Report No. 87

A report on the Crime and Misconduct Commission's assessment of a public interest disclosure

LEGISLATIVE ASSEMBLY OF QUEENSLAND

PARLIAMENTARY CRIME AND MISCONDUCT COMMITTEE

A report on the Crime and Misconduct Commission's assessment

of a public interest disclosure

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July 2012

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54th PARLIAMENT

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CHAIRMAN'S FOREWORD

In April 2012, the committee received a purported public interest disclosure from Ms Jo Barber containing allegations relating to the conduct, the regulation, registration and discipline of medical practitioners in Queensland.

Given the significant media and public interest surrounding this matter, the committee resolved to table this report despite the fact that the subject matter of the report is largely outside of the normal areas of responsibility of this committee.

The committee's report provides a brief background to the matter and appends the report of Mr Richard Chesterman AO RFD QC, who was engaged by the Crime and Misconduct Commission to undertake an independent assessment of Ms Barber's public interest disclosure.

A number of persons named in the report were not interviewed by Mr Chesterman. To afford those persons natural justice, the committee has removed identifying information in relation to those persons. Further, as one matter has been referred to the Queensland Police Service for investigation, information which could jeopardise any investigation or other proceedings relating to that matter have also been redacted.

In his report, at Appendix A of this report, Mr Chesterman, makes four recommendations which are directed to the Minister for Health. The Committee has no jurisdiction regarding the Minister for Health, the Department of Health, or the various boards, agencies and bodies which oversee Queensland's medical practitioners.

The report, which is not a report of the committee, speaks for itself.

Mrs Liz Cunningham MP
Chair

July 2012

1. INTRODUCTION

The Committee has resolved to table the report of Mr Richard Chesterman, who was engaged by the CMC to assess Ms Jo Barber's public interest Disclosure in the Legislative Assembly. It is the practice of the Committee when tabling such a report to provide some background detail regarding the role and powers of the Committee.

The PCMC monitors and reviews the performance of the functions of the CMC. The Committee is established under the *Crime and Misconduct Act 2001* as a bipartisan committee of the Queensland Legislative Assembly. It has the following functions:

- to monitor and review the performance of the CMC's functions;
- to report to the Legislative Assembly where appropriate on any matters pertinent to the Commission, the discharge of the Commission's functions or the exercise of the powers of the Commission;
- to examine reports of the CMC;
- to participate in the appointment of commissioners;
- to conduct a review of the activities of the CMC at the end of the Committee's term ("the Three Yearly Review"); and
- to issue guidelines and give directions to the CMC where appropriate.

The PCMC can also receive complaints and deal with other concerns of which it may be aware about the conduct or activities of the CMC or an officer or former officer of the CMC.

The Committee is assisted in its oversight process by the Parliamentary Commissioner. Mr Paul Favell was appointed as the Parliamentary Commissioner on 22 August 2011.

The Parliamentary Commissioner has a number of functions under the Act. These include, as required by the Committee:

- conducting audits of records kept by, and operational files held by, the CMC;
- investigating complaints made about, or concerns expressed about, the CMC;
- independently investigating allegations of possible unauthorised disclosure of information that is, under the Act, to be treated as confidential;
- reporting to the Committee on the results of carrying out the functions of the Parliamentary Commissioner; and
- performing other functions the Committee considers necessary or desirable.

2. BACKGROUND

Ms Jo-Anna Barber made a public interest disclosure to Mr Rob Messenger, in his then capacity as a Member of the Legislative Assembly, under section 14 of the *Public Interest Disclosure Act 2010* (the PID Act).

In April 2012, Mr Messenger referred Ms Barber's disclosure to the former Parliamentary Crime and Misconduct Committee (PCMC), in accordance with section 34(1) of the PID Act, as a public sector entity under the PID Act to deal with.

As noted above, the PCMC is an oversight committee with a statutory role to monitor and review the activities of the CMC. The PCMC has no jurisdiction to consider the activities of any other body, such as Queensland Health or the Health Quality or Complaints Commission or any officer of those bodies.

Further, under the PID Act, a public sector authority to which a person may make a disclosure is a proper authority if the information being disclosed relates to either: the conduct of the entity or any of its officers; or anything the entity has a power to investigate or remedy.

Having regard to the jurisdiction of the PCMC set out in the *Crime and Misconduct Act 2001*, the PCMC may only accept a public interest disclosure that relates to the conduct of the CMC or an officer of the CMC. Also, as Mr Messenger ceased to be a Member of the Legislative Assembly following the dissolution of the Parliament, the Committee considered that he was unable to take any further role in the processes provided for in the PID Act.

At a meeting on 24 April 2012 the former Committee considered that the appropriate body to investigate the matters raised by Ms Barber was the CMC. The Committee referred Ms Barber's disclosure to the CMC for investigation in accordance with section 31 of the PID Act as:

- the disclosure relates in part to the conduct of the CMC; and
- the CMC has the power to investigate and or remedy the other matters she raised.

The Committee considered that there was no unacceptable risk that a reprisal would happen because of this referral, in fact the Committee considered that the CMC is the best placed organisation to ensure that no instances of a reprisal occur in relation to the matters Ms Barber disclosed.

Upon receiving the referral of the disclosure from the PCMC, the Chairperson of the CMC, Mr Ross Martin SC, engaged Mr Chesterman to undertake an independent assessment of Ms Barber's disclosure.

3. THE REPORT OF MR RICHARD CHESTERMAN

The Chairperson of the Crime and Misconduct Commission provided the report of Mr Chesterman to the committee on 11 July 2012. The report outlines Mr Chesterman's assessment of the allegation of Ms Barber in her public interest disclosure.

The Committee resolved to not release certain attachments to Mr Chesterman's report in order to ensure the security of personal information and, importantly, that any investigation into matters referred to the Queensland Police Service is not jeopardised.

That report, which is not a report of the Committee, speaks for itself.

APPENDIX A

ASSESSMENT REPORT
Into allegations made by Ms Jo-Anne Barber in a statement dated 21 April 2012 and a submission delivered 8 May 2012.

In my Interim Report of 18 May 2012, I described the mechanism of my appointment and the scope of the agency conferred on me pursuant to Section 256 of the *Crime and Misconduct Act 2001*, and summarised the material provided by Ms Barber which was to form the basis of my assessment. It is not necessary to repeat that background, but for completeness sake I attach a copy of the interim report (*Attachment 1*). It will, however, be helpful to repeat what Ms Barber described as the purpose of her statement. She said:

> '...as a result of a combination of:
>
> 1. Several systemic failures at the MBQ, HQCC and QH; and
> 2. The culture of all of these agencies; and
> 3. The behaviour of some individuals within the agencies (for example MBQ and QH managers and investigators); and
> 4. The behaviour of some groups collectively (for example, QH and the Board in the decision making processes)
>
> Patients across Queensland in both private sector and the public sector hospitals are at risk of being harmed and even dying as a direct result of incompetent doctors.
>
> ... even when the incompetence of doctors comes to light and are reported to either QH, the MBQ and/or HQCC they are either not dealt with at all or, in the case of QH, hidden. Rarely is an appropriate outcome achieved which ensures public safety from the doctor.
>
> My allegations also demonstrate that in addition to patients being placed at risk of serious harm or death in hospitals ... the same risk ... is playing out in GP clinics and private practices or specialist doctors across the state.

In this respect I allege that MBQ (and now AHPRA) registers doctors it knows is not competent to practise ... without adequate supervision ... Despite placing ... written conditions on registration of these doctors MBQ never monitors ... the doctors ... This failure to ensure adequate monitoring of doctors with conditional registration has led to serious and systemic cases of unsafe doctors working across Queensland and the Board's records will show actual harm caused by these doctors, and in some cases deaths.'

The acronyms should be explained: MBQ is the Medical Board of Queensland; HQCC is the Health Quality Complaints Commission; QH is Queensland Health; and AHPRA is the Australian Health Practitioner Regulation Agency.

Although the statement names QH as a culprit, it emerged in my interview with Ms Barber that the complaints directed against QH have as their target the Ethical Standards Unit (ESU), an entity of QH. As I noted in my Interim Report, Ms Barber did not make any particular complaint about HQCC or identify any of its officers who were said to have failed in their duty, or to be guilty of misconduct. My assessment was therefore directed to MBQ and ESU to determine whether there is sufficient indication that an investigation of some type is warranted.

The allegations made, if true, are very serious, as are the implications for patients' safety. The immediate difficulty in undertaking the assessment was the extreme generality of the assertions and the lack of detail and specificity. 'Systemic failure' is a conclusion which can only be justified by reference to the number and description of particular failures in the organisation which are said to demonstrate the fact of pervasive failure. The same is true of the designation the 'culture' of an agency. The culture or prevailing attitude within a governmental entity can only be deduced from a pattern of behaviour, or statements made by responsible officers within the entity as to the manner in which its employees are to perform their duties. In other words, it was not possible to make any assessment of the allegations without having regard to details of particular instances.

Ms Barber was aware of this consideration. She included in her statement 'some cases ... to demonstrate my allegations ... The cases listed ... are just a small sample of many ... known to MBQ, QH and HQCC ... which prove the allegations I have made.'

She said, as well, that she had '... a great deal more information ... which is so vast I could not possibly write it all down. Once this matter is referred to a relevant agency or person/s for investigation I will make myself available and fully co-operate with the investigation of these matters.'

On analysis, Ms Barber contended that inadequately qualified doctors are registered, and that when failures, or incompetence, of medical practitioners are reported:

- the regulatory authorities (QH, MBQ and HQCC) do not deal with them at all
- QH conceals ('hides') the complaints so that they never result in action/sanction which adequately protects the public
- MBQ (formerly) and AHPRA (now) registers doctors it knows to be incompetent
- when doctors are registered subject to conditions, or conditions are imposed as a result of disciplinary sanction, compliance with the conditions is not monitored, leading to serious and systemic cases of unsafe doctors working across Queensland.

Eighteen cases were chosen to demonstrate the veracity of the allegations, though 3 of them, (2.5.7, 2.5.12 and 2.5.16) deal with complaints against more than one doctor. They refer respectively to GPs undertaking plastic surgery, the Mt Isa Base Hospital and the Cardiac Unit at The Townsville Hospital.

When one looks at the 'cases' one finds that information is incomplete, sometimes confused and often expressed with as much generality as the statement itself, and does not give particulars of the general assertions in the statement. These deficiencies might have been overcome had Ms Barber cooperated as indicated in the statement. I anticipated, after our first interview, that she would meet with Detective Inspector Byram to 'flesh out' her allegations, provide more detail where she

could, and in other cases indicate where the information might be found. As I noted in my Interim Report, Ms Barber declined to meet again with the CMC officers appointed to assist me to assess her information.

The cases go to the complaint of inadequate investigation/sanction of doctors. They are of less relevance to the complaints of lax registration and monitoring.

On 10 May 2012 Inspector Byram rang Ms Barber to arrange a further interview with her but spoke instead to Mr Messenger who answered her telephone. Mr Messenger told him that any further cooperation by him and Ms Barber was conditional upon their satisfaction that the information was being 'meaningfully and properly dealt with'. On 11 May 2012 I emailed Ms Barber saying I was anxious to proceed with the assessment of her information. I noted that Inspector Byram had unsuccessfully attempted to speak to her by telephone and asked her to contact him or me. Ms Barber replied on 14 May 2012 in a long email in which she described the material she had given to the CMC and said that 'the systemic failures I have witnessed ... are already well document by me as best I can', and to provide more information and for accuracy she would need 'access to all the records I created ... at the Medical Board ...'

On 16 May 2012 I emailed Ms Barber with a request for specific information relevant to a particular complaint she had made concerning the CMC. These complaints were addressed in my Interim Report. Ms Barber replied, also on 16 May 2012, to say that she did not understand my first question and could not answer my second 'without ... being able to access my material and recreate what was happening ...'

On 17 May 2012 I emailed Ms Barber to clarify the first question.

I have had no reply and she has not expressed any revision of her position that she would not meet again with the Commission's officers.

Mr Messenger behaved in a similar manner. In the interview of 8 May 2012 he had made points about the manner in which the CMC had behaved with respect to its oversight of the ESU investigation into the closure of the Townsville Cardiac Unit (about which more will be said later). The allegation, in essence, was that the CMC possessed information relevant to the investigation, part of which was being conducted by Ms Barber on behalf of the MBQ, but did not pass the information to her.

This complaint was of concern to me because, if correct, it may have indicated that it was not appropriate for the CMC (or me as its agent) to investigate Ms Barber's allegations. Accordingly, at my direction, Mr Evans emailed Mr Messenger on 10 May and requested him to provide 'a narrative setting out the facts of your complaints' about the CMC. The reply was a disdainful refusal. Mr Messenger declined to provide further information and asserted that he and Ms Barber had already given the CMC more than sufficient 'narrative' to proceed with the assessment. I wrote to him in response on 11 May 2012 to explain that I wanted clearly to understand the information he claimed the CMC had, but did not pass on to Ms Barber. I pointed out to him that his assertion to me on 8 May 2012 that he had evidence 'that the CMC has by incompetence or guilty act of misconduct failed their duty as an oversight body to protect hundreds of thousands of Queenslanders from substantial and specific threats to public health and safety' were serious and, if correct, deeply concerning, but it was impossible to assess because it was so general and nonspecific. I advised him that the allegations could only be tested by reference to factual detail which I had asked him to provide.

In an email to me on 17 May 2012, on a different topic, Mr Messenger said that he was 'now working on the other details' I had requested. I have never received them.

From time to time I have received from Mr Messenger letters and transcripts of conversations between Ms Barber and various medical practitioners, but none of this information was in response to my request for detailed information in support of Ms Barber's principal allegation.

The disappointing lack of cooperation has meant that I have had to deal with the substance of Ms Barber's complaint on the basis of her incomplete and inadequate material. *Attachment 10* to this report is Ms Barber's statement of 21 April 2012 to which has been added the CMC's transcript of the 19 audio tapes which accompanied her complaint. I have been able to supplement this with documents and records received from the Queensland Board of the Medical Board of Australia (QBMBA), AHPRA, HQCC, ESU and the CMC. (The latter was involved in the investigation of some of the cases which Ms Barber offered as particulars of her main thesis.)

I spoke to or interviewed:

(a) Ms Jo-Anna Barber

(b) Mr Stephen Hardy, former Director of ESU

(c) Ms Cheryl Herbert, CEO of HQCC

(d) Dr Richard Kidd, immediate past President of the Queensland Branch of the Australian Medical Association

(e) Mr Robert Messenger

(f) Mrs Anne Morrison, State Manager of AHPRA

(g) Ms Melanie Mundy, Acting Principal Complaints Officer CMC

(h) Detective Senior Sergeant Laurie Paul, Integrity Services CMC

(i) Ms Lisa Pritchard, formerly Director of the Professional Standards Unit of MBQ and presently Director of ESU

(j) Ms Kaye Pulsford, CEO of the Office of MBQ between July 2007 and June 2010

(k) Ms Lisa Todd Principal, Investigator with ESU and formally investigator with MBQ

(l) Dr Peter Woodruff, a Board Member of MBQ, and now Chairman of QBMBA

Mr Evans and/or Detective Inspector Byram spoke, at my request, to:

(m) Mr Paul Grainger, former Investigator with ESU

(n) Dr Don Kane, former President Salaried Doctors Queensland

and communicated with:

(o) Dr Steve Hambelton, President of the Australian Medical Association

AHPRA has been particularly helpful in producing files and preparing summaries of the cases which have been put forward by Ms Barber and others as illustrative of their thesis. I express my particular appreciation for AHPRA's cooperation and the considerable assistance given by Mrs Morrison and her staff.

In my Interim Report I noted that in my interview with Ms Barber on 8 May 2012 four topics were identified which were the subjects of her complaints and which she wished addressed. They were:

1. That two doctors (whom she named) remained in practice despite evidence that each, through neglect or deliberate misconduct, had killed patients.
2. That the CMC's involvement in the investigation of her complaints had been inadequate and that it had withheld information from her with respect to the investigation into the Townsville Cardiac Unit.
3. That AHPRA and QBMBA, which had taken over the registration and disciplinary responsibilities of MBQ, were not performing those functions any better than MBQ had.
4. That ESU had not properly investigated matters reported to it, concealed evidence and wrongdoing by employees of QH, disregarded complaints and preordained the outcomes of investigations.

Topic 2 was addressed in my Interim Report. Although I qualified it to leave open the possibility that my opinion could change if further evidence was produced, I see no reason to alter the opinion earlier expressed. Mr Messenger has not provided me with information, despite his promise to do so, which might have affected the earlier opinion.

The complaint in Topic 1 concerning one of the doctors still in practice was the subject of interim report No. 2 of 17 May 2012 (see *Attachment 2*). In relation to that, further material was provided to me by Mr Messenger by email dated 21 May 2012 in which he said:

> '... A1 has disclosed hearsay information, which raises suspicions that Dr JB 1 may have recently deliberately killed another patient.
>
> The alleged method of killing is different ... . A1 alleges that Dr JB 1 overdosed a patient using a saline infusion. A1 . further alleges that:
>
> - A colleague of Dr JB 1 (urologist), who witnessed the alleged murder, then covered up the act, by fraudulently altering medical records relating to the patient's death.
> - The urologist lied to the family of the deceased's person ... to protect Dr JB 1.'

The transcript of a conversation between Ms Barber and A1 contains what is said to be the hearsay information. A1 said:

> '... a urologist was talking to an anaesthetist and the urologist confided that JB 1 had killed one of his patients. JB 1 had given three times the recommended dose of a certain intravenous infusion and the old man died and then the urologist didn't know what to do so he told the relatives the man had died of infection. The urologist called in an anaesthetist to assess the situation and the anaesthetist calculated that it was at least three times the recommended dose ... the urologist went and lied to the family ...'

I did not share Mr Messenger's confidence that A1 had disclosed hearsay information of a homicide, but to be sure, on 14 June 2012 I requested that Mr Martin SC *(Attachment 3)* have the QPS investigator include the information in his consideration of whether criminal charges should be laid against Dr JB 1. I am informed orally that Detective Senior Sergeant Walker spoke to A1 on about 19 June 2012 and A1 refused, or was unable, to identify the urologist and declined or was

unable to assist the police in any way by providing information which might indicate the commission of an offence or the identification of witnesses to such an offence.

This report now addresses the remaining issues:

- Complaint regarding Dr JB 2, the second doctor mentioned in Topic 1 (see p. 7)
- Registration and disciplinary responsibilities
- Conduct of ESU.

Complaint regarding Dr JB 2

The second doctor mentioned in Topic 1 was Dr JB 2. Ms Barber's complaints were that Dr JB 2 performed surgery on an elderly woman, who did not speak English, to remove what was believed to be a cancerous growth. The patient began to bleed profusely after the operation. Nurses noticed the bleeding but she was not examined by Dr JB 2. Instead she was sent home with her daughter where she became seriously ill. Despite being taken urgently to the Royal Brisbane and Women's Hospital she died. Dr JB 2 was said by Ms Barber to have commented, 'I thought I might have nicked her bowel' when told of the death. He did not alert hospital staff to the possibility of the nick and the risk of consequent bleeding, with the result that the patient's condition was not monitored. The particular complaint about the MBQ is that it took no action against Dr JB 2 and placed no conditions on his right to practice.

Examination of the MBQ's files show the facts to be quite different. The operation was not open surgery but a flexible sigmoidoscopy for the endoscopic removal of a lesion which was in fact cancerous. The patient died at the Royal Brisbane and Women's Hospital on the morning of 12 December 2008. Doctors at the hospital referred the conduct of the operation to MBQ which promptly investigated it. The notification to MBQ was made on 18 March 2009 and was passed immediately to Ms Barber for assessment. Disciplinary proceedings were commenced on 25 May 2010. On 20 January 2012 the Deputy President of QCAT ordered that Dr JB 2 be reprimanded but

that the reprimand not appear on the public register. On 29 February 2012, QCAT ordered that Dr JB 2 be released from the undertakings he gave on 22 July 2009.

The reason for the imposition of the particular disciplinary sanction was that Dr JB 2 had voluntarily accepted restrictions on his practice when MBQ first looked into the matter, and he had undertaken a course of training to better equip him to perform such operations in the future. By the time the matter came before QCAT he had successfully completed the training and demonstrated his competence and fitness for unrestricted practice within the fields of his registration.

The assertion that MBQ took no action in respect of the complaint against Dr JB 2 is wrong.

In addition to the written complaint, Ms Barber told me in interview that when she raised the case with Dr Woodruff (then a board member of MBQ, now chairman of QBMBA) he said no action could be taken against the doctor because 'he had only killed one person'. Dr Woodruff had no recollection of making the remark. Significantly, a remark to similar effect was made to Ms Barber by A2 one of the practitioners at the Royal Brisbane and Women's Hospital who attended a meeting where it was decided to refer Dr JB 2's conduct to MBQ. According to her file note of the conversation, Ms Barber asked A2 whether his concerns about the case were sufficient to restrict Dr JB 2's practice pending the outcome of the investigation. The doctor's response was 'that should not happen as the result of one case... (which) may not reflect his general practice'. A fair inference from the material is that Ms Barber has exaggerated A2 remark, and attributed it to Dr Woodruff. The effect was to increase the seriousness of this complaint against MBQ.

The evidence that Dr JB 2 had, when told of the patient's death, said that he thought he might have nicked the bowel is much more equivocal than Ms Barber contended.

I include as *Attachment 4* to this report, a comprehensive analysis of the particular complaint and the facts established by documentary evidence obtained by the MBQ in the course of its

investigations. A review of that material does not support the allegation the MBQ should have, but did not, refer this matter to QPS for investigation and possible prosecution.

The analysis does show, however, a substantial delay in bringing the disciplinary complaint before QCAT. The result of the delay was largely to pre-empt any outcome other than the one imposed because of what had occurred by way of rehabilitation in the interim. While the individual result might not have been unjust either to the public or to the practitioner, the disciplinary process was allowed to drift and was not actively pursued by MBQ and AHPRA/QBMBA.

Registration and disciplinary responsibilities

The great majority of Ms Barber's complaints about the registration and failure to discipline doctors were aimed at MBQ which was responsible for both functions and, in her view, 'totally failed' to discharge both responsibilities. MBQ was established pursuant to the *Medical Act 1939* (repealed) and ceased to exist on and from 30 June 2010. Since then a national registration and accreditation scheme for medical practitioners (and other health professionals) has operated. Ms Barber's complaints relate entirely to the former MBQ.

The new scheme was established by the *Health Practitioner Regulation National Law Act 2009* (National law) which provides for the creation of national boards and state committees to which the national board may delegate its functions. The national scheme is said to be 'more robust and include more stringent public protections than the laws and regulatory system' that predated it. Relevantly, there is a Medical Board of Australia the members of which are appointed by a council of state and territory Ministers for Health. The relevant committee in Queensland is the Queensland Board of the Medical Board of Australia (QBMBA). Appointments to QBMBA are made by the (Queensland) Minister for Health. Most of the members of MBQ were appointed to QBMBA but the chair of MBQ was not, and QBMBA has a new chairman. The National law also established a national agency, AHPRA, whose function (Section 25 of the National law) is to:

a) Provide administrative assistance and support to QBMBA (and the other state and territory boards).

b) Develop and administer procedures for the efficient and effective operation of the national board.

c) To establish procedures for the national registration of practitioners.

d) To administer applications for registration as a health practitioner.

e) To establish an efficient procedure for dealing with notifications (complaints) against practitioners.

The national board is responsible for setting national standards and policy, including standards for the registration of general medical practitioners and specialists. QBMBA acts under delegation from the national board. It receives and deals with applications for registration within Queensland and complaints against practitioners in Queensland. Applications for registration are dealt with on the basis of the national standards which apply Australia-wide.

AHPRA has an office in each state and territory. It provides personnel and services to enable QBMBA to deal with applications for registration and notifications about practitioners. Each office has a state (or territory) manager with overall responsibility for AHPRA's functions within the state or territory. Ms Anne Morrison, who is the Queensland State Manager of AHPRA did not work for or play any role in the superseded MBQ. Ms Kaye Pulsford, the CEO of the Office of the MBQ between July 2007 and June 2010 did not transfer to AHPRA.

The National law speaks of notifications not complaints. The choice of terminology is deliberate to reflect the fact that the state and territory boards act to protect the public and not to adjudicate upon complaints. Notifications, which may be made by anyone, are received by AHPRA on behalf of QBMBA. The National law requires each state board and the relevant health complaint entities in that state to share complaint notifications and agree on how best to deal with them. In Queensland

it is HQCC which, consequent upon that obligation, signed a memorandum of understanding with AHPRA in October 2010.

A feature of the national scheme is mandatory notification. The National law requires practitioners and their employers to report 'notifiable conduct' to AHPRA. Notifiable conduct occurs where a practitioner has practised while intoxicated; or engaged in sexual misconduct in connection with practice; or placed the public at risk of potential harm because the practitioner has an impairment or because he/she practised in a way that constitutes a significant departure from accepted professional standards. A practitioner or his/her employer who forms a reasonable belief that another practitioner has engaged in notifiable conduct must report it to AHPRA as soon as practicable.

AHPRA is funded from registration fees set by the national board and paid by medical practitioners and other health professionals. Since the introduction of the national scheme, fees have been increased substantially to provide additional funding to enable AHPRA to perform its role of support to the state and territory boards.

The point of this recital is to explain that the new QBMBA, and AHPRA, function differently with different personnel and different resourcing to the former MBQ. Ms Barber's experience as a complaints assessment officer and as an investigator with MBQ, and her complaints about the manner of its functioning are limited to the historical context. She displayed no knowledge of how QBMBA or AHPRA presently discharge their functions. In deciding whether it is appropriate to recommend any investigation into the complaints against MBQ, it is of particular relevance that it no longer exists and entities with enhanced powers, increased administrative support and financial resources have taken over its role.

In a written response to Ms Barber's concerns, the Chairman of QBMBA, Dr Woodruff, wrote:

> 'A National Registration and Accreditation Scheme (NRAS) has been operating in Australia since July 2010. This new scheme ... includes more robust and stringent public protection than the laws and regulatory system previously in place. Some of the new measures include mandatory reporting requirements ... '
>
> 'The Medical Board of Australia takes seriously all concerns about registered medical practitioners. One of the key objectives underpinning the National law and the work of the MBA and AHPRA is to protect the public.'

An MBA media release on 25 April 2012 stated that:

> 'The Medical Board of Australia takes seriously all concerns about registered medical practitioners and encourages anyone with concerns about a practitioner's conduct to raise these issues with the Board. The core role of the Medical Board of Australia is to protect the public.'

Having spoken to Dr Woodruff and Mrs Morrison, I see no reason to doubt the sincerity of these statements. Whether the intention is matched by performance is something to which I will return.

I interviewed Ms Lisa Pritchard who is presently the Director of ESU but for some time was Director of the Professional Standards Unit at MBQ. Ms Pritchard impressed me as a woman of common sense, competence, frankness and professionalism. She does not support Ms Barber's criticism of MBQ and rejects the notion of systemic failure to investigate and discipline medical practitioners. It is, I think, significant that Ms Barber, who reported to Ms Pritchard when she was employed at MBQ, makes no criticism of her and in interview with me expressed confidence in Ms Pritchard.

Ms Pritchard provided me with some statistics for the last year in which MBQ operated. In 2009/10 MBQ:

- received 508 new complaints (up from 394 in the previous year)

- assessed 469 complaints (up from 325 in the previous year)
- issued 14 warning letters and referred 63 matters for investigation
- had 205 complaints under assessment and completed 82 investigations of which 30 resulted in disciplinary proceedings
- dealt with 101 ongoing investigations
- commenced monitoring 29 medical practitioners and completed the monitoring of a further 20. In the course of the year 80 medical practitioners were monitored.

The tale told by these figures is not one of an organisation that did not deal with complaints, or hid them. The figures suggest a degree of activity in responding to complaints.

In addition to her allegation of unresponsiveness to complaints, Ms Barber asserted that the registration of doctors was lax and the enforcement of conditions imposed on doctors was perfunctory or nonexistent.

The point was made to me by both Ms Pulsford and Ms Pritchard that Ms Barber was employed by MBQ as a complaints assessment officer and as an investigator. She was not involved in MBQ's registration procedures or the monitoring of practitioners subject to conditions. Her capacity to observe these activities was limited.

Ms Pulsford told me that in the three years in which she was CEO of the Office of the Medical Board of Queensland, a bureaucracy which existed for the three years that she was CEO, she introduced new registration procedures designed to overcome the shortcomings which had existed prior to July 2007 with respect to registration of foreign trained doctors. Ms Pulsford believes that the new procedure and the checks they required, did address the earlier problems. Ms Barber appeared to be unaware of the innovations; at least she did not mention them.

Another initiative undertaken by Ms Pulsford was to reorganise the complaints section of the Office of MBQ into three distinct teams: assessment, investigation and monitoring. Ms Barber was a

complaints assessment officer and later an investigator. The role of the monitoring team was, as its name suggests, to check that conditions imposed on practitioners were complied with. Ms Pulsford told me that the number of team members was adequate for the proper discharge of their role. Ms Pritchard made the same point. She said that there were two officers whose full time duty was to oversee the monitoring of practitioners subject to conditions. The workload was well within the capacity of two officers. Mrs Morrison said the same about QBMBA/AHPRA.

Ms Barber's duties with MBQ did not involve monitoring or registering. She was not in the position to have firsthand knowledge of whether monitoring conditions were or were not satisfied, or whether proper checks and enquiries were made when an application for registration was made. Ms Barber did not provide any specific example of a registration that should not have been made or evidence of a doctor practising under conditions that were not checked for compliance.

I interviewed Dr Richard Kidd, the immediate past President of the Queensland Branch of the Australian Medical Association, to ascertain whether the Queensland members of AMA had concerns about MBQ's discharge of its functions and whether they supported Ms Barber's complaints against MBQ. The enquiry was relevant because medical practitioners are the most frequent class of complainant against other medical practitioners and would be expected to express their dissatisfaction if they thought that their complaints had been ignored or trivialised.

Dr Kidd told me that there was no concern amongst his membership about MBQ. It was regarded as discharging its duties well and striking the appropriate balance between the protection of the public and allowing doctors to remain in practice, for the benefit of the public. Dr Kidd said his members supported the Board's emphasis on the rehabilitation of doctors who were seen to be in need of additional training, or the enhancement of skills. According to Dr Kidd members of the AMA had confidence in the members of MBQ and the way in which it functioned. The only complaints about MBQ that Dr Kidd was aware of had come from doctors who had been subject to its disciplinary processes.

Dr Kidd was likewise unaware of any pattern of failure to enforce conditions of practice or the monitoring of doctors where the conditions or the requirements of monitoring had been imposed by MBQ.

I also caused enquiries to be made of Dr Hambleton, the Federal President of the AMA. He said that he has not received complaints from his members about the failure of MBQ to properly regulate professional standards.

A possible interpretation of the presidents' satisfaction with MBQ is that it generally favoured practitioners in questions of complaints and compliance. That endorsement of MBQ may accordingly offer equivocal support.

A particular point raised by Ms Barber was that the process of registering doctors gave rise to a conflict of interest in that QH needed doctors but the duty of MBQ was to register only suitably qualified applicants. As the Chief Health Officer of QH was a board member of MBQ, this exacerbated the conflict. However, it was pointed out in response that the *Medical Practitioner Registration Act 2001* mandated the appointment of the Chief Health Officer to MBQ. The National law does not contain that mandate, though the Chief Health Officer has been appointed.

Ms Barber's claim that she spoke to MBQ members at their regular monthly meeting to raise her concerns about 'systemic failure' to investigate and proceed against underperforming or misbehaving medical practitioners may be doubted because, as Ms Pulsford pointed out, Ms Barber did not attend MBQ board meetings. She did attend meetings of the Complaints Assessment Committee, some of the members of which were board members, but she did not have the regular contact she claimed. The information available to me provides no support for the contention that MBQ did not investigate complaints against medical practitioners, or sought to conceal them. Ms Pritchard and Ms Pulsford both dispute Ms Barber's contention that she complained to them about MBQ's failures or refusals to investigate and take action against doctors who were the subject

of a complaint. Likewise, there is no evidence to support the allegations that registrations were granted inappropriately in the period subsequent to July 2007, or that conditions imposed on doctors were not monitored for compliance.

In any event Ms Barber's complaints related to MBQ not AHPRA or QBMBA of which she had had no first-hand knowledge. Even if there were some demonstrated misconduct on the part of MBQ officers, it would not be a sensible or appropriate response to recommend an investigation into the practices of AHPRA or QBMBA without evidence that those organisations deserve that scrutiny. It is not right to equate MBQ with the new entities.

I have been given a copy of an opinion by Mr Richard Douglas SC with respect to the amenability of MBQ and QBMBA to the jurisdiction of the CMC. Mr Douglas advised that MBQ was a unit of public administration for the purposes of Section 20 of the *Crime and Misconduct Act 2001* but that the members of that board are not now susceptible to investigation for official misconduct because MBQ no longer exists. Mr Douglas SC also advised that QBMBA is a unit of public administration and is therefore amenable to the jurisdiction of the CMC. He thought that AHPRA was not a unit of public administration.

The activities of MBQ may be subject to a different form of scrutiny but there is a real question whether the resources necessary for such an enquiry should be applied given that it no longer exists, has no functions, and its duties have been taken over by the new entities which function with wider powers, different leadership, better funding and a new regime for registering medical practitioners. The question does not need to be answered unless there be evidence of widespread corruption and/or failure by MBQ to protect the public from medical malpractice or misconduct.

I have found no such evidence.

So far I have dealt with Ms Barber's generalised assertions of widespread failure permeating the whole of MBQ's functioning. I have not yet considered the 18 examples put forward in Ms Barber's

material, amplified by her tape recorded comments, which are said to support her conclusion of systemic failure. Two of the 18 related to QH/ESU and not MBQ. They will be addressed subsequently. Of the remaining 16 examples, two have already been examined in detail, they being the cases of Dr JB 1 and Dr JB 2. I looked at them from the point of view of ascertaining whether Ms Barber was right to contend the doctors should have been referred to QPS. I agreed in the case of Dr JB 1, but there is no basis at all for taking such a course with Dr JB 2. In addition to that separate point Ms Barber relies on the two cases, together with the other 14, to support her proposition of habitual dereliction of duty by MBQ. I have commented on the delay in the case of Dr JB 2.

One feature of Ms Barber's criticisms of MBQ in relation to its investigation into Dr JB 1 should be mentioned. Ms Barber made a particular point of criticising MBQ for lack of powers, or lack of resolve in obtaining necessary information. She wrote in her statement:

> 'The investigation was hampered when (a private hospital) legal advisors got involved and refused to release material to the board to make a thorough investigation ... because the material, they said, was protected by legal privilege – and it was. The powers under the Act for the Board are effectively useless in these cases. Reliance was therefore solely on witnesses / recollection etc without access to records ...
>
> ... without definitive evidence ... because of the ineptness of the Board system. Dr JB 1 had the right to continue practice ... under supervision... '

The factual basis for the criticism is wrong. The records in question were delivered to Ms Barber herself. On 29 August 2007 Ms Barber wrote to (the private hospital). She said, *inter alia* that she required the hospital to give her 'material regarding any investigation the hospital may have conducted in relation to Dr JB 1's treatment of three patients listed below', and the complete original files relating to those same patients.

On 13 September 2007 the hospital replied and attached to its reply 'copies of the three patient files' (Ms Barber) ... requested.' In relation to the request for the hospital's own investigations the letter continued:

> 'An external review was commissioned by Ramsay Legal Services in relation to the three patients you have identified ... Our report was commissioned ... under legal professional privilege for the private and confidential use of Ramsay Health Care and Dr JB 1. It was not intended for use by any other party and as such we do not consent to its release to any other party. It is being provided to you on the condition that any request made under FOI for a copy of this report is referred back to Ramsay Health Care for approval.'

On the same day, 13 September 2007, Ms Barber spoke to staff at (a private hospital). She made a note of the conversations. Her notes show that while the hospital regarded the documents relating to its own investigation into Dr JB 1's treatment of the patients as privileged Dr JB 1's lawyers had asked the material to be released and the hospital had agreed. The letter confirms the arrangement. Another note on MBQ's files records the receipt of the material from (the private hospital) by 21 September 2007.

AHPRA has compiled a summary of the complaints and the actions taken in response to them in the remaining 16 cases identified by Ms Barber. I include the summary as *Attachment 5* to my report. It shows that the complaints were responded to and not ignored or hidden. I *attach* as well an analysis which compares Ms Barber's allegation in each of the 16 cases with the actual processes undertaken by MBQ or AHPRA/QBMBA (*Attachment 6*). The analysis shows that in many instances Ms Barber's allegations misstate the facts and are wrong in substance and detail. They do not support her proposition of 'systemic failure' or show a disregard for the public interest by not taking action against medical misbehaviour.

The analysis does, however, lend some support to Ms Barber's point that some disciplinary outcomes achieved by MBQ/QBMBA do not adequately protect the public, or, putting it differently, are not an adequate response to the complaint. Ms Barber's contention was that few, if any, complaints were dealt with, and as a result of that neglect appropriate outcomes were not achieved. There is, as I have said, no support for that extreme statement, but the analysis does suggest that there have been considerable delays in bringing disciplinary proceedings to completion and some cases in which suitably substantial sanctions were not obtained. This is a matter I address later.

Conduct of the Ethical Standards Unit of Queensland Health

This section of the report deals with two issues relating to this topic:

- Cardiac Unit of Townsville General Hospital
- Bundaberg Base Hospital (including ESU's treatment of 44 complaints)

Cardiac Unit of Townsville General Hospital

This is one of the examples put forward as evidence of systemic failure by QH/ESU/HQCC/MBQ. When looked at it is a complaint against QH and, more particularly, ESU, which undertook an investigation into the closure of the Cardiac Unit. MBQ had a subsidiary involvement in the investigation and does not appear to be the subject of criticism in this instance.

The unit was closed for several months in 2007 as a result, it was said by hospital managers, of intractable interpersonal differences between surgeons and doctors in the unit. These grew to such an extent that it was no longer safe for patients to be operated on. That unhappy episode produced a 491-page report authored by the then Director of ESU, Mr Stephen Hardy, which dealt comprehensively with the numerous interlocking and retaliatory complaints made by the doctors against each other. Included in the report was the result of a separate investigation undertaken by officers of MBQ which looked at complaints of unprofessional practice by some of the doctors. Ms Barber was the MBQ's investigator. The investigation was overseen and reviewed by the CMC. Detective Senior Sergeant Laurie Paul was the reviewing officer. The initial complaints were made

against Dr JB 16.1, an Indian-trained specialist, by colleagues and subordinates who accused him of rude and overbearing conduct. One of the complainants was Dr JB 16, himself an overseas-trained doctor, against whom Dr JB 16.1 subsequently made complaints of professional failings.

Ms Barber's present complaints concerning the Townsville Cardiac Unit are:

> '...it was written off by Queensland Health as personality clashes...it wasn't...there was serious concerns raised about the clinical competency of several of the doctors...including Dr JB 16.2 Dr JB 16...and Dr JB 8...who...is subject to tape 8 of my report. Dr JB 16 was seriously incompetent and was allowed to operate in that way with full knowledge of the administrators...a report ' A3 wrote for his senior advisors in Queensland Health...fails to actually raise any of the clinical competency issues...the serious harm that was being caused to patients and the complaint after complaint that he received...in regards to Dr JB 16 and Dr JB 16.2...its just another case that highlights just how often and how much is hidden by QH...when things go wrong.'

In interview with me, Ms Barber said she had no complaints about Dr JB 16.2's competency.

In his letter of 26 April 2012 to the CMC, Mr Messenger wrote:

> 'After Jo Barber...began asking questions about the basic medical qualifications and competency of the allegedly dangerously incompetent surgeon (Dr JB 16) he was reportedly given more than $100k and flown out of the country.

a) Can the CMC verify and guarantee the medical qualifications of Dr JB 16?
b) Was he given a certificate of good standing by QLD Health, so that he could continue his medical career overseas?
c) Where is he practising now?
d) Who authorised Dr JB 16's flight out of the country and the payment to him?

e) Will the CMC support an audit of the mortality and infection rates of patients of the Townsville Cardio Thoracic Unit prior to its closure?'

It does not appear that Dr JB 16's qualifications (as distinct from his competency) were ever the subject of complaint before Mr Messenger's recent letter and Ms Barber's statement of 21 April 2012. The relevant finding of the MBQ investigation (which Ms Barber claims to have undertaken herself) was that there was sufficient evidence to justify disciplinary action against Dr JB 16 for unsatisfactory professional conduct in that he:

> '... routinely tremored when undertaking scheduled tasks, failed to exhibit a satisfactory level of anatomy and medical knowledge, demonstrated poor aseptic technique and poor suture technique; and harvested saphenous veins in a traumatic fashion due to poor surgical technique. Further... (he) demonstrated a lack of skill and care'.

There is also a finding that he behaved unprofessionally in that he refused to work with a consultant surgeon despite never having met him, and made allegations of clinical incompetence against another doctor as reprisal action for that doctor's poor assessment of Dr JB 16's competence.

Six complaints against Dr JB 16 concerning his conduct as an employee of QH were not made out.

According to the ESU report, Dr JB 16 obtained his basic medical qualifications from Charles University in the Czech Republic in 1998, and gained further qualifications in South Africa. He obtained 'an area of need' registration with MBQ on 12 January 2006. It appears his registration to practice medicine in Australia did not occur in Queensland. He practised in Tasmania before moving here. Two surgeons at the cardiac unit of the Royal Hobart Hospital recommended him for the Townsville position. There is nothing in the MBQ report, or the ESU report or the QH employment files, to indicate that his qualifications were doubted.

I have spoken to Detective Senior Sergeant Paul whose recollection is to that effect. Detective Paul told me that Ms Barber made no complaint to him that officers of QH were attempting to conceal

relevant information, or produce a report uncritical or less critical of QH than the facts warranted. Mr Hardy to whom I also spoke denied any such concealment, or that he had been approached by any officer of QH with a view to concealing material or producing a result uncritical of QH. He rejected the suggestion out of hand. Mr Hardy no longer works for the Queensland Public Service and is free to criticise QH.

The suggestion that Dr JB 16 caused serious harm to patients appears to be an overstatement. There are two well documented episodes in which Dr JB 16 displayed inadequate surgical skill. In neither was the patient harmed. Dr JB 16 operated as part of a surgical team and any deficiencies or errors he made were detected and he was replaced in the performance of the task by someone competent. Dr JB 16.1 who was put forward as a critical witness by Ms Barber does not, in his statement, allege that Dr JB 16 actually caused harm to any patient.

The assertion that A 3 the hospital administrator, failed to raise an issue of incompetency is difficult to reconcile with the fact that an allegation against Dr JB 16 of medical incompetence was raised, investigated and substantiated by MBQ.

Dr JB 16 has not practised in Queensland since February 2007. He resigned from Queensland Health on 11 January 2009 and ceased to be registered to practice on 10 February 2009. My enquiries have found no support for the sensational allegation that he was paid in excess of $100,000 (or any amount) and flown out of the country. What appears to have happened is that he left Queensland, at his own expense, to return to Canada where he had lived before coming to Australia. He was a Canadian citizen. He did not return despite correspondence from QH pointing out that his failure to return was a breach of his employment contract. He was paid only what his contract entitled him to.

I asked Mr Messenger by email on 19 June 2012 to provide information in support of his report that payment was made to Dr JB 16, and whether any questions were in fact raised about his qualifications prior to the recent correspondence. He did not answer the questions.

One other aspect of the investigation into the Townsville Cardiac Unit should be mentioned. It emerged from an interview with Dr Kane who is now retired but who at the relevant time was president of Salaried Doctors Queensland, an organisation which represented Dr JB 16.1 in his dispute with QH. Dr Kane was (legitimately) concerned about the length of time the ESU investigation took, and he saw the delays in producing the report as unreasonable.

His concerns were compounded when in early 2010 the investigator and author of the report, Paul Grainger, who had promised to produce it by late December 2008 suddenly left ESU. The work of producing the report passed to Mr Hardy, the then Director of ESU. Despite assurances that the report was close to finalisation in December 2008 it was not delivered until April 2010. Dr Kane was suspicious that the delay and the replacement of the report's author might indicate that officers of QH were concerned that Mr Grainger's report would be critical of it and so manipulated his removal and replacement with a more compliant Mr Hardy.

The suspicions are unjustified. Mr Grainger left ESU to take up a position with the Independent Commission Against Corruption in New South Wales. His departure was voluntary, motivated only by his desire to change employment. When he left, his investigation was substantially incomplete (despite the optimism he had expressed as to the likely completion date of the report) and Mr Hardy was faced with the substantial task of addressing the evidence and complaints Mr Grainger had not completed. It took a considerable time. Mr Hardy adamantly rejects the notion that his investigation was influenced by any officer of Queensland Health (or anyone else). The report was, he said, the result only of his own assessment of the evidence obtained during the course of the investigation.

I see no reason to doubt Mr Hardy's statement. There is no evidence to the contrary. Mr Grainger has corroborated the circumstances of his leaving ESU.

Mr Hardy's report when ultimately received was extensively reviewed by the Acting Director Integrity Services of CMC. With some minor criticisms the findings were endorsed. The CMC was

particularly critical of the delay in producing the report, noting that initial complaints were received in early November 2007 but the report was not completed until April 2010 and was not received by the CMC until June 2010. In letters of 15 September 2010 the Acting Director criticised the delay and the conduct of managers at the Townsville Health Service District who had permitted a situation to develop in which the surgeons at the unit were incapable of working together and cooperate in the patients' interests.

On reading the reports and correspondence, one sees a sorry tale of egotistical collisions developing into malice; bad and inadequate management which let the problem escalate; spitefulness by administrators towards the doctor blamed for initiating the dispute; and unchecked bad behaviour all round. The public was poorly served. Dr JB 16.1 was shabbily treated but did in the end obtain some justice by an order of compensation from the Industrial Relations Commission. Ms Barber is, I think, mistaken when she asserts that poisonous personal relationships between doctors was not the reason for the closure of the unit. It seems clearly to have been the case. Management was rightly blamed for allowing the petulance to go unchecked.

I have not seen any evidence which supports the thesis that the cause of the closure was Dr JB 16's lack of qualifications and/or incompetence and that he was hurried out of the country with a substantial payment in order to conceal MBQ's mistake in registering him and QH's mistake of employing him. I have set out the facts as they appear in the files. I can see no justification for a further enquiry into the closure of the Cardiac Unit. The matter has been thoroughly investigated and no purpose would be served by a rehearsal. Most of those involved in the hospital administration at the time and in the Cardiac Unit have left QH and the state. The allegations now made by Ms Barber and Mr Messenger were not made at the time and find no support in the evidence available to me.

Bundaberg Base Hospital

There are two subjects of complaint in relation to the Bundaberg Base Hospital (BB Hospital). One relates to the manner in which a number of complaints made by a nurse at the hospital, A4 A4 were dealt with by QH. Ms Barber describes her email correspondence with A4 in March this year as the event that prompted her to contact Mr Messenger and seek publicity for the concerns which were eventually the subject matter of her statement and submission. The other, more serious complaint, is that a lack of credentialling of doctors of the BB Hospital was 'covered up' by MBQ which colluded with the then Minister for Health to achieve the concealment.

When Ms Barber's material is analysed one sees four allegations:

1. An internal audit of employed doctors at BB Hospital showed 37 of them 'were not properly credentialled'. Ms Barber was aware of this in 2009 when working at MBQ and raised it with Ms Pulsford the CEO of MBQ, who advised Ms Barber to do nothing and to ignore the lack of credentialling. No investigation was conducted by MBQ. Ms Barber overheard Ms Pulsford say 'she had just been on the phone to the Ministers Office' from which Ms Barber inferred that Ms Pulsford 'was willing to sweep this under the carpet in order to keep the Minister happy'. Ms Barber challenged Ms Pulsford who told her to go back to work. Ms Barber has 'no doubt...whatsoever...the records will show that nothing was ever done by the Board...because of Ministerial pressure'.
2. A4 made about 100 PRIME reports which QH did not pass on to MBQ. QH wrongly told MBQ that the reports 'did not relate to clinical matters' but were instances of non clinical misconduct. All of A4 's PRIME reports did relate to patient harm.
3. Two of the complaints were in fact passed to MBQ but QH 'already had put together evidence to counter claim A4 allegations' of unsafe practice at the hospital.

4. The PRIME reports revealed 'serious and systemic risks to patients ... as a result of poor resourcing of overseas trained doctors' but QH 'hid that evidence from (MBQ) ... they told us that they didn't have other than the two complaints ... of patient harm'.

Allegation 1 is the most serious. It is a distinct category. Allegations 2 – 4 concern the manner in which A4 complaints were handled.

As well as these matters Ms Barber told me in interview that ESU:

a) concealed complaints and evidence

b) attempted to pre-empt the outcomes of investigation rather than investigate things objectively

c) bowed to ministerial pressure to deliver politically acceptable results.

The first allegation, concerning the employment of doctors who were not credentialled; was described by Ms Barber in her statement as '... collusion with the Minister to react a certain way in relation to non-credentialled doctors in Bundaberg.'

Ms Barber's expanded account was:

> 'So when I saw that there was evidence that 37 doctors were not properly credentialed ... I became alarmed and I brought this up ... in a meeting at the Medical Board with my Director and with the CEO of the Board ... saying to them ... we need to involve a registration team and we need to get to Bundaberg ... to find out what's going on ... Now I was asked to leave that room that day ... but as I was leaving I was told that my services wouldn't be needed ... I can ... say that the Board never responded to those allegations ... I was alarmed ... and as I was leaving I heard my Board CEO Kaye Pulsford ... say to me that she had just been on the phone to the Minister's office that morning, the inference ... was that she was willing to sweep this under the carpet in order to keep the Minister happy ...'

Ms Pulsford has no recollection of the conversation with Ms Barber. It was puzzling, she said, because MBQ played no role in the credentialling of doctors. It was involved in registering medical practitioners but not in credentialling. A failure by a hospital to ensure that its doctors were properly credentialled would not have come within the MBQ's jurisdiction, although an individual doctor's neglect or refusal to obtain credentialling may have been a proper subject for the MBQ's attention. MBQ had no responsibility for credentialling doctors and no role to play in the failure by BB Hospital to ensure its doctors were properly credentialled, or to address the problem when it was discovered they were not. MBQ was told of the problem by the Director-General's office which is no doubt how Ms Barber got to hear about it.

Credentialling differs from registration. Credentialling defines the scope of clinical practice a medical practitioner may undertake by reason of qualifications and experience. It is a means of ensuring the quality of the service provided by the practitioner. QH policy requires periodic re-credentialling of practitioners at regular time intervals as well as where there is a change of circumstances of practice.

To ensure compliance with its credentialling policy, QH commissions periodic audits by independent third parties of doctors employed in various health districts. An audit of the BB Hospital by a national firm of accountants was scheduled for 2009. In anticipation, the management of BB Hospital commissioned an internal audit, conducted by Doctor Smart, in January 2009. He was asked to evaluate the status of credentialling at the hospital, compliance with the QH policy and to identify any corrective action that might be needed. His audit revealed that 37 employed doctors were not currently credentialled. In most, if not all, cases the lack was due not to inadequate qualification but to administrative error in the process of renewing or issuing credentials. Doctor Smart recommended the urgent credentialling of the affected doctors on an interim basis to allow them to provide the services they were employed for and the urgent formal credentialling once 'all supporting documentation has been collated'.

About a week later the CEO of Wide Bay Health Service District asked Doctor Newland to provide advice on the status of the credentialling at BB Hospital. She reported on the history of amalgamations of health districts and changes to policy which went some way to explain the administrative lapses which led to the lack of credentialling. Doctor Newland made 15 recommendations to address the problems. In May 2009 Queensland Health commissioned an audit of doctors' credentialling in the Wide Bay Health Service District by the Patient Safety and Quality Unit of the Central Area Health Service. The audit report contained a substantial number of recommendations to avoid a reoccurrence. On 11 February 2009 QH advised HQCC that as a result of a review of credentialling at BB Hospital 'issues had been identified'. HQCC then served a notice on QH pursuant to section 123 of the HQCC Act requesting relevant documents. These were provided and reviewed. The consequence was the issue of report by HQCC on 20 July 2009, 'Compliance with the Health Quality and Complaints Commission Act by Queensland Health at Bundaberg Base Hospital.' The report is extensive and addresses in detail the errors and oversight which led to the lack of credentials of medical staff. The report can be accessed on the HQCC website.

The report was critical of QH in several respects. It, too, made a number of recommendations for improved process. One of the criticisms was that managers at BB Hospital had wrongly advised Central Area Health Service that its 95 medical officers were appropriately credentialled. Given the findings by Doctor Smart and Doctor Newland, 'this could not have been correct'.

A result of that observation was that charges of official misconduct were brought against the District Manager Wide Bay Health Service District and the Executive Director of Medical Services at BB Hospital. The charge against the District Manager was not substantiated, but that against the Executive Director was upheld. The findings by the ESU investigator were endorsed by the ESU Director and the Director General of Health in January 2011.

This recital shows that Ms Barber's allegation that the circumstance that uncredentialled doctors were working at BB Hospital was concealed is completely wrong. On the contrary it was revealed by the hospital itself, reported to QH and by it to HQCC and was the subject of an audit report by QH, a report by HQCC and an investigation into official misconduct.

The complaints made to me in interview that ESU concealed complaints and acted in accordance with ministerial direction to produce desired outcomes are, I think, a product of Ms Barber's misunderstanding of how the credentialling problem at BB Hospital was handled. What emerges from the history of the affair is that MBQ was not involved, for the reasons I have explained. It had no role to play. Ms Barber appears ignorant of what actually happened and is mistaken about Ms Pulsford's role and the Minister's involvement.

The allegations last mentioned, those made in interview, were adamantly rejected by Mr Hardy and Ms Pritchard in their conversations with me. Mr Hardy was the Director of ESU when Ms Barber worked there. Ms Pritchard succeeded him. Both deny any ministerial interference or intimation as to what outcome was desired from a particular investigation. Both rejected suggestions that complaints were ignored or preordained results were achieved.

Given the emphatic refutation of these allegations by Mr Hardy and Ms Pritchard, both of whom impressed me as reliable and competent, I do not consider they warrant any further investigation. Ms Barber's mistaken belief of ministerial involvement in the credentialling question has, I suspect, led her to believe it occurred more generally. She has not produced any evidence that it occurred at all.

I now consider the other complaints about the ESU concerning A4

On 29 January 2009, A4 attended the offices of the CMC in the company of Mr Messenger MLA and Mr Dempsey MLA and reported her concerns about a number of incidents at the BB Hospital. Several investigations occurred as a result. Professor Peter Brennan conducted a review of

the Department of Emergency Medicine and reported in February 2009. Dr Steven Ayre reviewed PRIME reports made by A4 and the response to them by BB Hospital staff. Ms Lisa Todd, an investigator with ESU, conducted two other investigations. Ms Todd had formerly been an investigator with MBQ and knew Ms Barber personally. When Ms Barber transferred to ESU in July 2010 she again worked with Ms Todd. The two had been friendly but there are now differences between them. I have borne that fact in mind when considering what Ms Todd told me. The investigations were by the Wide Bay Health Service District but because of a lack of qualified staff they were in fact undertaken by Ms Todd who was seconded to the District for that purpose.

The first investigation was into three allegations; that a nurse in a senior position improperly influenced other nurses to enter false data on hospital information systems; staff members, not nurses, were directed to triage patients and staff members were directed to treat patients. On 25 February 2009, Ms Todd delivered her report finding that the complaints were unsubstantiated.

The second investigation was into A4 complaints. It took place in 2010. It was longer and more complicated than the first. The complaints were analysed in three categories: issues concerning the Department of Emergency Medicine at the BB Hospital: issues concerning the surgical ward; and Human Resources issues concerning A4 herself. A report 256 pages in length was delivered in November 2010.

Ms Barber had moved to ESU in July 2010 and gave Ms Todd some assistance in the second investigation. Ms Barber worked at ESU for 4 months only, July to October 2010. At the time she was in poor health and frequently absent on sick leave. Her attendances at the office were rare. Her capacity to observe the matters that became the subject of her complaints was limited.

The second allegation (see p. 7) is that A4 lodged more than 100 PRIME reports all of which related to patient harm, which were not passed on to MBQ. The allegation shows a misunderstanding of the nature and function of PRIME reports. PRIME is a system of reporting used

to collect data to support QH's incident management policy and its clinical incident management implementation standard. PRIME is used for two purposes — to report, investigate and manage complaints from patients; and for collecting analysing and reporting information on clinical (i.e. patient) incidents, both potential and actual. The present allegation concerns clinical incidents which are defined as:

> 'any event or circumstance which actually or could reasonably lead to unintended and/or unnecessary mental or physical harm to a patient ...'

The reporting policy required any staff member who became aware of a clinical incident to notify his or her immediate supervisor as soon as possible. The supervisor was to analyse the incident by reference to a scoring system and, depending upon the score, take appropriate action. The action taken would depend, obviously, on the nature and seriousness of the incident. It is clear from the policy that PRIME reports did not ordinarily go to MBQ. The PRIME system is not a complaint system, it is a patient safety mechanism. The subject matter of the report might or might not indicate unprofessional or unsatisfactory professional conduct by a medical practitioner. A PRIME report may initiate events culminating in a complaint to MBQ in which case the contents of the report might be evidence in support of the complaint.

Dr Ayre's review revealed that A4 had made 64 PRIME reports: 43 relating to the Emergency Department and 21 to the Surgical Ward. 55 of the reports had a subject matter which was reasonable to report. Only about a third of them related to clinical incidents. The others contained allegations of staff misbehaviour. A4 chief complaint about the PRIME reports was that none had been responded to. Dr Ayre found that there was a response to all but one of the reports.

Dr Ayre's findings were incorporated into Ms Todd's report.

This second allegation is without substance. It involves a misconception about PRIME reports and overlooks the relevant evidence.

The third allegation is nonsensical. There was an interagency meeting on 6 February 2009 involving ESU, HQCC, MBQ, QH and the Queensland Nursing Council to decide how to respond to A4 complaints. It was held at the offices of HQCC. Ms Barber attended for MBQ. Those at the meeting decided that two of A4 complaints should be referred to MBQ. They were that staff at BB Hospital had failed to transfer an elderly male patient to a bed in a ward leaving him on a hospital trolley on which he died; and an alleged assault on an 18-month-old child by an employed doctor. Ms Barber's allegation is that when the complaints were referred to MBQ, QH had 'already put together evidence to counter claim A4 allegations'. The complaint is silly because an investigator must look at all relevant evidence not just that which supports a complaint. It is not a sensible criticism to say that QH passed on information which cast doubt on the veracity of the complaint. In fact the investigator was Ms Barber herself who in an email to Ms Todd on 6 February 2009 advised that there was insufficient evidence to take action on either incident.

The fourth allegation was that 'systemic harm' was being caused to patients in the Emergency Department of BB Hospital. This was the subject of Professor Brennan's report which does not support the assertion that harm was caused to patients by reason of 'overseas trained doctors ... (who) didn't know what they (were) doing'.

Ms Barber's statement refers to a meeting 'involving senior staff at Queensland Health ... and from ESU (Stephen Hardy and Lisa Todd) and watched as they told MBQ and HQCC that A4 had no credibility and her complaints were without substance. Staff from the DG's office attended ... and the Minister (or someone from his staff) was also in attendance ... by telephone' Ms Barber also stated that later she heard Ms Todd describe A4 in derogatory terms and 'conspire with Bundaberg Hospital administrators ... to sweep her allegations under the carpet.'

Ms Todd believes the meeting occurred on 18 February 2009 at QH. Members of the Minister's staff were physically present. Dr Brennan and the CEO of Wide Bay District attended by telephone. Ms Todd confirms that A4 complaints were discussed. This was at a time when the first investigation was nearly complete and substantial work had been done on the second investigation. Dr Ayre's review was also well advanced. Any comments about A4 as a complainant were made with the knowledge then available.

Ms Todd rejects the suggestion that she conspired with staff at BB Hospital to dismiss A4 complaints. The length of the report and its history supports her rejection.

A draft of the second report was sent to A4 She responded with a 125-page letter taking issue with much if not all of the draft report. The report was completed and delivered in November 2010. On 11 July 2011 A4 complained to the Parliamentary Crime and Misconduct Committee (PCMC) about the CMC's conduct in relation to the ESU investigation. She contended that the CMC should itself have undertaken the investigation of her complaint. The CMC, by Mr Strange, Acting Chairperson, provided a detailed response to the PCMC by letter 17 January 2012. Mr Strange concluded:

> 'At a first meeting of CMC staff, A4 made a large number of allegations which required detailed examination by Queensland Health and the HQCC, with the investigation produced by Queensland Health requiring review by the CMC. The exhaustive enquiries undertaken by the agencies led to a protracted process that was made more difficult for the complainant by her misapprehension about, for example, the role of the CMC, the nature of evidence and the availability of investigation reports.
>
> My review of the records did not uncover any significant issues with the CMC's actions. Although on one occasion there was a delay ... it was explained by the circumstances.

Despite A4 views there are no further options available to the CMC to advance her concerns.'

On 13 October 2010, ' A4 emailed the then Chairman of the CMC complaining at length of what was said to be many substantial flaws in the ESU investigation. The Acting Director of Integrity Services replied briefly by letter of 20 October 2010. A comprehensive reply was sent under the hand of the Chairman by letter of 12 April 2011. It dealt in detail with the points raised by A4 The letter concluded:

'In the CMC's view the final report satisfactorily addresses all the concerns raised by A4 and her response to the Interim Reports.

The evidence does not support any finding of Official Misconduct or other conduct warranting consideration for disciplinary action on the part of any Queensland Health members of staff against who A4 has made a complaint.

The CMC is also of the view that there is no evidence of any corrupt or improper conduct on the part of any Queensland Health investigator, or any other Queensland Health officer, in relation to the investigation, which could constitute official misconduct or provide any other grounds for disciplinary action.

Further, there is no basis for the CMC to reinvestigate any of the concerns raised by A4

It is worth noting that in the tape-recorded particulars of the 'cases' provided by Ms Barber she expressed a desire to be interviewed in more detail about ESU's investigation into A4 complaints. As I pointed out, when asked to attend for further interviews, Ms Barber refused and claimed that she had provided all the material necessary to substantiate her allegations.

Ms Barber's complaints are no more than a re-agitation of some of the points which A4 argued with ESU and the CMC over the months in which her complaints were investigated and reported on. They have been looked at, reviewed and reassessed. I can see no point in reopening these old enquiries. There could be no justification for such a course in the absence of cogent material that the investigation miscarried or was tainted by fraud or corruption. Ms Barber expressed her opinions about credentialling without reference to any of the material that I have rehearsed. A4 ; complaints about the investigator and the investigation have previously been made and found to be unsubstantiated.

Subsequent complaints

On 30 May 2012, the MLA for Nicklin, Mr Peter Wellington, wrote to the CMC to pass on confidential information he had received from several persons who had a concern about matters which, according to Mr Wellington, involved seven doctors and four hospitals – two public and two private.

By letter on 21 June 2012, the Chairperson of the CMC asked me to peruse the material provided by Mr Wellington to consider whether it fell within the terms of my engagement, which was to assess whether there was sufficient evidence of systemic failure by any of the authorities regulating medical practice to warrant some type of investigation.

I have read all the material provided by Mr Wellington. Some of the complaints contained in it had been the subject of earlier correspondence sent to me by Mr Messenger.

There are several complaints and numerous complainants, some of whom chose to remain anonymous. I have considered them to the extent that they relate to Ms Barber's complaints of systemic failure by MBQ, HQCC, ESU and QH. Only three of the complaints fall into that category. Two express dissatisfaction with HQCC. One of those, mentioned particularly by Mr Wellington, involves extensive delays into finalising a report into the death of the complainants' family member. The delay is long and must be a legitimate source of anxiety and frustration. It should be addressed

urgently by HQCC and/or the coroner but it is not indicative of widespread or systemic failure by HQCC to investigate complaints. The delay seems to be bureaucratic in origin and to involve the Coroner's office as well.

The second complaint is by a disgruntled former patient of a medical practitioner who was dissatisfied with the service he received. His complaint to HQCC was investigated and dismissed. He is dissatisfied with the outcome, but again the circumstance does not indicate systemic failure by HQCC to deal with the complaint, or a failure of its processes.

The only other material that might have relevance to my assessment came from Doctor Peter Herbert who provided information at the request of Mr Messenger and Ms Barber. Doctor Herbert has made numerous complaints over a number of years about the conduct of the Psychiatric Ward at (a private hospital) and Doctor PW 2, a doctor employed in that ward and about Doctor PW 4 and Doctor PW 5, both doctors with Visiting Medical Practitioner Accreditation at the hospital. He has made allegations of widespread Medicare fraud, unlawful homicide and infliction of bodily harm on patients. The information was not in a form which allowed it to be readily assessed, so accordingly I requested Doctor Herbert to provide copies of his notifications and complaints to AHPRA about Doctors PW 4, PW 2 and PW 5. (His complaint about Doctor PW 1 appeared to be that he had committed homicide, a matter beyond my authority and capacity to investigate. Accordingly I asked QPS to be informed and invited a detective to interview Doctor Herbert about Doctor PW 1.) Doctor Herbert replied promptly to say that he could not easily provide comprehensive details of his approaches to the regulatory agencies and their responses, and suggested I contact the agencies directly. That had already been done, and I include as *Attachment 7* a schedule of the complaints and responses by AHPRA concerning doctors who were the subject of complaint from Doctor Herbert and others at the Sunshine Coast.

The pattern here is the same as with the doctors identified by Ms Barber. There were complaints, or notifications, which were looked into and actions taken which were thought appropriate by QBMBA.

There is no evidence of systemic failure by QBMBA to perform its statutory duty, or a collusive concealment of evidence or notifications.

The conduct of the Psychiatric Ward at (the private hospital) is not within the jurisdiction of the CMC and is beyond the scope of my appointment. Nevertheless the conduct of psychiatrists employed by or who worked at the hospital in that ward has been the subject of numerous serious complaints over a number of years. The complaints are current as is evident from Doctor Herbert's emails and the material given to Mr Wellington. Accordingly I requested hospital management to provide a response to the complaint, advising Mr Royle, the Executive Director of Uniting Care Health, the hospital's owner, that I had no power to compel an answer. His organisation responded cooperatively and I include as *Attachment 8* a letter dated 5 July 2012 setting out Uniting Care Health's response to the allegations. The memorandum may help to allay fears that the hospital has not responded to criticisms and has persisted with unsafe medical practices. I also *attach* a copy of an email to the CMC from HQCC dated 27 June 2012, a copy of a Summary provided by HQCC to the CMC on 6 June 2012 and a copy of a HQCC Internal Report dated 23 May 2012 of the 'HQCC Investigation into the quality of Mental Health Services provided by (the private hospital)' (*Attachment 9*). The detail of the attachments shows that all complaints with a comprehensible content have been investigated, or are being looked into by HQCC or AHPRA. Medicare has been told of the allegation of fraud against it. QPS has sought, unsuccessfully, to obtain details of the criminality vaguely alleged. The complainants, including Dr Herbert, when asked for detail that might be investigated were unwilling or unable to provide it. The repetition of generalities does not constitute particulars. The responses by QBMBA, HQCC, QH and (the private hospital) appear an adequate answer to the complaints.

The material provided by Mr Wellington consists of repeated and repetitious complaints made in apparently exaggerated terms of generalised misconduct. There is a marked paucity of detail. The subject matter of many of the complaints is, and is said to be, hearsay, the particular complainant

disclaiming any personal knowledge of events which might support an investigation or a finding. When pressed for detail or the identification of witnesses who could give first-hand accounts there is a reluctance to cooperate or a retreat into anonymity. It is said that a Sunshine Coast legal practitioner has been given substantial information about medical malpractice. Some of those who have given information to the solicitor are amongst the complainants. The solicitor declines to produce the information because he does not have instructions to do so from his clients. I am ready and willing to undertake an assessment of evidence, but assertions of the kind I have just described are inscrutable.

Discussion and conclusions

It should be apparent from what I have so far written that Ms Barber's alarming complaints of widespread dereliction of duty by MBQ, AHPRA/QBMBA, HQCC, ESU and QH are not supported by the information she provided or by the additional documentary material I have obtained from those agencies, from the CMC itself, and from interviews with current and past officers of the agencies.

The subject matter of my assessment has been Ms Barber's proposition that MBQ and QBMBA have signally failed to protect the public by lax registration allowing inadequately trained doctors to practise; has systematically failed to act in response to complaints about doctors' failures in practice; and has not monitored conditions imposed upon doctors who were found to require oversight or supervision in their practices.

The agency said to be most at fault was MBQ and its successor organisation QBMBA though criticisms were also levelled at ESU and QH. Though it was mentioned no particulars were provided against HQCC.

In the course of my assessment I was given information by Ms Barber and/or Mr Messenger which suggested that individual practitioners were not fit to practise and that some had committed serious

criminal offences. As well I was given some information suggesting that there are serious deficiencies in the running of a psychiatric ward in a private hospital.

These matters are beyond the scope of my appointment. I have been asked to assess whether the information provided, together with information that I have obtained, is sufficient to warrant an investigation into the entities regulating medical practice. Whether individual doctors or hospitals are functioning adequately is not something that I could determine without expert assistance. That subject is not within the jurisdiction of the CMC. Obviously I have no power or authority to investigate crime. When I received information which suggested criminality which had not already been referred to an appropriate investigative authority, I had the information passed onto QPS.

My focus has been on whether there is evidence of widespread or consistent failure by any of the regulatory authorities in their oversight of medical practitioners or hospitals.

In my opinion the information I have assessed does not warrant any further investigation into the conduct of ESU or HQCC or QH. The information available to me does not suggest any misconduct, official misconduct or criminality in any of those authorities with respect to the complaints made by Ms Barber, or by reference to the materials she provided as supplemented in the manner described. My conclusion is limited to the particular task I was appointed to undertake. I have not, obviously, conducted an audit of the activities of HQCC or ESU. One comment about each of those agencies is, I think, justified. It is that the investigations each undertakes are accompanied by substantial delays. This is obviously unsatisfactory and gives rise to understandable feelings of annoyance and frustration in those who have sought redress; and may give rise to a perception that their complaints are being ignored.

The examples of delay I have seen do not appear sinister but are a result of under-resourcing. That complaint was made to me by a number of senior managers in the agencies. For example the ESU, which has only a handful of investigators and assessors receives about 1000 complaints a year. I was

told that complaints are not ignored. When received they are entered on a computer database to which the CMC has access so it is not possible to 'hide' them. The limited number of assessment officers and investigators must mean delays, possibly substantial delays, in investigating matters, and those complaints which appear by comparison less important will be given low priority.

The same comments apply to HQCC and AHPRA.

This is an inopportune time to recommend the implementation of the obvious remedy: the appointment of additional staff. While the human resources available to the regulatory authorities remain at their current level, delays in investigating and finalising complaints must be expected.

A number of Ms Barber's particular allegations are plainly wrong. In some cases elementary enquiries would have shown the falsity of what she claimed. Examples are: her allegation that the CMC, through Ms Mundy, acted improperly in considering her initial complaints; that MBQ took no action with respect to Doctor JB 2; that MBQ or ESU 'covered up' lack of credentials for doctors at BB Hospital; that MBQ did not use its powers to obtain information from (a private hospital); that MBQ did not properly investigate the complaints involving clinical care at BB Hospital.

These errors cast considerable doubt on Ms Barber's credibility as a complainant.

Although I consider that Ms Barber has not demonstrated a basis for her criticism of ESU, and that her proposition that QBMBA has comprehensively failed to maintain adequate standards of medical practice is not justified, some of the information that has come to light during my assessment does raise concerns about the manner in which QBMBA discharges its disciplinary functions. I wish to make it clear that I have seen nothing to support the contention that the registration of medical practitioners is not conducted with appropriate rigour, or that the monitoring/supervision of doctors subject to restrictions or conditions is not adequately enforced; or that complaints of unprofessional conduct, or unsatisfactory professional conduct or professional misconduct, are not considered.

However the information I have gathered does suggest that QBMBA's disciplinary processes are not a proper response, in some cases, to what appears to be the seriousness of complaints.

The concerns arise from a perusal of the summaries prepared by AHPRA, and from discussion with the CEO of HQCC and the State Manager of AHPRA who was understandably circumspect in her comments.

Some examples will illustrate the point. On 1 September 2010 QBMBA received a comprehensive and thorough report into alleged professional misconduct by Doctor JB 1. The contents of the report clearly raised serious questions about Doctor JB 1's fitness to practise and whether he had committed serious criminal offences. The latter question was not addressed in the report. Regardless of the outcome of the QPS investigation Doctor JB 1's activity should have been referred to police. There have been extraordinary delays in dealing with the matter at a disciplinary level. Complaints were made in mid-2007. The investigation and gathering of information was complete in 2008. The report was not delivered until September 2010. It has not yet resulted in a disciplinary hearing and it appears doubtful whether QBMBA will deal with the matter itself or send it to QCAT. QBMBA's power to sanction a practitioner is limited. The question of Dr JB 1's fitness to practise should have been addressed urgently, as well as whether he should have been suspended pending the final decision.

Another example is that of Dr JB 15 / PW 3PW who was the subject of Section 2.5.15 of Ms Barber's statement, although she could not recall his name. A serious complaint was made about him in March 2009 concerning sexual misconduct towards his receptionist whom he also treated as patient, and serious complaints of dangerous medical practices. An investigation commenced on 24 July 2009. A decision to take disciplinary proceedings was only made on 9 December 2011. The matter is still before QCAT.

Dr JB 6, Dr JB 8 and Dr JB 12JB 12 are also cases in which there appears to have been excessive delays. In the case of Dr JB 12JB 12 the Coroner referred the matter to MBQ consequent upon an inquest into the death of a patient at Mt Isa Base Hospital. That was on 19 December 2007. On 14 April 2009 MBQ referred the case to the (former) Health Practitioners Tribunal. It was transferred to QCAT where it remains unheard.

Another example appears in the case of Doctor JB 7.1. His case was referred to QCAT in 2008 and is yet to be resolved. The complaint is serious: that he practised as a cosmetic surgeon at an unlicensed clinic and performed substantial plastic surgery inappropriately, causing significant risk to the patient.

Dr JB 2's proceedings are also relevant.

The last example is that of Dr JB 9. In November 1997 in response to a complaint, MBQ required that the doctor be examined by a psychiatrist who diagnosed a schizoid personality disorder. Dr JB 9 was allowed to practise subject to conditions. In April 2000, as a result of breaches of these conditions, he was examined by another practitioner who diagnosed bi-polar mood disorder; however, he was allowed to remain in practice. In 2002 the MBQ was concerned that Dr JB 9 was physically too unwell to practise. He refused to be examined. In April 2004 MBQ resolved that Dr JB 9 was impaired as defined in the *Health Practitioners (Professional Standards) Act 1999* and invited him to give an undertaking to restrict the manner of his practice. That was done. Meanwhile in July 2003 the Drugs and Dependency Unit notified MBQ that Dr JB 9 had breached the regulations with respect to prescribing controlled drugs. He was nevertheless allowed to remain in practice. In March 2006 MBQ invited Dr JB 9 to give up practice but he refused. In 2007 there were further concerns about his prescription of controlled drugs. Later that year he was suspended and in 2008 voluntarily relinquished his registration having been admitted to a mental hospital as an involuntary patient.

MBQ's response on each occasion when it was asked to consider the matter might have been justified, but an available interpretation of the record appears to be that Dr JB 9 was allowed to practise for over 15 years despite substantial and growing evidence that he was unfit.

This example concerns MBQ, not QBMBA, and the two cannot be equated, as I have explained. I mention it because it appears to be a case of 'light touch regulation' which did not protect the public.

There are other cases, of which Doctor PW 4's is one, in which the Board appears to accept the practitioner's account of things too readily so that notifications are designated unsubstantiated. The notion that a complaint is unsubstantiated where there is a conflict in evidence or opinion is facile. QBMBA in those cases, I consider, has an obligation to resolve the conflict and determine, as best it can, where the truth lies.

A perusal of the case summaries produced by AHPRA suggests the possibility that where several complaints are made over time against the same practitioner, QBMBA treats each as separate and distinct and does not, or may not, consider the cumulative effect of the complaints and the evidence obtained with respect to all. One consequence, noticeable in the cases of Dr PW 2 and Dr PW 4, is that where a complaint had been looked at and rejected and a subsequent similar complaint is made that too was rejected on the basis that the matter had been already looked into. The treatment of Dr JB 9 appears to be a prime example of this approach. Subsequent complaints and the evidence in support of them should be looked at to see whether the initial assessment was correct or should be reassessed. In any event the accumulation of evidence should be considered. This approach is expressly permitted, if not encouraged, by section 54 (3) of the *Health Practitioners Professional Standards Act 1999*.

Understandably investigations undertaken by AHPRA are not intended to determine whether there is evidence that a criminal offence had been committed. In those (hopefully rare) cases where

subsequently it appears that there may have been criminal misconduct, it may be too late for an effective criminal investigation. Consideration should be given to instructing/training AHPRA investigators who uncover what may be evidence of a criminal act by a doctor under investigation to notify QPS promptly so that a separate criminal investigation may, if thought appropriate, be initiated.

The CEO of HQCC advised me that there are occasions where AHPRA's investigations result in a recommendation that a practitioner be disciplined but the recommendation is not accepted by the Notification Advisory Committee. On other occasions the Committee recommends action but QBMBA refuses to act. I was told there are several instances in which AHPRA's recommendations that disciplinary action be taken have been rejected by the Committee and/or QBMBA. The Board's members (and the Committee's) are predominantly medical practitioners. These occurrences are of concern to Ms Herbert.

There are no doubt many reasons why investigations and disciplinary proceedings take time. QCAT itself has insufficient resources for its case load. Investigations have to be undertaken thoroughly, expert opinions and legal advice have to be obtained and the process of deliberation should be considered rather than rushed. Nevertheless, the examples appear to show extraordinary periods of time for dealing with matters concerning the safety of the public.

Although in my assessment there is no evidence of 'systemic failure' in the registration of medical practitioners, or in the investigation of complaints against them, there are indications that QBMBA may not adequately respond to the substance of complaints and may too readily find complaints to be unsubstantiated.

As a result of this assessment, I see no scope for an investigation or prosecution by the CMC, nor do I see any indication of misconduct or official misconduct within QBMBA, HQCC, ESU or Queensland Health with respect to the matters I have assessed. There are, however, actions available to the

Minister for Health, and I ask that the following recommendations be passed on for his consideration.

Recommendations

1. A legal practitioner with extensive experience in criminal law and a reputation for sound judgement be appointed to examine MBQ, QBMBA and AHPRA's files in all cases in which, in the last five years, a disciplinary sanction of some kind has been imposed on a medical practitioner in relation to circumstances in which a patient died or suffered serious bodily harm to determine whether in any such case criminal charges should be laid. QBMBA presently has a legal practitioner as one of its members. I intend and imply no criticism of that practitioner whose expertise is not criminal law.
2. That there be a review of all the cases of misconduct or alleged misconduct by medical practitioners, dealt with by QBMBA or in which AHPRA has recommended disciplinary action against a medical practitioner, including cases in which the Notification Advisory Committee and/or QBMBA rejected a recommendation by AHPRA to take disciplinary action. The review should be undertaken by a panel of three comprising a legal practitioner, a medical practitioner and someone who has served on regulatory boards and has a reputation for decisiveness. The purpose of the review should be to determine whether QBMBA has made timely and appropriate responses to the complaints and recommendations; and whether it is achieving the objectives of the *Health Practitioners (Professional Standards) Act 1999*, set out in s 6, to protect the public, uphold standards of medical practice and maintain public confidence in the medical profession.
3. That when appointments are made to QBMBA, the number of medical practitioners on the Board be reduced and that the number of other members be increased. These would include members with similar qualification to the third member of the review panel in recommendation (2); and a legal practitioner with a criminal practice to bring to the Board

the experience and knowledge mentioned in recommendation (1). Section 36 (5) and (6) provide that at least half of the members of QBMBA must be medical practitioners and at least two must be community members, so there is scope to make the recommended appointments.

4. Section 150 of the National law provides for the exchange of information about notifications between (relevantly) QBMBA and HQCC. Each must notify the other of a complaint received if it relates to the authority of the other with respect to the complaint. By subsection 3, QBMBA and HQCC 'must attempt to reach agreement about how the notification or complaint is to be dealt with...' Subsection (4) provides that if QBMBA and HQCC cannot reach agreement 'the most serious action proposed by either must be taken.' There is, I was told, a degree of uncertainty between AHPRA and HQCC as to the meaning of subsection (4). In particular it is thought to be unclear whether HQCC can insist that QBMBA take disciplinary action when HQCC think it is appropriate but QBMBA does not. The words of the subsection suggest, to me at least, that HQCC may insist upon firmer action in cases where they think it is appropriate. But because there is doubt about the HQCC's powers I recommend that the opinion of the Solicitor General be obtained as to the construction of section 150(4) of the National law. If the opinion is to the effect that HQCC may not insist upon a sanction more serious than QBMBA considers appropriate, then the National law be amended to give it this power.

RICHARD CHESTERMAN AO RFD QC **11 JULY 2012**

Attachment 3

CMC CLASSIFICATION
( ) Highly Protected
( ) Protected
(X) In-Confidence
( ) Unclassified

MEMORANDUM

TO: MR ROSS MARTIN SC
CHAIRPERSON

FROM: RICHARD CHESTERMAN

DATE: 18 May 2012

RE: CONFIDENTIAL - INTERIM REPORT

File No. MI-12-1198

By letter dated 1 May 2012, you appointed me pursuant to *Section 256 of the Crime and Misconduct Act 2001* (CM Act) to make an assessment, and advise you accordingly, of allegations made by Ms Jo-Anna Barber concerning the conduct of officers of Queensland Health (QH), the Ethical Standards Unit of Queensland Health (ESU), the Medical Board Queensland (MBQ) and the Health Quality and Complaints Commission (HQCC), and the Crime and Misconduct Commission itself (CMC). Ms Barber was, between January 2007 and June 2010, an investigator at the MBQ. You have asked me to identify if any of the allegations appear to warrant investigation.

Ms Barber complained that the CMC mishandled an investigation in which Ms Barber was involved into events at the Townsville Hospital Cardio Thoracic Unit 2007–10, and for that reason considers that her allegations should not be investigated by the CMC. Instead she referred the matter to the Parliamentary Crime and Misconduct Committee (PCMC) which, by letter of 24 April 2012 determined to refer Ms Barber's allegations to the CMC for investigation pursuant to *Section 31 of the Public Interest Disclosure Act 2010.*

I understand that my appointment pursuant to *Section 256* is to discharge the referral of the PCMC of 24 April 2012.

Ms Barber's material

There is a statement dated 21 April 2012 consisting of 43 pages supplemented by a CD the contents of which, when transcribed, take up a further 23 pages. This material was given to the PCMC and forwarded by it to the CMC on 24 April 2012.

The index to the statement of 21 April 2012 is inaccurate. There is no content in the statement to match Sections 2.1, 2.2, 2.3 & 2.4 (which in turn identifies 4 subsections) in the index.

There is as well a 'submission' given to me by Ms Barber and Mr Messenger at our interview on 8 May 2012. This submission is not paginated but is divided into eleven topics three of which (7, 8 & 9) relate to complaints of criminal misconduct by a medical practitioner on the Gold Coast, and two (10 & 11) which relate to complaints of misconduct and clinical malpractice by employees at the Townsville Hospital Cardio Thoracic Unit. Delivered with the submission was a CD containing recordings of telephone conversations between Mr Messenger and two witnesses of potential relevance to the criminal misconduct just mentioned; recordings of meetings between Ms Barber, Mr Messenger and CMC officers of 19 and 21 March 2012; supporting information in relation to a complaint made in the statement of 21 April 2012 concerning the Bundaberg Base Hospital; and a record of the initial meeting between Ms Barber and Mr Messenger.

Structure of statement

The statement is in two parts: an introduction and a summary of 18 'examples' of alleged medical malpractice intended to illustrate the general allegations that the regulatory authorities, MBQ, QH and

HQCC failed in the discharge of their responsibilities to ensure that only competent doctors would be registered or allowed to continue in practice.

The introduction to the statement contains serious allegations of incompetence and neglect of duty, but these are so generally expressed and so lacking in specificity as to make any assessment of them impossible. Ms Barber states:

> ... that as a result of a combination of:
>
> 1. Several systemic failures at the MBQ, HQCC and QH; and
> 2. The culture of all these agencies; and
> 3. The behaviour of some individuals within the agencies (for example MBQ and QH Managers and Investigators); and
> 4. The behaviour of some groups collectively (for example QH and the Board in the decision making processes)
>
> Patients across Queensland ... are at risk of being harmed ... as a direct result of incompetent Doctors ... when the incompetence ... comes to light and are reported to either QH, MBQ and/or HQCC they are either not dealt with at all or ... hidden ... MBQ are now AHPRA registers Doctors it knows is not competent to practise without adequate supervision or other appropriately qualified Doctors. Despite placing ... conditions on the registration of the ... Doctors MBQ never monitors ... conditions ... this failure ... led to serious and systematic cases of unsafe Doctors working across Queensland ... I have listed some cases within chapter 2 ... to demonstrate my allegations in this instance.

Despite the inclusion of HQCC in the organisations criticised, none of the material provided makes any particular complaint about it or identifies any of its officers as having failed in their duty or misconducted themselves.

The purpose of the statement is said to be to:

> ... document sufficient details for the relevant persons ... to understand the outline of my allegations ... The report sets out some samples of cases and events to demonstrate the nature of my allegations.
>
> I have a great deal more information to share ... which is so vast I could not possibly write it all down. Once this matter is referred to a relevant agency ... I will make myself available and fully cooperate with the investigation of these matters.

MBQ was abolished as from 1 July 2010. It was replaced by the Queensland Board of the Medical Board of Australia (QBMBA) established pursuant to the *Health Practitioner Regulation National Law Act 2009* which is part of legislation to establish a national scheme for the regulation of health practitioners. The Australian Health Practitioner Regulation Agency (AHPRA) is responsible for the administration of a national scheme and assists and provides services to the state and territory boards of the new Australian Medical Board. Ms Barber asserts that the failings of MBQ have passed to

AHPRA, but none of the material she has provided relates to decision/actions of the new board or AHPRA.

Likewise, despite ESU being named as part of a widespread systemic failure of regulatory authorities, there is only one complaint made about it. That complaint is that ESU failed promptly to respond to allegations about improper medical practices at the Bundaberg Base Hospital (subsequent to the events concerning Dr Patel).Subsequent to my appointment I wrote to Ms Barber inviting her to attend for an interview and provide further information as she had indicated. However, on 4 May 2012 I received an email letter from Ms Barber which expressed doubt about the integrity of the process of assessment I have now to undertake, and expressed reluctance to attend without the satisfaction of conditions it was impossible to comply with. Nevertheless both Ms Barber and Mr Messenger attended the CMC's offices on 8 May 2012 and were separately interviewed. The topic of conversation with Mr Messenger was his complaints about the CMC's handling of Ms Barber's allegation. The interview with Ms Barber was more extensive. It proceeded cordially and at its conclusion we identified four topics which were the subject of her material and which she wanted addressed. They were:

1. That two doctors remained in practice despite some evidence that each, through neglect or deliberate misconduct, had killed patients. (The case of one of these doctors has been addressed in Interim Report 2 delivered to you on 17 May).
2. That the CMC's involvement in the investigation/assessment of her complaints had been inadequate.
3. That the registration and disciplinary responsibilities of MBQ, which had been subsumed by QBMBA, were not being performed any better by the new organisation than they had been by MBQ.
4. That ESU had not properly investigated matters reported to it, had concealed evidence of wrongdoing by employees of QH, had disregarded complaints made to it, and had preordained the outcome of investigations.

At the conclusion of the interview, Ms Barber agreed to meet with Detective Inspector Byram in order to produce a more coherent, organised and detailed set of complaints/allegations, the seriousness and substance of which could be assessed more easily. Mr Byram was subsequently unable to make contact with Ms Barber to arrange further meetings. I emailed her on 11 May 2012 requesting her cooperation. She replied on 14 May 2012 asserting, in essence, that the material already provided was sufficient for the purposes of my assessment and declined further assistance save for the provision of an organisational chart of MBQ in her time as an investigator.

Similarly, an email request to Mr Messenger for a coherent account of his complaints against the CMC resulted in a refusal. Mr Messenger has not answered my subsequent email correspondence.

I have commenced an assessment of the material provided and have had regard to CMC's file in relation to:

1. the investigation into the Townsville Hospital Cardio Thoracic Unit
2. the recent approach by Ms Barber to the PCMC and the CMC, which had generated a complaint about the latter's conduct of her allegations.

I will not be able to complete my assessment before I leave for overseas on 23 May 2012. We discussed my absence prior to my appointment. I will return on 11 June 2012. I have addressed two of the four subjects identified in interview with Ms Barber as a matter of priority. The other subjects are not, I think, urgent. The two addressed are the complaint that officers of the CMC behaved improperly, and that a medical practitioner has committed homicide and/or attempted homicide and should not be allowed to practise.

Complaints against the CMC

There are two complaints against the CMC. The first concerns the CMC's response to the statement. The second concerns an alleged failure by the CMC to pass on to Ms Barber, who was then investigating numerous complaints and cross complaints by doctors in the Townsville Cardio Thoracic Unit against each other, relevant information which was given to the then Chairperson by Mr Messenger.

Alleged mishandling of recent complaint

There are three components:

a. Delay in responding to the complaint about Dr JB 1
b. Intimidation and threats made by the Assistant Commissioner Misconduct to Mr Messenger
c. Appointment of an officer with a conflict of interest to process the complaint.

a. The allegations concerning Dr JB 1 appear in the Statement of 21 April delivered to the CMC on 24 April. The material raised a concern about Dr JB 1's fitness to continue practice, but did not suggest any particular urgency, nor that he posed a present risk to the life or health of patients. That complaint was made in interview on 8 May and has been repeated by Mr Messenger in subsequent correspondence, in particular two letters of 16 May.

The risk was overstated. The material in the report of 1 September 2010 mentioned in Interim Report Number 2 does not support the conclusion that Dr JB 1 is psychotic. To describe him as a 'serial killer' is a distortion. The material, I think, shows that Dr JB 1 does constitute a risk to the health and/or life of a particular class of patient, but his present restricted practice does not bring him into contact with that class. In my view the report of 1 September was sufficient to justify Dr JB 1's immediate suspension from practice pending a police

investigation, but the decision whether or not to suspend him was one for the QBMBA. Suspension was not something that the CMC could order or control.

You already have my recommendation that Dr JB 1's conduct be investigated by QPS and that the Board be informed of the referral.

b. On 19 March 2012, Ms Barber and Mr Messenger met with the Director, Integrity Services of the CMC and the Acting Principal Complaints Officer. The interview was short. Discussion primarily centred on allegations regarding the CMC's conduct in investigating the Townsville Hospital Cardio Thoracic Unit. The interview terminated when Ms McFarlane indicated that she should not consider a complaint against the CMC in that regard because she had been involved in the initial investigation. Ms Mundy advised that she had not been involved in that early investigation and had no 'conflict of interest' other than being an employee of the CMC.

On 21 March 2012 Mr Messenger and Ms Barber met the Assistant Commissioner Misconduct and the Acting Principal Complaints Officer. The primary concern of this interview was whether the CMC was an appropriate agency to investigate Ms Barber's complaints. Following that meeting Mr Strange wrote to Ms Barber on 20 April 2012. He wrote, *inter-alia:*

> ... as advised during ... interview, we are not able to give you and Mr Messenger specific legal advice ...[Y]our previous discussions with Mr Messenger occurred in context of you making a disclosure to him in this capacity at that time as a Member of Parliament ... however, as Mr Messenger is no longer a Member of Parliament, he is unable to take any further role in the processes provided for in the *PID Act.*
>
> For that reason, it is unnecessary to go into the specific legal reasoning concerning the potential application of the confidentiality and other relevant provisions in the *PID Act.* It will suffice to note that in light of Mr Messenger's loss of his seat, it is considered that a disclosure now to the media by Mr Messenger would arguably be an offence against the *PID Act,* which requires a person who gains confidential information through involvement in the Act's administration, to keep that information confidential.

Mr Messenger replied by an email letter 2 April 2012. He described the letter to Ms Barber as:

> a shameful disgraceful and deceptive document.

Of present relevance the letter said:

> The shameful and disgraceful element of your letter, is the complacent threat contained in your correspondence to take legal action against me, now that you think I don't have legal protection or privileges afforded to an MP ... it is a

> disgrace that you should threaten anyone who would like to alert the public, through the media, about matters relating to the safety and welfare of thousand of Queenslanders.

If one reads Mr Strange's letter fairly, it is impossible to conclude that he made any threat of legal action against Mr Messenger. He alerted him to the possibility that, having lost his seat, disclosure of information given to him under the *PID Act* may be unlawful. He made it clear that no definitive advice was being given. It is not possible to construe the letter as containing a threat.

c. Events at the Townsville Hospital Cardio Thoracic Unit are a prominent part of Ms Barber's allegations. Her complaint of misconduct and/or incompetence by officers of the CMC centres on these events. Her complaint is that the CMC:

> ... either deliberately or by way of serious incompetence failed to hand to me specific evidence they received whilst 'monitoring' this investigation. This material was received by the CMC from Rob Messenger ... and ... Dr Don Kane on behalf of Dr JB 16.1.

That complaint relates to events in the early part of 2008. More recently Ms Barber complained that the CMC should not investigate the subject matter of her statement and submission.

> ... Given that the CMC's role in monitoring ... this [Cardio Thoracic Unit] investigation is under dispute...

Ms Barber makes particular point that Ms Mundy:

> ... who played a key role in these events will not declare that she has a conflict of interest in this matter and is being used by the CMC as the person who will take and investigate matters if I refer this matter to the CMC. This is even more incredible when her ... colleague Di McFarlane ... declared a conflict of interest in the first meeting ... at CMC offices with Rob Messenger. Di McFarlane excused herself from taking part in the investigation ... whilst Melanie Mundy did not ... the CMC have a vested interest and a bias in this matter.

In his letter to Mr Strange of 22 April 2012, Mr Messenger makes the same complaint that Ms Mundy had:

> ... admitted an involvement in the Townsville Cardio Thoracic crisis investigation, the same investigation officer McFarlane was forced to declare a conflict of interest.

The allegation that the CMC did not pass on relevant evidence to Ms Barber when she was investigating the Townsville Cardio Thoracic Unit was said to be made more serious because:

> ... meetings and phone conversations between [Ms Barber] and ... [Melanie Mundy and Di McFarlane] ... where advised of the [Medical Board's] role ... and ... of my role ... as ... lead investigator.

This complaint is untrue. I have spoken to Ms Mundy but not interviewed her formally. I have listened to the recording of the meeting between her, Ms McFarlane, Ms Barber and Mr Messenger of 19 March 2012. Ms McFarlane indicated her reluctance to participate in any investigation of the CMC's involvement into the earlier investigation of the Townsville Cardio Thoracic Unit because of her involvement in it on behalf of the CMC. Ms Mundy, contrary to what was said about her, stated that she had had no involvement in the earlier investigation and had no 'conflict of interest', though pointed out that she is a current employee of the CMC.

CMC and the Cardio Thoracic Unit

The complaint here is that the CMC did not pass on relevant information to Ms Barber who was leading the investigation into numerous complaints made by doctors and administrators employed at the unit. I have already set out the substance of the complaint which appears in Ms Barber's statement. The information was identified in the meeting of 22 March 2012 between Ms Barber, Mr Messenger, Mr Strange and Ms Mundy as a letter written by Mr Messenger to the then Chairman, Mr Needham, and dated 12 February 2007 (though written in 2008). Attached to that letter was a CD containing a record of a conversation between Mr Messenger and Dr JB 16, one of the doctors employed at the unit, who was both complainant and subject of complaint; a six-page attachment which appears to be a summary of the conversation; and a letter from Dr JB 16's solicitors to Mr Messenger.

By way of background, which I will state as briefly as possible, doctors employed at the unit made complaints against each other of clinical ineptitude, malpractice, dishonesty and workplace harassment and bullying. There were also complaints about the manner in which the complaints had been dealt with by the hospital administrator and QH. The investigations took years to complete. They were complex and contentious. As well, Dr JB 16.1, who was the subject of the first complaints, instituted proceedings against QH for his unfair dismissal from his employment. He was ultimately successful. A good summary of events and how they were dealt with appears in the judgement of the Queensland Industrial Relations Commission which dealt with Dr 16.1's successful claim for compensation. There were numerous complaints and numerous allegations. Ms Barber was an investigator, or the chief investigator, in MBQs probing of the allegations of clinical negligence or malpractice.

The complaint that the CMC failed to pass on relevant information to Ms Barber must have as a starting point the identification of the material withheld and an understanding of how it was relevant to the investigation and how it might have affected the outcome.

I wrote to Ms Barber and asked her to address those questions. I anticipated she would have no difficulty in providing her response given that the allegation is serious, was described as "specific" and appeared in a document that must have taken some time to prepare. Despite those observations I am yet to receive a coherent reply. Without that assistance I can say that Mr Messenger's letter and attachments do not appear to be relevant to the subject matter of the investigation.

By the time Mr Messenger spoke to Dr JB 16 the investigation into the competing complaints had been underway for about a year. Dr JB 16 and the other doctors had all been interviewed and statements taken. All were jostling for advantage over the others and pressing their claims for exoneration and vindication. Dr JB 16's approach to Mr Messenger must be seen in that context. (It is worth noting that at the time Mr Messenger supported Dr JB 16 against *inter-alia* JB 16.1. The latter is now put forward as a critical witness into misconduct by officers of QH, who are said to have negligently employed Dr JB 16, concealed his clinical failings and assisted him financially to flee the jurisdiction). Dr JB 16 was found as a result of the investigation to have inadequate clinical skills and to have given misleading evidence in support of a complaint against another doctor.

The point of this is that one would expect the investigator to have more information relevant to the complaints by and against Dr JB 16 than Mr Messenger obtained in February 2008. One may draw the conclusion more readily in the absence of a statement from Ms Barber as to the novelty and relevance of the information Mr Messenger was given.

Of greater significance is the fact that Mr Messenger wrote to the then Chairman of the CMC not to assist with the investigation, or provide information relevant to it, but to complain that it was 'fundamentally flawed and ... politically corrupted.' He called for a commission of inquiry into events at the Cardio Thoracic Unit, and sought the support of the CMC to achieve that result. His letter was expressly written for that purpose. It is not, therefore, surprising that the letter was dealt with on that basis, and that the information contained in it was not thought to contain information relevant to the investigation but unknown to the investigators. Mr Needham replied by letter dated 25 February 2008 explaining in detail why he did not consider a commission of inquiry was appropriate and expressing confidence in the investigative processes underway. Mr Messenger again wrote to the Chairman of the CMC on 12 March 2008 asserting that the CMC had failed to address three identified issues concerning the Cardio Thoracic Unit. Mr Needham replied on 14 March 2008 dealing with the substance of each assertion.

There is nothing in the correspondence which suggests that contained in it was information which it was thought the investigators did not have. Nor was it suggested that the correspondence should be forwarded to them. Mr Messenger's letters were written for a particular purpose which was to have the investigation supplanted by a commission of inquiry and the correspondence was dealt with on that basis. If, which is yet to be established, the letter did contain information relevant to the

investigation, the omission to pass it on to the investigators is readily explicable on grounds other than incompetence or deliberate concealment.

There was, as well, a complaint that information received by the CMC from Dr Don Kane was not passed on to Ms Barber. Dr Kane was the president of Salaried Doctors Queensland, an organisation which represented or supported Dr JB 16.1 in his employment dispute with QH. Dr Kane wrote to the Chairman of the CMC, Mr Needham and Mr Moynihan on several occasions between December 2009 and May 2010. He complained, with some justification, that the investigation into the complaints made by and against Dr JB 16.1 had taken an extraordinary time and that Dr JB 16.1 had been treated unfairly in the process by QH. The CMC was monitoring the investigation. Dr Kane sought his assistance to expedite the process. He also complained, on behalf of Dr JB 16.1, of vindictiveness by a hospital administrator. The act he complained of was at a time after Dr JB 16.1 had returned to India to practise and the complaint did not relate to the subject matter of the earlier complaints which were investigated by MBQ and Ms Barber.

I cannot see that the correspondence from Dr Kane was relevant to Ms Barber's investigation. A complaint that it was not given to her would be without substance.

I asked Ms Barber to explain how Dr Kane's correspondence was relevant. Her answer was that she could not do so without being given access to the files of her investigation. The answer would seem to indicate this particular complaint was made without a factual basis.

I do not consider that the complaints made against the CMC are shown to have any substance and do not, in my opinion, warrant any further assessment or enquiry.

I have addressed this question first to 'clear the decks'. It was, I thought, important to establish whether there was an impediment in the CMC (or me as its agent) undertaking the assessment you requested. My conclusion is of course expressed on the basis of information presently available. It may change if further evidence is produced.

On my return from overseas on 13 June I will address the remaining complaints. Mr Evans will undertake enquiries in my absence. I would anticipate completing my assessment shortly after my return.

RICHARD CHESTERMAN AO RFD QC

MSL&AV/TRIM 12/054632