QUEENSLAND CIVIL AND ADMINISTRATIVE TRIBUNAL

CITATION:	*du Toit v Health Ombudsman* [2023] QCAT 373
PARTIES:	**GEORGE DU TOIT** (applicant) **v** **HEALTH OMBUDSMAN** (respondent)
APPLICATION NO/S:	OCR194-22
MATTER TYPE:	Occupational regulation matters
DELIVERED ON:	15 November 2023
HEARING DATE:	16, 17, 18, 30, 31 May 2023; 25 July 2023
HEARD AT:	Brisbane
DECISION OF:	Judicial Member J Dick SC Assisted by: Professor D Ellwood AO, Medical Practitioner Panel Member Dr W Grigg, Public Panel Member Professor D Morgan OAM, Medical Practitioner Panel Member
ORDERS:	**The Tribunal sets aside the Health Ombudsman's decision of 27 June 2022.**
CATCHWORDS:	PROFESSIONS AND TRADES – HEALTH CARE PROFESSIONALS – MEDICAL PRACTITIONERS – DISCIPLINARY PROCEEDINGS – REVIEW OF DECISION OF REGULATOR – where the respondent Ombudsman formed the reasonable belief that the applicant practitioner posed a serious risk to patients and that it was necessary to take immediate action to protect public health and safety under s 58 of the *Health Ombudsman Act 2013* – where the respondent took immediate action and imposed conditions on the applicant's registration – where the conditions significantly restricted the applicant's practice of obstetrics and gynaecology – where the respondent relied on the report of an expert to take immediate action – where the expert originally reviewed eleven cases and identified repetitive themes or issues in the applicant's practice as an obstetrician and gynaecologist – where the expert has since provided an additional report – where the applicant has since obtained a report of an additional expert – where the experts disagree on whether the applicant's conduct falls within the realm of acceptable practice – where both experts were cross-examined before

the Tribunal – where the Tribunal undertakes a fresh hearing on the merits – where the Tribunal must make the correct and preferable decision – where the respondent says that the Tribunal should form a reasonable belief that the because of the applicant's health, conduct, or performance, the applicant poses a serious risk to persons and it is necessary to take action to protect public health or safety – where the respondent says that the Tribunal should form a reasonable belief that it is necessary to take action in the public interest – where the applicant says that the Tribunal would not form a reasonable belief that it is necessary to take action or that alternatively the Tribunal would take action and impose conditions that are less onerous – whether the Tribunal forms a reasonable belief under s 58 of the *Health Ombudsman Act 2013* – whether it is necessary to take action

Health Ombudsman Act 2013 s 3, 25, 59
Queensland Civil and Administrative Tribunal Act 2009 s 20

George v Rockett (1990) 170 CLR 104

Ord v Nursing & Midwifery Board of Australia [2014] QCAT 688

Ladhams v Medical Board of Australia (No. 2) [2014] QCAT 286

Liddell v Medical Board of Australia [2012] WASAT 120

Pearse v Medical Board of Australia [2013] QCAT 392

Porteous v Pharmacy Board of Australia [2021] QCAT 286

WD v Medical Board of Australia [2013] QCAT 614

APPEARANCES & REPRESENTATION:

COUNSEL:	J R Hunter KC, with C D Templeton, for the applicant I R Freckelton AO KC, with B Mendelson, for the respondent
SOLICITORS:	Moray & Agnew for the applicant McCullough Robertson Lawyers for the respondent

[1] The applicant was born on 20 June 1960. In 1984, he was awarded a Bachelor of Medicine and Bachelor of Surgery at Stellenbosch University (South Africa) and in the same year obtained registration as a medical practitioner with the Health Professions Council (HPC) of South Africa.

[2] In 1991, he was admitted to the Fellowship of College of Obstetricians and Gynaecology of South Africa. In the same year, he was awarded a Master of

Medicine (Obstetrics and Gynaecology) and obtained registration with the HPC as a specialist in gynaecology and obstetrics.

[3] He was in private practice as a gynaecologist in South Africa from 1 March 1999 to 21 February 2016.

[4] In 2016, he obtained registration as a medical practitioner with the Medical Board of Australia and, in the same year, he was admitted by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists as a Fellow of the College.

[5] Between 2016 and 2020, he worked as a consultant obstetrician and gynaecologist at Albany Health Campus, Western Australia. On 28 September 2020, he commenced as Clinical Director of Obstetrics and Gynaecology at Mackay Base Hospital (MBH). On 13 October 2021, he was suspended from his employment with Mackay Hospital and Health Service (MHHS). On the same date, the Office of the Health Ombudsman (OHO) received the first of a series of notifications concerning his performance. He formally resigned in March of 2022.

[6] On 26 May 2022 the OHO selected 11 patients for consideration by Dr Llewllyn Francis.[1] Given concerns identified by Dr Francis, Dr Francis was requested to provide a report for the purpose of immediate registration action. The report was received by the OHO on 21 June 2022.

[7] By a decision of 27 June 2022, the OHO decided to take immediate action against the applicant pursuant to s 58 and s 59(4) of the *Health Ombudsman Act 2013* (the Act) by imposing conditions on the applicant's registration. In doing so, the Health Ombudsman relied on the report of Dr Francis identifying "repetitive themes or issues" relating to the number of ureteric and bladder injuries sustained by patients considered by Dr Francis. The Health Ombudsman wrote that she had formed the reasonable belief that the applicant posed a serious risk to patients and that it was necessary to take immediate action to protect public health and safety. The respondent now says the immediate action is otherwise in the public interest pursuant to s 58(d). On 25 July 2022, the applicant sought to review the decision. The applicant seeks an order:

(a) setting aside the immediate action decision; or, alternatively;

(b) setting aside the decision and substituting a decision that imposes less onerous conditions that address the perceived serious risk.

[8] The hearing before the Tribunal is a *de novo* hearing of the respondent's decision.

The legal framework

[9] The legal framework is set out in Paragraphs 9 to 14 of the respondent's submissions filed on 3 July 2023 as follows.

[10] The functions of the Health Ombudsman include receiving health service complaints and identifying and dealing with health service issues by undertaking investigations, enquiries, and other relevant actions.[2] Section 3(1) of the Act sets out as its objects:

> (1) The main objects of the Act are—

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1 Dr Llewllyn Francis is a pseudonym used to refer to the expert whose identity is protected by a non-publication order.

2 *Health Ombudsman Act 2013* (Qld), s 25(a) and (b).

(a) to protect the health and safety of the public; and

(b) to promote –

(i) the professional, safe and competent practice by health practitioners; and

(ii) high standards of service delivery by health service organisations; and

(c) to maintain public confidence in the management of complaints and other matters relating to the provision of health services.[3]

[11] Section 4 provides as follows:

(1) The main principle for administering this Act is that the health and safety of the public are paramount.

(2) Without limiting subsection (1), the health and safety of the public is the main consideration for—

(a) the health ombudsman, when deciding what relevant action to take to deal with a compliant or other matter; and

(b) the director of proceedings, when deciding whether to refer a matter to QCAT; and

(c) QCAT, when deciding a matter referred to under this Act.

[12] Part 7 of the Act confers disciplinary powers on the Health Ombudsman to take "immediate registration action" in certain circumstances. Such action is defined to include suspension of a practitioner's registration or the imposition of conditions upon registration. Section 58(1) of the Act sets out the relevant criteria for exercising this power:

(1) The health ombudsman may take immediate registration action under this division in relation to a registered health practitioner if—

(a) the health ombudsman reasonably believes that –

(i) because of the practitioner's conduct, or performance, the practitioner poses a serious risk to persons; and

(ii) it is necessary to take the action to protect public health of safety; or

…

(d) the health ombudsman reasonably believes the action is otherwise in the public interest.

[13] If the Health Ombudsman proposes to take immediate registration action in relation to a registered health practitioner, she must give the practitioner a notice stating the

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3 *Health Ombudsman Act 2013* (Qld), s 3(1).

proposed action and invite the practitioner to make a submission about the proposed action.[4]

[14] The Health Ombudsman must have regard to any submissions made by the practitioner before deciding whether to take immediate action.[5]

[15] However, under s 59(4), if the Health Ombudsman is satisfied it is necessary to do so to ensure the health and safety of the individual or the public, the Health Ombudsman may take immediate registration action without complying with those show cause process steps.[6]

[16] The applicant accepts that the submissions correctly summarise the legal framework.

The legal tests

[17] The legal tests are also contained in the respondent's submissions filed on 3 July 2023 at paragraphs 15 to 18.

[18] The legal tests for the Tribunal when considering an application to review a decision to take immediate action are summarised as follows:

(a) an immediate action order does not entail a detailed enquiry;

(b) it requires action on an urgent basis because of the need to protect public health and safety;

(c) the taking of immediate action does not require proof of the conduct, but rather whether there is a reasonable belief that the registrant poses a serious risk;

(d) an immediate action order may be based on material that would not conventionally be considered as strictly evidentiary in nature, for example, complaints and allegations;

(e) the mere fact and seriousness of the charges supported by the untested statements of witnesses in a particular case may well be sufficient to create the necessary reasonable belief as to the existence of the risk;

(f) the material available should be carefully scrutinised in order to determine the weight to be attached to it;

(g) a complaint that is trivial or misconceived on its face will clearly not be given weight;

(h) the nature of the allegations will be highly relevant to the issue of whether the order is justified.[7]

[19] The applicant submits that the approach set out must "…be applied in the context and circumstances of each particular case".[8]

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4 *Health Ombudsman Act 2013* (Qld), s 59(1).
5 *Health Ombudsman Act 2013* (Qld), s 59(3).
6 *Health Ombudsman Act 2013* (Qld), s 59(4).
7 *WD v Medical Board of Australia* [2013] QCAT 614.
8 *Ord v Nursing & Midwifery Board of Australia* [2014] QCAT 688 at [9].

[20] The respondent further submits that the Tribunal is required to hear and decide a review of a reviewable decision by way of a fresh hearing on the merits.[9]

[21] In conducting the review, the Tribunal is able to consider further or fresh evidence that was not before the original decisionmaker.

[22] Since the decision, the applicant has provided further evidence including two expert reports by Dr Darcy Garland[10] and an affidavit by Dr du Toit. The Health Ombudsman has provided a further report by Dr Francis. Further, the experts participated in a conclave on 25 October 2022 and 8 November 2022 and have provided a joint report.

Reasonable belief

[23] A reasonable belief "does not require proof of conduct" but rather "an inclination of the mind towards assenting to rather than rejecting a proposition."[11]

[24] The respondent cites from *George v Rockett*:[12]

> The objective circumstances sufficient to show a reason to believe something need to point more clearly to the subject matter of the belief, but that is not to say that the objective circumstances must establish on the balance of probabilities that the subject matter in fact occurred or exists: the assent of belief is given on more slender evidence than proof. Belief is an inclination of the mind towards assenting to, rather than rejecting, a proposition and the grounds which can reasonably induce that inclination of the mind may, depending on the circumstances, leave something to surmise or conjecture.

[25] Further, the underlying facts giving rise to the relevant reasonable belief do not have to be established on the balance of probabilities.[13]

[26] As such, the Tribunal ought to consider the evidence of the applicant's conduct and performance, as a whole, when determining whether it holds a reasonable belief that his conduct and performance pose a serious risk to patients.

[27] In these proceedings, the Tribunal must consider the evidence of two highly qualified and experienced experts whose opinions are not in agreement, but the Tribunal need not resolve the differences between them or to prefer the evidence of one as against the other.

Serious risk

[28] The term "serious risk" is not legislatively defined. The parties agree it means "of grave aspect, weighty or important; giving rise for apprehension; critical; to be considered as an extreme example of its kind."[14]

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9 *Queensland Civil and Administrative Tribunal Act 2009* (Qld), s 20(2) and s 20(1).

10 Dr Darcy Garland is a pseudonym used to refer to the expert whose identity is protected by a non-publication order.

11 *Porteous v Pharmacy Board of Australia* [2021] QCAT 286 at [9]. *Pearse v Medical Board of Australia* [2013] QCAT 392 at [37].

12 (1990) 170 CLR 104 at 116.

13 *Porteous v Pharmacy Board of Australia* [2021] QCAT 286 at [10].

14 *Porteous v Pharmacy Board of Australia* [2021] QCAT 286 at [19].

[29] The applicant adds that determining whether he poses a serious risk requires identifying the particular aspects of his conduct or performance which are said to cause that risk.

[30] The immediate action ought to be the least onerous necessary to address the relevant risk.[15] While the health and safety of the public must remain paramount, the impact of the immediate action on the health practitioner cannot be underestimated.[16]

[31] The term "public interest" does not have a fixed or precise content.

[32] The respondent directs the Tribunal to observations made in *Medical Board of Australia v Liang Joo Leow* [2019] VSC 532, at [85] and [94] and quoted in *Ellis v Medical Board of Australia* [2020] VCAT 862 at [58].:

> …
>
> The meaning of public interest is informed by the example. It is necessary for the Tribunal to proceed on the basis that public confidence in the provision of services by health practitioners is an aspect of the public interest. However, the Tribunal does not need to apply the example as if it were a statutory test. Specifically, the Tribunal was not required to analyse the issue of whether public confidence would be maintained, as opposed to whether, and to what extent, public confidence would be impacted and whether the extent of any such impact would require, in the public interest, that immediate action be taken.
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> …
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> The concept of public confidence has no fixed meaning or content. It is a difficult concept to measure. In assessing how the public might view the facts, it is important that visceral responses, as prevalent or legitimate as they might be, do not dominate at the expense of a considered response, having regard to all of the competing factors.
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> …

[33] The applicant further points to the *Health Practitioner Regulation National Law (Queensland)* (the National Law) and submits there is also a public interest in health services being available.

[34] The respondent submits at paragraph [41] of its submission the complaints and concerns about the applicant's conduct or performance have been "widely reported causing significant community anxiety".

[35] There is, however, no direct evidence before the Tribunal of any media reporting. The applicant submits, and the Tribunal accepts that fundamental to achieving the main objects of the *Health Ombudsman Act* is a "transparent, accountable and fair

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15 *Pearse v Medical Board of Australia* [2013] QCAT 392 at [16], [18].

16 *Pearse v Medical Board of Australia* [2013] QCAT 392 at [19], citing with approval *MLNO v Medical Board of Australia* [2012] VCAT 123 at [5]. See also *Colagrande v Health Ombudsman* [2017] QCAT 107 at [18].

system for effectively and expeditiously dealing with complaints and other matters."[17]

Interim nature of immediate action

[36] The parties agree that the power to take immediate action is interlocutory in nature.[18] The Tribunal is not required to resolve the allegations nor to make a final determination on any sanction. The Tribunal is required to scrutinise the evidence before it carefully to assess the risk alleged by the respondent and the weight to be placed on the evidence.

The hearing

[37] The Tribunal had before it over 12,000 pages of evidence and five days of oral testimony from the applicant, Dr Garland and Dr Francis.

[38] Each party, in its submissions, is critical of the expert called by the other party.

[39] The Tribunal is of the view that the Tribunal should look at all of the individual cases litigated to conduct its careful scrutiny.

[40] Having said that, the Tribunal is concerned that Dr Francis on more than one occasion attributed behaviour to the applicant where he was not the surgeon involved.[19]

[41] The applicant says that the Tribunal should note that the respondent elected not to deal with seven of the 15 cases in which Dr Francis had been critical of the applicant's performance and that the themes "frequent and recurrent urinary tract injuries" and "troubling and disproportionate number of emergency hysterectomies, post-operative haemorrhaging, and urinary tract injuries" cannot now be maintained.[20]

Considering risk and outcome

[42] The respondent submits that the focus when assessing whether the applicant poses a serious risk to health and safety of patients should not be influenced by hindsight knowledge that the risk outcome did not eventuate.

The patients

Esther Fields[21]

[43] This patient was a 40-year-old female who had presented to the hospital in the context of an unprovoked antepartum haemorrhage at 34 weeks gestation.

[44] She had previously undergone two prior caesarean sections and four vaginal deliveries.

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17 *Braun v Health Ombudsman* [2021] QSC 209 at [60].

18 *Liddell v Medical Board of Australia* [2012] WASAT 120 at [23] – [25].

19 Applicant's submissions filed 24 July 2023 at [36], (patients [redacted], [redacted], [redacted], [redacted], [redacted]).

20 Applicant's submissions filed 24 July 2023 at [4], [44]-[48].

21 Esther Fields is a pseudonym used to refer to the patient whose identity is protected by a non-publication order.

[45] The patient was initially under the care of a registrar, Dr Archibald Stanfield,[22] who diagnosed her as a Grade 4 placenta praevia and assessed her to be at increased risk of a major post-partum haemorrhage.

[46] The applicant agreed with that assessment. He gave evidence of the fact of six previous births which was in itself a high-risk factor for post-partum haemorrhage. The fact that she had a haemoglobin count of 107 compromised her ability to cope with a post-partum haemorrhage. The applicant was also concerned that the patient had a heart operation in 1985 although Dr Stanfield noted the day before the procedure that she had "five yearly check-ups with ' nil concerns'". There was little other information in that respect and her ante-natal care involved only two visits.

[47] In recognition of these factors the applicant:

(a) consulted with the ICU to alert them to the prospect that intensive care might be required;

(b) liaised with the anaesthetics team to discuss the high risk of significant blood loss and the patient's cardiac condition;

(c) arranged for the paediatric team to review the patient and ensure sufficient staffing was available;

(d) arranged for the insertion of extra cannulas in case they were required;

(e) arranged for a cell saver to be present if required; and

(f) arranged for two units of packed red blood cells to be present in theatre if required.

[48] The applicant submits that the steps he took prior to the delivery showed his recognition of the risk posed by the patient's complex presentation.

[49] After the delivery of the baby and placenta "brisk bleeding" was noted.

[50] The anaesthetist had administered carbetocin and tranexamic acid which did not stem the bleeding. The applicant then sought to mechanically restrict the blood flow by applying a Foley catheter. The applicant then proceeded to perform a hysterectomy and ligated the internal iliac arteries and inserted a drain in case of post-operative haemorrhage.

[51] In the report of the expert's conclave, Dr Francis said that the hysterectomy was unnecessary.

[52] Dr Garland disagrees. He himself would not have performed a hysterectomy in the particular circumstances of the surgery, the condition of the patient and the foetus because he usually takes the more conservative approach but there is a spectrum of opinion about whether to be radical or conservative and the decision by the applicant was within the spectrum.

[53] The experts agreed there were methods other than hysterectomy to try to control the bleeding – more aggressive use of drugs, or B-Lynch suture or Bakri balloon.

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22 Dr Archibald Stanfield is a pseudonym used to refer to the registrar whose identity is protected by a non-publication order.

Blood loss

[54] This is an area in which the Tribunal has had difficulty simply working from the notes and which has led to dissention between the experts.

[55] Dr Francis in his first report opined that the decision for a hysterectomy was not necessary based on his belief that the placenta was delivered without significant bleeding. He repeated that opinion in his second report and in the joint report based on the anaesthetic notes recording blood loss of 150 ml and the postoperative documentation completed by the obstetric team suggesting 500 ml of blood loss.

[56] Dr Garland reported that he had perused the patient's clinical records "to look for blood transfusion volumes" and while unsure whether he found all of them, he did find "reference to six units of blood (or perhaps packed cells) and there may have been more".[23] Despite receiving these blood products post-operatively, the patient remained profoundly anaemic. He estimated the blood loss as 1500 to 2000 ml.

[57] In cross-examination, Dr Francis conceded he had not reconciled the patient's haemoglobin levels. Doing so reveals a significant blood loss which could only have occurred during the procedure. If it had occurred post-operatively, the blood would have been detected in a CT-Scan which was performed. Dr Francis conceded that the records of the blood loss may not have been correct.

The incision

[58] In cross-examination Dr Francis considered that an incision for an open hysterectomy could be vertical and was "within the realms of acceptable practice". Dr Garland described the incision as "perfectly acceptable".

Appropriateness of the hysterectomy

[59] The patient had consented to sterilisation. Despite Dr Francis being critical of this procedure in his second report, he did not maintain that criticism in evidence.

Resolution of the blood loss

[60] The way the matter was presented (without evidence from the authors of the notes), makes it difficult for the Tribunal to make definitive findings about it, other than to say the drop in haemoglobin and the blood transfusions administered suggest there was significant blood loss during the procedure. The fact that the patient had agreed to sterilisation and a hysterectomy, and her multiple previous births might lead a competent obstetrician to have a low threshold for moving to hysterectomy in the situation that unfolded.

[61] The Tribunal accepts that the applicant's treatment and management of this patient was within the realms of acceptable practice and does not show that the applicant poses a serious risk.

Karina Firenzo[24]

[62] This patient was a 16-year-old cognitively impaired person under the care of the Department of Child Safety. At the relevant time she was 40 weeks and six days into her pregnancy.

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23 See report of Dr [Garland] dated 3 April 2023 at page 10.

24 Karina Firenzo is a pseudonym used to refer to the patient whose identity is protected by a non-publication order.

[63] She presented on 29 August 2021. Labour was induced. The birth was being managed by Dr Fenton,[25] who was a principal house officer, and a midwife.

[64] The applicant was called in urgently at 16:26 and arrived by 16:33.

[65] The applicant gave evidence that he recognised the patient was cognitively impaired and highly distressed. A CTG suggested there was bradycardia (slowed heart rate) which suggested a risk of foetal harm or compromise. The applicant proceeded to deliver the baby using instruments. According to Dr Fenton's notes, the applicant administered a pudendal block using lignocaine. The applicant attempted to use Wrigley forceps which did not lock successfully. He then applied a Kiwi cup which obtained good descent with four pulls until it detached. He then used Neville Barnes forceps and the baby was delivered with one pull.

[66] The delivery resulted in a large rectal buttonhole tear which was repaired in the labour ward. The respondent says there are four main areas of concern:

(1) that the applicant did not identify or consider options that could have resulted in a less traumatic birth, for example, the use of tocolysis to slow down or delay contractions to allow the applicant to consider taking the patient to theatre;

(2) the use of three instruments to deliver the baby;

(3) the over-use of lignocaine;

(4) the undertaking the repair of the buttonhole tear in the labour ward rather than an operating theatre.

[67] As to (1), Dr Garland was adamant:

> It's gone way beyond that…it may be that the contractions have… led up to that, but you're now in the situation where the baby's heartrate has been right down for at least seven minutes, the time he took to drive in, and that's profoundly worrying. You want to get this kid out in two or three minutes if you can get it out. To say… they would have stopped the Syntocinon drip, yes, but to give tocolysis and… wait five or 10 minutes to see if the contractions die down, no…

[68] As well, the layout of the hospital might mean transferring the patient to theatre could take 25 to 45 minutes.[26]

[69] As to (2), on the evidence, the Tribunal is of the view there is nothing remarkable in the use of the three instruments to affect the desired result.

[70] As to (3), Dr Fenton recorded the use of a total of 500 milligrams. The applicant denies this and says he injected 20 millilitres (200 milligrams) in total. Dr Fenton's recording in milligrams is unusual and it was the applicant who was administering the lignocaine and might be expected to be correct in his measurements. In any event, even if 500 milligrams were administered, Dr Garland opined that in the circumstances the use of that volume would be justified. He said the standard amount would be 300 milligrams but "it would not be unusual to add in a bit more during the repair if the patient had pain".

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25 Dr Fenton is a pseudonym used to refer to the principal house officer whose identity is protected by a non-publication order.

26 See evidence of the applicant at T1 – 79, ll 17 – 19.

[71] The Tribunal finds there is no compelling evidence that there was an over-use of lignocaine or that the amount was potentially toxic.

[72] As to (4), there appears to be no dispute that it is acceptable to repair a second-degree tear in the ward, provided that conditions such as lighting are correct. The Tribunal is of the view that the optimal approach may be to repair the tear in an operating theatre but here there were a number of factors which supported the applicant's decision to do the repair in the labour ward – namely, the time to get theatre, the patient's distress and her cognitive impairment.

[73] The Tribunal accepts that in these circumstances it was appropriate to do the repair as quickly as possible and with minimal trauma.

[74] There is nothing in this case which suggests the applicant poses a serious risk.

Adelia Gordon[27]

[75] The patient was a 41-year-old who sought treatment for abnormally heavy menstrual bleeding, possible adenomyosis and a thickened endometrium.

[76] She underwent a vaginal hysterectomy on 10 May 2021. The applicant was the primary surgeon.

[77] The hysterectomy was straight forward. However, the applicant was informed at about 13:30 to 13:40 that the patient had experienced a significant post-operative bleed. He reviewed her at that time. The notes indicate the patient was hypotensive, her blood pressure was 80 over 54 and her pulse 106. Her haemoglobin had dropped from 128 to 104 and she was pale.

[78] The applicant's evidence was that he considered she might have a venous internal bleed and that it might settle with time. He said he would review her in 30 minutes.

[79] The patient remained in the post-anaesthesia care unit (PACU) where she was monitored by:

(a) a nurse assigned to monitor her;

(b) reviews by the anaesthetists;

(c) being connected to a monitor to record her vital signs; and

(d) being attended by her husband, Dr Gordon,[28] [a senior medical practitioner].

[80] When the applicant reviewed the patient at 14:10 she was still unwell, but the vaginal bleeding had reduced. Nevertheless, the applicant directed she remain fasted.

[81] The applicant gave evidence that Dr Gordon requested a CT-scan to be performed to check for internal bleeding. The applicant did not consider it appropriate to take the patient out of PACU to go to radiology, so he approached a colleague in the intensive care unit to perform a bedside ultrasound scan. This occurred between 15:30 and 16:00. The applicant said he discussed the findings with other doctors and

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27 Adelia Gordon is a pseudonym used to refer to the patient whose identity is protected by a non-publication order.

28 Dr Gordon is a pseudonym used to refer to the patient's husband.

formulated a plan to return to theatre. She was returned to theatre at 16:00 after the theatre was prepped and readied.

[82] The respondent takes the view that the applicant was only persuaded to arrange the scan because Dr Gordon requested the CT imaging and without that prompt, he would have continued to wait.

[83] Seen from another perspective, the applicant made arrangements such as fasting, which suggests he did consider he might need to return the patient to theatre, but that Dr Gordon was reluctant to do so without the evidence a CT-scan might disclose. In any event, Dr Gordon's evidence before the MHHS inquiry did not raise any concern about the applicant's post-operative management of his wife. The context here is important in that the patient was in PACU being closely monitored by nursing staff, anaesthetic staff, and the applicant.

[84] The applicant agrees that with the benefit of hindsight, it may have been advisable to return to theatre somewhat earlier, but retrospective analysis will sometimes lead to such a conclusion.

[85] The Tribunal is of the view that the applicant's responsiveness was within the realms of acceptable practice.

Lydia Jodorowski[29]

[86] This patient was a 34-year-old who was at 42 weeks gestation. She had given birth to three other children whose weights and gestations were: 3,289 grams at 40 weeks, six days; 3,969 grams at 41 weeks; and 4,330 grams at 41 weeks, two days.

[87] The patient was being managed by consultant Dr Dixon and a registrar,[30] Dr Forbes.[31] The patient wanted a natural vaginal birth and declined a number of offers for an induction of labour (IOL). The advice on 20 May 2021 was "strongly recommended to have IOL now". The applicant was not involved in the case until he was called in from leave on 23 May 2021.

[88] A progress note created by Dr Dixon stated:

> Dr. Du Toit wanted patient offered Caesarean today, If she not agreed-Dr.Du Toit is not happy to provide any further care at MBH
>
> Not happy to perform controlled ARM tomorrow as it is deemed unsafe
>
> Advised to call TUH or RBWH and transfer for further care.

[89] Radiology suggested that this was to be a large baby although there is some dispute about precisely how large. The experts agreed that a large baby gives rise to a risk of shoulder dystocia. Dr Francis agreed that risk was significant and around 20%. The risks of shoulder dystocia include Erb's palsy and hypoxia. They also agreed that in terms of the safety of the patient herself, there was no real difference in the facilities in Mackay and elsewhere. However, with respect to the safety of the newborn, the facilities in Townsville and Brisbane would be better.

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29 Lydia Jodorowski is a pseudonym used to refer to the patient whose name is protected by a non-publication order.

30 Dr Dixon is a pseudonym used to refer to the registrar whose name is protected by a non-publication order.

31 Dr Forbes is a pseudonym used to refer to the consultant whose name is protected by a non-publication order.

[90] TUH declined to accept the transfer of the patient because "IOL seem[ed] reasonable" with appropriate counselling but transfer to the Townsville University Hospital (TUH) seemed unnecessary and TUH felt the case could be managed at MBH.

[91] The Royal Brisbane and Women's Hospital (RBWH) accepted the transfer and the patient gave birth by artificial rupture membrane (ARM).

[92] The experts agreed that a caesarean was an option for this patient, but they disagree on whether it was right for the applicant to refuse to induce the patient in Mackay. The respondent submits that the applicant did not hold genuine concerns regarding the lack of neonatal services in Mackay and has retrospectively placed greater importance on this factor to "justify his decision and rationalise his intransigence." This submission does not sit well with Dr Dixon's notes wherein the applicant expressed concern for the risk.

[93] The Tribunal has no specific criticisms of the decision making or the clinical competence of the applicant in regard to this case.

Sarah Franklin[32]

[94] Miss Franklin was a 26-year-old patient pregnant with her first baby. She suffered an intra-uterine death at 37 weeks' gestation. She was administered Prostin at 7:30 am on 29 January 2021 to prepare for induction of labour and vaginal delivery.

[95] The applicant reviewed her at about 9:22 am on 30 January 2021. She was three centimetres dilated but experiencing rigors and with a temperature of 37.3 degrees. She was commenced on triple antibiotics.

[96] At 12:15 the registrar, Dr Folwell[33] called the applicant. The patient and her family were requesting a caesarean section. The applicant suggested Dr Folwell obtain a second opinion from TUH. Dr Gettler[34] at TUH agreed with the current management plan and said she would not recommend a caesarean section at that stage. Dr Folwell also contacted the Mater Mother's Hospital who also agreed with the applicant's plan to manage the patient with a vaginal birth.

[97] However, the applicant did agree to perform a caesarean and at 15:31 it was performed. There is no criticism of the applicant performing that operation. Dr Francis says the applicant should have seen the patient and family between the second opinion and the decision to perform the operation. Dr Garland disagrees on the basis that it appears the registrar had a good working relationship with the patient and her family.

[98] The Tribunal considers the length of time from which the induction was attempted was reasonable. A more "hands on" approach by the applicant may have provided greater support to the junior clinician and the applicant could have been more involved in counselling the patient. However, the Tribunal considers the applicant's conduct falls short of presenting a "serious" or "grave" risk to the patient.

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32 Sarah Franklin is a pseudonym used to refer to the patient whose name is protected by a non-publication order.

33 Dr Folwell is a pseudonym used to refer to the registrar whose name is protected by a non-publication order.

34 Dr Gettler is a pseudonym used to refer to the doctor whose name is protected by a non-publication order.

Rose Maxwell[35]

[99] The patient was a 56-year-old with a history of prolapse, recurrent urinary tract infection and stress urinary incontinence. She was booked for a Burch colposuspension which the applicant performed on 2 August 2021.

[100] During the procedure the applicant noticed and repaired a small bladder injury. The experts agreed that this is a recognised complication of such surgery.

[101] The respondent criticises the applicant's post-operative direction to leave the catheter in place for 48 hours.

[102] After the catheter was removed, the patient underwent a trial of void which measures the ability of the bladder to empty. The experts agree that the trial of void must be carried out before the patient goes home. If the trial of void is unsuccessful, the catheter must be reinserted. The experts agree that a trial of void does not test the strength or integrity of the repair to the bladder. Both experts say they would have left the catheter in for seven days, but Dr Francis, when asked what was normal practice amongst those who perform this procedure, said it was a rare procedure "…so I would think it's difficult to form a normal in this context." Dr Garland said there was no universally defined time.

[103] As for not reinserting the catheter, Dr Garland said most practitioners would not reinsert the catheter and Dr Francis accepted some practitioners would say that not reinserting the catheter was within the bounds of acceptable practice.

[104] The Tribunal considers that the removal of the catheter was too soon, but the bladder injury was small (one centimetre), and the trial of void was successful. It is difficult in those circumstances to find that the applicant's clinical management in this case poses a serious risk to patients.

Ruby Rosevear[36]

[105] This patient was a 46-year-old who presented with mixed symptomology of pelvic pain, problematic vaginal bleeding and urinary stress incontinence.

[106] The applicant performed a laparoscopic hysterectomy which was converted to an open hysterectomy as the patient developed cardiac asystole and persistent bleeding.

[107] The applicant gave evidence that he dissected and visualised the ureters before suturing. He stated he inspected the ureters after suturing and found no evidence they were impacted.

[108] Six days after surgery, the patient developed pain. She underwent a cystoscopy, and a stent was inserted. The findings of the cystoscopy included "?Kinked ureter from suture, partial occlusion." In the expert's conclave report, the allegation was that a ureter was injured during surgery but that this was not identified at the time, resulting in post-operative difficulty for the patient.

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35 Rose Maxwell is a pseudonym used to refer to the patient whose name is protected by a non-publication order.

36 Ruby Rosevear is a pseudonym used to refer to the patient whose name is protected by a non-publication order.

[109] The experts agree there was an obstruction in the ureter which was dealt with post-operatively by a temporary stent to ensure drainage and this resulted in a satisfactory outcome.

[110] The issue was identified as whether the ureter was "injured". There is debate as to whether or not the obstruction of the ureter is an injury resulting from surgery.

[111] Dr Francis gave evidence that the ureter was not functioning properly; therefore, he considered it to be an "injury" but conceded by strict definition this may not constitute an injury. Dr Francis hypothesised that the ureter was kinked or sutured during surgery. Initially in his evidence he also posited that a diathermy injury might be responsible but ultimately excluded such an injury as unlikely. As to the hypothesis that the ureter was kinked or sutured during surgery, when asked if that was just speculation he replied "Yeah, we don't know what caused it." No offending suture was identified.

[112] Dr Garland raised the possibility that the ureter was partially obstructed by a swollen pedicle. In evidence, he explained the mechanisms in detail. He said he had seen this happen "quite a few times".

[113] The Tribunal found the evidence of Dr Garland on this point compelling and the explanations proffered by Dr Francis vague and indecisive. The Tribunal concludes that this was a recognised complication of surgery, and it was managed appropriately.

[114] The second issue is whether the applicant should have performed a cystoscopy during the operation to look for possible injury. The applicant points to the evidence by Dr Francis on day 5 of the hearing that a swelling of the ureter might not have occurred immediately and might have taken some time to develop so that a cystoscopy at the time the surgery might have shown a normally functioning ureter. Dr Francis however considered it common practice to conduct a cystoscopy at the end of a total laparoscopic hysterectomy.

[115] Dr Garland's opinion was that few gynaecologists would have the necessary skills to undertake a cystoscopy and it would be unlikely to reveal an injury. To check the ureters would require the introduction of a retrograde catheter, something which is in the expertise of a urologist rather than a gynaecologist.

[116] This difference of opinion may reflect differences in the experience of the experts. Further, there is no identified body of literature or other surgical guidelines mandating or even recommending the performance of a cystoscopy in a standard hysterectomy or a hysterectomy in the circumstances of this patient.

[117] The Tribunal is not satisfied the evidence points to the applicant being a serious risk to patients.

Clara Thorn[37]

[118] The patient was a 33-year-old who underwent an emergency caesarean section at 34 weeks' gestation. The patient had previously had two caesarean sections and a laparotomy for an ectopic pregnancy resulting in many adhesions of her bladder and

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[37] Clara Thorn is a pseudonym used to refer to the patient whose name is protected by a non-publication order.

uterus. The applicant described her bladder as "morbidly adherent or on a scale of 0 to 10 a 10". This required a sharp dissection of the abdomen.

[119] The applicant accepts that during the dissection, he damaged the bladder wall rendering it susceptible to rupture. The risk of damage to her bladder was discussed with the patient preoperatively. The patient nevertheless consented to the procedure.

[120] The operation record notes that frank (obviously visible) blood was noted in the patient's urine, but no bladder defect was noted. The applicant undertook a visual inspection which the respondent says was insufficient. The applicant conceded he ought to have tested the integrity of the patient's bladder by filling it with saline. However, if the bladder had not been ruptured at that stage the test would not have revealed anything of concern and a significant rupture would usually be seen without doing this.

[121] An issue remains whether the injury occurred during surgery. The hospital records show the patient reported she "had been fine after the operation but half an hour ago moved and 'felt something go.'" She then felt severe pain. There was also evidence the patient produced good quantities of urine during the day and was in the neonatal ward when she felt the sensation. A CT-scan was performed, and the radiologist reported that the bladder contained blood. She was returned to theatre for repair.

[122] Dr Garland said there were four possible scenarios:

(a) that there was an obvious hole in the bladder which the applicant simply left unaddressed;

(b) there was a full thickness cut to the bladder which, if inspected, should have been seen;

(c) that, after the procedure, the catheter was blocked by a clot causing the weakened bladder wall to rupture;

(d) that when the catheter was blocked somebody put in a new catheter and perforated the bladder.

The first two are unlikely.

[123] In evidence, Dr Francis conceded it was possible the bladder ruptured post-surgery.

[124] The Tribunal is of the view, based on the patient's description, that the bladder was damaged at the time of the caesarean but that the rupture occurred when she was in the neonatal ward and felt the onset of severe pain.

[125] The fact that the bladder was damaged during this difficult surgery was an expected complication which was explained to the patient who nevertheless consented to the operation.

[126] The Tribunal does not find the evidence in respect of this patient shows the applicant is a serious risk to patients.

Colleague references

[127] Numerous colleagues have sworn affidavits attesting to the applicant's competency in his clinical practice and performance of surgery. These deponents are from both Western Australia and MBH. Two of the Western Australian doctors who worked

with the applicant observed him to be "an extremely competent surgeon" and his "surgical and clinical skills to be excellent". Those comments were echoed in statements from his colleagues at Mackay Base Hospital.

[128] Following his resignation from Mackay Base Hospital, the applicant obtained employment with Fiona Stanley Hospital in Perth and two of his colleagues from there give him glowing references.

Conclusion

[129] The evidence material before the Tribunal, on careful scrutiny, does not lead the Tribunal to the view that because of his conduct or performance, the applicant poses a serious risk to persons. The landscape of the matter has changed significantly since the Health Ombudsman's decision and on this *de novo* hearing, the Health Ombudsman's decision is set aside. However, it is the Tribunal's view that there are concerns conceded by the applicant in two areas:

(1) note taking;[38] and

(2) his leadership capability.[39]

[130] Neither of these issues pose a serious risk to patients. In relation to the latter, the respondent has already taken steps to address it.

[131] The Tribunal therefore sets aside the Health Ombudsman's decision of 27 June 2022 and orders that the applicant be allowed to return to clinical practice in Queensland.

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38 T1 – 104, l 6.

39 T2 – 131, ll 23 – 47, T2 – 132, ll 1 – 6.