QUEENSLAND CIVIL AND ADMINISTRATIVE TRIBUNAL

CITATION:	*Health Ombudsman v Alinia* [2021] QCAT 43
PARTIES:	**HEALTH OMBUDSMAN** (applicant) **v** **MAJID MOHAMMAD ALINIA** (respondent)
APPLICATION NO/S:	OCR255-19
MATTER TYPE:	Occupational regulation matters
DELIVERED ON:	17 February 2021 (*Ex Tempore*)
HEARING DATE:	On the papers
HEARD AT:	Brisbane
DECISION OF:	Judicial Member J Robertson Assisted by: Dr Jennifer Cavanagh Ms Jennifer Felton Dr Arankanathan Thillainathan

ORDERS:

1. **The respondent has engaged in professional misconduct.**
2. **The respondent is reprimanded.**
3. **The respondent pay to the applicant a fine of $10,000 within three months.**
4. **A condition be imposed upon registration of the respondent requiring that he undergo audits conducted quarterly by a Board approved auditor with the focus of ensuring that the prescribing of controlled and restricted drugs of dependency are in compliance with statutory requirements and are otherwise appropriate, and the respondent's clinical records meet the relevant requirements such as the RACGP guidelines; and enabling access to information such as clinical, billing and appointment records in an acknowledgement by the respondent that the applicant, the Board (and AHPRA) may seek to obtain data from the relevant government departments or agency.**
5. **The review period for the condition described above is 12 months.**
6. **No order as to costs.**

CATCHWORDS: PROFESSIONS AND TRADES – HEALTH CARE PROFESSIONALS – MEDICAL PRACTITIONERS – DISCIPLINARY PROCEEDINGS – PROFESSIONAL MISCONDUCT AND UNPROFESSIONAL CONDUCT – where the respondent was registered as a general practitioner – where the respondent prescribed controlled drugs, restricted drugs, and restricted drugs of dependency to a vulnerable patient – where the respondent's medical records were inadequate – where the patient had a history of mental health problems and died as a consequence of alcohol and drug toxicity – whether the respondent's conduct amounts to professional misconduct – what sanction is appropriate

Health Ombudsman Act 2013 (Qld), s 103, s 104.
Health Practitioner Regulation National Law (Queensland), s 41.
Health (Drugs and Poisons) Regulation 1996 (Qld).
Queensland Civil and Administrative Tribunal Act 2009 (Qld), s 32.

Briginshaw v Briginshaw (1938) 68 CLR 336
Health Ombudsman v Wabersinke [2019] QCAT 156
Medical Board of Australia v Evans [2013] QCAT 217
Medical Board of Australia v Hadges [2018] SAHPT 6

APPEARANCES & REPRESENTATION:

Applicant: Turks Legal

Respondent: Moray & Agnew

This matter was heard and determined on the papers pursuant to s 32 of the *Queensland Civil and Administrative Tribunal Act* 2009 (Qld).

REASONS FOR DECISION

Introduction

[1] These disciplinary proceedings were referred to the Tribunal pursuant to sections 103(1)(a) and 104 of the *Health Ombudsman Act* 2013 (the Act), on 25 September 2019 (The date stamp applied by the registry appears to be a year out). The allegations of fact underpinning the alleged professional misconduct by the respondent relate to his alleged wrongful prescription of various controlled and/or restricted drugs of dependency to a de-identified single patient known as BN between January 2012 and September 2016, and his failure to keep proper records, and comply with relevant codes and guidelines applicable to him as a healthcare provider.

[2] The hearing book index refers to the date of referral as being 25 July 2019 (which was the date on which it was signed), but it was not filed until 25 September 2019.

[3] According to the documents provided to the Tribunal and the assessors as part of this 709 page hearing brief contained in two large arch lever files, an amended referral was signed on 27 September 2019 and presumably filed on the same day, although there is no date stamp on the copy in the hearing brief.

[4] This elicited a response from the respondent, signed by his solicitors on 8 November 2019 and filed the same day. This pleading put in issue many of the allegations of fact set out in the amended referral, including that the respondent had engaged in professional misconduct.

[5] This led to the signing (by the applicant's solicitor), and the filing on 27 March 2020 of a further amended referral which, while maintaining the fundamental factual allegations pleaded in the original referral and amended referral, seems to take up and acknowledge as correct some of the pleadings in the response. To each of the referral, amended referral, and further amended referral, are annexed long lists of controlled drugs and restricted drugs of dependency prescribed to BN by the respondent.

[6] An amended response was signed and filed by the respondent's solicitors on 8 May 2020. Although it contained a number of admissions against interest (for example, relating to the inadequacy of his initial assessment of the history of BN), some inappropriate prescribing and recording keeping); nevertheless, the respondent's position still was that he had not engaged in professional misconduct.

[7] On 25 July 2020, the respondent's solicitor filed an affidavit sworn by him on 23 July 2020, to which are annexed eight references from either medical practitioners, registered nurses, or persons who had worked in administration with the respondent in his capacity as a general practitioner. All of these references were prompted by a letter from the respondent's solicitor which contained a copy of the further amended response and the amended response referred above, however it also advised that the respondent "has indicated to the Tribunal that he accepts the finding of professional misconduct".

[8] The parties have not filed an agreed statement of facts. However, as I will demonstrate by reference to the submissions filed on their behalf by their lawyers, they agree as to the conduct to be considered by the Tribunal, its characterisation as professional misconduct, and the appropriate sanctions. As the matter is listed for an on the papers hearing without appearances, it is difficult to fairly criticise either party. However, if there is ultimately no contest, or very minor contest, the utility of an agreed statement of facts is obvious. It is also difficult to understand why the Tribunal required a hearing brief of such size for what is a relatively straightforward matter. I have already referred to the publication on at least three occasions of a long list of drugs prescribed by the respondent to BN over approximately four and a-half years.

[9] The hearing brief also contains a large number of authorities (pages 476-739), many of which contain trite propositions of law and principle which are well accepted in the Tribunal, all printed on one side. In my opinion, this is completely unnecessary as the parties can refer to relevant passages in their submissions (which they have done), without burdening the Tribunal with a vast quantity of paper.

[10] It can be accepted that it is common ground that at all material times, the respondent:

(a) was registered under the Health Practitioner Regulation National Law 2009 (Queensland) (the National Law) as a medical practitioner, holding general registration and specialist registration as a general practitioner with the Medical Board of Australia (the National Board);

(b) was a health practitioner under the National Law, namely a medical practitioner;

(c) from 29 August 2013 was a health service provider within the meaning of section 8(a)(i) of the Act, being a health practitioner under the National Law, namely a medical practitioner;

(d) was subject to the registration standards, codes or guidelines developed by the National Board as to what constitutes appropriate professional conduct or practice for the medical profession, including Good Medical Practice; a Code of Conduct for Doctors in Australia (Code of Conduct), which is, in accordance with section 41 of the National Law, admissible in this proceeding as evidence of what constitutes appropriate professional conduct or practice;

(e) was subject to the *Health (Drugs and Poisons) Regulation* 1996 (Regulations) and the Standard of the Uniform Scheduling of Medicines and Poisons (SUSMP2 to SUSMP13) as they applied from time to time (collectively referred to as "Poisons regulations")

(f) worked as a general practitioner at Wamuran Medical Centre, between about 2008 and July 2016; and

(g) worked as a general practitioner at My Health, North Lakes Medical Centre, North Lakes from about July 2016.

The relevant conduct

[11] As I have noted, unfortunately, the parties have not filed an agreed statement of facts. In his submission filed on 10 September 2020 the respondent states (through his lawyers):

> The conduct in question concerns the respondent's prescribing of controlled drugs, restricted drugs, and restricted drugs of dependency to BN as well as the adequacy of his recordkeeping.
>
> The respondent admits the substantive allegations against him in respect of the inappropriate nature of that prescribing, and therefore the treatment of BN. Also, that his medical records were inadequate.[1]

[12] Apart from that reference, there is no contest to the factual allegations set out in the applicant's further amended response filed on 28 August 2020.

[13] The impugned conduct is summarised by the applicant in its submission in the following terms:

> 4. Patient BN was treated by the respondent between about 2011 and 2016. BN had a complex mental health history. She died on 13 September 2016 as a consequence of drug and alcohol toxicity.

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[1] Hearing Brief (HB) Tab B page 193, paras 13-14.

5. It is alleged the respondent's prescribing of controlled and restricted drugs to patient BN was inappropriate. The prescribing put BN at risk, and that risk was realised by her death on 13 September 2016.

6. It is also alleged that the respondent's medical records were inadequate. As a consequence, it is also alleged that by reason of this, he breached the code of conduct.

[14] The conduct is described in much more detail in the submission, which references both the further amended referral and the respondent's amended response and the patient's records and the findings of the coroner.

[15] BN consulted the respondent between May 2011 and 9 September 2016. The respondent says that BN "suffered from Borderline Personality Disorder, depression, anxiety, drug and alcohol abuse". The respondent was aware of BN's drug use history and that she had suffered dependency or addiction. She had made multiple attempts at self-harm.

[16] The respondent prescribed to BN various controlled and restricted drugs of dependency and restricted drugs. In doing so, he did not comply with the requirements imposed by the Poisons regulations when prescribing these drugs to her.

[17] BN was found at her house on 13 September 2016. Beside her body was an empty four litre cask of white wine. Various controlled drugs, restricted drugs, and restricted drugs of dependency prescribed by the respondent were also found, including:

(a) oxycodone and naloxone;

(b) nitrazepam;

(c) oxazepam;

(d) diazepam;

(e) olanzapine; and

(f) paracetamol and codeine.

[18] The coroner noted:

> …at autopsy, rapid toxicology was conducted and a fatal level of alcohol and olanzapine was detected along with numerous other drugs. Alcohol was at the level of 440mg/100ml, a lethal range. Olanzapine was documented at a lethal range. It was the opinion of the examining pathologist that the death was caused by alcohol and olanzapine and other drugs in her system, the combination of which would have contributed to a depressant effect on the nervous system and led to her death.

[19] Olanzapine (or Zyprexa as it is known by its trade name), is a schedule 4 benzodiazepine medication and is typically used to treat schizophrenia and bipolar disorder. The respondent prescribed olanzapine to BN as a mood stabiliser.

[20] At the last consultation he had with her on 9 September 2016, BN had complained of "pain" and apparently informed the respondent that she had lost her scripts. The respondent prescribed olanzapine and her "usual medications". He prescribed:

(a) Alepam (oxazepam);

(b) Mogadon (nitrazepam);

(c) Zyprexa (olanzapine);

(d) Panadeine Forte;

(e) Targin (oxycodone and naloxone);

(f) Valium, diazepam; and

(g) Zoloft.

[21] The Poisons regulations set out certain requirements for prescribing the medications, in particular, the prescribing of controlled drugs and restricted drugs of dependency to a patient who is drug dependent. During the course of the investigation, the respondent conceded that he was not aware of the requirements under the Poisons regulations.

[22] In his submission dated 21 September 2018, the respondent stated:

> At the time, I thought that it was only necessary to notify the drugs of dependence unit/medicines regulation quality in relation to a patient that was a doctor shopper and I was not aware that it was mandatory to notify if the patient was being treated with drugs of dependence or restricted drugs of dependency. Further, since undertaking further education, I now appreciate the circumstances in which I must notify – and I've notified the unit in relation to other patients whom I have treated since that time.

[23] He also stated:

> I clearly remember discussing with the chief doctor at the Caboolture Alcohol, Tobacco and Other Drugs Service about a different patient in a very similar situation to BN, except she was engaging in illicit drug and alcohol abuse… The chief doctor advised me that we must understand that these people have a mental illness, and that their drug seeking is part of their mental illness. He said that if we didn't provide some of these (sic) medications such as opioid painkillers, antidepressants and antianxiety medications, then the patients will simply find illicit drugs on the street. Consequently, I felt that I owed BN a duty of care to help her. Now, having further undergone further education, I accept that I should not have continued prescribing these drugs to BN without documenting the reasons for doing so in more detail.

[24] The Tribunal has before it the uncontested expert report of Associate Professor Harold Jacobs. Associate Professor Jacobs observed:

> The prescription of drugs of dependence is a well-acknowledged risk for a competent GP. All GPs are aware of their responsibilities to control medication, supply to individual patients, to comply with State law by notification to Queensland Health of prescriptions to drug-dependent persons or prolonged prescriptions of restricted drugs, to take great care in prescribing for patients with known substance abuse and to use the principles of state prescribing…
>
> Dr Alinia…admits to non-compliance with State law about S8 prescribing. This is from the mental knowledge for any GP working in Australia. Dr Alinia has commented that he thought this requirement applied to "doctor shoppers" without specific inquiry and adequate history from previous GPs, it would not be possible. He is certain that doctor shopping did not apply to BN. The Australian government provides a prescription shopping information service

> available to all doctors for the purposes of identifying such patients. There is no evidence in the medical records that Dr Alinia availed himself of their service to check if BN was such a doctor shopper.

[25] With respect to the respondent's prescribing to BN, the respondent submitted:

> My recollection is that I prescribed olanzapine 5mg on 10 January 2012 for symptoms consistent with bipolar disorder and referred BN to Dr Majumdar and that I increase dosage of olanzapine on 18 April 2012 because BN reported to me a partial improvement in her symptoms. I accept that I did not record those notes in my clinical records. At the time, I believe that Dr Majumdar had no objection to BN taking olanzapine. Dr Majumdar, specialist psychiatrist, was aware that BN was taking olanzapine and that he had not ceased or changed that medication, nor had he raised any concerns with me about BN taking that medication. However, in retrospect, I accept Associate Professor Jacobs' comments that Dr Majumdar's report appears to only deal with BN's alcohol dependency problem as it does not specifically address the necessity or otherwise for olanzapine.

[26] The respondent concluded that submission by stating that he thought he was providing appropriate treatment for BN. Having reflected upon the views of Associate Professor Jacobs expressed in his initial report in the investigation, the respondent stated:

> I still believe the prescription of olanzapine was justified in view of her symptoms, and that the prescription of olanzapine was effective given the subsequent improvement in BN's symptoms. I accept that I inadequately documented my reasons for commencing BN on olanzapine and increasing her dosage of olanzapine.
>
> I believe that I was providing appropriate clinical treatment to her, but I can now see that my reasons for treating her were not sufficiently justified in my records. I believe that I made a concerted effort to engage BN in appropriate diagnosis and management in her mental health problems, including referral to a psychiatrist, Dr Ken Arthur; Dr Ashim Majumdar, a psychologist; Lainie Nicholson; and Mariam McKenzie and the mental health clinic at Caboolture Hospital. BN also refused to follow detoxification treatment plans on at least two occasions.
>
> I accept that I did not keep satisfactory records in relation to BN's management and treatment, and I have made a concerted effort to improve the quality of my clinical records following the further education I have undertaken.

[27] However, Associate Professor Jacobs was of the view:

> Of great concern in considering Dr Alinia's prescribing for BN was a regular prescription of three separate benzodiazepines without explanation for each medication or the combination; lack of explanation for use of the Targin, and then escalation in dose of Targin from 10/5mg (26 September 2012) to 44/20mg (4 December 2013) and Dr Alinia's comment on 10 February 2015 "offered to swap Subutex with the Targin". Subutex (buprenorphine) is used as part of the medical, social, and psychological treatment program for patients depending on opioids. Again, Dr Alinia has offered prescription without any documentation of assessment, and any comprehensive treatment programs. BN has well-documented substance abuse problems involving "IV drug use" (18 April 2012), "binge drinking" (10 September 2013) and "drug abuse" (11 March 2014). I can find no evidence that Dr Alinia used suitable

> caution in prescribing drugs of dependence i.e. opioids and benzodiazepines. Possible precautions in prescribing drugs of dependence might include aspects listed above as universal precautions as well as random urine drug screens, [indistinct] inquiry about illicit drug use, efforts of regular dose reduction and consider the red flags such as lost or stolen scripts (30 January 2013, 11 December 2013, 19 February 2014.)

[28] Associate Professor Jacobs described the patient records as "very poorly documented" and observed:

> It would appear from the submissions made by Dr Alinia that he does not comprehend the purpose of medical records in spite of the education undertaken. Medical records include an accurate health summary with details of all previous problems including active and inactive problems, current medications, allergy and adverse effects, accurate family and social history, detailed investigations and actions required, details of correspondence inwards and outwards and any actions required, and filing progress notes that allow some understanding of the care provided or the education. If the medical records have such information, it should be possible to understand the details of the case within a brief period and take other care if needed e.g. when a locum is asked to see the patient… After reading the submission from Dr Alinia, I accept that he agrees his records are inadequate and has undertaken education to correct the problem. I do not believe he's acknowledged the role detailed medical records play in conforming the care provided to an individual patient. I do not believe that he has accepted the records presented do not justify any statements made in his submission about the care provided to BN.

[29] In this proceeding, the respondent in various pleadings, now concedes that his treatment of patient BN was inappropriate and substantially below the standard expected of a health practitioner. More particularly:

(a) he continued to prescribe controlled drugs and restricted drugs and drugs of dependency in circumstances where BN failed to comply with referrals and requests, reported occasional IV drug use and drug use, and complained of lost or stolen scripts;

(b) he did not make adequate inquiries with other medical practitioners or the medicines and plants and human tissue unit to obtain a collateral history in prescribing the medications;

(c) he failed to inquire with other medical practitioners and the relevant unit about BN's treatment history and to ascertain whether other practitioners were also prescribing controlled drugs to BN;

(d) he commenced, increased and/or maintained BN on high doses of Targin when it was not clinically or therapeutically warranted;

(e) he commenced, increased and/or maintained BN on Zyprexa (olanzapine) when it was not clinically or therapeutically warranted;

(f) he prescribed benzodiazepines in combinations and in circumstances where it was not clinically or therapeutically warranted;

(g) he prescribed Duromine (Phentermine) where it was not clinically or therapeutically warranted;

(h) he inadequately monitored BN's use of the controlled drugs and restricted drugs of dependency; and

(i) he failed to take into account BN's history and conduct and conduct an inadequate initial clinical assessment.

[30] The respondent also concedes now that he failed to maintain adequate clinical records. He also concedes that he was not aware of his obligation to comply with the Poisons regulations in treating BN as a drug dependent person with controlled drugs or restricted drugs of dependency.

[31] He admits by reasons of his inappropriate treatment of BN, he put her at risk or at potential risk of harm. As a consequence of these matters, the respondent now also concedes he failed to comply with the regulations, and the code of conduct as described in the further amended referral and further amended response.

[32] The inappropriate prescribing and inappropriate clinical observations and failure to keep proper records over so many years in relation to an extremely vulnerable patient is clearly professional misconduct, bearing in mind that it is the responsibility of the applicant to prove it to the standard identified in *Briginshaw v Briginshaw* (1938) 68 CLR 336 at 361-362.

[33] The prescription of medication (and in particular schedule 4 drugs and/or drugs of dependency) without proper clinical indication is a serious matter given the trust placed in medical practitioners by the public.[2] A failure to comply with the regulation, of itself, can lead to professional misconduct.

[34] In *Medical Board of Australia v Evans,*[3] the practitioner had failed to comply with the regulation when prescribing controlled and restricted drugs of dependency to patient. The then Deputy President of the Tribunal, Judge Horneman-Wren SC, stated:

> Failings of [that] kind… are not to be seen to be mere technical breaches of regulations. The systems of control established by the regulation are integral to the protection of members of the community from potentially harmful drugs. The privilege of an endorsed medical practitioner to prescribe such drugs brings with it a burden of responsibility of doing so only in compliance with the regulatory regime. This is particularly so when the persons for whom the drugs are being prescribed may be drug dependent.

[35] Similarly, on many occasions this Tribunal, and its equivalent in other jurisdictions, has emphasised the importance of proper record keeping as an aspect of public safety and risk to patients.

[36] The Tribunal is satisfied to the requisite standard that the respondent has engaged in professional misconduct as defined in section 5 of the National Law.

Sanction

[37] The purpose of these proceedings is protective not punitive. The paramount principle informing the exercise of the Tribunal's jurisdiction to discipline health care providers who have engaged in professional misconduct is the health and safety of the public.[4]

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2 *Medical Board of Australia v Hadges* [2018] SAHPT 6.
3 [2013] QCAT 217 at [19] – [20].
4 Section 4 of the Act.

[38] By reference to a number of authorities the applicant has extracted a number of factors that are relevant to the nature of the sanction here:

(a) where the inappropriate prescribing has occurred over a significant period of time;

(b) where there has been inappropriate prescribing of multiple medications;

(c) where the inappropriate prescribing may have caused harm to the patients;

(d) where the practitioner has sought to rationalise or justify their conduct; and

(e) where the practitioner has failed to maintain adequate records.

[39] While the respondent's conduct only relates to his treatment of one patient, many of the features outlined above are present in this matter. The authorities referred to also demonstrate that the factors relevant to the Tribunal's consideration include the extent to which admissions were made; the demonstration by the practitioner of their understanding of the significance of their misconduct; steps taken by the practitioner to address the areas of concern, and to ensure that there will be no further misconduct; and any undertakings given by the practitioner as to restrictions imposed upon their registration or ability to prescribe; and the practitioner's notification and disciplinary history.

[40] As indicated above, by reference to the pleadings and the various submissions made to the regulator by the respondent prior to proceedings being commenced in the Tribunal, the respondent has been slow to accept the serious nature of his conduct in relation to BN. As against that, he has undertaken some courses (in 2017) designed to educate him about his ethical and professional responsibilities, including an education plan prepared by his insurer. He has also undertaken other courses of education (in 2018), and an educational course with Dr Aline Smith who noted in her report dated 11 March 2020:

> …(Dr Alinia) acknowledged he had learnt a big lesson following the complaint and had been cognisant of the S4 and S8 legislation pertaining to Queensland Health regulations in prescribing such drugs. He didn't appear to understand these requirements in the past and he assured me that he knows this fact and understands the importance of compliance. I can see from our discussions he's made efforts in gathering this information through his own research even before our education meeting in February 2020. He's done a lot of self-reflection on this case and also of other patients who he has treated before and since the case that led to this complaining incident… It appears to me that Dr Alinia also had learnt a great deal about how important it was to document his records properly in relation to prescribing drugs of addictions. He understood the principle of good record keeping and was able to show me that his lack of documentation in this case has led him to receive a complaint against him. He was able to confirm with me his writing and comprehensive notes and he was looking at ways to improve his record keeping with better use of medical software. In summary, during my time with Dr Alinia, it appeared to me that Dr Alinia was insightful about these allegations, he could see how he had not done what he should and had informed me that he had already sought to address the short comings in these areas. He assured me that he was already applying these at his current practice.

[41] I agree with the applicant that Dr Smith's opinion in that report dated 11 March 2020 has to be read down in light of the fact that she did not have access to Associate Professor Jacobs' reports; nor did she have the pleadings apart from the

formal pleadings in the Tribunal; or the patient's records. She was provided with the original of the formal notice but at that point the respondent was still disputing the allegation of professional misconduct.

[42] In my opinion, the respondent still appears to lack real insight into the importance of record keeping and the prescribing of dangerous drugs; however, I am satisfied that given the positive matters in his favour, and given the long period of time that has elapsed since BN's tragic death, these issues can be addressed by the conditions proposed by the applicant. It is also relevant that this misconduct related to one patient only who had complex and difficult mental health issues. As against that, the respondent now accepts that he did not take an adequate history from her from the outset. Both parties contend for a reprimand along with a fine and for conditions to be imposed on his registration.

[43] As has often been noted in this Tribunal, a reprimand is not a trivial penalty for a professional person. It amounts to a public denunciation of his conduct.[5]

[44] Certainly, the passage of time is relevant; during which time no regulator saw fit to limit his prescribing rights by way of immediate action under the Act.

[45] The references annexed to the respondent's lawyer's affidavit attest to his otherwise good character and dedication to his profession.

[46] As has been noted on numerous occasions in circumstances where the parties agree as to sanction, the Tribunal ought not to depart from the proposed sanction agreed between the parties unless it falls outside of the permissible range of sanction for the conduct bearing in mind that the purpose of disciplinary proceedings is protective rather than punitive. I agree that in this case the proposed sanction does not fall outside the permissible range.

[47] In those circumstances the order of the Tribunal will be as follows:

1. The respondent has engaged in professional misconduct.
2. The respondent is reprimanded.
3. The respondent pay to the applicant a fine of $10,000 within three months.
4. A condition be imposed upon registration of the respondent requiring that he undergo audits conducted quarterly by a Board approved auditor with the focus of ensuring that the prescribing of controlled and restricted drugs of dependency are in compliance with statutory requirements and are otherwise appropriate, and the respondent's clinical records meet the relevant requirements such as the RACGP guidelines and enabling access to information such as clinical, billing and appointment records in an acknowledgement by the respondent that the applicant, the Board (and AHPRA) may seek to obtain data from the relevant government departments or agency.
5. The review period for the condition described above is 12 months.
6. No order as to costs.

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5 *Health Ombudsman v Wabersinke* [2019] QCAT 156.