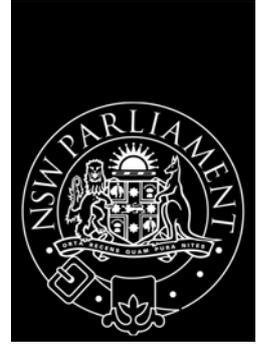


PARLIAMENT OF NEW SOUTH WALES



Committee on the Health Care Complaints Commission

REPORT ON THE INVESTIGATIONS BY THE HEALTH
CARE COMPLAINTS COMMISSION INTO THE
COMPLAINTS MADE AGAINST MR GRAEME REEVES

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Table of Contents

Membership & Staff	iii
Abbreviations	v
Terms of Reference	vii
Chair's Foreword	ix
List of Recommendations	xi
Executive Summary	xiii
CHAPTER ONE - BACKGROUND	1
CHAPTER TWO - THE HEALTH CARE COMPLAINTS SYSTEM IN NSW....	7
CHAPTER THREE - THE REEVES COMPLAINT PROCESS	15
CHAPTER FOUR - THE HEALTH CARE COMPLAINTS COMMISSION	21
CHAPTER FIVE - PROCEEDINGS AGAINST REEVES	27
CHAPTER SIX - THE MEDICAL PRACTICE AMENDMENT ACT 2008	35
CHAPTER SEVEN - CONCLUSION	41
Recommendations	45
APPENDIX ONE – THE HEALTH CARE COMPLAINTS COMMISSION REVIEW OF PAST HANDLING OF COMPLAINTS AGAINST DR GRAEME REEVES	47
APPENDIX TWO – CORRESPONDENCE BETWEEN THE COMMITTEE AND THE HEALTH CARE COMPLAINTS COMMISSION.....	49
APPENDIX THREE – TERMS OF REFERENCE OF THE GARLING SPECIAL COMMISSION OF INQUIRY	63
APPENDIX FOUR – CORRESPONDENCE BETWEEN THE COMMITTEE AND THE NSW MEDICAL BOARD.....	65
APPENDIX FIVE – MINUTES	69

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Abbreviations

AHS	Area Health Service
CEC	Clinical Excellence Commission
Hornsby Hospital	Hornsby Ku-ring-gai Hospital
MACAC	Medical Appointments and Credentials Advisory Committee
MPA	Medical Practice Act 1992
MPAA	Medical Practice Amendment Act 2008
HCCC	Health Care Complaints Commission
SAHS	Southern Area Health Service
The Act	Health Care Complaints Act 1993
The Board	The New South Wales Medical Board
VMO	Visiting Medical Officer

Terms of Reference

That, pursuant to the function of the Joint Parliamentary Committee on the Health Care Complaint Commission under s 65(1)(b) of the *Health Care Complaints Act 1993* to report to both Houses of Parliament, with such comments as the Committee thinks fit, on any matter appertaining to the Commission or connected with the exercise of the Commission's functions to which, in the opinion of the Committee, the attention of Parliament should be directed, the Committee:

1. examine the investigations by the Health Care Complaints Commission into the complaints made against Mr Graeme Reeves, de-registered medical practitioner; and
2. report to Parliament on any matters connected with the Committee's statutory functions.

Chair's Foreword

Each day, almost every one of us in New South Wales has health care decisions made on our behalf, whether it is the local chemist's recommendation of sunscreen, a specialist's choice of surgical procedure, or a health policy administrator's decision on trialling a new vaccine. In each and every case we have the right to know that these decisions are being made by professionals who have appropriate levels of training and competency, and who ultimately have our best interests at heart.

However, despite health care in New South Wales being amongst the best in the world, as in any human endeavour, procedures will occasionally go wrong – mistakes will be made, communication failures will occur, and people will suffer as a result. At that juncture, we also have the right to know that such errors will be appropriately investigated. These investigations must be aimed at both remedying as much as possible the individual situation, but - just as importantly - ensuring that the factors which led to that situation will not recur.

These fundamental rights form the basis for the Committee's decision to inquire into and report to Parliament on the conduct of investigations by the NSW Health Care Complaints Commission into complaints made against de-registered medical practitioner Graeme Reeves. Health care users have the right to expect that the Commission will promptly and properly investigate their complaints against health care providers, bearing in mind always the Commission's over-riding statutory responsibility to protect the public's health and safety.

Justice to those who have suffered as a result of medical errors must not only be done, but must be seen to be done. The Committee hopes that its Report will play a role in ensuring the transparency of decision-making in the wake of medical errors, thereby ultimately reducing their frequency and severity.



Hon Helen Westwood AM MLC
Chair

List of Recommendations

RECOMMENDATION 1: That the *Health Care Complaints Act 1993* be the subject of a thorough review, carried out with reference to the legislative changes made by the *Medical Practice Amendment Act 2008*, to identify and remove any unnecessary complexities in the health care complaints system in NSW.

RECOMMENDATION 2: That this review include input from the NSW Medical Board, all other Registration Authorities in NSW, and the Clinical Excellence Committee, and have reference to worldwide best practice.

RECOMMENDATION 3: That the following amendments be made to the *Health Care Complaints Act 1993*; amending s 21A to allow the HCCC to exercise all of the powers under s 34A as part of its assessment phase; and extending s 34A to give the HCCC power to compel documents and information from any person, rather than being limited to complainants and health service providers, as recommended by Ms Deirdre O'Connor.

RECOMMENDATION 4: That the *Health Care Complaints Act 1993* be amended to provide that, where the Commissioner reasonably believes that any part of the Commission's assessment or investigation process has revealed evidence of criminal conduct, the Commission may at that time provide such evidence to law enforcement authorities.

RECOMMENDATION 5: That all legislation establishing Registration Authorities in NSW be amended to provide, as much as is reasonably possible, for standardised internal complaint handling procedures in line with those of the NSW Medical Board.

RECOMMENDATION 6: That all of the Registration Authorities in NSW publish on their websites, or provide links to publication of, decisions relating to practitioners within their area of practice.

RECOMMENDATION 7: That the NSW Department of Health conduct a state-wide audit of practitioners practising with conditions, with the aim of ensuring that rural or remote areas of the State have sufficient number of appropriately functioning practitioners.

RECOMMENDATION 8: That the Health Care Complaints Commission focus on the needs of health care service users in rural and remote NSW as part of its current public awareness-raising project.

RECOMMENDATION 9: That the NSW Medical Board conduct a public education program with the aim of raising public awareness and understanding of the operation of its Performance Assessment processes and Impaired Registrants Program.

RECOMMENDATION 10: That the Medical Board and other Registration Authorities ensure that Continuing Medical Education requirements are complied with, and provide that failure by a practitioner to so comply is a ground for referral for Performance Assessment.

RECOMMENDATION 11: That all practitioners be required to display notices in their practice evidencing their compliance with the Continuing Education requirements of their area of practice.

Executive Summary

On 11 April 2008 the Committee on the Health Care Complaints Commission resolved to inquire into and report on the conduct of investigations by the Health Care Complaints Commission into the complaints made against de-registered medical practitioner Graeme Stephen Reeves, pursuant to s 65(1)(b) of the *Health Care Complaints Commission Act 1993*.

Having examined the role of the Commission in the conduct of these investigations, the Committee has concluded that the Commission failed to adequately discharge its statutory responsibilities in respect of the complaints made against Reeves. However, the Committee acknowledges that the Commission properly exercised its prosecutorial role before the Professional Standards Committee of the NSW Medical Board which heard complaints against Reeves in 1997, when the Commission sought to have him banned from all obstetrics and gynaecological practice.

The Committee considers that, having regard to the Medical Board's own psychiatric evidence about Reeves, the Professional Standards Committee erred in deciding to limit Reeves' ban to the practice of obstetrics at that time. However, the Committee acknowledges that it has reached this conclusion with the benefit of hindsight, and that even on the evidence available to it, it may be unreasonable to expect the Professional Standards Committee to have foreseen Reeves' subsequent extraordinary pattern of deceit.

Having examined the changes to the policies and practice of the Commission, the Medical Board, and the Department of Health generally; and bearing in mind subsequent amendments to the *Health Care Complaints Commission Act 1993* and the *Medical Practice Act 1992*, the Committee considers that the systems failings which led to the mishandling of the complaints against Reeves have been largely rectified. Nonetheless, the Committee has made a series of recommendations aimed at avoiding a repetition of this serious failure to protect the health and safety of the people of New South Wales.

Chapter One - Background

Introduction

In establishing the Health Care Complaints Commission under the *Health Care Complaints Act 1993* [the Act], the NSW Parliament expressly set out to create a body which would act as an independent investigator and prosecutor of serious health care complaints. The means by which the people of New South Wales keep the Commission to this statutory remit is the oversight exercised by the elected Members of the Parliament constituted as the Joint Parliamentary Committee on the Health Care Complaints Commission [the Committee].

As will be seen from the following material, the Committee is not established to second-guess every decision of the Commission; indeed it is expressly forbidden from doing so. The Committee's responsibility is to take a systems-wide view of the operations of the Commission to ensure that it is protecting the health and safety of the public. Relevant information comes to the Committee's attention by way of the Annual Reports and quarterly Performance Reports of the Commission, and from specific matters raised directly with the Committee by members of the public.

Accordingly, as there had been no reference made to the serious allegations against ex-medical practitioner Graeme Reeves in any of these usual channels of communication, the Committee had not been in a position to explore these allegations until very recently. When matters of such seriousness did come to its attention, the Committee resolved to seek an explanation from the Commission, and to report to both Houses of Parliament on the conduct of the Commission's investigation into complaints made against Reeves over a period of many years.

The Committee's response to the Reeves allegations

At its meeting of 6 March 2008, the Committee resolved to write to the HCCC Commissioner, Mr Kieran Pehm, expressing the Committee's extreme concern at the apparent failure of the Commission to act effectively on repeated complaints about Reeves. Specifically, the Committee informed the Commissioner that it was particularly concerned that:

- the Commission has repeatedly failed to take into account the pattern of Reeves' serious clinical failures over a period of many years; and
- the matters involving Reeves tend to suggest a systemic failure to protect the health and safety of the people of New South Wales, the Commission's chief object pursuant to s 3(2) of the *Health Care Complaints Act 1993*.

The Commission's own review of the Reeves case is attached as Appendix 1.

A letter was hand delivered to the Commission on 26 March 2008, together with a specific list of questions for the Commissioner. On 27 March 2008 the Commissioner replied to the Committee in detail. Whilst Committee Members considered that the Commissioner generally had answered the Committee's questions thoroughly and frankly, the Committee resolved at its meeting of 11 April 2008 to write further to the Commissioner, seeking clarification on a number of points raised in his answers, as a matter of urgency. The Commissioner responded to this letter on 14 April 2008 [see Appendix 2].

At its meeting of 11 April 2008, the Committee resolved as follows:

‘That the Committee’s correspondence with the Commissioner form the basis of a report to Parliament under s 65(1)(b) of the *Health Care Complaints Act 1993* on the conduct of the Commission’s investigations of the complaints against Mr Reeves’.

The statutory role of the Committee

The Health Care Complaints Commission is an independent body with responsibility for dealing with complaints under the Health Care Complaints Act, with particular emphasis on the investigation and prosecution of serious complaints in consultation with relevant registration authorities.¹ The Commission deals with health care complaints in a co-regulatory manner with other agencies in NSW, as outlined below.

The Committee, in turn, is established under s 64 of the Act. Its statutory functions specific to reviewing the conduct of the Commission’s investigations into Reeves are that the Committee must:

- monitor and review the exercise by the Commission of its functions under any Act;
- report to both Houses of Parliament, with such comments as thought fit, on any matter appertaining to the Commission or connected with the exercise of the its functions to which, in the Committee’s opinion, the attention of Parliament should be directed; and
- report to both Houses of Parliament any change which the Committee considers desirable to the functions, structures and procedures of the Commission.²

Based on the Committee’s statutory responsibilities, the Committee sought the Commissioner’s answers to questions which related to the conduct of the Reeves investigations, but which did not conflict with the specific limitations on the Committee’s functions set out in s 65(2) of the Act. These limitations are that the Committee is not authorised to:

- re-investigate a particular complaint;
- reconsider a decision to investigate, not to investigate or to discontinue investigation of a particular complaint; or
- reconsider the findings, recommendations, determinations or other decisions of the Commission, or of any other person, in relation to a particular investigation or complaint.³

The NSW Medical Board

As noted above, the health care complaint process in New South Wales is a co-regulatory one, with responsibility for determining the outcome of complaints against medical

¹ See s 3(1) of the *Health Care Complaints Act 1993*.

² *Health Care Complaints Act 1993*, ss 65(1)(a) (b) and (c) respectively. The Committee’s other functions are to examine each annual and other report made by the Commission, and presented to Parliament, under any Act and to report to both Houses of Parliament on any matter appearing in, or arising out of, any such report [s 65(1)(c)]; and to inquire into any question in connection with the Committee’s functions which is referred to it by both Houses of Parliament, and to report to both Houses on that question: s 65(1)(e).

³ *Health Care Complaints Act 1993*, ss 65(2)(a), (b) and (c) respectively.

practitioners shared by the Commission and other bodies, particularly registration authorities within the State.

The registration authority to which Reeves was answerable was the New South Wales Medical Board [the Board], a statutory authority established under the *Medical Practice Act 1992* [MPA], whose principal purpose is to protect the health and safety of the public by providing mechanisms designed to ensure that medical practitioners are fit to practise medicine.⁴ The Board's Registrar, Mr Andrew Dix, has stated that no information about Reeves' gynaecological practice had been brought to the attention of either the Board or the Commission.⁵

In assessing the effectiveness of the Commission's response to the complaints made against Reeves, the Committee will necessarily have to take into consideration the role of the Board throughout. Accordingly, on 11 April 2008 the Committee resolved to write to the Board requesting a copy of the Professional Standards Committee's 1997 Statement of Decision in respect of the complaints made against Graeme Reeves, pursuant to s 180(3) of the MPA.⁶

By letter dated 2 May 2008 the Board replied with a 'de-identified' copy of the Statement of Decision, citing s 180(4) of the MPA, under which the Board itself may provide a copy to such persons as the Board thinks fit. The Board also stressed that the material was provided to the Committee on a strictly confidential basis, for the sole purpose of the Committee exercising its functions under s 65 of the Act.⁷

The Garling Inquiry

On 24 January 2008 the Deputy NSW State Coroner handed down his findings into the November 2005 death of patient Vanessa Anderson at Royal North Shore Hospital. Although he made no formal recommendations, the Coroner called on the Minister for Health to 'consider a full and open inquiry into the delivery of health services in NSW'.⁸ In response, on 29 January 2008, the Governor confirmed the Terms of Reference for a Special Commission of Inquiry into the delivery of patient care within the NSW public health system, and appointed Peter Garling SC to lead the Commission. The Terms of Reference are attached as Appendix 2.

⁴ The Board currently consists of twenty nominees appointed by the Governor of New South Wales. Fifteen of the members are doctors, and five are non-medical members. The Board functions through its Registration, Professional Conduct, Performance and Health Committees which meet monthly, and report to the full Board meeting every second month: <http://www.nswmb.org.au/index.pl?page=2>.

⁵ 27 February 2008, 'Board "not aware of mutilations"', www.brisbanetimes.com.au/news/national/

⁶ Section 180(3) provides that a Professional Standards Committee of the Medical Board may provide the statement of a decision to such other persons as that Committee thinks fit.

⁷ On 27 February 2008, the Board made a statement to the effect that it was continuing to monitor closely the developments of investigations into Mr Reeves' practice, prior to his 2004 de-registration. The Board noted that, pursuant to the provisions of the *Medical Practice Act 1992*, it was legally prohibited from commenting on many of the issues being canvassed in the media: see www.Board.org.au/system/files/f8/o619/Reeves%20Statement%201.pdf

⁸ See *Government Response to the Findings of the Joint Select Committee on the Royal North Shore Hospital*, p 4. <http://bulletin/prod/parlment/committee.nsf/0/2067fbc90d0e6eb4ca2573b700008fbb/>. The Joint Select Committee had recommended that if there were any recommendations from the Coroner's Report that were within its terms of reference, the Parliament should consider re-establishing the Committee for inquiry and report into these matters.

Background

On 7 March 2008 the Minister for Health, Hon Reba Meagher MP, referred the handling of the appointment of Reeves to the Southern Area Health Service [SAHS] to the Garling Special Commission of Inquiry.⁹ The Special Commission of Inquiry ceased taking written evidence after 20 June 2008, and is expected to report in July 2008. Having regard to this, the Committee does not intend to examine the process by which Reeves was employed by the SAHS, except to the extent that it evidences his pattern of behaviour.¹⁰

Strike Force Tarella

Given the grave nature of the allegations made against Reeves in his Bega practice, on 27 February 2008 the NSW Police Force established Strike Force Tarella, consisting of 12 detectives from the Child Protection and Sex Crimes Squad, and Far South Coast Local Area Command.¹¹ The Commission is co-operating with the Strike Force in investigating the claims made against Reeves.¹²

As the allegations against Reeves are the subject of a current investigation, the Committee does not intend to make any comments as to the alleged criminality of his behaviour.

The O'Connor Reports

On the same day as the Committee resolved to write to the Commission, the Minister for Health informed the Legislative Assembly that Ms Deidre O'Connor - former President of the Administrative Appeals Tribunal - had been appointed to review all of the circumstances in relation to Reeves' appointment, and the relevant decisions of the Board.¹³ In September 2006, Ms O'Connor had been engaged by the then Minister for Health to conduct a review of the powers of the NSW Medical Board under s 66 of the MPA. In February 2008, the Minister requested that Ms O'Connor:

revisit the [*Medical Practice Amendment Bill*] in the light of public concern over the manner in which the system dealt with concerns in relation to the practice of Mr Graeme Reeves over the period of the 1990s until his de-registration in 2004.¹⁴

Ms O'Connor subsequently provided her advice in two parts:

- Part 1 Review of *Medical Practice Amendment Bill 2008* - to assist in assessing the need for changes to the MPA and the Health Care Complaints Act in relation to the management of complaints or concerns about registered practitioners; and
- Part 2 Review of the appointment, management and termination of Reeves as a visiting medical officer in the NSW public health system.

The terms of reference for Part 2 required Ms O'Connor to:

⁹ See, e.g., 'Inquiry to investigate "genital mutilation" doctor', www.abc.net.au/news/stories/2008/03/07/2182821.htm

¹⁰ The Committee notes that the Special Commission of Inquiry summonsed the Health Care Complaints Commission, requiring it to provide all relevant documents. The Commission responded to the summons by providing the relevant material on 11 April 2008.

¹¹ See 'Police yet to interview "Butcher of Bega"', *Herald Sun*, 11 May 2008.

¹² See <http://www.hccc.nsw.gov.au/downloads/MediaReleaseDrReeves26022008.pdf>

¹³ Hon R P Meagher MP, Answer to Question Without Notice, Legislative Assembly *Hansard*, 6 March 2008.

¹⁴ D O'Connor, *Review of Medical Practice Amendment Bill 2008*, 28 March 2008, pp 1-2.

- (i) identify whether the processes followed in each case complied with relevant NSW Health policies in place at the time;
- (ii) identify gaps, if any, in the relevant NSW Health policies in place at the time;
- (iii) review current NSW Health policies to ascertain whether they address any such gaps;
- (iv) identify improvements, if any which could be made to current NSW Health policies relating to the appointment, management and termination of visiting medical officers at NSW public hospitals; and
- (v) make any recommendations for changes to the legal and policy framework relating to these matters.¹⁵

Specifically, however, Ms O'Connor's terms of reference did not include reviewing the actions taken by the Medical Board and the Commission in relation to Reeves. The two Parts of her Report were made public on 26 May 2008 and 2 June 2008 respectively.

The scope of the Committee's Report

From the above it will be seen that the circumstances surrounding Reeves' appointments and practice have been - and continue to be - the subject of close scrutiny from various angles, in a number of quarters. At the outset, the Committee notes that its statutory oversight function is limited to the Health Care Complaints Commission – it has no equivalent responsibility with respect to any other health care complaint resolution body, or health care provider, in New South Wales.

Reeves first came to the attention of the Commission in 1990, and from that time until 2007 the Commission received some 24 complaints about him. These ranged from matters such as rudeness to patients through to the most serious clinical matters, involving the death of three patients.¹⁶ The aim of this Report is to establish whether in the light of contemporary legal and health policy practice, the Commission fulfilled its statutory responsibilities in respect of the complaints made against Reeves; whether there existed systemic failures in the investigation of health care complaints during the period in question; and, if so, to what extent these failures have been addressed by subsequent statutory and policy changes. Having considered these matters, the Committee will make recommendations which aim to remedy any continuing flaws in the system.

¹⁵ The Terms of Reference to Part 1 were for Ms O'Connor to review the material provided setting out the complaints and disciplinary history of Dr Graeme Reeves to:

- (a) identify whether that history indicates there are any areas where the provisions of the *Medical Practice Act 1992* and the *Health Care Complaints Act 1993* could be improved, and to the extent that such changes are not already addressed in the *Medical Practice Amendment Bill 2008*, or in the proposal announced by the NSW government to introduce mandatory reporting by medical practitioners of their colleagues in certain defined circumstances, make further specific recommended amendments to the Acts for inclusion in the Bill; and
- (b) identify any other issues arising in respect of the Acts, the statutory regulatory system for medical practitioners and/or the operation of the NSW Medical Board and the Health Care Complaints Commission that she considered may be worthy of further review or consideration. For further consideration, see Chapter 6.

¹⁶ See, e.g., 'Horror stories of rogue doctors mount up', *Sydney Morning Herald*, 13 March 2008.

Background

In doing so, the Committee will fulfil its statutory responsibility under s 65(1)(b) of the *Health Care Complaints Act 1993* to report to Parliament on this important matter connected with the exercise of the Commission's functions.

Chapter Two - The Health Care Complaints System in NSW

In her second report to the Department of Health, Deirdre O'Connor noted the complex and evolutionary nature of health care policy in NSW:

All systems evolve and respond to issues over time. It is clear the systems and policies in the NSW Health system relating to the appointment, management and termination of medical practitioners have improved considerably over the roughly 23 year period covered by this review...¹⁷

The Committee acknowledges the considerable changes which have been made to the process of health care complaints since the establishment of the Health Care Complaints Commission in 1994. Bearing in mind these changes, this Chapter will outline the manner in which health care complaints are currently dealt with in NSW.

The statutory framework

The *Health Care Complaints Act 1993* [the Act] defines the Commission's primary objects as:

- receiving and assessing complaints relating to health services and health service providers in New South Wales;
- investigating and assessing whether such complaints are serious and if so, whether they should be prosecuted;
- prosecuting serious complaints; and
- resolving or overseeing the resolution of complaints.¹⁸

The Act further sets out the relationship of the Commission with other agencies in the health care system in NSW, with specific reference to the Director-General of the Department of Health, public health organisations conducting health services, and registration authorities. Section 3A of the Act provides that registration authorities, such as the NSW Medical Board, are:

responsible for the registration of health professionals and the management of complaints in conjunction with the Commission. The registration authorities are also responsible for protecting the public through promoting and maintaining professional standards.¹⁹

To fulfil its statutory responsibilities under both the *Health Care Complaints Act* and the *Medical Practice Act*, the Board:

- maintains the Register of Medical Practitioners for NSW;

¹⁷ D O'Connor, *Review of the appointment, management and termination of Dr Graeme Reeves as a visiting medical officer in the NSW public health system*, 2 May 2008, pp 1-2.

¹⁸ See s 3(1) *Health Care Complaints Act 1993*. In doing so, the Commission is to have as its primary object the protection of the health and safety of the public: s 3(2).

¹⁹ The remaining Registration Boards are for Chiropractors, Dental Technicians, Nurses & Midwives, Optical Dispensers, Optometrists, Osteopaths, Pharmacists, Physiotherapists, Podiatrists and Psychologists.

The Health Care Complaints System in NSW

- administers the complaints and disciplinary provisions of the legislation which provide a means for serious complaints about doctors to be received, investigated, prosecuted, and adjudicated upon;
- administers the Health Program for doctors suffering ill-health which may affect their ability to practise medicine; and
- administers the Performance Program for doctors whose professional performance may be below the appropriate peer standards.²⁰

The co-regulatory role of Commission and Board can be summarised as follows:

- the Board and the Commission consult on initial assessment and subsequent handling of complaints – this takes place on a weekly basis;²¹
- serious complaints are referred to the Commission for investigation, or to the Health Conciliation Registry, if appropriate for conciliation;²²
- once investigated by the Commission, the Board and the Commission consult as to whether to refer the matter to the Commission's Director of Proceedings, for prosecution before a Medical Tribunal or Professional Standards Committee of the Board [PSC] - if so, the Commission acts as the nominal complainant;²³
- after a referral by the Director of Proceedings to a disciplinary hearing, the Board's Professional Conduct Section convenes a Hearing; and
- the Section will then implement the decisions of the disciplinary hearing and ensure that the practitioner complies with the orders of the Committee or Tribunal.²⁴

To facilitate these processes, the MPA currently contains the following notification provisions:

- the Board and the Commission are to notify each other when a complaint is made to, or by, either of them and this is to be done as soon as practicable after the complaint is made; and
- the Board and the Commission are also to notify each other of any matter that comes to the notice of either of them which may involve the professional misconduct of a registered medical practitioner. This is to be done as soon as practicable after the matter comes to the notice of either body.²⁵

²⁰ <http://www.nswmb.org.au/index.pl?page=2>

²¹ Before any action is taken on a complaint, the Board and the Commission are to consult in order to see if agreement can be reached between them as to the course of action to be taken concerning the complaint: s 49(1) of the *Medical Practice Act 1992*.

²² If less serious, complaints are referred to direct resolution or consideration by another body such as an Area Health Service.

²³ Either body *must* refer a complaint to the Tribunal if of the opinion that it may, if substantiated, provide grounds for the suspension or de-registration of a practitioner. The exception is if the allegations on which the complaint is founded relate solely or principally to the physical or mental capacity of the practitioner to practise medicine. If the Board decides not to refer the complaint to the Tribunal, it must refer the complaint to a PSC. If the Commission decides not to refer the complaint to the Tribunal, it must instead refer the complaint to the Board: s 52 of the *Medical Practice Act 1992*.

²⁴ See <http://www.Board.org.au/index.pl?page=4>.

²⁵ Section 46 *Medical Practice Act 1992*.

Moreover, the MPA further enmeshes the Commission with the Board by providing that the Board's Code of Professional Conduct is to be relevant in determining what is proper and ethical conduct.²⁶ Thus, the Code of Conduct should be taken into account in determinations of the Board, the Commission, and any other body dealing with complaints against medical practitioners.²⁷

Clinical Excellence Commission

For completeness in the statutory overview, the Committee notes that, in August 2004, the NSW Government established the Clinical Excellence Commission [CEC]. The main aim of the CEC is to ensure the safety and quality of services provided by NSW Health. To achieve this, it examines systemic issues which have an effect on patient safety and the quality of clinical services provided. After these issues have been identified, the CEC addresses them by way of the implementation of strategic programs.²⁸

Unlike the Commission, the CEC does not investigate complaints regarding individuals, its function is to identify and address systemic issues: if the CEC does receive any complaints, they are referred to the appropriate investigative body. The Commission may identify concerns of a systemic nature or trends in complaints and refer them to the CEC through the Department of Health.

The complaint process

Once in receipt of a complaint – or having decided itself to investigate - the Medical Board may:

- refer the complaint to the Commission for investigation, a Committee or the Tribunal;²⁹
- refer the matter to an Impaired Registrants Panel;
- refer the professional performance of the practitioner concerned for assessment under Part 5A;³⁰
- direct the practitioner concerned to attend counselling;
- refer the complaint to the Commission for conciliation or to be dealt with under Div 9 of Part 2 of the *Health Care Complaints Act 1993*; or
- determine that no further action should be taken in respect of the complaint.

²⁶ Section 99A(4) *Medical Practice Act 1992*. Although s 99A was added to the Act in 2000 by the *Medical Practice Amendment Act 2000*, the Code was only signed off by the then-Minister for Health in July 2005.

²⁷ www.Board.org.au/index.pl?page=44. Reeves' actions directly contravene Standards 2-4 of the Code.

²⁸ The CEC consists of the CEO, a Board and a Clinical Council. The Minister for Health appoints the Board, whose purpose is to ensure that the CEC properly executes its functions to provide strategic and independent leadership in relation to patient safety and clinical quality. The Clinical Council provides expert advice to the Board and CEC on its strategies and program implementation. The Council is made up of nursing, medical and allied health staff whose expertise can be utilised to ensure health provider participation.

²⁹ Section 50 *Medical Practice Act 1992*. Before, or when, it refers a complaint to a Committee or the Tribunal, the Board must refer the complaint to the Commission for investigation. The Commission must, on receipt of a complaint referred by the Board for investigation, investigate the complaint or cause it to be investigated: s 50(2) *Medical Practice Act 1992*.

³⁰ If the Board makes a referral the matter ceases to be a complaint for the purposes of the *Medical Practice Act 1992* and the *Health Care Complaints Act 1993*: s 51.

If the Board makes a referral to the Impaired Registrants Panel, or for assessment under Part 5A of the MPA, the matter ceases to be a complaint for the purposes of both Acts.³¹

For its part, the Commission's options are to:

- refer the complaint to the Board or, after consultation with the Board, to a Committee or the Tribunal;
- refer the complaint for conciliation or deal with the complaint under Div 9 of Part 2 of the *Health Care Complaints Act*,³²
- determine that no further action should be taken; or
- take any other action available to it under the Act.³³

The Committee's assessment and investigation process is set out in diagrammatic form on p 13.

Section 66 Inquiries

Pursuant to s 66 of the MPA, if the Board is satisfied that action in respect of a registered medical practitioner is necessary for the purpose of protecting the life or physical or mental health of any person, it must:

- (a) by order suspend that practitioner from practising medicine for such period (not exceeding eight weeks) as is specified in the order; or
- (b) impose on that practitioner's registration such conditions, relating to the practitioner's practising medicine, as it considers appropriate.³⁴

A pivotal provision whereby the Board and Commission effect their co-regulatory role is s 66B of the MPA, which details the manner in which some matters are referred by the Board to the Commission:

- the Board must, as soon as practicable after taking any action under s 66 and, in any event, within seven days after taking that action, refer the matter to the Commission for investigation;
- the matter is to be dealt with by the Commission as a complaint made to the Commission against the practitioner concerned; and
- the Commission is to investigate the complaint or cause it to be investigated and, as soon as practicable after it has completed its investigation and if it considers it appropriate to do so, refer the complaint to the Tribunal or a Committee.³⁵

³¹ Section 50, *Medical Practice Act 1992*. Part 5A provides generally for the Board to have a practitioner's professional performance - the knowledge, skill or care possessed and applied by the practitioner in the practice of medicine - assessed by one or more qualified assessors.

³² Div 9 Part 2 provides for an alternate and neutral means of resolving complaints that is independent of the investigative processes of the Commission: s 55B *Health Care Complaints Act 1993*.

³³ If the Commission refers a complaint to a Committee or the Tribunal, the Commission is to inform the Board accordingly. If the Commission refers a complaint to the Board, a Committee or the Tribunal, the Commission is to investigate the complaint or cause it to be investigated: s 51 *Medical Practice Act 1992*.

³⁴ The Board may take such action whether or not a complaint has been made or referred to the Board about the practitioner, and whether or not proceedings in respect of such a complaint are before the Tribunal or a Committee.

In the case of Reeves, in February 2003 the Board held a s 66 inquiry after becoming aware that he had been practising as an obstetrician in breach of his conditions of practice. Although it found that Reeves could not adequately explain his breach of conditions, the Inquiry felt that it could not suspend Reeves due to the wording of s 66, which at that time allowed the Board to take only such action as is 'necessary to protect the life or health of a person'.³⁶

The Committee notes that the s 66 Inquiry process has been extensively altered by the provisions of the *Medical Practice Amendment Bill 2008*. These amendments are dealt with in detail in Chapter Six.

Investigation outcomes

Section 39 of the *Health Care Complaints Act* provides that, at the end of the investigation of a complaint against a health practitioner - and after consulting with the appropriate registration authority - the Commission must do one or more of the following:

- refer the complaint to the Director of Proceedings;
- refer the complaint to the appropriate registration authority (if any) for consideration of the taking of action under the relevant health registration Act, such as the referral of the health practitioner for performance assessment or impairment assessment;
- make comments to the health practitioner on the matter the subject of the complaint;
- terminate the matter;
- refer the matter the subject of the complaint to the Director of Public Prosecutions; or
- take action under s 41A, which is to make a prohibition order, or a public statement giving warnings or information about the health practitioner and health services provided by the health practitioner.³⁷

Conclusion

From the above it will be seen that, despite streamlining, the health care complaints system remains a complicated series of processes with a multiplicity of interested parties. Indeed, this Chapter has focused on the role of the Medical Board, given that it was the registration authority responsible for Reeves as a gynaecologist and obstetrician. The picture is further complicated by the existence of another ten registration authorities, and by the fact that

³⁵ This section does not apply if the Board takes action against a registered medical practitioner under s 66 because the Board is of the opinion that the practitioner suffers from an impairment: s 66B(4) *Medical Practice Act 1992*.

³⁶ In 2006-07, the Board conducted 35 s 66 inquiries, which resulted in twelve doctors being suspended, and nineteen having conditions imposed on their registration.

³⁷ A prohibition order can: (i) prohibit the health practitioner from providing health services or specified health services for the period specified in the order or permanently; and/or (ii) place such conditions as the Commission thinks appropriate on the provision of health services or specified health services by the health practitioner for the period specified in the order or permanently.

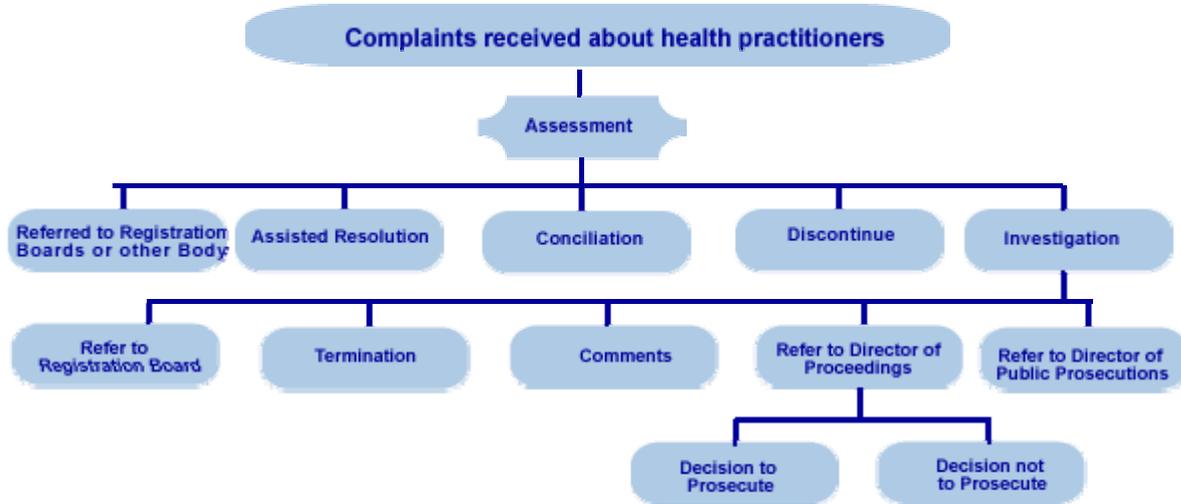
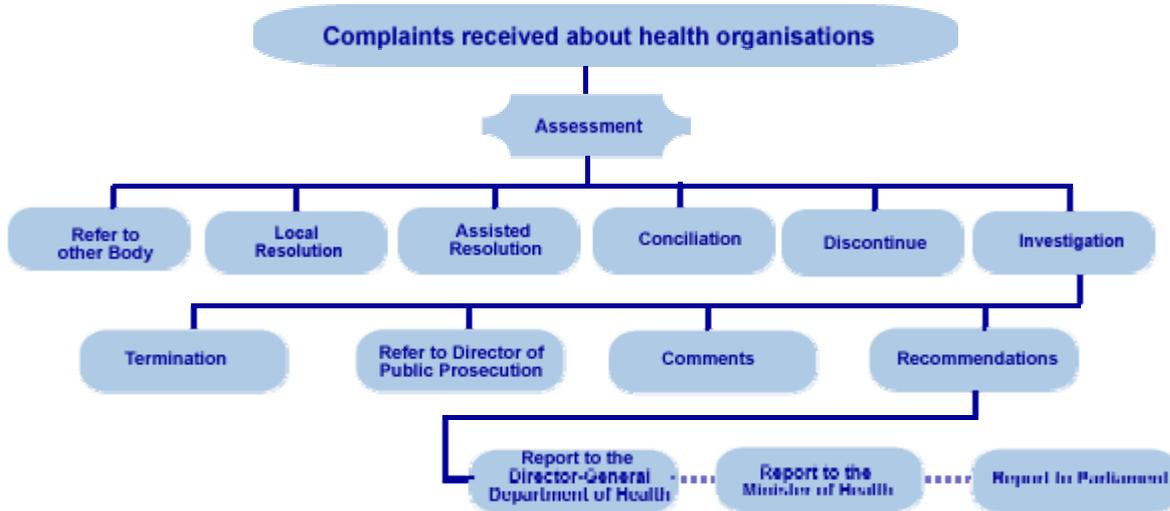
The Health Care Complaints System in NSW

since 2006 the Commission has also had responsibility for complaints made against unregistered practitioners.

In recent evidence to the Committee, the Commission's Director of Proceedings highlighted the difficulties in determining how to respond to a complaint, due to inconsistencies between the various registration Acts. Specifically, she noted that not all registration bodies have a Professional Standards Committee, but may only have a Tribunal or Boards of Inquiry, so that all matters are dealt with by the one body, regardless of the seriousness of the complaint.

The Committee agrees that legislative complexity and inconsistencies may inhibit proper and timely investigation of health care complaints. Accordingly, the Committee is currently preparing a Discussion Paper on the oversight of Registration Authorities in NSW generally, which it intends to use as a basis for recommending constructive change to the existing system.

The Health Care Complaints Commission Assessment and Investigation Process



³⁸ http://www.hccc.nsw.gov.au/html/complaints_Process.htm

Chapter Three - The Reeves Complaint Process

Background

Graeme Stephen Reeves graduated from the University of New South Wales in 1975 and became a member of the Royal Australian College of Obstetricians and Gynaecologists in 1981. At one stage he lectured at the School of Medicine at the University of New South Wales.³⁹ According to the Commission's website, between 1990 and 1997 the Commission received 24 complaints relating to the treatment of 14 patients by Reeves. Nine of these complaints eventually formed the basis for the Commission's 1997 prosecution before a Professional Standards Committee of the NSW Medical Board.

In preparing its Report, the Committee has not directly accessed the files of the Department of Health. Rather, the Committee acknowledges the reliance upon the Reports of Deirdre O'Connor, referred to in Chapter One. Overall, Ms O'Connor notes that, during the 1980s and the early 1990s there was an expectation that health services would manage complaints locally as much as possible.⁴⁰ Until 1995, NSW Health policy did not require health services to report complaints or incidents involving medical practitioners that may give rise to unsatisfactory professional conduct or professional misconduct to an appropriate body, such as the Board or the Commission.⁴¹

Hornsby Hospital

On 20 December 1985 Reeves was appointed to the position of Visiting Medical Officer [VMO] in obstetrics and gynaecology at Hornsby Ku-ring-gai Hospital [Hornsby Hospital] on 20 December 1985. The first complaint about his behaviour and clinical practice was made in June 1986. In the following 15 years approximately 35 complaints were made about him relating to around 20 separate incidents. The complaints were made by nursing staff, medical staff and patients, and related to various matters, including:

- bullying, aggressive and inappropriate behaviour to staff and patients;
- inappropriately humiliating and condescending behaviour towards junior medical staff and nursing staff in front of patients, including making allegations of incompetence;
- failing to adequately communicate with staff about treatment and transfer plans for patients; and
- failing to offer patients adequate anaesthetic or analgesia during procedures.

Despite the many complaints, Reeves was re-appointed 'some time in or around December 1988'; he would seem to have been further reappointed to his position in or around

³⁹ See *Decision of the Medical Tribunal of NSW*, 23 July 2004, p 6.

⁴⁰ The first NSW Health policy setting out specific requirements in relation to the investigation of complaints was introduced in the February 1998 *Better Practice Guidelines for Frontline Complaints Handling*.

⁴¹ This issue was addressed in October 1995 by the *Provision of Statutory Declarations to the Health Care Complaints Commission*, Circular No.95/84, which provided that health system managers should make a referral to the Commission in certain specified circumstances, including where the matter provides grounds for disciplinary action against a health practitioner. In August 2005 the *Health Services Act 1997* was amended to require chief executives of health services to report to the Board suspected unsatisfactory professional conduct or professional misconduct by medical practitioners.

The Reeves Complaint Process

December 1991 for a further five-year term.⁴² Finally, on 7 July 1995, the Hornsby Hospital warned Reeves that a repetition of certain behaviour would result in a 'formal review', with the potential for the termination of his appointment as a VMO. At this time Hornsby Hospital management considered referring Reeves to the Health Care Committee of the Board, for assessment by the Impaired Physicians Program, but decided against this course of action.⁴³

Later that year, as the result of a serious incident following the delivery of a non-viable foetus, the Hornsby Hospital convened a Medical Appointments and Credentials Advisory Committee [MACAC] to investigate various incidents involving Reeves. Following their investigation, on 19 March 1996 the MACAC made the following findings:

- there was no evidence Reeves had demonstrated clinical incompetence;
- on a number of occasions, Reeves demonstrated a lack of professional conduct; and
- Reeves' behaviour was unacceptable, and action needed to be taken to ensure it did not continue. It was noted there may be contributing personal/health issues.

The MACAC referred its findings to the Board, along with all documentation relating to the incidents, and resolved to reconvene again in six months to consider progress of the matter. Ms O'Connor notes that at this time the matter ought to have been referred to the Commission, but considered that the referral to the Board complied in substance with the applicable policy.⁴⁴

On 20 August 1996, the MACAC reconvened, and considered a letter from the Board advising that the Board had decided not to refer Reeves to an Impaired Registrants Panel, and recommending that the matter be dealt with by the Hospital. According to the Board, Reeves was managing his health related issues and had reduced his working commitments.⁴⁵ As there had been no further major incidents involving Reeves since making its findings, the MACAC therefore resolved to issue him with a formal warning.

On 20 August 1996, the Board wrote to the MACAC again stating that a further matter had been brought to the Board's attention, raising 'serious concerns' about Reeves' standard of clinical practice. The Board advised it was reviewing this matter to determine whether any further action was necessary, and requested any further information that may assist it in its

⁴² Ms O'Connor noted that:

Whilst there were no NSW Health policies relating to the reappointment of visiting medical officers at the time he was reappointed by [Hornsby Hospital] in 1988 and again 1991, I would have expected that good local practice, even in the absence of any such policy, would have involved properly documenting his reappointment, including making reference to his performance and behaviour issues at the time.

D O'Connor, *Review of the appointment, management and termination of Dr Graeme Reeves as a visiting medical officer in the NSW public health system*, 2 May 2008, p 4.

⁴³ D O'Connor, *Review of the appointment, management and termination of Dr Graeme Reeves as a visiting medical officer in the NSW public health system*, 2 May 2008, p 5.

⁴⁴ *Provision of Statutory Declarations to the Health Care Complaints Commission*, Circular No.95/84.

⁴⁵ However, Ms O'Connor notes that at this time the Hospital did not appear to have been informed that on 6 August 1996 the Board had referred to the Commission three patient complaints about Reeves, two of which had emanated from Hornsby Hospital itself, D O'Connor, *Review of the appointment, management and termination of Dr Graeme Reeves as a visiting medical officer in the NSW public health system*, 2 May 2008, p 6.

deliberations. Hornsby Hospital provided the Board with the requested information in response to this letter.

On 11 June 1997, a Professional Standards Committee of the Board reprimanded Reeves for his unsatisfactory personal conduct, and ordered that he cease the clinical practice of obstetrics and make immediate arrangements to cease delivering parturients and to transfer their care to other colleagues over the following four months.⁴⁶ On 30 June 1997 the Board wrote to Hornsby Hospital advising it of the decision. The PSC Decision is dealt with in detail in Chapter Five.

On 14 December 2000, following a memo advising that midwifery staff would be withdrawn from the gynaecology clinic attended by Reeves until the medical administration could guarantee a safe working environment and safe place for patients, Reeves was formally advised that he was not to attend the clinic or care for patients in the hospital pending an investigation. On 9 February 2001 Hornsby Hospital informed Reeves that his temporary conditional appointment with limited privileges at the hospital had expired; he had no current appointment or privileges; and there had been clear breaches of the conditions of his temporary appointment with limited privileges.⁴⁷

After his appointment at Hornsby Hospital expired, Reeves worked as a general practitioner in a medical centre.⁴⁸

Southern Area Health Service

On 17 September 2001 the Southern Area Health Service advertised for a specialist obstetrician and gynaecologist at the Bega and Pambula Hospitals. Reeves applied, and submitted supporting documentation including a letter from the Board of 27 December 2001 as representing the conditions attaching to his medical registration. That letter referred only to his registration being subject to health related conditions and monitoring related conditions. There was no reference to the current conditions fixed by the PSC directing that he cease the clinical practice of obstetrics.⁴⁹

Reeves commenced his substantive appointment as a VMO at SAHS in late April 2002. By October 2002 nursing staff were expressing concerns about his behaviour, and on 31 October 2002, a lengthy briefing note was prepared at Pambula Hospital outlining staff concerns about a 'progressive breakdown in communication and increasing tension levels' between staff and Reeves.⁵⁰

⁴⁶ Decision of the Professional Standards Committee, 11 June 1997, p 41.

⁴⁷ Decision of the Medical Tribunal of NSW, 23 July 2004, p 9.

⁴⁸ Decision of the Medical Tribunal of NSW, 23 July 2004, p 9.

⁴⁹ Ms O'Connor concluded that the information provided by Reeves indicating that he had been the subject of action by the Board, and had conditions imposed on his registration, should have led SAHS to make direct enquiries of the Board. Further, such enquiries should also have been prompted by the fact that during referee checks carried out on Reeves a clinician raised an issue about Reeves' practice rights in obstetrics. It is also relevant to note, however, that the failure to make enquiries of the Medical Board occurred in a context in which, as was ultimately recognised by the Medical Tribunal in 2004, Dr Reeves deliberately set out to deceive SAHS as to the conditions that had been placed on his registration as a result of the PSC decision in June 1997.

⁵⁰ D O'Connor, *Review of the appointment, management and termination of Dr Graeme Reeves as a visiting medical officer in the NSW public health system*, 2 May 2008, p 153

In November 2002 the SAHS became aware of the 1997 PSC Order prohibiting Reeves from carrying out obstetrics. The SAHS Director of Medical Services immediately raised the matter with Reeves, who asserted that his practices were not contrary to the conditions set, and that he was appealing to the Medical Tribunal for removal of the conditions. On the basis of this explanation, SAHS accepted Reeves' undertaking not to practise obstetrics.

In early January 2003 two incidents were reported to the SAHS to the effect that Reeves had been providing obstetric services, and on 10 January 2003 the Board advised the SAHS that Reeves had not made any application to the Tribunal for review of his conditions. On 26 February 2003, Reeves advised the SAHS of the outcome of the s 66 Inquiry held by the Board on 18 February 2003, which re-imposed the conditions preventing him from practising obstetrics. On 3 March 2003, the Board also provided SAHS with a full copy of the decision of the s 66 Inquiry.⁵¹

Finally, on 7 April 2003, SAHS wrote to Reeves informing him that the SAHS Board had resolved to terminate his contract and appointment as a VMO. The letter provided him with three months' notice of termination, advising that his contract would cease on 11 July 2003. It would seem that Reeves continued to provide gynaecological services up to the date of termination of his contract.⁵²

The Reeves allegations in the public arena

On 26 September 2007, in a Private Member's Statement, Andrew Constance MP, Member for Bega, first raised in the Parliament the issue of Reeves' appointment and the complaints made about his practice of obstetrics in the Bega district.⁵³ He stated that a constituent of his – later identified as Carolyn Dewaegeneire – went to Reeves in 2002 to have a pre-cancerous 20-millimetre skin abnormality excised from her labia minora. However, when she regained consciousness after the surgery, she found that an area 95 millimetres by 55 millimetres by 34 millimetres had been cut from her genital region. As a result Mrs Dewaegeneire said she was 'shattered and to this day feels mutilated'. On reviewing her case, a gynaecological oncologist said that the surgery in question had been:

out of favour for 30 years due to the significant level of deformity that it causes and the large amount of normal skin removed.⁵⁴

Mr Constance called on the Minister for Health, Hon Reba Meagher MP, to conduct an investigation into the employment of Reeves by the SAHS, and a review of similar processes across the Department of Health.⁵⁵

By February 2008, a number of other former patients of Reeves had come forward with claims of mistreatment by Reeves, now dubbed the 'Butcher of Bega' by the media. On 26 February 2008 a telephone counselling and support service had been established by the

⁵¹ Reeves commenced an appeal against the decision to terminate him, pursuant to the *Health Services Act* 1997. However, he ultimately did not proceed with the appeal.

⁵² D O'Connor, *Review of the appointment, management and termination of Dr Graeme Reeves as a visiting medical officer in the NSW public health system*, 2 May 2008, p 15.

⁵³ Private Members Statement, Legislative Assembly *Hansard*, 27 September 2007.

⁵⁴ Private Members Statement, Legislative Assembly *Hansard*, 26 September 2007. In August 2007 Mrs Dewaegeneire had received significant damages against Reeves in a civil action in the NSW District Court.

⁵⁵ Private Members Statement, Legislative Assembly *Hansard*, 26 September 2007.

Department of Health to enable former patients of Reeves to access support.⁵⁶ On that same date, the Minister announced that she would be introducing legislation to amend the *Medical Practice Act 1992*, in part to deal with the allegations of systems failures relating to Reeves. The Bill was eventually introduced into Parliament on 7 May 2008, passed the Legislative Assembly on 16 May 2008, and the Legislative Council on 4 June 2008. It received the Royal Assent on 11 June 2008. The Reeves matter was also the subject of an Order for Production of Documents in the Legislative Council in April 2008.⁵⁷

As noted in Chapter One, on 27 February 2008 the NSW Police Force established Strike Force Tarella, and on 7 March 2008 the Minister for Health referred the handling of Reeves' appointment to the SAHS to the Garling Special Commission of Inquiry.

During this period the allegations against Reeves were frequently the subject of media coverage. There were some 13 articles in the Sydney print media in the last week of February alone, with titles such as 'Strike force probes "mutilation" doctor' and 'Tales of butchery at hands of illegal doctor'.⁵⁸ Criticism of the perceived limited effectiveness of the relevant investigative authorities during this period was strident:

This culture of cover-up must stop. And there must be far more robust mechanisms to protect patients.

Both the NSW Medical Board and the Health Care Complaints Commission (HCCC) have proved - by this case alone - their utter uselessness.⁵⁹

⁵⁶ By 4 March 2008 the helpline had received 17 calls with regard to Reeves: Hon Reba Meagher MP, Ministerial Statement, Legislative Assembly *Hansard*, 4 March 2008. The Minister also noted that the Health Care Complaints Commission had received 11 formal complaints and 47 telephone calls relating to Reeves since 26 February 2008.

⁵⁷ See Hon Don Harwin MLC, Legislative Council *Hansard*, 9 April 2008.

⁵⁸ *Sydney Morning Herald*, 27 February and 29 February 2008 respectively. Based on such reports, the Committee suggested to the Commission that, since 26 February 2008, it had referred 11 cases to the Office of the Director of Public Prosecutions: see 'Butcher of Bega's "death toll" mounts', *Daily Telegraph*, 5 March 2008. The Commission replied that these were inaccurate, and noted that two complaints were referred to the DPP in 2006/07, 22 in 2005/06 and one in 2004/05. See Commission's 2006-07 *Annual Report*, Table 18.33, p 150. The bulk of referrals - 16 - concerned an unregistered health service provider where the investigation concluded that he was fraudulently providing purported cures to patients with incurable diseases for substantial sums of money. The Commission also noted that cases concerning medical practitioners generally relate to sexual offences and drug offences.

⁵⁹ 'Sick medical fraternity silence', *Daily Telegraph*, 27 February 2008.

The Reeves Complaint Process

As the disturbing material relating to Reeves came to their attention, Members of the Committee became increasingly concerned to establish what role the Commission had played in handling these serious complaints. It was with this in mind that the Committee resolved to write to the Commission, expressing the Committee's extreme concern at its apparent failure to act effectively on repeated complaints about Reeves, and ultimately to report to Parliament under s 65(b) of the *Health Care Complaints Act*.

Chapter Four - The Health Care Complaints Commission

Background

As was noted in Chapter One, the Committee resolved to use its correspondence with the Commission as the basis for its Report to Parliament. Accordingly, the information in this Chapter is largely sourced from that correspondence, attached as Appendix 2.

On 29 February 2008, the Commission announced that it would be conducting a full audit of its files concerning Reeves. By 28 March 2008 the Commission had completed this audit. As at that date, the Commission had received 91 inquiries, 34 written complaints and two requests for review of past complaints concerning Reeves. The audit was conducted by officers of the Commission's legal division, and involved a thorough review of the conduct of each file and an assessment of whether or not the complaint raised issues of possible criminal conduct. The Commission advised the Committee that the audit did not identify any breaches of the *Health Care Complaints Act* by the Commission in its handling of the complaints.

The Commissioner frankly admitted that he did not consider the length of time taken by the Commission to investigate and prosecute the complaints against Reeves was appropriate. He noted that the Commission did not publish any performance data on the time taken to investigate complaints until its *Annual Report* of 1995-96: that Report notes that the 'average time taken to investigate complaints finalised in 1995-96 was 718 days.' However, the Committee acknowledges that the Commission's timeframes for dealing with complaints have improved significantly since that time.⁶⁰

The Committee asked the Commissioner whether he was confident that, if matters such as those involving Reeves were to come before the Commission now, the Commission's response would be timely and effective. He noted that the Commission's assessment brief, prepared on each complaint received, now includes a print out of all prior complaints against the health practitioner(s) involved, together with the outcome of each matter. These prior complaints are considered when the Commission makes an assessment decision on how any individual complaint should be handled. Where there is a history of complaints, this informs both the level of Commission action and the degree of urgency given to the management of the complaint. Based on this, the Commissioner was confident that the response by the Commission now would be timely and effective.

The Reeves Complaints

Between 1990 and 1996 there were fourteen patients whose treatment by Reeves was the subject of complaint to the Health Care Complaints Commission. Nine of these formed the basis for the Commission's eventual prosecution of Reeves before a Professional Standards Committee [PSC] of the Medical Board. The cases brought before the PSC concerned Reeves' conduct relating to the practice of obstetrics. The PSC decided on 21 July 1997 to impose various conditions on Reeves, including that he not practise obstetrics.

⁶⁰ Health Care Complaints Commission, *Annual Report* 1996-97, p 27. The average current time frame for completing an investigation is 318 days: *Annual Report* 2006-07, p 7.

The Commission has advised the Committee that the earliest of the complaints that formed the basis for the prosecution before the PSC was received in February 1992. There was one further complaint in 1992; two in 1994; one in 1995; and three in 1996, one of which was from the Board itself and concerned two patients. However, the Commission noted that the ultimate decision of the PSC shows that the Commission's recommendations regarding the conditions that should have been imposed on Reeves were not accepted by the PSC.

In 1997, the Commission received a further three complaints about Reeves and investigated all of them, obtaining expert opinions on Reeves' conduct. In two cases, the experts found no grounds for criticism of Reeves' treatment of the patient. In the third, which concerned care provided in 1995-96 relating to childbirth, the expert was mildly to moderately critical of the care provided.

Despite this, in view of the conditions which had recently been imposed on Reeves' practice by the PSC, the Commission, after consultation with the Board, decided no further action was required.

In 2000 the Commission received two complaints concerning Reeves' rudeness and general poor communication. There were no significant clinical issues involved. The Commission referred the second complaint to the Board, which was considering referring Reeves to its Performance Assessment Program. In 2001 the Commission received one complaint about verbal abuse by Reeves, which the Commission also referred to the Board.

In November 2002, the Commission received a complaint about an inappropriate internal examination and breast examination by Reeves in his private practice at Pambula. The Commission referred this complaint to the Board, which advised during the required consultation about the complaint, that Reeves had been in the Board's Performance Assessment Program since the PSC decision in 1997. On this basis, the Commission agreed with the Board to refer the complaint to the Board. The Commission had no further statutory role in the matter, but its practice at the time was to appoint a Commission Officer to maintain contact with the complainant and keep them advised of progress. The Commission notes that its file shows regular contact by the Officer with the complainant and the Board.

The Committee considers that this is an egregiously unacceptable delay, especially given that the Commission has considerable experience in dealing with complaints of sexual misconduct - 38 cases in 2006-07 alone.⁶¹ However, the Commission insists that the delay with respect to this complaint was not caused by its processes. Moreover, the Commission no longer allocates Officers to maintain contact when complaints are referred to the Board, taking the view that it is the Board's responsibility to keep complainants informed as to the progress and outcome of their complaint.

Death in surgery

In 2003 the Commission received a complaint about a death in surgery in 1999. The surrounding circumstances were that a Registrar, with Reeves as consultant, had performed the surgery. The Commission obtained a report on the matter from the relevant Area Health Service [AHS], which was reviewed by a Commission Medical Adviser, who formed the view

⁶¹ See Health Care Complaints Commission, *2006-07 Annual Report*, p 16.

that the complaint had been adequately addressed by the AHS. The Commission decided that there were 'no grounds for investigation', and the matter was finalised after a meeting between the complainant and a Commission Resolution Officer.

However, as the Commission was made aware - as early as November 2002 - that Reeves had been in the Board's Performance Assessment Program since 1997, the Committee asked whether it was considered that Reeves' role as a supervising consultant during surgery carried such a significant onus of responsibility, that - together with his complaint history - both the Commission and the Board ought to have realised at that time that there were serious grounds for concern.

The Commission noted in response that it had also referred the complaint to the Board, which conducts the Performance Assessment Program, and that the Board does not advise the Commission of what action it takes through performance assessment, unless it deems that a practitioner's performance may warrant disciplinary action. If the Board, as a result of its performance assessment, makes a complaint to the Commission about the practitioner, then the Commission will investigate that complaint under the Act. However, the Board did not refer the complaint in question about Reeves back to the Commission.

De-registration

In 2004 the Commission received a complaint about gall bladder surgery undertaken by Reeves in 2002. The Commission decided to take no further action on this complaint because Reeves had been de-registered earlier that year.⁶² The Commission noted that, although it may investigate and prosecute any complaint against a practitioner who was practising at the time the conduct the subject of complaint occurred, the Act does not specifically address the situation where the practitioner has subsequently been de-registered and is de-registered at the time of the complaint.

The Commission noted that communication with an Area Health Service about practitioners who are de-registered, or who have conditions put on their practice, is the responsibility of the Board. An AHS does not communicate routinely with the Commission regarding suspended or de-registered practitioners. However, in response to the Committee's question, the Commission stated that it had no knowledge of any failures by the Board to carry out its statutory reporting obligations. The Commission also noted that it is the responsibility of the Board to ensure that a practitioner has insurance when considering applications for registration.⁶³

Referrals to the DPP

The Committee asked the Commissioner under what circumstances the Commission refers matters to the Office of the Director of Public Prosecutions, and whether the Commission intended to review this, in light of the serious failures relating to Reeves. The Commission responded that s 39(f) of the Act empowers the Commission to refer a complaint to the DPP at the end of an investigation; this occurs where the investigation discloses evidence that may amount to a criminal offence.

⁶² The Committee discusses the de-registration decision in detail in Chapter 5 of the Report.

⁶³ This practice has been considerably strengthened by the provisions of the *Medical Practice Amendment Act 2008*.

The Commission also noted that it is co-operating with Strike Force Tarella, and had reviewed all past complaints against Reeves as part of that process. The majority of complaints made against Reeves since the media publicity require further information to be obtained, either from the complainants themselves or from health service providers, including medical records from hospitals. As at early April 2008, the Commission had not referred any case regarding Reeves to the DPP, but is referring any matters potentially involving criminal conduct to the Strike Force where it has obtained the consent of the complainant to do so.

Changes proposed by the Commission

The Commission also advised the Committee that it has sought amendment of s 39 of the Act to allow it to hold the results of an investigation for the purpose of any potential application for re-registration by the practitioner concerned. The Commission has also sought amendment to the legislation to vest the power to oppose re-registration applications in the Commission, rather than the Board, where it currently resides. Amendments have also been sought to streamline the procedures for dealing with applications to re-register.

The Commission made extensive recommendations for legislative change to the Inquiry undertaken by Ms Deirdre O'Connor. In broad terms, the Commission's recommendations go to increasing its powers to assess and investigate complaints, the conduct of disciplinary proceedings, and increasing the transparency and accountability of the procedures and decisions of PSCs. The Commission has also recommended that the Act be amended to allow it to disseminate information and evidence to law enforcement authorities at any time. This would allow early referral to the NSW Police, who could then conduct a criminal investigation where appropriate.

Conclusion

The entire circumstances surrounding the handling of the Reeves complaints has been described as:

a tragedy that highlights the lacklustre authority of the Health Care Complaints Commission.⁶⁴

The Committee certainly concurs with the view of the Commissioner that the Commission's response to the numerous complaints against Reeves was not appropriate. Sadly, the Committee notes that systemic failures such as those involving Reeves were endemic at the Commission in the 1990's and eventually led, in part, to the Walker Inquiry into Camden and Campbelltown Hospitals in 2004, and the removal of the then-Commissioner. Whilst the Committee does not intend that to acknowledge this state of affairs is to exonerate the Commission as an organisation, it is nonetheless an unfortunate truth.

An inability to look at the bigger picture, communication failures, staff turnover, tardiness and a general lack of professionalism characterised the Commission during the period when complaints against Reeves ought to have created the realisation that this was a practitioner with the potential to cause serious harm to his patients. The Committee also considers that the cumbersome nature of the health care complaints system inhibited a free flow of information between Commission and Board which might otherwise have caused the relevant decision-makers to realise that Reeves ought to have been subject to closer

⁶⁴ Andrew Constance MP, Private Members Statement, Legislative Assembly *Hansard*, 5 March 2008.

scrutiny and supervision. In the following Chapter, the Committee will examine the actions of the Commission when it finally had the opportunity to bring Reeves under the requisite scrutiny process.

Chapter Five - Proceedings Against Reeves

Background

In the course of the litany of complaints brought against Reeves to both the Commission and the Board, Reeves was the subject of:

- a hearing before a Professional Standards Committee [PSC] of the NSW Medical Board, which led to conditions being placed on his practice;
- a s 66 Inquiry of the Board which confirmed the conditions; and
- a hearing before the Medical Tribunal of NSW which ordered his de-registration.

As the Committee has copies of the 1997 Statement of Decision of the PSC, and the 2004 decision of the Medical Tribunal,⁶⁵ this Chapter will examine those proceedings with particular reference to the role of the Commission as complainant.

The 1997 Professional Standards Committee Hearing

The complaint before the Professional Standards Committee of the Medical Board was that Reeves, being a medical practitioner registered under the *Medical Practice Act*, had been guilty of unsatisfactory professional conduct. There were eight separate 'particulars', which dated from June 1990 to September 1996; the Commission produced three volumes of evidence against Reeves.

At the time of the hearing Reeves had been suspended from Baulkham Hills Private Hospital, but continued to operate at Hornsby and the Sydney Adventist Hospital. In addition, his performance was being reviewed by the Medical Advisory Committee at Hornsby Hospital on a six monthly basis.⁶⁶

Experience of clinical staff

In the course of evidence, in response to questions as to how she had found Reeves in respect of a patient who had suffered hypovolaemic shock⁶⁷ and 'dramatic' blood loss, one doctor observed that Reeves was 'no different to usual', referring to her experience that he:

at times spoke to staff with a sharp and raised voice and was generally intimidating of (*sic*) staff.⁶⁸

In respect of the same incident, a Sister with 10 years' nursing experience stated that she was 'severely distressed', and that the experience 'severely shook her confidence in her

⁶⁵ See NSW Medical Board website, www.nswmb.org.au/system/files/f10/f18/o204//Reeves.pdf

⁶⁶ Decision of the PSC, p 31.

⁶⁷ Hypovolaemic shock is a clinical state in which tissue perfusion is inadequate due to a loss of blood or plasma. A reduction in blood volume causes a fall in systolic blood pressure, which triggers a sympathetic catecholamine response. Blood flow to the peripheries is reduced. Anaerobic metabolism with lactate production occurs in tissues that are inadequately perfused and this can go on to impair the function of vital organs such as the brain, heart, and kidneys: *Student BMJ*, <http://student.bmj.com/issues/05/04/education/139.php>

⁶⁸ Decision of the PSC, p 12.

capacity to work with doctors in the obstetric situation'.⁶⁹ Following another incident, midwives were told to work in pairs and not alone with Reeves.⁷⁰

Reeves himself admitted that his failure to investigate a patient after 48 hours of high temperatures may have resulted partly from his 'problems of communication with the nursing staff'.⁷¹

Therefore, it could not be said that Reeves' inappropriate and distressing behaviour was not widely known among his fellow practitioners and clinical staff generally. Nonetheless, at the hearing, Reeves was able to produce seven references, six of which were by fellow obstetricians and gynaecologists.⁷²

The Commission as complainant

The Commission submitted that the evidence against Reeves substantively supported all particulars of the complaints, and asked the PSC to find Reeves guilty of unsatisfactory professional conduct within the meaning of s 36 of the MPA.

In consideration of the PSC's duty to protect the public, the Commission recommended that:

1. Reeves be reprimanded by the PSC;
2. Reeves' practice of medicine be subject to the following restrictions:
 - (a) no conduct of obstetrics work; and
 - (b) no conduct of gynaecological surgery or invasive procedures; and
3. Reeves be directed to participate in relevant educational programs as approved by the Board in order to improve the following aspects of his practice:
 - (a) his skills in clinical examination, history taking and clinical reviews of patients;
 - (b) his record-keeping skills;
 - (c) his communication skills; and
 - (d) his management of displays of aggression in patients and anxiety towards his patients and colleagues.⁷³

The Commission further recommended that Reeves provide evidence of participation in these programs to the Board within six months of the date of the PSC's findings, and that a copy of the PSC's orders be made available to the Hills Private Hospital, Hornsby and Kurring-gai Hospitals and the Sydney Adventist Hospital.⁷⁴

In response, Reeves submitted that an appropriate response to the complaints would be:

a framework to allow rehabilitation and recovery and at the same time allow a continuing overview of [his] obstetric and gynaecological practice... the HCCC recommendation that he be suspended from the practice of obstetrics and

⁶⁹ Decision of the PSC, p 13.

⁷⁰ Decision of the PSC, p 15.

⁷¹ Decision of the PSC p 30.

⁷² Decision of the PSC, p 34.

⁷³ Decision of the PSC, p 32.

⁷⁴ Decision of the PSC, p 32.

gynaecology indefinitely was draconian and constituted an attempted de facto de registration.⁷⁵

Cause of Reeves' behaviour

According to the psychiatric report submitted by Reeves through the Medical Defence Union,⁷⁶ he was suffering from a depressive illness. In contrast, the psychiatrist appointed by the Board considered that Reeves' problems stemmed from personality issues and relationship problems, and that it was these that formed the basis of his difficulties with patients.⁷⁷

Ultimately, the PSC concluded that Reeves was:

afflicted by serious and long-standing personality traits of hostility, resentment, rigidity, extreme sensitivity and defensiveness associated with symptoms of anxiety and depressive mood.⁷⁸

Moreover, the PSC had 'little faith that such disabling and enduring features or personality can be altered with psychotherapy or the use of an antidepressant pill', given that Reeves had 'demonstrated an utter incapacity to transmit empathy or concern to his patients in situations of their great need'.⁷⁹

Findings of the PSC

The PSC found most matters proven. The enormity of Reeves' conduct is evidenced by a sample of their comments, for example:

- 'a clear instance of Dr Reeves' scant attempt at or failure of communication with the patient';
- 'a gross deviation from acceptable standards of medical care'; and
- 'an example of extremely inadequate care and poor judgement'.⁸⁰

The PSC concluded that Reeves had demonstrated a long history of conducting himself in an intimidating manner towards nursing staff which 'seriously compromised effective communication of clinical incidents which were critical to his patients' good care and welfare'.⁸¹ The PSC determined that it could not be confident that:

even with the greatest level of colleague support imaginable, a repetition of such poor judgment will never recur under a situation of severe strain in an acute situation.⁸²

Accordingly, the PSC ordered as follows:

- (i) Reeves be reprimanded for his unsatisfactory personal conduct;

⁷⁵ Decision of the PSC, p 33.

⁷⁶ Now Avant Mutual Group Ltd (Avant).

⁷⁷ Decision of the PSC, p 9 and p 22.

⁷⁸ Decision of the PSC, p 40.

⁷⁹ Decision of the PSC, p 40.

⁸⁰ Decision of the PSC, p 36 and p 38.

⁸¹ Decision of the PSC, p 38.

⁸² Decision of the PSC, p 41.

Proceedings Against Reeves

- (ii) Reeves cease the clinical practice of obstetrics and make immediate arrangement to cease delivering parturients and to transfer their care to other colleagues over the next four months; and
- (iii) the Medical Tribunal be the appropriate body in the event of Reeves applying for a review of the PSC's orders or conditions.⁸³

It would appear that Reeves was allowed to continue to practise as a gynaecologist, on the condition that he commence a programme of clinical supervision and monitoring, including a review of his gynaecological practice by a fellow of the Royal Australian College of Obstetricians and Gynaecologists nominated by him.⁸⁴ Other conditions related to him continuing to undergo psychiatric treatment.⁸⁵

The Committee notes that, pursuant to s 87(1)(a) of the MPA, the Commission could have appealed the decision of the PSC to the Medical Tribunal. However, the Committee has been advised by the Commissioner that a search of the relevant files has revealed no documentary evidence to establish why this did not take place.⁸⁶ Moreover, the officers handling the matter in 1997 are no longer employed by the Commission. Accordingly, the Committee is unable to state with any certainty why no appeal was lodged from the decision of the PSC.

In the course of 1997, the Commission received another three complaints about Reeves, all of which it investigated and obtained expert opinions. In two cases, the experts found no grounds for criticism, and in the third, the expert was mildly to moderately critical. However, in view of the above conditions imposed by the PSC, the Commission, after consulting with the Board, decided to take no further action.⁸⁷ The Committee notes that this course of action highlights the importance of the system's ability to *enforce* the findings against Reeves – the simple fact that the findings existed on paper tended to inhibit any further investigation of how he was actually performing as a medical practitioner.

Also, the Committee notes that Hornsby Hospital never received a copy of the full decision of the PSC, only a copy of the Orders and conditions. Moreover, it appears that Hornsby Hospital sought guidance from the Board at this time, but the Board's response was effectively that it was a matter for Hornsby Hospital to determine having regard to its own legal advice. In her second report, Ms O'Connor concluded that it was likely that Hornsby Hospital's position would have been 'improved' if it had had access to a copy of the full decision of the PSC.⁸⁸

As noted in Chapter 3, Reeves continued to work at Hornsby Hospital until 2001, whereafter he worked as a general practitioner in a medical centre, until fatefully applying to work for the Southern Area Health Service in 2002.

⁸³ Decision, of the PSC p 41.

⁸⁴ In 1998 the Australian and New Zealand Colleges amalgamated to form the Royal Australian and New Zealand College of Obstetricians and Gynaecologists.

⁸⁵ See Decision of the PSC, p 42.

⁸⁶ Facsimile letter from Mr Kieran Pehm, Commissioner of the Health Care Complaints Commission to Mr Mel Keenan, Manager, Committee on the Health Care Complaints Commission, 24 June 2008.

⁸⁷ See <http://www.hccc.nsw.gov.au/downloads/MediaReleaseDrReeves05032008.pdf>

⁸⁸ D O'Connor, *Review of the appointment, management and termination of Dr Graeme Reeves as a visiting medical officer in the NSW public health system*, 2 May 2008, p 9.

The 2004 Medical Tribunal Hearing

Between 10 May 2002 and 20 December 2002, Reeves breached the 1997 PSC Order by attending a total of 36 obstetric patients at Pambula District Hospital and Bega District Hospital. Reeves also failed to inform the SAHS during the recruitment process leading to his appointment by SAHS in April 2002 - or indeed at all - of the PSC Order that he cease the clinical practice of obstetrics. Based on this information, the Board convened an inquiry under s 66 of the MPA to determine whether Reeves had breached the PSC orders. On 21 February 2003, that Inquiry found that Reeves had indeed breached the PSC Order, and imposed yet further conditions on his practice. He was reprimanded for his unsatisfactory professional conduct.⁸⁹

Finally, the Commission laid a complaint against Reeves in the Medical Tribunal, seeking a finding that he was guilty of unsatisfactory professional conduct and/or professional misconduct in relation to his dealings with each of the patients involved, and an order that he be de-registered.⁹⁰

Findings of the Tribunal

The Tribunal found that Reeves was prepared to take whatever steps he deemed expedient for him to resume practice as an obstetrician. Those steps included 'bare faced lies and calculated omissions to provide information which he knew would effect his application'.⁹¹ He had deliberately deceived the SAHS by:

- failing to disclose the restrictions on his right to practise, as imposed by the PSC; and
- actively representing that the only restrictions to which he was subject were health related.⁹²

The Tribunal concluded that had Reeves been frank with the SAHS, honest with his fellow practitioners, and made his patients aware of the true position, he would not have been able to practise obstetrics.⁹³ Moreover, even in the course of the hearing, the Tribunal did not find him credible:

...the Tribunal believes that he would deceive and defy if given the further opportunity. That he would proffer lies, half truths and misrepresentations to further his aim.⁹⁴

The Tribunal was fully aware of the nature of the previous complaints against Reeves, noting that the evidence before the PSC showed that Reeves' treatment had led to a

⁸⁹ Reeves appealed against the conditions imposed by the s 66 Inquiry, and applied for a review of the conditions on his registration. However, immediately before the hearing commenced, Reeves withdrew his appeal against the conditions imposed. It had been agreed by consent the Tribunal should order that leave be granted to Reeves to withdraw his appeal; and that he pay the Board's costs of the appeal. The Tribunal made those orders.

⁹⁰ The Tribunal consisted of Judge J C McGuire, Dr Kenneth Atkinson, Dr Marina Vamos and Dr Maureen Gleeson PhD.

⁹¹ *Decision of the Medical Tribunal of NSW*, 23 July 2004, p 25.

⁹² The standard of proof to be applied by the Tribunal is that it be 'comfortably satisfied on the balance of probabilities': *Rejtek v McElroy* (1965) 112 CLR 517 at 521; *Bannister v Walton* (1993) 30 NSWLR 699.

⁹³ *Decision of the Medical Tribunal of NSW*, 23 July 2004, p 26.

⁹⁴ *Decision of the Medical Tribunal of NSW*, 23 July 2004, p 27.

number of deaths and endangerment of life.⁹⁵ The Tribunal held that Reeves was a danger to the public, and ordered that:

- i) he be removed from the register of practitioners of NSW;
- ii) there be no review of his de-registration for three years; and
- iii) he pay the Commission's costs.⁹⁶

Conclusion

Much criticism has been levelled at the Commission for failing to act on complaints made against Reeves after his 2004 de-registration. However, the *Health Care Complaints Act* itself limited the Commission's options, by rendering the Commission unable to pursue complaints against Reeves made thereafter.⁹⁷ Moreover, the evidence from the 1997 PSC hearing shows clearly that the Commission did its utmost to stop Reeves from ever practising obstetrics and gynaecology in the future.

This evidence also leads the Committee to conclude that the PSC erred in not accepting the Commission's submission that Reeves cease conducting obstetrics, gynaecological surgery or invasive procedures. The Committee acknowledges that it makes this conclusion in the light of the serious allegations which have arisen some many years later. However, it is based on two important factors in the PSC decision itself.

The first is that Reeves' behaviour was the subject of complaints which had occurred over a period of some six years, and that this behaviour was widely known amongst doctors, nursing staff and administrators at a number of hospitals. It was clearly a pattern of erratic and dangerous behaviour, and was intimately linked to the second important factor, which is that the PSC did not accept that Reeves' problems were the result of a depressive illness, nor amenable to psychological treatment. Most damningly, the PSC found that it:

could not excuse such reprehensible conduct on the part of a medical practitioner on the basis that it was the result of an underlying depressive illness. If such behaviour is the result of such an illness then the risks of this illness would appear to imperil the safe and competent care of patients should it recur.⁹⁸

On this statement alone it is difficult for the Committee to understand why the PSC did not remove Reeves completely from practice at this stage. Whilst effectively de-registering him - as the Commission recommended - would have created considerable hardship for Reeves, it would seem that on balance, it was foreseeable that he would continue to pose a considerable risk to patients in his care.

However, the Committee notes that the 2004 Tribunal decision was based solely on Reeves' breaches of the PSC Orders, and did not turn on the manner in which he carried out the procedures in question:

There is no charge levelled at the practitioner that in rendering obstetrical services in breach of the PSC order that he demonstrated any lack of skill or lack of care in the

⁹⁵ Decision of the Medical Tribunal of NSW, 23 July 2004, p 7.

⁹⁶ Decision of the Medical Tribunal of NSW, 23 July 2004, pp 31 and 32.

⁹⁷ The Commission received a complaint about gall bladder surgery by Dr Reeves in 2002. The Commission decided to take no further action on this complaint because Dr Reeves had been de-registered: HCCC website.

⁹⁸ Decision of the PSC, p 37.

practice of medicine. There was no suggestion that any of his patients were disadvantaged by his attentions and there was certainly no evidence of any adverse outcomes related to lack of skill or lack of competence...Clearly he was well regarded by practitioners in the Bega Valley who appreciated the assistance he had given them and their patients. It is to his credit that he earned their respect.⁹⁹

This seems surprising in the light of matters such as the District Court award of \$164,000 compensation to Carolyn Dewaegeneire, after Reeves was found to have 'grossly mutilated' her genitals at Pambula Hospital in August 2002.¹⁰⁰ However, it has recently been suggested that Reeves' illicit practice of obstetrics helped to make Pambula Hospital viable:

... nursing staff down there were uncomfortable and there was pressure put on them to keep quiet because they didn't want to lose him. He kept their [Pambula's] operating facilities open, basically, doing a list a week, which gave them enough to keep it going.¹⁰¹

Accordingly, while the Committee has no intention of impugning the *bona fides* of any health care professionals in the Bega district who worked with Reeves, it may be that workforce pressures in a small hospital meant that staff were more prepared to tolerate what was seen by them as 'erratic' behaviour on his part than would be the case in a large metropolitan hospital. Nonetheless, even if this were the case, the Committee notes that, had Reeves not lied his way into employment with the SAHS, staff would not have been put in this untenable position.

⁹⁹ *Decision of the Medical Tribunal of NSW*, 23 July 2004, pp 22 and 23.

¹⁰⁰ See, e.g., 'Rogue doctor facing lawsuits', *Sydney Morning Herald*, 3 March 2008.

¹⁰¹ Bega GP Dr Duncan MacKinnon, quoted in 'Collateral Damage', *Australian Doctor*, 26 March 2008 <http://www.australiandoctor.com.au/news/97/0c054e97.asp>

Chapter Six - The Medical Practice Amendment Act 2008

As noted in Chapter One, in September 2006 Deirdre O'Connor was engaged by the then Minister for Health to conduct a review of the powers of the NSW Medical Board under s 66 of the MPA. One of the principal ways in which the Board protects the health of members of the public is by suspending a practitioner or placing restrictions on that practitioner's practice, pursuant to s 66. However, although it was noted in Chapter 2 that Reeves was subject to a s 66 Inquiry of the Board in February 2003, the wording of s 66 at that time permitted the Board to take only such action as was necessary to 'protect the life or health of a person'.

The Committee notes that the Minister made specific reference to this issue in the Agreement in Principle Speech of the *Medical Practice Amendment Bill 2008*, when she stressed that actions under s 66 must henceforth be guided by the statutory purpose of the protection of the public or the public interest:

If this broader test had been applicable at the time of the section 66 inquiry in the Reeves matter, combined with the clarification that the paramount consideration is the protection of the public, there may well have been a different conclusion as to the appropriate action to take in order to protect the public.¹⁰²

Having regard to the context in which Ms O'Connor made her recommendations - namely, whether Reeves' complaints and disciplinary history indicated any areas where the MPA and the *Health Care Complaints Act* could be improved – the Committee considered that any forward-looking examination of the events surrounding the Commission's handling of the complaints against Reeves should examine in detail changes which are aimed at avoiding their recurrence.

Overview

The *Medical Practice Amendment Act 2008* [MPAA]'s amendments cover four main areas, namely:

- the Board's powers to take urgent action to protect the public under s 66 of the MPA;
- the ability of authorities in dealing with a complaint to have regard to the full picture of any previous complaints and previous adverse findings against that practitioner;
- accountability and transparency of disciplinary processes in respect of practitioners; and
- mandatory reporting requirements on the medical profession, requiring a practitioner to report to the Board a fellow practitioner whom he or she believes:
 - has engaged in sexual misconduct;
 - is intoxicated by drugs or alcohol at work; or

¹⁰² Hon R P Meagher MP, Agreement in Principle Speech, Legislative Assembly *Hansard*, 7 May 2008. The *Medical Practice Amendment Bill 2008* received the Royal Assent on 11 June 2008.

- has flagrantly departed from accepted standards of practice.

Section 66 of the Medical Practice Act 1992

According to the Minister for Health, the changes to the Board's powers under s 66 of the MPA will improve its capacity to take steps to protect the health and safety of the public.¹⁰³ The Board's s 66 powers and the avenues of appeal or review in respect thereof are amended in five main ways:

- actions taken under s 66 must be guided by what is needed to *protect the public interest*. Thus, the Board should look to the outcome that best addresses the statutory purpose of the protection of the public, or is otherwise in the public interest;¹⁰⁴
- although it is the role of the Commission rather than the Board to investigate complaints, the Board will have a new statutory power to require any person to provide it with information, documents or evidence for the purpose of exercising its s 66 powers;¹⁰⁵
- the Board will be required to include at least one non-medical practitioner on s 66 inquiries if the Board delegates the inquiry to other persons;¹⁰⁶
- PSCs and the Tribunal may designate certain orders as *critical compliance orders or conditions*, which, if breached, will lead to automatic suspension and de-registration;¹⁰⁷
- the MPAA creates a new avenue of appeal on points of law to the Chair or a Deputy Chair of the Tribunal - practitioners must exhaust this avenue of appeal before they can seek judicial review by the Supreme Court.¹⁰⁸

Finally, the MPAA proposes introducing a number of other more minor changes to s 66 powers and processes, including:

- permitting the Board, following a s 66 inquiry, to order a practitioner to take part in performance assessment under Part 5A of the MPA, but only if the Commission concurs;¹⁰⁹
- requiring the Board to make an audio recording of s 66 inquiries and allowing the Board to provide the Commission with any information or documents obtained by the Board for the purpose of a s 66 inquiry, including the audio recording;¹¹⁰

¹⁰³ In the case of Dr Sood, the Board took action and exercised its s 66 powers to suspend Sood, but the NSW Supreme Court subsequently stayed the Board's decision on technical grounds. Sood was allowed to continue practising until the Medical Tribunal eventually de-registered her some years later.

¹⁰⁴ Section 66(1) of the *Medical Practice Act 1992*.

¹⁰⁵ Section 69B of the *Medical Practice Act 1992*. The proposed provision includes a maximum penalty of 20 penalty units (currently \$2,200) for failure to comply with a request by the Board without a reasonable excuse.

¹⁰⁶ Section 66(6) of the *Medical Practice Act 1992*.

¹⁰⁷ Section 61(3) of the *Medical Practice Act 1992*. On this point the Minister noted that in Reeves' case it was clear the conditions imposed by the PSC in 1997 that he not practice obstetrics arose because of serious concerns held about deficiencies and failings in his practice as an obstetrician: Hon R P Meagher MP, Agreement in Principle Speech, Legislative Assembly *Hansard*, 7 May 2008.

¹⁰⁸ Section 95A of the *Medical Practice Act 1992*.

¹⁰⁹ Section 66BA of the *Medical Practice Act 1992*.

¹¹⁰ Section 66AA of the *Medical Practice Act 1992*.

- providing the Board with the power to give notice of action taken under s 66 to any agency or person whom the Board considers appropriate;¹¹¹
- requiring complaints arising from action taken by the Board under s 66 of the MPA to be listed for final hearing by the Tribunal or a PSC as soon as practicable;¹¹² and
- clarifying when the Chair or a Deputy Chair of the Tribunal can extend a period of suspension of a medical practitioner following a s 66 Inquiry.¹¹³

Patterns of behaviour

The second area of amendments relates to the way in which the system deals with practitioners who have multiple complaints or previous adverse findings made against them. When dealing with a complaint or exercising its public protection functions the Board must - to the extent relevant - now have regard to the following matters about a practitioner:

- any other complaint against the practitioner;
- any previous finding or determination of a Professional Standards Committee or Tribunal constituted under a health registration Act; and
- the outcome of any performance assessment in relation to the practitioner.¹¹⁴

Where - as in the case of Reeves - complaints are received *after* a medical practitioner has been struck off the register, such complaints must be considered if the practitioner applies for a review of their de-registration.¹¹⁵ Where multiple complaints in relation to the same practitioner are prosecuted concurrently before the Tribunal or a PSC, that body may have regard to the cumulative effect of all the material relating to all complaints when it makes factual findings and determines whether the conduct should be characterised as unsatisfactory professional conduct or professional misconduct.¹¹⁶

The MPAA allows the Tribunal and PSCs to take into account previous decisions and findings by a disciplinary body in relation to the same practitioner. Where the Tribunal or PSC is of the opinion that the judgement or finding is capable of establishing that a practitioner has engaged in conduct that is sufficiently similar to the conduct alleged against the practitioner in the proceedings, it may rely on that judgement or finding to:

- make a finding that the practitioner is guilty of unsatisfactory professional conduct or professional misconduct; or
- exercise any of its powers of sanction under the MPA.¹¹⁷

The MPAA also amends the definition of 'professional misconduct' in s 37 of the MPA, to clarify that a practitioner may be found to have engaged in professional misconduct based on a series or pattern of apparently less serious instances of conduct.¹¹⁸

¹¹¹ Section 191B(1A) of the *Medical Practice Act 1992*.

¹¹² Clause 10(2), Sch 2 to the *Medical Practice Act 1992*.

¹¹³ Section 67 of the *Medical Practice Act 1992*.

¹¹⁴ Section 140A of the *Medical Practice Act 1992*.

¹¹⁵ Section 94A(b) of the *Medical Practice Act 1992*.

¹¹⁶ Clause 5(2), Sch 2 to the *Medical Practice Act 1992*.

¹¹⁷ Clause 4 Sch 2 to the *Medical Practice Act 1992*.

¹¹⁸ Section 37(b) of the *Medical Practice Act 1992*.

The MPAA also amends the *Health Care Complaints Act 1993*, mirroring amendments to the MPA, to ensure that the Commission must have regard to previous complaints, including discontinued or terminated complaints or further complaints against a practitioner, if the Commission considers them relevant to the complaint.¹¹⁹ The Director of Proceedings of the Commission must also consider prosecuting multiple complaints against the same practitioner at the same time.¹²⁰

Accountability and Transparency

At present under the MPA, PSC hearings are held in private unless the PSC directs otherwise, and there is generally restricted access to PSC decisions. The MPAA makes PSC proceedings open to the public, unless the PSC directs otherwise.¹²¹ The MPAA also requires that PSC decisions are to be made publicly available, unless the PSC directs otherwise. This replicates current practice of the Medical Tribunal.¹²²

PSCs currently are comprised of two medical practitioners and one layperson: because the decisions of a PSC require a minimum of two votes, the medical members can effectively overrule the lay member. Thus, the MPAA adds to PSCs a fourth member who is not a medical practitioner, and who is to be legally qualified. This member must also act as the Chair of the PSC.¹²³

Mandatory Reporting

Since 2005, NSW medical practitioners have had an *ethical* obligation under the Board's Code of Conduct to report adverse performance and conduct of their colleagues. However, according to the Board, the level of reporting by practitioners since that time has not changed greatly.¹²⁴ Therefore, the MPAA requires practitioners to report to the Board where that practitioner believes, or ought reasonably to believe, that another practitioner has:

- committed sexual misconduct in connection with the practice of medicine;
- is intoxicated by drugs or alcohol while practising medicine; or
- has flagrantly departed from accepted standards of professional practice or competence and risks harm to a patient.¹²⁵

A demonstrated failure of a practitioner to report a colleague in these circumstances will be unsatisfactory professional conduct under s 36(1)(b), which in serious cases may even result in that practitioner being de-registered under s 37.¹²⁶ The Committee notes that concerns have been expressed as to the use of the term 'flagrant departures from accepted

¹¹⁹ Section 22A of the *Health Care Complaints Act 1993*.

¹²⁰ Section 90C(1A) of the *Health Care Complaints Act 1993*.

¹²¹ Section 176 of the *Medical Practice Act 1992*.

¹²² Section 180(4) of the *Medical Practice Act 1992*.

¹²³ Section 169(1) of the *Medical Practice Act 1992*. This mirrors the composition of the Medical Tribunal.

¹²⁴ Hon R P Meagher MP, Agreement in Principle Speech, Legislative Assembly *Hansard*, 7 May 2008.

¹²⁵ Section 71A of the *Medical Practice Act*. The *Medical Observer* on 14 March 2008 described the amendment as 'radical new legislation' and suggested that the lead of New South Wales might be followed by Queensland and Tasmania.

¹²⁶ Section 66(6) of the *Medical Practice Act 1992*. Practitioners who make a report in good faith against another practitioner are protected from legal action or other reprisals because they made a report: s 47 of the *Medical Practice Act 1992*.

standards of practice' in s 71A of the MPA.¹²⁷ On this point, the Minister for Health stated that this is intended to:

result in the reporting of only the most serious and obvious failures to comply with proper medical practice and where there is a clear potential for harm to patients.¹²⁸

Finally, the MPAA enables the Board to require practitioners to provide information about where they work, so that the Board can notify their employer about any orders or conditions imposed on the practitioner;¹²⁹ and requires medical practitioners to provide the Board annually with evidence of current professional indemnity insurance coverage.¹³⁰

Conclusion

The Committee considers that a number of inadequacies in the NSW health care complaints system have been addressed in the provisions of the *Medical Practice Amendment Act 2008*, and notes that in her second report to the Department of Health, Ms O'Connor concluded that she was:

confident the policy changes that have been made since Dr Reeves worked at Hornsby and Southern Area Health Service, and those proposed to be made in the Bill and the Service Check Register, will if properly implemented result in a system in which doctors like Dr Reeves will be dealt with at an early stage and not be allowed to continue to practise.¹³¹

As has been noted in the preceding chapters, despite having a history of complaints stretching back for more than a decade, and covering a number of public health organisations, Reeves continued to illicitly practise obstetrics in the Bega district due to a combination of gaps in the system, and his preparedness to shamelessly deceive fellow practitioners and patients. The Committee considers that the amendments which have been made to the MPA which ought to avoid a repetition of this unacceptable situation are:

- (i) generally, a series of apparently less serious instances of conduct can be taken into consideration to build up a pattern of misconduct;
- (ii) specifically, the Commission must have regard to previous complaints when deciding how to deal with a health care complaint;
- (iii) actions taken by the Board under s 66 need only be in the public interest generally, and not in the interest of a known at-risk individual;
- (iv) the Board may give notice of any s 66 action to any agency or person it considers appropriate;
- (v) a PSC or Tribunal may designate that the breach of certain orders will lead to *automatic* suspension and de-registration; and

¹²⁷ See, e.g., Jillian Skinner MP, Agreement in Principle debate, Legislative Assembly *Hansard*, 15 May 2008.

¹²⁸ Hon R P Meagher MP, Agreement in Principle Speech, Legislative Assembly *Hansard*, 7 May 2008.

¹²⁹ Section 127C(2) of the *Medical Practice Act 1992*.

¹³⁰ Section 127A(1A) of the *Medical Practice Act 1992*. Since 2002, the *Health Care Liability Act 2001* has required all doctors in NSW to have their own indemnity insurance.

¹³¹ D O'Connor, *Review of the appointment, management and termination of Dr Graeme Reeves as a visiting medical officer in the NSW public health system*, 2 May 2008, p 2.

- (vi) practitioners must report to the Board instances in which another practitioner has flagrantly departed from accepted standards of professional practice or competence, and risks harm to a patient.

However, the Committee notes that Ms O'Connor's recommendation of the following amendments to the *Health Care Complaints Act* were not included in the Act:

- amending s 21A to allow the HCCC to exercise all of the powers under s 34A as part of its assessment phase; and
- extending s 34A to give the HCCC power to compel documents and information from any person, rather than being limited to complainants and health service providers.¹³²

The Committee considers that this remains a gap, given that documents held by other persons or bodies may contain important evidence as to matters being considered by the Committee, especially as part of the process of piecing together a pattern of behaviour of a practitioner.

¹³² D O'Connor, *Review of the Medical Practice Amendment Bill 2008*, 28 March 2008, pp 3-4.

Chapter Seven - Conclusion

In first raising this matter in the Parliament, Andrew Constance MP noted that the stories of people who had allegedly suffered at the hands of Graeme Reeves needed to be heard so that 'our health system is the best that it can be'.¹³³ The Committee intends that this Report will be a contribution to ensuring that this is in fact the case.

The Committee makes no apologies for the failings of the Health Care Complaints Commission to deal with the complaints against Reeves in a timely and effective manner. As the key body in NSW responsible for investigating health care complaints since 1994, the Commission ought to have been at the forefront of moves to query Reeves' fitness to practise, and not relied on the bravery of patients and nurses in particular to bring these matters to light.

The evidence given by both practitioners and patients to the PSC hearing in 1997 is harrowing. Almost as disturbing is the fact that the behaviour complained of, stretched back over many years, ranged across a number of hospitals, and was widely known amongst Reeves' professional colleagues and medical administrators. It is difficult to understand why complaints were not heard by the Board prior to that time.

However, the Committee must acknowledge that in prosecuting Reeves before a Professional Standards Committee of the Medical Board, the Commission took an appropriately strong stand. Reeves' argument in those proceedings that the Orders sought by the Commission amounted to a 'de facto de-registration' was correct.¹³⁴ The Commission's recommendations were aimed at removing Reeves from anything to do with obstetrics and gynaecology, and to see that his every day clinical practices were the subject of re-training.¹³⁵

The PSC Orders did not go this far, but limited Reeves to practising gynaecology under supervision. The Committee notes that there is arguably some support for this decision from the fact that the complaints against Reeves in 1997 related to the practice of obstetrics rather than gynaecology. However, the Committee considers that the evidence of the Board's own psychiatrist, together with the PSC conclusion that, even with rigorous professional and psychiatric supervision, Reeves could not be trusted to ever practise again as an obstetrician,¹³⁶ ought to have outweighed that factor.

The Committee considers that the Commission went some way to making amends for its mishandling of complaints against Reeves by its stand at the PSC hearing. In fairness, the Committee has the benefit of hindsight, and perhaps even in its distrust of Reeves' ability to practise, the members of the PSC ought not to be expected to have known that he would shamelessly lie his way into the practice of obstetrics. Had the Orders which were made been properly implemented, it is unlikely that Reeves would ever have managed to practise obstetrics in the Bega District.

¹³³ Mr A J Constance MP, Private Members Statement, Legislative Assembly *Hansard*, 26 September 2007.

¹³⁴ Decision of the PSC 1997, p 33.

¹³⁵ Decision of the PSC 1997, p 32.

¹³⁶ Decision of the PSC, p 37.

Conclusion

From 2000 to 2004 the Commission received complaints against Reeves every year; these complaints appear to have been passed on to the Board. In 2003, the Commission investigated a complaint against Reeves about a death in surgery in 1999, in which he was acting as a consultant, but decided that 'there were no grounds for investigation'.¹³⁷ Given the Commission's awareness of the long history of serious complaints against Reeves, this hardly appears an appropriate response.

Reeves' ultimate de-registration by the Medical Tribunal in July 2004 was based not on allegations of his incompetence in obstetric procedures, but on his professional misconduct in carrying out those procedures in defiance of the 1997 ban. The Committee notes that in reaching the decision to de-register, the Tribunal made one of the few references to the position of Reeves' patients:

Clearly, it would be devastating to a female patient to learn that her doctor was executing surgical procedures upon her which he was prohibited from performing by reason of misconduct in carrying out similar procedures, which had caused serious harm to former patients.¹³⁸

The health care complaints system now and into the future

As was noted at the outset of this Chapter, the Committee is interested in playing its role in ensuring that the health system in NSW is the best it can be. The aim of this report was to not simply to point fingers, but to examine the health care complaints system failures, and to constructively see where that system is 'at' in 2008.

The Health Care Complaints Commission

In exercising its functions under the *Health Care Complaints Act*, the Commission is required to have as its primary object the protection of the health and safety of the public. The Committee has made strong criticisms of the Commission's obvious failure to do so in respect of the complaints about Reeves over a period of years.

However, the Committee notes that in a number of critical issues, the Commission has made considerable improvements to its operation. For example, in 2006-07, 83.7 per cent of complaints were assessed in the statutory time frame of 60 days, and the average time taken for assessment fell from 61 days in 2005-06 to 39 days.¹³⁹ Similarly, the average time for an investigation fell from 353 to 318 days, and nearly 70 per cent of investigations were completed in 12 months.¹⁴⁰ The Commission has professionalised its investigations area, with an improved Investigations Procedures Manual and multi-lateral assessment procedures, as opposed to the previous linear, paper-based approach. Also, the Commission now uses an electronic case management system, which enables a more active monitoring of cases by management.

The Committee considers that the Commission has undergone a process of considerable improvement in the manner in which it exercises its functions under the Act, and particularly how it engages with both health care complainants and others involved in the provision of health care in NSW.

¹³⁷ See <http://www.hccc.nsw.gov.au/downloads/MediaReleaseDrReeves05032008.pdf>

¹³⁸ *Decision of the Medical Tribunal of NSW*, 23 July 2004, p 28

¹³⁹ Health Care Complaints Commission 2006-07 *Annual Report*, p 7.

¹⁴⁰ Health Care Complaints Commission 2006-07 *Annual Report*, p 7.

Accordingly, while the Committee is unapologetic for its criticisms of the Commission's handling of the Reeves complaints, it considers that it is only fair to publicly acknowledge the efforts of the Commissioner and staff to improve the Commission's compliance with its statutory obligations.

The Medical Board

At the outset of the Report, the Committee noted that it had no oversight jurisdiction in respect of the NSW Medical Board. However, in a closely enmeshed system of co-regulation, it has been necessary to examine the Board's role in the handling of the complaints against Reeves to make any sense of the whole.

What a trained member of the profession considers an appropriate response to a medical error may vary wildly from that of a grieving member of the public. It can be extremely difficult for the profession to explain that it may be in the interest of public health generally if a practitioner is assessed and re-trained, rather than simply disciplined and removed from practice: it is human nature to want someone to blame when things go wrong.

Despite its conclusion that the failings of the Commission were compounded by the 1997 response of the PSC to the complaints against Reeves, the Committee acknowledges that the NSW Medical Board has undertaken significant changes in the way in which it responds to health care complaints since that time, particularly in the area of performance assessment. Nonetheless, the Committee welcomes the changes wrought by the *Medical Practice Amendment Act 2008*. By expanding lay participation and making hearings open to the public, the PSC process will be more attuned to reaching the balance between public expectation and professional competency.¹⁴¹

The health care complaint process

A quick glance at Chapter 3 of this Report will reveal that the system of health care complaints in NSW is complex and multi-faceted. This largely reflects the fact that many such complaints will themselves be complex, such as those relating to hospital care, in which a considerable number of clinical, theatre and nursing staff may be involved over a period of days or weeks.

Nonetheless, it is incumbent on all those involved in the NSW health care system to ensure that this complexity does not become overwhelming for either complainants or practitioners. The Committee considers that a number of positive changes brought about by the *Medical Practice Amendment Act 2008* will help to avoid this, especially:

- both Commission and Board can now take into account *patterns* of behaviour when considering complaints against practitioners;
- actions taken by the Board under s 66 need only be in the wider public interest;
- information sharing is improved by the Board's ability to give notice of a s 66 action to anyone the Board considers appropriate;

¹⁴¹ The Committee also notes that the NSW Medical Board may soon be playing a somewhat different role having regard to the March 2008 Intergovernmental Agreement on the health workforce signed by the Council of Australian Governments (COAG), which aims to establish a single national registration system for nine health professions, including medicine, planned for introduction by 2010.

Conclusion

- breach of certain designated orders of a PSC or Tribunal will lead to *automatic* suspension and de-registration; and
- mandatory reporting of flagrant departures from accepted standards of professional practice or competence removes any doubts as to the extent and content of practitioner responsibility to the public.

For its part, the Committee assures the Parliament and people of New South Wales that it will continue to do its utmost to ensure that the Commission's investigations of individual complaints are as responsive, thorough, and transparent as possible, and that the Commission does its utmost for complainants who may have suffered traumatic experiences as a result of their interactions with the health system, so as to avoid any repetition of the system failings which characterise the handing of the complaints made against Graham Reeves.

RECOMMENDATIONS

RECOMMENDATION 1:

That the *Health Care Complaints Act 1993* be the subject of a thorough review, carried out with reference to the legislative changes made by the *Medical Practice Amendment Act 2008*, to identify and remove any unnecessary complexities in the health care complaints system in NSW.

RECOMMENDATION 2:

That this review include input from the NSW Medical Board, all other Registration Authorities in NSW, and the Clinical Excellence Committee, and have reference to worldwide best practice.

RECOMMENDATION 3:

That the following amendments be made to the *Health Care Complaints Act 1993*;

- amending s 21A to allow the HCCC to exercise all of the powers under s 34A as part of its assessment phase; and
- extending s 34A to give the HCCC power to compel documents and information from any person, rather than being limited to complainants and health service providers,

as recommended by Ms Deirdre O'Connor.

RECOMMENDATION 4:

That the *Health Care Complaints Act 1993* be amended to provide that, where the Commissioner reasonably believes that any part of the Commission's assessment or investigation process has revealed evidence of criminal conduct, the Commission may at that time provide such evidence to law enforcement authorities.

RECOMMENDATION 5:

That all legislation establishing Registration Authorities in NSW be amended to provide, as much as is reasonably possible, for standardised internal complaint handling procedures in line with those of the NSW Medical Board.

RECOMMENDATION 6:

That all of the Registration Authorities in NSW publish on their websites, or provide links to publication of, decisions relating to practitioners within their area of practice.

RECOMMENDATION 7:

That the NSW Department of Health conduct a state-wide audit of practitioners practising with conditions, with the aim of ensuring that rural or remote areas of the State have sufficient number of appropriately functioning practitioners.

RECOMMENDATION 8:

That the Health Care Complaints Commission focus on the needs of health care service users in rural and remote NSW as part of its current public awareness-raising project.

RECOMMENDATION 9:

That the NSW Medical Board conduct a public education program with the aim of raising public awareness and understanding of the operation of its Performance Assessment processes and Impaired Registrants Program.

RECOMMENDATION 10:

That the Medical Board and other Registration Authorities ensure that Continuing Medical Education requirements are complied with, and provide that failure by a practitioner to so comply is a ground for referral for Performance Assessment.

RECOMMENDATION 11:

That all practitioners be required to display notices in their practice evidencing their compliance with the Continuing Education requirements of their area of practice.

Appendix One – The Health Care Complaints Commission Review of past handling of complaints against Dr Graeme Reeves

Between 1990 and 2007, the Commission received 24 complaints about Dr Reeves. These complaints concerned Dr Reeves' treatment of 25 patients (one complaint from the Medical Board concerned two patients).

1990 to 1996

There were 14 patients whose treatment by Dr Reeves was the subject of complaint. Nine of these formed the basis for the Commission's prosecution of Dr Reeves before a Professional Standards Committee [PSC] of the NSW Medical Board.

The cases brought before the PSC concerned Dr Reeves' conduct dating from 1990 relating to the practice of obstetrics (childbirth).

The PSC decided on 21 July 1997 to impose various conditions on Dr Reeves, including that he not practise obstetrics.

1997

The Commission received another three complaints about Dr Reeves and investigated all of them.

The Commission obtained expert opinions on Dr Reeves' conduct. In two cases, the experts found no grounds for criticism of Dr Reeves' treatment of the patient. In the third, which concerned care provided in 1995-96 relating to childbirth, the expert was mildly to moderately critical of the care provided.

In view of the conditions recently imposed on Dr Reeves' practice by the PSC, the Commission, after consultation with the Medical Board, decided no further action was required.

2000

The Commission received two complaints concerning Dr Reeves' rudeness and general poor communication.

There were no significant clinical issues involved.

The Commission referred the second complaint to the Medical Board, which was considering referring Dr Reeves to its performance assessment program.

2001

The Commission received one complaint about verbal abuse by Dr Reeves, which the Commission also referred to the Medical Board.

2002

In November 2002, the Commission received a complaint about an inappropriate internal examination and breast examination by Dr Reeves in his private practice at Pambula.

The Commission referred this complaint to the Medical Board, which advised that it would conduct a performance review of Dr Reeves' practice.

2003

The Commission received a complaint about a death in surgery in 1999. A registrar, with Dr Reeves as a consultant, had performed the surgery.

The Commission obtained a report on the matter from the Area Health Service. This was reviewed by a Commission medical adviser. The Commission decided that there were no grounds for investigation.

The matter was finalised after a meeting between the complainant and a Commission resolution officer.

2004

The Commission received a complaint about gall bladder surgery by Dr Reeves in 2002. The Commission decided to take no further action on this complaint because Dr Reeves had been de-registered.

2007

In April 2007, there was a further complaint to the Commission against Dr Reeves. The letter of complaint concluded by noting that Dr Reeves three year de-registration would expire in August 2007 and asked what action the Commission would take.

The Commission advised that the Medical Board defended applications to re-register it would send the papers to the Medical Board so that they could be submitted to any Tribunal should Dr Reeves apply to re-register [*sic*].

Note

There were two complaints received by the Commission concerning Dr Reeves while he was working at Pambula/Bega hospitals:

- the first, in 2002, concerned Dr Reeves' conduct in his private practice
- the second, in 2004, did concern surgery in Pambula Hospital but was received after Dr Reeves was de-registered.

The Commission is still reviewing the documentation involved in its prosecution of Dr Reeves before the Medical Tribunal resulting in his de-registration in August 2004.

Appendix Two – Correspondence between the Committee and the Health Care Complaints Commission

26 March 2008

File ref: HCC124

Mr Kieran Pehm
Commissioner
NSW Health Care Complaints Commission
Locked Mail Bag 18
STRAWBERRY HILLS 2012

Dear Mr Pehm

Complaints relating to the conduct of Graeme Reeves, De-registered Medical Practitioner

At its recent meeting the Committee resolved to write to you, expressing its extreme concern at the Commission's apparent failure to act effectively on repeated complaints about an individual medical practitioner. The practitioner in question is Mr Graeme Reeves, of whom there is considerable evidence that, over a period of many years, he has inflicted physical and mental suffering on a large number of female patients, in his practice as gynaecologist and obstetrician.

The Committee notes that Mr Reeves first came to the Commission's attention in 1990, and that from that time until 2007 the Commission received some twenty-four complaints about him, ranging from matters such as rudeness to patients through to the most serious clinical matters, involving the death of three patients.

The Committee is particularly concerned that:

- the Commission has repeatedly failed to take into account the pattern of Mr Reeves' serious clinical failures over a period of many years; and
- the matters involving Mr Reeves tend to suggest a systemic failure to protect the health and safety of the people of New South Wales, the Commission's chief object pursuant to s 3(2) of the *Health Care Complaints Act 1993*.

Accordingly, pursuant to the Committee's functions under s 65(1) of the *Health Care Complaints Act 1993*, I am submitting to you on the Committee's behalf a list of questions relating to the Reeves matter. I seek your written response to these questions as a matter of urgency.

Yours sincerely

Hon Helen Westwood AM MLC
Chair

**Questions with respect to complaints relating to
the conduct of Graeme Reeves**

1. On its website, the Commission notes that, between 1990 and 1997, the treatment of 14 patients by Mr Reeves was the subject of complaint, nine of which eventually formed the basis for the Commission's prosecution before the PSC of the NSW Medical Board. Do you consider that the length of time taken to prosecute Mr Reeves is appropriate?
2. In June 1997 the PSC did not refer Mr Reeves to the full Board, which could have de-registered him at that time. What was the Commission's role in this process?
3. In a number of relevant cases, e.g., that of Ms Griffin, there appears to have been considerable time delays with respect to the Commission's processes. Is the Commission re-investigating these cases? What procedures does the Commission have in place to ensure that this does not happen again?
4. The Greater Southern Area Health Service alleges that the NSW Medical Board supplied 'incomplete & misleading' documentation on Mr Reeves. Do you agree with this allegation of the GSAHS? Had the Commission ever considered that the Board has not fully complied with its duties of reporting and informing?
5. According to media reports, Mr Reeves' history of patient harm led to the introduction of compulsory professional indemnity insurance for medical practitioners, i.e., the *Health Care Liability Act 2001*. Do you agree with this claim?
6. Media reports also state that, since 26 February 2008, the Commission has referred 11 cases to the Office of the Director of Public Prosecutions. Please provide full details of these cases to the Committee.
7. The Commission notes that in 2003 it investigated a complaint against Mr Reeves about a death in surgery in 1999, but decided that 'there were no grounds for investigation'. Given the Commission's awareness of the long history of serious complaints against Mr Reeves, what was the basis for this decision?
8. Under what circumstances does the Commission make referrals to the Office of the Director of Public Prosecutions? Does the Commission intend to review this, in light of the serious failures relating to Mr Reeves? Also, does the Commission intend to revisit and review cases brought before it during the period in which the complaints against Mr Reeves were made, to reassess if those decisions were accurate and timely?
9. What, if any, communication is there between the Commission and an Area Health Service with respect to medical practitioners who are de-registered, or who have conditions put on their practice?
10. What, if any, is the role of the Commission where further complaints are made subsequent to a practitioner's de-registration?
11. What, if any, is the role of the Commission in ensuring that medical practitioners have current insurance?

Appendix Two – Correspondence between the Committee and the Health Care Complaints Commission

12. On 29 February 2008, it was announced that the Commission would be conducting a full audit of its files. What does this involve, how is it progressing, and when do you consider it will be concluded?
13. What other systems issues do you consider the case of Mr Reeves raise? How will they be addressed?
14. The publicity surrounding the Commission's response to Mr Reeves' malpractice over many years has seriously damaged the public's perception of, and trust in, the Commission. In what practical ways do you intend to attempt to create public confidence in the Commission?

27 March 2008

The Hon Helen Westwood AM MLC
Chair
Committee on the Health Care Complaints Commission
Parliament of New South Wales
Macquarie Street SYDNEY 2000

Dear Ms Westwood,

Complaints concerning Dr Graeme Reeves

Thank you for your letter of 26 March 2008. Each of the questions attached to your letter is responded to below:

1. On its website, the Commission notes that, between 1990 and 1997, the treatment of 14 patients by Mr Reeves was the subject of complaint, nine of which eventually formed the basis for the Commission's prosecution before the PSC of the NSW Medical Board. Do you consider that the length of time taken to prosecute Mr Reeves is appropriate?

As set out in the media release on the Commission's website, the Commission received 14 complaints between 1990 and 1996 and prosecuted nine of these before a Professional Standards Committee [PSC] of the NSW Medical Board in 1997. The earliest of the complaints that formed the basis for the prosecution was received in February 1992. There was one further complaint in 1992, two in 1994, one in 1995 and three in 1996, one of which was from the Medical Board and concerned two patients. I do not consider the length of time taken by the Commission to investigate and prosecute the complaints against Dr Reeves generally was appropriate. The Commission did not publish any performance data on the time taken to investigate complaints until its Annual Report of 1995/96. Page 27 of that report notes that the 'average time taken to investigate complaints finalised in 1995/96 was 718 days.' As the Committee is aware through the Commission's current regular performance reporting, timeframes for dealing with complaints have improved significantly over the last three to four years.

2. In June 1997 the PSC did not refer Mr Reeves to the full Board, which could have de-registered him at that time. What was the Commission's role in this process?

The Commission's role is to prosecute complaints before disciplinary bodies. The requirements of the *Medical Practice Act 1992* [MPA], are that a PSC is obliged to refer a complaint before it to the Medical Tribunal if it forms the opinion that the complaint 'may provide grounds for the suspension or de-registration' of a medical practitioner (section 179 MPA). This is a responsibility of the members of the PSC hearing the matter. The Medical Tribunal has the power to suspend or de-register a practitioner. There are no transcripts of proceedings before PSC's, which are constituted and administered by the Medical Board under the MPA, so it is difficult to be precise about the Commission's conduct of the prosecution. The decision of the PSC shows that the recommendations of the Commission regarding the conditions that should have been imposed on then Dr Reeves were not accepted by the PSC. The decision of the PSC has not been made public under the MPA.

Under section 104 of the MPA, the Medical Board may provide a copy of the statement of decision of a PSC 'to such persons as the Board thinks fit'.

3. In a number of relevant cases, e.g., that of Ms Griffin, there appears to have been considerable time delays with respect to the Commission's processes. Is the Commission re-investigating these cases? What procedures does the Commission have in place to ensure that this does not happen again?

Ms Griffin's complaint was received in November 2002. From the papers, the Commission was advised by the Medical Board, during the required consultation about the complaint, that the then Dr Reeves had been in the Board's performance assessment program since the PSC decision in 1997. On this basis the Commission agreed with the Board to refer the complaint to the Board. The Commission had no further statutory role in the matter but its practice at the time was to appoint a Commission officer to maintain contact with the complainant and keep them advised of progress. The Commission's file shows regular contact by its officer with the complainant and the Board. The delay with respect to this complaint was not with the Commission's processes. The Commission no longer allocates officers to maintain contact when complaints are referred to the Board, taking the view that it is up to the Board to keep complainants informed as to the progress and the outcome of their complaint. Following the publicity surrounding this matter, the Commission has received, as of today, 91 inquiries, 34 written complaints and 2 requests for review of past complaints concerning Mr Reeves. It is proposed to assess all of these matters together when it appears the bulk have been received to determine what further action is appropriate.

4. The Greater Southern Area Health Service alleges that the NSW Medical Board supplied 'incomplete & misleading' documentation on Mr Reeves. Do you agree with this allegation of the GSAHS? Had the Commission ever considered that the Board has not fully complied with its duties of reporting and informing?

This issue of the employment of then Dr Reeves by the GSAHS is the subject of investigation by a Ministerial appointee, former Federal Court Judge, Ms Deirdre O'Connor. It has also been referred to the Special Commission of Inquiry into Acute Health Care. The Commission has a meeting scheduled shortly with the Special Commission to ascertain whether or not the Special Commission will be specifically investigating this issue. The Commission has also commenced an investigation into this issue but does not have sufficient information at this stage to agree or disagree with the allegation put in the question. The Commission has no knowledge of failures by the Board to carry out its statutory reporting obligations.

5. According to media reports, Mr Reeves' history of patient harm led to the introduction of compulsory professional indemnity insurance for medical practitioners, i.e., the Health Care Liability Act 2001. Do you agree with this claim?

I do not know what factors led to the introduction of the Act in question. The Commission's Annual Reports for the period do not show the Act as one impacting on its work or arising from it. The only sources available to me for the reasons the Act was introduced would be those on the public record, such as the reading speeches, which are also available to the Committee.

6. Media reports also state that, since 26 February 2008, the Commission has referred 11 cases to the Office of the Director of Public Prosecutions. Please provide full details of these cases to the Committee.

The media reports, if correctly quoted, are inaccurate. Table 18.33 on page 150 of the Commission's 2006/07 Annual report sets out that two complaints were referred to the DPP in 2006/07, 22 in 2005/06 and one in 2004/05.

The Commission's electronic records do not identify the potential offence referred to the DPP but, on the basis that you requested an urgent response, the following can be gleaned from the summary of the complaint and my own knowledge of the referrals. The bulk of referrals (16) concerned an unregistered health service provider where the investigation concluded that he was fraudulently providing purported cures to patients with incurable diseases for substantial sums of money. Those cases concerning medical practitioners generally relate to sexual offences and drug offences.

7. The Commission notes that in 2003 it investigated a complaint against Mr Reeves about a death in surgery in 1999, but decided that 'there were no grounds for investigation'. Given the Commission's awareness of the long history of serious complaints against Mr Reeves, what was the basis for this decision?

The complaint the subject of the question was referred to the relevant Area Health Service for a report and also to the Medical Board. The AHS report was received in July 2003 and assessed by a Commission Internal Medical adviser who formed the view that the complaint had been adequately addressed by the AHS. The Medical Board advised the complainant that Dr Reeves was under its performance assessment program. The surgery the subject of the complaint was not performed by the then Dr Reeves but by a Registrar with Reeves acting as a supervising consultant.

8. Under what circumstances does the Commission make referrals to the Office of the Director of Public Prosecutions? Does the Commission intend to review this, in light of the serious failures relating to Mr Reeves? Also, does the Commission intend to revisit and review cases brought before it during the period in which the complaints against Mr Reeves were made, to reassess if those decisions were accurate and timely?

Section 39(f) of the *Health Care Complaints Act* [the Act] empowers the Commission to refer a complaint to the Director of Public Prosecutions [DPP] at the end of an investigation. The Commission makes referrals to the DPP where the investigation discloses evidence that may amount to a criminal offence. The Committee will be aware from media reports that a NSW Police Service strike force has been set up to investigate possible criminal conduct by Mr Reeves. The Commission is co-operating with that strike force and has reviewed all past complaints against Mr Reeves. Any complaints that raise potential criminal conduct are being referred to the strike force with the consent of the complainant.

9. What, if any, communication is there between the Commission and an Area Health Service with respect to medical practitioners who are de-registered, or who have conditions put on their practice?

This is an area of responsibility of the NSW Medical Board. Area Health Services do not communicate routinely with the Commission regarding suspended or de-registered practitioners.

10. What, if any, is the role of the Commission where further complaints are made subsequent to a practitioner's de-registration?

The Commission may investigate and prosecute any complaint against a practitioner who was practising at the time the conduct the subject of complaint occurred. The Act does not specifically address the situation where the practitioner has subsequently been de-registered and is de-registered at the time of the complaint. The Commission has sought amendment of section 39 of the Act to allow it to hold the results of an investigation for the purpose of any potential application for re-registration by the practitioner concerned. The Commission has also sought amendment to the legislation to vest the power to oppose re-registration applications in the Commission, rather than the Medical Board where it currently resides. Amendments have also been sought to streamline the procedures for dealing with applications to re-register.

11. What, if any, is the role of the Commission in ensuring that medical practitioners have current insurance?

None. It is the responsibility of the Medical Board to ensure that a practitioner has insurance when considering their applications for registration.

12. On 29 February 2008, it was announced that the Commission would be conducting a full audit of its files. What does this involve, how is it progressing, and when do you consider it will be concluded?

The Commission has completed its audit of all complaint files concerning Dr Reeves.

13. What other systems issues do you consider the case of Mr Reeves raise? How will they be addressed?

The Commission has made extensive recommendations for legislative change to the inquiry instituted by the Minister for Health referred to above. Some of the specific recommendations have been referred to above in response to particular questions. In broad terms the Commission's recommendations go to increasing its powers to assess and investigate complaints, the conduct of disciplinary proceedings, and increasing the transparency and accountability of the procedures and decisions of PSCs. The Commission has also recommended that the various health Registration Boards, including the Medical Board, be subject to the oversight of your Committee.

14. The publicity surrounding the Commission's response to Mr Reeves' malpractice over many years has seriously damaged the public's perception of, and trust in, the Commission. In what practical ways do you intend to attempt to create public confidence in the Commission?

Confidence in the Commission will be restored through the credibility and quality of its handling of complaints and the Commission has done a great deal of work to improve its performance in this respect. The major changes to the Commission's operations to this end

over the past three to four years have been reported in its Annual Reports. More particularly, the Commission established a position of Communications Officer in March 2008, responsible for enhancing the level of public and health service provider awareness about its role and services. The officer has drafted a 12 months action plan that is scheduled for endorsement by the Executive at the Planning Day on 28 March 2008. Key steps in this plan include, among other things:

- a. Wide distribution of the revised information material to Area Health Services, GP practices and consumer bodies.
- b. Close cooperation with the colleges and professional bodies to provide feedback about complaints received by the Commission and issues raised. The Commission has started, and will continue, to provide articles, presentations and workshops to the fellows of the Colleges and Associations.
- c. Close cooperation with key consumer bodies in NSW, again by the provision of information material, articles about the work and role of the Commission, and extending its program of presentations to consumers.
- d. Development of a campaign for both consumers and practitioners about 'Patients rights and responsibilities' once the Patient Rights Charter, currently being developed by the Australian Commission on Quality and Safety in Health Care, is released.
- e. Publicity of Tribunal decisions through media releases and making the Tribunal decisions available on or through its website.

I hope that the above responses go some way to addressing the Committee's concerns about the handling of the Reeves matters and any systemic issues that flow from it. I would of course be happy to elaborate on the above responses if further information is required.

Yours faithfully,

Kieran Pehm
Commissioner

11 April 2008

File ref: HCC124

Mr Kieran Pehm
Commissioner
NSW Health Care Complaints Commission
Locked Mail Bag 18
STRAWBERRY HILLS 2012

Dear Mr Pehm

Complaints relating to the conduct of Graeme Reeves, De-registered Medical Practitioner

Thank you for your prompt reply to the list of questions submitted to you on 26 March 2008 relating to the conduct of Mr Graeme Reeves.

There are a number of points raised in your answers on which the Committee would like to seek clarification. Accordingly, I am submitting to you on the Committee's behalf a list of further questions relating to the Reeves matter.

Again, I seek your written response to these questions as a matter of urgency.

Yours sincerely

Hon Helen Westwood AM MLC
Chair

**Further questions with respect to complaints relating to
the conduct of Graeme Reeves**

Q.1 In your answer to Question 1 of the Committee's previous letter you note that you '*do not consider the length of time taken by the Commission to investigate and prosecute the complaints against Dr Reeves generally was appropriate.*' Given the changes that have been made in the Commission's investigative processes, are you confident that, if matters such as those involving Mr Reeves were to come before the Commission now, the Commission's response would be timely and effective?

Q.2 In your answer to Question 3 you state that '*It is proposed to assess all of these matters [i.e., past complaints concerning Mr Reeves] together when it appears the bulk have been received to determine what further action is appropriate.*' How will the Commission know when the 'bulk' of complaints relating to Mr Reeves have been received? Please advise the Committee as soon as the Commission has determined what action it will take.

Q.3 In your answer to Question 4 you note that the Commission has a meeting scheduled shortly with the Garling Special Commission of Inquiry into Acute Health Care to ascertain whether or not the Garling Special Commission will be specifically investigating this issue. Can you please advise the Committee as soon as the Commission knows whether the Garling Special Commission will investigate the matters raised, and when the Commission has sufficient information to take a position on the allegation?

Q.4 In your answer to Question 6 you provide details of cases referred to the Office of the Director of Public Prosecutions in 2004/05, 2005/06 and 2006/07. Please provide details of the referral of any cases to the Director of Public Prosecutions since the 2006/07 Annual Report. Have any cases relating to Mr Reeves been referred to the Director of Public Prosecutions?

Q.5 In your answer to Question 7 you noted that the Commission determined that the complaint against Mr Reeves had been adequately addressed by the AHS. However, according to your answer to Question 3 the Commission was made aware in November 2002 that Mr Reeves had been in the performance assessment program since 1997. Do you consider that there is a significant onus of responsibility on a supervising consultant, which - combined with Mr Reeves' complaint history - ought to have raised concerns at both the Commission and the NSW Medical Board?

Q.6 In your answer to Question 8 you outlined the circumstances in which the Commission makes a referral to the Director of Public Prosecutions. Can you please clarify whether the Commission intends to review its approach generally to the referral of cases to the Director of Public Prosecutions during the period in which complaints were being made against Mr Reeves?

Q.7 In your answer to Question 12 you stated that, '*the Commission has completed its audit of all complaint files concerning Dr Reeves.*' Please provide clarification of the actual operation of the audit of the Commission's complaint files. Also, did the audit concern only complaints against Mr Reeves?

The Hon Helen Westwood AM MLC
Chair
Committee on the Health Care Complaints Commission
Parliament of New South Wales
Macquarie Street
SYDNEY NSW 2000

Your ref: HCC124

Dear Ms Westwood

Complaints relating to Graeme Reeves

Thank you for your letter dated 11 April 2008, received on 14 April 2008, regarding the Committee's further questions arising out of my letter to you of 27 March 2008. I respond as follows:

Q1. In your answer to Question 1 of the Committee's previous letter you note that you 'do not consider the length of time taken by the Commission to investigate and prosecute the complaints against Dr Reeves generally was appropriate.'

What changes have subsequently been made in the Commission's investigative processes, particularly, changes which would trigger an appropriate response to a series of complaints about a particular medical practitioner, to avoid this recurring? Are you confident that if matters such as those involving Mr Reeves were to come before the Commission now, the Commission's response would be timely and effective?

Response:

The Commission's assessment brief, prepared on each complaint received, includes a print out of all prior complaints against the health practitioner(s) involved, together with the outcome of each matter. These prior complaints are considered when the Commission makes an assessment decision on how any individual complaint should be handled. Where there is a history of complaints, this informs both the level of Commission action and the degree of urgency given to the management of the complaint. I am confident that if a series of complaints such as those involving Graeme Reeves came before the Commission now, the response by the Commission would be timely and effective.

Q2. In your answer to Question 3 you state that 'It is proposed to assess all of these matters [i.e., past complaints concerning Mr Reeves] together when it appears the bulk have been received to determine what further action is appropriate.'

How will the Commission know when the 'bulk' of complaints relating to Mr Reeves have been received? Please advise the Committee as soon as the Commission has determined what action it will take.

Response:

My answer to question 3 in my letter of 27 March 2008, where I said 'It is proposed to assess all of these matters together when it appears the bulk have been received' referred to the new complaints against Reeves, not those that had been received before the recent publicity. Most of the new complaints had been received by the end of March 2008, although

two more were received in early April. An initial assessment of these new matters was carried out on 3 and 4 April 2008. The majority of complaints require further information to be obtained, either from the complainants themselves or from health service providers, including medical records from hospitals. This initial assessment also identified matters that could be of interest to NSW Police Strike Force Tarella.

Q3. In your answer to Question 4 you note that the Commission has a meeting scheduled shortly with the Garling Special Commission of Inquiry into Acute Health Care to ascertain whether or not the Garling Special Commission will be specifically investigating this issue. Can you please advise the Committee as soon as the Commission knows whether the Garling Special Commission will investigate the matters raised, and when the Commission has sufficient information to take a position on the allegation?

Response:

The Special Commission of Inquiry recently determined that it will investigate the employment of the then Dr Reeves by the then Southern Area Health Service and required the Health Care Complaints Commission to provide all relevant documents. This Commission responded to the summons by providing the relevant material on Friday 11 April 2008. As a result, the Commission has determined to cease its investigation and is not in a position to comment further on the issue.

Q4. In your answer to Question 6 you provide details of cases referred to the Office of the Director of Public Prosecutions in 2004/05, 2005/06 and 2006/07. Please provide details of the referral of any cases to the Director of Public Prosecutions since the 2006/07 Annual Report. Have any cases relating to Mr Reeves been referred to the Director of Public Prosecutions?

Response:

The Commission has referred one matter to the Director of Public Prosecutions since 30 June 2007. This matter involves the apparently deliberate falsification of a health record to avoid investigation. The Commission has not referred any case regarding Graeme Reeves to the Director of Public Prosecutions but is referring any matters potentially involving criminal conduct to the police strike force where it has obtained the consent of the complainant to do so.

Q5. In your answer to Question 7 you noted that the Commission determined that the complaint against Mr Reeves had been adequately addressed by the AHS. However, according to your answer to Question 3, the Commission was made aware as early as November 2002 that Mr Reeves had been in the performance assessment program since 1997.

Do you consider that Mr Reeves' role as a supervising consultant during surgery carried such a significant onus of responsibility, that - together with Mr Reeves' complaint history - both the Commission and the NSW Medical Board ought to have realised that there were serious grounds for concern?

Response:

As well as referring the complaint the subject of this question to the relevant Area Health Service for a report, which was reviewed by the Commission's internal medical adviser, the Commission also referred the complaint to the NSW Medical Board, which conducts the performance assessment program. The Board does not advise the Commission of what action it takes through performance assessment unless it deems that a practitioner's performance may warrant disciplinary action. If the Board, as a result of its performance assessment, makes a complaint to the Commission about the practitioner, then the Commission investigates that complaint under the Act.

The Board did not refer the complaint in question back to the Commission.

Q6. In your answer to Question 8 you outlined the circumstances in which the Commission makes a referral to the Director of Public Prosecutions. Can you please clarify whether the Commission intends to review its approach generally to the referral of cases to the Director of Public Prosecutions during the period in which complaints were being made against Mr Reeves?

Response:

In practical terms, the Director of Public Prosecutions does not accept allegations of criminal conduct without a supporting brief of evidence. As advised, the Act currently provides for the Commission to refer matters to the DPP at the end of an investigation which has gathered and compiled the necessary evidence. In addition, the Commission has recommended that the Act be amended to allow it to disseminate information and evidence to law enforcement authorities at any time. This would allow early referral to the NSW Police, who could then conduct a criminal investigation where appropriate.

Q7. In your answer to Question 12 you stated that, 'the Commission has completed its audit of all complaint files concerning Dr Reeves.' Please provide clarification of the actual operation of the audit of the Commission's complaint files. Also, did the audit concern only complaints against Mr Reeves?

Response:

The audit of past complaints against Mr Reeves was conducted by officers of the Commission's legal division. It involved a thorough review of the conduct of each file and an assessment of whether or not the complaint raised issues of possible criminal conduct. The audit did not identify any breaches of the Act by the Commission in its handling of the complaints. The audit only concerned the complaints against Mr Reeves.

I trust the above information is of assistance to the Committee.

Yours sincerely

Kieran Pehm
Commissioner

Appendix Three – Terms of Reference of the Garling Special Commission of Inquiry

Letters Patent

ELIZABETH THE SECOND, by the Grace of God, Queen of Australia and Her other Realms and Territories, Head of the Commonwealth.

To Mr Peter Richard Garling SC.

By these Our Letters Patent, made and issued under the authority of the *Special Commissions of Inquiry Act 1983*, We hereby, with the advice of the Executive Council, authorise you as Commissioner to inquire into and report to Our Governor of the said State on the following matters concerning the delivery of acute care services in public hospitals in New South Wales:

2. any systemic or institutional issues in the delivery of acute care services in NSW public hospitals raised in submissions you receive that you consider appropriate for you to inquire into and recommend any changes which should be made to address them;
2. identify existing models of patient care used in the delivery of acute care services in NSW public hospitals with particular regard to case management including supervision of junior clinical staff, clinical note-taking and record-keeping, and communication between health professionals involved in the care of a patient;
3. recommend any changes which should be made to the existing models of patient care identified under paragraph 2 to improve the quality and safety of patient care in NSW public hospitals;
4. identify any systemic impediments to the implementation of changes recommended under paragraph 3;
5. recommend any changes which NSW Health should make to overcome any impediments identified under paragraph 4; and
6. recommend any changes which NSW Health should make to ensure that its workforce policies and practices support improved models of patient care.

You may have regard to the developments arising from the National Health and Hospitals Reform Commission and other Commonwealth-State reforms in relation to Australian health care delivery, to the extent that they arise before the date for the delivery of your report.

You are to refer any individual patient complaints identified in the course of your inquiry to the Health Care Complaints Commission.

You may seek the advice of such eminent persons as you choose to engage who have expertise in any one or more of medical practice, nursing practice, allied health practice,

hospital management and such other areas as you consider appropriate.

If you so desire, you may engage any such eminent persons from other States or the Territories or from outside Australia. This does not limit your ability to employ any other assistance under section 13 of the *Special Commissions of Inquiry Act 1983*.

AND hereby establish a Special Commission of Inquiry for this purpose.

AND OUR further will and pleasure is that you do, as expeditiously as possible, but in any case on or before 31 July 2008, deliver your final report in writing of the results of your inquiry to the office of Our Governor in Sydney.

AND pursuant to section 21 of the *Special Commissions of Inquiry Act* it is hereby declared that sections 22, 23 and 24 shall apply to and in respect of the Special Commission the subject of these Our Letters Patent.

IN TESTIMONY WHEREOF, WE have caused these Our Letters to be made Patent and the Public Seal of Our State to be hereunto affixed.

WITNESS Her Excellency Professor Marie Bashir,
Companion of the Order of Australia,
Commander of the Royal Victorian Order,
Governor of the State of New South Wales
in the Commonwealth of Australia.

Dated this 29th day of January 2008

Appendix Four – Correspondence between the Committee and the NSW Medical Board

11 April 2008

File ref: HCC124

Mr Andrew Dix
Registrar
NSW Medical Board
PO Box 104
GLADESVILLE NSW 1675

Dear Mr Dix

Complaints concerning Mr Graeme Reeves

I write in my capacity as Chair of the Joint Parliamentary Committee on the Health Care Complaints Commission.

In the course of its enquiries in relation to the handling by the Health Care Complaints Commission of the complaints against Mr Reeves, the Committee has ascertained that in June 1997 he appeared before the Board's Professional Standards Committee [PSC].

Under the provisions of the *Medical Practice Act 1992* [the Act], a PSC is obliged to refer a complaint before it to the Medical Tribunal if it forms the opinion that the complaint 'may provide grounds for the suspension or de-registration' of a medical practitioner [s 179(a)]. However, despite finding him guilty of serious unsatisfactory professional conduct, on this occasion the PSC did not refer Mr Reeves to the Tribunal, but placed conditions on his practice of medicine.

I note that there are no transcripts of proceedings before a PSC, and that this decision of the PSC has not been made public under the Act. However, I note also that, under s 180(3) of the Act, the Board may provide a copy of the statement of decision of a PSC 'to such persons as the Board thinks fit'.

Accordingly, at its meeting of today's date, the Committee resolved to write to you, requesting that you forward a copy of the PSC's 1997 statement of decision in respect of the complaints made against Mr Reeves, pursuant to s 180(3) of the Act. I note that the Committee cannot compel the Board to hand over this material, but if the Board decides not to do so, the Committee has the option of reporting this to the Parliament.

I would be pleased to receive your response as a matter of urgency.

Yours faithfully

Hon Helen Westwood AM MLC
Chair

Response from NSW Medical Board

HCC 126



NEW SOUTH WALES
Medical Board

C08/223

PO Box 104 Gladesville NSW 1675
DX: 22808 Gladesville
Telephone: (02) 9879 2200
Facsimile: (02) 9816 5307
www.nswmb.org.au

RECEIVED

23.04.08

Our Ref:
Your Ref:

21 April 2008

CONFIDENTIAL

The Hon Helen Westwood AM MLC
Chair
Committee on the HCCC
Parliament of NSW
Macquarie Street
SYDNEY NSW 2000

Dear Ms Westwood

**Re: Request for Professional Standards Committee Decision re
Mr Graeme Reeves**

I acknowledge your letter dated 11 April 2008 requesting a copy of the Professional Standards Committee written statement of reasons in relation to a complaint prosecuted by the Health Care Complaints Commission in relation to Mr Reeves.

As you would be aware, unless the Professional Standards Committee has ordered that the decision be released to a specified person or organisation, a subsequent decision to do so must be made by the Board. Your request will be considered at the next meeting, and you will be advised of its decision as soon as possible.

Should you have any questions, please contact Mr Anthony Johnson, Legal Director, on phone 9879-2252.

Yours sincerely

A E DIX
Registrar

Appendix Four – Correspondence between the Committee and the NSW Medical Board

108/302



NEW SOUTH WALES
Medical Board

HCC134

PO Box 104 | Gladesville NSW 1675
DX: 22808 Gladesville

Telephone: (02) 9879 2200

Facsimile: (02) 9816 5307

www.nswmb.org.au

Our Ref: MPO 165159

Your Ref:

2 May 2008

CONFIDENTIAL

The Hon Helen Westwood AM MLC
Chair
Committee on the HCCC
Parliament of NSW
Macquarie Street
SYDNEY NSW 2000

Dear Ms Westwood

Re: Request for Professional Standards Committee Decision re Mr Graeme Reeves

I refer to your letter dated 11 April 2008 requesting a copy of the Professional Standards Committee's 1997 statement of decision in relation to Mr Graeme Reeves.

Pursuant to section 180(4) of the *Medical Practice Act, 1992* the Board thinks fit to provide the Joint Parliamentary Committee (JPC) with a de-identified copy of the PSC written statement of reasons in relation to Mr Graeme Reeves.

To protect the confidentiality and privacy of patients' identities and personal and health information the names of patients have been redacted. For similar reasons the identity of witnesses have also been redacted.

The Board thinks fit to provide the JPC with this decision for the sole purpose of it exercising its functions pursuant to section 65 of the *Health Care Complaints Act 1993*. The Board notes that the JPC is bound by its own confidentiality provisions, however this information is provided on a strictly confidential basis to be used only for the purpose of the JPC exercising its functions pursuant to section 65 of the *Health Care Complaints Act 1993*.

Please contact me on 9879 2200 if you have any questions.

Yours sincerely



Anthony Johnson
Legal Director

Enclosures: 1. De-identified copy of PSC written statement of reasons in relation to Mr Graeme Reeves.

2 May 2008

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Appendix Five – Minutes

Minutes of Proceedings of the Committee on the Health Care Complaints Commission (No 6)

Thursday 6 March 2008 at 1.10 pm
Parliament House

Members Present

Hon Helen Westwood MLC (Chair); Dr Andrew McDonald MP (Deputy Chair); Hon David Clarke MLC; Mrs Judy Hopwood MP, Rev the Hon Fred Nile MLC.

In Attendance

Mr Mel Keenan (Committee Manager), Ms Jo Alley (Senior Research Officer), Ms Jacqui Isles (Committee Officer), Mr John Miller (Assistant Committee Officer)

...General Business

Mrs Judy Hopwood MP raised as a matter of extreme concern the recent media reports about the complaints handling performance of the Health Care Complaints Commission, especially in regard to recurring complaints about individual medical practitioners.

Moved on the resolution of Mrs Judy Hopwood MP, seconded by the Hon David Clarke MLC:

‘That a letter with respect to the Commission’s apparent failure to act effectively on repeated complaints about individual medical practitioners be:

- drafted in the terms discussed;
- circulated to Members for comment; and
- forwarded to the Commissioner of the Health Care Complaints Commission for a written response’

Minutes of Proceedings of the Committee on the Health Care Complaints Commission (No 7)

Friday 11 April 2008 at 8.30 a.m.
Parliament House

Members Present

Hon Helen Westwood MLC (Chair), Dr Andrew McDonald MP (Deputy Chair), Hon Kerry Hickey MP, Mrs Judy Hopwood MP, Mr Matthew Morris MP, Hon Fred Nile MLC.

In Attendance

Mr Mel Keenan (Committee Manager), Ms Jacqui Isles (Committee Officer), Mr John Miller (Assistant Committee Officer)

...Committee correspondence with the Commissioner of the Health Care Complaints Commission concerning Mr Graeme Reeves.

The Committee noted the Commissioner's response of 27 March 2008.

- Hon Fred Nile MLC moved the following amendment to Question 1:
'That the Commission be asked to clearly state in relation to its procedures what would trigger its response to a series of complaints about a particular medical practitioner if this occurred again today'.
- Dr Andrew McDonald MP moved the following amendment to Question 5:
'That the Commission be asked that Mr Reeves' role as a supervising consultant involved or had a significant onus of responsibility which, combined with Mr Reeves' complaint history ought to have raised concerns at both the Commission and the NSW Board?'

(i) Resolved on the motion of Hon Fred Nile MLC, seconded by Hon Kerry Hickey MP:

'That the Committee write again to the Commissioner with questions as amended, seeking urgent clarification of some of his responses'.

(ii) Resolved on the motion of Hon Kerry Hickey MP, seconded by Dr Andrew McDonald MP:

'That the Committee write to the NSW Medical Board requesting the copy of the 1997 Statement of Decision in relation to the complaints made against the former medical practitioner, Mr Graeme Reeves'.

(iii) Resolved on the motion of Hon Kerry Hickey MP, seconded by Mrs Judy Hopwood MP:

'That the Committee's correspondence with the Commissioner form the basis of a report to Parliament under s 65(1)(b) of the *Health Care Complaints Act 1993* on the conduct of the Commission's investigations of the complaints against Mr Reeves'.

Minutes of Proceedings of the Committee on the Health Care Complaints Commission (No. 8)

Friday 18 April 2008 at 8.30 a.m.
Parliament House

Members Present

Hon Helen Westwood MLC (Chair), Dr Andrew McDonald MP (Deputy Chair), Hon David Clarke MLC, Hon Kerry Hickey MP, Mrs Judy Hopwood MP, Mr Matthew Morris MP.

In Attendance

Mr Mel Keenan (Committee Manager), Ms Jacqui Isles (Committee Officer), Mr John Miller (Assistant Committee Officer)

...Committee correspondence with the Commissioner of the Health Care Complaints Commission re Mr Graeme Reeves.

The Committee noted that, pursuant to the Committee's resolution at its last meeting, a letter was sent to the NSW Medical Board regarding its 1997 Reeves decision. The Committee Manager, Mr Mel Keenan, informed the meeting that no response had been received, and that he would contact the Board on Monday 21 April.

Members noted the Commissioner's response of 14 April 2008 already distributed to them by email on 16 April 2008.

Minutes of Proceedings of the Committee on the Health Care Complaints Commission (No. 10)

Friday 6 June 2008 at 8.30 a.m.
Waratah Room, Parliament House.

Members Present

Hon Helen Westwood MLC (Chair), Dr Andrew McDonald MP (Deputy Chair), Hon David Clarke MLC, Mrs Judy Hopwood MP, Hon Fred Nile MLC.

In Attendance

Mr Mel Keenan (Committee Manager), Ms Jo Alley (Senior Committee Officer), Mr Jude Devesi (Committee and Research Officer on secondment), Ms Jacqui Isles (Research Officer), Mr John Miller (Committee Officer), Ms Lisa Kroesche (Assistant Committee Officer)

6. Report to Parliament on the Health Care Complaints Commission's handling of complaints against Mr Graeme Reeves

...Moved by Dr Andrew McDonald MP, seconded by Mrs Judy Hopwood MP:

‘That the draft Terms of Reference be adopted.’

Minutes of Proceedings of the Committee on the Health Care Complaints Commission (No 12)

Thursday 26 June 2008 at 8.30 a.m.
Waratah Room, Parliament House.

Members Present

Hon Helen Westwood MLC (Chair), Dr Andrew McDonald MP (Deputy Chair), Hon David Clarke MLC, Mr Kerry Hickey MP, Mrs Judy Hopwood MP, Hon Fred Nile MLC.

The Chair opened the meeting at 8.30 a.m.

1. Confirmation of the Minutes of the Previous Meeting and Matters Arising

Moved by Mrs Judy Hopwood MP, seconded by Hon David Clarke MLC:

‘That the Minutes of the meeting of 24 June 2008 be adopted’.

2. Apologies

Mr Matthew Morris MP.

5. Report to Parliament on the Health Care Complaints Commission’s Handling of Complaints against Mr Graeme Reeves.

Consideration of Chair’s Draft Report

Hon Fred Nile MLC suggested that paragraph 3 of the Chair’s Foreword include a statement that health care users have the right to expect that the Commission will promptly and properly investigate their complaints. Committee Members agreed.

Adoption of Report

Moved by Mrs Judy Hopwood MP, seconded by Hon Fred Nile MLC:

‘That the draft Report be adopted *in globo*, as amended, to be the Report of the Committee and that it be signed by the Chair and presented to the House and that the Chair and the Secretariat be permitted to correct stylistic, typographical and grammatical errors’.

Publication of the Report

Moved Mrs Judy Hopwood MP, seconded Hon David Clarke MLC:

‘That, once tabled, the Report be placed on the Committee’s website.’