was not setting out to mislead or be dishonest with the Medical Board. As I said, I provided this in haste and it has now come back to bite me on the bottom, so to say."

Dr Keating was shown the Assessment form he filled out for Patel in February 2005, for the purposes of "area of need" re-registration of Patel. This form was completed by Keating at a time when he knew that an investigation by the Chief Health Officer, Dr Fitzgerald, had begun. He did not make any notation to that effect on the Assessment Form to be sent to the Board. Dr Keating said he considered the investigation to be an internal matter and not one for the Board.⁴⁶ Though he was well aware of the role of the Board through his handling of the Dr Qureshi matter, he said, it "did not occur" to him that the Patel matter should be referred to the Board.

The matters involving Dr Keating's communications with the Medical Board of Queensland, it is respectfully submitted, raise questions of Official Misconduct under the *Crime and Misconduct Commission Act 2001*. For present purposes relating to issues of ongoing supervision of Dr Patel, it is respectfully submitted that the supervision arrangements set out in the affidavit of Mr Demy-Geroe, **Exhibit 420**, would significantly reduce the likelihood of a misleading Certificate of Supervisors being submitted to the Board in the future.

⁴² Exhibit DWK-70 to the statement of Keating (pages 204-210 bundle of exhibits)

⁴³ T6879-6883

⁴⁴ T6683

⁴⁶ T7019

It needs to be borne in mind that Patel's initial apparently fraudulent conduct also contributed significantly to the lack of supervision. Disclosure of the Oregon condition would have resulted in the Board at least imposing suitable conditions upon his Queensland Registration, including the requirement for supervision.

1.3 Vincent Victor BERG (TOWNSVILLE BASE HOSPITAL)

(a) Assessment and Registration of BERG

The registration of Vincent Berg ("Berg") is an example of the extent to which the Queensland Health System, in its substantial reliance upon the recruitment of IMGs, is at risk from that very low percentage of cases in which applicants for registration may present unverifiable, or even false, proof of medical qualifications obtained in other jurisdictions.

Berg was approved conditional registration under s.17C(a) *Medical Act* on 26 October 1999, to undertake post-graduate training in Psychiatry at Townsville General Hospital for a period of 12 months. That registration was due to expire in January 2001.

The Board first became aware of the forgery allegation relating to Berg's claimed Russian medical qualifications on 19 October 2001. On that date, the Board received a letter from the Royal Australian and New Zealand College of Psychiatrists ('RANZCP') to the Australian Medical Council ('AMC') in which Berg's qualifications from a Russian University were said to be false. At this time Berg had already ceased as a registrant in Queensland or any other State of Australia. Berg, however, chose to vigorously defend himself in letters to the AMC dated 30 October 2001 and 11 November 2001. The Board considered that it was not in a position to verify or disprove Berg's claimed qualifications. The Board's dilemma was compounded in that another government agency, the Commonwealth Department of Immigration, had accepted Berg's status as a Refugee. It appears that Berg's claimed status of a Russian Medical Practitioner had been a factor in his successful application to the Department of Immigration.

It is important to note that at the time the Board received the advice of the possible forgery, Berg was not a registrant in Queensland. He was not known to be a registrant in any other Australian jurisdiction.

It is submitted that the Board cannot be criticised for taking its initial view that Berg's qualifications were unable to be verified, rather than taking the more stringent view that they were false. Undoubtedly several factors influenced the Board's position as at late 2001:

- Berg had taken the step of seeking specialist registration through the AMC. A person who held demonstrably false qualifications may well not have taken such a step; and
- In two spirited defences, in direct response to the allegation of forgery, Berg claimed Refugee status and claimed that the bold assertion by the Russian University was yet another attempt to persecute him; and
- The Board's file showed that Berg had the support of a number of psychiatrists, both in Sydney and in Townsville, who spoke well of his clinical skills. This at least indicated the likelihood that he was duly qualified.

The Board is aware that the circumstances surrounding Berg's registration in Queensland are now the subject of an intensive police investigation, particularly in view of recent allegations that Berg may have engaged in sexual misconduct in Queensland, particularly in the course of his employment at Townsville Base Hospital. In all of those circumstances, may be inappropriate to further explore this issue in detail. It is anticipated that a thorough police investigation will establish once and for all whether Berg has been a skilful fraudster, or whether he has indeed been further persecuted by the allegation emanating from the Russian University that his proffered qualifications are bogus. The Board has recently given significant assistance to that Police investigation.

The Board strongly submits that this Commission of Inquiry is not in a position to actively assert that Berg's qualifications are forged. It is in a position to state that there is an allegation that Berg's qualifications were forged.

It should be kept in mind that if Berg is shown to be a skilful fraudster, then he has also managed to hoodwink the Department of Immigration, which conferred Refugee status upon him, at least partly, it seems, upon the strength of his claimed qualification as a specialist medical practitioner.

(b) The Board's response to the allegation of forgery

Events occurring after 19 October 2001 advice that Berg's University qualifications were claimed by that University to be forgeries, can conveniently be canvassed in these submissions without the risk of compromising the Queensland Police Service Investigation.

On 10 January 2002, the Medical Board of Queensland issued a Certificate of Good Standing which was valid for a period of three months. The Certificate was issued because the Board had the view at that time that it was unable to substantiate, one way or the other, the forgery claim. On 11 February 2002, the Western Australian Medical Board contacted the Deputy Registrar of the Queensland Medical Board after provisionally registering Berg's application for area of need registration. The Western Australian Board was advised of the Queensland Board's concerns regarding the veracity of Berg's qualifications. The Queensland Board was subsequently notified, on 15 March 2002, that W.A had cancelled Berg's registration. The Certificate of Good Standing dated 10 January 2002 contained within it a clear and important qualification which was meant to stimulate just the kind of inquiry which did come from Western Australia:

'the Board has not been able to verify the qualification on which Dr Berg's registration was granted'.

That qualification was placed on the Certificate in the expectation that any other Australian Board, or International Board, would be put on inquiry.

The Board acknowledged to the Commission, in its letter dated 16 August 2005⁴⁷ that the Certificate dated 10 January 2002 should not have been issued in all the circumstances. Indeed, it is apparent that the Board's position changed over time when Berg was unable to further verify his claimed Russian qualifications.

⁴⁷ Exhibit 288, p.2, paragraph 3

The Commission is aware that in a letter dated 28 January 2003, the then President of the Medical Board of Queensland acknowledged that Berg *'did not hold recognised qualifications to enable him to be registered to undertake post graduate training in psychiatry.'* This communication was not meant to indicate that the Board was in possession of any further information conclusive of the fraud allegation. It is to be hoped that the Queensland Police Service investigation will be able to conclude this issue once and for all by making appropriate inquiries directly and in person with the relevant Russian University.

The Board's letter dated 16 August 2005 makes it clear that, when three separate registering bodies were contacted in 2001 and 2002, in each case the Queensland Board advised that it had not been able to verify Berg's qualifications. At the very least, this shows that the relationships between the various Australian Medical Boards and the New Zealand Medical Board are such that there is a free flow of inquiry between them. In practical terms, this meant that Berg was not afforded permanent registration in any of these jurisdictions whilst the matter of the veracity of his qualifications remained unresolved. The fact that the matter had not been further investigated by the Queensland Board since that time was due to Berg no longer being registered within Queensland.

The Board has frankly acknowledged its regret that the Townsville Health Service District was not notified of the difficulties with Berg's registration until Dr Toft's letter dated 28 February 2003. The failure to notify occurred against the background that the Board, during 2002, held the view that the qualifications could not be verified one way or the other, and that he had departed Queensland, to the Board's knowledge.

In all of the circumstances, the Berg incident should be seen as unique. See in particular the evidence of **Dr John Allan**.⁴⁸

The events surrounding the registration and de-registration of Berg should also be seen as an example of the vulnerability of the Queensland Health system to possible sharp practice by International Medical Graduates. Current measures put in place by the Board since May 2005 are designed to detect such possible sharp practice.

(c) Monitoring of BERG whilst he was employed at Townsville

The second statement of Dr Andrew Johnson⁴⁹ clearly shows that there was a high level of supervision of Berg after he was appointed to Townsville Base Hospital. It is of note that Dr Johnson acknowledged that:

*"...there was a division within the psychiatry ranks regarding Vincent Berg and at least 2 consultants supported him".*⁵⁰

The statement of Dr John Allan⁵¹ also demonstrates a commendably high level of close supervision of Berg. As a result of this close supervision by Doctors Allan and Johnson, Berg's initial term of employment was not renewed, and indeed, after 8 months of the 12

⁴⁸ p3500 l.17 to p3501 l.10 Day 33

⁴⁹ Exhibit 234, paragraph 7 *et seq*

⁵⁰ Exhibit 234, paragraph 9

⁵¹ Exhibit 245, paragraph 16, *et seq*

month appointment had elapsed, Berg was already facing a "*show cause*" proceeding in relation to his questionable clinical performance.

Questions about Berg's qualifications only arose after Berg ceased to be registered in Queensland.

The Board respectfully submits that, on the question of monitoring of Berg whilst he was a Registrant, the evidence in this instance, in contradistinction to the evidence relating to Patel in Bundaberg, reveals the kind of supervision which the Board could reasonably expect to occur where an International Medical Graduate was registered for the purpose of employment in a supervised position in a Queensland Hospital.

1.4 Dr Vitomir ZEPINIC (TOOWOOMBA HOSPITAL)

In 1998, Dr Zepinic ("Zepinic") applied to the Australian Medical Council ("AMC") for assessment of his specialist qualifications in psychiatry.

In a letter dated 19 March 1999 the Royal Australian and New Zealand College of Psychiatrists ("RANZCP") advised Zepinic that he had been granted exemption from certain requirements, but was required to complete the General Medicine Examination and at least six months familiarisation before being eligible to sit the Clinical Examinations. The requirement for written confirmation of his psychiatric qualification from Yugoslavia was waived. The familiarisation period was a period of employment as a Medical Officer, with commitment from a specialist psychiatrist. Zepinic's supervisor was required to meet with him at least once a fortnight and provide a statement to the College at the completion of the period of familiarisation.

Zepinic's file held by the Medical Board of Queensland has been supplied to the Commission. It includes a Degree Certificate from the University of Sarajevo Faculty of Medicine, which shows that Zepinic graduated as a Medical Doctor in 1976.

A second Diploma from the University of Belgrade shows that Zepinic was awarded a Ph.D. Degree from the Faculty of Medicine of the University of Belgrade in 1985. The additional qualification is described as "*Doctor of Medical Sciences – Ph.D.*".

The College seems to have been influenced by the reference of Dr N Chuchkovich, a Psychiatrist practicing at Strathfield in New South Wales. The reference was a glowing one. It was dated 22 February 1999. Dr Chuchkovic expressed the opinion that Zepinic was performing in the area of Psychiatry "*at a level of Senior Consultant*". Dr Chuchkovic spoke of Zepinic's significant contribution to Psychiatry in Australia, New Zealand and at the European Universities from whence he came.

On 17 February 2000 Zepinic sought conditional registration to fill a training position at Toowoomba Health Service District Mental Health Service. This was to meet the College's requirement that he undertake a period of supervised clinical practice in psychiatry.

The Medical Board approved Zepinic's conditional registration pursuant to s.17C(f) on 4 April 2000.

On 3 January 2001, Zepinic's Supervisor, **Dr Mark Kluver** of the Toowoomba District Mental Health Service submitted a report which stated that Zepinic's clinical performance was satisfactory within the four domains of Psychiatric practise. Dr Kluver advised that his contract with the District had been extended. Dr Kluver added:

"...at this stage it would be our intention to offer him a permanent position should he be successful with the Fellowship exams."

On 8 May 2001 Zepinic sought to renew his conditional registration to undertake further specialist training in the District as a Senior Medical Officer – Psychiatry. This application was approved, consistent with the College's accreditation of Zepinic for training purposes.

The Board issued a conditional Certificate of Registration for the period 9 June 2001 to 8 June 2002. His employment in the Toowoomba District was also extended until that time. His registration was contingent upon him undertaking approved training within the District.

On 10 December 2001, the Office of Health Practitioner Boards received advice from RANZCP that it had "concerns" in relation to the veracity of documentation submitted by Zepinic to the AMC for his specialist assessment and advanced standing. RANZCP advised that it was seeking further advice from the AMC. A handwritten note on the letter suggests that further advice was obtained from RANZCP to the effect that the post graduate qualification was thought to be in the non-clinical field of Psychology.

On 22 January 2002, the Board resolved to distribute the RANZCP letter to the Toowoomba Hospital and to all other Boards and Councils.

On 5 April 2002, more detailed advice was received from the AMC to the effect that after cessation of hostilities in the old Yugoslavia it had re-established communication with Belgrade University and received advice from the Dean to the effect that Zepinic had completed post-graduate training in psychotherapy.

On 9 April 2002, the Board issued a Show Cause Notice to Zepinic. By that time, Zepinic had moved to Sydney. In a letter dated 24 April 2002 to the Board, Zepinic maintained that he had an overseas qualification in psychiatry and that he had made all appropriate disclosures to the examination and exemptions sub-committee of the RANZCP four years previously.

On 14 May 2002 the Board considered the response of Zepinic to the Show Cause Notice and considered that he had failed to adequately respond to the issues therein. Accordingly, the Board cancelled Zepinic's special purpose registration.

In the result, though Zepinic was appropriately qualified as a Medical Doctor, it appears that he overstated his post-graduate qualifications. That overstatement was detected by the AMC approximately 18 months after he commenced his employment in the Toowoomba District, as a routine part of the AMC's specialist accreditation process.

It is noteworthy that Zepinic impressed both an established Sydney Psychiatrist, who became his initial referee, and his immediate Supervisor in Toowoomba, an experienced Clinician.

The procedures for specialist assessment by AMC, at that time, and currently, meant that the Medical Board of Queensland had the satisfaction of knowing that the applicant's qualifications for the speciality of psychiatry would be rigorously assessed by AMC. Zepinic's employment was at all times in a training position. Many practitioners with a basic medical degree commence their specialist accreditation in a similar way. The significance of this matter is that Zepinic overstated his qualifications from Belgrade University.

The Board submits that this is yet another case which demonstrates the vulnerability of the system to applicants who overstate their qualifications as well as those who, perhaps like Vincent Berg, have falsely manufactured the appropriate qualifications.

The Board respectfully submits that it is not a matter in which it can be criticised for some serious failure in its processes.

It is noteworthy that these events unfolded in the period 1998-2001. Current procedures would minimise the risk of a similar occurrence today.

1.5 Dr Thamara Ranjika MUNASINGHE (TOWNSVILLE BASE HOSPITAL)

In October 2002, Thamara Munasinghe ("Munasinghe") applied for registration in an "area of need" position of Junior House Officer, Townsville Hospital. Her application and her supporting documentation showed that she had the following professional qualifications:

- (a) Assistant Medical Practitioner, Sri Lanka, 1990;
- (b) Registered Medical Practitioner, Sri Lanka Medical Council, 1999;
- (c) Graduate in General Medicine from the State Medical Academy of St Petersburg University, Russia – 2000;

Munasinghe had worked with the Sri Lankan Air Force, 1990-1992 and as a Medical Practitioner attached to the Department of Health, Sri Lanka, 1992-2002.

On 12 November 2002 the Board approved special purpose registration from November 2002 to January 2003 subject to completion of registration requirements. She was required to produce an original certificate of good standing, and to attend for interview with a Board member.

Munasinghe was due to give birth on 20 November 2002. She was interviewed by telephone by a Board member.

On 10 January 2003 the Deputy Director of Medical Services, Townsville Hospital, reported that he was unable to comment on Munasinghe's performance due to her advanced pregnancy, but that Townsville Hospital had appointed Munasinghe to a Junior House Officer position for the 2003 medical year and sought assistance in re-registering her.

There was a fresh application for special purpose registration, followed by a Board resolution on 28 January 2003, approving her special purpose registration until 18 January 2004.

On 2 June 2003 the Acting Deputy Director of Medical Services, Townsville Hospital, contacted the Board and advised that the Hospital had significant concerns regarding Munasinghe's competence, and was questioning whether she was medically qualified. She was subsequently interviewed by the Acting Deputy Director and Director of Medical Services, Dr Andrew Johnson, and asked to provide details of her training and experience, including her academic record. She did so. It then became apparent that there were two pathways to full registration as a Medical Practitioner with the Sri Lanka Medical Council. The second pathway was the completion of a paramedical course leading to qualification as an Assistant Medical Practitioner. After a period of eight years' service within Government institutions, the Director General of Health may then certify the person to be fully registered as a Medical Practitioner. The Board had not previously encountered an Applicant so qualified from Sri Lanka.

In a memorandum to the Registration Advisory Committee of the Medical Board, Deputy Registrar Michael Demy-Geroe described the circumstances of the awarding of the St Petersburg Degree as "*disturbing*". Mr Demy-Geroe reported that Munasinghe was granted extensive credits for her past training and experience and undertook only two years of external study and a 10 month residential period before qualifying for the Russian Degree. He reported that an Internship period did not appear to have been undertaken. Townsville Hospital advised that Munasinghe was interviewed again on 10 June 2003 in the company of her husband, who was a duly qualified Medical Registrar at the Hospital. She then resigned from her position.

There were no misrepresentations in Munasinghe's application. Her overall experience and qualifications gave the appearance of being acceptable for a Junior House Officer under supervision in a Hospital. It was her lack of skills which alerted the Townsville Hospital to the issue of her formal qualifications.

Mr Demy-Geroe expressed the view that there were no grounds upon which Munasinghe's registration could have been cancelled by the Board. Action would have been necessary on competency grounds. (see s.59 *Health Practitioners [Professional Standards] Act 1999*).

Mr Demy-Geroe expressed the intention to notify the AMC of the disclosed Sri Lanka registration issues and the circumstances of the St Petersburg Medical Degree. It was thought that other Russian medical schools might also be under suspicion.

As a consequence of these events, a direction was given to registration staff to take a more stringent approach to applicants relying on a Russian primary medical qualification for special purpose registration.

On 24 June 2003, the Board considered the memorandum and endorsed the actions and recommendations of Mr Demy-Geroe.

This is a case in which appropriate supervision brought Munasinghe's clinical shortcomings to light. A closer scrutiny of her primary qualifications was followed by appropriate action by the Board.

1.6 Dr Tariq Salman QURESHI (BUNDABERG BASE HOSPITAL)

Nurse Toni Hoffman gave evidence ⁵² at a time when she was acting DON, inappropriate behaviour by Dr Qureshi ("Qureshi"), an IMG was reported to her by other staff. The initial complaint related to the allegedly inappropriate way in which a patient was examined. Complaints were also received from two other nursing staff regarding allegedly inappropriate behaviour towards them. Nurse Hoffman said that she was requested by Director of Medical Services, Dr Keating to ask Qureshi to telephone him. Subsequently, she was notified that Qureshi was required to be chaperoned whilst working within the Hospital. Nurse Hoffman advised staff urgently about this development.

Nurse Hoffman said in evidence that subsequently, during a meeting with Dr Keating and incoming DON Linda Mulligan, she was advised that Police had attended at Qureshi's residence to find that he had left the country the day before.

On day 11 of the Commission of Inquiry hearings, the Commission was advised by Senior Counsel Assisting, Mr Andrews ⁵³ that on 21 October 2003, Dr Keating spoke with the patient involved in the complaint against Qureshi. The patient gave permission for Dr Keating to make a complaint to the Medical Board. Dr Keating advised Qureshi that the complaint had been made.

Dr Peter Miach also gave evidence ⁵⁴ that after he heard about complaints of sexual harassment, he became aware of an "*edict*" that Qureshi was required to be chaperoned in the hospital. Mr Miach recalled that Qureshi disappeared after Police showed an interest in him.

Nurse Martin Brennan gave evidence ⁵⁵ of a perception of inactivity in relation to Qureshi on the part of the Director of Medical Services, Dr Keating.

The Medical Board's file in relation to Qureshi was delivered to the Commission of Inquiry at an early stage. An examination of that file reveals that Dr Keating acted quickly in relation to Qureshi, once he received a complaint.

It should be acknowledged that sexual misconduct allegations are not peculiar to IMGs in an "*area of need*". The Board's file reveals that timely measures were taken to deal with the complaints when they were received.

The Board's file, which was supplied to the Commission, reveals the following chronology of events:

- 28.08.03 - written "*notification of complaint*" of a sexual nature received from patient;
- 28.08.03 – Dr Keating confronted Qureshi, who denied acting inappropriately. Dr Keating counselled Qureshi about his conduct. Dr Keating followed up with the patient, who told him she did not wish to take any further action.

⁵² T69, 70

⁵³ T1118, 1119

⁵⁴ T340

⁵⁵ T2174, 2175, xxmT2182, 2183

- 19.10.03 – “notification of complaint” of a sexual nature received from patient.
- 22.10.03 – Letter Keating to Medical Board Complaints Unit re: second complaint but referring also to first complaint.
- 06.11.03 – email Nurse Hoffman to Keating re: three inappropriate incidents with nursing staff. Hoffman advised that no formal complaint from the nurses was likely.
- 13.11.03 – memo complaints assessment co-ordinator to Medical Board Complaints Committee – Keating’s complaint described as a “professional standards issue” referred to Health Rights Commission.
- 17.11.03 – Medical Board advice to Keating that his complaint would be considered at the next meeting of the Board.
- 08.12.03 – Keating received a report from staff about inappropriate conduct with a patient.
- 09.12.03 – Keating interviewed the patient
 - Keating interviewed Qureshi who denied the allegations.
- 11.12.03 – Letter Keating to Medical Board Complaints Unit advising of further incident, that Qureshi has a chaperone and that administrative action has begun under Queensland Health Code of Conduct.
- 16.12.03 – “notification of complaint” from patient #3 re: inappropriate approach by Qureshi.
- 17.12.03 – Qureshi enquired of the Medical Board as to whether outstanding complaints would impact on his renewal of registration in March 2004.
- 18.12.03 – fax Medical Board Complaints Assessment Co-ordinator to Keating requesting further information re: the various complaints.
- 24.12.03 – Letter Keating to Medical Board Complaints Assessment Co-ordinator supplying further information.
- 29.01.04 – Q Health Internal auditor referred Keating’s complaints to CMC (see letter dated 13.04.04)
- 24.02.04 – Medical Board reviewed the complaint material and noted that an investigator had been directed to investigate.
- 11.03.04 – Letter Medical Board Complaints Co-ordinator to Keating advising that an investigator will be appointed, but there will be some delay because of the backlog of complaints.
- 13.04.04 – Letter Q Health internal auditor (investigations) to Medical Board advising that on 29 January 2004, it referred Keating’s complaints to the Crime and Misconduct Commission, who said that it intended to report the allegations to the Queensland Police Service. Also reporting QPS advise that prior to interviewing Qureshi he fled the jurisdiction. Warrant issued for Qureshi’s arrest and “passenger alert” and QPS advice to Australian Immigration and Interpol.
- 04.05.04 – Medical Board resolved to initiate an investigation if Qureshi re-registers in Queensland. Notice to be placed on the file.
- 23.07.04 – Letter Keating to Medical Board advising that Qureshi was terminated effective 14 March 2004.
- 21.04.05 – Advice from Medical Council of NZ to Medical Board re: presence of Qureshi in Gisborne, NZ.

Medical Board liaised with Detective Borland of Bundaberg CIB re: this information.

1.7 Dr Isak MAREE (TOWNSVILLE DISTRICT/CHARTERS TOWERS HOSPITAL)

On Sunday 17 December 2000, patient Kathryn Sabadina presented at Charters Towers Hospital with severe pain from an infected eye tooth. Dr Isak Maree ("Maree") administered a general anaesthetic for the purpose of her dentist removing the tooth. Almost immediately, an emergency developed and despite the attempts of numerous people to resuscitate her, Ms Sabadina died. The Queensland Health investigation was finalised by 20 February 2001, but the investigation of the Queensland Police Service was not forwarded to the Coroner until 25 November 2003. The Coroners Inquest commenced on 18 July 2005. The State Coroner, Mr Barnes, delivered his findings on 24 August 2005.

Maree was the Medical Superintendent of Charters Towers Hospital. He is an IMG registered to practice in an area of need.

Appearing in Appendix "B" attached hereto are the relevant findings of the State Coroner which the Board wishes to extract in full.⁵⁶

It is respectfully submitted that this tragic case has been expertly analysed by the Coroner. The Coroner's findings expose the difficulties facing IMG's in small regional hospitals.

1.8 Dr Dinesh SHARMA (HARVEY BAY HOSPITAL)

Dr Sharma ("Sharma") was a qualified Orthopaedic specialist in Fiji before obtaining registration to fill an area of need at Fraser Coast Health Service District from 25 February 2003 to 25 January 2004. Sharma was employed as a Senior Medical Officer at Hervey Bay Hospital.

Supervision

The Commission hearings firstly focussed upon the issue of supervision of Dr Sharma by staff Orthopaedic specialist Dr Naidoo. Attention was drawn to the letter from the Medical Board of Queensland dated 13 March 2003⁵⁷, in which Dr Sharma was initially advised of the granting of special purpose registration for the above period. The letter contained the following words:-

"conditions imposed on your registration are as follows: Nil"

It is respectfully submitted that any attempt to equate the imposition of "*conditions*" with the requirement for "*supervision*" of a Senior Medical Officer (being an International Medical Graduate with special purpose registration) is misconceived. Attention is drawn to Subdivision 7 of the *Medical Practitioners Registration Act* 2001, which provides the scheme for imposition of conditions of practice upon any Registrant. See in particular S.58 & 59.

⁵⁶ pages 24-30 State Coroners "*Findings of the Inquest into the death of Kathryn Marnie Sabadina*"

⁵⁷ Exhibit 358

It is respectfully submitted that a distinction must be drawn between the above legislative provisions on the one hand, and the expectation of the Board on the other hand, that an International Medical Graduate obtaining special purpose registration in a Q-Health Hospital as a Senior Medical Officer will be subject to supervision in the Hospital setting. That requirement and expectation is borne out by the terms of the following documents:-

Exhibit 361- "Form 1" application by employer

Exhibit 360 – "Assessment Form, special purpose registrants"

In the first-named document, the requirement as at early 2003, was for the employer to state in general terms the nature of the supervision which would be afforded to the International Medical Graduate.

As to the second-named document, the certification of the International Medical Graduate's clinical supervisor was required before re-registration could be approved. Thus, the method of special purpose registration as it existed in early 2003 did not provide for any formal certification by an identified supervisor until the first period of registration had passed, and re-registration was sought for a further period. As Mr Demy-Geroe, Deputy Registrar of the Board, explained in evidence;⁵⁸

"I think in the hospital structure generally one expects that there is supervision at all levels..."

Q: The employer didn't specify supervision available, in that respect, was that Form 1 deficient or is that how they are regularly left?

A: I think in the case of hospitals they are sometimes left like that and at that time that wouldn't have raised any concerns because, again, as I have indicated, there was an expectation that hospital's are a supervised environment..."

Mr Demy-Geroe agreed with Senior Counsel Assisting that it would be feasible for annual re-registration applications to require the applicant to obtain from the employer a certification as to the degree of supervision that the certifier has exercised.⁵⁹ Mr Demy-Geroe's Affidavit, **Exhibit 420**, demonstrates that current requirements for supervision are much improved.

Registration

The Commission hearings subsequently focussed upon the registration of Dr Sharma by the Board. Counsel Assisting raised the question whether Certificates of Special Purpose Registration for Drs. Sharma and Krishna⁶⁰ may amount to registration of those General Practitioners as a Specialist.

The "Certificate of Registration Special Purpose – Section 135" for Dr Sharma for the period 17 January 2005 to 16 January 2006 describes the "Special Purpose Activity" as follows:-

⁵⁸ T492

⁵⁹ T493

⁶⁰ Exhibit 438

"to fill an area of need as a Senior Medical Officer in Orthopaedics at Fraser Coast Health Service District or any public hospital authorised by the Medical Superintendent on a temporary basis." (emphasis added)

The Commission heard evidence that, although Dr Sharma had specialist qualifications in Orthopaedics recognised in Fiji, he was at all times recognised in Queensland as a General Practitioner and not as a Specialist.

The observations of Counsel Assisting⁶¹, and subsequent observations by the Commissioner, raised the question whether the Certificate of Registration, on its face, and as a matter of law, amounts to an impermissible registration of Dr Sharma as a Specialist in Orthopaedics.

The Commission of Inquiry has the Board's registration file in relation to Dr Sharma. Some relevant documents have been extracted from that file and are an Exhibit in the proceedings.⁶² The document entitled "*Queensland Health Application for Area of Need Certification*", signed by Director of Medical Services Dr Terry Hanelt and dated 14 January 2003, shows that the position in respect of which Q Health certification was sought and obtained was:-

"Senior Medical Officer, Orthopaedics"

Dr Hanelt gave evidence⁶³ about the difference in procedures between an International Medical Graduate obtaining general registration and the process for one who obtains "*deemed specialist registration*" in an area of need. As Director of Medical Services, Dr Hanelt said he was required to "*submit reams of documentation and forms to the Australian Medical Council*" in circumstances where deemed specialist registration is sought. Dr Hanelt also gave evidence that, in relation to the position of Senior Medical Officer within the hospital system throughout Queensland, some SMO's are Specialists and some are not.⁶⁴ With reference to the "*Queensland Health Application for Area of Need Certification*" (but in the context of the Application in respect of Dr Krishna), Dr Hanelt said that the position he applied for was a generalist position as a "*Senior Medical Officer – Orthopaedics*", not a Specialist position.⁶⁵ The position description for "*Senior Medical Officer – Orthopaedics*" for the Fraser Coast Health Service District is part of **Exhibit 446**. That document demonstrates firstly that the position classification of "*C1-1 to C1-5*" was a public service pay classification relating to General Practitioners employed as Senior Medical Officers in the Queensland hospital system. Dr Hanelt explained that Senior Medical Officers who were registered as Specialists had a pay scale which began with the designation "*MO*". In addition, page 4 of the position description recites that the appointee must have the minimum qualification of:-

"Registration as a Medical Practitioner with the Medical Board of Queensland."

⁶¹ T6677

⁶² Exhibit 447

⁶³ T6771, 6772

⁶⁴ T6775

⁶⁵ T6776

Dr Hanelt said⁶⁶ that on the "*Application for Area of Need Certification*", not only did he use the position description designation, but he ticked the box entitled "*Hospital*" and did not tick the box entitled "*Specialist Practice*"; nor did he tick the box for "*Private Practice*" in circumstances where he knew specialists in the public health system had a right to private practice.

It is submitted that the effect of Dr Hanelt's evidence is that in his first "*Application for Area of Need Certification*" he applied for, and was certified for, a generalist position within the Fraser Coast Health Service District, for a Senior Medical Officer practicing in Orthopaedics. The document shows that a representative of Queensland Health, M Catchpole, endorsed the certification on 16 January 2003. This certification is a condition precedent for registration. It was not a certification for a specialist position.

Exhibit 447 also contains a Certificate of Registration for the period 27 February 2003 – 25 January 2004 for Dr Sharma, which was created as a result of the Application to fill an area of need. The endorsement on the Certificate of Registration for that period states:-

"Special Purpose Activity: "to practise at Fraser Coast Health Service District or any public hospital authorised by the Medical Superintendent of Maryborough Base Hospital on a temporary basis".

A further "*Application for Area of Need Certification*" dated 12 November 2003 also shows that the position sought by Dr Hanelt was that of "*Senior Medical Officer, Orthopaedics*" being a generalist position and not a specialist position, in a hospital. The resultant Certificate of Registration states:-

"Special Purpose Activity: to practise at Fraser Coast Health Service District, or any public hospital authorised by the Medical Superintendent on a temporary basis".

The second Certificate of Registration is for the period 26 January 2004 – 25 January 2005.

It is the third Certificate of Registration, and the one put into evidence by Counsel Assisting as part of **Exhibit 438**, which has a different certification upon its face and relates to the further period 17 January 2005 – 16 January 2006:-

"Special Purpose Activity: to fill an area of need as Senior Medical Officer in Orthopaedics at Fraser Coast Health Service District or any public hospital authorised by the Medical Superintendent on a temporary basis". (emphasis added)

It is respectfully submitted that this third Certificate of Registration does not amount to evidence of the registration of Dr Sharma as a Specialist in Orthopaedics at the Fraser Coast Health Service District. Although the description of the Special Purpose Activity in the third Certificate is different in its terms to the first two Certificates, it is merely descriptive of

⁶⁶ T6776

the position for which certification for area of need was sought and obtained. Refer further to the Board's Executive Summary accompanying these submissions.

1.9 Dr Damodaran KRISHNA (HERVEY BAY HOSPITAL)

Dr Damodaran Krishna ("*Krishna*"), like Dr Sharma, was a qualified Orthopaedic Specialist in Fiji before first obtaining registration to fill an area of need at Fraser Coast Health Service District from 18 July 2002 to 18 July 2003.⁶⁷ Krishna was also employed as a Senior Medical Officer at Hervey Bay Hospital.

Supervision

The Board's submissions in relation to the distinction between the imposition of "*conditions*" and the requirement for "*supervision*" are set out in the previous submissions in respect of Dr Sharma. Those submissions apply equally to the position of Dr Krishna.

During the evidence of Dr Terry Hanelt, Director of Medical Services for the Fraser Coast Health District, issue was taken in relation to the certification of Dr Hanelt on the "Form 1" which at that time was required to be submitted to the Board where re-registration for an area of need position was sought. Dr Hanelt's attention was drawn to the following endorsements on the Form 1:-

"supervision available: supervision by a Staff Specialist "business hours" and as necessary after-hours".

"Consultant Advice Available: consultant advice and/or assistance is available 24 hours a day, 7 days a week."

Dr Hanelt acknowledged in evidence that, given the limited nature of the actual supervision able to be afforded by Dr Naidoo to Drs. Krishna and Sharma, in retrospect, a reference to "*remote supervision*" should have been included.⁶⁸ Dr Hanelt also conceded that it was more accurate to say that consultant advice was available 24 hours a day, 7 days a week, but that it was not accurate to report that consultant assistance was available on that basis.⁶⁹

Dr Hanelt said in evidence that Dr Naidoo had told him that he would make himself available to the SMO's if they required advice, over and above his formal on-call commitment:

*"certainly there were times when Dr Naidoo was not on-call that I was aware that he was called by the SMO's to provide assistance and I was not aware of times where he was in town that he was unwilling to provide advice or assistance."*⁷⁰

Dr Hanelt conceded that a more accurate expression of "*supervision available*" was:

⁶⁷ see Exhibit 446

⁶⁸ T6717

⁶⁹ T6718

⁷⁰ T6719

*"after hours, ...no direct supervision available"*⁷¹

For his part, Dr Krishna said in evidence that between commencement at Hervey Bay in July 2002 and the present date, he had performed 550 procedures.⁷² He acknowledged in evidence that the various forms of supervision provided by Dr Naidoo to him were as follows⁷³:

- He was directly observed by Dr Naidoo whilst he conducted surgical procedures.
- Dr Naidoo was in a position to assess post operatively the outcomes for Dr Krishna's patients. Dr Krishna could remember "a few times" when he received constructive comments from Dr Naidoo about the way he performed the procedure.⁷⁴
- From Dr Krishna's perspective, Dr Naidoo was in a position generally to assess his general level of surgical competence.
- Dr Naidoo conducted ward rounds involving Dr Krishna's patients.
- At Orthopaedic Clinic, on occasions Dr Naidoo directed patients to him and was in a position to know what those patients' outcomes were.
- Dr Naidoo was aware of the referees who supported Dr Krishna (e.g. Dr Robert Ivers of Toowoomba Base Hospital).
- Dr Naidoo was available for his assistance if he needed advice during a particular Orthopaedic surgical procedure.
- Dr Krishna said he was able to speak to Dr Naidoo by telephone to seek his advice. Dr Krishna could not remember any situation where such advice was not available.

Dr Krishna said that, apart from one particular case when Dr Naidoo did not attend to assist him, he could not recall any other instance when Dr Naidoo did not make himself available to him when he requested assistance.

It is respectfully submitted that the above evidence, though it describes different types of "supervision" must be evaluated against the background that an International Medical Graduate is unlikely to be overly critical of an issue such as supervision by a Supervisor who is a Queensland-registered Specialist. The IMG's tenure in Australia is dependant upon his/her tenure in employment in a declared area of need. The Commission is respectfully referred to the cross-examination of Dr Hanelt by Mr Farr on behalf of Q Health in this regard.⁷⁵

The evidence suggests that the nominated supervisor of Drs. Sharma and Krishna, Dr Naidoo, was absent on approved leave throughout a considerable period of the calendar year 2004.⁷⁶ Other evidence tendered before the Commission suggests that some days of Dr Naidoo's absences may have been unauthorised. This has yet to be affirmatively established.

⁷¹ T6720

⁷² T6509

⁷³ T6509

⁷⁴ T6509

⁷⁵ T

⁷⁶ Summary Exhibit 432

Against this background, it seems that the way in which Dr Naidoo managed the situation was to rely upon the ability of Drs. Krishna and Sharma to conduct Orthopaedic procedures within a "scope of service", which Dr Naidoo provided to them. It seems that the "scope of service" was provided to Dr Krishna on 1st January 2004⁷⁷, although Dr Krishna remembers being provided an earlier, less particular, "scope of service".

Dr Krishna did not characterise the content of the "scope of service" as a mere "act of faith" on the part of Dr Naidoo; on the contrary, Dr Krishna said:⁷⁸

"I think he must have based his assessment on the post-op outcomes because even if he has not seen the operating, he has seen the patient in the ward post-op and also he must have taken into consideration my employment in other hospitals in Queensland".

Dr Krishna's evidence is supported by the statement of **Dr Anthony Wilson**⁷⁹. Dr Wilson, an Orthopaedic Surgeon in Toowoomba, had Dr Krishna as his non-training registrar in 2002. Dr Wilson spoke highly of Dr Krishna's ability to work independently and to form a correct judgment as to any procedure which was beyond his scope of practice⁸⁰. He substantially, but not completely agreed with the scope of practice granted to Dr Krishna by Dr Naidoo. Dr Krishna clearly did not work under 100% supervision in Toowoomba.

Dr Krishna agreed in evidence that, for whatever reason, Dr Naidoo "was away quite a lot"⁸¹

Dr Krishna also said that Dr Mullen got upset when he learned that Dr Naidoo was on leave and that Dr Mullen was upset that Dr Krishna was being left unsupervised. Dr Krishna maintained, however, that he operated within his scope of practice and tried to practice safely at all times.⁸² Dr Krishna did not agree that the scope of practice provided to him by Dr Naidoo was "too generous". He said:

"I think Dr Naidoo based my assessment on me doing these cases which he has seen and also from the references I received when I applied for the post while I was employed in another hospital in Queensland."

Dr Krishna did concede, however that he would have been happier with more supervision.

Like Dr Sharma, Dr Krishna spoke highly of the supervision afforded him by Dr Kwon, who worked in the Fraser Coast District for four months from late January 2005.⁸³

Dr Krishna said he felt he could not complain to Director of Medical Services Dr Hanelt about lack of supervision because he felt that Dr Naidoo was receiving approved leave and

⁷⁷ T6466

⁷⁸ T6469

⁷⁹ Statement Exhibit 482, evidence from T7329

⁸⁰ See in particular T7338, 7345

⁸¹ T6474

⁸² T6477

⁸³ T6481

he felt that the hospital administration expected he and Sharma to continue to perform their duties "as per privileges."⁸⁴

Dr Krishna did identify one procedure in which, for some reason Dr Naidoo did not attend to assist him when he requested it.⁸⁵

Dr Morgan Naidoo agreed in general terms with the summary of leave taken by him from January 2002 to September 2005, as follows⁸⁶:

2002 -	13 weeks
2003 -	11 weeks
2004 -	19 weeks

Dr Naidoo agreed that when he was on leave, Drs. Sharma and Krishna were mostly left unsupervised.⁸⁷ Dr Naidoo agreed that it was not an ideal situation. Dr Naidoo insisted that when he was at the hospital "*I was always available*".⁸⁸ Dr Naidoo's most recent statement dated 21 October 2001 suggests that Dr Naidoo did keep somewhat erratic hours. Given the standard hospital hours, it is difficult to see how Dr Naidoo was "always available" as he claimed. No doubt Dr Naidoo's residence in Brisbane and his medical difficulties have contributed to a less than ideal provision of supervision.

Dr Naidoo said that he allowed them a degree of independence "*based on the information I had received about their skills*".⁸⁹ Dr Naidoo said that he formed a view that Dr Krishna, in particular, was capable of doing most of the common trauma procedures that came through a busy hospital.⁹⁰ In order to reach this opinion, he relied upon the references of Dr Ivers, Dr Pun and Dr Wilson. Dr Ivers was glowing in his assessment, whereas Dr Pun and Wilson provided "*fairly neutral*" references.⁹¹ Dr Naidoo said that he also relied upon a telephone conversation with Dr Krishna which occurred before the job interview with Dr Hanelt, and he also relied upon the content of the interview which occurred in May or June 2002.⁹²

Dr Naidoo said that Dr Ivers had previously been his Registrar. He said⁹³:

"I called Dr Ivers and I spoke to him about Krishna's capabilities and was informed that he was capable of doing general Orthopaedic trauma, what we would call routine trauma that comes through."

Dr Wilson's statement supports Dr Naidoo's evidence on this point.

Dr Krishna filled out a request for clinical privileges in late 2003⁹⁴ and this was used partly as a basis for the creation of the scope of practice document dated 1 January 2004. Dr

⁸⁴ T6482

⁸⁵ T6492

⁸⁶ Exhibit 432

⁸⁷ T6591

⁸⁸ T6952

⁸⁹ T6592

⁹⁰ T6620

⁹¹ T6621

⁹² T6621

⁹³ T6624

Naidoo's attitude to the scope of practice can be best summarised in the following passage⁹⁵:

"...the document that I provided on their scope of service was not a certification of what they could do but based on what they indicated to me they had done in the past and my observations of some of the work based on their recommendations or their references they received from Toowoomba, and that's' Dr Sharma's references, and also based on their post-operative review of patients."

Dr Naidoo formed the view that Drs. Krishna and Sharma were skilled enough to make a clinical judgment as to what procedures they could deal with. Consequently, he instructed them that they were to treat patients within their skill level. Other patients would be transferred to another tertiary hospital.⁹⁶ Again, Dr Wilson's statement supports Dr Naidoo's position.

As for the conduct of outpatient Orthopaedic Clinics Dr Naidoo said⁹⁷

"we had two categories of new patients on our waiting list, one which only a consultant can see, either myself or Dr Mullens because of the nature of the problem the patient had. The second waiting list was...what we would consider of a minor nature based on the GP's referral and we would allocate some of those patients to assessed by the SMO's and then referred to us if they needed further assessment."

In agreeing that the supervision of the two SMO's was not ideal, Dr Naidoo pointed out⁹⁸ that often surgeries would be occurring concurrently, but in circumstances where the SMO's would "mostly" discuss any particular procedure with him. In respect of the "vast majority of clinics", Dr Naidoo said he was "on the floor, or Dr Mullen was on the floor" whilst those clinics were being conducted by either Drs. Krishna or Sharma.

Dr Naidoo was questioned about the single occasion on which Dr Krishna described a failure on the part of Dr Naidoo to assist him with a procedure he considered difficult. Dr Naidoo could not remember the incident, but suggested that, at a time when there was a shortage of junior staff available to the Orthopaedic department, he felt that Dr Krishna was asking for someone to assist him rather than asking for a consultant to attend.⁹⁹ It appears that this response was somewhat speculative, since he did not recall the incident.

1.10 Dr Morgan NAIDOO (HERVEY BAY HOSPITAL)

Senior Nurse **Dale Frances Erwin-Jones** said in evidence ¹⁰⁰ that she expressed to the review team of Doctors North and Giblin, her view that Drs. Sharma and Krishna "...tried to

⁹⁴ Exhibit 433

⁹⁵ T6593

⁹⁶ T6593

⁹⁷ T6595

⁹⁸ T6597

⁹⁹ T6630

¹⁰⁰ T5401

work within their scope of practice, they knew what their limitations were. They unfortunately sometimes got into a position of not being able to control that, because once you get into the operating theatre, the surgery was more complex than they first understood it to be, that there was no supervision for them..." Nurse Erwin-Jones asserted in evidence that Dr Naidoo took an "inordinate amount of leave". She said that Dr Naidoo took at least 2-3 months per year in leave, being sick leave, study leave and annual leave.¹⁰¹ As a consequence, she said, the on call roster for Orthopaedic services was too demanding for those who remained available for duty, and a feature of the roster was the lack of supervision by a suitably qualified Orthopaedic specialist. Nurse Erwin-Jones complained generally that, as Nurse Unit Manager of the Operating Theatre, she was not informed of the extent to which particular practitioners needed particular levels of supervision for particular procedures.¹⁰²

Referring to Drs. Sharma and Krishna, Nurse Erwin-Jones said:

*"...from a professional clinical point of view, I would understand that they should have the availability of someone certainly within the District that should they get into a complex case, could come and assist. And that did occur on many occasions, where either Sharma or Krishna were performing surgery that again became more complex, and they did try to contact Dr Naidoo and on occasion Dr Mullins (sic) and were unable to contact him by phone, either they were unavailable in the District or they weren't willing to attend. There were various reasons. I can't give you specific dates, although a number of my staff could give you very clear examples."*¹⁰³

In fairness to Dr Naidoo, it should be pointed out that Nurse Erwin-Jones described him as being in the District from Monday to half day Friday "regularly"¹⁰⁴ but she pointed out that although Dr Naidoo was usually in the District during the week, he was not paid to be on call. The essence of Nurse Erwin-Jones' complaint was that an establishment of one Consultant and one "very, very part-time VMO" (Dr Mullen) was insufficient coverage for Hervey Bay Hospital. She estimated that at least two full Consultants and three or four VMO's was the necessary complement. If Drs. Sharma or Krishna were placed on call, a Consultant was never placed on call at the same time. Further, during standard working hours, she said that the specialist was regularly unavailable to supervise Drs. Sharma and Krishna in their work. This brought potential risks to Orthopaedic patients.¹⁰⁵

For his part, **Dr Hanelt** agreed that the ideal establishment of Orthopaedic staff was one which allowed a 1-in-3 roster. Dr Hanelt said that the current state of the roster was "too demanding".¹⁰⁶

Dr Sean Mullen gave evidence that during his time as a VMO at Hervey Bay Hospital, he developed strong concerns that Dr Naidoo's lack of supervision of Drs. Sharma and

¹⁰¹ T5402

¹⁰² T5403

¹⁰³ T5404

¹⁰⁴ T5405

¹⁰⁵ T5406

¹⁰⁶ T6757

Krishna allowed unsatisfactory medical situations to develop.¹⁰⁷ Dr Mullen described the situation as a failing in the administration of the hospital. Dr Mullen asserted that, at the time of the arrival of the two Fijian doctors in 2002, 2003;

*"Dr Naidoo was very rarely on call as the full-time Orthopaedic surgeon"*¹⁰⁸

During the evidence of Dr Hanelt, it was squarely put to him by Counsel Assisting that it was a "well known fact" that Dr Naidoo performed his "on-call" duties from Brisbane on occasions. Dr Hanelt replied that he was unaware of any such practice;¹⁰⁹ nor is there any evidence that such was the case.

Dr Mullen also gave evidence that the rostering of the two Fijian doctors was unacceptable to him because they were shown on the roster as being on call as the Consultant Orthopaedic Surgeon:

*"so they were basically being treated as specialist Orthopaedic Surgeons and they were autonomously operating, and there is a period of time where Dr Naidoo was absent on leave and they continued to do on call as the Orthopaedic Surgeon on call. There was no one supervising their surgery."*¹¹⁰

Dr Mullen described the situation as inappropriate and dangerous. Dr Mullen said that he raised this issue with the Director of Medical Services, Dr Hanelt, and that he "didn't get much satisfaction" over the matter. The tenor of Dr Hanelt's evidence on this point was that the lack of available orthopaedic specialists in the District meant that the two SMO's were inevitably required to perform on-call duties without the immediate supervision of a specialist. Dr Hanelt frankly acknowledged the difficulty, but said that, when Dr Naidoo was "in town available"¹¹¹, he made himself available to give them advice. He said he was aware of occasions when advice was given by Dr Naidoo in those circumstances. Nevertheless, patient safety depended upon the SMO's correctly determining whether they were competent to perform procedures unsupervised.

Dr Hanelt said that advice to an on-call SMO could also be obtained after hours from other hospitals as required, but he conceded that this was not "direct supervision".¹¹²

Dr Mullen said that, such were his concerns, that he eventually contacted the Australian Orthopaedic Association to voice his concerns.

Dr Mullen also said in evidence that he developed concerns that Dr Sharma and Krishna were conducting unsupervised outpatient Orthopaedic Clinics, where orthopaedic cases had to be assessed for the first time. His concern was that Dr Naidoo was not conducting these clinics in a supervisory role. Dr Mullen said that he raised these concerns with Dr

¹⁰⁷ T5449

¹⁰⁸ T5456

¹⁰⁹ T6758

¹¹⁰ T5457

¹¹¹ T6719

¹¹² T6720

Naidoo, who expressed the opinion that Drs. Sharma and Krishna were suitable to do the clinics unsupervised.¹¹³

Dr Naidoo agreed that Dr Mullen had raised concerns over the level of supervision of Drs. Sharma and Krishna.¹¹⁴ Naidoo agreed that full-time supervision of the two SMO's would have obliged him to work "impossible hours".

Dr Mullen said that such were his concerns he offered to make himself available for a one in two on call roster with Dr Naidoo. He said that he offered to do the roster free of charge if there was an issue of cost. He said that his offer was not accepted by Dr Hanelt.

*"I felt...that it was to do with the fact that there was a degree of conflict between the idea that people need to be credentialled to an appropriate level and between the concept that was being used in Hervey Bay where it was acceptable to have a lower standard of care because we were working in provincial area."*¹¹⁵

Dr Hanelt addressed in detail why Dr Mullen's offer was not taken up.¹¹⁶ He cited industrial reasons, and the fact that Dr Naidoo was not prepared to perform a 1-in-2 roster to match Dr Mullen. Dr Hanelt also suggested that his experience was that Dr Mullen was already unable to maintain his 1-in-4 commitment, so that a further sustained on-call commitment was unlikely to eventuate, in his view. Regrettably, Dr Hanelt's reasoning appears sound on this point. He also alluded to the fact that a shared on-call arrangement would break down when either specialist took leave.

Dr Dinesh Sharma was called upon during his evidence to distinguish between the supervision afforded him by a more recent locum Director of Orthopaedics, Dr Kwon, and that afforded to him by Dr Naidoo when he was the Director of Orthopaedics at Hervey Bay. One distinction made by Dr Sharma was that, Dr Kwon placed himself on call almost every day and he was available:

*"Whenever we needed him. That's seven days a week for that four months or how many months he was there."*¹¹⁷

Dr Sharma diplomatically said that Dr Naidoo was not available to the same extent as Dr Kwon. Dr Kwon also attended elective surgery cases in which Dr Sharma assisted him.

For his part, Dr Naidoo asserted that:¹¹⁸

"Dr Kwon didn't do any of the trauma and didn't do any of the administrative work that I do and certainly had more time on his hands than I did".

¹¹³ T5464

¹¹⁴ T6635

¹¹⁵ T5465

¹¹⁶ T6743, 6744

¹¹⁷ T5674

¹¹⁸ T6593

As to the question of rostering, Dr Sharma explained the differences he experienced under Dr Kwon compared with his experience under Dr Naidoo: ¹¹⁹

"We have an on-call roster that has got various people on-call and when Dr Kwon came in, he put his name on-call every day as the Consultant, so he was on-call every day. With Dr Naidoo, the on-call was shared by Dr Naidoo, Dr Mullen and the Senior Medical Officers. So not every time – or when the Senior Medical Officer was on-call, there was no consultant on-call."

Dr Hanelt suggested that Dr Kwon actively sought on-call work because he was planning to go overseas and *"it helps the wallet"*. ¹²⁰

Dr Sharma also said that during daytime hours the emergency calls were shared between himself and Dr Krishna, but when Dr Naidoo was in the hospital and not on leave, he had no problem in obtaining Dr Naidoo's opinion on a particular matter. ¹²¹

Dr Sharma could not recall any occasion when Dr Naidoo was supposed to be on duty but not in the hospital. Dr Sharma pointed out that Dr Naidoo may have been at Maryborough Hospital on any particular day, rather than at Hervey Bay.

As to the question of supervision of Orthopaedic Outpatient Clinic conducted by Dr Sharma, he said that on many occasions Dr Mullen was also taking Outpatient Orthopaedic Clinic, and so he was able to take Dr Mullen's advice on many occasions. As far as he was concerned, Dr Mullen was his supervisor on those occasions. ¹²²

It was pointed out to Dr Sharma that Nurse Erwin-Jones claimed in her statement that Dr Krishna was *"rarely"* able to obtain assistance from Drs. Naidoo or Mullen. Dr Sharma said this was not his experience. ¹²³

Dr Krishna also did not support that proposition. ¹²⁴

He said that when Dr Naidoo was at work he was *"around all the time"*. ¹²⁵

Dr Sharma disagreed with Nurse Erwin-Jones' statement that his requests for assistance were often refused or the supervising Doctor was unavailable. ¹²⁶ Dr Krishna did not suggest in his evidence that he was often refused assistance.

In summary, Dr Sharma said that he felt free to consult with specialists in Brisbane, with Dr Naidoo when he was available, and with Dr Mullen when he was available. ¹²⁷ Dr Sharma also said that he assisted Drs. Naidoo and Mullen on many occasions in theatre. Dr

¹¹⁹ T5674

¹²⁰ T6733

¹²¹ T5675

¹²² T5696

¹²³ T5696

¹²⁴ T6475

¹²⁵ T6479

¹²⁶ T5696

¹²⁷ T5696

Krishna gave evidence which was generally consistent on this aspect with that of Dr Sharma.

Absences of Dr Naidoo

Dr Hanelt said that he was aware of complaints from staff about Dr Naidoo's absences.¹²⁸ He checked with the HR section of Q Health and found that Dr Naidoo's leave was within his entitlements. Any reported absences by Dr Naidoo were checked. There was the added difficulty of having two hospital campuses in the District.

Dr Hanelt told the Commission that enquiries were currently underway to check Dr Naidoo's fuel dockets to determine whether the vehicle was being used in locations well away from Hervey Bay, such as to indicate perhaps unauthorised leave.¹²⁹ Dr Naidoo's latest statement does shed some light on the erratic hours kept by Dr Naidoo on some occasions.

It is respectfully submitted that the attempt to establish the possibility of unauthorised absences in Brisbane by the use of telephone records was rendered inconclusive after the receipt of the statement of Dr Andrew Christensen. Clearly, Dr Naidoo was undergoing Psychiatric treatment at New Farm on occasions when a call from his mobile telephone was picked up by the Kangaroo Point telephone tower. Parts of New Farm are located immediately opposite Kangaroo Point, across Brisbane River. It is respectfully submitted that a more detailed investigation by the appropriate authority is called for. There is no doubt that Dr Naidoo took significant amounts of authorised leave in the years 2003-2005, which left the Hervey Bay Hospital sometimes in considerable difficulty. Instances of persistent absenteeism without leave might raise questions of Official Misconduct, however such allegations may ultimately depend upon the reliability and completeness of Q Health leave records as maintained within the Fraser Coast Health District. It does seem to be in Dr Naidoo's favour that a number of witnesses, though complaining of his general absence from the District for periods of time, nevertheless acknowledge that there were many other occasions where he was available when contacted.

Any question of misconduct by Dr Naidoo, at this stage, remains unresolved.

1.11 Dr Anatole KOTLOVSKI (BUNDABERG BASE HOSPITAL)

Dr "**Lucky**" Jayasakera a staff surgeon employed at Bundaberg Base Hospital in early 2002, gave evidence¹³⁰ of surgical procedures in relation to two unidentified patients. He, in effect, claimed the operations were ineptly performed by an International Medical Graduate who was a locum to the Hospital for a period of about 2 months in early 2002. The medical practitioner was identified as Dr Anatole Kotlovsky.

Dr Jayasakera said in evidence that he at first agreed to Dr Nydam's request to supervise Dr Kotlovsky on condition that he was made aware of all patients upon whom Dr Kotlovsky was to operate. After the second operation, in which Dr Jayasakera alleged Dr Kotlovsky had ignored his instruction and performed a complex procedure unsuccessfully, Dr Jayasakera advised Dr Nydam that he was no longer prepared to supervise him.¹³¹

¹²⁸ T6731

¹²⁹ T6739

¹³⁰ T5962 *et seq*

¹³¹ T5965

Dr Kotlovsky strongly refutes the accounts given by Dr Jayasekera about these two procedures.

At the time of these events, it appears that Dr Jayasakera was Acting Director of Surgery at Bundaberg during the absence on study leave of Dr Sam Baker, the permanent staff specialist and then Director of Surgery for the Hospital.

Dr Nydam gave evidence ¹³² that the case of "*Dr. Anatoli*" was "*a bit of a disaster*". Dr Nydam said that Dr Jayasakera reluctantly agreed to supervise the Russian Doctor. ¹³³ Dr Nydam's account appears to be consistent with Dr Kotlovsky's statement that Dr Jayasekera appeared to resent having to supervise him on the state basis that he was not remunerated to do so. Dr Nydam said that, after hearing Dr Jayasakera's complaints and after hearing other suggestions about the Doctor's competence from other staff he was motivated to contact an unnamed Director of Surgery at a major Brisbane Hospital to enquire about the visiting surgeon. Dr Nydam said that he was told that Dr Kotlovsky should have been supervised, and that at that stage he was not in a formal training programme for surgery. Dr Nydam thereafter arranged for Dr Brian Thiele and Dr Martin Carter to supervise Dr Kotlovsky over a weekend during which Dr Jayasakera was on leave in Brisbane. ¹³⁴ Dr Nydam said that Dr Kotlovsky left Bundaberg Hospital at the conclusion of the locum period. Further requests for employment at Bundaberg from Dr Kotlovsky were refused. Dr Nydam said it did not occur to him to report his concerns to the Medical Board. ¹³⁵

After Dr Jayasakera was able to give more detail about the Russian Doctor during his evidence to the Inquiry, the Registrant was able to be properly identified and the Medical Board's file obtained. Briefly, that file reveals the following history:

- 1981 - Physician Diploma – Russian Medical University – said to be comparable to an Australian NVBS;
- 1986 – Specialist Paediatric Surgeon – Medical University.
- 1987 – Kandidat of Medical Science – Russian Medical University – said to be equivalent to an Australian PhD in Medicine;
- 1991 – First Grade Category Specialist Paediatric Surgeon;
- 27.02.96 – Conditional Registration in Queensland not taken up due to employment in Tasmania.
- 25.11.97 – Application for Conditional Registration to undertake Post Graduate Training in General Surgery and Neurosurgery at Townsville Hospital declined on the basis that the Board could not be satisfied that there was a genuine training position available;
- 23.12.97 Application for Conditional Registration declined until Applicant had passed the OSCE examination or the AMC MCQ examination;
- 27.10.98 Application for Conditional Registration to undertake a period of post graduate training and surgery approved at Ipswich Hospital for 12 months;

¹³² T4140 *et seq*

¹³³ T4180

¹³⁴ T4181

¹³⁵ T4181

- 08.08.00 Application for Conditional Registration at PA Hospital for 6 months approved.
- 26.02.02 **Application for Renewal of Conditional Registration approved, for an area of need for a period of 2 months at Bundaberg Base Hospital (SMO position in surgery) (25.02.02 – 12.04.02)**
- 22.07.03 Application for Special Purpose Registration at RBH approved from 21.07.03 – 18.01.04. Applicant to provide advice on progress towards AMC/FRACGP.
- 25.11.03 Application for Special Purpose Registration approved for RBH and Caboolture Hospital from 19.01.04 – 16.01.05. Registrant requested to advise the Board regarding progress towards AMC Certificate, FRACGP or Australian Specialist Qualification.
- 09.11.04 Application approved for a Special Purpose Registration as PHO in surgery at RBH from 17.01.05 – 16.07.05.
- 15.06.05 Registrant assessment form signed by Dr Barry O'Loughlin, Director of Surgery RBH – performance rated as *"consistent with level of position"* or *"better than expected"*.

The Registrant is currently registered under s.135 *Medical Practitioners Registration Act* until 15 January 2006. The Board's file reveals that he has received the support of the following eminent surgeons in the State of Queensland:

- Professor Peter Woodruff;
- Dr Barry O'Loughlin;
- Dr Ian Martin; and
- Dr Daryl Wall.

It is submitted that the Board's file reveals evidence of appropriate supervision in a large tertiary Hospital by a range of eminent surgeons. It also reveals that Dr Kotlovsky is well regarded.

Dr Kotlovsky's statement attaches 12 references which strongly support the suggestion that he was well-supervised in the larger Brisbane hospitals.

The unanswered question in the history of this matter is as to whether, in early 2002, Bundaberg Base Hospital's Acting Director of Surgery, Dr Kees Nydam, received formal advice from the Hospital from which the locum came, namely Royal Brisbane Hospital, that the locum surgeon required supervision. As at the end of public sittings of this Inquiry, that question remains unanswered.

As to the proper identification of the two surgical cases which were the subject of criticism by Dr Jayasakera of Dr Kotlovsky, this has not so far been possible. The Commission has two conflicting accounts of the procedures.

It is submitted that this case may highlight a breakdown in communication between RBH and BBH as to the requirement for supervision of Dr Kotlovsky. The two surgical cases of which Dr Jayasakera complains perhaps should be the subject of further investigation, during which Dr Kotlovsky's explanations could be taken into account.

1.12 Dr Keith MUIR – (NAMBOUR HOSPITAL)

The Medical Board first received an Application for registration from this Registrant on 20 July 1992. That Application for registration included a Certificate of Good Standing from the State of New Jersey Board of Medical Examiners. Dr Muir was granted provisional registration to fill an area of need from 21 July 1992.

On 25 August 1992, the Board resolved that Dr Muir be granted registration as a specialist in psychiatry, in mutual recognition of his New Zealand specialist qualifications.

The Board's file shows that Dr Muir was employed at Cairns Base Hospital.

On 10 November 1993, the New Jersey State Board of Medical Examiners ordered that Dr Muir's licence to practice medicine in New Jersey was revoked. The allegation was that Dr Muir maintained a long term sexual relationship with two patients and failed to keep appropriate patient records for one of those patients. It is of some note that the papers later obtained from the New Jersey Board recite that the "*moving papers*" were sent to Dr Muir in Australia at his last known address. At this stage it is now known whether those "*moving papers*" were ever received by Dr Muir.

In any event, Dr Muir appears to have taken no steps to advise the Board of the order against him in New Jersey. It first came to the attention of the Board on the complaint of one Gayle O'Neill on 16 April 2005.

By April 2005, Dr Muir was working at Nambour Hospital.

On 3 May 2005 Dr Muir was required by the Executive Officer of the Board, Mr Jim O'Dempsey, to show cause as to why the same orders should not be made in relation to his Queensland registration.

This is a matter in which an International disciplinary sanction came to the attention of the Board well after the Registrant obtained Queensland registration.

It is respectfully submitted that no adverse inference could or should be drawn against the Board in this matter. The orders were not in place at the time that Dr Muir obtained his Queensland registration, and he appears to have failed to subsequently advise the Board of those subsequent sanctions.

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

SEE PART "C" OF THE BOARD'S SUBMISSIONS RE: CLINICAL PROCEDURES OF DR PATEL

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

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

(b)(iv) the adequacy of the response by Queensland Health to any complaints received by it concerning Dr Patel – THE MEDICAL BOARD DOES NOT WISH TO MAKE SUBMISSIONS

(b)(v) whether or not there were any reprisals or threatened reprisals made by any official of Queensland Health against any person who made the complaints referred to in (iii) above. – THE MEDICAL BOARD DOES NOT WISH TO MAKE SUBMISSIONS

(c) - Any substantive allegations, complaints or concerns relating to the clinical practice and procedures conducted by other medical practitioners, or persons claiming to be medical practitioners, at the Bundaberg Base Hospital or other Queensland Public Hospitals raised at the Commission of Inquiry established by Commission of Inquiry Order (No. 1) 2005.

SEE PART "C" OF THE BOARD'S SUBMISSIONS RE: CLINICAL PROCEDURES OF OTHER PRACTITIONERS

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

(i) within the Bundaberg Base Hospital

This Term of Reference is taken to be a reference to action taken with the Bundaberg Health District.

Zone Manager – Dan Bergin

The Zone Manager who is based in Brisbane, **Mr Dan Bergin**, whose responsibility covered the Bundaberg Base Hospital, said in evidence that he did not receive any information about concerns raised in relation to Dr Patel's competence, in circumstances where he would have expected to be provided with such complaints or concerns when they occurred.¹³⁶ Quite apart from the Bundaberg Hospital Management making a judgment that the point had been reached to advise Mr Bergin of concerns about the competence of Patel, there was a more formal means by which the Zone Manager received formal notification of concerns held by staff about the competency of a particular medical practitioner; the Sentinel Event Form. **Leonie Raven** gave evidence that the only Sentinel Event report she received during the relevant period was in relation to the death of Mr Bramich (P11).¹³⁷ To her knowledge, this incident was being investigated by Dr Keating. Even in relation to Adverse Incident Reports, Raven said in evidence¹³⁸ that she searched 900 such reports personally and found only a handful that involved Dr Patel.

The lack of formal reporting of concerns about Dr Patel may serve to explain why the Zone Manager, Mr Bergin, did not receive timely advice about concerns relating to Dr Patel. This

¹³⁶ T6006

¹³⁷ T2301

¹³⁸ T2301

lack of formal reporting no doubt contributed to any failure to detect concerns about Dr Patel and report them to the Medical Board.

It is submitted that, leaving aside the formal methods available to start to report serious concerns about the competency of Patel, the Commission has also received evidence pointing to a culture of dealing with any complaints internally, and not evoking the assistance of external agencies such as the Health Rights Commission or the Medical Board.

An overview of the evidence as to why there was no complaint to the Medical Board of Queensland re: the clinical practice of Patel, until February/March 2005.

Though Nurse Hoffman had formulated a detailed complaint about Patel, which she put to Darren Keating, by October 2004, the first time any such question was raised with the Board was in February 2005.

On 15 February 2005, representatives of the Queensland Nurses Union, Ms Judy Simpson and Ms Kym Barry met with Executive Officer James O'Dempsey concerning a Gold Coast practitioner about whom a written complaint had been made on behalf of some of the Union's members.

On 24 March 2005, Queensland Health formally drew the Board's attention to concerns regarding Dr Patel's surgical expertise and requested that the Board conduct an assessment of Patel's performance. The matter was referred to the Board's Complaints Committee for initial consideration.

At its meeting on 6 April 2005, the Board's Registration Advisory Committee noted that Patel's special purpose registration had lapsed on 31 March 2005 as he had failed to renew his employment contract with the Bundaberg Base Hospital. Queensland Health's area of need certificate had been withdrawn as a consequence.

After initial assessment, the formal complaints concerning Patel were referred to the Health Rights Commission on 3 separate dates, namely, 29 April 2005, 6 May 2005 and 10 May 2005.¹³⁹

Events then took a different turn with the announcement of Commission of Inquiry No. 1 of 2005 in May 2005.

The fact that the October 2004 formal complaints of Nurse Hoffman were not brought to the attention of the Board, even informally, until mid February 2005 is due, it is submitted, to measures being taken internally by Queensland Health to attempt to deal with the issues. The Board does not wish to make submissions upon those matters, but is content to leave such submissions to the relevant parties.

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

¹³⁹ O'Dempsey Statement Exhibit 28, paragraph 32

(ii) outside the Bundaberg Base Hospital.

Executive Officer MBQ, James O'Dempsey

The Executive Officer of the Medical Board, Mr O'Dempsey, said in evidence ¹⁴⁰ that he first became aware of concerns about Dr Patel on Tuesday 15 February 2005. Representatives of the Queensland Nurses Union ("QNU") attended at his office after the meeting had been originally scheduled for late January and again early February. Mr O'Dempsey said that the main subject matter of the meeting with the QNU representatives concerned another Registrant. As to Dr Patel, Mr O'Dempsey said:

"...later during this meeting the two representatives of the QNU indicated that there members were concerned about Dr Patel and were being interviewed that morning by Dr Gerry Fitzgerald. I enquired as to why these concerns have not been put into writing by way of complaint to the Board. I cannot recall the response. However the next day after this meeting I spoke to Board member and Chief Health Officer for Queensland, Dr Gerry Fitzgerald, and he told me that he had been in Bundaberg to conduct a clinical review into surgical services. He stated he was awaiting clinical benchmark data prior to finalising his report. He also stated that there may be recommendations or information concerning Dr Patel referred to the Board as a result of his review. I was aware that Dr Patel had submitted an application for registration renewal and a decision on that application was required by the end of May 2005. I mentioned to Dr Fitzgerald and the Registration Advisory Committee ("RAC") would appreciate receiving any information about Dr Patel prior to the end of May in order that the Committee could consider whether it was necessary to recommend that the Board impose conditions upon Dr Patel's registration. This was because conditions upon registration would be more readily imposed under the MPRA than under the HPPS Act..."

The Medical Board ultimately received a number of written complaints, being cc's of correspondence from Rob Messenger MP to the Minister for Health after Mr Messenger raised matters about Dr Patel in Parliament. Those complaints were referred to the Health Rights Commission on 29 April 2005, 6 May 2005 and 10 May 2005.

Under cross examination by Mr Allen for the QNU, ¹⁴¹ Mr O'Dempsey explained that there was a power under the *Health Practitioners (Professional Standards) Act*, s.51-53 to proceed with an investigation after a complaint has been received. Pursuant to s.63 of that Act, the Board can initiate an investigation of its own motion, but:

"it is difficult to refer a matter to the Board under 63 without having some substance there."

¹⁴⁰ O'Dempsey Statement paragraphs 30-32

¹⁴¹ T642,643

It was in this context that Mr O'Dempsey said in evidence that, as at the conclusion of the meeting with the QNU representatives on 15 February 2005, he was left with the understanding that a written complaint about Dr Patel might be received from the QNU itself, or it might be received from Dr Fitzgerald after he had completed his investigations, which Mr O'Dempsey understood were then and there underway in Bundaberg.

After the meeting with the QNU on 15 February 2005, Mr O'Dempsey said in evidence ¹⁴² that he spoke to Dr Fitzgerald at a Registration Advisory Committee meeting the following day to ascertain what investigations he was doing and what was the likelihood of a referral to the Board. Dr Fitzgerald indicated that he was doing a clinical audit but he stressed that it was not an investigation of Dr Patel:

"I asked him (Fitzgerald) to ensure that we got the information as soon as he had completed his report in order that the Board could make a decision on what action it needed to take...he (Fitzgerald) indicated to me that he would be completing the audit when he had the clinical benchmark data and he indicated that that was going to take 3-4 weeks".

In the interim, Mr O'Dempsey said that Dr Patel's Medical Board file was marked so that he could not get reviewed by the Registration Advisory Committee until the Board had the benefit of Dr Fitzgerald's report. At that stage, Dr Patel was registered up to the end of March 2005, and under the relevant legislation, the Board had a further 60 days to make a decision about whether it would re-register Patel.

Evidence of Dr Gerry Fitzgerald

In his statement dated 2 June 2005¹⁴³ Dr Fitzgerald confirmed that he discussed Dr Patel with Mr O'Dempsey and Mr Demy-Geroe of the Board on 16 February 2005, following his return from meeting staff at the Bundaberg Hospital:

"it was agreed that the RAC would defer consideration of Dr Patel's current application for renewal until I had the opportunity of finalising my investigation and report into clinical services at the Bundaberg Hospital".

On the question whether the Board should have acted immediately to suspend Dr Patel's registration, Dr Fitzgerald said: ¹⁴⁴

"there were a number of factors that mitigated against the Board being able to take immediate action to suspend Dr Patel's registration. Those were:

- *both Dr Patel and Dr Keating had given undertakings to me during my trip to Bundaberg on 14 February 2005 that he would cease doing complicated procedures at the Bundaberg Hospital and the*

¹⁴² T652

¹⁴³ Exhibit 225

¹⁴⁴ Exhibit 225, paragraph 69

- patients requiring such procedures or who were seriously ill would be appropriately referred;
- at that time I had insufficient evidence to link Dr Patel's performance to particular adverse outcomes, the only information we had were complaints that Dr Patel was carrying out procedures outside his capacity and that of the hospitals."

Dr Fitzgerald formally referred his concerns about Dr Patel to the Medical Board in a letter dated 24 March 2005.¹⁴⁵ Dr Fitzgerald said that his expectation was that the Board in its investigation would have looked at Dr Patel's clinical expertise but also obtained information on his behaviour to staff in terms of assessing whether he was guilty of any professional misconduct.

On 9 April 2005 the Minister for Health, Mr Nuttall, announced that a comprehensive review would be undertaken of safety and quality at the Bundaberg Hospital. Two days earlier, on Thursday 7 April 2005, the Director General of Health Dr Steve Buckland visited Bundaberg Base Hospital with the Minister to speak with staff. At the conclusion of that visit, Dr Buckland was told by Dr Keating that he had undertaken a Google search and had found that Patel had restricted registration in Oregon and had been withdrawn from the register in the State of New York.¹⁴⁶ Dr Buckland said he returned to Brisbane on the Ministerial Plane without mentioning it to the Minister and that night at home, he conducted his own Google search to confirm that Dr Keating had told him. Dr Buckland passed this information onto Dr Fitzgerald, who in turn passed it onto Mr O'Dempsey. Accordingly, on 8 April 2005, O'Dempsey directed Demy-Geroe to prepare a report on all of the aspects relating to the registration of Dr Patel.¹⁴⁷ That report was put before the Board on Tuesday 12 April 2005 and forwarded to the Minister's office on Wednesday 13 April 2005. It was tabled in Parliament on Tuesday 19 April 2005 by the Minister for Health. It is respectfully submitted that from the above chronology it can be demonstrated that, once the staff of the Medical Board of Queensland became aware of concerns relating to the registration and clinical practice of Dr Patel, its ensuing action was timely and appropriate.

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

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

The Board is aware that Patel and Berg are currently the subject of police investigations, and it has assisted Police in those investigations.

The Board has no further submissions.

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

¹⁴⁵ Exhibit "GF-13" to Exhibit 225

¹⁴⁶ T5507

¹⁴⁷ Exhibit MDG-3 to the Statement of Demy-Geroe, Exhibit 24

The Board does not wish to make submissions about the actions of persons employed in units of public administration, and as to whether there is sufficient evidence to constitute official misconduct.

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

- (a) Evidence of "Unsatisfactory Professional Conduct" pursuant to the Health Practitioners (Professional Standards) Act 1999 – Medical Practitioners.

Refer to "Part C" of the Board's submissions.

- (b) Evidence of "Unsatisfactory Professional Conduct" – persons employed in units of public administration who are medical practitioners.

Any referral to the CMC might result in a referral of such evidence, if it exists, to the Board in cases where "official misconduct" is not established, but where "*unsatisfactory Professional Conduct*" is detected.

(iv) amendments to the Coroners Act 2003 in relation to appropriate reporting of deaths caused by or as a result of a health procedure. – THE MEDICAL BOARD DOES NOT WISH TO MAKE SUBMISSIONS

(v) For the purpose of clarification and the removal of doubt, the phrase "substantive allegations, complaints or concerns relating to acts or omissions by current and former employees of the Queensland Department of Health which relate to clinical practices or procedures conducted by medical practitioners or persons claiming to be medical practitioners including acts or omissions relating to waiting lists both for patients referred to specialist outpatient's appointments and for surgical procedures. THE MEDICAL BOARD DOES NOT WISH TO MAKE SUBMISSIONS

Ralph P Devlin
Kathryn McMillan
Counsel for the Medical Board of Queensland

Attachment "A"

CHRONOLOGY: Medical Board Registration of Patel

<i>Date</i>	<i>Registration Event</i>	<i>Evidence</i>
17/01/03	Letter Wavelength Consulting, to Medical Board of Queensland ("MBQ") enclosing Dr Patel's ("Patel") original Application for Registration as a medical practitioner in Queensland (general and special purpose registration) and relevant documents. Documents submitted by Wavelength include:	Exhibit 24 – MDG 12: Statement of Mr Michael Demy-Geroe dated 17 May 2005; T424
08/01/03	1. Letter from Bundaberg Base Hospital (BBH), Dr Kees Nydam, A/Director of Medical Services to (MBQ). Requested that Patel be approved as a "temporary resident doctor", SMO.	Exh 24 – MDG 13 T425
06/01/03	2. Completed Application Form (M1) signed by Dr Patel (submitted by Wavelength). <ul style="list-style-type: none"> Last employment Kaiser Permanente in Portland, Oregon October 1989 to September 2002; MBQ relies on Certificate of Good standing (COGS) or equivalent and history given by applicant; not practice to seek references from referees; practice not to contact previous employers. Patel answered "No" to Question 3¹ and Question 4² 'Fitness to Practice': false answers by Patel. Patel signed declaration that statements are true and correct. 	Exh 24 – MDG 14 T425,683 T425 T426, 678,704-705 T426
Undated	3. Form 1 "Area of Need Position Description" Bundaberg Base Hospital for position "Senior Medical Officer" (SMO) completed by the A/Director of Medical Services, Dr Kees Nydam	Exh 24 – MDG 16 T429,430
06/01/03	4. Form 2 "Summary of Experience Suitable to the Area of Need" completed by Patel.	Exh 24 – MDG 17 T433, 434, 699
undated	5. QH "Position Description" of "Senior Medical	Exh 24 – MDG 18

¹ "...have you been registered under a corresponding law applying, or that applied, in another State, or Territory, or a foreign country, and the registration was affected either by an undertaking, the imposition of a condition, suspension or cancellation, or in any other way?"

² "Has your registration as a health practitioner ever been cancelled or suspended or is your registration currently cancelled or suspended as a result of disciplinary action in any State or Territory or in any other country?"

various	Officer – Surgery”; reporting directly to Director of Surgery	T429-431, 433-436
	<p>6. Patel’s Curriculum Vitae. Last position held noted as staff surgeon, Portland Oregon, from “October 1989 to September 2002”.</p> <p>Supporting documentation included:</p> <ul style="list-style-type: none"> • Bachelor of Medicine and Bachelor of Surgery, Saurashtra University, 11 March 1973; • Masters of Surgery, Saurashtra University, 20 March 1976; • Surgery Intern Certificate 01/07/78 – 30/06/79 and resident in Surgery 01/07/79 – 31/12/81; • Certificate of Residency in General Surgery, State University of New York, Buffalo 01/07/82 – 30/06/83; Chief Resident in Surgery 01/07/83 – 30/06/1084; • State of Oregon Board of Examiners Licence dated 14/04/89; • Certificate of Registration for Medical Physician and/or Surgeon dated 14/04/89 – 31/12/03; • Controlled Substance Registration certificate dated 22/04/02; • American Board of Surgery Certificate dated 18/10/96. 	<p>Exh 24 – MDG 19 T434,435 T679,688,699,693</p> <p>Exh 24 – MDG 15 T427, 418, 428,429</p> <p>T427,418</p> <p>T427</p> <p>T427</p> <p>T427</p> <p>T427</p> <p>T427</p> <p>T427,693,694</p>
17/01/2002	7. Application for Area of Need Certification, completed and signed by Kees Nydam A/Dir Med Services.	Exh 24 – MDG 16 T429
21/01/03	Fax Wavelength to MBQ enclosing faxed copy Patel’s “Verification of Licensure”, or equivalent COGS.	Exh 24 – MDG 22 T436,437 T683
29/01/03	<p>Letter Wavelength to MBQ enclosing original “Verification of Licensure” from Board of Examiners, State of Oregon, stating “Standing: PUBLIC ORDER ON FILE : SEE ATTACHED”. Checked by Ms McMullin (did not notice these words and inquire further).</p> <p>Recruiting firm, Wavelength also did not notice the missing attachment.</p>	<p>Exh 24 – MDG 23 T436-438 T683, 697,698</p> <p>T438,</p>
03/02/03	Registration Checklist completed by Ms McMullen, Registration Officer. Indicates Ms McMullen’s belief that all requirements were complete; “Certificate of Good Standing” ticked “Yes”, signifying it was present and valid.	Exh 24 – MDG 24 T438

Jan/Feb 2003	<p>Mr Demy-Geroe, Deputy Registrar, states during January/February 2003 only 1.4 staff to process as many as 200 special purpose applications during peak periods of activity in Registration unit.</p> <p>[Staff numbers increased to 4 in special purpose registration unit]</p>	<p>T415,421,422</p> <p>T416</p>
03/02/03	<p>Registration Advisory Committee (RAC) Meeting - Mr Demy-Geroe, reviewed the registration application of Patel; considered suitability of Patel to position description (SMO). Raised issue that Patel not be represented as a specialist.</p> <p>RAC recommended that the Patel's special purpose registration be approved (refer RAC report dated 3 Feb 2002/3).</p>	<p>Exh 24 – para 34 T438, 439</p> <p>Exh 24 – MDG 25 T439</p>
Feb 2003	<p>Workload of RAC meeting fortnightly, during this peak period was 150-200 applications.</p> <p>[RAC workload now reduced since delegation of renewal applications for Area of Need]</p>	<p>T416</p> <p>T502</p>
11/02/03	<p>MBQ meeting - Patel's application for special purpose registration (s135) was approved for period 12 months from 1 April 2003 to 31 March 2004, as SMO at BBH, per RAC recommendation. Approval subject to Patel completing requirements of registration (interview).</p>	<p>Exh 24 – MDG 26 T440</p>
31/03/03	<p>Dr Waller interviewed Patel;</p> <p>MBQ letter listing all documents presented by Patel including a COGS (Dr Waller not required to check COGS or equivalent).</p> <p>Dr Waller signed certification stating Patel complied with the provisions of the <i>Medical Practitioners Registration Act 2001</i> and that he "possesses such qualifications as would, upon proof thereof satisfaction of the Board, entitle him to be registered".</p>	<p>Exh 24 – MBQ 29 T441</p>
01/04/03	<p>Letter MBQ to Patel granting special purpose registration - section 135, for the period 1 April 2003 – 31 March 2004, to practise as SMO in surgery at BBH;</p> <p>Patel provided a Certificate of special purpose registration.</p>	<p>Exh 24 – MDG 30 T441</p> <p>Exh 24 – MDG 31 T443</p>
03/12/03	<p>Letter MBQ to Patel advising his special purpose registration expires 31 March 2004; and "documentation submitted in respect of an initial application need not be resubmitted" ie. COGS</p>	<p>Exh 24 – MDG 32 T443, 444</p>
11/12/03	<p>Letter BBH (Dr Keating) to MBQ enclosing:</p>	<p>Exh 24 – MDG 33</p>

01/12/05	<ul style="list-style-type: none"> Form M1: Application for Special Purpose Registration for further 12 months until 31 March 2005; Patel answered "No" to Q.3,4 Fitness to Practice (refer footnotes 1 & 2); Form 1 (Area of Need Position Description:, completed by employer/signed by Dr Keating); "Director of Surgery:... his performance rates as excellent" Form 2; (Summary of Experience: completed by Patel); Assessment Form and payment: Dr Keating assesses Patel's performance as "Performance better than expected" in 9/11 categories, including clinical skills. 	<p>T444, 445</p> <p>T447</p> <p>T447</p> <p>T445</p>
15/12/03	<p>Registration Checklist completed by registration Officer, indicating complied with all requirements.</p> <p>RAC meeting recommended that Board approve Patel's application for special purpose registration for further 12 months.</p>	<p>Exh 24 – MDG 34 T447</p> <p>T448</p>
27/01/04	MBQ resolved to approve Patel's special purpose registration under s135 for 12 month period from 1 April 2004 – 31 March 2005.	Exh 24 – MDG 35 T448
09/03/04	<p>Letter MBQ to Patel granting special purpose registration for a further 12 months until 31 March 2005.</p> <p>Letter notified cancellation of registration where "materially false or misleading representation or declaration"; advised to notify MBQ if any registration is affected by "disciplinary action".</p>	<p>Exh 24 – MDG 37 T449</p> <p>T449</p>
Mid 2004	Nurse Michelle HUNTER, conducted "google search" after "a number of disasters involving Dr Patel" and noted that one of the number of Jayant Patels, "had negligence cases against his name". She informed the "nursing staff" but was "not sure" if she told the Nurse Unit Manager, commenting that "she would have heard". Did discuss the google search with Toni HOFFMAN on 4 January 2005 regarding P26.	T2041 - T2045
31/01/2005	Letter Queensland Health (Keating) to MBQ advising BBH has extended Patel's contract to 31 March 2009	T450
07/02/2005	Patel: Application for Renewal of Special Purpose Registration, including relevant Forms (M1, 1,2 and assessment)	Exh 24 – MDG 38 T451
14/02/2005	RAC meeting considered the renewal application per Checklist. Decision deferred due to matters raised on 15 April 2005.	Exh 24 – MDG 39 T452

15/02/2005	Meeting Mr O'DEMPSEY and Queensland Nurses Union representatives. Informal concerns verbally raised regarding a Dr Patel. Mr Demy-Geroe deferred Patel's renewal application until substantive evidence from FitzGerald or QNU.	T453 T454 -
16/02/05	Dr FITZGERALD discussed with Mr O'DEMPSEY and Mr Demy-Geroe that concerns had been raised re Dr Patel, with some substance ; advised MBQ not to proceed with renewal application. Dr Fitzgerald received undertaking from Patel and Dr Keating that the complex surgery would not be undertaken.	T453, 472 T6145, 4146
22/03/05	Rob Messenger MP raised allegations against Patel in Parliament per Toni Hoffman letter dated 22 October 2004.	T454
23/03/05	Letter Rob Messenger MP to MBQ re formal complaint of Dr Patel.	T473
30/03/05	Faxed letter Dr FitzGerald to MBQ formally requesting an assessment of Dr Patel, referring to results of his clinical audit.	T454, 6146
31/03/05	Telephone MBQ to Leck who confirmed Patel did not accept further employment contract with Bundaberg Base Hospital from 1 April 2005.	T455
01/04/05	Faxed letter BBH (Leck) to MBQ confirming calls (x2) that Patel's contract had ceased and his employment had ceased and that Patel intends to leave Australia on 4 April 2005.	Exh 24 – MDG 41 T456 475
05/04/05	Email QH to Board advising Area of Need for that position at BBH had been cancelled.	Exh 24 – MDG 42 T456
06/04/05	Internet search (of "Jayant M Patel") by Dr Darren Keating re Patel's disciplinary history in US (Oregon and New York Medical Board websites), discovered restrictions on Patel's licence due to "gross negligence" relating to 3 operations: peritoneal anastomoses, liver resection and pancreatic operations;	T 6812
07/04/05	Dr Keating informed Dr Fitzgerald re Patel's disciplinary history.	T6813
07/04/05	Dr Fitzgerald stated he advised Mr O'Dempsey of suggestion that Dr Patel might have been restricted in medical practice overseas and requested that this be investigated.	T4210
08/04/05	Mr Demy-Geroe conducted internet search and investigation regarding Patel's disciplinary history in Oregon, and to prepare a detailed report.	T456

13/04/05	MBQ report tabled in Parliament re circumstances of registration of Patel.	T456
13/04/05	Mr O'DEMPSEY met with The Honourable G NUTTALL MP, Minister for Health briefing him on the Patel's restricted registration in Oregon.	T5374
18/04/05	Report to Health Minister on remedial actions re special purpose registrants dated 19 April 2005.	Exh 25 JOD-14 T502

- Refer to MBQ statements:

1. Mr Michael Demy-Geroe dated 17 May 2005 ;
2. Mr James O'Dempsey dated 17 May 2005;
3. Dr Mary Cohn dated 17 May 2005.

ATTACHMENT "B"

"Issues of concern"

Although I have found that that Dr Maree should not face criminal charges in connection with the death of Ms Sabadina that does not mean I consider he was competent to safely carry out the duties of the position he held. Some of the numerous failings that I have listed above could easily have resulted in the death of a patient. Therefore, unless the systematic deficiencies that allowed for the appointment of a doctor ill-equipped to hold such a responsible position are addressed, deaths in future are foreseeable.

I therefore consider it within the scope of the inquest to examine how Dr Maree came to be appointed Medical Superintendent of the Charters Towers Hospital and what action the relevant authorities took when his deficiencies became apparent.

The recruitment of Dr Maree

The position of Medical Superintendent of the Charters Towers Hospital had been vacant since September 1999. Attempts to recruit an Australian trained and/or registered doctor to the position, which commenced in June 1999, were unsuccessful: indeed no applications were received. So, in May 2000, an international recruitment firm, which had previously acted for Queensland Health, was engaged. This firm nominated Dr Maree as a possible candidate and his contact details and curriculum vitae were supplied. The Queensland Health Area District Manager, Mr Peter Sladden then convened a selection panel consisting of himself, the Acting Medical Superintendent, Dr David Row, and the District Human Resource Manager, Mr Trevor Healy. The panel agreed that Dr Maree might be suitable for the position and he was interviewed by telephone. During the interview Dr Maree was asked (what the court was told were) some fairly simple clinical questions and to expand upon the description of his previous experience. The nature of the position was explained to him. He supplied two written references and Dr Row was commissioned to speak with the referees and report back to the panel.

Mr Sladden and Mr Healey say that after the telephone interview, the panel discussed Dr Maree and they unanimously concluded that he was suitable for the position, subject to referee checks. Dr Row claims he had reservations about the extent and recency of some of Dr Maree's experience, that he was suspicious of his enthusiasm for management and, what Dr Row considered to be, Dr Maree's over confidence in his clinical abilities. Dr Row checked with one referee who was effusive in his praise for Dr Maree. This, he said made him suspicious of the referee's veracity and caused him to consider that contacting the other referee would be pointless. Dr Row says he continued to have misgivings about recruiting Dr Maree which he expressed to Mr Sladden but he says that he was overridden and his concerns were ignored. When giving evidence at the inquest, Dr Row says Mr Sladden told him that Dr Maree would be appointed despite Dr

Row's concerns because Dr Maree was cheap. Dr Row sought to explain this alleged comment by referring to another plan he was at the time apparently considering. This plan involved offering a permanent appointment to a senior medical officer who had recently been recruited on a temporary, short term contract and allowing Dr Row to continue to act as medical superintendent while the search for a permanent appointment continued. Dr Row believed this would involve paying a lump sum to the recruitment agency that had provided this other doctor and that it was this payment which Mr Sladden was seeking to avoid by insisting on Dr Maree being appointed. Mr Sladden and Mr Healy deny any such conversation took place and deny that the plan conceived by Dr Row would have been more expensive than recruiting Dr Maree. I accept their evidence and I reject Dr Row's claim that he was unduly pressured into agreeing with the appointment of Dr Maree. I think a more accurate account of Dr Row's expressed views at the time of Dr Maree's appointment can be found in his interview with Drs Johnson and Farlow in which he is paraphrased as saying, "Dr Row acknowledges he provided advice to the District Manager at that point that Dr Maree did appear suitable for appointment. He expressed that he had some reservations at that stage, but that the appointment should proceed."

Having rejected the allegation that the appointment of Dr Maree was compromised by inappropriate considerations does not mean that I consider that it was made in accordance with the policies that applied at the time. Those policies required the selection panel to weight selection criteria and to then score candidates against them. They required documentation that clearly explained the decision making process in a form that allowed it to be reviewed.¹ None of that happened in this case. The panel asked Dr Maree a few general questions about his knowledge and experience and recorded their deliberations in a page and a half of untidy notes. There was no signed recommendation and no written justification or explanation of the appointment. These shortcomings made it difficult for the inquest to assess whether a merit based selection process had in fact been employed.

The best the court could do in these circumstances was to rely on the opinion of Dr Johnson, a medical executive from Townsville General Hospital, who gave evidence about his investigation of the various allegations made against Dr Maree. Dr Johnson said that based on the curriculum vitae and the references he would have been prepared to employ Dr Maree as a medical superintendent and that subject to the process confirming the experience outlined in the application he would have had no concerns. Dr Farlow also said that had it not been for his experience on the credentialing committee, which has led him to be less accepting of claims made by some overseas applicants, he, too, would have considered Dr Maree a suitable candidate. "I think their process of interview and referee checks was actually beyond reproach,"² he said. Therefore, although it is easy to validly criticise the process by which Dr Maree was chosen, the evidence

¹ see exhibit 48

² transcript day 5 p49

suggests that the decision itself was not unreasonable. That assessment seems inconsistent with the evidence demonstrating that Dr Maree's clinical abilities were seriously inadequate. The resolution of this apparent conflict, in my view, lies in what happened, or did not happen, when Dr Maree came to Australia in August 2000.

The induction/orientation of Dr Maree

After Dr Maree arrived in Queensland, there were three processes that could have identified his shortcomings and provided an opportunity for them to be addressed – all failed.

Because he had secured a position with Queensland Health the Medical Board granted Dr Maree conditional registration. All that it required of him was proof that he had such qualifications as would entitle him to registration and to be satisfied that he complied with the provisions of the Medical Act 1939. The Board satisfied itself of these matters by having Dr Maree interviewed by a senior doctor from the Townville Hospital who then wrote to the Board certifying that Dr Maree met these conditions for registration. It seems this process did not involve any assessment of Dr Maree's suitability for the position he was about to fill nor any review of his level of competence.

The next opportunity for protective or remedial action came when Dr Maree attended at the Townville Hospital for a week in early September. In his statement, Mr Sladden says of that event, "During the first week he attended orientation sessions at the Townsville Hospital..."³ However, Dr Callanan says that during this period Dr Maree really just met a few people who he could be expected to have contact with after he took up the position at Charters Towers. He did not even attend the anaesthetics department. Had he done so it would have been a simple matter to ensure that he was familiar with the machines that he would be working with in Charters Towers. If it became apparent that he was so unfamiliar with the equipment that he was unsafe, other more interventionist action could have been taken. None was. It was an opportunity lost.

The next procedure that should have acted to alert his superiors to Dr Maree's limitations was the privileging and credentialing system. The purpose of the credentials and clinical privileges process is said to be to ensure "that only those practitioners who are appropriately qualified, trained and experienced undertake clinical care"⁴ in Queensland Health facilities. The process involves peer review by a committee of clinicians which assesses the doctor's credentials and makes decisions about what procedures he/she will be privileged to undertake.

When he took up the position at Charters Towers, Dr Maree was told that he would need to make application to have his credentials recognised and his privileges delineated but it never happened. In the meantime he operated on

³ exhibit 18 para 8

⁴ exhibit 39 p5

what have been referred to as "implied privileges" that accrued on account of his position. That may have been acceptable had Dr Maree been a junior doctor working under the close supervision of a more experienced practitioner. It was obviously problematic when he was the "boss" of the hospital and expected to give clinical leadership to the other two doctors employed there.

After being reminded of the need to do so, Dr Maree made application to the Privileges Committee on 8 December. He was suspended two days after Ms Sabadina's death and did not return to work before he resigned in April 2001. The process was therefore never completed.

It is apparent from this brief description of the application of these policies and practises to Dr Maree's case that they were totally inadequate to ensure the competence of someone who was placed unsupervised in a highly responsible position. It is ironic that the most telling condemnation of those processes came from Dr Maree himself when he wrote to the Queensland Health Northern Zone Manager in response to an invitation to show cause why disciplinary actions shouldn't be taken against him. He said:-

The selection panel acted incompetently and Dr Row's behaviour is again shown to be questionable. I did not qualify for the position and should not have been granted clinical privileges. The orientation process I went through was very superficial and inadequate. Lastly it is the responsibility of Queensland Health to ensure appropriate candidates are placed in positions.⁵

Having reviewed all of the evidence it is difficult to disagree with his assessment. The response to Dr Maree's apparent shortcomings and the death of Ms Sabadina

Dr Row returned from leave to Charters Towers on the day of Ms Sabadina's death. He had already composed a letter to Mr Sladden detailing numerous concerns he had about Dr Maree's practice. That letter is dated 17 December 2000. It makes reference to Ms Sabadina's death in a handwritten post script. The day after Ms Sabadina's death, Dr Row also wrote the Medical Board advising them of the death and requesting the Board review Dr Maree's registration. On 19 December 2000, the Board communicated with Queensland Health and was advised that Dr Row's numerous allegations were under investigation and that Dr Maree was to be suspended from practice.

As has been mentioned earlier, over the next two months, Drs Johnson and Farlow undertook a comprehensive investigation. Their report recommended disciplinary action be taken by Queensland Health and that the report be referred to the Medical Board.

On 23 February 2001 the Board was given a copy of the report. On 22 March the Board wrote to Dr Maree calling on him to show cause why his registration

⁵ Dr Maree's response Mr Mehan to Johnson and Barlow report at p53

should not be suspended or his right to practice made subject to conditions. On 24 March he provided the Board with a copy of his response to the Johnson Barlow investigation report. On 27 March Dr Maree wrote to the Board advising of his intention to resign from Queensland Health and his intention not to practice medicine again in Australia.

On 6 April Dr Maree tendered his resignation effective from 17 April. This was conveyed to the Medical Board. On 27 November 2001 the Medical Board resolved to discontinue its investigation of Dr Maree's suitability for registration as he had resigned his position with Queensland Health which employment was a condition of his registration. The Board therefore made no finding in relation to the allegations against Dr Maree. The Board says it wrote to its equivalents in the other Australian states and New Zealand advising that Dr Maree was no longer registered to practice in Queensland. Dr Cohn, the current chair of the Board, told the inquest that the decision not to advise the home country of the doctor involved of the concerns about him was consistent with the Board's practice at the time but that now such advice would be given to any country in which it was thought the doctor in question might seek to practice.

When questioned at the inquest as to why the Board did not make a finding in relation to the allegations against Dr Maree, Dr Cohn, said that the decision was based on Dr Maree having left the country and was influenced by the fact that it had a large number of investigations to deal with at the time. She also said that the Board was waiting for other inquiries such as this inquest to be completed before taking action, to avoid parallel inquiries occurring.

In a submission by the solicitors for the Board, it was argued that no good purpose would have been served by the Board taking further action in this case as the most the Board could have done was to de-register Dr Maree and that had already happened as a result of his resignation. Further, they suggest that no disciplinary prosecution in the Health Practitioners Tribunal would have been likely to succeed in the absence of evidence of criminal negligence and as I have found such evidence is not available in connection with the death of Ms Sabandina, a disciplinary charge based on allegations of poor practice standards would not have succeeded. I shall respond to these submissions shortly.

Recommendations

Pursuant to s43(5) of the Act I am authorised to make riders or recommendations designed to reduce the occurrence of similar deaths to the one investigated by this inquest. In accordance with that power I make the following observation and recommendations.

The assessment of overseas trained doctors and the special needs of rural medicine.

This inquest focused solely on the cause and circumstances of the sad death of Kathryn Sabadina. However, it was apparent from the material admitted into evidence that in the three and a half months Dr Maree practiced in Charters Towers this fatal event was far from his only problem of a clinical nature. While I have no jurisdiction to look into those other allegations, I received sufficient information about them from reliable sources that had properly investigated those matters to enable me to conclude that the processes by which Dr Maree was selected, registered to practice and assessed as suitable for the position of Medical Superintendent were flawed.

I heard compelling evidence concerning the challenges facing a senior rural practitioner and the difficulties Queensland Health faces when trying to recruit doctors sufficiently competent to attend to these very wide ranging and demanding roles: experience in anaesthetics, obstetrics and general surgery is not something one would normally expect of a general practitioner. I was told that the relevant colleges are considering the creation of a discrete specialty of rural medicine. It is hoped that if this reform proceeds, general practitioners who currently need to leave the bush to train in a specialty at a metropolitan teaching hospital never to return, might be convinced that there is a satisfying career path for them in regional hospitals. It was also suggested that clinical networks of the various specialties could assist in raising the standards of those who need to practice across the specialties and could effectively contribute to an increase in the standard of care in regional hospitals. At least one well qualified witness suggested that until these reforms are in place, greater restrictions should be placed on the type of procedures undertaken in regional hospitals when emergencies are not involved.

I also received evidence that many of those systems and processes for assessing and credentialing practitioners have been reformed and that under current arrangements, the deficiencies in Dr Maree's abilities would be identified and responded to were he to be recruited to a similar position today.

I have considered whether I should make recommendations concerning these issues, to re-enforce the improvements that have been undertaken and to give greater impetus to those still gestating. I have concluded that having regard to the attention being given to these issues by the Commission of Inquiry into the Bundaberg Base Hospital and the review of Queensland Health systems being undertaken by Mr Peter Forster it would be inappropriate for me to seek to address such wide ranging issues on the basis of this one case that occurred five years ago. The issues are so important and complex that it is appropriate that the widest possible evidence base be considered when seeking to address them".

SUBMISSIONS BY THE MEDICAL BOARD OF QUEENSLAND

Part C- AS TO THE SURGICAL PROCEDURES PERFORMED AT BUNDABERG BASE HOSPITAL and HERVEY BAY HOSPITAL REFERRED TO IN THE TERMS OF REFERENCE, AND AS TO THE PROCEDURES PERFORMED AT HERVEY BAY HOSPITAL

(b)(i) Any substantive allegations, complaints or concerns relating to the clinical practice and procedures conducted by Dr Patel or other medical practitioners at Bundaberg Base Hospital (BBH) or other Queensland public hospital

The Medical Board of Queensland has as one of its principal responsibilities the maintenance of standards of clinical practice in the medical profession. Where a medical practitioner has a case to answer on allegations of "unsatisfactory professional conduct", the Board has the legislative responsibility for instituting such proceedings in the Health Practitioners Tribunal or a Professional Conduct Review Panel.¹

Unsatisfactory professional conduct is defined in the Schedule to the *Health Practitioners (Professional Standards) Act 1999* (Qld) to include:

- "(a) professional conduct that is of a lesser standard than that which might reasonably be expected of the registrant by the public or the registrant's professional peers;*
- (b) professional conduct that demonstrates incompetence, or a lack of adequate knowledge, skill, judgment or care, in the practise of the registrant's profession;*
- (c) infamous conduct in a professional respect;*
- (d) misconduct in a professional respect;*
- (e) conduct discreditable to the registrant's profession;*
- (f) providing a person with health services of a kind that are excessive, unnecessary or not reasonably required for the person's wellbeing;*
- (g) influencing, or attempting to influence, the conduct of another registrant in a way that may compromise patient care;*

¹ See s126 *Health Practitioners (Professional Standards) Act 1999* (Qld)

- (h) *fraudulent or dishonest behaviour in the practise of the registrant's profession;*
- (i) *other improper or unethical conduct."*

Under the Terms of Reference of this Inquiry,² the Commissioner is required to recommend disciplinary action in relation to medical practitioners, where appropriate, arising out of complaints received about clinical practice. The purpose of this part of the submissions is to collate the evidence relating to a large number of surgical procedures performed by Dr Jayant Patel and other practitioners at Bundaberg Hospital and elsewhere, which may constitute grounds for such action.

As a matter of practicality, there will be a range of serious surgical cases in which there is evidence of serious shortcomings in Dr Patel's professional practice. There will inevitably be other surgical cases showing less serious shortcomings which may give rise to possible disciplinary action. These submissions intend to attempt to differentiate between these classes of cases in terms of the recommendations the Commission might make. The Board's resources are necessarily limited and should be directed as efficiently as possible to achieving its legislative obligations. Accordingly, once successful disciplinary action is taken against a person in the position of Dr Patel, as a matter of practicality, other cases calling for possible disciplinary action or further investigation might ultimately not proceed down that path.

1. Surgical Procedures already under investigation by the Medical Board of Queensland and the subject of evidence at the Inquiry:

On 12 July 2005, the Board resolved to investigate four cases which had already been the subject of a considerable amount of evidence at the hearings of Inquiry No 1 of 2005.

1.1 Desmond Bramich (P11)

² Terms of Reference as amended 23rd September 2005-2(e)(iii)

Mr Bramich was a fifty-six year old man injured as a result of a caravan dislodging from its blocks and crushing him trapping him for ten minutes. His death was the pivotal point at which Sr Hoffman complained about Dr Patel.

Mr Bramich was admitted initially to the BBH emergency department on 25 July 2004 under Dr Gaffield's care at which time, and under his supervision, a drain was inserted into Mr Bramich's chest. A right flail chest with multiple rib fractures was diagnosed, but despite an x-ray a fractured sternum was not diagnosed at that time.

It is common ground that Mr Bramich progressed well after his initial treatment and on 26 July was transferred from intensive care to the surgery ward.

On 27 July he underwent physiotherapy late that morning which involved walking for approximately 15 metres. At approximately 1.00 p.m. that day he collapsed and was observed to be in a great deal of pain. Dr Boyd, then Dr Gaffield were called to assist him and he was immediately transferred to the intensive care unit ("ICU"). After that time and for approximately another 12 hours aggressive attempts to stabilise the patient (including resuscitation) were undertaken by number of clinicians. Dr Gaffield noted:

*"unfortunately over the following 6 hours the patient continued his progressive unstable status and ultimately expired approximately 12 hours after the event on the ward."*³

Sr Hoffman gave evidence of very significant concerns relating to Dr Patel's conduct in relation to this patient in her statement⁴ and in her oral evidence⁵. The concerns emerged from her chronology as follows:

1. that Mr Bramich was the patient of another doctor namely, Dr Gaffield and Dr Patel assumed his care⁶;

³ DWK 42 – Statement Dr Keating DWK-42, Exhibit 448

⁴ See [86] and following, TH 18-20

⁵ Also see T137-140 and T140-148

⁶ See T139.

2. that after a transfer had been arranged to Princess Alexandra Hospital in Brisbane Dr Patel interfered by ceasing the retrieval order⁷;
3. that Dr Patel expressed the view that this was a matter that could be dealt with in Bundaberg as it was a "*simple thing as fractured ribs*"⁸;
4. the patient was dyspnoeic, diaphoretic, blood pressure was fluctuating, in extreme pain, and in and out of consciousness;
5. Dr Younis attempted to resuscitate the patient assisted by a more junior practitioner namely Dr Boyd and other nursing staff;
6. Dr Patel dealt with a routine colonoscopy of another patient⁹;
7. Dr Carter accompanied the patient for a CT scan;
8. Dr Gaffield noted that the patient had 3,000 mls of blood in his chest and that he did need to go to Brisbane. He re-activated the Royal Flying Doctor Service;
9. Dr Patel returned to the patient and commented that he was too ill to travel to Brisbane;
10. That Dr Patel performed a pericardiocentesis to extract fluid from around the heart. This was contraindicated from the ultrasound. He did so with a needle and stabbed around the patient's heart 50 times¹⁰;
11. That Dr Patel was rude to the point of abusiveness to the patient's family
12. That her sentinel event form raising concerns about the patient had been downgraded by Dr Keating .¹¹

Dr Carter at the request of Dr Keating investigated the care of the patient and prepared a case report. The areas of concern isolated by Dr Carter were as follows:

⁷ T140.

⁸ T139.

⁹ T140, T142.

¹⁰ T141.

¹¹ This was incorrect- see evidence of Raven

1. *The delay in the arrival of the retrieval team. The request logged at 16:20, dispatched at 19:30 and arrived at 23:00;*
2. *Lack of co-ordination of care, two surgical teams involved. Mixed messages being conveyed to the family over the advisability of transferring the patient;*
3. *Pericardiocentesis being performed without any indication (see CT and PM report);*
4. *Lack of radiology support (CT not reported until 30 August 2004).*

Of the issues which emerged from the balance of the evidence and which involve other clinicians:

1. The inadequate/blocked drainage;
2. The physiotherapy administered to the patient;
3. The failure to transfer the patient earlier.

Inadequate/Blocked Drainage

The adverse event form¹² reported by Nurse Fox, in ICU, said:

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

The shift supervisor noted:

"...awareness of need for H₂O in underwater sealed drainage ,unsure of who set up unit."

The chart indicates that the underwater drain was not checked after 10.30 am that day, although the physiotherapy note indicates it was operational at 11.20 a.m.

Dr Gaffield said in evidence that the drain had appeared to work properly earlier in the surgical ward, but clearly after inserting the second drain, the resultant increased blood flow indicated it had been inadequate.

¹² Statement of L Raven Exhibit 162-annexure 9

Dr Gaffield could not say when the water would have been absent from the drain.¹³

Dr Younis said that the tube became blocked. He did not comment as to the situation of the water level, when the patient "got haemopneumothorax and started deteriorating critically"¹⁴. He placed these events at about 1300 hours.¹⁵

Dr Carter corroborated this: "*the right sided intercostal drain was noted to be non-functional at this time*"¹⁶ - being the time when he was moved to ICU.

Dr Woodruff in reviewing the chart noted that the complaint from the patient that he was in pain and that blood was around the drain were indicative of a blocked underwater seal drain. Dr Woodruff stated that allowing the drains to remain in a blocked state whilst three litres of blood pooled in Mr Bramich's chest caused his death.¹⁷

As noted at the autopsy, there was a large amount of blood collected in the chest cavity.

This failure, Dr Woodruff commented, could not be attributed –

*"to one solitary individual. There's Dr Patel in charge of the case, Dr Gaffield, who the patient was admitted under; there's the charge nurse; there's a whole succession of members of the team that should be working collaboratively together to ensure that an oversight such as this doesn't happen."*¹⁸

The inadequate drainage could be concluded as a team failure.

Physiotherapy

¹³ T4603

¹⁴ T3792

¹⁵ T3792

¹⁶ Dr Carter's report – DWK43 – D. Keating.

¹⁷ T4280-4281

¹⁸ T4339

Dr Ashby queried whether the physiotherapy administered to Mr Bramich may have been too vigorous for his condition particularly, given his as then undiagnosed fractured sternum. Dr Gaffield rejected this as an outmoded view of treatment.¹⁹

Failure to Transfer

Dr Ashby's evidence was that for Mr Bramich's optimal care he should have been transported to Brisbane once it was apparent he was stable, that is, by 26th July. Dr Gaffield, as the clinician responsible, rejected that contention. He stated that the patient would not have been accepted for transfer in Brisbane when he was stable on 26th July given the extent of the identified injuries. Once the patient deteriorated on 27th July, he was always too unstable to have been transported to Brisbane.²⁰

"Q: In your opinion, was there any realistic prospect at any time from 2.30 p.m. of transferring Mr Bramich?

A: Not safely".²¹

Dr Gaffield expanded by referring to the logistical difficulties involved in transferring to and from airports and treating the patient within the confines of an aircraft. Dr Gaffield expressed the opinion that the patient would not have survived.²²

Delay in the arrival of the retrieval team

Approximately 4 – 5 hours into the treatment of the patient, Dr Gaffield noted:

*"acute event, the option of transferring the patient to a tertiary centre in Brisbane was entertained. This option was initially voiced by anaesthesia and nursing staff. The thoracic service was contacted in Brisbane for additional advice regarding management of the severe blunt thoracic trauma."*²³

¹⁹ Cf evidence of Dr Ashby at T2709-2710 with that of Dr Gaffield at T4579

²⁰ T4579

²¹ T4603 and DWK 42 Statement D. Keating.

²² T4603

²³ Report of Dr Gaffield DWK42 – statement Dr Keating

Dr Younis placed the initial discussion as to transfer from about 2-2.30pm before Dr Gaffield left for theatre.²⁴ However the RWBH note has a telephone call logged at that time but as addressed later no request for transfer.

It was **Dr Carter's** decision, according to his report of the incident, to arrange for the patient to be transferred to a tertiary centre in Brisbane, which had the capacity to provide thoracic surgery, long-term ventilatory support and blood bank.

To that end, a flight co-ordinator was contacted at 1620 to arrange a retrieval flight.

Dr Smith, a consultant emergency physician at the Royal Women's Hospital, in her statement²⁵ said that at 4.20 p.m. Dr Brazil, another emergency physician, received a telephone call from Dr Carter, a doctor at Bundaberg Base Hospital. Dr Smith said that she understood that there was a discussion in relation to Mr Bramich. There was no request for retrieval at that stage. (That accords with Dr Gaffield's statement referred to previously.)

At 1600 -1700 hours Dr Carter accompanied the patient for a CT scan to assess the risk of transfer-it seems common ground that this was a time when the patient was the most stable.²⁶

At approximately 6.45 pm Dr Smith was contacted by **Dr Boyd** of Bundaberg Base Hospital and requested to arrange for the transfer of Mr Bramich to the PA Hospital. She did so and arranged for **Dr Jackie Butler**, a registrar from the RBWH to meet the Royal Flying Doctor Service at Brisbane Airport.

Normally there is a lead time of between 2-3 hours of bed confirmation in Brisbane and the retrieval team arriving in Bundaberg.

²⁴ T3793

²⁵ Statement of Dr Sharon Smith, Exhibit 423

²⁶ T3804-5

According to the clinical coordination form, Dr Butler left the RBWH at approximately 7.30 pm to meet the RFDS plane at Brisbane Airport - the flight arrived in Bundaberg at 2300 hours.

Sr Hoffman's evidence²⁷ identifies that the delay was as a result of interference by Dr Patel.

Dr Younis is the only other witness to corroborate Sr Hoffman's version. He gave evidence that Patel did slow the transfer of the patient. He felt there was "*resistance from Dr Patel*". This was at approximately 1900 hours when he performed the pericardentesis. He felt Dr Patel's attitude was one of:

"BBH must keep the patient at all costs and questioned what would or could be done in Brisbane".²⁸

The evidence of Drs Carter and Boyd (the latter being present during almost the entirety of Mr Bramich's care in the intensive care unit), negated any suggestion of Dr Patel interfering with the retrieval team.

The effect of their evidence was that it was to be arranged, surgeon-to-surgeon, and that a delay had occurred in attempting to arrange a bed in Brisbane for Mr Bramich i.e. between the hours of 2.30 p.m. and 4.30 p.m. Dr Carter's evidence was that Patel did not become involved in the patient's care until after 4.00 p.m.

Of particular note, Dr Smith records –

"I also do not recall being contacted by anyone at Bundaberg Base Hospital or otherwise, and being asked to defer or cancel the retrieval. If this had occurred, it would ordinarily be documented on the clinical coordination form."

It must be borne in mind that Sr Hoffman ceased duty at 7.30 p.m. Though Dr Younis appears to support an allegation based on hearsay, Dr Smith's evidence about the records of the RBWH is support for the proposition that any intervention by Patel did not actually delay an evacuation. No other staff

²⁷ Statement [94] and, T148.

²⁸ DWK44 – telephone call Dr Younis, 27 September 2004

member supports Hoffman or Younis. Her allegation of delay is not supported by any of the other witnesses other than Dr Younis. Dr Smith, refreshing her memory from the records of the RWBH, is objectively well placed to comment.

The lack of co-ordination of care

The evidence of Drs Boyd, Carter and Younis is that approximately from 4.30 p.m. until 6.00 p.m. Dr Patel was involved in surgery²⁹ thus he was not involved in Mr Bramich's care at that time.

At Dr Gaffield's invitation Dr Patel became involved in the patient's care due to his greater experience. During that time Dr Gaffield was involved in other surgical treatments. It is apparent from the evidence that the intersection of two different surgical teams created difficulties with the care of Mr Bramich, particularly as the family were given conflicting information. Dr Carter's contemporaneous report supports this view.

Pericardiocentesis being performed

On the evidence of Dr Carter and Dr Younis there was not sufficient fluid around Mr Bramich's heart. This was borne out by the diagnostic ultrasound and autopsy. Dr Carter allows that out of an abundance of caution, given Mr Bramich's condition, it was appropriate to have carried out that procedure, in the hope that it may have alleviated the situation. No other witness supported Hoffman's account that Dr Patel stabbed the witness 50 times. This could only be hearsay.

Whilst it is clear that Dr Patel applied ten or more stabbing motions, no eye witness saw 50 motions, as stated (as hearsay) by Hoffman.³⁰ Nonetheless, other witnesses are critical of the technique employed by Dr Patel in carrying out the procedure. Dr Younis agreed with the proposition that 3-4 attempts would have been sufficient.³¹

²⁹ but it was not routine

³⁰ No other witness corroborates Hoffman's hearsay version

³¹ T3798-in answer to a question by the former Commissioner

Dr Ashby, the pathologist, gave evidence that whilst it did not assist Mr Bramich it caused no particular harm. It may have caused him discomfort whilst not altering his condition. Dr Carter concurred.

Dr Younis agreed and expanded indicating that in fact it may cause a pericardial tamponade³² - it was not a "benign procedure".

Conclusion

The events of 27 July emerge as a confused picture of a patient suddenly deteriorating and *in extremis*. The issues identified by Dr Carter are pertinent.

Patel: The major criticism of Patel is that he interfered in the transfer, but other than Ms Hoffman and Dr Younis there emerges no evidence that Patel did so and it is negated by the evidence of Dr Smith and others. On the evidence of Dr Gaffield, Mr Bramich in any event was too ill to transfer on 27 July once he had deteriorated and prior to then, would not have been evacuated.

Dr Patel's performance of the pericardiocentesis was sub-optimal on all the evidence and may constitute an issue to refer for disciplinary action 'conduct of a lesser standard'.

Other clinicians

The issue which is of greatest significance is the blocked and/or inadequate drainage. It is submitted that Dr Woodruff's evidence is important on this issue. Given that the time period prior to this discovery is unclear there is insufficient evidence that the drainage failure can be sheeted home to Dr Patel over other staff. No referral for disciplinary investigation of any individual is justified. It was a team failure.

1.2 Una Connors (P14)

³² T3799

Mrs Una Connors, a 74 year old woman, was admitted to the Bundaberg Base Hospital on 29 March 2004. She underwent a sigmoid colectomy (with Dr Patel as the Surgeon) on that same date. Mrs Connors' left ovary was also removed during that operation.

On 8 April 2004 Mrs Connors was discharged, only to be readmitted later that same day for wound dehiscence, which was repaired by Dr Gaffield.

Mrs Connors suffered a heart attack and had a difficult, "stormy" post operative recovery. She was later diagnosed to have ovarian cancer and referred to a gynaecological oncologist at the Royal Brisbane Hospital. Mrs Connors was not a suitable candidate for further operative treatment to remove gynaecological organs given her condition and recent heart attack.

Dr Barry O'Loughlin provided a Statement to the Commission which detailed a number of concerns in relation to the care given to Mrs Connors. These were:

1. Inadequate assessment of the patient;
2. Mrs Connors was not seen by a gynaecologist prior to the operation despite the advice of the gastroenterologist to the patient's GP;
3. There were indications that this was not simply sigmoid cancer and that the patient may have had ovarian cancer;
4. Wound dehiscence;
5. Sub-optimal treatment;
6. A post operative heart attack meant that she was not a candidate for the optimal treatment for ovarian cancer.³³

The primary issues for concern are the appropriateness of operating without adequately assessing the patient's condition and the competence of the treatment provided to the patient.

³³ Statement of Dr Barry O'Loughlin, Exhibit 173A [39]

Appropriateness of operating without adequate assessment of the patient's condition

Ms Hoffman's evidence was that Mrs Connors should have had a CT scan to eliminate the risk of cancer as this may have led to a different form of treatment being offered other than surgery.³⁴ (It is clear that CT-Scans were ordered prior to surgery and on that issue Hoffman is incorrect.)

Dr Barry O'Loughlin stated that the CT-Scan indicated that this was not simply sigmoid cancer.³⁵ The results of the CT-Scan, dated 23 March 2004 were enigmatic. Upon examination on 22 March, there existed a large pelvic mass which was in contact with the uterus and possibly arose from either the uterus or large bowel but "*the exact origin of this mass is uncertain.*" Dr O'Loughlin gave evidence that in his opinion Mrs Connors was not adequately assessed prior to the operation and that her options were not properly considered before the sigmoid colectomy was performed.³⁶

Post-operative developments and wound dehiscence

Dr O'Loughlin could not exclude a link between the operation and Mrs Connors' heart attack, stating that as the wound was not healing properly there may have been "*systemic changes which contributed to the heart attack.*"³⁷ It is clear that the resulting heart attack was one of the primary reasons Mrs Connors was not considered suitable for further operations in relation to treatment for ovarian cancer.³⁸ Dr O'Loughlin believed that had Mrs Connors been adequately assessed she would have been in a position to be treated with the optimal procedure for ovarian cancer.³⁹

Dr Woodruff categorised the treatment of Mrs Connors as one in which Dr Patel contributed to an adverse outcome.⁴⁰ It was his evidence that "*there is*

³⁴ T101-102

³⁵ Statement of Dr Barry O'Loughlin, [32]

³⁶ T3965-3966

³⁷ T3966

³⁸ Letter from Dr Garrett, Fellow in Gynaecological Oncology Royal Brisbane Hospital and Royal Women's Hospital to Dr G Pratt Visiting Radiation Oncologist Bundaberg Base Hospital dated 8 December 2004

³⁹ Statement of Dr Barry O'Loughlin, [39].

⁴⁰ Woodruff Report, p121

sufficient indication of inadequate technique in the development of a wound dehiscence in itself."⁴¹ Dr O'Loughlin too emphasised that the operation was not performed appropriately given the later wound dehiscence.⁴²

Conclusion

The treatment of Mrs Connors does warrant further investigation with a view to disciplinary action by the Board. It seems likely that Dr Patel did not adequately assess Mrs Connors prior to operating and that he performed the operation at a less than satisfactory standard given the post operative difficulties faced by the patient. Furthermore, by conducting the surgery he denied Mrs Connors' future optimal care. She could not have further surgical intervention to remove her gynaecological organs followed by chemotherapy which would be the optimal treatment for ovarian cancer.

1.3 James Grave (P18)

Mr Grave was a 63 year old man who had a history which included hypertension, diabetes mellitus and ischaemic heart disease with an acute myocardial infarct in 1996.

On 6 June 2003 Mr Grave underwent a scheduled oesophagectomy for adeno-carcinoma of the gastro-oesophageal junction. The oesophagectomy report of 6 June 2003 reveals "*oesophageal/gastro-oesophageal junction mass mobile and palpable. Surrounding lymph nodes palpable, oesophageal wall and lesser curve of stomach.*"⁴³ The histology report of that date noted that there were 9 of 14 metastatic lymph nodes and stated that macroscopically there were numerous enlarged involved lymph nodes identified at the gastro-oesophageal junction at the lesser curve and greater curve.

Mr Grave suffered vocal cord paralysis, respiratory failure post operatively, the development of myocardial infarction and peritonitis. Mr Grave returned three

⁴¹ T4304

⁴² T3966

⁴³ Chart – p. 57

times to the operating theatre due to wound dehiscence on 12 June and 16 June 2003 requiring suturing and on 18 June 2003 leakage from the jejunostomy site was oversewn in the operating theatre.

This was the second oesophagectomy performed by Dr Patel which had required a prolonged ICU stay. Dr Joiner raised concerns with Dr Keating as to whether this type of surgery should be performed in Bundaberg and whether the patient should be transferred to Brisbane.

Dr Younis, in Dr Carter's absence, reviewed the patient and advised that he would remain in ICU in Bundaberg.⁴⁴ after the third operation. Subsequently there was a delay in locating an ICU bed in Brisbane, necessitating a fourth operation in Bundaberg.⁴⁵

The patient was transferred to the Mater Public Hospital on 20 June 2003 because of further complications. He was ultimately discharged home on 18 August 2003.

Mr Grave died on 8 January 2004.

Dr Woodruff's opinion was that Dr Patel contributed significantly to the adverse outcome. He referred to "*the litany of events there that contributed to his protracted post-operative course*"⁴⁶ and referred to the issues as outlined above as constituting the complications Mr Grave suffered as a result of his initial surgery by Dr Patel in Bundaberg. Although not attributing his death to the initial surgery and the subsequent re-admission for the complications Dr Woodruff is of the view that they all contributed to a deterioration of his condition.⁴⁷

⁴⁴ Upon Dr Carter's return, issues as to Bundaberg Hospital's ICU capacity to ventilate patients was addressed – see Review of Clinical Services – Woodruff Matuissi et al p. 33.

⁴⁵ T3786-Dr Younis

⁴⁶ T4366

⁴⁷ T4366

In essence, his weakened condition reduced his ability to be able to effectively deal with the cancer. Dr Woodruff noted his review had ceased on 18 August and his death was some three months later. Given that there had been a metastases identified from the original histopathology from the first operative procedure Dr Woodruff conceded that the procedure had hastened rather than necessarily contributed to his demise.⁴⁸

That Dr Patel had the initial decision to operate. The CT scan had identified pre-operatively the disseminated disease. This would constitute a further error of judgment in recommending this operation.⁴⁹ The chart reveals that as late as 26 May a CT scan indicated an enlarged lymph node. The histopathology of 21 May said "*invasive adenocarcinoma*".⁵⁰ Furthermore, given his complications as outlined above:

"Q: So this is a litany of surgical ineptitude. Is it probably the worst example you've found in this audit of that degree of ineptitude?"

A:.... It's .. yes ... it's as bad as any I believe."⁵¹

He opined that Dr Patel contributed significantly to the adverse outcome.

The issues raised in the treatment of Mr Grave by Dr Patel include whether Dr Patel operated outside his scope of expertise and by virtue of the lack of skill used in the first and subsequent operations and the capacity of the Bundaberg Base Hospital to care for such patients.

These factors warrant a referral for disciplinary action.

1.4 P26

On 23 December 2004, P26 was a fifteen year old male who was involved in a motorcycle accident on a property near Woodgate. P26 hit a tree stump

⁴⁸ T4367

⁴⁹ T4366-4367

⁵⁰ Pages 59, 89-90.

⁵¹ T4295

and sustained a severe laceration to his left groin, a laceration to his femoral vein and massive blood loss. P26 was resuscitated at the scene and airlifted from Woodgate to Bundaberg Base Hospital. Dr Stephen Rashford, who was the Director of Clinical Co-ordination and Patient Retrieval Services at the time, said that P26 required urgent surgical treatment to stop his bleeding and *"would not have survived to fly anywhere"* other than Bundaberg.⁵²

He arrived at Bundaberg Base Hospital in a critical condition. Dr Risson, who saw P26 when he arrived at Bundaberg Base Hospital, described the patient as peripherally shut down and hypotensive and with extensive bleeding from the left groin.⁵³ P26 was immediately transferred to the operating theatre where Dr Patel performed a femoral vein repair and debridement and closure of the wound, P26 also received a blood transfusion. It is common ground among medical witnesses that this initial surgery was life saving.⁵⁴

He was transferred to the Intensive Care Unit and intubated post-operatively. Within approximately 3 hours he was returned to the operating theatre for left leg compartment syndrome with a pulseless leg and upper and lower fasciotomies were performed. This was performed by Dr Patel. He was then returned to ICU.

Later that evening, approximately 4 hours later, he returned for the third time that day to the operating theatre with acute lower extremity ischaemia despite the thigh and leg fasciotomies. P26 had expiration and an arteriotomy with a bypass with gortex. He had good posterior tibial pulse at the end of that procedure. This surgery again was performed by Dr Patel. It was during this third occasion other medical staff apparently observed an injury to the femoral artery.

P26 was under Dr Patel's care until the morning of 26 December 2004. From that time he was under the care of Dr Gaffield.

⁵² Dr Stephen Rashford T2910

⁵³ Referral letter from Dr Risson to Dr Mark Ray dated 1 January 2005, exhibit 208

⁵⁴ Dr Carter T4075; Statement of Dr Jason Jenkins [22], exhibit 254 and T3697; and Statement of Dr Mark Ray [17], exhibit 257 and T3765;

Over the ensuing week the patient was placed in the surgical ward in Bundaberg and the rate of his deterioration over that time is the subject of controversy.

On or about 1 January 2005 contact was made with the Royal Brisbane Hospital in relation to transferring the patient in view of his deteriorating condition. P26 was transferred to the Royal Brisbane Hospital on 1 January 2005. Dr Ray described P26's condition on his arrival at the Royal Brisbane Hospital as follows:

"I could literally smell him when I entered the Emergency Department....He was in the resuscitation bay and he was lying on a trolley and was just really unable to converse with me effectively because he was profoundly sick, in a lot of pain, and very septic, and he had fairly- he was fairly floridly septic. He had a pulse that was racing and a temperature that was very high..."⁵⁵

P26 was taken to theatre where the fasciotomies were extended and the femoral vein repaired again. Dr Jason Jenkins then performed a through knee amputation the next day.

Dr Mark Ray stated:

"The first problem then is that P26 should have been moved to Brisbane after the initial operation. The second problem was that the second and third operations performed in Bundaberg were not performed well. The fasciotomies were inadequate and the "repair" to the femoral vein did not restore it's continuity. Moreover, the use of the prosthetic material was not in accordance with good practice.... The third problem was the delay in failing to move P26 from Bundaberg to Brisbane and the failure to recognise that this boy was very sick. The thing that disturbed me was that P26 had been seen by the consultant surgeon in Bundaberg earlier on the day that I saw him. The consultant had, notwithstanding the boy's temperature, stopped the antibiotics and ascribed his temperature to his venous line."⁵⁶

Some issues for concern raised by the treatment provided to P26 while at the Bundaberg Base Hospital include:

1. The decision not to transfer P26 until 1 January 2005;

⁵⁵ Dr Mark Ray T3762

⁵⁶ Statement of Dr Ray [18]-[19], exhibit 257

2. Whether the fasciotomies were adequate;
3. The circumstances involving ligation of the femoral vein; and
4. The use of prosthetic material in the third operation.

1. Failure to transfer P26 prior to 1 January 2005

There is no doubt that P26 could not have been transferred to Brisbane before his first operation. Nor can it be doubted that that operation saved P26's life

A number of witnesses did raise concerns as to the failure to transfer P26 by or around the time of the third operation, or at the latest some time prior to 1 January 2005.

Dr Risson stated in evidence to the Commission that he believed that the patient should have been transferred to Brisbane "as soon as the patient was stabilised and there was no other life threatening injuries"⁵⁷ This view is shared by **Dr Kariyawasam**, who agreed in his oral evidence that in hindsight P26 should have been transferred as soon as he was stable following the initial surgery.⁵⁸

The mother of P26 stated that she witnessed Dr Patel discussing whether P26 should be transferred to Brisbane with several other doctors prior to the third operation.⁵⁹ The mother of P26 apparently wanted her son transferred to Brisbane at that point but was told by one of the doctors that "*by the time they organised the plane from Brisbane it would take six hours and it would be too long by the time my son got to Brisbane. They decided to take him back to theatre.*"⁶⁰

Dr Athanasiov apparently raised the possibility of transferring P26 to Brisbane with Dr Patel on 23 December 2004. It was his evidence that Dr

⁵⁷ Dr Risson T2815

⁵⁸ Dr Kariyawasam T3099

⁵⁹ Statement of the Mother of P26 [18]-[19], exhibit 137

⁶⁰ Statement of the Mother of P26 [20], exhibit 137

Patel thought that there was no reason to transfer P26 as there was little more that could be done at that point.⁶¹

Martin Brennan, a nurse in Intensive Care, also stated that Dr Athanasiov was considering transferring P26 and that he was later told by Dr Athanasiov that Dr Patel thought P26 should remain at Bundaberg.⁶² Similarly nurse **Damien Gaddes** stated that Dr Athanasiov considered transferring P26 to Brisbane.⁶³ **Dr Boyd** also recalled the issue of transferring P26 being raised with Dr Patel but agreed that Dr Patel stated that there was no need to transfer.⁶⁴

In relation to the week during which Dr Patel was on leave and Dr Gaffield had taken over the care of P26, Dr Boyd admitted that P26 should have in hindsight been transferred to Brisbane. Dr Boyd felt, however, that Dr Patel and Dr Gaffield had *"done everything that could be done....I didn't push the issue any further."*⁶⁵

Dr Risson gave evidence that a number of doctors and nurses had raised concerns about the appearance of P26's foot and the possible absence of a pulse.⁶⁶

Dianne Jenkin, for example, stated that she *"was horrified at the state of his injuries"* and said to another nurse *"words to the effect of 'this boy's leg looks dreadful'."*⁶⁷ Her evidence is however untested at time of writing.

Viability of the leg

As to whether P26's leg could have been saved if he had been transferred, Dr Jenkins opines:

- *"I believe that if P26 had been transferred to Brisbane as soon as he had stopped bleeding, there is a significantly higher probability he would still have his leg".*⁶⁸

⁶¹ Dr Athanasiov T2071

⁶² Martin Brennan T2165

⁶³ Damien Gaddes T2133

⁶⁴ Dr Boyd T3851

⁶⁵ Dr Boyd T3850

⁶⁶ Dr Risson T2818-2819

⁶⁷ Statement of Diane Jenkins [19]-[20], exhibit 494

Dr Jenkins in oral evidence, reaffirmed that while he could not provide any guarantee, he believed that if P26 had been transferred he would have had "*possibly a slightly higher chance*" of keeping his leg.⁶⁹

In his opinion, P26 should have been transferred following the initial surgery or after the third operation, and at the very least he believed Dr Patel should have sought advice from the Royal Brisbane Hospital.⁷⁰ Dr Rashford similarly believed that Dr Patel should have sought the advice of Brisbane vascular surgeons.⁷¹

Dr Jenkins, though, stated that the hospital staff were not really responsible for failing to recognise that P26 should have been transferred earlier, in that junior staff were looking after P26's care during the holidays and they simply did not recognise the patient's condition.⁷²

Dr Ray also expressed concern at the failure of Dr Patel to even seek the advice of more experienced vascular surgeons.⁷³ In his opinion, the issue of transferring the patient should have been considered by Dr Patel after the first operation.⁷⁴ Dr Ray believed that had P26 been transferred to Brisbane quickly P26 *may* still have lost his leg but that this was an unlikely outcome.⁷⁵

Nevertheless, **Dr Woodruff** gave evidence that P26's leg was in all likelihood lost by approximately two or three o'clock on the afternoon of the accident, and that there really was no question of P26 being in a position to have been transferred and treated in Brisbane by this time.⁷⁶ He also stated that "*all vascular surgeons have encountered late diagnosis of blunt arterial injuries*".⁷⁷ Dr Woodruff accepted that Dr Patel may have mismanaged the care of the

⁶⁸ Statement of Dr Jenkins [20], exhibit 254

⁶⁹ Dr Jenkins T3703

⁷⁰ Statement of Dr Jenkins [22], exhibit 254

⁷¹ Statement of Dr Stephen Rashford, exhibit 210

⁷² Dr Jenkins T3706

⁷³ Dr Mark Ray T3766

⁷⁴ Dr Ray T3770

⁷⁵ Dr Ray T3768

⁷⁶ Dr Woodruff T4321, T4364

⁷⁷ Dr Woodruff T4321

patient following the life saving surgery, but felt that regardless, the leg would not have been salvageable.⁷⁸

Post-operative care

The post operative care of P26 at Bundaberg, however, was regarded by Dr Woodruff as being sub optimal, in that P26 was becoming septic from approximately 29 December 2004. On the whole, Dr Woodruff stated that P26 would not be in a better position now than if he'd been transferred to Brisbane earlier but -

*"he could have gone through the process without testing his chances to the degree that he did if he'd been transferred earlier."*⁷⁹

Michelle Hunter, who nursed P26 on 30 December gave evidence that P26 was very unwell, with a grossly swollen foot which was purple, mottled and cold, he was tachycardic and had a temperature around 39 or 40 degrees.⁸⁰

Diane Jenkins similarly stated that in the week Dr Patel was on leave P26's foot and leg were very swollen and that his foot was "a dusty navy colour."⁸¹ Ms Hunter stated that she spoke with the intern who was caring for P26 that day but she was told the doctors were aware of the patient's condition.⁸²

Dr Gaffield, who had taken over the care of P26 while Dr Patel was on leave, stated that he believed that P26's leg appeared to be improving then there was no change until a sharp decline in the twenty four hours prior to his transfer.⁸³

Dr Gaffield admitted he did not check P26's chart pathology results, limb observation charts and progress notes⁸⁴ then or at any time. Rather he relied

⁷⁸ Dr Woodruff T4321

⁷⁹ Dr Woodruff T4322

⁸⁰ Michelle Hunter T2034

⁸¹ Statement of Diane Jenkins [31], exhibit 494

⁸² Michelle Hunter T2034

⁸³ Dr Gaffield T4585

⁸⁴ T4604

upon Dr Patel's verbal handover.⁸⁵ Further elucidation on this issue was not permitted by the former Commissioner.⁸⁶

After considering the patient's pathology urine test results of 23 December 2004, which Dr Woodruff stated indicated dead and dying muscle, showing a rising white blood cell count and the lack of improvement, Dr Gaffield stated in evidence that he felt he should have transferred P26 earlier, possibly twenty four hours earlier.⁸⁷

A Brief to the Zonal Manager, Dan Bergin, was provided by Dr Keating following an email to Dan Bergin, Peter Leck and Darren Keating from Dr Rashford which raised concerns at the delay in transferring P26.⁸⁸ This report found that "*ideally patient should have been transferred to RBWH when stable on or about 25-26 December 04.*"⁸⁹ It was noted in this briefing that the hospital would institute a policy of transferring patients with emergency vascular conditions to tertiary facilities once the patient becomes stable. Dan Bergin stated in his evidence to the Commission that no policy at Bundaberg Base Hospital had been located but that he had requested the Acting District Manager to develop this policy.⁹⁰

Dr Keating gave evidence that he had intended to implement a written policy in relation to transferring patients but did not have the opportunity to do so prior to taking leave in April. Dr Keating merely spoke to Dr Patel and to Dr Gaffield and verbally mentioned the policy.⁹¹

Overall, it is clear that P26 should have been transferred as soon as he had been stabilised after the initial life saving surgery.

⁸⁵ Dr Gaffield T4600

⁸⁶ T4601

⁸⁷ Dr Gaffield T4587

⁸⁸ Email to Dan Bergin, Darren Keating and Peter Leck from Dr Stephen Rashford dated 4 January 2005, attachment "SJR1" to the Statement of Dr Rashford, exhibit 210 and *A Briefing to the Zonal Manager* prepared by Darren Keating to Dan Bergin dated 5 January 2005, attachment "JGS7" to the Statement of Dr Scott, exhibit 317 and attachment 10 to the Statement of Dan Bergin, exhibit 383

⁸⁹ *A Briefing to the Zonal Manager* dated 5 January 2005 page 2 of Clinical Summary

⁹⁰ Dan Bergin T6006

⁹¹ Statement of Dr Keating [174] and [177], exhibit 448

Notwithstanding this, when Dr Gaffield as the consultant assumed the patient's care it seems that, he did not undertake basic procedures to acquaint himself with the pertinent features of the case, nor it seems seek further guidance as to the management of the patient.

The responsibility for failure to transfer and to closely monitor the patient must rest with both Dr Patel and potentially Dr Gaffield. As to the latter, the evidence is incomplete and in his case further investigation is warranted.

However, even if P26 had been transferred following the initial operation, according to Dr Woodruff's evidence, there would still have been insufficient time for his leg to be saved.

2. Adequacy of the fasciotomies

In the opinion of Dr Jenkins, performing the fasciotomies on P26 was the appropriate treatment.⁹² However, Dr Jenkins and Dr Ray were both of the opinion that the fasciotomies were inadequate.⁹³ Nevertheless, Dr Woodruff commented that although there was a delay in diagnosing P26's condition, ultimately P26's leg could not have been saved even if P26 was transferred earlier as *"the operation that was done to re-establish circulation did in fact re-establish circulation."*⁹⁴

3. Ligation of the femoral vein

Dr Risson, who assisted Dr Patel in theatre at the time of the first operation, said that he believed that the laceration to the femoral vein was repaired but in hindsight believes the vein was actually ligated.⁹⁵

Dr Jason Jenkins stated that he believed Dr Patel *"did not recognise the venous anatomy"* and had ligated the vein with the other end retracting inside the abdominal cavity. In Dr Jenkins' opinion, had the vein been repaired, P26 would not have developed the difficulties with his leg.⁹⁶ However, Dr Jenkins

⁹² Dr Jenkins T3701

⁹³ Statement of Dr Jason Jenkins [17], exhibit 254; Statement of Dr Mark Ray [18], exhibit 257

⁹⁴ Dr Woodruff T4321

⁹⁵ Statement of Dr Risson [38]-[39], exhibit 207

⁹⁶ Statement of Dr Jason Jenkins [16], exhibit 254

stated in evidence that the ligation of the femoral vein took place in the context of the patient "*bleeding to death and that was his only option, then's (sic) not necessarily an unreasonable thing to do.*"⁹⁷

4. The by-pass graft

Dr Patel used gortex in performing the by-pass graft in P26's third operation. Dr Jenkin in a Statement supplied to the Commission provided the opinion that in some circumstances the use of synthetic material may not be unreasonable but in cases where the wound is possibly contaminated a vascular surgeon would not use gortex as it "*would almost certainly get infected, and this, in turn, is likely to lead to the rupture of the artery and perhaps even death.*"⁹⁸ Dr Jenkins stated that he believed approximately eighty percent of vascular surgeons would have used a vein rather than synthetic material.⁹⁹ However, in his oral testimony, Dr Jenkins stated that prosthetic grafts increase the chances of infection but the use of gortex here "*has no bearing on [P26's] outcome.*"¹⁰⁰

Conclusion

Dr Patel's treatment must be viewed in the context of the initial surgery being life saving. However, the following comments can be made in relation to the treatment provided to P26:

- (a) Dr Patel, as P26's treating surgeon, should have considered a transfer once P26 had stabilised rather than operating for the third time. At the very least, Dr Patel should have sought the advice of Brisbane specialists prior to operating for the third time.
- (b) The fasciotomies performed were inadequate. It does seem that it was appropriate to perform fasciotomies, and the long term impact of the inadequate fasciotomies is

⁹⁷ Dr Jenkins T3698

⁹⁸ Statement of Dr Jenkins [15], exhibit 254

⁹⁹ Dr Jenkins T3702

¹⁰⁰ Dr Jenkins T3705

questionable, in that P26 appears likely to have still lost his leg.

- (b) The use of the prosthetic material in performing a graft during the third operation was questionable in the circumstances of a motorcycle accident, given the evidence of Dr Jenkins.
- (c) On the evidence given by Dr Woodruff, P26 would still have lost his leg despite remaining at Bundaberg, as there simply would not have been enough time to transfer P26 and operate in Brisbane.
- (d) The post-operative care of P26 generally appears to have been suboptimal, and he certainly should have been transferred to Brisbane prior to 1 January 2005. Dr Woodruff stated that *"I believe the patient's management is definitely deficient from about this time on."*¹⁰¹ Nevertheless, Dr Woodruff was of the view that P26 would not have been in a better position than he is today had he been transferred earlier.

Dr Jenkins commented that:

*"It is not easy to give you a cut and dry answer on this. He [Dr Patel] obviously thought the kid's leg was going all right, so you wouldn't have transferred him till the next day anyway. So, you know, and then the damage may well have been done by then anyway. So it may not have changed the outcome, is all I am saying, but if he'd come earlier it would have. I am not saying it is technically possible to change it."*¹⁰²

On any view of the evidence, the patient would have been less compromised physically had he been transferred earlier and as adverted to responsibility rests with Drs Patel and potentially Dr Gaffield for this omission.

Conclusion

¹⁰¹ Dr Woodruff T4322

¹⁰² Dr Jenkins T3720

There are sufficient issues raised in relation to Dr Patel to warrant referral for disciplinary action as outlined above.

On the current state of the evidence it may warrant further investigation as to Dr Gaffield's management and failure to earlier transfer the patient.

2. Surgical Procedures currently under assessment by the Health Rights Commission and the subject of evidence at the Inquiry:

2.1 Ainslie, Frances (decd) (P164)

- Woodruff T4279; Table B2
- Woodruff Report at 133 ("*reasonable*")

2.2 Alexander, Noel (decd) (P71)

- Woodruff T4300

2.3 Anderson, Helen (P165)

- Woodruff Report at 133 ("*reasonable*")

2.4 Armstrong, Robert

2.5 Badke, Fredrick

2.6 Bailey, Kevin

2.7 Barber, Rhonda (P97)

2.8 Bender, Vicki (P171)

- Woodruff Report at 133 ("*reasonable*")

2.9 Blight, Darcy (P175)

- Woodruff T4340-4341
- De Lacy T3646-3647

2.10 Braund, Kerrie (decd) (P178)

- Woodruff Report at 133 ("*reasonable*")

2.11 Broome, Priscilla (P50)

- Woodruff Report at 133 ("*reasonable*")
- Statement of Dr Gaffield

- 2.12 Buckley, Katherine (P181)**
 - Woodruff Report at 133 ("*reasonable*")
- 2.13 Bury, Evelyn**
- 2.14 Carter, Matthew (decd) (P182)**
 - Woodruff Report at 133 ("*reasonable*")
- 2.15 Cox, Nelson (P15)**
 - Keating statement paragraph 340
 - Woodruff Report at 121
 - Statement of Dr O'Loughlin dated 10 August 2005 at [13]-[23]
 - Transcript Dr O'Loughlin 3962-3963, 3964
- 2.16 Cuthel, Dawn (P109)**
- 2.17 Deakin, Phillip (P16)**
- 2.18 Dorron, Noel (decd)**
 - Woodruff report at page126- Dr Patel maybe contributed to adverse outcome.
- 2.19 Douch, Kelly**
- 2.20 Ell, Ian**
- 2.21 Filmer, Suzanne**
- 2.22 Finch, Raymond (decd) (P207)**
 - Woodruff Report at 134 ("*reasonable*")
- 2.23 Fleming, Ian (P126)**
 - Woodruff Report at 121
 - Fleming T2510-2535
 - Statement of Dr Boyd dated 17 June 2005 at [15]-[19] and dated 29 June 2005 at [12]
 - Boyd T3823
- 2.24 Forrester, Michelle**
- 2.25 Fowles, Nora**
- 2.26 Gibson, Valerie**
- 2.27 Grambower, Janice (decd) (P220)**

- Woodruff Report at 134 (*"reasonable"*), then placed in Table B3 in Dr Woodruff's statement (patients adversely affected by Dr Patel), subsequently in evidence Dr Woodruff stated that there were others involved who played major contributing roles in Ms Grambower's death (at 4275). Also Woodruff T4347-4350.
- Dr Strahan T3270-3275, 3306-3307

2.28 Green, Leonard (decd) (P224)

- Woodruff Report at 127 (*"Dr Patel maybe contributed to adverse outcome"*)
- Woodruff T4287 and 4288

2.29 Halter, Trevor (P20)

- Woodruff Report at 121
- Halter T2415-2423; and Statement (Exhibit 171)

2.30 Hendricks, Margaret

2.31 Holder, George (P230)

- Woodruff Report at 135 (*"reasonable"*)

2.32 Hopton, Donna

2.33 Howard, Margaret

2.34 Hurley, Ronnetta

2.35 Jackson, N Kerry

2.36 Jones, Elwyn (P137)

- Woodruff Report at 135 (*"reasonable"*)

2.37 Karan, Serab

2.38 Karnauchow, Leo

2.39 Kemps, Gerard (P21)

Mr Kemps was initially admitted to the Bundaberg Base Hospital on 6 December 2004. His wife described him as looking anaemic around 3 December 2004 which resulted in Mr Kemps making an appointment to see his general practitioner. Mr Kemps was referred to the Bundaberg Base Hospital by the GP with suspected internal bleeding and symptoms of tiredness and difficulty swallowing.¹⁰³ His medical history included an aortic

¹⁰³ Statement of Aleida Kemps, annexure "AJK1," exhibit 126; Dr Smalberger T1960

procedure two years before which required a transfer to the Intensive Care Unit of the Royal Brisbane Hospital.

Dr Smalberger performed an endoscopy which revealed a mass at the gastro-oesophageal junction. The tumour apparently extended below the oesophageal sphincter. Dr Smalberger then ordered CT Scans of Mr Kemps' chest. The results of that scan revealed enlarged lymph nodes and shadows in the lungs, which suggested to Dr Smalberger that Mr Kemps' cancer was not limited to his oesophagus.¹⁰⁴ He explained to Mr and Mrs Kemps that he believed that Mr Kemps should be transferred to Brisbane and that keyhole surgery was an option.¹⁰⁵ Dr Smalberger stated in evidence that he believed Mr Kemps should have been treated with radiotherapy, chemotherapy a stent or a combination.¹⁰⁶ Dr Smalberger referred the patient to the Department of Surgery as he had found that Brisbane hospitals required the support of a surgeon for a transfer.¹⁰⁷ Dr Patel, however, spoke with Mr and Mrs Kemps and informed them that Mr Kemps would be operated on in Bundaberg and that he would perform an oesophagectomy. Mrs Kemps recalled that Dr Patel said "*It is a big operation but it is nothing because I've done hundreds of them.*"¹⁰⁸ Dr Patel arranged for Mr Kemps to be discharged home for two days, to return on 19 December 2004.

A number of staff raised concerns that Dr Patel had insisted that P44's ventilator be turned off in order to make a bed available in Intensive Care for Mr Kemps.¹⁰⁹ Dr Carter stated that Dr Patel indicated to him that he needed the bed in ICU and Dr Carter agreed to review P44's chart.¹¹⁰ Dr Patel had apparently requested Dr Joiner turn off the patient's ventilator the evening before, but Dr Joiner refused.¹¹¹ Dr Carter gave evidence that when he reviewed the patient he determined that "*there was no chance of Mrs P44*

¹⁰⁴ Dr Smalberger T1962

¹⁰⁵ Aleida Kemps T1896-1897; Dr Smalberger T1963-1964

¹⁰⁶ Dr Smalberger T1994

¹⁰⁷ Statement of Dr Smalberger [7], exhibit 133

¹⁰⁸ Statement of Aleida Kemps, annexure "AJK1," exhibit 126

¹⁰⁹ Statement of Martin Brennan [7]-[10], exhibit 154; Statement of Damien Gaddes [14]-[15] and annexure "DG1", exhibit 146; Statement of Toni Hoffman [135], exhibit 4

¹¹⁰ Statement of Dr Carter [59], exhibit 265

¹¹¹ Statement of Dr Joiner [9], exhibit 307

making any recovery from her stroke."¹¹² His evidence was that Dr Patel had pressured him to turn the patient's ventilator off but that he could and did ignore the pressure and made an appropriate decision, discussed the matter with P44's family and switched the ventilator off.¹¹³

On 20 December 2004 Dr Patel performed an Ivor Lewis Oesophagectomy on Mr Kemps. Damien Gaddes, the anaesthetic nurse, gave evidence that he told Dr Patel during the surgery that the bellovac drain was half full and blood was draining into the bellovac, but was told that this was what the drains were for.¹¹⁴ It was his evidence that all theatre staff could not believe that Dr Patel ordered the patient to be moved to the Intensive Care Unit as they believed he was haemorrhaging.¹¹⁵ Dr Berens too spoke of abnormal blood loss during the procedure and agreed that Dr Patel was made aware by all the staff members that there was *"active bleeding going on in the abdominal cavity and he [Dr Patel] just looked at it and he said 'It doesn't need opening of the abdomen at this stage.'*"¹¹⁶ Despite the evidence of internal bleeding Mr Kemps was transferred to Intensive Care.

Mr Kemps continued to bleed post operatively and was returned to theatre for a laparotomy, Dr Patel also performed a splenectomy. Mr Kemps received thirty nine units of blood.¹¹⁷ **Jenelle Law**, the scout nurse for the procedure, stated that she had given the scrub nurse 75 large sponges and 15 raytec and *"blood and blood clots were all over the floor."*¹¹⁸ Dr Patel was unable to locate the source of the bleeding and Mr Kemps died on 21 December 2004.

The Death Certificate records the cause of death as *"refractory shock"* with other conditions listed *"as aortic bleeding post operative, resection of oesophageal cancers and primary oesophageal cancer"*.¹¹⁹ The certificate was completed by **Dr Athanasiov**, who only held the retractors during both

¹¹² Statement of Dr Carter [60], exhibit 265

¹¹³ Statement of Dr Carter [62]-[63], exhibit 265; T4021-4023

¹¹⁴ Statement of Damien Gaddes [18]-[19], exhibit 146

¹¹⁵ Statement of Damien Gaddes [20], exhibit 146

¹¹⁶ Dr Berens T1923

¹¹⁷ Woodruff Report, p122

¹¹⁸ Statement of Jenelle Law [14], exhibit 160

¹¹⁹ Statement of Aleida Kemps, annexure "AJK2," exhibit 126

surgeries and was told the cause of death by Dr Patel.¹²⁰ Dr Athanasiov admitted in evidence that it would have been better for a more senior doctor who believed he knew what the cause of death is to complete the certificate.¹²¹ The case was not referred to the Coroner, which was a cause of concern for some staff members including Dr Berens and Dr Carter.¹²²

A number of staff raised both oral and written concerns after the death of Mr Kemps. It was following Mr Kemps' death that Dr Keating informed Dr Patel that he was not to perform any further oesophagectomies.¹²³

Dr Fitzgerald was of the opinion that Bundaberg Base Hospital did not have the capacity to provide the standard of care required for a patient who had undergone an oesophagectomy.¹²⁴ **Dr Berens** suggested that the difficulty for Bundaberg Base Hospital in relation to oesophagectomies is that the hospital did not have the resources to care properly for patients with post operative complications.¹²⁵

Dr Athanasiov gave evidence that Dr Patel had said to him following this surgery that possibly they should not be performing oesophagectomies.¹²⁶

Dr Risson also gave evidence that Dr Patel said during the second operation "words to the effect 'maybe I should start thinking about not doing these types of procedures anymore'".¹²⁷

Dr Woodruff stated that:

"to contemplate a major procedure such as an oesophagectomy, particularly when the CAT scan shows some ectasia or dilation and disease of the thoracic aorta, you can almost guarantee that (a) the tumour is not curable and (b) any attempt to separate it from this diseased aorta is going to produce aortic bleeding, and suturing that

¹²⁰ Dr Athanasiov T2066

¹²¹ Dr Athanasiov T2067

¹²² Statement of Dr Berens [20], exhibit 128; Statement of Dr Carter [], exhibit

¹²³ Dr Keating T6822

¹²⁴ Further statement of Dr Fitzgerald [7], exhibit 226

¹²⁵ Statement of Dr Berens [20], exhibit 128

¹²⁶ Dr Athanasiov T2057

¹²⁷ Statement of Dr Risson [21], exhibit 207

type of aorta is not dissimilar from trying to keep the yoke inside a non-cooked egg, suturing the eggshell."¹²⁸

Conclusion

There are a number of issues for concern raised by the treatment given to Mr Kemps including:

1. Dr Patel's judgment in choosing to perform an oesophagectomy given Mr Kemps' medical history and co-morbidities,
2. Dr Patel operating outside his expertise and that of the Bundaberg Base Hospital;
3. Dr Patel's decision to transfer Mr Kemps to the ICU despite the evidence of internal bleeding,
4. a junior doctor completing the death certificate; and
5. the decision not to refer the case to the Coroner.

Dr Woodruff said in relation to Dr Patel's judgment in deciding to perform the oesophagectomy:

*"I cannot understand how anybody could even contemplate doing this operation with that history."*¹²⁹

2.40 Kerr, Kathleen (decd) (P243)

- Woodruff Report at 135 ("reasonable")

2.41 Knust, Alan (P2)

- Woodruff Report at 135 ("reasonable")

2.42 Lealiifano, Matteo

2.43 Lee, Coral (P5)

2.44 Lester, Vicki (P108)

¹²⁸ Dr Woodruff T4291

¹²⁹ Dr Woodruff T4291

- Woodruff Report at 136 ("reasonable")
- Lester T2455-2471 and Statement (Exhibit 176)
- Keating statement para 334-337

2.45 Mallett, Katrina

2.46 Matteschek, Megan (P103)

2.47 McDonald, Dorothy

2.48 Monaghan, Brian (P267)

- Woodruff Report at 136 ("reasonable")

2.49 Morris, Mervyn (decd) (P28)

- Woodruff Report at 127 ("*Dr Patel maybe contributed to adverse outcome*")
- Woodruff T 4293 and 4308

2.50 Nagle, Eric (decd) (P30)

- Woodruff Report at 124
- Transcript- Carter; Druce; Miach; Pollock; Risson; Woodruff
- Statements of Kay Boisen, Lindsay Druce, Pollock, Risson, Woodruff

2.51 Pauza, George

2.52 Peterson, Douglas (P104)

2.53 Phillips, James (decd) (P34)

- Transcript- Dr Carter, Hoffman, Dr Joiner, Miach, Woodruff, Dr Younis
- Statements- Dr Carter, Toni Hoffman, Dr Joiner, Dr Miach, Dr Woodruff, Dr Younis, Karen Stumer RN

2.54 Punch, Tori (P285)

- Woodruff Report at 137 ("reasonable")

2.55 Rhodes, Doreen

2.56 Robbins, Desmond

2.57 Sanders, Edward

2.58 Scott, Allan

- 2.59 Small, Anacorita
- 2.60 Smith, Christopher (P298)
- 2.61 Snowden, Vera
- 2.62 Stanley, Jaykeb
- 2.63 Stuart-Sutherland, Jean (P38)
 - Woodruff T4326 (*"procedure banned in the United States"*)
 - Woodruff Report at 130 (*"maybe contributed to adverse outcomes"*)
 - Statement of White
 - Statement of Tapiolas
 - Statement of Dr Gaffield
- 2.64 Sullivan, Kevin
- 2.65 Swanson, Nancy (P41)
 - Statement of Toni Hoffman
 - Swanson T2447-2454 and Statement of Nancy Swanson (Exhibit 175)
- 2.66 Van Vliet, Lyn (P102)
 - Statement of Dr O'Loughlin dated 10 August 2005 at [24]-[30]
 - Dr O'Loughlin T3963-3964
- 2.67 Walk, Keith (Decd) (P98)
 - Woodruff Report at page 130 (*"maybe contributed to adverse outcome"*). However, in his statement Dr Woodruff chose to reclassify this case to Dr Patel *"did contribute to the adverse outcome"* (PWHW-4).
 - Woodruff T4292 and 4307
- 2.68 Watson, Audrey
- 2.69 Williams, Grace (dec'd) (P46 and 329)
 - Woodruff Report at 139 (*"reasonable"*)
- 3. Other surgical procedures the subject of evidence at the Inquiry- procedures conducted by Dr Patel at Bundaberg Base Hospital, in respect of which he was, to his knowledge, the

subject of conditions imposed upon him in Oregon in November 2000.

3.1 Oregon conditions

On 7 September 2000 the Oregon Board of Medical Examiners and Dr Patel entered a Stipulated Order. Under this Order Dr Patel agreed not to perform surgeries *"involving the pancreas, any resections of the liver, and constructions of ileoanal pouches."*¹³⁰

In addition to this term, Dr Patel was also to obtain second opinions prior to operating on *"complicated surgical procedures"* from surgeons approved by the Investigative Committee of the Board.¹³¹ An amendment to the Stipulated Order was made on 1 November 2000, under which Dr Patel was also ordered to obtain second opinions prior to operating on *"complicated surgical procedures"* from a surgeon with an unrestricted, full licence in Oregon and who is board certified as well as fully credentialed and privileged at the institution at which Dr Patel cared for the patient.¹³² *"Complicated surgical procedures"* are defined in Attachment A to the Stipulated Order. Those surgeries requiring second opinions include firstly major surgeries, that is abdominal-perineal resections, esophageal and gastric surgeries. Secondly, those surgeries involving high-risk patients with severe co-morbidities or classification of 4 or 5 in accordance with the American Society of Anaesthesiologists. Thirdly, post operative patients with more than two days hospitalisation in the Intensive Care Unit, more than eight days hospitalisation or those with the onset of clinical deterioration.¹³³

3.2 Barry Johnson

Dr Patel saw Barry Johnson, a fifty-seven year old male, at the Bundaberg Base Hospital on 16 September 2003 after he developed painless jaundice secondary to a mass in the head of the pancreas. Mr Johnson was scheduled for a possible Whipples procedure. On 22 September 2003 Mr Johnson was

¹³⁰ Stipulated Order, 7 September 2000, at 4.1

¹³¹ Stipulated Order, 7 September 2000, at 4.2

¹³² Amendment to Stipulated Order, 1 November 2000, at 4.2

¹³³ Stipulated Order, 7 September 2000, Attachment A.

admitted to Bundaberg Base Hospital and Dr Patel performed a cholecystojejunostomy and gastrojejunostomy. Mr Johnson initially appeared to be doing well post-operatively and was transferred from the Intensive Care Unit to the surgical ward on 24 September 2003. He died at the hospital on 1 October 2003, with the cause of death listed as pancreatic cancer.

The issues for concern raised by the treatment given to Mr Johnson include the failure of Dr Patel to diagnose or address the patient's deteriorating condition, possible inadequate records on the consent form, and the fact that Dr Patel intended to perform a Whipple's procedure, which was a prohibited procedure under the Oregon Stipulated Order.

Failure to adequately diagnose and address the patient's deteriorating condition

Dr Woodruff stated that the decision to perform the cholecystojejunostomy and gastrojejunostomy, given the finding on surgery that the mass was actually 10-15 cm in diameter and the CT scan report revealed that there was a pancreatic carcinoma, was a correct one. However, Dr Woodruff was concerned at the fact that while the patient appeared to be doing well initially following surgery, as supported by the full blood count results, his white cell count steadily increased indicating that the patient was becoming septic.¹³⁴ This coupled with the evidence that Mr Johnson began developing pain and that bile was draining through the drain suggested to Dr Woodruff that Mr Johnson developed biliary peritonitis. Dr Woodruff said that Dr Patel did not attempt to diagnose or address the patient's condition. Dr Woodruff indicated that some surgeons may feel following an unsuccessful palliation that it might be more humane not to operate further. However, he was of the belief that failing to re-explore was an error in judgment on the part of Dr Patel.¹³⁵ The Woodruff Report identified Dr Patel's level of care of Mr Johnson as having contributed to the patient's death.¹³⁶

¹³⁴ Transcript 4288-4289 and Medical Records of Barry Johnson, Pathology Reports

¹³⁵ Transcript 4289-4290

¹³⁶ Woodruff Report, 52

Possible inaccurate record keeping:

In his statement supplied to the Inquiry, Dr Woodruff discussed possible inaccurate medical records kept by Dr Patel, stating that generally the medical records were not inaccurate but there were some anomalies including the consent form completed by Dr Patel and the patient in relation to this procedure.¹³⁷ Dr Woodruff explained that Dr Patel appeared to have added to the handwritten list of risks of the procedure, as the last two entries on the list, pneumonia and death, appear to be in a distinctly different script than the other 8 items on the list.¹³⁸ However, as made clear by Dr Woodruff it is unknown whether Dr Patel simply added it a short time later or after some other event, and so the true relevance of the possible addition is unknown.

Operation outside the scope of practice of the Bundaberg Base Hospital and prohibited by the Oregon Order.

Dr Woodruff emphasised that the operation Dr Patel intended to perform was outside the scope of practice for the hospital and it was *"inappropriate to do this form of surgery in that environment, particularly with no recourse to any other colleagues."*¹³⁹

Procedures involving the pancreas were clearly prohibited by the Oregon Stipulated Order, and Dr Patel was knowingly in breach of those conditions when he operated on Mr Johnson.

Conclusion:

There are concerns as to Dr Patel's treatment of Mr Johnson in addition to issues of performing these types of operations at Bundaberg and in breach of the Oregon Order. It is submitted that this case should be referred to the Board for possible disciplinary action.

3.3 Antoine Gautray

¹³⁷ Statement of Dr Peter Woodruff, [25]

¹³⁸ Transcript 4342

¹³⁹ Transcript 4289-4290

- patients requiring such procedures or who were seriously ill would be appropriately referred;*

 - *at that time I had insufficient evidence to link Dr Patel's performance to particular adverse outcomes, the only information we had were complaints that Dr Patel was carrying out procedures outside his capacity and that of the hospitals."*

Dr Fitzgerald formally referred his concerns about Dr Patel to the Medical Board in a letter dated 24 March 2005.¹⁴⁵ Dr Fitzgerald said that his expectation was that the Board in its investigation would have looked at Dr Patel's clinical expertise but also obtained information on his behaviour to staff in terms of assessing whether he was guilty of any professional misconduct.

On 9 April 2005 the Minister for Health, Mr Nuttall, announced that a comprehensive review would be undertaken of safety and quality at the Bundaberg Hospital. Two days earlier, on Thursday 7 April 2005, the Director General of Health Dr Steve Buckland visited Bundaberg Base Hospital with the Minister to speak with staff. At the conclusion of that visit, Dr Buckland was told by Dr Keating that he had undertaken a Google search and had found that Patel had restricted registration in Oregon and had been withdrawn from the register in the State of New York.¹⁴⁶ Dr Buckland said he returned to Brisbane on the Ministerial Plane without mentioning it to the Minister and that night at home, he conducted his own Google search to confirm that Dr Keating had told him. Dr Buckland passed this information onto Dr Fitzgerald, who in turn passed it onto Mr O'Dempsey. Accordingly, on 8 April 2005, O'Dempsey directed Demy-Geroe to prepare a report on all of the aspects relating to the registration of Dr Patel.¹⁴⁷ That report was put before the Board on Tuesday 12 April 2005 and forwarded to the Minister's office on Wednesday 13 April 2005. It was tabled in Parliament on Tuesday 19 April 2005 by the Minister for Health. It is respectfully submitted that from the above chronology it can be demonstrated that, once the staff of the Medical Board of Queensland became aware of concerns relating to the registration and clinical practice of Dr Patel, its ensuing action was timely and appropriate.

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

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

The Board is aware that Patel and Berg are currently the subject of police investigations, and it has assisted Police in those investigations.

The Board has no further submissions.

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

¹⁴⁵ Exhibit "GF-13" to Exhibit 225

¹⁴⁶ T5507

¹⁴⁷ Exhibit MDG-3 to the Statement of Demy-Geroe, Exhibit 24

Mr Gautray, a seventy-six year old man, was admitted to the Bundaberg Base Hospital on 3 September 2004 with jaundice, abdominal pain and weight loss. A CT scan revealed a lesion in the head of the pancreas. There were several small bony lesions.¹⁴⁰ On 9 September Dr Patel performed a Whipple's procedure.

Mr Gautray died on 22 September 2004. The cause of death certificate noted that Mr Gautray died as a result of klebsiella pneumonia and inactivity, with the Whipples operation contributing to the death.¹⁴¹

The issues raised by the treatment of Mr Gautray include:

1. the procedure being banned under the Oregon Order;
2. this type of operation being beyond the scope of Bundaberg Base Hospital and Dr Patel's clinical judgment in operating in this case; and
3. Dr Patel's clinical judgment in operating in this case.

Whipples Procedures at Bundaberg Base Hospital:

Toni Hoffman, in evidence to the Inquiry, stated that Whipple's procedures should be done in tertiary hospitals given the complexity of such procedures.¹⁴² Dr Woodruff was less definitive, on the other hand, suggesting that this was an example of a case where Dr Patel *may* have operated outside his scope of expertise or that of the hospital.¹⁴³

Operating on Mr Gautray:

Dr Woodruff stated that Dr Patel significantly contributed to the adverse outcome in Mr Gautray's case.¹⁴⁴ He also questioned Dr Patel's motives in operating on Mr Gautray, stating that he believed "*there was a lack of*

¹⁴⁰ Medical Records of Antoine Gautray, Patient Report of 7 September 2004 and T4286

¹⁴¹ Sr Hoffman disputed the primary causation of death- T112, however other evidence does not raise this as an issue

¹⁴² Transcript page 112

¹⁴³ Woodruff Report,

¹⁴⁴ Statement of Dr Woodruff, sworn 15 August 2005 at p5 para (d) Table B3

judgment in even putting the patient forward for this type of operation.”¹⁴⁵

Given Mr Gautray's CT scans indicated other possible small lesions, which Dr Woodruff thought suggested possible metastatic disease, surgery was questionable.

Procedure banned under the Oregon Order:

Under the Oregon Order, Dr Patel was prohibited from performing operations involving the pancreas. The treatment of Mr Gautray raises issues as to Dr Patel's clinical judgment and is a clear example of a procedure which Dr Patel was banned from performing in Oregon.

Conclusion:

The performance of the type of procedure banned in Oregon coupled with the lack of judgment in operating at all upon Mr Gautray given the CT Scan results warrant the referral of the matter for possible disciplinary action by the Medical Board.

3.4 P238

P238 was a fifty-four year old female admitted to the Bundaberg Base Hospital on 30 June 2003. P238 had previously undergone a pancreato-duodenectomy at the Royal Brisbane Hospital on 25 February 2002 and had suffered a number of complications following the Whipples procedure. P238 then attended the Royal Brisbane Hospital for a drainage of the pseudocyst in February 2003.

On 30 June 2003 Dr Patel performed a pancreatic cysto-gastrostomy upon P238, assisted by Dr Igras. P238 died at the Bundaberg Base Hospital on 2 July 2003.

Dr Woodruff stated in evidence that P238 did need surgery, but should have been referred to the Royal Brisbane Hospital. Performing surgery in

¹⁴⁵ Transcript p. 4286

Bundaberg given her medical history was said to reflect *"more than a lack of judgment on Dr Patel's behalf. I question the man's motive."*¹⁴⁶

This case further was identified in the Woodruff Report as one in which Dr Patel *may* have operated outside his scope of expertise or that of the hospital.¹⁴⁷

Conclusion

Operating on P238 at Bundaberg raises issues as to Dr Patel's clinical judgment and whether he performed operations which were outside his own expertise or that of the Bundaberg Base hospital. In addition, Dr Patel was banned from performing surgeries involving the pancreas.

In performing an operation banned by another regulatory body Dr Patel's conduct would fall within the definition of *"unsatisfactory professional conduct"*. This case should be referred to the Board for possible disciplinary action.

3.5 Dorothy Bryen

Dorothy Bryen was a seventy-six year old woman who was admitted to the Bundaberg Base Hospital on 8 June 2003. Dr Patel operated on Ms Bryen on 9 June 2003 and repaired an incarcerated epigastric hernia.

During the course of the operation Dr Patel damaged the small bowel which he then repaired during the surgery. Mrs Bryen was discharged on 15 June 2003 but was readmitted on 20 June 2003.

She was subsequently transferred on 30 June 2003, ventilated, to the Mater Private Intensive Care Unit.

¹⁴⁶ Transcript, p 4281

¹⁴⁷ Woodruff Report at 132

The issues for concern include the error made during the procedure and the procedure being one of those banned under the Oregon Order. It warrants referral for disciplinary action.

4. Other cases which may be recommended to the Board

4.1 P273

P273 attended the Bundaberg Base Hospital on 16 April 2003 for a colonoscopy and OGD for anaemia. At that time, however, the colonoscopy was not performed and the patient was discharged home with the procedure rebooked.

P273 returned to the hospital on 21 May 2003. Dr Patel performed the colonoscopy on this date, despite the patient apparently being very disoriented and confused.¹⁴⁸

Dr Woodruff believed that P273's care did not reflect the "*same clinical magnitude or impact*" as some of the other cases he had considered, but he did regard Dr Patel as having contributed to an adverse outcome.¹⁴⁹ The issue raised by Dr Woodruff in his evidence to the Commission was whether performing a colonoscopy under these circumstances, where P273 was highly disoriented, was appropriate.¹⁵⁰ Dr Woodruff stated that he believed it was "*inappropriate to proceed with any sort of invasive procedure that's not lifesaving on somebody so disoriented, confused that she was unable to state what procedure she's having or the date of her birth. So, to me, this raised questions about the appropriateness of case selection and why he was actually doing the procedure.*"¹⁵¹

This case, involving questionable consent is one which could be recommended to the Board for further investigation in the event that other

¹⁴⁸ Day Surgery Record 21/05/03, recorded in the pre-operative nursing assessment

¹⁴⁹ Dr Woodruff T4308 and Statement of Dr Woodruff Table D3; in the Woodruff Report this case is treated as one in which Dr Patel *may* have contributed to an adverse outcome at 129

¹⁵⁰ Dr Woodruff, T4295

¹⁵¹ Dr Woodruff T4295

successful disciplinary action has not already concluded. However, it is submitted that the treatment of P273 does not represent a clear case warranting disciplinary action.

4.2 P276

The Woodruff Report initially identified Dr Patel's care of P276 as being reasonable.¹⁵² In his Statement to the Commission, however, Dr Woodruff revised his assessment of this case and stated that Dr Patel may have contributed to the adverse outcome.¹⁵³

P276 was admitted to the Bundaberg Base Hospital on 17 July 2004. An eighty-two year old man, he was transferred by the RFDS from Eidsvold Hospital with PR bleeding.

On 17 July 2004 Dr Patel, with the assistance of Dr Kariyawasam, performed a sigmoid colectomy. P276 was transferred to the ward on 24 July but then began experiencing pain in his chest on 25 July, when the nursing notes record that he was "*becoming less lucid. Colour pale.*" He went into respiratory arrest and was transferred back to the Intensive Care Unit where he was intubated.

P276 died at the hospital on 25 July 2004 with the cause of death listed as "*coronary occlusion and emergency sigmoid colectomy*"¹⁵⁴.

In his Statement to the Commission, Dr Woodruff considered the nursing notes, which record only small or no PR bleeds, lead to a question of appropriateness of operating upon P276 given his age and condition.¹⁵⁵ Further, the patient's history of myocardial infarction and the ECG results also led Dr Woodruff to form an opinion that "*consultation and more conservative*

¹⁵² Woodruff Report, 137

¹⁵³ Statement of Dr Woodruff "PWHW-4"

¹⁵⁴ Medical Certificate of the Cause of Death 26 July 2004

¹⁵⁵ Statement of Dr Woodruff "PWHW-4"

management by Dr Patel may have produced a better outcome."¹⁵⁶ Dr Woodruff believed that P276's symptoms were *"more likely caused by the onset of a heart attack than a significant bleed from the bowel."*¹⁵⁷

This case is another example of one which may reflect poor judgment on Dr Patel's part. While poor clinical judgment may amount to *"unsatisfactory professional conduct"*, it is submitted that this is not a case that should be referred to the Board for further investigation, in the circumstances where there are more serious cases of possible *"unsatisfactory professional conduct"*.

4.3 Mona Slater (P297)

Mrs Slater was an eighty-eight year old female operated on by Dr Patel at the Bundaberg Base Hospital on 15 December 2003. Dr Patel performed a low anterior resection. Mrs Slater remained unwell following the procedure and died at the hospital on 24 December 2003, with her cause of death listed as cardiopulmonary respiratory failure, fluid overload and low anterior resection. Other conditions listed on the death certificate include hypertension, angina, gout and atrial fibrillation.¹⁵⁸

Dr Woodruff questioned whether, during the operation on 15 December, there was a ureteric injury.¹⁵⁹ In his opinion, Mrs Slater's anuric renal failure *may* have been caused by some damage to the ureter during the operation.¹⁶⁰ This possibility in itself would not be sufficient to refer the matter to the Board for possible disciplinary action. However, Dr Woodruff also questioned Dr Patel's motivation in performing such an operation on an elderly woman and at Bundaberg. In evidence, Dr Woodruff stated this operation was:

*"a challenging operation and there are undoubtedly better places and more expert colorectal surgeons that would have a greater chance of success in a difficult situation like that."*¹⁶¹

¹⁵⁶ Statement of Dr Woodruff "PWHW-4"

¹⁵⁷ Statement of Dr Woodruff at 5

¹⁵⁸ Medical Certificate of the Cause of Death 24 December 2003

¹⁵⁹ Woodruff Report, 129 and Dr Woodruff T4325

¹⁶⁰ Dr Woodruff T4325

¹⁶¹ Dr Woodruff T4325

Performing this operation, in addition to indicating a possible lack of judgment, appears to be in breach of the Oregon Order governing complicated surgical cases. Under the Oregon Order Dr Patel was to seek second opinions before operating on "*complicated surgical cases*". It is noted that the definition of "*complicated surgical cases*" includes surgeries involving high risk patients. High risk patients are those with "*severe co-morbidities, including uncompensated heart failure, severe chronic obstructive pulmonary disease and renal failure...*"¹⁶²

It is submitted that Mrs Slater's chronic renal failure places her within the category of a high risk patient governed by the Oregon Order as one in which Dr Patel needed to obtain a second opinion prior to operating.

It is further submitted that this case should be referred to the Board for possible disciplinary action as it appears to indicate a lack of professional judgment on the part of Dr Patel and a breach of the conditions imposed by the Oregon Board of Medical Examiners.

4.4 Harold Roach (P36)

P36 was admitted to the Bundaberg Base Hospital on 18 January 2005. A seventy-three year old man at the time of admission, he was suffering abdominal pain and was found to have a subacute bowel obstruction. On 22 January 2005 Dr Patel performed a subtotal colectomy for obstructive colon carcinoma. P36 was unwell following surgery, he was hypotensive and tachycardic, and he was intubated and ventilated on 24 January 2005. P36 was also suffering from increased abdominal pressure. On 25 January 2005 Dr Patel performed an exploratory laparotomy finding an ischaemic colon just distal to the anastomosis. An ileostomy was performed at this time. P36 developed an atrial flutter but appeared to be doing better and was extubated. However, he required resuscitation on 10 February 2005 and was intubated

¹⁶² Oregon Stipulated Order, Attachment A

and ventilated again. P36 was subsequently transferred to the Mater Hospital in Brisbane on 14 February.

This patient's care was initially classified as one in which Dr Patel may have contributed to the adverse outcome.¹⁶³ Dr Woodruff, however, reclassified this case in his Statement to the Commission as one in which Dr Patel had contributed to the adverse outcome as Dr Woodruff regarded the decision not to perform a colostomy at the first operation as "an error of judgment which significantly contributed to the adverse outcome."¹⁶⁴ Dr Woodruff repeated this view in his evidence to the Commission where he stated that to perform the first operation on 22 January 2005 "without some form of colostomy and/or diversion was an error of judgment."¹⁶⁵

The care of P36 is suboptimal but the issue is essentially one based on clinical judgment and may not warrant disciplinary action.

4.5 Warren Stanaway (P40)

Warren Stanaway was admitted to the Bundaberg Base Hospital on 23 February 2004 for an elective re-anastomosis of double barrel colostomy. Mr Stanaway returned to theatre on 28 February 2004 for a laparotomy as his condition had deteriorated and he had considerable pain and a fever. The laparotomy indicated there was fluid in the peritoneal cavity. Dr Patel drained the fluid and noted that there was an enterotomy in the small bowel. Mr Stanaway was intubated on 29 February 2004.

On 3 and 4 March 2004 there was some concern raised as to whether Mr Stanaway should be transferred to the Royal Brisbane Hospital.¹⁶⁶ Dr Patel requested a second opinion from Dr Anderson who suggested a further laparotomy. On 4 March 2004 Mr Stanaway underwent the laparotomy and Dr Patel drained an abscess and performed a loop ileostomy. He was transferred

¹⁶³ Woodruff Report at 129

¹⁶⁴ Statement of Dr Woodruff, "PWHW4"

¹⁶⁵ Dr Woodruff T4324

¹⁶⁶ Dr Berens T1952 and Inpatient Progress Notes 4 March 2005 10:00 review by Dr Berens

from Intensive Care to the ward on 10 March 2004 and discharged on 14 March 2004 at his request, but he returned on 15 March 2004 as he was unable to cope at home.

Dr Woodruff identified this patient's care as one in which Dr Patel had contributed to an adverse outcome.¹⁶⁷ In his evidence to the Commission, Dr Woodruff stated that the finding of a two millimetre enterotomy in the small bowel on 28 February 2004 revealed a technical problem, and having to perform a further procedure leading to draining an abscess and performing a loop ileostomy reveals "*a technical performance that is definitely deficient.*"¹⁶⁸

Dr Berens, who had reviewed the patient in Intensive Care, was concerned that Dr Patel denied there was a leak of the anastomosis yet performed the operation on 4 March 2004 as if he were repairing a leak.¹⁶⁹ **Dr Anderson** was of the opinion that the loop ileostomy could have been performed on 28 February as opposed to having to operate again at a later date and he questioned whether the procedure on 28 February was indeed adequate.¹⁷⁰

Dr Patel's care of Mr Stanaway appears to have been sub-optimal. This case is one which should be referred to the Board for possible disciplinary action.

4.6 Ian Vowles

Dr Patel first operated on Mr Vowles to remove a malignant tumour in Mr Vowles' bowel in December 2003. Mr Vowles had a history of bowel cancer and was regularly scheduled to have colonoscopies. Dr Patel performed one such colonoscopy on 14 September 2004. This colonoscopy revealed a polyp in the bowel which Dr Patel advised was benign.¹⁷¹

Dr Patel recommended a total bowel removal and this was performed on 4 October 2004.

¹⁶⁷ Woodruff Report at 124-125

¹⁶⁸ Dr Woodruff T4326

¹⁶⁹ Statement of Dr Berens [7] and T1917

¹⁷⁰ Dr Anderson T2766-2767

¹⁷¹ Statement of Ian Vowles [6]

Mr Vowles was then readmitted on 25 October 2004 for revision of the ileostomy. There were further complications with the surgery, namely that the ileostomy was flush with the skin.

On 4 May 2005 Mr Vowles was referred to Dr O'Loughlin. Dr O'Loughlin found that the stoma was unsatisfactory as the ileostomy was narrowed and was not situated above or flush with the skin.¹⁷² The treatment Dr O'Loughlin said he would have advised would have been removal of the polyp with a colonoscope. Dr O'Loughlin did perform a revision of Mr Vowles' stoma at the Royal Brisbane Hospital. The treatment of Mr Vowles appears to indicate not only deficient technique, in terms of the unsatisfactory stoma but the total removal of the bowel was said by Dr O'Loughlin to be "*unnecessary*."¹⁷³

It is submitted that this case should be referred to the Board for possible disciplinary action.

4.7 P170

P170, a thirty-one year old male, was admitted to the Bundaberg Base Hospital on 10 October 2004 for an elective right inguinal hernia repair scheduled for 11 October 2004. The Surgeon's Report noted that Dr Patel was the surgeon with Dr Kariyawasam his assistant. Dr Kariyawasam, however, gave evidence to the Commission that it was he who performed this operation under the direction of Dr Patel.¹⁷⁴

The Surgeon's Report records that during the course of the operation the "*vas deferens [was] inadvertently divided*."¹⁷⁵ This error was explained to the patient post-operatively. Dr Kariyawasam advised that this operation was a difficult hernia repair and he was learning skills by following Dr Patel's instructions, but that he did not feel that he was operating outside his depth

¹⁷² Statement of Dr O'Loughlin [5]-[6]

¹⁷³ Statement of Dr O'Loughlin [7]

¹⁷⁴ Statement of Dr Kariyawasam [103] and T3102

¹⁷⁵ Surgeon's Report 11 October 2004

and he was confident with Dr Patel's instructions that he could perform the procedure.¹⁷⁶ He was of the opinion that the mistake could have happened to any surgeon.¹⁷⁷

P170 had surgery again on 3 December 2004 for an infected scrotal haematoma. He was discharged that day but returned to the hospital on 7 December 2004 with an infection. A further operation to drain the scrotal haematoma was performed by Dr Kariyawasam on 9 December 2004. P170 was discharged on 17 December 2004. P170 was eventually referred to Dr de Lacy after his GP discovered he still had an infection. Dr de Lacy performed additional procedures on 1 June 2005. P170 states that Dr de Lacy advised him that part of his bowel was wrapped in the mesh and he had removed the mesh and inserted new mesh.¹⁷⁸

Dr Woodruff categorised this patient's case as one in which Dr Patel contributed to the adverse outcome.¹⁷⁹ In his testimony to the Commission Dr Woodruff pointed both to the vas deferens being divided and the scrotal haematoma as evidence of "*deficient technical performance*."¹⁸⁰ This case is one which warrants further investigation by the Board in terms of possible "*unsatisfactory professional conduct*" in relation to Drs Kariyawasam and Patel.

4.8 P136

On 14 May 2003 P136 was scheduled to have a right epididymectomy in day surgery at the Bundaberg Base Hospital. However, nursing staff mistook P136 for a patient with the same first name scheduled for a gastroscopy that day. Dr Patel performed the gastroscopy on P136.¹⁸¹ An incident report completed on 14 May 2003 states that the staff had the right chart but the wrong patient.¹⁸² Jennifer White RN stated that the nurse in the Day Surgery Unit just called the

¹⁷⁶ Dr Kariyawasam T3103

¹⁷⁷ Dr Kariyawasam T3103

¹⁷⁸ Statement of P170 [16], Dr de Lacy has not given evidence in relation to this comment

¹⁷⁹ Woodruff Report at 120

¹⁸⁰ Dr Woodruff T4300

¹⁸¹ Progress Notes, note of Dr Kingston 14/05/03

¹⁸² Annexure "LTR16" to Statement of L Raven, exhibit 162

patient's first name and he answered.¹⁸³ The Incident Report further notes that the nurse was directed to the patient without a formal nursing handover, and that neither Dr Patel nor the anaesthetist checked the patient's arm band ID.¹⁸⁴ Staff discovered the error while P136 was still in the unit and the error was explained to the patient and he then underwent the scheduled procedure.¹⁸⁵

The Woodruff Report identifies Dr Patel as having contributed to an adverse outcome in respect of P136.¹⁸⁶ Nevertheless, the mistake appears to be a hospital failure rather than one which can be attributed to Dr Patel alone,¹⁸⁷ and the hospital appears to have put in place measures to prevent further such mistakes. Jennifer White stated that in her opinion, *"it's the system's problem. Where there was a lot of patients booked on that particular list the staff were anxious to get through the procedures so they could go home on time, and at that stage endoscopy patients, there wasn't a checklist completed for them."*¹⁸⁸ Dr Keating notes that changes would be made in relation to checking patient names and identification in the Day Surgery and operating theatres and that patients undergoing operations would be handed over to operating theatre staff by Day Surgery staff.¹⁸⁹ While operating on a patient without their consent is certainly a serious concern, Dr Patel's role in the mistaken identity may not be such as to refer the case to the Board for investigation leading to possible disciplinary action. A number of hospital personnel appear to have contributed to the error in this case.

4.9 P270

P270 was admitted to the Bundaberg Hospital on 7 March 2005. A sixty-eight year old woman, P270 was scheduled for repair of a para-oesophageal hernia and also underwent a splenectomy. On her return from surgery she began

¹⁸³ Jennifer White T1236

¹⁸⁴ Annexure "LTR16" to Statement of L Raven, exhibit 162

¹⁸⁵ Annexure "DWK76" to the Statement of Dr Keating, exhibit 448; Statement of Jennifer White [27], exhibit 71

¹⁸⁶ Woodruff Report at 122

¹⁸⁷ Dr Keating T6940

¹⁸⁸ Jennifer White T1237

¹⁸⁹ Annexure "DWK76" to the Statement of Dr Keating, exhibit 448

complaining of chest pain. P270 returned to theatre on 9 March 2005 for exploration as a result of wound dehiscence.

The Woodruff Report also identified this patient's adverse outcome as having been contributed to by Dr Patel.¹⁹⁰ In his evidence to the Commission, Dr Woodruff stated that this case provided another example of wound dehiscence which reflects a procedure "*classified as technically deficient.*"¹⁹¹ The treatment of P270 provides further evidence of Dr Patel's technical errors but, it is submitted that this case is not of sufficient seriousness to be referred to the Board for further investigation.

4.10 Carl Robinson (P288)

P288, a seventy-four year old male, had a low anterior resection on 14 April 2003. Post operatively P288 suffered a number of complications. Initially P288 had an anastomotic leak, which Dr Patel treated with a colostomy on 20 April 2003. On 18 July 2003 P288 underwent a colostomy reversal. He was then transferred to the Bundaberg Base Hospital by the QAS on 3 August 2003 with wound infection and breakdown.

Dr Woodruff stated in relation to this patient's care that P288's post-operative admission for infection "*raises questions of surgical detail and technique.*"¹⁹² Dr de Lacy's concerns related to Dr Patel's failure to fully remove the tumour and what he perceived to be an attempt by Dr Patel to mislead the pathologists in relation to the sample provided.¹⁹³ There do appear to be valid concerns with respect to Dr Patel's clinical competence in relation to his treatment of P288.

4.11 P37

¹⁹⁰ Woodruff Report at 124

¹⁹¹ Dr Woodruff T4324

¹⁹² Dr Woodruff T4324

¹⁹³ Dr de Lacy T4432 and Statement of Dr de Lacy attachments "GAD2" and "GAD3", exhibit 252

P37 was admitted to the Bundaberg Base Hospital on 10 August 2004. On 13 August 2004 Dr Patel, assisted by Dr Kariyawasam, operated on the seventy two year old patient to repair an incarcerated ventral hernia.

P37 commented that she was in pain after the operation. On 25 August 2004 Dr Kariyawasam performed an evacuation of the haematoma after a CT Scan revealed that there was a collection or haematoma in the abdominal wall:

Ms Hoffman's concerns¹⁹⁴ were said to be that Dr Patel allegedly attempted an evacuation without analgesia and that he stated that the patient was doing well when she required admission to the Intensive Care Unit following surgery.¹⁹⁵ The inpatient notes do record an attempted evacuation leading to a decision that the patient would require further surgery on 25 August 2004.

Dr Woodruff noted that the Surgeon's Report of 13 August 2004 recorded serosal tear with the diathermy. The need for an evacuation of the collection or haematoma was the reason for identifying this patient's adverse outcome as one that was contributed to by Dr Patel.¹⁹⁶

Based on Dr Woodruff's opinion of the care given to P37 this case is likely to warrant possible disciplinary action by the Board.

4.12 P306

Dr Patel performed a colectomy on this sixty-two year old patient on 6 January 2004 after she perforated the diverticulum. Post-operatively P306 suffered with infection and deep vein thrombosis in the left leg. A second operation was performed after the stoma retracted.

The Woodruff Report identified this patient's adverse outcomes as one in which Dr Patel contributed.¹⁹⁷ The need for a second operation reflected, in Dr

¹⁹⁴ Based on information from Karen Stumer

¹⁹⁵ Statement of Toni Hoffman at [60] and T111

¹⁹⁶ Woodruff Report, 124 and T4325

¹⁹⁷ Woodruff Report, 125

Woodruff's opinion, an "*unquestionably deficient technique*."¹⁹⁸ This case is one which could be referred to the Board for possible disciplinary action.

5. Patients the Commission has heard evidence regarding, but whose care is unlikely to warrant disciplinary action

5.1 Marilyn Daisy (P52)

A chronology of her care is as follows:¹⁹⁹

23/08/2004	The patient was seen in the Outpatients at the Nephrologist Private Clinic by Dr Miach. He referred her to Royal Brisbane Hospital and asked the patient to return in six weeks time.
24/08/2003	The patient was seen in Outpatients in a medical ward review. A below knee amputation was planned and also to optimise renal function and to exclude significant coronary artery disease.
07/09/2004	The patient was seen again in Outpatients in a medical ward review. She was assessed as suitable for a below knee amputation.
07/09/2004	The patient was seen in Outpatients in a surgical ward review by Dr Patel. He notes that she is for a below knee amputation.
20/09/2004	The amputation was carried out by Dr Patel.
21/09/2004	The patient was seen by Dr Patel in the ward postoperatively.
21/09/2004	The patient was seen by a surgical medical officer.
22/09/2004	The patient was seen by Dr Sanjeeva, Surgical PHO.
22/09/2004	The patient was seen by Dr Smalberger and others on a ward round.
23/09/2004	The patient was seen by Dr Patel. He ordered removal of a drain and steri-strips and indicated he will review the stump.
23/09/2004	The patient was seen by Dr Smalberger and others.

¹⁹⁸ Dr Woodruff T4327

¹⁹⁹ Exhibit 100 and Statement Dr Keating

23/09/2004)	
)	
24/09/2004)	The patient was seen by Dr Miach
)	
25/09/2004)	
27/09/2004		The patient was seen by Dr Patel. He indicated to continue physiotherapy.
27/09/2004		The patient was seen by Dr Smalberger.
27/09/2004		The patient was seen by Dr Miach.
28/09/2004		The patient was seen by Dr Patel, He recommended the patient be transferred to the medical ward and noted that the stump was healing well, that there were no concerns surgically that the patient should be followed up in the outpatients department and that she should be seen at the outpatients department in two weeks time.
02/10/2004		The patient was transferred from the surgical ward to the medical ward for dialysis. The patient was wanting to be discharged and was advised that it would be against medical advice.
04/10/2004		The patient was seen by Dr Gardner. He noted some problems with the stump, that the patient is to have a permacath inserted by Dr Gaffield the next day and that the patient is to have a surgical review of her stump by Dr Patel's team. She was to have the temporary catheter out as soon as the permacath was put in and can potentially go home after dialysis if the surgical team is happy.
04/10/2004		The patient was seen by a Surgical PHO, who noted that the stump looked okay with a small area of wound breakdown on the lateral edge of the wound. He ordered daily dressing and review.
05/10/2004		The patient was seen by a surgical house officer. He reviewed chest x-rays with Dr Gaffield and ordered the patients return to ward.
06/10/2004		The patient elected to be discharged from hospital despite advice from a medical officer that she may become unwell and even die.
09/10/2004		The patient presented to the emergency department indicating that she was advised to present by the medical ward for dressing change.

- | | |
|------------|---|
| 11/10/2004 | The patient cancelled an outpatients appointment with Dr Miach. |
| 12/10/2004 | The patient had her dressing changed in emergency. |
| 12/10/2004 | A surgical ward's outpatients note indicates appointment with no entry. |
| 19/10/2004 | The patient had a dressing change in the emergency |

Dr Jenkins, the vascular surgeon revealed three issues in relation to her care which concerned him. Firstly, that she had not been offered the option of saving her leg with a by-pass operation. Secondly, that the surgeon, Dr Patel, had not reviewed his work and had not seen her since the initial surgery. Thirdly, that the sutures remained in place despite the lapse of six weeks since the surgery.²⁰⁰

Option of procedure other than amputation

Dr Jenkins outlined alternatives which might have avoided the surgery. If the patient suffered dry gangrene and was non-life threatening it would be appropriate to attempt to save her leg. If she had wet gangrene, which was infective, then the appropriate treatment was either urgent revascularisation (which is not an option in Bundaberg) or amputation. He qualified his opinions indicating he did not know how her arterial tree appeared as prior to the surgery. He said that unless she had had an angiogram or ultrasound then that was difficult to discern.²⁰¹

In essence the only reasons, according to his evidence, not to offer an option of revascularisation was that she was too unwell, if she did not desire it or had a degree of gangrene on her lower extremity.²⁰²

Dr Miach, as her treating renal physician swore that he was unaware that she had been admitted by Dr Patel for a below knee amputation.²⁰³ He further

²⁰⁰ Para 9 of Statement of Jason Jenkins. See also his exhibit 17.

²⁰¹ He expanded upon this to the extent that if she had significant small vessel disease then the probability is low that she would have had a limb that was salvageable – T3718 – T3727.

²⁰² T3727.

gave evidence that as a consequence he was unaware of her post-operative care. He said that she was extremely ill by the time that he was able to consult with her. This will be dealt with in greater detail further in these submissions.

Dr Smalberger gave evidence that he recorded that the amputation had been planned in his notes of 7 September.

Dr Kariyawasam, who assisted Dr Patel in the surgery, was unable to enlighten the Inquiry as to whether the patient had been offered any other option as to amputation.²⁰⁴

Review of the patient

Dr Jenkins' understanding was that the patient had not been reviewed at all by the surgeon and Dr Miach's evidence was that Dr Patel had left her in the ward under his care without advising Dr Miach although she was suffering from severe kidney failure and diabetes. By the time that he saw her she was almost comatose and suffering from uraemic encephalopathy. Dr Jenkins opined that he would have expected a review of the surgery the morning after it had occurred.²⁰⁵

Dr Miach complained that he had not been advised until one of his junior doctors – and it seems likely that it was Dr Smalberger from the evidence – advised him that she was an inpatient. Dr Miach said that given her severe kidney failure he would have expected to have been consulted and involved in the management of the kidney failure. Once he became involved in her care he treated her extensively for weeks until she recovered and was stable sufficiently to travel to Brisbane for further treatment. Dr Miach maintained that as she was admitted under the surgical unit she remained their responsibility.

²⁰³ See statement of Dr Miach para 76.

²⁰⁴ See T3101.

²⁰⁵ T3728.

Cross-examination of Dr Miach revealed the following:

- That he suspected his staff as medical people knew nothing of the forthcoming procedure and probably would have informed him. However, exhibit 100 reveals 24 August and 7 September that the out-patient clinic review notes indicated a planned amputation in the writing of Dr Smalberger, a medical physician.
 - 19 September there is a ward review pre-operatively by Dr Smalberger.
 - 22 September a review including medical team consisting of Dr Smalberger and others. It is clear from records that there was an acute deterioration on that day in renal function.²⁰⁶
- 23 September Dr Miach attended patient. Dr Miach conceded that she has been seen by the medical team prior to his attendance on 23 September.
- Dr Miach ultimately indicated that she was reviewed by a physician within the Department of Medicine who had organised her admission.
- Dr Smalberger was undertaking daily ward rounds but was particularly alive to cardiac issues with this patient.²⁰⁷
- It was he who recommended on the second post-operative day that Dr Miach become involved and when that did not occur until the third day he made a direct referral to that.

The sutures remaining in the amputated stump

Dr Jenkins is critical of the fact that the sutures remained in situ for up to six weeks by the time he saw her in Brisbane and his letter²⁰⁸ indicated that the sutures were both painful and difficult to remove. By the time he gave evidence he had become aware that against medical advice she had

²⁰⁶ See T1620-1621 and exhibit 100. Progress notes 23 September.

²⁰⁷ T1978.

²⁰⁸ Exhibit 17.

discharged herself on 6 October. Nonetheless he indicated that there were particular issues involving indigenous patients such as their reluctance to remain in hospital that would indicate that particular care needs to be taken with their admission.

According to Dr Kariyawasam's statement²⁰⁹, there were no arrangements made by the medical team for the outpatient's surgical follow-up. It is his understanding that follow-up appointments would usually be arranged by the ward clerks after a note had been made in the chart. He stated that their surgical team was not made aware of her self-discharging on 6 October 2004 and had they been informed a follow-up would have been arranged for continuing monitoring of the wound. Dr Woodruff in his evidence²¹⁰ indicated that this case was not as straightforward as it initially had seemed in that there were at least three people involved in her care in Bundaberg. She was also sent off for another procedure to another hospital. It did not excuse the oversight of leaving the sutures in place but made it explicable. It was placed on the list of adverse outcomes in relation to Dr Patel because although the circumstances were explicable, they did not exonerate him for some responsibility.

Conclusion

There is insufficient evidence to indicate whether there were other options offered to the patient in relation to procedures other than amputation. This is not simply a matter that goes to clinical judgment but really goes to the issue of informed consent. Secondly, as to the issue of the failure to inform Dr Miach and therefore attend to her renal needs this is not as clear cut given on the evidence a member of his team albeit from a slightly different focus was attending her both pre-admission and also within two days of her operative procedure. Whilst there was clearly a breakdown in communication this is of less significance than it had first seemed. As to the third issue of the non-removal of the sutures, clearly this was an adverse outcome for the patient in that the sutures presented considerable difficulty for her. Whilst Dr Patel

²⁰⁹ Para 94.

²¹⁰ T4304

contributed to this outcome it could not be said that he was solely to blame given the patient's self discharge and the involvement of other practitioners as Dr Woodruff stated. The ground which may well fall for consideration for possible disciplinary action is the lack of informed consent to this procedure by the patient and possibly as to the failure (given the patient's co-morbidities) to plan for her holistic care. As Dr Miach indicated he would have expected to have been consulted about the amputation as a matter of courtesy. In this case consultation may be seen as a necessity given her very considerable needs in relation to her chronic renal failure.

Further references in the evidence are as follows:

Statements – Jason Jenkins, Kariyawasam, Miach

Transcript – Jenkins 3695-3697, 3717-3718, 3727-3728;)
Kariyawasam 3101-3102)
Miach – 286-288; 1567-1570, 1573-1574, 1591-1594,)
1613-1629, 1657-1659)
Smalberger – 1977-1978)

5.2 Linda Parsons (P99)

Exhibit 100,101

Statement- Parsons; Dr Boyd – Ex 108, 106, 109, 112, 113
Transcript- Woodruff 4324; Parsons 1716-1774; Boyd 2824-2828

5.3 Geoffrey Smith

Statement Ex 174

6. Clinical Practices at Hervey Bay Hospital

Terms of Reference

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

6.1 Gloria Green (P430)

This was an elderly patient aged seventy-nine at the time of admission, she was a resident of Torbay Nursing Home with core morbidities being severe dementia and cardiac problems. She was initially admitted in the accident and emergency unit after a fall in which she sustained a mid shaft spiral closed left humerus fracture. Initially, a plaster was applied to her arm, which she removed overnight. In a summary of her admission prepared by a resident medical officer²¹¹, on 27 July the patient was booked for manipulation to occur under sedation.²¹²

Prior to this time the note in the summary states:

"Proximal fragment, punctured skin – 11 am 0.8 cm wound applied in theatre by Dr Naidoo".

In cross examination of Dr Naidoo, a further nursing note was put to him which corroborated there was a broken area of skin noted over the fracture site²¹³. He denied that and maintained there was no open wound at the time of the initial surgical procedure.

He elected to perform the procedure conceding it was not ideal, for the following reasons:

1. The internal fixation with a plate and screws would have failed because of the nature and extent of her osteoporosis and because of the difficulty to control the patient and her need to be frequently sedated.
2. The ideal procedure, he stated, would have been intramedullary nails and supplementary fixation. He discounted this because the equipment was not available and would have been required on loan. The second reason is it would have increased the risk of mortality because of her general medical condition. He confirmed that he had sought an opinion as to this from the duty anaesthetist.

²¹¹ This is part of an annexure relating to this patient to the statement of Dr Sean Mullen

²¹² as due to her general medical condition, Dr Naidoo stated that the anaesthetist elected to perform the procedure under sedation rather than full general anaesthetic

²¹³ Nursing note 27 July 2000

Dr Naidoo indicated that despite the fact that she had already removed one plaster cast herself prior to his surgical procedure of 27 July, nonetheless this was the preferable option on the day.

Secondly, as there was not an open wound it was not contra-indicated. He accepted that if it was an open wound the situation would have differed.

The summary further notes that on 29 July, the bandages were soaked and there was hemoserous fluid. The bone was seen medially. Dr Naidoo was phoned and advised: *"leave it in situ and re-bandage"*.

Dr Naidoo also accepted the note on 30 July 2000, a note which provided that:

"PT still same/deteriorating ↓↓/confused... - back slab on ... - Dr Naidoo informed last night and she is medically too unwell – discussed ... James, Medical PHO".

He accepted that prior to his going on leave on 31 July he did not review the patient himself despite the fact she had been deteriorating since the procedure on 27 July as advised. He states that he may not have been rostered on from 29-31 July.

He accepted that he made no formal arrangements, or indeed informal arrangements, for the handover of her care to another medical practitioner skilled or experienced in orthopaedics.

Dr Naidoo accepted that on 2 August 2000 Dr Mullen became involved with the patient at that time. According to Dr Mullen's evidence, in his statement²¹⁴ and his oral evidence, he then took the patient to surgery and applied an external fixator, and generally attended to the now exposed and infected wound. Dr Mullen's procedure whilst the wound was open was appropriate although, as it became apparent, was also fraught with difficulty because of the patient's dementia.

²¹⁴ Exhibit 330, paras 6-12

On his return, Dr Naidoo resumed the care of the patient when he observed the external fixator was loose with dislodgment of the pins and fragmentation of the fracture.

Eventually on 10 August the patient had her arm amputated.

Dr Naidoo accepted Dr Mullen's opinion, that he had not seen a "*closed ... non-open fracture of the humerus in a low velocity situation in an old patient end up with amputation*".²¹⁵

Dr Naidoo accepted Dr Mullen's opinion that with these sorts of situations one needs to attend in a fairly prompt period of time to deal with the problem²¹⁶. This is borne out by the fact that Dr Naidoo²¹⁷ had been admonished by Dr Hanelt after the amputation had occurred in that he expected Dr Naidoo to notify Dr Mullen of a patient such as Mrs Green when he was to be absent on leave and hand-over to Dr Mullen informing him of the condition of the patient and her needs.

Dr Naidoo did not accept Dr Mullen's indication that the delay would have led to the outcome of the amputation.²¹⁸

Conclusion

There are two particular issues arising from Mrs Green's care. Firstly, the original procedure carried out by Dr Naidoo on the 27 July and, secondly, the lack of review and/or handover by Dr Naidoo.

As to the first issue, it is clear that the matter was particularly complicated because of the presence of significant other medical conditions in Mrs Green's presentation. Neither of the courses adopted by either surgeon was ultimately successful in securing the fracture. Dr Naidoo did concede that if

²¹⁵ T5450

²¹⁶ T5453

²¹⁷ Cross-examination by Counsel for Dr Hanelt

²¹⁸ T5453

the wound was open, that Dr Mullen's election to leave the wound open and attempt the procedure he did was appropriate. The nursing notes certainly reveal that there was an open wound at the time that Dr Naidoo carried out the first procedure. It may well be decided that this was a difference of opinion and it was a difference in clinical judgment between the two doctors.

The second issue is far more significant. There was clearly an ongoing need for close attention to Mrs Green's condition. When there must have been concern as to the effectiveness of the procedure and also the presence of her other significant symptoms, the only physical occasion there was a review by Dr Naidoo was on the day after the procedure. He was contacted at least twice thereafter until he went on leave during which he was made aware that the patient was deteriorating. It is unclear whether those contacts were on the weekend when he was not rostered on. Even if it were so, given the complexity of the patient's condition and the deteriorating nature of it, there should have been arrangements made as he was later admonished by Dr Hanelt²¹⁹. This issue and the ultimate very significant consequences may well sound in the matter being referred for possible disciplinary action as constituting a standard of care which is less than expected of one's peers.

6.2 J. Howard Osborne

Statement paras 23-26

This was a patient who Dr Mullen ultimately at the invitation of the theatre sister took over an operative procedure being performed by Drs Krishna and Sharma. He described that there was a fracture of the femur which had occurred during placement of the nail which had been put in place. The patient had also sustained a fractured ankle because of the extended period of time the patient had been anaesthetised and the blood loss. Dr Mullen was of the view that it was best that he attended to the fractured ankle as quickly as possible to return the patient back to the ward as the anaesthetists were concerned about the temperature and the general condition of the patient.

²¹⁹ T6706

He conceded that where a fracture has occurred whilst nailing a femur is not unexpected. His concern was that the selection of device to use in that particular situation was inappropriate because the device was a newer device which required greater skill to place and often needed two assistants as there was no external support to hold the patient in place, the device being a retrograde femoral nail.²²⁰

Drawing on his own experience as a trauma surgeon and given the difficulty in use of that device his view would have been that it was the wrong selection and again Dr Naidoo should have been supervising the situation.

He had understood that as he was on duty that evening Dr Naidoo had been the orthopaedic specialist on duty during the day. It was Dr Mullen's evidence that he had been contacted several times by nursing staff during difficulties encountered.²²¹

The surgical note records that the patient was anaesthetised at 1.36 p.m., that the surgery commenced at 2.24 p.m. and finished at 6.45 p.m. with the patient departing from the operating theatre at 6.55 p.m.²²² The operation report confirms that Dr Mullen was involved in the operative procedure on that date.

Dr Krishna's evidence was:

- That he had not sought to contact Dr Naidoo.
- That it was a comminuted complex fracture.

It was not part of his scope of practice document.²²³ However he drew attention to the fact that the operation was performed in 2003. The scope of practice document was drawn up in 2004.

He had performed a couple of these procedures and thought it was not unreasonable to perform it unsupervised. Whilst Dr Sharma indicated to Dr

²²⁰ T5767

²²¹ T5768

²²² See operating room nurse's report

²²³ See annexure 6 to Dr Krishna's statement

Mullen he would have preferred assistance, Dr Krishna was comfortable without it.

He defended his choice retrograde nail as being appropriate and which he had known of since 2001.

He had had the assistance of Drs Sharma and Hugh McGregor.

The retrograde femoral nail as appropriate as there were two fractures close to the knee joint which this was particularly designed for.²²⁴

6.3 Allan Smith (P436)

This patient sustained an injury whilst falling from a boat ladder in March 2004.

Dr Krishna initially operated upon the patient on 28 March by performing an open reduction internal fixation of the right hip, achieved with a pin and plate.

The patient unfortunately developed wound infection which required a month in hospital.

Dr Mullen reviewed the patient on 18 July 2004 and highlighted the particular issues of note:

- He was a heavy man,.
- There was a large amount of force involved in the fall.
- this was a fracture of the proximal intertrochanteric region of the right femur .He opined that it was a dangerous area because it is difficult to get fixation there.
- The fracture was also comminuted;

²²⁴ T6487

- His opinion was that the fixation used was inadequate, that is, there were only four screw holes in the plate to fix the bone to the shaft whereas there should have been between eight and twelve.

In addition, Dr Mullen opined there was at the time of the surgery other techniques available which were better suited to the circumstances such as using a long plate or a big nail that goes into the canal of the bone which can provide more stability²²⁵.

- The x-ray revealed non- union of the fracture
- There was loosening of the fixation, particularly the screw within the femoral head and a "*windscreen wiper effect*"²²⁶. But that in itself did not indicate that the fracture hasn't healed, maybe that the fracture had been loose and then subsequently healed. But it did indicate that the fracture was unstable still.²²⁷ He conceded however that it was not easy to determine that and he had to consult with the patient twice to form that diagnosis.

He conceded that his statement at p. 6 was incorrect as he had not seen the patient some nine months later but approximately three months later²²⁸.

As at the date of the review the causation of the non-union was obscure as to whether it was due to non-fixation or infection.

- The patient had complained in outpatients over a 9 month period of pain and non-weight bearing on the hip;
- There was no supervision by Dr Naidoo of Dr Krishna²²⁹;
- Ultimately, the patient underwent a total hip replacement on 6 December 2004 by Dr Mullen which could have been avoided.

²²⁵ T5778

²²⁶ Ex 370-extract re Allan Smith

²²⁷ T5801

²²⁸ T5803

²²⁹ Para 34 Statement Dr Mullen

In his oral evidence Dr Mullen was more forthright indicating that the failure of fixation because there was an adequate device used on a very unstable fracture in a heavy man.²³⁰

In cross-examination Dr Mullen conceded that the treatment received by him would be standard for injury which would be slightly higher and less unstable.²³¹ Hence an intratracheal fracture a pin and plate with four holes would be "a good device and works well".²³²

In subsequent correspondence to the patient's general practitioner, the patient was making an uneventful recovery²³³.

Dr Krishna

Whilst accepting many of the features as described by Dr Mullen, Dr Krishna rejected that the suggestion that either of the techniques described by the latter as being preferable that is a long plate with a different type of screw into the ball of the femur or intramedullary nailing, into the canal of the bone, were appropriate.²³⁴

The essential difference for Dr Krishna that in his view this was not a subtrochanteric but rather an intertrochanteric fracture.²³⁵

He also maintained that he had followed up the patient adequately and had not required supervision:

- The patient was comfortable and able to bear weight;
- x-rays of 7 May 2004 indicated new bone was forming and the fracture had healed;

²³⁰ T5800

²³¹ T5799

²³² T5799

²³³ Ex 370

²³⁴ T6495-6

²³⁵ T6496

As he had deep vein thrombosis and was monitored weekly by his general practitioner, the general practitioner could be contacted if there was a problem.

Conclusion

In essence, this case does not warrant further investigation for disciplinary action as there is clearly a difference in opinion which can be differentiated on perusal of the x-rays as to what type of fracture it was.

Secondly the cause of the non-union is unclear as Dr Mullen says Dr Mullen also conceded that there was a history of infection and that area of the body is notorious for non-union of bone.

If it were a sub-trochanteric fracture the chances of non-union were high and implant failure was high because of muscle imbalances²³⁶, whereas if it was intra-trochanteric the fixation achieved good stabilisation. The resolution of that difference of opinion by having regard with the x-rays.

It was his view that if an apparatus requiring 8-12 screw holes would have been inappropriate because the instability and the fractures were not in the shaft it was all above the lesser trochanter. However his opinion necessarily rested on the fact as to whether the fracture was the intra-trochanteric location.

6.4 Brendan Thomas (P434)

This patient was aged fifteen upon his admission following a football injury. There was a closed reduction of the fractured wrist in surgery.

The patient was reviewed by Dr Mullen on 18 and 25 September, consecutively one and two weeks after his surgery. On the latter date the x-rays confirmed that the fracture was still well aligned, there was a 5° dorsal angulation at the fracture site but that was within acceptable limits. He was planned for further review in another four weeks.

²³⁶ T6518

The review notes indicate that he was subsequently seen in the orthopaedic review clinic on 23 October but it is unclear by whom. The patient was next seen on 6 November by a Dr Bacon and subsequently not until 29 May and 16 June 2003, both times it would appear from the signature, by Dr Sharma.

The critical issue according to Dr Mullen was that in this type of injury where there was instability of the joint a further loss of reduction does not occur necessarily within the first couple of weeks but it develops in a period of between six and twelve weeks post injury. Dr Mullen's concern in relation to Mr Thomas' injury was that it was poorly treated with a lack of supervision in the aftercare and that as a result the patient required major reconstruction in Brisbane with Dr Peter Rowan, a hand and upper limb surgeon.²³⁷

Whilst he does not criticise Dr Sharma who carried out the review in May and June 2003 it was Dr Mullen's view that he should have been supervised by Dr Naidoo or an experienced orthopaedic surgeon. Dr Mullen noted that it was a difficult fracture because it often led to problems with stability of the joint and the fracture could move position over a period of time in the post-fracture weeks and therefore needed close supervision. It was his understanding that the patient would be followed-up through the outpatient orthopaedic clinic.²³⁸

When he reviewed the patient in February 2004 Dr Mullen's diagnosis was that he was suffering from a subluxation of the distal radioulnar joint of the right hand side from a malunited Galeazzi fracture. In Dr Mullen's view junior staff would not necessarily recognise that the joint remained unstable.

Although the long term outcome is satisfactory for the patient because of the operative procedure carried out by Dr Rowan it would have been less traumatic in terms of the surgical procedure if it had been corrected at an earlier time.²³⁹

²³⁷ See para 31 of his statement. See also T5769.

²³⁸ T5770

²³⁹ T5771

Conclusion

There is not a ground for a referral for disciplinary action against Dr Sharma. In relation to Dr Naidoo, it is part of the broader issue of possible lack of supervision which was made available to Drs Krishna and Sharma. The criticism of Dr Mullen flows from the proposition that the original surgery was appropriate.

The post-operative care offered to the patient was inadequate. An area of uncertainty emerges as it appears from the x-ray evidence that apparently shows that the degree of angulation was more than 15° in the x-rays ordered on 30 October 2003 by Dr Mullen.²⁴⁰ Whether that sounds in any consequence in relation to the initial surgery, indeed the follow-up of the instability, or some error by the radiographer is a matter which could call for further investigation.

6.5 Dylan Neil (P446)

This was a young patient fifteen years old who presented with a fractured left tibial plateau after falling while playing football. He described a twisting injury to his leg as his knee impacted on the ground. He was operated on 24 May 2004 by Dr Naidoo, assisted by Dr Krishna. It was a comminuted displaced fracture whereby the fracture extended into the knee joint.

On 2 June, Mr Neil returned to surgery for the insertion of percutaneous screws to the left lateral tibial plateau.

It was noted:

"the wound has healed well without problems, he has a normal gait and a good range of motion".

A recent x-ray shows the fracture union in good alignment.

Dr Crawford's critique of the care of Mr Neil was that the screws inserted during the first operation were too short to get across the *"two bits of bone*

²⁴⁰ T5790-T5792

and hold them together... There was a bit of bone and there was a bit of bone from the joint which had not been put back into place".²⁴¹

The observations of Dr Crawford arose from the x-rays taken post-operatively between the two operations. As the discharge summary makes clear, after the x-rays were viewed (and Dr Naidoo accepted this) a decision was made to return to the operating theatre on 2 June.

Dr Crawford stated that the second operation was to try to pull the bone back together *"but I suspect it wasn't recognised that the bones were in the wrong place and couldn't be pulled together with just the screws..."*.

It was also his view that the wound should have been re-opened to put the bone back together, in effect, to replace it appropriately.

Dr Naidoo rejected that the second operation was ineffectually performed in that the wound should have been re-opened. Dr Naidoo said that may well have led to infection.

In any case, it is clear that the patient has in the short term recovered well and is functioning, in the words of Dr Crawford, *"surprisingly well"*. However, in the longer term he opined, in answer to questions from Counsel Assisting:

"Does it seem reasonable to conclude that the prospects of his suffering arthritis later are increased because of the way these procedures were performed? ... Yes."

Dr Naidoo rejected this opinion and indicated that the likelihood of osteoarthritis is really predicated at the time of injury, rather than as a result of subsequent treatment. Whilst there is no note of him having reviewed the patient subsequently, Dr Naidoo swore that he had done so.

The x-rays following the first procedure revealed that the procedure (which Dr Crawford conceded was a difficult one to perform) had not been successful in terms of its outcome. Based on the opinion of Dr Crawford, it would not seem that this matter would warrant referral for possible disciplinary action for lack of competence on the part of Dr Naidoo.

²⁴¹ T6309

6.6 Rita Jackson (P444)
HBH UR070090

Ms Jackson was a patient who was first brought to the attention of the inquiry by Dr Mullen²⁴² who identified that she had had a big toe fusion that was performed without her consent and it led to significant disability and was being treated by Dr Blenkin in Brisbane. Dr Mullen's criticism was that the procedure was carried out by Dr Krishna unsupervised at Hervey Bay. Dr Mullen said that the supervision should have been followed up by Dr Naidoo. In his oral evidence Dr Mullen said that if a toe is fused in the wrong position it would allow for poor function of the foot and it is quite difficult to get the position right. It would take "*a fair amount of experience to do that. So I do believe that it should not have been done by Dr Krishna*"²⁴³.

This patient was also reviewed by Dr Crawford on 2 June this year. He noted that she had had a first MTP fusion on 3 September 2003. He noted in her history that she had a significant bunion and that she sustained a deal of pain from her joint. In the history he took from her he noted that there was an issue in the outpatient notes²⁴⁴ that she had not fully understood the procedure and it was postponed at that time. She was subsequently seen some eight days later and was consented for a bunionectomy and MTP fusion. She had originally been consented for bunionectomy. Dr Crawford noted that in his review there had been some degenerative changes on the original x-rays and whilst it was difficult to be sure she did have some degenerative changes and fusion may well have been a reasonable option.

Dr Crawford noted that she had sustained ongoing problems and had impaired enjoyment of former activities. He noted that the angle of the fusion on the x-ray suggested that it was 15° but clinically less significant. Upon his review he provided options for further treatment which would in his opinion

²⁴² See para 32 of his statement, exhibit 330

²⁴³ T5773

²⁴⁴ 13 August 2003 noted in his report 9 June 2005

provide her with a reasonably good chance of making her significantly better than she is now.

The issues which then arise are – firstly, performing a procedure which was not properly consented in that she had apparently consented to a bunionectomy and not a fusion and secondly, the issue in relation to the performance of the actual procedure. As to the latter issue Dr Anthony Wilson gave evidence that this would fall within the type of procedure that Dr Krishna would have been able to perform unsupervised. As to the skill with which it was performed it is noteworthy that Dr Crawford in his evidence indicated that the correct position for the fusion was achieved and the joint was appropriately stiffened but not quite in the right position. In his words:

*"If you saw that someone who is competent had done this and achieved the same result, I mean, it wouldn't ring any alarm bells ..."*²⁴⁵

Therefore on the second issue there seems to be an issue of differing clinical judgment rather than issues which would merit disciplinary action. The former issue appears to be resolved satisfactorily as Dr Crawford notes in his report in relation to the subsequent consent noted 21 August 2003. There is also in the patient consent form the addition which appears of the fusion "MTP J initials including RJ".²⁴⁶

6.7 Judith Harris

Judith Harris was a patient highlighted also in Dr Mullen's evidence. Her complaint to the Health Rights Commission is currently under investigation.²⁴⁷ She sustained a distal tibial shaft fracture and tibial and fibular fractures on 4 January 2005. She slipped and fell whilst walking in a paddock and was transported to the Hervey Bay Hospital. She was assessed in a backslab and admitted to a ward.

²⁴⁵ T6306

²⁴⁶ Pages 155 and 156 of the chart

²⁴⁷ T6489

Due to staff shortages, surgery was postponed and she was discharged to return to surgery. She underwent an open reduction internal fixation of the left tibia and fibular on 11 January 2005 performed by Dr Krishna.

She had a prolonged stay in hospital for 11 days due to some bleeding from the medial wound.

She subsequently returned and was admitted on several occasions to both Maryborough and Hervey Bay Hospitals due to wound infections and required antibiotic treatment. She sought treatment with Dr Mullen who on-referred her to Dr Journeaux at the Mater Hospital in Brisbane. Upon his examination in May 2005 Dr Journeaux observed that upon examination and review of the x-rays there was an obvious non-union of both the tibial and fibular fractures. According to Dr Journeaux' report she would require further surgical work including removal of metalwork, excision of dead bone and perhaps bone transportation. He suggested a consultation with Dr Tettsworth.

The essence of the issues are firstly, the performance of the procedure by Dr Krishna as an SMO rather than a qualified orthopaedic surgeon and secondly, the standard of the procedure performed.

Dr Krishna himself during the performance of this procedure indicated that he had required assistance from Dr Naidoo and had been told to in effect "open up the patient and contact Dr Naidoo if necessary". When he commenced to operate he indicated the fracture was very comminuted, distal fibular and confirmed by the chart.²⁴⁸ Dr Naidoo did not attend and there is a further note where there was no surgical assistant available despite requests from Dr Krishna noted. Dr Krishna's evidence was that he contacted Dr Naidoo twice to attend.²⁴⁹ This was a procedure on the assessment of Dr Naidoo, that Dr Krishna required supervision. Dr Naidoo's evidence was that that would relate to a more junior assistant specialist which notation is left blank in the relevant form. Nonetheless he accepted he was not available to assist Dr

²⁴⁸ See p. 203 of the chart

²⁴⁹ T6494

Krishna. This may be a matter requiring further investigation of Dr Naidoo's apparent failure to attend to supervise Dr Krishna when requested to do so.

6.8 Madge Payne (P445)
UR108708

This patient's treatment was highlighted by Dr Crawford as being similar to that administered to Rita Jackson. This case is subject to current investigation by the Health Rights Commission. The patient was reviewed by Dr Crawford on 2 June 2005.

She was first seen at the Hervey Bay Hospital on 28 July 2003 with bi-lateral painful bunions and x-rays showed severe degenerative changes in the first MTP joint. She had an arthrodesis of her left first MTP joint on 27 August 2003. Dr Crawford noted that she healed well without significant problems. Subsequently on 27 July 2004 she had a right first MTP fusion. She healed unremarkably although she subsequently noticed to have stiffness of the "DOP" joint on her right side.

She had formerly been a keen dancer but is unable to stand on the front of her foot with her ankle flexed. She was unable to do some other activities because of the limited movement in the joint of her toe and other symptoms. On examination which was confirmed by the x-ray there is a significantly greater degree of extension at the IP joint whereas on the right side there was approximately only a 5° extension. Dr Crawford noted that she has two particular problems. One is the functional limitation due to the lack of extension in the position in which the IP joint has been fused.²⁵⁰ In essence Dr Crawford concluded that on one side:

- "the left side – she had a very good result. Everything seems to have been done completely appropriately. On the right side she had the same problem as the previous patient mentioned P444 had, that the joint just wasn't – didn't quite have enough of an angle on it and she had ongoing difficulty walking because of that. Subsequently I similarly

²⁵⁰ See exhibit 407 for a more extensive description of the treatment and difficulties sustained by Mrs Payne.

*had to perform corrective surgery in Maryborough to readjust the angle."*²⁵¹

Dr Crawford's criticism centred around the lack of supervision for Dr Krishna as contained in the following passage of evidence:

*"... had there been supervision in place at the time of that second operation in her case and the operation in P444's case, that moderate angle difference might have been discerned by the specialist and corrected there and then? ... That's correct yes."*²⁵²

It is submitted that Dr Krishna's conduct in performing the operation showed an error in judgment in the error in the angle of fixation in the second operation whereas he had successfully performed the same operation on the same patient a year earlier.

Her adverse outcome which now appears to be rectified by Dr Crawford's subsequent procedure would not warrant a referral for disciplinary action in relation to Dr Krishna.

This was a procedure Dr Krishna was assessed as being able to perform without supervision.

6.9 William Skene (P442)

Dr Crawford reviewed this patient at the outpatient department at Hervey Bay Hospital on 2 June 2005. He presented with pain in his left foot mainly complaining of pain underneath the plantar aspect of the left foot where he indicated he had two lumps.

The patient was first seen in the outpatients clinic on 31 October 2003 where it was noted that he had bi-lateral hammer toes more severe on the left side and no callosities at that time. The x-rays demonstrated osteoarthritis. Dr Crawford's view was that the outpatient notes showed a brief but reasonable assessment of the problem.²⁵³

²⁵¹ T6307

²⁵² T6315

²⁵³ Report prepared by Dr Crawford exhibit 405

The patient was reviewed on 14 November 2003 at the same department for consenting and the notes indicate it was for correction of the hammer toes to the four lesser toes and fusion of the MTP joints with K wires.

The patient underwent surgery on 28 January 2004 involving excision of the second and fourth metatarsal heads, excision of POP joints to the lesser four toes, extensive tenotomies and K wiring. Subsequently reviews on 6, 13, 19 and 27 February were uneventful save for superficial infection noted on the second review date. On 12 March the wiring was reviewed and the toes were noted to be viable.

Dr Crawford's impression was that the first clinical review was reasonable but it was not noted that he had a history of rheumatoid arthritis and that the MTP joints were dislocated on x-ray which were apparent from the films from October 2003²⁵⁴. The decision to go ahead with surgery did seem reasonable to Dr Crawford. The majority of the procedure would have been the right thing to do except for the decision to fuse the MTP joints. In oral evidence Dr Crawford expanded:

"The aim of the operation is to stiffen one row of joints in the toes and excise a second row and leave them floppy, which would be a standard procedure, and that's what the patient was booked for. So the patient was actually booked for appropriate surgery but when the operation was performed the patient actually had two rows of joints stiffened rather than just one, which was I think, clear because of his ongoing pain and symptoms. He subsequently had corrective surgery which I performed in Maryborough to excise one of the rows of joints that had been stiffened, which basically put him back to the situation he would have been if he had had the original surgery. So I think his final outcome is the same as it would have been. In fact I am not aware of it being a prescribed operation, to actually stiffen both rows of joints."

Dr Crawford added in answer to a question from Counsel Assisting that if an orthopaedic surgeon had supervised Dr Krishna it is not something that a surgeon might have permitted Dr Krishna to do.²⁵⁵

²⁵⁴ Exhibit 405.

²⁵⁵ T698

Dr Krishna in examination-in-chief by Counsel Assisting accepted that the surgery was unsupervised but did not consider calling for supervision.

Dr Krishna responded that he performed this procedure in an inappropriate fashion which necessitated further operative procedures being performed by Dr Crawford with this patient²⁵⁶. It is a matter which may warrant further investigation with a view to discerning whether this was performed with the skill of a lesser standard than that which might be expected of a non-specialist medical practitioner.

6.10 Marilyn Costello

This patient suffered a flexion contracture of the left middle and little fingers. Most of the contractures were confined to the proximal interphalangeal joints but a tight cord is also felt on the radial aspects of the volar surface of the fingers. It was also noted that she had a Dupuytren's contractual release in the right hand. Dr Sharma in a letter to a general practitioner on 31 July 2003²⁵⁷:

"I have advised her about the condition and have told her that we could do a surgical release but the common observation is that flexion contractures of the interphalangeal joints are hard to correct, and so there is no guarantee that surgical correction will improve this contracture. However, she wishes to have the surgical release to see whether it improves ... and will put her name on the waiting list for an attempt to release those contractures, but as I have said this may not improve the flexion contracture of those fingers."

On 8 December 2004 Dr Sharma performed the surgery to effect a release of the Dupuytren's contracture.

Subsequently, she was reviewed by Dr Crawford in the outpatients clinic at Hervey Bay Hospital. Her complaint on seeing Dr Crawford in June 2005 was the contracture in the scar, although she still had limitation of extension at her PIP joints and had limited flexion at the DIP joints. She was unable to indicate

²⁵⁶ T6501

²⁵⁷ Check whether this has been tendered

whether the restricted flexion of the DIP joints was present pre-operatively or not.

On examination Dr Crawford noted that she had scar over the palmar aspect of the hand. The scars had formed keloid and although she had other scarring on her body they had not formed keloid.

Dr Crawford noted that the patient had persisting Dupuytren's disease in the palm over the middle ray. He noted the movements in her PIP joint which indicated varying levels.

In terms of whether future operative procedures may improve her situation Dr Crawford advised that revision with Z-plasties may be beneficial. However he gave the proviso that with or without further release, the disease will not gain her increased flexion and she will need to still have further occupational therapy.

He referred her on to Dr Rowan who provided a report dated 11 August 2005. On examination Dr Rowan noted a persistent contracture of the PIP joints particularly of the middle right and little fingers. It was Dr Rowan's view that she would require scar revisions but concurred with Dr Crawford's view that they would not fix her dystrophic symptoms.

Dr Sharma's letter of 31 July 2003 appears to have expressed appropriate caution in relation to the possible outcomes of the proposed procedure. In those circumstances, it is difficult to see any warrant for referral for disciplinary action in relation to Dr Sharma's management of this patient.

7. Pattern of Practice

Part 7 and in particular Section 125 of the *Health Practitioners Professional Standards Act 1999* relevantly provides:

- "(1) A registrant's board may start disciplinary proceedings against the registrant if it reasonably believes a disciplinary matter exists in relation to the registrant.

- (2) *Without limiting subsection (1), a registrant's board may start disciplinary proceedings against the registrant on the basis of -*
- (a) *a single complaint received about the registrant; or*
 - (b) *a number of complaints about the registrant, including, for example, a number of complaints suggesting a pattern of conduct or practice."*

It is open on the evidence for there to be a referral in relation to a pattern of practice for the following three patients:

1. Gloria Green;
2. Judith Harris; and
3. J. Howard Osborne.

In these particular cases it is said by a number of witnesses that Dr Naidoo was unavailable at critical times. The evidence is controverted in relation to Mrs Harris in that Dr Naidoo maintains he was conducting a clinic at that time. It is arguable that these three cases may constitute a pattern of practice.

If the Commission finds on the evidence as a totality that Dr Naidoo failed to supervise in a generalised sense this would add support to this avenue being investigated.

A central complaint in relation to each of them is Dr Naidoo's unavailability at critical times.

7.1 Impairment

Part 7 of the *Health Practitioners Professional Standards Act 1999* applies if the Board believes because of a complaint, relevantly for these purposes, that a registrant may be impaired the Board may decide to deal with the registrant under this Part as an alternative to the investigation pattern.

"*Impairment*" relevantly includes a mental impairment, disability, condition or disorder that detrimentally affects, or is likely to affect, the registrant's physical

or mental capacity to perform the registrant's profession and includes substance abuse or dependence.

However this is caveated if the Board reasonably believes a suspected matter may provide a ground for suspending or cancelling the registrant's registration and then must investigate the matter pursuant to the investigation part or a further matter pursuant to s. 126 for hearing by the Health Practitioners Tribunal²⁵⁸.

If the registrant is impaired the Board may impose conditions upon the registrant's registration requiring supervision, entering into an undertaking or referring the matter pursuant to s. 126 for hearing by the panel or tribunal.²⁵⁹

Dr Naidoo has given both oral and written evidence as to the fact that he is currently on stress leave and more pertinently that he was diagnosed in August 2000 that he was suffering from depression by Dr Andrew Christenson, a psychiatrist.

He has been hospitalised in the New Farm Clinic for depression three times. Once in 2003 and again in 2004. It is of note that the 2000 period was significant for three weeks and for two weeks in each of 2003 and 2004.²⁶⁰ It may be of relevance noting for instance the patient Gloria Green was treated in July 2000 and Dr Naidoo's depression was first diagnosed in August of that year.

Dr Naidoo had been discharged it seems for approximately 2-3 weeks by the time Mrs Harris had her operative procedure in the Hervey Bay Hospital. It may well be that the nature of Dr Naidoo's condition has no bearing upon any relevant referral for disciplinary action. However it is a matter that warrants further consideration by the Commission and the Medical Board.²⁶¹

²⁵⁸ Section 268 sub-section (2)

²⁵⁹ See s. 299

²⁶⁰ See exhibit 431

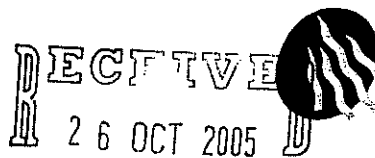
²⁶¹ See statement of Dr Andrew Christensen, exhibit 439.

It is also of note that in relation to Dr Krishna in his scope of practice as annexed to his statement DK6 Dr Naidoo had approved that the procedure should have been done under supervision.²⁶²

²⁶² See DK6 exhibit 424

Submissions

Ms Deborah MILLER



Crown Law

Queensland Government

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BY: _____

Department of
Justice and Attorney-General

26 October 2005

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

Dear Mr Groth

Submissions in response to Notices of Potential Adverse Findings

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

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

Yours faithfully

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for Crown Solicitor

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QUEENSLAND PUBLIC HOSPITALS COMMISSION OF INQUIRY

SUBMISSIONS ON BEHALF OF DEBORAH MILLER

1. Relevantly, the evidence of Ms Miller appears at:
 - (a) Exhibit 416 – Statement of Deborah Miller;
 - (b) Transcript – T6409/34–6410/51; 6413/50–6415/42; 6417/26–6418/6; 6418/50–6419/55;
 - (c) Exhibit 460 – Executive Services Guidelines.

Re paragraph 1 of Notice

2. Ms Miller spoke of the information system known as Recfind as being an electronic index system for some documents (including submissions). Whilst Recfind would probably be the first place to look in an attempt to identify documents in relation to an FOI application,¹ it was not the only avenue of search available to an employee responding to an FOI application.²
3. Accordingly, the removal of a document from Recfind might at worst lengthen the search process, although that would not necessarily be so, but it would not reduce the potential for the document to be accessed pursuant to the *Freedom of Information Act*. On Ms Miller's evidence, other areas of search would be utilised in the process of responding to an FOI application.
4. Importantly, the removal of a document from Recfind has no bearing to its continued retention on the hard drive system of Queensland Health. Recfind is merely an electronic index system. It is not the system on which the document was originally created, and on which the document would be retained.
5. Whilst the removal of a document from Recfind has the potential to lengthen the search process in the event of a FOI request, there is no evidentiary basis for a conclusion that Ms Miller intended to cause the document to be more difficult to locate or to cause its non-retention. That being so, even though Ms Miller may have misunderstood the nature of the Recfind system, there is no reasonable basis for the making of findings adverse to Ms Miller.

¹ T6417/26 – 55.

² T6409/50 – 6410/15.

Re paragraph 2 of Notice

6. It is acknowledged that Ms Miller's evidence was inconsistent with some Queensland Health guidelines.³ However, that error would at most be an indication of a misunderstanding of administrative procedures.
7. It must be noted that there is no evidence before the Inquiry that these guidelines had ever been brought to Ms Miller's attention. She was not questioned about them during her evidence. The topic was however raised with Dr Buckland who said that, whilst he did not recall ever reading the guidelines, he was of the opinion that they were designed to assist executive support staff.⁴
8. Adverse findings, even if they are not accompanied by any recommendations for disciplinary or other action, can have a deleterious effect on career prospects. Such findings should therefore only be made in relation to areas of significance, on clear and unequivocal evidence. For the reasons stated above, no reasonable basis exists for the making of any adverse findings against Ms Miller.

³ Exhibit 460.

⁴ T7104/10-17.

Submissions

Ms Linda MULLIGAN

OUTLINE OF SUBMISSIONS ON BEHALF OF LINDA MULLIGAN

OVERVIEW

1. The evidence demonstrates that Linda Mulligan performed her duties as the District Director of Nursing ("DDON") of the Bundaberg Health Service District appropriately at all times.
2. There is clear evidence that any issues which were brought to Mrs Mulligan's attention were acted upon by her within her delegation and in a timely manner.
3. Mrs Mulligan gave evidence at the Bundaberg Hospital Commission of Inquiry ("the previous Commission") and tendered a detailed statement with attachments (exhibit 180). Following this, Mrs Mulligan was provided with a letter of comfort signed by David Andrews SC, Senior Counsel assisting the previous Commission, dated 26 August 2005 (attached). The letter is not binding on the current Commission, but it should be noted that the sentiments expressed in the letter were made after the previous Commission had seen and heard the witnesses, including Mrs Mulligan, give evidence and be cross-examined. In those circumstances, the opinions expressed in the letter should, it is submitted, be given appropriate weight.

BACKGROUND

4. Any assessment of the performance of Mrs Mulligan has to be made in the context of the background of issues pre-dating her appointment, the timing of her appointment and the workload attaching to her position consequent upon the management structure inherited by her at the Bundaberg Base Hospital ("the Hospital").
5. When Mrs Mulligan commenced in her position as the DDON on 17 March 2004, it was almost 12 months after Dr Patel had commenced as the Director of Surgery at the Hospital and approximately 6 months after the retirement of the previous DDON, Glennis Goodman in September 2003.

6. Ms Goodman's retirement seemed to coincide with the raising of a proposal that the nursing service be reformed as part of a general ongoing reform process taking place at the Hospital¹.
7. There was a very flat management structure within the Hospital where 25 staff reported directly to Mrs Mulligan on both operational and professional matters. This management structure was not of Mrs Mulligan's choosing but was in place prior to her appointment. In particular, the Assistant Director of Nursing ("ADON"), had been removed from the line management reporting structure prior to Mrs Mulligan's appointment.² This had been put into operation by the District Manager ("DM"), Peter Leck, as a result of a suggestion from the then Acting DDON, Beryl Callanan.³ This meant that all Nurse Unit Managers ("NUMs") reported directly to Mrs Mulligan rather than through the ADON as had occurred previously. This necessarily dramatically increased Mrs Mulligan's workload and level of responsibility⁴.
8. In her role as DDON, Mrs Mulligan reported directly to the DM, Mr Leck.⁵ In particular, in a situation where there was a question as to the clinical competence of a member of the medical staff, Mrs Mulligan was required to report that issue to the DM, Mr Leck.⁶ Mrs Mulligan had no authority to independently investigate such issues nor would it have been appropriate for her to undertake any such independent investigation. Although Mrs Mulligan could and did⁷ refer medical matters to Dr Darren Keating, Director of Medical Services ("DMS") for his opinion, she had no authority to overrule or challenge the clinical decisions or judgments made by any member of the medical staff.⁸

¹ T.7267: 12-25 (Leck).

² Paragraphs 31, 32, 124 and 125, attachment LMM10, statement Mulligan (Exh 180); T.2450: 19 – 21 (Mulligan); T.7267: 47 – 54; T.7268: 23 – 24 (Leck).

³ T.7267:51 – T.7267:14 (Leck).

⁴ Paragraphs 45 and 47, statement Mulligan; T.2450: 33 – 40 (Mulligan); T.7268: 16 - 34.

⁵ T.7265: 40 – 43 (Leck).

⁶ T.7265: 45 – T.7266: 18 (Leck); para 110, statement Mulligan.

⁷ Paragraph 156, statement Mulligan.

⁸ T.7266: 20 – 42 (Leck).

9. As DDON and a member of the Executive at the Hospital, Mrs Mulligan was dependent to a large extent on others reporting to her to keep her abreast of developments occurring within the Hospital. There were a number of committees, forums and meetings where such information could be disseminated⁹. At no point after taking up her position in March 2004 and prior to the reporting of the sentinel event involving Mr Bramich in August 2004, were there any issues raised directly with Mrs Mulligan by any person or at any of the committees, forums or meetings she attended alerting Mrs Mulligan to issues of the clinical competence of Dr Patel. As such, it is submitted that there is no evidence suggesting Mrs Mulligan failed to act appropriately.
10. The context in which operational decisions were made by Mrs Mulligan and the remainder of the Executive included budgetary constraints imposed by Queensland Health.¹⁰
11. It is in the context of the matters raised above that the evidence concerning Mrs Mulligan's response to issues raised and the adequacy of that response must be viewed.

INFORMATION CONCERNING DR JAYANT PATEL, DIRECTOR OF SURGERY

12. Soon after Dr Patel commenced as Director of Surgery, Toni Hoffman, the NUM of the Intensive Care Unit ("ICU"), became concerned about the number of patients suffering postoperative complications following surgery conducted by Dr Patel¹¹.
13. As at June 2003, Ms Hoffman had concerns about Dr Patel's clinical soundness, but had not yet formed a view that he was clinically unsound¹².
14. In around February 2004, Ms Hoffman became aware that Dr Miach had given instructions that his patients were not to be operated on by Dr Patel. It was Ms

⁹ See attachment LMM5 to statement Mulligan and generally T.7270 – 7278 (Leck) and Exh 478.

¹⁰ T.7129: 20 – 35; T.7137: 12 – 25 (Leck).

¹¹ Paragraph 8 statement Hoffman: T.1354: 22 – 30 (Hoffman).

¹² T.1361: 12 – 17 (Hoffman).

Hoffman's evidence that she became aware of this directive first hand at a medical services meeting¹³.

15. Ms Hoffman did not recall any specific meeting at which she discussed this directive with Mrs Mulligan¹⁴. Mrs Mulligan says the matter was not raised by Ms Hoffman as part of the handover from Ms Hoffman as Acting DDON in March 2004 or at all¹⁵.
16. By the time Ms Hoffman prepared the document which is attachment TH10 to her statement (exhibit 4), which she provided to Mr Leck at a meeting in late February 2004, she had formed the view that Dr Patel was clinically unsound¹⁶. Despite this, Ms Hoffman did not include a comment to that effect in attachment TH10¹⁷, nor did she mention this to Mr Leck in their meeting¹⁸. Indeed, Ms Hoffman specifically informed Mr Leck (and was adamant) that she did not want him to take any formal action¹⁹.
17. Ms Hoffman, in her capacity as Acting DDON, was careful not to make any adverse comments about Dr Patel during her handover to Mrs Mulligan in March 2004²⁰. Ms Hoffman did not raise any issues with Mrs Mulligan concerning Dr Patel at the time of the handover²¹.
18. Further support for this view is contained in the evidence of Mr Leck where he acknowledged that Mrs Mulligan had informed him that she had been told by Ms Hoffman at the handover that she had been to see Mr Leck and that there were no clinical issues²².
19. It is also clear that despite the fact that Ms Hoffman had raised serious events concerning Dr Patel with Dr Keating, Dr Carter, Mr Leck, Ms Goodman, and Mr

¹³ Para 48, statement Hoffman: T.1370: 38 – 54 (Hoffman).

¹⁴ T.1370: 56 – 58; T.1371: 1 – 14 (Hoffman).

¹⁵ Para 27 statement Mulligan.

¹⁶ T.1378: 17 – 20; T.1379: 1 – 7 (Hoffman).

¹⁷ T.1378: 25 – 27 (Hoffman).

¹⁸ T.1380: 54 – 58 (Hoffman).

¹⁹ Para 53, statement Hoffman; T.1377: 15 – 21 (Hoffman); para 17, statement Leck (Exh 462); T.7215: 55 – T.7217: 50 (Leck).

²⁰ Para 54, statement Hoffman; T.1381: 10 – 17 (Hoffman).

²¹ Para 24, statement Mulligan; T.1381: 44 – 53 (Hoffman).

²² T.7219: 30 – T.7220: 21; T.7281: 1 – 13 (Leck).

Martin, those events were not revealed to Mrs Mulligan by Ms Hoffman, nor by anyone else.²³

20. On 11 May 2004, during a meeting between Mrs Mulligan and Ms Hoffman, Mrs Mulligan says that Ms Hoffman did not raise any concerns regarding Dr Patel²⁴. When this was put to Ms Hoffman, she said she could not see what was written down for the meeting and could not recall. She said she would probably be prepared to stand by what Mrs Mulligan's notes say (see attachment LMM2, statement Mulligan)²⁵. Those notes make no reference to Dr Patel.
21. Similarly, in a series of meetings between 5 May 2004 to and including 8 July 2004, with other NUMs within the Hospital, no issues concerning Dr Patel were raised with Mrs Mulligan²⁶.
22. On 8 July 2004, Mrs Mulligan met with Ms Hoffman for a routine performance and development assessment.²⁷
23. Mrs Mulligan's evidence is that it was during the course of this meeting that Ms Hoffman first expressed concerns about Dr Patel's style of communication and behaviour²⁸ and although Ms Hoffman was given the option of lodging a formal complaint or grievance against Dr Patel or alternatively meeting with Dr Patel together with Dr Keating and Mrs Mulligan to discuss the issues, Ms Hoffman declined both options²⁹.
24. Mrs Mulligan's evidence is and Ms Hoffman agreed that, at that meeting, Mrs Mulligan suggested to Ms Hoffman that it might help her skill development to consult a psychologist from the Employee Assistance Service ("EAS") and that Mrs Mulligan gave her a book on dealing with difficult people.³⁰
25. It was at this meeting that Ms Hoffman raised the issue of the admission/transfer to ICU and the unit's capacity for ventilated beds. Ms Hoffman told Mrs Mulligan that

²³ T 1381: 47-52 (Hoffman).

²⁴ Para 28, statement Mulligan; T.1381: 55 – T.1382: 24 (Hoffman).

²⁵ T.1396: 20 – 33 (Hoffman).

²⁶ Para 105, statement Mulligan.

²⁷ Para 137, statement Mulligan; T.1411: 1 – 5 (Hoffman).

²⁸ Para 137, statement Mulligan.

²⁹ Para 139 and 140, statement Mulligan.

³⁰ Para 141, statement Mulligan; T.1411: 44 – 54 (Hoffman).

this was an issue that she had discussed with Dr Carter, that there were problems between doctors in internal medicine and those in surgical and that the situation could be improved by updating the existing admission/transfer guidelines. Ms Hoffman also told Mrs Mulligan that there was an existing policy which had been in place for some time to the effect that if there were more than two ventilated patients in the ICU arrangements would be made for transfer and that was because caring for more than two ventilated patients was difficult with the available nursing staff.³¹

26. Mrs Mulligan recalls that Ms Hoffman expressed the view that having a clear and concise updated policy would assist in resolving the communication issues between Dr Patel and herself, although Ms Hoffman said she did not remember the specifics of that.³² Ms Hoffman agreed with Mrs Mulligan that she would work with Dr Carter (the Director of the ICU) to progress the updating of the admission/transfer policy.³³
27. This evidence of Mrs Mulligan is supported in every material particular in evidence given by Ms Hoffman during her cross-examination.³⁴ Ms Hoffman agreed that the meeting of 8 July 2004 may have been the first occasion on which she told Mrs Mulligan of any issues that she had with Dr Patel³⁵. Ms Hoffman also indicated that she had agreed with Mrs Mulligan at that meeting that she proposed to work with Dr Carter to progress the updating of the admission/transfer policy of the ICU³⁶.
28. That this was Ms Hoffman's stated intention as at 8 July 2004 is further supported by the monthly cost centre summary reports submitted by Ms Hoffman as NUM of the ICU. Each such cost centre report is in the same pro forma style with a number of categories required to be completed by the Cost Centre Manager, which in the case of the ICU is Ms Hoffman. On the fourth page into the August 2004 document the following is noted:

³¹ Para 143 statement Mulligan; T.1412: 1 – 20 (Hoffman).

³² Para 146, statement Mulligan; T1413: 10 – 20 (Hoffman).

³³ Para 146 statement Mulligan; T.1413: 22 – 27 (Hoffman).

³⁴ Paras 136 – 148, statement Mulligan; T.1411: 1 – 1413: 48 (Hoffman).

³⁵ T.1413: 32 – 48 (Hoffman).

³⁶ T.1413: 22 – 25 (Hoffman).

"5. Quality activities/improvements actioned
Review of ICU/CCU policies ongoing.
Little time for any other activities this month."³⁷

29. There are similar entries in the monthly cost centre summary reports for October, and November 2004 and February 2005.³⁸
30. On 3 August 2004, Mrs Mulligan received a copy of an adverse event report form and a sentinel event report form from DQDSU relating to the treatment of Mr Bramich. Copies were also sent to Dr Keating and Mr Leck³⁹.
31. Mrs Mulligan took action as detailed in paragraphs 150 to 161 of her statement. This action, it is submitted, was adequate and entirely appropriate. Mrs Mulligan was not involved and nor could she be in investigating the complaint concerning Mr Bramich. The complaint involved medical issues and hence Mrs Mulligan was not responsible for such an investigation nor was it within her area of expertise or delegational capacity to investigate such a complaint.⁴⁰
32. Although Ms Hoffman gave evidence that Mrs Mulligan did not contact her regarding the complaint concerning the treatment of Mr Bramich prior to Ms Hoffman sending Mrs Mulligan an e-mail of 26 August 2004 (exhibit 21)⁴¹, Ms Hoffman conceded in cross-examination that her recollection was incorrect as she had received an e-mail from Mrs Mulligan on 13 August 2004,⁴² informing her of the progress of the investigation of the complaint relating to Mr Bramich.
33. Although it was Ms Hoffman's evidence that she forwarded statements regarding the complaint to Mrs Mulligan over a number of weeks from 3 September 2004⁴³, in fact only one statement, that of Karen Fox of 2 September 2004, was forwarded to Mrs Mulligan with the balance of the statements being sent by Ms Hoffman directly to Mr Leck⁴⁴.

³⁷ Exh 186.

³⁸ Exh. 186.

³⁹ Para 149, statement Mulligan.

⁴⁰ T.7266: 4 – 22 (Leck).

⁴¹ T.150: 29 – 40 (Hoffman).

⁴² Exh. 86.

⁴³ Para 112 – 114, statement Hoffman.

⁴⁴ Para 158 and 161, statement Mulligan; T.1427: 50 – T.1428: 7 (Hoffman).

34. Ms Hoffman conceded that Mrs Mulligan visited the ICU on 18 October 2004 and that they discussed Mrs Mulligan's meeting with the Queensland Nurses Union and that Mrs Mulligan told Ms Hoffman that she was the only person who had raised any issues regarding Dr Patel⁴⁵. Ms Hoffman also conceded that they talked about issues regarding the number of ventilated patients and transfer issues⁴⁶ and Mrs Mulligan met with three ICU staff regarding Mr Bramich⁴⁷.
35. Mrs Mulligan met with Ms Hoffman on 20 October 2004 but it was Mrs Mulligan not Ms Hoffman who called the meeting⁴⁸. This meeting was to discuss the unresolved behaviour/communication issues concerning Dr Patel together with the option of mediation between the parties⁴⁹.
36. It was during this meeting that Ms Hoffman raised serious concerns that she had regarding Dr Patel's clinical competence⁵⁰. Mrs Mulligan's evidence is that this was the first time Ms Hoffman raised issues regarding Dr Patel's clinical competence with her, apart from the incident regarding Mr Bramich⁵¹. Although initially Ms Hoffman conceded only that that may be the case, she subsequently admitted that this was the first time Mrs Mulligan had heard about these issues from Ms Hoffman⁵². It is submitted that Mrs Mulligan's evidence should be accepted.
37. Shortly thereafter Mrs Mulligan arranged for Ms Hoffman to meet with her and Mr Leck regarding the issues Ms Hoffman had raised at the meeting that day⁵³. Mr Leck asked Ms Hoffman to put her concerns in writing⁵⁴.
38. Both Mrs Mulligan and Mr Leck seemed horrified at the revelations made by Ms Hoffman at that time⁵⁵ and appeared not to be aware of the full details.⁵⁶

⁴⁵ T.1428: 55 – T.1430: 10 (Hoffman); para 167 statement Mulligan.

⁴⁶ T.1430: 12 – 14 (Hoffman); para 169 statement Mulligan.

⁴⁷ T.1430: 36 – 38 (Hoffman); para 170 statement Mulligan.

⁴⁸ Para 174, statement Mulligan; cf para 120, statement Hoffman; T.1430: 43 – 46 (Hoffman).

⁴⁹ Para 175 – 176 statement Mulligan; T.1430: 53 – T.1431: 57 (Hoffman).

⁵⁰ Para 176, statement Mulligan, T.1431: 16 – 58 (Hoffman).

⁵¹ Para 178, statement Mulligan.

⁵² T.1432: 46 – 49; T.1435: 21 – 33; and T.1437: 32 – 36 (Hoffman).

⁵³ Para 170, statement Mulligan; T.1432: 51 – 53 (Hoffman); P.7283: 28 – 33 (Leck).

⁵⁴ Para 179, statement Mulligan; para 125, statement Hoffman; T.1432: 57 – T.1433: 2 (Hoffman); T.7283: 38 – 39 (Leck).

39. Mrs Mulligan was supportive of Ms Hoffman during both of these meetings⁵⁷.
40. Mr Leck, as DM and Mrs Mulligan's line manager, assured Mrs Mulligan that the matter would be dealt with and indicated to Mrs Mulligan that he would progress the complaint⁵⁸. This was entirely appropriate since the complaint being made by Ms Hoffman concerned medical issues and specifically the clinical competence of the Director of Surgery.
41. Mrs Mulligan was on leave from 22 to 31 October 2004 and when she returned from leave, she became aware that Ms Hoffman had sent an e-mail to Mr Leck on 22 October 2004 setting out fully her concerns regarding Dr Patel⁵⁹.
42. The action taken by Mrs Mulligan between the time when she returned from leave in October 2004 and until she commenced her leave over the Christmas/New Year period on 21 December 2004, is set out in paragraphs 184 to 187 of her statement.
43. On the day Mrs Mulligan returned from leave over the Christmas/New Year (4 January 2005), she went on walkabout around the clinical areas of the Hospital. When she was in the ICU, she asked Ms Hoffman whether any issues had arisen while she was on leave and Ms Hoffman stated that no issues had arisen in ICU but that she had heard further rumors about Dr Patel from nursing staff in theatre and the surgical ward⁶⁰. In response to this information, Mrs Mulligan took the steps set out in paragraphs 191 - 202 of her statement to obtain details of these issues and refer them to Mr Leck. Again, this activity by Mrs Mulligan, it is submitted was entirely appropriate and timely.
44. Mrs Mulligan met with Ms Hoffman, Ms Jenkin and Ms Doherty on 13 January 2005 and told them that an investigation would be proceeding concerning Dr Patel and reassured them about the process. She also asked them to talk to their staff to see if they had any issues and to tell them that there would be no retribution to staff

⁵⁵ Para 177, statement Mulligan; T.1434: 31 - 53 (Hoffman); and Exh. 88 (email Hoffman to Callanan 25/10/2004).

⁵⁶ T.1437: 20-37 (Hoffman).

⁵⁷ T.1435: 16 - 19 (Hoffman).

⁵⁸ Para 181, statement Mulligan; para 46, statement Leck..

⁵⁹ Para 183, statement Mulligan.

⁶⁰ Para 190, statement Mulligan.

who brought issues forward. She requested that they confirm to her that they had done so.⁶¹ Mrs Mulligan later received confirmation that this had been followed through⁶².

45. Mrs Mulligan subsequently received other complaints from various nursing staff regarding Dr Patel. On each such occasion, Mrs Mulligan actioned the complaints appropriately, in accordance with her delegation in a timely manner⁶³.

CONCLUSION

46. In light of the above demonstrated sequence of events, it is submitted that it can not be fairly suggested that Mrs Mulligan failed to act appropriately on information provided to her concerning Dr Patel.
47. It seems clear that the first occasion on which any comment concerning Dr Patel specifically was made to Mrs Mulligan was 8 July 2004. It is also clear that the information concerned behavioural/communication issues which Ms Hoffman declined to take any further despite being given the clear choice to do so by Mrs Mulligan.
48. When Mr Bramich's complaint was made, Mrs Mulligan became aware that it had been referred to Mr Leck and understood that it was being appropriately investigated.
49. The issue of Dr Patel's clinical competence was not raised with Mrs Mulligan on any occasion before 20 October 2004 (apart from the incident regarding Mr Bramich) and, when it was, it was immediately and appropriately reported to Mr Leck for investigation. Mrs Mulligan was thereafter led to believe, reasonably it is submitted, that the complaint was taken seriously and properly investigated by Mr Leck.

⁶¹ Para 204 – 206, statement Mulligan; para 143, statement Hoffman; T.1438: 13 – T.1439: 44 (Hoffman).

⁶² Para 207, statement Mulligan; T.1439: 46 (Hoffman); T.2151: 34 – 50 (Gaddes).

⁶³ Para 217, statement Mulligan.

OTHER ISSUES

Information Contained in Monthly Cost Centre Summary Reports From the ICU Between April and November 2004, ICU Policy on Admission, Discharge and Transfer and Mrs Mulligan's response

50. It is clear that during this period issues concerning the operation of the ICU were raised. These included:

- (i) Patients were being ventilated for more than 48 hours;
- (ii) The number of hours that patients underwent ventilation in the ICU was increasing during 2004;
- (iii) There were occasions when 3 ventilated patients were treated in the ICU at the same time;
- (iv) As a consequence of the matters raised in (i) - (iii) above, it could well be inferred that the ICU was operating outside its service capability frame work as a level 1 ICU;
- (v) There had been a number of unplanned admissions to the ICU from the operating theatre;
- (vi) Patients had been returned to the operating theatre from the ICU on several occasions;
- (vii) Patients had been unexpectedly returned to the ICU from other wards on several occasions; and
- (viii) Concerns had been raised about the scheduling of large operations and the capacity of the ICU to provide adequate postoperative care for those patients.

51. In addition to the above which relates to the period April to November 2004, it should be noted that the Monthly Cost Centre Summary Reports for ICU for 2003 contain the following data:⁶⁴

- (i) Ventilated hours (per month) were as high as 587 hours;
- (ii) There were many occasions when patients were ventilated for longer than 24 to 48 hours and more than one patient was ventilated at any time;
- (iii) 11 patients were readmitted within 72 hours during that year;
- (iv) Patients were being ventilated for up to 10 days.

52. This information must have been brought to the then Executive's attention at a time prior to Mrs Mulligan's appointment. It should be inferred that Mrs Mulligan was entitled to believe that these issues were ongoing and being dealt with by the Executive.

53. In relation to paragraph 50(viii) above, during the period April to November 2004, the only issue (apart from the incident involving Mr Bramich) which was brought to

⁶⁴ Exh 186

Mrs Mulligan's attention regarding the capacity of the ICU to provide adequate postoperative care in cases of complex surgery was when Ms Hoffman emailed her on 26 August 2004 regarding concerns she had about an impending surgical procedure which was to be performed by Dr Patel. The evidence is clear that Mrs Mulligan dealt with that issue immediately and appropriately by forwarding the email to Dr Keating and seeking his advice on the issue and then responding to Ms Hoffman once she had received Dr Keating's response.⁶⁵

54. As the DDON, Mrs Mulligan had no power to direct Dr Carter (the Director of the ICU) to take any action in respect of any of the issues referred to above⁶⁶.
55. In particular, Mrs Mulligan had no ability or capacity to overrule any judgments made by medical staff as to the number of ventilated patients in the ICU at any one time or as to whether such patients should be transferred out of the ICU⁶⁷.
56. Furthermore, and generally, issues as to the way in which the ICU operated are essentially issues required to be addressed by the medical staff and it is clear from the evidence that there was a degree of flexibility about what constituted the proper approach⁶⁸. In any event, the Service Capability Framework which was brought into operation in July 2004 was intended to be fully operational within a period of 12 months.⁶⁹
57. The Executive Council, Leadership and Management Committee and Finance Committee addressed generally issues referred from the Clinical Service Forums.⁷⁰ All members of the Executive sat on these committees.⁷¹ The individual Clinical Service Forums were established to address in detail, at the clinical level, issues relevant to those clinical areas.⁷² The Clinical Service Forum relevant to the ICU

⁶⁵ Paras 155 and 156, attachments LMM15 and LMM16, statement Mulligan; attachments TH21 and TH22, statement Hoffman.

⁶⁶ T.7266: 40 – 52 (Leck).

⁶⁷ T.7266: 25 – 35 (Leck).

⁶⁸ T.4087: 41 – T.4088: 20; and T.4072: 45 – T.4074: 15 (Carter) and T.6946: 34 – 43 (Keating); paras 29 – 35, statement Carter.

⁶⁹ T.3147: 50 – 3149: 3; 3149: 11 – 15 (Fitzgerald).

⁷⁰ T.7268: 36 – 7260: 21; T.7275 (Leck).

⁷¹ Exh 478

⁷² T.7131: 42 – 7132:11; T.7275 (Leck).

was the ASPIC Committee⁷³. Dr Martin Carter, the Director of the ICU, is the Chair of the ASPIC Committee⁷⁴. Executive members of that Committee were Mr Leck and Dr Keating.⁷⁵ Ms Hoffman is also a member of that Committee.⁷⁶ However, Mrs Mulligan is not a member of the ASPIC Committee.⁷⁷

58. Dr Carter was also a member of the Medical Staff Advisory Committee. The Executive members of that Committee were Mr Leck and Dr Keating.⁷⁸

59. From Mrs Mulligan's point of view, it was clear that issues concerning the operation of the ICU were being raised at the appropriate forums, taken seriously and addressed within the confines of the procedures mandated by Queensland Health⁷⁹.

60. At the meeting of the ASPIC clinical forum on 14 April 2004, the issue of the high cost of long term ventilation for patients in the ICU was raised. The comments in the minutes record:

"Director of Anesthesia/Surgery and Num of ICU + DMS or DNS need to have a proactive meeting about transferring ventilated patients"⁸⁰.

61. It is to be noted that nowhere in those minutes is there any suggestion that issues of the clinical competence of Dr Patel were in any way related to the long term ventilation of patients in the ICU. Furthermore, for the period following that meeting and up to the reporting of the sentinel event concerning Mr Bramich in August 2004, there was no mention to Mrs Mulligan in documentary or other form of issues concerning the clinical competence of Dr Patel.

62. Dr Carter, as the Director of the ICU and presumably the person who had the clearest understanding of any difficulties faced by the operation of the ICU and Dr Patel's role in creating those difficulties apparently did not ever, in this period, take action to bring to notice of the Executive issues of clinical competence of Dr Patel.

⁷³ Para 92, statement Carter(Exh 265).

⁷⁴ Para 92, statement Carter.

⁷⁵ T.7275: 20 – 21 (Leck); Para 94, statement Carter.

⁷⁶ Minutes of ASPIC meetings (TH11 which is Exh 81 and Exh 478(H)).

⁷⁷ T.7275: 16 – 18 (Leck); Para 95, statement Carter.

⁷⁸ T.4034: 30 – 46 (Carter).

⁷⁹ See generally minutes of various meetings collected at Exh 478.

⁸⁰ The minutes are TH11 to statement Hoffman and Exh 81.

63. In such circumstances, it is difficult to see how Mrs Mulligan could be at all criticised for her role in these events as they unfolded.
64. When the Executive Council met on 3 September 2004, the ventilation hours in the ICU were tabled for discussion and a reference was made to the ASPIC minutes of 18 August 2004⁸¹. Those ASPIC minutes⁸² referred to the staff working long hours and made reference to one sentinel event (presumably that concerning Mr Bramich), from July 2004. Those minutes also record a discussion concerning the ICU category and the fact that the investment by Queensland Health was mainly being made in Brisbane, the Gold Coast and Nambour.
65. Once again, from Mrs Mulligan's view point, one would be entitled to infer that she gained some comfort from the understanding that the issues concerning ICU as they were articulated in various minutes as discussed, indicated an awareness of difficulties and a preparedness to address those difficulties. This is in the context where at no stage was there a connection being made between issues of the clinical competence of Dr Patel and the problems with the ventilation hours in the ICU either from the minutes of the various forums and committees or from staff members reporting issues of concern.
66. At the leadership and management committee meeting of 1 November 2004, the issue of the medical staff advisory committee of 14 October 2004 was raised. It was noted that the DQDSU and NUM ICU had been requested to provide data and that the DM had requested the DDON and DMS to review ICU activity⁸³. Dr Keating gave evidence that Ms Hoffman provided data pursuant to that request which data was being analysed by Dr Keating and that he had some assistance in that process from Mrs Mulligan. Dr Keating went on to indicate that the exercise was done separately to the issues concerning Dr Patel even after the complaint of Ms

⁸¹ Exh.478.

⁸² Also Exh. 478

⁸³ Exh 478.

Hoffman of 22 October 2004 since those issues were being separately, and in his view, appropriately investigated by Mr Leck as DM⁸⁴.

67. There can be no doubt that as at November 2004, Mrs Mulligan was entitled to believe as mentioned earlier that Mr Leck was undertaking an appropriate investigation of the very serious matters raised by Ms Hoffman in her correspondence of 22 October 2004.
68. Dr Carter gave evidence that the statistics from the ICU which indicated an increase in ventilated hours and the like were taken by him to two forums being the Medical Staff Advisory Committee and the Executive Council. He indicated that the statistics were provided to the meetings as part of his normal report but that he could not remember when he first took the figures to those forums. Dr Carter agreed that the volume of complex surgery performed by Dr Patel contributed to the overtaxing of the resources in ICU but it was not the sole cause⁸⁵.
69. Significantly, Dr Carter gave the following evidence:

“So, are you saying that you did not regard Dr Patel’s undertaking complex surgery as a significant factor in the rise of ventilated hours? - Correct. So therefore, you wouldn’t have voiced any concern to Executive as to the complexity of any surgery he was undertaking? - That is correct.”⁸⁶”
70. It is submitted that when the issue concerning the admission, transfer and discharge policy for the ICU was raised by Ms Hoffman with Mrs Mulligan on 8 July 2004, together with concerns about Dr Patel’s behaviour and issues concerning communication between the doctors, it was agreed informally between Mrs Mulligan and Ms Hoffman that Ms Hoffman would speak with Dr Carter and they would together seek to update the policies as a way of resolving the then known difficulties involving Dr Patel. That was a not unreasonable approach by Mrs Mulligan to the difficulty in light of what she had been told about the nature of the problem at that time. Had Ms Hoffman revealed what her true thoughts in respect of Dr Patel were as at 8 July 2004, undoubtedly, Mrs Mulligan would have taken further action of the kind she ultimately took when fully informed in October 2004.

⁸⁴ T.6987: 7 – 6988: 12 (Keating).

⁸⁵ See generally T.4034: 30 – 4036: 1 (Carter).

⁸⁶ T.4036: 15 – 21 (Carter).

However, she should not be criticised for failing to act in circumstances where she was not given the information to trigger a different response.

71. That is where the matter rested with Mrs Mulligan believing that Ms Hoffman had in fact spoken to Dr Carter (something that apparently did not occur until both Dr Keating and Mrs Mulligan directed Dr Carter and Ms Hoffman respectively to update the policies early in 2005)⁸⁷.
72. On the basis of the evidence referred to above, it can not be suggested, it is submitted, that at any stage during the period April to November 2004, Mrs Mulligan failed to take action appropriate to the information she had been given.

Mrs Mulligan's Management Of Nursing Staff

73. It is clear that Mrs Mulligan had a different management style from her last full-time predecessor, Glennis Goodman. Ms Goodman was in the habit of doing second-daily ward rounds which some of the nursing staff seemed to think was more appropriate than Mrs Mulligan's more infrequent unannounced rounds at the Hospital.
74. What is clear however, is that the fact that Ms Goodman was purportedly more accessible did not seem to translate into an ability to inform her as DDON of any concerns in respect of Dr Patel's clinical competence such that action could be taken at an earlier time.⁸⁸
75. There seems to be no basis for an assertion that any perceived difficulty in accessing Mrs Mulligan was a cause for the failure of the difficulties concerning Dr Patel being brought to notice at an earlier time.
76. Mrs Mulligan has dealt in some considerable detail with issues concerning her accessibility at the Hospital⁸⁹.
77. Again, this topic must be viewed in the context of the system Mrs Mulligan inherited when she took over as DDON. She had an enormous workload which

⁸⁷ T.4028: 22 – 48 (Carter).

⁸⁸ T.1362: 19 – 1364:3 (Hoffman); para 64 statement Mulligan.

⁸⁹ Paras 49 – 72, statement Mulligan.

included the significant task of reforming the nursing stream at the Hospital, a task that it may be inferred did not always endear her to those members of the staff.⁹⁰

78. The sample of nurses whose evidence is before the Inquiry and who were generally critical of Mrs Mulligan's management style could not be said to be representative of the nursing workforce.
79. References tendered on behalf of Mrs Mulligan from those who had contact with her at previous workplaces were supportive of her management style.⁹¹
80. Ms Hoffman gave an example of an occasion when she claimed that Mrs Mulligan was not accessible but upon closer analysis in cross examination, it was revealed that there were many opportunities at which Ms Hoffman could have availed herself of an audience with Mrs Mulligan if she had so desired⁹².
81. To summarise the issues concerning Mrs Mulligan's accessibility:
 - (i) Mrs Mulligan attended a number of committees and meetings at which the nurses could have raised issues with her;
 - (ii) Mrs Mulligan was available to meet generally with staff. (At the very first meeting with level 3-5 nurses, Mrs Mulligan made the point that she would be available to see any level 3's on the same day with respect to urgent matters and by appointment otherwise)⁹³;
 - (iii) Mrs Mulligan's contact numbers were listed in the Hospital's internal telephone directory and she carried a free set with her which had the same number as used by the previous DDON, Ms Goodman;
 - (iv) Mrs Mulligan toured the Hospital areas according to the needs of a particular area rather than on a defined roster basis but received reports from the ADON who conducted regular rounds of the Hospital areas;
 - (v) Mrs Mulligan was available to be contacted by e-mail at any time;
 - (vi) Mrs Mulligan kept her mobile on at all times so she was always contactable by NO level 3/4/5s, other Executive members and switch.

⁹⁰ T.7267: 9 – 41 (Leck).

⁹¹ LMM1 statement Mulligan.

⁹² Para 189, statement Mulligan; T1408: 41 – 1410:22 (Hoffman).

⁹³ Minutes (Exh 84)

82. Mrs Mulligan also took steps to ensure that staff were able to raise any complaints or concerns with her. An example illustrating this occurred in Mrs Mulligan's early days in her position on 23 April 2004 when prior to a meeting with nursing staff, she sent out an e-mail inviting them to raise any issues with her⁹⁴.
83. Mrs Mulligan also took appropriate steps to impress upon staff the need to properly document incidents within the Hospital to foster a learning and quality improvement environment.
84. To this end, Mrs Mulligan sent an e-mail to all level 3 and 5 nurses that they were expected to attend training on the updated process for documenting adverse events⁹⁵.
85. It is submitted that Mrs Mulligan was entitled to believe that the nursing staff generally were a professional body of persons who took their work seriously and performed it with pride and dedication. She was entitled to expect that if they had concerns, they would see it as their professional responsibility to bring those concerns to her notice either directly or via their line manager and she encouraged them to do so.⁹⁶
86. She should not be held accountable for the activities of a small minority who chose for reasons best known to themselves, not to voice their concerns to her so that she could address those concerns in an appropriate and professional manner.

A J MACSPORRAN

Counsel for Mrs Mulligan

26 October 2004

⁹⁴ TH 12, statement Hoffman (Exh 4) and T 1395: 19-38

⁹⁵ Exh 181 (email of 20/4/04)

⁹⁶ Paras 73 and 75, statement Mulligan.



brian bartley & associates
LITIGATION LAWYERS

28 October 2005

BY EMAIL: david.groth@qphci.qld.gov.au

AND BY FACSIMILE NO: 3109 9151

Mr David Groth
Secretary
Queensland Public Hospitals Commission of Inquiry

Contact: Selina Hunt
Email: shunt@bartleylaw.com
Our ref: BDB.SH.8000776

Dear Mr Groth

OUR CLIENT: LINDA MULLIGAN

We **enclose** supplementary outline of submissions on behalf of our client (which relates to the evidence of Ms Jenner and Ms Doherty from yesterday).

As you will see in the body of the submission at paragraph 4, reference is made to a Ward Work Allocation Report for the ICU for 18 October 2004. As explained in the submission itself, this document was uncovered by our client during the course of her preparation for the making of this submission. The document should, in our submission, be tendered into evidence as it is clearly a relevant piece of evidence supporting the version given by our client when she completed her witness statement dated 8 July 2005. We apologise for the late production of the document but, as mentioned above, our client only discovered the document this morning. The document really speaks for itself but, of course, its authenticity could be confirmed by Queensland Health if necessary.

Please inform us if you do not propose to tender the document into evidence so that we may make further submissions.

Yours faithfully

Brian Bartley & Associates

QUEENSLAND PUBLIC HOSPITALS - COMMISSION OF INQUIRY

SUPPLEMENTARY OUTLINE OF SUBMISSIONS ON BEHALF OF LINDA MULLIGAN

EVIDENCE OF KAREN LOUISE JENNER

1. Ms Jenner gave evidence that after the meeting on 23 March 2005 with Mr Leck and Ms Walls, Acting DDON, she was frustrated because she had never met Mr Leck previously and he had not offered any support to her regarding her complaint about Dr Patel.¹
2. In oral evidence Ms Jenner stated that no one in the Executive contacted her regarding her complaint about Dr Patel until she was asked to attend an interview with Queensland Health staff (in connection with the Investigation by Dr Fitzgerald and Mrs Jenkins)².
3. Mrs Mulligan did not, at any time, receive a copy of the statement prepared by Ms Jenner concerning the incident involving Dr Patel as the statement was sent by Ms Hoffman directly to Mr Leck.³
4. Mrs Mulligan visited the ICU on 18 October 2004 and, while she was in the ICU, she met with three staff, two female RNs and one male RN, who talked about the incident involving Mr Bramich and gave examples of concerns they had about Dr Patel (which, other than the incident involving Mr Bramich which was being investigated, related to Dr Patel's behaviour, not his clinical competence).⁴ In preparation for the making of this submission Mrs Mulligan found an official Hospital record which details the staffing of the ICU at the Hospital for the day shift for 18 October 2004 (attached).⁵ The report clearly reveals that the two female RNs and one male RN who met with Mrs Mulligan in the ICU on that day were Karen Fox, Daniel Aitken and Karen Jenner. We respectfully submit that the report should be tendered into evidence as being clearly relevant to the resolution of the apparent conflict in the evidence between Mrs Mulligan and Ms Jenner.

¹ Para 15, statement Jenner (Exh 508).

² T.7391: 25 – 35; T.7393: 5 – 8 (Jenner).

³ Para 33, submissions Mulligan; Paras 158 and 161, statement Mulligan; T.1427: 50 – T.1428: 7 (Hoffman).

⁴ Para 34, submissions Mulligan; T.1430: 36 – 38 (Hoffman); para 170 statement Mulligan.

⁵ Ward Work Allocation Report for the ICU for 18/10/04.

5. When it was put to Ms Jenner that she would have been in contact with Ms Hoffman regarding her complaint, she responded that she had asked Ms Hoffman many times if she had heard anything and she had not.⁶
6. It is not correct that Ms Hoffman had heard nothing regarding the complaint about the incident involving Mr Bramich. The evidence is clear that Ms Hoffman did receive feedback regarding that incident and her subsequent complaint concerning Dr Patel which was made in October 2004. The action taken by Mrs Mulligan is detailed in paragraphs 30 to 45 of the outline of submissions of Mrs Mulligan dated 26 October 2005. If the true position is that Ms Hoffman, as Ms Jenner's line manager, did not pass on any feedback received from Mrs Mulligan to Ms Jenner, Mrs Mulligan should not be held accountable for Ms Hoffman's failure.

EVIDENCE OF GAIL YVONNE DOHERTY

7. Ms Doherty gave evidence about elective surgery targets and staffing issues within theatre.⁷ She said that she after she raised those matters with Karen Smith, the elective surgery coordinator, she did not receive any other response from the Executive other than the email from Dr Keating (attachment GD1, statement Doherty).⁸
8. It is evident from the face of attachment GD1 that Mrs Mulligan did not receive a copy of that email.
9. Ms Doherty did not raise her concerns regarding the email with Mrs Mulligan.
10. Ms Doherty gave evidence that the Executive would have been given indications of the extent of overtime being undertaken in theatre through reports prepared by the After Hours Nurse Manager and sent to the DDON every morning and in cost centre reports because it would have impacted on fatigue leave, sick leave and the like.⁹
11. Mrs Mulligan spent a lot of time attempting to resolve theatre staffing issues.

⁶ T.7391: 37 – 39 (Jenner).

⁷ Paras 24 – 26, statement Doherty (Exh 509).

⁸ T.7403: 12 – 16 (Doherty).

⁹ T.7403: 26 – 36 (Doherty).

12. Prior to Jennifer White resigning as NUM theatre (which was effective in August 2004), Mrs Mulligan worked with Ms White in relation to theatre staffing.¹⁰
13. The issue of theatre staffing was dealt with at a number of Committee meetings.¹¹ In particular, during the course of the Leadership and Management meeting of 24 January 2005, Mrs Mulligan as DDON and Peter Heath as Director of Corporate Services gave an overview of issues concerning the operating theatre. It was reported that discussions had been held with staff regarding workloads and rosters and it was agreed that a review should be undertaken with Dr Keating, the Director of Medical Services, and Mrs Mulligan to advise the Mr Leck, the District Manager, of preferred people to undertake the review.
14. The minutes do not reveal at any stage there being a connection between the theatre staffing issues and Dr Patel.
15. Despite claims that Executive management failed to take appropriate action in respect of theatre staffing issues, there is no evidence that Mrs Mulligan failed to take appropriate action in a timely manner in response to concerns brought to her notice.

A J MACSPORRAN

Counsel for Mrs Mulligan

28 October 2004

¹⁰ Paras 243 – 247 statement Mulligan; T.1299: 13 – T.1304:14 (White).

¹¹ Exh 478 (Executive Council meetings of 7/5/04, 4/6/04 and 2/7/04; ASPIC meeting of 18/08/04; Leadership and Management meetings of 27/09/04, 18/10/04 and 24/01/05).

Ward Work Allocation Report

Printed: 25/04/2005
17:08:13

Ward: **INTENSIVE CARE UNIT**

Cycle Date: **Day - 18/10/2004**

WL	Position	Staff Name	Shift	Start	End	Rate	WL	Rate	WL	Rate
W01	RN L1 G8	FOX, Karen	7:30		5	FULLERTON, DOUGLA	10:00	2:30		
W02	RN L1 G8	AITKEN, Daniel	7:30		4	OREGGE, CLIVE	4:50	2:50		
W03	RN L1 G7	JENNER, Karen	7:30		7	STROHFELDT, CLIFFO	10:00	2:30		
N/A					1					
					2					
					3					
					4					
					5					
					6					
					7					
					8					

Shift Total

Available Hours: 22:30

Required Hours: 24:50

Variance: -2:20 UNDER

NOTES: This report identifies patients / workload allocated to individual or team nurses for the selected shift.
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Page 1 of 3



brian bartley & associates
LITIGATION LAWYERS

31 October 2005

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01 NOV 2005

BY EMAIL: david.groth@qphci.qld.gov.au

BY:

AND BY FACSIMILE NO: 3109 9151

Mr David Groth
Secretary
Queensland Public Hospitals Commission of Inquiry

Contact: Selina Hunt
Email: shunt@bartleylaw.com
Our ref: BDB.SH.8000776

Dear Mr Groth

OUR CLIENT: LINDA MULLIGAN

We **enclose** submissions on behalf of our client in response to submissions on behalf of the Queensland Nurses Union and others.

Yours faithfully

Brian Bartley & Associates

SUBMISSIONS ON BEHALF OF LINDA MULLIGAN IN RESPONSE TO

SUBMISSIONS ON BEHALF OF THE QUEENSLAND NURSES UNION ("QNU") AND OTHERS¹

1. At various points in submissions made on behalf of the QNU and others, there is criticism of the "Executive Management" of the BBH for failing to take action in respect of concerns raised about Dr Patel and criticism generally of "management"².
2. Although it is not entirely clear, some at least of the references referred to above are impliedly critical of Mrs Mulligan. To the extent that that is the intention of those submissions, such criticism, where it is broadly stated and not referenced to the transcript or exhibits or is otherwise not supported by the evidence, is rejected as unfounded.
3. The submission made that the "failure of the Director of Nursing, Ms Linda Mulligan, to provide effective nursing leadership contributed to the dysfunctional gulf between Executive Management and clinical nursing staff"³ is meaningless with respect. If what is sought to be conveyed is that Mrs Mulligan failed to act appropriately once in possession of the true facts, then the submission is factually incorrect for the reasons advanced in the primary submission on behalf of Mrs Mulligan dated 26 October 2005.
4. After all, for example, the previous full time DDON, Glennis Goodman, on being told of concerns in relation to Dr Patel's clinical competence in May and June 2003, apparently passed those concerns onto Mr Leck. Ms Goodman is not criticised for failing to do more, nor could she be.
5. Presumably for the same reason, Ms Goodman was never called to give evidence before this or the previous Commission to explain any perceived "failure on the

¹ See footnote nos 2 and 6.

² See QNU submission 28/10/05, paras 7, 21, 27, 28, 49, 50, 51, 54, 70, 78, 80, 81 and 90; See also Dr Buckland submission 26/10/05, paras 20 and 25(f); Patient Support Group submission, Executive Summary (b)(iv) para 1, (d) paras 2 and 3, para 146, 155, 179, 184 and 185.

³ QNU submission, para 13.

part of executive management" to take action in response to concerns about the clinical competence of Dr Patel.

6. Indeed, even Ms Hoffman, while she was Acting DDON, did not report her concerns to Mrs Mulligan in February or March 2004 concerning Dr Patel.
7. It is difficult then to understand why Mrs Mulligan should be singled out for criticism when firstly she was not told initially of the true position and secondly when she was informed, she acted immediately and appropriately.
8. That Mrs Mulligan was proactive in following up even a hint of a complaint and supporting the staff involved is revealed in the evidence generally and, in particular, is well illustrated by the events of January 2005 when Mrs Mulligan returned from annual leave to learn of a difficulty that had arisen in her absence with staff from theatre and the surgical ward⁴.
9. It is unfortunate that in a submission the QNU no doubt wished to be taken seriously, reference is made in paragraph 22 to the Executive Management exemplifying the "three monkeys" management ethos and, in particular, to Mrs Mulligan as "one of the three monkeys" who would "hear no evil". The only reference given for such an outlandish claim in respect of Mrs Mulligan is to the evidence of Mr Leck⁵.
10. There are several points that should be noted⁶:
 - (a) Mrs Mulligan gave evidence before Mr Leck and this issue was never raised;

⁴ Paras 190 - 209, attachments LMM 21, 22, 23 and 24, statement Mulligan; exhibits 147, 148, 149, 151, 152 and 153; attachment TH43, statement Hoffman; T.2151: 34 - 50 (Gaddes).

⁵ See also QNU submission, para 43.

⁶ These would relate to both paras 22 and 43 of the QNU submission and page 12 of the Queensland Health submission dated 27/10/05.

- (b) Mrs Mulligan's instructions on this point (put to Mr Leck in cross-examination)⁷ are that there was no mention at the meeting of Ms Hoffman giving Mr Leck a note;
- (c) Mrs Mulligan's instructions are consistent with the natural reading and meaning of the email from Mr Leck to Dr Scott of 11 April 2005⁸;
- (d) The evidence of Dr Keating is consistent with the note being destroyed and not shown to anyone by Mr Leck⁹;
- (e) Mrs Mulligan had been told by Ms Hoffman, during the handover shortly after Mrs Mulligan commenced as DDON in March 2004, that there were no clinical issues of concern with respect to the operation of the ICU and that she had met with and given Mr Leck the same information;
- (f) As at March 2004, Mrs Mulligan had no awareness of any issues concerning Dr Patel. (Ms Hoffman, as Acting DDON, had been careful not to make any adverse comments about Dr Patel during the handover);¹⁰
- (g) Mrs Mulligan's purported response to Mr Leck (that she did not wish to see the note which in her view should have been handed back to Ms Hoffman), is inconsistent with Mrs Mulligan's reaction to information provided to her by Ms Aylmer (which evidence was not even challenged)¹¹;
- (h) It would not have been unreasonable to take a view that such a document should be handed back to the author for signing and dating to make it official and able to be formally acted upon¹².

⁷ T.7278: 47 - 7281: 16 (Leck).

⁸ Exh 317 JGS12.

⁹ T.7005: 20; Keating submission, paragraph 52, 28/10/05.

¹⁰ Mulligan submission, para 17.

¹¹ Para 217, Statement Mulligan; T2596: 46 - 48; T.2599:4 - 16 (Mulligan).

¹² Woodruff review, Exh 102, p7, para 15; Exh 497, attachment MS-1 Recommendation 15.

11. In summary, the claim made at paragraph 22 of the QNU submission so far as it relates to Mrs Mulligan is completely without substance and, in those circumstances, is grossly unfair to her and constitutes an unjustified attack on her character and reputation.
12. The general criticisms made in paragraphs 45 - 48 inclusive of the QNU submission have already been appropriately addressed in Mrs Mulligan's earlier submission¹³.
13. However, the following should be borne in mind:
 - (a) In relation to paragraph 46, Mrs Mulligan was on annual leave from 21 December 2004 until 4 January 2005 and was not aware of the death of Mr Kemps until her return from leave. On the day she returned, she went on walkabout of the Hospital and the action she took was entirely appropriate and supportive of staff.¹⁴
 - (b) In relation to paragraph 47, whilst it accepted that Mrs Mulligan received information in such reports it is not accepted that the information provides a basis to conclude that Mrs Mulligan should have been more proactive. Reference has already been made to the failure by the reporters of the information to connect that information with issues concerning the clinical competence of Dr Patel and as this being a significant impediment to the ability or need for Mrs Mulligan to act in a way other than as the evidence demonstrates.¹⁵
 - (c) In relation to paragraph 48, the QNU submission seeks to advance the proposition that Mrs Mulligan's lack of leadership of nurses left them in a position where they had to seek leadership from their union officials.

¹³ Mulligan submission, paras 73 - 96; para 159, statement Mulligan; T.1408:41 - 1410:45 (Hoffman).

¹⁴ See footnote no 4.

¹⁵ Mulligan submission, paras 50 - 72.

- (i) It is of concern that there appears to have been an attitude within the QNU to discourage the proper reporting of concerns by nurses through the DDON¹⁶.
 - (ii) Again, Mrs Mulligan can hardly be legitimately criticised for failing to act on information that was not given to her.
14. It is noted that the submission from the QNU attaches as Appendices 1 and 2 the submissions made to the previous Commission seeking leave to appear and submissions made to the Foster Review respectively.
15. Appendix 1 contains a summary of the way in which the QNU then expected the evidence to unfold before the previous Commission.
16. No doubt so far as Mrs Mulligan's interests are concerned, this Commission will ignore any statements contained in that submission which are detrimental to Mrs Mulligan's interests where those submissions are not supported by evidence.
17. Similar consideration should be applied to the terms of Appendix 2.

A J MacSporran
Counsel for Mrs Mulligan
31 October 2005

¹⁶ Paras 111 and 132, Statement Hoffman; T.171: 10-40; and T.1435: 55 - T.1436: 40 (Hoffman).

Submissions

Dr Morgan NAIDOO

Queensland Public Hospitals Commission of Inquiry

Submissions for Morgan Neelan Naidoo

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1. Terms of Reference

- 1.1 The Queensland Public Hospitals Commission of Inquiry sent a letter to Dr Morgan Naidoo on 14 October 2005 containing a notice of potential adverse findings and recommendations. The letter advised that the Inquiry would consider whether to make findings about Dr Naidoo's conduct and make recommendations that are adverse to Dr Naidoo. The letter mentioned two particular terms of reference of the Commission of Inquiry. The terms of reference are as follows:

- (1) Term of Reference 2(c);
- (2) Term of Reference 2(e)(iii).

The Terms of Reference are located within the *Commissions of Inquiry Order (No. 2) 2005*. Term of Reference 2(e)(iii) is contained within the *Commissions of Inquiry Order (No. 2) of 2005 as amended by Commissions Amendment Order (No. 1) 2005*. These Terms of Reference are as follows:

- (1) Term of Reference 2(c): any substantive allegations, complaints or concerns relating to the clinical practice and procedures conducted by other medical practitioners, or persons claiming to be medical practitioners, at the Bundaberg Base Hospital or other Queensland Public Hospitals raised at the Commission of Inquiry established by *Commissions of Inquiry Order (no.1) of 2005*.
 - (2) Term of Reference 2(e)(iii): In relation to (a) – (d) above, whether there is sufficient evidence to justify the bringing of disciplinary or other proceedings or the taking of other action against or in respect of any person.
- 1.2 Term of reference 2(e) is limited by way of express reference to terms of reference (a) to (d). The Notice of Potential Adverse Finding can only therefore refer to term of reference 2(c).
- 1.3 Accordingly, the inquiry is confined to making a finding under term of reference 2(e) to matters, which fall within the ambit of term of reference 2(c). Term of reference 2(e) does not provide for any wider jurisdictional basis than that provided by term of reference 2(c). It would not therefore be open to this Inquiry to make any finding under term of reference 2(e) with respect to any issue, subject matter, or evidence which does not itself fall within the ambit of term of reference 2(c).

- 1.4 Term of reference 2(c) is confined to the "*clinical practice and procedure*" of persons acting in their capacity as medical practitioners.
- 1.5 It is noted that there is no prospect that any finding be made concerning the clinical practice and procedures of Dr Naidoo himself. Indeed, the 'absence from duty' referred to in paragraph 1(a) of the Notice is not said to encompass any finding touching upon or concerning the clinical practice and procedure of any medical practitioner, including Dr Naidoo. The allegation is confined expressly to whether or not there has been an absence from duty.
- 1.6 Accordingly, for the Notice to provide a valid basis for findings, it must be confined to activities of Dr Naidoo relating to the clinical practice and procedures of Drs Sharma or Krishna. That much would appear to be recognised by the terms of paragraph 1(b) of the Notice.
- 1.7 Term of reference 2(c) was the subject of particular reference (by way of expansion of the terms of reference) in clause 2(f). That clause does not in any sense widen the terms of clause 2(c) insofar as all or any of the potentially adverse findings are concerned. Indeed, clause 2(f) makes it clear that clause 2(c) does not and cannot concern alleged management or supervisory deficiencies save to the extent that those deficiencies concern the clinical practices and procedures of Drs Sharma and Dr Krishna.
- 1.8 Further, term of reference 2(c) can only relate to alleged deficiencies in supervision to the extent that it can be found that those alleged deficiencies, actually or potentially, impacted upon the clinical practices and procedures undertaken by Krishna and Sharma. Yet the Notice does not assert such a conclusion at all.
- 1.9 Broadly, it is the submission of Dr Naidoo that paragraphs 1(a) and 2 of the Notice do not comprehend matters, which fall within the terms of reference. For example, alleged absence from duty cannot found a referral for disciplinary action under clause 2(e) except to the extent that there is a demonstrated factual basis for a finding under clause 2(c).
- 1.10 These submissions will deal with each of the paragraphs in the Notice. That is done only subject to the objection set out above and should not be construed as any concession that paragraphs 1(a) and 2 are findings which fall within the Terms of Reference.

2. Notice of Potential Adverse Findings and Recommendations

Potential Adverse Finding 1 (a):

Between August 2002 and February 2005 there were numerous occasions when you were in Brisbane or otherwise absent from duty when you should have been on duty in the Fraser Coast Health Service District for the Hervey Bay Hospital, and you were not on approved leave.

- 2.1 It is noted that the original Notice dated 14 October 2004 referred to 'several occasions' between January 2004 and February 2005. It is accepted that the amended Notice dated 21 October concerns an expanded timeframe.

- 2.2 Nonetheless, it is inappropriate for a Commission of this kind to rely upon or utilise subjective notions such as "numerous" when it is considering a finding, which has clear potential to seriously impact upon Dr Naidoo.
- 2.3 For the Notice to be one justifying a particular finding and capable of proper response, it should at least specify the number of occasions and indeed the dates themselves.
- 2.4 That the Notice does not do so is, perhaps, explicable on the basis that the records kept by the hospital concerning attendance on duty, hours worked, or leave taken are incomplete and inadequate. That inadequacy ought not however be a basis upon which a generalised, sweeping finding is made without descent into appropriate specifics.
- 2.5 Specificity is at the very least something, which a party subject to this Notice is entitled to expect and receive.
- 2.6 In the submission of Dr Naidoo, a finding ought not be made in the terms sought and to the extent that the commission identifies, as it should, specific instances, Dr Naidoo should be given a further opportunity to respond to those specifics and to provide an explanation where possible.
- 2.7 Were it otherwise, Dr Naidoo would be the subject of a finding, which is almost impossible to properly respond to, and which is one, which, in terms of potential publication in the media, would doubtless have a significant impact upon him. That much is clear from the media reporting, which has occurred already.
- 2.8 It is important that the Commission frame its findings in a way, which neither encourage nor permit expansive and grandiloquent treatment in the media.
- 2.9 The actuality or otherwise of Dr Naidoo's presence at Hervey Bay Hospital is unable to be determined on the evidence. Given the issues with accuracy of HR records that have been suggested by a number of parties, including Dr Hanelt and Dr Naidoo, these records constitute insufficient evidence justifying an adverse finding against Dr Naidoo.
- 2.10 There are three aspects it would appear, to the allegation. Firstly, that Dr Naidoo was not at the hospital at all when he ought to have been, i.e. unauthorised leave and secondly, that he was either late in arriving or early to leave during a working week and thirdly, that he was otherwise uncontactable.

Leave

- 2.11 It is submitted that the Commission of Inquiry ought not make an adverse finding against Dr Naidoo on the basis of the amount of leave he took whilst director of orthopaedic services. The leave that Dr Naidoo took over this time was approved leave that he was entitled to.
- 2.12 The Commission of Inquiry is unable to make adverse findings on the basis that Dr Naidoo took his entitlements. By taking that leave, the result, in practice, was that the hospital was indeed short staffed. That is a matter, which ought properly be laid at the feet of the appropriate party, not at the feet of a doctor who had for many many years selflessly, and at great personal expense, carried the burden of orthopaedic services at Hervey Bay.

- 2.13 Similarly, it is submitted that there is an insufficient evidentiary basis for the Commission to make any adverse finding to the effect that Naidoo took unauthorised leave.
- 2.14 It is submitted that Dr Morgan Naidoo always put in leave forms when he took planned leave and when he took unplanned leave, he always made a telephone call to the clinical support officer or to HR generally. Evidence to that effect was given by Dr Naidoo and has not been contradicted by any witness. Accordingly, the Commission should accept it without reservation.
- 2.15 The Commission should also refer to Dr Terry Hanelt's supplementary statement where he stated that: *"there are some times when leave was paid, but no application/approval form has been located and some times where leave has been approved but normal hours have been paid and leave has not been deducted."*
- 2.16 The Commission should refer to the final paragraph of page 3 of Dr Terry Hanelt's supplementary statement where Dr Hanelt referred to the: *"calculations of the HR department in relation to Dr Naidoo's long service leave entitlement and errors made within such calculations, combined with situations where there are approved leave forms in the HR file but no leave has been deducted and where leave has been paid despite no application being on the file and evidence that Dr Naidoo was at work on some occasions where he has been paid for being on leave."*
- 2.17 As Dr Hanelt stated in that supplementary statement, these points raise significant concerns in relation to the accuracy of data from the HR department and as such, there is insufficient evidence that Dr Naidoo was absent from the hospital without approved leave.
- 2.18 As Dr Naidoo stated at page 6594 of the transcript, when taking planned leave, he prepared a memorandum setting out what was to occur in his absence. Dr Naidoo stated there would be two memorandums for each occasion that he was on leave and one would go to the elective surgery coordinator for operating sessions and one would go to the clinic supervisor to indicate what was happening for the clinics.
- 2.19 Dr Naidoo stated that leave memoranda would not be created if he were on unplanned leave, for example, sick leave.
- 2.20 In Dr Hanelt's supplementary statement dated 7 October 2005, at page 2, Dr Hanelt stated that:

"Copies of any leave forms are held by the HRM department at the Maryborough Hospital. These have been requested and can be supplied. An analysis of these records has been performed as far as has been possible in the limited time available. These show some times when leave was paid but no application/approval form has been located and some times where leave has been approved but normal hours have been paid and leave has not been deducted. The rosters also show times where leave was marked but there is no other record of that leave being applied for or deducted."

- 2.21 On page 3 of the supplementary statement, Dr Hanfelt discussed the inaccuracy of the calculations made by the HRM department in relation to Dr Naidoo's long service leave entitlements.
- 2.22 When you combine:
- (1) the significant error made by the HRM department regarding the calculated figure of long service leave entitlements;
 - (2) situations where there were approved leave forms in the HRM file but no leave has been deducted;
 - (3) situations where leave has been paid despite no application being on the file, and
 - (4) the evidence that Dr Naidoo was at work on some occasions where he has been paid for being on leave,
- significant concerns are raised in relation to the accuracy of data from the HRM department.
- 2.23 No witness was called from the HR department to explain the discrepancies or indeed to provide any sufficient evidentiary foundation for a finding that Dr Naidoo took unauthorised leave.
- 2.24 Given that the Director of Medical Services of the Fraser Coast Health Service District believed that there were significant concerns in relation to the accuracy of data from HR, it is submitted that it would be manifestly unfair for the Commission of Inquiry to make any adverse findings and recommendations on the basis that Dr Naidoo was absent from duty when he should have been on duty in the Fraser Coast Health Service District as it is entirely possible that the times that Dr Naidoo was absent from duty were actually occurrences where he called in sick, as was his practice, and for one reason or another, the HRM department has failed to take note of that approved absence. We would make that submission in relation to both planned and unplanned leave.
- 2.25 There is a related issue, which requires comment. That is whether Dr Naidoo discharged his on-call obligations whilst in Brisbane.
- 2.26 Ms Irwin-Jones stated at paragraph 31 of her statement and reiterated at page 5408 of the transcript that it is a well-known fact that over the years Dr Naidoo worked for the district he often did on-call from Brisbane. This was advice she received from staff prior to her working in Hervey Bay. Ms Irwin-Jones made this comment without any evidence of it being true.
- 2.27 Throughout the entirety of the evidence produced to the Commission of Inquiry, there has been no evidence that Dr Naidoo did indeed do on-call from Brisbane.
- 2.28 Dr Naidoo himself has said that he generally remained at Hervey Bay between Monday and Friday and, when on-call over a weekend, remained in Hervey Bay on that weekend.
- 2.29 There is no evidence before the Inquiry to gainsay that assertion by Dr Naidoo. Indeed it was not suggested to him in cross-examination by counsel assisting that he was in fact in Brisbane when he was in fact on call.

- 2.30 If it be found that he was absent when he should have been on duty, that finding in itself cannot sustain the broader conclusion that he discharged his on-call obligations by telephone from Brisbane.
- 2.31 At page 6758 of the transcript, Dr Terry Hanelt responded to the question of whether Dr Naidoo often did on-call from Brisbane by stating that: *"it is a comment he has heard raised but he is unaware of any time when Dr Naidoo was in Brisbane when he was on-call."*
- 2.32 It is important to note also that neither Drs Krishna or Sharma ever asserted that Dr Naidoo had been in Brisbane when he should have been on call.
- 2.33 There was one occasion touched on in evidence by Dr Krishna when he said that he could contact Dr Naidoo but that he declined to attend. It was suggested to Dr Krishna that that was because Dr Naidoo was in Brisbane.
- 2.34 That suggestion was flatly and cogently rejected:

At 6492-6493.

Did you consult - did Dr Naidoo supervise you when you performed the procedure on this patient?-- No.

Did he consult with you?-- I called him. He didn't come.

Why did you call him?-- I called him on the day of surgery. I told him because she's got a lot of swelling, it might be a very difficult situation, and he talked to me by phone and he said, "Open, if there's any problem, let me know." When I opened up, the fibula fracture was more comminuted than we expected in the x-ray, because x-ray's are just a two-dimensional picture. When we open up we see three-dimensional bone. So it was more comminuted. I was seeking assistance and he did not come.

Did you make it clear to him that you would have preferred him to be present?-- Twice.

Did he explain why he would not come?-- No. He said, "You are SMO, you should be able to do this."

COMMISSIONER: Did he say where he was?-- I think he was in his room. He was still in his residence— In Brisbane?-- No, no, no. He stays in one of the motels close to the hospital.

But he stayed in Brisbane quite a lot. He lived actually in Brisbane, didn't he?-- No, that day he was definitely in his motel. All right.

MR ANDREWS: How is it that you know he was definitely in his motel? Presumably you phoned him on his mobile?-- No, we got him on his freeset. The freeset doesn't catch if he's in Brisbane, and - sorry, and he did come back - come to the hospital just after we finished the procedure. So he couldn't have been in Brisbane."

- 2.35 Further, Mr Andrews asked Dr Sharma at page 5681 of the transcript if he ever found that there were occasions Dr Sharma wanted the help of Dr Naidoo but

was unable to give it to him because he was in Brisbane. Dr Sharma states that he "did not have that kind of situation at any time".

- 2.36 The suggestion made to Dr Krishna and Dr Sharma set out above perhaps reflects an unfounded suspicion that the second hand evidence given by Ms Irwin-Jones had some foundation.
- 2.37 Just as Dr Krishna and Dr Sharma flatly rejected it, so should this Commission.
- 2.38 The reality is, that the notion that Dr Naidoo was in Brisbane whilst on call probably emanates from instances in which nursing staff were unable to contact him.
- 2.39 From that position, the unfounded conclusion is drawn that he was not in the district or area at the relevant time.
- 2.40 A simple but balanced review of the evidence will establish conclusively that there is no substance at all in either proposition.
- 2.41 The Commission should refer to page 4 of Terry Hanelt's supplementary statement of 7 October 2005 where he stated:

"There were incidents where staff reported to me that they were unable to contact Dr Naidoo. On each of these occasions, I then attempted to contact Dr Naidoo, unless I already knew his whereabouts and was able to make contact. Reasons for difficulty in contacting Dr Naidoo included being scrubbed in theatre; being on approved leave; delays in the paging message being received (this can be quite substantial for long range pagers); poor mobile phone reception locally and in transit between the two towns (Maryborough and Hervey Bay); and staff members using only one method of attempting to make contact when that method was unavailable at that time (eg. Trying to contact via mobile phone when Dr Naidoo was in an area where mobile phones must be switched off due to potential interference with medical equipment such as the operating theatres, intensive care and Emergency Department). I was satisfied on all but one or two occasions that Dr Naidoo was where he should have been under the terms of his employment. The couple of occasions when Dr Naidoo was not where he should have been (in theatre, in a clinic, in transit between the two hospitals, or on leave) were in the morning when he should have started work, and he told me he was en route but delayed by problems with traffic. As his explanations for being elsewhere were plausible and there were only a couple of occasions, I took no further action. Also, Dr Naidoo often worked longer than the required hours." (emphasis added).

- 2.42 Dr Hanelt's observation emphasised above ought be given its full effect by the Commission. The reality is that there is no suggestion that Dr Naidoo worked anything other than his required hours per week.
- 2.43 There is no suggestion that he failed to discharge his obligations to the hospital during his working week.
- 2.44 Indeed, it is not suggested in the Notice that he in any way was derelict in his duty due to, or as a consequence of, any alleged absence.

- 2.45 Apart from nurse Dale Irwin-Jones, the other possible source for the unsubstantiated allegation is the North Giblin Report.
- 2.46 The North Giblin Report into orthopaedic health care in the Fraser Coast Health Region stated at page 15, in relation to availability of Dr Naidoo, that several staff interviewed expressed concern about Dr Naidoo being in Brisbane for a large proportion of his time and frequently being absent on recreation leave, sick leave, conference leave or study leave.
- 2.47 The Report does not identify who those staff were. None of the supporting material upon which the report was based has been put into evidence.
- 2.48 The comment at page 15 of the North Giblin Report was the subject of some evidence by Dr North. The reality is that the complaint was no more specific than that Dr Naidoo was "very hard to find".

(at 5143)

COMMISSIONER: Could I just ask a question arising out of that? Given that Dr Naidoo lived in Brisbane and it's a three or perhaps more realistic, three and a half hours to Hervey Bay from where he lived, were you able to judge how much time he actually spent in Hervey Bay?-- We weren't.

Sorry?-- We were not.

Did you have any indication from staff there as to what that was?-- He was - we constantly got the sentence, "He is very hard to find".

- 2.49 The passage of evidence set out above explains the conclusion expressed in the North Giblin Report that Dr Naidoo was extraordinarily difficult to contact, being either out of range or out of town and that he simply did not respond to messages left by staff to contact them.
- 2.50 However, if the Commission refers to Terry Hanelt's supplementary statement, at page 4, Dr Terry Hanelt stated that there were incidents where staff reported to him that they were unable to contact Dr Naidoo, but on each of these occasions when he attempted to contact Dr Naidoo, he was able to make contact. The reasons for difficulty in contacting Dr Naidoo included being scrubbed in theatre, being on approved leave, delays in the paging message being received, poor mobile phone reception locally and in transit between Maryborough and Hervey Bay and that staff members using only one method of attempting to make contact when that method was unavailable at the time.
- 2.51 The North Giblin Report is not a source upon which the commission should rely in this, or indeed in many other, instances.
- 2.52 At page 6680 of the transcript, Dr Naidoo stated that the mobile phones did not work in certain areas and if he was in transit between Maryborough and Hervey Bay a certain segment of that area was not covered by mobile phones and within the hospital there were drop out areas with mobile phones but he would emphasise that whenever he was on duty during the day that he was at either one of the campuses.

- 2.53 At page 6760 Dr Hanelt agreed that over the years people made complaints about being unable to contact Dr Naidoo, and Dr Hanelt investigated those complaints. Dr Hanelt agreed that he personally attempted to contact Dr Naidoo on those occasions. It was then put to Dr Hanelt that he said that he was successful on all occasions in contacting Dr Naidoo the only qualified being on a couple of occasions over the years when Dr Hanelt found Dr Naidoo to be on the way to Hervey Bay from Brisbane. Dr Hanelt qualified this a little further by stating that occasionally it was impossible to personally contact Dr Naidoo because he was scrubbing in the operating theatre and you could locate where he was.
- 2.54 Dr Hanelt stated that when people questioned where Dr Naidoo was, some of the time he was on leave and people simply were not aware that he was on leave. Other times he was contactable but had not been contacted by appropriate means: *"If you are in the operating theatre, your mobile phone must be turned off."*
- 2.55 Dr Hanelt stated at page 6801 of the transcript that the majority of the time when there were complaints about Dr Naidoo not being on duty when he supposed to be on duty, he was located and he was performing what he was supposed to be doing or he was already on legitimate leave, that the staff member who had claimed he was absent without leave simply did not know he was on leave.

Telephone Records

- 2.56 Counsel assisting cross-examined Dr Naidoo at some length on the basis of telephone records.
- 2.57 Only certain parts of those records were put to Dr Naidoo for comment and the Commission should therefore confine itself to those particular instances. To do otherwise would be to not accord him procedural fairness as counsel assisting was, obviously, deliberately selective in taking Dr Naidoo only to those areas which must have been of interest to the Commission.
- 2.58 Care should be taken in relying upon either the records themselves or some of Dr Naidoo's answers, which were elicited during this part of the cross-examination.
- 2.59 Counsel assisting quite properly withdrew any suggestion that calls logged as being from Kangaroo Point meant, for example, that Dr Naidoo could not have been in the New Farm Clinic. Counsel assisting also quite properly accepted that Dr Naidoo was indeed hospitalised in the New Farm Clinic in December 2004.
- 2.60 The records that were put to him initially seemed (erroneously) to establish that that was not the case. Between pages 6617 and 6619, Dr Naidoo accepted (no doubt by reason of the apparent logical force of the questioning and observations) that he was not in hospital when of course, he was. Care should be taken in relying upon any concession made by Dr Naidoo during this part of the cross-examination, as his evidence was no doubt affected by Dr Naidoo's acceptance of what was shown ultimately to be incorrect. He dealt with this in his supplementary statement.

- 2.61 One specific instance was put to Dr Naidoo by counsel assisting at page 6600, 6616 and 6617 of the transcript concerning late January 2004.
- 2.62 The phone records specifically show that Dr Naidoo was back in Hervey Bay on 4 February 2004. Some of the telephone records are entirely consistent with Dr Naidoo travelling up and back on one day. Unless he was on call, and there is no evidence that he was, there can be no criticism of him travelling up and back each day, particularly as is the case, he discharged all of his duties and worked more than his required hours per week.
- 2.63 It would be unfair of the Commission to make an adverse finding against Dr Naidoo on the basis that one interpretation of the evidence is that he was not at work when there is an equally likely interpretation of the evidence that he was. For example, in relation to the evidence relating to the phone records of 19 January 2004, the phone records show calls made outside of business hours, one at approximately 7.42am and the second one at 9.28pm. Both of these times are outside of normal working hours and as such, it is as likely as not that Dr Naidoo was at the Hervey Bay Hospital on duty on this day. Unless further evidence is provided, an adverse finding cannot be found on this basis alone.
- 2.64 At page 6609 of the transcript, Mr Andrews attempted to show that no leave was taken in the week of 22 January 2004 by stating there was no leave memo, that there was no record with HR of the leave and that Dr Naidoo had no memory of taking leave.
- 2.65 There is a memorandum that commences 27 January 2004 so the dates in question are only 2 working days; 22 January 2004, 23 January 2004 because 26 January 2004 was a public holiday.
- 2.66 The phone records show that Dr Morgan Naidoo was in Stones Corner or its surrounds on 27 February 2004, which was a Friday. In relation to 27 February 2004, Dr Naidoo is certain that he would not have just simply taken a day off work but that it would have been a sick day for which he made a call to the clinical support officer. There is no evidence to the contrary.
- 2.67 The next period of time relates to 21 – 23 April 2004. Once again, this was planned leave provided for in a leave memorandum of 12 December 2003 from Dr Morgan Naidoo to Terry Hanelt. In that form, Dr Naidoo states that he would be on leave from 21 April 2004 to 23 April 2004. That time was spent at the knee symposium held by Striker at Couran Cove, Gold Coast. No leave form has been discovered for this period of time. However the memorandum is consistent with what in fact occurred.
- 2.68 Monday, 26 April 2004 was a public holiday as stated in the table annexed to Dr Naidoo's supplement statement regarding the telephone records. On Monday 3 May 2004, Dr Naidoo would have been looking after his son who had been discharged from the Mater Private Hospital on 1 May 2004 after surgery.
- 2.69 Dr Naidoo was hospitalised for depression in August 2004 from 13 – 28 August. Forms were submitted for this period providing sick leave. The HR records are not complete in this regard. They leave out certain dates where Dr Naidoo was clearly in hospital. For example, the leave records of the HR department do not show that Dr Naidoo was on leave on 13 August 2004, when he was clearly in hospital and had provided information to Terry Hanelt to that effect.

- 2.70 From 4 – 6 August 2004, Dr Naidoo attended a conference in Queenstown; the Foot and Ankle Society Conference. This leave was approved via memorandum from Terry Hanelt.
- 2.71 No leave form has been discovered for this period of time, however a leave form would have been required for Dr Terry Hanelt to approve such leave. This deficiency tends to establish that there is almost a practice in the HR department of failing to maintain accurate and complete personnel files. The lack of an accurate and complete personnel file requires the Commission to consider whether it would be prudent to rely on such a file in order to make adverse findings against a medical practitioner, such as Dr Morgan Naidoo. In this regard, it is submitted that the evidence is insufficient to sustain an adverse finding against Dr Naidoo.
- 2.72 At TMH38 of the attachments to Dr Hanelt's original statement to the Inquiry, one finds an orthopaedic senior medical officer on-call roster for January 2005. During the Inquiry, the Counsel assisting the Inquiry put a number of telephone records to Dr Naidoo. Part of these telephone records identify 20 and 21 January 2005 as dates where Dr Naidoo was making telephone calls in Brisbane rather than being located in Hervey Bay where he was on duty. If one looks at the document TMH38, one finds that for the Thursday and Friday, 20 and 21 January 2005, Dr Kwon is listed as the consultant on duty and not Dr Naidoo. Dr Naidoo's name does not appear on this roster for those two particular days and as such, we would submit he was not on duty at Hervey Bay or at any hospital in the Fraser Coast Health District on these two particular days.
- 2.73 Similarly, Exhibit TMH38A to Dr Hanelt's original statement to the Commission of Inquiry, contains an orthopaedic senior medical officer on-call roster for February 2005. This roster demonstrates both the daily duty roster and the on-call times outside of normal working hours. The Commission of Inquiry's attention is directed towards Thursday and Friday, 3 and 4 February 2005. These two dates are dates for which the Counsel assisting the Commission of Inquiry put to Dr Naidoo in evidence that he was in Brisbane making telephone calls when he should have been at Hervey Bay. The roster for these two particular dates would show that the daily duty SMO and on-call SMO for these two dates was Dr Krishna and the Maryborough and Hervey Bay daily consultant on duty for these two dates was Dr Kwon. The district on-call medical officer for these two dates was, for Thursday, Dr Padayachay and Dr Kwon and for Friday, Dr Krishna and Dr Kwon. The admitting consultant on these two days was Dr Kwon. In other words, Dr Naidoo was not required to be on-call at Hervey Bay or Maryborough Hospital on Thursday or Friday, 3 or 4 February 2005. As such, the Commission of Inquiry cannot rely on these dates as evidence of occasions when Dr Naidoo was in Brisbane or otherwise absent from duty when he should have been on duty at the Fraser Coast Health Service District.
- 2.74 The supplementary statement of Dr Morgan Naidoo signed 10 October 2005 in particular contains a table addressing issues regarding absences from Hervey Bay arising out of the telephone records. This appears at page 15 of the supplementary statement of Dr Naidoo. The Commission ought to consider that table with reference to the table provided in the second supplementary statement of Dr Naidoo, dated 21 October 2005.

- 2.75 The reality is that the telephone records do not in any sense justify a conclusion of absence from duty on "numerous" occasions. Indeed, counsel assisting addressed only a few occasions throughout the entire period. At its highest, the evidence does not in any sense support the allegation in the Notice.
- 2.76 Moreover, there is a sufficient degree of uncertainty concerning any identified absence and the accuracy of the HR records, which, effectively precludes the commission from making any finding at all concerning unauthorised leave taking or failure to observe on-call obligations.

Fuel Records

- 2.77 The only document, which the Inquiry can rely on in relation to the fuel records, is exhibit 496 and the supplementary statement of Dr Naidoo dated 21 October 2005 regarding exhibit 496.
- 2.78 Exhibit 496 in its entirety was only provided to Dr Naidoo less than 24 hours before the deadline for submitting a supplementary statement on its contents. This did not afford Dr Naidoo the requisite opportunity to be able to consult all relevant records. His responsive statement is predicated upon an acceptance, but not a concession concerning the accuracy of the schedule prepared by Mr Stella on behalf of the Commission.
- 2.79 The Commission is referred to the table contained within the supplementary statement of Dr Naidoo dated 21 October 2005 regarding exhibit 496 and highlight the numerous occasions which are evidenced there where Dr Naidoo was absent from work on legitimate leave which is not represented in the records of the HR department.
- 2.80 In the absence of a detailed analysis of the original dockets it is not possible to test the validity of exhibit 496.
- 2.81 Exhibit 496 suggests some occasions on which Dr Naidoo may have left before the end of the working week or arrived during Monday morning. Even if that conclusion be accepted, there is ample explanation for it, consistent with the uncontradicted evidence.
- 2.82 Dr Hanelt mentioned at page 5 of his supplementary statement that Dr Naidoo often worked longer hours than the required hours.
- 2.83 Dr Hanelt also stated in his original statement at paragraph 61 (ii) that senior staff often work overtime for which they did not claim and in recognition of that fact, some flexibility was allowed in taking time off in lieu of payment of this overtime.
- 2.84 For the periods of time where Dr Naidoo may have left early or arrived late reference is made to his supplementary statement:

"I worked through my lunch break, almost without fail and was not paid for this time. As I stated in my original statement to the commission, I organised in-service meetings a 4-6 times in a year. Meetings often went from 5 to 9 pm. I never claimed payment for this overtime. From Tuesday to Thursday I often went in to work well before I was rostered to start. I would also like to mention that I very often took work home with me from the hospital, which I would

complete over the weekend in Brisbane. I believe that these practices mitigate the occasional late arrival or early departure."

- 2.85 We would submit that the schedule of fuel purchases provided by the Commission points to approximately 17 incidences of late arrivals and early departures over a period of 4 years. This is an average of 4 times per year. This is not substantial enough to be considered "numerous" when placed in its proper context. Dr Naidoo has provided almost 30 years of service to the health care system in Queensland, most of that within Queensland Health.

Inadequacy of HR Records

- 2.86 It is apparent from the foregoing that the records kept by the HR department at the hospital cannot be relied upon as a sufficient evidentiary basis to establish any dereliction of duty on behalf of Dr Naidoo.
- 2.87 In particular, annexure D to Dr Terry Hanelt's supplementary statement concerns Dr Naidoo's leave. If one looks at the entry start date 22 January 2004, one finds that Dr Naidoo was on sick leave on this date. Dr Hanelt has made a note in the comments section of the table stating that no application was found but that a phone call had been made that Dr Naidoo was off sick. 22 January 2004 was a day, which the Commission put to Dr Naidoo in his evidence that he had made a telephone call from Brisbane when he should have been at the Fraser Coast. We would submit that this particular day he was on sick leave, which was approved leave and thus he was not merely taking the day off. The Commission also put to Dr Naidoo various phone calls from 27 January 2004 to 30 January 2004. The summary of leave in Dr Hanelt's statement at annexure D also shows that this was a period of leave and the comment in the table of Dr Hanelt is that leave is shown on the roster but no application can be found.
- 2.88 Dr Terry Hanelt's annexure D, which is a summary of Dr Naidoo's leave in chronological order, is itself not even a complete record of the leave taken by Dr Naidoo. This table does not make any reference to the dates of 21 to 23 April 2004, which Dr Naidoo took as ARL. There is a memorandum from Dr Naidoo dated 12 December 2003 addressed to Terry Hanelt stating that this is a period of planned leave for the first half of 2004. Further, it is known that Dr Naidoo was attending a conference at this time. The conference he attended was the Knee Symposium presented by Striker at Couran Cove on the Gold Coast. That attendance is sworn to in annexure 4 to his supplementary statement of 10 October 2005. There is no record of this leave in the HRM file or in Dr Hanelt's tables. The Commission would not be able to say with sufficient certainty whether this oversight is the responsibility of the HRM department or Dr Naidoo. As such, the Commission of Inquiry cannot make an adverse finding about an absence of Dr Naidoo from the health district on these dates.
- 2.89 In August 2004, Dr Naidoo was hospitalised for depression at the New Farm Clinic. This hospitalisation occurred from 13 August 2004 to 28 August 2004. HR has recorded sick leave from 9 – 12 August 2004 and the next sick leave is from 16 August 2004 – 20 August 2004. HR has failed to record sick leave for 13 August 2004, which was a Friday. This cannot be held to be the responsibility of Dr Naidoo, but rather, goes towards establishing a pattern of inaccuracies recorded by the HRM department.

Evidence of Kristine Wyatt

- 2.90 Ms Wyatt was called apparently to buttress the case against Dr Naidoo with respect to his absence from duty. Notwithstanding her clear animus against Dr Naidoo, she herself has conceded, in exhibit 16 to the statement of Dr Hanelt that many of the complaints against Dr Naidoo arose from bias engendered by his personality.
- 2.91 To the extent that Ms Wyatt is in fact critical of Dr Naidoo, her evidence should be disregarded completely.
- 2.92 In Ms Wyatt's evidence, she stated (at page 7356 of transcript) that she recalled times when Dr Naidoo was difficult to contact and numerous occasions where Dr Naidoo cancelled surgery on the day of surgery. At page 7357, Ms Wyatt stated that she would have spoken to Mr Allsopp about Dr Naidoo several times. Ms Wyatt also stated that she recalled raising problems about Dr Naidoo at monthly surgical services committee meetings (which post 2001 was known as the Surgical Services Management Advisory Committee).
- 2.93 Ms Wyatt conceded in cross-examination by Mr Perry that Dr Naidoo's explanation for the cancellations she referred to were that they were for clinical reasons. There is simply no evidence to the contrary.
- 2.94 When questioned at page 7359 about the minutes of the surgical meetings, Ms Wyatt stated that she would expect the minutes to be an accurate reflection of what occurred in the meeting.
- 2.95 The minutes of various meetings of the Surgical Services Committee were entered as Exhibit 502. There are minutes from meetings of 30 January 2002, 25 March 2002, 7 May 2002, 3 June 2002, 9 July 2002, 7 August 2002, 4 September 2002, 9 October 2002, 6 November 2002, 5 February 2003, 12 March 2003, 7 May 2003, 4 July 2003, 1 August 2003, 5 September 2003, 17 October 2003, 7 November 2003, 5 December 2003, 6 February 2004, 12 March 2004, 2 April 2004, and 14 May 2004. This is a total of 22 meetings for which none of the minutes reflect an issue of cancellations or absences raised by any member of the committee regarding Dr Naidoo. The minutes do not reflect Ms Wyatt ever raising the issue either.
- 2.96 In the meeting of 9 October 2002, it stated: *"Discussion on booking for the orthopaedic lists. Bookings are done 6 weeks ahead for joints. Problems being experienced are patients are either unfit once they go to pre admission clinic or not enough Physiotherapy cover."* This would suggest that cancellations were for genuine clinical reasons. There is no mention of Dr Naidoo here.
- 2.97 In the meeting of 12 March 2003, Dr Naidoo commented that: *"the Emergency Theatre sessions at HBH cannot always run due to Anaesthetic numbers. Dr Naidoo has requested that the Anaesthetic Department communicate with other Units what staff they have available for theatre sessions."* In the meeting of 2 April 2004, Ms Dale Erwin-Jones raised the issue of the anaesthetic shortage and Ann Spring advises that in this context, *"theatre sessions cancelled or changed at the last minute"*. This would also suggest that possible cancellations were due to staffing and resource issues in other departments and thus, for genuine clinical reasons, raised by Dr Naidoo and other staff members.

- 2.98 Ms Wyatt stated that several times since 1997 she had spoken to Mr Allsopp about cancellation issues with Dr Naidoo (page 7360). However, it was pointed out to her by Mr Farr that Mr Allsopp began working as district manager in 2001. Ms Wyatt could not remember if she raised the issues with the previous district manager. There is no documentation from Ms Wyatt to Mr Allsopp regarding the issues. Further, Ms Wyatt stopped working at Hervey Bay Hospital in October 2003.
- 2.99 Ms Wyatt agreed (at page 7356 of transcript) that there were times when Dr Naidoo could have been on leave and she was not aware of it.
- 2.100 Ms Wyatt recalled that she raised the issues with many people but was unable to recall any specifics of times, dates, years, whether or not she documented her concerns, any of the advice given to her by those she spoke with, or whether she was told to raise it at the surgical services management advisory committee (see page 7367 of transcript). Ms Wyatt did not recall whether she put anything in writing after the meeting with Mr Allsopp or whether she put in an incident report (see page 7368 of transcript).
- 2.101 It is submitted that there is no evidence that Ms Wyatt raised any of these issues with anyone else. Further, we would submit that if someone in the position of Ms Wyatt thought these issues to be serious, they would put them in writing and follow protocols by documenting the issues in incident reports and taking issues to the relevant committees and having the issues recorded in those forums. It could not possibly have been a matter of serious concern to Ms Wyatt as there is no documentation of her raising the issues at any point of time with anyone.

Insufficient Evidence to make a finding under paragraph 1(a) of the Notice

- 2.102 The Commission ought not accept the speculative evidence concerning Dr Naidoo's alleged absence from duty.
- 2.103 The reality is decidedly to the contrary. Uniformly, the assertion is based upon rumour and scuttlebutt not evidence.
- 2.104 The telephone and fuel records do not sustain the findings sought to be made. At their highest, they may indicate episodic instances over a period of many years, which, even if proven, are more than counterbalanced by the uncontradicted evidence of Dr Naidoo's working hours, and commitment to the hospital.

Potential Adverse Finding 1 (b):

- 2.105 The purpose of the Notice is clearly to meet the requirements of procedural fairness with respect to potentially adverse findings. To do so, the Notice must provide sufficient details to Dr Naidoo to enable him to properly respond to it.
- 2.106 That requirement presupposes that the individual matters specified in (i), (ii) and (iii) occurred in a particular context sufficient in itself to establish that the conduct specified in those subparagraphs was conduct, which ought not to have occurred for some particular reason.
- 2.107 That is, the Notice ought to specify the particular context in which the alleged conduct occurred. The fact, if established, that each of (i), (ii) and (iii) occurred

is not of itself a sufficient basis for an adverse finding to be made unless and until it can also be established that that conduct should not have occurred and or if it occurred, constitutes a dereliction of duty or failure to maintain appropriate standards of clinical practice and procedure.

- 2.108 The Notice ought therefore to specify why it is that Dr Naidoo should not have done the things alleged against him. The Notice does not do that.
- 2.109 The Notice should specify consequences, actual or potential, which might have flowed from each of (b)(i), (ii) and (iii). The Notice does not do that.
- 2.110 The Notice should identify what the 'certain orthopaedic procedures' were which ought not to have been authorised in the light of the matters referred to in (i), (ii), and (iii). The Notice does not do that.
- 2.111 It is not possible to properly respond to such an allegation where there was quite clearly a range of orthopaedic procedures, which Dr Krishna and Dr Sharma should quite properly have been authorised to perform and no distinction is made between those procedures and those, which the Commission might find, ought not to have been authorised.
- 2.112 The Notice should specify or at least refer to a body of evidence, or conclusions to be drawn from such evidence, which would necessarily or potentially place the conduct alleged against Dr Naidoo in the category of conduct warranting an adverse finding.
- 2.113 It might be speculated that the clinical competence, as exhibited in the clinical practice and procedure of Drs Krishna and Sharma was such that Dr Naidoo ought not to have done that which is alleged against him.
- 2.114 It cannot however be asserted that that conclusion could be warranted across the broad range of activities undertaken by each of those two doctors. Indeed, the Notice does not even pretend to make such a broad assertion.
- 2.115 It can only therefore be that there were particular aspects of their competence, as revealed in their clinical practice and procedure, which were such that required Dr Naidoo to do the converse of that which is alleged against him. If that be the case, or if there be a different context in which the allegations against Dr Naidoo ought properly be considered, then that context should be specified in the Notice. The Notice does not do that.
- 2.116 The deficiency in the Notice constitutes a fundamental deficiency in terms of procedural fairness.
- 2.117 Dr Naidoo is therefore compelled to attempt to answer paragraph 1(b) by hypothesising as to what it is that the Notice seeks a response to.

Ground 1(b)(i) is in the following terms:

Between July 2003 and August 2004 you as Director of Orthopaedics at the Hervey Bay Hospital authorised Dr Krishna and Dr Sharma ("the Senior Medical Officers") to perform certain orthopaedic procedures in circumstances where:

(i) Apart from 4 occasions in which you observed Dr Krishna perform procedures, you had not observed either of the Senior Medical Officers performing those procedures;

2.118 The Notice of potential adverse findings or recommendations in relation to supervision of the SMOs, Dr Krishna and Dr Sharma, states that between July 2003 and August 2004, Dr Naidoo only observed Dr Krishna performing procedures on 4 occasions. We would submit that the Commission has failed to recognise the fact that Dr Krishna arrived at Hervey Bay Hospital on 20 July 2002. When Dr Krishna first arrived at Hervey Bay Hospital, Dr Naidoo took Dr Krishna along with him to various operating sessions and had an opportunity to observe him in this initial period of employment.

2.119 At page 6595 of the transcript, Dr Naidoo gave evidence concerning his memorandum dated 2 October 2002, which indicated that Dr Krishna could do certain elective cases without supervision. At that stage, Dr Krishna had been at the hospital for about 9 weeks and Dr Naidoo had observed him performing surgery. Dr Krishna was in the operating theatre with Dr Naidoo for about 4 operating lists per week and did parts of procedures with Dr Naidoo. In other words, Dr Naidoo observed Dr Krishna's surgical abilities at periods of time before July 2003 (the date specified in the Notice of potential adverse findings and recommendations).

2.120 In simple terms, the Notice is deficient in form and content.

Role of Senior Medical Officers

2.121 It would appear that there is no ready description of the level of competence or experience required for appointment. That is perhaps a deficiency, which the Commission may wish to address.

2.122 What is apparent is that Drs Krishna and Sharma were appointed, not by Dr Naidoo, but by the department upon a particular basis.

2.123 That basis is set out in their appointment documentation.

2.124 The Senior Medical Officers, Dr Krishna and Dr Sharma were hired under an Area of Need provision. The documentation for an area of need position provides a section for supervision. Dr Hanelt stated at page 6715 of the transcript that the supervision indicated in such a document would primarily be supervision by Dr Naidoo.

2.125 In relation to the Form 1 Area of Need documentation that was used in order to be able to recruit senior medical officers for the orthopaedic department (TMH-31 to Dr Hanelt's original statement), Dr Hanelt referred to a person who could undertake the management of a wide range of conditions with: *"minimal supervision"*.

- 2.126 The hospital management itself envisaged minimal supervision in the recruitment of senior medical officers for the orthopaedic department. The hospital had the intention that these officers provide orthopaedic services with minimal supervision. As such it would be inappropriate to make an adverse finding against Dr Naidoo on the basis that the Senior Medical Officers in fact required more than the level of supervision, which the hospital itself used as a benchmark for their appointment.
- 2.127 At page 6760 of transcript, Dr Hanelt was asked whether Dr Naidoo was aware that the hospital's intention was in seeking someone who would be, upon appointment, capable of providing management of a wide range of conditions with minimal supervision, to which Dr Hanelt replied: "yes".
- 2.128 Mr James Patrick O'Dempsey swore an affidavit for the Commission of Inquiry dated 14 October 2005. An annexure to that statement is JPO16K, which is a letter to Dr Krishna dated 28 June 2002 which informed him that he had been granted special purpose registration as a medical practitioner in Queensland, effective from 18 July 2002 until 18 June 2003. That letter advised that he was not registered as a specialist.
- 2.129 JPO16O is a letter to Dr Krishna dated 6 June 2003 where Dr Krishna was informed that he had been granted special purpose registration as a medical practitioner in Queensland effective from 18 July 2003 to 17 July 2004. In that letter, it was stated that there were nil conditions imposed on his registration. In that letter, there was no mention of the supervision, which would be required for Dr Krishna. It merely stated that special purpose registration enabled him to practice as an SMO in orthopaedics at Fraser Coast Health Service District, or any other public hospital authorised by the medical superintendent of Maryborough Hospital on a temporary basis.
- 2.130 JPO16S is a letter to Dr Krishna dated 8 July 2004. In that letter, a person signing for the registrar advised Dr Krishna, that he had been granted special purpose registration as a medical practitioner in Queensland effective from 18 July 2004 until 17 July 2005. He was informed that there were nil conditions imposed on his registration. The letter merely stated that his special purpose registration enabled him to fill an area of need at Hervey Bay Hospital and Maryborough Hospital or any other public hospital authorised by the medical superintendent on a temporary basis. Supervision requirements were not mentioned in the letter.
- 2.131 These letters annexed to James O'Dempsey's affidavit cover the period discussed by the Notice of Potential Adverse Findings and Recommendations set out in 1(b) of the letter to Dr Naidoo dated 14 October 2005. Dr Naidoo allowed Dr Krishna to perform orthopaedic procedures in circumstances which directly correlated with the conditions set out in the letters regarding the SMOs' registration.
- 2.132 Dr Naidoo cannot be held responsible for a subsequent change in standards. This subsequent change in standards is evidenced in JPO16U which provides some details as to a board meeting held on 21 December 2004 regarding Dr Krishna. In that meeting, it was recommended that Dr Krishna's general registration with supervised practice conditions be effective from 14 June 2005. That was the first time Dr Krishna was provided with supervised practice conditions imposed on his registration. As that occurred on 14 June 2005, it is

outside the scope of the dates (July 2003 to August 2004), which the Commission has dictated in its Notice against Dr Naidoo.

2.133 The documents relating to Dr Sharma which are attached to the affidavit of James O'Dempsey follow a similar pattern to the documents for Dr Krishna. JPO17C is a letter to Dr Sharma dated 13 March 2003 where he is informed that he has been granted special purpose registration as a medical practitioner in Queensland effective from 27 February 2003 and valid until 25 January 2004. The conditions imposed on his registration were nil. Dr Sharma was merely told that special purpose registration enabled him to practice at Fraser Coast Health Service District or any public hospital authorised by the medical superintendent of Maryborough Base Hospital on a temporary basis. No mention of supervision was made in that letter.

2.134 JPO17G is a letter from the registrar dated 11 February 2004 to Dr Sharma. This letter informed Dr Sharma that he had been granted special purpose registration as a medical practitioner in Queensland effective from 26 January 2004 and valid until 25 January 2005. Conditions imposed on Dr Sharma's registration are listed as nil. Once again, Dr Sharma was told the special purpose registration enabled him to practice at Fraser Coast Health Service District or any public hospital authorised by the medical superintendent on a temporary basis. There was no mention in the letter of supervision.

2.135 JPO17J is another letter, which follows the same pattern as the previous letters. It is a letter from the registrar dated 30 November 2004 to Dr Sharma where he was informed that he had been granted special purpose registration as a medical practitioner effective from 17 January 2005 and valid until 16 January 2006. The conditions imposed on his registration were nil. Dr Sharma was told again that special purpose registration enabled him to fill an area of need as a SMO in orthopaedics at Fraser Coast Health Service District or any public hospital authorised by the medical superintendent on a temporary basis. Once again, no mention of supervision was made in this letter.

2.136 At paragraph 31 of his statement, Dr Sharma stated that:

*"as for supervision, I said to the investigators that I had no problems when the consultant was around and that during on-call hours there was none available. I always discuss cases before surgery when needed and would get the consultant into theatre when needed. I did not have any problems with communication between the leadership of the Hospital. **I would also like to comment that people at SMO level are not expected to supervised all the time**". (emphasis added)*

2.137 Dr Sharma went on at paragraph 32 to state the following:

"I agree that in my role I may need supervision, but I do not agree with the level of it. There are procedures that I can perform with no consultant present in theatre and there will be occasions where I will need one. For example, in straightforward trauma and some minor elective procedures I have not needed any supervision and there were no hospital rules to the contrary."

2.138 Dr Sharma continued at paragraph 33 to state:

"Even during my training at Royal Newcastle Hospital, I was able to do surgical procedures with no specialist in theatre. I also note that Dr Krishna worked in a teaching hospital as a PHO and even then 60% of the procedures he performed did not have any specialist in theatre."

Supervision-Ambit and Content

- 2.139 The Commission of Inquiry has heard that there are various levels of supervision. The categories of supervision would be from very close supervision to very distal supervision. The position of a RMO or a PHO is different to an SMO. You would expect a PHO or a RMO to have a very limited degree to which they could perform independently with procedural aspects of clinical patient care. This increases as you move up through the varying ranks. By the time one gets to an SMO level there is an expectation that SMO's would be able to perform a number of procedures without supervision or distal supervision.
- 2.140 Dr Hanelt at page 6716 of transcript explains distal supervision as situations such as a situation where all of the specialist orthopaedic surgeons in the district were unavailable (for example both Dr Mullen and Dr Naidoo), then supervision would be by contact with other orthopaedic specialists at other hospitals, in other words distal supervision.
- 2.141 Dr Hanelt stated at page 6716 of transcript that it is widespread throughout Queensland that there are senior medical officers who work independently after hours without direct supervision.
- 2.142 At the time that Dr Krishna and Dr Sharma were SMOs at Hervey Bay Hospital the Medical Board did not strictly define the levels of supervision required. The Medical Board has since defined the parameters within which an SMO can work. It would be unfair to hold Dr Naidoo to a standard that was not defined at the point in time the events occurred.
- 2.143 The level of supervision provided for Dr Krishna and Dr Sharma was consistent with the level of supervision provided in other health care services throughout Queensland and indeed throughout Australia. Dr Sharma stated at page 5682 of the transcript that the situation for SMOs existed not just at Hervey Bay Hospital but also at other hospitals including Rockhampton where the consulting doctor is at the Royal Brisbane Hospital.
- 2.144 Central to the question of supervision is the role of Dr Krishna and Dr Sharma in identifying those procedures or patients, which required the involvement of a supervising specialist. Each of them confidently asserted that they were able to safely and competently make that decision. For example, at page 6527 and 6528 Dr Krishna clearly and unequivocally agreed with the suggestion that in making the decision in question he always acted with prudence and caution and indeed would only proceed unsupervised where he was completely confident that there was no possible risk to the patient.
- 2.145 It is not enough to simply reject Krishna's evidence in that regard because of what Dr Mullen or Dr North may have said. Even if one were to do that, that step in itself does not provide a sufficient basis for a finding that Dr Naidoo was derelict in relying upon his two senior medical officers to call him as and when required.

- 2.146 At page 6608 of the transcript, Dr Krishna made it clear that in relation to scope of service, he was familiar with the procedures and was sure that he would not have called Dr Naidoo in any of those procedures except for the two arthroscopies.
- 2.147 It was both Dr Naidoo's and Dr Wilson's experience that Dr Krishna would call for help when he required it. It was also the experience of other staff members.
- 2.148 At page 5407 of transcript Ms Irwin-Jones stated that Dr Krishna always worked within his scope of practice. Implicit in that was that he knew what his scope of practice was and that he knew what his limitations were. Ms Irwin-Jones stated that they were advised that his capabilities and that of Dr Sharma's could meet that need and they did not see any evidence to show that he wasn't competent in performing.
- 2.149 Dr Wilson, who had Dr Krishna as his training registrar, provided evidence at page 7330 of transcript that Dr Krishna called him when he felt he was not happy about how it was going and at page 7338 of transcript, in answer to the question of whether Dr Krishna had the insight to call upon assistance if performing something unsupervised and it became more complex than anticipated, Dr Wilson stated that was his understanding of Dr Krishna's time at Toowoomba. Dr Wilson stated: *"I wasn't concerned about his-his-him trying to take on too much and making inappropriate decisions based on that."* Dr Wilson reiterates at pages 7345 and 7346 of transcript that Dr Krishna: *"knew when to call for help."* We would submit that it would be unfair to find adversely against Dr Naidoo for failing to come to the assistance of an SMO who failed to ask for help.
- 2.150 On 26 October 2005 Commission staff provided Deacons with a statement of Dr David Morgan. That statement is cogent and probative evidence, which should be accepted as establishing Dr Sharma's competence.
- 2.151 Dr Naidoo stated at page 6686 of the transcript that: *"The senior medical officer on duty is fully capable in determining whether a patient needed admission or needed to be discharged to the care of a general practitioner or would require and outpatient appointment."*
- 2.152 Dr Naidoo was not the only member of staff who relied on the senior medical officers to advise of what procedures they felt they were competent to perform. At page 6726 of the transcript, Dr Hanelt made it clear that when Dr Naidoo was absent on leave, it was left to the SMOs to assess what was in their range of competence to perform, which is what they were happy to perform and competent to perform, in the context of what had been assessed to be within their scope of service.
- 2.153 At page 6805 of the transcript, it was put to Dr Hanelt that the situation in the orthopaedic department worked in the following manner: *"Dr Krishna would never perform surgery he did not feel comfortable with performing, and we may also have heard from Dr Sharma. We have also heard from Dr Naidoo that he was confident that Dr Krishna and Dr Sharma would make careful decisions as to what surgery they would perform and what they would not perform. And we have heard that in circumstances where they were the only people available and they weren't comfortable with performing the surgery, they would refer it on – to transfer the patient."* Dr Hanelt stated that this was his understanding of the situation.

- 2.154 At page 7340 Dr Wilson gave evidence where he agreed with the proposition that using the term 'supervision' for Dr Krishna may mean that Dr Krishna might need to be supervised for the performance of a procedure a number of times before he could competently perform it on his own or it may mean only to perform it once and that depends upon the initial observation of his initial ability.
- 2.155 Dr Wilson stated that it was certainly true that the skills one acquires in the performance of one or two procedures would equip a doctor to perform other procedures of a similar nature. That: *"you have to extrapolate between cases"*.
- 2.156 Dr Krishna was cross-examined by Mr Devlin at pages 6508-6514. That evidence demonstrates that Dr Krishna had a clear appreciation of the circumstances in which he should seek help and acted consistently with that appreciation.
- 2.157 Significantly, the criticism given in evidence before the Commission by Dr Mullen is not that Dr Naidoo did not adequately supervise while at the hospital but that supervision was lacking because Dr Naidoo was on leave.
- 2.158 That is the true position. That position is consistent in fact with all of the evidence and should be accepted unequivocally.
- 2.159 We would also refer the commission to the minutes of the Surgical Services Management Advisory Committee held on 12 March 2004, contained within Exhibit 502. Page 2 of the minutes indicates that Dr Hanelt: *"reminded medical staff that we are not funded as teaching hospital and therefore we should be mindful of the time when teaching does occur."* In a regional hospital, with a very tight budget, the resources that one does have are required to be used as effectively as possible.
- 2.160 How can it be that Dr Naidoo can justly be criticised where the hospital placed constraints of this kind upon him?
- 2.161 There is an ample body of evidence concerning the competence of Dr Krishna and Dr Sharma. There is more than sufficient evidence as to their awareness of and appreciation of the circumstances in which they should seek assistance. They had had significant experience and were appointed to fulfil a role requiring minimal supervision.
- 2.162 It is apparent that Dr Naidoo was able to assess their competence, by particular reference to post-operative outcomes.
- 2.163 As Dr Wilson referred to, in cross-examination by Mr McDougall, differences of expert opinion by experienced surgeons do not equate with a sufficient basis to make an adverse finding against Dr Naidoo.

Potential Adverse Finding 1 (b)(ii):

You were aware that neither Senior Medical Officer had been appropriately privileged or credentialed in accordance with Queensland Health policy;

- 2.164 It is clear that a credentials and clinical committee had not been established contrary to Queensland Health Policy. Dr Hanelt stated at page 6723 of the transcript that Dr Sharma and Dr Krishna should have been privileged and this is an assessment, which Dr Naidoo would agree with.

- 2.165 At page 6623 of the transcript, Dr Naidoo stated that it is not the role of the Director of Orthopaedic Surgery to prepare the scope of service for senior medical officers. It is usually done by a credentialing or clinical privileges committee, which would consist of two or more people so there is no bias in the assessment.
- 2.166 Dr Hanelt stated at page 6723 of the transcript that it was Mr Allsopp, the District Manager's responsibility to set up a committee. According to Mr Allsopp at page 7077, he then assigned the management of the implementation of the clinical privileges policy to the Director of Medical Services (Dr Hanelt). Dr Hanelt and Mr Allsopp made attempts to organise a clinical privileges committee and when they saw the lack of success they attempted to amalgamate clinical privileges processing with Bundaberg Health Service District together with the Fraser Coast Health Service District in order to get college representatives acting on those committees.
- 2.167 Once again it is submitted that an awareness by Dr Naidoo that neither SMO had been appropriately privileged or credentialed in accordance with Queensland Health Policy is not something which should result in adverse findings against Dr Naidoo because it is clearly stated by both Dr Hanelt and Mr Allsopp that this is a responsibility belonging to Mr Allsopp as District Management of the Fraser Coast Health Service District. At page 7077 of the transcript, Mr Allsopp is asked: *"Were you aware that you were responsible, as district manager, for ensuring that a process was in place to enable credentialing and privileging to occur?"*, to which Mr Allsopp replied: *"That's correct."*
- 2.168 The failure to properly privilege or credential Drs Krishna and Sharma was a matter beyond Dr Naidoo's control.
- 2.169 What then should he have done? It was obviously impractical to treat Drs Krishna and Sharma as registrars or PHOs requiring a greater level of supervision. Indeed, neither doctor was hired as such and neither doctor saw himself as such.
- 2.170 As the Notice fails to specify those procedures, which ought not to have been undertaken unless Drs Krishna and Sharma had been passed by a credentialing committee, it is simply impossible to properly or adequately meet such an uncertain and indeed vague allegation.
- 2.171 The Notice does not specify what operations ought only to have been performed had Drs Krishna and Sharma been subject of a proper committee deliberation.

Scope of Work Document prepared by Dr Naidoo

- 2.172 It is not alleged in the Notice that any potentially adverse finding is or might be made against Dr Naidoo arising out of or relating to this document.
- 2.173 That being the case, it is difficult to see how any adverse finding can be made against Dr Naidoo at all with respect to any formal or de facto credentialing process.
- 2.174 At page 6631 of the transcript, Mr Andrews asked Dr Naidoo why he did not get another orthopaedic specialist in Hervey Bay or even further a field to assist him

in prescribing the privileges and the answer is that Dr Naidoo responded to what the director of medical services wanted. In relation to the privileges committee, it was not up to Dr Naidoo to establish one. This was the role of the director of medical services and/or the district manager. Dr Naidoo did not attempt to set up a credentialing committee, as it was his understanding that the director of medical services, Terry Hanelt, had already commenced such a process.

- 2.175 It would be manifestly unfair for the Commission to make an adverse finding against Dr Naidoo for his awareness or otherwise of the fact that senior medical officers had not been appropriately privileged or credentialed in accordance with Queensland Health policy. This is a matter for people at a higher level within the organisation than Dr Morgan Naidoo as Director of Orthopaedic Services.
- 2.176 In submissions touching upon ground 1(c), there is a table concerning the elective surgery "privileges" which Dr Naidoo prepared in the scope of service documentation and a comparison with the evidence of Drs Mullen and Wilson.
- 2.177 Were such a task to be undertaken with respect to this ground relating to trauma surgery, it would be apparent that of the approximately 56 categories, Dr Naidoo and Dr Wilson disagreed on 10.
- 2.178 As the notice does not attempt to identify any particular procedure, which ought not to be authorised, it is not appropriate to address individual instances, save as to observe again that experts familiar with the individuals may have differing opinions as to their competence.
- 2.179 Most importantly, there is no identification of any clinical procedure actually undertaken by Drs Krishna or Sharma, which it is now said, they should not have been authorised to undertake.
- 2.180 In the absence of that fundamental level of specificity, ground 1(b) is an allegation, which is not capable of sustaining a rational or fair conclusion against Dr Naidoo.
- 2.181 It should also be recognised of course that trauma surgery requires, by definition, an instant response whether or not a supervising specialist is present or available.

Potential Adverse Finding 1 (b)(iii):

Instead you relied on each Senior Medical Officer to advise you of what procedures they felt they were competent to perform.

- 2.182 Dr Morgan Naidoo did not simply rely on what each Senior Medical Officer advised were the procedures they felt they were competent to perform. Dr Naidoo asked them what they performed in their previous employment and what they were comfortable doing and this formed part of his assessment, but did not complete the assessment. The evidence shows that there were a number of factors involved in Dr Naidoo's decisions of what procedures the SMOs could perform unsupervised. These were based on the references provided in their previous course of employment (which, were provided by doctors known to Dr Naidoo), a period of observation by Dr Naidoo of the SMOs performance at the beginning of their employment with the Hervey Bay Hospital, observing their

clinical practices in clinics and surgery and looking at post-operative care of patients.

- 2.183 To a certain extent, Dr Naidoo did rely on what each senior medical officer advised of what procedures they felt they were competent to perform. As stated at page 6593 of the transcript, what Dr Naidoo instructed was that they were to treat patients whom they thought were within their skill level and if they could not handle the situation; they were then to call Dr Naidoo. If Dr Naidoo were not available, the arrangement would be that patients would be transferred to another tertiary hospital.

Experience of SMOs

- 2.184 It is submitted that it is inappropriate for the Commission to make an adverse finding against Dr Naidoo on this basis as it appears that the Commission is failing to recognise that people at the level of SMO do have a certain amount of skill. We are not talking about a position, which involves people coming straight out of a tertiary institution. These are people with many years of training and experience in orthopaedics. Dr Krishna had over 10 years of experience in orthopaedics and Dr Sharma had 14 years of experience in orthopaedics.
- 2.185 Dr Krishna provided the Commission of Inquiry with a written statement dated 28 July 2005. In that statement, he outlined his orthopaedic training prior to coming to work in Australia. Dr Krishna was enrolled in the Fiji Orthopaedic Training Program in 1990. Dr Krishna also went through the process of graduating with a Diploma in Orthopaedics (Australian Orthopaedic Association) in 1995. Dr Krishna was registered as a specialist in orthopaedics in Fiji in 1998. At paragraph 10 of his statement, Dr Krishna stated that in 1997, he worked as a chief medical officer in orthopaedics in one of the three divisional hospitals in Fiji as its sole orthopaedic surgeon. In paragraph 11, he elaborated that during the Fiji Orthopaedic Training Program, he received supervised formal training by visiting orthopaedic specialists from Australia, New Zealand, America and Canada. Similarly to Dr Sharma, Dr Krishna had a 6-month period at the Royal Newcastle Hospital as a registrar in 1995 before the examination for the AOA Diploma in Orthopaedics. Once Dr Krishna started working in Queensland, he worked in the orthopaedic department of Toowoomba Base Hospital as a principal medical officer (PHO) from 5 December 2000 until 20 July 2002. From this point, Dr Krishna became an SMO in orthopaedics at Hervey Bay Hospital.
- 2.186 Dr Dinesh Sharma made a statement on 27 July 2005. In that statement, he outlined his training in orthopaedics. In paragraph 10 of that statement, Dr Sharma sets out that in Fiji he was registered as a specialist after completing two years of post-graduate practice under supervision. In paragraph 11, Dr Sharma elaborated by stating that the training program was structured similarly to the FRACS (Ortho). He did similar part 1 basic science exams followed by clinical training and clinical exams in Sydney. The Diploma of Orthopaedics from the Australian Orthopaedic Association was only presented to him after extensive and thorough examination and not on the basis of participation in professional development as claimed in the North Griblin Report. Dr Sharma provided documentation from his training. Although this qualification does not allow Dr Sharma to be recognised as a specialist in Australia, we would suggest that Dr Sharma does have qualifications in orthopaedics which knowledge assisted Dr Naidoo in making a decision as to what orthopaedic procedures he was able to perform without supervision. At paragraph 8 of his

statement, Dr Sharma stated that he had 14 years of orthopaedic experience and had reached the level of a consultant in the largest teaching hospital in Fiji. During his years of training and work experience, he had worked with prominent orthopaedic surgeons from Australia, New Zealand, Canada and the USA. Given this wealth of experience, Dr Naidoo's assessment that Dr Sharma was able to perform procedures without his observation, was based on an extensive history supported by documentation from former colleagues and supervisors.

- 2.187 From the extensive amount of orthopaedic training that the two SMOs had received before their time at Hervey Bay, we can deduce that these two doctors had a level of experience in orthopaedics not equalled by someone, for example, in a registrar position. The Commission of Inquiry should recognise that while these qualifications were not considered to be the equal of specialist qualifications in Australia, that these two surgeons were, nonetheless, very experienced orthopaedic surgeons. Dr Naidoo was aware of their qualifications and work experience and these factors weighed heavily in a decision by Dr Naidoo as to what kinds of procedures and the scope of procedures should fall within the scope of practice for these two particular surgeons. By allowing these surgeons to work in cases where they felt confident of their abilities, Dr Naidoo was affording the SMOs the respect that they deserved given their experience and qualifications before working for hospitals under the umbrella of Queensland Health. When you consider this in light of the fact that there were no true guidelines for someone in the position of Director of Orthopaedics as to what level of supervision truly was required for such doctors as Dr Krishna and Dr Sharma, it would be difficult to make an adverse finding against Dr Naidoo on this basis as you would be holding Dr Naidoo to a standard which did not exist at the time that these judgment calls were made.

Undefined Parameters of Supervision for SMOs

- 2.188 At page 5402 of the transcript, Ms Irwin-Jones is asked the following question: *"The position of senior medical officer in orthopaedics, is it the case that it is accepted in Queensland that when one is a senior medical officer in orthopaedics and one doesn't have Australian specialist qualifications, that it means one is supposed to be supervised by a consultant?"* Ms Irwin-Jones answers this question by stating that her understanding was: *"up until the Bundaberg Inquiry, that there was no definition as to what level of supervision an SMO would have. Certainly since that time, they had been directed that there will be specific levels of supervision."*
- 2.189 Ms Irwin-Jones continued at page 5403 of the transcript: *"in Queensland Health we have PHOs and we need to know whether they can operate independently, whether they need to be directly supervised. Certainly since the Inquiry, we have still requested to have a clear definition on that: Do they need direct supervision in the operating theatre, do they need supervision within the hospital, do they need supervision within 30 minutes? I have not seen a document out of Queensland Health states what level of supervision there is for any member of staff under consultant."*
- 2.190 Ms Irwin-Jones continued at page 5403 of the transcript by stating that it was her understanding that there is no degree to which senior medical officers must be supervised.
- 2.191 Mr Allsopp provided evidence at page 7075 of the transcript that the situation with the supervision of SMOs was not that Dr Naidoo was not around often

enough to supervise the two SMOs, but rather, that the issue was related to the terms of the supervision being unclear, and that that was an interpretation of supervision, which was the subject of disagreement between Dr Naidoo and Dr Mullen: *"It was on this basis that Dr Hanelt indicated that we would get an external review to actually clarify what the supervision requirements were."*

- 2.192 Exhibit 332 is a draft of a summary of a meeting between Dr Terry Hanelt, Dr Morgan Naidoo and Dr Sean Mullen held on Friday, 16 January 2004. At this meeting, a number of points were agreed upon. One of the points included *"that the AOA Review Report would provide guidance for supervision requirements and clinical privilege delineation for the SMOs. These matters to be further considered after that report in an attempt to find a system that is acceptable to the district, the orthopaedic surgeons and the AOA."* This evidences the fact that the various interested parties had different ideas as to what the supervision requirements were and as such, supervision as a concept was not well defined.
- 2.193 The evidence demonstrates that a number of parties at various levels within the organisation were confused about the role of Senior Medical Officers within the hospital.
- 2.194 In Mr Devlin's cross-examination of Dr Terry Hanelt on and around page 6775 of the transcript, Mr Devlin asked Dr Hanelt many questions regarding public service documentation concerning specialist senior medical officers. The Commissioner stopped Mr Devlin a number of times by essentially stating that the question whether senior medical officer orthopaedic is a specialist qualification is a matter of law. Given that even to this date no-one is able to say clearly whether "senior medical officer orthopaedic" is a specialist qualification or not, we would submit that a decision to allow senior medical officers to perform certain procedures in the orthopaedic department between July 2003 and August 2004, is not necessarily something which can be the subject of adverse findings, as the scope of allowable service for people in these positions, is not something that is understood by a room full of lawyers, let alone someone in the position of the Director of Orthopaedics. It would be unfair for the Commission to hold Dr Naidoo as Director of Orthopaedics at a higher standard of understanding in interpretation than the understanding of the Commission of Inquiry itself.
- 2.195 It is really impossible for the allegation in 1(b)(iii) to be made out. In the absence of a formal credentialing committee, is it really to be suggested that Dr Naidoo was remiss in relying upon the professional morality of Drs Krishna and Sharma with respect to whether or not they acted prudently and cautiously.
- 2.196 To make that finding one must in effect find that Drs Krishna and Sharma were sufficiently incompetent not to be able to recognise the circumstances in which supervision was appropriate or were sufficiently duplicitous to be so aware but to conceal that from Dr Naidoo and Dr Hanelt.
- 2.197 In the light of the evidence of Drs Morgan and Wilson it is simply inconceivable that either proposition can be properly made out here.

Potential Adverse Finding 1 (c):

Between July 2003 and August 2004 you allowed Dr Krishna and Dr Sharma to perform elective orthopaedic procedures without providing either with an appropriate level of supervision or consultant support.

- 2.198 This ground is, in the terms expressed, significantly deficient. It proceeds upon the assumption that the level of supervision or consultant support actually provided was insufficient to permit any elective orthopaedic procedures to be performed between the relevant dates.
- 2.199 If that is the true allegation, then it is patently absurd. As will be apparent from the table contained in these submissions, there was no disagreement between Drs Naidoo, Mullen and Wilson with respect to many aspects of elective surgery being performed without supervision.
- 2.200 Doing the best one can to hopefully divine the true intent behind the Notice, it may be the case that what is to be asserted is that when Dr Naidoo was on leave there was not a sufficient level of supervision or support.
- 2.201 If that is the case, then fault can hardly be attributed to Dr Naidoo. The level of supervision to be provided while Dr Naidoo was on leave and the orthopaedic services to be provided while Dr Naidoo was on leave were matters not for him but for Dr Hanelt and Dr Allsopp.
- 2.202 Where the Notice is deficient is that it does not pretend to specify what elective procedures should not be performed nor does it specify what constitutes an appropriate level of supervision or support.
- 2.203 That deficiency could have been rectified by enumerating the procedures in question and by providing a reference point in the evidence concerning supervision and support. The Notice however does not do that nor attempt to do that.
- 2.204 It is apparent from the submissions that Dr Naidoo considered that there was an appropriate level of supervision whilst he was on duty or on call.
- 2.205 Indeed, Drs Sharma, Krishna and Hanelt held a similar view.

Supervision an Issue of Resources

- 2.206 It is true that the situation with supervision provided in the orthopaedic department at Hervey Bay Hospital was not adequate. Dr Naidoo stated that himself, however it was considered more beneficial for the Fraser Coast community to have an orthopaedic department rather than not. The types of work undertaken by the SMOs were of a minor nature, which at their level of experience did not require such close supervision. It would have been beneficial for both the community and the doctors involved if more supervision had been provided, however the lack of a number of orthopaedic surgeons in the region made this difficult and in fact impossible. It would be grossly unfair to blame this situation on Dr Naidoo as the only orthopaedic surgeon prepared to be full time in the Fraser Coast Public Hospital Health District.
- 2.207 At page 6591 of the transcript, Mr Andrews put to Dr Morgan Naidoo that while he was on leave, the SMOs were mostly left unsupervised. Dr Naidoo agreed

with that. Mr Andrews asked Dr Naidoo if he would agree that that's far from ideal and Dr Naidoo agreed that it was not ideal. We would submit that the fact that the SMOs could not be supervised at the time that Dr Naidoo was on leave was not the responsibility of Dr Naidoo. The amount of supervision that Dr Naidoo was able to provide was limited by a number of factors, including the workload of the hospital providing that he be elsewhere from where the SMOs were and the ability for him to take his leave entitlements.

2.208 At page 5406 of transcript Ms Irwin-Jones stated that the situation where there would be no specialist in the district available to supervise Dr Krishna and Sharma was a situation which was far from ideal and that it would be the fault of Dr Naidoo or Dr Hanelt that there was no specialist in the district available to supervise them. Ms Irwin-Jones did however continue by stating that it is very difficult to attract any medical specialists out of the metropolitan. As such, it would be unfair to lay the blame for the lack of an appropriate number of specialists being available in the district to supervise the senior medical officers at Dr Naidoo's door.

2.209 At page 5418 to 5419 of transcript Ms Irwin-Jones stated that she believed that the Director of Medical Services and the District Manager were putting processes in place to manage Dr Naidoo. Apparently, they had attempted to address some of the issues in relation particularly to leave. They did not outline to her exactly how they were going to deal with Dr Naidoo but as she had never seen any major clinical poor outcomes for Dr Naidoo or the 2 SMOs she didn't feel she had significant evidence to give them to say: *"you must act on this"*. Once again it is submitted that if there was insignificant evidence to state to the Director of Medical Services that there was a requirement to do something about Dr Naidoo's leave or supervision generally, then that situation still remains.

2.210 It would be manifestly unfair to blame Dr Morgan Naidoo for what is essentially an issue of resources.

2.211 The transcript, at page 6515, moves on to the 100% supervision provided to Dr Krishna by Toowoomba Base Hospital. It would be unfair to make a comparison between the supervision provided by doctors at Toowoomba and the supervision provided by Dr Naidoo as it does not take into account that Toowoomba had 7 VMOs, Dr Punn and Dr Ivers (page 6523 of transcript), whereas Hervey Bay had Dr Naidoo and the intermittent availability of Dr Mullen once per week. To make such a comparison and lay the blame for the difference with Dr Naidoo would be to blame Dr Naidoo for what is essentially an issue of supply of resources in regional hospital health care in Queensland.

2.212 At page 6593 Mr Andrews questioned Dr Naidoo regarding level of supervision as being 100% supervision. That kind of supervision is not sustainable and is not something that could or should be expected of a director of orthopaedics such as Dr Morgan Naidoo, because of its unsustainability. Dr Kwon was only present at Hervey Bay Hospital for a period of about 4 months and further:

"Mr ANDREWS: Now, I'll put up on the screen another orthopaedic specialist's level of supervision. This is again from the evidence of Dr Krishna yesterday in the transcript at page 6481, speaking of Dr Kwon's level of supervision. You will see it too was 100 per cent supervision but apparently even more so, more intense than had been provided in Toowoomba?—

I agree with that but Dr Kwon didn't do any of the trauma and didn't do any of the administrative work that I do and certainly had more time on his hands than I did."

- 2.213 The Commission of Inquiry heard evidence from Dr Hanelt that the district had difficulty in recruiting full-time orthopaedic surgeons, VMOs and locum orthopaedic surgeons. Dr Hanelt, as Director of Medical Services employed a number of methods in order to obtain such specialists. These included talking to the locum provision services of specialist colleges (this does not function in the orthopaedics area). The other methods were multiple locum agencies, multiple recruitment agencies who were notified when there is a position that the district needs to fill. The other method is through the staff themselves, through their contacts, their college meetings, etc (see page 6798 of the transcript).
- 2.214 At page 6749 of the transcript Dr Hanelt outlined his requests for an orthopaedic specialist surgeon for the district. This position was approved and advertised without success. The district had advertised and done two mail-outs to every registered orthopaedic surgeon in Australian and in New Zealand in conjunction with St Stephens Hospital to try and attract staff. This lack of resources led to Dr Morgan Naidoo being the only orthopaedic surgeon full time at Hervey Bay Hospital in the Fraser Coast district.
- 2.215 At paragraph 5.2 of Mr Mike Allsopp's statement to the Commission of Inquiry, he stated that currently the district had three accredited orthopaedic surgeons and has been recruiting for at least the last two years in conjunction with St Stephen's Private Hospital to increase that number to four. Unfortunately, the district had not been able to recruit due to the nationwide shortage of orthopaedic surgeons. Mr Allsopp then continued at paragraph 5.4 by stating:

"The employment of SMOs was a support strategy to provide an infrastructure that would allow the orthopaedic surgeons to concentrate on joint replacements while the SMOs perform the minor orthopaedic work within their scope of practice."

- 2.216 You cannot blame one party, one particular orthopaedic surgeon, for the lack of the *"necessary critical mass of orthopaedic surgeons"* which would, in Mr Allsopp's opinion, take the orthopaedic service to the *"next level"*. To make an adverse finding against Dr Naidoo on these facts would be to blame him for a systemic issue.

Trust in abilities of Senior Medical Officers

- 2.217 In the examination of Dr Naidoo it was put to him that leaving the SMOs to perform orthopaedic work, be it clinical or surgical work at the hospital when he was away or on leave and another specialist was not available, was unacceptable. At page 6705 of transcript, it was put to Dr Naidoo that while that may have been an unacceptable situation it was a situation where Dr Naidoo had a degree of trust in Dr Krishna and Dr Sharma in the performance of their work. Dr Naidoo agreed with this proposition.
- 2.218 The basis for that trust is in large part traversed in previous submissions concerning other grounds.

- 2.219 Dr Naidoo had a degree of trust in the judgement of Dr Krishna and Dr Sharma as to what they could comfortably handle with regard to orthopaedic problems. Dr Wilson in his evidence at page 7338 agreed with the proposition that as Dr Krishna's supervising consultant, a degree of trust developed between those two people.
- 2.220 At page 7338 of the transcript, Dr Wilson is asked, as Dr Krishna's: *"supervising consultant, if I can use that description, the relationship between you as supervising consultant and Dr Krishna as your registrar, does a degree of trust develop between the two of you? In other words, do you develop a trust in Dr Krishna's judgment to make decisions like that?"* to which Dr Wilson responded: *"Yeah, you get- you get to know the person reasonably well. Obviously when- there's some doubt to start when you're asking about cases and what the x-ray shows and what the examination shows, but once you've confirmed that what he says is- is a good description of what's going on, then, you know, you're much more comfortable and that sort of trust develops over a period of a number of cases over a few months, really, I would say."*
- 2.221 Cases which the SMO's were not able to deal with were to be evacuated to another hospital or through the retrieval system or simply transferred. The nature of the injury would have an impact on where that trauma was transferred to. Dr Naidoo trusted Dr Krishna and Dr Sharma to make a competent judgement as to what they could handle and what they could not handle in the absence of supervision by a consultant.
- 2.222 Dr Hanelt's evidence at page 6732 provides an important light on the subject of the provision of an orthopaedic service. It is important to provide a medical orthopaedic service. Even when you do not have orthopaedic staff, you are still required to provide an orthopaedic service: *"People turn up with broken wrists, dislocated shoulders and those sorts of things"*.
- 2.223 Dr Hanelt stated that the elective procedures that Drs Krishna and Sharma were allowed to perform were of a very basic nature. As they were of a very basic nature, the appropriate level of supervision was provided.
- 2.224 In relation to clinics, Dr Naidoo was running a clinic at the same time as the SMOs were running clinics. Thus, he was within close proximity to offer supervision if required. Given the busy casework involved at Hervey Bay, it would have been ridiculous for the director to be present 100% of the time with his SMOs and indeed it was prudent to run a clinic within close proximity so that if supervision or assistance was required, it could be offered. The fact of the matter is that the SMOs did not ask. An adverse finding cannot be made against Dr Naidoo on the basis that he did not provide the appropriate level of supervision when the impression that the SMOs had provided him was that no greater supervision was required.
- 2.225 At page 6736 of the transcript, the Commissioner asked Dr Terry Hanelt if the level of the service in orthopaedics provided was inadequate leaving emergency work to one side. Dr Hanelt responded that there is inadequate coverage for any major elective orthopaedic work. The distinction to make is that it was not major elective orthopaedic work that Dr Krishna and Dr Sharma were assessed as being capable of doing in the scope of service documentation. They were only performing minor elective procedures that were within their scope of competence. At page 6804 of the transcript, Dr Hanelt stated that Dr Naidoo performed the majority of the elective surgery at Hervey Bay Hospital.

Dr Hanelt stated that the elective surgery performed by Dr Sharma and Dr Krishna was of a minor nature.

- 2.226 There was but one case raised with Dr Naidoo concerning elective orthopaedic procedures performed by Dr Krishna and Dr Sharma. Dr Krishna and Dr Hanelt have provided a more than adequate explanation of what was done in that case. The likelihood is that Dr Mullen missed a significant aspect of the injury and accordingly his criticism is misconceived.
- 2.227 This case was put to Dr Wilson at page 7343 of the transcript. Dr Wilson's evidence was that both an antegrade nail and a retrograde nail are reasonable procedures in the circumstances. In relation to the retrograde nail, Dr Wilson stated:

"I think that sounds reasonable treatment because the fracture extended towards the knee joint and it's hard to get fixation from an antegrade nail down at the knee joint, especially if the proximal femur's in good condition."

- 2.228 There is no reference in the Notice to any particular case or patient. Accordingly, no submissions are to be addressed to specific instances of clinical practice or procedures undertaken by Drs Krishna or Sharma.

Lack of Complaints

- 2.229 At page 5408 of transcript Ms Irwin-Jones stated that she never put any complaints that she had regarding supervision for Dr Sharma and Dr Krishna in writing. She stated that she spoke to Dr Hanelt on several occasions about the lack of support and supervision for Drs Sharma and Krishna but she never put anything in writing because to her knowledge there was never any negative outcome from those events. Given that there was no adverse outcome for the patients regarding supervision no written complaint was made.
- 2.230 At page 5399 of the transcript, Ms Irwin-Jones stated that she was never asked or given any concerns by the staff in relation to the Drs Sharma, Krishna and Naidoo.
- 2.231 At page 5429 of the transcript Ms Irwin-Jones stated that prior to Dr Mullen's complaint to the AOA, no-one, not Dr Mullen not Dr Naidoo not Dr Hanelt not any of the nursing staff had every brought to her attention any concern about the capabilities of Dr Sharma or Dr Krishna.
- 2.232 At page 6761 of the transcript, Dr Hanelt stated that he did not recall the matter of inadequate supervision being raised by the nursing staff. The complaints made by nursing staff in email form only appeared once it had become known to staff that the North Giblin review was to take place. It is only after the North Giblin Report and the review undertaking by North and Giblin that staff members such as Ms Irwin-Jones thought to put such complaints in writing. The only concerns that nursing staff members had raised earlier, according to Dr Hanelt, were in relation to communication skills and leave matters.
- 2.233 It is submitted that the staff of the hospital obviously did not see the issue as a particularly significant one as there is a complete lack of documentation of these 'issues' throughout.

Evidence of Dr Anthony Wilson

- 2.234 We note that Dr Wilson's evidence was not provided at the request of Dr Naidoo's solicitor's as stated by Mr David Andrews at page 7327 of the transcript.
- 2.235 Paragraph 4 of Dr Wilson's statement refers to the scope of service document for Dr Krishna, prepared by Dr Naidoo. In that paragraph, Dr Wilson stated that there are two additional procedures for which Dr Wilson would have wanted Dr Krishna to be supervised.
- 2.236 The following table summarises the evidence as provided by the scope of service document prepared by Dr Naidoo for Dr Krishna, and the evidence of Dr Mullen and Dr Wilson on the scope of service document for Dr Krishna.

Dr Krishna capable of performing independently			
Procedure	Dr Naidoo	Dr Mullen	Dr Wilson
Elective			
Rotator cuff tendonitis/rupture simple- Open acromioplasty and cuff repair	Yes	Concerns-number of orthopaedic surgeons referring to shoulder surgeons (page 5817 transcript)	'Prefer supervision' (page 7337)
Rotator cuff tendonitis/rupture complex- Open acromioplasty and cuff repair	No	No	No
Recurrent anterior dislocation shoulder- open anterior stabilisation bankart/putti platt	No	No	No
CTS- CTD/synovectomy	Yes	Yes in transcript, states 'possible after training' on the document	Yes
Dupuytren contracture- excision and z-plasty	Yes	No	Yes
Ganglion/bursa/bakers cyst-excision	Yes	Yes	Yes for ganglion and bursa - 'bakers cyst

			may need supervision' (page 7337 transcript)
Trigger finger- release tendon sheath	Yes	Yes	Yes
Extensor tendon rupture thumb-secondary repair/tendon transfer	Yes	No- would send it away to hand surgeon	Yes- rupture thumb-supervision for tendon transfer (page 7337)
Implants for fracture fixation	Yes	No mention in transcript but states 'only simple ones' on document	Yes
Foreign body	Yes	Yes	Yes
Wrist arthropathy	Yes	No	Probably still need supervision
Fracture non unions	Yes	No	Depends on size
Achilles tendon rupture	Yes	Does not mention in transcript but states possible after training on document	Yes
Hallux valgus	Yes	No- but in relation to bunions, states 'possible after training' on document	Need supervision for bunions
Hammer toes	Yes	Does not mention in transcript but states 'possible after training' on document	Yes
Moreton's neuroma	Yes	Does not	Yes

		mention in transcript but states 'possible after training' on document	
Subtalar osteoarthritis arthropathy	Yes	No	Need supervision
Cuboid/ talonavicular osteoarthritis/arthropathy	No	No	No- done by orthopaedic surgeon
Knee effusion	Yes	Does not mention	Yes
Knee infection osteoarthritis-arthroscopic debridement	Yes	Personally, Dr Mullen finds it difficult for himself to do	Yes
Knee internal derangement-arthroscopic memisectomy	Yes	Personally, Dr Mullen finds it difficult for himself to do	Yes
Knee internal derangement-meniscal repair/ replacement	No	No	No
Knee internal derangement-ACL/PCL reconstruction	No	No	No
Loose bodies	No	No	No
Non viable neuropathic fingers, toes, limbs- amputation	Yes	Yes	Yes

2.237 The table above demonstrates that there are three, occasionally differing, interpretations of the capabilities of Dr Krishna in evidence. Each of the three orthopaedic specialists agrees and disagrees with each other at one point or another. This demonstrates that the issues of supervision of Senior Medical Officers were more a difference of the approach of different orthopaedic surgeons and to elevate one interpretation above another is clearly outside of the expertise of the Inquiry.

2.238 At page 7341 of the transcript, Mr McDougall questioned Dr Wilson on his comments regarding the scope of what Dr Krishna could perform supervised and unsupervised and how those agreed and disagreed with Dr Mullen and Dr Naidoo. Mr McDougall stated: *"That tends to suggest, doesn't it, that different orthopaedic surgeons observing Dr Krishna's abilities form different opinions as to his ability?"* to which Dr Wilson replied: *"It does suggest that."*

2.239 This is further evidenced by Dr Hanelt at page 6744 of the transcript where he stated that under the ideas of the North Giblin Report any orthopaedic

procedure performed by anyone should be supervised by a specialist. Dr Hanelt disagreed with the North Giblin assessment of what was required by stating that *"if you are a medical superintendent at Emerald Hospital and somebody comes in with a dislocated finger, you have no specialist to fix it so you need to do it."*

- 2.240 It is submitted that it would be preferable for the Inquiry to agree with the proposition that it is impossible for the Inquiry to make a judgment as to which opinion to prefer as it does not possess sufficient uncontradicted evidence to make a decision.
- 2.241 If, however, the Inquiry were to elevate the opinion of one orthopaedic surgeon over another, we would highlight to the Inquiry that Dr Naidoo and Dr Wilson had more opportunities to observe Dr Krishna than Dr Mullen. Dr Naidoo was present on the same campus as Dr Krishna for four days per week (see roster at MNN-3 of exhibit 431), Dr Wilson had Dr Krishna as his registrar for 3 days per week (see page 7329 of transcript), whereas Dr Mullen was only present at the Hervey Bay Hospital one day per week (see transcript at page 5812).
- 2.242 Dr Wilson agreed at page 7342 of the transcript with the proposition that to pass comment on Dr Krishna's ability to perform the various items on the trauma list or the elective list required a reasonably close association as a supervising consultant in order to form that opinion. We would submit that one day a week is not sufficient.
- 2.243 In Dr Hanelt's statement at page 34, Dr Hanelt stated that Dr Mullen raised concerns that he did not share the same opinion as Dr Naidoo regarding the range of procedures that could be undertaken by the SMOs without supervision. This concern was tempered by the knowledge that at times, Dr Mullen was prepared to allow these same SMOs to perform at least some of these procedures on patients under his care without supervision as documented in the attachment to Dr Hanelt's statement, TMH20. If one goes to the document TMH20, Dr Krishna performed a number of procedures without supervision by Dr Mullen when Dr Mullen was the admitting surgeon, some of which Dr Mullen disagreed with in the scope of service documentation. These procedures included:
- (a) Open reduction fracture metacarpus with internal fixateur;
 - (b) Open reduction fracture femur with internal fixateur;
 - (c) Open reduction FX shaft radius and ulna internal fixation;
 - (d) Debridement of open fracture site;
 - (e) Open reduction fracture distal radius with internal fixation;
 - (f) Removal of loose body of ankle;
 - (g) Internal fixation of fracture of trochanteric or subcapital femur.
- 2.244 We would submit that if the Commission is to make an adverse finding against Dr Naidoo on the basis of allowing certain procedures to be undertaken by the SMOs without direct supervision, Dr Naidoo cannot be the only doctor for whom an adverse finding is applied.

Conclusions

- 2.245 At paragraph 25 of Dr Krishna's statement to the Commission of Inquiry, Dr Krishna states that all elective surgery was done with Dr Naidoo or was done unsupervised for **minor** elective cases, as per surgical privileges. Minor unsupervised cases would include carpal tunnel decompression, arthroscopy of knee and bunion corrections.
- 2.246 Given that Dr Krishna and/or Dr Sharma performed only minor orthopaedic procedures without direct supervision or support, we submit that it would be unfair to make an adverse finding against Dr Naidoo on the basis of allowing the doctors to perform elective orthopaedic procedures without appropriate supervision, as we would submit that appropriate supervision was provided.
- 2.247 Dr Naidoo judged what was appropriate in terms of supervision after assessing the clinical performance for each SMO. This process is a process that ought to be done by a credentialing committee, but due to the lack of resources for such a credentialing committee (i.e. the inability for the district to attract a member of the Colleges to sit on such a committee), the task fell to Dr Naidoo. To make an adverse finding against Dr Naidoo on this basis is to hold him responsible for a lack of support from the entire orthopaedic community for health care in regional Queensland. Dr Naidoo should not be weighted with such a burden.

Potential Adverse Finding 2:

With respect to Term of Reference 2(e)(iii) the Inquiry is considering whether your conduct should be referred to the Director-General of Queensland Health to further investigate whether you have been absent from work without approved leave and should be disciplined under section 87(1)(c) of the Public Service Act 1996.

- 2.248 As submitted at the outset, this term of reference can only relate to a finding under term of reference 2(c). The only finding proposed in that regard concerning absence is that set out in paragraph 1(a) of the Notice.
- 2.249 We would refer the Commission to each of our submissions relating to the potential adverse outcome of 1(a) above.
- 2.250 This ground focuses upon circumstances where Dr Naidoo was allegedly absent **without approved leave**.
- 2.251 That is, it quite properly does not refer to circumstances where Dr Naidoo was allegedly late for work or left early.
- 2.252 At page 25 of Dr Hanelt's original statement to the Commission of Inquiry, at paragraph 61(ii), Dr Hanelt attends to the allegation against Dr Naidoo of his frequently being absent from the hospital. In his statement, Dr Hanelt stated that senior staff often work overtime for which they do not claim. In recognition of this fact, some flexibility is allowed in taking time off in lieu of payment for this overtime. This is done on the basis that there is alternate coverage provided during these periods when they flex off. Given the attitude of administration regarding staff absences, and when considered with Dr Hanelt's observation in his supplementary statement of 7 October 2005 at page 5 when he stated that "Dr Naidoo often worked longer than the required hours", Dr Naidoo, or someone in the position of Dr Naidoo, would be forgiven for thinking that once

they had completed their duties or completed their hours per week and were not on-call, approved leave was not required.

- 2.253 Any consideration of a referral ought also take into account the service, which Dr Naidoo had provided over many years in a selfless way and which caused him significant personal detriment and harm.
- 2.254 There are significant practical difficulties inherent in any disciplinary proceeding.
- 2.255 Such a proceeding would necessarily involve a finding to the requisite level of satisfaction, that particular specified absences had occurred without approval, either express, tacit, or implied.
- 2.256 The deficiencies in the HR records and the attitude of Dr Hanelt concerning Dr Naidoo discharging his obligations effectively preclude any prospect of a successful case being made out against Dr Naidoo.
- 2.257 Further, a referral for disciplinary proceedings is not justified in this case for what might be described as, purely discretionary reasons. Namely, the absence of any evidence of detriment or harm being occasioned to patients, the absence of any evidence of Dr Naidoo financially benefiting from any absence, and the absence of any evidence of there being any impact at all upon clinical practice and procedure at the Hervey Bay Hospital by reason of any alleged absence.

3. General Observations

- 3.1 At paragraph 50 of his statement to the Commission of Inquiry, Dr Krishna makes the following observation:

"In my personal opinion, the shortfalls in orthopaedic care in the district cannot be blamed on any one person, but on a number of components including staff shortages, other departments involving emergency especially, the ability to provide supervision to non-specialist staff and the ever increasing workload."

- 3.2 We would agree with this statement that no one person could be blamed for the shortfalls in orthopaedic care in the Fraser Coast Health District. The lack of resources and the lack of support provided to the orthopaedic department in the Fraser Coast Health District have its genesis in Queensland Health itself. To make an adverse finding against Dr Naidoo when the blame lies squarely with a dysfunctional department would be to create a scapegoat.
- 3.3 At page 5193 of the transcript, Dr North himself states that in relation to the investigation at Hervey Bay: *"we recognise probably this investigation more than the other one how regional Queensland is somewhat dysfunctional from a health care services point of view and we did take that into account. I would be very happy to practice at Hervey Bay but only if there were 4 or 5 people available for on-call, for instance."*
- 3.4 To allow an adverse finding against Dr Naidoo for practising under such dysfunctional health care service conditions as exist in regional Queensland would be to put the blame somewhere where it does not belong. Orthopaedic specialists such as Dr North are attempting to hold Dr Naidoo to a standard that they would not even be prepared to place upon themselves.

- 3.5 Making adverse findings against Dr Naidoo for what is essentially an issue of resources in regional Queensland is to place the blame far from its rightful owner with those who ought to address issues of resources in regional Queensland. We would submit that this responsibility lies within the Department of Queensland Health. To lay the blame of an entirely dysfunctional health system with one doctor after 30 years experience in providing orthopaedic health care is grossly unjust.

MSSRS DEACONS ON BEHALF OF DR MORGAN NAIDOO

Submissions

Hon Gordon NUTTALL MP

RECEIVED
26 OCT 2005



Crown Law
Queensland Government

Your ref:
Our ref: CS3/HEA027/5780/KAL
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BY:-----

Department of
Justice and Attorney-General

25 October 2005

The Secretary
Queensland Public Hospitals Commission of Inquiry
9th Level Magistrates Court Building
363 GEORGE STREET
BRISBANE QLD 4000

E-MAILED
25/10/05

Attention: Mr Cowley-Grimmond

PRIVATE AND CONFIDENTIAL

Dear Sir

NOTICE OF POTENTIAL ADVERSE FINDINGS

I refer to your letter dated 14 October 2005 addressed to the Hon Gordon Nuttall MLA for whom I act.

Your letter lists four possible adverse findings against Mr Nuttall and invites submissions in relation to them. I wish to make submissions on behalf of Mr Nuttall in respect of each possible adverse finding. These submissions were drawn and settled by Mr Gotterson QC and Mr O'Sullivan of counsel. It is convenient to deal with the possible adverse findings in the order in which they are listed in your letter. It is not proposed to set out the proposed adverse finding to which each submission relates.

Possible Adverse Finding 1 – Submission

1. Mr Nuttall stated in evidence that when Dr FitzGerald attended on him on 22 March 2005, the latter advised Mr Nuttall as follows:-

- (a) he had conducted an investigation concerning allegations about Dr Patel;

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- (b) his report of the investigation was near completion and would be finalised in the near future;
- (c) Dr Patel had performed surgery outside his scope of practice;
- (d) he (Dr FitzGerald) had advised Bundaberg Hospital that Dr Patel was to cease performing surgery outside his scope of practice. (Exhibit 319 para. 27).

This written evidence was confirmed in his oral testimony at T5311.30 – T5312.12. He was not challenged on this.

- 2. On the same date, Dr FitzGerald emailed to the Senior Departmental Liaison Officer in Mr Nuttall's office, a document containing a suggested response to parliamentary questions. The document is titled "Surgical Services at Bundaberg Hospital Suggested response". It is within Exhibit 391. The document consists of two parts, namely Background and Suggested Response.
- 3. The Background includes the following statements:-

"The key findings to date are:

- Procedures have been performed at Bundaberg which are beyond the capacity and facilities of the Bundaberg Hospital. The hospital executive, in collaboration with clinicians, should define service levels for the hospital using the Queensland Health Service Capability Framework which outlines the minimum support services, staffing, safety standards and other requirements to facilitate the delivery of safe and appropriately supported clinical services. **The Medical Superintendent has taken action to limit the scope of surgery performed by this surgeon and to ensure that critically ill patients are appropriately referred to higher level hospitals.**
- Concerns were raised regarding the rates of wound dehiscence (break down). The data have shown that this rate is reducing.
- Concerns were also raised regarding the rate of unplanned re-admissions. This rate also appears to be reducing.
- With regard to other complications, these concerns relate particularly to the more complex procedures. Benchmarking data suggest that, for one complication, Bundaberg Hospital appears to have a higher rate than

other similar hospitals, however, this has not been tested for statistical significance.

- There is significant conflict within the workplace which requires attention by the hospital administration and behavioural management strategies put in place.

The significant issue regarding the competency of Dr Patel appears to relate to his preparedness to take on cases which are beyond the capacity of the Bundaberg Hospital and possibly beyond his personal capacity. There is no evidence that his general surgical skills are inappropriate or incompetent.

However, the fact that he has taken on those cases may reflect significantly poor judgment to a level which may be grounds for disciplinary action by the Medical Board. Thus, the CHO has recommended that this matter be referred to the Medical Board for attention.” (emphasis supplied)

4. The Suggested Response includes the following suggested response points prepared by Dr FitzGerald:-

“The Chief Health Officer, Dr Gerry FitzGerald, has undertaken a review of clinical outcomes at the hospital and is currently finalising his report.

Dr Fitzgerald has identified a number of issues of concern at the hospital and will be making recommendations in regard to those concerns.

There is insufficient evidence at this time to take any particular action against any individual, and to suspend anyone would be unjust and inappropriate.

The Bundaberg Hospital has taken certain action to limit the scope of some general surgery performed at the hospital which should address the majority of issues raised by staff. The report will also make recommendations regarding the management of staff conflict at the hospital.

However, the report has also identified that there is a relatively high satisfaction amongst patients and that waiting times for elective surgery have been reduced considerably in recent times. Junior staff have been very complementary in regard to the teaching and guidance provided to them.

However, Dr FitzGerald has raised concerns about the clinical judgment exercised by one member of staff and will be referring these concerns to the Medical Board for consideration.” (emphasis supplied)

5. What Dr FitzGerald advised in his emailed document is consistent with the oral advice that he gave to Mr Nuttall on 22 March 2005. At no time after 22 March and before 9 April 2005 did Dr FitzGerald communicate to Mr Nuttall any information which might have given Mr Nuttall reason to suspect that the findings or opinions expressed or advice given to Mr Nuttall on 22 March 2005 were not accurate at that date or that Dr FitzGerald had subsequently altered or modified his findings, opinions or advice.
6. It is submitted that the evidence does not warrant the making of this possible adverse finding for the following reasons.
 - (a) That Mr Nuttall took no action to ascertain from Dr FitzGerald the substance of his findings or preliminary findings.

Reasons

Mr Nuttall did take action to ascertain from Dr FitzGerald the substance of his findings or preliminary findings. He conferred with Dr FitzGerald on 22 March 2005 at which time Dr FitzGerald advised Mr Nuttall of his findings concerning Dr Patel as set out in paragraph 1 *ante*. These findings were confirmed in Dr FitzGerald's emailed document of the same date as set out in paragraph 3 *ante*, and were not thereafter qualified by him in any communication addressed to Mr Nuttall as noted in paragraph 5 *ante*.

- (b) That Mr Nuttall took no action to suspend Dr Patel or to restrict his scope of practice.

Reasons

As noted, the advice given by Dr FitzGerald in the document emailed on 22 March 2005 was that there was insufficient evidence at that time to take any particular action against any individual, and that to suspend anyone would be unjust and inappropriate: see paragraph 4 *ante*.

The professional advice from Dr FitzGerald, the Chief Health Officer, at 22 March 2005 therefore was that there was insufficient evidence to suspend Dr Patel or to restrict his scope of practice. That advice was not altered by Dr FitzGerald in any communication to Mr Nuttall at any time on or before 9 April 2005. Given that advice, it would not have been appropriate for Mr Nuttall to have suspended Dr Patel or to have restricted his scope of practice.

- (c) That Mr Nuttall took no action to further investigate or cause further investigation of Dr Patel's actions.

Reasons

The advice given by Dr FitzGerald on 22 March 2005 was that there was no evidence that Dr Patel's general surgical skills were inappropriate or incompetent: see paragraph 3 *ante*. That advice was not altered by Dr FitzGerald in any communication to Mr Nuttall at any time on or before 9 April 2005.

Dr FitzGerald identified two issues with respect to Dr Patel in the document emailed on 22 March 2005. The first was his preparedness to take on cases which were beyond the capacity of the Bundaberg Hospital and possibly beyond his personal capacity: see paragraph 3 *ante*. As to that issue, Dr FitzGerald advised that the Medical Superintendent of Bundaberg Hospital had taken action to limit the scope of surgery performed by Dr Patel and to ensure that critically ill patients were appropriately referred to higher level hospitals: see paragraph 3 *ante*.

The second issue concerned Dr Patel's clinical judgment, namely, that he might have had significantly poor judgment to a level which might be grounds for disciplinary action by the Medical Board: see paragraphs 3, 4 *ante*. As to this issue, Dr FitzGerald advised that he would be referring concerns relating to Dr Patel's clinical judgment to the Medical Board: see paragraph 4 *ante*.

The effect of Dr FitzGerald's advice therefore was that the two issues that he had identified in respect of Dr Patel had been addressed or were being addressed by him. That advice having been given, there was no cause for Mr Nuttall to investigate or cause further investigation of Dr Patel's actions.

Possible Adverse Finding 2 – Submission

7. Mr Nuttall gave evidence that he had no knowledge of the existence of the FitzGerald Report until matters concerning Dr Patel were raised in the Parliament on 22 March 2005. After speaking with the director-General, Mr Nuttall was of the opinion that the FitzGerald Report could not be released because:-
- (a) it was incomplete;
 - (b) Dr Patel could not give his version of events to the Chief Health Officer and therefore Dr Patel could not be afforded natural justice;
 - (c) the report contained confidential patient information (Exhibit 319 paragraphs 97-100).
8. Mr Nuttall did attend a meeting at the Bundaberg Base Hospital on 7 April 2005, during which the staff at the hospital were informed by him of the matters addressed in

paragraph 1(a), (b) and (c) hereof. Further, similar information was provided to the media by Mr Potter on the Minister's behalf. (Exhibit 319 paragraphs 98-99).

9. It is suggested by the Commission that the conduct of Mr Nuttall in respect to his advice to the staff is capable of supporting a finding that it was misleading, unreasonable and careless.
10. It is submitted that the evidence does not warrant the making of any such adverse findings against Mr Nuttall for the following reasons:-
 - (a) The report being prepared by the Chief Health Officer was incomplete.

Reasons

Mr Nuttall did state to the staff that the report was incomplete. At that time, Mr Nuttall was acting on information that had been given to him by Dr Buckland, the Director-General, and by the Health Department (Exhibit 319 paragraph 100, and refer T5321 ff, esp T5323.60).

Mr Nuttall attended the staff meeting with Dr Buckland. In respect to that meeting, Dr Buckland gave evidence that the information provided by him to staff of the hospital as follows:-

"I also advised that Dr Patel had left the country, the audit process being conducted by Dr FitzGerald in relation to Dr Patel would be difficult to finalise as natural justice had not been afforded to him...

In hindsight, I can see that perhaps I caused confusion by the expressions I used at the meeting and by my failure to clearly articulate how the audit process works and the difference between the finalisation of the audit report and the finalisation of the audit process. In my mind, I stated that no action could be taken against Dr Patel without first according him an opportunity to respond to the CHO's report but the review process would continue, and recommendations could be implemented, in relation to the broader systemic issues that the report raised. In writing this statement, though, I can see that this was probably not clear to all of the staff because of the terminology I used and because I spoke from a perspective that assumed the staff understood the subtleties of the audit process." (Exhibit 335 paragraphs 33-34).

It is clear that Mr Nuttall was acting on what he understood to be the advice provided to him by the Director-General when he informed the staff as discussed above. Dr Buckland has conceded that he failed to articulate the distinction between the finalisation of the audit report and that of the audit process. This may have led to some misunderstanding in the mind of the Minister. Nevertheless, Mr Nuttall was entitled to upon the advice as he understood it. There is no evidence that he knew that the information he provided to staff was incorrect. In consequence, it is submitted that his conduct could not be regarded as misleading, unreasonable or careless.

- (b) Dr Patel had not given his version of events to the Chief Health Officer and therefore had not been afforded natural justice.

Reasons

This information provided to staff was consistent with the advice received by Mr Nuttall from the Director-General as referred to in the preceding section. There is no evidence that Mr Nuttall believed this view of the matter to be incorrect. It has never been suggested to him that he was not entitled to hold this view. In fact, Mr Nuttall was advised by the Department of the importance of the natural justice issue in the briefing note dated 15 April 2005 (Exhibit 350). This note stated that one of the "key messages" was as follows:

"It would further compromise natural justice to make public comment about the competence or otherwise of Dr Patel and other staff at Bundaberg Hospital until the review process is complete."
(Key Message no. 5)

In the circumstances, it is submitted that this conduct could not lead to any adverse finding against him.

- (c) The report contained confidential patient information.

Reasons

As at 7 April 2005, Mr Nuttall had not been provided with the FitzGerald Report. He did not know of its contents save for that information which had been supplied to him by the Department. Corroborating the fact that Mr Nuttall had not seen the report is the ministerial briefing note dated 15 April 2005 (Exhibit 350) which outlines the audit findings for the attention of the Minister. This briefing note was noted by Mr Nuttall on 23 April 2005.

With respect to the proposition that the report could not be released, Mr Nuttall gave evidence that, as far as clinical audit reports were concerned, it was not the normal practice to release them because of privacy issues as the report "referred to individuals by name" (T5323.30-.60).

Reference is made to the evidence given by Dr Buckland, Director-General, in respect of clinical audit reports. At paragraph 25 of his statement (Exhibit 335), Dr Buckland said as follows:

"It is not usual for the report or the recommendations of clinical audits to be publicly released. Public release can result in informants and patients being identified (even where carefully de-identified) by the context and the concern by the CHO is that it would make his job harder in future audits as patients and staff may be less willing to voluntarily provide information if there is a risk of their identities being disclosed."

Dr Buckland thereby verified that the reports were not usually released to the public. Further, he verified that release of such reports can result in patients being identified even in circumstances where steps had been taken to prevent such an occurrence. In the circumstances, Mr Nuttall was justified in having concerns generally about the release of the report and its impact on privacy issues. Whilst Mr Nuttall did state that the report referred to individuals by name, it is obvious that this is an overstatement of the matter. What is clear from the evidence of Dr Buckland is that patients can be identified even if not named in the report. Therefore, it is respectfully submitted that, given the privacy concerns held by Mr Nuttall and the fact that the release of the report could identify patients, the slight misstatement of the matter to staff could not amount to conduct sufficient to support an adverse finding against Mr Nuttall.

- (d) The report therefore could not be completed or publicised in incomplete or complete form.

Reasons

Mr Nuttall gave evidence that the audit reports "as a matter of course, were not audits released publicly" (T.5323.28). This evidence is supported by Dr Buckland, Director-General, as referred to above. Neither Dr Buckland nor Mr Nuttall, at any stage, stated to staff that there was to be no further action in respect to the report (Exhibit 335 paragraph 33). In fact, Dr Buckland gave an undertaking to staff that Dr FitzGerald would return to Bundaberg to brief staff on his findings and that any system or hospital recommendation made would be followed up by Dr FitzGerald (Exhibit 335 paragraph 33). To this extent, it was foreshadowed to staff that any findings would be presented (or published) to them. In the circumstances, this issue could not lead to any adverse finding against Mr Nuttall.

- (e) You subsequently gave the media the same information in (d) above.

Reasons

Mr Potter gave information to the media that the report could not be completed because of the absence of Dr Patel and because it contained confidential information (Exhibit 319 paragraphs 98-99). The basis for the provision of this information has been addressed above.

Possible Adverse Findings 3 – Submission

11. By the time Mr Nuttall became Health Minister, the Surgical Access Team was no longer collecting information on the number of patients on waiting list for specialist outpatient services, that having ceased about March 2003. Mr Nuttall did not make any recommendation to Cabinet concerning the taking of such waiting lists to Cabinet.
12. Mr Nuttall was not Health Minister at the time any decisions were made concerning the taking of measured quality reports to Cabinet. He did not make any recommendations to Cabinet concerning that matter.



13. Insofar as this possible adverse finding is levelled at Mr Nuttall as a member of Cabinet, he relies on the submissions to be made to the Commission on behalf of Cabinet with respect to it.

Possible Adverse Findings 4 - Submission

14. Any generalised finding about the reliability or plausibility of Mr Nuttall's evidence, if adverse, would need to be based on a significant number of significant contradictions between his oral evidence and, for example, reliable contemporaneous documentary evidence or the oral evidence of a number of witnesses.
15. That is not the case with Mr Nuttall's evidence. For example, his oral evidence as to what Dr FitzGerald advised him on 22 March 2005 when he attended upon Mr Nuttall is corroborated by Dr FitzGerald's emailed document of the same date (Exhibit 391) as explained in the response to possible adverse finding 1. As well, his evidence as to what he said at the Bundaberg Base Hospital about the FitzGerald Report is consistent with and corroborated by Dr Buckland's evidence as noted in the submissions in respect of possible adverse finding 2 *ante*.
16. It is acknowledged that there is a discrepancy between the evidential accounts of Mr Nuttall and Dr Buckland concerning when and how Mr Nuttall learned of Dr Patel's disciplinary history in the United States. Each account is based solely upon individual recollection, uncorroborated by the evidence of other witnesses. There is no documentary evidence which suggest that one account is more reliable than the other.
17. In any event, it is submitted that the discrepancy is relatively unimportant so far as timeliness in addressing the issues at Bundaberg Hospital is concerned. Even if Dr Buckland's version, which puts it at Friday 8 April, is accepted, Mr Nuttall approved the appointment of the Review Team, the personnel of which included an expert suggested by him, on the following day.
18. In these circumstances, it is submitted that the discrepancy in question would not warrant any generalised findings about Mr Nuttall's evidence.

I respectfully request that the Commissioner takes these submissions into account in his deliberations. If you have any questions in relation to them, please contact me on 3239 3375.

Yours faithfully


Lucinda Kasmer
Principal Lawyer
for Crown Solicitor 



Crown Law

Queensland Government

Your ref: *
Our ref: CS3/HEA027/5780/KAL
Contact: Margot Blue
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Department of
Justice and Attorney-General

31 October 2005

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

Attention: Mr Cowley-Grimmond

PRIVATE AND CONFIDENTIAL

Dear Sir,

REPLY TO REVISED SUBMISSION OF QUEENSLAND NURSES UNION

The revised submission by the Queensland Nurses Union (QNU) refers to the meeting held at the Bundaberg Base Hospital on 7th April 2005 attended by Dr Buckland, Mr Nuttall and staff of the hospital. I have already addressed issues arising from this meeting at paragraphs 4-6 of my letter to you dated 25th instant.

The revised submission by QNU refers specifically to the evidence of Ms Mears (T7375.3,4) in respect to her recollection of a statement allegedly made by Mr Nuttall concerning Mr Messenger. Unfortunately no attempt has been made in the submission to draw attention to the denial of such statement by Mr Nuttall. In the circumstances I refer you to the evidence of Mr Nuttall given during the course of his cross-examination by Mr Allen of Counsel representing QNU (T5321.20 - .30):-

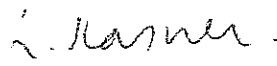
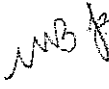
"But just before we leave the 7th of April, I suggest you told the meeting words to the effect that, 'The only way we can stop this rubbish', and that is these public ventilation of complaints about Bundaberg Hospital, 'The only way we could stop this rubbish and stop Mr Messenger was to vote him out at the next election'? -- That is a total fabrication. Simply -- that is simply not true and, again, I find that very offensive."

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Further, I note that Ms Jenner RN (statement Ex 508) gave evidence at the Commission hearing (T7384-7385) and made no reference to any statement by Mr Nuttall concerning Mr Messenger.

It is respectfully submitted that whether or not Mr Nuttall made the comments alleged about Mr Messenger, they are of no relevance to any issue concerning matters before the Inquiry. In any event there is no reason why the evidence of Mr Nuttall should not be preferred to that of Ms Mears. Given the lack of relevance of this matter and the lack of any adverse notice concerning this issue, I submit that the Commission should make no finding in respect to the issue.

Yours faithfully,


wub  Lucinda Kasmer
Principal Lawyer
for Crown Solicitor

Submissions

Dr Kees NYDAM

RECEIVED
26 OCT 2005



Crown Law

Queensland Government

Your ref:
Our ref: CS5/HEA027/5744/DZP
Contact: Peter Dwyer
Direct ph: 3239 6169
Direct fax: 3224 7431

BY: _____

Department of
Justice and Attorney-General

26 October 2005

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

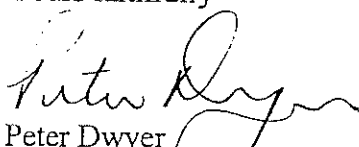
Dear Mr Groth

Submissions in response to Notices of Potential Adverse Findings

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

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

Yours faithfully


Peter Dwyer
Principal Lawyer
for Crown Solicitor

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QUEENSLAND PUBLIC HOSPITALS COMMISSION OF INQUIRY

SUBMISSIONS ON BEHALF OF DR KEES NYDAM

Non appointment of Dr Jayasekera to the position of Director of Surgery

1. The evidence relevant to this issue from Dr Nydam appears at:
 - (a) Exhibit 51 – Statement of Dr Nydam – paragraph 32;
 - (b) Transcript 4110/49 – 4118/44; 4122/10 – 4124/10; 4125/25 – 45; 4168/36 – 4170/46; 4188/1 – 60.
2. The evidence from Dr Jayasekera on this issue appears at:
 - (a) Exhibits 308 and 381 – Statements of Dr Jayasekera – paragraphs 32 – 37;
 - (b) Transcript – 5965/45 – 5966/31; 5970/1 – 5791/40; 5978/30 – 5981/1; 5981/25 – 5984/10.
3. The evidence establishes the following:
 - (a) The position of Director of Surgery was advertised three times in 2002. The second time had a closing date of 16 September 2002 and the third time had a closing date of 2 December 2002¹;
 - (b) When the position was advertised with the closing date of 16 September 2002, there were three applicants. The first was a Dr Strekov². The second was Dr Jayasekera. The third applicant did not meet the selection criteria³;
 - (c) Whilst Doctors Strekov and Jayasekera both satisfied the selection criteria, the selection committee, comprised of Dr Nydam, Dr Anderson and Mr Leck, chose Dr Strekov⁴;
 - (d) Dr Jayasekera was advised by letter dated 15 October 2002 that he had been unsuccessful in securing the position⁵;

¹ T4112/40.

² T4112/55.

³ T4113/30.

⁴ T4113/40.

⁵ T4115/40.

- (e) Dr Strekov declined the position and the position was readvertised with a closing date of 2 December 2002⁶;
 - (f) There were no applicants when the position was readvertised with a closing date of 2 December 2002⁷;
 - (g) Whilst Dr Jayasekera applied for the position in circumstances where he had been encouraged to do so by Dr Nydam, Dr Nydam gave evidence that he urged everybody *"to apply for a position because I think it's a part of their professional development to experience the process of a formal interview"*⁸;
 - (h) Dr Nydam had reservations about Dr Jayasekera⁹. He did not think he was the most ideal candidate for lots of reasons not only concerning his level of skill¹⁰;
 - (i) Significantly, Dr Nydam gave evidence that even if he was being asked *"right now"* whether or not he would recommend Dr Jayasekera for the position, his answer would be no¹¹;
 - (j) Dr Nydam had informal discussions with Dr Jayasekera following his failed application in which he indicated that his performance at interview did not really reflect well in terms of his capabilities and skills¹². During this conversation, Dr Jayasekera indicated to Dr Nydam that he wasn't disappointed because he wanted to move back to Brisbane closer to his family¹³;
 - (k) Dr Jayasekera did not apply when the position was readvertised¹⁴.
4. Dr Jayasekera gave evidence that he:
- (a) Did not want the position¹⁵;
 - (b) Did not feel he could perform it in all of its requirements¹⁶;

⁶ T4113/50.

⁷ T4115/45.

⁸ T4117/5.

⁹ T4116/50.

¹⁰ T4117/25.

¹¹ T4117/10.

¹² T4168/50.

¹³ T4169/55.

¹⁴ T4170/5.

¹⁵ T5970/13; 5971/22-30.

¹⁶ T5971/22-30.

- (c) Had no intention of remaining in Bundaberg even if he had been offered the position of Director of Surgery¹⁷;
 - (d) Only applied at the urging of others¹⁸;
 - (e) Was not interested in reapplying when the position was readvertised¹⁹.
5. The fact that Dr Jayasekera satisfied the selection criteria did not mean that he should be appointed to the position of Director of Surgery, after Dr Strekov declined the position. Part of the selection process included an interview. Dr Nydam gave evidence that Dr Jayasekera performed poorly in that interview, and he gave Dr Jayasekera feedback to that effect²⁰.
 6. Further, Dr Nydam gave evidence that notwithstanding that Dr Jayasekera satisfied all of the selection criteria, he was of the view that Dr Jayasekera would not be an appropriate person to hold the position. This view is one formed after the benefit of the interview process, and there is no evidence before this Commission that this view was not a genuinely held view on the part of Dr Nydam. Mr Leck gave evidence that Dr Nydam expressed the view that Dr Jayasekera was not suitably experienced to undertake the position²¹.
 7. When Dr Strekov declined the position, a decision was made to re-advertise the position. This is not unreasonable having regard to Dr Nydam's views. His preference was to "*have the best person we could recruit*"²². Dr Jayasekera did not reapply for the position when it was subsequently readvertised²³. Dr Nydam was entitled to have regard to that fact.
 8. In circumstances where:
 - (a) The selection panel recommended that the position be offered to an applicant other than Dr Jayasekera;
 - (b) When that applicant declined the offer, and the position was readvertised, Dr Jayasekera did not reapply;

¹⁷ T5979/1 – 5981/14.

¹⁸ T5970/12-22; 5971/31 – 38.

¹⁹ T5979/10.

²⁰ T4168/50.

²¹ T7139/55 – 7140/1.

²² T4111/30.

²³ T5979/10

- (c) Dr Jayasekera had performed poorly at interview and was known to be wanting to move closer to Brisbane,

Dr Nydam's failure to appoint Dr Jayasekera to the position of Director of Surgery was reasonable, and did not constitute carelessness, inefficiency or a lack of competence.

The appointment of Dr Patel

9. The evidence relevant to this issue from Dr Nydam appears at:
 - (a) Exhibit 51 – Statement of Dr Nydam – paragraphs 7 – 35;
 - (b) Transcript 4119/60 – 4120/20; 4120/40 – 4122/8; 4123/42 – 4124/40; 4125/48 – 4126/15; 4127/10 – 4128/10; 4129/29 – 43; 4132/10 – 4133/20; 4181/40 – 4182/3.
10. The evidence relevant to this issue from Dr Bethel of Wavelength appears at:
 - (a) Exhibit 41 – Statement of Dr Bethel;
 - (b) Transcript - T671 – 699, 717 - 727
11. It is conceded that the documentation submitted to the Medical Board of Queensland indicated that the position to which Dr Patel would be appointed reported to the Director of Surgery.
12. However, the evidence does not support a finding that Dr Nydam at all relevant times intended to appoint Dr Patel as Director of Surgery:
 - (a) Bundaberg Base Hospital had retained Wavelength in November 2002 to recruit a Senior Medical Officer – Surgery²⁴. This was at a time when Dr Nydam was readvertising the position of Director of Surgery.
 - (b) The reference in the e-mail of 20 December 2002 to "*Payment in the first instance will be as an SMO*" referred to Dr Nydam's expectation that Dr Patel would, after a period of time, apply through the college to become an Australian recognised Fellow and the payments would change thereafter²⁵;

²⁴ Exhibit 41 – para 4.

²⁵ T4132/30.

- (c) When the Director of Surgery position failed to produce any applicants following its readvertising in December 2002, it was necessary to obtain a second staff surgeon. That position was filled on 9 January 2003 by Dr Gaffield²⁶;
 - (d) The Bundaberg Base Hospital only had two staff surgeon positions. The Director of Surgery position is not a separate position. When both staff surgeon positions are occupied, one of the staff surgeons would usually take on responsibility of Director of Surgery²⁷. It is an administrative position, carrying a small allowance²⁸.
 - (e) Dr Patel was the more senior of the two and was more experienced and did more general surgery²⁹. Out of those two, he was the natural choice to undertake the duties of Director of Surgery³⁰;
 - (f) Dr Nydam signed material that was submitted to the Medical Board on 8 January 2003. This was just prior to the appointment of Dr Gaffield. It was not his intention to mislead or deceive the Board³¹. His failure to notify the Medical Board of Queensland of Dr Patel's subsequent appointment to the vacant position of Director of Surgery was an "*oversight*"³²;
 - (g) While Dr Nydam accepted a suggestion that from at least December 2002 he had Dr Patel earmarked as the likely Director of Surgery, this acceptance, in the context of all of the evidence, amounts merely to an acknowledgement that once two staff surgeons are appointed, the position would be filled by one of the staff surgeons.
13. On the whole of the evidence it should be accepted that Dr Nydam at all times acted conscientiously and in good faith, in an effort to ensure the proper workings of the Bundaberg Base Hospital. Any errors by him in the performance of those duties do not justify a conclusion that he intentionally misrepresented Dr Patel's position to the Medical Board. The failure to notify the Medical Board of Dr Patel's appointment as

²⁶ T4126/35.

²⁷ T4171/10.

²⁸ T4171/20 – 40.

²⁹ T4126/50.

³⁰ T4126 – 4127.

³¹ T4181/45.

³² T4133/15

Director of Surgery is properly to be characterised as an “oversight”. It does not constitute carelessness, inefficiency or incompetence. In this context, it is relevant that Dr Nydam only remained as the Acting Director of Medical Services for approximately two weeks after Dr Patel commenced duties, some six days after Dr Patel was appointed to the vacant position of Director of Surgery.

Dr Patel’s references

14. The evidence relevant to this issue from Dr Nydam appears at:
 - (a) Exhibit 51 – Statement of Dr Nydam – paragraph 15 – 17;
 - (b) Transcript – 4137/44 – 4138/10.
15. Dr Bethel gave evidence that during the recruitment process Wavelength ran reference checks on Dr Patel. On 20 December 2002 the references, as well as the result of reference checks, were forwarded to Dr Nydam³³.
16. Dr Nydam received these reference checks from Wavelength³⁴. Dr Bethel accepted that Dr Nydam’s instructions to offer Dr Patel the position occurred after Dr Nydam had been supplied with the references and reference checks³⁵.
17. In circumstances where a recruitment agency is engaged for the purposes of obtaining a suitable candidate to fill a position, it is not unreasonable that the relevant reference checks be undertaken by that agency particularly where, as here, copies of the references and details of the reference checks are provided to the prospective employer prior to any offer of employment being made. Dr Nydam knew that such checks had been performed by a highly regarded recruitment agency³⁶. His acceptance of the results of those reference checks was entirely reasonable in the circumstances, and does not constitute carelessness, inefficiency or incompetence.

The credentialling and privileging process

18. The evidence relevant to this issue from Dr Nydam appears at:

³³ T720/1 – 721/30.

³⁴ Exhibit 51, para 17.

³⁵ T721/10 – 31.

³⁶ T4137/45.

- (a) Exhibit 51 – Statement of Dr Nydam – paragraphs 36 – 37
- (b) Transcript T4135/38 – 4137/8; 4139/19 – 42; 4140/10 -32; 4141/20 – 4146/19; 4186/13 -4187/30.

19. The evidence of Dr Wakefield relevant to this matter appears at:

- (a) Exhibit 290 B – Statement of Dr Wakefield – paragraph 16(c)
- (b) Transcript – T4487/50 – 4489/5; 4555/2 -4557/5; 4569/20 -4570/50.

20. The evidence of Dr Thiele relevant to this matter appears at:

- (a) Exhibit 118 – Statement of Dr Thiele – paragraph 51 – 52.
- (b) Transcript – T1857/23 – 1859/35.

21. It is unclear what, if any, system of credentialling and privileging was in place at the time that Dr Thiele held the position of Director of Medical Services. Dr Wakefield, who replaced Dr Thiele, stated that there was no formal credentialling and privileging process in place at the time that he commenced as Director of Medical Services³⁷.

22. Dr Wakefield introduced a system of credentialling and privileging whilst he held the position of the Director of Medical Services.³⁸

23. In July 2002, Queensland Health introduced a standard policy of credentialling and privileging³⁹. Pursuant to that policy, the responsibility for credentialling and privileging lay with the District Manger.

24. Dr Nydam did not fail to maintain a credentialling and privileging process. On the contrary, he took steps to improve the previous system such that a degree of independence and impartiality was introduced.

25. Dr Nydam gave evidence that he attempted to improve the credentialling process when he was the Acting Director of Medical Services by incorporating Hervey Bay, Maryborough and Bundaberg into one process. This was an attempt to minimise the risk of “*mate credentialling mate*”⁴⁰, thereby increasing the degree of impartiality in the process. That process was subsequently developed into a policy in 2003.⁴¹

³⁷ T4569/55.

³⁸ Exhibit 290B, paragraph 16(c) and attachment JGW – B and T4555/1 – 20.

³⁹ Exhibit 279.

⁴⁰ T4139/36.

⁴¹ Exhibit 276.

26. Whilst Dr Nydam did not ensure that Dr Patel was subject to the process of credentialling and privileging prior to his employment at the Bundaberg Base Hospital, this must be viewed against the background of there being a joint committee which was endeavouring to have a College representative appointed to allow credentialling or privileging to be undertaken.
27. Importantly, Dr Nydam ceased acting as the Director of Medical Services two (2) weeks after Dr Patel arrival.
28. Further, the District Manager, Mr Leck, gave evidence that he later issued temporary privileges for Dr Patel (and others) at the relevant time. This is a practice which accords with Section 7.3 of Exhibit 279.
29. Having regard to all of the evidence, there is no sufficient evidential basis to find that Dr Nydam acted carelessly, inefficiently or incompetently in relation to the credentialling and privileging of Dr Patel.

The death of Mr Bramich

30. The evidence in relevant to this issue from Dr Nydam appears at:
 - (a) Exhibit 51 – paragraphs 49 – 54;
 - (b) Transcript – T4150/50, 4151/50, 4172/1 – 50.
31. The evidence relevant to this issue from Dr Keating appears at:
 - (a) Exhibit 448 – Statement of Dr Keating paras 132 - 160;
 - (b) Transcript – T 6999.
32. Dr Nydam was not directed, or even requested, to investigate the death of Mr Bramich, or to obtain reports from Dr Carter and Dr Patel. Dr Keating forwarded a memorandum to those Doctors requesting they undertake an audit and report to Dr Keating and Dr Nydam⁴².
33. Dr Keating gave evidence that he was later directed by Mr Leck to cease any investigation⁴³.

⁴² Exhibit 448, attachment DWK 39.

⁴³ T 6999.

34. There is no evidence before the Inquiry as to any recommendations made by Dr Nydam in relation to the death of Mr Bramich.
35. There is no evidence that Dr Nydam failed to investigate the death of Mr Bramich, or that he was careless, inefficient or incompetent.

Conclusions

36. In performing his duties as Acting Director of Medical Services, Dr Nydam acted conscientiously and in good faith. There is no basis to properly find that any deficiencies in his actions were other than errors of judgement. No adverse finding or recommendation should be made against him.



Crown Law

Queensland Government

Your ref:
Our ref: CS5/HEA027/5744/DZP
Contact: Peter Dwyer
Direct ph: 3239 6169
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RECEIVED
01 NOV 2005

Department of
Justice and Attorney-General

31 October 2005

BY:-----


Mr David Groth
Secretary
Queensland Public Hospitals Commission of Inquiry
Level 9, Brisbane Magistrates Court
PO Box 13147 George Street
BRISBANE QLD 4003

Dear Mr Groth

Dr Kees Nydam

I **enclose** further submissions on behalf of Dr Kees Nydam in response to a subsequent Notice of Potential Adverse Findings dated 24 October 2005.

Yours faithfully


Peter Dwyer
Principal Lawyer
for **Crown Solicitor**

encl

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QUEENSLAND PUBLIC HOSPITALS COMMISSION OF INQUIRY

FURTHER SUBMISSIONS ON BEHALF OF DR KEES NYDAM

Sponsorship form for Dr Patel (Form 55)

1. During the period Dr Nydam held the position of Acting Director of Medical Services, he spent a considerable portion of his time trying to maintain staffing levels and rosters. He often utilized locums to fill short term contracts and was in frequent contact with recruitment consultants at three different recruitment agencies as well as having regular contact with other Directors of Medical Services¹. Consequently, Dr Nydam considered that he had a good knowledge of the market and the difficulties in filling vacant positions².
2. On 8th January, 2003, Dr Nydam signed a document entitled **"Sponsorship for Temporary Residence in Australia (Non Business) Form 55"**. That form related to Dr Patel's proposed employment. Prior to signing the document Dr Nydam had approached three recruitment agencies in relation to the position of Senior Medical Officer - Surgery³.
3. The document had been forwarded to Dr Nydam for his signature on 3rd January, 2003 by Ms Suzy Tawse of Wavelength Consulting Pty. Ltd. Ms Tawse had already completed the relevant sections⁴. Dr Nydam signed and returned it.
4. There is no evidence before the Inquiry as to whether Dr Nydam supplied the information to Ms Tawse that appears in paragraph 17 of Form 55 or whether it had simply been assumed by her that the advertising had occurred or whether Ms Tawse may have confused the advertising which had occurred for the Director of Surgery position with the Senior Medical Officer position.

¹ Paragraphs 10 and 11 Exhibit 487

² Paragraph 12 Exhibit 487

³ Paragraph 13 Exhibit 487

⁴ Paragraphs 5 and 6 of Exhibit 487

5. Further, examination of paragraph 17 reveals an inconsistency within itself. It asks the question:

“Was Labour Market Testing required?”

The answer provided is “No.” The “detail” which the form then requires to accompany such an answer was not given. The form clearly indicates that one of the explanatory boxes must be ticked in such a case. It is only when the answer to the above question is “Yes” that a written explanation is required and copies of advertisements need to be attached.

6. Whether Labour Market Testing in fact was required as a prerequisite is explained on pages 3 and 4 of Form 55. Unfortunately, the exhibit does not have these pages attached. An updated copy of Form 55 is attached to this submission. Whilst its layout is slightly different, its contents are apparently similar to the contents of the exhibited form. (It may be appropriate for this form to be made an Exhibit).
7. Labour Market Testing is not required if the position is in “**an area of need**” identified by the relevant State/Territory health authority⁵. This was such a position.
8. Whilst it is conceded that Dr Nydam should have checked the accuracy of the document before signing it, the evidence would not allow a finding to the effect that Dr Nydam intended to mislead or deceive. Dr Nydam had no such intention.
9. Dr Nydam believed the relevant position had been advertised. There is no evidence to support a finding that he is being dishonest in that regard. Further, the form contains an inconsistency, and may contain information that was not even required in the first place.
10. Against this background, this is not an occasion that would, or should, result in any adverse finding or recommendation against Dr Nydam.

⁵ See page 4 of Form.



Sponsorship for temporary residence in Australia (non-business)

Please Note:

If your applicant's intended stay is for 3 months or less, then a Business (short stay) visa (subclass 456) may be more appropriate (see pages 4 and 5).

Who should use this form?

Use this form to sponsor a person for temporary employment in Australia under one of the following non-business visa subclasses:

- foreign government agency
- educational
- sport
- media and film staff
- public lecturer
- domestic worker for overseas executive
- religious worker
- temporary medical practitioner.

Details about each subclass are on pages 4 and 5.

Other sponsorship arrangements NOT covered by this form

If you want to sponsor a skilled person for long stay temporary business employment in Australia, you should complete a sponsorship form 1196 *Sponsoring temporary overseas employees to Australia*.

If you want to sponsor the entry of an overseas entertainer, you should complete form 148 *Sponsorship for temporary entry of overseas entertainers to perform in Australia*.

All DIMIA forms are available from
www.immi.gov.au/allforms/index.htm

Who can be a sponsor?

Any business which is a legally operating entity in Australia who needs to recruit non-resident temporary personnel and who will be offering employment to the person can be the sponsor.

A company which is recruiting people from overseas to be employed by another company cannot be the sponsor.

Sponsorship undertaking

The sponsor must sign the undertaking at the end of the form.

The undertaking is provided to support the principle that the entry of temporary residents should not result in financial cost to the Australian community. This means that the Australian government can request a sponsor to reimburse it for any outstanding debts owed to the Commonwealth which are accrued by the sponsored person during their stay in Australia.

This could include medical costs related to the sponsored person or their dependants, or travel costs if repatriation became necessary and the employee was unable or unwilling to pay for the costs involved.

It does not include personal debts that a sponsored person might owe to private individuals or organisations in Australia.

Who should be included in the sponsorship?

All family unit members (accompanying your sponsored person) need to be listed on the sponsorship form, including family members who may wish to join their family later.

How to apply

Step 1

Check if sponsorship and Labour Market Testing are required

Check the details for each visa subclass on pages 4 and 5 to see if sponsorship is required for the proposed length of stay in Australia. In most cases it is needed for a stay of more than 3 months.

Also check to see if Labour Market Testing (LMT) is required for the proposed visa subclass and proposed period of stay.

If you require further information you should contact the nearest DIMIA office.

Step 2

Check if a charge is required

You may be required to pay the non-refundable charge when you lodge the sponsorship application.

Method of payment

Payment must accompany your application and is generally not refunded if the application is unsuccessful. To make a payment in Australia, please pay by credit card, debit card or by bank cheque or money order payable to Department of Immigration and Multicultural and Indigenous Affairs. **Please do not pay by cash or personal cheque.**

Payment of the charge does not guarantee approval of the sponsorship.

Step 3

If required, carry out Labour Market Testing

If LMT is required, you must:

- lodge the vacancy with a job placement provider for national listing for a minimum of 4 weeks during the 8 weeks before lodging the nomination, or
- obtain a waiver of this requirement from a job placement service provider,

and

- advertise the vacancy in a Saturday and a weekday edition of both a metropolitan and a national daily newspaper (*a total of 4 separate advertisements*), or

Continued on the next page ►

- if the business is outside major metropolitan areas, advertise the vacancy in both the Saturday edition and a weekday edition of both a major local or regional and a national daily newspaper (*again a total of 4 separate advertisements*),
- advertise the vacancy through other appropriate means. For example, in trade or professional journals, private employment agencies or union consultations. Advertisements in local community language newspapers may also be appropriate.

Advertisements must accurately reflect the duties of the position, salary and other benefits offered. They must be prominently displayed to attract as big a response as possible. You should provide copies of all the advertisements you have lodged and evidence that they have appeared in the last 6 months.

When LMT is complete, the employer must provide with this sponsorship, original advertisements, details of all local applicants including whether they were Australian permanent residents, and reasons for non-suitability of the applicants.

Step 4

Complete your sponsorship form

Please use a pen and write neatly in English using BLOCK LETTERS.

Give all the information requested. If you need more space to answer, attach a sheet giving the required details.

Use the Checklist at **Part I** to make sure you have answered all the questions and provided everything required.

Step 5

Lodge your application

Your completed sponsorship form, charge, and any relevant documentation, may be lodged in person or by a representative or sent by mail, to the office of the Department of Immigration and Multicultural and Indigenous Affairs (DIMIA) nearest to your place of business in Australia.

What happens then?

You will be advised in writing whether your sponsorship has been approved or not. The letter will explain the steps your sponsored person will need to follow to obtain their visa.

Your sponsored person will need to satisfy certain regulatory criteria in order to have their application for a visa approved. This may include the need to undergo a medical check.

Step 6

Make sure the sponsored person lodges a visa application

The sponsored person should lodge form 147 *Application for temporary residence visa (non-business)* as soon as possible after you receive advice that your sponsorship has been approved.

Medical Practitioner (subclass 422) only

If your sponsored person will be applying for a temporary Medical Practitioner (subclass 422) visa, you should inform them that their visa application (on form 147 *Application for a temporary residence visa non-business*) should be lodged in Australia at the same DIMIA office where you lodged this sponsorship application. This applies to all 422 applicants, regardless of whether they are in Australia or overseas.

If the sponsored person is overseas

You should advise the sponsored person to lodge their visa application as soon as you receive advice that your sponsorship has been approved.

If the sponsored person is in Australia

It will save time if your sponsored person's visa application (*and appropriate charge*) is lodged when you lodge this sponsorship application. However, you should be aware that if your sponsorship application is refused, there will be no refund of any charges.

About the information you give in this form

DIMIA is authorised to collect information provided on this form under Part 2 of the *Migration Act 1958* 'Control of Arrival and Presence of Non-Citizens'. The information provided will be used for assessing your application, and for other purposes relating to the administration of the Migration Act.

The information provided might also be disclosed to agencies who are authorised to receive information relating to adoption, border control, business skills, citizenship, education, health assessment, health insurance, health services, law enforcement, payment of pensions and benefits, taxation, review of decisions and registration of migration agents.

The collection, access, storage, use and disclosure by DIMIA of the information you provide in this form is governed by the *Privacy Act 1988* and, in particular, by the 11 Information Privacy Principles. The information form 993i *Safeguarding your personal information*, available from DIMIA offices, gives details of agencies to which your personal information might be disclosed.

The *Freedom of Information Act 1982* also relates to your personal information. Under this Act you can apply for access to documents containing your personal information. You or someone authorised to access information on your behalf can apply to do this at any DIMIA office in Australia. There is no fee for accessing your own information. If you are overseas, you must provide an address in Australia to which copies of your personal records can be sent. More information on how to make a request under the *Freedom of Information Act 1982* is given on the form 424 *Request for access to documents*. The outcome of this application may be made known to the person/organisation who has submitted a sponsorship form regarding your application.

Authorisation of a person to receive written communications

You may authorise another person to receive all written communications about your sponsorship with DIMIA. To do this you will need to complete **Part F Options for receiving written communications** and **Part G Authorised recipient details** in this form. The authorised recipient will need to sign at **Part H**. You can only appoint one authorised recipient at any time. DIMIA will communicate with the most recently appointed authorised recipient.

DIMIA is required under section 494D of the *Migration Act 1958* to send to your authorised recipient any written communications relating to your application that would otherwise have been sent to you. DIMIA will only send to your authorised recipient information which you are entitled to receive. For example, if you are a visa applicant and have a sponsor, your authorised recipient will not receive personal information about your sponsor, unless your sponsor also appointed the same authorised recipient.

If you decide to change the authorised recipient that you have nominated after you have lodged your application, you must promptly advise DIMIA in writing of the details of that person. You may use form 1231 *Appointment of authorised recipient* for this purpose.

Authorisation of a migration agent to act on your behalf

If you have a migration agent acting on your behalf in relation to your sponsorship you need to complete **Part F Options for receiving written communications** and **Part I Migration agent details**. The migration agent will need to sign at **Part J**.

Appointing a migration agent to act on your behalf includes authorising DIMIA to send to that agent any written communication about your sponsorship that would otherwise have been sent to you. You will be taken to have received any documents sent to that agent as if they had been sent to you.

When you provide details of the migration agent please make sure you give the agent's 7-digit migration agent registration number (MARN) and the agent's full name.

If you change your migration agent or end his/her appointment after you have lodged this application you must promptly advise DIMIA by using the form 956 *Appointment of migration agent or exempted agent*, which is available on the DIMIA website or from your migration agent. You should also notify the agent of this, preferably in writing.

Appointing a migration agent to act on your behalf includes authorising DIMIA to:

- discuss your sponsorship with your agent and seek further information via your agent; and
- send to your agent any written communication about your sponsorship that would otherwise have been sent to you.

This means your migration agent will be your authorised recipient for written communication under section 494D of the *Migration Act 1958* and you will be taken to have received any documents sent to the migration agent as if they were sent to you.

DIMIA will communicate with your agent about your application, including your personal information, financial viability and sponsoring relationships. If your agent authorises it, this communication may take place by e-mail. DIMIA will only send to your agent information which you are entitled to receive.

In some situations DIMIA staff will need to speak with you directly, rather than your migration agent, for example, if you are applying for a visa DIMIA may interview you about your personal circumstances relevant to the visa application. In some situations DIMIA staff will also send the documents to you directly instead of sending these to your agent, but will inform your agent that it has done so.

If you have appointed a migration agent to act for you, you are still responsible for the accuracy of information and supporting documentation that you provide to your agent so that your agent can provide it to DIMIA.

Using a migration agent

You are not required to use a migration agent. However, if you intend to use a migration agent you are advised to use a registered migration agent.

Under Australian law, anyone who uses knowledge of migration procedures to offer immigration assistance to a person wishing to obtain a visa to enter or remain in Australia must be registered.

A list of registered migration agents is available from the Migration Agents Registration Authority (MARA) website www.themara.com.au

You can contact the MARA at:

PO Box Q1551
QVB NSW 1230
AUSTRALIA

Telephone: 61 2 9299 5446

Facsimile: 61 2 9299 8448

E-mail: themara@themara.com.au

Registered migration agents are bound by the Migration Agents Code of Conduct and generally charge for their services. The MARA investigates complaints against registered migration agents and may take disciplinary action against them. If you have a concern about a registered migration agent, you should contact the MARA. You can also download a copy of the complaint form from MARA's website.

Using an agent exempted from registration

Only registered migration agents can provide immigration assistance for a fee or gift. However, certain people, such as sponsors of visa applicants, are able to provide immigration assistance as exempted agents so long as they do not receive a fee or gift.

If you wish to appoint an exempted agent you must complete form 956 *Appointment of migration agent or exempted agent* and attach it to this application form.

Consent to communicate electronically

DIMIA may use a range of means to communicate with you. However, electronic means such as fax or e-mail will only be used if you indicate your agreement to receiving communication in this way.

To process your application DIMIA may need to communicate with you about sensitive information, for example, health, police checks, financial viability and personal relationships. Electronic communications, unless adequately encrypted, are not secure and may be viewed by others or interfered with. If you agree to DIMIA communicating with you by electronic means, the details you provide will only be used by DIMIA for the purpose for which you have provided them, unless there is a legal obligation or necessity to use them for another purpose, or you have consented to use for another purpose. They will not be added to any mailing list.

The Commonwealth Government accepts no responsibility for the security or integrity of any information sent to DIMIA over the internet or by other electronic means.

If you authorise another person to receive documents on your behalf and they wish to be contacted electronically, their signature is required on the form to indicate their consent to this form of communication.

Continued on the next page ►

SUBCLASS	PURPOSE	SPONSORSHIP AND OTHER REQUIREMENTS
415 Foreign Government Agency	For foreign government officials to conduct official business on behalf of their government where the officials do not have diplomatic or official status in Australia. It includes cultural institutions such as the Alliance Française, Goethe Institute, British Council, Italian Cultural Institute and other tourist offices and cultural institutions as well as foreign government agencies and departments.	<p>Sponsorship – for stays of up to 3 months, or cases involving directors of Alliance Française, Goethe Institute or Italian Cultural Institute a statement of support is required from the Foreign Ministry. In all other cases sponsorship is required.</p> <p>Labour Market Testing – not required.</p> <p>Condition 8107¹ is a mandatory condition attached to all visas in this subclass.</p>
418 Educational	<p>For qualified people to join educational and research institutions or organisations to fill academic, teaching or research positions which are unable to be filled from the Australian Labour Market.</p> <p>Note: The Temporary Business (Long Stay) visa (Subclass 457) is the preferred visa for this group. For stays of under 3 months, the 456 Business (Short Stay) is also an option.</p>	<p>Sponsorship – is required for a stay of more than 3 months.</p> <p>Labour Market Testing – is required except where the:</p> <ul style="list-style-type: none"> - stay is for less than 12 months; - position is for senior academic/research staff; or - position forms part of a labour agreement. <p>Details that must be attached to the sponsorship application:</p> <p>The employing institute must provide a letter of appointment detailing: the duration and type of employment (ie. full or part-time), title of position offered, duties, remuneration and reason why overseas recruitment is required.</p> <p>Condition 8107¹ is a mandatory condition attached to all visas in this subclass.</p>
421 Sport	<p>Temporary stay of elite sports people with an established reputation to engage in competition with Australian residents, and to improve the quality of sport in Australia through high calibre participation in competition and training.</p> <p>Note: Non-elite players and coaches should apply for a 456 Business (Short Stay) for under 3 months or 457 Temporary Business (Long Stay) for over 3 months.</p>	<p>Sponsorship is not required if the sports person has an established sporting reputation.</p> <p>Sponsorship – All persons coming to be a player, coach or instructor in relation to an Australian team or organisation, or to participate in a structured sport-training program. In most other cases, sponsorship is required for stays of more than 3 months.</p> <p>Monitoring – to evaluate the integrity of this visa subclass, sponsors will be monitored by DIMIA to ensure that they comply with their sponsorship undertakings in relation to the visa holder and accompanying family members.</p> <p>A letter of endorsement from the peak sporting body in Australia is required. Condition 8107¹ is a mandatory condition attached to all visas in this subclass.</p> <p>Sponsored persons can only undertake 'incidental work' for the sponsor.</p>
422 Medical Practitioner	For qualified medical practitioners where there is a demonstrated need for employing practitioners from overseas.	<p>Sponsorship – required in all cases.</p> <p>Labour Market Testing – is not required if:</p> <ul style="list-style-type: none"> – the position is part of a labour agreement, or – is in an 'area of need' identified by the relevant State/Territory health authorities, or – the occupation is on the Migration Occupations in Demand List (MODL). <p>Condition 8107¹ is a mandatory condition attached to all visas in this subclass.</p>

¹ Condition 8107 states you must not:

- cease to be employed, or cease to undertake the activity, in relation to which your visa was granted; or
- work in a position, or engage in an activity, that is inconsistent with the position or activity in relation to which your visa was granted; or
- engage in work for another person or on your own account while undertaking the employment or activity in relation to which your visa was granted.

SUBCLASS	PURPOSE	SPONSORSHIP AND OTHER REQUIREMENTS
423 Media and Film Staff	<p>For correspondents and other professional media staff posted to Australia by overseas news organisations, and photographers and film and television crews making documentaries or commercials for overseas consumption.</p> <p>Note: Media staff (only) can be considered for a 456 Business (Short Stay) for under 3 months or 457 Temporary Business (Long Stay) for over 3 months.</p>	<p>Sponsorship – is required for a stay of more than 3 months.</p> <p>Labour Market Testing – is not required.</p> <p>Details that must be attached to sponsorship application:</p> <p>The proposed subject matter and intended locations in Australia; the purpose for which the film/videotape is to be used; where the film is to be processed; conditions of employment for crew members; and Australian technical staff and/or entertainers to be hired (including numbers and positions).</p> <p>Condition 8107¹ is a mandatory condition attached to all visas in this subclass.</p>
424 Public Lecturer	<p>For professional lecturers or subject experts invited to make public presentations.</p> <p>Note: If the period of stay is for less than 3 months, the 456 Business (Short Stay) is appropriate.</p>	<p>Sponsorship – is required for a stay of more than 3 months, unless the sponsored person seeks to enter Australia under a bilateral agreement between Australia and another country.</p> <p>Labour Market Testing – may be requested by DIMIA.</p> <p>Details that must be attached to sponsorship application:</p> <p>The itinerary showing details of venues and appearances; details of the fee or salary to be paid to the sponsored person; and a brief biography of the sponsored person.</p> <p>Condition 8107¹ is a mandatory condition attached to all visas in this subclass.</p>
427 Domestic worker for overseas executive	<p>For domestic staff of holders of visas in subclass 457 Long-stay temporary business entry (executives only). A visa in this subclass may only be granted where it can be shown that the entry of domestic staff is necessary for the proper discharge of the executive's representational duties.</p>	<p>Sponsorship – is required if the executive is sponsored.</p> <p>If the executive is not sponsored an acceptable employment agreement must be provided. The agreement is between the applicant and the executive and should outline details of the position including the salary package, which must be commensurate with the awards and standards for equivalent positions in the Australian labour market.</p> <p>Labour Market Testing – may be requested by DIMIA.</p> <p>Condition 8107¹ is a mandatory condition attached to all visas in this subclass. The holder of the visa must not remain in Australia after the permanent departure of their employer.</p>
428 Religious Worker	<p>For religious workers, including ministers, priests and spiritual leaders to serve the spiritual needs of people of their faith in Australia.</p>	<p>Sponsorship – required in all cases.</p> <p>Religious Worker agreement – may be negotiated with the sponsoring organisation. An agreement would specify the number and type of religious workers to be sponsored over a period of time, and annual monitoring arrangements.</p> <p>Monitoring – to evaluate the integrity of this visa subclass, sponsors with Agreements will be monitored by DIMIA to ensure that they comply with their sponsorship undertakings in relation to the visa holder and accompanying family members.</p> <p>Labour Market Testing – may be requested by DIMIA.</p> <p>Details that must be attached to sponsorship application:</p> <p>Evidence that: the sponsorship is supported by a senior authority of the religious organisation in the relevant State/Territory; a written undertaking guaranteeing provision of applicants travel expenses on leaving Australia if required, and a guarantee not to attempt to recover any costs from the applicant related to any travel costs and support in Australia; and if sponsoring for the first time, evidence that the organisation is a 'religious' organisation.</p> <p>Condition 8107¹ is a mandatory condition attached to all visas in this subclass.</p>

¹ Condition 8107 states you must not:

- i) cease to be employed, or cease to undertake the activity, in relation to which your visa was granted; or
- ii) work in a position, or engage in an activity, that is inconsistent with the position or activity in relation to which your visa was granted; or
- iii) engage in work for another person or on your own account while undertaking the employment or activity in relation to which your visa was granted.

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Australian Government

Department of Immigration and
Multicultural and Indigenous Affairs

Sponsorship for temporary residence in Australia (non-business)

Form

55

Part A – Details of sponsor

1 Details of sponsoring organisation or sponsor in Australia

Name of organisation or sponsor

Street address of organisation or sponsor

POSTCODE

Postal address of organisation or sponsor.

(If same as street address, write 'AS ABOVE')

POSTCODE

2 Australian Business Number / Australian Company Number (if applicable)

--

3 Do you agree to DIMIA communicating with you by facsimile, e-mail or other electronic means?

No ☐

Yes ☐ Give details

Facsimile number (AREA CODE)

--

E-mail address

--

4 Is this your first sponsorship?

No ☐

Yes ☐ Refer to Part L for documentation that must be attached

5 Nature of business

--

6 Details of employees

How many people are employed by the organisation/sponsor in Australia?

--

How many are in the same occupation as the sponsored position?

--

How many employees are not Australian citizens or residents?

--

Part B – Details of sponsored position

7 Job title

--

8 Occupation (if not described by job title)

--

9 Is the position

Full-time ☐

Part-time ☐

10 Proposed period of employment in Australia (years, months)

--

11 Address of workplace

POSTCODE

12 Will the sponsored person receive a salary?

No ☐

Yes ☐ Give details

--

13 Details of salary package

Annual salary

--

Other benefits

OR tick if details are attached ☐

14 Job description

OR tick if details are attached ☐

15 Qualifications and essential skills required for the position

OR tick if details are attached ☐

Continued on the next page ►

Family name

Given names

Sex Male ☐ Female ☐

Date of birth DAY MONTH YEAR

Relationship to sponsored person

Citizenship of passport

Family name

Given names

Sex Male ☐ Female ☐

Date of birth DAY MONTH YEAR

Relationship to sponsored person

Citizenship of passport

Part F – Options for receiving written communications

- 25 All written communications about this application should be sent to:
(Tick one box only)
- Sponsor ☐ All written communications will be sent to the address for communications that you have provided in this form. Go to Part K
- Migration agent ☐ Go to Part I
- Agents exempted from registration ☐ You must complete form 956 *Appointment of migration agent or exempted agent* and attach it to this application form. Go to Part K
- Authorised recipient ☐ This is a person authorised to receive written communications other than a migration agent. All written communications that would otherwise have been sent to you in relation to this application will be sent to that person.

Continued on the next page ►

Part E – Assistance with this form

- 22 Did you receive assistance in completing this form?
- No ☐ ► Go to Part F
- Yes ☐ ► Please give details of the person who assisted you

Family name (not a business or company name)

Given names

Address

POSTCODE

Is the person a registered migration agent?

- No ☐
- Yes ☐ ► Go to Part F

- 24 Did you pay the person and/or give a gift for this assistance?

- No ☐
- Yes ☐ ► How much did you pay?

A\$ AND/OR

What kind of gift did you give? (eg. jewellery)

Value of gift (approximately)

A\$

Note: Do NOT complete this section if you are a migration agent, go to Part I

Note: Do NOT complete this section if you are a migration agent, go to Part I

- Title: Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other

Family name

Given names

	POSTCODE

Office hours (AREA CODE)

Mobile phone

7 As the authorised recipient named on this form, do you agree to DIMIA communicating with you by facsimile, e-mail or other electronic means?

No ☐

Yes ☐ Give details

Facsimile (AREA CODE)

E-mail address

- 28** Signature of authorised recipient

Date

DAY	MONTH	YEAR
/	/	

▶▶ Now go to Part K

29 Provide the details requested below about the migration agent who is authorised to act on your behalf and to receive all written communications about this application.

Migration Agent Registration
Number (MARN)

7 DIGITS

Title: Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other

Family name

Given names	
-------------	--

Business or company name: _____

Postal address

POSTCODE

Office hours (AREA CODE)

Mobile phone

30 As the migration agent named on this form, do you agree to DIMIA communicating with you by facsimile, e-mail or other electronic means?

No ☐

Yes ☐ Give details

Facsimile (AREA CODE))

E-mail address _____

- 31 I understand and accept that I am the person appointed by the
applicant to receive all written communications and act as his/her
migration agent.

**Signature of
migration
agent**

Date

DAY	MONTH	YEAR
/	/	

Part K – Payment details

32 How will you pay your application charge?

- Bank cheque ☐ Please make payable to: Department of
Immigration and Multicultural and
Indigenous Affairs
- Money order ☐
- EFTPOS ☐
- Credit card ☐ Give details below

Payment by (tick one box)

Australian Dollars

MasterCard <input type="checkbox"/>	Visa <input type="checkbox"/>
Bankcard <input type="checkbox"/>	Diners Club <input type="checkbox"/>
American Express <input type="checkbox"/>	JCB <input type="checkbox"/>

Credit card number

Expiry date /

Cardholder's name

Telephone (AREA CODE)

Address

Signature of
cardholder

Credit card information will be used for charge paying purposes only.

Part L – Documents you must attach

33 Please attach the following documents to this application if you have ticked the 'attached' box in response to any question or if the document is listed as a requirement for your sponsored person's visa subclass.

Take a copy of the documents for your own records.

	Documents	Attached?
Q4	Evidence, such as financial or annual reports, bank statements, audit reports, a statement on company letterhead, or other material to show: <ul style="list-style-type: none"> the type of business the company is operating; recent business undertakings; financial status; the size of the business including the number of employees and the location of offices or plants; and how long the company has been operating. 	<input type="checkbox"/>
Q13	Details of salary package	<input type="checkbox"/>
Q14	Job description	<input type="checkbox"/>
Q15	Details of qualifications and essential skills required for the position	<input type="checkbox"/>
Q16	For religious organisations only – evidence of tax exemption status from the Australian Taxation Office.	<input type="checkbox"/>
Q21	Details of additional family members	<input type="checkbox"/>
	Other attachments as listed for the sponsored person's visa subclass	<input type="checkbox"/>

Continued on the next page ►

Part M – Your sponsorship undertaking

34 I/We accept responsibility for:

- all financial obligations to the Commonwealth incurred by the sponsored person arising out of that person's stay in Australia;
- compliance by the sponsored person with all relevant legislation and awards in relation to any employment entered into by the sponsored person in Australia; and
- unless the Minister otherwise decides, compliance by the sponsored person with the conditions under which that person was allowed to enter Australia; and
- the provision of information about the sponsorship (or any information relating to the sponsorship application or approval) to assist DIMIA in the monitoring process.

Signature of
sponsor or
delegated
officer of
sponsor

Date DAY MONTH YEAR

Name

Job title/
position



If this form was completed by a **business** with fewer than 20 employees, please provide an **estimate** of the time taken to complete this form.

Include:

- the time actually spent reading the instructions, working on the questions and obtaining the information
- the time spent by all employees in collecting and providing this information.

Hours Minutes

Submissions

Queensland Cabinet

SUBMISSION TO THE PUBLIC HOSPITALS COMMISSION OF INQUIRY ON BEHALF OF CABINET

1. This document responds to the Commissioner's invitation on 14 October 2005 for submissions as to potential adverse findings which might be made concerning various Cabinet decisions. Those findings appear at pages 6088-6089 of the Transcript. This submission addresses two matters.
2. First, it is submitted that the proposed findings ought not be made because such findings lie outside the terms of reference of the Commission of Inquiry. This is not surprising because the nature of Cabinet, and its special position in responsible Westminster government, does not lend itself to incidental findings of the kind foreshadowed.
3. Second, the submission sets out the reasons why the potential findings are neither made out on the evidence nor warranted in any event.

CABINET AND THE PUBLIC INTEREST

4. The potential findings proceed upon the basis that Cabinet decisions, otherwise regularly made, can be criticised or called into question incidentally by the Commission of Inquiry for being contrary to the public interest. That, by reason of Cabinet's position and the terms of reference of the Commission, is not so.
5. Cabinet answers to Parliament and through it to the people of Queensland. These accountability mechanisms, and well-established conventions, leave to Cabinet judgments as to what the public interest is, being the interests of Queenslanders as a whole. Cabinet is uniquely placed to make such judgments and it is no part of the functions of the Commission, in accordance with its terms of reference, to make a judgment about whether political decisions made by Cabinet were or were not in the public interest.

6. The question of what is and is not in the public interest is something elected representatives are best placed to decide. That is because the term bears different meanings in particular contexts. It involves a “*discretionary value judgment ... by reference to undefined factual matters*”¹. There must always be an element of conjecture in a decision as to what is in the public interest².
7. It is a question which Cabinet, being comprised solely of elected representatives responsible to Parliament³ is best placed to judge. As Bowen CJ said in *Minister for Arts, Heritage and Environment v Peko-Wallsend* (1987) 75 ALR 218 at 225:

It is to [federal] Cabinet that the highest decisions of policy affecting Australia are brought. Often the questions arising involve intense conflicts of interest or of opinion in the community. In Cabinet these conflicts have to be resolved. Decisions have to be taken in the public interest, notwithstanding that the lives, interests and rights of some individual citizens may be adversely affected by the decision.

8. There is no general rule that disclosure of material such as the Hospital Reports is always in the public interest. The question involves weighing competing tensions: the interest of the public in citizens being informed of the processes of their government and its agencies on the one hand and the public interest in the proper working of government and its agencies on the other⁴. It is inherent in Cabinet deliberations that they often involve consideration of more than one controversial path, even though only one may, despite differing views, prove to be sufficiently acceptable⁵. But the decision must be, in the end, one which Cabinet as a whole supports. That must, given the nature of Cabinet in the Westminster system, be the end of the matter as far as the Commission is concerned.

¹ See the discussion of the wide scope of “the public interest” in the context of decision making by public bodies in *O’Sullivan v Farrer* (1989) 168 CLR 210 at 216-217; *Harburg Investments Pty Ltd v Mackenroth* [2005] QCA 243 at [3] per McPherson JA.

² *Re Howard and Treasurer of the Commonwealth* (1985) 3 AAR 169 at 1777

³ *Constitution of Queensland Act 2001* s 42(1)

⁴ *Harris v Australian Broadcasting Corporation* (1983) 78 FLR 236 at 246

⁵ *Commonwealth v Northern Land Council* (1993) 176 CLR 604 at 615-616.

9. It would be a surprising thing for an Executive to establish a Commission of Inquiry one of whose tasks was to inquire, incidentally, whether particular decisions of the Executive were or were not in the public interest and then to make a finding accordingly. This Executive did not do so and none of the terms of reference actually justifies an inquiry of that kind.
10. The widest of the terms of reference is paragraph 2(d) which, in its opening paragraph, requires that inquiry be made as to "[t]he appropriateness, adequacy and timeliness of action taken to deal with any of the allegations, complaints or concerns referred to in (a), (b) and (c) ..."
11. Even the word "appropriateness" does not justify a view that the Commission is enjoined to make findings that decisions of Cabinet were or were not in the public interest. Whether particular decisions had some kind of effect may well be a matter of relevant inquiry; but whether the decision was in the public interest when it was made is not.
12. It is therefore submitted that, while it is open to the Commission to consider the effect of any particular decision that has been taken, so long as the effect is a matter within its terms of reference, it is no part of the function of the Commission of Inquiry to make and publish a judgment about whether decisions of Cabinet were or were not in the public interest.

SUBMISSIONS ON THE EVIDENCE

Measured Quality Reports

13. Cabinet considered submissions concerning these documents on 11 November 2002 (Phase 1) and on 10 June 2003 (Phase 2).
14. Preparation of the reports was overseen by Mr Collins who was the Manager, Measured Quality Services within Queensland Health. The program's main

objective was to improve the quality of services provided by Queensland Health to the public. Mr Collins explained to the Commission that the program involved a sample of hospitals being taken and their performance identified and measured against certain indicators. He said 80 per cent of the data was drawn from existing records in Queensland Health and that the remaining data was sourced through surveys.

15. Two levels of reports were brought into existence:
 - (a) annually, reports concerning individual hospitals (**the Hospital Reports**);
 - (b) biennially, a general report containing an overview of trends across Queensland Hospitals (**the Aggregate Reports**).
16. The Aggregate Report was publicly released. This was in accordance with recommendations made to Cabinet.
17. With respect to the Hospital Reports which Cabinet was asked not to make public, Cabinet also chose to act on the recommendation.
18. The potential finding raises these questions:
 - (a) whether it was contrary to the public interest for Cabinet to adopt recommendations made to it not to publicly release the Hospital Reports;
 - (b) whether it was contrary to the public interest for Cabinet not to adopt a recommendation made to it that the Phase 1 Hospital Reports be disseminated to district and zonal managers within Queensland Health;

- (c) whether it was contrary to the advice of Queensland Health not to disseminate to district and zonal managers within Queensland Health the Phase 1 Hospital Reports.

Public release

19. Cabinet, in deciding not to release publicly the Hospital Reports, acted on advice and in accordance with the recommendation put to it. Cabinet is a deliberative body which relies on the recommendations of those involved on a day to day basis with the relevant matters. Mr Collins says of the Phase I reports "it was decided to advise Cabinet that it was not intended to release the Phase 1 hospital reports publicly"⁸. His oral evidence was that it was never intended the Phase 1 Hospital Reports would be released publicly⁹.
20. As Mr Collins pointed out in his oral evidence, there may be good reasons (which are not addressed in the Reports themselves) for the variations between the data for individual hospitals, including the size of the hospital and the ability to garner the services of surgeons, nursing and other essential staff¹⁰. The public could not be expected to know these matters. Without that information, the Hospital Reports would be meaningless and be more likely to cause confusion than inform the public.
21. Communications at higher levels of government are more likely to involve sensitive issues¹¹. Disclosure which will inhibit frankness and candour in future pre-decision communications is more likely to be considered not to be in the public interest. The same applies to disclosure which will lead to confusion and result in misinformed debate.
22. There are other good reasons why releasing the Hospital Reports publicly would not have been in the public interest:

⁸ Collins addendum statement Ex 378 para 30.

⁹ Transcript p 5920 ln 35.

¹⁰ Transcript p 5903.

¹¹ *Re Howard and the Treasurer of the Commonwealth of Australia* (1985) 3 AAR 169

- (a) Mr Collins's evidence was that there was a tension between what clinicians and hospital managers need to be provided with for the report to have real effect, and what the public required in order to have a proper understanding of the data¹². This is correct. The clinicians and managers have the benefit of experience in the particular hospital and knowledge of the issues it faces. The public of course do not have that background, requiring those matters to be properly explained if the report is to be understood in proper context;
- (b) Mr Collins said, with these considerations in mind, his team split the reports into the two levels with a view to "meet the needs of clinicians and managers as well as the public"¹³. The clinicians would have the data for the relevant hospital to identify problems, and the public would have the relative performance data at a Statewide level;
- (c) Queensland Health sought to create a constructive "blame-free" environment in which to disseminate the results in the Hospital Reports "so that genuine quality improvement can be achieved"¹⁴. In Mr Collins's mind were what he said to be numerous Australian and international studies showing that in order to meaningfully and effectively engage clinicians in quality and safety improvement processes, a blame-free environment was necessary¹⁵ and that this would be impossible were the hospital reports to be released to the public without first allowing investigation¹⁶. That constructive process was proper because, in the end, the primary objective of the Hospital Reports and the Measured Quality program as a whole was to improve the levels of service provided by Queensland Health. It was necessary for the reports to be able to be given effect to in a constructive manner, removed from fear of unfair or misinformed reprisal;

¹² Addendum Statement of Collins Ex 378, para 8

¹³ Addendum Statement of Collins Ex 378, para 9

¹⁴ Para 20 of the 10 June 2003 Cabinet Submission

¹⁵ Addendum Statement of Collins, Ex 378 para 4.

¹⁶ Addendum Statement of Collins, Ex 378 para 6.

- (d) the team of which Mr Collins was manager comprised relatively junior members of staff who fulfilled more of a data collection role albeit with some analysis of the results. They should not be understood, however, as being in any sense specially qualified to make findings and recommendations in any overarching sense. Their role, on the approach adopted, was more limited and contained. It allowed individual hospitals to correct any erroneous conclusions which had been reached without the benefit of all necessary background information;
- (e) when the Hospital reports were released to the particular districts, Queensland Health made available staff to "assist ... with interpreting the results"¹⁷. The release of the data without this explanation could have resulted, the submission relied upon by Cabinet observed, in misinterpretation of the results. Not only would the public not have had this assistance, the reports would have been read by them without the background knowledge and specialist expertise which district managers and others possess. It would have caused misinterpretation, confusion and misinformed debate in the sense that issues would have been ventilated which were in fact false issues or simply misunderstandings. Mr Collins said as much. The reports were prepared on the basis of data which had been collected before the Hospitals had had an opportunity to investigate the results.

23. A decision of Cabinet made in these circumstances cannot be the subject of the potential finding.

Release to district and zonal managers

24. It is not as if the Hospital Reports were never used or disseminated. Mr Collins said the Hospital Reports were used in this way¹⁸:

¹⁷ Cabinet Submission para 20

¹⁸ Statement of Collins Ex 377 para 19(d).

- (a) zonal management within Queensland Health were briefed by MQS project officers on the results for specific hospitals within their zone. This approach was adopted because face-to-face communication was considered to be more effective than simply delivering the report itself to the hospital;
 - (b) after 2004, each District Manager was provided with an electronic copy of the reports;
 - (c) more recently, the reports were available to district managers (and staff under them with district manager approval) on a secure website;
 - (d) there was then a process in place whereby comments would be made on the reports by the district including for identifying areas where further monitoring of the Hospital was required.
25. It is only in the case of the Phase 1 Hospital Reports that Cabinet did not adopt immediately a recommendation made to it that the reports “be released to each of the District Manager and Zonal Managers within Queensland Health for dissemination and action where necessary”. Cabinet, just as it is entitled to adopt recommendations, is entitled to reject them. It would be wrong, however, to say the recommendation in this case was rejected outright. Two members of Cabinet were vested with the task of managing dissemination of those reports. Dissemination took place, albeit after some months (mid 2003 according to Mr Collins¹⁹). The timing was not critical, because fears had been held even at the time Phase 1 Hospital Reports were being prepared that the data was out of date²⁰.

Cabinet decision contrary to advice of Queensland Health?

26. The terms of the potential finding, in saying Cabinet’s decision in late 2002 was contrary to the advice of officers of Queensland Health, is unfounded because the

¹⁹ Transcript p 5909.

²⁰ Evidence of Collins, p 5932 lns 25-30

only advice Cabinet received was that contained in the relevant Cabinet submissions.

27. It would be misplaced to rely upon communications between officers of Queensland Health and Mr Brad Smith to find that Queensland Health “advised” Cabinet. Recommendations to Cabinet are made by Ministers. That is the advice upon which Cabinet acts. In *Minister for Arts, Heritage and Environment v Peko-Wallsend* (1987) 75 ALR 218 at 225 Bowen CJ said:

... there are recognized channels for communicating arguments or submissions. Each Minister has the support and advice of a Department of State.

28. In any event, Mr Brad Smith is not the “Secretary of Cabinet” (contrary to what was suggested by Senior Counsel assisting²¹). Communications with him are not communications with Cabinet.
29. In summary, the decision to prepare two levels of report was taken before the relevant Cabinet decisions were made. One level, the Hospital Reports, were prepared on the basis that they would not be publicly disseminated. With that in mind, the higher level report was prepared to be released publicly. That is the context in which the reports came to Cabinet. And it is not as if the Hospital Reports were withheld. They were sent (albeit with some delay so far as Phase 1 was concerned) to the public officials who had a direct interest in their contents. They had been written for an audience of this kind and written for the purpose of those people considering the report and making changes to the way they provided services to the public with the aim of improving those services. Not only then were the Hospital Reports not “withheld” by Cabinet, they were made available for the particular purpose for which they had been prepared. And in the end, the reports were used with a view to improving services delivery to the public and not in a manner contrary to the public interest.

²¹ Transcript p 5927.

30. For the reasons set out, provision of the reports to the public without proper background and explanation had a real likelihood of causing confusion and uninformed debate. The focus was improving service delivery and having individual hospitals act on the results, not on embarrassing particular hospitals and in doing so creating a defensive response from them which would have distracted from the primary focus of improving hospital performance. The worst that might be said is that there was delay, and regrettable delay, in the dissemination of the Phase 1 Hospital Reports to individual hospitals.

Waiting Lists

31. It is correct to say that between 1998 and the present time, Cabinet released to the public the elective surgery lists, and that Cabinet, between 1997 and 1998, did not permit the disclosure of such information.
32. The Cabinet in existence in 1997 and 1998 was not a Cabinet of this Government and, consistent with well-established convention, the present Government does not seek to defend or explain why Cabinet at that time made the decisions it did. The fact remains, however, that Cabinet under a Labor government has made available more information than had Cabinets under the previous the Coalition Government.
33. The potential finding, so far as it has relevance to the present Cabinet, is that it was misleading and contrary to the public interest to disclose the elective surgery lists without what the Commissioner has described as the "anterior lists", namely a list of people who had not yet been assessed for elective surgery.
34. What is said above in relation to Cabinet decisions not being susceptible to findings of acting contrary to the public interest is relied on in connection with this potential finding also.

35. Contrary to what the potential finding suggests, disclosure of the so-called anterior list would have misled the public. This emerges once the basis upon which such lists are prepared is fully appreciated.
36. The Queensland Government measures and reports elective surgery waiting lists as part of a national agreement (known as the Australian Health Care Agreement) which has the objective of securing public access to public hospital services. Each State Government and the Commonwealth is a party to that agreement. Its significance is that it applies National Health Dictionary Definitions which in turn provide a common platform for there to be a sharing of data and some meaningful comparisons made. The agreement forms one of the bases upon which the Commonwealth provides funding to Queensland for use towards its public hospital services. If Queensland were not a party to this agreement, or did not comply with it, this component of Commonwealth funding would not be paid and Queensland would not be able to participate in the data sharing arrangements.
37. Each party to the Commonwealth agreement is required to report certain performance indicators and to agree to that data being published in order to improve the transparency of the public hospital system's performance (Schedule C Clause 4). One set of such performance indicators are waiting times for elective surgery (Schedule C, Attachment A). The reporting is required to adhere as closely as possible to the National Health Data Dictionary.
38. The point to be made from this can be stated briefly: the elective surgery lists are the only lists prepared in compliance with the relevant National Health Dictionary Definitions. Those definitions, and especially "Hospital Waiting List" requires that the data consist only of patients "assessed as needing elective hospital care".
39. Any anterior list would not follow the prescribed national definitions and would therefore proceed on an entirely different footing from the data published pursuant to the Australian Health Care Agreement. For these reasons, Queensland has one

centrally-managed waiting list for elective surgery prepared in accordance with the National Scheme.

40. An anterior list would not only have no meaning in the context of the national scheme, but it would be misleading because it would proceed on an entirely different basis – at a fundamental level – to what is accepted practice across Australia for recording these matters.
41. But perhaps most importantly, there is no anterior list which is centrally collected to common standards which can be meaningfully compared to the elective surgery list. There is no centrally and consistently collected anterior list. For the purposes of the Australian Health Care Agreement, the only outpatient data collected is for non-admitted patients “occasions of service”. This is not prepared at the patient level and therefore is of no use whatsoever in interpreting the elective surgery list.
42. The snapshot of these lists taken by Queensland Health in July 2004 is not a list of the nature of the elective surgery list. It is in a completely different category.
43. Contrary to what the potential findings suggest, disclosure of the surgery list was not misleading but necessary when regard is had to Queensland’s obligations under the Australian Health Agreement. To have supplemented that with a list prepared on some alternative and unorthodox basis would have misled the public as to the true position with respect to elective surgery waiting times, and done so by adopting a basis for measurement which was contrary to the universally accepted national standard for such matters.

Dated 25 October 2005

A handwritten signature in black ink, appearing to be 'W. Sofronoff', written over a horizontal line.

WALTER SOFRONOFF QC

A handwritten signature in black ink, appearing to be 'J. M. Horton', written in a cursive style.

JONATHAN HORTON



Crown Solicitor

28 October 2005

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

Dear Mr Groth

QPHCI - Submissions on behalf of Cabinet

I refer to my letter dated 26 October 2005 attaching submissions to the Public Hospitals Commission of Inquiry on behalf of Cabinet.

Those submissions responded to the Commissioner's invitation on 14 October 2005 for submissions as to potential adverse findings which might be made concerning various Cabinet decisions. The relevant potential findings appear at pages 6088-6089 of the transcript.

Those potential findings did not concern the manner in which persons affected by the conduct of Dr Patel might be compensated.

Since lodging Cabinet's submissions, my office has been provided by the Commission with a copy of the final submissions of the Bundaberg Hospital Patient Support Group dated 26 October 2005. At paragraph 4 on the fourth page of the Executive Summary and paragraph 186 on pages 46 and 47, various allegations are made concerning the fairness and appropriateness of the scheme by which individuals who may have suffered loss by reason of Dr Patel's conduct might be compensated.

Matters of this kind did not form part of the Notice directed to members of Cabinet, and to my knowledge, no notice raising potential findings of this kind has been directed to the State of Queensland.

It is my respectful submission that findings or recommendations as to these matters would fall outside the Commission's terms of reference. I further submit that should the Commission nevertheless propose to make findings or recommendations about the scheme by which patients of Dr Patel might be compensated, and in particular the adequacy of any scheme of that kind, the Commission should afford to the State an opportunity to respond to the allegations, and to call necessary evidence on the issue.

Yours faithfully

A handwritten signature in black ink, appearing to read 'CW Lohe', written in a cursive style.

• CW Lohe
Crown Solicitor

PRE052/1440:1210610 v2

QUEENSLAND PUBLIC HOSPITALS COMMISSION OF INQUIRY

28 October 2005

Crown Solicitor
Crown Law
GPO Box 149
BRISBANE QLD 4001

Dear Mr Lohe

Submissions on Behalf of Cabinet

I refer to your letter of 28 October 2005. You observe that in the final submissions of the Bundaberg Patient Support Group dated 26 October 2005 various allegations are made concerning the fairness and appropriateness of the scheme by which individuals who may have suffered loss by reason of Dr Patel's conduct might be compensated. The Commission does not currently propose to make findings or recommendations about the scheme by which patients of Dr Patel might be compensated. If this intention changes, I will alert you so that the State has an opportunity to respond to the allegations and to call necessary evidence on the issue.

Yours sincerely



David Andrews
Senior Counsel Assisting

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Submissions

Queensland Clinician
Scientists' Association &
Dr Con ARONEY

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TO: Qld Public Hospitals Commission of Inquiry
ATTN: David Groth
FAX NO: 07 3109 9151

DATE & TIME: 27 October 2005: 9.28 pm approx

NO OF PAGES: 21 (including cover sheet)

MESSAGE:

Re: Queensland Clinician Scientists' Association

David,

A copy of the previously emailed submissions for the above and Dr Aroney is attached.

Yours Sincerely,
Raelene Kelly

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In the Matter of
QLD PUBLIC HOSPITALS COMMISSION OF INQUIRY
pursuant to the *Commissions of Inquiry Act 1950*

Submissions on behalf of the
Queensland Clinician Scientists' Association
and Dr Con Aroney

27 October 2005

- 1 The Queensland Clinician Scientists' Association ("the QCSA") is an unincorporated association of medical officers of varying levels of seniority and includes Visiting Medical Officers engaged by Qld Health.
- 2 The Association produced to the Morris Commission two statements of evidence, of which one was put into evidence, being that of Dr Con Aroney. Dr Aroney's evidence was primarily concerned with the impact of non-clinical decisions (of an administrative or budgetary nature, and in some cases, in the nature of misconduct) on clinical care in the Prince Charles Hospital and generally in cardiology services.
- 3 Dr Aroney's statement was Exhibit 263 (with Ex. 264 being the confidential patient identity key), he gave oral evidence on 10 August but had not yet been cross-examined when the Morris Commission ended. His cross-examination occurred on 30 September.

4 Dr Aroney's evidence is valuable for the demonstration it offers of some of the multifarious dysfunction in Queensland Health ("QH"), namely –

4.1 The inability of hospital and QH management to deal honestly and reasonably with both a service delivery problem and the exposure of that problem;

4.2 The subordination in priority of critical patient care to corporate-style planning targets, when the people affected by the planning (patients, clinicians and even local managers) do not support the changes or the means of their achievement;

4.3 The willingness on the part of management to sacrifice the interests of patients and the public health career of a leading specialist, in a misguided attempt to protect QH's corporate reputation and punish him for (initially) writing to the Premier;

4.4 The readiness of QH's resort to overseas-trained doctors to patch up management failures which result in clinical staff attrition, and to threaten clinical staff with their replacement by overseas-trained doctors;

4.5 The misuse by a hospital of the privileging and credentialling procedure to achieve improper purposes, namely the punishment and exclusion of a former specialist from the hospital, even when that specialist is volunteering assistance on (his own) groundbreaking clinical procedures;

4.6 The willingness of QH and hospital management to wield budget allocations and cuts as mechanisms of control of clinical staff, or at the very least, to represent to clinical staff that QH in fact punishes/rewards by means of budget.

- 5 Dr Aroney also provided an interesting catalyst for measuring QH's current respect for the Commission's endeavour, for the need to respond transparently and fairly to his evidence.

Submission 4.1 The inability of hospital and QH management to deal honestly and reasonably with both a service delivery problem and the exposure of that problem and

Submission 4.6 The willingness of QH Aroneynd hospital management to wield budget allocations and cuts as mechanisms of control of clinical staff, or at the very least, to represent to clinical staff that QH in fact punishes/rewards by means of budget.

- 6 The first service delivery problem to which this submission relates is the massive increase in demand for cardiac services up to 2003, for which no provision was made: Ex 263, par 5-11. QH's responses were to do nothing (Ex 263, par 11), to walk out of meetings (Ms Podbury- Ex 263, par 14), to replace clinical management with a cumbersome administrative structure (Ms Podbury- Ex 263 par 10), to close the anti-smoking clinic (Ex 263 par 10), to threaten to dismiss a critical clinician (Ex 263 par 8, Ex 401), and finally to institute budget cuts (Ex 263, par 12-15).

- 7 The second service delivery problem followed the first round of cuts referred to above. Rather than welcome Dr Aroney's exposure of the problem to the Premier, QH threatened him with reprisals. Dr Scott's extraordinary response to Dr Aroney on 8 January 2004 was that he regarded the letter (which didn't mention him) as "personally offensive" to him, and threatening to "come after" Dr Aroney: Ex 263 CA5, par 23.
- 8 Dr Buckland responded to the service delivery problem in cardiac services by attending a Cardiac Society meeting chaired by Dr Aroney and behaving aggressively with the effect of intimidating speakers, and claiming the information being presented was "Prince Charles-centric". [A similar line has been pursued by QH in cross-examining Dr Aroney and in QH's non-tendered statements in response to Dr Aroney].
- 9 When Dr Aroney and his colleagues compiled a very detailed submission, at QH's request, on the future of cardiac services in Qld, submitted in July 2004 (Ex 263, CA2), neither Dr Scott nor the Minister were able to say that they had read it.
- 10 The third round of cuts was represented to the clinicians as a punishment for Dr Aroney's public statements (Ex 263 par 44- Dr Scott); and indirectly by Ms Wallace when she was announcing the cuts. In response to Dr Aroney's claim to be advocating for the patients, and saying "we are bullied", Ms Wallace's response, as minuted, was-

"Perceptions of the cardiology programme are not good. We have to be more politically savvy": Ex 301C MIC 19 page 2

- 11 The obvious inference was the one which Dr Aroney drew. The "political savvy" statement was made in the context of patient advocacy by Dr Aroney, an assertion of being bullied, and the announcement of budget cuts.
- 12 Ms Wallace was not produced. Clearly, as current Deputy Director-General of QH she could have provided a statement to rebut Dr Aroney's evidence, but did not do so. A Jones v Dunkel inference should be drawn.
- 13 In the circumstances of
- that inference,
 - Dr Scott's statement to the cardiologists,
 - the preceding threats against Dr Aroney in January by Dr Scott, and
 - Dr Buckland's aggression in February -
- it is submitted that the finding is open that the third round of cuts was an improper response to Dr Aroney's disclosures, designed to punish him without regard for cardiac patients.
- 14 Even if not satisfied of that on the evidence (which evidence remains in the control of QH, it must be said), it is submitted that the Commission should at least find that the representation was made to clinicians that QH had the power and the willingness to wield the power to control clinicians' conduct by means of budget allocations and cuts.

- 15 In October 2004 Dr Scott again attacked Dr Aroney, this time on ABC television. Dr Scott's statements were plainly dishonest. See Ex 263 par 46, CA 13, CA 14 and CA 11; transcript at 3945 line 35ff; transcript at p5268 line 10 to p5271; transcript at p5274-5.
- 16 The following week, Dr Buckland was reported in the Courier Mail which interpreted his remarks as a "crackdown" on Prince Charles hospital, which was alleged to have been applying guidelines in an inappropriately liberal way: Ex 263 par 48. Dr Buckland's reported remarks were directly contradicted by the determination of the Cardiac Procedures Workshop the following month (MIC 24 to the untendered statement of Dr Cleary dated 29 September 2005) which found that it was Princess Alexandra hospital whose guidelines were not consistent with other hospitals.
- 17 There is, it is submitted, in the conduct of Messers Scott, Buckland and Cleary a cavalier disregard for accuracy and transparency. A failure to respond reasonably to a health funding crisis was covered up by attacks on the messenger, in this case Dr Aroney. Dr Aroney's disclosures were not characterised as assisting them in the joint endeavour to make politicians and Treasury more acutely aware of the crisis, but rather as a failure of QH's 'damage control': see Scott's response at transcript p5290-1, which is a clear example of the priority placed on QH media management over public knowledge of death rates.

- 18 There are many failings of Scott's and Buckland's period of QH management, but the most profound is the dishonesty which became the management tool of choice.

Submission 8.2 The subordination in priority of critical patient care to corporate-style planning targets, when the people affected by the planning (patients, clinicians and even local managers) do not support the changes or the means of their achievement

- 19 QH's defence of the budget and service cuts to Prince Charles cardiac services in 2003-04 was a master plan to support the development of cardiac services at Princess Alexandra (PA) hospital: Ex 301C pars 23-30. It was acknowledged by Dr Cleary that Prince Charles was better equipped and more experienced in cardiac care, that the transfers themselves would give rise to an estimated 188 additional procedures required per annum, and that Prince Charles hospital could treat the patients more cheaply than PA: transcript at 4842 line 45ff; Dr Cleary also testified that he "personally found it difficult to support the transfer" (transcript 4843 line 4), and that a large number of people on the working party expressed that view, including cardiac clinicians: 4844 line 38 ff. He said the decision was ultimately made by Dr Buckland: 4845 line 10.
- 20 Whether the proposal was well-intentioned or not, the bungling in its planning and execution was inexcusable. Dr Cleary claims not to have known for 18 months after the hospital administrators had agreed in principle to proceed (July 2003: Ex 301C par 28) that PA had a non-

standard categorisation of patient priority: Ex 301C par 41; 4833 line 20 to 4835. Certainly there is no evidence that anyone questioned or challenged Dr Buckland's assertion in Ex 301C-MIC12 of there being no Category 1 patients and only 2 Category 2 patients at PA, while there were 229 and 78 at Prince Charles respectively.

21 Ultimately, it was conceded by documents attached to the untendered statement of Cleary that there was a miscategorisation at PA and adjustment was required. That was at the end of November 2004, more than a year after cuts at Prince Charles had commenced. There has been no evidence produced by QH (whether tendered or not) showing that patients transferred pursuant to this master plan were actually treated at PA. Indeed it seems likely, at least prior to the end of 2004, that Cat 1 patients from Prince Charles went to PA and were there categorised as Cat 3 and accordingly placed on the waiting list for non-urgent patients. Dr Aroney's evidence was that a Cat 3 categorisation meant that treatment was not required within three months (4802 line 10 to 4803), so if Cat 1 (treatment required within 48 hours) patients from Prince Charles went onto a Cat 3 waiting list at PA, then it is likely that at least some of them were not ultimately treated.

22 The effect of the above is that a transfer of resources occurred, but there is no evidence that the alleged transfer of services occurred.

23 A close examination of MIC 12 (to Ex 301C) is warranted- this is Dr Buckland's memorandum recording the decision. Its subject is not "proposal to support the cardiac program at PA", but "cardiac services at the Prince Charles hospital". It commences by referring to Dr Scott's meeting with Dr Aroney on 8 January (the "we'll come after you" meeting). At the top of page 2 after some self-serving statements for the record, Dr Buckland attributes the failure of equitable access to treatment for urgent patients to a failure of clinical collaboration by cardiac services at Prince Charles with other providers such as PA. There is nothing in the memorandum consistent with the position which Drs Buckland and Scott now present to the Commission, namely that theirs was a brave and constant struggle for resources. On the contrary, inadequacy of resources is not mentioned at all, self-promoting spin is evident (see eg last paragraph), and the real subject of the memorandum is to insitute transfers following Dr Aroney's allegations.

24 Finally in relation to this issue, Dr Aroney said at 6242 line 6ff:

"There's been a lot of talk about classification of lists today and yesterday, but these patients were misclassified and put on an elective list, and this was the reason, over a 12 month period, why patients were then transferred, in the full knowledge of Queensland Health of this misclassification, to the Princess Alexandra Hospital, and that those patients on Category 3 presumably were put further and further back. We have no knowledge of what the death rates were on that Category 3 list. So to say that there was no hidden list is clearly untrue. Dr Cleary's statement, MIC(12), from Dr Buckland doesn't mention any Category 3 patients, and we know they existed. It's a fact,

and those numbers should be able to be obtained from Queensland Health exactly how many there were. We understood there were several hundred."

Submission 8.3 The willingness on the part of management to sacrifice the interests of patients and the public health career of a leading specialist, in a misguided attempt to protect QH's corporate reputation and punish him for (initially) writing to the Premier

- 25 There is no question that Dr Aroney was a thorn in the side to QH management; he was articulate, well-acquainted with his facts, well-credentialled, and authoritative. He refused to be bullied, responding to Dr Scott's threats by issuing a press release: Ex 263, par 25. It is important to remember that the first threat to Dr Aroney was after he had *written to the Premier*: this was hardly the act of a media-manipulating terrorist, but was an attempt to get through to the person ultimately responsible and accountable for the consequences of his administration.
- 26 Equally, there is no question that Dr Aroney was and is a highly-esteemed and dedicated expert clinician; he was the principal author of the National Guidelines in his field (MIC 1 to Ex 301C; Ex 263 CA1), several witnesses spoke highly of him (eg Dr Molloy at 583 line 38ff; Dr Nankivell at 3053 line 30), and even Dr Cleary conceded his contribution (Ex 301C, par 18). He pioneered three procedures in Qld (at 6289 line 3).
- 27 Rather than an appropriate response to Dr Aroney (which might range from fixing the problem of which he was complaining, to engaging in an

honest and open debate to remonstrate and defend), QH resorted to threats, lying about the facts on ABC television, criticising Dr Aroney's hospital in the newspaper, keeping the Maher and Thomas-Ayre reports into deaths confidential, and insinuating that Dr Aroney had breached the QH Code of Conduct for "releasing into the public arena details of the hospital's waiting lists without approval": Ex 301C, MC20 page 3.

- 28 Far from breaching the QH Code of Conduct, Dr Aroney was in fact the only person involved in these events who complied with it. It required all employees to resolve conflicts in the public interest, to disclose maladministration of which they were aware, to advance the common good of the community they serve: transcript 6290.
- 29 Wallace and Scott then linked the third round of cuts to Dr Aroney's outspokenness (Ex 301C MIC 19 page 2; Ex 263 par 44; transcript 6290 line 47ff), whereupon Dr Aroney felt that it was necessary for him to leave in order to protect the hospital from further retribution: Ex 263 par 56; transcript 3951 line 15ff; transcript 6266.
- 30 The priority which QH places on its public image was established elsewhere in the Morris Commission's evidence. Its treatment of Dr Aroney in order to uphold that public image was not unconscionable, it resulted in the loss to the public patients of Qld of a much-needed committed and world-class specialist.

Submission 8.4 The readiness of QH's resort to overseas-trained doctors to patch up management failures which result in clinical staff attrition, and to threaten clinical staff with their replacement by overseas-trained doctors

31 QH was cavalier as to the loss of Dr Aroney, as outlined above, because as Ms Wallace indicated before the event, Dr Aroney and his colleagues could be readily replaced with overseas-trained doctors: Ex 301C MIC 19.

Submission 8.5 The misuse by a hospital of the privileging and credentialling procedure to achieve improper purposes, namely the punishment and exclusion of a former specialist from the hospital, even when that specialist is volunteering assistance on (his own) groundbreaking clinical procedures

32 The punishment of Dr Aroney continued after his resignation, in the form of refusal by Dr Cleary to accept his offer to volunteer his services to assist his colleague in developing the expertise to conduct Dr Aroney's groundbreaking procedures: transcript page 3925; 6287-9. The refusal continues: transcript 6291.

33 [Cross-examination of Dr Cleary as to this matter was curtailed by Commissioner Morris' view that he was "frankly not interested in looking for someone to blame" 4836 line 16, but only in what he termed "systemic issues": 4846 lines 29-30. Mr Morris explained his approach to these halfway through Dr Cleary's evidence on 23.08 (at 4791 line 5 to 4792) and 24.08 at 4796 and then fully in a three page statement read into the record commencing at 4820. However it is clear from the attachments to Ex 301B dealing with privileging that the refusal to

privilege Dr Aroney ought to have been referred to the appropriate clinical committee, rather than be a decision of Dr Cleary.]

Submission 9- ongoing matters

34 The capacity of Dr Aroney's to answer challenges to his evidence was jeopardized by the late delivery and non-delivery of evidence by QH and Dr Scott. Specifically –

- Dr Aroney's statement was tendered on 10 August (Ex 263 and 264), his evidence-in-chief given that day, with a re-appearance due on 12 August;
- QH privately, with Counsel assisting's knowledge, requested a longer period than planned before Dr Aroney's resumption, in order to prepare its cross-examination. Dr Aroney agreed to that;
- Dr Aroney was then scheduled for 19 August and sent away due to witness overruns;
- Dr Cleary's statement was not produced until 23 August, a fortnight after Dr Aroney's evidence-in-chief, and the day before Dr Aroney was booked (for the third time) for resumption;
- Dr Aroney received Dr Cleary's statement late on the night before his resumption of evidence on 24 August (page 4816-7);
- Because Dr Aroney responded orally to some matters traversed in Dr Cleary's statement, QH sought and received a further

adjournment to take instructions to respond to those matters (page 4816-7);

- More than a month elapsed before Dr Aroney resumed his evidence on 30 September. For the second time, QH produced statements relevant to Dr Aroney only on the day before he was due to give evidence, (this time from Drs Cleary and Garrahy). Dr Aroney was only able to read them for a few minutes before entering the witness box;
- Further, although Dr Aroney was cross-examined by Senior Counsel for Dr Scott, the statements of Dr Scott's witnesses, Drs Galbraith and McNeil, were not put to Dr Aroney, despite that the statements bore word processor dates of 7 and 12 September respectively. These statements were not available to Dr Aroney until 4 October, after his evidence was finished.

35 The last four statements (of Drs Cleary, Garrahy, Galbraith and McNeil) were then not tendered, after Dr Aroney had advised of a requirement to cross-examine the deponents. The lateness of evidence allowed challenges to be made to Dr Aroney's evidence as to particular preventable deaths, but those challenges were themselves protected from scrutiny by the decision not to tender the statements.

36 Further there was no evidence at all from Ms Podbury or Ms Wallace, both of whom were in a better position than Dr Cleary to answer Dr Aroney's allegations.

37 Similarly, QH did not produce evidence which could have settled a number of issues in contention, namely

- the petition to Podbury which Cleary said she could not recall (unearthed by Dr Aroney and now Ex 401)
- the waiting list data for cardiac patients at PA, as to which the untendered Statement of Dr Garrahy makes oblique denial, and which Dr Aroney invited QH to produce: transcript 6279 line 12
- Dr Pohlner's evidence as to the Biomedicus device issue (invited by Dr Aroney at 6282 line 40ff).

38 QH's attitude to Dr Aroney's evidence was that it was something of a side-issue or distraction: its junior counsel suggested that two matters required re-examination of Dr Cleary, and that

"both regrettably relate to the cardiac issue, Commissioners." page 4863 line 49-50

39 It is submitted that the late dropping on the table of statements relevant to Dr Aroney was conduct tactically designed to prejudice rather than facilitate the Commission's examination of these issues.

Credit- Cleary

40 Dr Cleary was not the best-placed witness for QH to produce to answer Dr Aroney's allegations, as Podbury and Wallace were more directly concerned in the events to which Dr Aroney referred. Leaving aside the issue of his reliance on Podbury's reported memory of the threatened dismissal and consequent petition (Ex 401), he was in error

even in those matters he could be expected to know: eg, his assertion that Dr Aroney had been on leave for two years (Ex 301C par 16; transcript page 4774 line 3 and page 4831); the wrong identification in his report which was Ex 301C, MIC17A of patients alleged to have died: see transcript 4805, line 4ff. Dr Cleary persists that he did not know of the miscategorisation of patients at PA until January 2005, even though he had been through an 18 month long process to transfer patients to there. When pressed, he says clinicians' concerns were expressed to him but were not specific. Given that people were likely to die if miscategorised, that was an extraordinary position for him to accept without query, a point which he finally conceded: transcript 4864-5. In any event, Dr Aroney insists that Dr Cleary was told repeatedly throughout 2004 of the discrepancy: transcript 4802-3. Dr Cleary's history included a stint as medical advisor to the elective surgery team for QH in 1996-7, in which the categorisation of patients was proposed and standardised: see Ex 301A, MIC1 pages 6-7; transcript 5725 line 19 where Dr Stable said Dr Cleary was "in charge of" waiting lists. In those circumstances, his failure to tune in to the allegations of clinicians is spurious.

- 41 Finally, Dr Cleary's history and demeanour all suggest he was very much a headquarters man, defending the corporate line, and following Dr Scott's example in being "too much an activist" for the government

(a concession which Dr Scott made about himself at transcript 5287 line 40).

Credit- Scott

42 It is submitted that the concession made by Dr Scott is wholly warranted:

"I think probably if I look back in retrospect, I would say that I probably was more of an activist for the Government and the Minister than perhaps I should have been." at 5287 line 40 ff

Other concessions which ought to have been made were as to what constitutes a "cut" to services, that threatening to "come after" Dr Aroney was to bully him, that his and Buckland's opposition to the publication of death rates (Ex 263, CA8) was nonsensical, that bullying and dysfunction within QH were some of the reasons for medical staff attrition (transcript at 5289), that the "no surprises" rule in JS3 to his statement meant what it said, viz, the Minister only wanted good news (5265 line 25).

43 Dr Scott shamelessly lied on television to the public, about matters with which the public ought properly to have been concerned. Prior to their dismissals, it was his, and Dr Buckland's, persistent position that waiting lists ought not to be published: transcript at 3941 line 39 to 3942 line 17. As Dr Aroney said, regardless of what position he now attests to, when he was in a position of power to make a difference, Scott adopted a very different approach: transcript at 6252.

- 44 A further notable discrepancy with Dr Scott's position is the claim to credit now being made in submissions made on his behalf dated 7 September 2005. At paragraphs 4(b), 4(g) and 6, credit is claimed for Dr Scott providing funds in response to need. First, it is odd that Dr Scott should claim credit for the provision of public funds at all, but secondly, it is at odds with the denial that it was within her "client's gift to be handing out money for this or that..." made by his senior Counsel to Mr Morris at 4827 line 10. Dr Scott ought not to claim credit for matters which elsewhere he asserts were beyond his control and responsibility.
- 45 As to the character references for Dr Scott provided by Edmond and Nuttall: there was no point even in cross-examining Ms Edmond, given that the day before Mr Morris had indicated his attitude to her likely fate and that of others, including Dr Scott. There is no question that Mr Morris favoured the witness, and protected her from scrutiny: see for example, page 5008 at line 30 to Page 5009 line 10.
- 46 Further, at 5092 line 22ff, Mr Morris said -
- "Commissioner: ...Ms Edmond, can I tell you really from the bottom of my heart how much we appreciate your coming out of political retirement to assist this Inquiry with your evidence. I have to be careful in what I say because I don't want anyone to think I've prejudged things, but my impression, I can say very confidently, is that the evidence you've been giving over the last two days has been accurate, honest and reliable to the best of your recollection. If there are some inconsistencies that come to light, I have no doubt that that's because you've put things out of your mind for obvious reasons?-- Mmm.
Your insights into the broader issues of the administration of*

Queensland Health have been extremely valuable and will be at the forefront of our consideration as we're pondering the matters before this Inquiry. We are very grateful to you and you're formally excused from further attendance."

47 As to the proposition put to Ms Edmond that Dr Scott had been alleged to have a "bullying, attacking, overbearing and intransigent" manner (4970 line 58 to page 4971), if that was a reference to Dr Aroney's evidence, it mis-stated it. Dr Aroney did not assert that Dr Scott's manner was, in any general sense, "bullying, attacking, overbearing and intransigent", but merely that Dr Scott had bullied him. The facts of what was said are not contested- merely the inference which might be drawn from them. Further, Ms Edmond did not explain what staff it was in what office who fell about laughing when "they read that in the paper", given that she had retired the year before, a point she made repeatedly in her evidence.

48 Similarly, Mr Nuttall sought to resist the inevitable conclusion that either Drs Scott and Buckland had failed to keep him fully and frankly informed, or he had failed to respond to the crisis in QH (transcript 5348ff). He couldn't account for why Dr Scott had been dismissed, and denied unsurprisingly that he had seen Dr Scott bully anyone (transcript 5362-3). Mr Nuttall's evidence is unreliable.

Credit - Aroney

49 Dr Aroney was a careful and measured witness; he made important concessions where necessary (transcript at 3940 line 31ff; 3926 line

25ff; 3947 line 45), and even in case they were necessary (6283 line 10).

- 50 In what has become a standard QH response to criticism, Dr Aroney's motivation has been impugned as if it were self-interested. The best answer to that is Dr Aroney's own words: (at 3945 line 10) -

"This lack of accountability to our patients really was a thing that hurt me most about what had happened in Queensland Health, that there really was no human face to Queensland Health and that we were faced with a massive cut which would lead to further deaths..."

Raelene Kelly
Counsel for the QCSA

Submissions

Queensland Health



Crown Law

Queensland Government

Your ref:
Our ref: CS5/HEA027/5744/DZP
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Department of
Justice and Attorney-General

27 October 2005

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

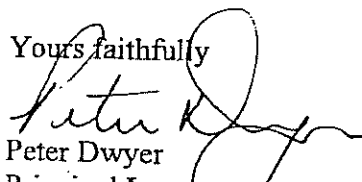
Dear Mr Groth

Submission on behalf of Queensland Health

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

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

Yours faithfully



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Queensland Public Hospitals *Commission of Inquiry*

Submission of Queensland Health

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

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

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

¹ s7(1)
² s3

The Act

Relevantly, the Act provides as follows:

- The Board's functions include ³ -
 - (a) to assess applications for registration;
 - (b) to register persons who satisfy the requirements for registration;
 - (c) to monitor, and assess, when the registrants comply with any conditions of registration; and
 - (d) to keep a register of, and records relating to, registrants.
- In performing its functions, the Board is to act independently and in the public interest. ⁴
- The Board may delegate its powers, but not its powers ⁵ -
 - (a) to decide to register, or refuse to register, an applicant for registration;
 - (b) to refuse to renew a renewable registration;
 - ...
 - (d) to cancel a registration; or
 - (e) to impose, or remove, conditions on a registration.
- An application for general registration must be made to the Board. ⁶
- A person may obtain special purpose registration to undertake an activity for a purpose (a "**special purpose**") mentioned in, inter alia, section 135. ⁷ A person is eligible for special purpose registration for a special purpose if the person -
 - (a) is fit to practise the profession; and
 - (b) is qualified for registration under this subdivision.
- A number of the requirements for application for general registration apply for special purpose registration. ⁸ Those include the procedural requirements for applications for

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

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

- In deciding whether an applicant is fit to practise the profession,⁹ the Board may have regard to, inter alia, if the applicant is, or has been, registered under a corresponding law (under Schedule 3: "Corresponding Law" means a law applying, or that applied, in another foreign country that provides, or provided for the same matter as, inter alia, the *Medical Practitioners Registration Act 2001*) and the registration was affected -
 - (i) by the imposition of a condition - the nature of the condition and the reason for its imposition; or
 - (ii) by its suspension or cancellation - the reason for its suspension or cancellation; or
 - (iii) in another way - the way it was affected and the reasons for it being affected.
- The purpose of registration under section 135 is to enable a person to practise the profession in an area the Minister has decided is an area of need for a medical service. It is for the Minister to decide whether there is an area of need for a medical service,¹⁰ that is, whether there are insufficient medical practitioners practising in that part of the State, to provide the service at a level that meets the needs of people living in that part. If the Minister so decides, that there is such area of need, the Minister must give the Board written notice of such.
- A registrant who is registered, under section 135, to practise the profession in a specialty in an area of need, whilst so registered, is taken to also be a specialist registrant in the specialty.¹¹ Under Schedule 3: "Specialty" means a branch of medicine prescribed under a regulation to be a specialty. Section 6 of the Medical Practitioners Registration Regulation 2002 provides that, for the definition, *Specialty* in Schedule 3 of the Act, a branch of medicine mentioned in Schedule 1, Column 1 is a specialty. "General Surgery" is mentioned in Schedule 1, Column 1.
- The approved form for a Certificate of Special Purpose Registration must provide for the inclusion of -

⁹ s45
¹⁰ s135(3)
¹¹ s143A

- (a) details of the special purpose and activity for which the registrant is registered;
and
- (b) if the special purpose involves the practise of a specialty, details of the specialty.

Dr Patel

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

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

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

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

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

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

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

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

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

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

Although the Oregon Licensure Verification was twice provided by Dr Patel to Wavelength, the Wavelength personnel involved failed (on both occasions) to notice that the annexures were missing¹³. On 6 January 2003, Dr Patel's application was submitted by Wavelength to MBQ. Included was the incomplete Licensure Verification and a Declaration by Dr Patel answering the following questions in the negative:

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

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

Ainslie McMullen, an experienced MBQ staff member, processed Dr Patel's application. On or about 3 February 2003, she completed a MBQ registration check list which signified her having sighted a Certificate of Good Standing in respect of Dr Patel¹⁴.

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

¹³ Bethel : T683/ 35

¹⁴ Exhibit 24 "MDG-24"

Conclusions

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

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

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

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

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

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

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

¹⁵ s135(2)

¹⁶ s131(2)

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

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

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

17/06/2003

P-18 - James Graves (Oesophagectomy)

On 18, 19 June 2003, Nurse Hoffman emailed, respectively, Glennis Goodman²¹ and Darren Keating²² with her concerns regarding this patient. Substantively, the emails complained that the surgery done on P18 fell outside the scope of BBH. Previous to Nurse Hoffman's first email to Goodman on 18 June, Dr Joiner met with Dr Keating on 17 June and, in the context of P18's case, queried whether BBH should do oesophagectomies.²³ Dr Joiner also sought the transfer of P18 saying Dr Patel refused it. In response, Dr Keating arranged for Dr Younis, an anaesthetist, to review the patient. Dr Younis reported back that P18 was not in need of immediate transfer. Dr Keating then met with Drs. Patel, Younis and Joiner and it was agreed P18 would remain in BBH ICU for 1-2 days longer under review.²⁴ When Dr

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

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

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

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

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

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

²⁵ Exhibit 448 paragraphs 60-62

²⁶ Ibid

²⁷ Exhibit 448 paragraphs 52-55 & T6832/20 & T6833/1

²⁸ Exhibit 448 paragraph 59

²⁹ T4003/18

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

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

July 2003

Wound dehiscence

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

The relevant discussion commences with Gail Aylmer's email re dehiscence on 3 July 2003.³² Notably, this correspondence was not "Dr Patel specific". On 7 July 2003, Aylmer raised her email at a Leadership and Management Meeting and agreed to present a report.³³ On 9 July 2003 a further discussion of dehiscences were noted in the Minutes.³⁴ There was a further note that the issue was to be brought forward for further discussion. In Dr Keating's belief,³⁵ the issue had been openly discussed, researched and resolved satisfactorily. His expectation was that Gail Aylmer would continue to monitor it in her role as Infection Control Co-Ordinator.

Dehiscence was again raised on 14 April 2004 by Di Jenkin and noted in the ASPIC Minutes.³⁶ The May 2004 ASPIC Minutes³⁷ records a resolution that dehiscences were to be reported as adverse events.³⁸

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

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

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

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

September 2003 P-39

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

³⁸ Nurse Jenny White acknowledged that, from July 2004, it was resolved dehiscences were to generate Adverse Event Forms: T1234/10-20
³⁹ Exhibit 90
⁴⁰ Exhibit 64
⁴¹ T908/10-20
⁴² Exhibit 448 paragraph 67
⁴³ Exhibit 448 paragraph 68. The junior doctors disavowed any suggestion that Patel's charts were not full and accurate. See, for example, T2051/35-40 (Athanasiov)
⁴⁴ Exhibit 4 - "TW-6"
⁴⁵ When testifying to the Commission, Dr Carter expressly disavowed the making of the alleged agreement with Patel: T3999/25

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

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

2004

Dr Miach's Renal Patients

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

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

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

⁴⁶ Exhibit 448 paragraphs 82-86

⁴⁷ Exhibit 448 paragraph 19 & T6845/35

⁴⁸ T986

⁴⁹ Exhibit 69

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

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

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

March 2004

Letter - Nurse Hoffman to Mr Leck

Following Goodman's retirement, Nurse Hoffman acted as DDON for one or two weeks in March. Towards the end of this period, Nurse Hoffman reported to Mr Leck with a letter⁵⁴ in which she raised some issues regarding Dr Patel. She said the letter was about Dr Patel's "behaviour" and this is borne out on a fair reading of the letter. At the same time, Nurse Hoffman said "*I wanted to see you about this but I don't want you to take it further*".⁵⁵ Subsequently, Mr Leck drew the letter to the attention of both Mulligan and Dr Keating. Mulligan later told him she'd spoken to Nurse Hoffman about managing Dr Patel's

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

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

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

14/04/2004

ASPIC Meeting concerning long-term ventilated patients at BBH

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

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

As Dr Keating explained in evidence, Nurse Hoffman did not specifically raise at this meeting clinical inadequacies in surgery being carried out by Dr Patel.⁵⁷ In her evidence, Nurse Hoffman agreed.⁵⁸ Further, during 2004 BBH experiencing difficulties transferring patients to Brisbane because of increased demand for ICU beds resulting from closure of certain services at Rockhampton and Redcliffe-Caboolture. There also were restrictions on night-time transfers due to the refusal of retrieval staff to fly helicopters at night without adequate insurance. In consequence, the overtime hours in Bundaberg ICU increased. Dr, Keating examined statistics provided by Nurse Hoffman⁵⁹ and concluded that the demand for ventilation in ICU from all specialties (not just surgical) had increased and applied at least equally to medical patients. That being so, the data did not point to any increase being due to any poor or inadequate clinical practice or procedure by Dr Patel.

⁵⁶ Exhibit 463 paragraphs 19-26

⁵⁷ Exhibit 448 paragraph 123

⁵⁸ T1387/55

⁵⁹ Exhibit 448 paragraph 129 & Exhibit 94

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

July 2004

P-11 - Desmond Bramich

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

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

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

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

An adverse event form ⁶⁰ documented:

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

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

Transfer

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

⁶⁰ Exhibit 162 Annexure "LR-9"

⁶¹ Exhibit 4 "TH-21"

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

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

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

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

Lack of co-ordination of care

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

Pericardiocentesis

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

⁶² T4579

⁶³ Exhibit 423

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

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

Clinical issues

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

Investigation

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

21/12/2004

P-21 Gerard Kemps

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

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

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

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

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

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

⁷⁵

T1897/15 (Mrs Kemps)

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

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

Late December 2004/January 2005

P-26

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

He was transferred to ICU and intubated.

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

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

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

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

⁷⁶

T6822

⁷⁷

Exhibit 448 paragraph 264

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

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

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

On 5 January 2005, at Mr Leck's request, Dr Keating prepared a brief on this case for submission to Zonal Manager, Dan Bergin. Dr Keating's report⁷⁹ recommended a patient with major vascular injury be transferred as soon as the patient's condition is stable. Subsequently, Dr Keating spoke to Drs. Patel and Gaffield and explained that, as a result of his review, any patients undergoing emergency vascular surgery shall be transferred as soon as they were stable.

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

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

- (a) The critical time in which to save a leg is 6 hours from time of injury;⁸⁰
- (b) The first operation by Dr Patel was life-saving (t/s 4320.50);⁸¹
- (c) The patient could not be transferred from BBH until haemorrhage was controlled and he had been resuscitated;⁸²

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

- (d) The leg was irretrievably lost by 2.30pm or 3.00pm on admission date to BBH;⁸³
- (e) There was absolutely no question of getting the patient to the vascular operating theatre of RBH or PA in time to save the leg;⁸⁴
- (f) This was a case of mismanagement by Dr Patel (retaining the case at BBH) but not such as caused ultimate harm. The patient would have lost leg anyway but would not have been so sick had he been earlier transferred out;⁸⁵

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

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

Conclusions

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

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

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

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

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

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

Suspension of Dr Patel

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

Mr Leck acknowledged that, as District Manager, he had power to suspend Dr Patel from BBH.⁸⁸ He also appreciated that it was necessary to determine that there were grounds so to do.⁸⁹ He thought of suspending Dr Patel after receiving Toni Hoffman's letter on 20 October 2004.⁹⁰ However, Mr Leck said that Dr Keating was adamant that the issues were personality based and he had no clinical information to give immediate grounds for action.⁹¹

⁸⁷ *Public Service Act 1996* s.87(1)(a)

⁸⁸ T7162/40

⁸⁹ T7162/67

⁹⁰ T7163/26

⁹¹ T7163/20

As 2005 proceeded, Mr Leck became more concerned about Dr Patel but had no medical qualifications of his own and relied on Dr Keating's judgement⁹² accepting it to the point of not feeling it necessary to suspend Dr Patel.⁹³

As evidenced by Mr Leck's email - 13 January 2005 to Dr Scott⁹⁴ - as late as 13 January 2005, Dr Keating was still advising Mr Leck that the issues were personality-driven.

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

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

Dr FitzGerald's belief was that he had insufficient information to suspend Dr Patel.¹⁰³ This view was formed having regard to the conflicting information available to him, including the disparate views of other practitioners as to Dr Patel's competency¹⁰⁴, the conflicting data¹⁰⁵ and the views of the anaesthetists that Dr Patel "*was not the best surgeon neither was he the worst*"¹⁰⁶.

⁹² T7164/20

⁹³ T7196/21

⁹⁴ Exhibit 225 "GF-9"

⁹⁵ T6847/30 & T7001/7

⁹⁶ T6847/32

⁹⁷ T6847/38

⁹⁸ T7050/17-26

⁹⁹ T7050/29

¹⁰⁰ T7050/33

¹⁰¹ T6878 & 6822

¹⁰² T6828

¹⁰³ T6143/44

¹⁰⁴ T6149/20

¹⁰⁵ T6161/45; see all T616/25 – 50: 6163/10

¹⁰⁶ T6149/30; 6154/20; see also 6119/5

Importantly, Dr FitzGerald took steps to:

- (a) Obtain from both Dr Patel and Dr Keating prior to leaving BBH in February 2005, undertakings that Dr Patel would *"undertake only those procedures which are within the scope of the surgical services and relevant support services"* of the hospital and *"to transfer patients more readily to higher level facilities"*.¹⁰⁷ It was entirely reasonable for Dr FitzGerald to accept that Dr Patel and Dr Keating would honour those undertakings, particularly as he was informed such an arrangement was already in place¹⁰⁸. Dr Keating *"would know what those procedures were"*¹⁰⁹. These undertakings satisfied the principal issues and complaints that had been brought to Dr FitzGerald's attention;
- (b) Ensure the MBQ deferred consideration of any registration renewal by Dr Patel. Upon his return to Brisbane following the visit to BBH, Dr FitzGerald, on 16 February 2005, contacted the MBQ to advise that there were possible concerns and to arrange that the MBQ defer consideration of Dr Patel's application for renewal of registration until after the finalisation of his Clinical Audit report¹¹⁰ and any further investigation¹¹¹. Dr FitzGerald knew that Dr Patel was an area of need registrant, that such registration only lasted 12 months and that Dr Patel could not work unless that registration was renewed by the MBQ¹¹². Dr FitzGerald had been advised by Mr Leck that Dr Patel's contract expired on 31 March 2005;
- (c) Have the MBQ undertake a formal assessment of Dr Patel. On the day he delivered his memorandum to the Director General enclosing the Clinical Audit report, Dr FitzGerald wrote to the MBQ seeking an assessment of Dr Patel's performance. In that letter¹¹³ he stated:

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

¹⁰⁷ T6107 – 6108.

¹⁰⁸ T3247/40.

¹⁰⁹ T6108/25.

¹¹⁰ Exhibit 225, para 67: T6146/25 – 35.

¹¹¹ T6147/20 – 30.

¹¹² T6147/15 – 30.

¹¹³ Exhibit 24, attachment MDG-5.

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

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

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

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

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

Credentialing and clinical privileging

In July 2002, Queensland Health introduced a standard policy of credentialing and privileging¹¹⁷. Pursuant to that policy, the responsibility for credentialing and privileging lay with the District Manager. Mr Leck gave evidence that he had delegated this function to Dr Keating.

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

¹¹⁴ T5496/45-50 & T5497/1/2-11

¹¹⁵ T5497/4-5

¹¹⁶ T5561/5

¹¹⁷ Exhibit 279.

thereby increasing the degree of impartiality in the process. That process was subsequently developed into a policy in 2003¹¹⁸.

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

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

In his Clinical Audit report, Dr FitzGerald specifically raised the need for an effective credentialing and clinical privileging process to be undertaken at the BBH. By requesting a formal assessment of Dr Patel by the MBQ¹¹⁹, Dr FitzGerald ensured that an assessment would be undertaken before any re-registration of Dr Patel. The effect of this was that Dr Patel would be unable to practice in Queensland prior to that formal assessment being undertaken. This rendered superfluous any need for Dr FitzGerald to review, or have reviewed, Dr Patel's credentials or clinical privileges. Having regard to the concerns expressed by Dr FitzGerald with respect to Dr Patel's judgment, a formal assessment by the MBQ was the more appropriate procedure in all the circumstances.

Non-publication of Dr FitzGerald's Report

Dr FitzGerald gave evidence that he undertook a clinical audit process focussed on quality improvement not on individual blame¹²⁰. His approach to clinical audits was in accordance with expert views and literature reviews¹²¹. As a rule, clinical audits are kept confidential. This encourages people to provide information and make complaints for the purposes of the particular clinical audit then being undertaken and for future clinical audits. If a patient or informant is identified from a publicly released clinical audit report, it may discourage patients or informants providing information or making complaints in the future¹²².

¹¹⁸ Exhibit 276.

¹¹⁹ Exhibit 24, attachment MDG-5.

¹²⁰ T3227/50-3228, T6121/18-28

¹²¹ T6121/23-28

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

In the case of the Bundaberg clinical audit report, Dr FitzGerald gave evidence that it was difficult in the case of a report into a small country town facility, such as Bundaberg, to de-identify the report because everybody knows everybody¹²³.

Dr Steve Buckland confirmed in evidence that the clinical audit process is an improvement process not a process of blaming individuals,¹²⁴ and that it is not usual for clinical audit reports or recommendations to be publicly released¹²⁵. At paragraph 25 of his statement dated 30 August 2005, he stated:

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

Evidence was also given by Dr John Wakefield about the benefits of a no-blame approach to some investigations in order to promote organisational learning¹²⁶.

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

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

¹²³ T3229/37-43 and T4227/43-45

¹²⁴ T5505/52-56

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

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

¹²⁷ Exhibit 225 paragraph 84 and T4227/17-20

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

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

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

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

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

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

Dr Jayasekera's evidence was that he:

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

- (a) Did not want the position; ¹³²
- (b) Did not feel he could perform it in all of its requirements; ¹³³
- (c) Had no intention of remaining in Bundaberg even if he had been offered the position of Director of Surgery; ¹³⁴
- (d) Only applied at the urging of others; ¹³⁵
- (e) Was not interested in re-applying when the position was readvertised. ¹³⁶

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

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

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

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

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

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

Dr Patel submitted a revised CV in connection with this MBQ Registration Application claiming that he had been employed by Kaiser Permanente until September 2002.¹³⁹ Unfortunately, due to the change of personnel from Dr Bethel to Suzy Tawse, the anomalous CVs and, in particular, the obvious inconsistency between the second CV and Dr Patel's claim to Bethel that he had retired, was not picked up. In evidence, Bethel agreed that a reasonable explanation for the submission of a revised CV appeared to be that Wavelength's Suzy Tawse (who was then progressing Dr Patel's registration application through MBQ) suggested to Dr Patel that his non-employment for 12 months or so might be an issue with MBQ.

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

In circumstances where a recruitment agency is employed for the purposes of obtaining a suitable candidate to fill a position, it is not unreasonable that the relevant reference checks be undertaken by that agency particularly where, as here, copies of the references and details of the reference checks are provided to the prospective employer prior to any offer of employment being made. Dr Nydam knew that such checks had been performed by a highly regarded recruitment agency¹⁴¹. His acceptance of the results of those reference checks was entirely reasonable in the circumstances, and does not constitute carelessness, inefficiency or incompetence.

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

Dr Jayasekera resigned on 28 December 2002. As the Director of Surgery position failed to produce any applicant, another surgical appointment was needed and Dr James Gaffield was recruited on 9 January 2003. Dr Gaffield was junior to, and less experienced than, Dr Patel. His special interest was plastic surgery and he had no general surgical focus. In light of this, and his practical need for one of these two surgeons to act as Director of Surgery,¹⁴² Dr Nydam appointed Dr Patel Acting Director of Surgery at BBH as evidenced by his instruction to "Georgie, Val" on 9 April 2003 to augment Dr Patel's salary by the payment of a Director's Allowance.¹⁴³ Dr Patel was the more senior of the two and was more experienced and did more general surgery¹⁴⁴. Out of those two, he was the natural choice to undertake the duties of Director of Surgery¹⁴⁵.

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

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

Air fares

The original Queensland Health letter of offer to Dr Patel¹⁴⁸ dated 24 December 2002 contained a term under the heading "Travel" whereby BBH agreed to pay a one-way economy airfare for Dr Patel and his wife or a business class fare for Dr Patel if travelling alone from the United States to Bundaberg. This letter was silent as to return airfares, although there was a provision as to payment of relocation expenses.

¹⁴² An administrative position carrying a small allowance; T4171/20-40

¹⁴³ Exhibit 51 Annexure "KN-12"

¹⁴⁴ T4126/50.

¹⁴⁵ T4126 - 4127.

¹⁴⁶ T4129/12-22

¹⁴⁷ T4130/10-20

¹⁴⁸ Exhibit 51 "KN-9"

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

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

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

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

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

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

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

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

Refer to submissions (b)(i) above.

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

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

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

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

There was good reason why this should be so:

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

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

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

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

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

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

Lennox Report

A Joint OTD/TRD Support Committee (*Joint Committee*) was established¹⁶⁰ in November 2002. One of the aims of the Joint Committee was to consider appropriate mechanisms for the screening and assessment of overseas trained doctors¹⁶¹. Members of the Joint Committee included the AMAQ, Queensland Health, the MBQ, the Department of Health and Ageing and the Department of Immigration, Multicultural and Indigenous Affairs¹⁶². Dr Michael Catchpole, the Principal Medical Adviser was the Queensland Health representative on that committee. Dr Lennox participated in the committee at times when he was Acting Principal Medical Adviser.¹⁶³

At the June 2003 meeting of the Joint Committee, a paper¹⁶⁴ was presented by Dr Lennox for consideration. This paper had previously been tabled at a meeting of the Medical Workforce

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

¹⁶⁰ Attachment SMB46 to Exhibit 336

¹⁶¹ Exhibit 55 paragraph 23

¹⁶² Exhibit 55 paragraphs 22-24

¹⁶³ Exhibit 336 paragraph 145

¹⁶⁴ Attachment DRL11 to Exhibit 55

Advisory Committee of Queensland¹⁶⁵. The paper was the subject of ongoing discussion by the Joint Committee and was subsequently redrafted to address issues relating to the management of temporary resident international medical graduates. A new paper entitled '*Medical Jobs@Health, Management of International Medical Graduates*' was tabled at the July meeting of the Joint Committee¹⁶⁶. This paper became known in the Commission as the Lennox Report.

On 11 August 2003 a meeting took place between Dr Lennox, Dr Toft, President MBQ and Mr Michael Demy-Geroe, Deputy Registrar MBQ¹⁶⁷ at which time the '*appropriateness of Dr Lennox's report*'¹⁶⁸ was considered. It was the view of Dr Toft and Mr Demy-Geroe that this was a draft report and that implementation of the proposals would be a major undertaking and require cooperation of a number of organisations¹⁶⁹. In evidence, Mr Demy-Geroe stated that, to his mind, the report remained a draft and was never promulgated to a final report¹⁷⁰.

In his statement, Dr Lennox referred to a request by Dr Steve Buckland, then General Manager (Health Services) for a briefing regarding the proposal for integrated management of OTDs¹⁷¹. A briefing dated 28 August 2003, prepared by Dr Lennox, outlined the proposal for integrated management of IMGs and the involvement of MBQ to implement the report¹⁷².

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

¹⁶⁵ Exhibit 55 paragraph 26

¹⁶⁶ Exhibit 55 paragraph 27

¹⁶⁷ Exhibit 349 paragraph 6

¹⁶⁸ Exhibit 349 paragraph 9

¹⁶⁹ Paragraph 11 of Exhibit 349; T477/10-20

¹⁷⁰ T477/10-15

¹⁷¹ Exhibit 55 paragraph 19

¹⁷² Attachment DRL9 to Exhibit 55

¹⁷³ Exhibit 336 paragraph 150

¹⁷⁴ Exhibit 336 paragraph 151

¹⁷⁵ T5516/10-15

The letter attached to the briefing¹⁷⁶ appears to have been signed by Dr Buckland, however there is uncertainty about whether it was ever received by the MBQ. Dr Toft has stated that the letter and draft report were never received¹⁷⁷.

It was the belief of Dr Lennox that the report was finalised and that this view was endorsed by Dr Buckland given his decision to write to the MBQ¹⁷⁸. That was not Dr Buckland's view.

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

Ms Wendy Edmond, the then Minister for Health, first became aware of the Lennox Report in October 2003, after a request from a journalist for a copy of the report¹⁸². Ms Edmond was informed that the report was a draft working document. In November 2003, Ms Edmond was briefed for the purpose of attending a meeting with the AMAQ. That briefing made reference to the existence of the joint QH/AMAQ working party set up to address matters relating to OTDs¹⁸³.

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

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

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

Similarly, Dr Robert Stable, then Director General was not aware of existence of the Lennox Report until being informed on 21 October 2003 that a journalist had sought a copy of the report¹⁸⁷. In his statement, Dr Stable stated that Dr Lennox's assertion that the report was supported by the AMAQ was an overstatement. He stated *'It seems to me that the AMAQ contemplated at least an appreciable rewriting of Dr Lennox's report before it was considered further'*¹⁸⁸.

Whilst the concepts promulgated in the report were considered to be of value in addressing the problems surrounding OTDs, the report was never publicly released. With the exception of Dr Lennox, the report was not considered to have been finalised. The proposals contained in the report had not been costed by Treasury and it had not been submitted to Queensland Health senior management for approval. It was a report prepared for consideration by the Joint Committee (of which Queensland Health was only one member) and not commissioned by Queensland Health¹⁸⁹. The report was not adopted by the Joint Committee¹⁹⁰ and the evidence before the Commission of some of the members of the Joint Committee was that it was a working document¹⁹¹.

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

Vincent Berg

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

¹⁸⁶ T4926/22-24

¹⁸⁷ Exhibit 366 paragraph 63

¹⁸⁸ Exhibit 366 paragraph 61

¹⁸⁹ Transcript 5516/30-32

¹⁹⁰ Exhibit 336 paragraph 151

¹⁹¹ See for example T477; attachment DRL10 to Exhibit 55; paragraphs 11 and 14 of Exhibit 349

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

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

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

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

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

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

¹⁹² T 3502/3-15

¹⁹³ T 3052/20

¹⁹⁴ Exhibit 376C paragraph 22

Dr Steve Buckland, then GMHS, on 5 December 2002.¹⁹⁵ At that meeting Dr Brown expressed her concern in relation to Dr Johnson's proposal to make a public announcement regarding Berg. She states *"my concerns involved weighing up the potential risks to mental health patients as against the public benefit of such a disclosure."*¹⁹⁶ Given the audit undertaken at TGH did not suggest any major issues surrounding provision of care by Berg, Dr Brown favoured selected follow up over public disclosure.¹⁹⁷

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

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

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

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

¹⁹⁵ Exhibit 376C paragraphs 17-18

¹⁹⁶ Exhibit 376C paragraph 20

¹⁹⁷ Exhibit 376 paragraphs 21-22

¹⁹⁸ Exhibit 336 paragraphs 224-8

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

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

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

²⁰² T5525/1-25

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

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

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

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

The then Director General, Professor Stable, agreed that the Berg decision was a difficult one²⁰⁶ and that it was a reasonable decision at that time not to engage in non-directed publication or media release.²⁰⁷

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

²⁰³ T4953/30-40

²⁰⁴ T4953/50-60

²⁰⁵ T4956/25

²⁰⁶ T5733/10

²⁰⁷ T5736/50

Cardiology Services

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

In overview, the evidence establishes:

- (a) In early 2003, following a submission received from the Princess Alexandra Hospital, ("PAH") in early 2002 seeking to expand its cardiac service, QH made a decision to expand cardiac services at PAH through a transfer of funding and services from TPCH.²⁰⁹ This was before Dr Aroney went to the media and the press release on 6 January 2004.²¹⁰
- (b) The intention of the proposed transfer was to improve the access and timeliness of interventions through managing patients across the service.²¹¹ It was also to make the service at PAH more sustainable, to build up a greater volume of work there, and provide a service more accessible to those living on the southside of Brisbane.²¹²
- (c) As originally implemented, the transfer involved a redirection of clinical cases from TPCH to PAH with a corresponding transfer of the associated funding to treat those patients. The transfer in activity and funding commenced between April and July 2004.²¹³ In hindsight, the same result might have been accomplished if TPCH funding had been left undisturbed and the PAH service had simply been allocated new growth funding with redirection of southside patients to PAH.²¹⁴
- (d) Although Dr Aroney insisted that the transfer of cases to PAH was rationalised on the basis of a "hidden category 3" waiting list at that hospital, Dr Aroney agreed that it was cardiologists - clinicians - at PAH who were responsible for classifying patients there.²¹⁵

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

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

- (e) Dr Aroney thought "category 3" meant the same thing at both Hospitals.²¹⁷ This had also been Dr Cleary's assumption at the time when the transfer from TPCH to PAH was being implemented.²¹⁸ In truth, the two Hospitals had, at that time, a different classification system. This contributed to the significant difference in the presentation of waiting list numbers at the two Hospitals.²¹⁹
- (f) A Cardiac Procedure Workshop was set up by QH to assist in the development of a common and coordinated approach to waiting list management for cardiology procedures. Dr Aroney conceded that he was not present at that workshop and was unaware which categorization system was ultimately adopted.²²⁰
- (g) Overall, cardiac activity within Queensland Health increased,²²¹ as did funding to the Cardiology Department at TPCH.²²² Additional funding in the sum of \$2.4M was provided to TPCH in the 2004-2005 financial year to undertake additional cardiac surgery.²²³ Dr Aroney had no knowledge of these matters. He admitted having never worked at PAH²²⁴ and agreed that he had no knowledge of any overall increase in funding or activity.²²⁵
- (h) Between 2003-2005, the time when TPCH was allegedly being punished, the cardiology department at TPCH had an overall funding increase of \$5.5M²²⁶. There was also an increase in activity across other Queensland Health hospitals²²⁷.

Dr Aroney's assertions of an *'attempted cover-up by Queensland Health of the true circumstances of the death..'* of patients on the cardiology waiting list²²⁸ are without substance. The concerns raised regarding patient deaths on the cardiology waiting list had in fact been the

²¹⁶ T6281/38-42

²¹⁷ T6278/58

²¹⁸ Exhibit 301C paragraph 41

²¹⁹ Exhibit 301C paragraph 41

²²⁰ T6278/30

²²¹ T6024/55 and Exhibit 301C paragraph 101

²²² Exhibit 301C paragraph 99

²²³ Exhibit 301C paragraph 33

²²⁴ T6277/1

²²⁵ T6258/25 & 45

²²⁶ Exhibit 301C paragraphs 99-100

²²⁷ Exhibit 301C paragraph 101-102

²²⁸ T6283/1

subject of an independent investigation²²⁹. Whilst Dr Aroney alleged that Dr Cleary provided incorrect details of the date of death of two patients in an attempt to 'cover up' the truth, Dr Aroney conceded that *'there may have been an error made, the dates were given to me by staff at the hospital...'*²³⁰.

Dr Aroney's assertion that, during a meeting on 29 September 2004, the cardiologists at TPCH were bullied by Ms Gloria Wallace by threatening to replace them with foreign-trained doctors is also without substance. The minutes of the meeting²³¹ referred to by Dr Aroney do not record any such threat.

Fraser Coast Health Service District

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

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

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

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

- (a) agreement was reached that formal teaching sessions for the Senior Medical Officers in Orthopaedics must be held regularly;
- (b) agreement was reached that formal Morbidity and Mortality Meetings are to commence;
- (c) the Australian Orthopaedic Association review is expected to provide some guidance

²²⁹ Exhibit 301C paragraphs 57-66

²³⁰ T6283/5-10

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

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

- (d) the Australian Orthopaedic Association review is expected to provide guidance for supervision requirements and clinical privilege delineation for the Senior Medical Officers;
- (e) the issue of consultant availability was raised. It was accepted that due to the limited number of specialist Orthopaedic Surgeons available, there would be occasions when other hospital medical staff would perform treatment within the bounds of their clinical privileges and that protocols would be developed for obtaining advice from remote specialists where such consultation was required prior to treatment.

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

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

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

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

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

The Chief Health Officer advised the Director-General:²³³

- (a) the report should not be published as that would further the impact of any potential defamation;
- (b) the interviewers have not sought or been in a position to validate any of the concerns of

²³² Attachment TMH 14 A and B to Exhibit 444

²³³ Attachment GF32 to Exhibit 225

the hospital staff that had been raised with them;

- (c) ordinarily such concerns would require a more formalized investigation;
- (d) the investigators= recommendations to cease orthopaedic services at the hospital has significant clinical, legal, industrial and community implications and that alternative solutions to the issues of concern should be first sought;
- (e) that certain actions to address the concerns should be taken.

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

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

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

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

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

- (a) the report was twelve months out of date by the time it was presented;
- (b) during that time steps designed to improve the service had been undertaken;
- (c) the Acting Director of Orthopaedics had been maintaining proper supervision of the Senior Medical Officers since his appointment in January 2005;
- (d) the Acting Director of Orthopaedics had expressed the opinion that patient safety was not an issue whilst he held that position;²³⁴

- (e) the unvalidated complaints detailed in the report would require investigation, including:
- examination of patient charts;
 - conducting full interviews with staff with interviewee's acknowledgment of the accuracy of the recording;
 - conduct patient interviews;
 - conduct interviews of supervisors from previous workplaces;
 - conduct a full audit of Dr Naidoo=s leave history and entitlements;
 - make efforts to either confirm or refute hearsay or gossip; and
- (f) patient safety was not at risk in the interim due to the changes which had occurred as outlined above.

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

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

In relation to the supervision issue raised in the report, the evidence shows that Dr Hanelt, Dr Krishna, Dr Sharma and Mr Allsop all relied on the opinion of Dr Naidoo as to what was appropriate. That was not an unreasonable approach given Dr Naidoo=s experience in Orthopaedics. The evidence of Dr Wilson²³⁵ tends to support Dr Naidoo=s opinion in relation to Dr Krishna=s clinical skills, decision making ability, preparedness to seek assistance and insight into his own limitations. Similarly, Dr Sharma has been the subject of favourable reports from Dr Mullen and Dr Morgan.²³⁶

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

²³⁵ T7326
²³⁶ Exhibit 503

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

- (d) The appropriateness, adequacy and timeliness of action taken to deal with any of the allegations, complaints or concerns referred to in (a), (b) and (c) above, both:
- (i) within the BBH; and
 - (ii) outside the BBH.

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

- (e) In relation to (a) to (d) above, whether there is sufficient evidence to justify:
- (i) referral of any matter to the Commissioner of Police Service for investigation or prosecution; or
 - (ii) action by the Crime and Misconduct Commission in respect of official misconduct or disciplinary matters; or
 - (iii) the bringing of disciplinary or other proceedings or the taking of other action against or in respect of any other person; or
 - (iv) amendments to the Coroner's Act 2003 in relation to appropriate reporting of deaths caused by or as a result of a health procedure.

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

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

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

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

These measures included:

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

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

²³⁸ See generally T4645 and 4691

