QUEENSLAND INDUSTRIAL RELATIONS COMMISSION

CITATION:	*Coffey v State of Queensland (Wide Bay Hospital and Health Service)* [2019] QIRC 056
PARTIES:	**Coffey, Gregory Dr** (Applicant) **v** **State of Queensland (Wide Bay Hospital and Health Service)** (Respondent)
CASE NO:	TD/2017/94
PROCEEDING:	Application for Reinstatement
DELIVERED ON:	5 April 2019
HEARING DATES:	13 November 2018 24 and 25 January 2019
MEMBER:	Thompson IC
HEARD AT:	Brisbane
ORDERS:	**1. The application for reinstatement is granted;** **2. Dr Gregory Coffey is to be reinstated to his former position of District Director of Medical Services at the Wide Bay Hospital and Health Service from 28 September 2017;** **3. The reinstatement is on the basis that his continuity of service is maintained; and** **4. Dr Coffey is to be paid all remuneration lost or likely to have been lost as a result of the dismissal after taking into account any employment benefits or wages received by him since the dismissal. Failing agreement, a further application can be made to the Commission.**
CATCHWORDS:	INDUSTRIAL LAW - APPLICATION FOR REINSTATEMENT - Termination of employment - Dismissal - Witness evidence - Allegations - Disciplinary process - Credentialing Committee, Policy and Procedure - Investigation Report - Was termination harsh, unjust or unreasonable - Is reinstatement impracticable - Remedy - Application for reinstatement granted - Continuity of service maintained - Remuneration.

LEGISLATION: *Industrial Relations Act* 2016 (Qld), s 316, s 318, s 320, s 387

Public Service Act 2008, s 188, s 189, s 194

CASES: *Byrne v Australian Airlines Ltd* [1995] HCA 24 at 128

Barsha v Motor Finance Wizard (Sales) Pty Ltd [2002] 171 QGIG 139

Stewart v University of Melbourne [2000] AIRC 1201 at [74]

Gold Coast Health District v Walker [2001] 168 QGIG 258

Lamb v Redland City Council [2014] QIRC 041

Sarvestani v State of Queensland (Metro South Hospital and Health Service) [2017] QIRC 085

de Villiers v State of Queensland [2017] QIRC 105

Bostik (Australia) Pty Ltd v Gorgevski No. 1 (1992) 36 FCR 20 at 28

Auto Logistics Pty Ltd v Kovacs (1997) 155 QGIG 320

Perkins v Grace Worldwide (Aust) Pty Ltd [1997] IRCA 15

APPEARANCES: Mr R. Reitano of Counsel, instructed by Hall Payne Lawyers for the Applicant.

Mr C. Murdoch of Counsel, instructed by McCullough Robertson Lawyers, for the Respondent.

Reasons for Decision

Background

[1] An application for reinstatement was lodged with the Industrial Registrar on 18 October 2017 by Dr Gregory Coffey (Dr Coffey) following the termination of his employment on 28 September 2017 by the State of Queensland (Wide Bay Hospital and Health Service)(WBHHS).

[2] The termination of employment was said to be harsh, unjust or unreasonable for reasons that included:

- Dr Coffey whose experience spanned more than 40 years including a 5-year history with the WBHHS, all of which had been exemplary and unblemished;

- in the course of his employment with the WBHHS he had at no time been subject to disciplinary action;

- Dr Coffey's performance appraisals had always been positive and often exceptional and in the period 1 July 2015 to 30 June 2016 the Chief Executive, Adrian Pennington (Pennington) having conducted a performance and development review stated he had demonstrated excellent outcomes in each of the clinical governance systems dimensions;

- Dr Coffey's professional judgement as a medical practitioner and a medical administrator had never been the subject of criticism;

- there was no evidence of Dr Coffey having acted dishonestly, wilfully or negligently in respect of the allegations against him; and

- the penalty of termination was disproportionate to the gravity of the allegations against him.

Witness List

[3] The witness for the Applicant was Dr Coffey.

[4] The witnesses for the Respondent were:

- Pennington;
- Stephen Bell (Bell); and
- Robyn Bradley (Bradley).

Applicant

Dr Coffey

[5] Dr Coffey gave evidence regarding his employment history as a medical practitioner that included experience both in Australia and overseas as a practitioner and medical administrator. Prior to the commencement of his employment at the WBHHS in or around December 2012 he had held the position of Executive Director of Medical Services at the Mt Isa Hospital for approximately seven years.

[6] As the District Director of Medical Services his direct report was to the Executive Director of Clinical Governance who in turn reported directly to the Chief Executive of the WBHHS/

[7] He was responsible for the recruitment and retention of medical officers at three hospitals:

- Bundaberg Hospital;
- Hervey Bay Hospital; and
- Maryborough Hospital.

[8] The role was based at the Hervey Bay Hospital and he would visit the Bundaberg Hospital about once a week to attend to various tasks that included:

- meeting with the medical administration team;
- reviewing staffing levels against operations;
- managing the budget for the Medical Services unit;

- chairing meetings of the Credentialing Committee;
- chairing the Clinical Directors Committee;
- maintaining contact and communication with the senior clinicians at the Bundaberg Hospital; and
- reviewing and assisting with the selection and retention of locum staff.

[9] Dr Coffey had overwhelmingly positive performance reviews for the period of his employment at the WBHHS and his role involved the management of hundreds of permanent and locum doctors across the three hospitals.

[10] Dr Coffey was the Chair of the Credentialing Committee for the WBHHS that was responsible for assessing credentialing applications and approving credentialing for senior medical officers and the checking of documentation for the senior medical practitioners. On commencement in the role, applications for credentialing were put before a committee comprised of senior medical practitioners within the hospital with one person from each of the ten departments or medical speciality, in addition to representatives from the nursing department.

[11] The process at the time included the review of the bundle of documents assembled by the Medical Administration Unit in respect of the application. The documentation relating to a candidates credentialing included amongst other things:

- curriculum vitae;
- any Australian Health Practitioner Regulation Agency (AHPRA) conditions;
- results of a Google search;
- applicant's qualifications; and
- referee reports.

[12] Twelve months after commencement in the role a streamlined version of the credentialing process was adopted by the hospital with the new procedure involving three senior clinicians being charged with reviewing the documents, electronically assembled in relation to the credentialing candidate by the medical administration team, in detail prior to making a decision about whether credentialing would proceed. The three senior medical practitioners were referred to as the "Credentialing Review Panel" and were selected from a pool comprising of about 10 to 20 people. If a query was

raised by one or more members of the panel than that query would be put to the remainder of the Credentialing Committee at the scheduled meeting and a resolution sought. In such circumstances a reviewer may identify the issue with medical practitioner's skills or experience with the rest of the Credentialing Committee to seek advice or guidance as to how to proceed with the application. Once the members of the Credentialing Review Panel had made their recommendation, Dr Coffey would review the application, the views of the Panel and then provide his views as to the application for credentialing including the supervision level he thought was appropriate.

[13] The composition of the Credentialing Committee changed, also to include between four to five senior medical practitioners, the Chief Operations Officer, the Senior Dentist, Director of Allied Health representatives, the Deputy Director of Medical Services and the Director of Nursing.

Dr Cloete

[14] Prior to obtaining a permanent position at the Bundaberg Hospital, Dr Jocobus Cloete (Dr Cloete) had performed work at the Hervey Bay Hospital as an obstetrician/gynaecologist reporting to Dr Dirk Ludwig (Dr Ludwig) as the Head of the Department. The circumstances of the employment had not required him to be credentialed nor had he been issued with interim credentials prior to obtaining permanent employment.

[15] On or about 24 May 2016 Dr Cloete's medical practitioner's registration with AHPRA was subject to conditions with the details available to the public through the AHPRA website. It was also possible to view a notation on the AHPRA website to the effect there were also private conditions in operation. The AHPRA conditions formed part of the documents that were provided by the medical administration unit in respect of his application for the permanent part-time obstetrician position at the Bundaberg Hospital.

[16] On 2 September 2016, Dr Coffey received a copy of the full set of AHPRA conditions including the private conditions that had been imposed on Dr Cloete's registration when they were emailed to him by Dr Kuehnast. On 14 September 2016 Dr Coffey chaired a meeting of the Credentialing Committee that considered Dr Cloete's credentialing application of 29 August 2016. Prior to the Credentialing Committee consideration of Dr Cloete's credentialing application it had been reviewed by three members of the Credentialing Review Panel comprising of:

- Dr Ludwig;
- Dr Bolton; and
- Dr Williams.

The Credentialing Review Panel were required to have separately reviewed all the material and based on the practices at the time, would have received the following documents:

- the credentialing application;
- his curriculum vitae;
- AHPRA public conditions of Dr Cloete's registration;
- Google search results;
- Dr Cloete's qualifications and referee reports;
- completed professional development material; and
- passport photos.

[17] The Credentialing Review Panel had recommended Dr Cloete for credentialing with varying degrees of supervision, specifically:

- Dr Bolton recommended level five supervision;
- Dr Ludwig recommended level four supervision; and
- Dr Williams recommended level four supervision.

Upon his own review of the material presented to the Credentialing Review Panel, Dr Coffey recommended Dr Cloete have level four supervision in addition to the supervision and mentoring conditions imposed on his AHPRA registration which were being complied with by Dr Cloete at the time of his credentialing application.

Credentialing

[18] The Credentialing Committee on 14 September 2016 with all members, save for one abstention recommended Dr Cloete for credentialing with level four supervision. The decision was taken with the knowledge that:

- there were private AHPRA conditions; and
- the details of the private conditions had not been disclosed to the Credentialing Committee.

Email

[19] On 15 September 2016 he attempted to telephone Pennington without success in relation to Dr Cloete's credentialing, leaving a message to return the call. He also on the same day sent Pennington the following email having copied in Bell:

> Adrian, relating to my phone message:
> This obstetrician is being appointed at Bundaberg 0.5FTE.
> He has AHPRA conditions as attached, which include non-published conditions which are deemed by AHPRA to be not publicly available due to privacy obligations. These were discussed at yesterday's credentialing meeting and he was recommended for scope of practice in O&G.
> Elize Bolton and Stephen Bell are fully aware and support the appointment. Elize and Dirk Ludwig were both involved in his interview, and both had had previous contact with him as a locum.
> His CV is very impressive, also attached.
> I can expand by phone when convenient.

[20] Pennington did not return the telephone call or email, and consequently there were no discussions prior to Dr Cloete being offered permanent employment.

[21] In response to a telephone call from Bell on 16 September 2016 as to why he and Pennington had been sent the email he responded in words to the effect of:

> I wanted to make sure that Adrian [Pennington] was aware that Dr Cloete had conditions on his registration and given him the opportunity to discuss any concerns he might have about employing him, before we made the formal offer.

Incident

[22] Dr Cloete commenced his permanent part-time appointment in Obstetrics and Gynaecology on 19 September 2016 and or around 7 November 2016 another doctor at the Bundaberg Hospital noticed that Dr Cloete's breath smelt of alcohol and reported their concerns to Dr Bolton in accordance with the accepted practice for escalating concerns regarding the conduct of colleagues. Dr Bolton subsequently asked Dr Cloete to complete an alcohol breath analysis test left the hospital to collect his breathalyser kit from home and subsequently never returned to the hospital. On or about 22 November 2016 Dr Cloete's employment was terminated.

Investigation

[23] Dr Coffey received correspondence from Paula Hoctor (Hoctor), Investigator with Q Workplace Solutions on 16 December 2016 regarding a health service investigation and was the subject of an interview on 18 January 2017.

Show Cause

[24] On 12 April 2017 Dr Coffey received a letter from WBHHS directing him to show cause as to why he should not be disciplined in relation to his involvement in the credentialing of Dr Cloete. At the same time, he was provided with a copy of the Investigation Report. The correspondence under the signature of Pennington contained the following allegations:

> **Allegation One**
>
> That between September 2016 and November 2016 you failed to ensure the highest professional and ethical standards were observed for the credentialing of Dr J Cloete.
>
> **Allegation Two**
>
> That on 15 September 2016 you sent a misleading email to me, for the purpose of approving Dr Cloete's credentialing application, in which it was implied that the Full Conditions were not publicly available and therefore not attached, were discussed by the Credentialing Committee that approved his scope of practice, and that Mr Stephen Bell was "fully aware" of the details of the appointment including the Full Conditions.
>
> **Allegation Three**
>
> That between September 2016 and November 2016 you failed to take appropriate action to mitigate the potential risks to patients (and/or others) of employing a medical officer with an identified alcohol issue.

[25] The Show Cause letter contained the particulars relating to each of the allegations, identified possible grounds for discipline and provided Dr Coffey with 14 calendar days to respond to the allegations.

[26] Dr Coffey's legal representative provided a 15-page response to the Show Cause Notice (dated 5 May 2017) in which challenged any proposed disciplinary action being considered by the WBHHS and in doing so relied upon statements lifted from the Investigation Report prepared by Hoctor that included:

- While there have been a number of issues identified above in relation to Dr Cloete's appointment and credentialing, there is no evidence that the conduct of any WBHHS employee (excluding Dr Cloete) was deliberate or knowingly in breach of any relevant policy or procedure;
- All witnesses impressed as cooperative and credible, and it is accepted that all witnesses were acting with the best of intentions in relation to the appointment and credentialing of Dr Cloete; and
- This particular situation is unprecedented in the experience of witnesses.

[27] The response included denials by Dr Coffey in respect of each of the allegations and commentary that included:

- Ms Hoctor made no findings critical of Dr Coffey's actions nor did she recommend any disciplinary action be taken by the HHS against Dr Coffey or any other employee;
- At all times Dr Coffey strived to ensure that the highest professional and ethical standards were observed for the credentialing of Dr Cloete;
- Dr Coffey's email of 15 September 2016 was not misleading and was not intended to mislead;
- Dr Coffey did not fail to take appropriate action to mitigate potential risks to patients by the employment of Dr Cloete.

[28] Following the receipt of the response to the show cause notice, the WBHHS through correspondence under the signature of Pennington (dated 15 May 2017) suspended Dr Coffey from duty on full pay due to "serious concerns about whether you [Dr Coffey] should continue to perform your role or remain in the workplace".

[29] On 16 May 2017 the WBHHS sent correspondence to Dr Coffey confirming that the allegations that had been levelled against him were found to be substantiated and that disciplinary action in the form of "termination of employment" was being considered and he was afforded seven days to respond, at which time consideration would be given to the final determination of the disciplinary action taking into account:

- your overall work record, including any previous disciplinary actions;
- the seriousness of the substantiated allegations;
- any explanation given by you;
- any extenuating circumstances which may have had a bearing on your actions;
- the degree of risk to the health and safety of staff and clients;
- the impact the substantiated allegations have on your ability to perform the duties of your position.

[30] On or around 22 May 2017 Dr Coffey instructed his legal representatives to lodge an appeal notice with the Queensland Industrial Relations Commission (Commission) on the basis of a "fair treatment decision". The appeal in effect ran its course and on 14 September 2017 a decision was released that dismissed the appeal having found that the findings made by the decision maker were available to be made.

[31] The disciplinary process recommenced with correspondence from the WBHHS (dated 15 September 2017) under the signature of Bradley in which Dr Coffey was given to 19 September 2017 to respond to the proposed disciplinary action.

[32] A response was prepared by his legal representative (dated 21 September 2017) and on 28 September 2017 the WBHHS in correspondence, under the signature of Bradley, terminated Dr Coffey's employment with immediate effect.

[33] Dr Coffey was subsequently the subject of an investigation by AHPRA with regards to the events at the WBHHS arising from a notification made by Pennington. The issues investigated were:

- **Other - other issue**

  Whether Dr Gregory Coffey (the practitioner) provided inaccurate and/or misleading information to the Credentialing Committee at the Wide Bay Hospital and Health Service ("the Hospital and Health Service") about the conditions on Dr Jacobus Cloete's registration.

- **Other - other issue**

  Whether the practitioner failed to take steps to manage the risk to patient health or safety at the Hospital and Health Service due to the conditions on Dr Cloete's registration.

[34] AHPRA formally advised Dr Coffey in correspondence (dated 29 June 2018) that no further action would be taken in terms of his performance arising from the notification of Pennington.

Personal Consequences

[35] Dr Coffey gave evidence with regards to the profound impact the termination of his employment had on both his professional standing, financial position and the ability to secure alternative employment. In the period between March 2018 and July 2018 he had completed two periods (each of four weeks) of work as a locum in Wollongong and remained registered with two employment agencies.

[36] Dr Coffey also provided an affidavit in reply having read the affidavits of Bradley, Pennington and Bell.

Credentialing Committee Meeting

[37] The meeting of 14 September 2016 was notable due to the large number of proxies in attendance which Dr Coffey only became aware of when he attended the meeting. He had considered postponing the meeting however there were no formal policies or procedures in place regarding the postponement of a meeting. Dr Coffey also had

concerns that to postpone the meeting may have jeopardised a number of applicants that were due to be considered for credentialing and scopes of practice as the applicants and medical administration team were often subject to tight timeframes before a prospective employee could be presented with a formal offer of employment. Such delays in processing were known to have the potential for prospective employees to obtain employment elsewhere.

[38] Dr Coffey determined it was desirable to proceed with the meeting even though his understanding of the proxies that were in attendance had previously not participated in a meeting of the Credentialing Committee. He had further concerns that the proxies may not have been aware of the strict confidentiality obligations that apply to members of the Committee in the performance of their role. Of particular concern was the confidentiality being breached in respect of Dr Cloete, as it was his considerable experience as an administrator, the disclosure of salacious and/or scandalous information about employees was liable to be circulated around a hospital.

[39] The effect of such gossip being circulated about a new employee and a senior practitioner loomed large in his mind because:

- it can be difficult for that employee to settle into their new role;
- it can impact the employee's ability to effectively perform their work; and
- it has implications for the employee's ability to properly manage, mentor and direct staff, where required.

[40] The circumstances were compounded in Dr Coffey's view by factors that included a lack of procedure or policy in existence on how to manage the confidential obligations of the Committee and as he had not been involved in selecting the proxies he had been aware of what had been explained to the proxies about confidentiality.

Dr Cloete's application

[41] They took about 20 minutes to discuss Dr Cloete's application which is a longer time than the average for discussion around an application with the reasons for the extended discussion being due to the existence of the AHPRA conditions. In the absence of the AHPRA conditions on his registrations he would have been approved with level five supervision, being the lowest of the levels.

[42] In the course of the meeting with regards to Dr Cloete's application, he had said words to the effect:

> Dr Cloete's AHPRA registration is subject to conditions. There are both public and private conditions. You have copies of the public conditions but there has been a request to keep the private conditions confidential. Barb can explain further.

The reference to "Barb" was to Dr Kuehnast who was said to have informed the meeting of a request from Dr Bolton not to disseminate Dr Cloete's private conditions on his registration and further words to the effect she had "seen the private conditions. I am aware of them and I accept them". Dr Coffey also informed the meeting that he had seen the full conditions and supported Dr Cloete's application with appropriate supervision and that the full schedule of the AHPRA conditions were not available on their website so as to protect his privacy.

[43] The majority of the comments about Dr Cloete's application came from the medical officers present and the effects of those discussions were:

- the Committee was supportive of the full conditions not being disclosed; and
- the Committee did not consider that it was unable to assess Dr Cloete's application without having sighted the full set of conditions.

[44] The Committee resolved to approve Dr Cloete's application with level four supervision and Dr Coffey held the view that full disclosure of the private conditions would or should not have made a difference to the outcome of the deliberations.

Conversation with Stephen Bell

[45] Dr Coffey disagreed with Bell's evidence that he had significantly downplayed Dr Cloete's AHPRA conditions and more to the point he had not had a detailed discussion with Bell about Dr Cloete's conditions. The entirety of his conversation with Bell would have been approximately five minutes and did not include the credentialing process because to do so would have overloaded him with such information.

[46] The evidence of Bell around the nature of Dr Cloete's AHPRA conditions was indicative of his misunderstanding of the conditions because there had been no requirement for him to have regular or random breathalyser tests. Dr Cloete was subject to conditions that included the WBHHS being able to demand a test should they have any clinical concerns. The power of the Committee was not unfettered when it came to discretion in terms of conditions it can impose on a practitioner as it can only vary levels of supervision that broadly align with AHPRA.

[47] Under cross-examination Dr Coffey conceded that as the Director of Medical Services he had the responsibility for the oversight of professional issues for medical services across the health service, to ensure the highest professional and ethical standards were observed by all medical staff, provide advice to the Chief Executive on all professional medical issues, taking the lead role in the medical implications of clinical service strategy, service configuration, clinical performance and conduct, medical education, consultant appraisal, revalidation and credentialing [Transcript pp. 2-9 and 2-10). In

overseeing the credentialing process and the scope of clinical practice he was required to ensure that the relevant staff had a clear understanding of role accountabilities [Transcript p. 2-10]. Dr Coffey was taken to a document entitled "Credentialing and Defining Scope of Clinical Practice" which was a WBHHS document, but according to Dr Coffey was not relied upon in this process because it may have been superseded by the procedure [Transcript p. 2-12] which was titled "The Wide Bay Hospital and Health Service credentialing procedure" [Transcript p. 2-13].

[48] Dr Coffey was the responsible executive team member for the approval and implementation of the policy and the procedure document had been drafted by him [Transcript p. 2-14]. The purpose of the formal process was to verify qualifications, experience, professional standing, competence and professional ability to provide a safe and high-quality health service [Transcript p. 2-15]. The Credentialing Committee was comprised of people with the skill, knowledge and experience to determine the scope of practice, for example a nursing representative would comment on nurse practitioner applications, an allied health representative would give comment on allied health applications [Transcript p. 2-17]. Normally the committee would have access to all information that was relevant to the professional suitability of a person to perform safe high-quality health care services. This would include any conditions which had been imposed upon that person's practice [Transcript p. 2-19]. The application for a Senior Medical Officer position is accompanied by all relevant documentation which includes any conditions upon their registration and were all relevant to the decision making although the procedure at the time did not require that all conditions be made known to the Committee [Transcript p. 2-20]. In this case it was the Committee's responsibility to ensure that someone was complying with the AHPRA conditions [Transcript p. 2-21].

[49] Dr Cloete was first appointed as a locum at the Hervey Bay Hospital in July 2016 working under the supervision of Dr Bolton and due to the nature of the position had not required credentialing or a scope of clinical practice [Transcript p. 2-22]. In September 2016 Dr Coffey received a full set of Dr Cloete's AHPRA conditions which he discussed with Dr Kuehnast (who had provided the information) [Transcript p. 2-23]. He was informed by Dr Bolton that contact had been made with Dr Cloete's mentor and there were no concerns about him and through Dr Kuehnast he had learnt that he had recovered from his alcoholism and was in the final stages of the processes of AHPRA [Transcript p. 2-24]. Dr Kuehnast had informed him that Dr Cloete was well and truly past his alcohol difficulties and had denied using alcohol since AHPRA had imposed conditions [Transcript p. 2-24]. Dr Coffey was taken to the private AHPRA conditions imposed on Dr Cloete which included the unqualified capacity to have Dr Cloete undergo a breathalyser testing [Transcript p. 2-27]. Dr Coffey gave evidence that AHPRA conditions regularly changed and there was often a lack of sequence with the conditions [Transcript p. 2-30]. In respect of the requirement to keep a breathalyser log and have results forwarded to the Board, it was Dr Coffey's evidence that those conditions were "presumably being left over from the previous regular testing

conditions" [Transcript p. 2-32]. It was his understanding if Dr Cloete's breathalyser reading went above 0.000 per cent that he could not work the shift scheduled for the day [Transcript p. 2-32]. He seriously considered that Dr Cloete was out of the woods in respect of his alcohol problems [Transcript p. 2-32]. Dr Cloete was at the very tail end of the normal AHPRA restrictions for alcohol and narcotic use [Transcript p. 2-32]. There was no provision under any policy to allow for random breath testing and in this case, it raised the possibility of discrimination [Transcript p. 2-33]. Any breathalyser test would have to be done by a registered practitioner, qualified to do the test in confidential circumstances [Transcript p. 2-34]. Both Dr Kuehnast and Dr Bolton told him they did not think breath testing was necessary [Transcript p. 2-35] and in the case of Dr Kuehnast she had told him around 2 September 2016 of not needing regular testing [Transcript p. 2-36]. There was an informal process in place that if Dr Cloete required a breathalyser test it could have been conducted by either Dr Kuehnast or Dr Bolton [Transcript p. 2-37]. The requirement for Dr Cloete to abstain from alcohol had been implemented two years previous [Transcript p. 2-38]. Dr Coffey conceded that he had never specifically spoken to Dr Bolton about this matter [Transcript p. 2-38].

[50] Dr Coffey had no knowledge of any testing or supervision that had occurred prior to Dr Cloete commencing work at the Hervey Bay Hospital [Transcript p. 2-38]. Dr Cloete had five referee reports and there was information from his mentor that he was clear of his alcohol issues [Transcript p. 2-39]. The level four supervision placed upon Dr Cloete allowed him to have the full responsibilities for patients without being required to defer to anybody else [Transcript p. 2-40]. There was no requirement for the person supervising Dr Cloete to be present when he treated patients or even to be at the hospital whilst he was working [Transcript p. 2-41] which was also applicable to virtually all people who had any sort of AHPRA restrictions [Transcript p. 2-41]. Dr Coffey had no previous involvement in situations where people had alcohol problems that prevented them from being on call although he may have had an issue with a junior doctor who had alcohol issues and had to work between 9.00 am and 5.00 pm [Transcript p. 2-42]. Dr Coffey conceded that conditions could have been imposed on Dr Cloete which would have required him to be the subject of some form of breath testing [Transcript p. 2-42]. He did not accept that it would have been prudent to put additional steps in place when employing Dr Cloete [Transcript p. 2-43]. It was not normally the role of the Credentialing meeting to require an applicant to undertake some form of breath testing and whilst it would have been open to impose a 9.00 am to 5.00 pm work period only, such a decision by the Committee would have been inappropriate [Transcript p. 2-44]. The role of the Credentialing Committee was to establish who is a practitioner and determine the scope of practice in addition to ensuring people are complying with their AHPRA conditions. On the continued abstaining from alcohol by Dr Cloete and the role of the Committee, the evidence was that "the committee was reassured by the assurances of those who were providing information about him" [Transcript p. 2-44]. The employer in certain circumstances had the power to get Dr Cloete to undertake a breathalyser test [Transcript p. 2-44].

[51] The reliance upon Drs Bolton and Kuehnast's knowledge of Dr Cloete's private AHPRA conditions was due to them being his immediate line manager and his supervisor [Transcript p. 2-45]. Dr Coffey acknowledged that he would rewrite the procedure so that the full Committee would be aware of the restrictions [Transcript p. 2-45]. Initially he had endorsed a request for the credentials to go out via a flying minute because there was a timing problem with the application but after further consideration and discussions with Dr Kuehnast he withdrew his authorisation which assured the application would go to the Committee meeting [Transcript p. 2-46]. Dr Coffey gave evidence of those in attendance at the Credentialing Committee meeting that included:

- Mr Duffy acting Director of Nursing - proxy for Ms Sewel;
- Mr Ross-Edwards - team leader of community and allied health;
- Dr Robert Burness - acting Director of Orthopaedics - proxy for Dr Gehr;
- Dr Leonida - head of Dental Services;
- Dr Terry George - Director of Emergency Services; and
- Dr Kuehnast. [Transcript p. 2-47]

Dr Coffey had concerns that a number of proxies may not have been strictly aware of the confidentiality obligations and he had considered they may have breached confidentiality [Transcript p. 2-48]. He identified persons whom he lacked confidence in keeping confidentiality [Transcript pp. 2-50 and 2-51]. A number of the proxies had never attended a meeting of this nature [Transcript p. 2-51] and he had only become aware of four proxies attending the meeting about one hour before the meeting started, although it was reasonable to have a proxy provided that proxy was familiar with all the nuances of credentialing. In this case, the proxies were of concern to Dr Coffey but he continued with the meeting because of the number of applications for credentialing [Transcript pp. 2-52 and 2-35]. The Committee had discussed the matter at length and ultimately agreed that it was reasonable to issue credentialing and scope of practice to Dr Cloete without the full knowledge of the conditions. If the Committee had requested access to the private conditions in retrospect he probably would have postponed the decision, taken expert advice and reconvened in some fashion [Transcript p. 2-53].

[52] Dr Cloete's application was discussed for about 20 minutes which was longer than normal and the extended discussion was due to the existence of the AHPRA conditions [Transcript p. 2-54]. Dr Coffey accepted that he would "do it differently in future" [Transcript p. 2-54]. The request to keep the private conditions confidential had come from Dr Cloete through Dr Kuehnast and were meant for those other than the people he

reported to [Transcript p. 2-54]. There was no requirement to consider such a request but Dr Coffey in this case had deferred to the views of Dr Kuehnast and his own personal views on the matter [Transcript p. 2-55]. There had been discussion amongst the Committee about whether the private conditions ought to be disclosed but such discussion was unnecessary because the procedure did not provide for that to occur [Transcript p. 2-56]. Dr Coffey did not accept that the procedure allowed for the Committee to have the full conditions [Transcript p. 2-57]. Dr Coffey denied that not apprising the Committee of the procedure he had allowed the Committee to miscarry [Transcript p. 2-57].

[53] Dr Cloete had posed no greater risk to patient safety than any other practitioner, notwithstanding the conditions on his registration, from a statistical perspective [Transcript p. 2-57]. Dr Coffey did not accept the proposition that he had no credible basis that he could be satisfied there was no greater risk to patient safety with Dr Cloete compared to another doctor [Transcript p. 2-58]. Dr Coffey had telephoned Pennington because Dr Cloete's application was not straightforward and he wanted to ensure Pennington was aware of the appointment, it had been through the Credentialing Committee and there were private conditions in existence that had been the subject of discussion but only known to certain parties within the credentialing process and to reassure Pennington there were no concerns about patient safety [Transcript p. 2-59]. In the circumstances it was not a usual practice to email or telephone Pennington following the credentialing of a particular candidate. The inclusion of Bell had been normal practice because he was referenced in the email [Transcript p. 2-59]. In the email he had stated:

> He has AHPRA conditions as attached, which include non-published conditions which are deemed by AHPRA to be not publicly available due to privacy obligations. These were discussed at yesterday's credentialing meeting and he was recommended for scope of practice in O&G.

[54] The email referenced discussion about the published and non-published conditions. He accepted that his email had not distinguished between the existence of conditions and the discussion of conditions [Transcript p. 2-60]. He did not accept that the email had been misleading [Transcript p. 2-61]. The reference to Bell in the email had been a "mistaken statement" but he only became aware of that a day or two later [Transcript p. 2-61]. He took no steps to inform Pennington of his mistake as it had not crossed his mind at the time [Transcript p. 2-61]. Dr Coffey had a discussion with Bell of the existence and the nature of the conditions and what they were likely to be [Transcript p. 2-62]. He denied he was making up the discussion with Bell about Dr Cloete and conditions that related to alcohol usage [Transcript p. 2-62]. He told Bell he was "reluctant to disclose these private conditions fully" [Transcript p. 2-62] and that he was confident Dr Cloete was a safe practitioner [Transcript p. 2-63].

[55] Dr Coffey confirmed the knowledge he had regarding Dr Cloete's employment circumstances after 24 March 2016 and whilst there was always a risk that he could

relapse he did not accept that Dr Cloete was an enhanced risk compared to another practitioner [Transcript p. 2-64]. He disagreed with the proposition that he had acted inconsistently with his obligation to ensure that the highest professional and ethical standards were observed by all medical staff, in this case, Dr Cloete [Transcript p. 2-64].

[56] Dr Coffey gave evidence of his termination that occurred in September 2017 and of the circumstances relating to his application for reinstatement being delayed for financial reasons despite having earned a significant salary in the four or five years prior to the termination [Transcript p. 2-66]. He had in the period between the termination and lodging of his reinstatement application spent about eight weeks overseas [Transcript p. 2-67]. He had obtained limited employment since being terminated, none of which had been local [Transcript p. 2-70].

[57] In re-examination Dr Coffey confirmed he had complied with the highest professional standards in considering Dr Cloete's circumstances and in particular having taken into account that AHPRA had failed to make any findings against him with regards to professional behaviour. He did not accept that random breath testing made any difference if someone was "going to fall off the wagon". On the call to Pennington, it had partly been made because Dr Pike was on leave and he wanted to explain to him that he reached a conclusion that he was able to be credentialed and was a safe practitioner. The telephone call and email to Pennington had not been responded to and he had not followed up because it was not a "big deal". Bell had asked him about the nature of Dr Cloete's non- published conditions but had not requested a copy of the conditions. The financial considerations of making an application for reinstatement related to an estimated overall cost of $150,000 later dropping to $100,000. In terms of putting conditions on Dr Cloete's employment, it was the case that normally you comply with the agency's specifics and to add extra random conditions on a registration could be challenged as being potentially unfair.

[58] Dr Coffey was recalled to give further evidence-in-chief where he questioned his earlier evidence regarding the discussion with Bell indicating that on reflection it may have been with a person called Thomas and not Bell.

[59] Under cross-examination he was unable to guarantee that he had spoken to Bell about Dr Cloete's private conditions that were invariably about drug and alcohol use [Transcript p. 2-78].

WBHHS

Pennington

[60] Pennington, the Chief Executive Officer of the WBHHS, disputed that Dr Coffey had commenced employment with the WBHHS in November 2012 as claimed but rather in

December 2013. There was no agreement either, in respect of Dr Coffey's claim with regards to his performance being "exceptional" or "overwhelmingly positive".

[61] Pennington had concerns regarding the high proportion of proxy members at the Credentialing Committee meeting and how the meeting had been run, particularly that the members had relied upon Dr Coffey's reassurance about the AHPRA conditions. Based on the findings of the Investigation Report five members were aware that full conditions existed but did not know their contents. Of the Credentialing Review Panel, it was only Dr Bolton that was aware of the private conditions. The recommendation of the Credentialing Committee was also problematic for Pennington on the basis it was only Dr Coffey and Dr Bolton who knew of the AHPRA private conditions relating to Dr Cloete. He had commissioned the Investigation Report as a result of concerns he had about the credentialing of Dr Cloete.

[62] Upon receipt of the Investigation Report he wrote to the Show Cause letter to Dr Coffey (dated 11 April 2017) which included all the relevant materials to enable Dr Coffey to respond to the allegations. After receipt of Dr Coffey's response provided by his legal representative (dated 5 May 2017) Pennington made the decision to suspend Dr Coffey on full remuneration pursuant to s 189(1) of the *Public Service Act 2008* (PS Act).

[63] On 16 May 2017 having fully considered the responses provided on behalf of Dr Coffey he found the allegations substantiated on the balance of probabilities and determined pursuant to the PS Act that he had performed his duties carelessly, incompetently or inefficiently and was liable to disciplinary action. The second Show Cause in terms of disciplinary action was then forwarded to Dr Coffey requesting a response on why termination of employment should not be imposed.

[64] Pennington denied having made a notification to AHPRA but had notified the Office of the Health Ombudsman (OHO) on 16 May 2017.

[65] Prior to commencing leave Pennington had provided an overview of the matter to Bradley at one of the handover meetings held on or about the week of 4 to 8 September 2017 in the presence of the WBHHS Director of Legal Services and Director of Human Resources. In the meeting he advised Bradley that no decision had yet been made as he was awaiting a decision from the Commission. At this meeting he had not provided any documents to Bradley. Whilst he had not authored the correspondence that had recorded Dr Coffey's termination he agreed with Bradley's reasons and conclusions.

[66] The role formally performed by Dr Coffey had now been filled and there were no suitable alternative positions currently available at the WBHHS that he could perform.

[67] In the course of the disciplinary process Dr Coffey was given the opportunity to define whether he would do the same again in terms of decision making. He confirmed that he would, given the serious nature of the event this would be unacceptable and a danger to the community we service. Dr Coffey's credibility to provide good advice to senior clinicians and executives had been compromised by appointing medical staff with a known deficiency. Trust and confidence had been lost in Dr Coffey as a senior medical officer responsible for safety of clinicians and their activities.

[68] Under cross-examination Pennington was taken to the recommendations contained in the Hoctor Investigation Report and, in respect of the recruitment and selection process, there were five recommendations made that were put to Pennington as not having anything to do with Dr Coffey, to which he stated, "it depends where the line is drawn" between selection and appointment [Transcript p. 2-89]. Pennington did not accept that credentialing was not part of the recruitment process but he did accept that credentialing was quite different and a separate part of employing someone [Transcript p. 2-89]. Dr Coffey in the case of Dr Cloete had been responsible for the credentialing and ensuring that the medial administration had fulfilled their role in complying with the recruitment process [Transcript p. 2-89]. Pennington accepted that on 22 August 2016 he approved the selection panel recommendation to appoint Dr Cloete and that Dr Coffey was not on the selection panel [Transcript p. 2-90]. He accepted that the selection process was conducted separate to the credentialing process [Transcript p. 2-91]. The three stages of the employment process being:

- recruitment and selection;
- credentialing; and
- contract offered. [Transcript p. 2-92]

[69] Hoctor had made a recommendation that around clarifying credentialing procedure so that proxies cannot make up a quorum for decisions about credentialing applications [Transcript p. 2-93]. That recommendation had been implemented about 16 months ago [Transcript p. 2-94]. There were a number of other recommendations that were implemented about the credentialing process, including having an external person available to give advice [Transcript p. 2-94]. Another change was that any conditions on a candidate's registration must be in writing and provided before signoff [Transcript p. 2-96]. Pennington had expectations of being notified of AHPRA conditions and the nature of conditions and that had always been expected to happen [Transcript p. 2-99].

[70] Hoctor had made no recommendation about any action to be taken against any particular officer within the hospital or WBHHS nor did she in anyway suggest that any one particular officer was to "blame" for what happened [Transcript p. 2-100]. The majority but not all recommendations arising from the Hoctor Investigation had been implemented [Transcript p. 2-100]. In correspondence forwarded under Pennington's

signature to the OHO on 16 May 2017 it was advised that the WBHHS had implemented a number of actions (seven dot points) but a number of them were in place before and remained in place [Transcript p. 2-102]. Pennington had not written to inform the OHO he had made a mistake [Transcript p. 2-104].

[71] Pennington's evidence was that he did not receive a phone call from Dr Coffey on 15 September 2016 [Transcript p. 2-104]. In terms of the email sent on the same day, it was said to be strange [Transcript p. 2-105] but he had no recall of calling Dr Coffey despite it being a strange email. The content confirming the AHPRA conditions was not something a chief executive would be involved in [Transcript p. 2-106]. He saw nothing important within the content that was urgent and any individual within the executive team could get hold of him within a 24-hour period [Transcript p. 2-107]. He received about 200 emails a day and Dr Coffey's email did not define anything of urgency [Transcript p. 2-107]. The email from Dr Coffey had confirmed that the AHPRA conditions were reviewed by the Credentialing Committee and recommended to scope [Transcript p. 2-109]. Pennington did not accept there were shortcomings on his behalf in not having contacted Dr Coffey in response to his email [Transcript p. 2-110].

[72] The investigation undertaken by Hoctor into the appointment of Dr Cloete was the only investigation regarding the appointment and at the time the recommendations made by Hoctor were largely accepted [Transcript p. 3-2]. He confirmed he had not spoken to any qualified or registered person qualified in medical administration about the matters that arose in this case prior to receiving Hoctor's Report [Transcript p. 3-2]. Pennington's approval of the selection panel's choice of Dr Cloete prior to pre-employment checks and credentialing was not contrary to the recruitment policy because the documentation signed was not "an offer of contract" [Transcript p. 3-3]. Pennington when taken to the "Recruitment and Selection Process" conceded his conduct was both inconsistent with policy and practice and he had failed to comply with policy [Transcript p. 3-4]. The selection panel was responsible for checking references, AHPRA conditions and making recommendations to the Credentialing Committee. Dr Coffey had not been a member of the selection panel [Transcript p. 3-5] and was never disciplined in relation to the selection process [Transcript p. 3-7]. Pennington after receiving Hoctor's Report became aware that Dr Coffey had Dr Kuehnast outline the circumstances of Dr Cloete's AHPRA conditions at the Credentialing Meeting [Transcript p. 3-8]. He had lost trust and confidence in Dr Coffey because he had confirmed in writing that he would do the same again [Transcript p. 3-9].

[73] Hoctor had interviewed about a dozen people all of whom were connected with the credentialing process and it was agreed by Pennington that "this particular situation is unprecedented in the experiences of all witnesses" [Transcript p. 3-10]. He was taken to the content of his affidavit where it was stated:

> The individual was, during the disciplinary process, given opportunity to define whether he would do the same again in terms of the decision making. He confirmed he would - he would, given the - he confirmed that he would. Given the serious nature of the event, this would be unacceptable and a danger…

[74] He was appraised of Dr Coffey's comment during the show cause process where it was stated:

> However, with the benefit of hindsight, if faced with the same situation again, Dr Coffey would adjourn Dr Cloete's application to a meeting of a committee made of a full complement of permanent members.

[75] Pennington confirmed the content of his affidavit at paragraph 30 was not correct in that Dr Coffey had confirmed he would do the same again [Transcript p. 3-13]. In the period between 15 September 2016 and 21 September 2017 there were changes implemented to the credentialing process with some of the suggestions coming from Dr Coffey [Transcript p. 3-14]. Dr Coffey was saying that he would do things differently if confronted with the same circumstances again [Transcript p. 3-14]. Pennington was given the opportunity to withdraw paragraph 30 from his affidavit but refused after being shown documents contrary to his evidence [Transcript p. 3-15]. No other person involved in the selection or credentialing process besides Dr Coffey was subject to disciplinary action [Transcript p. 3-16].

[76] In re-examination he explained that Dr Coffey was disciplined over the credentialing because in Pennington's opinion he was responsible. In the case of Dr Kuehnast, she had left. He considered that credentialing was part of the recruitment process because of the requirement to validate references, internet searches and AHPRA notifications, especially private notifications which was Dr Coffey's role. It was confirmed that he had not spoken to Dr Coffey about the content of his email as the contact between the two was not as frequent as with other executives because he was based in Bundaberg and Dr Coffey worked out of the Fraser Coast. Pennington claimed documentation had existed where Dr Coffey stated he would do the same again and after given a period of time to locate the documentation, he was unable to do so.

Bell

[77] Bell, the General Manager, Division of Family and Community Health Services at WBHHS, was interviewed by Hoctor as part of the investigation into the credentialing of Dr Cloete. Following the interview on 24 February 2017 he was provided with a record of interview. His role has responsibilities that include direct reports from:

- Clinical Directors of Obstetrics, Gynaecology and Paediatric Medicine;

- Nurse Unit Managers for Maternity and Paediatric Wards; and

- Community Health and Indigenous Health Teams.

Bell now had additional responsibility for Oral Health Services, the Public Health Unit and Acute Allied Health Department at WBHHS.

[78] Bell had been a member of the interview panel that employed Dr Coffey and had worked with him up until his employment ceased with the WBHHS. From his membership of the Credentialing Committee for approximately one year in or about 2014 he agreed with paragraphs 18 and 19 of Dr Coffey's affidavit that Dr Coffey was Chair of the Credentialing Committee and that Committee was responsible for assessing credentialing applications and approving credentialing for senior medical officers including checking documentation of senior medical practitioners. Bell accepted that the content of Dr Coffey's affidavit was an accurate record in respect of:

- his knowledge of matters leading up to the credentialing of Dr Cloete;
- knowledge of matters relevant to the email he received from Dr Coffey (dated 15 September 2016); and
- his views on what should have occurred regarding Dr Cloete's credentialing and what he would have done had he known Dr Cloete's full AHPRA conditions before he was appointed.

[79] Bell further evidenced that:

- he received the email from Dr Coffey noting that there was also an attachment being the curriculum vitae (CV) of Dr Cloete and a publicly available extract of Dr Cloete's AHPRA conditions;
- agreed that he had a telephone conversation with Dr Coffey on 16 September 2016;
- agreed that he said words to the effect:

> Why did you send that email to Adrian and I, yesterday?

- did not agree that Dr Coffey said words to the effect:

> I wanted to make sure that Adrian [Pennington] was aware that Dr Cloete had conditions on his registration and given him the opportunity to discuss any concerns he might have about employing him, before we made the formal offer.

[80] Bell was very adamant that in the telephone conversation with Dr Coffey in September 2016 that the doctor had not said words to the effect:

> Where there are private conditions they are almost invariably about drugs or alcohol use.

[81] Under cross-examination Bell recalled an informal meeting with Dr Bolton (at around the time of Dr Cloete's employment in September 2016) where she spoke of conditions on his registration but did not mention "unavailable or private conditions" [Transcript pp. 3-25 and 3-26]. In a statement provided to Hoctor he mentioned that Dr Bolton had told him Dr Cloete needed a mentor and contrary to his evidence there was reference to restrictions that were not publicly available on the AHPRA register. He had not asked Dr Bolton any questions and was satisfied or drew the conclusion that she was happy to have Dr Cloete on the team [Transcript pp. 3-26 and 3-27]. Despite the fact that Dr Bolton had not disclosed the restrictions on Dr Cloete's registration he thought that "she'd obviously employed a good doctor into the role" [Transcript p. 3-27]. He had full faith and confidence in Dr Bolton and absolutely trusted her professional judgement in relation to Obstetrics and Gynaecology clinical matters [Transcript p. 3-28]. In regards to the email sent by Dr Coffey to Pennington on 15 September 2016 to which Bell was copied in, it had been stated that "Elize Bolton and Stephen Bell are fully aware and support the appointment". Bell disagreed that he was "fully aware" but was certainly supportive of the appointment [Transcript p. 3-29]. Bell did not respond to the email (in writing) but did telephone Dr Coffey the following day because the email was unusual enough to prompt him to make the phone call [Transcript pp. 3-29 and 3-30]. In the course of the telephone conversation he did not recall asking any specific questions about Dr Cloete but it was more about why he had been included in the email [Transcript p. 3-30]. Despite his conversation with Dr Bolton about Dr Cloete's marital problems and the private conditions he had never given any thought that they may be related to alcohol or drugs [Transcript p. 3-31]. Whilst he had one years' involvement in the Credentialing Committee he had no experience looking at conditions placed on doctors [Transcript p. 3-32]. When he was on the Committee he would rely on the advice of specialists who were familiar with that area of practice [Transcript p. 3-32]. If Dr Bolton was employing someone in her area he would give significant weight to her opinion [Transcript p. 3-32]. If the health service was employing somebody with conditions like Dr Cloete's he would personally want to make sure that the accountable officer (Chief Executive) knew that someone like that was being brought into the organisation [Transcript p. 3-33]. If he had been on the Credentialing Committee at the time and was aware of the private conditions relating to Dr Cloete he would have gone to his direct manager [Transcript p. 3-34]. On the matter of breathalyser testing his reading of the AHPRA private conditions pertaining to Dr Cloete were that if the WBHHS directed him to be breathalysed he would have done so [Transcript p. 3-34].

Bradley

[82] Bradley is the Executive Director of Mental Health and Specialised Services at the WBHHS and in that role had the responsibility for the strategic management of alcohol and other drugs, mental health and prison health services.

[83] At the time of Dr Coffey's termination Bradley had been acting in Pennington's role as Chief Executive and throughout the duration of the relevant period held the requisite delegation to determine what disciplinary action was reasonable in Dr Coffey's circumstances. Prior to commencing in the acting role, she had attended meetings with Pennington, the Director of Legal Services (Josephine Leveritt) and the Director of Human Resources (Peter Heinz) with discussions about various matters that would require attention during Pennington's absence.

[84] Bradley recalled a meeting on or about 4 September 2017 where Pennington gave her a summary of the incident and actions that had occurred relevant to Dr Coffey and of being "on hold" due to a proceeding before the Commission. No documentation was provided at that time however she was subsequently provided with relevant documents from WBHHS Human Resources on commencement in the acting Chief Executive role.

[85] On 14 September 2017 upon receipt of a decision by Industrial Commissioner Roney of the Commission she arranged for correspondence (dated 15 September 2017) to be sent to Dr Coffey requiring him to respond to the proposed disciplinary penalty of termination of employment. This was a further opportunity for Dr Coffey who had been afforded the same option in correspondence (dated 16 May 2017).

[86] Dr Coffey through his legal representative responded in correspondence (dated 21 September 2017) and after careful consideration of his response, the evidence before her and mitigating factors she formed the view she no longer had confidence in Dr Coffey to perform the various senior roles of District Director of Medical Services and Chair of the Credentialing Committee. Consequently, she decided the appropriate disciplinary action as termination of Dr Coffey's employment with payment in lieu of notice. Dr Coffey was notified in correspondence dated 28 September 2017.

[87] Bradley had no awareness of any conflict of interest that had impacted on her ability to make the decision to terminate Dr Coffey's employment nor had he had any knowledge of the Public Interest Disclosure (PID) said to have been made by him about her at the time of making the decision to terminate his employment.

[88] Under cross-examination Bradley acknowledged that she had no medical qualifications or expertise in medical administration [Transcript pp. 3-38 and 3-39]. She was aware of Dr Coffey's employment history of roughly 40 years including work as a medical administrator [Transcript p. 3-39]. Bradley's evidence was that the Hoctor Investigation was commissioned to look at the conditions around Dr Cloete's employment and as far as she was aware it was the only formal investigation into the facts of the matter and was "one of the many documents" reviewed in relation to the

decision [Transcript p. 3-39]. Bradley conceded that the Hoctor Report had contained no particular findings about Dr Coffey and was aware of findings made in relation to shortcomings of other people but not specifically to Pennington [Transcript pp. 3-39 and 3-40]. Hoctor had made no recommendation in relation to the institution of disciplinary action against any particular person but had made recommendations about systemic failings that required change [Transcript p. 3-41]. The overall findings covered areas that were wider than the simple issues of credentialing [Transcript p. 3-41].

[89] Dr Coffey was not disciplined in relation to issues regarding the selection process of Dr Cloete and had nothing to do with that process as credentialing was a secondary process to recruitment and selection [Transcript p. 3-42]. Hoctor in terms of recruitment and selection had found there had not been compliance to the letter of the policy in that pre-employment had not been conducted correctly [Transcript p. 3-44]. Hoctor had recorded that:

> Mr Pennington, the delegate, approved the selection panel recommendations to appoint Dr Cloete on 22 August. This was four days after the interview and prior to completion of the pre-employment checks. The investigator considers that this approach was inconsistent with the policy and the process.

[90] Bradley had given no consideration to Pennington's inconsistency because it was not one of the allegations and it was the credentialing process she was reviewing [Transcript p. 3-44]. The recruitment process had some flaws which were identified in the report [Transcript p. 3-44]. Bradley conceded that Pennington had failed to satisfy himself that the pre-employment checks had been conducted before he approved the selection panel recommendations. She did not consider that Pennington's failing mitigated the seriousness of anything Dr Coffey was involved with [Transcript p. 3-45]. She had considered it as a factor with all factors being important but had placed no particular emphasis on that factor [Transcript p. 3-48].

[91] Bradley considered Dr Coffey's 40 years of service and medical administration but had not sought advice from anyone qualified in medical administration [Transcript p. 3-49]. On the finding of AHPRA that Dr Coffey had not undertaken any practices in the health profession that were contrary to current accepted standards, Bradley stated:

> I would suggest that AHPRA regulations are different to management actions that we can put in place. [Transcript p. 3-50]

She was aware that matters had been referred to AHPRA and no adverse findings had been made in respect of Dr Coffey [Transcript p. 3-50]. Bradley had considered issues around the demanding nature of the work in the WBHHS and the pressure to ensure adequate resources were available to deliver services [Transcript p. 3-51]. It was fair to say that "there were contributing systemic factors to circumstances that occurred in relation to the incident, or the processes" [Transcript p. 3-52]. She believed that there

were other contributing factors but could not identify any of those failings in Hoctor's Report [Transcript p. 3-52].

[92] Bradley was involved in Dr Coffey's disciplinary process and was unaware if other individuals were disciplined but had an understanding that other people had "some management action in terms of potential discussions" [Transcript p. 3-53]. Having made no enquiries about any action against others there had been no consideration of this factor in making her decision [Transcript p. 3-54]. Hoctor's Report had contained the following comment:

> Where there has been a number of issues identified above in relation to Dr Cloete's appointment and credentialing, there is no evidence that the conduct of any Wide Bay Hospital employee -
>
> …including Dr Cloete, was deliberately or knowingly in breach of any relevant policy or procedure.

[93] Bradley took all conclusions into account and many other factors including unprecedented circumstances and it was the case that Dr Coffey had made a serious error in terms of the credentialing process [Transcript p. 3-54]. Hoctor found Dr Coffey had made an honest mistake and it was put to Bradley that the decision to terminate Dr Coffey was a "gross exaggeration in the circumstances" which she denied [Transcript p. 3-56]. Bradley in reaching her decision had taken into account Dr Coffey's email and attempt to call Pennington but had not inquired of Pennington why he had not responded to the email [Transcript p. 3-57]. It was not unprecedented for an email not to be responded to although in similar circumstances Bradley would have followed up if she believed there was a conversation required [Transcript p. 3-58]. On whether the email mitigated against the seriousness of the incident it was Bradley's evidence that email had indicated the issue had been dealt with [Transcript p. 3-58]. She conceded that it was a fair assumption on reading the email that Dr Coffey wanted to talk to Pennington about Dr Cloete's credentialing [Transcript p. 3-60]. It was acknowledged there had been no criminality involved in Dr Coffey's conduct but refused to accept that he had acted honestly despite having in the termination letter stated there were no allegations of "fraud, criminal misconduct or other dishonesty". Also, the Hoctor Report had recorded that "all witnesses" had "impressed as cooperative and credible".

[94] In re-examination the evidence was that Pennington's failure had not mitigated the seriousness of Dr Coffey's conduct because it was a small factor in the consideration of the larger picture. The email sent by Dr Coffey to Pennington had not accurately reflected what had occurred.

Submissions

[95] Written outlines of submissions were tendered that were supplemented by oral submissions.

Applicant - Written Submissions

[96] The submission referenced Dr Coffey's employment history in excess of 40 years as a medical practitioner working in Australia and overseas with at least half of that time in the public service. In the course of his entire career he had not been the subject of any disciplinary action relating to his performance or conduct at work and his history at the WBHHS was unblemished. His most recent performance review described that he had demonstrated "excellent outcomes" in each of the clinical governance dimensions described in the review.

Reasons for Dismissal

[97] Dr Coffey was dismissed on 28 September 2017 in correspondence authored by Bradley in her then role as acting Chief Executive. The reasons relied upon related to Dr Coffey's involvement in the credentialing of Dr Cloete who had been employed as an Obstetrician/Gynaecologist. The three allegations levelled against Dr Coffey concerned:

- a claimed failure by him to ensure the highest, professional and ethical standards were followed for the credentialing of Dr Cloete;

- sending a misleading email about conditions on Dr Cloete's ability to practice; and

- not taking appropriate action to mitigate the potential risks to patients and others in employing a medical officer with a known or identified medical condition.

Circumstances leading to dismissal

[98] The applicant relied upon the findings and recommendations of the Hoctor Investigation with it being significant that Hoctor identified departures from policy and procedure on the part of some people but made no such finding in relation to Dr Coffey. Whilst a number of recommendations were made there was no recommendations concerning action to be taken against any individual.

[99] Dr Coffey was the Chair of the Credentialing Committee and also a member without holding any special or different status to any of the other members who in some cases were relatively senior medical officers and Heads of other medical disciplines such as nursing and dentistry. The Committee had the role of credentialing but not all doctors that worked at the hospital required credentialing particularly in the case of junior staff. Dr Cloete had been employed at the hospital previously in a junior position and had not required credentialing.

[100] The purpose of credentialing was to ensure that medical and dental officers providing clinical services had the appropriate qualifications, skills and experience to provide safe and high-quality care and was not an "employment screen" but rather directed at making sure the practitioner held the appropriate medical qualifications. Hoctor had observed there were a number of short comings in the recruitment and selection process including a reference to the pre-employment checks not being done prior to the selection panel signing off on the selection report. The approval by Pennington of the selection panel recommendation prior to the completion of the pre-employment checks had been inconsistent with the Recruitment Policy and the Medical Appointment Process. Hoctor had made a recommendation that in future the recruitment and

selection panel have access to and have reviewed the AHPRA registration of the medical practitioner and that prior to any selection decision being made, the selection panel will have reviewed and considered any private conditions of the practitioner's registration. Pennington had approved Dr Cloete's recruitment and selection on 22 August 2016, nearly three weeks before the credentialing process took place and without those doing the recruitment and selection having access to the private conditions. If this recommendation had been implemented before Dr Cloete's selection and recruitment the outcome may have been different.

[101] Dr Cloete had previously worked at the hospital without having been credentialed because he was working as a locum and whatever risk he may have presented before he was credentialed was a risk they were prepared to accept by reason of their operative policies and procedures. In any event the assessment of Dr Cloete was enhanced by the fact he had previously worked with Drs Bolton and Ludwig with Dr Bolton well aware of Dr Cloete's public and private conditions and had supported the credentialing. At the very least Dr Ludwig knew there was a condition that "related to alcohol" and had supported his credentialing. Dr Cloete had been working under Dr Bolton following the credentialing process and Dr Coffey was aware at the time of the credentialing he would have Dr Bolton as his supervisor at the hospital and they were well aware of his private and public conditions.

[102] There were two types of conditions that could be imposed on medical practitioners by AHPRA being public and private conditions with the public conditions publicly available on the internet and known to everyone and the private conditions not publicly available due to privacy concerns. The private conditions did not prohibit Dr Cloete from medical practice and did not require him to inform prospective employers about those conditions.

[103] It was not necessary for the hospital to have known about Dr Cloete's private conditions because in their terms they imposed a condition that only Dr Cloete was required to comply with and did not require the hospital to regularly or randomly breath test Dr Cloete. In Hoctor's Report a finding was identified in that:

> The evidence substantiates that the WBHHS did not require regular breathalyser testing of Dr Cloete, however this was not required by the Full Conditions imposed on Dr Cloete's registration.

The existence of the private conditions were divulged by Dr Coffey to the Credentialing Committee without one member of the Committee insisting on being told about the conditions or ultimately rejecting the credentialing of Dr Cloete which had the effect of trusting Dr Coffey and Dr Kuehnast's judgement on the matter.

[104] Following the Credentialing Committee meeting Dr Coffey took the unusual step of emailing Pennington to inform him of Dr Cloete's registration circumstances and

despite the email being described as "unusual" or "strange" it had the effect of alerting Pennington to the existence of the conditions and that Dr Coffey wanted to discuss the matter. There was an offer by Dr Coffey to expand by phone when convenient but that offer was not taken up. The entire process of bringing Pennington into the loop was unusual and should have alerted the recipient of the email to a circumstance that required him to talk to Dr Coffey, yet he did nothing. The internal investigation found there were a number of systematic failings that had contributed to what happened being the notification form attachment and it should be noted that Dr Coffey himself had designed some of these conditions and suggested their implementation. There had been no allegations that Dr Coffey had acted dishonestly or had been untruthful at any time and AHPRA had found:

> There is no indication that the way the practitioner practices [in] the health profession contrary to accepted standards or that the public interest is at risk.

Dismissal was harsh, unjust and unreasonable

[105] The dismissal was harsh "because it was disproportionate to the gravity of the misconduct in respect of which the employer acted" - *Byrne v Australian Airlines Ltd*[1]. Dr Coffey had not engaged in any conduct that involved dishonesty, fraud, personal gain, criminality or violence. At the very highest for the hospital his conduct can be described as an honest mistake. It was also harsh because Dr Coffey had a distinguished career spanning more than 40 years and in his short time at the WBHHS his performance of work had been described as excellent.

[106] The termination was unjust and unreasonable because Dr Coffey occupied no special or different position to anyone else on the Committee but appears to be singled out for special consideration for no obvious or apparent reason. It was unreasonable because Dr Coffey had informed Pennington of the existence of the conditions on Dr Cloete's registration and was given the "brush". Finally, it was irrational and unreasonable to suggest that the absence of policies or procedures dealing with the circumstance that arose did not mitigate against Dr Coffey's alleged conduct.

Reinstatement

[107] If reinstatement of Dr Coffey was opposed on the basis of Pennington and Bradley having lost trust and confidence in Dr Coffey, then such a claim must be carefully assessed as having a rational and reasonable basis and in this case, there is no such basis. Even if there was some friction between the parties there was no reason why mature professional persons could not put the differences behind them and get on doing the good work they had done over the last four years.

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[1] *Byrne v Australian Airlines Ltd* [1995] HCA 24 at 128

[108] There should be consequential orders made for back pay (with deductions for monies earnt since termination in other employment) and an order maintaining continuity of service.

Oral Submissions

[109] Dr Coffey had made a mistake, it was acknowledged, because he had humanly sought to deal with Dr Cloete's situation taking into account both the public and private interests. Dr Coffey was an experienced and qualified medical administrator of many years standing and was well placed to make the assessment he had made which it appears had been supported by Drs Bolton and Kuehnast. It was not abundantly clear that there had been a departure from policy and the eight individuals at the Committee meeting were made aware there were private conditions and not one person sought to defer the decision. The experienced medical practitioners had also been in favour of credentialing Dr Cloete.

[110] There must be some reason that the private conditions were treated by AHPRA differently to the public conditions with a fair analysis being that it was intended despite they were disseminated to people they remain private to Dr Cloete because of the word "private". The position is by no means black and white.

[111] There was no sensible explanation why Pennington in receiving what he described as a "strange" email did not give Dr Coffey the courtesy of a reply or respond to the telephone message left by Dr Coffey. The message conveyed in the email advised Pennington of the private conditions and whatever might be said about the subtle nuances in the way the email was put together, one thing is absolutely clear, it was not misleading, deceptive, confusing or ambiguous about the wording "I want to talk to you about this". Despite the approach, Pennington does nothing in response to a sensible attempt to discuss with someone "up the line".

[112] The executive summary in the Hoctor Report adequately and fairly put forward the facts of the matter which included the identification of failures in the selection and recruitment process, quite apart from the credentialing, and in particular was the failure of Pennington to comply with relevant policies. Despite the eagerness of Pennington and Bradley to load up Dr Coffey with all the responsibility, this was not one man's doing but a serious of failings of a systemic nature identified in Hoctor's Report. The investigation had not been prepared to say that there was a serious failing by Dr Coffey and had correctly, put at the forefront a number of systemic failures. All witnesses interviewed by Hoctor, including Dr Coffey, were said to have been credible and cooperative and had acted with best intentions in relation to Dr Cloete's appointment.

[113] The system despite all that occurred with the selection and credentialing proved to be failsafe because an employee picked up on Dr Cloete's inebriation or potential of being under the influence of alcohol. In situations where people had behaved honestly, doing

what they thought were in the best interests of the WBHHS it was only Dr Coffey who was dismissed because of a departure from policy.

[114] Dr Coffey had an unblemished record in a professional career expanding more than 40 years and had never been the subject of previous disciplinary action. When you combine his record with the circumstances of having made mistake and not involved in any serious wrongdoing then reinstatement was not impactable. the loss of trust and confidence by Pennington in respect of Dr Coffey arise from a wrong and incorrect view that he would not change his behaviour in the future. Further there was no evidence from anyone else in the line of command that would support there was a justifiable reason for the loss of confidence.

Respondent - Written Submissions

Background of matter

[115] The relevant conduct concerned three allegations substantiated by the respondent being that:

- between September 2016 and November 2016, the Applicant failed to ensure that highest provisional and ethical standards were observed for the credentialing of Dr J. Cloete;

- on 15 September 2016, the Applicant sent a misleading email to the Respondent's Chief Executive, Mr Adrian Pennington, for the purpose of approving Dr Cloete's credentialing application, in which it was implied that the Full Conditions (relevantly, both the public and non-published conditions imposed on Dr Cloete's registration as a health practitioner by the Australian Health Practitioner Regulation Agency (AHPRA)) were not publicly available and therefore not attached, were discussed by the Credentialing Committee that approved his scope of practice, and that Mr Stephen Bell was "fully aware" of the details of the appointment, including the Full Conditions; and

- between September 2016 and November 2016, the Applicant failed to take appropriate action to mitigate the potential risks to patients (and/or others) of employing a medical officer with an identified alcohol issue.

[116] The show cause process had commenced on 11 April 2017 and proceeded pursuant to the following chronology:

- 5 May 2017 - Dr Coffey responds to show cause through legal representative;

- 16 May 2017 - WBHHS advises that the allegations were substantiated;

- 22 May 2017 - Dr Coffey commenced a "fair treatment" appeal pursuant to the PS Act;

- 23 May 2017 - disciplinary process stayed pending "fair treatment" decision;

- 7 June 2017 - conciliation conference held before Industrial Commissioner Black;

- 14 September 2017 - Industrial Commissioner Roney dismissed the "fair treatment" appeal; and

- 15 September 2017 - WBHHS provides Dr Coffey additional time to respond (19 September 2017).

[117] The employment of Dr Coffey was terminated on 28 September 2017 at which time he was paid three months in lieu of notice along with termination pay that included outstanding entitlements.

[118] An application for unfair dismissal remedy in accordance with the *Industrial Relations Act 2016* (IR Act) was lodged on 18 October 2016 with a response filed by the WBHHS on 26 October 2017. A conciliation conference was held before the [then] Vice President Linnane and as the matter was not resolved at conciliation a certificate was issued under s 318(3)(a) of the IR Act on the same day. Dr Coffey took no further steps in the matter until 3 August 2018 almost six months after the certificate had been issued.

Legislation

Section 316 of the IR Act

[119] The issue between the parties was whether the dismissal of Dr Coffey on 28 September 2017 was harsh, unjust or unreasonable pursuant to s 320 of the IR Act. In the matter of *Barsha v Motor Finance Wizard (Sales) Pty Ltd*[2] the [then] Commissioner Asbury cited *Steward v University of Melbourne*[3] in which Ross VP had stated that a termination of employment may be:

- *harsh*, because of its consequences for the personal and economic situation of the employee or because it is disproportionate to the gravity of the misconduct;

- *unjust*, because the employee was not guilty of the misconduct on which the employer acted; and/or

- *unreasonable*, because it was decided on inferences which would not reasonably have been drawn from the material before the employer.

Notified applicant of reason - s 316(a) of the IR Act

[2] *Barsha v Motor Finance Wizard (Sales) Pty Ltd* [2002] 171 QGIG 139
[3] *Stewart v University of Melbourne* [2000] AIRC 1201 at [74]

Opportunity to respond - s 387(c) of the IR Act

[120] Dr Coffey had been notified of the allegations and provided with a range of opportunities to respond to the allegations.

Any other matters - s 320(d) of the IR Act

[121] It was submitted that:

- Dr Coffey was not disadvantaged at any stage of the process leading to the termination of his employment and at all times was legally represented;

- termination of employment was sound, defensible and for well-founded reasons. Dr Coffey had lost the trust and confidence of the respondent as he had been found to have performed his duties carelessly, incompetently or inefficiently. The ability of Dr Coffey to perform important and critical elements of his very senior role was in doubt; and

- all relevant circumstances of Dr Coffey's employment were taken into account however these factors did not outweigh the seriousness of the allegations and the loss of trust and confidence in Dr Coffey.

[122] The decision makers were, on the evidence, well capable of being reasonably satisfied that Dr Coffey had convened the relevant section of the PS Act: See *Gold Coast Health District v Walker*[4].

[123] The alternatives to termination of employment were considered pursuant to s 188 of the PS Act however Dr Coffey's conduct was so serious as to warrant the termination of employment. Relevantly:

- the decision to grant Dr Cloete the Scope of Practice when there was a clear risk to patients meant that Dr Coffey failed to manage the situation in respect of alcohol issues;

- Dr Coffey had put the personal issues of Dr Cloete ahead of the best interests of patients and the WBHHS and in particular the alleged concerns about Dr Cloete's privacy above any consideration of public safety;

- Dr Coffey had failed to speak to Dr Cloete's supervisor (from his work as a short-term locum) choosing to rely on Dr Kuehnast;

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[4] *Gold Coast Health District v Walker* [2001] 168 QGIG 258

- the Credentialing Procedure required full discloser of conditions to the Credentialing Committee. It was not for Dr Coffey to decide for himself not to apply the Procedure and to withhold Dr Cloete's full conditions from the Committee. There was nothing ambiguous about the Procedure drafted by Dr Coffey;

- the investigator had considered to properly assess a credentialing application, it was necessary for Panel members to have access to the full conditions on a practitioner's registration, even private conditions;

- Dr Coffey was aware that the majority of the Credentialing Committee had no knowledge of Dr Cloete's full conditions to be able to properly consider the matter and also that there were a number of proxies, some of whom were not experienced in credentialing matters;

- Dr Coffey rather than meet his obligation to provide all relevant information as required gave assurances to Committee members who trusted his judgement and as such allowed the Credentialing Committee to act in breach of the Credentialing Procedure thus to miscarry;

- Dr Coffey's email to Pennington about Dr Cloete's credentialing was misleading given the statements made about the conditions had been discussed by the Committee and that Bell was fully aware and supported the appointment, when in fact, neither of those statements were true. No satisfactory explanation about why those false statements were made or allowed to remain in place. Any criticism of Pennington for not following up on the email ought to be rejected and in any event Dr Coffey had never followed up either;

- notwithstanding the level four supervision, Dr Coffey neither implemented or arranged for any measures to minimise the risk for patients arising out of alcohol use by Dr Cloete. No steps were taken to review Dr Cloete's performance, notwithstanding the knowledge of the private conditions;

- Dr Coffey had left the responsibility to Dr Bolton to supervise Dr Cloete in the absence of any guidance or direction about how that supervision should occur;

- at the time of the incident in November 2016 no tests had been conducted by the WBHHS because Dr Cloete had not been requested to undertake such tests nor was consideration given to whether there were testing devices available;

- whilst there was no requirement in the AHPRA conditions for routine or random breath testing, where the full conditions pertaining to Dr Cloete highlighted a

known risk there was a requirement for the highest professional ethical standards to be observed as opposed to leaving it to chance;

- Dr Coffey's failure to put effective systems in place or even consider them was conduct that was a clear departure from the fundamental aspects of his role;

- the assertion that Dr Coffey was concerned about confidentiality ought to be rejected; and

- Dr Coffey's evidence around having informed Bell as to the private conditions relating to drug or alcohol issues ought to trouble the Commission as to the veracity of his evidence overall, and his reliability as a person of truth.

[124] The fact that Dr Coffey had not previously been the subject of disciplinary action at the WBHHS does not of itself mean that the termination of employment was harsh, unjust or unreasonable. There was reliance on other matters where the termination of a long-term employee with an unblemished past record had been upheld by the Commission. These included:

- *Lamb v Redland City Council*[5];

- *Sarvestani v State of Queensland (Metro South Hospital and Health Service)*[6]*;* and

- *de Villiers v State of Queensland*[7]*.*

[125] The claim by Dr Coffey that his conduct had been cleared by AHPRA was an incomplete observation. The two issues referred to AHPRA were:

> - whether the Applicant provided an accurate and/or misleading information to the Credentialing Committee at the Respondent about the conditions on Dr Cloete's registration; and
>
> - whether the Applicant failed to take steps to manage the risk to patient health or safety at the Respondent, due to the conditions on Dr Cloete's registration.

[126] AHPRA's correspondence to Dr Coffey on 29 June 2018 cannot be read as in any way clearing him of any wrong doing or otherwise condoning his conduct (as fount to be substantiated by the WBHHS). Specifically, under the terms of AHPRA's correspondence to Dr Coffey:

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[5] *Lamb v Redland City Council* [2014] QIRC 041

[6] *Sarvestani v State of Queensland (Metro South Hospital and Health Service)* [2017] QIRC 085

[7] *de Villiers v State of Queensland* [2017] QIRC 105

- no further action was taken on the first of the referred issues because of the fact that proceedings before the Commission were still afoot (see paragraph 3(i)(vi) of the letter) and because of post-incident actions taken by the Respondent; and

- no further action was taken on the second of the referred issues on the basis that changes made by the Respondent mitigated any risk posed.

[127] No weight can effectively be placed on the decision by AHPRA to take no further action to support the claim that Dr Coffey's termination was harsh, unjust and unfair.

Remedy

[128] The WBHHS opposes the application for reinstatement or compensation for financial detriment. On the termination of Dr Coffey's employment causing hardship that principle had been addressed in the matter of *Bostik (Australia) Pty Ltd v Gorgevski No. 1*[8] where Sheppard J had relevantly observed:

> Any harsh effect on the individual employee is clearly relevant but of course not conclusive. Other matters have to be considered such as the gravity of the employee's misconduct.

[129] In any event, Pennington gave evidence that having made enquiries there was no other suitable alternative position currently available at the WBHHS that Dr Coffey could perform. There were questions over Dr Coffey presenting a danger to the community, given the serious nature of the event and clearly his cavalier attitude to the truth regarding Bell supports a lack of ability to act as a credible senior executive.

[130] On the issue of compensation, it was not warranted in this matter for the reason that he had not taken reasonable steps to mitigate any alleged financial loss since his employment was terminated on 28 September 2017 noting that:

- Dr Coffey cannot be said to have urgently pursued reinstatement or any financial compensation remedy for some six months without any credible reason given for the delay;

- Dr Coffey had chosen to limit his job search to areas "close to" where he and his partner intend to retire;

- Dr Coffey's asserted registration with two employment agencies but had been unable to secure permanent employment getting locum roles only; and

- Dr Coffey had spent considerable time overseas which was inconsistent with a conscientious desire to obtain work.

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[8] *Bostik (Australia) Pty Ltd v Gorgevski No. 1* (1992) 36 FCR 20 at 28

Oral Submissions

[131] This case is really straightforward relating to the competence or lack thereof to perform the significant and important responsibilities of the Director of Medical Services. the position occupied by Dr Coffey was of high trust and responsibility remunerated in the order of $560,000 gross per annum. He was the person responsible for the development of the Credentialing Procedure and in fact wrote the Procedure making him more than a participant in credentialing. The Procedure was unambiguous in that the Credentialing Committee recommendations took take into account any conditions imposed on an applicant. The Procedure amongst other things says credentialing of medical practitioners is:

> Verification of qualifications, and training, experience, professional standing and other relevant professional attributes to ensure staff's professional competence, performance and professional suitability in providing safe, high quality healthcare services within the organisation.

[132] When scrutinising the wording of the Procedure it is clear they are about ensuring professional competence, performance and professional suitability in providing safe, high quality healthcare services naturally requires that the AHPRA conditions imposed on the relevant practitioner be considered. Dr Coffey allowed the Credentialing Committee in the absence of material the Committee was required to consider to conduct of their deliberations without giving them Dr Cloete's full conditions. The Claim that Dr Coffey denied the Committee the private conditions imposed by AHPRA because of some concern about confidentiality ought not be accepted.

[133] The email sent to Pennington represented two matters that were untrue:

- the full conditions had been disclosed to the Committee; and
- Bell was fully aware of the full conditions.

The recall of Dr Coffey to give evidence regarding Bell was quite extraordinary behaviour for a person seeking to be reinstated to a position of trust and responsibility.

[134] The private conditions imposed on Dr Cloete were as recent as May 2016 and it was clear he was a person who had a problem with alcohol and to minimise the risk there should have been some form of regular or random testing. AHPRA was so concerned that it imposed a total absolute ban on him consuming alcohol. Dr Coffey had a lack of direct knowledge in respect of Dr Cloete and apart from putting in place the generic level four supervision nothing was done specifically about the alcohol issues. Dr Cloete was allowed to work as a Senior Medical Officer, including on-call being the most senior doctor present. Dr Coffey had acted in a careless, incompetent and inefficient manner for the purposes of s 187(1)(a) of the PS Act.

[135] The termination of employment had been procedurally fair and the reasons for termination outlined in the termination letter were substantially fair. In terms of reinstatement, the circumstances of Dr Coffey's position is that there is a direct reporting relationship between Pennington and himself with Pennington having to rely upon him for proper, correct and safe advice. A similar issue in relation to other senior executives also exists.

[136] In respect of each of the allegations levelled against Dr Coffey there had been a serious departure from the standard expected particularly given his responsibilities.

Applicant - Submissions in Reply

[137] Dr Coffey despite the fact he was Chairperson of the Credentialing Committee, was but one member who provided the Committee with advice and it was a nonsense that in that role he was not entitled to rely upon the professional judgement of Dr Kuehnast who reported to him on the professional judgement of Dr Bolton who had direct exposure to Dr Cloete. There was nothing to be gained by Dr Coffey in relation to the manner in which he dealt with the issue of confidentiality and it was an admirable attribute that he sought to balance the competing interests of Dr Cloete's privacy with the public interest he was charged to fulfil. It was an incredible claim to suggest that his actions were not legitimate in trying to protect Dr Cloete's privacy and private interests.

[138] Dr Coffey had been let down by Pennington in circumstances where he had failed to return his telephone call or respond to the email particularly when the email had the wording "I can expand by phone when convenient". Dr Coffey's return to the witness box in respect of Bell should not impact upon his credit because he had realised that his recollection was wrong and at the same time acknowledged Bell was an honest person. This is the direct opposite to the scenario that confronted Pennington when he gave evidence of Dr Coffey stating he would not change anything in the future and when presented with "black and white words" that was not the case he refused to withdraw his evidence.

[139] There was no evidence in the proceedings that Dr Cloete had turned up drunk for work nor was there evidence as to whether he was affected by alcohol. The evidence was that someone had smelt alcohol on his breath and there was no evidence that supported the overstatement that Dr Cloete had turned up drunk. It was redolent of other overstatements in the case presented by the WBHHS in terms of loading up Dr Coffey with responsibility for everything.

[140] The Hoctor Investigation was not specifically concerned with Dr Coffey's conduct and as the only investigation undertaken, if the findings are not accepted of no wrongdoing by Dr Coffey then there is no procedural fairness. Hoctor had been engaged to investigate the appointment and credentialing of Dr Cloete including the relevant policies and procedures, systemic failings and failings of other individuals. Whilst

Dr Coffey's performance was not found to be deserving of criticism it had been specifically pointed out that there were issues with Pennington's failing. On the criticism of Dr Coffey having travelled overseas following his termination, he had only been away for a period of six weeks and in any event if back pay compensation was to be the subject of orders, the parties could be directed to confer upon that issue.

Conclusion

[141] The disciplinary circumstances that lead to the termination of Dr Coffey as the Executive Director of Medical Services at the WBHHS commenced on 12 April 2017 when he received correspondence from the WBHHS directing him to show cause as to why he should not be disciplined in respect of three allegations. The correspondence under the signature of Pennington stated also:

> I am in receipt of a report dated 6 March 2017 - Investigation into the appointment and credentialing of Dr Jacobus Cloete to the Wide Bay Hospital and Health Service. After giving careful consideration to the material available to me, I am of the view that you may be liable for disciplinary action pursuant to sections 187 and 188 of the *Public Service Act 2008*.

The Allegations

[142] The allegations were as follows:

> **Allegation One**
>
> That between September 2016 and November 2016 you failed to ensure the highest professional and ethical standards were observed for the credentialing of Dr J Cloete.
>
> **Allegation Two**
>
> That on 15 September 2016 you sent a misleading email to me, for the purpose of approving Dr Cloete's credentialing application, in which it was implied that the Full Conditions were not publicly available and therefore not attached, were discussed by the Credentialing Committee that approved his scope of practice, and that Mr Stephen Bell was "fully aware" of the details of the appointment including the Full Conditions.
>
> **Allegation Three**
>
> That between September 2016 and November 2016 you failed to take appropriate action to mitigate the potential risks to patients (and/or others) of employing a medical officer with an identified alcohol issue.

Disciplinary Process

[143] Upon examination, the process embarked upon by the respondent had been compliant with the legislative requirements in terms of providing Dr Coffey with particulars of the allegations, the Investigation Report (commissioned by the WBHHS) and allowed

times that were sufficient so as not to disadvantage Dr Coffey in responding to the show cause notices.

[144] Dr Coffey on or around 22 May 2017 exercised a right pursuant to Chapter 7 - Appeals of the PS Act to lodge an appeal notice under s 194(1)(eb) an "unfair treatment decision" which amongst other things had the effect of placing the disciplinary process on hold whilst that appeal ran its course.

[145] The "fair treatment decision" appeal was subsequently dismissed in a decision of Roney IC (dated 14 September 2017) with the disciplinary process recommenced the following day by the issuing of correspondence whereby Dr Coffey was afforded four days to further respond to the proposed disciplinary action of the termination of employment. Dr Coffey's legal representative responded on his behalf in correspondence (dated 21 September 2017). On 28 September 2017 his employment was terminated with immediate effect.

[146] Overall, the process including the suspension of Dr Coffey from duty on full pay, effective from 15 May 2017, was in my view procedurally fair, to the extent that grounds do not exist whereby the disciplinary process itself can reasonably be the subject of challenge.

Credentialing Committee, Policy and Procedure

[147] Dr Coffey was the Chair of the Credentialing Committee for the WBHHS with the Policy for Credentialing and defining scope of clinical practice describing the term credentialing as:

> The formal process used to verify the qualifications, experience, professional standing and other relevant professional attributes of practitioners for the purpose of forming a view about their competence, performance and professional suitability to provide safe, high-quality healthcare services within specific organisational environments.

[148] The WBHHS had at the relevant time to this application a Procedure in place (version 3) that was required to be adhered to in credentialing of medical and dental practitioners. The Procedure at clause 3.1 contained an overview that included the following references:

- An eligible Medical or Dental Officer's application for a SoCP accompanied by a complete set of documentation (credentials) is presented to the Wide Bay Hospital and Health Service (WBHHS) Credentialing Committee for consideration.

- The WBHHS Credentialing Committee has accountability for ensuring it reviews comprehensive documentation and seeks relevant third party advice regarding each practitioner's application of SoCP. The committee cannot consider any incomplete application, or endorse any recommendation about any practitioner's SoCP while they are waiting for further information.

[149] Relevant consideration for the Credentialing Committee in a standard process required at clause 3.2.1 of the Procedure that:

> The committee must, as minimum, examine the following:
>
> - A complete application form which must include signed declaration and signed authority
>   - In checking the application for SoCP, should an applicant respond 'yes' to any questions under 'applicant's declaration and authorisation', principles of natural justice and procedural fairness must be applied before making an adverse decision against the applicant based on the information provided by the applicant. It is the obligation of the practitioner to advise the committee of the following:
>   - Limitation on SoCP by another public health facility;
>   - any other matter the committee could reasonably expect to be disclosed in order for the committee to make an informed decision on credentials and SoCP.
>
>   Failure to fully inform the committee may result in suspension and a review of the applicant's SoCP.
>   …
> - Verification of practitioner's registration status in the appropriate category with the Medical/Dental Board of Australia. Any conditions or undertakings on registration must be taken into account.

[150] The Credentialing Committee was comprised of the following members:

> - The District DMS (or their nominee) will act as chair of the committee
> - The Deputy District DMS
> - Two Clinical Directors from separate clinical disciplines
> - The Executive Director Nursing Services or their nominee
> - The Director of Oral Health
> - The Chief Operating Officer (who is familiar with the requirements of the Queensland Health recruitment and selection process in accordance with the provisions of Human Resource Policy 81)(effective July 2010)
> - The Directors of Allied Health

Credentialing of Dr Cloete

[151] The application by Dr Cloete for credentialing went to a meeting of the Credentialing Committee, chaired by Dr Coffey on 14 September 2016. In terms of the meeting, evidence before the proceedings from Dr Coffey indicated:

- many of the Committee members had not attended the meeting choosing to send proxies in their place;

- Dr Coffey had considered cancelling or postponing the meeting but had not done so on the basis of no precedent in similar circumstances;

- the consequences of postponing the meeting may have led to prospective employees of the WBHHS withdrawing their applications and seeking employment elsewhere;

- Dr Coffey acknowledged that of the proxies in attendance none had previously participated in a meeting of the Credentialing Committee and that gave him concerns regarding their awareness of the "strict confidentially obligations"; and

- had the confidentiality of the meeting been breached in respect of Dr Cloete there was potential for the disclosure of salacious and/or scandalous information to be circulated around the hospital.

[152] The meeting considered Dr Cloete's application for credentialing, including the scope of practice and an appropriate level of supervision that would be required. Generally, such considerations were disposed of in times as little as one to two minutes however Dr Cloete's application occupied some 20 minutes of discussion. The reason for the extended time period was due to the existence of AHPRA conditions on Dr Cloete's registration. In the absence of such conditions, based on the strength of the application it was likely approval would have been given without an extended discussion with the lowest level of supervision (level five) imposed. Dr Coffey was said to have informed the Committee that:

> Dr Cloete's AHPRA registration is subject to conditions. There are both public and private conditions. You have copies of the public conditions but there has been a request to keep the private conditions confidential. Barb can explain further.

The reference to "Barb" was in respect of Dr Kuehnast.

[153] A member of the Committee (unnamed) had enquired about the "private conditions" to which Dr Coffey responded by advising he had seen the full conditions, continued to support Dr Cloete's application with the appropriate level of supervision. He further informed the meeting that the full conditions were not available on the AHPRA website so as to protect Dr Cloete's privacy.

[154] The Committee according to the evidence of Dr Coffey had discussions on whether there was a need to see the full conditions prior to making a decision on Dr Cloete's

application with a majority of the commentary on the issue being from medical officers. The effect of the discussion was that:

- Committee was supportive of full conditions not being disclosed; and
- Committee was able to consider the application without having sighted the full set of conditions.

[155] Dr Coffey in the course of cross-examination conceded in retrospect, if the Committee had requested to access the private conditions he probably would have postponed the decision and sought some expert advice. Dr Coffey did not accept that the procedure allowed the Committee to have access to the full conditions imposed on Dr Cloete by AHPRA despite the WBHHS procedure document which he had authored stating at clause 3.2.1 *Relevant considerations for the credentialing committee in standard process:*

> - Verification of practitioner's registration status in the appropriate category with the Medical/Dental Board of Australia. Any conditions or undertakings on registration must be taken into account.

[156] The Committee subsequently approved the credentialing and scope of practice for Dr Cloete imposing level 4 supervision. The General Manager, Surgery, proxy for the Chief Operating Officer had abstained from voting on the application but was said not to have expressed any reservations regarding the application being approved without the full set of AHPRA conditions having been disclosed.

[157] In terms of the private conditions imposed on Dr Cloete it had been Dr Coffey's evidence that they had been in existence for two years and:

> Dr Cloete was not subject to conditions that required him to have regular or random breathalyser tests. Dr Cloete was subject to conditions that, among other matters, permitted the WBHHS to demand a test should there be any clinical concerns.

[158] The conditions on Dr Cloete's AHPRA registration, available on the website included:

> 1. This registration is subject to conditions that are not publicly available due to privacy obligations.
>
> 2. The practitioner must be mentored by another registered health practitioner in relation to his clinical practice and work performance and must meet the Medical of Australia's (the Board's) [sic] specific requirements in relation to this:
>
>   For the purposes of this condition, 'mentoring' is defined as a relationship in which a skilled registered practitioner (the mentor) helps to guide the professional development of another practitioner.

The Credentialing Committee's access to the conditions on the registration of Dr Cloete were those available on the AHPRA website.

[159] The full conditions included a private component that had been imposed by the Medical Board of Australia upon Dr Cloete's registration on 24 May 2016 that was not publicly available on the AHPRA website nor provided openly to those persons whom constituted the Credentialing Committee on 14 September 2016 when undertaking their consideration of Dr Cloete's credentialing application.

[160] In the Investigation Report commissioned by the WBHHS on 12 December 2016 the private conditions imposed on Dr Cloete were identified as:

Alcohol

7. The practitioner will abstain from consuming alcohol.

8. The practitioner will undergo alcohol breathalyser testing when directed by his employer and the Board:
    a. by a registered practitioner who is to supervise the testing, and
    b. with a breathalyser unit approved by the Board or its delegate.

9. The results of the breath test required by condition 11 must be recorded in a log on each occasion and be countersigned by the person approved to supervise the testing.

10. The practitioner will forward the breathalyser log required by condition 12 to the Board within seven days of the end of each calendar month.

11. If the result of the breath test taken in accordance with condition 11 registers above 0.00% the practitioner will not work his shift scheduled for that day and the practitioner will inform AHPRA of the result immediately. Within fourteen days of the notice of the imposition of these conditions, the practitioner is to provide to AHPRA, on the form provided, the details of any and all places of practice, together with, where relevant, confirmation from the Director of Medicine (the senior person) at each and every place of practice that they have sighted a copy of these conditions.

12. With each and every subsequent place of practice the practitioner must, within seven days of the commencement of practice, provide to AHPRA the details of the subsequent place of practice together with written confirmation, where relevant, from the senior person at each and every subsequent place of practice that they have sighted a copy of these conditions.

[161] Prior to the credentialing process the following medical officers at the WBHHS had, according to the Investigation Report, received the Full Conditions of Dr Cloete's registration on the following dates:

- Dr Bolton - received notification from AHPRA 2 September 2016;

- Dr Kuehnast - notified in writing by Dr Bolton 2 September 2016; and
- Dr Coffey - notified in writing by Dr Kuehnast 2 September 2016.

[162] Other officers who had reviewed or were otherwise provided with AHPRA conditions noting the private conditions were:

- Dr Ludwig - on or around 11 July 2016; and
- Debbie Carroll - on 11 July 2016.

[163] The following attendees at the Credentialing Committee meeting of 14 September 2016 according to the Investigation Report were aware the Full Conditions existed although the nature of the private conditions were unknown:

- Dr Terry George;
- Dr Irina Leonida;
- James Thomas;
- Ben Ross-Edwards; and
- Robert Burness.

Also in and around September 2016 Bell in discussions with Dr Bolton was aware Dr Cloete had conditions on his registration that required him to have mentoring and that there were additional private conditions on the registration that were not provided to him.

[164] In determining that Allegation One had been substantiated, Pennington had relied upon what he had identified as failings by Dr Coffey in respect of the credentialing process, particularly in circumstances where he held the position of Chair of the Credentialing Committee and the responsibilities associated with that role. In correspondence advising of the substantiation of the allegation, Pennington had stated:

> As Chair of the Credentialing Committee and in your role as District Director Medical Services it was incumbent on you to ensure that the Committee was appropriately constituted with representation by a sufficient number of experienced members and for those members to be in a position to make an informed decision. Your response in regard indicates a lack of appreciation of the seriousness of your conduct.

[165] On consideration of the evidence and material before the proceedings it is evident that the credentialing process in respect of Dr Cloete had not met the highest professional

standard with some aspects of Dr Coffey's conduct, warranting criticism, investigation and ultimately it was not unreasonable for a disciplinary process to be mounted whereby a judgement could be made having all the relevant material available.

[166] Another failure that occurred in respect of Dr Cloete's employment application involved Pennington as the Chief Executive Officer of the WBHHS who had approved the recruitment and selection of Dr Cloete on 22 August 2016 without pre-employment checks being completed which rendered that aspect of the process deficient to the extent that a similar level of criticism could easily be made and questions raised around not having met the highest professional standard. In fact the Investigation Report on this matter stated:

> In Dr Cloete's case, the delegate, Mr Pennington approved the selection panel recommendation to appoint Dr Cloete on 22 August 2016. This was 4 days after the interview and prior to the completion of the pre-employment checks. The Investigator considers this approach inconsistent with the Recruitment Policy and the Medical Appointment Process.

[167] Clearly on the evidence the credentialing involving Dr Coffey and recruitment circumstances involving Pennington, the highest professional standards had not been met however that does not, in my view, enliven a situation where a valid case can be made out that the conduct was unethical. In fact, to question the ethics of either Dr Coffey or Pennington in these circumstances would be done so in the absence of any reasonable grounds.

[168] The referencing of Pennington's involvement with the recruitment process is done clearly on the understanding that the Commission in its deliberations was not required to make findings about this aspect of Dr Cloete's employment application however where it assumes some relevance is that had Pennington not departed from the Recruitment Policy requirements, three weeks prior to the Credentialing Committee considering the application, it potentially could have altered the circumstances in how the Committee may have approached their task. In any event this hypothetical scenario does not form part of this arbitrated outcome.

[169] Counsel for Dr Coffey in submissions suggested at the very highest his conduct was "an honest mistake" and that he had not engaged in any conduct that involved dishonesty or fraud. There was an absence of any personal gain for Dr Coffey emanating from his conduct. The evidence indicates that Dr Coffey's actions in ensuring the private conditions of Dr Cloete's AHPRA registration were withheld from absolute release were done in a humane manner basically to afford Dr Cloete the opportunity to continue with his medical career in an environment absent of embarrassment following what had been turbulent times in his personal life.

[170] The decision to substantiate the allegation in that between September 2016 and November 2016 Dr Coffey had failed to ensure the highest professional and ethical standards in the credentialing of Dr Cloete is on the evidence without standing.

Dr Coffey, I accept, had failed to meet the highest professional standard however his conduct would more aptly be described in the circumstances as a blemish or an imperfection rather than a higher level of failure as found by the employer.

Misleading email

[171] On 15 September 2016 Dr Coffey sent the following email to Pennington, subsequent to having attempted to make contact in the first instance by telephone:

> Adrian, relating to my phone message:
> This obstetrician is being appointed at Bundaberg 0.5FTE.
> He has AHPRA conditions as attached, which include non-published conditions which are deemed by AHPRA to be not publicly available due to privacy obligations. These were discussed at yesterday's credentialing meeting and he was recommended for scope of practice in O&G.
> Elize Bolton and Stephen Bell are fully aware and support the appointment. Elize and Dirk Ludwig were both involved in his interview, and both had had previous contact with him as a locum.
> His CV is very impressive, also attached.
> I can expand by phone when convenient.
> Regards
> Greg

[172] Dr Coffey in cross-examination conceded that it was not his usual practice to email or telephone Pennington following the credentialing of a particular candidate but had done so in an effort to reassure Pennington there were no concerns about patient safety. In his evidence-in-chief when questioned by Bell on 16 September 2016 about why he [Bell] and Pennington had been sent the email he said words to the effect:

> I wanted to make sure that Adrian [Pennington] was aware that Dr Cloete had conditions on his registration and given him the opportunity to discuss any concerns he might have about employing him, before we made the formal offer.

It was noted that Bell in his evidence disputed that Dr Coffey had said the words as claimed but did confirm there had been a telephone call.

[173] There is evidence of intent by Dr Coffey, at least on the face, to have sought to appraise the WBHHS CEO of the private conditions attached to Dr Cloete's AHPRA registration at a time contemporaneous to the decision of the Credentialing Committee and before any formal offer of employment had been made. Pennington in reasons provided to Dr Coffey in substantiating Allegation Two indicated that whilst he held the view that he (Dr Coffey) had attempted to mislead him, he did "accept that you did not have dishonest intent" in sending the email.

[174] Pennington evidenced that the email from Dr Coffey was "strange" but had saw nothing important with the content of the email that was urgent and did not accept there were any shortcomings on his behalf in not having responded to Dr Coffey's email.

[175] In further reasons for substantiating Allegation Two he said that the email:

> …did not alert me to any extraordinary matters, by contrast, your email gave me reason to believe that the Committee had made an informed decision to endorse your recommendation based on a discussion of all conditions, and that the General Manager Mr Bell was "fully aware". Neither was the truth.

[176] I acknowledge that the construction of the email had not necessarily reflected a "plain and ordinary meaning" in terms of the message it had sought to convey which could simply have been addressed by Pennington by either telephoning Dr Coffey as suggested in the email or responding by email. Pennington's evidence was that he received over 200 emails daily and that any individual in the executive team could get hold of him in a 24-hour period. In this case it seems that the holder of the most senior medical posting at the WBHHS, had contrary to Pennington's evidence, not been able to get in contact with him about an issue of some significance.

[177] In circumstances where Dr Coffey's email of 15 September 2016 and also the telephone call were ignored by Pennington, it would be unreasonable to then "cry foul" about the content and alleged purpose of the email to mislead Pennington. Such a position would have had a better chance of acceptance had Pennington not ignored Dr Coffey's approach which clearly offered the opportunity to "expand by phone" on the content of the email.

[178] The evidence in the proceedings does not, based upon the requisite standard of proof, support the allegation that Dr Coffey had sought to mislead Pennington in the email forwarded on 15 September 2016 and in fact supports an intent to discuss Dr Cloete's circumstances prior to a formal offer of employment being made by the WBHHS.

Failed to mitigate potential risk to patients

[179] The particulars in respect of Allegation Three relied upon in the Show Cause Notice (dated 11 April 2017) comprised of the following:

- Dr Coffey had received a copy of the Full Conditions pertaining to Dr Cloete's registration on 2 September 2016;

- Investigation Report found that at the Credentialing Committee Meeting on 14 September 2016 Dr Coffey had made a statement that there was "no risk to patient safety" and further the minutes of the Committee meeting recorded that "Dr Coffey is aware of the Conditions as per AHPRA and is satisfied of compliance and that these conditions would not impact on patient safety";

- no management plan put in place to deal with a potential situation in which there may be a reasonable suspicion of Dr Cloete being under the influence of alcohol;

- no management plan put in place to demonstrate mentoring and reporting requirements in accordance with the AHPRA conditions; and

- no management plan put in place to monitor compliance by Dr Cloete in terms of his obligations to report to the Board.

[180] In the first instance it must be noted that prior to the application for credentialing by Dr Cloete he had been employed as a locum at both the Hervey Bay Hospital and Bundaberg Base Hospital without having been either interim or fully credentialed and absent of concerns being raised in the course of those appointments in regard to his clinical skills or any suspected consumption of alcohol.

[181] Prior to the Credentialing Committee considering the application of Dr Cloete for credentialing, the Credentialing Review Panel comprising of Dr Ludwig, Dr Bolton and Dr Williams had separately reviewed the following material in relation to the application:

- credentialing application;

- curriculum vitae;

- AHPRA public conditions of Dr Cloete's registration;

- Google search results;

- completed professional development material; and

- passport photos.

[182] The Investigation Report found that Dr Bolton had received notification from AHPRA on 2 September 2016 of the Full Conditions of Dr Cloete's registration and Dr Ludwig was provided with the AHPRA conditions that noted the private conditions on or around 11 July 2016.

[183] The Credentialing Review Panel had recommended Dr Cloete for credentialing with the following levels of supervision:

- Dr Bolton - level five supervision; and

- Drs Ludwig and Williams - level four supervision.

[184] In terms of the supervisory levels it was the case that level five does not require any formal supervision whilst level 4 supervision requires supervision from the Director or nominated delegate. The approved supervisor at this level must act as a mentor by overseeing the practitioners practice, be available for consultation if the practitioner requires assistance and periodically conduct a review of the practitioners practice.

[185] Dr Cloete upon the recommendation of Dr Coffey was credentialed with level four supervision.

[186] In responding to Allegation Three Dr Coffey advised of having contacted Dr Cloete's compliance officer at AHPRA who had confirmed that the purpose of the conditions were to allow an employer to insist on testing should there be any clinical suspicion and were not intended to impose an obligation to conduct testing. The conditions with respect to breath testing were permissive not mandatory. Dr Coffey had formed the view that Dr Cloete's conditions were consistent with a doctor who had made a good recovery and was well and truly on the path to full remission from an episode of alcohol abuse.

[187] Dr Bolton on 1 September 2016, according to the Investigation Report received a report from Dr John Salmon (dated 22 August 2016) which updated the mentoring process as it pertained to Dr Cloete. Dr Salmon had said he:

> …had no cause to be concerned about Dr Cloete's clinical role during this mentoring period and at this stage I am entirely satisfied that Dr Cloete's professional conduct and clinical performance are satisfactory.

[188] This was in my view further evidence that contemporaneous to the consideration of Dr Cloete's credentialing by the Committee, Dr Cloete was assessed by his mentoring medical practitioner as having "entirely satisfied" requirements around his conduct and clinical performance.

[189] On the question of the failure to put in place a management plan to deal with a potential incident where there may be a reasonable suspicion of Dr Cloete being under the influence of alcohol, it is not disputed that a "stand-alone" plan in respect of Dr Cloete was not seen by Dr Coffey as essential in the circumstances, particularly where Dr Cloete's supervisor was to be Dr Bolton whom Dr Coffey considered to be a highly skilled and experienced medical practitioner with nine years of specialist experience, who had acted as one of Dr Cloete's referees and had engaged in extensive communication with AHPRA and Dr Cloete's mentor.

[190] Dr Coffey in responding to Allegation Three claimed that the most "compelling evidence" supporting that he had taken adequate steps to mitigate the risk associated with Dr Cloete and alcohol consumption was that when he attended work smelling of

alcohol his supervisor was notified and immediately completed the clinical management of the situation in a timely manner. Dr Coffey had declined to initiate a management plan to monitor Dr Cloete's AHPRA obligations on the basis that the private conditions had not mandated such a process.

[191] The private conditions that had been imposed upon Dr Cloete's registration on any reasonable interpretation included a not insignificant component of self-reporting in any event whereby it was Dr Cloete who bore the burden of providing AHPRA with relevant details of any required breath testing. Examples of which included:

- The practitioner will forward the breathalyser log required by condition 12 to the Board within seven days of the end of each calendar month.

- With each and every subsequent place of practice the practitioner must, within seven days of the commencement of practice, provide to AHPRA the details of the subsequent place of practice together with written confirmation, where relevant, from the senior person at each and every subsequent place of practice that they have sighted a copy of these conditions.

[192] The Investigation Report, in respect of the incident, stated in the Executive Summary that the evidence had substantiated the WBHHS had not required regular breathalyser testing of Dr Cloete nor was this required by the Full Conditions imposed on his registration. Directly relating to the incident, the Report findings were:

- On 7 November 2016, Dr Bolton directed Dr Cloete to undergo a breathalyzer test, but that test could not be carried out because Dr Cloete did not have his approved breathlyser [sic] on his person. Dr Cloete went home to collect the breathalyzer but did not return to the hospital;

- Dr Bolton notified AHPRA as soon as possible that she had directed Dr Cloete to undergo a test, that he did not have his testing unit with him and had not returned to the hospital.

[193] It must be noted there was no evidence before the proceedings of a factual standard that would enable a finding to be made that Dr Cloete was at the time of the incident affected by alcohol and whilst probable grounds may exist for such a view to be held, it is no higher than a suspicion.

[194] The evidence in the proceedings does not, in my view, establish that Dr Coffey's conduct was of a nature that could be assessed as having failed to mitigate the potential risks to patients for the obvious reason that on the very first occasion there was some suspicion regarding Dr Cloete having presented for work in a questionable state, the procedures in place at the WBHHS to address these very circumstances had "kicked in" and adequately dealt with the situation.

Investigation Report

[195] In correspondence (dated 12 December 2016) Debbie Carroll, the Acting Chief Executive of the WBHHS, appointed the Investigator to examine the appointment and credentialing of Dr Cloete to the WBHHS. The Terms of Reference required the investigation to investigate the following:

- When were officers of the WBHHS advised verbally and/or in writing by the Medical Board of Australia, that Dr Cloete had a schedule of conditions imposed upon his registration;

- What process was undertaken to issue interim credentials to Dr Cloete prior to the Credentialing Committee meeting of 14 September 2016;

- What information was given to the recruitment and selection panel regarding the schedule of conditions imposed on Dr Cloete's registration and what action was taken by the recruitment and selection panel in response to this information;

- What information was given to the Credentialing Review Panel on or before 29 August and 13 September 2016 in regard to Dr Cloete's schedule of conditions of registration and what information was shared with the Credentialing Committee on 14 September 2016;

- What, if any actions have been taken by officers of the WBHHS to comply with the schedule of conditions imposed by the Medical Board of Australia, in particular breathalyzer testing and reporting of results to the Medical Board.

[196] On 12 March 2017 the Investigation Report was presented to the WBHHS and upon examination the Report could genuinely be described as a credible document that recorded a thorough investigation of circumstances relating to Dr Cloete's appointment and the credentialing pursuant to the Terms of Reference imposed by the WBHHS.

[197] The Executive Summary recorded the following conclusion at page 13 of the Report:

- The work undertaken at WBHHS is demanding and there is continuous pressure placed on WBHHS to ensure adequate resources to deliver services.

- There is evidence that the WBHHS have some difficulties in attracting senior medical officers to fill vacant roles, including the role which was vacant for a significant period prior to the appointment of Dr Cloete.

- When suitable applicants are identified, in circumstances where the Clinical Director requires the clinician to commence work as soon as possible, there is pressure placed on WBHHS officers to complete the recruitment and credentialing processes as quickly as possible and there is evidence that this may have driven officers of the WBHHS to speed up recruitment and credentialing in Dr Cloete's case.

- Further, there is evidence that concerns were held by members of the selection panel and credentialing committee about protecting Dr Cloete's privacy (and avoiding exposing Dr Cloete to embarrassment), and that these concerns contributed to the decision not to disclose the Full Conditions.

- While there have been a number of issues identified above in relation to Dr Cloete's appointment and credentialing, there is no evidence that the conduct of any WBHHS employee (excluding Dr Cloete) was deliberate or knowingly in breach of any relevant policy or procedure.

- All witnesses impressed as cooperative and credible, and it is accepted that all witnesses were acting with the best of intentions in relation to the appointment and credentialing of Dr Cloete.

- This particular situation is unprecedented in the experience of all witnesses.

[198] The Investigation Report had not identified grounds requiring consideration in terms of initiating disciplinary action against any member of the WBHHS for their conduct in the appointment or credentialing of Dr Cloete and had referenced that all witnesses (which included Dr Coffey) had:

> …impressed as cooperative and credible, and it is accepted that all witnesses were acting with the best intentions in relation to the appointment and credentialing of Dr Cloete.

AHPRA Sanctions

[199] Pennington on or around 16 May 2017 had notified the OHO of the relevant events at the WBHHS including information advising that a number of actions had been implemented arising from the Investigation Report.

[200] It would appear from the evidence that Dr Coffey had been the subject of an investigation undertaken by AHPRA in regards to the following issues:

> 1.1 Other - other issue
>
> Whether Dr Gregory Coffey (the practitioner) provided inaccurate and/or misleading information to the Credentialing Committee at the Wide Bay Hospital and Health Service ("the Hospital and Health Service") about the conditions on Dr Jacobus Cloete's registration.
>
> 1.2 Other - other issue
>
> Whether the practitioner failed to take steps to manage the risk to patient health or safety at the Hospital and Health Service due to the conditions on Dr Cloete's registration.

[201] Dr Coffey was advised by AHPRA in correspondence (dated 29 June 2018) that:

> On 27 June 2018, the Queensland Notifications Committee of the Medical Board of Australia (the Committee) decided to take no further action under section 167(a) of the Health Practitioner Regulation National Law, as in force in Queensland (the National Law).

[202] Further on in the correspondence in respect of Dr Coffey allegedly having failed to take steps to manage patient health and safety at the WBHHS due to the conditions on Dr Cloete's registration, it was recorded:

> There is no indication that the way the practitioner practises the health profession is contrary to current accepted standards or that the public is at risk. Any risk posed had been mitigated by the changes made by the WBHHS.

Dr Coffey's evidence of conversation with Bell

[203] Dr Coffey had been recalled to give further evidence regarding a discussion with Bell, on the basis of a reflection that it may well have been with a person other than Bell.

[204] The recall was said to have impacted negatively on Dr Coffey's credibility however that in my view is not necessarily the case. In response to questioning from the Commission, it had been the evidence of Dr Coffey that:

> I had always considered that that was Mr Bell. Mr Bell's an honest person. If he has said we never had a discussion, then it must have been Mr Thomas; if I'm mistaken. I wanted to make that crystal clear. [Transcript p. 2-79]

[205] Dr Coffey could have left the determination to the Commission on whether Bell or himself was a witness of truth on this issue but in my view the approach adopted by him to give further evidence to clarify the position did not reflect poorly on his credibility.

Was Dr Coffey's termination harsh, unjust or unreasonable

[206] The legislative considerations to be observed in determining whether a termination of employment was harsh, unjust or unreasonable are located at s 320 of the Act:

> **320 Matters to be considered in deciding an application**
>
> In deciding whether a dismissal was harsh, unjust or unreasonable, the commission must consider -
>
> (a) whether the employee was notified of the reason for dismissal; and
>
> (b) whether the dismissal related to -
>
> (i) the operational requirements of the employer's undertaking, establishment or service; or
>
> (ii) the employee's conduct, capacity or performance; and
>
> (c) if the dismissal relates to the employee's conduct, capacity or performance -
>
> (i) whether the employee had been warned about the conduct, capacity or performance; or
>
> (ii) whether the employee was given an opportunity to respond to the claim about the conduct, capacity or performance; and

(d) any other matters the commission considers relevant.

[207] In the case of the termination of Dr Coffey I expressed a view at paragraph 146 of this decision that overall I was satisfied that the process relied upon by the agency had been procedurally fair and that grounds did not exist whereby the disciplinary process could not reasonably be the subject of challenge. Dr Coffey had been afforded the opportunity to respond to the allegations that had been levelled against him and he was notified of the reasons for dismissal.

[208] The dismissal had been effected pursuant to s 320(c) of the Act in that it had related to his alleged conduct, capacity and performance.

[209] In the matter of *Bostik (Australia) Pty Ltd v Gorgevski No. 1*[9] Sheppard and Heerey JJ had said in respect of the phrase "harsh, unjust and unreasonable" that:

> These are ordinary non-technical words which are intended to apply to an infinite variety of situations where employment is terminated. We do not think any redefinition or paraphrase of the expression is desirable. We agree with the learned trial judge's view that a court must decide whether the decision of the employer to dismiss was, viewed objectively, harsh, unjust or unreasonable. Relevant to this are the circumstances which led to the decision to dismiss and also the effect of that decision on the employer. Any harsh effect on the individual employee is clearly relevant but of course not conclusive. Other matters have to be considered such as the gravity of the employee's misconduct.

[210] In deciding whether the decision of the WBHHS to dismiss Dr Coffey was harsh, unjust or unreasonable I have carefully considered the findings to substantiate each of the three allegations, relied upon as grounds for terminating his employment on 28 September 2017 and found each of the allegations were on the evidence and material before the Commission, on the balance of probabilities, incapable of being substantiated. In doing so I have recorded elsewhere in this decision the following commentary in regards to each allegation:

Allegation One

[211] The decision to substantiate the allegation in that between September 2016 and November 2016 Dr Coffey had failed to ensure the highest professional and ethical standards in the credentialing of Dr Cloete is on the evidence without standing. Dr Coffey, I accept, had failed to meet the highest professional standard however his conduct would more aptly be described in the circumstances as a blemish or an imperfection rather than a higher level of failure as found by the employer.

Allegation Two

[9] *Bostik (Australia) Pty Ltd v Gorgevski No. 1* (1992) 36 FCR 20 at 37

[212] The evidence in the proceedings does not, based upon the requisite standard of proof, support the allegation that Dr Coffey had sought to mislead Pennington in the email forwarded on 15 September 2016 and in fact supports an intent to discuss Dr Cloete's circumstances prior to a formal offer of employment being made by the WBHHS.

Allegation Three

[213] The evidence in the proceedings does not, in my view, establish that Dr Coffey's conduct was of a nature that could be assessed as having failed to mitigate the potential risks to patients for the obvious reason that on the very first occasion there was some suspicion regarding Dr Cloete having presented for work in a questionable state, the procedures in place at the WBHHS to address these very circumstances had "kicked in" and adequately dealt with the situation.

[214] I acknowledge that in consideration of Allegation One I have found that Dr Coffey's conduct did contain an imperfection in terms of having failed to meet the highest professional standard however to terminate his employment after some 5 years of exemplary service in the most senior medical role at the WBHHS would be disproportionate to the gravity of the misconduct, as observed in the matter of *Byrne v Australian Airlines Ltd*[10] where McHugh and Gummow JJ had stated:

> It may be that the termination is harsh but not unjust or unreasonable, unjust but not harsh or unreasonable, or unreasonable but not harsh or unjust. In many cases the concepts will overlap. Thus, the one termination of employment may be unjust because the employee was not guilty of the misconduct on which the employer acted, may be unreasonable because it was decided upon inferences which could not reasonably have been drawn from the material before the employer, and may be harsh in its consequences for the personal and economic situation of the employee or because it is disproportionate to the gravity of the misconduct in respect of which the employer acted.

[215] Additional factors of relevance, subject of consideration also included:

- the findings of the independent investigation commissioned by the WBHHS that failed to establish any grounds existed that warranted disciplinary action against Dr Coffey;

- the decision to approve the credentialing of Dr Cloete was made collectively on the unanimous vote of the Credentialing Committee (with one abstention) and not solely by Dr Coffey; and

- the fact that neither the OHO or AHPRA found fault with Dr Coffey in terms of his professional conduct in relation to Dr Cloete's recruitment or credentialing.

[216] On consideration of all the evidence and material before the Commission, I have determined that Dr Coffey's termination was harsh, unjust and unreasonable and accordingly was an unfair dismissal.

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[10] *Byrne v Australian Airlines Ltd* [1995] HCA 24 at 128

Is reinstatement impracticable?

[217] In deciding whether or not reinstatement may be impracticable it needs to be more than just difficult or inconvenient to an employer for such an outcome not to be fully considered. In *Auto Logistics Pty Ltd v Kovacs*[11] de Jersey P on this matter stated:

> That word does in my view bear its ordinary meaning, and it is not enough, to establish practicability, to show that restoration of employment would be merely inconvenient or difficult. As the dictionaries confirm, the word means practicably impossible.

[218] Subject to a finding that the dismissal of Dr Coffey was in the circumstances unfair the WBHHS had contended that reinstatement was impracticable for reasons that included:

- the period of time that Dr Coffey had been absent from the WBHHS having been terminated on 28 September 2017;
- the failure of Dr Coffey to pursue his application for reinstatement in a timely manner, waiting almost to the expiry date of the six-month period following the initial conciliation conference to request the application go to hearing;
- Dr Coffey would be a danger to the community given the serious nature of his conduct;
- documentation (according to Pennington) existed which confirmed Dr Coffey said he would do the same again in similar circumstances;
- trust and confidence had been lost in Dr Coffey to undertake his duties as the Senior Medical Officer responsible for the safety of clinicians and their activities; and
- the position previously occupied by Dr Coffey had been offered to an another medical practitioner and the offer accepted.

[219] In addressing the contentions pressed by the WBHHS on being impracticable for reinstatement to occur, I have found:

- *absence from the WBHHS* - the period of absence was lengthy although in that time Dr Coffey had been able to obtain two periods of employment in a similar or same role which allowed him to "keep his hand in";
- *failure to pursue hearing of the application in a timely manner* - Dr Coffey had worked within the legislative confines with regards to the request for hearing and

[11] *Auto Logistics Pty Ltd v Kovacs* (1997) 155 QGIG 320

I accept the reasoning relied upon that the financial cost he was to incur was a factor in his decision;

- *danger to the community* - absolute "codswallop" and not supported by AHPRA who had found that Dr Coffey had practised to the accepted standard of the health profession not putting the "public at risk";

- *documentation existed confirming Dr Coffey would act in a similar way in the same circumstances* - Pennington having made the claim was afforded every opportunity by the Commission to produce such documentation but failed to do so. Dr Coffey in the course of cross-examination had evidenced that he would "do it differently in the future" [Transcript p. 2-54];

- *trust and confidence lost in Dr Coffey* - a simple statement that a dismissed employee no longer had the trust or confidence of the employer is not on its own sufficient to support a finding that reinstatement is impracticable. In the matter of *Perkins v Grace Worldwide*[12], a Full Bench of the Fairwork Commission had stated:

> Trust and confidence are concepts of degree. It is rare for any human being to have total trust in another. What is important in the employment relationship is that there be sufficient trust to make the relationship viable and productive. Whether that standard is reached in any particular case must depend upon the circumstances of the particular case. And in assessing that question, it is appropriate to consider the rationality of any attitude taken by a party.
>
> It may be difficult or embarrassing for an employer to be required to re-employ a person the employer believed to have been guilty of wrongdoing. The requirement may cause inconvenience to the employer. But if there is such a requirement, it will be because the employee's employment was earlier terminated without a valid reason or without extending procedural fairness to the employee. The problems will be of the employer's own making. If the employer is of even average fair-mindedness, they are likely to prove short-lived. Problems such as this do not necessarily indicate such a loss of confidence as to make the restoration of the employment relationship impracticable.

  There is no evidence before these proceedings of sufficient standing that would allow for a conclusion that the WBHHS had genuine grounds for their claim that they had lost trust and confidence in Dr Coffey to undertake his substantive role if reinstated; and

- *another medical practitioner in the role* - the WBHHS knew on 18 October 2017 that Dr Coffey had lodged an application for reinstatement and in appointing another person, permanently to his role, pre-empting the decision of the Commission, is not prohibitive of Dr Coffey's reinstatement being ordered by the Commission.

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[12] *Perkins v Grace Worldwide (Aust) Pty Ltd* [1997] IRCA 15

[220] In this case where findings had been made that the dismissal of Dr Coffey was harsh, unjust and unreasonable and that he effectively had not engaged in serious misconduct as alleged, then for reinstatement not to occur there needed to be strong grounds advanced regarding the impracticability of such reinstatement. I am satisfied no such grounds have been made and there is no acceptable evidence that would prevent Dr Coffey's reinstatement.

Remedy

[221] In circumstances where the Commission was satisfied that an employee had been unfairly dismissed, the following options pursuant to ss 321 and 322 of the Act are available for consideration as an appropriate remedy:

- reinstatement or re-employment; and
- if reinstatement or re-employment would be impracticable - compensation.

[222] On determining that in the case of Dr Coffey reinstatement in the circumstances was not impracticable, then legislative requirements to be met are those at s 321 of the Act:

321 Remedies - reinstatement or re-employment

(1) This section applies if the commission is satisfied an employee was unfairly dismissed.

(2) The commission may order the employer to reinstate the employee to the employee's former position on conditions at least as favourable as the conditions on which the employee was employed immediately before dismissal.

(3) If the commission considers reinstatement would be impracticable, the commission may order the employer to re-employ the employee in another position that the employer has available and that the commission considers suitable.

(4) The commission may also -
(a) make an order it considers necessary to maintain the continuity of the employee's employment or service; and
(b) order the employee to repay any amount paid to the employee by, or for, the employer on the dismissal; and
(c) order the employer to pay the employee the remuneration lost, or likely to have been lost, by the employee because of the dismissal, after taking into account any employment benefits or wages received by the employee since the dismissal.

(5) This section does not limit the commission's power to make an interim or interlocutory order.

Orders

[223] The following Orders are made with reliance upon the previously expressed reasoning:

1. The application for reinstatement is granted;

2. Dr Gregory Coffey is to be reinstated to his former position of District Director of Medical Services at the Wide Bay Hospital and Health Service from 28 September 2017;

3. The reinstatement is on the basis that his continuity of service is maintained; and

4. Dr Coffey is to be paid all remuneration lost or likely to have been lost as a result of the dismissal after taking into account any employment benefits or wages received by him since the dismissal. Failing agreement, a further application can be made to the Commission.

[224] I so order.