From: Don Kane
To:
Subject: Re: Hansard corrections - Medical complaints process in Australia
Date: Tuesday, 8 November 2016 2:24:30 PM
Attachments: image001.png
VEGA VEGA.pdf

Question: 1 Hansard page reference: Q38 Hansard extract: Attachment 1

Question: 2 Hansard page reference: 38 Hansard extract:

Professor Paddy Dewan and Dr Leong Fook Ng have had contact with the AHPRA CEO, Martin Fletcher, and could provide information regarding their efforts to liaise with AHPRA to attempt to assist AHPRA to rectify the deficiencies in its system. They may be able to provide details of this. I do know that Professor Dewan, as organiser of the HPARA conference in April 2016 at Sydney, offered time to Mr Fletcher who initially showed interest in participating and then declined to attend.

Regards,
Don Kane

SUPREME COURT OF QUEENSLAND

CITATION:	*Vega Vega v Hoyle & Ors* [2015] QSC 111
PARTIES:	**ANTONIO VEGA VEGA** (applicant) **v** **DR PHILIP MATTHEW HOYLE, Investigator pursuant to s 190 Hospital and Health Boards Act 2011** (first respondent) and **MS MEGAN FAIRWEATHER, investigator pursuant to s 190 Hospital and Health Boards Act 2011** (second respondent) and **MS SONJA READ, Investigator pursuant to s 190 Hospital and Health Boards Act 2011** (third respondent) and **PROFESSOR VILLIS MARSHALL, Clinical Reviewer Investigator pursuant to s 125 Hospital and Health Boards Act 2011** (fourth respondent) and **DR HOWARD LAU, Clinical Reviewer Investigator pursuant to s 125 Hospital and Health Boards Act 2011** (fifth respondent) and **IAN MAYNARD, Director-General, Queensland Department of Health** (sixth respondent) and **STATE OF QUEENSLAND** (seventh respondent) and **CENTRAL QUEENSLAND HOSPITAL AND HEALTH SERVICE** (eighth respondent)
FILE NO:	BS No 8591 of 2014
DIVISION:	Trial Division
PROCEEDING:	Application for statutory review
ORIGINATING COURT:	Supreme Court at Brisbane
DELIVERED ON:	5 May 2015
DELIVERED AT:	Brisbane

HEARING DATE: 4,5 February 2015

JUDGE: A Lyons J

ORDER:

1. **The applicant is entitled to orders in terms of the relief sought in paragraphs 4 and 6 of the Amended Application for a Statutory Order of Review.**
2. **I will hear from the parties as to the terms of the orders and as to costs.**

CATCHWORDS: ADMINISTRATIVE LAW – JUDICIAL REVIEW – REVIEWABLE DECISIONS AND CONDUCT – DECISIONS TO WHICH JUDICIAL REVIEW LEGISLATION APPLIES – MEANING OF DECISION – REPORTS AND RECOMMENDATIONS – where the applicant was subject to three parallel investigations under the *Hospital and Health Boards Act* 2011 (Qld), namely a Root Cause Analysis, a Clinical Review and a Health Service Investigation, which were initiated by the eighth respondent and the Queensland Department of Health – where adverse findings were made against the applicant in the Clinical Review Report and the Health Service Investigation Report – whether these adverse findings would constitute decisions of an administrative character under the *Judicial Review Act* 1991 (Qld)

ADMINISTRATIVE LAW – JUDICIAL REVIEW – REVIEWABLE DECISIONS AND CONDUCT – DECISIONS TO WHICH JUDICIAL REVIEW LEGISLATION APPLIES – DECISIONS UNDER AN ENACTMENT – PARTICULAR CASES – where the applicant was subject to three parallel investigations under the *Hospital and Health Boards Act* 2011 (Qld), namely a Root Cause Analysis, a Clinical Review and a Health Service Investigation, which were initiated by the eighth respondent and the Queensland Department of Health – where adverse findings were made against the applicant in the Clinical Review Report and the Health Service Investigation Report – whether these adverse findings would constitute decisions made under an enactment under the *Judicial Review Act* 1991 (Qld)

ADMINISTRATIVE LAW – JUDICIAL REVIEW – GROUNDS OF REVIEW – PROCEDURAL FAIRNESS – EXISTENCE OF OBLIGATION – RIGHTS AND INTERESTS AFFECTED BY DECISION – where the applicant argues that the provision of the Clinical Review Report and the Health Service Investigation Report, which contained adverse findings against him, was a precondition to the sixth respondent issuing directions which may affect the applicant's ability to practice medicine in an effective manner – whether the adverse findings made against the applicant in

the Clinical Review Report and the Health Service Investigation Report affected his rights

ADMINISTRATIVE LAW – JUDICIAL REVIEW – GROUNDS OF REVIEW – PROCEDURAL FAIRNESS – BIAS – APPREHENSION OF BIAS – where the applicant argues that a reasonable apprehension of bias arises out of the appointments of the second and third respondents as health service investigators – whether a finding of reasonable apprehension of bias can be sustained against the second and third respondents

ADMINISTRATIVE LAW – JUDICIAL REVIEW – GROUNDS OF REVIEW – PROCEDURAL FAIRNESS – HEARING – NATURE OF HEARING – DISCLOSURE OF EVIDENCE AND MATERIAL FACTORS – where the applicant argues that the first to fifth respondents failed to provide him with all the material relied upon by the health service investigators and clinical reviewers – where the first to fifth respondents argue that they were unable to provide such material because of the confidentiality requirements under the *Hospital and Health Boards Act* 2011 (Qld) – where the first to fifth respondents argue that the draft Clinical Review Report and the draft Health Service Investigation Report provided to the applicant fairly and comprehensively summarised the material relied upon – whether such a degree of confidentiality was required – whether sufficient disclosure was made to the applicant – whether the failure to provide all material relied upon by the health service investigators and clinical reviewers amounted to a breach of the rules of natural justice

ADMINISTRATIVE LAW – JUDICIAL REVIEW – GROUNDS OF REVIEW – PROCEDURAL FAIRNESS – BIAS – GENERALLY – where the applicant argues that the failure of the first respondent to provide material relied upon in the Clinical Review Report and the Health Service Investigation Report constitutes actual bias or gives rise to an apprehension of bias – whether a finding of actual bias or apprehension of bias can be sustained against the first respondent

ADMINISTRATIVE LAW – JUDICIAL REVIEW – GROUNDS OF REVIEW – PROCEDURAL FAIRNESS – GENERALLY – where the applicant argues that the first to fifth respondents failed to respond to his concerns about the material relied upon by the health service investigators and clinical reviewers – whether the failure to respond to the applicant's concerns about the material relied upon by the health service investigators and clinical reviewers amounted to a breach of the rules of natural justice

ADMINISTRATIVE LAW – JUDICIAL REVIEW – GROUNDS OF REVIEW – RELEVANT CONSIDERATIONS – where the applicant argues that the first, fourth and fifth respondents failed to take into account relevant considerations and ignored or rejected favourable evidence concerning the applicant without providing reasons – whether the failure to take into account relevant considerations and ignoring or rejecting favourable evidence concerning the applicant without providing reasons amounted to a breach of the rules of natural justice

Health Practitioner Regulation National Law Act 2009 (Qld), s 156
Hospital and Health Boards Act 2011 (Qld), s 45, s 47, s 51A, s 124, s 125, s 126, s 129, s 132, s 189, s 190, s 191, s 194 s 197, s 199
Judicial Review Act 1991 (Qld), s 4, s 5, s 6, s 20, s 21, s 22

Ainsworth v The Criminal Justice Commission (1992) 175 CLR 564, cited
Australian Broadcasting Tribunal v Bond (1990) 170 CLR 321, followed
Calardu Penrith Pty Ltd v Penrith City Council [2010] NSWLEC 50, cited
Eastman v Australian Capital Territory (2008) 227 FLR 279, cited
Ebner v Official Trustee in Bankruptcy (2000) 205 CLR 337, followed
Edelsten v Health Insurance Commission (1990) 27 FCR 56, cited
Gamaethige v Minister of Immigration and Multicultural Affairs (2001) 109 FCR 424, cited
Gascor v Ellicott [1997] 1 VR 332, cited
Greenwood v Winsor [2008] QSC 68, cited
Griffith University v Tang (2005) 221 CLR 99, followed
Guss v Deputy Commissioner of Taxation (2006) 152 FCR 88, cited
Hot Holdings v Creasy (1996) 185 CLR 149, followed
IW v The City of Perth (1997) 191 CLR 1, cited
Johnson v Johnson (2000) 201 CLR 488, cited
Kioa v West (1985) 159 CLR 550, followed
Minister for Aboriginal Affairs v Peko-Wallsend (1986) 162 CLR 24, followed
Minister for Immigration v Jia Legeng (2001) 205 CLR 507, cited
Minister for Immigration v Maman (2012) 200 FCR 30, cited
R v Brisbane City Council; ex parte Read (1986) 2 Qd R 22, cited

Sun v Minister of Immigration and Ethic Affairs (1997) 151 ALR 505, cited
Vega Vega v Medical Board of Australia (2014) QCAT 328, cited
Webb v The Queen (1994) 181 CLR 41, cited
Wells v Carmody & Anor [2014] QSC 59, distinguished

COUNSEL:	S Keim SC for the applicant D Kelly QC for the respondents
SOLICITORS:	Ashurst Australia for the applicant Corrs Chambers Westgarth for the respondents

ANN LYONS J:

The Overview of the Current Application

[1] Dr Antonio Vega Vega, the applicant, is a specialist urologist who had been employed at the Rockhampton Base Hospital (Hospital) since late 2007. On 22 January 2014, he performed a left nephrectomy (removal of a kidney) on a patient who had a "complex anatomy as a consequence of spina bifida, adhesions from previous spinal fusion, severe scoliosis, and an in situ ventriculo-peritoneal shunt for management of hydrocephalus." It was a difficult surgery which commenced laparoscopically, but when complications arose from continued bleeding it was converted to open laparotomy. The surgery lasted seven hours and whilst the surgery was performed at the correct site, the wrong kidney, which was also compromised, was removed.

[2] The removal of the wrong kidney did not become known until the patient was re-admitted to the Hospital some three months later on 25 April 2014.

[3] On 29 April 2014, Dr Vega Vega's employment was suspended by the Central Queensland Hospital and Health Service (Health Service), the eighth respondent.

[4] On the same day, Minter Ellison Lawyers (Minters) were instructed by the Queensland Department of Health (Qld Health) to undertake a number of steps in relation to that surgery at the Health Service and the actions of the clinicians involved, including Dr Vega Vega. Those steps included a notification to the Australian Health Practitioner Regulation Agency (AHPRA) and the initiation of three parallel investigations under the *Hospital and Health Boards Act* 2011 (Qld) (*Boards Act*) which included the institution of a Root Cause Analysis (RCA), a Clinical Review (CR) and a Health Service Investigation (HSI).

[5] On 7 May 2014, a specialist urologist and an eminent surgeon were appointed to conduct the CR. On the same day, a medical practitioner with a specialty in hospital administration and a solicitor employed by Minters were appointed as health investigators under the *Boards Act* for the purposes of the HSI.

[6] On 9 May 2014, the Medical Board suspended Dr Vega Vega's registration. Dr Vega Vega applied to QCAT for a review of that decision and the Medial Board's subsequent

decision of 20 June 2014 to impose conditions on his registration. On 27 June 2014, Judge Horneman-Wren set aside both decisions of the Medical Board.

[7] The three parallel Qld Health investigations continued. On 5 September 2014, the HSI Report, which included the CR Report, was delivered to the Acting Director-General of Qld Health.

[8] On 12 September 2014, Dr Vega Vega filed this application for a statutory order of review arguing that there had been a breach of the rules of natural justice in relation to the final HSI Report delivered on 5 September 2014 (Final Report).

[9] Dr Vega Vega essentially seeks orders that the HSI Report and the CR Report be quashed and set aside or a declaration made that the Reports were produced in breach of natural justice and is invalid. Orders are also sought restraining the seventh and eighth respondents from taking action adverse to Dr Vega Vega on the basis of any material contained in the Reports.

History

[10] In order to fully understand the issues in this case, it is necessary to recite in some detail the initiation and history of the three parallel investigations by Qld Health which were essentially operating at the same time. Those three investigations were; (i) the RCA; (ii) the CR; and (iii) the HSI. In addition to those three investigations under the *Boards Act*, the AHPRA was undertaking its own investigation and review of Dr Vega Vega which ultimately led to action by the Medical Board.

Minters' Involvement

[11] Minters is one of the two firms on the panel of lawyers who regularly provide legal advice to the Qld Health. On 29 April 2014, the firm was engaged to provide legal advice in relation to the clinical incidents which had occurred at the Health Service involving Dr Vega Vega. Shane Evans is the partner from the firm who was primarily involved and Sonja Read, the third respondent, is a solicitor employed by the firm who was also working on the file. She was advised by Mr Evans that a file had been opened in relation to those incidents and it could only be accessed by Mr Evans, herself and their secretaries. She was also advised that a RCA, which is a confidential investigation under the *Boards Act* had been instituted. The main purpose of that investigation is to identify factors that have contributed to a reportable event and to institute remedial measures to prevent a recurrence of a similar reportable event. This analysis excludes investigation of professional competence and blame.

[12] On 2 May 2014, Mr Evans advised Ms Read that he was involved in drafting a notification from the Health Service to the AHPRA.

[13] On 6 and 7 May 2014, Ms Read was asked by the Health Service to provide advice in relation to a request which had been received seeking information about Dr Vega Vega and to provide advice about the establishment of those three investigations (the RCA, the

CR and the HSI) under the *Boards Act*. Advice was also sought from her in relation to a request from the Queensland Police Service for the disclosure of information in relation to patients and documents at the Hospital.

The Appointments

[14] On 7 May 2014, Dr Philip Hoyle, the first respondent, and Ms Read were appointed by the Director-General of Qld Health (Chief Executive), the sixth respondent, as health service investigators under Part 9 of the *Boards Act*. They were required to conduct a HSI in relation to clinical incidents involving four of Dr Vega Vega's patients (patients referred to as patients A, B, C and D) at the Hospital and the compliance or non-compliance with policies and procedures. Part A of the report was to be completed by 6 June 2014 and Part B by 20 June 2014.

[15] Dr Nicholas Brook and Dr Howard Lau, the fifth respondent, were appointed as clinical reviewers under Part 6 of the *Boards Act* for the purpose of providing expert clinical advice to the investigators, Dr Hoyle and Ms Read.

[16] On 8 May 2014, when Ms Read received formal notification of her appointment as an investigator, she advised Qld Health's chief legal counsel that she could not continue to provide advice to the Health Service or Qld Health about the matters relating to the clinical incidents because of her appointment as an investigator.

The Medical Board Decision and Appeal to QCAT

[17] As previously indicated, on 9 May 2014 the Medical Board suspended Dr Vega Vega's registration under s 156 of the *Health Practitioner Regulation National Law Act* 2009 (Qld) (Health Practitioner Regulation National Law). It would seem that that action related to five patients, four of whom were the subject of the investigations pursuant to the *Boards Act.* There was one patient, therefore, who was not common to the inquiries.

[18] The application to QCAT for a review of the Medical Board's decision was filed on 20 May 2014. On 2 June 2014, the Medical Board repealed its decision to suspend Dr Vega Vega's registration and accepted his undertaking not to practice.

[19] Professor Villis Marshall, the fourth respondent, was subsequently appointed as a clinical reviewer in place of Dr Brook and the Director-General granted an extension of time for the Reports until 4 July 2014.

[20] On 11 June 2014, Dr Hoyle advised Dr Vega Vega of the investigation and he was given a copy of the terms of reference and Dr Hoyle's Instrument of Appointment. In an email sent on that date, Dr Hoyle stated that he and Professor Marshall were the lead investigators and he invited the applicant to participate in an interview on 21 July 2014. Dr Hoyle stated that Dr Lau was "a technical advisor on urology" and that Ms Sonja Read was a "process advisor". He advised that "It is not expected that either Dr Lau or Ms Read will meet with anyone directly". Dr Vega Vega informed his lawyers of the investigation and the review later that day. Dr Vega Vega had existing commitments overseas and

accordingly extensions of time were given to the investigators and reviewers to finalise the Reports in light of his absence.

[21] On 19 June 2014, the AHPRA, on behalf of the Medical Board, wrote to Dr Vega Vega and advised him of their proposed immediate action to impose conditions on his registration and invited him to make a submission in respect of that proposed action.

[22] On 20 June 2014, Dr Vega Vega made a written submission to the Medical Board and after considering his submission, the Medical Board decided to impose conditions on his registration.

[23] On 23 June 2014, Dr Vega Vega's application for a review of the Medical Board's decision was then heard before QCAT.

[24] On 24 June 2014, Dr Hoyle sent an email to Dr Vega Vega asking him to attend an interview with himself and Professor Marshall in Rockhampton on 21 July 2014 and asked whether he needed a copy of the medical records of the four nominated patients who were the subject of the HSI Report. Further emails were sent to Dr Vega Vega on 3 and 7 July 2014 asking him to participate in an interview.

[25] On 27 June 2014, Judge Horneman-Wren gave *ex tempore* reasons and (i) set aside the decision of the Medical Board of 2 June 2014 to suspend Dr Vega Vega's registration; and (ii) set aside the Medical Board's decision of 20 June 2014 to impose conditions on his registration.

The Continuing Investigations

[26] On 3 July 2014, Dr Vega Vega received a letter from the Health Service inviting him to participate in the RCA in relation to the care and treatment of Patient A.

[27] On 7 July 2014, Dr Hoyle sent an email to Dr Vega Vega stating it would be in his interest to participate in the HSI process otherwise findings would be made on the evidence available without input from him. The HSI is of course a different investigation to the RCA.

[28] On 9 July 2014, Dr Hoyle sent a letter to Dr Vega Vega by email which included a list of questions that he was to respond to in writing by 21 July 2014. That letter also set out the concerns of the investigators in relation to Dr Vega Vega's management of Patients A and C and stated that the lack of evidence in the medical records about Dr Vega Vega's action to deal with the errors identified might be the basis for adverse comments about him in the investigation report. Dr Hoyle attached the extracts of the medical records.

[29] On 10 July 2014, the Deputy Director-General granted an extension of time for the Reports to 8 August 2014 and requested an Interim Investigation Report in relation to Part B by 23 July 2014.

[30] On 17 July 2014, Dr Vega Vega's solicitors wrote to Dr Hoyle indicating that he did not wish to participate in an interview for the purposes of the RCA, but that he was happy to make available the material which had been placed before QCAT with respect to his treatment of patients at the Hospital for the limited purposes of the RCA. This was later clarified to indicate that the material could be used for the CR and HSI, as Dr Hoyle had no involvement in the RCA.

The Interim Investigation Report

[31] On 25 July 2014, the Interim Investigation Report in relation to Part B was delivered to the Director-General.

[32] On 29 July 2014, QCAT's written reasons in the matter of *Vega Vega v Medical Board of Australia*[1] were published, having been delivered *ex tempore* on 27 June 2014.

The Initial Application for Judicial Review

[33] On 29 July 2014, Dr Vega Vega filed and served an application for judicial review against the State of Queensland which related to the Health Service's decision to suspend the his employment without pay. That application was subsequently resolved without a hearing.

[34] On 1 August 2014, the chief legal counsel for Qld Health asked the solicitors for Dr Vega Vega whether they would consent to Minters acting for the State of Queensland in relation to the judicial review application which had been filed on 29 July 2014. An email in reply on that date advised that Dr Vega Vega would not waive the conflict in Minters acting for the State of Queensland.

[35] On 1 August 2014, Dr Hoyle wrote to Dr Vega Vega's solicitors stating that the material provided on 18 July 2014 did not address the questions in his letter of 9 July 2014 and sought a written response to the issues which were set out in Attachment A to the letter by 6 August 2014. Dr Hoyle also set out the potential adverse comments that were proposed to be made.

[36] The written reasons of QCAT were forwarded to Dr Hoyle on 1 August 2014.

[37] On 4 August 2014 Dr Hoyle received a letter requesting an extension of time until 27 August 2014 from Dr Vega Vega's solicitors.

[38] On 6 August 2014, the Director-General appointed Megan Fairweather, the second respondent, a senior associate at Minters as a health service investigator with effect from 11 August 2014 to replace Ms Read who was going overseas on that date. The Director-General also granted an extension of time for the completion of the Reports until 22 August 2014.

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1 [2014] QCAT 328.

[39] On 6 August 2014, Dr Hoyle sent an email to Dr Vega Vega's solicitors stating that whilst Dr Vega Vega had been aware since 9 July 2014 of the issues being considered in the Reports, the investigators and reviewers wished to provide him with an opportunity to respond if he wished to do so by 15 August 2014.

The Requests for Material

[40] Later on the day of 6 August 2014, Dr Vega Vega's solicitors requested:

- a list of all material that had been sighted by the reviewers and investigators, including but not limited to medical record statements and policy documents;

- a list of all material that had been relied on by the reviewers and investigators in reaching their preliminary views, including but not limited to medical records, statements and policy documents; and

- copies of all of that material except for the medical records which Dr Vega Vega's solicitors already had a copy.

[41] On 7 August 2014, Dr Hoyle emailed Dr Vega Vega's solicitors and stated that he could respond to the issues and the questions set out in the letter of 1 August 2014 on the basis of the medical reports and stated that the materials collected and sighted by him in the investigation were not necessary for such a response. Dr Hoyle also advised that he had received clinical advice from the clinical reviewers that the nephrectomy performed by Dr Vega Vega on Patient A was, in principle, appropriate for the patient's condition and he would not therefore be making any adverse comment about the appropriateness of performing the nephrectomy which, it must be recalled, had trigged the three parallel investigations.

[42] On 11 August 2014, Ms Fairweather's appointment commenced and Dr Hoyle sent a letter to Dr Vega Vega's solicitors setting out two potential adverse findings that might be made with respect to Dr Vega Vega. Ms Read's appointment as a health service investigator ceased on 13 August 2014.

[43] On 14 August 2014, Dr Hoyle received a letter from Dr Vega Vega's solicitors requesting clarification about the nature of the HSI and the CR the *Boards Act* and copies of the Instruments of Appointment for Ms Read, Dr Lau and Professor Marshall. The letter also set out a number of concerns in relation to Dr Hoyle's questions and potential adverse findings, which they considered were inconsistent with the material provided by Dr Vega Vega. A request was also made for the material relied on by the investigators and reviewers. The letter also stated that Dr Vega Vega was concerned that aspects of the Reports may be published in a way which would adversely impact on his reputation and sought an undertaking that no attempt would be made to publish the report until he had an opportunity to fully litigate the natural justice concerns raised in the correspondence.

[44] On 15 August 2014, Dr Vega Vega's solicitor advised Ms Fairweather that proceedings were about to be commenced in the Supreme Court in relation to the investigation. In

that conversation, Ms Fairweather indicated she had taken over from Ms Read as a health service investigator and that the investigation was a HSI under the *Boards Act*, which included a CR by Professor Marshall and Dr Lau, and that her role included assisting Dr Hoyle, Professor Marshall and Dr Lau to finalise the Reports and ensuring that natural justice obligations were met. She stated that after considering the matters raised in the letter of 14 August 2014, an opportunity was to be given to Dr Vega Vega to respond to full and complete drafts of the soon to be completed CR and HSI Reports. A two week response period was subsequently confirmed by Ms Fairweather in written correspondence.

The Provision of the Draft Reports to Dr Vega Vega

[45] On 19 August 2014, draft copies of the Reports were forwarded to Dr Vega Vega's solicitors. A written response was required by 3 September 2014. The letter stated that Dr Vega Vega and his insurer were to maintain strict confidentiality in relation to the draft copies of the Reports and their contents.

[46] On 20 August 2014, Ms Fairweather sent an email to Dr Vega Vega's solicitors indicating there were errors in the draft HSI Report and that the references should be to Patient A and B and not Patient C. On that date, Dr Vega Vega's solicitors sought a copy of Ms Read's Instrument of Appointment and full particulars of all involvement by persons from Minters in acting for entities associated with the Qld Health or other Queensland entities that in any way concerned Dr Vega Vega.

Further Requests for Information

[47] The letter of 20 August 2014 also requested a copy of all material considered by the investigators and clinical reviewers and raised issues in relation to the question of confidentiality which had been requested. The letter also stated that the question as to whether a period of two weeks would be sufficient to provide Dr Vega Vega with natural justice would depend on the length, detail and complexity of the draft reports and any additional documentation provided. That letter also indicated that given the concerns in relation to confidentiality, neither Dr Vega Vega nor the lawyers had opened the draft reports.

[48] On 21 August 2014, Ms Fairweather wrote to Dr Vega Vega's solicitors, stating that neither she nor Ms Read had acted for Qld Health or any other government entity in any other matter relating to Dr Vega Vega. She also indicated that Dr Vega Vega's solicitors were provided with the medical reports of the four patients in late May 2014 and that they were the primary source for the comments made about Dr Vega Vega in the draft Reports. She advised that she was seeking urgent instructions in relation to the other documents relied on in the Reports and that she intended to provide a list of documents. Ms Fairweather also advised that s 197 of the *Boards Act* was the basis of the request for Dr Vega Vega and the insurers to maintain confidentiality because the information could be considered adverse to the interests of other parties. That letter also stated a response was due by 3 September 2014.

[49] On 22 August 2014, Ms Fairweather received a letter from the Acting Director-General indicating an extension of time had been granted to 12 September 2014 to finalise the Reports and the Acting Director-General requested an Interim Investigation Report. On that date, Ms Fairweather sent a letter to Dr Vega Vega's solicitors which confirmed the de-identified references for the patients and also set out the documents considered by Dr Hoyle to be directly and indirectly relevant to the views formed in relation to Dr Vega Vega. That letter included two confidential documents and also invited Dr Vega Vega and his solicitors to request copies of any of the documents which were listed.

[50] On 25 August 2014, Ms Fairweather sent a letter to Dr Vega Vega's solicitors enclosing a PRIME incident report in relation to Patient B dated 22 November 2011.

[51] On 28 August 2014, Ms Fairweather received a letter from Dr Vega Vega's solicitors raising allegations of apprehended bias and asserting that the list of documents was incomplete because it did not include interview notes. The letter also raised allegations of actual or apprehended bias specifically against Dr Hoyle. The letter, however, indicated that Dr Vega Vega agreed to use the Reports solely for the purpose of protecting his interests including commencing legal proceedings and sought Ms Fairweather's confirmation that the undertaking was sufficient to allow them access to the draft Reports.

[52] On 29 August 2014, Ms Fairweather wrote to the solicitors for Dr Vega Vega stating that whilst Dr Vega Vega had declined to attend an interview or respond to questions, the investigators and reviewers welcomed his response to any matters that he considered adverse. The letter indicated, however, that the blanket request for all documents that were gathered was not a requirement of natural justice and was not sustainable. Ms Fairweather also stated that Dr Hoyle had instructed her that the evidence obtained during his conferences with the witnesses had been fairly and comprehensively reported in the draft HSI Report and that Dr Vega Vega's statement to QCAT and the urology experts' opinions submitted to QCAT had been considered by Dr Hoyle, Professor Marshall and Dr Lau. Ms Fairweather also stated that there was no basis for the allegations of bias against her, Ms Read and Dr Hoyle. She sought a written response to the adverse comments in the draft Reports by 3 September 2014.

[53] On 2 September 2014, Dr Vega Vega's solicitors wrote to Ms Fairweather maintaining their concerns in relation to bias and asserting that the list of documents was incomplete as it did not include interview notes and phone records. A further request was made for access to all material and an intimation was made that in the absence of undertakings not to finalise the Reports, it was anticipated there would be an interim hearing to consider interlocutory relief on 3 September 2014.

[54] On 3 September 2014, Ms Fairweather wrote to Dr Vega Vega's solicitors indicating that some amendments had been made in the draft Reports. She also reiterated that the blanket request for all documents was unreasonable and unnecessary, but that they were prepared to provide specific documents. She indicated, however, that the handwritten interview notes would not be provided because witnesses were interviewed in strict confidence and the substance of the comments potentially adverse to Dr Vega Vega had been reflected in the draft Reports. The letter to Dr Vega Vega's solicitors also stated that the telephone records of 28 April 2014 were not required to be provided and that any further comments were to be received by close of business that day.

The CR Report

[55] Professor Marshall and Dr Lau finalised the CR Report on 3 September 2014.

Concerns raised in relation to Rejected Evidence

[56] On 4 September 2014, Dr Vega Vega's solicitors sent a further letter to Ms Fairweather which outlined their concerns that the investigators and reviewers had rejected evidence without giving reasons. References were also made to examples of the investigators and reviewers ignoring evidence available to them. The letter also referred to the Terms of Reference, in particular s 5.5 of the Terms of Reference, as the basis for the request for disclosure of the documents contained in the investigation. That letter also stated that the confidentiality obligation in s 197 of the *Boards Act* did not prevent the disclosure of the witness statements.

[57] The letter of 4 September 2014 also sought an undertaking that the Reports would not be finalised.

The Delivery of the Final Report to the Acting Director-General

[58] On 5 September 2014, the investigators, Ms Fairweather and Dr Hoyle, finalised the HSI Report, which included the CR Report, and arranged for it to be delivered to the Acting Director-General.

The Application for a Statutory Order of Review

[59] On 12 September 2014, the current application for a statutory order of review was filed and an amended application was filed on 4 February 2015. Those amendments were not objected to and the amended application is in the following terms:

> "Application to review the decisions of the First to Fifth Respondents as either Investigators (the First to Third Respondents) or Clinical Reviewers (Fourth and Fifth Respondents) in purported pursuance of their respective appointments by the Sixth Respondent pursuant to either s. 190 or 125, respectively, of the *Hospital and Health Boards Act 2011* ("the Boards Act") to deliver an Investigation Report or Report of a Clinical Review, respectively, into the treatment of four named patients at the Rockhampton Hospital of the Eighth Respondent and the compliance or non-compliance with policies in place at the Rockhampton Hospital.
>
> The Applicant is aggrieved by the decision because, in each case, the four patients are patients in whose treatment he was integrally involved and he is potentially the subject of adverse findings in the Investigation Report and/or Report of the Clinical Review.
>
> The grounds of the application are:
>
> 1. That a breach of the rules of natural justice happened in relation to the decisions in that a reasonable apprehension of bias arose out of the

Second and Third Respondents' appointment and participation as Investigators and their status as employees of Minter Ellison, solicitors, in circumstances where Minter Ellison has been engaged in an advocacy role for either the Queensland Department of Health (an entity forming part of the Seventh Respondent) or the Eighth Respondent in respect of the same matters concerning the Applicant as were the subject of the Investigation and Clinical Review.

2. That a breach of the rules of natural justice happened in relation to the decisions in that the First to Fifth Respondents prevented the Applicant from having access to information and documents relied upon by the Investigators and Clinical Reviewers including the notes of interviews with some 58 witnesses interviewed as part of the Investigation and Clinical Review and, thereby, prevented the Applicant from knowing the basis of the case against him and from making properly informed responses during the process of the Investigation and Review.

3. That a breach of the rules of natural justice happened in relation to the decisions in that the conduct referred to in the preceding paragraph contributed to and reinforced the reasonable apprehension of bias that had arisen as a result of the matters referred to in paragraph 1 of these grounds.

4. That a breach of the rules of natural justice happened in relation to the decisions in that the First and Second and the Fourth and Fifth Respondents, in preparing documents setting out potential adverse findings against the Applicant or Draft Reports of their Findings, rejected evidence of or on behalf of the Applicant without providing reasons for that rejection or ignored evidence supportive of the Applicant (without giving reasons).

5. That a breach of the rules of natural justice happened in relation to the decisions in that the conduct referred to in the preceding paragraph contributed to and reinforced the reasonable apprehension of bias that had arisen as a result of the matters referred to in paragraph 1 of these grounds.

6. That a breach of the rules of natural justice happened in relation to the decisions in that the First and Second and the Fourth and Fifth Respondents, having received correspondence on behalf of the Applicant raising the types of concerns set out in paragraph 4 of these grounds, failed to reply to such correspondence and, without further reference to the Applicant, proceeded to make their respective decisions by concluding and delivering their reports to the Sixth Respondent (in the case of the Fourth and Fifth Respondents, by way of delivering it to the First and Second Respondents).

7. That a breach of the rules of natural justice happened in relation to the decisions in that the conduct referred to in the preceding paragraph contributed to and reinforced the reasonable apprehension of bias that had arisen as a result of the matters referred to in paragraph 1 of these grounds.

7A. The fourth and fifth respondents failed to take into account a relevant consideration, namely, the effect of expert evidence as revealed in the reasons of His Honour, Judge Horneman-Wren, when His Honour gave judgment for the applicant in proceedings brought against the Medical Board of Australia in Queensland Civil and Administrative Tribunal on 27 June 2014.

The applicant claims:

1. An order that, by way of final order, the Investigation Report of the First, Second and/or Third Respondents delivered to the Sixth Respondent purportedly pursuant to s. 199 of the Boards Act is hereby quashed and set aside;

2. Further and in the alternative, a declaration that the Investigation Report of the First, Second and/or Third Respondents delivered to the Sixth Respondent purportedly pursuant to s. 199 of the Boards Act was produced in breach of natural justice and is, thereby, invalid;

3. An order that, by way of final order, the Report of the Clinical Review of the Fourth and Fifth Respondents delivered to the First and Second Respondents purportedly pursuant to s. 136 of the Boards Act is hereby quashed and set aside;

4. Further and in the alternative, a declaration that the Report of the Clinical Review of the Fourth and Fifth Respondents delivered to the First and Second Respondents purportedly pursuant to s. 136 of the Boards Act was produced in breach of natural justice and is, thereby, invalid;

5. An order that, by final order, the Seventh and Eighth Respondents are restrained, from taking any action adverse to the Applicant on the basis of any finding, recommendation or other material contained in either the Investigation Report or the Report of the Clinical Review;

6. An order that the Seventh Respondent pay the costs of the Applicant."

The Decision Making Regime under the *Boards Act*

[60] As I have previously indicated, three parallel investigations were initiated under the *Boards Act*. The two relevant investigations for the purposes of this application are the HSI and the CR. Those two investigations were initiated by the sixth respondent under the *Boards Act* as Chief Executive. The purpose of the CR was to provide expert clinical advice in relation to the particular clinical incidents at the Hospital which would then inform the HSI which examines the management, delivery and administration of public sector health services in the hospital.

[61] The correspondence reveals that there was confusion at times about which investigation was the operative investigation when various requests were made for information. There would also seem to have been some overlapping of roles at times, as Dr Hoyle conducted some interviews with one of the clinical reviewers. Dr Hoyle and Professor Marshall

conducted 18 interviews jointly[2] from 20 to 22 July 2014 at the Hospital. Dr Hoyle states he met with 39 witnesses individually and in groups by himself from 14 to 20 June 2014.

[62] The *Boards Act* and the Instruments of Appointment, however, made it clear that the health service investigators who were responsible for preparing the HSI Report were required to have regard to the CR Report provided by the clinical reviewers, whose role was to provide that expert clinical advice to them as investigators. The CR Report was therefore an essential component of the ultimate HSI Report, but it has no other operative effect under the *Boards Act*.

[63] Once that HSI Report is provided to the Chief Executive, *after considering the HSI Report* the Chief Executive *may* issue a direction to a hospital and health service.

[64] Queensland Health's view of the investigations is outlined in the following communication from the chief legal officer to Dr Hoyle on 9 May 2014 at the time of his appointment:

> "Essentially, the Department anticipates that Part A of the health service investigation will allow a 'quick' review of the 4 clinical incidents involving Dr Vega Vega which have been identified. We expect that review of the clinical incidents will primarily be conducted by the clinical reviewers (surgeons) and that you will be informed by their views in relation to the procedures.
>
> However, we anticipate that your expertise as a medical administrator will allow you to provide an opinion (in addition to those views expressed by the clinical reviewers) on the credentialing and privileging process for Dr Vega Vega and the clinical governance around the performance of these types of procedures at Rockhampton Hospital. In summary, Part A is very focussed upon these incidents involving Dr Vega Vega.
>
> We anticipate that Part B of the investigation will have a much broader scope in relation to the Rockhampton Hospital generally and that Sonya would play a more background role to assist and guide you in collating and compiling the report in relation to this broader issue."

[65] Given the essential nature of those investigations and reports, it is necessary to consider the nature of the decisions being made by both the clinical reviewers and the health service investigators in some detail in order to ascertain if they are decisions which are capable of judicial review pursuant to the *Judicial Review Act* 1991 (Qld) (*JR Act*), as the respondents maintain that they are not decisions which are capable of review under the *JR Act.*

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[2] Although Professor Marshall has indicated that it was 12 interviews in paragraph 20 of his Affidavit sworn on 6 November 2014.

Clinical Reviews

[66] Division 3 of Part 6 of the *Boards Act* provides for clinical reviews.

[67] The clinical reviewers were appointed by the Chief Executive pursuant to s 125(1) and were required pursuant to s 124(c) to conduct a clinical review and provide expert clinical advice to the health service investigators who had been appointed by the Chief Executive. The purpose of the CR was therefore to provide expert clinical advice in relation to the particular incidents at the hospital which would then informs the HSI which examines the management, delivery and administration of public sector health services in the hospital.

[68] Section 126 provides that a clinical reviewer's appointment and powers are subject to any conditions as set out in the instrument of appointment or notice given to the clinical reviewer or by regulation. Section 129 sets out the general powers of a clinical reviewer which includes being able to ask an employee of the Department's hospital or health service to give a reviewer a document including a document which contains confidential information. Section 132 then contains provisions in relation to confidentiality and the exceptions to the duty of confidentiality as follows:

> "**132 Duty of confidentiality of clinical reviewers**
>
> (1) This section applies to a person who –
>
> (a) is or has been a clinical reviewer; and
>
> (b) in that capacity was given information.
>
> (2) The person must not disclose the information to anyone else.
>
> Maximum penalty—100 penalty units.
>
> (3) However, the person may disclose the information to someone else –
>
> (a) to the extent necessary to perform the person's functions under or in relation to this Act; or
>
> (b) if the person to whom the information relates consents in writing to the disclosure.
>
> (4) Also, the person may disclose the information to someone else if—
>
> (a) the disclosure is to—
>
> (i) the relevant chief executive; or
>
> (ii) another person authorised in writing by the relevant chief executive to receive the information; and
>
> (b) the purpose of the disclosure under this section is to allow further disclosure of the information under section 160."

[69] Section 136(2) then contains the mandatory requirement that where a clinical review is undertaken to provide clinical advice to a health service investigator then the clinical reviewer **must** prepare and provide a report to the health service investigator. Section

136(3) also provides that the report **may** include recommendations on ways in which the safety and quality of public sector health services can be maintained and improved.

[70] The Instrument of Appointment of the clinical reviewers is dated 7 May 2014 and the Terms of Reference were set out in Schedule 1 of that document. The Instrument of Appointment of the clinical reviewers required them to undertake a CR in accordance with the Terms of Reference and to provide the CR Report to the health service investigators. It is clear from that documentation that the CR was in relation to the treatment of the four named patients and that the clinical reviewers were to review relevant clinical and administrative policies and procedures, specifically those relating to clinical governance and surgical safety, to consider whether appropriate policies and procedures were in place, and whether the compliance or non-compliance with those existing policies and procedures had any impact on the standard and quality of care provided to the four named patients.

[71] I also note that it specifically included a review of "the qualifications, training, experience and scope of practice of *the surgeon*" (my emphasis) as well as a review of the surgical procedures and decision making undertaken in relation to each of those four named patients. It also specifically stated that the review was to proceed in accordance with the principles of natural justice and provided that:

> *"The Clinical Reviewers must provide any clinician with potential adverse findings with the opportunity to attend an interview and with the opportunity to respond verbally to the matters under review. Material which is adverse to any clinician, and credible, relevant and significant to the findings to be made by the Clinical Reviewers, is to be released to the clinician during the course of the Review. This can be released verbally at interview'."*

[72] It should also be noted that the CR was conducted by two very senior surgeons, namely Professor Marshall and Dr Lau. They provided expert clinical advice to the health service investigators. Dr Lau was the head of urology at the Westmead Private Hospital and was a recognised expert in the field. Professor Marshall is also the chair of the Australian Commission on Safety and Quality in Health Care with particular knowledge of urology and kidney disease. The role of the clinical reviewers under the *Boards Act* was to provide expert clinical advice in the form of a report which had to be given to the health service investigators.

[73] An examination of that expert clinical advice which was contained in the CR Report reveals that the review refers specifically to the management of the four named patients. The review was based on a consideration of the case notes of those patients and outlined in some detail the care that was provided. Whilst I note that Professor Marshall was involved in between 12 and 18 interviews at the Hospital, he does not refer to these interviews in the CR. An examination of that CR makes it manifestly clear that the CR was about Dr Vega Vega. Professor Marshall and Dr Lau also made very clear clinical recommendations in that report based on their specific expertise in urology. I also note that paragraph 12(b) of the Final Report records Dr Hoyle's reliance on the findings of the expert clinical reviewers in the following terms "While one of the investigators is a medical practitioner, Dr Hoyle has not made any clinical findings regarding the standard or quality of care provided to patients at Rockhampton Hospital".

[74] Accordingly, those clinical findings by the experts Professor Marshall and Dr Lau were clearly pivotal to Dr Hoyle's findings and recommendations. It is significant, in my view, that the CR Report contained the surgeons' findings about Dr Vega Vega, which included specific findings about his technical competence, his compliance with safety procedures, his communication style, his document keeping and his compliance with disclosure obligations. Specific findings were also made in relation to Dr Vega Vega's duty under the Medical Board of Australia's Code of Conduct.

Health Service Investigations

[75] Part 9 of the *Boards Act* provides for health service investigations and requires that such investigations be conducted by health service investigators.

[76] Section 190 provides that the Chief Executive of the Department can appoint a person as an investigator to conduct an investigation in the Department or a hospital and health service. Section 189 states the functions of an investigator are to investigate and report on any matters relating to the management, administration or delivery of public sector health services including "employment matters".

[77] Section 194 sets out the powers of an investigator which include a power to ask an employee of the Department or a hospital and health service to give an investigator a document including a document which contains confidential information. Section 191 provides that the investigator holds office on any conditions stated in the instrument of appointment or pursuant to a signed notice or a regulation.

[78] Section 197 imposes a duty of confidentiality, however, that duty is subject to a number of exceptions which allow an investigator to disclose information.

> "**197 Duty of confidentiality of health service investigators**
>
> (1) This section applies to a person who –
>
> (a) is or has been a health service investigator; and
>
> (b) in that capacity was given information.
>
> (2) The person must not disclose the information to anyone else.
>
> Maximum penalty—100 penalty units.
>
> (3) However, the person may disclose the information to someone else –
>
> (a) to the extent necessary to perform the person's functions under or in relation to this Act; or
>
> (b) if the person to whom the information relates consent in writing to the disclosure; or
>
> (c) if the disclosure is otherwise required or permitted by another Act or law.
>
> (4) Also, the person may disclose the information to someone else if –
>
> (a) the disclosure is to –

(i) the relevant chief executive;

(ii) another person authorised in writing by the relevant chief executive to receive the information; and

(b) the purpose of the disclosure under this section is to allow further disclosure of the information under section 160."

[79] Section 199(1), (2) and (3) provide that an investigator must prepare and provide a report to the Chief Executive and that in preparing the report, the investigator must have regard to any report provided by a clinical reviewer and attach the clinical reviewer's report to the investigator's report. A clinical review report is therefore a pre-requisite to a health service investigation report and an essential component of it. Furthermore, given the requirements of the *Boards Act* and the Terms of Reference, Dr Hoyle could not have prepared the HSI Report without having regard to the CR Report. I consider therefore that the CR Report was in itself an essential pre-condition to the completion of the HSI Report.

[80] The investigator's report may include recommendations and ways in which the administration, management or delivery of public sector health services including employment matters can be improved.

[81] In the present case, the Instrument of Appointment of the health service investigators is also dated 7 May 2014 and Schedule 1 sets out the Terms of Reference which provided that the purpose of the investigation was to:

"(i) Part A: assess the treatment provided to [four named patients] at the Rockhampton Hospital and the compliance or non-compliance with policies and procedures in place at the hospital in respect of the treatment of those patients; and

(ii) Part B: to assess the clinical governance policies, processes and procedures at the Rockhampton Hospital."

[82] The Terms of Reference required at paragraph 3.2 that Findings and Recommendations be made, but also required that it proceed in accordance with the principles of natural justice. Paragraph 5 relates to the Conduct of the Investigation and relevantly it provides:

"5.5 Material that is adverse to any person concerned in this investigation and credible, relevant and significant to the investigation is to be released to that person during the course of the investigation. Where this material is contained in writing, it is to be provided to that person within a reasonable time prior to any interview or within a reasonable timeframe to permit a written response. Prior to releasing documentation to the person, the investigators will consult with me as confidentiality undertakings may be required before the release of documentation to that person' and

……

5.7 The names of persons providing information to the investigators must be kept confidential and referred to in a de-identified form in the body of the

> *report, unless the identification of the person is essential to ensure that natural justice is afforded to any particular person."*

[83] The Executive Summary of the HSI Report presented on 5 September 2014 indicates that the immediate trigger for the investigation was a series of four clinical incidents which arose at the Health Service between 2013 and 2014. Those incidents were referred to as wrong site surgery, a missed diagnosis of testicular torsion, undetected post-operative bleeding and wrong site nephrectomy. The Terms of Reference also clearly indicate that the qualifications, training, experience and scope of practice of Dr Vega Vega were to be investigated and, in particular, certain surgical procedures were to be examined in relation to four identified patients. There is no doubt that Dr Vega Vega was the primary focus of the whole HSI and not just the CR.

[84] Furthermore, pursuant to s 189 of the *Boards Act*, the HSI Report was to include an investigation and report on any matters relating to the management, administration or delivery of public sector health services which specifically includes "employment matters". The powers of the investigators under s 194 included the power to enter public sector health service facilities and to request confidential information.

[85] Paragraph 2.4 of the Final Report comprises the recommendations regarding Part (A) of the Terms of Reference which related to the surgery on the four named patients. At that paragraph, the investigator, Dr Hoyle, specifically agreed with the recommendations proposed by the clinical reviewers and at paragraph 2.4(a)(ii) the following recommendation was made based on the advice of the clinical reviewers:

> "The Clinical Reviewers have identified a number of serious issues that are likely to impact on the ability of Dr A to provide safe and competent care to patients undergoing complex urological surgery. It is recommended that **Dr A be required to provide to Department of Health with undertakings** (sic) that will correct the shortcomings identified in his surgical practice as a consultant undertaking complex urological surgery. These undertakings will need to be robust to provide Department of Health with a high level of confidence that patient safety will not be compromised in the future. **Dr A's clinical privileges with Department of Health should remain suspended** until he has defined a process and strategies that will overcome the deficiencies in his surgical practice that have been identified by this Review to the satisfaction of Department of Health. Our reason for proposing this approach is that Dr A in our view lacks insight and he is largely in denial with regard to the harm his poor judgment and practice has caused his patients and certainly in the past not capable of apologising." (my emphasis)

[86] The HSI Report also proposed at paragraph 2.4(b) a number of recommendations including that the urologists at the Health Service (with specific reference to Dr Vega Vega) be mentored and supervised by a senior urologist and that Dr Vega Vega be provided with certain formal training.

The provision of the HSI Report to the Chief Executive pursuant to s 199 of the *Boards Act*

[87] Once the HSI Report was completed, s 199 requires that it be provided to the Chief Executive. The relevant provisions of s 199 are as follows:

"**199 Reports by health service investigators**

(1) A health service investigator must prepare and provide a report to the appointer for each health service investigation.

(2) In preparing the report, the health service investigator must—

(a) have regard to any report provided by a clinical reviewer under section 136; and

(b) attach the reviewer's report to the investigator's report.

(3) The investigator's report may include recommendations on ways in which the administration, management or delivery of public sector health services, including employment matters, can be improved.

(4) Subsection (5) applies to a report provided to the chief executive after an investigation in a Service.

(5) After considering the report, the chief executive may issue a direction to the Service.

(6) The Service must comply with the direction."

[88] Accordingly, once the clinical reviewers and the health service investigators were appointed, the *Boards Act* required that the CR and the HSI had to be conducted in relation to the matters specified in the Terms of Reference and the Reports had to be provided to the Chief Executive. They were essentially expert reports initiated by the Chief Executive on specific issues and included clinical findings by experts about medical procedures which had been undertaken. I note in this regard that the Chief Executive is not required to be a medical practitioner.

[89] Once the HSI Report is provided to the Chief Executive, s 199(5) provides that *after considering the HSI Report* the Chief Executive *may* issue a direction to a hospital and health service. As s 45(n) provides that one of the functions of the Chief Executive is monitoring the performance of services, the HSI Report could therefore inform "remedial action when performance does not meet expected standards." It would seem to me, however, that the power of the Chief Executive to issue a direction based on the HIS Report, which incorporates the CR Report, is found in section 199(5) and that any directive issued by the Chief Executive pursuant to s 47 or s 51A of the *Boards Act* is distinct from a direction which may be issued as a result of the HSI Report under s 199(5). A direction pursuant to s 199(5) can only be issued if both a clinical review and a health service investigation have occurred and there has been a consideration of the HSI Report by the Chief Executive.

[90] At this point in time, it is clear that no such direction has as yet been made. It would seem to me that the Chief Executive cannot make a direction pursuant to s199(5) without a consideration of the HSI Report which contains the CR Report.

[91] By his application, Dr Vega Vega seeks judicial review of the decisions of the clinical reviewers and the health service investigators pursuant to the *JR Act* on various grounds. The respondents argue, however, that those decisions are not decisions which are

susceptible to review pursuant to the *JR Act.* I turn then to a consideration of this preliminary issue.

Preliminary issue – is relief available under Part 3 or 5 of the *JR Act*?

The JR Act

[92] As *Griffith University v Tang*[3] made clear, the *JR Act* provides that a person who is aggrieved by a decision to which the Act applies may apply to the Supreme Court for a statutory order of review under Part 3 of the Act in relation to the decision.

[93] Section 3 provides that "reviewable matter" means:

> "(a) a decision; or
>
> (b) conduct, including conduct engaged in for the purpose of making a decision; or
>
> (c) a failure to make a decision or to perform a duty according to law."

[94] Section 3 also provides that "statutory order of review" means:

> "an order on an application made—
>
> (a) under section 20 in relation to a decision; or
>
> (b) under section 21 in relation to conduct engaged in for the purpose of making a decision; or
>
> (c) under section 22 in relation to a failure to make a decision."

[95] Section 30 of the *JR Act* sets out the powers of the Court in relation to applications for statutory orders of review and Part 5 of the *JR Act* sets out the relevant provisions in relation to the relief available pursuant to prerogative orders and injunctions.

[96] Three distinct separate elements are therefore necessary before an application can be made pursuant to s 20, s 21 or s 22. Firstly, a decision to which the *JR Act* applies, secondly, an aggrieved applicant and thirdly, reliance on one of the grounds of review listed in the relevant sections.

[97] The relevant sections of the *JR Act* are s 4, s 5 and s 6 which provide:

> "**4 Meaning of *decision to which this Act applies***
>
> In this Act—
>
> ***decision to which this Act applies*** means—
>
> (a) a decision of an administrative character made, proposed to be made, or required to be made, under an enactment (whether or not in the exercise of a discretion); or

[3] (2005) 221 CLR 99.

…

5 Meaning of *making of a decision and failure to make a decision*

In this Act, a reference to the ***making of a decision*** includes a reference to—

(a) making, suspending, revoking or refusing to make an order, award or determination; or

(b) giving, suspending, revoking or refusing to give a certificate, direction, approval, consent or permission; or

(c) issuing, suspending, revoking or refusing to issue a licence, authority or other instrument; or

(d) imposing a condition or restriction; or

(e) making a declaration, demand or requirement; or

(f) retaining, or refusing to deliver up, an article; or

(g) doing or refusing to do anything else;

and a reference to a ***failure to make a decision*** is to be construed accordingly.

6 Making of report or recommendation is making of a decision

If provision is made by an enactment for the making of a report or recommendation before a decision is made, the making of the report or recommendation is itself taken, for the purposes of this Act, to be the making of a decision."

[98] There would appear to be no real argument that the nature of the decisions made here were of an administrative character. The real question is whether those decisions of the clinical reviewers and the health service investigators are decisions to which the *JR Act* applies?

[99] The respondents argue that relief is not available under Part 3 or 5 of the *JR Act* on three grounds. Firstly, that the CR Report and HSI Report are not decisions within the meaning of s 4, s 5 and s 6 of the *JR Act* and that the *Boards Act* does not require that the HSI or the CR be conducted and reports prepared before a decision is made. The respondents argue that the decision in *Wells v Carmody & Anor*[4] is authority for the proposition that s 6 of the *JR Act* is not engaged because the *Boards Act* does not require that any decision affecting the applicant's rights or interests be made as a result of the provision of those reports.

[100] Secondly, it is argued that even if the provision of the Reports could be regarded as coming within the extended definition in s 6, then the Reports could not be characterised as a "decision" within the purview of the *JR Act* because they failed to exhibit the essential features of a decision and they lacked the character or quality of finality or an outcome reflecting something in the nature of determination of an inquiry or dispute.[5]

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4 [2014] QSC 59, [36]-[54].

5 *Wells v Carmody & Anor* [2014] QSC 59, [57]-[58].

[101] The third basis is that it is argued that the Reports do not themselves have any legal effect and have no legal consequences either direct or indirect. Accordingly, there is no occasion for the Court to consider the ground of relief by way of prerogative orders in the nature of certiorari, prohibition, declaration or injunction. The respondents rely on the decision in *Ainsworth v The Criminal Justice Commission*[6] to argue that the Reports delivered to the Chief Executive of the Health Department had no legal effect and carried no legal consequences. The respondents argue that *Ainsworth* held that the report in that case did not legally affect rights because the appellants may have ultimately been granted the licences they sought in direct opposition to the recommendations in the report in question.

Are the Reports of the clinical reviewers and the health service investigators *decisions* within the meaning of s 4, s 5 and s 6 of the *JR Act*?

[102] Are the decisions of the clinical reviewers and health service investigators, which are contained in the Final Report delivered to the Chief Executive on 5 September 2014, decisions within the meaning of s 4, s 5 and s 6 of the *JR Act*?

[103] In *Australian Broadcasting Tribunal v Bond*,[7] Mason CJ stated:

> "….a reviewable 'decision' is one for which provision is made by or under a statute. That will generally, but not always, entail a decision which is final or operative and determinative, at least in a practical sense, of the issue of fact falling for consideration. A conclusion reached as a step along the way in a course of reasoning leading to an ultimate decision would not ordinarily amount to a reviewable decision, unless the statute provided for the making of a finding or ruling on that point so that the decision, though an intermediate decision, might accurately be described as a decision under an enactment."

[104] In *Griffith University v Tang*,[8] Gummow, Callinan and Heydon JJ held that the first question is the existence of a decision to which the *JR Act* applies. That is the question as to whether it is a decision of an administrative character made under an enactment as follows:

> "[79] The decision so required or authorised must be 'of an administrative character'. This element of the definition casts some light on the force to be given by the phrase '*under* an enactment'. What is it, in the course of administration that flows from or arises out of the decision taken so as to give that significance which has merited the legislative conferral of a right of judicial review upon those aggrieved?
>
> [80] The answer in general terms is the affecting of legal rights and obligations. Do legal rights or duties owe in an immediate sense their existence to the decision, or depend upon the presence of the decision for their enforcement? To adapt what was said by Lehane J in *Lewins*, does the decision in question derive from the enactment the capacity to affect legal rights and obligations? Are legal rights and obligations affected not under the general law but by virtue of the statute?" (citations omitted)

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6 (1992) 175 CLR 564, 580 and 595.
7 (1990) 170 CLR 321, 337.
8 (2005) 221 CLR 99, 128.

[105] The majority held, therefore, that the determination of whether a decision is made under an enactment involves two criteria. Firstly, it must be expressly or impliedly required or authorised by the enactment and secondly, the decision must itself confer, alter or otherwise affect legal rights or obligations, and in that sense the decision must derive from the enactment. Accordingly a decision will only be 'made under an enactment' if both these criteria are met. The relevant decision is not required to only affect or alter *existing* rights or obligations, but it is sufficient that the enactment requires or authorises decisions from which new rights or obligations arise and it is not necessary that the relevantly affected legal rights owe their existence to the enactment in question. An affect "of the rights or obligations derived from the general law or statute will suffice."[9]

[106] Counsel for Dr Vega Vega argues that the decisions of the clinical reviewers and investigators affect rights and as such are analogous to the challenged decisions in issue in *Guss v Deputy Commissioner of Taxation*,[10] which involved the issue of a penalty notice under the *Income Taxation Act Assessment Act* 1936 (Cth), and the decision in *Australian Broadcasting Tribunal v Bond*,[11] which involved a finding that the license holder was not a fit and proper person to hold a license. Counsel argues that in *Bond* the finding was an intermediate determination, but it was a decision on a matter of substance for which the statute provided as an essential preliminary matter prior to the making of the ultimate decision.

[107] In *Bond*, Mason CJ held that normally a conclusion reached in a step along the way in a course of reasoning leading to an ultimate decision would not ordinarily amount to a reviewable decision "unless the statute provided for the making of a finding or ruling on that point so that the decision, though an intermediate decision, might accurately be described as a decision under an enactment".[12] The High Court decision in *Hot Holdings v Creasy*[13] established that where a preliminary decision must be taken into account by the ultimate decision maker then an order for certiorari was available. The majority consisting of Brennan, Gaudron and Gummow JJ held:[14]

> "If Thomas J had been there indicating that, as the authorities now stand, a report which *may* be taken into account by an ultimate decision-maker sufficiently affects legal interests for certiorari, then, with respect, we would disagree. That conclusion would not be in accordance with the authorities to which we have referred. Certainly, *Ainsworth* may have been decided differently, because bodies acting under other legislation may well have been entitled to take into account the report of the Criminal Justice Commission in making decisions affecting legal rights.
>
> However, Thomas J indicates that certiorari lies where a preliminary decision *must* be taken into account by a body entrusted with the power to make a decision directly determining legal rights. We agree with that conclusion. That this was the point which his Honour sought to make is evident when he later said:

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9 (2005) 221 CLR 99, 131.
10 (2006) 152 FCR 88, 91.
11 (1990) 170 CLR 321.
12 (1990) 170 CLR 321, 337.
13 (1996) 185 CLR 149.
14 *Hot Holdings v Creasy* (1996) 185 CLR 149, 165.

> "A line needs to be drawn between the 'purely recommendatory' decisions and those which are regarded as having a sufficient effect upon the rights of an individual. In the former category there may fall Royal Commissions and recommendations which are not conditions precedent to the making of a final decision and which the final decision-making body may ignore."

If the final decision-making body is not obliged to take the recommendations into account, then certiorari will not lie.

The conclusion of de Jersey J on the nature of the Council's role is to similar effect:

> "The making of the Local Authority's determination is an integral and important part of the sequence of events provided for by the statute, and I am unconvinced that its merely 'tentative' effect excludes the availability of certiorari to quash it in an appropriate case."

A preliminary decision or recommendation, if it is one to which regard must be paid by the final decision-maker, will have the requisite legal effect upon rights to attract certiorari." (citations omitted)

[108] In *R v Brisbane City Council; ex parte Read*,[15] the Full Court had held that certiorari lay against a preliminary determination by the Brisbane City Council on a rezoning application which gave objectors a right to appeal to the Local Government Court. The Council was then bound by the decision of the Court. The Court considered that whilst an outright decision to grant the application could not be made until the appeal procedures were exhausted, the preliminary nature of the determination was clear. Thomas J held that:

> "[T]he nature of the Council's determination demonstrates that it was an important step on the path to a rezoning. …..It had the further effect that the determination itself was a proposal which could be regarded by the Local Government Court as the views of the responsible planning authority and to which it could properly attach weight in considering the matter."[16]

[109] Accordingly, it is argued that the decisions in the present case are not mere recommendations which may be ignored, but are essential prerequisites to the final determination which is capable of being prejudicial to Dr Vega Vega's rights. Therefore, it is argued that the decisions of the first to fifth respondents are decisions of an administrative character to which the *JR Act* applies and are amenable to orders for a statutory order of review.

[110] Section 5 of the *JR Act* provides that the making of a decision is defined in that section to include the making of an order or determination, imposing a condition or restriction and the making of a declaration, demand or requirement. It is clear that s 5 of the *JR Act*

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[15] (1986) 2 Qd R 22.

[16] *R v Brisbane City Council; ex parte Read* (1986) 2 Qd R 22, 41.

provides an expansive definition of the term "making a decision". Section 6 provides that if a provision is made by an enactment for the making of a report or recommendation before a decision is made, then the making of the report or the recommendation is of itself taken to be a decision.

[111] The respondents argue that the *Boards Act* did not require that any decision affecting Dr Vega Vega's rights had to be made as a result of the provision of the HSI Report and that s 6 of the *JR Act* is not therefore engaged. In this regard, they place particular reliance on the decision in *Wells v Carmody & Anor*.[17] In that decision, the meaning of s 6 was examined in detail by Martin J. In the circumstances of that case, Martin J held that whilst the relevant Order in Council was an enactment for the purposes of s 6, that Order in Council did not refer to any decision which might follow from the Commissioner's report. It was held, therefore, that at most there was an aspirational statement and there was no requirement that any decision be made. It was held, therefore, that the making of the report in that case was not the making of a decision for the purposes of s 6 of the *JR Act*. In the present case, however, it is clear that s 199(5) of the *Boards Act* makes specific provision for a decision which might follow from the HSI Report. Furthermore, no such decision can be made without consideration of the HSI Report, which, in my view, must mean that it is a precondition to such a decision.

[112] I also note in *Wells v Carmody & Anor* that references were made to the reasoning of the Full Court of the Federal Court in *Edelsten v Health Insurance Commission*[18] and *Eastman v Australian Capital Territory.*[19] In *Edelsten,* the Court held that s 3(3) of the *Administrative Decisions (Judicial Review) Act* 1977 (Cth) (*ADJR Act)* applies where there is a provision in an enactment that a particular report or recommendation had to be made as a condition precedent to the making of a decision under that enactment or under another law. Similarly, in *Eastman* the Court held that the section was intended to encompass reports leading to decisions of the type to which the *ADJR Act* generally applies, that is, decisions made under enactments. A necessary characteristic of such decisions is that the decision must itself confer, alter or otherwise affect legal rights or obligations whether existing or new.

[113] Before turning to a detailed consideration of the other requirements of the *JR Act,* it is important to look at the factual context within which the investigations under the *Boards Act* occurred, to examine the nature of the actual decisions being made by the clinical reviewers and the health service investigators and examine how those decisions fitted within the scheme of decisions under the *Boards Act.* An examination of circumstances surrounding the initiation, nature and conduct of the investigation and the provision of the Final Report can be summarised as follows:

- The immediate trigger for the investigation was a series of four serious clinical incidents which arose at the Health Service between 2011 and 2014 involving four of Dr Vega Vega's urology patients.

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[17] [2014] QSC 59.
[18] (1990) 27 FCR 56.
[19] (2008) 227 FLR 279.

- The investigation into the clinical incidents at the Hospital was initiated by the Chief Executive and publicly announced by Qld Health on 9 May 2014 via a media statement.

- Dr Vega Vega was suspended from practice at the Health Service and notice was given to the AHPRA.

- Eminent specialists with expertise in urology were appointed to conduct the CR.

- A HSI headed by an experienced medical practitioner with expertise in hospital administration was initiated.

- The reviewers and investigators were given significant powers to enter health service facilities and obtain confidential information.

- The investigation covered issues which included technical competence, compliance with safety procedures and issues in relation documentation and to post-operative care plans.

- 58 witnesses were interviewed by Dr Hoyle or Professor Marshall.

- The Final Report contained 26 findings in relation to the investigation and Dr Vega Vega, which included findings and references in relation to the Medical Board's Code of Conduct and shortcomings in relation to surgical practice involving complex urological surgery.

- The Final Report contained recommendations which recommended that Dr Vega Vega's surgical privileges remain suspended and that he be required to give undertakings to Qld Health.

[114] Were the findings and recommendations of the clinical reviewers in the CR Report themselves a decision under the *JR Act* and was the HSI Report a decision under the *JR Act?* Alternatively, were those determinations merely steps along the way which in no way affected legal rights or obligations? Did the relevant statute here, namely the *Boards Act*, provide for a finding or ruling on the point so that those determinations by the clinical reviewers and health service investigators could accurately be described as a decision *under an enactment?*

[115] Having considered the Final Report provided on 5 September 2014, there is no doubt that the HSI Report made findings and contained recommendations. The recommendations in relation to Part A related to the quality and standard of care provided to four named patients at the Health Service by Dr Vega Vega and other unnamed clinicians and in relation to Part B a series of findings and recommendations were made in relation to clinical governance and management structures, quality, safety and governance systems, safety and quality data, the cultural context, credentialing and the scope of clinical practice, open disclosure and the impact of clinical governance on the four names patients. The Final Report was in excess of 100 pages in length. It referred in detail to "The key

findings of the clinical review report" which included specific conclusions about Dr Vega Vega's technical competence.

[116] I consider, therefore, that when one examines the circumstances surrounding the initiation of the reviews, the qualifications of the clinical reviewers and investigators, the powers they were given, the extent of the inquiry, the nature of the recommendations and the consequences which followed, the conclusion that follows is that the determinations by the clinical reviewers and the investigators were expert findings on the particular clinical incidents which had triggered the investigations. I consider that the Reports were determinative in relation to the issues of fact falling for consideration irrespective of whether a direction is actually made.

[117] I consider therefore that the determinations, findings and recommendations of the clinical reviewers and the investigators were decisions under an enactment because the regime of determinations which were required by s 199 were such that they constituted final decisions including factual determinations about those matters. The Reports were reports by experts on matters within their expertise based on their investigations. The Chief Executive could in no way alter those findings or recommendations. The Chief Executive could clearly decline to make a direction pursuant to s 199(5), but that in no way affected the finality of the findings and recommendations of the experts.

[118] Furthermore, a direction under s 199(5) was predicated on a consideration of the Final Report and therefore the Final Report, which contained the CR Report, was an essential requirement for a s 199(5) direction.

[119] In the present case, it is clear that once initiated by the Chief Executive, the CR Report and the HSI Report had to be provided and they were an essential pre-requisite to any s 199(5) direction. I consider that those Reports were a condition precedent to the making of a direction under s 199(5) and not mere steps along the way.

Were Dr Vega Vega's rights affected by the provision of the Reports?

[120] Section 199(5) of the *Boards Act* then provides that "after considering the report, the chief executive may issue a direction to the Service". In my view, whilst the Chief Executive could issue Health Service Directives under s 47 and s 51A of the *Boards Act*, a direction under s 199(5) could only be issued after a consideration of the Final Report which incorporated the CR Report. The Final Report was therefore an essential requirement to such a direction. Accordingly, the question would seem to be whether Dr Vega Vega's rights were actually affected given the Chief Executive could simply decline to do anything.

[121] In the circumstances of this case, it must be recalled that the HSI Report was provided against a background in which Dr Vega Vega's clinical privileges at the Hospital had actually been suspended. In the prevailing circumstances in which the recommendation was made, the recommendation was for the continuation of a state of affairs which prevented Dr Vega Vega from conducting his practice of medicine at the Health Service. In practical terms, the Chief Executive had to either maintain the current situation or do

something else and the Chief Executive would in fact have been required to consider the HSI Report in order to make a direction pursuant to s 199(5).

[122] Furthermore, under the Health Practitioner Regulation National Law, copies of any investigation conducted in a health service could be required to be provided to an investigator appointed under that Act. In this regard, I note that the affidavit of Jonathan King-Christopher indicates that such a request was indeed made after the Final Report was provided.[20]

[123] In any event, I consider that irrespective of whether the Chief Executive ever makes a direction pursuant to s 199(5), Dr Vega Vega's rights have already been affected by the very provision of the Final Report to the Chief Executive. The Final Report made express findings about Dr Vega Vega in relation to his surgical skill and his competence as a specialist urologist. There were express findings about his skill levels in relation to complex urological procedures. A recommendation was also made by the experts that his clinical privileges should remain suspended and that he be required to provide a series of undertakings and undergo further training in relation to his surgical practice. Nothing the Chief Executive does or does not do into the future can actually alter the fact that those findings and recommendations have been made. I consider that the making of those findings and recommendations altered his rights because they affected his ability to practice medicine particularly within a health service in Queensland. I consider, therefore, that Dr Vega Vega's rights were affected once the Final Report was provided to the Chief Executive.

[124] If I am wrong in this respect, I consider that at the very least Dr Vega Vega's reputation was affected. In my view, the very initiation of the CR and HSI under the *Boards Act* would have affected Dr Vega Vega's reputation. In this regard, I note that in *Ainsworth v Criminal Justice Commission*[21] Brennan J held:

> "It is especially appropriate that judicial review should be available when the function conferred by statute is to inquire into and report on a matter involving reputation, even though the report can have no effect on legal rights or liabilities, for no remedy may otherwise be available to vindicate the damaged reputation. The judgment of this Court in *Annetts v. McCann* shows that where an inquisitorial power is being exercised without observing the rules of natural justice and reputation is at risk, the court may order that the rules of natural justice be observed and the court can thus, to an extent, protect the reputation at risk." (citation omitted)

[125] That effect on his reputation was then compounded by the findings which were made in both Reports. There is no doubt in my mind that the initiation and provision of the Reports had the consequence of damaging Dr Vega Vega's reputation amongst his colleagues and the hospital staff irrespective of what action ever flowed pursuant to s 199(5).

[126] In summary, I consider that the Reports of the clinical reviewers and the health service investigators were expressly required and authorised by the *Boards Act* and that the delivery of the CR Report was a precondition to the completion of the HSI Report.

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[20] Affidavit of Johnathan King-Christopher sworn on 22 October 2014, p 4.
[21] (1992) 175 CLR 564, 585.

[127] I am also satisfied that the two essential requirements for a decision to be considered "a decision under an enactment" as discussed in *Griffith University v Tang* are present in this case. The decision, namely the HSI Report, which incorporated the CR Report, was a decision which was required by the enactment **and** I consider that that decision of itself conferred, altered or otherwise affected Dr Vega Vega's rights.

[128] I turn then to the substantive grounds of the application.

Does the appointment of an employee of Minters as a health service investigator raise a question as to reasonable apprehension of bias?

[129] As previously noted, two solicitors from Minters were appointed under *the Boards Act* as investigators at a point in time when that firm was already providing legal advice to Qld Health and the Health Service in relation to clinical incidents at the Hospital involving Dr Vega Vega. Counsel for the applicant argues that a reasonable apprehension of bias arises out of the appointment and participation in the HSI by the two solicitors who were employed by Minters when Minters had previously been engaged to act in an advocacy role by Qld Health in relation to the same incident.

[130] In this regard, paragraph 12(a) of the Final Report provides as follows:

> "Although there were two investigators appointed by the Director-General, in accordance with direction from the Department of Health, the interviews and document review was conducted by Dr Hoyle alone. The role of Ms Read and then, Ms Fairweather of Minter Ellison Lawyers was limited to assisting Dr Hoyle in relation to procedural matters during the investigation and in assisting in the finalisation of the report. The analysis of evidence, findings and recommendations set out in this report are those of Dr Hoyle."

[131] The applicant argues that the Minters solicitors were not mere cyphers in the investigation and in fact had the potential to influence the other decision-makers involved in the investigation. It is argued that the reasonable apprehension of bias in relation to Ms Read and Ms Fairweather infects the collegial decision-making of the investigation and clinical review teams and as such render the results of the process invalid. In particular, it is argued that the following factors give rise to the apprehension of bias:

(a) The important nature of the two inquiries including their potential adverse impact on the applicant.

(b) The choice of patients whose treatments were to be investigated always indicated that the Terms of Reference effectively provided for a commission of inquiry into Dr Vega Vega's performance as a medical practitioner and clinician.

(c) The interlinked nature of the two inquiries gives rise to the reasonable apprehension of bias because the CR Report was the raw material for the findings of the HSI Report.

(d) The nature of the involvement of Minters in matters inappropriate to the ethos of an impartial investigation.

(e) The long period during which the reviewers and the investigators worked together as a team on the combined inquiry, as the inquiry stretched over four months. Whilst Ms Fairweather was only involved for three weeks, that was an intense period of involvement.

(f) The private nature of the combined inquiry.

(g) The opaque circumstances in which advice passed from Ms Read and Ms Fairweather to other members of the inquiry team.

[132] It is argued that the manner in which the previous engagement of solicitors from Minters as lawyers for Qld Health would possibly divert Ms Read and Ms Fairweather from deciding the case on the merits and this diversion could have influenced the other appointees to the investigation and the review task.

[133] In particular, it is argued that the second respondent was not only employed by Minters, but acted on behalf of the Health Service with respect to the initial aspects of the incident which included the provision of documents to police and a notification to AHPRA. The affidavit material sets out the involvement that Minters had with the Queensland Police Service and it would seem quite clear that Minters provided material on behalf of the Health Service in response to a request from police.[22] There is no doubt that Minters were acting for the Health Service in the early stages of the investigation into the incidents which had occurred at the Hospital. Does the involvement of Minters prior to the appointment of its own employees as investigators give rise to a reasonable apprehension of bias?

[134] The respondents argue that the role that the second and third respondent played was that whilst they were appointed as investigators, their role was limited to assisting Dr Hoyle in ensuring that the HSI Report properly responded to the Terms of Reference. It is also argued that that they were not generally involved in attending interviews, gathering or assessing evidence or making findings about the matters under consideration. In particular, it would seem that at the point where Ms Fairweather was appointed, the gathering of evidence was in fact complete.

[135] Whilst I accept that their primary role was to assist in providing advice on the process which was to be followed, there is no doubt that the solicitors played a crucial role in the investigation. In her affidavit, Ms Fairweather states[23] that she was aware that Minters had been instructed to assist the Health Service with two matters. One was the RCA investigation and the other was to assist Qld Health with any statewide issues that might arise as a result of the investigation. In her affidavit, she states that Ms Read managed the credentialing and statewide issues Advisory File and that she was to provide supervision to another lawyer, Ms Nicole Morgan, who would manage the RCA file. Ms Fairweather

[22] Affidavit of Megan Fairweather sworn on 11 November 2014; Affidavit of Sonja Read sworn on 12 November 2014.

[23] Affidavit of Megan Fairweather sworn on 11 November 2014.

stated she had no involvement in the Advisory File and did not have any direct access to the file. In relation to the RCA file, I accept that the RCA review process is focussed on enabling the Health Service to identify ways to improve its systems so that it can prevent similar events occurring in the future. I accept that the RCA is not an investigation into individual blame or competency of health practitioners.

[136] It is clear, however, that Ms Fairweather was involved and knew of the involvement of Mr Shane Evans, a partner in the Health and Aging Group at Minters, in the notification to AHPRA and the fact that she had indeed seen the draft notification. I accept that she did not provide any advice in relation to that notification, but it is clear that she did have some follow up involvement with the Health Service in relation to the RCA file. It would seem that she was involved in relation to the file and the RCA on 2 and 6 May 2014. Whilst Ms Fairweather acknowledged that she was to supervise Ms Morgan, she indicated that she did not at any stage provide that supervision, and whilst her assistance was sought on one occasion, she was not in the office and that assistance was provided by a colleague.

[137] In her affidavit, Ms Sonja Read,[24] the initial health service investigator appointed under the *Boards Act*, indicates that she was initially involved with Mr Evans on work for the Health Service in late April and early May 2014. She states in her affidavit that on 1 May 2014 she was advised by Mr Evans that an advisory file had been opened for the Health Service and Qld Health and this was to be an electronic file that would be only accessed by him, her and the secretary. She was also advised on that date that an RCA had been initiated and a file had been opened. As previously noted, a RCA is a systematic process of analysis which identifies factors that contributed to the happening of a reportable event and remedial measures that could be put in place to prevent a recurrence of a similar reportable event. It is clear that such an analysis does not include investigation of professional competence but rather the event itself. It is clear that Ms Read was copied into emails between Mr Evans, the Health Service and Qld Health in late April and early May 2014. She was also aware that Mr Evans was settling a notification from the Health Service to AHPRA. A draft notification was attached to the email she received on 2 May 2014.

[138] It is also clear that Ms Read worked on the file, specifically on 6, 7 and 8 May 2014, and Ms Read states that she made time entries on the bill for both days on the advisory file. Ms Read also provided advice about requests for information about the establishment of the HSI, the CR and the RCA. She was also instructed by the Health Service to provide advice about a request from the Queensland Police Health Service for disclosure of information about certain patients and documents. She states that she was not provided with the copies of the documents, but rather gave in principle advice.

[139] Ms Read states that she was advised by Ms McMullen, chief legal counsel for Qld Health, on 8 May 2014 that her appointment as an investigator had commenced. She considered, therefore, that she could not continue to provide advice to the Health Service or Qld Health about matters relating to the clinical incident and that her role would be that of an investigator only. Ms Read states:[25]

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[24] Affidavit of Sonja Read sworn on 12 November 2014.
[25] Affidavit of Sonja Read sworn on 12 November 2014, paragraph 27.

> "On 8 May 2014, I telephoned my contacts at CQHHS [Health Service] to advise that I had been appointed as an investigator by the Director General and would no longer be able to provide advice to the Department [Qld Health] or CQHHS [Health Service]. My recollection is that I made these calls in the afternoon of 8 May 2014 after I received my instrument of appointment and discussed this issue with Ms McMullen."

[140] It is clear that after that date, Ms Read was not instructed by Qld Health in any other matter involving Dr Vega Vega other than the investigation. Ms Read states, however, that she was aware that work on the advisory file would continue to be performed by Ms Penelope Eden (special counsel) who had been supervising her in relation to her work on the file as well as Ms Morgan who was an associate at the firm. She states, however, that she has no knowledge of the advice that they or any other lawyer at Minters provided to the Health Service or Qld Health on matters directly affecting Dr Vega Vega.

[141] I accept that Ms Read and Ms Fairweather did not access those files after 8 May 2014 during the time that they were investigators. I have no doubt that Ms Read and Ms Fairweather are capable lawyers who would have approached their roles as investigators diligently and professionally. I am concerned, however, that both Ms Read and Ms Fairweather were employed by the same firm that was giving ongoing advice to both the Health Service and Qld Health in relation to the investigation. Furthermore, Ms Read was engaged to give advice in relation to the initiation of the investigation but within weeks she was appointed as an investigator of that very review. I consider that a reasonable observer may have concerns about the closeness of the association between the investigators and the firm who was providing advice to Qld Health. Indeed, the affidavit material indicates that both Ms Read and Ms Fairweather had a network of contacts within Qld Health and the Health Service.

[142] There is no doubt that the bias rule is flexible and it varies with the factual and legal circumstances of every case. It is clear, however, that the determination is made by reference "to the standards of the hypothetical observer, who is fair minded and informed of the circumstances. That observer is also aware of community standards and general social trends and can therefore move with the times."[26] I also note the discussion by Aronson and Groves in their text on *Judicial Review of Administrative Action* that decision-makers should not be devoid of experience and that whilst knowledge and experience are useful and important influences "the bias rule is best understood to require an open mind but not an empty one. But difficult questions remain. At what point does experience move from being a legitimate and desirable influence to an improper one?"[27]

[143] A finding of apprehended bias means that a fair minded and reasonably well informed observer might conclude that the decision-maker in question "might not approach the issue with an open mind". It is clear that that finding is about an apprehension of bias which might exist rather than a belief that it does exist. It comes down to a suspicion that does not involve an investigation of the actual mind of the decision-maker. It is clear that if a claim of apprehended bias is upheld, the court is not required to make adverse findings

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[26] *Judicial Review of Administrative Action*, 5th ed, by Mark Aronson and Matthew Groves, Law Book Company 2013, p 609.

[27] *Judicial Review of Administrative Action*, 5th ed by Mark Aronson and Matthew Groves, Law Book Company 2013 p 611.

against the decision-maker, but rather simply a conclusion that a reasonable observer might conclude that the decision-maker might not be impartial.

[144] In this case, two issues concern me. Firstly, the closeness of the association between the investigator and the firm which was providing legal advice to both Qld Health and the Health Service. Secondly, the fact that prior to the appointment of Ms Read, she was aware that a decision had been reached by Qld Health to suspend Dr Vega Vega's employment and there had been a notification to the AHPRA. There is no doubt that Minters was involved in those decisions and that Ms Read was actively involved in the file at the time those decisions were made. In my view, a reasonably well informed observer might conclude that this does "not look good" because it gives rise to a perception that a concluded view, although a preliminary view, had already been reached about the very matters which were the subject of the inquiry.

[145] The affidavit material also reveals that Minters is the firm that Qld Health often engages for legal advice and there is certainly a familiarity in the tone of the correspondence with the chief legal officer, Ms McMullen, and the two solicitors. I note that Ms Read and Ms Fairweather state that they were simply facilitating the administrative aspects of the investigation and did not take part in the investigation per se. However, it is clear that both Ms Read and Ms Fairweather were involved in decisions about the procedure which was to be adopted. In particular, they made key decisions about the nature of the interviews, the nature of the information which was to be disclosed to Dr Vega Vega and the timetable for the provision of information. The affidavits indicate that there were in fact occasions where Ms Fairweather did sit in on interviews and it would seem that both solicitors made key decisions in relation to issues of confidentiality, particularly, in relation to the question as to whether the names of the persons interviewed would be disclosed to Dr Vega Vega. It is unclear to me whether that was their considered view or whether that was Qld Health's usual position which they were simply maintaining in this investigation. That possibility is also a concern.

[146] Whilst I note that Ms Read and Ms Fairweather were only part of the investigation, the decision of *IW v The City of Perth*[28] held that the bias of an individual member is sufficient to invalidate a collegial decision. In particular, it is clear that from the outset Dr Hoyle, in an email dated 11 May 2014, was seeking Ms Read's contributions, particularly in relation to the list of documents and the persons who needed to be interviewed. He indicated: "I put my initial thoughts down on the attached list, pending your additions." It is clear that Ms Read provided her input the following day, particularly in relation to the list of documents for review and with respect to state policies in use at the Hospital in relation to clinical audits, clinical incidents and complaint and performance review for clinical staff.

[147] The test for apprehended bias is well known and was set out in *Ebner v Official Trustee in Bankruptcy*.[29] The test has been stated in these terms as to whether a:

> "fair-minded lay observer might reasonably apprehend that the judge might not bring an impartial mind to the resolution of the question the judge is required to decide. That principle gives effect to the requirement that justice

[28] (1997) 191 CLR 1, 49-50.
[29] (2000) 205 CLR 337.

> should both be done and be seen to be done, a requirement which reflects the fundamental importance of the principle that the tribunal be independent and impartial. It is convenient to refer to it as the apprehension of bias principle."[30] (citations omitted)

[148] The High Court considered that the principle was so important that "even the appearance of departure from it is prohibited lest the integrity of the judicial system be undermined".[31] It is clear that the question is one of possibility (real and not remote) not probability but that it does not require a prediction about how the judge would in fact approach the matter.[32] Similarly, if the matter has already been decided, it is not a test which requires any analysis about what factors actually influenced the outcome.[33] As the High Court made clear, there is no requirement of a need to inquire into the actual thought processes of the judge or juror.[34]

[149] The process, however, does require two steps. The first step is the identification of what it is said might lead the decision-maker to decide a case other than on its legal and factual merits and the second step is that there must be a logical connection between the matter and the feared deviation from the course of deciding the case on its merits.

[150] In *Greenwood v Winsor*,[35] Byrne SJA referred to the established principles and reiterated that a reasonable apprehension of bias must be firmly established and it is not enough that the reasonable bystander has a "vague sense of unease or disquiet".[36] It must also be a reasonable apprehension as distinct from a "fanciful or fantastic apprehension".[37] Byrne SJA further indicated that a hypothetical fair-minded person is to be regarded as reasonable, intelligent and neither complacent "nor unduly sensitive or suspicious".[38] Other factors which must be taken into account in evaluating any argument about apprehended bias is that it is material to consider the non-curial character of the decision-making process as well as the significance of the decisions that the investigator might make, especially for Dr Vega Vega's employment. It is also significant to consider the task that has been committed to the decision-maker.

[151] In considering those factors, I accept that this was a non-curial decision-making process which led to the preparation of two reports which were to be submitted to the Chief Executive. Counsel for the respondents submits that there is no suggestion in this case of pecuniary or non-pecuniary interest or of prejudgment or of any person being a witness in their own case. Counsel for the respondents further argues that the submission of apprehended bias here rests entirely upon an imprecise concept of association which is premised upon inaccurate portrayals of the facts. In essence, Counsel for the respondents argues that the submission of apprehended bias is merely speculation.

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30 *Ebner v Official Trustee in Bankruptcy* (2000) 205 CLR 337, 344.
31 *Ebner v Official Trustee in Bankruptcy* (2000) 205 CLR 337, 345.
32 *Ebner v Official Trustee in Bankruptcy* (2000) 205 CLR 337, 345.
33 *Ebner v Official Trustee in Bankruptcy* (2000) 205 CLR 337, 345.
34 *Ebner v Official Trustee in Bankruptcy* (2000) 205 CLR 337, 345.
35 [2008] QSC 68, [89].
36 *Minister for Immigration v Jia Legeng* (2001) 205 CLR 507, 549 [135].
37 *Gascor v Ellicott* [1997] 1 VR 332, 342.
38 *Johnson v Johnson* (2000) 201 CLR 488, 509 [53].

[152] There is no doubt that the identification of association is not sufficient. In particular, in *Greenwood v Winsor*, it was held that the decision-maker in a public service internal disciplinary proceeding did not have to be entirely free from any prior association with the employee under investigation.[39] Byrne SJA referred to the decision of Deane J in *Webb v The Queen*[40] where it was held that no conclusion of apprehended bias by association could be drawn until the court examines the nature of the association, the frequency of contact, and the nature of the interests of the person associated with the decision-maker. His Honour also noted that each case must turn on its own facts and that it would be erroneous to suppose that a decision is automatically infected with an apprehension of bias just because the person has an association or interest with the decision-maker.

[153] Ultimately, on the facts before me, I am not satisfied to the requisite standard that a finding of reasonable apprehension of bias can be sustained despite my concerns. Whilst I have a sense of unease and disquiet in relation to the association between Minters and the decision-makers, I do not consider that the fact Minters were involved at an early point in time necessarily means that a view had been formed in relation to Dr Vega Vega's actions. Whilst Minters provided advice in relation to the provision of material to the Queensland Police Service about the credentialing process involving Dr Vega Vega, I do not accept that supplying material to the Queensland Police Service in response to a request gives rise to an inference that a view had been formed that Dr Vega Vega had engaged in criminal activity. Similarly, the fact that Minters had assisted in the notification to AHPRA does not give rise to an inference that the solicitors Minters had been engaged to advance a view that had been formed about Dr Vega Vega.

[154] Accordingly, I am not satisfied that this ground of appeal has been made out.

Does the failure to provide documents constitute a breach of the rules of natural justice?

[155] The applicant argues that a breach of the rules of natural justice happened in relation to the decisions made in that the first to fifth respondents prevented Dr Vega Vega from having access to information and documents that were relied upon by the investigators and the clinical reviewers. The applicant argues that the information relied upon by the reviewers and investigators included the notes of interviews with the 58 witnesses who were interviewed by Dr Hoyle and Professor Marshall. The applicant submits that the failure to be provided with this information prevented him from knowing the basis of the case against him and from making properly informed responses during the process of the HSI and CR.

[156] Dr Hoyle states that most of the interviews were conducted solely by him but that a number were conducted jointly with Professor Marshall and whilst their estimates vary it seems that between 12 and 18 witnesses were interviewed by them jointly by them in July 2014. In terms of the notes that were kept, paragraph 11.1(c) of the Final Report indicates that a series of interviews were conducted "face to face" by Dr Hoyle in June 2014 and that "All interviews were documented by Dr Hoyle taking contemporaneous notes".

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[39] [2008] QSC 68, [113].
[40] (1994) 181 CLR 41, 74.

Paragraph 11.1(d) of the Final Report states that a second round of interviews were then conducted in July 2014 "concentrating on clinical staff involved" in the care of the four patients. In relation to the July interviews the Final Report stated that "These interviews were held jointly by Dr Hoyle and Professor Marshall. These interviews were documented by Dr Hoyle or Professor Marshall taking contemporaneous notes". Professor Marshall states that he conducted two interviews by himself and added his handwritten notes of those interviews to Dr Hoyle's notebook. They were the only notes he made during the two days of interviews.[41] Paragraph 11.1(e) of the Final Report states that "Relevant portions of the contemporaneous notes taken during the interviews are referred to in this report, as required by the terms of reference."

[157] It would seem clear, therefore, that some of the interviews were considered so important that two experts would in fact attend some of them. It is also clear that at least one of the experts made notes at the time and those notes were kept. The names of those who were interviewed were noted. Some of the information provided in the joint July interviews was in fact used by Professor Marshall in the formulation of the CR Report.[42] He states in his affidavit that his opinions on the care of the patients was based "almost solely" on the basis of the medical records and a statement from Dr Vega Vega's dated 10 June 2014.[43] Professor Marshall then stated "Although I attended the interviews at the Rockhampton Hospital, the information received during those interviews did not affect the preliminary views that I had formed from a review of the medical records except in respect of patient C. In that instance, the information obtained resulted in in me changing my preliminary view in favour of the applicant." The nature and source of the information however was not revealed.

[158] The interview notes were clearly used by Dr Hoyle as the basis for some of the comments in the Final Report and on my calculation there are at least thirty one footnotes in which he refers to the source of the information as an interview. In particular, the reference is simply to "interview with ICU staff member", "interview with a senior surgeon" or "interview with staff". In terms of the Final Report, Dr Hoyle was clearly the sole decision maker as to what aspects of the testimony given were considered to be relevant and credible. He determined whether witnesses were considered to be objective or in a position or role to fairly comment on the clinical matters relating to Dr Vega Vega's practice.

[159] The critical factual issues in relation to the failure to provide information have already been outlined in paragraphs [10] to [57] of these reasons. It would seem apparent that the allegations about the failure to provide critical documents became manifest by early August 2014 and continued until the delivery of the Final Report on 5 September 2014. That is no doubt that the issue of the interview notes became crucial at this time because the draft reports which were provided made it clear that those interviews had taken place and that information provided in those interviews was being relied upon.

[160] On 6 August 2014, Dr Vega Vega sought a list of the material which had been described by Dr Hoyle as the information currently before the clinical reviewers and investigators.

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41 Affidavit of Professor Villis Marshall sworn on 6 November 2014, paragraph 21.

42 Clinical Review Report, p 4. Reference was made to the information provided by the Executive Director Medical Services of the Health Service to the reviewers.

43 Affidavit of Professor Villis Marshall sworn on 6 November 2014, paragraph 59.

The response given was that it was not considered necessary to provide access to the materials collected in the investigation in order for Dr Vega Vega to be able to respond to the issues and questions. On 14 August 2014, Dr Vega Vega argued that natural justice required that he be provided with the information upon which the investigators were making their decision. That request was then reiterated on a number of occasions and, in particular, it was stressed in the letters dated 28 August 2014 and 2 September 2014. The applicant argues that given Dr Hoyle had overnight changed his opinion on a fairly crucial proposition about whether the removal of a kidney was appropriate in relation to one patient, then the information that the investigators and reviewers were relying on to form their conclusions was critical.

[161] The respondents argue that the requirements of natural justice have been met with respect to the provision of documents because on 19 August 2014, Dr Vega Vega was provided with complete versions of the draft CR Report and the draft HSI Report which also included the Executive Summary as well as Part A and Part B. Accordingly, it is argued that the relevant evidence from the witnesses was "fairly and comprehensively summarised in the draft reports." The investigators argued that those draft Reports were provided in circumstances where Dr Vega Vega had refused to attend an interview as requested and further contended that information relied upon did not have to be supplied because Dr Vega Vega did not identify why the information that was sought was required.

[162] There is no doubt that there was a consistent failure to supply such information despite repeated requests that all the information was considered to be significant by Dr Vega Vega. I note, in particular, the letter from the solicitors for the Health Service dated 3 September 2014 which is in the following terms:

> "The record will show that I have reasonably asked you, several times, to advise what documents you do not already have in your possession that relate to comments potentially adverse to your client, including to invite you to read the draft reports. I believe I have taken steps well beyond what is required of me in an effort to resolve this issue including to seek instructions from Dr Hoyle and the CQHHS [Health Service] in order to ascertain, in my own mind, what documents you may not have in order for me to be in a position to provide them urgently if requested. I did that in the face of your refusal, until very recently, to simply advise positively that you had possession of the patient records. These are, according to my instructions that have been conveyed to you previously, the primary source of the comments relating to your client in both draft reports.
>
> I am not aware of any obligation that requires an independent and impartial investigator to proactively anticipate what documents may assist another party to understand their position in relation to adverse comments. Particularly when the party concerned has representation from lawyers who appear well versed in the issues under investigation and appear to have had significant involvement from very early stages, through a number of processes.
>
> I remain prepared to provide any specific documents you request that will enable you to be in a position to advise your client, to the extent that I am permitted to do so. I am not obliged to provide documents if there are other obligations imposed on me such as a duty of confidentiality. That is, as long

as the substance of the comments are fairly articulated for your client's consideration."

[163] Ms Fairweather reiterated that the request for all documents was unreasonable and in relation to the request for specific handwritten file notes of witness conferences and telephone records for 28 April 2014 the letter stated:

> "1. Dr Hoyle and I had carefully considered your request for the handwritten notes of witness conferences made by Dr Hoyle and/or Professor Marshall.
>
> **Dr Hoyle and Professor Marshall obtained witness evidence in strict confidence in order to encourage people to speak freely to them about a number of issues as outlined in the terms of reference.** The information (including as contained in records created by Dr Hoyle and Professor Marshall) is protected by section 197(1) of the *Hospital and Health Boards Act 2011 Qld.* I again advise that witness conference notes will not be provided. I am satisfied, to the best of my ability to say following a review of those documents and without having been present for the interviews, that the substance of the comments potentially adverse to your client have been fairly reflected in the draft reports. I note multiple positive comments that have been included in the draft report about your client.
>
> Dr Hoyle has advised that he disregarded a number of negative comments made about your client where he considered witnesses were either not objective or not in a position or role to fairly comment on clinical matters pertaining to your client's practice." (my emphasis)

[164] The Terms of Reference at paragraph 5.5 clearly required that material, which was adverse to Dr Vega Vega, that was credible, relevant and significant had to be released to him. Furthermore, if it was in writing, it had to be provided within a reasonable time frame. Furthermore the Terms of Reference at paragraph 5.7 provided that the identity of persons providing information had to be kept confidential "unless the identification of the person *is essential to ensure that natural justice is afforded to any particular person."* (my emphasis) It was clear therefore that natural justice had to be afforded to Dr Vega Vega and the letter of 4 September 2014, the solicitors for Dr Vega Vega pointed that out to the investigators. I note, therefore, the continued request for the notes of the interviews with the 58 witnesses and the continued refusal in the face of those clear requests.

[165] Two reasons given for the non-disclosure of those interview notes. One was an argument as to confidentiality and the second was that a sufficient disclosure had been made of the contents of the interviews.

[166] I turn first to a consideration of the issues of confidentiality.

Was this degree of confidentiality required?

[167] There is no doubt that the health service investigators prima facie had a duty of confidentiality as did the clinical reviewers. The provisions in s 132 and s 197 of the

Boards Act provided that *information* which was given to the investigators or reviewers in those capacities was not to be disclosed. However, the sections clearly state that disclosure could occur to the extent that it was necessary for the investigator or reviewer to perform their functions under the *Boards Act*. The reviewers and investigators had a clear duty to afford natural justice to Dr Vega Vega and there was a clear specific requirement to provide adverse material which was credible, relevant and significant to the findings was to be released.

[168] The confidentiality that seems to have been primarily protected by the investigators was the *identity* of the witnesses. Why was their anonymity considered to be important? The argument seems to be that if their identity is not known, they will be more inclined to provide full and frank disclosure in relation to a particular clinical incident. Such a principle may be relevant to a RCA where the clear intent of the review is not to assign blame, but to look at the underlying problems. In my view, however, it should not be a relevant consideration when a rigorous clinical review and investigation are being conducted by experienced clinicians to assess the actual treatment which was in fact provided to four patients and to determine compliance with policies and procedures. In my view, the HSI Report in the circumstances of this case was in fact about assigning blame.

[169] The reviews here had enormous consequences to Dr Vega Vega which included not only the cessation of his medical practice and surgical privileges but possible referrals to police and further reports to AHPRA. The evidence given to the reviewers and investigators therefore needed to be accurate. The evidence also needed to be captured with clarity and precision. Nothing assures accuracy more than a statement which is at the very least signed by the author of the statement as an accurate record of what he or she said. The interviews should have been conducted with rigour given the potential consequences to Dr Vega Vega. In those circumstances, I consider that more formal processes and procedures needed to be put in place in this investigation. The Terms of Reference for the clinical reviewers and the investigators in fact foreshadowed such a process, as that document expressly provided that "All evidence, including official agreed transcripts of interview/signed statements (not a summary of the working notes) are to be appended to the report." Those source documents clearly should have been provided to Dr Vega Vega.

[170] In this regard, I note that the affidavit of Nicola Kent sworn on 4 December 2014 outlines certain matters which have occurred since the delivery of the Final Report and refers to signed statements from four medical practitioners who were working at the Health Service at the time. In my view, signed statements in that format should have been taken and provided to Dr Vega Vega from the outset. In that way, Dr Vega Vega would have been made aware of the precise nature of the allegations and evidence against him. I also consider that in order to accurately assess the weight of the information, the identity of a witness should have been provided.

[171] The Final Report at paragraph 11.1(b) indicated that the 58 persons interviewed comprised a complete cross section of people and included senior clinical managers, system managers, quality expert staff, clinical staff, the hospital service board members and former staff. If allegations of poor communication were to be assessed and responded to, it would be critical to know if the allegations were being made by a person who was an expert clinical staff member or simply a board member. In particular, I note that at

page 31 of the Final Report, there is extensive reference to findings about Dr Vega Vega's failure to communicate with the ICU staff. The Final Report refers to confusion as to what was actually going on in the ICU when the wrong nephrectomy was discovered and also to a "history of ill feeling between some ICU staff and Dr A". In my view, it was critical to know what evidence Dr Hoyle was relying on to form the view about the failure to communicate and the source and identity of that information.

Was there sufficient disclosure?

[172] Given the seriousness of the consequences, it was important that the evidence collected and ultimately relied upon was not only rigorously collected but rigorously scrutinised and tested. If Dr Vega Vega was unaware of the author of a particular adverse comment, how was he to weigh the significance of the evidence let alone appropriately respond to it? I also agree with the submission that there was a possibility that the investigators and reviewers might miss favourable aspects of the evidence or deliberately cherry pick unfavourable parts and that such a possibility grows more likely as the complexity and detail of the investigation grows.

[173] The rules of natural justice are not fixed and they depend on the particular statutory framework and the circumstances of each case, particularly the nature of the inquiry, the subject matter and the rules under which the decision-maker is acting.[44] It is clear that there needs to be a flexible adaptation in the circumstances of every case so that fair procedures are adopted. As Brennan J stated in *Kioa v West*:[45]

> "What the principles of natural justice require in particular circumstances depends on the circumstances known to the repository at the time of the exercise of the power or the further circumstances which, had he acted reasonably and fairly, he would have known. The repository of power has to adopt a reasonable and fair procedure before he exercises the power and his observance of the principles of natural justice must not be measured against facts which he did not know and which he would not have known at the relevant time though he acted reasonable and fairly."

[174] I consider that the content of the information obtained in the interviews was crucial to the findings and recommendations made by Dr Hoyle. I agree with the submission of Counsel for Dr Vega Vega that the interviews were significant, particularly when the Final Report stated that the reason why the clinical reviewers and health service investigators disagreed with the conclusions of Dr Wood and Dr Sillar, who provided evidence at the hearing before Judge Horneman-Wren, was because those doctors had not interviewed the staff at the Hospital in relation to the care that had been provided to the patients whose cases were under review.

[175] Furthermore, as the history of the matter sets out, there were repeated requests for this information because it was considered to be significant to the legal representatives for Dr Vega Vega. The request was repeated after the provision of the draft Reports. Counsel for the respondents argues that complete versions of all the draft Reports were provided

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44 *Kioa v West* (1985) 159 CLR 550.
45 (1985) 159 CLR 550, 627.

and that any "relevant evidence from the witness interviews which Dr Hoyle had conducted was fairly and comprehensively summarised in the draft reports." It would seem to me that that was not a matter solely for Dr Hoyle to determine, but rather a matter for the legal representatives to decide after the material had been provided.

[176] I accept that as the New South Wales Court of Appeal stated in *Calardu Penrith Pty Ltd v Penrith City Council*[46] that "procedural fairness is not like a potentially endless game of tennis where every submission…hit over the net had to be returned…Nor is procedural fairness to be equated with a duty of unlimited discovery". However, as Flick and Foster JJ made clear in the Federal Court decision of *Minister for Immigration v Maman*:[47]

> "The obligation to disclose potentially adverse information imposed by the rules of procedural fairness is not discharged by determining that which may ultimately prove to be relevant or significant to the final opinion reached. Although some information may be capable of being put to one side at the outset of the decision making process, other information may be more immediately central to the ultimate conclusions to be reached. Yet other information may be less centrally important but nevertheless not capable of being summarily cast aside. Some information, which may not initially appear to be of central importance, may if disclosed, occasion further factual input and may ultimately assume greater importance to the ultimate conclusion."

[177] I consider that given the significance of the interviews, it was insufficient to provide extracts from statements rather than the entire content of the interviews. I am satisfied, therefore, that there has been a breach of the rules of natural justice due to this failure.

Was the delivery of the Final Report in the face of requests for disclosure a breach of the principles of natural justice?

[178] I also consider that the delivery of the Final Report in the face of repeated requests for information and repeated requests for more time to consider the information was a breach of the rules of natural justice. In particular, the letter from the solicitors for Dr Vega Vega to Ms Fairweather on 2 September 2014 made it abundantly clear that Dr Vega Vega did not consider he was fully aware of all of the allegations against him:

> "In terms of the continuing refusal to provide documents, we note, from page 17 of the draft Final Investigation Report, that your investigation and review had the benefit of the evidence of interviews with 58 separate persons, some of whom were interviewed more than twice. On our reading of the two draft reports, we are not at all satisfied that the brief references to what some witnesses said provides our client with a proper right to know the case against him. In addition, the failure to provide legible, full notes of interviews not only deprives our client from knowing what the review and investigation relied on to come to adverse views but also prevents him from knowing the strength of that evidence in its full context and prevents him from accessing some material that may well be helpful to his cause in the Inquiry.

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[46] [2010] NSWLEC 50, [180].
[47] (2012) 200 FCR 30, 46 [50].

> Especially, since the draft reports reject aspects of our client's evidence without giving a reason (paragraph 1.3.5 of the draft Clinical Review Report: kidneys were in normal positions and, therefore, Dr Vega Vega had lost his landmarks) or where it is directly supported by documentation (draft Final Investigation Report: paragraph (a) on page 30: failed to communicate the error adequately to the clinical ICU handover team: compare clinical records: page 74 of 296: 'As per verbal report by Dr. Vega Vega this morning to Dr Poggenpoel, he is convinced that the functioning R kidney had been inadvertently removed and non-functioning L kidney persists .... '), it is crucial to our client's natural justice rights that he has all of the interview notes so that he can identify those further areas where the members of the Investigation and Clinical Review may have interpreted the evidence, in a manner that is neither accurate nor fair to him.
>
> So, for the record, our client again requests, access to all material relied upon by the review and investigations including all the interview notes. There now appears to be no phone record documents (footnote 22 on page (e) of the draft Final Investigation Report). However, if any such records are in the possession of the teams, we request those records. If all of the requested material is not provided, that will be relied upon as an additional ground in the application.
>
> Our client is concerned, from the terms of your most recent letter that the two reports may be delivered by 4 September 2014 (Thursday of this week). Accordingly, we would, in the absence of an undertaking from the review and investigation members, expect to receive instructions to seek an interim hearing to consider interlocutory relief, this Wednesday, 3 September 2014."

[179] That letter finished with a request that the Final Report not be released until 15 September 2014 so that issues in relation to disclosure could be the subject of an application to this Court. On 4 September 2014, the solicitors for Dr Vega Vega again wrote to Ms Fairweather indicating that there were two serious matters where the parties were at an impasse and suggesting a way forward. In spite of that proposal, on 8 September 2014 Ms Fairweather advised that the CR Report was finalised on 3 September 2014 and that the HSI Report was finalised on 5 September 2014 and had been delivered to the acting Director-General of Health.

[180] In my view, the delivery of the Final Report in full knowledge of Dr Vega Vega's objection to the process and at a time when that issue was the subject of negotiation was procedurally unfair to him.

Do the actions of Dr Hoyle constitute actual or apprehended bias?

[181] I am not satisfied, however, that such a failure amounts to or contributes to a reasonable apprehension of bias on the part of any of the respondents, given the matters I am required to be satisfied about before such a finding can be made as previously outlined in these reasons.

[182] Neither am I satisfied that the actions of Dr Hoyle in failing to provide this material to Dr Vega Vega constitutes actual bias. A finding of actual bias is notoriously difficult and

will only be found if it is clearly established that the relevant decision-maker approached the determination of an issue with a closed mind and was unable or unwilling to decide the issue impartially.[48] Furthermore, clear evidence of the state of mind of the decision-maker is required. None of these factors are present in this case.

Has there been a failure to take into account relevant considerations?

[183] In this regard, Counsel for Dr Vega Vega argues that Dr Hoyle and the clinical reviewers were reluctant to take into account the views of the independent experts that Dr Vega Vega had presented to QCAT. It is argued that the evidence of Dr Wood before QCAT was that, in his opinion, the removal of a kidney was appropriate on the knowledge that was available at the time with respect to patient A. It is argued that Dr Hoyle gives no explanation as to why he comes to a different view to Dr Wood.

[184] It is also argued that Dr Hoyle's view that it was inappropriate to carry out the surgery at the Hospital does not take into account the opinion of Dr Wood, which was that it was reasonable to operate at the Hospital. It is argued that Dr Wood was cross-examined before QCAT and that Judge Horneman-Wren made findings based on his evidence. Furthermore, Judge Horneman-Wren found that operating in Rockhampton was reasonable.

[185] Counsel for Dr Vega Vega also submits that Dr Hoyle has not explained why he expressed a distinctly different view. It is also argued that Dr Wood expressed the view that it was appropriate for Dr Vega Vega to make the decision about whether to attempt the surgery and this was endorsed by Judge Horneman-Wren. A different view, however, was taken by Dr Hoyle who did not explain why his view differed to that of Dr Wood and QCAT. Further evidence was also referred to by Counsel for Dr Vega Vega as having been ignored or rejected despite having been considered by QCAT.

[186] It is argued, therefore, that Dr Hoyle has failed to come to terms with the evidence or explain why the evidence put forward by Dr Vega Vega was rejected. It is argued that it is inappropriate for the expert evidence, which was subsequently supported by the findings of QCAT, to be departed from without a detailed explanation. Similarly, the explanation for rejecting Dr Vega Vega's evidence before QCAT should also have been explained. Counsel for Dr Vega Vega also referred to a comment made by Dr Hoyle that he wanted to shake Dr Vega Vega up.

[187] Counsel for Dr Vega Vega also argues that Professor Marshall totally ignored the reasons of QCAT and they were a key part of Dr Vega Vega's case as presented to the CR. It is argued that the failure of the doctors to consider and take into account the evidence of Dr Wood, as recorded in the reasons of QCAT, is a failure to take into account a relevant consideration and is sufficient to render the CR Report invalid. Consequently, the invalidity of the CR Report also means the HSI Report is invalid.

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[48] *Sun v Minister of Immigration and Ethic Affairs* (1997) 151 ALR 505, 551-522; *Gamaethige v Minister of Immigration and Multicultural Affairs* (2001) 109 FCR 424, 442-443.

[188] In this regard, I accept the submissions of the respondents that the clinical reviewers and investigators were not required to take that information into account. As Mason J made clear in *Minister for Aboriginal Affairs v Peko Wallsend*,[49] the ground of failure to take into account a relevant consideration can only be made out if the decision-maker is actually bound by legislation to take that factor into consideration. What a decision-maker has to take into account is determined by the statute which confers the discretion on the decision-maker. Mason J held that where a ground of review is that a relevant consideration has not been taken into account and the discretion is unconfined by the terms of the statute, "the court will not find that the decision-maker is bound to take a particular matter into account unless an implication that he is bound to do so is to be found in the subject matter, scope and purpose of the Act."[50]

[189] I am, therefore, not satisfied that this ground has been established.

Conclusion

[190] I am therefore satisfied:

1. That the decisions of the first to fifth respondents as contained in the CR Report and the HSI Report to which it was appended, which were presented to the Acting Director-General of Health on 5 September 2014, were decisions of an administrative character which were made under an enactment;

2. That a breach of natural justice occurred in relation to the preparation of the CR Report and the HSI Report in that the decisions of the first to fifth respondents prevented the applicant from having access to information and documents relied on by the health service investigators and clinical reviewers in their Reports;

3. That a breach of natural justice occurred in relation to the preparation of the CR Report and the HSI Report in that the health service investigators proceeded to deliver their report to the Acting Director-General of Health on 5 September 2014 despite the denial of that information to the applicant; and

4. That the applicant is aggrieved by those decisions.

[191] I consider that the applicant is entitled to orders in terms of the relief sought in paragraphs 4 and 6 of the Amended Application for a Statutory Order of Review.

[192] I will hear from the parties as to the terms of the orders and as to costs.

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[49] (1986) 162 CLR 24, 39-40.
[50] *Minister for Aboriginal Affairs v Peko-Wallsend* (1986) 162 CLR 24, 40.