Review of documentary material in relation to the appointment of Dr Gayed, management of complaints about Dr Gayed and compliance with conditions imposed on Dr Gayed by local health districts

Gail B Furness SC

21 January 2019

Table of contents

Executive summary

1. On 21 June 2018, the Secretary of NSW Health, Ms Elizabeth Koff, appointed me to conduct an independent inquiry to review documentary material provided by each local health district in relation to the appointment of Dr Gayed, management of complaints about Dr Gayed, and compliance with conditions imposed on Dr Gayed by relevant regulatory bodies, including the Medical Council of New South Wales (**Medical Council**), at Kempsey District Hospital, Cooma Hospital, Manning Hospital and Mona Vale Hospital. My terms of reference required me to review documentary material; however, with respect to Manning Hospital, I interviewed a number of people who held key positions at the relevant time.

2. The Secretary of NSW Health appointed Dr Greg Jenkins MBBS FRANZCOG, Clinical Associate Professor O&G, UNDA, to assist the inquiry. Dr Jenkins is an obstetrician and gynaecologist.

3. Ms Georgina Wright of counsel assisted me in the inquiry.

Medical Council inquiry

4. On 29 June 2018, I was appointed by the Medical Council to undertake an independent review of processes undertaken pursuant to Part 8 of the *Health Practitioner Regulation National Law* (NSW) with respect to Dr Emil Gayed from the date of his registration as a medical practitioner in New South Wales until 7 March 2018.

5. The resulting report was titled *Review of processes undertaken by the Medical Council of New South Wales pursuant to Part 8 of the Health Practitioner Regulation National Law (NSW) with respect to Dr Emil Gayed* and dated 31 October 2018. The report has been published on the Medical Council website.

6. I was provided with all relevant documents by the Medical Council. To the extent relevant, I have referred to those documents in my inquiry under s 122 of the *Health Services Act 1997* (NSW) (**Health Services Act**).

7. The report from each of these inquiries should be read together. The reader cannot understand the actions of each local health district without appreciating the information held and actions taken by the Medical Board and the Medical Council.

Registration

8. On 17 May 1994, Dr Gayed was registered as obstetrician and gynaecologist to practice in positions approved by Medical Board.

Grafton Hospital

9. In 1994, Dr Gayed commenced work at Grafton Hospital, Clarence District Health Service, and completed his last procedure in June 1995.

10. Based on the documents available to the inquiry, the Clarence District Health Service appropriately appointed Dr Gayed, including delineating his clinical privileges. No relevant conditions were imposed by the district health service on his appointment, his clinical privileges were not varied or withdrawn and his clinical privileges were consistent with his registration. There were no complaints made to the district health service.

Cooma Hospital

11. Dr Gayed was appointed to Cooma Hospital in February 1996. Between April 1997 and July 1998, staff at Cooma Hospital, primarily nurses, completed incident reports recording 15 events concerning Dr Gayed's clinical treatment and his conduct in the operating theatre.

12. Five of the incidents involved needlestick injuries.

13. By the fourth incident, concern was being expressed about Dr Gayed's eyesight. In relation to the seventh incident, on 11 November 1997, a nurse wrote a memo to the Health Service Manager stating that staff were expressing concern for patients under their care. She referred to Dr Gayed's complication rate and his haste and possible poor eyesight.[1]

14. A review of Dr Gayed's eyesight was suggested; however, no review was undertaken.

15. On 29 July 1998, Dr Gayed was temporarily suspended from Cooma Health Service on the basis of concerns raised by Visiting Medical Officers and other staff about aspects of his clinical practice, as set out in the 15 incidents.[2]

16. Following legal advice, Dr Gayed's suspension was withdrawn.[3]

17. On 8 October 1998, Mr Gleeson, as Chief Executive Officer (**CEO**) of the Southern Area Health Service, complained to the Health Care Complaints Commission (**HCCC**) about Dr Gayed's conduct.

18. Mr Gleeson advised that, as a result of growing general concern, the Southern Area Health Service suspended Dr Gayed's appointment and that:

[1] Vol 1 Tab 25 various documents Professional Standards Committee
[2] Letter from CEO to Dr Gayed with Incident forms attached dated 20 August 1998
[3] Letter from CEO to HCCC dated 8 October 1998

> At the same time, several general practitioner Visiting Medical Officers at Cooma who provide anaesthetics to Dr Gayed when he operated there, each took a personal decision to withdraw their anaesthetic services for a time.

19. Dr Gayed resigned from Cooma Hospital in February 1999.

20. In my view, it was appropriate for the area health service to make the complaint it did to the Health Care Complaints Commission in October 1998. As Dr Jenkins states, it takes an accumulation of incidents over a period of time to come to such a conclusion. However, both Dr Jenkins and I consider that Cooma Hospital or the Southern Area Health Service should have restricted Dr Gayed's clinical privileges pending the outcome of the investigation.

21. Based on the documents available to the inquiry, the Monaro District Health Service (which at that time was responsible for Cooma Hospital) appropriately appointed Dr Gayed, including delineating his clinical privileges, which were consistent with his registration. No relevant conditions were imposed by the district health service.

22. There was no requirement under the Health Services Act, as in force in 1998, for the Southern Area Health Service to report the complaint against Dr Gayed or his underlying conduct to the Medical Board.

Professional Standards Committee

23. Between October 1998 and 2001, the HCCC investigated the complaints forwarded by the Southern Area Health Service as well as complaints directly made to the HCCC. On 15 March 2001, the HCCC made 10 complaints, concerning nine patients, to a Professional Standards Committee about Dr Gayed's clinical work as an obstetrician and gynaecologist between July 1996 and July 1998 at Cooma Hospital. It also made one complaint that Dr Gayed suffered from an impairment—namely, high myopia.

24. The Professional Standards Committee found that, over the period of 15 months in 1997 and 1998, a number of incidents and complications had occurred involving Dr Gayed's gynaecological practice leading to a gradual loss of confidence in Dr Gayed by his general practitioner (**GP**) colleagues and his nursing colleagues.

25. The Professional Standards Committee found that Dr Gayed suffered from an impairment—high myopia—which detrimentally affected or was likely to detrimentally affect his physical capacity to practise medicine.

26. In relation to the other 10 complaints, it found Dr Gayed guilty of unsatisfactory professional conduct in half of those complaints and not guilty in the remaining five complaints.

27. Overall, the Professional Standards Committee found Dr Gayed guilty of unsatisfactory professional conduct. It:

- reprimanded Dr Gayed;
- ordered that his registration be subject to the condition that he not undertake microsurgery;
- ordered that he be assessed by an ophthalmologist approved by the Medical Board at intervals determined by the ophthalmologist and reports forwarded to the Medical Board with the first assessment to take place before the end of December 2001;
- recommended to the Medical Board that a performance assessment in accordance with Part 5 of the Act be undertaken in respect of his practice at Manning Base Hospital at a time deemed appropriate by the Board;
- ordered that a full copy of the decision be provided to:
  - the Medical Board;
  - the HCCC;
  - Dr Gayed and his adviser;
  - the peer reviewers;
  - the Chief Executive Officer, Southern Area Health Service; and
- ordered that a de-identified copy of the decision be forwarded to Royal Australian and New Zealand College of Obstetricians and Gynaecologists for the purposes of educational training.

Kempsey District Hospital

28. Dr Gayed provided services at Kempsey District Hospital from October 1999 until June 2002.

29. Following the Professional Standards Committee decision in October 2001, the Medical Board notified the Mid North Coast Area Health Service of the condition imposed that Dr Gayed not undertake microsurgery.

30. However, the Medical Board did not notify Mid North Coast Area Health Service of the Professional Standards Committee's finding of unsatisfactory professional conduct, the reprimand or orders or recommendations made.

31. Based on the documents available to the inquiry, the Mid North Coast Area Health Service appropriately appointed Dr Gayed, including delineating his clinical privileges. No relevant conditions were imposed by the area health service.

32. However, his privileges were not varied to reflect the condition imposed by the Professional Standards Committee in October 2001. They should have been.

33. There were no complaints made to the area health service.

Mona Vale Hospital

34. Dr Gayed was first appointed as a Visiting Medical Officer to Mona Vale Hospital in May 2002 with clinical privileges consistent with the usual practice of obstetrics and gynaecology.

35. Dr Gayed held a temporary appointment at Mona Vale Hospital between 10 May and 10 June 2002 and a five-year appointment commencing 1 July 2002.

36. Northern Sydney Health suspended Dr Gayed between 11 August 2003 and 30 September 2003. Dr Gayed resigned from his appointment on 7 March 2007 after being informed on 6 March 2007 by the Director of Medical Services that his appointment was suspended.

37. I have reviewed the policies applying in Northern Sydney Health at the time of Dr Gayed's appointment and the available documentation relating to his appointment. I am satisfied that, prior to appointing Dr Gayed, Mona Vale Hospital did not check Dr Gayed's registration status with the Medical Board. There is no evidence that the hospital sought from Dr Gayed information as to his conditions of registration or his consent to contact the Medical Board and/or the HCCC. The inquiry has been informed that, prior to Dr Gayed's temporary appointment at Mona Vale Hospital, the Director of Medical Services obtained a positive verbal reference from Dr Jim Wills, Director of Medical Services at Manning Hospital.

38. I conclude that Dr Gayed was selective in the information he provided to Northern Sydney Health when he sought appointment. Specifically, he made no mention of the HCCC investigation or the Professional Standards Committee and its outcome in his curriculum vitae or any of the supporting material he provided.

39. As a result, the clinical privileges granted to Dr Gayed by Northern Sydney Health did not reflect the conditions imposed on his registration in that there was no restriction on microsurgery. The inquiry has been informed that Mona Vale Hospital had no microsurgical capability at that time. Accepting that this was the case and that the condition not to do microsurgery was therefore of minor significance, I consider it nevertheless concerning that his eyesight issues were not known to the hospital or area health service at the time of his appointment.

40. Northern Sydney Health first became aware of the conditions on Dr Gayed's registration, the Professional Standards Committee and the conditions imposed and recommendations made by the Professional Standards Committee after concerns arose in relation to his management of patients in June 2003.

41. Complaints about Dr Gayed's management of patients at Mona Vale Hospital were made to the hospital executive each year following his appointment in 2002. Incidents were notified by staff.

42. In June 2003, a number of cases involving Dr Gayed as consultant came to the attention of the Director of Medical Services, Dr Annette Pantle. Dr Pantle

proposed reviewing the cases; however, pending that review, further clinical incidents occurred in relation to patients under the care of Dr Gayed.

43. On 12 August 2003, Dr Gayed was suspended pending investigation of his clinical performance.

44. Northern Sydney Health convened a Credentials Committee. Around this time, Mona Vale Hospital sought and obtained confirmation from the Medical Board as to Dr Gayed's conditions of medical registration. However, there was no reference to the Professional Standards Committee, its orders, the reprimand or the recommendation it made that a performance assessment be undertaken. I am nevertheless satisfied that, by this time, Mona Vale Hospital was aware that Dr Gayed had been the subject of a Professional Standards Committee.

45. On 22 September 2003, the Credentials Committee met and noted a number of matters, including the following:

    (a) the cluster of cases was not comparable with any other doctors at Mona Vale Hospital;

    (b) there was a pattern of performing operative procedures on the same patients, at intervals, which could possibly be interpreted as overservicing;

    (c) the conditions placed on his registration by the Medical Board and Dr Gayed's adherence to them; and

    (d) in respect of four of the patients, on balance, the clinical judgment demonstrated was within an acceptable range. The Credentials Committee noted potential suboptimal outcomes for the other three patients.

46. Notwithstanding concerns expressed by the Credentials Committee, it recommended:

    (a) the reinstatement of full clinical privileges;

    (b) that Dr Gayed's appointment be reviewed in the event of any replication of similar concerns; and

    (c) notification to the Medical Board.

47. On 31 May 2004, nursing staff submitted an incident reporting form for a 'Major Clinical Incident' relating to a patient of Dr Gayed.

48. On 7 October 2004, that case was presented at a multidisciplinary peer review meeting. Dr Gayed was not present. The review concluded that a number of clinicians had correctly observed and documented features which were not consistent with the diagnosis being treated by Dr Gayed and, as such, it remained unclear why the surgery had been undertaken. It was recommended that a further case review meeting involving all the clinicians involved take place. The inquiry has

not been provided with any documentation indicating that a further review of the case, as recommended by the multidisciplinary review, took place.

49. Dr Jenkins considers that there are a number of factors about that case which raise concerns about Dr Gayed's clinical performance. Dr Jenkins and I consider that this case should have prompted a review of Dr Gayed's clinical privileges in accordance with the outcome of the Medical Appointments and Credentials Advisory Committee meeting in September 2003.

50. In December 2005, concerns were again raised about a number of cases in which Dr Gayed was the treating doctor.

51. Northern Sydney Health did not reconsider Dr Gayed's appointment or clinical privileges. Dr Jenkins and I consider that two of those cases seen in the context of the other cases, warranted a referral to the area health service Credentials Committee for review and consideration of whether Dr Gayed's clinical privileges should be restricted. If the outcome of a review by the Credentials Committee had been adverse to Dr Gayed, it would have been incumbent on the area health service to report the cases to the Medical Board as involving suspected unsatisfactory professional conduct.

52. Northern Sydney Health did not formally notify the cases to the Medical Board, although the CEO contacted the Medical Board to seek information about Dr Gayed's performance assessment. The Medical Board provided an extract of the report which indicated that the assessors considered his performance to be satisfactory.

53. The Director of Medical Services discussed Dr Gayed's performance with the Director of Clinical Services at Manning Hospital. The assessment provided was in positive terms.

54. On 25 September 2006, staff registered another incident on the Incident Information Management System (**IIMS**) concerning Dr Gayed's surgical management of a patient The Director of Medical Services decided to investigate the incident as a Level 2 'Complaint or concern about a clinician' as outlined in the NSW Health Guideline GL2006_002. This required:

    (1) notification to the Director of Clinical Governance;

    (2) consideration as to whether variations to clinical privileges are required; and

    (3) an investigation.

    These steps were carried out. The Director of Medical Services engaged an independent obstetrician gynaecologist to conduct a review of the case.

55. On 4 December 2006, another incident was notified in IIMS. That case was also referred to external reviewer.

56. Both reviewers were critical of Dr Gayed's treatment of the patients concerned.

57. One of the reviewers was also asked to provide an opinion with regard to de-identified data relating to surgery conducted between 1 September 2004 and 31 August 2006 by obstetrics and gynaecology specialists at Mona Vale Hospital. He advised that, of the four doctors concerned, Dr 'B', whose identity was not known to him, had a higher rate of general complication and difficult complications without an obviously different practice from the other doctors. I am satisfied that it is likely that Dr B was Dr Gayed.

58. In March 2007, two further cases of concern came to light. By this time, there were widespread concerns regarding the practice of Dr Gayed at Mona Vale Hospital and various investigations and reviews were underway.

59. On the evening of 6 March 2007, the Director of Medical Services met with Dr Gayed at Dr Gayed's request. Dr Gayed felt the current and past reviews were personally motivated rather than being motivated by safety concerns. He presented his resignation.

60. On 16 March 2007 the Chief Executive of Northern Sydney Central Coast Area Health Service also notified the Medical Board of the cases of concern, of the decision to suspend Dr Gayed pending the outcome of investigations, and of Dr Gayed's subsequent decision to resign. This was the second occasion during Dr Gayed's appointment on which the Chief Executive had brought to the attention of the Medical Board the area health service's serious concerns about Dr Gayed's clinical practice.

61. During the period of his appointment, it is apparent that Northern Sydney Health, then Northern Sydney Central Coast Area Health Service, had effective and quite robust systems in place for notifying and managing complaints, particularly following the introduction of IIMS and related policies in 2005. They included notifying matters to the Medical Board and seeking information from the Medical Board.

Manning Hospital

62. Dr Gayed commenced working as a Visiting Medical Officer Obstetrician/Gynaecologist at Manning Hospital in August 1999. He sought reappointment in 2003, 2006 and 2011.

63. In each application Dr Gayed signed a release for enquiries to be made to, among others, previous places of employment, the HCCC and registration authorities.

64. There are no documents indicating that the area health service checked with Cooma Hospital, the Medical Board and/or the HCCC before reappointing Dr Gayed in 2003, 2006 and 2011. I conclude that those checks were not made. These are serious omissions. The policies requiring this information to be acquired as part of consideration of reappointing Visiting Medical Officers are significant elements of a

system designed to identify concerns about practitioners who work across various private and public health facilities.

65. On each occasion the relevant area health service was informed by the Medical Board that conditions had been imposed on Dr Gayed's registration, there were delays in reflecting those conditions in his clinical privileges. The most significant was in 2001, when some 16 months elapsed after the area health service was told that Dr Gayed's registration was conditional on him not performing microsurgery.

66. In most years from 1999 to 2016 there was a complaint or concern raised about Dr Gayed's clinical treatment of a patient. They were expressed by nursing staff, anaesthetists and other medical practitioners as well as, more recently, patients themselves.

67. Those concerns continued notwithstanding:

    (a) the findings of a Professional Standards Committee in 2001 and the conditions imposed on Dr Gayed's practice;

    (b) the assessments by the Medical Board and Medical Council at various times over a decade and the imposition of further conditions on his registration; and

    (c) the effective termination of his contract at three hospitals: Cooma in 1999, Delmar in 2007 and Mona Vale in 2007.

68. Of most concern is that a repeated theme in the complaints and concerns was the unnecessary removal of organs, unnecessary or wrong procedures, perforations of organs and reluctance to transfer to tertiary facilities.

69. In June 2018, a public inquiry line was established at Manning Hospital. Almost 200 women who had a concern about their treatment by Dr Gayed contacted the hospital. Their treatment spanned the time of Dr Gayed's appointment.

70. Dr Nigel Roberts, the Director of Obstetrics and Gynaecology at Manning Hospital, met with most of those women; reviewed their medical records, to the extent they were available; and wrote a report about their treatment and his opinion as to its adequacy.

71. Dr Gayed remained at Manning Hospital until early 2016, when he was suspended and then resigned.

72. By that time, at Manning Hospital alone, there had been 50 women whose treatment, according to advice by Dr Jenkins, which I accept, warrants a complaint to the HCCC and many more who had complained directly to the HCCC.

73. Most of these 50 women I have referred to the HCCC—that is, 30 in number—were treated between 2011 and 2015.

74. The health system failed each of these women.

What went wrong at Manning Hospital

75. First, Dr Gayed was a Visiting Medical Officer in obstetrics and gynaecology. He saw patients in his private rooms where he carried out assessments, examined patients and made diagnoses. He booked women in for surgery at Manning Hospital. They often returned to his private rooms and some were encouraged not to attend Manning Hospital after complications arose. His medical records were not available to the hospital, nor were any test results. It follows that the extent to which oversight could have occurred, if there was a view it should have, was limited.

76. I am concerned about a situation in which a public hospital provides facilities for a Visiting Medical Officer obstetrician gynaecologist to practise without the hospital having the capacity to ensure that those female patients are being cared for at the standard expected in a public hospital.

77. In my view, the public health system should have sufficient information about patients receiving procedures in its hospitals and using its ancillary staff to be satisfied that the procedures are being performed to an appropriate standard.

78. Secondly, mechanisms for oversight were not used. There was a requirement for regular performance reviews of Visiting Medical Officers. This did not occur with Dr Gayed.

79. There were no clinical supervision plans of him as required by policy.

80. Aggregate reviews of incidents recorded on IIMS were not completed or not documented.

81. The doctors did not record concerns on IIMS at all and the nurses did so selectively.

82. There was no evidence available to me that, before the arrival of Dr Roberts, there was any review of the IIMS undertaken to enable any pattern to be detected; or reviews followed up.

83. Thirdly, senior staff were not available to provide supervision and monitoring. There was no Director of Obstetrics and Gynaecology until April 2015. It is no coincidence that IIMS and other complaints escalated from mid-2015. An anaesthetist, Dr Bourke told me that there were discussions among colleagues and no reporting because ‘there was no-one to report to’.

84. The Director of Clinical Services was a Career Medical Officer Emergency Department doctor who responded to IIMS reports concerning Dr Gayed. I have documented the occasions on which Dr Wills was unduly favourable to Dr Gayed, did not follow policy and minimised the seriousness of concerns raised.

85. Fourthly, the hospital was reliant on Dr Gayed providing most of the obstetrician and gynaecologist services.

86. Local health districts need to identify these circumstances, particularly in regional, rural and remote areas, and ensure there is external oversight of the performance of medical practitioners providing such services.

87. Fifthly, the indicators in place, Morbidity and Mortality meetings and various 'trigger' events were not sufficiently sensitive or effectively monitored to detect Dr Gayed's poor performance.

88. Sixthly, there was an attitude which prevailed that what occurred outside Manning Hospital with Dr Gayed was irrelevant to the experience of Manning Hospital. Hence:

    (a) Following the report of the Professional Standards Committee in 2001, the Mid North Coast Area Health Service did not carry out a review of Dr Gayed's clinical privileges or a risk assessment as to Dr Gayed's continued appointment at the Hospital.

    (b) The area health service / local health district did not make any enquiries of previous places of employment, the Medical Board / Medical Council or the HCCC when Dr Gayed reapplied for appointment as a Visiting Medical Officer in 2003, 2006, 2007 and 2011.

    (c) The local health district did not carry out a review of Dr Gayed's clinical privileges after it was notified by the Director of Clinical Governance at Northern Sydney and Central Coast Area Health Service of its effective suspension of Dr Gayed.

    (d) After that notification, the local health district did not have Dr Gayed's performance reviewed by one or more clinicians who were of the same speciality and did not have an appointment with or work as a staff specialist at Manning Hospital. Such a review would have avoided any conflict or bias towards a Visiting Medical Officer who carried a large burden of the roster of the hospital and was a colleague of many at Manning Hospital.

89. With the appropriate leadership, within both the hospital and the local health district, this attitude should not have prevailed.

90. Finally, staff relied too heavily on the Medical Board providing oversight and imposing conditions on or correction of Dr Gayed's performance. They believed that, because Dr Gayed's performance did not change after intervention by the Medical Board, his performance was satisfactory.

91. Staff became desensitised to his poor performance.

92. Dr Wills told me that he relied on the Medical Board / Medical Council to determine whether Dr Gayed was fit for practice and did not consider that to be his role. He said he made statements and gave evidence based on his experience of Dr Gayed alone.

93. Dr Wills was entitled to rely upon the Medical Board / Medical Council to carry out its regulatory functions. The Medical Board / Medical Council was the only body with overall knowledge of performance concerns of Dr Gayed from his public and private appointments and private practice. It assessed his performance from time to time and had the benefit of the views of those assessors.

94. However, the responsibility of the Medical Board / Medical Council did not relieve the hospital from properly reviewing Dr Gayed's performance by a clinician with the same expertise, on a regular basis. That was not done.

95. Hunter New England Local Health District told me that there are now a number of mechanisms in place which should identify a practitioner with similar problems. I am told that some of these processes were in place during the time Dr Gayed was working at Manning Hospital.

96. I have not considered current practices and procedures at Manning Hospital in respect of the above matters.

Recommendations

97. I recommend that governance processes of Hunter New England Local Health District be reviewed to ensure that IIMS reports are monitored at a local health district level to enable issues of patient safety relative to a particular clinician to be identified and to ensure that relevant staff have undertaken the reviews and investigations which the IIMS records as to be or having been undertaken.

98. I recommend that public hospitals which have arrangements with Visiting Medical Officers to undertake procedures on their private patients, using public facilities, should establish mechanisms to ensure access to sufficient information about those patients to be satisfied that the procedures are being performed to an appropriate standard.

99. The hospital was reliant on Dr Gayed providing most of the obstetrician and gynaecologist services. Local health districts need to identify these circumstances, particularly in regional, rural and remote areas, and ensure there is external oversight of the performance of medical practitioners providing such services.

Chapter 1: Introduction

1. Inquiry established under the s 122 of the *Health Services Act 1997* (NSW)

100. On 21 June 2018, the Secretary of NSW Health, Ms Elizabeth Koff, appointed me to conduct an independent inquiry.

101. The inquiry was established under s 122 of the *Health Services Act 1997* (NSW) (**Health Services Act**).[4]

1.1 Terms of reference

102. The terms of reference for the inquiry are as follows:

> I, Elizabeth Koff, Secretary, NSW Health hereby initiate an inquiry under section 122(1)(c) of the Health Services Act 1997.
>
> Ms Gail Furness SC is appointed to conduct an inquiry to review the actions of the following local health districts at which Dr Gayed held an appointment between 1990 and 2016 in respect of the appointment of Dr Gayed, management of complaints about Dr Gayed, and compliance with conditions imposed on Dr Gayed by relevant regulatory bodies including the NSW Medical Council (and formerly the NSW Medical Board):
>
> - Kempsey District Hospital (being a public hospital controlled by Mid North Coast LHD)
> - Cooma Hospital and Health Service (being a public hospital controlled by Southern NSW LHD)
> - Manning Hospital (being a public hospital controlled by Hunter New England LHD)
> - Mona Vale Hospital (being a public hospital controlled by Northern Sydney LHD) (the LHDs)
>
> Ms Furness will be assisted in the inquiry by a medical advisor with expertise in obstetrics and gynaecology.
>
> The terms of reference for the inquiry are:
>
> (1) To review documentary material to be provided by each LHD relating to
>
> (a) appointment (including delineation of clinical privileges) of Dr Gayed as a visiting medical officer in obstetrics and gynaecology, and
>
> (b) the management of Dr Gayed following his appointment, including:
>
> (i) management of any complaints, adverse events or performance issues in relation to Dr Gayed;
>
> (ii) monitoring of compliance by Dr Gayed with any conditions of appointment imposed by the LHD;
>
> (iii) any variation or withdrawal of Dr Gayed's clinical privileges by the LHD; and

[4] *Health Services Act 1997* (NSW) s 122(1)(c).

(iv) the consistency of Dr Gayed's conditions of appointment and/or clinical privileges at an LHD with any registration or other conditions or orders imposed on Dr Gayed by the NSW Medical Council (formerly the NSW Medical Board), a professional standards committee or tribunal, notified to the LHD,

to identify whether the processes followed complied with applicable NSW Health and LHD policies in place at the time.

This will include an assessment of compliance by the LHDs (as applicable given relevant date ranges) with the following NSW Health policy directives: PD2008_071 Identification and management of medical practitioners in compliance with registration conditions (issued on 24 December 2008), and PD2009_004 Service Check Register for NSW Health Services (issued on 30 January 2009, including any replacement policy).

(2) Review the material provided to identify whether each LHD appropriately reported to the NSW Medical Council (formerly the NSW Medical Board) any conduct of Dr Gayed that may constitute professional misconduct or unsatisfactory professional conduct pursuant to section 99A of the Health Services Act 1997, or notifiable conduct under the Health Practitioner Regulation National Law (NSW).

(3) In light of the above review, advise of in respect of any further review or audit of clinical outcomes that in the reviewer's opinion should be considered in respect of Dr Gayed's clinical practice, including in respect of any specific procedures or cohorts of patients.

(4) If during the course of the inquiry the reviewers identify any matters that trigger a mandatory notification obligation to the Australian Health Practitioners Regulation Agency, these are to be promptly notified to AHPRA and at the same time advised to the Health Care Complaints Commission.

The inquiry is required to provide a report on the outcome of the review by 30 September 2018.

103. The terms of reference were amended on 2 July 2018 to include Grafton Hospital. The time frame was extended until 31 October 2018.

104. Ms Georgina Wright of counsel assisted me in the inquiry.

1.2 Dr Jenkins' appointment

105. The Secretary of NSW Health appointed Dr Greg Jenkins MBBS FRANZCOG, Clinical Associate Professor O&G, UNDA, to assist the inquiry. Dr Jenkins is an obstetrician and gynaecologist.

1.3 Medical Council inquiry

106. On 29 June 2018, I was appointed by the Medical Council of New South Wales (Medical Council) to undertake an independent review of processes undertaken pursuant to Part 8 of the *Health Practitioner Regulation National Law* (NSW)

(**National Law**) with respect to Dr Emil Gayed from the date of his registration as a medical practitioner in New South Wales until 7 March 2018.

107. The resulting report titled Review of processes undertaken by the Medical Council of New South Wales pursuant to Part 8 of the Health Practitioner Regulation National Law (NSW) with respect to Dr Emil Gayed and dated 31 October 2018 has been published on the Medical Council website.

108. I have determined that, because the scope of each inquiry and the issues to be addressed differ, although the subject matter is necessarily related and overlaps, it is necessary to issue a separate report for each inquiry. Whereas the focus of this inquiry under s 122 of the Health Services Act is the management of Dr Gayed by the local health districts and their response to complaints, adverse events or performance issues which arose, the Medical Council inquiry is focused upon the regulatory response of the Medical Council.

109. I have been provided with all relevant documents by the Medical Council. To the extent relevant, I have referred to those documents in my inquiry under s 122 of the Health Services Act.

1.4 Extension

110. On 30 October 2018, at my request, the Secretary of NSW Health extended my reporting deadline for the inquiry under s 122 of the Health Services Act to 31 January 2019. The reason for that extension is that several audits or reviews were being conducted by the Hunter New England Local Health District of clinical outcomes involving patients treated by Dr Gayed in that local health district. The outcome of those audits or reviews were relevant to this inquiry.

1.5 Assistance provided by NSW Health

111. At the time the inquiry was established, the Ministry of Health issued a media release announcing the inquiry and established a page on the Ministry's website with information about the inquiry, including:

- a copy of the inquiry terms of reference;
- details about how any person may make a submission to the inquiry via a dedicated inquiry email address; and
- contact telephone numbers at all five local health districts for any person concerned about the treatment they have received from Dr Gayed.

112. The local health districts telephone lines have remained in operation since the commencement of the inquiry.

113. Some former patients who contacted the dedicated telephone numbers asked to be put in direct contact with the inquiry and others emailed the inquiry. Inquiry

staff contacted each person. As at 30 November 2018, 26 women had contacted the inquiry.

114. The Ministry of Health also wrote to all licensed private health facilities in New South Wales advising of the inquiry.

115. On behalf of the inquiry, the Ministry of Health has also written directly to:

- the Manning Hospital Medical Staff Council through its chairman; and
- individual clinicians who worked with Dr Gayed at Manning Hospital,

inviting any individual who wishes to make a submission, or to provide information to the inquiry, to do so using the dedicated inquiry email address.

116. I provided a draft report of relevant sections to each of the local health districts (via the Ministry of Health) to provide each with an opportunity to make submissions. Substantive submissions were received from Northern Sydney Local Health District, Hunter New England Local Health District and Northern NSW Local Health District. I also provided a draft of the chapter concerning Mona Vale Hospital to Dr Annette Pantle, then Director of Medical Services at Manly and Mona Vale Hospitals, who provided a submission in response.

117. I provided the draft report in relation to Manning Hospital to Dr Jim Wills, Manager Clinical Services and Director of the Emergency Department at Manning Hospital; and Dr Nigel Roberts, Director of the Department of Obstetrics and Gynaecology, in order to provide the same opportunity. I received submissions from each of them.

118. I provided Dr Gayed with the draft report to afford him the opportunity to make submissions. He sought and was granted a two-week extension additional to the time given. He provided a short submission.

119. Following the extension of the inquiry and receipt of further information from Hunter New England Local Health District, there were necessary additions made to this report. I provided chapter 8 to Hunter New England Local Health District to provide them with the opportunity to make submissions. Submissions were made on 11 January 2019.

120. All submissions have been taken into account in this report.

2. Contacts to the local health districts

121. As at 30 November 2018, 199 women had contacted Manning Hospital with concerns about the treatment they received from Dr Gayed during his time as Visiting Medical Officer at the hospital.

122. There have been 52 contacts to Mona Vale Hospital. They comprise a combination of calls generated by Mona Vale, calls into the inquiry line and a small number of other types of contacts.

123. Eight people have called Grafton Hospital.

124. Four women contacted Cooma Hospital and wished to speak with the inquiry, which they did. Three women have contacted Kempsey Hospital.

3. Local health districts

125. Currently, 15 local health districts provide hospital services to defined geographical areas which encompass the State of New South Wales. Each local health district controls the public hospitals within its area. However, this has not always been the case. Prior to 1 July 1993, public hospitals in regional areas were governed by their own independent boards. Further, over the period covered by the inquiry, the boundaries, names and governance arrangements of health districts within New South Wales have changed. These changes are summarised below.

126. As at 1 January 1990, New South Wales was divided into six country health regions and 10 area health services in Sydney, Newcastle and Wollongong. Public hospitals within country health regions were managed by their own independent boards, whereas area health services had control of public hospitals within their areas.

127. This remained the same until 1 July 1993, when the six country health regions were replaced by 23 district health services, which assumed control of rural public hospitals. District health services and area health services now controlled all public hospitals (excluding some specialist hospitals such as the Royal Alexandra Hospital for Children).

128. On 16 March 1996, eight larger rural health services were formed to replace the 23 district health services.

129. On 1 July 1998, with the passing of the Health Services Act, rural health services became area health services, meaning that a uniform model applied to regional and metropolitan New South Wales. The whole state was now divided into 17 area health services.

130. On 1 January 2005, the 17 area health services were amalgamated into eight larger area health services.

131. On 1 January 2011, the eight area health services were replaced by 15 local health networks, which were renamed local health districts on 1 July 2011.

4. The Medical Council

132. The primary responsibility of the Medical Council is to protect the public of New South Wales by ensuring that all doctors are properly trained and maintain high standards of professional conduct and competence.

133. The Medical Council was established on 1 July 2010 with the commencement of the National Registration and Accreditation Scheme for health professionals. At that time, responsibility for registering medical practitioners transferred from the New South Wales Medical Board (**Medical Board**) to the Medical Board of Australia.

134. It was the Medical Board that initially registered Dr Gayed as a medical practitioner in New South Wales in 1994. Since 2010 the Medical Board of Australia, supported by the Australian Health Practitioner Regulation Agency, is the registration body for doctors (and other health professionals). The introduction of a national scheme means that health professionals no longer need to hold multiple registrations in the same profession and that uniform registration standards apply across all jurisdictions. In 2010, Dr Gayed's registration as a medical practitioner carried over to the Australian Health Practitioner Regulation Agency.

135. New South Wales did not adopt the regulatory part of the National Registration and Accreditation Scheme which handles complaints and notifications about practitioners. Instead, it retained its own independent complaints processes involving the Health Care Complaints Commission (**HCCC**), the Medical Council and NSW Civil and Administrative Tribunal (a 'co-regulatory' environment). The Medical Board was replaced by the Medical Council. The Medical Council and the HCCC continue to be responsible for receiving and managing complaints about the professional performance, conduct and health of medical practitioners who practise in New South Wales (and medical students). Part 8 of the National Law sets out complaints-handling processes in New South Wales.

5. Co-regulatory structure (1994–2018)

136. The HCCC was established on 1 July 1994. It is an independent body with responsibility for dealing with complaints against, relevantly, medical practitioners, with particular emphasis on the investigation and prosecution of serious complaints in consultation with relevant professional councils.[5]

137. The Medical Board, then the Medical Council, has always been required to notify the HCCC and, since 2010, national boards, of complaints and consult with the HCCC to see if agreement can be reached between them as to the course of action to be taken concerning the complaint.[6]

[5] *Health Care Complaints Act 1993* (NSW) s 3A.
[6] *Medical Practice Act 1992* (NSW) ss 46, 49 (as at 22 March 2005); *Health Practitioner Regulation National Law* (NSW) ss 144C, 145A.

138. The courses of action available to the Medical Board before 2000 included referring the complaint to the HCCC, a committee or the Medical Tribunal of New South Wales (**Medical Tribunal**) for investigation; establishing an Impaired Registrants Panel for conciliation; or directing that the practitioner attend counselling.[7]

139. From October 2000, additionally, the Medical Board could refer the professional performance of the practitioner concerned for assessment.

140. Section 3A of the *Health Care Complaints Act 1993* (NSW) (H**ealth Care Complaints Act**) provides an outline of the HCCC's role in relation to government agencies with functions in connection with the health care system. It also contains principles to which the HCCC and those government agencies are to have regard in carrying out those functions.

141. Those principles are stated in s 3A as follows:

(a) the Commission and those government agencies are to be accountable to the New South Wales community,

(b) the decision-making processes are to be open, clear and understandable for clients and health service providers,

(c) an acceptable balance is to be maintained between protecting the rights and interests of clients and health service providers,

(d) the processes of the Commission and those government agencies are to be effective in protecting the public from harm,

(e) the Commission and those government agencies are to strive to improve the efficiency of the administration of those functions so as to benefit the New South Wales community,

(f) the Commission and those government agencies are to be flexible and responsive as the health care system evolves and changes.

142. The Secretary of NSW Health is responsible for:

(a) facilitating the achievement and maintenance of adequate standards of patient care within public hospitals and in relation to other services provided by the public health system, and

(b) inquiring into the administration, management and services of public health organisations and arranging, as appropriate, inspection of such organisations,[8] and

(c) developing and overseeing the implementation of health policy and regulation and responding to policy and regulatory issues as they emerge.

[7] *Medical Practice Act 1992* (NSW) s 50 (as at 14 July 2001).
[8] *Health Services Act 1997* (NSW) s 122(1).

6. Policies

143. The terms of reference require me to consider whether the processes followed by the local health districts in managing Dr Gayed complied with applicable NSW Health and local health district policies in place at the time.

144. NSW Health had a large number of relevant policies in place in the time frames concerned with this inquiry. A summary of relevant requirements of the policies is set out in chapter 2.

7. Clinical privileges

145. The terms of reference require me to consider the delineation of clinical privileges by each local health district. The delineation of clinical privileges takes place as part of the appointment process and may be reviewed as required. Clinical privileges refer to the kind of work that the local health district determines a doctor is to be allowed to perform at its hospitals. Clinical privileges result from the credentialing process and form part of the conditions of the practitioner's appointment.

146. From at least 1995, and possibly as early as 1985, NSW Health had a policy (Circular 95/24, 'Guidelines for the Delineation of Clinical Privileges of Medical Staff') that required that delineation of clinical privileges occur at the time of appointment and reappointment and that clinical privileges be regularly reviewed with the aid of a Credentials Committee. It required that the then area health service by-laws allow for review of clinical privileges where particular circumstances deem it necessary.

147. Clinical privileges are to be contrasted with conditions of registration. All medical practitioners seeking to practise medicine in New South Wales are required to be registered. Applicants for medical registration must meet certain requirements to become eligible for registration. There are (and were at the time Dr Gayed sought registration) various categories of registration to match different levels of training and experience. The registration categories include, relevantly, doctors with foreign specialist qualifications and experience. Under the legislation, the Medical Board (prior to 2010) and the Medical Board of Australia (since 2010) may, upon registering a doctor, impose such conditions on registration as it thinks appropriate[9] or 'necessary or desirable'.[10] Conditions on a doctor's registration may relate to aspects of practice or to any impairment, or other matters. Conditions on practice prevent the doctor from legally undertaking the relevant clinical practice. As such, clinical privileges granted by a hospital or area health service should be aligned with the doctor's registration status.

[9] Former *Medical Practice Act 1992* (NSW) s 7.
[10] *Health Practitioner Regulation National Law* (NSW) s 83.

8. Reporting to the Medical Board / Medical Council

148. The terms of reference require me to identify whether each local health district appropriately reported to the Medical Council (formerly the Medical Board) any conduct of Dr Gayed that may constitute professional misconduct or unsatisfactory professional conduct as required under s 99A of the Health Services Act or notifiable conduct under the National Law.

149. The duty to report commenced on 1 August 2005 (when s 99A was inserted into the legislation).

150. 'Unsatisfactory professional conduct' is defined by reference to categories of conduct relating to professional practice.[11] It includes, most relevantly to this inquiry, any conduct that demonstrates that the knowledge, skill or judgment possessed, or care exercised, by the practitioner in the practice of medicine is significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience. It also includes any contravention by the practitioner (whether by act or omission) of a condition to which his or her registration is subject.

151. The term 'professional misconduct' does not have a specific meaning; it is a category of 'unsatisfactory professional conduct' which is sufficiently serious to justify suspension or cancellation.[12]

9. Short-form chronology

152. Annexure 1 to this chapter is a short-form chronology.

10. Dr Gayed's professional history

153. Annexure 2 to this chapter is a summary of Dr Gayed's professional history.

[11] *Health Practitioner Regulation National Law* (NSW) s 139B(1); formerly it was defined in s 36 of the *Medical Practice Act 1992* (NSW).
[12] *Health Practitioner Regulation National Law* (NSW) s 139E; formerly, s 37 of the *Medical Practice Act 1992* (NSW).

Annexure 1: Short-form chronology

DATE	KEY EVENTS AND OUTCOMES OF COMPLAINTS MADE TO HCCC
17 May 1994	Dr Gayed is registered as obstetrician and gynaecologist to practise in positions approved by Medical Board. Dr Gayed commences work at Grafton Hospital.
1996	Dr Gayed commences work at Cooma Hospital.
July to October 1997	Three complaints made to HCCC arising from treatment at Cooma Hospital resulted in two of them being prosecuted before Professional Standards Committee in 2001 and the third discontinued as a result of no clinical criticism.
May 1997 – October 1998	Fifteen adverse events at Cooma Hospital reported to Southern Area Health Service.
October 1998	Complaint from Southern Area Health Service to HCCC which was prosecuted before Professional Standards Committee in 2001.
December 1998	Three complaints to HCCC arising from treatment at Cooma Hospital, one of which resulted in no further action as a result of no clinical criticism, one discontinued following investigation as a result of no clinical criticism, and one prosecuted before Professional Standards Committee in 2001.
February 1999	Dr Gayed resigns from Cooma Hospital.
February 1999	Dr Gayed commences at Manning Hospital.
October 1999	Dr Gayed commences at Kempsey District Hospital
April–May 2000	Two complaints to HCCC arising from treatment at Cooma Hospital, one of which prosecuted before Professional Standards Committee in 2001 and the other resulted in no further action because of no clinical criticism.
October 2001	Professional Standards Committee decision: • Guilty of unsatisfactory professional conduct and suffers from an impairment; • Reprimand; • Condition that not perform microsurgery; • Ophthalmologist review; and • Recommend Performance Assessment.
2002	Dr Gayed commences at Mona Vale Hospital.

June 2002	Dr Gayed resigned from Kempsey District Hospital.
2002–2003	Five complaints to Northern Sydney Area Health Service arising from Mona Vale Hospital which resulted in performance assessment by Medical Board.
September 2003	Dr Gayed temporarily suspended from Mona Vale Hospital then reinstated with condition that appointment be reconsidered if further complaints are made.
13 September 2003	First performance assessment by Medical Board.
14 January 2004	Performance assessment report concluded that Dr Gayed was at the standard reasonably expected and that he should have informal counselling.
March 2004	Complaint to HCCC arising from treatment at Mona Vale Hospital with the result of no further action because the clinical advice was not critical.
March 2006	By consent, the Medical Tribunal removed the conditions of not performing microsurgery and ophthalmology review.
June 2007	Northern Sydney Area Health Service referred to HCCC four cases that occurred between December 2006 and March 2007 which were dealt with by way of performance assessment by Medical Board.
March 2007	Dr Gayed resigned from Mona Vale Hospital when told he would be suspended.
March 2007	Dr Gayed's clinical privileges temporarily suspended at Delmar Private Hospital arising from the treatment of three patients.
August 2007	Complaint to Medical Board arising from treatment at Mona Vale Hospital and Delmar Private Hospital which was dealt with by way of performance assessment by Medical Board.
October 2007	Second performance assessment by Medical Board.
January 2008	Performance assessment report was critical of Dr Gayed's competence and recommended Performance Review Panel.
April 2008	First Performance Review Panel by Medical Board.
June 2008	Finding of Performance Review Panel was unsatisfactory professional performance and the panel imposed conditions limiting surgery he could perform and required a mentor.

July 2009	Complaint referred from HCCC to Medical Board arising from treatment at Manning Hospital which resulted in no further action.
August 2009	Mentoring condition removed.
May 2010	Complaint to Medical Board arising from treatment at Manning Hospital was discontinued.
July 2011	Complaint to HCCC arising from treatment at Manning Hospital was discontinued.
October 2013	Performance reassessment by Medical Council found that Dr Gayed's performance was unsatisfactory.
November 2013	Complaint to HCCC arising from treatment at Manning Hospital was discontinued.
October 2014	Second Performance Review Panel by Medical Council.
December 2014	Second Performance Review Panel report found that Dr Gayed's performance was satisfactory and made a minor variation to conditions on his registration.
March 2015	Complaint to HCCC arising from treatment at Manning Hospital was discontinued because Dr Gayed was already in performance assessment.
November 2015	Two complaints to HCCC arising from treatment at Manning Hospital was prosecuted before the NSW Civil and Administrative Tribunal.
February 2016	Dr Gayed suspended then resigned from Manning Hospital.
March 2016	Complaint to HCCC arising from treatment at Manning Hospital was discontinued.
March 2016	Complaint to HCCC from Hunter New England Local Health District concerning six patients of which two were prosecuted before the NSW Civil and Administrative Tribunal.
March 2016	Three complaints to HCCC arising from treatment at Manning Hospital, two of which were prosecuted before the NSW Civil and Administrative Tribunal and one was discontinued.
April 2016	Section 150 proceedings by Medical Council: further conditions imposed.
May 2017	Complaint to HCCC arising from treatment at Manning Hospital was discontinued.

July 2017	Complaint to HCCC arising from treatment at Manning Hospital was discontinued.
November 2017	Complaint to HCCC arising from treatment at Manning Hospital was discontinued.
November 2017	Complaint to HCCC arising from treatment at Manning Hospital was discontinued.
December 2017	Dr Gayed's registration suspended by Medical Council.
February 2018	Medical Council lifts suspension, replaces with condition not to practice.
March 2018	Dr Gayed surrenders his registration.
June 2018	NSW Civil and Administrative Tribunal disqualifies Dr Gayed from being a registered medical practitioner for three years.
October 2018	NSW Civil and Administrative Tribunal hands down reasons for decision.

Annexure 2: Dr Gayed—professional history

1. Background

154. Dr Gayed presented curriculum vitae at the time of his applications for appointment as a Visiting Medical Officer to Manning Hospital (2003) and to Mona Vale Hospital (2002). The professional history described here is largely sourced from those documents.[13] Information about his professional history postdating those applications is sourced from other documents obtained during the inquiry.

2. Qualifications

155. Dr Gayed's curriculum vitae notes that he holds the following qualifications:

(a) MB, BCh, Ain Shams University, Cairo, December 1976;

(b) LRCP (Edinburgh), LRCS (Edinburgh), LRCPS (Glasgow), April 1982;[14]

(c) D Obst RCP, Ireland, April 1983;[15]

(d) DRCOG, London, May 1983;[16]

(e) MRCOG,[17] London, January 1985;[18]

(f) FRACOG, Australia, October 1993;[19] and

(g) FRCOG, London, April 1998.[20]

3. Training

156. Dr Gayed's curriculum vitae indicated that he held the following general training positions:

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[13] Dr Emil Gayed, Curriculum Vitae, undated (likely 2003) (Tab 2.a.5, HNELHD documents); Letter from Dr Emil Gayed to Dr Robert Porter, Area Director Clinical Services, Mid North Coast Area Health Service, 20 March 2003, enclosing Mid North Coast Area Health Service, Senior Medical & Dental Staff Application for Employment, signed 20 March 2003 (Tab 2.a.4, HNELHD documents); curriculum vitae (Tab 2.2, NSLHD documents).

[14] Letter from Registrar, Royal College of Physicians or Edinburgh, Royal College of Surgeons of Edinburgh, Royal College of Physicians and Surgeons of Glasgow, to Dr Emil Shawky Gayed, 5 April 1982 (Tab 2.a.4, HNELHD documents).

[15] Letter from Secretary, Royal College of Physicians of Ireland, to Dr Gayed, April 1983 (Tab 2.a.4, HNELHD documents).

[16] Letter from Secretary, Royal College of Obstetricians & Gynaecologists, to Dr Emil Shawky Gayed, 20 May 1983 (Tab 2.a.4, HNELHD documents).

[17] Medical Council documents (Tabs 310, 356).

[18] Letter from College Secretary, Royal College of Obstetricians and Gynaecologists, to Dr Emil Shawky Gayed, 25 January 1985 (Tab 2.a.4, HNELHD documents).

[19] Letter from FC Hindle, President, The Royal Australian College of Obstetricians and Gynaecologists, to Dr Emil S Gayed, 30 October 1993 (Tab 2.a.4, HNELHD documents).

[20] Letter from College Secretary, Royal College of Obstetricians & Gynaecologists, to Dr ES Gayed, 23 March 1998 (Tab 2.a.4, HNELHD documents).

(a) 1 March 1977 – 28 February 1978
General and Elective Training
Intern Resident House Officer
Ain Shams University Hospital, Cairo;

(b) 1 March 1978 – 31 August 1978
Training in General Surgery
Senior House Officer in General Surgery
Coptic Hospital, Cairo;

(c) 1 April 1979 – 31 December 1979
General and Elective Training
Senior House Officer in Geriatric Medicine
Fairfield General Hospital, Bury, Lancashire;

(d) 1 February 1980 – 31 July 1980
General and Elective Training
House Officer in General Medicine
Hairmyers Hospital, East Kirlbride, Scotland; and

(e) 1 August 1980 – 31 January 1981
Training in General Surgery
House Officer in General Surgery
Glasgow Royal Infirmary, Glasgow.

157. Dr Gayed's curriculum vitae indicated that he held the following training positions in obstetrics and gynaecology:

(a) 1 February 1981 – 31 January 1982
Pre-membership Training in Obstetrics and Gynaecology
Senior House Officer in Obstetrics and Gynaecology
Victoria Hospital and Forth Park Hospital, Kirkcaldy, Fife;

(b) 1 March 1982 – 10 May 1982
Pre-membership Training in Obstetrics and Gynaecology
Senior House Officer in Obstetrics and Gynaecology
Dyrburn Hospital, Durham;

(c) 10 May 1982 – 9 November 1982
Pre-membership Training in Obstetrics and Gynaecology
Senior House Officer in Obstetrics and Gynaecology
St Mary's Hospital, London;

(d) 6 December 1982 – 5 July 1983
Pre-membership Training in Obstetrics and Gynaecology
Registrar (Acting) in Obstetrics and Gynaecology
Gravesend and North Kent Hospital, Gravesend;

(e) 4 July 1983 – 31 July 1983
Pre-membership Training in Obstetrics and Gynaecology
Registrar in Obstetrics and Gynaecology
East Glamorgan General Hospital, Church Village, Pontyprid, Wales;

(f) 1 August 1983 – 31 March 1984
Pre-membership Training in Obstetrics and Gynaecology
Registrar (Acting) in Obstetrics and Gynaecology
Birch Hill Hospital, Rochdale, Lancashire;

(g) 1 April 1984 – 20 May 1985
Post-Membership Training in Obstetrics and Gynaecology
Registrar in Obstetrics and Gynaecology
Stirling Royal Infirmary, Stirling, Scotland;

(h) 20 May 1985 – 7 July 1985
Post-Membership Training in Obstetrics and Gynaecology
Senior Registrar in Obstetrics and Gynaecology
Guy's Hospital, London;

(i) 8 July 1985 – 20 July 1986
Post-Membership Training in Obstetrics and Gynaecology
Senior Registrar (Acting) in Obstetrics and Gynaecology
Farnborough Hospital, Orpington, Kent;

(j) 28 July 1986 – 7 September 1986
Post-Membership Training in Obstetrics and Gynaecology
Consultant Obstetrician and Gynaecologist
Walsgrave Hospital, Coventry; and

(k) 15 September 1986 – 12 October 1986
Post-Membership Training in Obstetrics and Gynaecology
Consultant Obstetrician and Gynaecologist
District General Hospital, Eastbourne.

4. Positions held as a specialist obstetrician and gynaecologist other than in New South Wales

158. Dr Gayed's curriculum vitae indicated that he held the following positions as a specialist obstetrician and gynaecologist overseas:

(a) 28 November 1986 – 14 January 1989
Specialist Obstetrician and Gynaecologist
Al Hasa and Dhahran Health Centres
Aramco, Dhahran, Saudi Arabia;

(b) 15 January 1989 – 21 April 1994
Head Obstetrician and Gynaecologist

Al Hasa and Dhahran Health Centres
Aramco, Dhahran, Saudi Arabia; and

(c) 12 April 1988 – 22 April 1988
21 May 1990 – 28 May 1990
15 March 1993 – 28 March 1993
13 January 1994 – 25 January 1994
Locum Consultant Obstetrician and Gynaecologist
(while working in Saudi Arabia)
Farnborough Hospital, Farnborough, Orpington, Kent

159. In his curriculum vitae, Dr Gayed reported that while working as a consultant with the Aramco Medical Services Organisation in Saudi Arabia he was appointed as chairman of the Quality Assurance Committee.

160. Dr Gayed reported that in 1989, when he was promoted to the position of Head Obstetrician and Gynaecologist (at Aramco), he led a team of 15 consultants. He reported that:

(a) He reviewed organisational policies and procedures and developed new ones, participated in Senior Staff Executive Meetings and assisted the General Medical Director in developing best-practice management guidelines and protocols.

(b) He coordinated the Perinatal Morbidity/Mortality Committee, organised seminars and meetings for general practitioners and developed a monthly educational conference for obstetricians and gynaecologists.

(c) He supervised, supported and taught registrars and junior medical staff and participated in the teaching of medical students and student midwives.

(d) He ran the Obstetric and Gynaecological Department, including sharing on-call duties, organising duty rosters, reviewing adverse outcomes, addressing complaints, reporting to higher management and assuring the quality of care of all services delivered.

5. Positions held as a specialist obstetrician and gynaecologist in New South Wales and Canberra

161. Dr Gayed's curriculum vitae, other documents and more recent statements required to be provided under the National Law[21] indicate that he held the following positions as a specialist obstetrician and gynaecologist in Australia (noting, however, that there were some discrepancies between CVs presented):

[21] For example, notices provided to the Medical Council (Tabs 310, 356).

(a) 18 May 1994 – 30 June 1995
Specialist Obstetrician and Gynaecologist – VMO
Grafton Base Hospital, Grafton, NSW;

(b) July 1995 – February 1995
Specialist Obstetrician and Gynaecologist – VMO
Canberra Hospital, ACT;[22]

(c) 1 July 1995 – 30 June 2002
Specialist Obstetrician and Gynaecologist – VMO
John James Memorial Hospital, Deakin, ACT;

(d) 22 January 1996 – 30 June 2002
Specialist Obstetrician and Gynaecologist – VMO Calvary Private Hospital, Bruce, ACT;

(e) 1 February 1996 – 9 February 1999
Specialist Obstetrician and Gynaecologist – VMO
Cooma Hospital, Cooma, NSW;[23]

(f) 10 August 1999 – 28 February 2016
Specialist Obstetrician and Gynaecologist – VMO
Manning Base Hospital, Taree, NSW;[24]

(g) 25 October 1999 – 3 June 2002
Specialist Obstetrician and Gynaecologist – VMO
Kempsey District Hospital, NSW;[25]

(h) 1 July 2002 – 5 March 2007
Specialist Obstetrician and Gynaecologist – VMO
Mona Vale Hospital, Mona Vale, NSW;[26]

(i) Mayo Private Hospital, NSW
Precise dates unknown: approx 2001–2016;

[22] Dr Emil Gayed, Curriculum Vitae, undated (likely 2001) (Tab 19, PSC documents); but not referred to in the curriculum vitae presented to Hunter New England Area Health Service.
[23] Dr Emil Gayed, Curriculum Vitae, undated (likely 2001) (Tab 19, PSC documents); curriculum vitae presented to Mona Vale Hospital (Tab 2, NSLHD documents); his 2003 curriculum vitae did not refer to Cooma Hospital experience (HNELHD documents)
[24] Dr Emil Gayed, Curriculum Vitae, undated (likely 2003) (Tab 2.a.5, HNELHD documents); Hunter New England Local Health District, Dr E Gayed Employment Timeline (Tab 1, HNELHD documents); Letter from Dr Gayed to Dr Osama Ali, Deputy Director Clinical Services, Manning Rural Referral Hospital, 28 February 2016 (Tab 4.a.59, HNELHD documents).
[25] Not referred to in curriculum vitae presented to Mona Vale Hospital (Tab 2.2, NSLHD files); Letter to Inquiry from Mid North Coast Local Health District, 4 July 2018.
[26] Dr Emil Gayed, Curriculum Vitae, undated (likely 2003) (Tab 2.a.5, HNELHD documents); Dr Gayed also had two temporary appointments to Mona Vale Hospital: 10–13 May 2002 and 7–10 June 2002; Letter from Dr Pantle to Dr Gayed, 9 May 2002 (Tab 1.1, NSLHD documents); Letter from Dr Sanderson to Dr Gayed dated 7 March 2006 [with 2006 apparently a typographical error] (Tab 4.43, p 1096, NSLHD documents).

(j) Warringah Day Surgery, Brookvale, NSW
Precise dates unknown: approx 2008–2016; and

(k) Delmar Private Hospital, Dee Why, NSW
Precise dates unknown: at least 2004–2007.

162. In his curriculum vitae, Dr Gayed reported that in Grafton, New South Wales, he worked a 1 in 2 obstetric roster and that he performed 684 gynaecological procedures over a period of 14 months.

163. In his curriculum vitae, Dr Gayed reported that in Canberra he had a well-established private practice with private rights at the John James Memorial Hospital from July 1995 and at Calvary Private Hospital from January 1996. He reported that he also had a large number of public obstetric patients to whom he provided both antenatal and postnatal care. He reported that he performed a total of 654 gynaecological procedures at Canberra private hospitals.

164. Dr Gayed reported that he held a public position at Cooma Hospital, New South Wales, from February 1996 to February 1999. He reported that he performed a total of 477 gynaecological procedures during this time.

165. Dr Gayed reported that he held a position as a Visiting Medical Officer obstetrician gynaecologist at the Manning Hospital in Taree, New South Wales, from August 1999. He noted that he participated in a 1 in 4 obstetric roster and a busy gynaecological practice.

166. Dr Gayed reported in his curriculum vitae that he had a subspecialty interest in 'high risk Obstetrics and Maternal-Fetal medicine'. He stated that in gynaecology he had a subspecialty interest in infertility and gynaecological endocrinology. He stated that he had also 'developed a major interest in minimally invasive surgery in the form of operative hysteroscopy, endometrial ablation and laparoscopic hysterectomy'.

6. Teaching

167. Dr Gayed reported in his curriculum vitae (in both 2002 and 2003) that he was involved in teaching registrars and resident medical officers, including at 'morning hand over meetings, ward rounds, weekly educational sessions, case studies and journal club'. He noted that he regularly gave a lecture or two on an annual basis to general practitioners in Canberra and Taree and made presentations to the ACT Family Planning Clinic Educational Meetings.

7. Research

168. Dr Gayed noted in his curriculum vitae (as at 2003) that he had completed the following research:

(a) a three-year study in diabetes in pregnancy;

(b) a three-year study in sickle cell disease in pregnancy;

(c) a one-year study in shoulder dystocia and related birth injuries;

(d) monitoring of caesarean sections for seven years; and

(e) development of a large obstetric database program, including data for almost 20 000 patients over a seven-year period in Saudi Arabia.

169. Dr Gayed did not provide information about the location of these studies, other than the obstetric database.

8. Post-membership continuing medical education

170. Dr Gayed reported that he undertook continuing medical education on an annual basis from 1987 onwards.[27] In his 2003 curriculum vitae, Dr Gayed reported that he had completed more than the required amount of continuing medical education for the five-year period ending in November 2003.[28]

9. Patient satisfaction survey and John James Memorial Hospital data

171. On 20 June 2001, the Royal Australian and New Zealand College of Obstetrics and Gynaecology provided Dr Gayed with the results of a patient satisfaction survey. The report noted: 'Overall, these results are a reflection that the majority of your patients are very satisfied with the level of care they receive from your practice. For this you and your staff should be congratulated.'[29] He put that survey forward in support of subsequent applications for appointment and later when complaints arose.

172. In July 2001, Dr Gayed made a request to the John James Memorial Hospital for clinical indicator data. On 26 July 2001, the hospital provided clinical indicator results in relation to a number of areas, including unplanned returns to hospital within 28 days of discharge; unplanned returns to operating room during the same admission; post-operative pulmonary embolism; clean surgical site infections; contaminated surgical site infections; and hospital-acquired bacteraemia. The data showed Dr Gayed's rates in each area to be lower than both the general hospital rate and the Department of Obstetrics and Gynaecology rate at John James Memorial Hospital.[30]

[27] Also see Curriculum Vitae (likely 2001) (Tab 19, PSC documents).
[28] Dr Emil Gayed, Curriculum Vitae, undated (likely 2003), p 8 (Tab 2.a.5, HNELHD documents).
[29] Letter from Ms Valerie Jenkins, Manager, Fellowship Services, to Dr Emil Gayed, enclosing The Royal Australian and New Zealand College of Obstetricians and Gynaecologists, Patient Satisfaction Questionnaire Report, ID No 143 (Tab 4.a.19, HNELHD documents).
[30] Letter from Ms Gillian Kailofer, Quality Development Unit, John James Memorial Hospital, to Dr Emil Gayed, 26 July 2001 (Tab 4.a.5, HNELHD documents).

10. References

173. A significant number of references were provided for Dr Gayed by other practitioners over the years and are among the material made available to the inquiry. Dr Gayed put forward references in a number of contexts: in support of his application for membership of the Royal Australian College of Obstetricians and Gynaecologists; for appointment at various hospitals; for the purpose of the disciplinary proceedings in the Professional Standards Committee; and for the purpose of, and in response to, performance assessments undertaken by the Medical Board. An outline of the main references is provided in this section.

174. Many positive references for Dr Gayed were located in the documents.

175. On 20 July 2001, Dr BF, Gynaecologist and Urogynaecologist, noted that:

> Whilst operating in the same hospitals as Emil I have had no reason to doubt his competence. He has performed a large number of elective and emergency procedures in Manning Base Hospital where he has been part of a 1:4 roster. As far as I am aware he has had no major complications or unscheduled returns to theatre in the last 2–3 years.
>
> There have been no concerns raised with me by nursing staff or patients with regard to any aspect of Dr Gayed's practice.[31]

176. Further, Dr Jim Wills of the Mid North Coast Area Health Service provided positive references for Dr Gayed on many occasions between 2001 and 2014, the detail of which appears in the report.

177. On 29 July 2001, Ms LW, a registered nurse who worked at the John James Memorial Hospital, noted that Dr Gayed always remained calm, courteous and polite to the entire theatre team. She further noted: 'I have always found him to be very consistent and methodical and I have not been involved in any call-backs with his patients.'[32]

178. On 31 July 2001, Dr PM, obstetrician/gynaecologist in Canberra, reported that he had not personally seen Dr Gayed operate but that, as chairman of the Division of Obstetrics and Gynaecology from 1990 to 1996 and as ACT chairman of the College of Obstetrics and Gynaecology since 1996, he had not received or heard one adverse report concerning the care of his patients. Dr PM also noted that he had reviewed data from John James Memorial Hospital and that it would appear from the hospital data that the complication rate concerning Dr Gayed's surgery is less than the average for his colleagues.[33]

179. On 6 August 2001, the Chief Executive Officer of the Mayo Private Hospital noted that Dr Gayed had been a visiting obstetrician and gynaecologist for two years. The

[31] Letter from Dr BF, Gynaecologist and Urogynaecologist, to Ms Helen Turnbull, United Medical Protection, 20 July 2001 (Tab 10, PSC documents).
[32] Reference from Ms LW for Dr Gayed, 29 July 2001 (Tab 13, PSC documents).
[33] Letter from Dr PM, Obstetrician/Gynaecologist, to Mrs Helen Turnbull, United Medical Protection, 31 July 2001 (Tab 18, PSC documents).

reference noted that, during the period that Dr Gayed had operated at the Mayo Hospital, there had been only one complication which was returned to theatre. The reference stated:

> Dr Emil Gayed has been practising at the Mayo Hospital for the past two years and in that time, have [sic] proven to be a competent and diligent surgeon. It would be without hesitation that I would recommend him to any other private facility.[34]

180. On 7 August 2001, Dr PY, Consultant Anaesthetist, noted that he had known Dr Gayed for six years, since he commenced practice at the John James Memorial Hospital in Canberra. Dr PY noted that the hospital regularly publishes Clinical Indicators that relate to individual practitioners. He stated: 'Dr Gayed's rates are without question excellent and probably the best in the hospital, enforcing my own personal perception.' He further stated: 'I have no hesitation in recommending Dr Gayed to a potential patient. His training and experience have produced a very competent gynaecologist who performs successful surgery with minimum complications.'[35]

181. On 7 August 2001, Ms AM, who worked with Dr Gayed as a perioperative sister in the Mid North Coast Area Health Service, stated:

> [Dr Gayed] works calmly and effectively in all operative situations and especially when emergencies arise. In the time that I have worked with Dr Gayed I have never known a patient to return for post-operative surgical complications.[36]

182. On 25 April 2007, Dr JF, Specialist Anaesthetist, who had worked with Dr Gayed for eight years at the Mayo Private Hospital in Taree, stated:

> He has gentle hands, is quick and efficient, with a good tissue sense, and he achieves what he sets out to do.
>
> In the eight years I have seen not one case come back to theatre and have heard no adverse comments on his results from either staff, hospital or patients. …
>
> It is obvious to me that his personality and humanity, coupled with his training and experience, have produced a very competent gynaecologist who performs successful surgery, with minimal complications, while maintaining a pleasant operating environment, happy staff and at the end of it all, very grateful patients.[37]

183. On 24 April 2007, Dr BS, also a Visiting Medical Officer obstetrician gynaecologist at Manning Hospital in Taree, stated:

> [Dr Gayed is] well liked and respected with the midwifery and nursing staff as well as the theatre staff. I have no doubt in his excellent surgical skills which he is willing to offer

[34] Reference from Mr TJ, Chief Executive Officer, Mayo Private Hospital, for Dr Emil Gayed, 6 August 2001 (Tab 7, PSC documents).
[35] Letter from Dr PY, Consultant Anaesthetist, to Ms Helen Turnbull, United Medical Protection, 7 August 2001 (Tab 2.b.3, HNELHD documents).
[36] Reference from Ms AM for Dr Emil Gayed, 7 August 2001 (Tab 11, PSC documents).
[37] Reference from Dr JF for Dr Gayed, 25 April 2007 (Tab 2.b.3, HNELHD documents).

> and share at any possible time if necessary. Dr Gayed has been an excellent colleague to work with.[38]

184. On 9 December 2007, Dr RS, a general practitioner in the Manning Valley area, noted that Dr Gayed is one of his main referral specialists in obstetrics and gynaecology and that he had total confidence in him.[39]

185. On 20 December 2007, Dr EG, a general practitioner in Brookvale, noted that feedback from both gynaecological and obstetric patients had been very positive and that none of his patients operated on by Dr Gayed have had any major surgical complications.[40]

186. On 20 December 2007, Dr HB, a general practitioner in Brookvale, stated that Dr Gayed had 'approached the various problems presented to him in a competent and thoughtful manner and been very respectful towards my patients'.[41]

187. On 25 January 2008, Dr DH, a general practitioner in Taree, stated:

> I have found that his management of my patients has been excellent. He has been very attentive to their problems and has been successful in ensuring a good outcome. I have not had any disappointments from my referrals to him.[42]

[38] Reference from Dr BS, Obstetrician & Gynaecologist, Mayo Specialist Centre, for Dr Emil Gayed, 24 April 2007 (Tab 2.b.3, HNELHD documents).
[39] Reference from Dr RS for Dr Emil Gayed, 19 December 2007 (Tab 2.b.3, HNELHD documents).
[40] Reference from Dr EG, Vale Medical Clinic for Emil Gayed, 20 December 2007 (Tab 2.b.3, HNELHD documents).
[41] Reference from Dr HB for Dr Emil Gayed, 20 December 2007 (Tab 2.b.3, HNELHD documents).
[42] Reference from Dr DH for Dr Emil Gayed, 25 January 2008 (Tab 2.b.3, HNELHD documents).

Chapter 2: Policy requirements

1. Department of Health / Ministry of Health policies

188. In the time frames concerned with this inquiry, there were a large number of policies in place in relation to the appointment of visiting medical practitioners and the management of incidents and complaints about medical practitioners, including reporting and investigation requirements. While many of them touch upon some of the issues the inquiry is concerned with, it is most useful to consider only the key policies.

189. A summary of relevant requirements of the key policies is set out in this chapter.

190. The policies commonly refer to 'health services' or 'health organisations'. These expressions include area health services (when they existed) and local health districts (as they are currently known).

191. The application of the various policies to the events relating to Dr Gayed is addressed in later chapters of the report concerning Dr Gayed's appointments to public hospitals in New South Wales.

2. Policies governing the appointment of visiting medical practitioners and delineation of clinical privileges

192. At all times between December 1993 and 28 February 2016 that Dr Gayed worked in public hospitals in New South Wales, he was appointed as a Visiting Medical Officer rather than as employed staff. A Visiting Medical Officer is engaged under service contracts.

193. At the time of Dr Gayed's appointments as a Visiting Medical Officer to Grafton, Cooma, Kempsey and Manning hospitals, a number of policies of the (then) Department of Health applied, including:

- Circular 80/135, 'Checking the Credentials of Trained and Professional Staff' (published as a circular on 5 May 1980 and rescinded on 24 January 2005), was a 'reminder to all hospitals of the need to check the credentials of trained and professional staff in their employ'.[43]
- Circular 81/130, 'Registration of Professional Personnel' (PD2005_013, first published as a circular on 18 May 1981 and rescinded on 24 January 2005), 'emphasises again the need for Hospitals to check the registration of all professional and trained staff who require a certificate to work'.[44]

[43] NSW Health, Circular 80/135, 'Checking the Credentials of Trained and Professional Staff', 5 May 1980 (Tab 1, Policies on the appointment of VMOs 1990–2016).
[44] NSW Health, Circular 81/130, 'Registration of Professional Personnel', 18 May 1981 (Tab 10, Policies on the appointment of VMOs 1990–2016).

- Circular 87/225, 'Guidelines Concerning the Assessment of Applicants for Appointment as Visiting Medical Practitioners and Staff Generally' (published 21 October 1987 and rescinded on 8 August 2001), contained guidelines concerning the assessment of applicants for appointment as Visiting Medical Officers and staff generally. It deals with matters of information and confidentiality and, in that context, references. It is concerned with adverse references being kept confidential and applicants being given an opportunity to respond to them.[45]

194. At the time of Dr Gayed's first appointment to a public hospital in New South Wales (Kempsey in 1994), Circular 84/100, 'Delineation of Clinical Privileges', probably applied. The date of publication is not known, but it was rescinded on 3 April 1995 when Circular 95/24 came into force. The policy cannot be found. The existence of that policy suggests that the delineation of clinical privileges was part of the appointment process in 1994.

195. Circular 95/24, 'Guidelines for the Delineation of Clinical Privileges of Medical Staff', probably applied at the time of Dr Gayed's appointments to Cooma Hospital (1996), Kempsey Hospital (1999), Manning Hospital (1999) and Mona Vale Hospital (2002). The policy was published as a circular on 3 April 1995, but the date of rescission is not known. Circular 95/24 contained broad guidelines for the delineation of clinical privileges of medical staff.[46]

196. Circular 95/24 required that delineation of clinical privileges occur at the time of appointment and reappointment and that clinical privileges be regularly reviewed with the aid of the Credentials Committee structure. It required that the area health service by-laws allow for review of clinical privileges where particular circumstances deem it necessary.

197. As set out in Circular 95/24 clinical privileges form part of the conditions of the practitioner's appointment.

198. Circular 95/24 recommended that the Credentials Committee provide advice on privileges for visiting practitioners to the Medical Appointments Advisory Committee, which provides recommendations to the area health service board. The policy stated that the credentialing process must be based on the individual's curriculum vitae, qualifications / college fellowship, a log of procedures or treatments where relevant, evidence of maintaining continuing medical education and experience, competence in the performance of specific procedures or treatments and a supervised assessment where relevant. The policy also set out,

[45] NSW Health, Circular 87/225, 'Guidelines Concerning the Assessment of Applicants for Appointment as Visiting Medical Practitioners and Staff Generally', 21 October 1987 (Tab 4, Policies on the appointment of VMOs 1990–2016).
[46] NSW Health, Circular 95/24, 'Guidelines for the Delineation of Clinical Privileges of Medical Staff', 3 April 1995 (Tab 5, Policies on the appointment of VMOs 1990–2016).

among other matters, the composition of the Credentials Committee and types of privileges.

199. At the time of Dr Gayed's appointments to Kempsey Hospital (1999), Manning Hospital (1999 and 2003/2004) and Mona Vale Hospital (2002), Circular 97/80, 'Procedures for Recruitment and Employment of Staff and Other Persons—Vetting and Management of Allegations and Improper Conduct', applied (published 11 August 1997 and rescinded 25 January 2005). It dealt with procedures for the recruitment and employment of staff and other persons; however, its primary purpose seems to have been in relation to probity screening and managing allegations of criminal and improper conduct.

200. Circular 97/80 required, relevantly:[47]

- criminal record checks for new staff and visiting practitioners;
- health services to request written authorisation from registered health professionals to obtain relevant information from the Health Care Complaints Commission (**HCCC**) and/or registration authority, including of any conditions placed on practice, the nature of any outstanding complaints or pending disciplinary action against the applicant;
- recommended applicants who are registered health professionals to produce proof of current registration, including any conditions on registration;
- 'structured reference checking' involving asking at least two referees specific questions to obtain information 'demonstrating past behaviour and performance of the applicant in situations similar to those which will occur in the position for which they have applied'. It stated that contact with previous and current employers may be desirable, the latter with the applicant's permission. Further, it notes that health services 'reserve the right to contact an applicant's previous employer(s) or institution(s)'; and
- at the time of interview, the health service should discuss with the applicant its right to contact previous employers and/or seek consent to contact current employer.

201. Dr Gayed was appointed to Mona Vale Hospital as a Visiting Medical Officer in 2002. He sought reappointment to work as a Visiting Medical Officer at Manning Hospital in 2003, 2004, 2007 and 2011.

202. Policy 2001/74, 'Framework for recruitment and selection', applied in the period 8 August 2001 (date of publication) to 27 January 2005 (when it was rescinded by NSW Health).

[47] NSW Health, Circular 97/80, 'Procedures for Recruitment and Employment of Staff and Other Persons—Vetting and Management of Allegations and Improper Conduct', 11 August 1997, p 2 (Tab 6, Policies on the appointment of VMOs 1990–2016).

203. Policy 2001/74 outlined the recruitment and selection process. A selection committee was required to make recommendations following the selection process to the chief executive officer (**CEO**) or delegate. Relevantly, the policy stated that 'selection committees are to make all reasonable efforts to verify the claims of the preferred applicant … in relation to achievements, qualifications, employment history and other significant matters'. It required proof of registration and referee checks.

204. In 2005, Circular 97/80 was replaced by Policy Directive PD2005_109, 'Improper Conduct—Procedures for Recruitment/Employment of Staff and Other Persons', which is, relevantly, in similar terms.[48] It was rescinded in 2008.

205. Also, in 2005, the appointment and reappointment of Visiting Medical Officers was the subject of Policy Directive PD2005_496, 'Appointment of visiting practitioners', which applied from 28 February 2005 to 10 January 2014.[49]

206. Policy Directive PD2005_496 required the establishment of various committees; however, relevantly for this inquiry's purpose, it notes that past performance will be taken into account in reappointments: 'It is incumbent on the management of the public health organisation to review the performance of visiting practitioners on a regular basis.' Previous satisfactory service is a relevant and major factor, and previous unsatisfactory performance should only be taken into account when it forms part of the regular performance review process.[50]

207. From February 2005, NSW Health Policy Directive PD2005_497 'Visiting practitioners and staff specialists—Delineation of clinical privileges' (published 28 February 2005 and still in force) sets out the requirements in the event of a review of a practitioner's clinical privileges occurring within an appointment period or as part of a performance review. It recommends a review of clinical privileges when a performance review indicates a practitioner's lack of competence—for example, in the event of higher than expected complications among patients or the outcome of an investigation following a complaint to either the HCCC or the registration authority indicates that a review is appropriate.[51] Like the previous policy concerning clinical privileges, Policy Directive PD2005_497 outlines the role of the Medical and Dental Appointments Advisory Committee as being a committee that provides advice to the area health service chief executive on appointments and the clinical privileges that should be granted and on reviewing privileges for non-routine purposes as required. The Medical and Dental Appointments Advisory

[48] NSW Health, Policy Directive PD2005_109, 'Improper Conduct—Procedures for Recruitment/Employment of Staff and Other Persons', 25 January 2005 (Tab 11, Policies on the appointment of VMOs 1990–2016).
[49] NSW Health, Policy Directive PD2005_496, 'Appointment of visiting practitioners', 28 February 2005 (Tab 14, Policies on the appointment of VMOs 1990–2016).
[50] NSW Health, Policy Directive PD2005_496, 'Appointment of visiting practitioners', 28 February 2005, p 21 (Tab 14, Policies on the appointment of VMOs 1990–2016).
[51] NSW Health, Policy Directive PD2005_497, 'Delineation of clinical privileges for visiting practitioners and staff specialists', 28 February 2005, p 19 (Tab 15, Policies on the appointment of VMOs 1990–2016).

Committee should form subcommittees to advise it, including a Credentials (Clinical Privileges) Subcommittee.

208. The policies which applied from 2014 to date (PD2014_001, 'Appointment of Visiting Practitioners in the NSW Public Health System'; PD2015_023, 'Visiting Practitioner Appointments in the NSW Public Health System'; PD2016_052, 'Visiting Practitioner Appointments in the NSW Public Health System') are in similar terms, although they clarify that matters relevant to suitability which were not addressed in any earlier performance reviews can be considered.[52]

209. To summarise, at the time of Dr Gayed's appointments as a Visiting Medical Officer to the public hospitals at which he practised medicine in New South Wales, the policies applying to the various appointments were as shown in the table below (and as outlined above insofar as relevant to this inquiry).

Policy	**Appointment of Dr Gayed**
Circular 80/135, 'Checking the Credentials of Trained and Professional Staff'	All public hospitals (Grafton, Cooma, Kempsey, Manning Base and Mona Vale hospitals)
Circular 81/130, 'Registration of Professional Personnel'	All public hospitals (Grafton, Cooma, Kempsey, Manning Base and Mona Vale hospitals)
Circular 84/100 'Delineation of Clinical Privileges'	Grafton Hospital
Circular 87/225, 'Guidelines Concerning the Assessment of Applicants for Appointment as Visiting Medical Practitioners and Staff Generally'	All public hospitals (Grafton, Cooma, Kempsey, Manning Base and Mona Vale hospitals)
Circular 95/24, 'Guidelines for the Delineation of Clinical Privileges of Medical Staff'	Cooma (1996) Kempsey (1999) Manning Base (1999) Mona Vale (2002)
Circular 97/80, 'Procedures for Recruitment and Employment of Staff and other persons—vetting and management of allegations and improper conduct'	Kempsey (1999) Manning Base (1999 and 2003/2004) Mona Vale (2002)

[52] NSW Health, Policy Directive PD2014_001, 'Appointment of Visiting Practitioners in the NSW Public Health System', 10 January 2014 (Tab 27, Policies on the appointment of VMOs 1990–2016); NSW Health, Policy Directive PD2015_023, 'Visiting Practitioner Appointments in the NSW Public Health System', 14 July 2015 (Tab 28, Policies on the appointment of VMOs 1990–2016); NSW Health, Policy Directive PD2016_052, 'Visiting Practitioner Appointments in the NSW Public Health System', 16 November 2016 (Tab 31, Policies on the appointment of VMOs 1990–2016).

Policy 2001/74, 'Framework for recruitment and selection'	Mona Vale (2002) Manning Base (2003/2004 only)
Policy Directive PD2005_496, 'Appointment of visiting practitioners'	Manning Base (2007, 2011)
Policy Directive PD2005_497, 'Delineation of clinical privileges for visiting practitioners and staff specialists'	Manning Base (2007, 2011)
Policy Directive PD2005_013 (same as Circular 81/30)	Manning Base (2007, 2011)
Policy Directive PD2005_109, 'Improper Conduct—Procedures for Recruitment/Employment of Staff and Other Persons'	Manning Base (2007)
Policy Directive PD2005_498, 'Performance review of visiting practitioners'	Manning Base Mona Vale

2.1 Compliance with registration conditions

210. In December 2008, NSW Health published a new policy that does not appear to have had any predecessor.

211. Policy Directive PD2008_071, 'Identification and Management of Medical Practitioners in Compliance with Registration Conditions', was published with the aim of ensuring 'that Health Services have procedures in place to facilitate identification, monitoring and compliance with relevant medical registration conditions for any medical practitioner working within the NSW public health system'.[53] This policy remains current.

212. The policy directive requires health services to check, on a quarterly basis, the registration status of all their employed or contracted medical practitioners who have practice conditions placed on their registration by the New South Wales Medical Board (**Medical Board**) and to report as to the compliance of the medical practitioner with the conditions of their registration to the Department of Health.[54]

[53] NSW Health, Policy Directive PD2008_071, 'Identification and Management of Medical Practitioners in Compliance with Registration Conditions', 24 December 2008, p 3 (Tab 39, Policies on the management of incidents, complaints and disciplinary processes 1990–2016).
[54] NSW Health, Policy Directive PD2008_071, 'Identification and Management of Medical Practitioners in Compliance with Registration Conditions', 24 December 2008, p 7 (Tab 39, Policies on the management of incidents, complaints and disciplinary processes 1990–2016).

213. The policy directive states: 'This report should verify that all doctors with practice conditions working in Health Services are compliant with their registration and any attached practice conditions.'[55]

214. The policy states that health services will become aware of conditions through notification by the Medical Board, notification by the practitioner, during the recruitment process or in the context of a review by the health service of the Medical Board's online listing of registered practitioners.

215. The policy says the health service must review the online register for the registration status of all employed or contracted medical practitioners at least on an annual basis.

216. The policy makes clear that the source of the conditions is irrelevant to the requirement to monitor—whether they were imposed by the Medical Board at the time of registration or with the consent of the practitioner, or by a disciplinary or impairment body such as the Medical Tribunal of New South Wales (**Medical Tribunal**) or Professional Standards Committee, an Impaired Registrants Panel or a Performance Review Panel.

217. However, the policy states that the health service is only concerned with practice or registration conditions and 'health conditions about which it has been specifically advised'. The policy explains the difference between health conditions and practice or registration conditions. The latter impact on the doctor's practice of medicine, whereas the Medical Board has responsibility for ensuring compliance with health conditions.

218. This policy also requires the following action by health services:

- the development of a local 'Management and Clinical Supervision Plan' in relation to a practitioner who has practice conditions (which should 'establish a system and timeframes for review of the Plan and the practitioner's performance in relation to both the Plan and the conditions'). The purpose of the plan is to ensure the practitioner undertakes duties in compliance with the conditions;[56] and
- maintenance of a central 'Register of Doctors with Practice Conditions'.[57]

219. The policy refers to the obligation of practitioners to notify health services of any changes to current conditions or where conditions are imposed, consistent with the

[55] NSW Health, Policy Directive PD2008_071, 'Identification and Management of Medical Practitioners in Compliance with Registration Conditions', 24 December 2008, p 10 (Tab 39, Policies on the management of incidents, complaints and disciplinary processes 1990–2016).
[56] NSW Health, Policy Directive PD2008_071, 'Identification and Management of Medical Practitioners in Compliance with Registration Conditions', 24 December 2008, p 8 (Tab 39, Policies on the management of incidents, complaints and disciplinary processes 1990–2016).
[57] NSW Health, Policy Directive PD2008_071, 'Identification and Management of Medical Practitioners in Compliance with Registration Conditions', 24 December 2008, p 9 (Tab 39, Policies on the management of incidents, complaints and disciplinary processes 1990–2016).

requirement in the NSW Health Code of Conduct for reporting of any situations that may affect clinical or professional standards (Policy Directive PD2008_071, section 2.4).

3. Policies governing the management of incidents or complaints about a medical practitioner

3.1 Between 1993 and 2001

220. There does not appear to have been any policy in force for managing complaints about doctors in the first half of 1994, when Dr Gayed was a Visiting Medical Officer at Grafton Hospital.

221. From July 1994 to December 1995, Policy 94/61 required all critical incidents in patient care or hospital management to be referred immediately to the Director, Executive Support Unit (within the Department of Health). This included, relevantly, 'significant bad outcomes due to possible poor hospital/service administration'. The policy did not prescribe a process for less serious incidents. In cases where a question of health system responsibility or ongoing quality of patient care arose, the Director was required to ensure the relevant area, district or departmental director provided advice as to action required.

222. On 15 August 1994, Policy 94/74, 'Management of complaints about Health Services and the Health System' (date of rescission unknown), was published following the establishment of the HCCC. The 'old Complaints Unit of the Department of Health' was disbanded as a consequence. The policy states that the Department's Executive Support Unit would still have a role in coordinating complaints from various sources, including the HCCC.

223. Policy 95/42, 'Changes to Critical Incident Reporting', replaced Policy 94/61; however, the protocols remained the same. A new division in the Department, called the Performance Management Division, would take over the role of the Executive Support Unit in relation to critical incident reports.

224. Policy 97/58, 'Incidents reportable to the Department' (published 20 June 1997; date of rescission unknown), replaced the concept of 'critical incidents' with 'reportable incidents' and broadened the reporting requirements to include incidents that affect public health or safety and, relevantly, a 'complication or adverse outcome in clinical care suggesting an unexpected risk to patients or clients in similar settings in the health system' (Policy 97/58, section 3.1). The CEO of a health service was required to ensure that 'appropriate and effective Reportable Incident procedures are currently in place' within the health service. CEOs were required to send briefings about such incidents to the Department. A briefing was to include information about the incident as specified in the policy (including location and other particulars, description of what happened, cause, and action already taken and to be taken) as well as recommendations.

225. In 1998, 'Better practice guidelines—Complaints handling frontline' was issued. It was reissued as GL2005_061 on 20 May 2005. This policy set out a framework for managing complaints (by a patient, staff, a family member or any person) about any health care or non–health care matter. Health services were required to implement systems and processes to achieve minimum practice. The minimum practice required of health services was outlined in the policy. It included such matters as having written policies and procedures on the health service's complaints-handling system, a simple and consistent complaints-handling system, a system of delegation for management of complaints, policies to acknowledge complaints within three days of the complaint, a requirement to inform parties of the progress of the investigation and finalise the outcome within 35 calendar days, and a data collection system and other matters. The policy also set out a 'generic flowchart' of key steps in complaints handling. (It did not in terms require adverse clinical incidents to be notified or outline how they should be managed if so notified, apart from what could be garnered from the generic flowchart. The policy in effect placed responsibility for developing an effective complaints-handling process on the health service.)

226. Policy 2001/112, 'A framework for managing the disciplinary process in NSW Health' (published 30 November 2001; date of rescission unknown), applied to breaches of discipline rather than clinical incidents; however, it included within the concept of a breach of discipline instances where a practitioner is negligent, careless, inefficient or incompetent in the discharge of his or her duties. CEOs of health services were required to ensure that the health service had a disciplinary policy and procedures and to report to relevant agencies. The policies and procedures must include assessment and investigative processes to identify the key facts of an alleged breach of discipline, address procedural fairness to the staff member involved and keep adequate records. The policy states that risk management strategies are required, including considering options for temporary transfer or suspension from duty pending the outcome of an investigation (Policy 2001/112, section 3.2.1). The policy reminds health services that findings of professional misconduct are the subject of reporting requirements under the *Health Services Act* 1997 (NSW) (**Health Services Act**) by employees and contractors. This policy appears to have been reissued on 27 January 2005 as Policy Directive PD2005_225, 'Disciplinary Process in NSW Health—A Framework for Managing', which was in force until 21 November 2014. PD2005_225 is in the same terms.

3.2 Between 2002 and 2006

227. The policy for managing complaints against doctors and other clinicians applying from 2001 was Policy Directive PD2005_586, 'Guideline on the management of a complaint or concern about a clinician'.

228. NSW Health has informed the inquiry that PD2005_586 was first published in November 2001. It was in force until 21 July 2005.

229. PD2005_586 set out three levels for managing a complaint or concern about the performance of a clinician. The policy states that it was intended to reflect a move from the previous 'serious or nothing' approach. The policy stated that the decision about which level applied depended on the circumstances and the discretion of the general manager of the hospital.

230. The first level of action is in response to a concern about the performance, practice or clinical outcomes achieved by a clinician, short of unexpected mortality or serious morbidity, to be raised with the general manager, who then causes a review of the clinician's performance. The clinician is informed; the method of review depends on the circumstances; and a report is prepared for the general manager and, if necessary, the CEO.

231. The second level of action is warranted when a more serious level of concern arises which warrants an investigation rather than a review. There may be one or more events involving unexpected mortality or increasingly serious morbidity. There may be a pattern of suboptimal performance or variation in clinical outcomes over a period of time. The process of investigation required notification to the CEO of the concern; identifying the issues; collecting relevant information, including, if appropriate, an independent expert opinion; allowing the clinician to respond to the issues; making findings and recommendations based on the evidence; and reporting to the CEO and any relevant statutory bodies. The investigation report should include recommendations and a decision on whether the matter warrants further investigation and communication with the relevant statutory bodies under Level 3 procedures.

232. The third level of action is met when there is a significant concern about the performance of an individual clinician. The policy stated that this may be occasioned, relevantly, by one or more serious events involving unexpected mortality or serious morbidity, poor insight into gaps in own performance or serious concerns by colleagues regarding the health and safety of patients. The registration board must be notified immediately. In consultation with the HCCC, it then determines whether to investigate the matter under its legislation. The health service is also to investigate to determine whether, among other matters, the clinical privileges remain appropriate; and whether the clinician should be supervised, suspended or have their appointment terminated.

233. Policy 2003/88, 'Reportable Incident Briefs to the NSW Department of Health' (published 8 December 2003; date of rescission unknown), applied to health care incidents. It replaced Policy 97/58 and was to be read in conjunction with Policy 2002/19. It introduced a system for the prioritisation and notification of incidents to the Department of Health using a 'NSW Severity Assessment Code' (**SAC**). The term 'reportable incident' was to be used.

234. Under Policy 2003/88, the CEOs of area health services were responsible for establishing systems to ensure the timely notification of incidents to the Department of Health by submitting a written Reportable Incident Brief to the Minister's Office, Director-General of NSW Health (and other specified positions such as Deputy Director-General). CEOs were responsible for ensuring that RIB system protocols and deadlines were adhered to and effectively managed; reviewing all incident reports to ensure they met the SAC criteria before forwarding them to the Department of Health; ensuring root cause analyses were conducted when appropriate and reports of root cause analyses were sent to the Department of Health within 50 days of an incident occurring; and ensuring that regular reports were sent to the health service's board (root cause analyses are outlined further below).

235. Under Policy 2003/88, health service boards were responsible for receiving regular reports about Reportable Incident Briefs in the health service, ensuring that appropriate action was taken to address the causes of the incidents and ensuring that appropriate policies were in place to allow the effective management and prevention of health care incidents.

236. The key steps in the Reportable Incident Brief process are stated in the policy as being:

(a) Incident is identified and reported to a manager;

(b) Incident is prioritised using SAC;

(c) All incidents rating of SAC 1 or 2 are reported to area CEO or delegate;

(d) CEO reassesses incident against SAC matrix to ensure agreement;

(e) SAC 1 incidents must be reported to Department of Health within 24 hours and a RCA [root cause analysis] must be commenced within 5 days;

(f) SACS 2, 3 or 4 that are likely to attract external attention must be reported to Department;

(g) Other incidents may be reported to Department of Health at CEO's discretion;

(h) A report of the results of RCA to be forwarded to Department within 50 days of incident occurring.

237. A SAC score is to be applied to all incidents, whether of a corporate or clinical nature. The score is based on an assessment of the severity of an incident based on the consequences of the incident and the likelihood of its recurrence.

238. This policy was reissued as Policy Directive PD2005_337 on 27 January 2005. It was in force until 8 July 2005. It was then replaced by Policy Directive PD2005_604, 'Incident Management Policy', on 8 July 2005. This was in similar terms. A root cause analysis for a SAC1 incident was required within 65 days rather than 50 days. PD2005_604 was replaced by PD2006_030 on 19 May 2006. That policy directive is outlined below.

239. The Department developed an electronic Incident Management System (**IIMS**) to meet the requirements of Policy 2003/88. The accompanying policy, 2004/82, 'Incident Management System Policy', commenced on 1 December 2004.

240. This policy has had several iterations. It was reissued as Policy Directive PD2005_404 on 27 January 2005, which was in place until 19 May 2006. Policy Directive PD2006_030, 'Incident Management Policy', then came into place, which in turn was replaced by PD2007_061 until 10 February 2014. In turn, that policy was replaced by Policy Directive PD2014_004, 'Incident Management', on 10 February 2014. PD2014_004 is still current (and is outlined later in this chapter). The broad parameters of the IIMS have remained the same.

241. As stated in the original policy (2004/82), the IIMS is intended to record all health care incidents, assist managers to manage incidents that occur in their area, record the results of reviews or investigations and provide reports on incidents recorded in the system. Public health organisations are required to use the IIMS and all staff are responsible for notifying incidents, including adverse events and near misses, in the IIMS (Policy 2004/82, section 4.2.2).

242. According to Policy 2004/82, the IIMS uses four categories of incident: clinical, staff, property/security/hazard, and complaints. Notification of incidents is required as soon as practicable and preferably on the same day as the incident. The policy outlines how incidents are managed. In general, the person responsible for the ward or service area has first-line responsibility for managing (including reviewing and assessing the level of investigation required) incidents in their area. Senior management is required to decide whether recommendations are accepted and approved. The policy makes clear that incidents pertaining to performance or inappropriate behaviour by staff require an investigation in accordance with 'Guideline on the management of a complaint or concern about a clinician' (that is, lodging an incident in the IIMS is not sufficient). An IIMS incident number must be documented in the patient health record to facilitate linkages between information sources. (The updated versions of the IIMS policy are outlined further below.)

243. Findings relating to a concern or complaint about a clinician were not intended to be documented in detail in IIMS (see Appendix 1 of Policy 2004/82). Concerns about a clinician were to be managed separately from the incident management processes, although they were required to be entered into IIMS. This is depicted in a flow diagram in Appendix 2 of Policy 2004/82.

244. On 26 July 2005, Policy Directive PD2005_608, 'NSW Patient Safety and Clinical Quality Program', set out the guiding principles for managing risks and developing systems to identify risks and manage incidents. A key component in the overall management of risk is stated to be the IIMS system to facilitate timely notification of incidents, track investigation and analysis of health care incidents, enable reporting and understand lessons learned. Another component was the introduction of Clinical Governance Units in each area health service to report

directly to the chief executive to develop and monitor policies and procedures in relation to patient safety.

3.3 From 2006 to date

245. From 2006, the following NSW Health policies applied to the management of complaints and incidents:

- PD2006_007, 'Complaint or concern about a clinician—Principles for Action' (published 30 January 2006 and still current);[58]
- GL2006_002 'Complaint or concern about a clinician—Management Guidelines' (published 30 January 2006 and still current);
- PD2006_030, 'Incident Management Policy' (published 19 May 2006 and rescinded on 24 July 2007);
- PD2006_073, 'Complaint Management Policy' (published 29 August 2006 and still current); and
- GL2006_023, 'Complaint Management Guidelines' (published 20 December 2006 and still current).

246. PD2006_007 and GL2006_002 have principal relevance to this inquiry.

247. PD2006_007 and GL2006_002 relevantly retain the three levels of action. There is greater emphasis on considering whether variations to clinical privileges are warranted.

248. The main requirements of Policy Directive PD2006_007 are as follows:

- The chief executive of the area health service has primary obligation to ensure complaints and concerns are acted upon by way of investigation and, where necessary, appropriate action to implement findings and recommendations resulting from the management of complaints or concerns.
- The chief executive is also responsible for reporting to the Medical Board (or other registration authority) in accordance with the Health Services Act any conduct of a Visiting Medical Officer that the chief executive suspects on reasonable grounds may constitute professional misconduct or unsatisfactory professional conduct.

[58] NSW Health, Policy Directive PD2006_007, 'Complaint or Concern about a Clinician—Principles for Action', 30 January 2006 (Tab 28, Policies on the management of incidents, complaints and disciplinary processes 1990–2016).

- The area health service Director of Clinical Governance takes overarching responsibility for ensuring that the system for managing complaints about clinicians is in place and functions effectively.
- All Clinical Governance Units are required to have an identified Designated Senior Complaints Officer who is contactable 24 hours a day, seven days a week.
- The policy sets out general principles applying to management of complaints, including such matters as notification of incidents, reporting to supervisors and line managers, suspending clinicians or altering clinical privileges, investigating, risk management, privacy and confidentiality.

249. GD2006_020 sets out the process for implementing PD2006_007. All complaints or concerns should be notified to the relevant line manager. Senior management must notify the Director of Clinical Operations, who in turn informs the chief executive and the Director of Clinical Governance of the complaint or concern.

250. All complaints and concerns are required to be graded according to their severity to assist in determining appropriate action. The severity ratings and actions required following risk assessment are as shown in the table below.

Severity rating	**Severity description used to assess a complaint or concern**	**Actions required following risk assessment of the complaint or concern**
1	Very serious complaints or concerns arising from one or more events involving unexpected mortality or serious morbidity, gaps in clinical performance, an external event (such as a criminal conviction or termination of employment in another facility) or serious concerns by colleagues about the health and safety of patients.	Notify chief executive / Director of Clinical Governance immediately. Determine whether requires notification to registration board and any other relevant authority (eg coroner, police). Consider immediate suspension of clinical privileges in cases of suspected professional misconduct. Consider whether variations to clinical privileges are required.
2	Significant complaint or concern, where there may be one or more events involving unexpected mortality or increasingly serious morbidity (SAC1 or SAC2) and there may be a pattern of suboptimal performance or variation in clinical outcomes over a period of time.	Notify Director of Clinical Governance. Consider whether variations to clinical privileges are required. Investigate.
3	Complaint or concern that the performance, practice or clinical outcome achieved by an individual	Notify Director of Clinical Governance.

	clinician varies from peers or from expectations but where there has not been any event involving unexpected mortality or serious morbidity.	Management and investigation as per area health service policy/procedure. Manage outcomes in accordance with relevant policy or award.
4	Complaint or concern appears frivolous, vexatious or trivial.	Management and investigation as per area health service policy/procedure. Continue standard performance monitoring and management. Notify Director of Clinical Governance of findings and actions.

251. GD2006_020 sets out a model for an expeditious investigation, including obtaining an independent expert opinion on the issues under investigation to ensure there is no actual or perceived bias in the investigation and obtaining information from all appropriate sources, including other clinicians and staff members and the notifier/complainant.

252. GD2006_020 recommends that the investigation be concluded within 60 days and require an investigation plan containing time frames for action in the event it is likely to take longer. It also sets out the steps to ensure that the clinician concerned has an opportunity to fully respond to the allegation/s. Recommendations are required to be provided to the chief executive based on the findings of the investigation.

253. GD2006_020 advises the area health service to liaise with the registration board and/or HCCC to ensure the organisation's investigation does not impact adversely on any investigation by those entities.

254. GD2006_020 states that the 'DCG should be advised of the findings and outcome of the investigation, and how, if required, the clinical risk will be managed (for example, whether the matter is to be referred to the credentialing subcommittee or any other remedial action' (Guideline GD2006_020, section 3.1).

255. GD2006_020 states that the investigation of a complaint or concern will lead to one or more of:

(1) a finding of professional misconduct or unsatisfactory professional conduct, which must be reported by the chief executive to the relevant registration board under the Health Services Act and the Director of Clinical Operations and the Director-General via a Reportable Incident Brief;

(2) identification of performance issues but they are not sufficiently serious to warrant reporting to the registration board. In such case, further action may

be required such as skills development, referral to the Medical Board for management under the Performance Assessment Program or local performance monitoring or review;

(3) identification of behaviour issues (such as not being available for scheduled work);

(4) impairment, which is required to be referred to the appropriate registration board for action for dealing with impaired registrants;

(5) identification of systems issues;

(6) no identification of individual performance or system issues.

256. Disciplinary matters were required to be managed in accordance with Policy Directive PD2005_225, 'A Framework for Managing the Disciplinary Process in NSW Health' (published 27 January 2005 and rescinded 21 November 2014) (which is in the same terms as 2001/112, described earlier).

257. Policy Directive PD2006_073, 'Complaint Management Policy', related to complaints made by patients, other members of the public or external organisations. Guideline GL2006_023, 'Complaint Management Guidelines', provides the operational framework for dealing with a complaint under PD2006_073. GL2006_023 is still current. Complaints must be registered in IIMS via a Complaint Notification Form, which, for clinical incidents, must be linked to the Clinical Incident Form. Patient complaints must be acknowledged within five calendar days (in writing or verbally). An initial assessment must be made, which includes applying a SAC code as per the Incident Management Policy, followed by an investigation, followed by a response and resolution and follow-up action. The person managing the complaint must make findings and recommendations for action. The policy states that complaints that identify an individual clinician must be managed as per Policy Directive PD2006_007.

258. In 2006, Policy Directive PD2006_030, 'Incident Management Policy', replaced PD2005_604 and PD2005_404, which are described above. It related to notification of incidents by staff in IIMS, which included requirements for assessing the severity of the incident using the SAC matrix. The policy states that all incidents notified in the IIMS require investigation. All SAC1 incidents require the completion of a root cause analysis within 70 days and notification to the Department via a Reportable Incident Brief within 24 hours of notification in IIMS. The investigation of SAC2 incidents must be completed within 28 days, with the possibility for a revised completion date subject to provision of a management plan. The policy also relevantly clarifies that individual performance issues must be managed via Policy Directive PD2006_007.

259. PD2006_030 was replaced by PD2007_061, which is in similar terms. It was in place until 10 February 2014. In turn, that policy was replaced by Policy Directive PD2014_004, 'Incident Management Policy', on 10 February 2014.

260. PD2014_004 outlines the incident management process, the key steps of which are as follows:

- identification of incident—by such methods as direct observation, team discussion, complaints, morbidity and mortality meetings;
- immediate action to mitigate harmful consequences;
- notification of incident into the IIMS under relevant incident type—all staff have this responsibility; and allocation of an initial SAC rating and documenting the IIMS number in patient's medical record. The notification stage also requires the manager to review the notification and SAC rating, an open disclosure process with the patient and family or carer, and notification to the Treasury Managed Fund if there is potential for a medico-legal claim;
- prioritisation—confirming the SAC rating and preparing and submitting a Reportable Incident Brief for all SAC1 incidents and others as mandated by the Ministry of Health. The policy states that the degree of harm suffered is the key consideration, as experience had shown that assessing the likelihood of recurrence in determining the SAC rating had led to inappropriate downgrading of incidents. SAC guides the level of investigation and the need for additional notification;
- investigation:
  - for a clinical SAC1—a privileged root cause analysis is to be completed and a report is to be submitted to the Ministry of Health within 70 days of the date of notification of the incident;
  - for a clinical SAC2—an investigation by the local health district, with a report being submitted within 45 days. The investigation may be in the form of a root cause analysis or any other investigative methodology. A privileged root cause analysis may be required if the CEO considers the incident may be result of a serious systemic problem;
  - for a clinical SAC3 and SAC4—a local investigation or review at the clinical unit or division level within 45 days; an aggregated analysis of a number of similar SAC3 or SAC4 incidents may be appropriate; a privileged root cause analysis if system issues are suspected;
- classification followed by analysis to identify emerging themes/trends; and
- action to complement recommendations and any action plan.

261. Relevantly, the policy states that investigations under that policy should not attempt to assess the adequacy of an individual's performance or competence, as those issues are managed via the organisation's performance management system and/or PD2006_007 and GL2006_002.

262. Finally, as to PD2014_004, it also outlines the Reportable Incident Brief system, which, as noted in the predecessor policies, is designed for the reporting of specific health care incidents to the Ministry of Health. It specifies that the Director of Clinical Governance is responsible for monitoring and evaluating notifications in the IIMS.

263. From November 2014, a policy directive set out mandatory requirements for managing alleged or suspected misconduct, which is relevantly defined as including behaviour or conduct which seriously or repeatedly breaches expected standards, including registration standards (PD2014_042, 'Managing Misconduct').[59] They include review, managing risks including by suspending the clinician concerned, investigation and the various options available following findings. Performance issues are not intended to be dealt with by this policy (PD2014_042, section 2.2).

3.4 Root cause analyses

264. A root cause analysis is a method used to investigate and analyse incidents to identify the root causes and factors that contributed to the incident. The process is intended to yield recommended actions directed at the prevention of a similar occurrence.

265. Chief executives of local health districts (formerly area health services) are required to comply with the root cause analysis provisions of the *Medical Practice Act 1992* (NSW) (**Medical Practice Act**). Those provisions have been in force since 1 March 2005.

266. As outlined earlier, all SAC1 incidents must be the subject of a root cause analysis. The chief executive has a discretion to appoint a root cause analysis team to investigate any clinical incident of a lesser severity than SAC1.

267. Under s 20M within Division 6C of Part 2 of the *Health Administration Act 1982* (NSW) (**Health Administration Act**), when a 'reportable incident' involving a relevant health services organisation is reported to the chief executive of the organisation, the organisation is required to appoint a root cause analysis team in relation to the reportable incident.

268. A 'reportable incident' means an incident relating to the provision of health services by a relevant health services organisation, being an incident of a type prescribed by the regulations or set out in a document adopted by the regulations. The regulations define it by reference to Ministry of Health policy.

269. On 1 January 2006, the Department of Health issued a policy to support the root cause analysis process: Policy Directive PD2005_634, 'Reportable Incident Definition under section 20L of the Health Administration Act'. It determined that a reportable incident involves an incident that has had 'serious clinical consequences'

[59] NSW Health, Policy Directive PD2014_042, 'Managing Misconduct', 21 November2014, (Tab 47, Policies on the management of incidents, complaints and disciplinary processes 1990–2016).

and the probability of recurrence must fall into one of categories (i) and (iv) listed in the policy, or the incident must have had 'major clinical consequences' as defined in the policy.

270. PD2005_634 was superseded by Policy Directive PD2014_004, 'Incident Management Policy', published in the Gazette on 24 January 2014.

271. Under the current regulations, a 'reportable incident' means an incident of a type set out in Appendix D to PD2014_004. This has retained the language from PD2005_634. Relevantly, a serious clinical consequence includes an unexpected intra-partum stillbirth. An incident with major clinical consequences includes one involving the patient suffering a major permanent loss of function (sensory, motor, physiologic or psychological) unrelated to the natural course of the illness and differing from the expected outcome of patient management, or significant disfigurement (and other categories not immediately relevant).

272. PD2014_004 is dealt with further elsewhere in this chapter. It notes that the only reason for decommissioning a root cause analysis is where the root cause analysis team identifies individual clinician conduct, impairment or performance issues that may be responsible for the incident and there are no readily identifiable systems issues to consider.

273. The root cause analysis process is afforded statutory privilege (broadly, root cause analysis team members and those assisting them cannot be compelled to produce or give evidence of any document created for the dominant purpose of the root cause analysis investigation or the final root cause analysis report).

274. Under s 20O(2) of the Health Administration Act, where a root cause analysis team forms the opinion that an incident may involve professional misconduct, unsatisfactory professional conduct or impairment by an individual clinician, the team must notify the chief executive in writing.

275. Under s 20O(2), if a root cause analysis team forms the opinion that an incident may involve unsatisfactory professional performance by a clinician, the team may notify the chief executive in writing.

3.5 Performance reviews

276. NSW Health Policy Directive PD2005_498, 'Performance review of Visiting practitioners: Policy for implementation' (published on 28 February 2005), outlined the components of a performance review system for visiting practitioners. It required a performance review at least once a year or more frequently if required by the area health service or Visiting Medical Officer. It did not apply to the management of concerns or complaints about a clinician. The policy said that, if any matter raised in the performance review process required a review of clinical privileges, it should be referred to the Medical and Dental Appointment Advisory

Committee and the clinical privileges policy would apply (that policy is outlined in the section 2.2 above).[60]

277. That policy directive was replaced by Policy Directive PD2011_008, 'Visiting medical officer (VMO) Performance Review and Appointment Arrangements', on 31 January 2011. PD2011_008 was replaced by PD2011_010 one week later. PD2011_010 is still in place.

278. PD2011_010 requires that once every 12 months public health organisations complete a 'Level 1' performance review for each specialist Visiting Medical Officer. The reviewer is usually the supervisor or a medical administrator. An interview is not mandatory. A 'Level 2' performance review is required during the penultimate year of appointment for appointments of three years or longer. Two reviewers must conduct a Level 2 performance review, including the Visiting Medical Officer's supervisor/manager and the hospital Director of Medical Services, Divisional Director or a medical administrator. The Visiting Medical Officer is required to nominate three referees from whom comments can be obtained.

279. The review (either Level 1 or Level 2) is required to consider the Visiting Medical Officer's scope of practice. Where it appears that the clinical privileges should be reviewed, the matter should be referred to the Medical and Dental Appointment Advisory Committee. PD2011_010 clarifies in section 5.1 that more significant issues should be dealt with in accordance with the policy and guidelines dealing with concerns or complaints about a clinician (PD2006_007 and GL2006_002).

3.6 Service Check Register

280. From 30 January 2009, Policy Directive PD2009_004, 'Service Check Register for NSW Health Services',[61] required health services to check all visiting practitioners (and other staff) against a Service Check Register as part of the recruitment process or prior to finalising actions arising out of a disciplinary process.

281. The Service Check Register is an electronic statewide database.

282. Section 2.3 of PD2009_004 required health services to create a record in the Service Check Register when, relevantly:

- a visiting practitioner is suspended;
- restrictions, including to clinical privileges, are placed on a visiting practitioner during or at the conclusion of an investigation of serious disciplinary matter;

[60] NSW Health, Policy Directive PD2005_498, 'Performance review of visiting practitioners', 28 February 2005 (Tab 19, Policies on the management of incidents, complaints and disciplinary processes 1990–2016).
[61] NSW Health, Policy Directive PD2013_036, 'Service Check Register for NSW Health', 31 October 2013, p 6 (Tab 45, Policies on the management of incidents, complaints and disciplinary processes 1990–2016).

- an appointment is terminated;
- a visiting practitioner resigns during an investigation of a serious disciplinary matter where the matter is serious enough that it could have led to a dismissal, termination or non-renewal of appointment.

283. This policy was replaced by PD2013_036, 'Service Check Register for New South Wales Health'. That policy required health services to create a record in the Service Check Register where, relevantly, '[t]here is alleged misconduct and a decision has been made to take administrative action to mitigate any immediate or ongoing risks relating to the alleged misconduct while any investigation or other action is ongoing', including where the person has resigned.[62] The expression 'administrative action' is defined to mean any risk management action taken against an individual to manage alleged misconduct while it is being established if the misconduct occurred. It includes altered privileges, duties with no patient contact, and rosters that allow for more supervision or alternate work locations. It includes suspension. Misconduct is defined to include behaviour or conduct that seriously breaches the expected standards as identified in relevant legislation, including the Health Services Act, the *Health Practitioner Regulation National Law* (NSW), registration standards, the NSW Health Code of Conduct (for example, on hand hygiene), 'etc'. The definition also includes criminal charges that have an adverse impact on the workplace, including offences committed outside the workplace.

284. All preferred applicants for positions across NSW Health must be checked against the Service Check Register before an offer of employment or appointment can be made.

3.7 Other policies about incidents

285. At times relevant to this inquiry, the Department of Health had other policies for managing concerns about specific issues such as criminal allegations, charges and convictions, the application of which does not arise in this inquiry, except to the extent addressed in the body of this report.

286. The inquiry is not required to review actions relating to 'open disclosure' policy requirements.

[62] Brief from Mr Peter Reay, Human Resources Manager, Hunter New England Local Health District, to Mr Michael DiRienzo, Chief Executive, Hunter New England Local Health District, 'Application for Approval to Create a Service Check Register Record', 9 February 2016 (Tab 4.a.29, HNELHD documents).

Chapter 3: Grafton Base Hospital

1. Appointment

287. On 15 November 1993, Dr Jude, Area Medical Superintendent at Grafton Base Hospital, sought confirmation from the New South Wales Medical Board (**Medical Board**) of Dr Gayed's eligibility for registration in New South Wales. On 18 November 1993, the Royal Australian College of Obstetricians and Gynaecologists wrote to Dr Jude to advise that the College council had endorsed a recommendation that Dr Gayed be admitted as a Fellow of the College following assessment of his overseas-obtained specialist qualifications and experience and that Dr Gayed would receive his fellowship certificate with effect from 30 October 1993.

288. On 22 November 1993 the Medical Board provided telephone advice to Dr Jude that Dr Gayed would be eligible for specialist registration if he was a permanent resident and had passed an occupational English test, but if these conditions were not satisfied he would be eligible for temporary registration to work in approved Area of Need posts.[63]

289. On 7 December 1993, Dr Gayed was appointed by Grafton Base Hospital and the Clarence District Health Service Board of Directors as a Visiting Practitioner—Medical (Specialist Obstetrician and Gynaecologist) at Grafton Base Hospital. He was granted full clinical privileges in the speciality of obstetrics and gynaecology.[64]

290. His appointment was conditional upon, among other matters, 'attend[ing] his patients subject to the limits of any conditions imposed by the Board after considering the facilities of the Hospital and, where applicable, the recommendations of a duly constituted Credentials Committee'.

291. This appears to be a standard condition and the reference to the 'Board' is likely to be a reference to the Board of Directors and not the Medical Board. The inquiry has not had access to any document in which the board imposed conditions.

292. The information set out below is from the Medical Council of New South Wales (**Medical Council**) files and none of it was located on the Northern NSW Local Health District files.

293. Dr Gayed applied for registration with the Medical Board on 10 May 1994. His covering letter, sent by facsimile and express post, sought urgent registration as an overseas-trained specialist on the basis that Grafton, where he had just arrived, had had no gynaecologist for several months.

[63] Tab 3, Medical Council files.
[64] Vol 1, Tab 28, Professional Standards Committee. A surgical roster was provided to the inquiry by Northern NSW Local Health District.

294. In support of his application he provided proof of his eligibility to apply, in the form of letters from the Royal Australian College of Obstetrics and Gynaecologists and the Australian Medical Council. He also provided a letter of employment from Grafton Base Hospital, his curriculum vitae, copies of his qualifications, identification documents and two references from a consultant obstetrician and gynaecologist at Farnborough Hospital in the United Kingdom and the Director of Medical Services at Al Hasa Health Centre in Saudi Arabia, being hospitals where he had previously worked.

295. The letter from the Australian Medical Council dated 10 May 1994 to the board confirmed that:

> [Dr Gayed] is eligible to apply for registration with conditions an Overseas Trained Specialist on the basis of having:
>
> 1) Permanent resident status;
>
> 2) A primary medical degree from a medical school listed in the WHO Directory of Medical Schools and
>
> 3) Passed the Occupational English Test conducted by the National Languages and Literacy Institute of Australia or been granted an exemption by the AMC [Australian Medical Council].

296. The Australian Medical Council enclosed a letter dated 7 November 1993 from the Royal Australian College of Obstetrics and Gynaecologists confirming that Dr Gayed had been recognised as a specialist medical practitioner in obstetrics and gynaecology.

297. The letter from the Royal Australian College of Obstetrics and Gynaecologists dated 7 November 1993 stated that its council had endorsed a recommendation made by the Postgraduate Education Committee that Dr Gayed be advised that, following assessment of his qualifications and experience as a specialist in obstetrics and gynaecology, he be admitted as a Member of the College and elevated to fellowship subject to certified evidence of Australian residency status and 'the usual conditions'.

298. Dr Gayed provided a certificate of fellowship of the Royal Australian College of Obstetrics and Gynaecologists dated 30 October 1993. The letter from Grafton Base Hospital and Health Service to the Department of Immigration dated 8 December 1993 stated that he had been appointed as a specialist obstetrician and gynaecologist and was expected to commence duty on 31 January 1994.

299. Dr Gayed's curriculum vitae referred to his 'full registration' with the General Medical Council (United Kingdom) and various overseas qualifications, including a Bachelor of Medicine and Bachelor of Surgery from Ain Shams University in Egypt and membership of the Royal College of Obstetricians and Gynaecologists (UK), as well as a summary of medical posts held overseas, as set out in annexure 2 to chapter 1.

300. On 11 May 1994, Dr Gayed's application was sent to the chairperson of the Medical Board's registration committee (Dr J Alexander) for approval of conditional registration to work as an obstetrician and gynaecologist in positions approved by the board and approval to work at Grafton Base Hospital and Health Service.

301. On 16 May 1994, Dr Gayed provided further material, in the form of an application for registration form and a statutory declaration to the effect that he was 'currently in good standing with the General Medical Council of UK' and would provide certification to this effect as soon as possible. He provided a copy of his annual registration certificate with the General Medical Council for a 12-month period from 22 December 1993. There is no evidence that he provided certification of his good standing with the General Medical Council as stated in his statutory declaration.

302. On 18 May 1994, Dr Gayed sent a facsimile to the Medical Board to 'confirm' that he would be mainly working at a private practice at 146 Fitzroy Street, Grafton, with duties at Grafton Base Hospital.[65] He said the Health Insurance Commission would not issue him with a provider number until it had confirmed his practice address with the board.

303. On 19 May 1994, the Medical Board informed Dr Gayed that his application had been approved and enclosed a certificate of registration.[66] On 17 May 1994, the Medical Board proceeded to register Dr Gayed as a medical practitioner under s 7(1)E of the *Medical Practice Act 1992* (NSW) (**Medical Practice Act**) in the speciality of obstetrics and gynaecology only and subject to a condition that he practise in positions approved by the board.

304. Dr Gayed first performed surgery at the hospital on 23 May 1994, and his final procedure was performed in June 1995.

305. There is no evidence that there was any variation or withdrawal of Dr Gayed's clinical privileges by the hospital or district health service during the time of his appointment.

1.1 Compliance with appointment policies

306. Chapter 2 sets out the policies in place during the time frame covered by this inquiry. In relation to Grafton Base Hospital, the following apply to Dr Gayed's appointment:

- Circular 80/135, 'Checking the Credentials of Trained and Professional Staff';
- Circular 81/130, 'Registration of Professional Personnel' (1981–2005); and

[65] Tab 4, Medical Council files.
[66] Tab 5, Medical Council files.

- Circular 87/225, 'Guidelines Concerning the Assessment of Applicants for Appointment as Visiting Medical Practitioners and Staff Generally' (1987–2001).

307. The district health service sought confirmation of registration from the Medical Board prior to appointing Dr Gayed. In my view, the correspondence with the Medical Board and the Royal Australian College of Obstetrics and Gynaecologists was sufficient to satisfy the district health service that Dr Gayed had the necessary credentials and registration for appointment. His clinical privileges were consistent with his registration.

308. There is no evidence whether references were sought by the district health service and, if so, how they were managed. However, it is noted that, at that time, Dr Gayed had positive references available to him.

2. Complaints, adverse events and performance issues

309. The Northern NSW Local Health District, which now controls the Grafton Base Hospital, has informed the inquiry that there are no records of any complaints, adverse events or performance issues made in relation to Dr Gayed.

310. On 9 October 1998, Dr Gayed provided the Southern Area Health Service with a document, which presumably he created, setting out the 684 gynaecological procedures he said he performed at Grafton Base Hospital between May 1994 and June 1995. The four most performed procedures were laparoscopic sterilisation, caesarean section, hysteroscopy and laparoscopy.

311. He asserted that all procedures had 'excellent results'.

312. It appears that, as part of the Professional Standards Committee proceedings which took place in 2001, the Health Care Complaints Commission (**HCCC**) sought to have this assertion made by Dr Gayed confirmed. The Northern NSW Local Health District was unable to provide that confirmation.[67]

3. Conclusion

313. Based on the documents available to the inquiry, the Clarence District Health Service appropriately appointed Dr Gayed, including delineating his clinical privileges. No relevant conditions were imposed by the district health service, his privileges were not varied or withdrawn and his clinical privileges were consistent with his registration. As there were no complaints made to the district health service, there is no issue of the service reporting to the Medical Board.

314. Dr Jenkins advises me that no further review or audit of Dr Gayed's clinical outcomes in relation to Grafton Base Hospital is necessary. I note that NSW Health has advised the public that each of the hospitals the subject of this inquiry will

[67] Vol 1, Tab 28, Professional Standards Committee.

make direct contact with any patient who has previously raised issues or complaints in the past regarding the treatment they received from Dr Gayed.

315. Anyone else with concerns about treatment they may have received were encouraged to call a dedicated telephone line set up at each of the hospitals. A senior clinician is available to answer questions and make any appropriate referrals for follow-up care.

316. I understand that a number of calls have been made to this telephone line about Dr Gayed's treatment or appointment at Grafton Base Hospital.

317. I assume that this service will be monitored and, in the event the calls suggest further review or audit, that will occur.

Chapter 4: Cooma Hospital

1. Background

318. As at 1 January 1994, Cooma Hospital was controlled by the Monaro District Health Service. On 16 March 1996, the hospital was transferred to Southern Rural Health Service. On 1 July 1998, the Southern Rural Health Service became the Southern Area Health Service, then the Southern New South Wales Local Health Network, which was renamed the Southern New South Wales Local Health District from 1 July 2011.

319. Dr Gayed was appointed as a Visiting Medical Officer Obstetrics and Gynaecology at Cooma Hospital in February 1996. He also had appointments at that time at John James Memorial Hospital, Deakin, in the Australian Capital Territory (**ACT**) and the Calvary Private Hospital, Bruce, ACT.

320. In October 1998, the Southern Area Health Service referred a complaint, concerning 15 incidents recorded in incident reports made by staff, to the Health Care Complaints Commission (**HCCC**) about Dr Gayed's clinical treatment. The HCCC prosecuted a complaint before a Professional Standards Committee based, in part, on the Southern Area Health Service complaint.

321. On 9 February 1999, Dr Gayed resigned from Cooma Hospital.

322. The Southern New South Wales Local Health District has relatively few documents detailing its engagement and management of Dr Gayed. However, largely as a result of the investigation and prosecution of Dr Gayed before a Professional Standards Committee, documents from other sources are available.

323. It follows that there are documents not available to me which bear on my capacity to answer each of the terms of reference for the Southern Area Health Service—in particular, the response of the area health service to complaints or concerns and any monitoring of Dr Gayed.

2. Appointment

324. On 30 January 1996, the Medical Appointments Advisory Committee recommended that Dr Gayed be appointed to the vacant Visiting Medical Officer Gynaecologist position and be granted clinical privileges in specialist obstetrics and gynaecology initially for a period of three months commencing February 1996, when it was to be reviewed by the district board.[68] It is not known whether that review took place or any other details of the appointment process.

[68] Minutes of Medical Appointments Advisory Committee meeting held on 30 January 1996.

2.1 Compliance with appointment policies

325. There is no evidence that the district board checked his credentials or registration. However, the key requirement for a credentialing process was followed.

326. I am advised by Dr Jenkins and am satisfied that Dr Gayed's appointment as Visiting Medical Officer in Obstetrics and Gynaecology was consistent with his conditional registration and his qualifications and experience.

3. Complaints, adverse events and performance issues

3.1 Incident reports

327. Between April 1997 and July 1998, staff at Cooma Hospital, primarily nurses, completed incident reports recording 15 events concerning Dr Gayed's clinical treatment and his conduct in the operating theatre.

328. Each incident report form has space for a description of the event and the comments of others, including more senior members of the hospital.

329. The information set out below is from each incident report form, unless otherwise stated.

3.1.1 First incident

330. On 22 April 1997, a nurse working in the operating theatre reported an incident as follows: 'while performing blunt dissection during a posterior vaginal repair Dr Gayed noted faecal contamination in the wound. The defect into the rectum was closed with a suture and the operation continued.' The department head recorded that he completed an Infection Control Notification Form and had a discussion with the Area Director of Medical Services and the Deputy Area Director of Medical Services 'for advice'. It is not known what advice, if any was proffered.

3.1.2 Second incident

331. On 24 June 1997, the department head reported that the patient had 'consented to a D & C and biopsy and not to a cystoscopy and sigmoidoscopy' in circumstances where Dr Gayed had performed the latter procedure.

332. He reported 'as department head I would like written approval from Deputy Area Director of Medical Services for Dr Gayed to undertake such procedures'.

333. On 26 June 1997, the divisional head (the holder of that position at that time is not clear from the document) responded that the 'position of gynaecologist clarified. Acceptable to perform diagnostic cystoscopy/sigmoidoscopy when clinically appropriate'.[69]

[69] Incident report dated 24 June 1997.

334. It is not clear whether, prior to this event, Dr Gayed had the privileges to perform the procedure, whether his performance on that occasion was acceptable clinically or whether he was effectively given approval to perform the latter procedure from that date. However, what is clear is that he performed the procedure without consent.

335. Accordingly, the two office holders referred to above were aware of the lack of consent on this occasion.

3.1.3 Third, fourth, fifth, sixth and seventh incidents

336. In June, July, September and November 1997, seven needlestick injuries occurred during Dr Gayed's surgery. Nurses, anaesthetists and Dr Gayed suffered the injuries. A review was foreshadowed after each incident; however, in an interview with HCCC on 17 December 1998, the Area Director of Medical Services said that, as far as he knew, the review had not been completed.[70] He said that he had not had any discussion with Dr Gayed about the needlestick injuries.[71]

337. In relation to the seventh incident, on 11 November 1997, a nurse wrote a memo to the Health Service Manager stating that staff were expressing concern for patients under their care. She referred to Dr Gayed's complication rate and his haste and possible poor eyesight.[72]

3.1.4 Eighth incident

338. On 29 November 1997, while in Canberra, Dr Gayed admitted a patient to Cooma Hospital without the patient being under the care of a Visiting Medical Officer. A general practitioner (**GP**) recorded that Dr Gayed's conduct was in breach of 'acceptable standards of care and arrangements the Hospital and Visiting Medical Officers have made with Dr Gayed for such circumstances'.

3.1.5 Ninth incident

339. On 24 February 1998, it was reported by a nurse that, at the completion of a hysterectomy, Dr Gayed observed that his patient had some unexplained blood loss from the vagina. Dr Gayed then placed his unprotected hands in her vagina.

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[70] Record of Interview of Dr Robert Arthuson held on 17 December 1998 (Vol 1, Tab 24, Professional Standards Committee).

[71] [71] Record of Interview of Dr Robert Arthuson held on 17 December 1998 (Vol 1, Tab 24, Professional Standards Committee).

[72] Various documents, Vol 1, Tab 25, Professional Standards Committee.

3.1.6 Tenth and eleventh incidents

340. On 12 May 1998, Dr Gayed commenced a pelvic floor repair procedure. Shortly after he had commenced it, he informed the operating theatre staff he would perform a vaginal hysterectomy. The patient had given consent for pelvic floor repair only.

341. Nursing staff and the anaesthetist made Dr Gayed aware of the nature of the consent given. Prior to commencing the hysterectomy, Dr Gayed spoke with the patient, who was sedated with a spinal anaesthetic. He then performed the hysterectomy.

342. Dr Gayed then amended the consent form to add in parenthesis 'the patient consented to vaginal hysterectomy, as well, in theatre'.

343. Two nurses and the anaesthetist each completed incident forms.

344. The Area Director of Medical Services told the HCCC that he 'had mentioned to him on the telephone, when organising theatre lists, that he should ensure that the patients were properly consenting in writing'.[73]

345. In relation to the same patient, on 12 May 1998, a nurse recorded that, after the procedure, Dr Gayed placed his ungloved hands into the edge of the vagina to check for blood loss.[74]

3.1.7 Twelfth incident

346. On 16 June 1998, a GP was anaesthetising for Dr Gayed's list at Cooma Hospital. One patient had distinct obstetric risks. At the end of the list, Dr Gayed asked the GP to take over the care of the patient as he was returning to Canberra. The GP wrote to the Manager of Cooma Hospital: 'I feel that patients referred to specialist care should be treated as such and not referred back to the on-call doctor against their wishes.' No response to that letter has been seen.[75]

347. In a statement made on 18 December 1998 to the HCCC, the GP said he had become so concerned for patients that he did not refer patients to Dr Gayed anymore. He said that his partner in the practice withdrew his services the week before the GP did.[76]

[73] Vol 1, Tab 24, Professional Standards Committee.
[74] Incident form, 12 May 1998.
[75] Letter from Dr Wiles to Manager, Cooma Hospital, 8 July 1998.
[76] Statement of Dr Wiles (Vol 1, Tab 17, Professional Standards Committee).

3.1.8 Thirteenth, fourteenth and fifteenth incidents

348. On 21 July 1998, during an elective hysterectomy by Dr Gayed, there was unexpected blood loss. Dr Gayed did not immediately inform the anaesthetist and left the patient prior to extubation.[77]

3.2 Complaint

349. On 27 June 1997, a patient's solicitors made a complaint to Cooma Hospital about her treatment between 20 May 1997 and 3 June 1997. The Health Service Manager referred it to the Director, Medical Services. She also informed the solicitors that she would commence 'anaesthetist internal review' of the care provided to their client.[78]

350. On 3 July 1997, the Area Deputy Director of Medical Services advised the solicitors that he was investigating the circumstances of management of the patient at Cooma Hospital.[79] He did so by seeking reports from two doctors involved in her care.[80] He also engaged a consultant obstetrician and gynaecologist at Macquarie Street, Sydney, to review and make recommendations on her treatment.[81] A copy of his review is not among the Professional Standards Committee exhibits.

351. On 21 July 1997, Dr Gayed wrote to the Area Deputy Director of Medical Services and denied any negligence or failure to communicate.

352. The solicitors wrote to the Area Director of Medical Services on 20 April 1998 seeking confirmation that the investigation was still on foot and a report pending.[82] He replied on 29 April 1998 that he would provide all information to a Fellow of the Royal Australian College of Obstetricians and Gynaecologists for an opinion before concluding the investigation.[83] A copy of any opinion obtained is not among the Professional Standards Committee exhibits.

353. On 14 October 1998, the New South Wales Medical Board (**Medical Board**) and the HCCC agreed that DP's complaint should be investigated by the HCCC. It ultimately formed part of the Professional Standards Committee proceedings.

[77] Incident form, 21 July 1998; statement by Clinical Nurse Specialist, 23 July 1998.
[78] Vol 6, Tab 23, Professional Standards Committee.
[79] Vol 6, Tab 23, Professional Standards Committee.
[80] Vol 6, Tab 23, Professional Standards Committee; Vol 6, Tab 25, Professional Standards Committee.
[81] Vol 6, Tab 23, Professional Standards Committee.
[82] Vol 6, Tab 21, Professional Standards Committee.
[83] Vol 6, Tab 21, Professional Standards Committee.

3.3 Performance issues raised by staff

3.3.1 Reappointment of Dr Gayed

354. The Area Director of Medical Services told the HCCC that in June 1997, when Dr Gayed's reappointment was due, the Credentialing Committee was aware of a number of incidents 'but did not feel there was sufficient grounds for limiting the terms of his reappointment'. He said the 'concerns had not been investigated and proven'. The discussion in the Credentialing Committee was not minuted.

355. The reappointment process was not completed until 27 April 1998 and Dr Gayed's previous appointment was then extended on the same terms;[84] that is, with all the clinical privileges normally attendant on an obstetrician and gynaecologist, as limited by the circumstances of their practice (such as the delineated role of the hospital). There is no documentation indicating the hospital management considered altering his clinical privileges or appointment in 1998. No conditions were imposed. I address the adequacy of the response to the incidents below.

356. The Area Director of Medical Services said the several events prior to the last two incidents were treated as separate matters.

3.3.2 Medical Staff Council meetings

357. The Medical Staff Council and Hospital Executive met on 1 June 1998. The minutes record a discussion about anaesthetic services. An anaesthetist is recorded as advising he was 'no longer happy to provide anaesthetic services to Dr Gayed. Lengthy discussion followed and it was agreed that Visiting Medical Officers will follow their own conscience in this regard'. The minutes continue:

> Visiting Medical Officer's [sic] feel their clients do not currently have a satisfactory service in Cooma and are going to Canberra for treatment. [A doctor] to discuss the feelings of Visiting Medical Officers with Dr Gayed.[85]

358. It is not known whether this occurred.

359. The Medical Staff Council and Hospital Executive met on 6 July 1998. The minutes record a discussion about anaesthetic services:

> Discussed at length. Visiting Medical Officers registered their concern at the many unsatisfactory incidents involving Dr Gayed. [Area Director of Medical Services] and [Health Service Manager] to review past cases and make a decision on the next step to be taken. Data to be collected on incidents not already reported and forwarded to Health Service Manager over the next month.[86]

360. It is not known whether that review occurred.

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[84] Vol 5, Tab 9, Professional Standards Committee.
[85] Vol 2, Tab 2, Professional Standards Committee.
[86] Vol 2, Tab 2, Professional Standards Committee.

3.3.3 Other concerns raised by staff

361. On 22 July 1998, a radiographer wrote to the Health Service Manager concerned about the continuing appointment of Dr Gayed. She referred to the number of post-operative complications and that Dr Gayed was demanding and lacking compassion. However, it was his surgical procedures which most concerned her.[87]

362. On 23 July 1998, six anaesthetists separately advised the Health Service Manager in writing that they would no longer provide anaesthetic services for Dr Gayed.[88]

4. Response of the Southern Area Health Service

4.1 Suspension and withdrawal of suspension

363. On 29 July 1998, Dr Gayed was temporarily suspended from Cooma Health Service on the basis of concerns raised by Visiting Medical Officers and other staff about aspects of his clinical practice, as set out in the incidents documented above.[89]

364. Following legal advice, Dr Gayed's suspension was withdrawn.[90] A copy of that advice has not been provided. It may have been related to the requirement for notice having not been met.

365. On 18 August 1998, a meeting was held between the Chief Executive Officer (**CEO**) of the Southern Area Health Service, Mr Gleeson and Dr Gayed. The detail of the discussion is not known.[91]

366. On 20 August 1998, Mr Gleeson informed Dr Gayed that the incidents described above were being investigated and invited him to respond in writing to those incidents.[92]

367. The board of the Southern Area Health Service met on 21 August 1998. It was minuted: 'if the doctor wishes to continue with his lists he has been informed that he must negotiate with [Area Director of Medical Services] to employ staff willing to provide anaesthetic support.' The board endorsed the initial and follow-up action taken by the CEO.[93]

4.2 Dr Gayed's response to the Southern Area Health Service

368. Dr Gayed provided a detailed response to each incident. In short, he defended his treatment at some length.[94]

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[87] Vol 1, Tab 25, Professional Standards Committee.
[88] Vol 1, Tab 25, Professional Standards Committee.
[89] Letter from CEO to Dr Gayed with incident forms attached dated 20 August 1998.
[90] Letter from CEO to HCCC dated 8 October 1998.
[91] Letter from Dr Gayed to CEO dated 16 September 1998.
[92] Letter from Dr Gayed to CEO dated 16 September 1998 and response dated 25 September 1998.
[93] Minutes of board meeting held on 21 August 1998.
[94] Vol 1, Tab 4, Professional Standards Committee.

369. He provided a document in which he set out the procedures he performed at Cooma Hospital from February 1996 to July 1998: 440, with most being laparoscopy followed by hysteroscopy. He noted that there had been a 50 per cent increase in the number of consultations he performed between 1996 and 1997.

370. While it is not perfectly clear, it appears that Dr Gayed recommenced operating at Cooma Hospital, with the assistance of a GP – Visiting Medical Officer providing anaesthetics in September 1998. That is consistent with the minutes from the board meeting, set out above, that he would need to find his own anaesthetist. There is no evidence that any conditions were placed on his clinical privileges.

4.3 Complaint to the HCCC

371. On 8 October 1998, Mr Gleeson, as CEO of the Southern Area Health Service, complained to the HCCC about Dr Gayed's conduct.

372. He advised that, as a result of growing general concern, the Southern Area Health Service suspended Dr Gayed's appointment and that:

> At the same time, several general practitioner Visiting Medical Officers at Cooma who provide anaesthetics to Dr Gayed when he operated there, each took a personal decision to withdraw their anaesthetic services for a time.

373. On 9 October 1998, Mr Gleeson provided the HCCC with Dr Gayed's written response to the complaint and sought its urgent advice as to the action the Southern Area Health Service should take:

> Dr Gayed also mentioned that he felt that all these issues stemmed from a 'dispute' between himself and a group of Cooma doctors related to the quantum of rent they wished to charge him when he utilised their premises.

374. On 13 October 1998, the HCCC consulted with the Medical Board and it was agreed that the complaint would be investigated.

375. Dr Gayed resigned effective February 1999.[95]

5. Monitoring and management of Dr Gayed

5.1 Should Dr Gayed's clinical privileges have been restricted?

376. It is Dr Jenkins' opinion that the complaint made by the Southern Area Health Service to the HCCC regarding Dr Gayed was made at the appropriate time. Dr Jenkins considers that there are two serious clinical incidents included in the above (being the bowel injury and ureteric injury), both of which resulted in significant patient harm.

[95] Minutes of board meeting held on 22 January 1999.

377. The Southern Area Health Service requested external investigation of Dr Gayed by the HCCC once it became apparent that there were concerns that his performance as a specialist obstetrician and gynaecologist was below the expected standard. This is what occurred and what should have occurred.

378. Dr Jenkins notes that in the vast majority of instances it takes an accumulation of incidents over a period of time to come to such a conclusion. All clinicians will at some time in their practice have adverse outcomes and sometimes even very safe and competent clinicians have small clusters of such events. It is only when there is a persistent pattern of suboptimal performance or behaviour that it becomes apparent that there is a departure from the expected standard of care or behaviour.

379. However, both Dr Jenkins and I consider that Cooma Hospital or the Southern Area Health Service should have restricted Dr Gayed's clinical privileges pending the outcome of the investigation. It seems apparent based on the number of complaints and the range of complainants that there was within Cooma Hospital a proportion of staff, both medical and nursing, who had lost confidence in Dr Gayed's capacity to safely and competently perform some of his clinical duties. As such, it would have been reasonable at this time—October 1998—for Cooma Hospital to restrict his duties.

380. Dr Jenkins is of the view that the greatest potential risk to patient safety (and staff safety and wellbeing) was related to Dr Gayed's performance of major gynaecological surgery in operating theatre. As such, Cooma Hospital should have limited his operating theatre privileges to minor procedures only, pending the outcome of the investigation.

381. I note that, by restricting his clinical privileges, there would have been an effect on his income, which is not the case when employees are stood down pending the resolution of a complaint. Usually in the latter case, the employee is paid during that time.

382. Dr Gayed appears to have had limited insight into his potential clinical shortcomings and it is therefore very likely that he would not have accepted restricted privileges without challenge. In fact, when this sequence of complaints occurred at Cooma Hospital, he produced several very supportive references from credible referees and also data from other institutions supporting his assertion of safe clinical practice. However, that was a matter to be managed rather than a reason for taking no action.

383. The Southern Area Health Service considered limiting his practice when he was considered for reappointment in June 1997. At that time, it determined not to do so, and the pattern referred to above had not emerged. As stated above, it was when the complaint was referred to the HCCC that the area health service should have taken protective action.

5.2 Monitoring compliance with conditions of appointment

384. Dr Gayed's appointment to Cooma Hospital was on terms that he has all the clinical privileges normally attendant on an obstetrician and gynaecologist, as limited by the circumstances of their practice (such as the delineated role of the hospital).[96]

385. There were no relevant conditions of appointment imposed by the Southern Area Health Service.

5.3 Consistency with any registration or other conditions or order

386. Dr Gayed's clinical privileges were consistent with the conditions imposed on his registration.

5.4 Compliance with reporting policies

387. There was no requirement under the *Health Services Act 1997* (NSW), as in force in 1998, for the area health service to report the complaint against Dr Gayed or his underlying conduct to the Medical Board.

388. However, the effect of the health complaints legislation in force in 1998 was that a complaint to the HCCC was the subject of consultation with the Medical Board, which is what occurred in this case.

389. The relevant policies are set out in chapter 2. There is no evidence that the area health service reported the complaint to the Department as three circulars suggested it should have:

- Circular 94/74, 'Management of Complaints about Health Services and the Health System';[97]
- Circular 97/58, 'Incidents Reportable to the Department'; and
- Circular 97/97, 'Critical Indent Manual: Policy and Guidelines'.[98]

6. Conclusion

390. Based on the documents available to the inquiry, the Monaro District Health Service appropriately appointed Dr Gayed, including delineating his clinical privileges, which were consistent with his registration. No relevant conditions were

[96] Vol 5, Tab 9, Professional Standards Committee.
[97] NSW Health, Circular 94/74, 'Management of Complaints about Health Services and the Health System', 15 August 1994 (Tab 2, Policies on management of incidents, complaints and disciplinary processes 1990–2016).
[98] NSW Health, Circular 97/58, 'Incidents Reportable to the Department', 20 June 1997 (Tab 5, Policies on management of incidents, complaints and disciplinary processes 1990–2016); NSW Health, Circular 97/97, 'Critical Indent Manual: Policy and Guidelines' (Tab 6, Policies on management of incidents, complaints and disciplinary processes 1990–2016).

imposed by the district health service. His appointment was suspended and then withdrawn for the reasons set out above.

391. Between April 1997 and 21 July 1998, 15 incidents were recorded, five of which involved needlestick injuries. A review was suggested following most of them; however, no review was undertaken. By the fourth incident, concern was being expressed about Dr Gayed's eyesight.

392. It was appropriate for the area health service to make the complaint it did to the HCCC in October 1998. As Dr Jenkins states, it generally takes an accumulation of incidents over a period of time to come to such a conclusion. However, both Dr Jenkins and I consider that Cooma Hospital or the Southern Area Health Service should have restricted Dr Gayed's clinical privileges pending the outcome of the investigation.

393. There was no requirement under the *Health Services Act 1997* (NSW), as in force in 1998, for the area health service to report the complaint against Dr Gayed or his underlying conduct to the Medical Board.

394. Dr Jenkins advises me that no further review or audit of Dr Gayed's clinical outcomes in relation to Cooma Hospital is necessary. I note that NSW Health has advised the public that each of the hospitals the subject of this inquiry will make direct contact with any patient who has previously raised issues or complaints in the past regarding the treatment they received from Dr Gayed.

395. Anyone else with concerns about treatment they may have received were encouraged to call a dedicated telephone line set up at each of the hospitals. A senior clinician is available to answer questions and make any appropriate referrals for follow-up care.

396. I understand that four complaints have been made to this telephone line about Dr Gayed's treatment at Cooma Hospital.

397. I assume that this service will be monitored and, in the event calls suggest further review or audit, that will occur.

Chapter 5: Professional Standards Committee decision

398. On 15 March 2001, the Health Care Complaints Commission (**HCCC**) made 10 complaints, concerning nine patients, to a Professional Standards Committee about Dr Gayed's clinical work as an obstetrician and gynaecologist between July 1996 and July 1998 at Cooma Hospital. It made one complaint that Dr Gayed suffered from an impairment—namely, high myopia.

399. A Professional Standards Committee heard the 11 complaints against Dr Gayed in August 2001. Dr Gayed was advised by United Medical Protection.

400. Dr Stewart provided evidence as a peer reviewer.

401. The first complaint concerned Dr Gayed's treatment of a patient who had complained directly to the HCCC that Dr Gayed had perforated her uterus and caused tears to her bowel. Dr Gayed admitted the particulars of the complaint. The Professional Standards Committee found the complaint was proven and that Dr Gayed was guilty of unsatisfactory professional conduct.

402. The second complaint concerned Dr Gayed performing an unnecessary laparotomy, among other matters. Dr Gayed admitted most of the particulars of the complaint. The Professional Standards Committee noted that, in his original submission, Dr Gayed had described one aspect of his treatment as an error of judgment; however, in his final submission he admitted that he had inappropriately performed a laparotomy.

403. The Professional Standards Committee found three particulars of the complaint proved and one not proved. They noted that, in relation to the latter, there was conflicting evidence. It found that Dr Gayed was guilty of unsatisfactory professional conduct.

404. The third complaint concerned another patient who had complained directly to the HCCC. The complaint was in relation to an examination under anaesthetic. Dr Stewart was only mildly critical of Dr Gayed's treatment. Dr Gayed did not accept the criticism. The Professional Standards Committee found the complaint proven in part and that Dr Gayed was not guilty of unsatisfactory professional conduct. They considered Dr Gayed's techniques were not best practice and did not amount to unsatisfactory professional conduct.

405. The fourth complaint concerned incidents 10 and 11. Dr Gayed denied the breach of protocol in relation to not using gloves and admitted altering the consent form. The Professional Standards Committee found the complaint proven and that Dr Gayed was guilty of unsatisfactory professional conduct.

406. The fifth complaint concerned incident 12. Dr Gayed admitted the particulars of the complaint that he had handed over the care of a high-risk patient to a general practitioner (**GP**). The Professional Standards Committee found the complaint proven and that Dr Gayed was guilty of unsatisfactory professional conduct.

407. The sixth complaint concerned incidents 13, 14 and 15 and the performance of a hysterectomy. Dr Stewart was critical of aspects of Dr Gayed's treatment. Dr Gayed did not admit the complaint.

408. The Professional Standards Committee found two of the three particulars of the complaint proven and that Dr Gayed was guilty of unsatisfactory professional conduct. The third particular was in relation to communication with the anaesthetist.

409. The seventh complaint concerned five incidents (incidents 3, 4, 5, 6 and 7), including needlestick injuries, a scalpel injury to a nurse and failure to follow appropriate safe practice. The incidents occurred in 1997. Dr Stewart's criticism was mild to moderate. Dr Gayed admitted the factual allegations and denied any inappropriate behaviour.

410. The Professional Standards Committee found four of the five particulars proven and that Dr Gayed was not guilty of unsatisfactory professional conduct. The fifth particular was considered by the Professional Standards Committee to be a systems failure.

411. The eighth complaint concerned incident 8. Dr Gayed admitted the complaint that he had acted contrary to protocol when admitting a patient. The Professional Standards Committee found that a system failure was a contributing factor. It found Dr Gayed was not guilty of unsatisfactory professional conduct.

412. The ninth complaint concerned another patient who had complained directly to the HCCC. The complaint concerned preoperative consultation and his knowledge in performing a procedure. Dr Stewart's criticism was moderate to severe and was shared by another expert. Dr Gayed admitted part of the complaint.

413. The Professional Standards Committee found two of the four particulars were proven and that Dr Gayed was not guilty of unsatisfactory professional conduct.

414. The tenth complaint related to a patient experiencing postoperative bleeding and Dr Gayed placing his ungloved hand in the patient's vagina (incident 9). Dr Gayed did not recall the incident. Dr Stewart was moderately critical. The Professional Standards Committee did not accept that Dr Gayed had conducted himself as alleged. It found the complaint not proven and that Dr Gayed was not guilty of unsatisfactory professional conduct.

415. The final complaint, that of impairment, was that Dr Gayed had high myopia which impacted on his ability to perform certain procedures. Dr Gayed admitted he had high myopia and denied it impacted on his ability to adequately perform surgical procedures.

416. The Professional Standards Committee found the complaint proven and that Dr Gayed suffered from an impairment which detrimentally affected or was likely to detrimentally affect his physical capacity to practise medicine.

417. In its summary, the Professional Standards Committee stated that, over the period of 15 months in 1997 and 1998, a number of incidents and complications had occurred involving Dr Gayed's gynaecological practice leading to a gradual loss of confidence in Dr Gayed by his GP colleagues and his nursing colleagues.

418. Dr Gayed provided the Professional Standards Committee with a number of documents, including positive references from Dr Farnsworth at Manning Hospital; Dr Johnson, Chief Executive Officer, Mayo Private Hospital, Taree; and the Quality Development Unit of John James Memorial Hospital.

419. These references are detailed in annexure 2.

420. The Professional Standards Committee found Dr Gayed guilty of unsatisfactory professional conduct. It:

- reprimanded Dr Gayed;
- ordered that his registration be subject to the condition that he not undertake microsurgery;
- ordered that he be assessed by an ophthalmologist approved by the New South Wales Medical Board (**Medical Board**) at intervals determined by the ophthalmologist and that reports be forwarded to the Medical Board, with the first assessment to take place before the end of December 2001;
- recommended to the Medical Board that a performance assessment in accordance with Part 5 of the Act be undertaken in respect of his practice at Manning Hospital at a time deemed appropriate by the Medical Board;
- ordered that a full copy of the decision be provided to:
  - the Medical Board;
  - the HCCC;
  - Dr Gayed and his adviser;
  - the peer reviewers Dr Stewart and Dr Ferrier;
  - the Chief Executive Officer, Southern Area Health Service; and
- ordered that a de-identified copy of the decision be forwarded to the Royal Australian and New Zealand College of Obstetricians and Gynaecologists for the purposes of educational training.

Chapter 6: Kempsey District Hospital

1. Background

421. As at 1 January 1990, Kempsey District Hospital was part of North Coast Country Health Region but was governed by its own independent board. On 1 July 1993, control of the hospital was transferred to Macleay–Hastings District Health Service. On 16 March 1996, control of the hospital was transferred to Mid North Coast Rural Health Service. On 1 July 1998, Mid North Coast Rural Health Service was reconstituted as Mid North Coast Area Health Service.

2. Appointment

422. At its meeting on 7 December 1999, the Medical Credentials Committee of the Central Sector of the Mid North Coast Area Health Service recommended that Dr Gayed be granted specialist privileges in obstetrics and gynaecology at Kempsey District Hospital. It noted that Dr Gayed currently held those privileges at Manning Hospital.[99]

423. Its recommendation was endorsed by the Mid North Coast Area Health Service Board on 3 February 2000.[100]

424. In his application for Visiting Medical Officer with Mid North Coast Area Health Service dated 26 April 2000, Dr Gayed was not required to sign any release or consent to any checks or provide any information about complaints, conditions and the like.[101]

425. The application form included a page titled 'For Office Use Only' and had space for indicating that certificates/registration had been sighted or checked, referees had been contacted, and the Credentials Committee and Medical Appointments Advisory Committee had considered the application. The 'For Office Use Only' page was blank.

426. Dr Gayed was advised on 10 July 2000 that the board of the Mid North Coast Area Health Service accepted the recommendation of the Medical Appointments and Credentials Committee and approved his appointment until 30 June 2003 with clinical privileges as 'Specialist Obstetrician and Gynaecologist'.[102] No relevant conditions were imposed on his appointment.

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[99] Minutes of the Central Sector Medical Credentials Committee Meeting, Mid North Coast Area Health Service, 7 December 1999 (Tab 1B, MNCLHD documents).
[100] Area Board Minutes, Mid North Coast Area Health Service, 3 February 2000 (Tab 1C, MNCLHD documents).
[101] Mid North Coast Area Health Service, Application for Appointment and Clinical Privileges (Tab 2.a.3, HNELHD documents).
[102] Letter from Ms Fauna Tyne, Acting Director of Operations, Central to Dr Emil Gayed, 10 July 2000 (Tab 2.c.2, HNELDH documents).

427. Dr Gayed provided 'gynaecological services' at Kempsey District Hospital between 25 October 1999 and 3 June 2002. During that period, there were 120 admissions under Dr Gayed.[103]

428. From the dates, it appears that Dr Gayed worked at the hospital prior to the Credentials Committee approving his appointment. I am advised by Dr Jenkins that currently credentialing happens at the time of the appointment; however, in 2000 it was 'not unusual for the Credentialing committee to be quite separate from the appointments process'. Thus, it would be not unusual for a clinician to commence work (undertaking the generally accepted scope of practice for the relevant specialty) and then at the next meeting of the Credentials Committee the clinical privileges would be formally delineated.

429. Notwithstanding the usual practice, the relevant policy, Circular 95/24, 'Guidelines for the Delineation of Clinical Privileges of Medical Staff', requires that it should have been part of the appointment process.

430. Chapter 2 sets out the policies in place during the time frame covered by this inquiry. In relation to Kempsey District Hospital, the following apply to Dr Gayed's appointment:

- Circular 80/135, 'Checking the Credentials of Trained and Professional Staff';
- Circular 81/130, 'Registration of Professional Personnel' (1981–2005);
- Circular 87/225, 'Guidelines Concerning the Assessment of Applicants for Appointment as Visiting Medical Practitioners and Staff Generally' (1987–2001);
- Circular 95/24, 'Guidelines for the Delineation of Clinical Privileges of Medical Staff' (1995 – unknown (probably 2005));[104] and
- Circular 97/80, 'Procedures for Recruitment and Employment of Staff and Other Persons—Vetting and Management of Allegations and Improper Conduct' (1997–2005).[105]

431. All that is known about Dr Gayed's appointment is set out above. Thus, his appointment was subject to a credentials process. Dr Jenkins advises me, and I am satisfied, that his clinical privileges were reflective of his conditional registration and his qualifications and experience.

[103] Letter from Mr Stewart Dowrick, Chief Executive, Mid North Coast Local Health District, to Ms Gail Furness SC, 4 July 2018 (Tab i, MNCLHD documents).
[104] NSW Health, Circular 95/24, 'Guidelines for the Delineation of Clinical Privileges of Medical Staff', 3 April 1995 (Tab 5, Policies on the appointment of VMOs 1990–2016).
[105] NSW Health, Circular 97/80, 'Procedures for Recruitment and Employment of Staff and Other Persons—Vetting and Management of Allegations and Improper Conduct', 11 August 1997, p 2 (Tab 6, Policies on the appointment of VMOs 1990–2016).

432. There is no evidence that the information required by Circular 97/80 was obtained; however, this is not surprising given his appointment was nearly 20 years ago.

3. Compliance with registration or other conditions

433. On 16 November 2001, Dr Gayed wrote to Mr Terry Clout, the Chief Executive Officer of the Mid North Coast Area Health Service, that he had been 'requested by NSW Medical Board to report to you a finding made at a recent board hearing and provide you with a copy of that finding'. He further stated that the 'reported incidents occurred several years ago while visiting Cooma Hospital, when I was based as an Obstetrician and Gynaecologist in Canberra and have never recurred'.[106]

434. Dr Gayed did not include a full copy of the decision—in particular, he omitted that part of the decision which included the conditions imposed on his registration and the recommendation made.

435. On 23 November 2001, the New South Wales Medical Board (**Medical Board**) notified Mr Clout that Dr Gayed had a condition placed on his registration that he not undertake microsurgery.[107]

436. The Medical Board did not advise the chief executive that the Professional Standards Committee had ordered that Dr Gayed be reprimanded and had recommended that the Medical Board undertake a performance assessment in respect of Dr Gayed's practice at Manning Hospital; nor did the Medical Board inform him that Dr Gayed was to be assessed by an ophthalmologist at intervals determined by the ophthalmologist and reports were to be forwarded to the Medical Board. In my *Review of processes undertaken by the Medical Council of New South Wales pursuant to Part 8 of the Health Practitioner Regulation National Law (NSW) with respect to Dr Emil Gayed*, I have concluded that the Medical Board should have provided Mr Clout with the Professional Standards Committee decision. The Medical Board was entitled to do so by the applicable legislation, and that information was obviously necessary for the hospital and area health service to monitor Dr Gayed's performance.[108]

437. On 26 November 2001, Mr Clout wrote to Dr Gayed regarding the findings of the Medical Board hearing. He acknowledged that Dr Gayed provided him with a copy of the findings of the document but noted that, without the full report, it 'is difficult to understand the context of these findings'. Mr Clout noted that Dr Gayed had not stated whether the Medical Board had placed any conditions on his registration as a result of either the findings or Dr Gayed's physical impairment and

[106] Letter from Dr Emil Gayed to Mr Terry Clout, Chief Executive Officer, Mid North Coast Area Health Service, 16 November 2001 (Tab 4A, MNCLHD documents).
[107] Letter from Ms M Anne Harvey, Legal Officer, New South Wales Medical Board, to Mr Terry Clout, Chief Executive Officer, Mid North Coast Area Health Service, 23 November 2001 (Tab 4B, MNCLND documents).
[108] *Medical Practice Act 1992* (NSW) s 180(4).

that 'it is necessary for the Mid North Coast Area Health Service to understand the details of these matters in order to ensure that the privileges afforded to you in obstetrics and gynaecology are appropriate'. Mr Clout indicated that he had asked the Area Director Clinical Services to discuss these issues with Dr Gayed in full so that the Mid North Coast Area Health Service 'can ensure that it is complying with any medical board requirements'.[109]

438. On 27 December 2001, the Area Director Clinical Services wrote to Dr Gayed, noting that Dr Gayed had provided further documentation that was 'quite clear' and that as such it was not necessary to meet to further discuss the matter.[110] It is not known what further documents were provided, if any.

439. The Mid North Coast Local Health District told the inquiry that microsurgery was not within the delineated role at Kempsey District Hospital and there was no evidence of changes to Dr Gayed's clinical privileges while at that hospital to reflect that condition.

440. While microsurgery was not within the delineated role at Kempsey District Hospital, the condition was imposed on Dr Gayed's registration by the Professional Standards Committee and his clinical privileges should have reflected his conditional registration.

4. Complaints, adverse events and performance issues

441. The Mid North Coast Local Health District told the inquiry that, if there had been any 'consumer complaints' against Dr Gayed between 1999 and 2003, they had been culled and destroyed in 2015 in accordance with the *State Records Act 1998* (NSW).

442. The Incident Management System (**IIMS**) currently in place does not record complaints or incidents before October 2003, by which time Dr Gayed had left Kempsey District Hospital. In any event, no complaints or incidents against Dr Gayed were found.

5. Conclusion

443. Based on the documents available to the inquiry, the Mid North Coast Area Health Service appropriately appointed Dr Gayed, including delineating his clinical privileges. No relevant conditions were imposed by the area health service.

[109] Letter from Mr Terry Clout, Area Chief Executive Officer, Mid North Coast Area Health Service, to Dr Emil Gayed, 26 November 2001 (Tab 4C, MNCLHD documents).
[110] Letter from Dr Robert Porter, Area Director Clinical Services, Mid North Coast Area Health Service, to Dr Emil Gayed, 27 December 2001 (Tab 4D, MNCLHD documents).

444. However, his privileges were not varied to reflect the condition imposed by the Professional Standards Committee and advised to the chief executive officer of the area health service. They should have been.

445. As there were no complaints made to the area health service, there is no issue of the area health service reporting to the Medical Board.

446. Dr Jenkins advises me that no further review or audit of Dr Gayed's clinical outcomes in relation to Kempsey District Hospital is necessary. I note that NSW Health has advised the public that each of the hospitals the subject of this inquiry will make direct contact with any patient who has previously raised issues or complaints in the past regarding the treatment they received from Dr Gayed.

447. Anyone else with concerns about treatment they may have received were encouraged to call a dedicated telephone line set up at each of the hospitals. A senior clinician is available to answer questions and make any appropriate referrals for follow-up care.

448. I understand that three calls have been made to this telephone line about Dr Gayed's treatment at Kempsey District Hospital.

449. I assume that this service will be monitored and, in the event that calls suggest further review or audit, that will occur.

Chapter 7: Northern Sydney Area Health Service

1. Background

450. Dr Gayed was first appointed as a Visiting Medical Officer to Mona Vale Hospital in May 2002.

451. As at May 2002, Mona Vale Hospital was within the area health service known as Northern Sydney Health. On 1 January 2005, Northern Sydney Health was known as the Northern Sydney Central Coast Area Health Service. Since the dissolution of area health services in 2011, Mona Vale Hospital is within the Northern Sydney Local Health District.

452. Dr Gayed held a temporary appointment at Mona Vale Hospital between 10 May and 10 June 2002 and a five-year appointment commencing 1 July 2002. He resigned from that appointment on 7 March 2007 after being informed on 6 March 2007 by the Director of Medical Services that his appointment was suspended. Northern Sydney Health also suspended Dr Gayed between 11 August 2003 and 30 September 2003.

2. Appointment of Dr Gayed to Mona Vale Hospital

453. The appointment process in relation to Dr Gayed was as follows.

454. On 22 March 2002, Dr Gayed wrote to Dr Annette Pantle, Director of Medical Services at Mona Vale Hospital, to apply for the position of Visiting Medical Officer in Obstetrics and Gynaecology at the hospital 'as recently advertised'.

455. He enclosed his curriculum vitae and 'other relevant information' in support of his application. In his cover letter Dr Gayed stated as follows:

> I have been in private practice as Specialist Obstetrician and Gynaecologist in Canberra since July 1995. I have had a VMO [Visiting Medical Officer] position with the John James Hospital since July 1995 and VMO position with the Calvary Private Hospital since January 1995. I also have a VMO position with the Manning Base Hospital in Taree, NSW, since August 1999.
>
> I am experienced in all aspects of general Obstetrics and Gynaecology. I am also well experienced and trained in Minimal Access Surgery in the form of Operative Hysteroscopy, Endometrial Ablation and Laparoscopic Hysterectomy. I have a strong commitment to teaching and research and excellent interpersonal and communication skills. I have demonstrated the ability to lead and work within a multidisciplinary team environment.
>
> I practiced for many years in the U.K. and obtained several diplomas in Obstetrics and Gynaecology. In 1987 I took a challenging position as a Consultant with Aramco Medical Organisation, Saudi Arabia. I was appointed as Chairman of the Quality Assurance Committee for three years and was heavily involved with several Hospital activities and Committee functions. In 1989 I was promoted to the position of Head Obstetrician and Gynaecologist, leading a team of 15 Consultants, all qualified with the American Board

> or M.R.C.O.G. I held this position for six years until I resigned in 1994. The Hospitals were fully accredited, run and managed at the highest level of American Health Standards.
>
> Looking forward to hearing from you in the near future.

456. Dr Gayed enclosed with his letter a copy of his New South Wales Medical Board (**Medical Board**) registration card, which indicated his status as 'conditional'. He also provided a copy of his Medical Board certificate of conditional registration issued on 17 May 1994, which stated that he was registered 'to work only as an Obstetrician & Gynaecologist in positions approved by the Board'.[111]

457. He enclosed an application for employment form signed and dated 22 March 2002 on which he indicated that he was previously or currently employed at Manning Hospital, Taree.[112]

458. In answer to the question on the application form 'Are you aware of any circumstances regarding your health which may interfere with the satisfactory discharge of your duties of the position for which you are applying?', Dr Gayed struck the place for comments through.[113] He signed consents for a criminal record check and Working With Children Check and a prohibited employment declaration.

459. He provided the names of three referees, being Dr Philip Mutton (Obstetrician Gynaecologist), Dr Peter Yorke (Consultant Anaesthetist) and Dr Bruce Farnsworth (Obstetrician Gynaecologist). The referee reports were strongly supportive of his skills, clinical practice and character.

460. His curriculum vitae ran to some 63 pages. It is summarised in annexure 2. It included his medical registration numbers in the Australian Capital Territory (**ACT**), New South Wales and London. He outlined his training and experience, commencing in Cairo and continuing in Lancashire, Scotland, London and other locations in the United Kingdom. He described posts as a specialist in Saudi Arabia and the United Kingdom as well as posts and clinical experience as a specialist in Australia at the following hospitals:

- Grafton Base Hospital from 18 May 1994 to 30 June 1995;
- two private hospitals in Canberra from 1 July 1995 to the (then) present time;
- Cooma Hospital from 1 February 1996 to 9 February 1999; and
- Manning Hospital, Taree, from 10 August 1999 to (then) present time.

461. His curriculum vitae indicated subspecialty interests in high-risk obstetrics and maternal–fetal medicine, infertility and gynaecological endocrinology. He claimed

[111] New South Wales Medical Board, Certificate of Conditional Registration (Tab 2.2, p 72, NSLHD documents).
[112] Northern Sydney Health, Application for Employment (Tab 2.1, p 17, NSLHD documents).
[113] Northern Sydney Health, Application for Employment (Tab 2.1, p 20, NSLHD documents).

to have developed a major interest in minimally invasive surgery in the form of operative hysteroscopy, endometrial ablation and laparoscopic hysterectomy.

462. On 26 April 2002, Dr Pantle wrote to Dr Stephen Christley, Chief Executive Officer (**CEO**) of Northern Sydney Health, seeking approval under delegated authority to appoint Dr Gayed to the position of Visiting Medical Officer in the Department of Obstetrics & Gynaecology at the Mona Vale Hospital from Friday 10 May to Monday 13 May 2002 and Friday 7 June to Monday 10 June 2002.[114]

463. Dr Pantle's letter stated that the appointment was due to the resignation of another doctor and that the clinical privileges associated with the appointment would include admitting, consultation, diagnostic, operating, day surgery and on call but would exclude outpatients, teaching, research and special privileges. She attached his curriculum vitae.

464. The request was approved.

465. On 8 May 2002, at a meeting, the Medical Appointments and Credentials Advisory Committee of Northern Sydney Health noted the appointment under delegated authority of Dr Gayed as a locum Visiting Medical Officer in Obstetrics & Gynaecology at Mona Vale Hospital.[115]

466. On 9 May 2002, Dr Pantle wrote to Dr Gayed confirming that the area health service had approved his temporary appointment during the relevant period (from Friday 10 May to Monday 13 May 2002 and from Friday 7 June to Monday 10 June 2002).[116]

467. Dr Pantle's letter stated that the appointment carried with it the responsibilities and obligations as stated in the hospital's by-laws and did not carry with it any obligation by the hospital for appointment beyond the stated period of time.[117] She informed Dr Gayed that the following conditions applied:

> 1. That you shall be currently registered with the NSW Medical Board and remain so, in accordance with the Medical Practitioners Act 1938 as amended.
>
> 2. That you shall comply with the legislation and meet statutory requirements as required to do so, as a Medical Practitioner.
>
> 3. That you shall comply with the Area By-laws, Hospital Rules and Board Policies, and ensure conduct in compliance with the AMA Code of Ethics.

[114] Letter from Dr Annette Pantle, Director of Medical Services, Mona Vale Hospital to Dr Stephen Christley, Chief Executive Officer, Northern Sydney Health, 26 April 2002 (Tab 1.1, p 1, NSLHD documents).
[115] Minutes of Medical Appointments and Credentials Advisory Committee, Northern Sydney Health, 8 May 2002, section 7 (Tab 1.2, p 10, NSLHD documents).
[116] Letter from Dr Annette Pantle, Director of Medical Services, to Dr Emil Gayed, 9 May 2002 (Tab 1.3, p 12, NSLHD documents).
[117] Letter from Dr Annette Pantle, Director of Medical Services, to Dr Emil Gayed, 9 May 2002 (Tab 1.3, p 12, NSLHD documents).

468. On 28 May 2002, Dr Gayed attended an interview for a five-year appointment as Visiting Medical Officer at Mona Vale Hospital. There were four applicants for four positions.

469. The interview panel, of which Dr Pantle was convenor, also comprising Dr Elizabeth Swinburn, Dr Jonathan Hayman and Dr John Newlinds as College representative, was unanimous in recommending his appointment with full clinical privileges consistent with the practice of obstetrics and gynaecology. A record relating to him and two other candidates states they 'interviewed well demonstrating a good understanding of the requirements of the position and had good referee reports'.

470. On 13 June 2002, the Medical Appointments and Credentials Advisory Committee agreed to recommend that Dr Gayed be appointed to a five-year appointment as Visiting Medical Officer 'with full clinical privileges consistent with the usual practice of Obstetrics and Gynaecology. In addition, extension of clinical privileges to Manly Hospital to provide short term cover, leave relief, single procedures'.[118]

471. On 28 June 2002, Dr Gayed signed a contract with Northern Sydney Health to provide services during the period 1 July 2002 to 30 June 2007 as Visiting Medical Officer. The contract itemised his clinical privileges consistent with the usual practice of obstetrics and gynaecology as being, specifically, admitting privileges, operating theatre privileges, consultative privileges, diagnostic privileges, on-call privileges, research and training. Additional privileges provided for were the extension of clinical privileges to Manly Hospital (admitting, operating theatre, on-call) when providing short-term cover, leave relief and single procedures.[119]

472. On 17 July 2002, Mr Frank Bazik, Executive Director of Manly/Mona Vale Hospitals, sought approval from the CEO of Northern Sydney Health, Dr Christley, for Dr Gayed to be appointed as a senior specialist.[120] No reasons were given.

473. On 28 August 2002, the Northern Sydney Health Board approved Dr Gayed's advancement to senior specialist in the Department of Obstetrics & Gynaecology at Mona Vale Hospital. Dr Gayed was formally notified by letter dated 12 September 2002.[121] I am informed by Dr Jenkins that progression to a senior specialist appointment is based solely on the number of years of practice as a specialist.

[118] Minutes of Medical Appointments and Credentials Advisory Committee, Northern Sydney Health, 13 June 2002, section 4.3.7 (Tab 2.6, p 664, NSLHD documents).
[119] Northern Sydney Health, Sessional Service Contract signed 28 June 2002 (Tab 2.8, p 682, NSLHD documents).
[120] Memorandum from Frank Bazik, Executive Director, Manly/Mona Vale Hospitals, to Dr Stephen Christley, CEO, Northern Sydney Health, 17 July 2002 (Tab 2.10, p 697, NSLHD documents).
[121] Letter from Frank Bazik, Executive Director, Northern Sydney Health to Dr Emil Gayed (Tab 2.10, p 696, NSLHD documents).

2.1 Observations on appointment

2.1.1 Policy requirements relating to appointment of a Visiting Medical Officer

474. The policies applying at the time of Dr Gayed's appointment to Mona Vale Hospital are outlined in chapter 2.

475. In relation to Circular 95/24, 'Guidelines for the Delineation of Clinical Privileges of Medical Staff', the principles which it contains were generally applicable through the Northern Sydney Health By-Laws.

476. The Northern Sydney Health By-Laws at the time of Dr Gayed's appointment required, relevantly, the establishment of a Medical and Dental Appointments Advisory Committee to provide advice and make recommendations to the board concerning the proposed appointment of visiting practitioners and concerning the clinical privileges which should be allowed to visiting practitioners. The Medical and Dental Appointments Advisory Committee was required to establish a Credentials (Clinical Privileges) Subcommittee to provide advice to the Committee 'on all matters concerning the clinical privileges of visiting practitioners', including at the time of appointment and on review of clinical privileges at the request of the practitioner or Northern Sydney Health (Northern Sydney Health By-Laws, clause 45).

477. Clause 45(2) of the Northern Sydney Health By-Laws stated that any matter concerning the clinical privileges of any person who is appointed as a staff specialist or a visiting practitioner is to be referred to the Credentials Subcommittee for advice.

2.1.2 Compliance with policy in appointing Dr Gayed as Visiting Medical Officer

478. Northern Sydney Health had established appropriate committees, in accordance with its by-laws, for providing advice and making recommendations to the board concerning matters relating to the proposed appointment and reappointment of visiting practitioners and concerning the clinical privileges which should be allowed to visiting practitioners.[122]

479. Dr Gayed was selective in the information he provided to Northern Sydney Health when he sought appointment.

480. In his cover letter, he did not refer to his appointment at Cooma Hospital; however, he did so in his lengthy curriculum vitae. He made no mention of the Health Care Complaints Commission (**HCCC**) investigation, or the Professional Standards Committee and its outcome, in his curriculum vitae or any of the supporting material he provided; nor did he make any reference to Kempsey Hospital, where he worked from 25 October 1999 to 3 June 2002.

[122] Northern Sydney Health, By-Law (Tab 6.1, p 1132, NSLHD documents).

481. The application form specifically asked him about any health-related matters that might interfere with the duties of the position and he struck the question through, by which he must have intended to convey that the answer was no.[123] This was at least misleading in light of the impairment which the Professional Standards Committee found and the condition imposed by it.

482. There are no interview notes or other documentation from the time of his appointment to clarify what was known to Dr Pantle, the interview panel or the Medical Appointments and Credentials Advisory Committee.

483. However, the events which transpired in 2003 confirm that Dr Gayed's disciplinary history, the Professional Standards Committee and the conditions imposed and recommendations made by the Professional Standards Committee were not known at the time of the appointment. The documentation makes clear that Northern Sydney Health first became aware of the conditions on Dr Gayed's registration after concerns arose in relation to his management of patients in June 2003.

484. I am satisfied that, prior to appointing Dr Gayed, Mona Vale Hospital did not check Dr Gayed's registration status with the Medical Board. The inquiry has been informed that, prior to Dr Gayed's temporary appointment at Mona Vale Hospital, Dr Pantle (as Director of Medical Services) sought and obtained a verbal reference from Dr Jim Wills, Director of Medical Services at Manning Hospital. Dr Pantle said Dr Wills spoke in 'glowing terms of the contribution Dr Gayed had made at Taree including taking on the role of Head of Department and there were no adverse comments at all'.[124] Dr Gayed was not the Head of Department at Manning Hospital at any time. I accept that Dr Pantle received that positive reference, as Dr Wills gave several positive references about Dr Gayed between 2001 and 2014 (as set out in Chapter 8 of this report).

485. There is no evidence that the hospital sought from Dr Gayed information as to his conditions of registration or his consent to contact the Medical Board and/or the HCCC. The application form for his appointment did not contain a section seeking the applicant's written authorisation to obtain information from the HCCC or Medical Board. Circular 97/80, 'Procedures for Recruitment and Employment of Staff and Other Persons—Vetting and Management of Allegations and Improper Conduct', required that it be sought.

486. Section 99(2) of the *Health Services Act 1997* (NSW) (**Health Services Act**) did not require Dr Gayed to inform any new employer of a finding of unsatisfactory professional conduct as the duty is to do so 'within 7 days of receiving notice of the finding'. However, the NSW Health Code of Conduct did require it.

487. The applicable recruitment policy required the area health service to seek consent from registered medical practitioners to verify registration status with the Medical

[123] Northern Sydney Health, Application for Employment (Tab 2.1, p 20, NSLHD documents).
[124] Email response by Dr Annette Pantle dated 3 October 2018 to draft inquiry report.

Board. Absent such a check, the fact Dr Gayed's medical registration was noted as 'conditional' on his Medical Board registration card and certificate of registration, copies of which he provided with his curriculum vitae, may have appeared unexceptional to those recruiting him, given that he had entered Australia as an overseas-trained specialist and was assessed by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists as such. The danger in assuming that this is the reason for conditional registration is laid bare in this matter.

488. The references Dr Gayed provided included those submitted to the Professional Standards Committee in 2001 (and additional references dated March 2002).[125] The references did not refer to the Professional Standards Committee, but some references dated 2001 were addressed to Dr Gayed's solicitor at United Medical Protection. This might have put an astute reader on notice that the references had been obtained in a particular context which warranted checking. Regardless, the policy required that the referees be contacted, and this apparently did not occur.

489. In the result, the clinical privileges granted to Dr Gayed by Northern Sydney Health did not reflect the conditions imposed on his registration in that there was no restriction on microsurgery. His eyesight issues were apparently not known to the hospital or area health service at the time of appointment.

490. Dr Gayed's clinical privileges were reviewed in 2003, albeit as a result of complaints which were made; however, as set out below, his clinical privileges were not varied.

491. Dr Jenkins considers that Dr Gayed's five-year appointment as a Visiting Medical Officer with full credentials would have been standard practice at the time given that the area health service appears to have been unaware of the Professional Standards Committee or its outcome. Dr Jenkins considers that the condition imposed not to do microsurgery was of very minor significance to an obstetric gynaecology practice because it is rarely performed by obstetrician gynaecologists. Dr Pantle informed the inquiry that Mona Vale Hospital had no microsurgical capability at that time.

492. Under current policy,[126] an applicant is less likely to be successfully appointed without being required to divulge conditions on registration and disciplinary

[125] Reference from Louise White, 29 July 2001 (Tab 2.2, p 109, NSLHD documents); Reference from C van Eimeren, 30 July 2001 (Tab 2.2, p 110, NSLHD documents); Reference from Johanna Huisman, 17 August 2001 (Tab 2.2, p 111, NSLHD documents); Reference from Anne McCormack, 7 August 2001 (Tab 2.2, p 112, NSLHD documents); Letter from Dr Bruce Farnsworth to Ms Helen Turnbull, United Medical Protection, 20 July 2001 (Tab 2.2, p 113, NSLHD documents); Reference from Trent Jennison, Chief Executive Officer, Mayo Private Hospital, 6 August 2001 (Tab 2.2, p 114, NSLHD documents); Letter to Ms Helen Turnbull from Dr Jim Wills, Manager, Clinical Services & Director, Emergency Department, 25 July 2001 (Tab 2.2, p 115, NSLHD documents); Letter from Ms Gillian Kailofer, Quality Development Unit, John James Memorial Hospital, to Dr E Gayed, 26 July 2001 (Tab 2.2, p 123, NSLHD documents); Letter from Dr Peter Yorke to Ms Helen Turnbull, United Medical Protection, 7 August 2001 (Tab 2.2, p 166, NSLHD documents).

[126] Policy Directive PD2016_052, 'Visiting Practitioner Appointments in the NSW Public Health System' (Tab 31, Policies on the appointments of VMOs 1990–2016).

history. Current policy requires a checklist of critical actions to be undertaken when recruiting visiting practitioners, including undertaking referee checks and verifying registration status using the Australian Health Practitioner Regulation Agency website. Reference checks are now required to be conducted in a more structured manner. The current policy contains a template setting out minimum requirements when conducting such checks. An additional protection is that, where an applicant already holds a position as visiting practitioner in NSW Health (which was the case for Dr Gayed when he applied to Mona Vale Hospital), the policy states that at least one referee should be a person with a management or oversight role in respect of the applicant. The applicant must be advised that the purpose of a reference check is to help verify current information and any relevant conduct or performance issues.

3. Information sharing by the Medical Board

493. The extent to which the Medical Board was free to share information about Dr Gayed with Northern Sydney Health is an important issue in this inquiry. It is apparent from the Medical Board files relating to Dr Gayed, and the queries raised by Northern Sydney Health with the Medical Board, that at times the Medical Board believed it to be constrained in the information it could provide about Dr Gayed's disciplinary history and the current action being taken by the Board.

494. The key provisions affecting the sharing of information by the Medical Board with Northern Sydney Health during the period Dr Gayed was a Visiting Medical Officer at Mona Vale Hospital were as follows.

495. The legislation allowed the Medical Board to provide a copy of the Professional Standards Committee's decision to such persons as the Board 'thinks fit'.[127]

496. The Register of Medical Practitioners for New South Wales was required to be available for inspection by any person at the office of the Medical Board and by such other means, including by Internet access, as the Board determined (Schedule 1 to *Medical Practice Act 1992* (NSW) (**Medical Practice Act**), cl 21). In or about 2001, the Board determined that the Register would include, relevantly:[128]

- conditions on registration, subject to information relating to the physical or mental capacity of the practitioner (that is, impairment conditions) being excluded;
- details of any order made by a disciplinary body; and
- particulars of any caution or reprimand issued as a result of a hearing during the period in which any conditions or orders remain on the practitioner's registration. When all conditions/orders have been lifted or have expired,

[127] *Medical Practice Act 1992* (NSW) s 180(4).
[128] NSW Medical Board Policy 96/442 created June 2001; revised August 2001, December 2004.

the reference to the reprimand/caution will be removed. If the reprimand/caution is issued, but no conditions/orders are made, the reprimand/caution will not be recorded.

497. In practice, the Medical Board did not publish the registration status of medical practitioners on the Internet in 2002.

498. The Medical Board had no express power under the Medical Practice Act to provide information to a hospital at which a doctor was a visiting practitioner or employed about that doctor's compliance with conditions on registration. The legislation required the Medical Board to give public health organisations notice of any order made against a practitioner and of any conditions imposed.[129] That requirement, coupled with the discretion to provide copies of Professional Standards Committee and Medical Tribunal of New South Wales (**Medical Tribunal**) decisions to any person it thought fit, might be thought to have allowed the Medical Board to inform relevant hospitals of a doctor's compliance with orders and conditions imposed. However, the Medical Practice Act contained a general prohibition on the disclosure of information obtained in connection with the administration or execution of the Act subject to certain exceptions. It appears that, in the case of Dr Gayed, the Medical Board had doubts about its right to share information about Dr Gayed's compliance with his conditions of registration in the absence of express statutory permission.

499. In relation to the Performance Assessment Program, the legislation distinguished between performance assessment reports and reports of a Performance Review Panel.[130] This remains the case under the current legislation.[131] A performance assessment report is a 'protected report', meaning that a person may not disclose information contained in such a report, or the report itself, except to the HCCC or for the purposes of exercising functions under the legislation. The decision and report of a Performance Review Panel is not a 'protected report' under the legislation. A Performance Review Panel was (and still is) required to provide, within one month of its decision being made, a written statement of its decision to the Medical Board / Medical Council of New South Wales (**Medical Council**) and the relevant doctor and is permitted to provide it to any other persons it thinks fit.[132] Therefore, whether the Medical Board had a discretion to provide a report in relation to a performance assessment to any person it thought fit in the absence of the consent of the medical practitioner is a moot point.

[129] *Medical Practice Act 1992* (NSW) s 191B.
[130] *Medical Practice Act 1992* (NSW) s 190B and Sch 3A, cl 8.
[131] *Health Practitioner Regulation National Law* (NSW) ss 138, 176F.
[132] *Medical Practice Act 1992* (NSW) s 86P.

4. Management of cluster of incidents in 2003

500. Complaints about Dr Gayed's management of patients at Mona Vale Hospital were made to the hospital executive each year following his appointment in 2002. For the most part, incidents were notified by staff. The complaints, adverse events and performance issues, and the response by the hospital and area health service, are outlined below. NSW Health had policies in place setting out how complaints and concerns about medical practitioners should be managed. They are summarised in chapter 2. I address compliance with policy in this chapter.

4.1 Incidents raised by staff in June 2003

501. In June 2003, a number of cases involving Dr Gayed as consultant came to the attention of Dr Pantle. Dr Pantle, who had been involved in recruiting Dr Gayed in 2002, still occupied the role of Director of Medical Services at Mona Vale Hospital. A briefing summary prepared in October 2003 states that five cases were notified in writing via the hospital's routine system of reporting to a Patient Safety Office and two by verbal reporting to Dr Pantle.[133]

502. By 7 June 2003, Dr Pantle had reviewed three of the cases with the Head of the Department of Obstetrics & Gynaecology. Both were satisfied that the cases warranted review beyond a routine Morbidity and Mortality process.

503. On 7 June 2003, Dr Pantle was informed of additional cases of unplanned returns to theatre and was looking into them—a task she proposed to complete the following day.[134]

504. Dr Pantle discussed the concerns relating to Dr Gayed with Dr Alex Bennie, Director of Clinical Services Development.

505. Dr Bennie made recommendations to Dr Pantle:

(1) Dr Pantle should review the cases of concern with the Head of Department.

(2) If concerns were confirmed, the series of cases may represent a serious risk and therefore the doctor should be stood down while a review is undertaken.

(3) Dr Pantle should arrange an urgent meeting with the doctor to inform him of the concerns and indicate the area health service's decision to stand him down.

(4) Following that meeting, a committee would be set up to review the matter and make a recommendation to the CEO.

[133] Summary Briefing from Dr Alex Bennie, Director, Clinical Services Development re 'Dr Emil Gayed, VMO Obstetrician and Gynaecologist, Mona Vale Hospital', October 2003 (Tab 4.28, p 1045, NSLHD documents).
[134] Email from Dr Alex Bennie to Dr Annette Pantle, 8 June 2013 (Tab 3.1, p 703, NSLHD documents).

506. Following Dr Pantle's discussion with Dr Bennie on 7 June 2003, Dr Pantle was made aware of a possible complication of an operation that had occurred the previous Monday. She conveyed that information to Dr Bennie.

507. On 8 June 2003, Dr Pantle informed Dr Bennie by email, copied to the CEO of the area health service, Dr Christley, that she and Clinical Risk Manager Fran Buchan had commenced a review of the previous 12 months' theatre activity for unplanned returns to theatre and readmissions to hospital within 28 days. This required manual checking, which was time consuming. Dr Pantle said she was working towards holding a meeting with Dr Gayed the following Thursday. She told Dr Bennie that she would arrange for Dr Gayed's upcoming on-call shifts to be covered by others. There is no record to confirm whether this occurred.

508. On 8 June 2003, Dr Bennie provided further guidance to Dr Pantle as to the action required in an email, in which he recommended:[135]

(a) a meeting at her office between Dr Gayed, Dr Pantle and Dr Bennie following Dr Pantle's review of the additional cases;

(b) advising Dr Gayed of the decision to suspend him pending an investigation;

(c) providing Dr Gayed with a letter briefly stating the concerns and the decisions to suspend and notify the Medical Board;

(d) sending a letter to the Medical Board;

(e) that Dr Bennie inform the CEO, seek advice from lawyers and advise the Chair of the Medical Appointments and Credentials Advisory Committee; and

(f) using the Credentials Committee with two external obstetrics and gynaecology specialists.

509. The CEO, Dr Christley, who was copied to the emails, endorsed the approach.

510. On 24 June 2003, Dr Pantle was made aware of a major clinical incident involving a patient under the care of Dr Gayed.[136] This related to a patient who bled postpartum, was transferred to theatre for a dilation and curettage and then transferred to the Intensive Care Unit for overnight care due to significant blood loss.[137]

511. On 30 June 2003, Dr Gayed approached Dr Pantle in her office to request an increase in his allocated operating sessions at Mona Vale Hospital. Dr Pantle spoke to Dr Gayed about the incident of which she was notified on 24 June and the other matters.[138] Dr Pantle made a file note of their conversation.[139] Dr Pantle questioned

[135] Email from Dr Alex Bennie to Dr Annette Pantle, 8 June 2013 (Tab 3.1, p 703, NSLHD documents).
[136] File note, Dr Annette Pantle, 'Dr Emil Gayed', 30 June 2003 (Tab 3.1, p 700, NSLHD documents).
[137] Northern Beaches Health Service, Major Clinical Incident or other Reportable Event table, 'Dr Gayed', 29 July 2002 (Tab 3.1, p 716, NSLHD documents).
[138] File note, Dr Annette Pantle, 'Dr Emil Gayed', 30 June 2003 (Tab 3.1, p 700, NSLHD documents).
[139] File note, Dr Annette Pantle, 'Dr Emil Gayed', 30 June 2003 (Tab 3.1, p 700, NSLHD documents).

him about the conditions of his registration and said she was aware of the conditions, having spoken to the Medical Board. Dr Pantle told Dr Gayed that she had been advised that he must undergo annual ophthalmological examination and inform the Medical Board of his practice locations. Her file note does not refer to the condition that he not undertake microsurgery or the Professional Standards Committee decision.

512. There is no file note of Dr Pantle's conversation with the Medical Board in June 2003 in either the Northern Sydney Local Health District or the Medical Council files available to the inquiry. It is likely that Dr Pantle contacted the Medical Board after conferring with Dr Bennie, who recommended contact with the Board. Although Dr Pantle's file note regarding her conversation with Dr Gayed states that she told him that she was 'aware of the conditions', having spoken to the Medical Board, it is not clear whether the Medical Board told Dr Pantle of the microsurgery condition or the background at Cooma Hospital.

513. Dr Pantle recorded that Dr Gayed told her that there had been one case when he was operating at a hospital outside Canberra where a patient had taken a personal vendetta approach against him following a poor outcome following complicated 'gynae surgery'. He said that the Board-nominated ophthalmologist had 'treated him like a criminal', presumed him guilty 'of some crime' and found his vision to be impaired. He had disputed the findings and requested a second opinion, which found his vision to be OK. Dr Gayed told Dr Pantle that he had continued to operate at that hospital for a further 12 months and then left of his own accord, with no further incidents.

514. It is probable that the reference to the patient with the poor outcome was at Cooma Hospital. If Dr Gayed was referring to Cooma Hospital, it was misleading for him to say that he continued to operate at the hospital for a further 12 months and then left 'of his own accord'. Although he resigned from Cooma Hospital in February 1999, the account given to Dr Pantle, as recorded in her file note, was not the full story given the circumstances outlined in chapter 4 (involving concerns being raised by staff about incidents involving multiple patients between April 1997 and July 1998).

515. Dr Pantle informed Dr Gayed that she needed to discuss the question of extra theatre sessions with the head of department and the theatre Nursing Unit Manager and would advise him of the outcome.

516. Dr Pantle recorded in her file note that, in discussing the obstetric case notified to her as a 'Major Clinical Incident', there appeared to be no system issues and the clinical management was appropriate.

517. Documents within the Northern Sydney Health files suggest that a review of Dr Gayed's theatre activity over the previous 12 months for unplanned returns to theatre and readmissions to hospital was carried out, consistent with what Dr Pantle stated to Dr Bennie on 8 June 2003. The documents outline the date of

'executive review' and action taken in respect of some cases (including records being reviewed by the Clinical Risk Manager).[140] It was resolved that some cases would be reviewed in a Morbidity and Mortality meeting. Other cases would be referred to an 'expert review panel' that was being set up as a subcommittee of the Medical Appointments and Credentials Advisory Committee. The Credentials Subcommittee was not convened for this purpose until 12 August 2003.

4.2 Further incidents raised by staff

518. On 15 July and 22 July 2003, three incident reporting forms for 'Major Clinical Incident or other Reportable Event' were submitted by nursing staff relating to Dr Gayed's patients.

519. Dr Pantle signed those forms on behalf of the hospital's executive on 25 July 2003.

520. The incidents involved two unexplained complications resulting in unplanned overnight admissions of patients and a case involving an unplanned return to the operating theatre.[141]

521. One patient had been admitted for a laparoscopy for endometriosis. There was postoperative intra-abdominal bleeding requiring a return to the operating theatre the following day for abdominal hysterectomy. Histopathology demonstrated no evidence of endometriosis.

522. Another case involved a perforation of transverse colon during an elective laparoscopy for drainage of ovarian cyst, which led to a laparotomy, repair and irrigation and a prolonged hospital stay. A different consultant was called in.

523. The third form reported an unplanned return to theatre in respect of a patient who developed small bowel obstruction following a total hysterectomy on the previous Tuesday that had resulted in the need for a laparotomy.[142] The form noted that this was the second unplanned return to theatre of the patient following abdohysterectomy. The surgery was complicated initially by postoperative bleeding necessitating a return to theatre for securing of haemostasis.

524. On 6 August 2003, Dr Pantle signed another form submitted by nursing staff reporting an unexplained complication consisting of a patient's uterus being perforated during a procedure for endometrial ablation resulting in her having to stay in hospital overnight.[143]

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[140] Northern Beaches Health Service, Major Clinical Incident or other Reportable Event table, 'Dr Gayed', 29 July 2002 (Tab 3.1, p 716, NSLHD documents).
[141] Northern Beaches Health Service, Incident Reporting Form, 25 July 2003 (Tab 3.1, p 721, NSLHD documents).
[142] Northern Beaches Health Service, Incident Reporting Form, 25 July 2003 (Tab 3.1, p 720, NSLHD documents).
[143] Northern Beaches Health Service, Incident Reporting Form, 6 August 2003 (Tab 3.1, p 727, NSLHD documents).

4.3 Response of Mona Vale Hospital to incidents in 2003: suspension and reinstatement

4.3.1 Suspension of Dr Gayed

525. On 12 August 2003, Dr Pantle, Dr Bennie (Director of Clinical Services Development) and Dr Gayed met in Dr Pantle's office at 2 pm.[144]

526. Dr Pantle made a detailed file note of the meeting.[145]

527. Dr Bennie advised Dr Gayed that the area health service wished to raise issues to which Dr Gayed needed to respond and that Dr Bennie was participating in the process as Dr Christley's representative. Dr Bennie informed Dr Gayed that Dr Pantle had raised matters that the area health service 'could not let pass' and that Dr Gayed needed to consider the cases.

528. Dr Bennie handed Dr Gayed a letter dated 11 August 2003 signed by Dr Christley advising of seven cases that Dr Bennie said were all of 'deep' and 'serious clinical concern' to the hospital and the area health service. Dr Bennie told Dr Gayed that the matters could not be reviewed by standard hospital Morbidity and Mortality processes and that a separate Credentials Subcommittee would be established under area health service by-laws comprising two members of the area Medical Appointments and Credentials Advisory Committee and an eminent obstetrics and gynaecology specialist.

529. The letter from Dr Christley advised Dr Gayed that 'your clinical privileges are suspended pending investigation of your clinical performance'.[146]

530. In the meeting on 12 August 2003, Dr Bennie asked Dr Gayed to respond to the issues in writing to assist the area health service. Dr Bennie advised Dr Gayed of his right to seek legal advice and to take action under the Health Services Act, but he reiterated that Dr Gayed was required to provide a written response for the committee to consider. Dr Bennie informed Dr Gayed that he and his advisers were welcome to look at the hospital records but could not photocopy or remove them.

531. Dr Bennie advised Dr Gayed that the review would be undertaken on a confidential basis and that no-one would be advised of the reasons for Dr Gayed's suspension, other than the committee and the CEO. The principles of fairness and natural justice would apply. Dr Bennie advised Dr Gayed that the area health service had not formed a final view on the issues.

532. Dr Pantle's file note records that Dr Gayed was very distressed by the material presented to him and asked why each of the cases had not been raised with him as they happened. He said he was aware of the cases and had been expecting Dr

[144] File note, Dr Annette Pantle, 'Dr Emil Gayed', undated (Tab 3.1, p 698, NSLHD documents).
[145] File note, Dr Annette Pantle, 'Dr Emil Gayed', undated (Tab 3.1, p 698, NSLHD documents).
[146] Letter from Dr Stephen Christley, Chief Executive Officer, Northern Sydney Health, to Dr Emil Gayed, 11 August 2003 (Tab 4.1, p 850, NSLHD documents).

Pantle to speak with him. Dr Pantle told him that the cases had been notified to her in a cluster over a period of about two weeks and that the trend they presented required referral to the area health service.

533. Dr Gayed expressed distress at the similarity of the process to one he went through at Cooma Hospital. Dr Gayed told Dr Bennie and Dr Pantle that in that case there were eight to 10 cases referred to the HCCC and that it took some time and a great deal of distress 'to clear his name'. (This was not true, as set out in an earlier chapter, given that he was found guilty of unsatisfactory professional conduct and reprimanded.) The file note records that Dr Gayed left the meeting for a short period to compose himself and returned after five minutes.

534. The file note records that Dr Gayed then presented data (similar to that attached to his curriculum vitae) relating to complication rates, quality assurance data from John James Memorial Hospital, a patient satisfaction survey and written references and testimonials. Some of the references had been submitted to the Professional Standards Committee in 2001 and were also relied upon by Dr Gayed at the time of his appointment.

535. Dr Gayed asked that the suspension of clinical privileges be deferred until he was allowed to respond to the cases presented. Dr Bennie denied that request, saying the process had been endorsed by the CEO, but he reassured Dr Gayed that no decision had been made.

536. In that meeting, Dr Gayed acknowledged a higher complication rate in gynaecology surgery but stated that this was due to family stress. He also said that he had experienced problems with his submandibular gland and had consulted a specialist, who would operate in a few months. In some of the cases he admitted he made a mistake. Dr Gayed 'begged' for the suspension decision to be reconsidered. Dr Bennie agreed to take the request to the CEO.

537. At the end of the meeting Dr Gayed undertook to try to respond in writing within two weeks. The meeting ended at 3 pm. Dr Pantle recorded that she was to advise theatres, 'switch' and the wait list coordinator that Dr Gayed was on leave for two weeks after the CEO decision on suspension was known.

538. There is no information to suggest that the decision to suspend Dr Gayed's privileges was reconsidered favourably to him following that meeting.

539. The seven cases outlined in Dr Christley's letter to Dr Gayed were as follows. Dr Jenkins has considered the available material in relation to each case and his comments are also set out here:

    (1) elective laparoscopy for drainage of ovarian cyst complicated by bowel perforation necessitating laparotomy and prolonged hospital stay. Dr Jenkins considers that this case was a serious incident raising the issue of Dr Gayed's possible lack of surgical skill.

(2) elective laparoscopy for investigation of pelvic pain. A diagnosis of advanced endometriosis was made at the time of surgery. The procedure was complicated by postoperative intra-abdominal bleeding requiring return to operating theatre the following day for abdominal hysterectomy. Histopathology demonstrated no evidence of endometriosis. Dr Jenkins considers that this case was a serious incident raising the issue of Dr Gayed's possible lack of surgical skill and judgment.

(3) elective abdominal hysterectomy complicated initially by postoperative vaginal bleeding necessitating return to operating theatre for securing of haemostasis. Secondarily complicated by a further return to operating theatre on postoperative day 7 for management of small bowel obstruction and repair of a small bowel perforation. Dr Jenkins considers that this case was a serious incident involving the issue of Dr Gayed's possible lack of surgical skill.

(4) abdominal hysterectomy and removal of ovaries (33 years old) for severe endometriosis / severe pelvic pain. Histopathology showed no evidence of endometriosis. Dr Jenkins considers that this case involved a potentially unnecessary hysterectomy and removal of ovaries in a young woman and raises the issue of a possible lack of proper judgment or lack of ethical professional conduct on the part of Dr Gayed.

(5) elective hysteroscopy and laparoscopy for investigation of pelvic pain and menorrhagia, followed four months later by an abdominal hysterectomy. Dr Jenkins considers that this case involved possible overservicing by Dr Gayed.

(6) elective hysteroscopy and laparoscopy for investigation of heavy periods (36 years old); patient was also keen to conceive (no children). Admitted two weeks later for laparotomy and myomectomy. Admitted one month later for abdominal hysterectomy due to ongoing heavy periods. Dr Gayed states on the initial hysteroscopy that there were no fibroids distorting the uterine cavity; however, histopathology on the hysterectomy specimen confirms the presence of fibroids beneath the endometrium causing distortion of the uterine cavity. This suggests that these fibroids were the cause of her heavy bleeding and possibly could have been treated surgically without the need for hysterectomy. Dr Jenkins considers that this case involved multiple procedures culminating in hysterectomy on a young woman with no children and raises the issue of possible poor clinical judgment and possible overservicing by Dr Gayed. It also raises the issue of a possible lack of surgical competence (missed diagnosis of fibroids at hysteroscopy).

(7) elective endometrial ablation complicated by uterine perforation and overnight admission. Dr Jenkins notes that this was a recognised complication of the procedure and the case was possibly significant in view of the cluster of events, suggesting possible lack of surgical skill.

4.3.2 Decision to review cases in Credentials Subcommittee

540. On 13 August 2003, the Northern Sydney Health Medical Appointments and Credentials Advisory Committee, chaired by Professor Carol Pollock, discussed the suspension of clinical privileges. The Committee recommended that a Credentials Subcommittee be convened comprising two nominees of the Committee, an outside senior gynaecologist, a representative of the CEO and a senior medical administrator within the work environment of the practitioner concerned.[147] The minutes record that Dr Brett Gardiner stressed the importance of not rushing decisions and making sure documentation was complete.

541. On 18 August 2003, Dr Gayed provided an 83-page written response to the hospital addressed to Dr Bennie. The response consisted of a letter dated 14 August 2003 and attachments.[148] He addressed each of the seven cases in detail, defending his management of each case.

542. The attachments he provided included statistics as to his surgical experience, a quality assurance study, a patient satisfaction questionnaire, information as to his continued medical education and high-risk management and references. The references included those submitted at the time of his application for appointment, which, as noted earlier, included references submitted to the Professional Standards Committee in 2001.

543. He requested that the suspension of his clinical privileges be temporarily lifted so as to prevent major disruption to his surgical lists.

544. On 18 August 2003, Dr Christley acknowledged Dr Gayed's response and informed him that a Credentials Subcommittee, comprising members of the Northern Sydney Health Medical and Dental Appointments Advisory Committee and an independent obstetrician and gynaecologist, would consider the matter and that the names of the committee members would be confirmed. Dr Christley said the area health service would seek to expedite the matter.[149]

545. Dr Christley responded to Dr Gayed's particular concern that the matters had not been brought to his attention until 12 August despite some of the matters being managed the previous year. Dr Christley confirmed that the matters came to the attention of management in the previous few weeks in a cluster and the trend of concerns required referral for consideration by the area health service.

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[147] Minutes of Medical Appointments and Credentials Advisory Committee, Northern Sydney Health, 13 August 2003 (Tab 4.4, p 945, NSLHD documents).

[148] Letter from Dr Emil Gayed to Dr Stephen Christley, Chief Executive Officer, Northern Sydney Area Health Service, 14 August 2003 (Tab 4.2, pp 855–943, NSLHD documents); NSW Health, TMF Incident Report (Tab 3.1, p 729, NSLHD documents); Letter from Dr Emil Gayed to Dr Alex Bennie, 13 August 2003 (Tab 4.1, p 852, NSLHD documents).

[149] Letter from Dr Stephen Christley, Chief Executive Officer, Northern Sydney Health, to Dr Emil Gayed, 18 August 2003 (Tab 4.3, p 944, NSLHD documents).

546. On 27 August 2003, a solicitor from United Medical Protection wrote to Dr Christley on behalf of Dr Gayed seeking further information and noting that Dr Gayed was currently considering an appeal from the decision to suspend his clinical privileges.[150] The solicitor requested a copy of the complaint instigating the 'investigation' and the Northern Sydney Health policy on the management of complaints.

547. Dr Christley responded to that letter on 3 September 2003.[151] He confirmed the names of the members of the Credentials Subcommittee and enclosed the Northern Sydney Health policy, 'Management of a complaint or concern about a clinician'. He confirmed that there was no written complaint which instigated the review in that the Director of Medical Services' attention had been drawn to case management issues of concern through the surveillance systems operating within the organisation. He enclosed relevant incident report forms. He noted that Dr Gayed had not notified of concerns in respect of some of the patients despite the contractual obligation under the Visiting Medical Officer Contract for Liability Coverage.

4.3.3 Review of cases by Credentials Committee

548. Northern Sydney Health convened a Credentials Advisory Committee (**Credentials Committee**).

549. On 25 August 2003, Dr Bennie briefed the Credentials Committee with correspondence between the area health service and Dr Gayed. The Credentials Committee comprised Professor Pollock, Dr Lou Izzo, Dr Pantle, Dr Bennie and Dr Ken Atkinson as the independent obstetrics and gynaecology specialist.[152]

550. Dr Bennie said in his covering memorandum that the role of the Credentials Committee was to review the clinical privileges of Dr Gayed in light of the information available and make an assessment as to whether he met the essential and desirable criteria for appointment as a visiting practitioner with North Sydney Health.

551. The records show that on 28 August 2003 the Medical Board sent a facsimile to the hospital (to Gail Kingston) attaching the conditions on Dr Gayed's registration 'as requested'.[153] It appears from the minutes of the subsequent Credentials

[150] Letter from Ms Georgie Haysom, Solicitor, United Medical Protection, to Dr Stephen Christley, Northern Sydney Health, 27 August 2003 (Tab 4.6, p 951, NSLHD documents).
[151] Letter from Dr Stephen Christley, Chief Executive Officer, Northern Sydney Health, to Ms Georgie Haysom, Solicitor, United Medical Protection, 3 September 2003 (Tab 4.7, p 953, NSLHD documents).
[152] Memorandum from Dr Alex Bennie to Prof Pollock, Dr Izzo, Dr Pantle and Dr Atkinson, 'Credentials Committee, Review—Dr Gayed', 25 August 2003 (Tab 4.5, p 950, NSLHD documents).
[153] Facsimile from Ms Kym Wroth, New South Wales Medical Board, to Ms Gail Kingston, 28 August 2003 (Tab 1.4, p 14, NSLHD documents).

Committee meeting that Dr Pantle had requested a written copy of the conditions.[154]

552. The conditions were stated to be as follows:

> Employment:
>
> 1. To work as an [sic] specialist obstetrician and gynaecologist in positions to be notified to the Board.
>
> 2. may not undertake microsurgery.
>
> 3. to be assessed by an ophthalmologist approved by the New South Wales Medical Board at intervals determined by the ophthalmologist and reports forwarded to the Board.
>
> General:
>
> 1. To work solely as a specialist in Obstetrics and Gynaecology.
>
> Health:
>
> NIL

553. There was no reference in the document to the Professional Standards Committee, its orders, the reprimand or the recommendation it made that a performance assessment be undertaken.

554. However, I am satisfied that, by this time, Mona Vale Hospital was aware that Dr Gayed had been the subject of a Professional Standards Committee which resulted in conditions being imposed on his registration because:

(a) In June 2003 Dr Pantle documented her awareness of the conditions (although there is not specific reference to the nature of conditions in her file note), as referred to above.

(b) On 12 August 2003, Dr Gayed informed Dr Pantle and Dr Bennie that he had been through a process at Cooma Hospital resulting in eight to 10 cases being referred to the HCCC which required him 'to clear his name', as referred to above.

(c) Contained on the files is a page from the Medical Board's Annual Report 2002 summarising in a de-identified manner the Professional Standards Committee outcome relating to Dr Gayed (headed 'Poor gynaecological practice and physical impairment'). Dr Pantle informed the inquiry that she made these notes after speaking to the Medical Director at the Medical Board. This was in June or August 2003. Dr Pantle's handwritten notes were:

[154] Minutes, Credentials Advisory Committee Meeting, Northern Sydney Health, 8 September 2003 (Tab 4.8, p 956, NSLHD documents).

> Professional Standards Committee. No special obligation on us with respect to Board. RCA. Advise Board of outcome. If concerns notify board + Do something internally first wouldn't involve college at this stage board will do this.[155]

(d) Next to the Annual Report summary stating that '[t]he Committee also recommended that the Board perform a Performance Assessment on his practice' is a handwritten note 'did not do this'.

(e) In correspondence dated 30 September 2003 to the Medical Board, Dr Christley acknowledged that the area health service only became aware during the review that Dr Gayed held a conditional registration with the Medical Board and may have had his performance previously considered by the Medical Board.

555. On 8 September 2003, the Credentials Committee met for the first time to review the concerns. The minutes record that:

> This committee was convened to review concerns arising out of a recent series of cases undertaken at Mona Vale Hospital by Dr Gayed and whether the issues raised were substantial enough to make recommendations regarding his privileges and/or appointment.[156]

556. The Credentials Committee included an independent gynaecologist.

557. The minutes record that Dr Gayed had been suspended while the review was undertaken and that the meeting 'was requested to determine if the concerns were sufficient to suggest a lack of confidence in Dr Gayed's ability to function as a VMO as required in the normal course of duties within Northern Sydney Health'.

558. At that meeting, the Credentials Committee recommended that:

(1) the Medical Board be approached to formally disclose if Dr Gayed has met the conditions of his registration;

(2) Dr Gayed be requested to confirm if restrictions or conditions have been placed on his indemnity insurance which may have been available and not disclosed at interview and appointment, including record of claims as required in his subsequent Treasury Managed Fund contract with the area health service;

(3) Dr Gayed be asked to respond as to why he had failed to comply with conditions within his contract requiring notification to the Treasury Managed Fund of any possible adverse outcomes potentially leading to claims against Northern Sydney Health, particularly in light of his acknowledgment of issues raised in respect of several patients identified by the area health service to him;

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[155] Excerpt, New South Wales Medical Board, Annual Report 2002 (Tab 1.4, p 16, NSLHD documents).
[156] Minutes, Credentials Advisory Committee Meeting, Northern Sydney Health, 8 September 2003 (Tab 4.8, p 955, NSLHD documents).

(4) subsequent to the above information being made available to the committee, the committee would review the information and at the same time consider a request of Dr Gayed to address the Committee; and

(5) the Committee would meet in two weeks to review further information.

559. On 10 September 2003, Dr Gayed sent to the Minister of Health a notice of appeal under ss 106 and 107 of the Health Services Act against the decision to suspend his clinical privileges.[157]

560. On the same date, Dr Gayed's solicitor sought further information from Dr Christley, including as to how and when the issues of concern were brought to the attention of the Director of Medical Services and a copy of the hospital records for each patient.[158] The solicitor also wrote to Professor Pollock to seek an opportunity for Dr Gayed to provide information to the Committee either by way of presentation to it or in writing.[159]

561. On 12 September 2003 Dr Christley conveyed to Dr Gayed the Credentials Committee's request for a response to the matters referred to above.[160]

562. Dr Gayed provided the Treasury Managed Fund with incident reports for each of the seven cases of concern notified in Dr Christley's letter date 11 August 2003.[161] The Treasury Managed Fund is a public sector insurer. Doctors appointed to public health organisations have obligations to notify incidents to their own insurer and also to the hospital's insurer.

563. On 17 September 2003, Dr Gayed sent a letter to Dr Christley confirming that there were no restrictions or conditions on his membership with United Medical Protection. He took issue with the suggestion that he may have breached his Contract of Liability Coverage in not reporting incidents which could reasonably be expected to trigger the indemnity under the contract. He said that he had received no complaints or intimation of any claim by any of the patients and did not consider the matters to be 'incidents' requiring reporting prior to his meeting with Dr Bennie and Dr Pantle on 12 August 2003. He said several of the cases raised differences of opinion as to the clinical management of the patients' conditions rather than being 'adverse outcomes' or 'complications'.[162]

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[157] Letter from Dr Emil Gayed to Mr Morris Iemma MP, Minister of Health, 10 September 2003 (Tab 4.9, p 957, NSLHD documents).

[158] Letter from Ms Georgie Haysom, Solicitor, United Medical Protection, to Dr S Christley, Northern Sydney Health, 10 September 2003 (Tab 4.10, p 960, NSLHD documents).

[159] Letter Ms Georgie Haysom, Solicitor, United Medical Protection, to Professor Pollock, Chairman, MACAC, 10 September 2003 (Tab 4.10, p 964, NSLHD documents).

[160] Letter from Dr Stephen Christley, Chief Executive Officer, Northern Sydney Health, to Ms Georgie Haysom, Solicitor, United Medical Protection, 12 September 2003 (Tab 4.1, p 966, NSLHD documents).

[161] Letter from Dr Emil Gayed to Dr Annette Pantle, Director of Medical Services, Mona Vale Hospital, 10 September 2003 (Tab 3.2, p 736, NSLHD documents).

[162] Letter from Dr Emil Gayed to Dr Stephen Christley, Chief Executive Officer, Northern Sydney Health, 17 September 2003 (Tab 4.12, p 1000, NSLHD documents).

564. In relation to the request to consent to contact the Medical Board to disclose whether he had met the conditions of his registration, he said, 'I confirm that I have complied with the conditions on my registration' and provided the consent.

565. On 22 September 2003, Dr Pantle contacted the Medical Board to request the conditions of Dr Gayed's registration and information as to his compliance for the purpose of a credentialing meeting scheduled for that evening. Dr Pantle was particularly interested in whether Dr Gayed had complied with the requirement to undergo regular ophthalmological examinations. The Medical Board required consent from Dr Gayed to disclose the information to Dr Pantle. Dr Pantle had already obtained consent in writing from Dr Gayed and was therefore able to provide it.

566. On 22 September 2003, the Medical Board sent a letter to Dr Pantle setting out the conditions of Dr Gayed's registration (those listed above).[163] The letter did not refer to the Professional Standards Committee. The letter stated that regarding compliance with his conditions:

1. Dr Gayed notified the Board that he is working at Mona Vale Hospital;
2. Dr Gayed informed the Board by letter dated 18 September 2003 that he continues to comply with the condition as to microsurgery;
3. Dr Iain Dunlop is the Board-appointed ophthalmologist. He has provided reports to the Board as requested. Dr Gayed has his next appointment to see Dr Dunlop on 3 October 2003. This complies with the Board's requirements.

567. The letter did not refer to the Professional Standards Committee's recommendation that a performance assessment be undertaken. While that was a recommendation rather than a condition, it was clearly relevant to Northern Sydney Health's consideration of his credentials. The legislation at the time permitted the Medical Board to provide a Professional Standards Committee decision to such persons as it thinks fit (s 180(4) of the Medical Practice Act). The Medical Board should have provided Northern Sydney Health with a copy of the Professional Standards Committee decision given the nature and context of Dr Pantle's request.

4.3.4 Further meeting of Credentials Committee

568. On 22 September 2003, the Credentials Committee met again as planned. The Committee was provided with correspondence between Northern Sydney Health and the solicitor for Dr Gayed, the Northern Sydney Health complaints policy

[163] Letter from Ms Kirsten Johnston, Monitoring Assistant, New South Wales Medical Board, to Dr Annette Pantle, 22 September 2003 (Tab 4.14, p 1010, NSLHD documents).

'Management of complaint or concern about a clinician', incident reports and correspondence from the Medical Board.[164]

569. The Credentials Committee noted the following:

(a) The cluster of cases was not comparable with any other doctors at Mona Vale Hospital;

(b) A pattern of performing operative procedures on the same patients, at intervals, which could possibly be interpreted as over servicing;

(c) The conditions placed on his registration by the Medical Board and Dr Gayed's adherence to this condition [sic];

(d) The nature of the UMP [United Medical Protection] high risk review which it appeared had been initiated at the request of Dr Gayed rather than UMP;

(e) The failure of Dr Gayed to alert the TMF [Treasury Managed Fund] in relation to the potential for claims in relation to a number of the matters as is required in the TMF contract;

(f) That in respect of four of the patients, on balance, clinical judgment demonstrated was within an acceptable range;

(g) The Committee noted potential suboptimal outcomes for the other three patients;

(h) The Committee noted a number of specific matters in respect of each of these patients who had undergone surgery.[165]

570. The minutes of meeting record that the Credentials Committee:

(a) was concerned about the cluster of cases over a short period of time;

(b) noted that, for a number of the patients, 'although the outcome may not have been ideally satisfactory, there were issues, where "on balance" the clinical judgment was within a clinically acceptable range'; and

(c) noted the matters in relation to the three patients where a range of concerns were identified in relation to the management of the patients.

571. The Credentials Committee considered that the review initiated by Northern Sydney Health was appropriate and recommended that a 'conditional reappointment' should be made.

572. Notwithstanding all the concerns expressed by the Credentials Committee, it recommended:

(1) that Dr Gayed be recommended to the Medical Board to recommence full privileges;

[164] Minutes, Credentials Advisory Committee Meeting, Northern Sydney Health, 22 September 2003 (Tab 4.15, p 1013, NSLHD documents).
[165] Minutes, Credentials Advisory Committee Meeting, Northern Sydney Health, 22 September 2003 (Tab 4.15, p 1014, NSLHD documents).

(2) that, should there be replication of similar concerns, Dr Gayed's appointment would again be reviewed and this should be a condition of continued appointment; and

(3) that, in fairness to both the interest of Dr Gayed and the community, it was determined to raise the review and issues with the Medical Board.

4.3.5 Lifting of suspension and reinstatement

573. On 30 September 2003, Dr Christley informed Dr Gayed that the area health service board had determined to lift the suspension of his clinical privileges.[166]

574. Dr Christley informed Dr Gayed that the Credentials Committee noted a number of cases indicating concerns but was prepared to accept that the management of a number of other patients was within acceptable boundaries. Dr Christley told Dr Gayed in the letter that his return to his appointment was subject to written confirmation by Dr Gayed of a continuing condition that, should there be any replication of any adverse events relating to management of patients under his care, his performance and appointment may be subject to further review. He informed Dr Gayed that details of the review would be provided to the Medical Board.

575. On the same day Dr Christley informed the Registrar of the Medical Board, Andrew Dix, of the review and its outcome—namely, the lifting of the suspension and the imposition of a condition of appointment.[167] Dr Christley's letter makes clear that the area health service became aware during the review (and not before) that Dr Gayed held conditional registration with the Medical Board and may have had his performance previously considered by the Medical Board. Dr Christley's letter attached documentation (around 90 pages) relating to the seven patients whose treatment by Dr Gayed gave rise to clinical concerns.

576. Dr Christley also lodged a complaint with the HCCC.

577. On 2 October 2003, the Medical Board informed Dr Christley of its intention to assess his notification in consultation with the HCCC.[168]

578. On 8 October 2003, the HCCC and the Medical Board consulted and agreed to refer Dr Gayed to the Performance Assessment Program.[169]

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[166] Letter from Dr Stephen Christley, Chief Executive Officer, Northern Sydney Health, to Dr Emil Gayed, 30 September 2003 (Tab 4.18, p 1025, NSLHD documents).
[167] Letter from Dr Stephen Christley, Chief Executive Officer, Northern Sydney Health, to Dr Andrew Dix, Registrar, Medical Board of New South Wales, 30 September 2003 (Tab 4.17, p 1024, NSLHD documents).
[168] Letter from Ms Rebecca Forbes, Manager Professional Conduct, New South Wales Medical Board, to Dr S Christley, 2 October 2003 (Tab 4.20, p 1029, NSLHD documents).
[169] HCCC Referral to NSW Medical Board form dated 9 October 2003 (Tab 71, Medical Council NSW files).

579. On 9 October 2003, the HCCC referred the matter to the Medical Board for that purpose. It also informed Dr Christley that it had referred the complaint to the Medical Board for its management.[170]

580. Through his solicitor, Dr Gayed sought details of the three patients in respect of whom concerns had been noted by the Credentials Committee.[171] On 30 October 2003, Dr Christley provided those details on behalf of Northern Sydney Health.[172]

581. On 29 October 2003, Dr Gayed's solicitor advised Dr Christley of Dr Gayed's intention to withdraw his appeal against the suspension under the Health Services Act and to sign the written confirmation of the condition on his appointment.[173]

582. At a meeting of the Medical Appointments and Credentials Advisory Committee on 5 November 2003, Professor Pollock advised that the subcommittee had recommended that his privileges be reinstated. It was resolved that the matter would be referred to the Medical Board for its urgent consideration.[174] Dr Bennie advised the meeting that Dr Gayed had signed off on a condition of his reinstatement that, should any event in the future arise, the Committee 'had the right to rescind his privileges'. The Committee recommended that his ongoing practices be monitored closely.

583. A copy of the condition signed by Dr Gayed on his reinstatement, which Dr Bennie referred to in the Medical Appointments and Credentials Advisory Committee meeting, is not among the documents made available to the inquiry. An unsigned copy of the document states:

> your return to your appointment is subject to your written confirmation of a continuing condition of your appointment that should there be any replication of any adverse events relating to management of patients under your care that your performance and appointment may be subject to further review.

584. While a copy signed by Dr Gayed is not on the file, the file contains a letter from Dr Gayed's solicitor dated 29 October 2003 stating that Dr Gayed 'will shortly provide a signed copy' of the relevant document. I am satisfied that Dr Gayed signed that document.

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[170] Letter from Chris Waters, Manager, Complaint Resolution Team, Health Care Complaints Commission to Dr S Christley, 9 October 2003 (Tab 5.2, p 1112, NSLHD documents); HCCC Referral to NSW Medical Board form dated 9 October 2003 (Tab 71, Medical Council NSW files).

[171] Letter from Ms Georgie Haysom, Solicitor, United Medical Protection, to Dr S Christley, Northern Sydney Health, 1 October 2003 (Tab 4.19, p 1028, NSLHD documents); Letter from Dr Stephen Christley, Chief Executive Officer, Northern Sydney Health to Ms Georgie Haysom, Solicitor, United Medical Protection (Tab 4.21, p 1030, NSLHD documents).

[172] Letter from Dr Stephen Christley, Chief Executive Officer, Northern Sydney Health, to Ms Georgie Haysom Solicitor, United Medical Protection, 30 October 2003 (Tab 4.26, p 1039, NSLHD documents).

[173] Letter from Ms Georgie Haysom Solicitor, United Medical Protection, to Dr S Christley, Northern Sydney Health, 29 October 2003 (Tab 4.23, p 1033, NSLHD documents).

[174] Minutes, Medical Appointments and Credentials Advisory Committee, Northern Sydney Health, 5 November 2003 (Tab 4.27, p 1042, NSLHD documents).

585. On 7 November 2003, the Coordinator of the Medical Board's Performance Assessment Program advised Dr Christley that his notification had been referred to the Performance Assessment Program and that the Performance Committee had resolved to undertake a performance assessment. Two assessors would be appointed by the Medical Board for that purpose.[175] Dr Christley was informed that he would be advised of the outcome in due course. The Coordinator sought a copy of the review conducted by the area health service.

586. On 26 November 2003, Dr Christley sent to the Coordinator of the Medical Board's Performance Assessment Program the minutes of the Credentials Committee of 22 September 2003 outlining the review undertaken and recommendations made in respect of Dr Gayed.[176]

587. The Medical Board's decision to undertake a performance assessment was made at a meeting of its Performance Committee on 28 October 2003. The resolution was that it should occur 'as a matter of urgency'.

588. Dr Gayed, through his solicitor at United Medical Protection, asked the Medical Board to reconsider the decision to undertake a performance assessment. On 19 December 2003, the Medical Board informed United Medical Protection that a performance assessment would be undertaken in view of the totality of his history with the Medical Board, not only the notification from Northern Sydney Health.

4.4 Compliance with policy and adequacy of response by Credentials Committee / Medical Appointments and Credentials Advisory Committee in 2003

589. It was appropriate and accorded with Northern Sydney Health By-Laws and NSW Health policy, that Northern Sydney Health reviewed Dr Gayed's appointment and clinical privileges in response to the seven cases of concern.

590. As noted, the outcome of the Credentials Committee review on 22 September 2003 of the seven cases of concern was:

(a) the reinstatement of full clinical privileges;

(b) that Dr Gayed's appointment to be reviewed in the event of any replication of similar concerns; and

(c) notification to the Medical Board.

591. The applicable NSW Health and Northern Sydney Health policies required that the registration board be notified immediately and that there be an investigation of the

[175] Letter from Ms Diane Mackowski, Coordinator—Performance Assessment Program, New South Wales Medical Board, to Dr Stephen Christley, 7 November 2003 (Tab 5.3, p 1114, NSLHD documents).
[176] Letter from Dr Stephen Christley, Chief Executive, Northern Sydney Health, to Ms Diane Mackowski, Coordinator—Performance Assessment Program, New South Wales Medical Board, 26 November 2003 (Tab 5.4, p 1115, NSLHD documents).

concerns by the area health service to determine whether, among other matters, the clinical privileges remained appropriate.

592. It seems that, instead of investigating the cases prior to submitting them to a Credentials Committee for consideration of whether Dr Gayed's clinical privileges should be varied, Northern Sydney Health submitted the cases directly to the Credentials Committee for evaluation. The membership of the Credentials Committee included an independent obstetrician gynaecologist.

593. Dr Jenkins and I have considered whether reinstatement of full privileges was reasonably justifiable. We both consider that, if the Medical Appointments and Credentials Advisory Committee had known of the cases at Cooma Hospital which led to a disciplinary hearing, it should have sought out more information about those cases in order to have the full background of complaints. As outlined at above, I am satisfied that the Professional Standards Committee decision was known to the area health service; however, it appears that it did not seek the full Professional Standards Committee decision from the Medical Board.

594. On the assumption that the Medical Appointments and Credentials Advisory Committee / Credentials Committee did not have any information about the cluster of cases that gave rise to the Professional Standards Committee, its decision to reinstate Dr Gayed with full clinical privileges may be considered reasonable. Dr Gayed had been working at Mona Vale Hospital for a relatively short period of time and, while a number of these cases raised quite serious performance issues, as an isolated cluster the recommendations made were reasonable.

595. However, with the benefit of knowing the events which transpired at Cooma Hospital, this is not an isolated cluster of cases, and the issues which are raised by the Mona Vale Hospital cases demonstrate some common themes within the issues raised by the Cooma cases. Had this been known and taken into account, Dr Jenkins is of the view that there would have been justification to consider review of clinical privileges or other action. For instance, there may have been a basis for restricting Dr Gayed's clinical privileges to minor gynaecological surgery and to operating with a peer when undertaking major gynaecological surgery.

596. The extremely positive references, surgical outcome statistics and reports from John James Memorial Hospital, Mayo Private Clinic and Manning Hospital provided by Dr Gayed were very much at odds with the Cooma Hospital and Mona Vale Hospital experiences and would have made such a decision much more challenging.

5. Monitoring of Dr Gayed following reinstatement

597. Following the Medical Appointments and Credentials Advisory Committee's review on 22 September 2003, Dr Bennie prepared a briefing summary dated October 2003 in which he said that Dr Gayed's practice would be monitored by the Director of Medical Services at Mona Vale Hospital as follows:

(a) Routine flags would continue to be the primary vehicle for case review;

(b) The review of any such cases will be undertaken by the Director Medical Services in consultation with the Head of Department;

(c) A review of routine data collection of clinical indicators at least quarterly by the Director Medical Services, identifying unusual trends;

(d) Any case of concern reported directly to the Director Medical Services or senior executive will be reviewed and referred to area health service if relevant;

(e) Quarterly meetings between the Director Medical Services and Dr Gayed;

(f) Appraising Dr Gayed of any outstanding issues, including reported TMF cases, at the annual review of contract;

(g) The Area TMF coordinator would be asked for a list of reported cases from Mona Value on a monthly basis but ensuring confidentiality of VMOs.[177]

598. It is not known, on the basis of the records, whether Dr Bennie sent that briefing summary, which set out a plan for monitoring, to anyone.

599. The available records do not indicate whether Mona Vale Hospital carried out the monitoring planned by Dr Bennie in the form of reviewing routine data collection, holding quarterly meetings between the Director of Medical Services and Dr Gayed or seeking reported cases from the Treasury Managed Fund coordinator.

600. However, as events transpired, a further serious case involving one of Dr Gayed's patients occurred seven months later. In my and Dr Jenkins' view, that case should have, but did not, prompt a further review by the hospital of Dr Gayed's appointment and privileges in accordance with the Medical Appointments and Credentials Advisory Committee's recommendations in September 2003 and November 2003.

6. Major clinical incident notified by nursing staff in 2004

601. On 31 May 2004, nursing staff submitted an incident reporting form for a 'Major Clinical Incident or other Reportable Event' relating to a patient of Dr Gayed.[178]

602. The patient underwent an elective hysterectomy which was complicated by massive intraoperative haemorrhage requiring a large blood transfusion and postoperative admission to the Intensive Care Unit. The form noted that the procedure was much more complicated than first anticipated and required a surgeon from a neighbouring theatre to be consulted. An anaesthetist informed Dr Gayed of the risk of continuing the operation.

[177] Summary Briefing from Dr Alex Bennie, Director, Clinical Services Development re 'Dr Emil Gayed, VMO Obstetrician and Gynaecologist, Mona Vale Hospital', October 2003 (Tab 4.28, p 1045, NSLHD documents).
[178] Manly & Mona Vale Hospitals & Community Health Services, Incident Reporting Form, 31 May 2004 (Tab 3.3, p 749, NSLHD documents).

603. A memorandum dated 22 June 2004 from the 'Executive Committee' of Manly & Mona Vale Hospital & Community Health Services Executive to Jenny Powell, Theatres Mona Vale Hospital, indicates that the case was reviewed by the Executive Committee at a meeting on 15 June 2004. The major clinical incident form dated 31 May 2004 and patient's medical record were reviewed; and the Executive Committee agreed that the action taken was appropriate and no further action was required.[179]

604. The minutes of the Executive Committee are not contained within the (former) area health service records and therefore the basis for the decision to take no further action is not known. It is not apparent from the documentation whether the incident was allocated a Severity Assessment Code (**SAC**).

605. On 5 July 2004, the Head of the Department of Anaesthetics, Dr Nigel Theaker, wrote to the Head of the Department of Surgery about the case and suggested a joint Morbidity and Mortality meeting based on the case between the departments of surgery obstetrics, gynaecology and anaesthetics.[180] His department had identified during their routine departmental Morbidity and Mortality review that one of the issues was inadequate preoperative discussion between the specialists involved.

606. On 7 October 2004, the patient's case was presented at a multidisciplinary peer review meeting involving members of the anaesthetic, general surgery and gynaecology departments. Dr Gayed was not present.[181]

607. The review concluded that a number of clinicians had correctly observed and documented features which were not consistent with the diagnosis being treated by Dr Gayed (that is, uterine enlargement due to fibroids in the absence of other more significant pathology) and, as such, it remained unclear why the surgery had been undertaken. It was recommended that a further case review meeting involving all the clinicians involved take place.

6.1 This inquiry's review of this patient's case

608. Dr Jenkins considers that there are a number of factors in her case which raise concerns about Dr Gayed's clinical performance. The presence of a large pelvic mass in a woman with a history of pelvic lymphoma should have been of some concern. The CT scan (26 May 2004) comments that, while uterine fibroids are present, recurrence of lymphoma cannot be excluded. The comment that the mass is seen extending to the sidewalls and compressing and in some areas encasing the iliac vessels should have been of grave concern.

[179] Memorandum from Executive Committee to Jenny Powell, Theatres, Mona Vale Hospital signed by Frances Buchan, Clinical Risk Manager, 22 June 2004 (Tab 3.3, p 752, NSLHD documents).
[180] Letter from Dr Nigel Theaker, Head, Dept of Anaesthetics to Head, Dept of Surgery, 5 July 2004 (Tab 3.3, p 753, NSLHD documents).
[181] Minutes of Multi-disciplinary peer review meeting, 7 October 2004 (Tab 4.29, p 1053, NSLHD documents).

609. The inquiry has not been provided with any documentation indicating that a further review of the case, as recommended by the multidisciplinary review on 7 October 2004, took place. It appears that nothing was done with respect to Dr Gayed's performance in the case for another 19 months. The case was considered again in December 2005 when other concerns arose.

610. The patient did in fact have recurrence of lymphoma. Dr Jenkins informs me that it was fortunate that the outcome of the surgery performed by Dr Gayed was not worse. This case demonstrates a lack of proper preoperative assessment, lack of teamwork and communication with colleagues (the anaesthetist) and lack of proper judgment. Dr Jenkins considers that she should not have undergone her surgery at Mona Vale Hospital but should have been referred to Royal North Shore Hospital for further assessment and management. He considers that Dr Gayed's management was below the standard of care expected from a specialist obstetrician and gynaecologist.

611. Dr Jenkins notes that the outcome of the Medical Appointments and Credentials Advisory Committee review in September 2003 was that Dr Gayed's privileges should be reviewed if there was any replication of similar concerns. This case should have prompted such a review. I accept Dr Jenkins' opinion about this case.

612. I would add that, based on the documentation, the review by the Executive Committee consisting of reviewing the incident form and patient records appears to have been rather perfunctory and was in any event inadequate.

6.2 Adequacy of response to this patient's case: compliance with policy and reporting to the Medical Board

613. When the treatment of this patient took place in May 2004, there was no duty imposed by the legislation to report suspected professional misconduct or unsatisfactory professional conduct to the Medical Board. The duty to report commenced in 1 August 2005, when s 99A of the Health Services Act came into force.

614. NSW Health policy as at May 2004 required that SAC1 and SAC2 incidents be reported to the area health service CEO (or delegate) and the Department of Health (NSW Health Circular 2003/88, ''Reportable Incident Briefs to the NSW Department of Health'), as set out in chapter 2. The Policy Directive PD2005_586, 'Guideline on the management of a complaint or concern about a clinician', also required a decision to be made about which level of action applied, and this depended on the circumstances and the discretion of the general manager of the hospital.

615. It is not apparent from the documentation whether consideration was given to the level of action required. However, the documentation tends to suggest that the seriousness of the incident was not recognised in that the decision made by the Executive Committee of the hospital, after review of the patient's record, was that

no further action was required. It is not apparent whether the incident was allocated a SAC code. The incident was not recorded on the **IIMS**, as that system was introduced in December 2004 (Policy 2004/82, 'Incident Management System Policy', commenced on 1 December 2004). Dr Pantle informed the inquiry that the IIMS was not fully operational until mid-2005.[182]

616. Dr Jenkins considers that Level 2 action was required. The Level 2 process of investigation required notification to the CEO of the concern; identification of the issues; collection of relevant information, including, if appropriate, an independent expert opinion; allowing the clinician to respond to the issues; making findings and recommendations based on the evidence; and reporting to the CEO and any relevant statutory bodies.

617. Dr Jenkins informs me, and I accept, that it was not commonplace at the time to report to the Medical Board as soon as a serious incident occurred. However, if, after reviewing the case and the doctor's clinical privileges, the Credentials Committee had placed restrictions on the doctor's practice, it would then be good practice and necessary to inform the Medical Board about the restrictions imposed. I accept that an evaluative process is required before notifying the Medical Board.

618. As set out above, the matter should have been referred to the area health service Credentials Committee. The outcome of the Medical Appointments and Credentials Advisory Committee review in September 2003 was that Dr Gayed's privileges should be reviewed if there was any replication of similar concerns. This case clearly required such a review.

6.3 Performance assessment by the Medical Board in September 2004

619. The Northern Sydney Health files contain a letter (though unsigned and undated) from Dr Christley to the Medical Board seeking to know what action the Board had taken in response to Dr Christley's letter of September 2003.

620. In August 2004 the Medical Board advised Mona Vale Hospital that it was intending to send an assessment team to the hospital on 13 September 2004 to assess the professional performance of Dr Gayed.[183] As noted above, the Medical Board had first informed the CEO of Northern Sydney Health of the proposal to carry out a performance assessment in a letter dated 7 November 2003.

621. The Medical Board appointed two obstetrician gynaecologists to conduct the assessment, to be accompanied by the Board's Medical Director, who would facilitate the assessment. The two assessors would observe Dr Gayed operating and the team would need to spend time with Dr Gayed in discussion. The assessors

[182] Email response by Dr Pantle to draft report dated 3 October 2018.
[183] Letter from Ms Diane Mackowski, Coordinator Performance Program, New South Wales Medical Board, to Mr Frank Bazik, General Manager, Mona Vale Hospital, 3 August 2004 (Tab 4.28, p 1052, NSLHD documents); Letter from Ms Diane Mackowski, Coordinator Performance Program, New South Wales Medical Board, to Mr Frank Bazik, General Manager, Mona Vale Hospital, 24 August 2004 (Tab 4.28, p 1043, NSLHD documents).

were briefed with a number of documents, including Dr Christley's notification and attachments, minutes of the Northern Sydney Health Credentials Committee meeting of 22 September 2003 and the Professional Standards Committee report of 30 October 2001.

622. The assessors attended Mona Vale Hospital on 13 September 2004.[184]

623. The procedures which the assessment team observed Dr Gayed perform were an elective caesarean section, dilation and curettage, hysteroscopy, diathermy of cervix, laparoscopy and tubal ligation.

624. On 14 January 2005, they provided a report, which was endorsed by the Medical Board's Performance Committee on 25 January 2005. The assessors found, in summary, that Dr Gayed 'makes reasonable decisions regarding surgical intervention. He is competent with the procedures that were observed, but he could tighten up some of his techniques'.

625. In my report on the Medical Council's management of Dr Gayed, I conclude that the Medical Board was too slow in attending to the Performance Committee's resolution of 28 October 2003 that a performance assessment by conducted 'as a matter of urgency'.[185] Holding the performance assessment almost one year after the resolution that it must occur urgently was tardy, to say the least. I also make findings in that report about the adequacy of the performance assessment undertaken on this occasion.[186] They are summarised below.

626. It was not until 1 February 2006 that the Medical Board informed Dr Christley that the performance assessment had been completed. The Medical Board did not provide Dr Christley with the report or inform him of the outcome, apart from providing general information that a performance assessment can draw to a doctor's attention aspects of practice they may not have considered were in need of improvement. In my view, the Medical Board should have given Dr Christley a copy of the assessors' report. I return to this aspect further below.

[184] Letter from Ms Anne Harvey, Legal Officer, New South Wales Medical Board, to Dr Bruce Sanderson, Director of Medical Services, Mona Vale Hospital, 21 February 2006 (Tab 4.38, p 1080, NSLHD documents); Letter from Ms Diane Mackowski, Coordinator—Performance Program, New South Wales Medical Board, to Dr Stephen Christley, Chief Executive Officer, Northern Sydney Area Health Service, 1 February 2006 (Tab 4.34, p 1076, NSLHD documents).

[185] *Review of processes undertaken by the Medical Council of New South Wales pursuant to Part 8 of the Health Practitioner Regulation National Law (NSW) with respect to Dr Emil Gayed*, report dated 31 October 2018, para 370.

[186] *Review of processes undertaken by the Medical Council of New South Wales pursuant to Part 8 of the Health Practitioner Regulation National Law (NSW) with respect to Dr Emil Gayed*, report dated 31 October 2018, Part 16.1.

7. Staff raise further incidents in November 2005

627. In December 2005, Dr Gayed's surgical competence was again reviewed by Mona Vale Hospital after concerns were raised about a number of cases.[187]

628. On 7 November 2005, a patient sustained a right ureteric injury during vaginal hysterectomy performed by Dr Gayed. A Major Clinical Incident was reported on 10 November 2005 and a SAC2 Reportable Incident Brief was prepared.[188] The hospital's Executive Committee reviewed the matter. No system issues were identified. The Director of Medical Services was to follow up issues of individual performance.

629. On 30 November 2005, the Nursing Unit Manager of Operating Theatres sent an email to Dr Bruce Sanderson documenting her concerns regarding Dr Gayed.[189] The manager stated that, generally, scrub staff felt as if they were having to practise outside their scope of practice when scrubbing for Dr Gayed. They were having to give clinical advice, such as 'that is bleeding quite a bit, do you think we should tie it off?' or 'that looks like the ureter'.

630. In her email the Nursing Unit Manager referred to an incident involving a vaginal hysterectomy the previous Monday, when Dr Gayed thought he had made a hole in the bladder and was doing a cystoscopy and was looking for ureters, which he was having difficulty doing. The nursing staff eventually asked the surgical registrar to assist. Dr Gayed left 1700 mls of water in the bladder and, when the scrub nurse pointed it out, he let out about 300 mls. She asked again 'are you going to empty the bladder before closing?'. He did not seem familiar with the cystoscope or the process of cystoscopy. The Nursing Unit Manager also mentioned that, when operating, he criticises the equipment and the scrub nurses and she was having difficulty getting her staff to work with him.

631. File notes indicate that the Nursing Unit Manager discussed the case with Dr Sanderson on 1 December 2005. Dr Sanderson had taken over the role of Director of Medical Services from Dr Pantle, who left Mona Vale Hospital in early 2004 to undertake a role in the area health service.[190] Theatre staff had raised with Dr Pantle that Dr Gayed required supervision, as he could otherwise miss things. There were particular concerns regarding the recent vaginal hysterectomy.

632. On 5 December 2005, Dr Sanderson discussed the concerns with Dr Gayed. It was mutually agreed to cancel his surgery list that day.

633. Dr Sanderson and Dr Gayed met at 2 pm on 5 December 2005.

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[187] Briefing for Director of Clinical Governance, undated (Tab 3.8, p 789, NSLHD documents).
[188] NSCCH Reportable Incident Brief, (Tab 3.5, pp 774–779, NSLHD documents).
[189] Email from Jan McCaig to Bruce Sanderson, 30 November 2005 (Tab 3.6, p 780, NSLHD documents).
[190] File note by Dr Bruce Sanderson, Director of Medical Services, undated (Tab 4.30, p 1059, NSLHD documents).

634. In that meeting Dr Sanderson raised two surgical cases from the previous 18 months that had been flagged because of complications and an additional concern relating to a case done on 21 November 2005 involving a vaginal hysterectomy (apparently, the case raised by the Nursing Unit Manager referred to above).

635. The two cases from the previous 18 months was first flagged by nursing staff on 31 May 2004; and the second case dated 7 November 2005.

636. Dr Gayed presented to Dr Sanderson a wide range of data and evaluations of his past performance, including the Medical Board review done in September 2004, to 'support [his] view that [he was] a competent surgeon'. He provided a medical certificate stating that his eyesight was of an acceptable standard for surgery, post cataract surgery. He expressed concerns that he had been reviewed by both the area health service and the Medical Board in the past and deemed to be safe but was again being subjected to review. He said he would have no option but to resign if a further, unjustified, review was to be undertaken.[191]

637. Dr Sanderson informed Dr Gayed that he would discuss the issues with the area health service Director of Clinical Governance, Dr Philip Hoyle, following which he would inform Dr Gayed of the outcome.

638. Dr Sanderson discussed the concerns with Dr Hoyle on 6 December 2005.

639. On 7 December 2005, Dr Sanderson wrote to Dr Gayed to follow up.[192] In his letter Dr Sanderson informed Dr Gayed that it had been decided:

(1) that Dr Gayed could recommence routine surgery lists;

(2) that there would be a review of surgical outcomes for 2004–2005 to allow benchmarking of complication rates for all clinicians;

(3) that he would seek Dr Gayed's permission to discuss his performance with Manning Base Hospital and the Medical Board; and

(4) that Dr Gayed must provide a report about the three cases of concern.

640. On 7 December 2005, Dr Sanderson informed the Nursing Unit Manager that Dr Gayed's theatre sessions would recommence and asked that any further practice issues raised by registered nurses be reported to him as soon as possible.

641. On 9 December 2005, Dr Gayed told Dr Sanderson that he would restrict his cases at Mona Vale Hospital to low-risk cases in the following six months to 'build up confidence in staff'.[193]

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[191] File note by Dr Bruce Sanderson, Director of Medical Services, undated (Tab 4.30, p 1059, NSLHD documents).
[192] Letter from Dr Bruce Sanderson, Director of Medical Services, to Dr Emil Gayed, 7 December 2005 (Tab 4.30, p 1057, NSLHD documents).
[193] File note by Dr Bruce Sanderson, Director of Medical Services, undated (Tab 4.30, p 1060, NSLHD documents).

642. On 21 December 2005, Dr Gayed indicated his intention to prepare a medical report about the three cases.[194]

643. On 4 January 2006, Dr Sanderson wrote to Dr Gayed to remind him to provide written permission for Dr Sanderson to discuss his performance with the Medical Board and Manning Hospital.[195] Dr Sanderson requested Dr Gayed's medical report on the three cases by the end of January.

644. On 17 January 2006, Dr Gayed provided his written consent for Dr Sanderson to contact Dr Wills, Director of Clinical Services at Manning Hospital, Taree.[196] He also consented to contact being made with the Medical Board regarding the performance assessment in September 2004 through his solicitor.

7.1 Inquiry's review of the three cases

645. On 25 January 2006, Dr Gayed provided a report to Dr Sanderson outlining his response to the management of the three patients.[197] He defended his approach.

646. One of the cases was that referred to above. Although the matter was apparently being considered again, further review did not result in the area health service reviewing Dr Gayed's appointment or credentials. As I outlined earlier, this action should have been taken in June 2004 in light of the seriousness of that case.

647. The second case, also referred to above, involving a ureteric injury during a vaginal hysterectomy. Dr Jenkins considers that the case demonstrates a concerning lack of insight on the part of Dr Gayed. Dr Jenkins states:

> The indication for this procedure was uterovaginal prolapse and patient request for hysterectomy (permanent sterilisation). It was noted to be a difficult hysterectomy.
>
> Postoperatively the patient demonstrated vaginal leakage of urine. Investigations demonstrated urinary tract injury sustained at the time of the hysterectomy.
>
> Return to operating theatre on 10 November 2005. Cystoscopy performed and right ureteric injury identified. Unable to be managed at Mona Vale Hospital.
>
> The patient transferred to RNSH [Royal North Shore Hospital] and percutaneous nephrostomy performed on 11 November 2015. Repeat cystoscopy on 15 November 2015 and successful insertion of ureteric stent. Further cystoscopy and removal of stent 1 month later.

[194] Letter from Dr Emil Gayed to Dr Bruce Sanderson, Director of Clinical Services, Mona Vale Hospital, 21 December 2005 (Tab 4.33, p 1071, NSLHD documents).
[195] Letter from Dr Bruce Sanderson, Director of Medical Services, to Dr Emil Gayed, 4 January 2006 (Tab 4.31, p 1061, NSLHD documents).
[196] Letter from Dr Emil Gayed to Dr Bruce Sanderson, Director of Medical Services, Mona Vale Hospital, 17 January 2006 (Tab 4.32, p 1062, NSLHD documents).
[197] Letter from Dr Emil Gayed to Dr Bruce Sanderson, Director of Medical Services, Mona Vale Hospital, 25 January 2006 (Tab 4.33, p 1063, NSLHD documents).

> Outcome of IIMS review indicated no system issues identified and DMS [Director of Medical Services] to follow up issues of individual performance.[198]
>
> Dr Gayed's written response to the patient's ureteric injury dated 26 January 2006[199] demonstrates no appreciation of the significance of this complication and gives no explanation of how or why it occurred. Dr Gayed states that the patient wanted to have a hysterectomy and that she had been advised of the risks and that he had documented this in his notes and the letter to the GP. He also notes that it was only a partial injury. Dr Gayed's response demonstrates a concerning lack of insight.

648. Dr Jenkins considers that, when seen in the context of the other cases, Dr Gayed's lack of insight is the concern.

649. The third case (involving overdistended bladder at time of cystoscopy) did not, in Dr Jenkins' view, raise a serious issue; however, the management was not ideal. The case does not warrant any further comment.

7.2 Duty to report to Medical Board / action taken by Northern Sydney Health in response to cases

650. Northern Sydney Health did not formally notify either case to the Medical Board, although the CEO did contact the Medical Board to seek information about Dr Gayed's performance assessment, as outlined in the next section.

651. Section 99A of the *Health Services Act* provided (as at December 2005):

> The chief executive of a public health organisation is to report to a registration authority any conduct of a visiting practitioner that the chief executive officer suspects on reasonable grounds may constitute professional misconduct or unsatisfactory professional conduct under the health registration Act by which the registration authority is constituted.

652. 'Unsatisfactory professional conduct' was defined to include any conduct that demonstrates that the knowledge, skill or judgment possessed, or care exercised, by the practitioner in the practice of medicine is significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience (s 36 of the *Medical Practice Act* as then in force).

653. Section 99A commenced on 1 August 2005. Although one of the surgeries took place in May 2004, it was still being considered by Northern Sydney Health in 2005 after s 99A commenced.

654. Although s 99A imposes a duty to report suspected unsatisfactory professional conduct to the Medical Board, an evaluative process is required to determine whether there has been a departure from expected standards. I understand from Dr Jenkins that the usual process is for the matter/s of concern to be investigated

[198] IIMS update (Tab 3.5, p 777, NSLHD documents).
[199] Letter from Dr Emil Gayed to Dr Bruce Sanderson, Director of Medical Services, Mona Vale Hospital, 25 January 2006 (Tab 4.33, p 1068, NSLHD documents).

and if necessary submitted to a Credentials Committee. This is reflected in NSW Health policies. Only after that evaluation is carried out does the duty to report to the Medical Board need to be considered.

655. Northern Sydney Health did not reconsider Dr Gayed's appointment or clinical privileges in light of either case. As noted earlier in my report, one case should have prompted a review of his appointment in accordance with the recommendation made in 2003 by the Credentials Committee that any replication of concerns should prompt reconsideration of his credentials.

656. Dr Jenkins and I consider that both cases seen in the context of the other cases, warranted a referral to the area health service Credentials Committee for review and consideration of whether Dr Gayed's clinical privileges should be restricted. If the outcome of a review by the Credentials Committee had been adverse to Dr Gayed, it would have been incumbent on the area health service at that stage to report the cases to the Medical Board as involving suspected unsatisfactory professional conduct.

7.3 Performance assessment

657. Dr Christley and Dr Sanderson followed up with the Medical Board as to the results of Dr Gayed's performance assessment carried out in September 2004. On 1 February 2006, the Medical Board informed Dr Christley that Dr Gayed's involvement in the Performance Assessment Program 'arising from your notification, is now completed'.[200]

658. The Medical Board's letter stated that 'a comprehensive, detailed assessment' of Dr Gayed's practice had been undertaken, which had included observing Dr Gayed consulting patients and operating. The assessors had provided a detailed report, but the Medical Board did not provide this to Dr Christley. Dr Christley asked to have a discussion on 21 February 2006 with Dr Sanderson about the Medical Board's letter.[201]

659. On 3 February 2006, Dr Sanderson wrote to the Registrar of the Medical Board to seek a copy of the performance assessment and a notification of any restrictions still in place on Dr Gayed's registration.[202] Dr Sanderson stated in his letter that Dr Gayed had informed him as part of a health service performance review that previous conditions on his registration had been lifted and that Dr Gayed said he

[200] Letter from Diane Mackowski, Coordinator—Performance Program, New South Wales Medical Board, to Dr Stephen Christley, Chief Executive Officer, Northern Sydney Area Health Service, 1 February 2006 (Tab 4.34, p 1076, NSLHD documents).
[201] Handwritten notation on letter from Diane Mackowski, Coordinator—Performance Program, New South Wales Medical Board, to Dr Stephen Christley, Chief Executive Officer, Northern Sydney Area Health Service, 1 February 2006 (Tab 4.34, p 1076, NSLHD documents).
[202] Letter from Dr Bruce Sanderson, Director of Medical Services, to Mr Andrew Dix, Registrar, NSW Medical Board, 3 February 2006 (Tab 4.35, p 1077, NSLHD documents).

asked his legal advisor to write to the Medical Board so that the full report could be released to Dr Sanderson.

660. On 3 February 2006, Dr Sanderson also wrote to Dr Wills, Director of Clinical Services at Manning Hospital, to seek an assessment of Dr Gayed's performance at Manning Hospital. Dr Sanderson asked Dr Wills for an outline of any adverse events, complaints or concerns regarding Dr Gayed's clinical outcomes while he was providing services at Manning Hospital, for the purpose of a performance review.[203]

661. Dr Wills replied on 10 February 2006.[204] Dr Wills stated that Dr Gayed had been working as a Visiting Medical Officer at the Manning Hospital since 1999 and had not demonstrated untoward infection rates, rates of return to theatre, complication or mortality rates. His practice had not been a cause of concern at any stage over the previous six years. No substantiated complaints had been received about his practice either from patients or hospital staff.

662. On 21 February 2006, the Medical Board sent to Dr Sanderson a two-page letter containing extracts from the conclusion and recommendations made by the assessors in their report, which had been endorsed by the Medical Board's Performance Committee on 25 January 2005.[205] The extract was in terms:

> CONCLUSION
>
> Dr Gayed is a committed, pleasant and approachable practitioner with an excellent approach to his patients and good communication skills with them. His communication and interaction with colleagues are more difficult to comment on. It appears that to some extent, circumstances and the system have created a problem for Dr Gayed, resulting in his Performance Assessment as a means of finally determining his level of competence and performance.
>
> …
>
> Overall Dr Gayed appears to be a competent clinician, and adequate surgeon. He displayed good interpersonal skills with his patients and appeared to have a reasonable relationship with staff in the operating theatre and staff in his rooms.
>
> …
>
> RECOMMENDATIONS
>
> In accordance with the *Medical Practice Act 1992* it is the finding of these Assessors that Dr Gayed's professional performance is at the standard reasonably expected of a practitioner of an equivalent level of training or experience.

[203] Letter from Dr Bruce Sanderson, Director of Medical Services, to Dr Jim Wills, Director of Clinical Services, Manning Base Hospital, 3 February 2006 (Tab 4.36, p 1078, NSLHD documents).
[204] Letter from Dr Jim Wills, Manager, Clinical Services and Director, Emergency Department, to Dr Bruce Sanderson, Director of Medical Services, Mona Vale Hospital and Community Health Services, 10 February 2006 (Tab 4.37, p 1079, NSLHD documents).
[205] Letter from Ms Anne Harvey, Legal Officer, New South Wales Medical Board, to Dr Bruce Sanderson, Director of Medical Services, Mona Vale Hospital, 21 February 2006 (Tab 4.38, p 1080, NSLHD documents).

> The Assessors believe that Dr Gayed would benefit from some constructive feedback and recommend that one of the assessors informally counsels Dr Gayed about aspects of his practice that could be further explored.
>
> In addition, the Assessors believe that the existing conditions on Dr Gayed's registration, other than the condition required because of his status as a Conditional Specialist, serve no continuing useful purpose.

663. The letter also set out that Dr Gayed's performance was assessed as satisfactory in 11 areas 'as observed' and as 'uncertain' in two areas—namely, prescribing skills and management of psychosocial aspects of illness.

664. Unfortunately, the Medical Board did not provide Northern Sydney Health with the complete assessors' report.

665. Medical Council files reveal that the Medical Board consulted with Dr Gayed's solicitor about Dr Sanderson's request for the performance assessment report. Dr Gayed's solicitor objected to the full report being provided to Mona Vale Hospital. The Medical Board asked the solicitor to prepare a version that could be disclosed. Dr Gayed's solicitor suggested that limited information relating to Dr Gayed's 'approachable manner' as a practitioner and the outcome summary and conclusions be provided. The Medical Board adopted that approach.

666. In my view, the Medical Board should have provided Northern Sydney Health with the full report. Provision of only favourable passages would have suggested to Dr Sanderson that the Medical Board accepted them as representative of the findings.

667. Further, I have reservations about the adequacy of the performance assessment undertaken. The assessors were provided with a number of documents prior to the assessment. The documents included:

(a) letter from Dr Christley (CEO of North Shore Area Health Service) to the Medical Board dated 30 September 2003 with attachments:

(i) letter to Dr Gayed from Dr S Christley dated 11 September 2003;[206]

(ii) letter to Dr S Christley from Dr Gayed dated 14 August 2003;

(iii) minutes of Northern Sydney Health Credentials Advisory Committee Meeting held on Monday 22 September 2003; and

(b) Professional Standards Committee Inquiry Report dated 28 August 2001.

668. Dr Jenkins is of the view that it was clear from those documents that the most serious concerns about Dr Gayed's performance related to his surgical performance. Of the seven cases of concern at Mona Vale Hospital, all related to gynaecological surgery. Of the 11 complaints heard by the Professional Standards

[206] Although the report refers to it as being dated 8 August 2003, this appears to have been an error, as the letter was dated 11 August 2003.

Committee, nine related to gynaecological surgery or incidents within the operating theatre and one to visual impairment as manifested during gynaecological surgery.

669. The assessment team observed Dr Gayed perform the following procedures:

- caesarean section: an elective caesarean section on a primiparous woman;
- dilation and curettage, hysteroscopy, diathermy of cervix;
- dilation and curettage, laparoscopy, tubal ligation: although the procedure was considered satisfactory, there were some concerns noted by the assessors regarding his competence to perform more complex procedures; and
- dilation and curettage, diathermy of cervix.

670. In the summary of the assessment team's report it is recorded that 'Dr Gayed makes reasonable decisions regarding surgical intervention. He is competent with the procedures that were observed, but he could "tighten up" some of his techniques'.

671. Dr Jenkins observes that there was no observation of Dr Gayed performing major gynaecological surgery. The procedures that were observed are some of the least technically challenging and most basic procedures that a specialist would perform and yet there were concerns raised about his techniques during those procedures. Dr Jenkins does not believe that the assessment team had sufficient opportunity to make an assessment of Dr Gayed's surgical expertise. He considers that it is questionable whether or not the performance assessment addressed the concerns about Dr Gayed's performance raised by Dr Christley and the Professional Standards Committee. It could be argued that, given the nature of the complaints, a more thorough review of Dr Gayed's surgical performance was necessary.

672. I agree with Dr Jenkins' views about the performance assessment.

673. Further, in my view, the assessors did not adequately assess Dr Gayed's eyesight issues. The Medical Board was equipped with recommendations by the Board-nominated ophthalmologist, Dr Iain Dunlop, made in February 2002, June 2002 and again in October 2002. Dr Dunlop had said on three occasions that he could not assess Dr Gayed's perceptual or practical facility in performing laparoscopy, using monocular instruments or viewing two-dimensional video monitors, doing telescopic work or binocular surgery and the 'only way to assess Dr Gayed's vision for telescopic work was to have his function with the instrument observed by a gynaecologist who could comment on his abilities with the instrument'.

674. It would have been appropriate for the tasks nominated by Dr Dunlop to be observed in the performance assessment. While the assessors observed a laparoscopy, the particular issues raised by Dr Dunlop should have been brought to the assessors' attention and they should have been asked to comment on them.

675. The legislation allowed the Medical Board to have the professional performance of a doctor assessed generally or as to 'any particular aspect of aspects of the practitioner's professional performance' (s 86G of the Medical Services Act). It would have been open to the Medical Board to brief the assessors to assess particular aspects of Dr Gayed's technical skills in light of his eyesight issues.

676. In relation to Dr Gayed's statement to Dr Sanderson on 9 December 2005 that he would restrict his practice at Mona Vale Hospital to low-risk cases in the following six months, the inquiry did not receive Dr Gayed's surgical logs to enable a conclusion to be drawn about Dr Gayed's compliance with that undertaking (which he appears to have given voluntarily). The most that can be said is that no serious surgical issues were raised by staff or patients during the following six months, as far as can be ascertained from the area health service files.

8. Removal of conditions on registration

677. Following the assessors' recommendation that the existing conditions on Dr Gayed's registration served no continuing useful purpose (other than the condition required because of his status as a conditional specialist), Dr Gayed successfully applied to the Medical Tribunal under s 92 of the Medical Practice Act to review the orders of the Professional Standards Committee of 31 October 2001 placing conditions on his registration. He effectively sought removal of the conditions. The HCCC did not oppose the application.

678. On 30 March 2006, the Medical Tribunal handed down reasons for determination. The Tribunal found that Dr Gayed 'does not suffer from an impairment within the meaning of Clause 3 of the Dictionary of the *Medical Practice Act 1992*'. The Medical Tribunal ordered that 'the conditions placed on the Applicant's registration by the Professional Standards Committee on 31 October 2001 be removed'.

679. On 8 May 2006, Dr Gayed wrote to Dr Sanderson to advise him that the Medical Tribunal had agreed to his application to remove the 'conditions' placed on his registration in October 2001.[207] On 12 April 2006, the Medical Board informed Dr Gayed's solicitor of the Medical Tribunal's findings and the amendment to the Register of Medical Practitioners for New South Wales with effect from 30 March 2006.[208] The Medical Board stated that the only remaining condition on his registration was pursuant to s 7(1)E of the Medical Practice Act, which limited the registration to practise as a specialist in obstetrics and gynaecology.

680. Dr Gayed said to Dr Sanderson that the reason for the only remaining condition—namely, that he practise only as a specialist obstetrician gynaecologist—was that he

[207] Letter from Dr Emil Gayed to Dr Bruce Sanderson, Director of Medical Services, Mona Vale Hospital, 8 May 2006 (Tab 5.8, p 1127, NSLHD documents).
[208] Letter from Ms Anne Harvey, Legal Officer, New South Wales Medical Board, to Ms Helen Turnbull, Legal Manager Disciplinary Services, United Medical Protection Limited, 12 April 2006 (Tab 5.7, p 1123, NSLHD documents).

did not sit for the Australian Medical Council exam to qualify for unconditional registration to obtain rights of general practice. He said that this had never been his interest notwithstanding his ability to obtain unconditional registration based on his full registration with the General Medical Council in London.

681. There appears to have been a misunderstanding within the Medical Board that the condition on Dr Gayed's registration that he must seek approval from the Medical Board for positions he held as a specialist was imposed by the Professional Standards Committee. In fact, that requirement was imposed at the time of his initial registration as an overseas specialist. Yet the consequence of the Medical Tribunal's decision in 2006 was that the Medical Board treated that condition as being removed.[209]

9. Serious clinical incident on 25 September 2006

682. On 25 September 2006, Dr Gayed performed a laparotomy on a patient with the intention to perform a bilateral salpingo-oophorectomy. The indication for the procedure was to prevent potential ovarian cancer in the future. During the surgery, both the small bowel and bladder were perforated, requiring surgical repair. The surgery was not completed, as neither ovary was removed.

683. Staff registered an incident on the IIMS concerning Dr Gayed's surgical management.[210] The IIMS required a Reportable Incident Brief to be sent to the Area Clinical Governance Unit and the Chief Executive.

684. A discussion took place between Dr Sanderson (Director Medical Services); the Acting Area Director of Clinical Governance, Christine Conn; and the Area Director of Clinical Operations, Phillipa Blakey. It was decided to investigate the incident as a Level 2 'Complaint or concern about a clinician' as outlined in the NSW Health Guideline GL2006_002.

685. A Level 2 complaint or concern related to 'a significant complaint or concern, where there may be one more event involving unexpected mortality or increasingly serious morbidity (SAC 1 or 2) and there may be a pattern of suboptimal performance or variation in clinical outcomes over a period of time'.

686. It required:

(1) notification to the Director of Clinical Governance;

(2) consideration as to whether variations to clinical privileges are required; and

(3) an investigation.

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[209] As I set out in my report on the Medical Council's management of Dr Gayed, *Review of processes undertaken by the Medical Council of New South Wales pursuant to Part 8 of the Health Practitioner Regulation National Law (NSW) with respect to Dr Emil Gayed*, report dated 31 October 2018, at para 438.
[210] AIMS Incident Detail (211137-20), Incident recorded 25 September 2006 (Tab 3.8, p 785, NSLHD documents).

687. It appears from a letter sent to Dr Gayed on 11 October 2006 that Dr Sanderson discussed the matter with him on Friday 6 October. Dr Sanderson informed Dr Gayed that he would be reviewing the case and any other issues of concern with a view to engaging an external expert to investigate and make recommendations.

688. On 11 October 2006, Dr Sanderson sent Dr Gayed a letter confirming the intention to investigate. He stated that he had not advised the area health service to suspend Dr Gayed's surgical privileges but requested that Dr Gayed discuss any major abdominal cases with him before scheduling such cases.[211] He requested from Dr Gayed, by 30 October, a report concerning the patient, which was to be considered as part of the investigation.

689. On 16 October 2006, Dr Sanderson sent a brief to the Director of Clinical Governance regarding the incident. He noted that the operating theatre scrub nurse, the anaesthetists and the general surgeon involved had raised concerns about the case directly with management (in addition to registering an IIMS). The concerns related to:

- the indications for surgery and the apparent poor history taking and clinical decision making;
- poor preparation of the patient for surgery (no urinary catheter prior to surgery);
- slow recognition of the perforations and inadequate response and surgical management of them; and
- a general lack of confidence expressed by the anaesthetic Visiting Medical Officers, some general surgeons and operating theatre nurses in Dr Gayed, with reluctance by some to participate in his lists.

690. Dr Sanderson recommended that a Level 2 investigation be commenced in accordance with Policy Directive PD2006_007 and Guideline GL2006_002.[212] He recommended that an external expert be sourced to review the case and any others of concern, including those previously reviewed. Finally, he recommended that Dr Gayed's clinical privileges be reviewed by the Northern Sydney Central Coast Area Health Service's Credentials Committee upon completion of the review unless the review raised significant issues of patient safety requiring immediate suspension by the Chief Executive.

691. In the briefing Dr Sanderson outlined the background commencing in August 2003, when Dr Gayed's clinical privileges were suspended and subsequently reinstated, followed by the review of his surgical competence in December 2005.

[211] Letter from Dr Bruce Sanderson, Director of Medical Services, to Dr Emil Gayed, 11 October 2006 (Tab 3.8, p 791, NSLHD documents).
[212] Briefing for Director of Clinical Governance, undated (Tab 3.8, p 789, NSLHD documents).

692. Dr Sanderson stated that Dr Gayed believed there was a possible racial bias against him in Mona Vale Hospital operating theatres and that this was the reason his complications were always brought to the attention of medical administration. Dr Gayed had expressed the view that he was being forced to resign.[213]

693. A handwritten file note (undated) includes the notation 'at this stage no [illegible] surgical activity but may change once investigation and review completed'. However, neither Dr Sanderson's letter to Dr Gayed of 11 October 2006 nor his brief to the Director of Clinical Governance dated 16 October 2006 refer to any restriction on Dr Gayed's surgical activity being imposed pending the outcome of the investigation. The fact he told Dr Gayed that he had not advised the area health service to suspend Dr Gayed's surgical privileges but requested Dr Gayed to discuss any major abdominal cases with him before scheduling them suggests that no restrictions were imposed.

9.1 SAC2 investigation of this case

694. In a separate email that day, Dr Sanderson informed the Director of Clinical Governance that he had commenced a Level 2 investigation.[214] He was trying to source an independent expert from outside of the area health service.[215]

695. On 24 October 2006, Dr Gayed wrote to Dr Sanderson acknowledging his letter of 11 October and request for a report. He requested a copy of the incident form relevant to CP's case and the hospital medical records relating to the admission.[216]

696. On 8 November 2006, Dr Sanderson sent to Dr Gayed a copy of the IIMS notification and the notes and requested that they be treated with confidentiality.[217]

697. On 8 November 2006, Dr Sanderson requested a written report from the other doctors involved in the surgery—a colorectal surgeon whose advice was sought during surgery; his surgical registrar, who assisted in repairing the bowel perforation; and the anaesthetist on duty—for the purpose of a performance review.[218] As the anaesthetist was the Head of Department, Dr Sanderson also asked him to request any doctors who had expressed concerns about Dr Gayed's performance to put in writing their concerns.

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[213] Briefing for Director of Clinical Governance, undated (Tab 3.8, p 790, NSLHD documents).
[214] Email from Dr Bruce Sanderson, 16 October 2006 (Tab 3.8, p 787, NSLHD documents).
[215] See also Dr Sanderson's handwritten note, undated (Tab 3.8, p 788, NSLHD documents).
[216] Letter from Dr Emil Gayed to Dr Bruce Sanderson, Director of Medical Services, Mona Vale Hospital, 24 October 2006 (Tab 3.8, p 793, NSLHD documents).
[217] Letter from Dr Bruce Sanderson, Director of Medical Services, 8 November 2006 (Tab 3.8, p 794, NSLHD documents).
[218] Letter from Dr Bruce Sanderson, Director of Medical Services, to Dr Stuart Pincott, 8 November 2006 (Tab 3.8, p 795, NSLHD documents); Letter from Dr Bruce Sanderson, Director of Medical Services, to Dr Gaby Vasica, 8 November 2006 (Tab 3.8, p 796, NSLHD documents); Letter from Dr Bruce Sanderson, Director of Medical Services, to Dr Adam Osomanski, 8 November 2006 (Tab 3.8, p 797, NSLHD documents).

698. Reports were submitted to Dr Sanderson by the Director of Anaesthesia, the surgical registrar, the colorectal surgeon and the scrub nurse involved in the surgery. Dr Gayed also submitted a 21-page report including attachments.[219]

699. The anaesthetist regularly worked with Dr Gayed on alternate Monday mornings and occasionally after hours. In general, he found his operating lists proceeded without incident. The majority of the workload comprised hysteroscopic and laparoscopic procedures. They had a friendly and collegial relationship. He stated that during the early months of his own appointment he had reported through the IIMS system an incident preventable by improved communication. The matter was promptly addressed and resolved. He said he was 'now well satisfied with the consistency and quality of the professional communication with Dr Gayed, allowing safe and effective conduct of his lists'.

700. However, the anaesthetist reported that Dr Gayed did not seem to enjoy the full support and confidence of all members of the operating theatre team. The doubts were 'neither clearly voiced nor formally stated, but rather may at times take the form of requests for clarification of intended course of action'. He commented that it would be difficult to operate under such conditions.

701. That doctor, who was the Head of Department, had advised members of his department of Dr Sanderson's request and received no written expressions of concern regarding Dr Gayed's performance.

702. The surgical registrar gave a factual account of the surgery, with no explicit criticism or support of Dr Gayed.

703. The colorectal surgeon provided an account of his intervention following a request by Dr Gayed conveyed by the anaesthetist during the procedure. He had been told it was due to a bowel perforation. The colorectal surgeon said that after his arrival Dr Gayed provided clinical details, being a 68-year-old lady undergoing elective laparotomy and bilateral oophorectomy for prevention of ovarian cancer due to a previous history of colonic cancer. The colorectal surgeon reported that he saw the patient on referral by her GP after the surgery. At that consultation he discovered that she had no previous history of colorectal carcinoma. He provided an opinion regarding the indication for surgery and patient selection in the case.

704. The scrub nurse criticised the timing of the incision (prior to diathermy and suction being connected) and the management of the perforation and other matters.

[219] Letter from Dr Adam Osomanski, VMO Anaesthetist, Director of Anaesthesia, Mona Vale Hospital, to Dr Bruce Sanderson, Director of Medical Services, 6 December 2016 (Tab 3.8, p 799, NSLHD documents); Letter from Dr Gabriella Vasica, Surgical Registrar, to Dr Bruce Sanderson, Director of Medical Services, 8 December 2006 (Tab 3.8, p 800, NSLHD documents); Letter from Dr Stuart Pincott, Colorectal Surgeon, to Dr Bruce Sanderson, 4 December 2006 (Tab 3.8, p 801, NSLHD documents); Letter from Fiona Deegan CNS to Dr Bruce Sanderson, Director of Medical Services, 2 October 2006 (Tab 3.8, p 803, NSLHD documents); Letter from Dr Emil Gayed to Dr Bruce Sanderson, 24 November 2006 (Tab 3.8, p 805, NSLHD documents).

705. In his report, Dr Gayed defended his management of the patient. He commented on the indication for surgery, patient selection, the management of intra-operative complications, the outcome and final recovery of the patient.

9.2 External review by Dr Pardey

706. On about 20 November 2006, Dr Sanderson engaged an independent obstetrician gynaecologist who practised at Nepean Hospital, Dr John Pardey, to conduct a review of the case (as part of the Level 2 investigation).[220] The General Manager of the Mona Vale Hospital informed Dr Pardey that the area was conducting an audit of all open gynaecological surgery at Mona Vale Hospital over the previous 12 months and would provide it to Dr Pardey once complete.

707. Dr Pardey received copies of the letter of complaint; the reports provided by Dr Gayed, the surgical registrar, the registrar and the anaesthetist; and the clinical notes.[221]

708. On 11 December 2006, Dr Pardey indicated that he would take around a week to review the material and would then seek to visit Mona Vale Hospital to speak to those involved. He would decide whether or not the review should extend to previously reviewed cases. At that stage he did not feel that Dr Gayed should be restricted from performing abdominal surgery given the level of his experience but said Dr Gayed should be advised that the review was proceeding. He recommended that Dr Gayed discuss any proposed major abdominal surgery with a senior colleague and Dr Sanderson.[222] He stated that he did not suggest that Dr Gayed needed supervision at this point.

709. On 14 December 2006, Dr Sanderson informed Dr Gayed in writing of the appointment of Dr Pardey and of Dr Pardey's suggestion that Dr Gayed discuss any proposed major abdominal surgery with a senior colleague and Dr Sanderson before adding it to his waiting list.[223]

710. Dr Gayed acknowledged the letter and said that since that case he had performed nine abdominal hysterectomies outside of Mona Vale Hospital with no complications.[224]

711. The records indicate that Dr Gayed and Dr Sanderson discussed the proposed review at length. Dr Sanderson informed Dr Gayed that the review may be

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[220] Letter from Mr Frank Bazik, General Manager, to Dr John Pardey, 20 November 2006 (Tab 4.39, p 1082, NSLHD documents).
[221] Letter from Dr John Pardey to Dr Bruce Sanderson, Northern Sydney Central Coast NSW Health, 11 December 2006 (Tab 3.8, p 831, NSLHD documents).
[222] Letter from Dr Bruce Sanderson, Director of Medical Services, Northern Beaches Health Service, to Dr Emil Gayed, 14 December 2006 (Tab 3.8, p 833, NSLHD documents).
[223] Letter from Dr Bruce Sanderson, Director of Medical Services, Northern Beaches Health Service, to Dr Emil Gayed, 14 December 2006 (Tab 3.8, p 833, NSLHD documents).
[224] Letter from Dr Emil Gayed to Dr Bruce Sanderson, Director of Medical Services, 3 January 2007 (Tab 3.8, p 834, NSLHD documents).

extended beyond that case after the initial review. Dr Gayed felt that operating theatre registered nurses at Mona Vale Hospital were overly critical of his work compared with other surgeons and this was reflected in his lack of critical incidents and complaints at all other present and past locations of work.[225] Dr Sanderson told him that Dr Pardey was aware of his concerns in this regard. Dr Gayed was also concerned about the need to discuss open abdominal cases with a peer and Dr Sanderson but appeared to accept the approach.

712. Dr Pardey was also asked to provide an opinion with regard to de-identified data relating to surgery conducted between 1 September 2004 and 31 August 2006 by obstetrics and gynaecology specialists at Mona Vale Hospital.[226] On 20 December 2006, Dr Pardey advised that, of the four doctors concerned, Dr 'B', whose identity was not known to him, had a higher rate of general complication and difficult complications without an obviously different practice from the other doctors. He said '[t]his falls short of obvious malpractice but may be of concern and his practice should be reviewed'. From the material provided, it is not known whether Dr 'B' was Dr Gayed.

713. I am satisfied that it is likely that Dr B was Dr Gayed. Dr Gayed had acknowledged to Dr Pantle and Dr Bennie in their meeting of 12 August 2003 that he had a higher complication rate in gynaecology surgery.

714. On 2 March 2007, as part of his review, Dr Pardey conducted a series of interviews with the staff involved—namely, the operating theatre registered nurse, the Visiting Medical Officer colorectal surgeon, the Divisional Director Anaesthetics, the Visiting Medical Officer anaesthetist and Dr Gayed.[227]

715. While Dr Pardey was preparing his report, some further cases of concern came to light. On 11 April 2007, Dr Sanderson informed Dr Pardey of Dr Gayed's resignation and the two new cases, which had been notified to the Medical Board and HCCC.[228] He requested Dr Pardey's report on the incident of 25 September 2006.

716. On 10 May 2007, Dr Pardey provided his report to Dr Sanderson.[229]

717. Dr Pardey recommended referral of Dr Gayed to the Medical Board and that Dr Gayed's practice 'should continue to be restricted' at Mona Vale Hospital. In summary, Dr Pardey found:

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[225] Letter from Dr Bruce Sanderson, Director of Medical Services, to Dr Pardey, 2 January 2007 (Tab 3.8, p 835, NSLHD documents).
[226] Letter from Dr John Pardey to Dr Bruce Sanderson, Northern Sydney Central Coast NSW Health, 20 December 2006 (Tab 4.40, p 1083, NSLHD documents).
[227] Letter from Dr Bruce Sanderson, Director of Medical Services, to Dr Stuart Pincott, 21 February 2007 (Tab 3.8, p 836, NSLHD documents).
[228] Letter from Dr Bruce Sanderson, Director of Medical Services, to Dr John Pardey, 11 April 2007 (Tab 4.45, p 1098, NSLHD documents).
[229] Letter from Dr John Pardey to Dr Bruce Sanderson, Northern Sydney Central Coast NSW Health, 10 May 2006 [with 2006 apparently a typographical error] (Tab 3.8, p 838, NSLHD documents).

(a) Dr Gayed's history taking was inadequate;

(b) Dr Gayed was unclear about the actual indication for surgery;

(c) Dr Gayed should have strongly recommended against surgery and if surgery were to proceed it should have been performed at a tertiary centre such as Royal North Shore Hospital;

(d) in the event that Dr Gayed had determined to proceed with surgery at Mona Vale Hospital, the planning and preoperative preparation were inadequate;

(e) the intra-operative performance was inadequate;

(f) there was inadequate follow-up;

(g) of great concern was that Dr Gayed did not show insight into the nature of either this or his previous complications and persisted with his insistence that he had been treated unjustly; and

(h) Dr Pardey commented that it is unlikely that counselling alone would resolve these issues.

718. Dr Pardey stated that 'Dr Gayed appeared not to have a clear understanding that as a Consultant it can be important to deny surgery to a patient who requests it where the potential risks outweigh the benefits'.

719. The reference by Dr Pardey that Dr Gayed's practice 'should continue to be restricted' is unclear, given the lack of any suggestion in the material that the hospital or area health service imposed any restriction on his practice in any way other than by asking him to discuss any major abdominal surgery with Dr Sanderson prior to engaging in it, as outlined previously.

9.3 Consideration of this case by this inquiry

720. Dr Jenkins notes that the patient was referred to Dr Gayed by her GP with a small right ovarian cyst and underlying concerns about ovarian cancer. She gave a history of having two first-degree relatives with ovarian cancer (her grandmother at age 63 years and her sister at age 70 years). CP was 68 years of age. The ultrasound arranged by her GP showed a small ovarian cyst with no features suggestive of ovarian cancer. A blood test had been performed to check for markers for ovarian cancer and these results were negative.

721. Dr Gayed ascertained that she had previously undergone the following abdominal operations:

(a) appendicectomy at age 27 years;

(b) cholecystectomy at age 35 years;

(c) abdominal hysterectomy at age 47 years;

(d) ‘bowel surgery’ at age 62 years; and

(e) ‘bowel surgery’ at age 63 years.

722. There is no evidence that Dr Gayed sought any additional information about the nature of the bowel surgeries other than noting that the operations were performed at Concord Hospital. It was subsequently determined by the General Surgeon that the procedures were a rectopexy using either mesh or sponge for rectal prolapse and an anterior resection for chronic constipation. One could anticipate a high probability of there being extensive intra-abdominal adhesions following these operations. Dr Jenkins considers that Dr Gayed should have known this information before making a decision regarding surgery.

723. Examination by Dr Gayed confirmed abdominal scars consistent with the above operations: two long left-sided paramedian scars, a right paramedian scar, a low transverse scar and an appendectomy scar. Dr Gayed mentioned that for the patient there was a real risk of bowel injury associated with laparoscopy, but he appeared unconcerned about performing a laparotomy for removal of her ovaries.[230]

724. Dr Jenkins considers it to have been quite clear from the letter Dr Gayed sent to the GP dated 25 July 2006 that the indication for the surgery was ovarian cancer risk reduction.[231] While Dr Gayed mentions that the benefits and risks of the surgery were discussed, he makes no specific mention of the real and serious risk of bowel injury.

725. Dr Jenkins states that the indication for the surgery is an important point. It is vitally important that the surgeon assesses risks versus benefits for any procedure to be performed. It is very clear that the risks associated with this procedure (laparotomy and bilateral salpingo-oophorectomy) are substantially greater than any purported benefit (ovarian cancer risk reduction in a patient who has not been formally assessed for her risk of familial ovarian cancer).

726. Dr Gayed performed a low transverse laparotomy (via the previous abdominal hysterectomy scar). It was noted by the operating theatre scrub sister that Dr Gayed did not insert a urinary catheter before commencing the procedure and commenced the skin incision before she was fully prepared for him to do so. Neither of these were likely to have had a significant impact on the outcome of the procedure.

727. Dr Gayed experienced difficulty in gaining entry to the peritoneal cavity and in attempting to do so created a two-centimetre laceration/tear in the small bowel. Sister Deegan suggested to Dr Gayed that, given the difficulties being encountered and that a bowel injury had occurred, Dr Gayed should request assistance from the general surgical team. Dr Gayed declined and continued the dissection. In doing so,

[230] Letter from Dr Emil Gayed to Dr Mary Riddington, 27 June 2006 (Tab 3.8, pp 817–818, NSLHD documents).
[231] Letter from Dr Emil Gayed to Dr Mary Riddington, 25 July 2006 (Tab 3.8, p 820, NSLHD documents).

he caused injury to another organ, most likely to have been the bladder. It would appear that, with significant coercion, Dr Gayed agreed for the general surgical team to assist. Dr Gayed repaired what was most likely to have been the bladder with 3/0 Vicryl and, once scrubbed in, the surgical registrar began to repair the small bowel with 3/0 PDS. The general surgeon arrived during repair of the bowel and also scrubbed in and assisted the surgical registrar with the repair. Once the bowel repair was completed, the general surgeon advised Dr Gayed that it would be in the best interests of the patient to terminate the surgery, to which Dr Gayed agreed. Dr Gayed and the surgical registrar closed the abdomen. During the procedure Dr Gayed informed the general surgeon that the previous bowel surgeries were performed for bowel cancer.

728. The patient made an uncomplicated recovery from this procedure.

729. Dr Jenkins notes that this case was the subject of an independent external review by Dr Pardey and a SAC2 investigation. Dr Jenkins agrees with the conclusions reached by Dr Pardey. Dr Jenkins' view is that this case demonstrates the following serious concerns:

(a) Dr Gayed's lack of adequate history taking and failure to obtain details regarding her previous bowel surgeries;

(b) Dr Gayed's failure to undertake a proper risk assessment for familial ovarian cancer;

(c) Dr Gayed's lack of clinical judgment in performing a laparotomy on a patient at very high risk of bowel injury without there being a well-validated indication for the procedure. It is, in my view, entirely inadequate to suggest that the indication for the procedure was that the patient wanted to have it performed and therefore it was justified;

(d) Dr Gayed's apparent failure to appreciate the difficulties encountered during the surgery, manifested by his reluctance to seek assistance from the general surgery team, continuing with the procedure and, in doing so, causing further injury to the patient;

(e) Dr Gayed providing false and misleading information to the general surgical team intraoperatively regarding her previous bowel surgeries. She had no history of bowel cancer; and

(f) Dr Gayed's written response to the Critical Clinical Incident demonstrating a significant lack of insight, which is consistent with his responses to previous critical incidents. Dr Gayed comments that 'the patient had accepted the risks involved with her surgery and when the incident occurred and was treated appropriately, she quickly and fully recovered'.[232]

[232] Letter from Dr Emil Gayed to Dr Bruce Sanderson, Director of Medical Services, Mona Vale Hospital, 27 November 2006 (Tab 3.8, p 809, NSLHD documents).

730. I address the area health service's compliance with policy relating to management of this complaint below.

10. Serious clinical incident on 4 December 2006

731. On 4 December 2006, Dr Gayed was involved in the intrapartum care of a patient. Dr Gayed's involvement in her care relates to his performance of delivery by way of assisted vaginal birth with vacuum and forceps. The delivery resulted in a stillbirth.

732. The incident was notified in IIMS on 7 December 2006. The case was the subject of a root cause analysis, which was signed off by the hospital's executive on 8 February 2007.[233] Dr Sanderson referred the case, including the root cause analysis report and hospital records, to an external reviewer.[234]

10.1 External review by Professor Bennett

733. Dr Sanderson engaged Professor Michael J Bennett, Professor of Obstetrics and Gynaecology at the School of Women's and Children's Health at the University of New South Wales, to conduct an external review of the case. Dr Sanderson asked Professor Bennett to review hospital records and a root cause analysis report relating to the case.[235]

734. On 26 February 2007, Dr Sanderson received a report from Professor Bennett.[236]

735. Professor Bennett was highly critical of Dr Gayed's note-keeping in terms of both its accuracy and completeness, Dr Gayed's interpretation of a fetal heart rate trace and communication in the labour ward. He was also highly critical of the nursing staff.

736. Professor Bennett made the following observations with regard to Dr Gayed's involvement:

(1) Dr Gayed's interpretation of the cardiotocography (CTG) monitoring suggested that he did not fully appreciate that the fetus was severely compromised in the period of time leading up to the birth. Dr Gayed interpreted the CTG as not being ominous.

(2) Dr Gayed attempted delivery of the baby in the birth unit with vacuum extraction. The vacuum detached from the baby's scalp on three occasions. Dr Gayed did not record what the vaginal examination findings were prior to applying the vacuum and did not record the vacuum detachments. Dr Gayed was not able to deliver the baby with vacuum extraction in the birth unit and the patient was transferred to operating theatre for a further attempt at

[233] NSW Health, Final RCA report, 18 February 2007 (Tab 3.8, p 843, NSLHD documents).
[234] NSW Health, Final RCA report, 18 February 2007 (Tab 3.8, p 843, NSLHD documents).
[235] See p 1097.
[236] Letter from Dr Michael J Bennett to Dr Bruce Sanderson, Director of Medical Services, Mona Vale Hospital, 26 February 2007 (Tab 4.41, p 1090, NSLHD documents).

assisted vaginal birth or possibly a caesarean section. It is not clear why the vacuum-assisted birth was not successful. The root cause analysis team concluded that there may have been a fault with the equipment.

(3) In the operating theatre Dr Gayed made a further attempt with the vacuum to deliver the baby. Again, the vacuum detached. He proceeded to deliver the baby with forceps (Wrigley's). Dr Gayed did not document the further vacuum detachment and did not document that the baby was ultimately delivered with forceps.

(4) Unfortunately, the baby was stillborn and was unable to be resuscitated.

(5) Professor Bennett commented that Dr Gayed's notes were neither accurate nor complete and that Dr Gayed (and the nursing staff) did not appreciate the seriousness of the situation.

(6) Professor Bennett commented that there were some inconsistencies between his interpretation of events and that of the root cause analysis team.

(7) The root cause analysis did not identify any performance issues with respect to Dr Gayed.

737. Professor Bennett stated: 'This baby was in pretty serious trouble for very nearly three hours before he died and there is to my mind no evidence that either the nursing staff or Dr Gayed had any appreciation of the seriousness of the situation.'

10.2 Review of stillbirth case by this inquiry

738. Dr Jenkins reviewed the material available in relation to this case, including Professor Bennett's report. Dr Jenkins agrees with Professor Bennett's opinion. The case was already at the level of catastrophe by the time Dr Gayed was called; however, Dr Gayed misinterpreted the CTG and therefore did not recognise or appreciate the severity of the situation from a fetal perspective. Dr Jenkins considers that Dr Gayed's documentation of the instrumental birth was inadequate.

739. I address the area health service's compliance with policy in managing this case below.

11. Suspension and resignation of Dr Gayed

740. In March 2007, two further cases of concern came to light.

741. During surgery on or about Friday 2 March 2007, Dr Gayed perforated the bowel of two patients in operations he conducted in his private hospital surgery list.[237] The

[237] Email from Dr Bruce Sanderson to Ms Philippa Blakey, 7 March 2007 (Tab 4.42, p 1094, NSLHD documents).

patients were admitted to and operated on at Mona Vale Hospital the following Monday and Tuesday (5 and 6 March).

742. On 6 March 2007, Dr Sanderson briefed Dr Phillipa Blakey, Director Clinical Operations, on 'widespread concerns' regarding the practice of Dr Gayed and the various investigations and reviews that had been completed or were underway.[238]

743. Dr Sanderson and Dr Blakey agreed that there was such a level of concern about patient safety from Dr Gayed's colleagues, and based on feedback from previous reviews and investigations, that he should be immediately suspended from all duties at the hospital. Ms Blakey informed Dr Sanderson that the Chief Executive supported the decision to suspend and asked Dr Sanderson to notify the Medical Board.

744. On the evening of 6 March 2007, Dr Sanderson met with Dr Gayed at Dr Gayed's request.[239] Dr Gayed was very upset because of the two private patient cases. He said he had been very anxious and concerned about the investigation by Dr Pardey of the surgical case from 25 September 2006 and he felt that it may have influenced his performance the previous Friday. He felt the current and past reviews were personally motivated rather than being motivated by safety concerns. He presented his resignation.

745. Dr Sanderson outlined the various concerns to Dr Gayed arising from the preliminary findings regarding the recent stillbirth, the two private patient incidents and the ongoing Pardey review. He said he had lost confidence in Dr Gayed's ability to deliver the level of service required and that, following discussions with Dr Blakey and Mr Bazik, and with the agreement of Dr Christley, he had decided to suspend Dr Gayed immediately. Dr Sanderson accepted Dr Gayed's resignation and waived the three-month notice period.

746. Dr Sanderson then informed Dr Blakey of the meeting and said he would notify maternity and theatres about the resignation.

747. Dr Gayed provided a resignation letter dated 5 March 2007, which Dr Sanderson accepted in writing on 7 March 2007.[240] Dr Sanderson confirmed in his letter that, as discussed in their meeting on 6 March 2007, he had waived the three months' notice and the resignation was effective from 7 March 2007.

12. Notification to the Medical Board and the HCCC

748. On 8 March 2007, the Director of Medical Services at Mona Vale Hospital contacted the Medical Board to notify it of the concerns about Dr Gayed and that a Level 2

[238] Email from Ms Philippa Blakey to Dr Bruce Sanderson, 6 March 2006 (Tab 4.42, p 1094, NSLHD documents).
[239] Email from Dr Bruce Sanderson to Ms Philippa Blakey, 7 March 2007 (Tab 4.42, p 1094, NSLHD documents).
[240] Letter from Dr Bruce Sanderson, Director of Medical Services, to Dr Emil Gayed, 7 March 2006 [with 2006 apparently a typographical error] (Tab 4.43, p 1096, NSLHD documents).

investigation was being carried out by an external reviewer. He informed the Medical Board that Dr Gayed had resigned.

749. On 16 March 2007, the Chief Executive of Northern Sydney Central Coast Area Health Service, Dr Christley, notified the Medical Board of the four patients' cases, the decision to suspend Dr Gayed pending the outcome of investigations, and Dr Gayed's subsequent decision to resign.[241]

750. This was the second occasion on which Dr Christley had brought to the attention of the Medical Board the area health service's serious concerns about Dr Gayed's clinical practice.

751. The Medical Board informed Dr Christley that it would consult with the HCCC regarding his notification as required under the legislation.

752. On 16 March 2007, Dr Christley notified the HCCC of the outcome of the review of the stillbirth case. He said that an external expert review of a perinatal fetal death that occurred at Mona Vale Hospital in December 2006 had raised concerns regarding the clinical practice of Visiting Medical Officer Dr Gayed, the attending midwife and student midwife.[242] Dr Christley stated that:

> The VMO was Dr Emil Gayed. We have notified our concerns to the Medical Board of NSW. Dr Gayed has now resigned from NSCCAHS. We have taken steps to notify our concerns to other hospitals where we are aware of Dr Gayed working

753. At around the same time, Dr Hoyle, Director of Clinical Governance at Northern Sydney Central Coast Area Health Service, spoke with Dr Wills of Manning Hospital about Dr Gayed's suspension and resignation and followed that discussion with an email.[243] The email noted: 'We regard this as sufficient to suspend Dr G as an MCCC level 1. In fact, he resigned first, but the risk triage remains.' The email also stated: 'There are unrelated concerns re Gynaecology, with two additional cases of surgical mishap in the last two weeks. They happened in the private sector but were referred to our hospital for fixing up.' The email further noted that 'Gyne in isolation is probably a MCCC 2 but given the impracticality of supervision we would be suspending him from that too pending a detailed investigation'.[244]

754. On 29 March 2007, the Medical Board and the HCCC consulted regarding Dr Christley's letter and determined to treat it as a notification regarding Dr Gayed and to await the outcome of the area health service's investigation.[245]

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[241] Tab 107.

[242] Letter from Dr Stephen Christley, Chief Executive, to Mr Kieran Pehm, Commissioner, Health Care Complaints Commission, 16 March 2007 (Tab 4.44, p 1097, NSLHD documents).

[243] Email from 'Philip' to 'Jim', undated (Tab 3.a.14, HNELHD documents). The HNELHD index refers to this document as 'Correspondence—Mona Vale—Gayed—Death of baby [name], report from Mona Vale Hospital 2007' (Tab 3.a.14, HNELHD documents).

[244] Email from 'Philip' to 'Jim', undated (Tab 3.a.14, HNELHD documents).

[245] Assessment sheet dated 29 March 2007 (Tab 107, p 1489, Medical Council NSW files).

755. On 24 April 2007, the Medical Board's Performance Committee considered Dr Christley's notification together with a notification from the Delmar Private Hospital and background information, including the performance assessment of 13 September 2004, a related counselling report of 1 November 2005 and a summary of Dr Gayed's complaint history. The Performance Committee was satisfied that matters indicated that Dr Gayed's professional performance was unsatisfactory in the areas of procedural skills and clinical judgment. It resolved that a performance assessment be undertaken.

756. On 30 May 2007, the Medical Board replied to Dr Christley's letter.[246] The Medical Board asked to be advised of the findings and outcome of the area health service's investigation. It said it would advise of the outcome of any action it took in relation to Dr Gayed.

757. On 26 June 2007, Dr Christley sent to the Medical Board the reports of both Dr Pardey and Professor Bennett.[247] Delegates of the Medical Board considered those reports and determined that urgent action under s 66 of the Medical Practice Act was not required and that an assessment of Dr Gayed's professional performance was warranted. The Medical Board's Performance Committee also met on 24 July 2007 to consider the reports of Dr Pardey and Professor Bennett. The Performance Committee noted the delegates' decision to deal with the matter via the performance pathway rather than to hold a s 66 inquiry. In my report on the Medical Council's management of Dr Gayed, I conclude with Dr Jenkins that the evidence available at this time would have justified the Medical Board taking action against Dr Gayed under s 66 of the Medical Practice Act to impose conditions on his registration restricting him from operating without prior written approval of the Medical Board and to submit a log of all procedures performed to the Medical Board.[248]

[246] Letter from Mr Anthony Johnson, Legal Director, New South Wales Medical Board, to Dr Stephen Christley, 30 May 2007 (Tab 4.46, p 1099, NSLHD documents).
[247] Letter from Dr Stephen Christley, Chief Executive, to Mr Anthony Johnson, Legal Director, NSW Medical Board, 26 June 2007 (Tab 4.47, p 1100, NSLHD documents).
[248] Section 20.1 of *Review of processes undertaken by the Medical Council of New South Wales pursuant to Part 8 of the Health Practitioner Regulation National Law (NSW) with respect to Dr Emil Gayed* dated 31 October 2018.
report.

758. On 31 July 2007, the HCCC wrote to Mr Terry Clout, who took over from Dr Christley as Chief Executive, regarding the area health service's complaint about the clinical competence of Dr Gayed arising out of the four cases.[249] The HCCC had obtained a response from Dr Gayed regarding one of the patients, who had also complained directly to the HCCC. The HCCC informed Mr Clout that, after consultation with the Medical Board, it had decided to refer the complaint to the Medical Board for its management.

12.1 Maternity services review

759. In his letter to the HCCC of 16 March 2007, Dr Christley said that he had asked that a further 'broadly ranging external review be undertaken of the operation of the Maternity Unit at Mona Vale Hospital' in light of the comments made by the external reviewer (being Professor Bennett) about general system issues within the Mona Value Maternity Unit.

760. That review took place. At the joint request of the General Manager for Northern Beaches Health Service and the Director of Clinical Operations within the Northern Sydney Central Coast Area Health Service, a review of the maternity services at Mona Vale Hospital occurred on 23 and 24 August 2007.

761. The external review team comprised Dr Robert Buist, obstetrics and gynaecology specialist at Royal Hospital for Women, Randwick; Professor David Ellwood, Deputy Dean and Professor of Obstetrics & Gynaecology at the ANU Medical School and then Vice-President of Women's Healthcare Australasia; and Ms Sue McBeath, Executive Director of Women's and Children's Health Service, Launceston General Hospital, and Executive Member of Women's Healthcare Australasia. Terms of reference included reviewing the midwifery and obstetric practices at Mona Vale Hospital; the unit's clinical risk management system; all peer review, Morbidity and Mortality and mandated clinical committees and the Midwifery Model of Care; providing recommendations; and advising on any issues of concern.

762. The review team reviewed the facilities, interviewed staff, were provided with documentation relating to the clinical outcomes at Mona Vale Hospital (not limited to Dr Gayed's patients) and were given access to the unit's policies and procedures manuals. The review team made recommendations for improvement.

13. Monitoring of compliance with conditions of appointment

763. The terms of reference for this inquiry require me to review the monitoring of compliance by Dr Gayed with any conditions of his appointment imposed by the area health service. Dr Gayed had full clinical privileges during his appointment to Mona Vale Hospital except for the period of his suspension in 2003 and, in those

[249] Letter from Mr Ian Thurgood, Director, Assessments and Resolution, Health Care Complaints Commission, to Mr Terry Clout, 31 July 2007 (Tab 5.10, p 1129, NSLHD documents).

circumstances, the issue as to monitoring compliance with conditions of his appointment does not arise.

14. Variation or withdrawal of Dr Gayed's clinical privileges

764. The terms of reference also require me to consider any variation or withdrawal of Dr Gayed's clinical privileges by the local health district to identify whether the processes followed complied with applicable NSW Health and local health district / area health service policies in place at the time. I interpret this to include consideration of whether clinical privileges should have been varied or withdrawn at any time.

765. The issue arises in relation to the period after the first cluster of concerns about Dr Gayed's competence came to light in 2003.

766. The Northern Sydney Health By-Laws required that any matter concerning the clinical privileges of any person appointed as a visiting practitioner be referred to the Credentials Committee for advice. The relevant NSW Health policies are outlined in chapter 2 of this report.

767. At no stage prior to 30 March 2006 did Northern Sydney Health restrict Dr Gayed's clinical privileges to conform with the condition on his registration as a medical practitioner that he not undertake microsurgery. The relevance of 30 March 2006 is that on that date, by order of the Medical Tribunal, the condition of his registration imposed by the Professional Standards Committee that he not undertake microsurgery was removed.

768. Northern Sydney Health should have known about the condition on Dr Gayed's registration at the time it appointed him as a Visiting Medical Officer to Mona Vale Hospital. In June 2003, when Northern Sydney Health learned of the condition, the matter should have been referred to the Credentials Committee and a condition or restriction on Dr Gayed's clinical privileges (and thus his appointment) should have been imposed to the effect that he not undertake microsurgery at the hospital. Whether Dr Gayed did undertake microsurgery while he was a Visiting Medical Officer at Mona Vale Hospital cannot be determined by my Inquiry.

769. Further, in May 2004, November 2005, September 2006 and December 2006, when serious clinical incidents occurred, Northern Sydney Health should have reviewed Dr Gayed's appointment through the Credentials Committee, particularly in light of the recommendation of the Credentials Committee of 22 September 2003 that, if there was any 'replication' of concerns, Dr Gayed's appointment may be reviewed. Dr Gayed in fact signed a new condition on his reinstatement in 2003 that, should any concerns in the future arise, the Credentials Committee may review his appointment (as noted in the meeting of the Medical Appointments and Credentials Advisory Committee on 5 November 2003).

770. Dr Gayed's appointment was not considered by Medical Appointments and Credentials Advisory Committee or the Credentials Committee at any time after November 2003. In light of the concerns that were raised about his performance, in my view, his appointment and privileges should have been reviewed well prior to his resignation in 2007. As outlined in this chapter, the case in May 2004 clearly justified such a review.

771. Although Dr Pardey's report suggested that his surgery should 'continue to be restricted', the area health service did not document—or therefore, I assume, impose—any restriction on Dr Gayed's practice.

772. Northern Sydney Health suspended Dr Gayed on two occasions: for a period in August 2003 prior to his reinstatement with full clinical privileges; and again, on 6 March 2007 prior to his resignation.

15. Consistency of conditions of appointment with registration

773. The terms of reference require me to consider the consistency of any conditions of appointment imposed on Dr Gayed and the clinical privileges granted to him with the registration or other conditions imposed on him by regulatory bodies such as the Medical Board.

774. As set out above, Dr Gayed's appointment with Northern Sydney Health to Mona Vale Hospital, and the clinical privileges granted to him as part of that appointment, were not consistent with the condition imposed on his registration by the Professional Standards Committee—namely, that he not undertake microsurgery. Even after Northern Sydney Health discovered the existence of that condition on registration in about June 2003 (but no later than August 2003), Dr Gayed's clinical privileges were not restricted to make clear that he was not permitted to undertake microsurgery at the hospital.

775. As a practical matter, this inconsistency between Dr Gayed's registration status and his appointment to Northern Sydney Health is unlikely to have been significant given that, as Dr Jenkins has noted, gynaecologists rarely perform microsurgery. I note further that microsurgery was not a feature of Dr Gayed's practice according to his curriculum vitae.

16. Compliance with policies

776. The applicable policies are summarised in chapter 2.

777. Northern Sydney Health had its own local policy: 'The Management of a Complaint or Concern about a Clinician' (August 2002). The Northern Sydney Health policy was consistent with NSW Health Policy Directive PD2005_586. Although the Northern Sydney Health policy provided that it applied to concerns about the possibility of an 'impaired practitioner', it appears to have applied to the management of concerns or complaints about performance more generally, in that it said it was to 'be read in

conjunction with' the NSW Health policy referred to above. The Northern Sydney Health policy stated in clause 7:

> Where the issue is potential very serious (e.g. there has been or there was the real risk of a death or serious injury), then the Health Care Complaints Commission and the relevant registration board should be involved in the process very early.

778. The Northern Sydney Health policy also provided:

> When a material impairment comes to attention, it is the interest of all involved that the relevant registration board be involved as early as possible. This is because:
>
> a. The registration board may be in possession of important additional information.
>
> b. The involvement of the registration board is an unmistakable signal to the clinician that the issue is serious
>
> c. The registration board has access to expert assistance …
>
> d. The clinician may be practising elsewhere, unbeknown to NSAHS.
>
> Furthermore, all clinicians (including clinician managers) who hold professional registration are now obliged to inform the registration authorities of impaired colleagues. As noted earlier, where the issue has had a potential serious patient impact, the Health Care Complaints Commission should be advised.

779. I am satisfied that Northern Sydney Health complied with policy in relation to the seven cases identified in June and July 2003, as the cases were referred to the Credentials Committee for consideration of Dr Gayed's clinical privileges.

780. I am satisfied that Northern Sydney Health did not comply with applicable policies in relation to the subsequent cases which arose in 2004 and 2005. No further action was taken in relation to these cases, despite the recommendations made by the Medical Appointments and Credentials Advisory Committee in September and November 2003 that Dr Gayed's appointment be reviewed if there was any replication of concerns about his performance.

781. In relation to the case which occurred on 25 September 2006, on 16 October 2006 Dr Sanderson referred to the policy requirements of PD2006_007 and GL2006_002 in his brief to the Director of Clinical Governance regarding that case.[250] He applied the policies, which required notification to the Director of Clinical Governance, consideration of whether variations to clinical privileges were required and an investigation.

782. Dr Sanderson, as Director of Medical Services, also gave consideration to whether to suspend Dr Gayed's surgical privileges. On 11 October 2006, he informed Dr Gayed that he had decided not to do so.[251]

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[250] Briefing for Director of Clinical Governance, undated (Tab 3.8, p 789, NSLHD documents).
[251] Letter from Dr Bruce Sanderson, Director Medical Services, to Dr Emil Gayed, 11 October 2006 (Tab 3.8, p 791, NSLHD documents).

783. There was no variation or withdrawal of the clinical privileges prior to the decision on 6 March 2007 to suspend Dr Gayed. The Credentials Committee was not convened. In my opinion, it would have been reasonable and preferable to do so pending the outcome of Dr Pardey's review.

784. The external review by Dr Pardey was not complete until 10 May 2007. This was well outside the recommended 60-day period for concluding an investigation. The Medical Board was notified of the case, and the other cases of concern, on 8 March 2007 (prior to completion of Dr Pardey's review). In my view, the Northern Sydney Central Coast Area Health Service could and should have taken steps to expedite completion of Dr Pardey's report.

785. I am satisfied, however, subject to the failure to convene the Credentials Committee, that the Northern Sydney Central Coast Area Health Service complied with policy requirements in relation to one of the incidents, although it would have been desirable that the investigation be finalised more expeditiously.

786. In relation to the case on 4 December 2006, an investigation was undertaken, including by way of an external peer review. I am satisfied that the Northern Sydney Central Coast Area Health Service complied with the policy requirements.

787. In relation to performance reviews generally, there is no indication that Dr Gayed was subject to routine performance reviews.

17. Reporting unsatisfactory professional conduct to Medical Board

788. The four cases notified to the Medical Board in March 2007 took place in September 2006, December 2006 and March 2007.

789. The legislation requiring the chief executive of an area health service to report to the Medical Board any suspected unsatisfactory professional conduct or professional misconduct did not specify a time limit within which such a report was required to be made (s 99A of the Health Services Act, set out above).

790. An issue arises whether the duty under s 99A of the Health Services Act to report suspected unsatisfactory professional conduct to the Medical Board requires the report to be made when the incident occurs or once the investigation of the incident is complete.

791. GL2006_002 advises that, when a decision is made to investigate, the area health service should liaise with the registration board or HCCC to ensure the investigation does not impact on an investigation by either of those bodies.[252] It requires a report to be made to the registration board following the outcome of an investigation (if required by the outcome).[253] It is not clear whether a report should be made to the registration board as soon as the incident is notified and a decision

[252] Clause 2.3 of GL2006_002 (see chapter 2 of this report).
[253] Appendix 1 of GL2006_002 (see chapter 2 of this report).

is made to investigate, or whether the report should be made once the outcome of the investigation is known.

792. On one view, the duty to report does not depend on any investigation of the conduct being completed. The words 'suspects on reasonable grounds' in s 99A support this view.

793. However, I accept that there needs to be an evaluation of an incident, and possibly a full investigation and findings and recommendations made, before a report can be made to the Medical Board. This may entail convening a Credentials Committee. However, in my view, if the evaluative process is to be a lengthy one, and particularly if the doctor is still practising, the Medical Board should be notified earlier rather than later.

794. The report made to the Medical Board in March 2007 in respect of the case of CP which occurred on 25 September 2006 was tardy. Waiting six months to report was too long.

795. The NSW Health policy which applied, Guideline GL2006_002, is still current. It should be clarified in the policy that, where the suspicion on reasonable grounds exists prior to the investigation, the duty to report is engaged.

18. Further review or audit

796. Dr Jenkins advises me that no further review or audit of Dr Gayed's clinical outcomes in relation to Mona Vale Hospital is necessary. I note that NSW Health advised the public that each of the hospitals the subject of this inquiry would make direct contact with any patient who has raised issues or complaints in the past regarding the treatment they received from Dr Gayed. Other people with concerns about treatment they may have received were encouraged to call a dedicated telephone line set up at each of the hospitals.

797. I understand that calls have been made to this telephone line about treatment delivered by Dr Gayed at Mona Vale Hospital.

798. I assume that this service has been and will be monitored and that, in the event the calls suggest further review or audit, that will occur.

19. Conclusion

799. During Dr Gayed's appointment at Mona Vale Hospital, there were two to three serious clusters of complaints: seven in 2003 that resulted in Dr Gayed's clinical privileges being suspended for a few months; and a number in each of 2004, 2005, 2006 and 2007. He resigned knowing he was to be suspended in early 2007.

800. During the period of his appointment, it is apparent that Northern Sydney Health, then Northern Sydney Central Coast Area Health Service, had effective and quite robust systems in place for notifying and managing complaints, particularly

following the introduction of IIMS and related policies in 2005. They included notifying matters to the Medical Board and seeking information from the Medical Board.

801. However, in my and Dr Jenkins' opinion, following the area health service's management of the initial cluster of incidents in 2003, complaints in May 2004, November 2005, September 2006 and December 2006 warranted a further review of Dr Gayed's clinical privileges by the Medical Appointments and Credentials Advisory Committee with advice from the Credentials Committee (notably the case in 2004 required it, in view of the Medical Appointments and Credentials Advisory Committee's conclusion in 2003). This did not occur. There was also a delay in finalising the investigation of the incident in September 2006, and it was the escalation of concerns in March 2007 that led to Dr Gayed being suspended.

Chapter 8: Manning Hospital

1. Investigations

1.1 Documents from Hunter New England Local Health District

802. The nature of my investigations of the response by the Hunter New England Local Health District and Manning Hospital to concerns about Dr Gayed differed from those I conducted concerning the hospitals the subject of earlier chapters.

803. As I indicated in the Introduction to this report, I was dependent upon the completeness of the searches conducted by each local health district to locate and provide me with all documents relevant to my inquiry. My terms of reference were directed to documents evidencing the response of the local health districts to concerns about Dr Gayed.

804. By letter dated 25 June 2018, I sought all documents related to my terms of reference from each relevant local health district. The Hunter New England Local Health District provided four volumes.

805. As part of that material, Incident Information Management System (**IIMS**) reports dated between 2012 and 2016 in relation to seven patients were produced. A further IIMS report was provided in early August 2018 concerning an incident in 2006. None named Dr Gayed; however, the attached correspondence made clear he was the surgeon concerned. As is evident in this chapter, not all IIMS reports were critical of Dr Gayed.

806. I was initially surprised that there were so few patients at Manning Hospital who had been the subject of reports by staff through the IIMS system. Given Dr Gayed's performance at Cooma and Mona Vale hospitals, it seemed unlikely that his treatment had improved so markedly while at Manning Hospital that there were few documented concerns among clinical staff.

807. In June 2018, a public inquiry line was established at Manning Hospital. Almost 200 women who had a concern about their treatment by Dr Gayed contacted the hospital.

808. Dr Nigel Roberts, the Director of Obstetrics and Gynaecology at the hospital, met with most of those women, reviewed their medical records, to the extent they were available, and wrote a report about their treatment and his opinion as to its adequacy.

809. In a submission to me, he informed me of his process and preliminary opinion. I sought and received copies of his reports. One referred to an IIMS report I had not been given.

810. Being concerned there may be further IIMS reports, on 25 October 2018 I requested that the local health district conduct a search of their relevant systems

based on the names of those women to ascertain whether any reports or IIMS reports had been made.

811. Further IIMS reports on about a dozen patients were located and given to me on 9 November. Two patients were known to the inquiry from earlier information forwarded by the local health district. Dr Gayed was named as the surgeon responsible in two of those reports.

812. An additional four IIMS reports were provided on 20 November, concerning four patients. Not all of those IIMS reports concerned Dr Gayed's clinical treatment of patients.

813. I make observations about these matters at the conclusion of this chapter, including the IIMS system and the review conducted by Dr Roberts, which ultimately became known as Lookback 3.

1.2 Interviews with staff

814. In addition, on behalf of the inquiry, the Ministry of Health wrote directly to:

- the Manning Hospital Medical Staff Council through its chairman; and
- individual clinicians who worked with Dr Gayed at Manning Hospital,

inviting any individual who wished to make a submission, or to provide information to the inquiry, to do so using the dedicated inquiry email address. I received two responses.

815. I also interviewed a number of former and current administrators and practitioners from Hunter New England Local Health District and Manning Hospital:

(a) Dr Philip Walkom, former Visiting Medical Officer (Obstetrics and Gynaecology), Manning Hospital;

(b) Dr Jim Wills, former Director, Clinical Services and Director, Emergency Medicine, Manning Hospital;

(c) Dr Osama Ali, Acting Director, Medical Services, Manning Hospital;

(d) Dr Nigel Lyons, former Chief Executive Officer (**CEO**), Hunter New England Area Health Service;

(e) Mr Michael DiRienzo, Chief Executive, Hunter New England Local Health District;

(f) Dr Rosemary Aldrich, former Deputy Director Clinical Governance Unit, Hunter New England Area Health Service;

(g) Dr Alan Bourke, Anaesthetist, Manning Hospital;

(h) Mr Michael de Wright, Nursing Manager, Perioperative Unit, Manning Hospital;

(i) Dr Nigel Roberts, Director of Obstetrics and Gynaecology, Manning Hospital; and

(j) Ms Sharron Brown, Clinical Nursing Unit Manager, Operating Theatres, Manning Hospital.

816. As stated in Chapter 1, I was assisted in my inquiry by Dr Greg Jenkins, obstetrician and gynaecologist.

2. Appointments

817. As at 1 January 1999, Manning Hospital was controlled by the Mid North Coast Area Health Service. On 1 January 2005, Manning Hospital transferred to the Hunter New England Area Health Service. From 1 January 2011, Manning Hospital was within the Hunter New England Local Health Network, which was renamed the Hunter New England Local Health District on 1 July 2011. It is variously referred to as Manning Base Hospital, Manning Rural Hospital and Manning Hospital. I refer to it as Manning Hospital in this report.

818. Dr Gayed held appointments at Manning Hospital between 1999 and 2016. The key staff at the time of his appointments were Dr Jim Wills, Director of Clinical Services, from about 1999 until about 2015. Dr Osama Ali then became the Acting Director. There was no Director of Obstetrics and Gynaecology until Dr Roberts was appointed to that role in April 2015.

819. Dr Gayed commenced working as a Visiting Medical Officer Obstetrician/Gynaecologist at Manning Hospital in August 1999. He sought reappointment in 2003, 2006 and 2011.

820. In early September 1999, the Mid North Coast Area Health Service Board endorsed the three-year appointment of Dr Gayed as an obstetrician and gynaecologist and he was granted clinical privileges in relation to obstetrics and gynaecology at Manning Hospital.[254]

821. As with his Kempsey Hospital appointment (see Chapter 6), it appears that Dr Gayed worked at the hospital prior to the Credentials Committee approving his appointment. I am advised by Dr Jenkins that, currently, credentialing happens at the time of the appointment; however, in 2000, it was 'not unusual for the Credentialing committee to be quite separate from the appointments process'. Thus, it would be not unusual for a clinician to commence work (undertaking the generally accepted scope of practice for the relevant specialty) and then at the next meeting of the Credentials Committee the clinical privileges would be formally delineated.

[254] Minutes of Area Board Meeting, Mid North Coast Area Health Service, 2 September 1999 (Tab 1A, MNCLHD documents).

822. Notwithstanding the usual practice, the relevant policy, Circular 95/24, 'Guidelines for the Delineation of Clinical Privileges of Medical Staff', is to the effect that it should have been part of the appointment process.

823. In November 2001, following the Professional Standards Committee decision, set out in chapter 5, the New South Wales Medical Board (**Medical Board**) advised the Mid North Coast Area Health Service that Dr Gayed had a condition placed on his registration that he not undertake microsurgery.[255] The area health service did not vary Dr Gayed's clinical privileges after this notification until 2003.

824. Dr Gayed reapplied for a position as a Visiting Medical Officer in 2003. In the application form, Dr Gayed had an option of recording his registration as 'full' or 'conditional'. He ticked 'full'. He left blank the section requiring details of any hospital or facilities where an application for appointment or reappointment had been refused or privileges reduced or removed.

825. He signed a release for enquiries to be made to, among others, previous places of employment, the Health Care Complaints Commission (**HCCC**) and registration authorities. He declared he had not had his privileges withdrawn or reduced or any appointment terminated by any hospital or health service. He stated that he was not a prohibited person and agreed to a Criminal Record Check.

826. A document was provided to the inquiry which recorded that Dr Gayed's status was 'cleared' in relation to a Working With Children Check as at 25 October 2002, apparently on the basis that clearance had been given to him in his capacity at Mona Vale Hospital.[256]

827. The documents provided by Hunter New England Local Health District do not include the results of any other such checks or inquiries made by the area health service.

828. In May 2003, the Area Medical and Dental Appointments Advisory Committee met and recommended that Dr Gayed's clinical privileges consist of 'Specialist Obstetrics and Gynaecology including laparoscopy (Does not include microsurgery)', noting that 'Privileges subject to six monthly Medical Board agreement with visual acuity and review—Agreed with proviso'.[257] There is no information as to what the 'proviso' was. This was the first occasion on which the condition imposed by the Medical Board was incorporated into Dr Gayed's clinical privileges.

829. Dr Gayed was advised on 16 June 2003 that the board of the Mid North Coast Area Health Service, following advice from the Medical Appointments and Credentials

[255] Letter from Ms M Anne Harvey, Legal Officer, New South Wales Medical Board, to Mr Terry Clout, Chief Executive Officer, Mid North Coast Area Health Service, 23 November 2001 (Tab 4B, MNCLND documents).
[256] NSW Health Department, 'Clearance already provided to another location within the past 9 months', 16 May 2003 (Tab 2.a.4, HNELHD documents).4
[257] Minutes of Area Medical and Dental Appointments Advisory Committee Meeting, Mid North Coast Area Health Service, 19 May 2003 (Tab 1F, MNCLHD documents).

Committee, offered him the Visiting Medical Officer appointment from 1 July 2003 until 30 June 2008 with clinical privileges in specialist obstetrics and gynaecology, including laparoscopy (not including microsurgery) (these privileges were subject to six-monthly Medical Board agreement with visual acuity and review).[258]

830. The conditions on Dr Gayed's registration that he not perform microsurgery and the order that he undergo ophthalmological review were removed in March 2006 by the Medical Tribunal of New South Wales (**Medical Tribunal**). There is no indication that Manning Hospital was informed of this change in practice conditions. There is no evidence that Dr Gayed's clinical privileges were amended as a result.

831. Dr Gayed was required to reapply in 2006. In his application, he signed the same form as he had in 2003 permitting various checks.

832. As part of that process, he signed that 'I declare, except as indicated on this application, I have not had my privileges withdrawn or reduced or any appointment terminated by any hospital or health service'.[259]

833. The documents provided by Hunter New England Local Health District do not include the results of any such checks or inquiries made by the area health service. His application did not disclose that his appointments were suspended in relation to Cooma Hospital in 1998 (see Chapter 4) and in 2003 at Mona Vale Hospital (see Chapter 7).

834. On 14 June 2007, Dr Gayed was appointed as a Visiting Medical Officer (Obstetrician and Gynaecologist) by the Hunter New England Area Health Service from 1 July 2007 until 30 June 2012 with his delineation of privileges being Manning Rural Referral Hospital in obstetrics and gynaecology. A document records that a Working With Children Check had been obtained and his status was 'cleared'. There were no relevant conditions on his appointment.[260]

835. On 1 July 2008, the Medical Board informed the Hunter New England Area Health Service of practice conditions which had been imposed on Dr Gayed's registration[261] that he is 'to not perform the following surgery':

- complicated laparoscopy, including hysterectomy (laparoscopically assisted vaginal hysterectomy and total laparoscopic hysterectomy)
- laparoscopic treatment of moderate or severe endometriosis

[258] Letter from Dr Robert Porter, Area Director Clinical Services, Mid North Coast Area Health Service, to Dr Emil Gayed, 16 June 2003 (Tab 2.c.5, HNELHD documents).
[259] Hunter New England Area Health Service, Senior Medical Staff Application for Appointment, signed 30 October 2006 (Tab 2.a.1, HNELHD documents).
[260] Letter from Hunter New England Area Health Service to Dr Emil Gayed (Tab 2.c.1, HNELHD documents).
[261] Letter from Ms Diane Mackowski, Coordinator—Performance Program, New South Wales Medical Board, to Mr Terry Clout, Chief Executive, Hunter/New England Area Health Service, 1 July 2008 (Tab 5.2, HNELHD documents).

- advanced urogynaecology including mesh procedures and oncology procedures (for cervical or uterine malignancy).

836. A Credentialing Subcommittee was formed and a series of emails between members of the subcommittee resulted in amendment to Dr Gayed's clinical privileges being adopted by the Medical and Dental Appointments Advisory Committee on 16 September 2008. The Medical and Dental Appointments Advisory Committee resolved that Dr Gayed's privileges were to be amended to reflect the limitation on his registration notified by the Medical Board until further notice and subsequent review by a credentials subcommittee.[262]

837. In August 2008, Dr Gayed informed Dr Wills that he and his two obstetrician and gynaecologist colleagues working at Manning Hospital strongly opposed any further appointments of obstetricians and gynaecologists to the hospital. He suggested changes to on-call arrangements and rosters, with the result that he would effectively perform extra work himself.[263]

838. In his 2011 application for appointment from 2012 to 2017, he responded 'yes' to the question, 'have you ever had conditions imposed by any Medical Board or Council' and referred to p 86 of his curriculum vitae for details. That page has not been located.

839. The form asked the applicant to supply a copy of his logbook detailing clinical activity. Dr Gayed responded by referring to his curriculum vitae. No logbook has been located in the material provided. Dr Wills told me that he had not seen a logbook of Dr Gayed's procedures.

840. Dr Gayed drew a line through the space provided in answer to 'details of any Hospitals or facilities where an application for appointment or re-appointment was refused or privileges reduced or removed'.

841. He signed a declaration and consent in relation to a Working With Children Check and a National Criminal Record Check.[264] He also signed a release for enquiries to be made to, among others, previous places of employment, HCCC and registration authorities.

842. Again, the documents provided by Hunter New England Local Health District do not include the results of any such checks or inquiries made by the Local Health District. Dr Gayed seems not to have revealed that his appointment was suspended in relation to Cooma Hospital in 1998 and in 2003 and March 2007 at Mona Vale Hospital.

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[262] Letter from Mr Peter Marshall, Director Medical Workforce Development, Hunter New England Area Health Service, to Dr Emil Gayed, 25 September 2008 (Tab 2.c.8, HNELHD documents).
[263] Letter from Dr Emil Gayed, to Dr Jim Wills, Director of Medical Services, Manning Base Hospital, 20 August 2008 (Tab 2.c.9, HNELHD documents).
[264] NSW Health, Applicant Declaration and Employment Screening, Consent for Child Related Employment (Tab 2.a.2, HNELHD documents).

843. This application included a section regarding 'Health Care Complaints' which asked the question, 'Have you had or do you have any complaints involving your care that were or are currently being reviewed by the New South Wales Health Care Complaints Commission or similar authority?'. Dr Gayed answered 'no' to this question. However, by 2011 a significant number of complaints had been made to the HCCC regarding his practice at Cooma Hospital and at Mona Vale Hospital, he had been before a Professional Standards Committee in relation to complaints about his treatment of patients at Cooma Hospital, and the Medical Board had conducted two performance assessments (2004 and 2007) and a Performance Review Panel (2007).

844. There is no evidence that Dr Gayed's clinical privileges were varied after September 2008 and before he was suspended on 9 February 2016.

3. 1999–2005

845. The IIMS was implemented in New South Wales Health in May 2003 and the first IIMS report from Manning Hospital was on 4 January 2004.

846. Prior to that time, any documented reports of clinical performance would be likely to be confined to a file relating to the practitioner. In this section I outline the reports documented and incidents notified in IIMS relating to Dr Gayed in the period 1999 to 2005.

3.1 2000: Infection Control Committee and the Occupational Health and Safety Committee raise a concern

847. In early 2000, Manning Hospital's 'Infection Control Committee and the Occupational Health and Safety Committee' reported to Dr Wills an incident which occurred on 31 December 1999 where a member of the operating theatre nursing staff was asked to use her hands as retractors during gynaecological abdominal surgery, resulting in a needlestick injury. Dr Wills wrote to Dr Gayed, informed him of the incident and reminded Dr Gayed that this was no longer an acceptable practice.[265]

848. He noted that the Operating Theatre Nurse Unit Manager was aware of the incident and 'will not allow similar circumstances to occur again'.

849. He provided Dr Gayed with an excerpt from the Royal Australian College of Surgeons policy document on infection control in surgery.[266]

[265] Letter from Dr Jim Wills, Mid North Coast Area Health Service, to Dr Emil Gayed, 18 February 2000 (Tab 4.a.4, HNELHD documents).
[266] Letter from Dr Jim Wills, Mid North Coast Area Health Service, to Dr Emil Gayed, 18 February 2000 (Tab 4.a.4, HNELHD documents).

850. I am of the view that this response was appropriate, as there was some oversight of his future conduct via the Nurse Unit Manager and Dr Gayed was provided with information about appropriate practices.

3.2 August 2001: reference by Dr Wills

851. In August 2001, a Professional Standards Committee heard a number of complaints against Dr Gayed. Ten complaints alleged unsatisfactory professional conduct by Dr Gayed and one complaint alleged that he suffered from an impairment (see Chapter 5). I asked Dr Wills when he first learned that Dr Gayed had had a complaint against him arising from Cooma Hospital. He informed me that he, Dr Wills first knew of it when he retired (in 2017/2018).

852. I then asked him about the reference he provided for Dr Gayed dated 25 July 2001:

> Dr Gayed's practice has not suffered any greater infection rates, rates of return to theatre, complication rates in theatre or mortality rates than his peers. These matters are peer reviewed every three months and Dr Gayed's practice has not been a cause for concern at any stage over the last 2 years.
>
> I am very pleased to have an obstetrician/gynaecologist of Dr Gayed's stature and experience on my staff.[267]

853. Dr Wills told me he was asked to provide the reference by Dr Gayed's medical defence organisation. He only knew that Dr Gayed was going before the Medical Board and that there was some sort of 'disciplinary action'.

854. He said he asked the medical defence organisation, the Medical Board and Dr Gayed and no-one told him 'what is was all about'.

855. I am surprised that a Director of Clinical Services would provide a reference for a Visiting Medical Officer without first ascertaining the nature and circumstances of the disciplinary action for which it was sought.

856. It is evident that Dr Wills knew about disciplinary action in 2001 and, as will be set out later in this report, knew that conditions were imposed on Dr Gayed's practice as a consequence of that action.

857. Dr Wills provided references or made comments in almost identical terms for Dr Gayed in 2006, 2007, 2009, 2013 and 2014.

3.3 November 2001: Mid North Coast Area Health Service is told of disciplinary action against Dr Gayed

858. On 16 November 2001, Dr Gayed wrote to Mr Terry Clout, the CEO of the Mid North Coast Area Health Service, to the effect that he had been 'requested by NSW Medical Board to report to you a finding made at a recent board hearing and

[267] Letter from Dr Jim Wills, Mid North Coast Area Health Service, to Ms Helen Turnbull, United Medical Protection, 25 July 2001 (Tab 9, PSC documents).

provide you with a copy of that finding'. He further stated that the 'reported incidents occurred several years ago while visiting Cooma Hospital, when I was based as an Obstetrician and Gynaecologist in Canberra and have never recurred'.[268]

859. Dr Gayed did not include a full copy of the Professional Standards Committee decision—in particular, he omitted that part of the decision which included the conditions imposed on his registration and the recommendations made.

860. On 23 November 2001, the Medical Board notified Mr Clout that Dr Gayed had a condition placed on his registration that he not undertake microsurgery.[269]

861. The Medical Board did not advise the Chief Executive that the Professional Standards Committee had ordered that Dr Gayed be reprimanded and had recommended that the Medical Board undertake a performance assessment in respect of Dr Gayed's practice at Manning Hospital; nor did the Medical Board inform the Chief Executive that Dr Gayed was to be assessed by an ophthalmologist at intervals determined by the ophthalmologist and reports forwarded to the Board.

862. In my *Review of processes undertaken by the Medical Council of New South Wales pursuant to Part 8 of the Health Practitioner Regulation National Law (NSW) with respect to Dr Emil Gayed*, I concluded that the Medical Board should have provided Mr Clout with the Professional Standards Committee decision. The board was entitled to do so by the applicable legislation, and that information was obviously necessary to the hospital and area health service to monitor Dr Gayed's performance.[270]

863. According to the Medical Board's records, on 18 December 2001 the Performance Committee of the Medical Board met to consider the Professional Standards Committee report. It resolved that Dr Gayed be considered for inclusion in the Performance Assessment Program 'should further concerns be received about his professional performance' and that the Australian Capital Territory (**ACT**) Medical Board be notified about his health problems and the recent Professional Standards Committee decision.[271]

864. The area health service was not aware of this resolution.

865. On 26 November 2001, Mr Clout wrote to Dr Gayed regarding the findings of the Professional Standards Committee hearing. He acknowledged that Dr Gayed provided him with a copy of the findings of the document but noted that, without

[268] Letter from Dr Emil Gayed to Mr Terry Clout, Chief Executive Officer, Mid North Coast Area Health Service, 16 November 2001 (Tab 4A, MNCLHD documents).
[269] Letter from Ms M Anne Harvey, Legal Officer, New South Wales Medical Board, to Mr Terry Clout, Chief Executive Officer, Mid North Coast Area Health Service, 23 November 2001 (Tab 4B, MNCLND documents).
[270] *Medical Practice Act 1992* (NSW) s 180(4).
[271] Minutes of meeting (Tab 103); Minutes of meeting of Performance Committee (Tab 46, Medical Council NSW files).

the full report, it 'is difficult to understand the context of these findings'. Mr Clout noted that Dr Gayed had not stated whether the Medical Board had placed any conditions on his registration as a result of either the findings or Dr Gayed's physical impairment and that 'it is necessary for the Mid North Coast Area Health Service to understand the details of these matters in order to ensure that the privileges afforded to you in obstetrics and gynaecology are appropriate'. Mr Clout indicated that he had asked the Area Director Clinical Services to discuss these issues with Dr Gayed in full so that the Mid North Coast Area Health Service 'can ensure that it is complying with any Medical Board requirements'.[272]

866. On 27 December 2001, the Area Director Clinical Services wrote to Dr Gayed, noting that Dr Gayed had provided further documentation that was 'quite clear' and that, as such, it was not necessary to meet to further discuss the matter.[273] It is not known what further documents were provided.

3.4 March 2003: concerns about Dr Gayed's vision

867. On 7 March 2003, the 'NUM [Nursing Unit Manager] of Manning Base Operating Suite' reported to Dr Wills the concerns of nursing staff that Dr Gayed was having trouble seeing while operating, including holding instruments the right way, and that he could not see 'small bleeders'. On that date, Dr Wills reported that concern to Dr Robert Porter, Area Director of Clinical Services, noting that he, Dr Wills, 'understood that Dr Gayed had long standing vision problems' and that his registration was 'endorsed "not to perform microsurgery"'.[274] It is noted that, while Dr Gayed's clinical privileges were not amended until May 2003 to reflect that condition, Dr Wills had knowledge of the underlying condition.

868. Dr Wills said that he had had no reports of adverse incidents as a result of this visual problem and that he would discuss with Dr Gayed whether he required additional assistance. Dr Wills advised that it 'may be prudent to obtain a further ophthalmological opinion as to Dr Gayed's ability to perform surgical procedures'.[275] There is no evidence that this occurred.

869. A week later, Dr Wills told Dr Porter that he had spoken with Dr Gayed about his vision. He noted that Dr Gayed reported that he had an ophthalmologist review every six months and that the ophthalmologist reported to the Medical Board, which reviews 'whether Dr Gayed's ability to operate should be curtailed' and that

[272] Letter from Mr Terry Clout, Area Chief Executive Officer, Mid North Coast Area Health Service, to Dr Emil Gayed, 26 November 2001 (Tab 4C, MNCLHD documents).
[273] Letter from Dr Robert Porter, Area Director Clinical Services, Mid North Coast Area Health Service, to Dr Emil Gayed, 27 December 2001 (Tab 4D, MNCLHD documents).
[274] Memorandum from Dr Jim Wills, Manager Clinical Services, Director, Emergency Department, to Dr Robert Porter, Area Director of Clinical Services, Mid North Coast Area Health Service, 'Dr Gayed's Vision', 7 March 2003 (Tab 5C, MNCLHD documents).
[275] Memorandum from Dr Jim Wills, Manager Clinical Services, Director, Emergency Department, to Dr Robert Porter, Area Director of Clinical Services, Mid North Coast Area Health Service, 'Dr Gayed's Vision', 7 March 2003 (Tab 5C, MNCLHD documents).

up to that time it had not opted to curtail his operating. Dr Gayed had told him that his 'contact lenses that he wears for operating probably need updating and he will attend to this this week'. Dr Wills also noted that Dr Gayed said:

> He does not feel that his ability to perform surgery (other than microsurgery such as tubal reanastomoses) is compromised. He says that he will voluntarily cease operating if he is worried about his ability to see adequately.

870. Dr Wills further noted his view that:

> Dr Gayed's vision is under continuous review by the Medical Board on a 6-monthly basis. There have been no reports of adverse incidents involving Dr Gayed due to his myopia. I don't think further action should be taken at this stage.[276]

871. I am of the view that it was not unreasonable for Dr Wills to have taken that approach; however, it would have been prudent to check this himself with the Medical Board. There is no evidence he did so.

872. Dr Jenkins is of the view that it would have been 'good practice' on his behalf to ensure that it was being done. I agree.

873. Dr Wills submitted to me that he recalls Dr Gayed bringing him an ophthalmologist's report on one occasion stating that his visual acuity was satisfactory to conduct surgery.

3.4.1 Medical Board records

874. In fact, on 3 February 2003 the Board-appointed ophthalmologist, Dr Dunlop, provided a report to the Medical Board in which he stated that Dr Gayed's 'visual situation is essentially stable'. He suggested a review in another six months.

875. On 20 October 2003, Dr Dunlop informed the Medical Board that he had examined Dr Gayed again on 3 October 2003.[277] His vision remained essentially the same. He suggested a further review in 12 months unless his vision deteriorated in the meantime.

876. On 3 November 2003, the Medical Board informed Dr Gayed that he was required to arrange a further appointment with Dr Dunlop on around 3 October 2004 or on an earlier date if his vision noticeably deteriorated before then. A corresponding letter was sent to Dr Dunlop.

877. This did not occur. Dr Gayed was not reviewed by a Medical Board nominated ophthalmologist again until January 2006. That review was prompted following the outcome of a performance assessment, which recommended the removal of the

[276] Memorandum from Dr Jim Wills, Manager Clinical Services, Director, Emergency Department, to Dr Robert Porter, Area Director of Clinical Services, Mid North Coast Area Health Service, 'Dr Gayed's Vision', 14 March 2003 (Tab 5D, MNCLHD documents).
[277] Letter from Dr I Dunlop to Medical Board (Tab 71, Medical Council NSW files).

conditions imposed on his registration by the Professional Standards Committee (discussed further below).

3.5 2004–2005: performance assessment by the Medical Board

878. A performance assessment of Dr Gayed was carried out by the Medical Board in 2004–2005.

879. The records provided by the Medical Board include the assessors' report which, among other matters, recorded that the assessors sought to speak to two of Dr Gayed's colleagues about his practice. One medical practitioner colleague informed the assessors that Dr Gayed was not popular in the operating theatre and cited a recent case where Dr Gayed had undertaken a laparotomy to explore an abdominal mass which turned out to be a lymphoma. He felt that the preoperative work and planning were substandard. The other colleague approached at Dr Gayed's suggestion was unwilling to contribute comments.

880. The assessors observed Dr Gayed during the performance of his morning surgical list. The assessors made some criticisms of his technique and the indication for surgery in respect of the cases observed. For example, he did not appear to have a very methodical approach in performing laparoscopy, and the assessors would have had some concerns if he were performing more complex laparoscopic procedures. In other cases, he failed to consider the use of colposcopy. He handled the needle on several occasions directly with his fingers instead of forceps. He did not fully explore alternatives to surgery in one case. They had no concerns with his consultation skills or in their review of 10 patient records (which they said was the number to review according to the Medical Board's protocol).

881. The assessors found that his professional performance was at the standard reasonably expected of a practitioner of an equivalent level of training or experience. They believed that he would benefit from some constructive feedback and recommended that one of the assessors informally counsel him about aspects of his practice that could be further improved. In the recommendations section of their report, they stated their belief that the existing conditions on his registration, other than the condition required because of his status as a conditional specialist, served no continuing useful purpose.

882. On 1 February 2006, the Medical Board informed Dr Stephen Christley, CEO of Northern Sydney Central Coast Area Health Service, that the performance assessment had been finalised. It did not inform Dr Christley of the outcome or forward the report.

883. It did not inform Hunter New England Area Health Service as to the fact of or outcome of the performance assessment.

3.6 Information from Manning Hospital clinical review

884. As set out in section 1.1, almost 200 women contacted the hospital in mid-2018 to discuss their concerns about their treatment by Dr Gayed at Manning Hospital.

885. Dr Roberts reviewed the clinical records and consulted with many of those women. He prepared a report for each. Dr Jenkins read each of Dr Roberts' reports and provided me with his opinion as to the standard of care provided by Dr Gayed.

886. Between 1999 and 2005, of the patients who were treated by Dr Gayed, nine patients, in my view, based on Dr Jenkins' advice, warrant referral to the HCCC for investigation. I have referred those patients' care to the HCCC.

887. The treatment of one of these patients has been investigated by the HCCC.

888. The local health district has not provided the inquiry with any IIMS reports in relation to the treatment of any of these women other than one. I do not know whether their treatment came to the attention of the local health district at or around the time of the treatment and was not the subject of an IIMS report or any other documented process.

889. I am advised by Dr Jenkins that the treatment of two of the patients should have given rise for concern among hospital staff. I asked the local health district for its response to Dr Jenkins' opinions.

890. The local health district told me that it accepted that it should have been informed of the care and clinical outcomes of the two women at the time of care or as reasonably close to that time as possible. It accepted that the treatment of one of the women should have been the subject of an IIMS notification under the heading 'clinical management'. The procedure performed on the second woman occurred before the implementation of IIMS; however, the local health district advises that should have been presented to a Morbidity and Mortality meeting. The local health district also acknowledged that notification of these incidents may have provided the district with a more timely and comprehensive understanding of Dr Gayed's clinical performance. It certainly should have done so.

891. I accept that there was nothing observable which warranted a written report being made about most of the patients' treatment at the time. I make comments in the Conclusions concerning the information generally available to Manning Hospital in relation to Dr Gayed's patients.

4. 2006–2010

4.1 February 2006: report from Dr Wills

892. On 3 February 2006, Dr Bruce Sanderson, Director of Medical Services, Northern Sydney Central Coast Area Health Service, wrote to Dr Wills seeking an assessment of Dr Gayed's performance at Manning Hospital. Dr Sanderson asked Dr Wills for an

outline of any adverse events, complaints or concerns regarding Dr Gayed's clinical outcomes while providing services at Manning Hospital, for the purpose of a performance review.[278]

893. Dr Wills replied on 10 February 2006.[279] Dr Wills stated that Dr Gayed had been working as a Visiting Medical Officer at the Manning Hospital since 1999 and had not demonstrated untoward infection rates, rates of return to theatre, complication rates or mortality rates. His practice had not been a cause of concern at any stage over the previous six years. No substantiated complaints had been received about his practice either from patients or hospital staff.[280]

4.2 February 2006: stillbirth after Dr Gayed's delayed arrival

894. On 6 February 2006, an IIMS report was created by a nurse in relation to a stillbirth on 1 December 2005. The incident report noted that Dr Gayed had been notified regarding concern about 'maternal tachycardia, and fetal bradycardia'. Dr Gayed arrived at the hospital 30–35 minutes after he had been notified. A caesarean section was performed; however, the child was 'declared deceased' after delivery. The incident report noted as a contributing factor 'Delay in the On-call obstetrician to respond to nursing staff request for attendance'. The incident report also noted that the levels of Resident Medical Officer training and the absence of a system for effective fetal monitoring contributed to the incident.[281]

895. The incident report stated that the actual Severity Assessment Code (**SAC**) was a SAC1 and that a Reportable Incident Brief was required.[282] (Chapter 2 outlines details of the relevant policies.)

896. As required by Policy Directive PD2005_604, 'Incident Management Policy', and Hunter New England local policies, a root cause analysis was completed on 6 February 2006. It relevantly recommended that when a Visiting Medical Officer is on call they are to:

- be available to respond appropriately to attend the hospital; and
- make the hospital their priority in order to ensure a timely response and assessment.[283]

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[278] Letter from Dr Bruce Sanderson, Director of Medical Services, to Dr Jim Wills, Director of Clinical Services, Manning Base Hospital, 3 February 2006 (Tab 4.36, p 1078, NSLHD documents).
[279] Letter from Dr Jim Wills, Manager, Clinical Services and Director, Emergency Department, to Dr Bruce Sanderson, Director of Medical Services, Mona Vale Hospital and Community Health Services, 10 February 2006 (Tab 4.37, p 1079, NSLHD documents).
[280] Letter from Dr Jim Wills, Manager, Clinical Services and Director, Emergency Department, to Dr Bruce Sanderson, Director of Medical Services, Mona Vale Hospital and Community Health Services, 10 February 2006 (Tab 4.37, p 1079, NSLHD documents).
[281] IIMS Incident Detail (96386-20), Incident recorded 5 December 2005 (Tab 3.a.18, HNELHD documents).
[282] IIMS Incident Detail (96386-20), Incident recorded 5 December 2005 (Tab 3.a.18, HNELHD documents).
[283] Hunter New England Area Health Service, Final RCA Report—Clinical SAC 1, 13 February 2005 (Tab 4.a.14, HNELHD documents).

897. The outcome measure was 'No delays in assessment' and the measure date was six months (July 2006).[284] It is not known whether any work was undertaken to determine whether there were no delays in assessment in July 2006 and, if so, the result.

898. It is not known from the documents provided to me whether the various reports required by the policy to be made to the Department of Health were made. I have been told, however, by Hunter New England Local Health District that a Reportable Incident Brief was submitted to the Department of Health.

4.3 March 2006: variation of conditions on registration

899. According to the records from the Medical Board, on 30 March 2006 the Medical Tribunal made orders removing the following conditions placed on Dr Gayed's registration:

(a) that he not undertake microsurgery; and

(b) that he be assessed by an ophthalmologist approved by the Medical Board at intervals determined by the Board.

900. The Medical Tribunal found that Dr Gayed 'does not suffer from an impairment within the meaning of Clause 3 of the Dictionary of the *Medical Practice Act 1992*'.

901. There is no evidence that the Medical Board informed Manning Hospital or other places where Dr Gayed worked of the change to Dr Gayed's registration status as a result of the Medical Tribunal decision.

902. I note that the legislation did not require publication of Medical Tribunal decisions until December 2006.[285]

4.4 March 2007: response to Mona Vale review and suspension of Dr Gayed

903. On 16 March 2007, Dr Christley, CEO of Northern Sydney Central Coast Area Health Service, notified the HCCC of the outcome of the review of a stillbirth at Mona Vale Hospital. He said that an external expert review of that perinatal fetal death in December 2006 had raised concerns regarding the clinical practice of the Visiting Medical Officer, Dr Gayed, the attending midwife and student midwife.[286] Dr Christley stated that:

> The VMO [Visiting Medical Officer] was Dr Emil Gayed. We have notified our concerns to the Medical Board of NSW. Dr Gayed has now resigned from NSCCAHS [Northern Sydney

[284] Hunter New England Area Health Service, Final RCA Report—Clinical SAC 1, 13 February 2005 (Tab 4.a.14, HNELHD documents).
[285] *Health Legislation Amendment (Unregistered Health Practitioners) Act 2006* (NSW) Sch 3.4, [4].
[286] Letter from Dr Stephen Christley, Chief Executive, Northern Sydney and Central Coast Area Health Service, to Mr Kieran Pehm, Commissioner, Health Care Complaints Commission, 16 March 2007 (Tab 4.44, p 1097, NSLHD documents).

> Central Coast Area Health Service]. We have taken steps to notify our concerns to other hospitals where we are aware of Dr Gayed working.

904. At around the same time, Dr Philip Hoyle, Director of Clinical Governance at Northern Sydney Central Coast Area Health Service, spoke with Dr Wills and followed that discussion with an email.[287] In reference to the stillbirth case, the email noted: 'We regard this as sufficient to suspend Dr G as an MCCC level 1. In fact, he resigned first, but the risk triage remains.' The email also stated: 'There are unrelated concerns re Gynaecology, with two additional cases of surgical mishap in the last two weeks. They happened in the private sector but were referred to our hospital for fixing up.' The email further noted that 'Gyne in isolation is probably a MCCC 2 but given the impracticality of supervision we would be suspending him from that too pending a detailed investigation'.[288]

905. This email appears to have attached a report of 26 February 2007 from Professor Michael Bennett, Professor of Obstetrics and Gynaecology from the University of New South Wales, who performed the review of the case involving the stillbirth. Professor Bennett concluded that:

> Dr Gayed's notes are neither accurate nor complete. … This baby was in pretty serious trouble for nearly three hours before he died and there is to my mind no evidence that either the nursing staff or Dr Gayed had any appreciation of the seriousness of the situation.[289]

906. In response to that communication, on 15 March 2007, Dr Wills prepared a memo for Mr Tim Mooney, General Manager, Manning Hospital, and Dr Rosemary Aldrich, Deputy Director, Clinical Governance Unit, Hunter New England Area Health Service, in which he noted that he had 'searched through our records with respect to Dr Gayed and consulted with our Patient Safety Officer and there are no clinical competence issues on record'. The memo noted that in relation to Dr Gayed's performance:

- He has had no complaints of a clinical nature made about him in the time that he has worked here
- He attends (and in fact organises) obstetric M&M (Morbidity and Mortality) meetings enthusiastically
- He fulfils and has fulfilled all his commitment to the hospital both with respect to on-call and participation in the general hospital community

[287] Email from 'Philip' to 'Jim', undated (Tab 3.a.14, HNELHD documents). The HNELHD index refers to this document as 'Correspondence–Mona Vale–Gayed–Death of baby X, report from Mona Vale Hospital 2007' (Tab 3.a.14, HNELHD documents).
[288] Email from 'Philip' to 'Jim', undated (Tab 3.a.14, HNELHD documents).
[289] Letter from Professor Michael J Bennett, Professor of Obstetrics and Gynaecology, School of Women's & Children's Health, The University of New South Wales, to Dr Bruce Sanderson, Director of Medical Services, Mona Vale Hospital, 26 February 2007 (Tab 4.a.16, HNELHD documents).

- He has a condition on his medical registration relating to his eyesight (i.e. that he has an annual check-up with an ophthalmologist) which he has complied with.[290]

907. At this time, the condition concerning ophthalmologist review had been removed and, accordingly, there was no condition that required any check-up. However, as indicated above, there is no indication that the Medical Board told the Hunter New England Area Health Service about the removal by the Medical Tribunal on 30 March 2006 of the conditions imposed by the Professional Standards Committee.

908. Dr Wills appended to the memo a copy of the email from Dr Hoyle and Professor Bennett's report.

909. On 16 March 2007, Dr Wills prepared an unsigned brief to Dr Aldrich which referred to an attached email and the letter referred to above.[291]

910. The brief stated, among other matters, that 'the case against Dr Gayed is not well spelt out from the information available to me'.[292] However, it also noted that the copy of Professor Bennett's report was the trigger for Dr Hoyle's referral to the Medical Board. As set out in chapter 7, that report was comprehensive in its discussion of the failings of Dr Gayed on that occasion.

911. The brief concluded: 'In my view Dr Gayed does not pose a risk to patients at Manning Hospital.' The brief noted that Dr Wills had consulted the Northern Sydney Central Coast Area Health Service through a telephone conversation with Dr Hoyle, Director of Clinical Governance at Northern Sydney Central Coast Area Health Service, 'during which the issues from NSCCAHS' point of view were spelt out'.[293]

912. The brief includes a risk assessment, which gave a risk rating of R (likelihood 'possible' and consequence 'minor') that:

- Dr Gayed may pose an increased risk of harm to patients (given the information supplied by Northern Sydney Central Coast Area Health Service of professional misconduct at Mona Vale Hospital); and

[290] Memo from Dr Jim Wills, Manager Clinical Services & Director, Emergency Department, to Mr Tim Mooney, General Manager and Dr Rosemary Aldrich, Deputy Director, Clinical Governance Unit, 'Dr Emil Gayed', 15 March 2007 (Tab 4.a.10, HNELHD documents).
[291] Brief from Dr Jim Wills, Manager, Clinical Services, Manning Rural Referral Hospital, to the Chief Executive Officer, 'Disciplinary action taken against HNEAHS VMO by NSAHS', 16 March 2007 (Tab 4.a.1, HNELHD documents).
[292] Brief from Dr Jim Wills, Manager, Clinical Services, Manning Rural Referral Hospital, to the Chief Executive Officer, 'Disciplinary action taken against HNEAHS VMO by NSAHS', 16 March 2007 (Tab 4.a.1, HNELHD documents).
[293] Brief from Dr Jim Wills, Manager, Clinical Services, Manning Rural Referral Hospital, to the Chief Executive Officer, 'Disciplinary action taken against HNEAHS VMO by NSAHS', 16 March 2007 (Tab 4.a.1, HNELHD documents).

- public confidence in the obstetric service at MRRH may be undermined should details of professional misconduct allegations become public.[294]

913. The brief recommended: 'No further action be taken at this stage.'[295]

914. On 23 March 2007, Dr Wills had a conversation with Dr Gayed in which he confirmed that he and the Hunter New England Area Health Service Clinical Governance Unit were aware of the circumstances surrounding Dr Gayed's resignation from the Northern Sydney Central Coast Area Health Service. Dr Wills reported that he had reviewed the 'reasons behind the NSCCAHS decision to refer [Gayed] to the NSW Medical Board' and that he saw 'no rationale in it to take any action at Manning Hospital'. He noted that in the eight years that Dr Gayed had worked at Manning Hospital that there had been 'no serious allegations of misconduct and no documented evidence of clinical error'.[296]

915. Dr Wills further noted that:

> The Clinical Governance Unit had asked me to tell you that we will be obliged to conduct another risk assessment (similar to the one I have just conducted by talking to you and reviewing the records) in another three months and that in the meantime any complaint against you will be dealt with according to the 'Guidelines for management of a complaint or concern about a clinician'.[297]

916. He continued:

> I wouldn't get too upset about these suggestions, because this is what we do all the time routinely for every clinician that works for us and is the way we have always dealt with you, since the day you started to work here.[298]

917. I asked Dr Wills about his response to the report from Mona Vale Hospital that Dr Gayed was suspended. He said that he was relying upon the Medical Board to analyse Professor Bennett's report and consider what action should be taken. He said Professor Bennett's opinion was only one opinion and normally there would be several opinions. He also told me he had asked the head of department at John Hunter Memorial Hospital to review Dr Gayed. That person declined to do so on the basis that the Medical Board was about to review Dr Gayed. I note that the Medical Board did carry out a performance assessment on Dr Gayed later in 2007.

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[294] Brief from Dr Jim Wills, Manager, Clinical Services, Manning Rural Referral Hospital, to the Chief Executive Officer, 'Disciplinary action taken against HNEAHS VMO by NSAHS', 16 March 2007 (Tab 4.a.1, HNELHD documents).
[295] Brief from Dr Jim Wills, Manager, Clinical Services, Manning Rural Referral Hospital, to the Chief Executive Officer, 'Disciplinary action taken against HNEAHS VMO by NSAHS', 16 March 2007 (Tab 4.a.1, HNELHD documents).
[296] Memo from Dr Jim Wills, Manager Clinical Services & Director, Emergency Department, to Dr Emil Gayed, 'Summary of our conversation Friday the 23rd March', 26 March 2007 (Tab 4.a.11, HNELHD documents).
[297] Memo from Dr Jim Wills, Manager Clinical Services & Director, Emergency Department, to Dr Emil Gayed, 'Summary of our conversation Friday the 23rd March', 26 March 2007 (Tab 4.a.11, HNELHD documents).
[298] Memo from Dr Jim Wills, Manager Clinical Services & Director, Emergency Department, to Dr Emil Gayed, 'Summary of our conversation Friday the 23rd March', 26 March 2007 (Tab 4.a.11, HNELHD documents).

918. I suggested to Dr Wills that, in his conversation with Dr Gayed as set out above, he tended to minimise the concerns of the Clinical Governance Unit. He told me that Dr Gayed told him he was being victimised and his (Dr Wills') comments were designed to assure Dr Gayed that Dr Wills treated everyone the same.

919. I remain of the view that Dr Wills minimised the seriousness of the concerns of the Clinical Governance Unit ('suggestions') and undermined the force of the unit's response. It was a missed opportunity to make clear to Dr Gayed that his performance would be under review and be scrutinised.

920. Notwithstanding the Clinical Governance Unit's advice that there would be a risk assessment carried out three months later, there is no evidence that this occurred.

921. Similarly, there are no documents evidencing any regular performance reviews of Dr Gayed as required by policy since 2005. Dr Wills told me that there were yearly 'events' at which an individual's aspirations for the following year were discussed. He said there was not a high degree of scrutiny. Dr Walkom, an obstetrician and gynaecologist Visiting Medical Officer at Manning Hospital, expressed a similar view to Dr Wills to me.

4.4.1 Compliance with policy

922. The relevant policy was Policy Directive PD2006_007, 'Complaint or concern about a clinician—Principles for Action' (published 30 January 2006 and updated in September 2018 (PD2018_032));[299] and Guideline GL2006_002, 'Complaint or concern about a clinician—Management Guidelines' (published 30 January 2006 and updated in September 2018 (PD2018_032)). Its provisions are set out in chapter 2.

923. In my view, the notification by Northern Sydney Central Coast Area Health Service about its action in respect of Dr Gayed required Manning Hospital to ascribe a severity rating of 1 under the policy. A 1 rating applied when, among other matters, the events notified involved very serious concerns arising from one or more events involving gaps in clinical performance, a termination of employment in another facility and serious concerns by colleagues about the health and safety of patients. I note that is the rating which was applied by the area health service.

924. The action required under the policy was to:

1. Notify CE/DCG immediately.
2. Determine whether requires notification to registration board, and any other relevant authority (e.g. Coroner, police).

[299] NSW Health, Policy Directive PD2006_007, 'Complaint or Concern about a Clinician—Principles for Action', 30 January 2006 (Tab 28, Policies on the management of incidents, complaints and disciplinary processes 1990–2016).

3. Consider immediate suspension of clinical privileges in cases of suspected professional misconduct

4. Consider whether variations to clinical privileges are required.

925. The guidelines set out a model for an expeditious investigation, including obtaining an independent expert opinion on the issues under investigation to ensure no actual or perceived bias in the investigation; and obtaining information from all appropriate sources, including other clinicians and staff members and the notifier/complainant.

926. As to the application of this policy, Dr Wills notified the Deputy Director Clinical Governance in a timely manner and was aware that Dr Gayed had been referred to the Medical Board. In relation to clinical privileges, Dr Wills noted that Dr Gayed was due for reappointment via the normal re-credentialing process. I note there is no evidence that the notification from Northern Sydney Central Coast Area Health Service was considered in Dr Gayed's reappointment post 2007.

927. Dr Wills also reported in his risk assessment that local concerns about Dr Gayed were monitored through the IIMS process and he participated in Morbidity and Mortality meetings.

928. In my view, Dr Wills' response to the notification did not comply with the policy. There was no investigation as required, let alone by a person independent of the hospital. Instead, Dr Wills undertook a risk assessment. That risk assessment did not consider whether the conduct disclosed at Mona Vale Hospital was related to the work Dr Gayed was doing at Manning Hospital.

929. Dr Aldrich told me that, when an event of the significance of a suspension occurs, it can be followed by a deterioration in the performance of the practitioner suspended. Thus, having in place a monitoring process for Dr Gayed at Manning Hospital would have enabled his performance to be observed.

4.4.2 Dr Jenkins' opinion

> There was every reason for Dr Wills to be deeply concerned about the issues raised at Mona Vale Hospital. Dr Hoyle appears to have gone to some trouble to ensure that Dr Wills was fully apprised of the circumstances. Dr Hoyle had judged that it warranted the classification of Level 1 MCCC. Clearly these were not trivial issues and similar issues had arisen at Cooma Hospital. Something beyond a routine surveillance approach was indicated—for example, a more formal performance process within the hospital—and this should have been unequivocally communicated to Dr Gayed by Dr Wills.

4.4.3 Conclusion

930. I accept and agree with Dr Jenkins' opinion.

4.5 April 2007: reference from Dr Wills

931. On 5 April 2007, Dr Wills wrote a reference for Dr Gayed, probably in the context of a performance assessment carried out by the Medical Board later in 2007. It noted that Dr Gayed had been interested in performance review processes and quality improvement. The reference stated:

> Dr Gayed's relationship with our Emergency Department has been especially good, with sound advice and prompt attendance in person upon our patients when requested being a feature of his practice. He has a sound working relationship with the maternity ward staff.[300]

932. The reference further noted that 'Dr Gayed has not demonstrated untoward infection rates, rates of return to theatre, complication or mortality rates' and that these matters are peer reviewed every three months.[301]

933. I asked Dr Wills for his sources of information for untoward infection rates, rates of return to theatre, complication rates or mortality rates. He told me that he relied on the minutes of the Morbidity and Mortality meetings. On further discussion Dr Wills told me that he did not attend all of those meetings and he acknowledged that, from 2011, the names of the patients' doctors were not included in the minutes. Dr Wills then said that he also spoke to the nursing staff before giving the references and that the Nursing Unit Manager Maternity would bring up concerns with him. That manager had not raised any concerns with him.

934. Dr Wills produced to me a report on unplanned returns to theatre from 2006 that recorded that the rate for Dr Gayed's patients was less that each of his peer surgeons. He told me that no reports were made to him documenting any concerns.

935. This is most surprising given Dr Gayed's history. It was only a matter of weeks after the communication from Mona Vale Hospital (Dr Hoyle) and the Clinical Governance Unit's concerns. Further, Dr Wills knew that in 2006 a root cause analysis had been conducted on a stillbirth. A contributing factor was the delay in Dr Gayed responding to the nursing staff request for attendance.

936. I note that a few years before, in August 2003, Dr Gayed acknowledged to Mona Vale Hospital that, at that hospital, he had a higher complication rate in gynaecology surgery than his colleagues.

937. As set out in chapter 7, on 20 December 2006 Dr John Pardey, when undertaking a review for Mona Vale Hospital, considered de-identified data relating to surgery conducted between 1 September 2004 and 31 August 2006 by four obstetrics and

[300] Reference from Dr Jim Wills, Manager, Clinical Services and Director, Emergency Department, Manning Base Hospital, for Dr Emil Gayed, 5 April 2007 (Tab 2.b.3, HNELHD documents).
[301] Reference from Dr Jim Wills, Manager, Clinical Services and Director, Emergency Department, Manning Base Hospital, for Dr Emil Gayed, 5 April 2007 (Tab 2.b.3, HNELHD documents).

gynaecology specialists at Mona Vale Hospital.[302] Of four doctors, he concluded that Dr 'B', whose identity was not known to him, had a higher rate of general complication and difficult complications without an obviously different practice from the other doctors. He said, '[t]his falls short of obvious malpractice but may be of concern and his practice should be reviewed'. I am satisfied from Dr Gayed's acknowledgement to the hospital, as set out above, that Dr 'B' was Dr Gayed.

938. I accept that Dr Wills did not have access to this information from Mona Vale Hospital.

4.6 October 2007: Medical Board undertakes a performance assessment

939. According to the records of the Medical Board, a performance assessment was conducted in 2007. The assessors who conducted it recommended that a Performance Review Panel be convened to review the professional performance of Dr Gayed. They stated that he would benefit from working in the company of other specialists and registrars in training for a period of time.

940. In particular, they observed that:

- he demonstrated no competence in performing even basic obstetric ultrasounds;
- there seemed to be a pattern of multiple operations on patients;
- he gave two examples of how he protected a colleague which involved giving misleading information to a patient;
- he demonstrated borderline surgical skills for a senior gynaecologist, with lack of systematic assessment, poor tissue handling, inappropriate knot-tying technique, the use of continuous suturing in anterior repair and suboptimal infection control, with contamination of sterile equipment and inadequate handwashing; and
- patients were under-informed with respect to operative complications and management options.

941. They found that he did not fully understand his professional responsibilities.

942. There is no evidence that Manning Hospital was aware of these observations.

4.7 June 2008: Performance Review Panel of Medical Board holds hearing

943. According to the records of the Medical Board, a Performance Review Panel was held. The Panel agreed with the assessors that the matters the subject of the performance assessment in relation to ultrasound, multiple operations and surgical techniques supported the assessors' finding of unsatisfactory professional

[302] Letter from Dr John Pardey to Dr Bruce Sanderson dated 20 December 2006 (Tab 4.40 p 1083).

performance and their recommendation that he was below the standard reasonably expected of a practitioner of his training and experience in their four identified areas of basic clinical skills, clinical judgment, patient management skills and practical/technical skills.

944. It directed that conditions be placed on his registration as set out below.

4.8 July 2008: Medical Board notifies regarding the conditions on Dr Gayed's registration

945. On 1 July 2008, the Medical Board notified Mr Clout, then Chief Executive of the Hunter New England Area Health Service, that practice conditions had been imposed on Dr Gayed's registration.[303]

946. The letter noted that Dr Gayed was registered as a conditional specialist, with the 'inherent condition' that he was to work as a 'Specialist in Obstetrics and Gynaecology' and that he 'may not undertake any medical work outside his speciality'. The letter further noted practice conditions were imposed on his registration with the Medical Board with effect from 25 June 2008, including:

- that he 'provide for approval by the NSW Medical Board the name … of a registered medical practitioner in a senior position who has agreed to act as his professional mentor' for an initial period of 12 months; and
- that he is 'to not perform the following surgery':
  - 'complicated laparoscopy, including hysterectomy (laparoscopically assisted vaginal hysterectomy and total laparoscopic hysterectomy)
  - laparoscopic treatment of moderate or severe endometriosis
  - advanced urogynaecology including mesh procedures and
  - oncology procedures (for cervical or uterine malignancy)'.[304]

947. On 23 July and again on 28 August 2008, the Medical Board wrote to the Chief Executive of the Hunter New England Area Health Service (the occupant of that role had changed in the interim) regarding the conditions on Dr Gayed's registration, noting that assessing the level of complexity in any case was Dr Gayed's responsibility. Each letter stated that:

> Please note that Dr Gayed is aware of the procedures he may/may not perform. It was with Dr Gayed's agreement that this Practice Condition was imposed, with the aim of restricting him from carrying out more complicated surgical procedures. Assessing the

[303] Letter from Ms Diane Mackowski, Coordinator—Performance Program, New South Wales Medical Board, to Mr Terry Clout, Chief Executive, Hunter/New England Area Health Service, 1 July 2008 (Tab 5.2, HNELHD documents).
[304] Letter from Ms Diane Mackowski, Coordinator—Performance Program, New South Wales Medical Board, to Mr Terry Clout, Chief Executive, Hunter/New England Area Health Service, 1 July 2008 (Tab 5.2, HNELHD documents).

> level of complexity in any particular case is a matter for Dr Gayed's professional judgement and solely his responsibility. There is no requirement for his employer to have patients assessed by another specialist to ascertain whether or not Dr Gayed is acting in compliance with the condition.
>
> Notwithstanding the above, the Board would appreciate your advice if there is clear indication that Dr Gayed has acted in contravention of this condition.[305]

948. The Medical Board did not provide or advise Hunter New England Area Health Service of the report or findings (apart from the conditions imposed) of the performance assessment or the Performance Review Panel. The legislation permitted the Medical Board to provide a copy of the decision of the Performance Review Panel to such persons as the Board thought fit (s 86P of the *Medical Practice Act 1992* (NSW)). No similar provision applied with respect to performance assessments.

949. In my report to the Medical Council, I recorded my view that the Medical Council should have a discretion to inform employers, broadly described, of the outcome of a performance assessment in circumstances where, as a result, a performance review panel is to be held, the practitioner is counselled or directed to attend counselling or conditions are imposed. Each of these outcomes is relevant to a current employer, as each will tell them there are continuing concerns about the practitioner and enable them to seek further information and impose their own restrictions.

950. It obviously would have been relevant for Manning Hospital to have information about the reason for the imposition of conditions as set out in the decision of the Performance Review Panel.

951. Without knowing the reasons, it would be difficult to understand the extent of the measures it needed to have in place and to know whether there was 'a clear indication that Dr Gayed had acted in contravention of the condition' imposed by the Medical Board. There is no evidence which I have seen to indicate any steps the Hunter New England Area Health Service took to position its staff to be aware of such a 'clear indication'.

4.9 July 2008: concerns about Dr Gayed's eyesight

952. Among the documents provided to the inquiry were unsigned notes dated July 2008 regarding 'Dr Gayed's List' reporting a number of concerns about Dr Gayed's surgery, including difficulty identifying and tying off 'bleeders', needing to 'be told that the tie was not around the haemostat when he had requested staff to remove the haemostat', 'cutting into haemostats with tissue scissors' and being 'unable to

[305] Letter from Ms Amy Harrison, Monitoring Officer, New South Wales Medical Board, to Mr Terry Clout, Chief Executive, Hunter/New England Area Health Service, 23 July 2008 (Tab 5.1, HNELHD documents); Letter from Ms Amy Harrison, Monitoring Officer, New South Wales Medical Board, to Dr Nigel Lyons, Chief Executive, Hunter/New England Area Health Service, 28 August 2008 (Tab 4.b.18, HNELHD documents).

find the end of a suture to tie a knot'. The author of these notes is not known. Handwriting on the bottom of the typed notes is largely illegible. It seems to indicate that someone spoke to Dr Gayed about these concerns and that Dr Gayed responded by broadly indicating that there was not a problem with his vision.[306]

953. I note that, by this time, the condition on his registration arising from his visual impairment was removed on 30 March 2006 by the Medical Tribunal. I also note that some of those concerns were shared by the assessors in 2007.

4.10 September 2008: variation in Dr Gayed's clinical privileges

954. The Hunter New England Area Health Service was informed of the conditions on Dr Gayed's practice on 1 July 2008 and his clinical privileges were amended in late September 2008. That occurred following a credentialing process.

4.11 April 2009: Dr Gayed not washing his hands

955. On 30 April 2009, Dr Wills wrote a memo to Dr Gayed to notify him that he had been 'sprung not washing his hands between patients (by the nursing staff)'. Dr Wills reminded Dr Gayed of the need for good infection control and was provided with a document '5 moments for hand hygiene'.[307]

956. This was the second time infection control was an issue; however, the previous incident was almost a decade earlier and, on each occasion, Dr Gayed was provided with information to advise him how to improve his practice and why he should do so.

4.12 May 2009: reference from Dr Wills

957. On 18 May 2009, Dr Wills signed another reference for Dr Gayed. Dr Wills stated that Dr Gayed 'stands out as a fine example of the sort of obstetrician I am looking for to employ at my hospital. He has impressed me with his enthusiasm and clinical acumen'. Dr Wills further stated:

> Dr Gayed has not demonstrated untoward infection rates, rates of return to theatre, complication or mortality rates. These matters are peer reviewed every three months and Dr Gayed's practice has not been a cause for concern at any stage since he has worked in Taree. I have not received any substantiated complaints about his practice from either his patients or the hospital staff, in fact I am heartened by the fact that Dr Gayed's [sic] has had no serious complications or infections at all in the time I have known him and his mortality rate is zero.[308]

[306] Notes, Dr Gayed's List, July 2008 (Tab 4.a.13, HNELHD documents).
[307] Memo from Dr Jim Wills, Manager Clinical Services & Director, Emergency Department, to Dr Emil Gayed, 'Hand washing', 30 April 2009 (Tab 4.a.9, HNELHD documents).
[308] Reference from Dr J Wills, Manager Clinical Services and Director, Emergency Department, Manning Rural Referral Hospital, for Dr Emil Gayed, 18 May 2009 (Tab 4.a.22, HNELHD documents).

958. Dr Wills concluded: 'I know that the Medical Board has attached conditions on Dr Gayed's practice. From my extensive first-hand knowledge of this practice in my hospital, I, with the greatest respect, see no reason why these conditions should not be lifted as soon as the Board has had the opportunity to review his practice.'[309]

959. It appears from the date of this reference—18 May 2009—that it was likely to have been prepared at the request of Dr Gayed ahead of 25 August 2009 meeting of the Performance Committee which considered the question of whether the mentoring and surgery conditions on Dr Gayed's registration should be removed. The mentoring condition was ultimately removed by the Medical Board at that meeting.

960. Dr Wills' reference is essentially the same reference as that provided on 5 April 2007, prior to the 2007–2008 performance assessment and Performance Review Panel.[310]

4.13 February 2010: Dr Gayed is charged with indecent assault

961. In February 2010, Dr Gayed was charged with the offence of 'Assault with act of indecency'.[311] This matter related to an allegation made by one of Dr Gayed's staff—an office junior in his private practice.[312]

962. On 15 February 2010, Dr Gayed wrote to Dr Wills to inform him that he had 'received a charge from the Police on Friday 5th February'. Dr Gayed told Dr Wills: 'As per my usual practice, I will continue to use a chaperone whenever I attend to patients at the Taree Hospital.'[313]

963. On the same day, Dr Wills prepared a memo for Mr Tim Mooney, the General Manager of Manning Hospital. Dr Wills noted that he had read the relevant policy directive (PD2006_026, 'Criminal Allegations, Charges and Convictions against Employees'). Dr Wills noted that:

- the charge fell within the definition of a 'serious sex or violence' offence under section 3.1 of the policy directive;
- he had asked Dr Gayed to provide an explanation and notification to the CEO;
- he did not know the age of the alleged victim but presumed that the police would make any necessary notifications;

[309] Reference from Dr J Wills, Manager Clinical Services and Director, Emergency Department, Manning Rural Referral Hospital, for Dr Emil Gayed, 18 May 2009 (Tab 4.a.22, HNELHD documents).
[310] Reference from Dr Jim Wills, Manager, Clinical Services and Director, Emergency Department, Manning Base Hospital, for Dr Emil Gayed, 5 April 2007 (Tab 2.b.3, HNELHD documents).
[311] Court Attendance Notice, Gayed H 40283428, 5 February 2010 (Tab 4.a.21, HNELHD documents).
[312] New South Wales Police, Facts Sheet, 5 February 2010 (Tab 4.a.21, HNELHD documents).
[313] Letter from Dr Emil Gayed to Dr Jim Wills, Director of Clinical Services, Manning Base Hospital, 15 February 2010 (Tab 4.a.23, HNELHD documents).

- it was not possible for the area health service to independently investigate this matter, as it allegedly occurred outside the area health service;
- he suggested that Dr Gayed be accompanied by a staff member at all times during patient assessments within the hospital; and
- Dr Gayed had voluntarily instigated a chaperone system in his own private practice for the same reasons.[314]

964. Dr Wills conducted a risk assessment on 17 February 2010. In the risk assessment, he noted that 'I consider the matter to be low risk, given Dr Gayed's exemplary behaviour record within the hospital system and presence of nursing staff to chaperone him when in contact with patients in this facility'.[315]

965. On 22 February 2010, Mr Mooney wrote to Dr Gayed to advise that he had obtained the approval of the Chief Executive for Dr Gayed to continue practice at Manning Hospital, subject to the condition that he had a member of the nursing or medical staff with him when in contact with patients within the facility. Mr Mooney noted that the condition had been 'recorded on the NSW Health Services Service Check Register in accordance with NSW Health Policy'. Mr Mooney noted that the condition would be 'reviewed upon resolution of the matter before the Court'.[316]

966. I can only presume that the reference to 'exemplary behaviour' is a reference to the absence of a previous complaint.

967. There is no evidence of the Hunter New England Area Health Service monitoring this condition. There is no reference to the area health service advising any of the nursing staff who were effectively chaperoning Dr Gayed of the reason for such action. Dr Jenkins is of the view that there should have been a formal and minuted meeting with Dr Gayed about expectations of his conduct and the measures which needed to be followed. The issue of inappropriate sexual conduct is particularly sensitive given the nature of Dr Gayed's specialty. I agree. No such minute has been provided to the inquiry.

968. It appears that Dr Wills agreed to give a reference for Dr Gayed for the criminal proceedings, although a copy of that, if it was given, was not on file.[317]

969. The charge against Dr Gayed was dismissed by a magistrate on 2 May 2011.

970. The relevant policy directive is PD2006_026, 'Criminal allegations, Charges and Convictions against Employees'. This policy directive required that, if an employee

[314] Memo from Dr Jim Wills, Manager Clinical Service & Director, Emergency Department, to Mr Tim Mooney, General Manager, 'Charge against Dr Emil Gayed', 15 February 2010 (Tab 4.a.27, HNELHD documents).
[315] Hunter New England Area Health Service, Risk Assessment—Initial Assessment, Dr Emil Shawky Gayed, 17 February 2010 (Tab 4.a.28, HNELHD documents).
[316] Letter from Mr TP Mooney, General Manager, Manning Hospital, to Dr Emil Gayed, 22 February 2010 (Tab 4.a.24, HNELHD documents).
[317] Letter from Avant Law Pty Ltd to Dr Jim Wills, Director of Clinical Services & Manager of Emergency Department, 22 June 2010 (Tab 4.a.25, HNELHD documents).

was charged with an offence of this nature, the health service must immediately notify the Chief Executive, conduct an immediate risk assessment and decide whether the employee should be placed under direct supervision.[318] The process followed was consistent with these requirements of the policy directive, although, as stated above, the reason for the condition imposed does not seem to have been conveyed to those providing the chaperoning.

4.14 Information from Manning Hospital clinical review

971. As set out earlier in this chapter, almost 200 women contacted the hospital in mid-2018 to discuss their concerns about their treatment by Dr Gayed at Manning Hospital.

972. Dr Roberts reviewed the clinical records and consulted with many of those women. He prepared a report for each. Dr Jenkins read each of Dr Roberts' reports and provided me with his opinion as to the standard of care provided by Dr Gayed.

973. Between 2006 and 2010, of the patients who were treated by Dr Gayed, eleven patients, in my view, based on Dr Jenkins' advice, warrant referral to the HCCC for investigation. I have referred those patients' care to the HCCC.

974. One patient was the subject of an IIMS report at the time of the treatment.

975. I do not know whether the treatment of the other 10 patients came to the attention of the local health district at or around the time of their treatment and was not the subject of an IIMS report or any other documented process.

976. As I indicated in section 3.6 above, in my view it is likely that, in many of these cases, there was nothing observable which warranted a written report being made about the patient's treatment at the time. I make comments in the Conclusions concerning the information generally available to Manning Hospital in relation to Dr Gayed's patients.

977. I am advised by Dr Jenkins that the nature of the treatment of two patients who were not the subject of the IIMS report should have given rise to concern among hospital staff.

978. Again, I asked the local health district for their response to Dr Jenkins' opinions.

979. The local health district told me that it accepted that it should have been informed of the care and clinical outcomes of the two women at the time of care or as reasonably close to that time as possible. It accepted that the treatment of one of the women should have resulted in an IIMS report under the heading 'Clinical

[318] NSW Health, Policy Directive PD2006_026, 'Criminal Allegations, Charges and Convictions against Employees', 21 April 2006, p 6 (Tab 30, Policies on the management of incidents, complaints and disciplinary processes 1990–2016).

management' and the other should have been presented to a Morbidity and Mortality meeting.

980. The local health district also acknowledged that notification of these incidents may have provided the district with a more timely and comprehensive understanding of Dr Gayed's clinical performance. Again, it should have provided that understanding and by now precipitated increased oversight of Dr Gayed.

5. 2009–2016: monitoring of compliance with conditions of registration

981. In December 2008, NSW Health Policy Directive PD2008_071, 'Identification and Management of Medical Practitioners in Compliance with Registration Conditions', was published.[319] The policy directive requires that health services must check the registration status of all their employed or contracted medical practitioners who have practice conditions placed on their registration by the Medical Board each quarter and report compliance to the Department of Health.[320] In addition, it requires a Register of Doctors with Practice Conditions to be kept and a Management and Clinical Supervision Plan be developed for each practitioner.

982. Documents evidencing compliance with that policy were not provided in the initial material provided to the inquiry. I provided a draft of my report to the Hunter New England Local Health District in October 2018 in order to permit it to make submissions. On receipt of the draft report, which was critical of the absence of evidence of compliance, Hunter New England Local Health District produced further documents. These indicate that Hunter New England Area Health Service monitored Dr Gayed's compliance with the conditions of his registration in accordance with the policy. However, no register or Management and Clinical Supervision Plans for Dr Gayed were provided to the inquiry.

983. The Hunter New England Local Health District has informed the inquiry that:

> A formal Register of Doctors with Practice Conditions is not currently maintained however altered practice conditions are tabled at the monthly Medical and Dental Appointment Advisory Committee (MDAAC) from which historical information can be obtained.
>
> All direct line managers are notified of altered practice conditions and monitoring occurs at facility level. There are no documented formal Management and Clinical Supervision Plans for Dr Gayed, however periodic risk assessments were completed.
>
> HNELHD [Hunter New England Local Health District] recognised some inadequacies with management of clinicians with practice conditions prior to the submission of evidence to the s122 Inquiry. HNELHD have subsequently commenced an audit and review of all

[319] NSW Health, Policy Directive PD2008_071, 'Identification and Management of Medical Practitioners in Compliance with Registration Conditions', 24 December 2008, p 3 (Tab 39, Policies on the management of incidents, complaints and disciplinary processes 1990–2016).
[320] NSW Health, Policy Directive PD2008_071, 'Identification and Management of Medical Practitioners in Compliance with Registration Conditions', 24 December 2008, p 7 (Tab 39, Policies on the management of incidents, complaints and disciplinary processes 1990–2016).

> clinicians with practice conditions. HNELHD have provided profession specific email addresses for automatic notification from the NSW Health Professional Councils Authority and are developing District wide processes to assess, monitor and review clinicians with practice conditions. The progress of this work is being reported monthly to the HNE Management of a Complaint or Concern about a [Clinician] (MCCC) Committee.[321]

984. I assume that the reference to 'periodic risk assessments' were those that arose in response to particular incidents, the criminal charge and the response to the notification by Mona Vale Hospital (Dr Hoyle). There is no evidence of other risk assessments.

6. 2011–2014

6.1 August 2011: extensive perineal tearing

985. An IIMS report was completed concerning an incident on 18 August 2011, the outcome of which was described as extensive perineal tearing. It was a 'trigger' incident and a SAC3 was the assessment. It was recorded that it was dealt with by undertaking an aggregate review.

986. I am informed that this refers to a process whereby the Nursing Unit Manager regularly reviewed all the 'trigger' IIMS reports collectively. I have been informed that there was no documentation created following this process 'at this time'.

987. If, as stated on the report, a Reportable Incident Brief was not required because an aggregate review was undertaken, it is a reasonable expectation that the process and results of such a review be documented. Otherwise, any learnings from such a review may be lost and there may be doubt whether it was competed.

988. As I observe in my Conclusions, an effective system whereby IIIMS reports are monitored at a local health district level is needed. In such a system, it is expected that the results of any 'aggregate review' would be available for scrutiny and, if one was not done, the system should allow that to be identified and remedied.

989. In these circumstances, I cannot be satisfied that the process complied with the relevant policy, as there is no evidence that an aggregate review was undertaken.

6.2 September 2011: postpartum haemorrhage

990. An IIMS report was completed by a nurse/midwife concerning an incident on 11 September 2011 in which a woman had a postpartum haemorrhage which it was noted may have had 'some preventable factors'. A SAC3 was assigned. The results of the incident review were to refer 'some of these IIMS to Medical Director regarding this obstetrician'. It was noted that there would be a Morbidity and

[321] Email from Mr Dean Bell to Ms Gail Furness, 10 August 2018, forwarding email from Ms Melissa O'Brien to Mr Dean Bell, 10 August 2018.

Mortality review. No evidence has been provided that either of these events occurred.

6.3 October 2011: unplanned return to operating suite

991. An IIMS report was completed by a nurse/midwife concerning an incident on 27 October 2011. The incident was described as the patient having been taken to theatre numerous times for necrotising fasciitis post emergency caesarean, resulting in an increased length of stay. It was viewed as an uncommon complication.

992. The notifier described the consequence as moderate and the likelihood of harm as 'possible' and hence classified the incident as a SAC2. The Nursing Unit Manager who reviewed the IIMS report assigned a SAC3 with the reasoning that the consequence was 'minor'.

993. Dr Jenkins is of the view that the incident is a potentially life-threatening complication and permanent disfigurement is likely as a result of multiple surgeries. He would therefore describe the consequences as 'major', thereby warranting a SAC2. I accept his opinion.

994. According to policy, a SAC2 requires the Deputy of Clinical Governance to be notified and give consideration to whether clinical privileges should be varied and an investigation undertaken.

995. What is recorded is that a Reportable Incident Brief was considered to be not required, as an 'aggregated review was undertaken'.

996. I repeat my observations above at section 6.1. In these circumstances, I cannot be satisfied that the process complied with the relevant policy, as there is no evidence that an aggregate review was undertaken.

6.4 December 2011: communication

997. An IIMS report was completed concerning an incident on 22 December 2011 which concerned communication between the obstetrician and a patient. It is noted that the result was said to be that an aggregate review was undertaken.

998. I repeat my observations above at section 6.1. In these circumstances, I cannot be satisfied that the process complied with the relevant policy, as there is no evidence that an aggregate review was undertaken.

6.5 March 2012: provision of antibiotics

999. In March 2012, a 'Nurse/midwife' created an IIMS Incident Detail in relation to an incident on 15 March 2012 where Dr Gayed did not provide intravenous antibiotics to a woman who was 'GBS positive' in line with the relevant NSW Health policy

directive (NSW PD2005_240).[322] The incident type is noted as being clinical management and the treatment provided is described as 'wrong'. The senior staff member who reviewed the incident was the Nursing Unit Manager, who described the incident as an 'Actual incident with no adverse outcome'. The final Severity Assessment Code given to the incident was a SAC4. A Reportable Incident Brief was recorded as not being required, as the case was being considered by the and Morbidity and Mortality meeting.

1000. On 4 April 2012, Dr Gayed wrote to Dr Wills to respond to the incident report, stating that he had followed appropriate policy in this case.[323]

1001. There is no further reference to this incident.

6.5.1 Dr Jenkins' opinion

> The patient presented at term with spontaneous rupture of membranes and not in labour. Based on previous screening she was known to be GBS positive. The appropriate management would have been to commence intravenous antibiotics and commence induction of labour at the earliest opportunity. This would be consistent with the RANZCOG [Royal Australian and New Zealand College of Obstetricians and Gynaecologists] Guideline 'Maternal Group B Streptococcus in pregnancy: screening and management'[324]
>
> Dr Gayed in his response indicates that during the vaginal examination he performed, amniotic fluid was seen, confirming the diagnosis of ruptured membranes. Whether it was a 'hindwater leak' or not is entirely irrelevant. He also implies in his response that he was aware of her GBS status. It is concerning that Dr Gayed defends the decision he made when clearly it was the wrong decision, the fact that there was no harm caused is irrelevant. The midwife was quite correct in indicating that Dr Gayed did not follow the policy. GBS sepsis in neonates can cause serious illness and even neonatal death. It is incumbent on all health care professionals involved in intrapartum care to be aware of and comply with policies to minimise the risk. Dr Gayed's lack of knowledge is demonstrated by both his actions and his response to the IIMS and this should have been followed up by the hospital. It is not clear what further action the hospital took.
>
> In terms of severity grading of the incident, it is a potentially common event and even though no actual harm occurred there was potential for serious harm to have occurred. SAC3 would have been appropriate.
>
> It is not usual for such an event to be discussed at a M&M [Morbidity and Mortality] meeting as there was no morbidity. It would be expected that the head of the obstetrics and gynaecology department would be asked to review the case or if the review was conducted by the Director of Medical Services then advice should have been sought from within the obstetrics and gynaecology department.

[322] IIMS Incident Detail (1221900-20), Incident recorded 21 March 2012 (Tab 3.a.1, HNELHD documents).
[323] Letter from Dr Emil Gayed to Dr Jim Wills, Director of Medical Services, Manning Base Hospital, 4 April 2012 (Tab 3.a.15, HNELHD documents).
[324] RANZCOG C-Obs 19 p 7, point 5.3.

6.5.2 Conclusion

1002. I note that Dr Roberts became the inaugural Director of the Department of Obstetrics and Gynaecology in April 2015. From my interviews of staff and review of the documentation, it is apparent to me that the absence of a director prior to that time explains why Dr Wills reviewed a number of incidents which came to attention about Dr Gayed, without himself being an obstetrician and gynaecologist. Dr Wills told me that his review of an incident would have consisted of speaking to the Nursing Unit Manager of the theatre and/or one of the other specialists. I make observations about this arrangement in the Conclusions to this chapter.

1003. I note that the incident was dealt with in accordance with relevant state and local policies, whether it was classified as either a SAC3 or a SAC4—that is, that the complaint was resolved at the local level by way of a Morbidity and Mortality Meeting.

6.6 June 2012: obstetric management

1004. On 7 June 2012, a nurse/midwife completed an IIMS report concerning the management of a patient. An initial SAC3 was reduced to a SAC4 and it was noted that an 'aggregate review was undertaken'.

1005. I repeat my observations above at section 6.1. In these circumstances, I cannot be satisfied that the process complied with the relevant policy, as there is no evidence that an aggregate review was undertaken.

6.7 July 2102: unplanned readmission

1006. An IIMS report was completed on 12 July 2012 by the Nursing Unit Manager concerning a patient's readmissions. It was initially classified as a SAC2 and actually as a SAC3.

1007. Dr Jenkins is of the opinion that, as the patient had a permanent colostomy and therefore permanent disfigurement, a SAC2 classification was warranted. I accept his opinion.

1008. Reflecting the seriousness of the outcome, the incident status was noted to be 'investigate'. I have seen no documents evidencing any investigation.

6.8 October 2012: unplanned return to operating theatre

1009. On 24 October 2012, an IIMS report was created by a nurse/midwife following an unplanned return to the operating theatre after a lower section caesarean section and the need for a blood transfusion and admission to a critical care area. The Nursing Unit Manager reviewed the incident, a SAC3 was assigned and it was noted that an 'aggregate review undertaken'.

1010. I repeat my observations above at section 6.1. In these circumstances, I cannot be satisfied that the process complied with the relevant policy, as there is no evidence that an aggregate review was undertaken.

6.9 2012–2013: prolonged surgery and bleeding

1011. On 12 July 2012, an IIMS report was created in relation to the clinical management of a patient relating to procedural complications following a total abdominal hysterectomy and subsequent readmission and procedures. The incident status was 'investigate'. I became aware of this report when I received Dr Roberts' reports in October 2018.

1012. On 27 January 2013, another IIMS report was created in relation to the clinical management of the patient.[325] The notifier is identified as a 'Nurse/midwife'. The incident date was given as 23 January 2013, and the incident was described as being an 'IIMS trigger report' due to a transfer to a higher facility in the context of a TPL (threatened preterm labour). The incident report noted as a contributing factor that two vaginal examinations were performed instead of a fibronectin test, which would have prevented the transfer. The incident was reviewed by the Nursing Unit Manager, who noted it to be an actual incident with no adverse outcome. The potential Severity Assessment Code was noted to be a SAC4. A Reportable Incident Brief was noted as not being required, as an 'Aggregate review' was being undertaken.

1013. I repeat my observations above at section 6.1. In these circumstances, I cannot be satisfied that the process complied with the relevant policy, as there is no evidence that an aggregate review was undertaken.

1014. On 15 March 2013, a further IIMS report was created in relation to the clinical management of the patient.[326] The incident report did not indicate who notified the incident. The incident occurred on 13 March 2013, when the 'Patient present for D&C, Diathermy of cervix, with active bleeding per vagina'. The incident description noted that Dr Gayed stated that he could not see the cervix and that he was 'unable to locate bleeding vessel or needle tip despite nursing staff clearly identifying both using retraction and suction'. The incident description noted that 'Surgery was prolonged and the bleeding exacerbated due to the surgeon's inability to locate cause of bleeding'. The incident report described the clinical management as amounting to inadequate treatment and gave an initial Severity Assessment Code as a SAC2.

1015. The incident report was reviewed by a senior staff member, Dr Wills, who noted that:

[325] IIMS Incident Detail (1396388-20), Incident recorded 27 January 2013 (Tab 3.a.2, HNELHD documents).
[326] IIMS Incident Detail (1423985-20), Incident recorded 15 March 2013 (Tab 3.a.7, HNELHD documents).

> This IIMs is expressed as a failing of the surgeon's visual acuity. It is actually a function of the complicated pathology of the woman, which was satisfactorily dealt with by the surgeon, despite the nature of the pathology.

1016. Dr Wills stated that the incident 'was not worth even a 4 SAC rating, but regrettably, there is no option in this system to rate this as a 5, mistaken notification, so I have had to rate it as a 4'.[327]

1017. On 18 June 2013, Dr Gayed wrote to Dr Wills regarding his treatment of the patient. The copy of the letter provided to the inquiry is incomplete; however, it generally suggested that his treatment was effective.[328]

1018. On 4 December 2015, the Hunter New England Local Health District made a notification to the Treasury Managed Fund of an incident that may lead to a health care liability claim in relation to Dr Gayed's treatment of the patient.[329]

1019. Ultimately, Dr Gayed's treatment was considered during s 150 proceedings by the Medical Council in April 2016 (see section 10). The written reasons for decision dated 11 May 2016 recorded Dr Gayed as agreeing that he could have treated the problem conservatively and stating that, 'looking at the ultrasound report, he would not recommend a curettage'. The Medical Council agreed.[330]

6.9.1 Dr Jenkins' opinion

> The patient underwent a caesarean (her 5th caesarean) on 18 February 2013 by Dr Walkom (her private obstetrician) at almost 34 weeks' gestation due to preterm labour. Dr Walkom was then away on leave for her further follow-up.
>
> The patient presented to Manning Hospital Emergency Department on 8 March 2013 (18 days postpartum) with heavy vaginal bleeding. She was not haemodynamically compromised. Apparently, an ultrasound demonstrated evidence of retained products of conception (RPOC), but as far as I can ascertain the ultrasound report is not included in the information provided. On the basis of her presentation and the ultrasound Dr Gayed (consultant covering Manning Hospital for that day) arranged for a D&C to be performed. During the D&C significant bleeding was noted from the cervix requiring diathermy for haemostasis. Histopathology demonstrated retained products of conception.
>
> RPOC is a very uncommon cause of excessive postpartum bleeding following caesarean birth. The most common cause would be endometritis and this would usually be managed conservatively in the first instance with intravenous antibiotics with recourse to D&C only if antibiotic treatment was not successful. The amount of tissue reported on the histopathology report (32x22x6mm which included blood clot) is in fact only a small amount and it may be that her bleeding would have subsided with a more conservative approach to management. Also performing a postpartum D&C on a woman with 5

[327] IIMS Incident Detail (1423985-20), Incident recorded 15 March 2013 (Tab 3.a.7, HNELHD documents).
[328] Letter from Dr Emil Gayed to Dr Jim Wills, Director of Medial Services, Manning Base Hospital, 18 June 2013 (Tab 3.c.15, HNELHD documents).
[329] NSW Health, TMF Incident Report, Dr Emil Gayed, 4 December 2015 (Tab 3.c.20, HNELHD documents).
[330] Medical Council Written Reasons for Decision dated 11 May 2016, p 4.

previous caesarean sections should be something undertaken with great caution. The decision to perform the D&C I think demonstrates questionable judgement on Dr Gayed's behalf, however given the findings of RPOC on the histopathology it could be viewed as justifiable.

She re-presented to Manning Hospital Emergency Department on 13 March 2013 with further vaginal bleeding. She then underwent another procedure by Dr Gayed. He performed a D&C, Loop diathermy of cervix and a cone biopsy of cervix. There is some contention as to the findings on the final histopathology report. If there was a vascular malformation then this would explain the issues encountered and justify the excessive bleeding.

An IIMS was submitted in relation to this second operation 13 March 2013 (unclear who submitted it) raising concerns about the competency with which Dr Gayed performed this procedure. The issues related to his ability to clearly visualise the cervix and the control the bleeding. As such the procedure was associated with increased blood loss and took an excessive amount of time.

It is entirely unclear what pathology Dr Gayed thought he was treating at this second procedure. There does not appear to be any indication for a second D&C and yet this was performed. If the diagnosis was cervicitis, then vaginal/cervical swabs and antibiotics would have been appropriate. Precancerous lesions of the cervix are treated with loop diathermy or cone biopsy (which is what was performed) but precancerous lesions do not cause bleeding and he had not undertaken any screening for such abnormalities (Pap smear or colposcopy). Cancer of the cervix will cause bleeding and there is some suggestion from the patient that Dr Gayed mentioned this as a possible diagnosis, in which case loop diathermy and cone biopsy would have been completely inappropriate management options. The review of this incident (IIMS 13 March 2013) by the Hospital was superficial and inadequate. It is extremely unusual for a patient to undergo 2 procedures for vaginal bleeding within 4 weeks of what should have been a routine caesarean and should have prompted some evaluation of the indications for these procedures and the overall management. I suspect that the histopathology finding suggesting a vascular malformation (extraordinarily unusual) obscured further evaluation of some of the pertinent issues. Dr Wills' comments in downgrading this case to SAC5 would be consistent with this view. A SAC3 or 4 would be appropriate.

6.9.2 Conclusion

1020. I accept Dr Jenkins' conclusion as to the review by the hospital. It is supported by Dr Gayed's admission before the s 150 proceedings that he could have treated the problem conservatively and, further, that he would not recommend a curettage.

1021. I asked Dr Wills how he, as an emergency career medical officer, had the expertise to opine on Dr Gayed's surgery. He said that he would have spoken to the Nursing Unit Manager of the theatre or one of the other specialists. If he did so, that is not apparent from the document. Dr Wills accepted that his opinion as expressed in the form was unduly favourable to Dr Gayed.

1022. The response was dealt with in accordance with relevant state and local policies, whether it was classified as either a SAC3 or a SAC4—that is, that the complaint was resolved at the local level. However, it did not conform to the substance of the

policy—that is, the local resolution was inadequate. Again, it raises an issue as to the appropriateness of the reviewer (Dr Wills) not being in the same field of medical practice as the doctor whose performance is being reviewed.

6.10 February 2013: a stillborn baby

1023. On 9 February 2013, Dr Gayed attended a patient who gave birth at 23 weeks to a baby who died immediately after delivery.[331]

1024. Two IIMS reports were created in relation to the patient's care. The first on 10 February 2013, by a midwife, is described as having been triggered due to the baby being stillborn on 9 February 2013. Both the initial and the actual Severity Assessment Codes are noted as being SAC3. The senior staff member who reviewed the incident noted that there had been a 'Still birth at 23.5 weeks following presentation in established labour'. A Reportable Incident Brief is noted as not being required.[332]

1025. The second IIMS report was created on the same day, also by a midwife, and is described as having been triggered by a complaint that was made in relation to the patient's care during her labour. The incident report noted that both the patient and her family and the obstetrician shouted at each other during the labour. It noted that the 'Patients family have now expressed anger and concern over OBs practice and wish to make formal complaint to medical board and HCCC'. This incident report noted the initial Severity Assessment Code as being SAC3 and the final Severity Assessment Code as being SAC4. The senior staff member who reviewed the incident, the Nursing Unit Manager, noted that the family met with the midwife and the 'Medical Administrator'. A Reportable Incident Brief is noted as not being required and the case was being considered by the Morbidity and Mortality meeting.[333]

1026. In a meeting with hospital staff including the Manager Clinical Services & Director, the patient and her family made a number of complaints, including that there was no female Aboriginal obstetrician available for the birth, that Dr Gayed was culturally insensitive and had raised his voice, and that Dr Gayed had twisted the baby's body, breaking his head and neck.[334] At the meeting with the family, Dr Wills explained to the family that X-rays did not reveal any fractures, either of the baby's neck or lower limbs, and that in his view Dr Gayed's raising of his voice was in

[331] IIMS Incident Detail (1404375-20), Incident recorded 10 February 2013 (Tab 3.a.4, HNELHD documents); IIMS Incident Detail (1404390-20), Incident recorded 10 February 2013 (Tab 3.a.5, HNELHD documents).
[332] IIMS Incident Detail (1404375-20), Incident recorded 10 February 2013 (Tab 3.a.4, HNELHD documents).
[333] IIMS Incident Detail (1404390-20), Incident recorded 10 February 2013 (Tab 3.a.5, HNELHD documents).
[334] Memo from Dr Jim Wills, Manager Clinical Services & Director, Emergency Department, to 'Me', 'L0107053 and baby of L2271915', 13 February 2013 (Tab 3.a.6, HNELHD documents).

response to his inability to make himself understood or to attract the patient's attention.[335]

6.10.1 Dr Jenkins' opinion

> Dr Gayed perhaps demonstrated a lack of culturally sensitive behaviour but this was clearly a very difficult situation for all concerned and I do not think it demonstrates any performance concerns.

6.10.2 Conclusion

1027. I note that the incident was dealt with in accordance with relevant state and local policies, whether it was classified as either a SAC3 or a SAC4—that is, the complaint was resolved at the local level.

6.11 July 2013: wound infection

1028. An IIMS report was completed by a nurse/midwife concerning an incident on 25 July 2013 when a patient was readmitted after a total abdominal hysterectomy with a postoperative wound infection and wound dehiscence. The initial SAC2 classification by the reporting nurse/midwife was reduced to an actual SAC3. It was noted that satisfactory discharge information was not provided.

6.12 November 2013: endometrial ablation

1029. An IIMS report was competed by Dr Roberts in February 2018 concerning an incident in November 2013 in which he recorded that a Visiting Medical Officer performed an endometrial ablation in a setting of endometrial hyperplasia on a patient.

1030. There is no evidence that any issue in relation to this patient's treatment had been previously brought to the attention of the Hunter New England Local Health District.

1031. The patient presented in February 2018 and the treatment given in November 2013 was investigated. I understand that this patient was one of the catalysts for the Lookback, which was established in June 2018.

6.13 2013: Medical Council performance reassessment

1032. The Medical Council records indicate that on 10 October 2013 an assessment of Dr Gayed's professional performance was carried out by assessors nominated by the Medical Council at Manning Hospital and in Dr Gayed's rooms in Taree.

[335] Memo from Dr Jim Wills, Manager Clinical Services & Director, Emergency Department, to 'Me', L0107053 and baby of L2271915', 13 February 2013 (Tab 3.a.6, HNELHD documents).

1033. The Medical Board provided Dr Gayed with an unsigned copy of the assessors' report and provided an opportunity for him to comment on it.[336] The assessors recommended that a Performance Review Panel be held.

1034. Dr Gayed provided a lengthy submission on the report and submitted through his medical defence solicitor that, instead of proceeding to a Performance Review Panel, he should be mentored on an ongoing basis.

1035. On 25 February 2014, the assessors signed their report.[337]

1036. The assessors considered that Dr Gayed's practice was unsatisfactory in the areas of surgical technique, communication with patients, patient examination, ultrasound examination, criticism of colleagues and clinical judgment. The performance reassessment concluded that 'Dr Gayed's surgical and clinical skills remain unsatisfactory' and that 'Dr Gayed's practice of ultrasound is inappropriate and unsatisfactory'.[338]

1037. They recommended that a Performance Review Panel be convened to review the professional performance of Dr Gayed and that he undergo ophthalmological assessment on a regular basis.

1038. The assessors also suggested that consideration be given to Dr Gayed:

- transferring all of his practice to Taree;
- investigating the possibility of sharing his operating list with another specialist obstetrician/gynaecologist or a more senior registrar; and
- restricting his practice of ultrasound to basic studies such as diagnosis of pregnancy, determination of fetal viability and determination of fetal position.

1039. According to documents provided to me by the Hunter New England Local Health District, it is likely that Dr Gayed provided the draft copy of the report to the hospital, probably Dr Wills. It seems likely that that occurred around the time Dr Gayed received it.[339] The Hunter New England Local Health District told me that it was provided to Dr Wills by Dr Gayed 'some extended time after the performance re-assessment occurred'. The local health district did not receive any 'official report'. The district told me it believes that it was obtained when 'other issues were emerging about Dr Gayed'. The district also told me that Dr Wills requested an 'official document' from the Medical Council; however, the Medical Council refused to provide it.

[336] Letter to Dr Gayed dated 18 February 203 (Tab 292, Medical Council NSW files).
[337] Signed Performance Assessment report dated 25 February 2013 (Tab 294, Medical Council NSW files).
[338] Medical Council of New South Wales, Performance Re-Assessment, Dr Emil Shawky Gayed, 10 October 2013, p 15 (Tab 4.a.17, HNELHD documents).
[339] Medical Council of New South Wales, Performance Re-Assessment, Dr Emil Shawky Gayed, 10 October 2013 (Tab 4.a.17, HNELHD documents).

1040. During the performance reassessment, Dr Wills was interviewed and is reported to have confirmed that Dr Gayed was operating within the restrictions placed on him by the Medical Council and that this was updated by a report to the 'Hospital Board every three months'.[340] I note that there were no longer Hospital Boards in 2013.

1041. Dr Wills told the assessors that Dr Gayed was good at his job and 'did an exceptional clinical job, stating that he had never had any concerns about his performance'. He said no other incidents had been reported and that he had no concerns about Dr Gayed's workload.[341]

1042. The Hunter New England Local Health District provided the inquiry with a copy of Dr Gayed's submissions in relation to the draft performance reassessment report, which are dated 17 March 2014. It is likely that Dr Gayed provided this document to the local health district.[342]

1043. In his submission, Dr Gayed noted that, following the placement of conditions on his registration by the Performance Review Panel in 2008, his professional performance should be reassessed no sooner than six months after the decision of the Performance Review Panel and that this reassessment was not conducted until October 2013.[343] Dr Gayed responded to the criticisms contained in the performance reassessment report. He stated:

> On both this occasion and in 2007 the Assessors arrived with the preconceived idea that my practice was unsatisfactory. They appeared to be looking for evidence to support their ideas and, in the process, positive findings in my practice are mentioned but not given any consideration.
>
> The findings are not accurately representative of my usual practice and are contradictory with what the hospital management, other surgeons and my colleagues observe in my practice on a daily basis.[344]

6.13.1 Dr Jenkins' opinion

> The report, of which Hunter New England Local Health District had a copy, identifies serious concerns about a number of aspects of Dr Gayed's performance which would be relevant to his public hospital duties:
>
> - Basic clinical skills (interview/examination)
> - Clinical judgement

[340] Medical Council of New South Wales, Performance Re-Assessment, Dr Emil Shawky Gayed, 10 October 2013, p 10 (Tab 4.a.17, HNELHD documents).
[341] Medical Council of New South Wales, Performance Re-Assessment, Dr Emil Shawky Gayed, 10 October 2013, p 10 (Tab 4.a.17, HNELHD documents).
[342] Letter from Dr Emil Gayed to Ms Diane Winton, Performance Program Manager, Medical Council of NSW, 17 March 2014, p 19 (Tab 4.a.18, HNELHD documents).
[343] Letter from Dr Emil Gayed to Ms Diane Winton, Performance Program Manager, Medical Council of NSW, 17 March 2014, p 2 (Tab 4.a.18, HNELHD documents).
[344] Letter from Dr Emil Gayed to Ms Diane Winton, Performance Program Manager, Medical Council of NSW, 17 March 2014, p 19 (Tab 4.a.18, HNELHD documents).

- Practical/Technical skills
- Interaction/Communication with patients

However, at this point, all of the major incidents had occurred outside of Manning Hospital. There was nothing of significance in terms of clinical incidents that had occurred at Manning Hospital. There was of course the 2007 Medical Board Performance Review Panel which placed some significant restrictions on his practice, but it does not appear that Manning Hospital received a copy of the report (although it received notification of the conditions). Further, Manning Hospital also had Dr Hewson's report from 2008 which was very supportive of Dr Gayed.

The Performance Assessment would therefore seem to be not consistent with their experience with Dr Gayed, nevertheless the findings should have been extremely concerning and I think difficult to justify not taking any action. It should also be noted that Dr Gayed was doing 50% of the hospital on-call at this time, so Manning Hospital were very dependent on him. If they restricted his practice which meant he couldn't function on the on-call roster would involve finding others, including locums who may not be available or reliable and expensive. However, if this was a determining consideration, it should not have been.

6.13.2 Conclusion

1044. I accept that Hunter New England Local Health District did not have a signed and dated copy of the performance assessment report.

1045. As I have said earlier in this chapter, in my report to the Medical Council, I recorded my view that the Medical Council should have a discretion to inform employers, broadly described, of the outcome of a performance assessment in circumstances where, as a result, a performance review panel is to be held, the practitioner is counselled or directed to attend counselling or conditions are imposed.

1046. I note that in this instance, the areas of Dr Gayed's professional performance which were unsatisfactory are similar to those evidenced at Cooma and Mona Vale hospitals.

6.14 2014: reference from Dr Wills

1047. Dr Wills provided a reference for Dr Gayed to support Dr Gayed's submissions before a Performance Review Panel of the Medical Council. It was substantially in the same terms as his previous references.[345] He also gave evidence which was similar to the information he provided in the interview he gave to the performance reassessment process in October 2013.

1048. The report records him as giving evidence that there 'were no discussions at Morbidity and Mortality meetings about Dr Gayed's patients'.[346]

[345] Tab 309, Medical Council files.
[346] Tab 311, Medical Council files.

1049. I asked Dr Wills about these words attributed to him and he said that it should have read that there were no items *of concern* brought up at Morbidity and Mortality meetings (my emphasis).

1050. It would have been incorrect to say that there were no discussions at all because the documents reveal there were discussions.

1051. First, the IIMS form in relation to the patient who was GBS positive in 2012 records that the incident was being considered by the Morbidity and Mortality meeting. Secondly, the form concerning the treatment of the patient was considered at an aggregate review.

1052. Further, Dr Wills provided to the inquiry the minutes of Morbidity and Mortality meetings from June 2010. Only two of the minutes provided contained the names of doctors. In June 2010, two out of the five patients discussed were Dr Gayed's and, in September 2010, five out of the six patients discussed were Dr Gayed's patients.

6.15 September 2014: Performance Review Panel report

1053. According to records held by the Medical Council, a Performance Review Panel was convened in October 2014. They heard evidence from other obstetricians and gynaecologists who had assessed Dr Gayed and from Dr Wills.

1054. In its report dated 15 December 2014, the Performance Review Panel said that it placed significant weight upon the positive assessments conducted of each of those.[347] It noted that Dr Wills had worked with Dr Gayed for 10 years and the other two doctors had spent more time with Dr Gayed than the performance assessors. The Performance Review Panel noted the positive references from other medical practitioners and from patients.

1055. They found that Dr Gayed's professional performance 'is at present satisfactory and that in accordance with section 153 and 153A of the *Health Practitioner Regulation National Law* (NSW) the knowledge, skill or judgment possessed and applied by Dr Gayed in the practice of medicine is of the standard reasonably expected of a practitioner of an equivalent level of training or experience'.

1056. However, in view of the report of the performance assessors (in 2103), the Performance Review Panel considered that it was prudent to continue the conditions upon Dr Gayed's practice and noted that these conditions could be varied or removed altogether at a later date. A minor variation to the conditions was recommended to the Medical Council.

[347] Performance Review Panel report dated 15 December 2014, p 3742 (Tab 311, Medical Council NSW files).

1057. At that time, the Medical Council was not under an obligation to inform Dr Gayed's employer or hospitals at which he held appointments of the variation of the conditions made as a consequence of the Performance Review Panel proceedings.

1058. Nevertheless, as I have concluded in my *Review of processes undertaken by the Medical Council of New South Wales pursuant to Part 8 of the Health Practitioner Regulation National Law (NSW) with respect to Dr Emil Gayed*, the Medical Council should have notified relevant employers and public health organisations in any event.

1059. There is no evidence that the Hunter New England Local Health District was informed of the Performance Review Panel or its report.

6.16 Information from Manning Hospital clinical review

1060. As set out earlier in this chapter, almost 200 women contacted the hospital in mid-2018 to discuss their concerns about their treatment by Dr Gayed at Manning Hospital.

1061. Dr Roberts reviewed the clinical records and consulted with many of those women. He prepared a report for each. Dr Jenkins read each of Dr Roberts' reports and provided me with his opinion as to the standard of care provided by Dr Gayed.

1062. Between 2011 and 2014, of the patients who were treated by Dr Gayed, 23 patients, in my view, based on Dr Jenkins' advice, warrant referral to the HCCC for investigation. I have referred those patients' care to the HCCC.

1063. Two of those cases have already been referred to the HCCC.

1064. Two of those cases (not those who have been referred to the HCCC) were the subject of an IIMS report made by staff at the time of the treatment. The latter two IIMS reports were provided to me by the local health district after I had requested that further searches be made.

1065. I do not know whether their treatment, or that of the other 21 patients who were not the subject of IIMS reports, came to the attention of the local health district at or around the time of the treatment and, if so, whether each patient's treatment was the subject of any documented process.

1066. As I indicated in section 3.6, it is in my view likely that, in many of these cases, there was nothing observable which warranted a written report being made about the patient's treatment at the time. I make comments in the Conclusions concerning the information generally available to Manning Hospital in relation to Dr Gayed's patients.

1067. I am advised by Dr Jenkins that, in addition to those patients the subject of an IIMS report, the treatment of three of the women should have given rise to concern among hospital staff .

1068. I asked the local health district for their response to Dr Jenkins' opinions.

1069. Again, the local health district told me that it accepted that it should have been informed of the care and clinical outcomes of the three women at the time of care or as reasonably close to that time as possible. The treatment provided to two of those women should have resulted in an IIMS report under the heading 'Clinical management' and the other case that was identified should have been presented to a Morbidity and Mortality meeting.

1070. The local health district told me that 'on reflection from senior clinicians the culture at Manning hospital at the time did not encourage reporting for such events'. I note that the time referred to was 2015.

7. 2015

7.1 March 2015: complaint

1071. On 3 March 2015, a patient made a complaint to the HCCC regarding her treatment by Dr Gayed at Mayo Private Hospital.[348] When asked by the HCCC to respond to the complaint, Mr Michael DiRienzo noted that Manning Hospital was unable to address concerns regarding 'poor follow-up care from Dr Gayed regarding incisional hernia', as 'the procedure was done in a private hospital and the subsequent follow up care was conducted by Dr Gayed in his private clinic'.[349]

1072. Mr DiRienzo told the HCCC that he gave feedback to Dr Gayed. The nature of the feedback is not known, although Dr Gayed did write to the patient to try and resolve her concerns.[350] The hospital also reviewed her medical records.[351]

7.2 March 2015: unplanned readmission

1073. An IIMS report was created by a nurse/midwife. The patient's baby was born on 20 March and she was discharged home on 21 March. On 26 March 2015, she was readmitted to the operating theatre. She had the retained products of conception.

1074. An initial SAC4 was ascribed and confirmed, as the incident was a rare complication. I accept Dr Jenkins' opinion that this was an appropriate response.

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[348] Health Care Complaints Commission, Complaint Form, 3 March 2015 (Tab 3.c.2, HNELHD documents); IIMS Incident Detail (1864193-20), Incident recorded 25 March 2015 (Tab 3.c.1, HNELHD documents).
[349] Letter from Mr Michael DiRienzo, Chief Executive, Hunter New England Local Health District, to Ms Janette Campbell, Assessment Officer, Health Care Complaints Commission, 17 April 2015 (Tab 3.c.4, HNELHD documents).
[350] Letter from Mr Michael DiRienzo, Chief Executive, Hunter New England Local Health District, to Ms Janette Campbell, Assessment Officer, Health Care Complaints Commission, 17 April 2015 (Tab 3.c.4, HNELHD documents).
[351] Letter from Mr Michael DiRienzo, Chief Executive, Hunter New England Local Health District, to Ms Janette Campbell, Assessment Officer, Health Care Complaints Commission, 17 April 2015 (Tab 3.c.4, HNELHD documents).

7.3 April 2015: a Director of Obstetrics and Gynaecology is appointed

1075. In April 2015, Dr Roberts was appointed the first Director of Obstetrics and Gynaecology at Manning Hospital. Mr DiRienzo told me that that position was created following a review of maternity services in the local health district. He said the aim was to provide leadership to the department and attract staff specialists to replace the Visiting Medical Officers. Dr Roberts told me that he was not informed of that latter aim.

1076. The review arose from neonate deaths and was unrelated to gynaecological practice or Dr Gayed.

1077. Dr Roberts' previous employment was at Ipswich Hospital in Queensland.

7.4 May 2015: the wrong procedure?

1078. On 4 May 2015, an IIMS report was created in relation to the clinical management of a patient, following surgery performed by Dr Gayed on 4 April 2015. The report does not identify who made the notification.[352]

1079. The report was that Dr Gayed had performed a 'Wrong procedure', described as an 'Inappropriate salpingectomy for incorrect diagnosis of ectopic pregnancy—normal tube removed as patient had intrauterine pregnancy'. The initial Severity Assessment Code was noted to be a SAC2.[353]

1080. The senior staff member who reviewed the incident report, Dr Wills, noted that:

> This was a very complicated case with an extremely rare combination of pathologies. This lady had both an ectopic tubal pregnancy (demonstrated by histology) and a probably non-viable intrauterine pregnancy. This was not a case of an unnecessary tube removal and the diagnosis of ectopic pregnancy was not incorrect.[354]

1081. The actual Severity Assessment Code was noted to be a SAC4.

1082. In a case summary Dr Roberts raised concerns about the management of this patient.[355] Dr Roberts confirmed with me he held those concerns, which differed from Dr Wills' opinion as expressed in the incident report.

1083. On 13 July 2015, Dr Gayed wrote to Dr Wills to provide information about the management of the patient, expressing his concern that the incident report contained errors and wrong conclusions.[356]

[352] IIMS Incident Detail (1889338-20), Incident recorded 4 May 2015 (Tab 3.a.9, HNELHD documents).
[353] IIMS Incident Detail (1889338-20), Incident recorded 4 May 2015 (Tab 3.a.9, HNELHD documents).
[354] IIMS Incident Detail (1889338-20), Incident recorded 4 May 2015 (Tab 3.a.9, HNELHD documents).
[355] Manning Base Hospital, Case Summary, L0071706, unsigned, undated (Tab 3.a.10, HNELHD documents).
[356] Letter from Dr Emil Gayed to Dr Jim Wills, Director of Clinical Services, Manning Hospital (Tab 3.a.11, HNELHD documents).

7.4.1 Dr Jenkins' opinion

> It was reasonable for this to be reported. It was very likely to have been a heterotopic pregnancy i.e. a coexisting intrauterine pregnancy and an ectopic pregnancy which is exceedingly rare, approx. 1:40 000 pregnancies. Whilst there were some deficiencies with Dr Gayed's management, they are relatively minor issues and essentially, he did the correct things. The SAC4 classification is reasonable.

7.5 May 2015: concerns raised by Director of Obstetrics and Gynaecology

1084. On 6 May 2015, Dr Roberts wrote to Dr Wills regarding 'a number of concerns that have been brought to my attention over the management' of a patient who was treated by Dr Gayed in mid-April 2015. Dr Roberts stated: 'In summary, the overall findings would be consistent with methotrexate having been given to a patient with a viable intra-uterine pregnancy who then had unnecessary and inappropriate removal of organs.'[357]

1085. Dr Roberts told the inquiry that he recalled that a junior doctor had raised concerns with him. No IIMs report has been provided to the inquiry.

1086. In a file note dated 7 May 2015, Dr Wills noted that he met with Dr Roberts and Dr Gayed and that it was agreed that it was not necessarily the case that the patient had an intrauterine pregnancy; that she did not want the pregnancy or any future pregnancies; and that Dr Gayed 'had explained all steps in her management comprehensively as they went along'. The file note reported that Dr Gayed had the 'NICE guidelines explained to him' and was to 'go home to study same further'. Dr Wills' file note further indicated that it had been agreed with Dr Gayed and Dr Roberts that 'Open Disclosure is not required in this case'.[358]

1087. Dr Roberts told me he thought that Dr Gayed had made a mistake out of ignorance which could be remedied by improving his understanding of the guidelines.

7.5.1 Dr Jenkins' opinion

> The patient was administered methotrexate as ordered by Dr Gayed for a presumed diagnosis of ectopic pregnancy. The diagnosis of ectopic pregnancy and treatment with methotrexate was not made in accordance with accepted clinical guidelines. It is possible, although unlikely, that the patient may have had a viable intrauterine pregnancy at the time the methotrexate was administered.
>
> Five days after administration of methotrexate the patient saw Dr Gayed in his consulting rooms for follow up and that evening was admitted to MBH for laparotomy, and underwent bilateral salpingectomy, left oophorectomy and adhesiolysis. It is not clear whether the indication for this procedure was concern about ruptured ectopic pregnancy post methotrexate, in which case the appropriate management would have

[357] Letter from Dr Nigel Roberts, Director O&G, Manning Hospital, to Dr James Wills, Medical Super Intendent, Manning Hospital, 6 May 2015 (Tab 3.a.16, HNELHD documents).
[358] Memo from Dr Jim Wills, Director, Clinical Services & Director, Emergency Department to 'Me', 'L0049572, , 7 May 2015 (Tab 3.a.17, HNELHD documents).

been admit to hospital, blood tests, ultrasound and review results, or elective sterilisation, in which case it was not appropriate for this to be done under these circumstances on an afterhours operating list.

This case demonstrates a number of concerning issues around Dr Gayed's clinical judgement:

- He administered methotrexate to a woman in early pregnancy without having a clear diagnosis
- He undertook an emergency laparotomy without any clear indication for the procedure
- He removed the patient's normal left ovary. In early pregnancy it is expected that there will be a corpus luteal cyst on one of the ovaries and it is inexplicable to me that a gynaecologist would remove an ovary for this indication
- He subjected the patient to a laparotomy to perform a procedure which (if indicated) should have been performed laparoscopically. If Dr Gayed's registration conditions precluded him from performing this procedure laparoscopically he should have disclosed this to the patient in order to give her the option of having the procedure performed laparoscopically by another gynaecologist.

It is noted that this incident occurred relatively soon after Dr Roberts commenced his appointment at Manning Base Hospital. It appears that Dr Roberts' response was to increase surveillance on Dr Gayed's clinical work. Given all of the circumstances, this was a reasonable response.

Further action was warranted, probably in the form of the reviews that Dr Roberts undertook a few months later.

7.5.2 Conclusion

1088. I note that this patient was reviewed by Dr Roberts a couple of weeks after he started in the position of Director of Obstetrics and Gynaecology. Dr Roberts told me that at that stage he was not aware of the outcome of the Professional Standards Committee in 2001 or the events at Mona Vale Hospital. When he started, he was aware of the conditions which had been placed on Dr Gayed's registration and was told he had been moved on from other districts but the reason was not clear. It appears that Dr Wills told him of these matters.

1089. Dr Roberts told me that he watched Dr Gayed more closely after this incident. On 24 July 2015, he attended theatre to observe Dr Gayed performing a procedure and made some comments to him about his surgery. He said that Dr Gayed had not appreciated his presence or his comments and was very angry.

1090. As is set out below, Dr Roberts met with Dr Gayed in late July to raise concerns about his management of patients.

1091. In these circumstances, I agree with Dr Jenkins that Dr Roberts' response was reasonable.

7.6 August 2015: further concerns of Director of Obstetrics and Gynaecology

1092. On 3 August 2015, Dr Roberts wrote to Dr Gayed to confirm a discussion at a meeting on 31 July 2015. At that meeting, Dr Roberts and Dr Gayed discussed 'concerns over operations being performed without standard indications'. Dr Roberts noted that these concerns included:

> LLETZ [large loop excision of the transformation zone] procedures for women without biopsy proven cervical dysplasia, division of congenital adhesions for pain relief, routine use of curette at salpingectomies for ectopic pregnancies and at the time of laparotomies for other procedures.[359]

1093. Dr Roberts told me that one of the patients came to his attention because she attended the outpatient clinic he had established after being appointed director.

1094. The outcome of the discussion between Dr Gayed and Dr Roberts was that Dr Gayed agreed to having Dr Roberts review cases before they proceeded to theatre and to send to Dr Roberts the letters sent to the GP for each patient who is booked for theatre. Dr Roberts acknowledged that Dr Gayed had 'stressed that this is a voluntary act on [Dr Gayed's] part'. Dr Roberts also stated that he wished 'to proceed down this route as I hope that it provides reassurance to myself and others that any concerns regarding over-servicing are unfounded'.[360]

1095. Dr Jenkins is of the view that it was a reasonable response to a doctor about whom one had concerns. I accept his opinion; however, given that it was voluntary on Dr Gayed's part, it relied on his willingness to telling Dr Roberts about the procedures in advance.

1096. Dr Roberts told me that Dr Gayed did not provide the information to permit Dr Roberts to review his cases. Dr Roberts said he frequently spoke with Dr Gayed about his failure to adhere to the agreement to do so.

1097. He said that Dr Gayed responded to these overtures from Dr Roberts by indicating that he would only speak with Dr Roberts with his lawyer present.

7.7 August 2015: delayed review

1098. An IIMS report was created by a nurse/midwife following a delay in investigations by Dr Gayed in relation to a patient suffering from heavy blood loss on 27 August 2015. An initial SAC2 was revised to an actual SAC3 following review by the Nursing Unit Manager, Emergency Department senior director and obstetrics and gynaecology head of department.

1099. I understand that this incident has been referred to the HCCC.

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[359] Email from Dr Nigel Roberts to Dr Emil Gayed, 3 August 2015 (Tab 4.a.2, HNELHD documents).
[360] Email from Dr Nigel Roberts to Dr Emil Gayed, 3 August 2015 (Tab 4.a.2, HNELHD documents).

7.8 October 2015: unplanned readmission

1100. A patient was discharged from maternity with home midwifery service follow-up. She was readmitted with possible sepsis/endometritis. A nurse/midwife created an IIMS entry and classified the incident as SAC4. It was reviewed by the Nursing Unit Manager and the SAC4 classification was confirmed. It was noted that an 'aggregate review [was] undertaken'.

1101. I repeat my observations above at section 6.1. In these circumstances, I cannot be satisfied that the process complied with the relevant policy, as there is no evidence that an aggregate review was undertaken.

7.9 November 2015: tearing the ureter

1102. Dr Gayed performed surgery on a patient on 25 October 2015. In November 2015, who made complaints to Manning Hospital and to the HCCC.

1103. Dr Gayed provided his account of the surgery to Dr Wills:

> The patient sadly has suffered from quite recognised but rare pelvic injury when I performed the laparotomy procedure for her on 25th October 2015. Her pelvic pathology was quite severe involving advanced pelvic endometriosis and very significant pelvic adhesions caused by previous pelvic inflammatory disease.
>
> The causes for the delay in diagnosing the left uretic injury was, as already stated, due to the complex clinical nature and not because of lack of care on anyone's part including myself.[361]

1104. Dr Wills then wrote to the patient and acknowledged that Dr Gayed had 'nicked' the ureter and it was possible the urologist at John Hunter Memorial Hospital may have completed the tear in the ureter while trying to insert a stent to fix the problem.[362]

1105. On 4 December 2015, the Hunter New England Local Health District facilitated a notification to the Treasury Managed Fund on behalf of Dr Gayed. The notification was of an incident that may lead to a health care liability claim in relation to Dr Gayed's treatment of the patient.[363]

1106. An IIMS report noted that the actual Severity Assessment Code to be a SAC3. The incident report noted that the incident was resolved through feedback to the clinician concerned.[364]

1107. On 21 December 2015, Mr DiRienzo wrote to the HCCC regarding the complaint. He offered an apology to the patient for any distress and inconvenience caused to her

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[361] Letter from Dr ES Gayed to Dr James T Wills, Director of Clinical Services, Manning Hospital, 20 November 2015 (Tab 3.c.29, HNELHD documents).
[362] Letter from Dr Jim Wills, Director, Clinical Services and Director, Emergency Department, Manning Hospital, to the patient, 27 November 2015 (Tab 3.c.28, HNELHD documents).
[363] NSW Health, TMF Incident Report, Dr Emil Gayed, 4 December 2015 (Tab 3.c.31, HNELHD documents).
[364] IIMS Incident Detail (2036722-20), Incident recorded 15 December2015 (Tab 3.c.22, HNELHD documents).

as a result of her experience at Manning Hospital. He noted that the patient had also referred her concerns about her treatment directly to Manning Hospital and that Dr Wills had contacted the patient by phone to discuss her concerns. Mr DiRienzo also provided the HCCC with a copy of the response provided to her by Dr Wills.[365]

1108. On 2 March 2016, the HCCC informed Mr DiRienzo that the patient did not wish to proceed with the resolution process.[366]

1109. Dr Gayed told the Medical Council during its s 150 proceedings on 1 April 2016 that it had been a misjudgement to operate on the patient and he should never have done the surgery in a rural hospital.[367] The Medical Council agreed.

7.9.1 Dr Jenkins' opinion

> The patient had a complicated gynaecological history having undergone numerous procedures in the past, demonstrating extensive pelvic adhesions with possible underlying pelvic inflammatory disease and endometriosis. She had also undergone a midline laparotomy in association with removal of her gallbladder. She had a history of chronic pelvic pain.
>
> On 21 October 2015 she underwent a D&C by Dr Gayed for management of early pregnancy miscarriage. This was a routine and uncomplicated procedure.
>
> She presented to Manning Hospital Emergency Department on 23 October 2015 with worsening lower abdominal pain. It is not clear whether or not any imaging was undertaken to try to ascertain the cause of the pain. The pain was predominantly right sided.
>
> On 25 October 2015 she underwent a laparotomy for division of adhesions and right salpingo-oophorectomy. During the procedure the left ureter was injured and this injury was unrecognised. Histopathology does not demonstrate any abnormality of the right ovary and tube.
>
> She had a difficult postoperative course and it was not until 8 days post operatively that her ureteric injury was diagnosed. She ultimately required transfer to John Hunter Hospital for further management involving major surgery to reimplant the left ureter. It is interesting that both Dr Gayed and Dr Wills attempt to trivialise the nature of the injury by referring to it as a 'nicked ureter' and suggest that the urologist may have made it worse by attempted insertion of a stent. This may have been what occurred but any ureteric injury sustained during benign gynaecological surgery cannot be considered acceptable, and there is no doubt that Dr Gayed caused a ureteric injury.

[365] Letter from Mr Michael DiRienzo, Chief Executive, Hunter New England Local Health District, to Ms Deepa Rohtagi, Assessments Officer, Health Care Complaints Commission, 21 December 2015 (Tab 3.c.22, HNELHD documents).
[366] Letter from Wayne Farmer, Resolution Officer—Newcastle, Health Care Complaints Commission, to Mr Michael DiRienzo, Chief Executive, Hunter New England Local Health District, 2 March 2016 (Tab 3.c.24, HNELHD documents).
[367] Medical Council Written Reasons for Decision dated 11 May 2016, p 5.

> This case demonstrates a concerning lack of clinical judgement by Dr Gayed. There was significant risk associated with performing this operation on the patient. It is not unexpected that she would experience an exacerbation of her chronic abdominal pain in the few days following a D&C for miscarriage. A normal right tube and ovary were removed and, in my view, it is extremely unlikely that this would have improved her pain. At any rate, unless there was ultrasound evidence of a concerning ovarian mass (which there clearly wasn't) it would be reckless to proceed with surgery under these circumstances. It is also inexplicable how the left ureter was injured given that the purpose of the operation was apparently to remove the right tube and ovary. This calls into question not only the judgement to perform the procedure but the skill and expertise with which the procedure was performed.
>
> The ongoing support of Dr Gayed by Dr Wills is hard to justify on the basis of the available evidence at this time. Resolving the issue though feedback to Dr Gayed was a superficial and inadequate response.

7.9.2 Conclusion

1110. I accept Dr Jenkins' comment.

1111. I accept Dr Roberts' comment to me that Dr Gayed did not abide by the agreement he had struck with him to provide him with information about the patient's condition before Dr Gayed performed any surgery.

7.10 December 2015: an anaesthetist complains

1112. On 8 December 2015, Dr Roberts wrote to Dr Alan Bourke in response to concerns about Dr Gayed.[368] Dr Bourke was an anaesthetist at Manning Hospital.[369] Dr Roberts noted that Dr Bourke had concerns about Dr Gayed, which were as follows:

- Possible visual impairment.
- Technical skills—as he appears in comparison to other O&G specialists to have more bleeding, more trauma, more surgeon involvement and he appears to take longer to complete similar procedures.
- Decreased confidence—as he appears sometimes to be buying time in an attempt to hand over difficult cases to other colleagues.
- Poor decision making—choosing to operate on patients who may not require a specific operation.
- Does not always come in when called.
- Takes on too many on-call shifts and appears overloaded.

1113. Dr Roberts noted that Dr Bourke believed that 'some of his skill, decision making and reluctance to review patients may be due to his being overloaded' and confirmed that Dr Gayed would no longer perform routine locum shifts. Dr Roberts

[368] Email from Dr Nigel Roberts to Dr Alan Bourke, 8 December 2015 (Tab 4.a.3, HNELHD documents).
[369] Letter from Dr Emil Gayed to Dr James T Wills, Director of Clinical Service, Manning Hospital, 20 November 2015 (Tab 3.c.29, HNELHD documents).

said: 'It is believed that [this] will lead to a substantial improvement in his performance.' He also noted that 'ongoing monitoring of Dr Gayed's performance is important to maintain patient safety' and requested that any specific concerns be detailed and notified through the IIMS 'so that a more formal systematic approach to dealing with any concerns can be utilised'.[370]

1114. There are no further documents regarding Dr Bourke's concerns.

1115. Dr Roberts told me that Dr Bourke did not tell him of any specific case to permit Dr Roberts to investigate and take any particular action other than, as set out, to continue to monitor Dr Gayed's performance through the IIMS.

1116. I refer to Dr Bourke's comments to me about these events in section 17 of this chapter.

7.10.1 Dr Jenkins' opinion

> Considering the mounting evidence at this time, most recently the 2013 Medical Board Performance Re-Assessment's adverse findings and recent serious clinical incidents it does not seem appropriate that no action was taken.
>
> The concerns raised by the anaesthetist are consistent with a number of the issues raised by the Medical Board's performance assessment. It seems rather fanciful to suggest that altering his rostered workload is going to result in a 'substantial improvement in his performance' with respect to those issues.
>
> It would seem reasonable that a review of Dr Gayed's clinical privileges should have taken place rather than using the IIMS system to await further incidents. In terms of patient safety, it could be argued that there was now an imperative to take a proactive rather than a reactive approach to Dr Gayed's work at Manning Hospital.

7.10.2 Conclusion

1117. Dr Roberts told me that he had not been informed of any adverse findings from the Medical Council performance reassessment or from the 2014 performance assessment carried out by the Medical Council. He told me that he considered a review of Dr Gayed's clinical privileges as a result of this incident. However, Dr Wills told him that the Australian Medical Association and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists had already investigated Dr Gayed. This was not the case, although the Medical Council had, and the College had been involved in counselling Dr Gayed.

1118. Dr Jenkins commented that some of the anaesthetist's concerns were consistent with a number of issues raised by the Medical Council's performance reassessment held on October 2013. I have noted above that the Hunter New England Local Health District was not aware of the final report. I note that Dr Roberts commenced

[370] Email from Dr Nigel Roberts to Dr Alan Bourke, 8 December 2015 (Tab 4.a.3, HNELHD documents).

his position as Director about 18 months after the report was completed. I accept Dr Roberts' submission that his actions were timely in all the circumstances.

7.11 Information from Manning Hospital clinical review

1119. As set out earlier in this chapter, almost 200 women contacted the hospital in mid-2018 to discuss their concerns about their treatment by Dr Gayed at Manning Hospital.

1120. Dr Roberts reviewed the clinical records and consulted with many of those women. He prepared a report for each. Dr Jenkins read each of Dr Roberts' reports and provided me with his opinion as to the standard of care provided by Dr Gayed.

1121. In 2015, of the patients who were treated by Dr Gayed, seven patients, in my view, based on Dr Jenkins' advice, warrant referral to the HCCC for investigation. I have referred those patients' care to the HCCC.

1122. One of these patients was the subject of an IIMS report made at or around the time of the treatment. This report was provided to the inquiry after I requested that further searches be made.

1123. I do not know whether the treatment of the other six patients came to the attention of the local health district and was not the subject of an IIMS report or any other documented process.

1124. As I indicated in section 3.6, it is in my view likely that, in many of these cases, there was nothing observable which warranted a written report being made about the patient's treatment at the time. I make comments in the Conclusion concerning the information generally available to Manning Hospital in relation to Dr Gayed's patients.

8. 2016: the concerns escalate

1125. From early 2016, Dr Roberts began the process of documenting concerns about Dr Gayed with a view to initially taking him off on-call, which occurred on 6 February 2016, and suspending him, which was done on 8 February 2016. That process culminated in a review of six of his patients based on the policy directive 'Complaint or Concern about a Clinician—Principles for Action',[371] which commenced on 8 February 2016 and was completed on 5 April 2016. Dr Gayed resigned on 28 February 2016 before the review was complete. What follows is an account of the events between February and April 2016.

[371] NSW Health, Policy Directive PD2006_007, 'Complaint or Concern about a Clinician—Principles for Action', 30 January 2006 (Tab 28, Policies on the management of incidents, complaints and disciplinary processes 1990–2016).

8.1 January 2016: patient information

1126. The IIMS report by a nurse/midwife recorded that, on 8 January 2016, a patient was admitted to maternity unit with pain. It was recorded that Dr Gayed had not informed her of the need to book in to have the baby or to have her blood glucose level monitored. The initial SAC3 was revised by the Nursing Unit Manager to SAC4. It was noted that the obstetrics and gynaecology staff specialist was to address the issue with the relevant obstetrician. Again, an aggregate review was said to have been undertaken.

1127. I repeat my observations above at section 6.1. In these circumstances, I cannot be satisfied that the process complied with the relevant policy, as there is no evidence.

8.2 February 2016: high-risk patient

1128. A document dated 9 February 2016 and signed by a patient details a complaint made to Acting Midwifery Unit Manager about Dr Gayed's surgery performed on a patient on 4 February 2016.[372]

1129. At some time after 6 February 2016, Dr Roberts completed detailed notes regarding her treatment as part of his notes supporting a decision to remove Dr Gayed from being on call on that day. Dr Roberts observed:

> This patient has a complicated surgical history and was a very high risk surgery. Dr Gayed had been counselled to send the patient to John Hunter Hospital for any surgery. Dr Gayed was also counselled that he should perform the minimum possible procedure in her case due to the high risk of surgical complications. He ignored both of these recommendations—by myself, the anaesthetist and (as I have subsequently discovered), the patient.[373]

1130. Dr Roberts also noted that the patient had expressed anger that:

- Dr Gayed ignored her request for a referral to JHH
- Dr Gayed seemed determined to perform a hysterectomy
- Dr Gayed could not identify a 10cm fibroid in the uterus
- Dr Gayed did not perform the minimum procedure requested by herself
- She will now enter menopause earlier [than] she would have otherwise.[374]

1131. A record of an 'Open Disclosure' discussion noted that Dr Osama Ali, the Acting Director of Clinical Services, and Dr Roberts met with the patient and her husband on 29 March 2016 to discuss her treatment. The form notes that a 'minimal procedure (myomectomy) should have been performed' but that the procedure

[372] General Manager Manning Hospital, Complaint, 9 February 2016 (Tab 3.c.8, HNELHD documents).
[373] Dr Nigel Roberts, 'Issues leading to decision to take Dr Emil Gayed of call on 6/2/16', February 2016 (Tab 4.a.35.13, HNELHD documents).
[374] Dr Nigel Roberts, 'Issues leading to decision to take Dr Emil Gayed of call on 6/2/16', February 2016 (Tab 4.a.35.13, HNELHD documents).

that was performed 'resulted in massive blood loss, subtotal hysterectomy and bilateral salpingo-oophorectomy and an ICU admission'. The form records that an apology was offered to the patient. The form also noted that the incident was 'fully investigated by the hospital executive team and appropriate actions were implemented'.

1132. The record of the Open Disclosure discussion also noted that the 'case has been reported to the Australian Health Practitioner Regulation Agency'.[375] I am told that a simultaneous notification was made to the Medical Council and the HCCC.

1133. The 'Review of Concerns Relating to Dr Gayed' noted the following concerns in relation to the patient included:

- Very high risk surgically complex patient operated upon at Manning Hospital despite advice to refer the patient to a Tertiary Centre/John Hunter Hospital for this surgery.
- Failure to perform the minimum procedure possible in this high risk patient, despite a request by the patient and advice from the anaesthetist caring for the patient and the Director of Obstetrics and Gynaecology.
- Failure to identify the large uterine fibroid that was present.
- Failure to ensure adequate haemostasis … at the end of the procedure, resulting in an intra-abdominal bleeding requiring massive transfusion protocol, further surgery (including a bilateral salpingo-oophorectomy) and an ICU admission.[376]

1134. The review team concluded:

> Considering that there is a Tertiary Referral Hospital within two hours of Manning Hospital, the failure to refer this patient represents performance that is below the standard reasonably expected by a fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists.[377]

8.2.1 Dr Jenkins' opinion

> This case demonstrates terrible clinical judgement, complete lack of insight and inadequate surgical skills. It is very similar to the case at Mona Vale in 2004. The review team conclusions are entirely appropriate.

[375] Hunter New England Local Health District, Clinical Governance Record of Open Disclosure Discussion, 4 February 2016 (Tab 3.c.7, HNELHD documents). The patient's case was included in the notification to the Australian Health Practitioner Regulation Agency via the Medical Council and the HCCC, by letter of 24 February 2016. Letter from Mr Michael DiRienzo, Chief Executive, Hunter New England Local Health District, to the Medical Council of NSW, 24 February 2016 (Tab 4.a.51, HNELHD documents).
[376] Hunter New England Local Health District, Review Team, Confidential Review Report, 5 April 2016, p 4 (Tab 4.a.35.14, HNELHD documents).
[377] Hunter New England Local Health District, Review Team, Confidential Review Report, 5 April 2016, p 4 (Tab 4.a.35.14, HNELHD documents).

8.2.2 Conclusion

1135. I accept Dr Jenkins' opinion. I note that in 2016 the Medical Council expressed the view that the surgery should not have been done on a high-risk patient in a rural hospital.

8.3 February 2016: failed to perform pregnancy test before surgery

1136. On 11 November 2015, Dr Gayed performed an 'endometrial ablation, ablation of uterine fibroids and excision of large left vaginal polyp' on a patient at Manning Hospital.[378]

1137. She was 10 weeks pregnant at the time of the procedure performed by Dr Gayed. She stated: 'Dr Gayed could not give us any answers as to how this has happened. He also could not tell us if the baby would be "normal" or if it had suffered any trauma during my surgery.' Dr Gayed arranged for her to travel to Sydney for a termination on Monday 18 January. Dr Gayed provided her with a cheque of $2400 to cover the costs of the termination and another cheque of $1000 for expenses.[379]

1138. In February 2016, Dr Roberts completed notes regarding her treatment as part of his notes supporting a decision to remove Dr Gayed from being on call on 6 February 2016. These notes record:

> Dr Gayed allegedly told her that the matter would be fully investigated. To my knowledge no report of the incident has been placed and no investigation has subsequently taken place. A situation that [as Director] of Obstetrics and Gynaecology I would find completely unacceptable.[380]

1139. On 11 February 2016, the practice manager of Dr Gayed's private practice wrote to the patient requesting receipts for the costs incurred in Sydney following her treatment in January 2016. The letter noted that Dr Gayed had given her the money for 'humane reasons'. The letter also noted that Dr Gayed's insurer had been informed of the situation and 'his legal advisor understands the exceptional circumstances and the reasons for Dr Gayed to give this money and appreciates the care and compassion he gave you that day'. The letter concluded:

> It is not clear how the early pregnancy could survive the surgery, instrumentation and general anaesthetic, as normally a miscarriage will occur. Because of the complexity of this very rare situation your management will be reviewed by the department of obstetrics and gynaecology at Taree Hospital and by Dr Gayed's medical insurer, once all the necessary reports are received.[381]

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[378] Letter from Dr Emil Gayed to Dr Thai Don, West Street Medical Centre, 11 November 2015 (Tab 3.c.10, HNELHD documents).
[379] Undated summary of complaint against Dr Gayed, (Tab 3.c.12, HNELHD documents); Copy of cheques (Tab 3.c.9, HNELHD documents).
[380] Dr Nigel Roberts, 'Issues leading to decision to take Dr Emil Gayed of call on 6/2/16', February 2016 (Tab 4.a.35.13, HNELHD documents).
[381] Letter from Ms Laurel Roberts, Practice Manager, 11 February 2016 (Tab 3.c.10, HNELHD documents).

1140. This patient was considered during the 'Review of Concerns Relating to Dr Gayed' conducted in early 2016. The 'Concerns' noted by the review in relation to her included:

- Direct vision endometrial ablation was performed at over ten weeks gestation.
- Failure to disclose a SAC 2 event immediately to either the Director of Obstetrics and Gynaecology, or the Director of Clinical Services.
- Concerns that Dr Gayed may have provided payments to the patient for expenses related to a Termination of Pregnancy.[382]

1141. The review team concluded that 'the standard of care provided by Dr Gayed in the performance of this procedure was below the standard reasonably expected by a fellow of the Royal Australian and New Zealand College of Obstetricians'. The review team further concluded that Dr Gayed making payments in relation to the termination of pregnancy was in breach of the NSW Health Code of Conduct.[383]

1142. Dr Jenkins agrees with the conclusion of the review team. The Medical Council considered this case during its 2016 s 150 proceedings and found that Dr Gayed's response to the matter showed a severe lack of judgment.

9. February 2016: suspension and review of Dr Gayed's performance

1143. On 6 February 2016, Dr Roberts decided to remove Dr Gayed from on-call following a discussion with the hospital executive.[384] Dr Roberts made detailed notes regarding the 'Issues leading to decision to take Dr Emil Gayed off call on 6/2/16'. Dr Roberts noted that 'Over the last week I have had an increasing number of concerns regarding Dr Gayed's performance. These events have certainly not occurred in isolation, rather on a background of concerns and complaints raised by patients and staff'. He further noted:

> We cannot afford to ignore these very serious issues. They represent a repetitive pattern of behaviour. Both of the excellent registrars I have had through 2015 have told me that they (and their predecessors) would come up with reasons to not attend Dr Gayed's surgical list because they don't want to be associated with what he is doing and the complications that may occur.[385]

1144. Dr Roberts told me that the two registrars declined to make a formal or written complaint about Dr Gayed.

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[382] Hunter New England Local Health District, Review Team, Confidential Review Report, 5 April 2016, p 5 (Tab 4.a.35.14, HNELHD documents).
[383] Hunter New England Local Health District, Review Team, Confidential Review Report, 5 April 2016, p 6 (Tab 4.a.35.14, HNELHD documents).
[384] Dr Nigel Roberts, 'Dot Points Relating to Decision to Remove Dr Gayed from On-Call over the Weekend of 6/2/16', 8 February 2016 (Tab 4.a.35.5, HNELHD documents).
[385] Dr Nigel Roberts, 'Issues leading to decision to take Dr Emil Gayed of call on 6/2/16', February 2016 (Tab 4.a.35.13, HNELHD documents).

1145. The 'staff' he referred to was the anaesthetist, Dr Bourke.

1146. On 8 February 2016, a meeting of the Obstetrics & Gynaecology Department of Manning Hospital noted that concerns over the performance of Dr Gayed had been raised with Dr Ali on 6 February 2016. Dr Gayed was present at the meeting and indicated that he wished to reply in writing.[386]

1147. Dr Ali wrote to him that day and required a response in writing addressing each of the allegations by 19 February 2016. The letter also informed Dr Gayed that his appointment as a Visiting Medical Officer was suspended:

> Due to the significance of the allegations if substantiated you are advised that your appointment as a Visiting Medical Officer is suspended until further notice while the investigation is being finalised.[387]

1148. On 8 February 2016, a 'Management of Complaint or Concern about a Clinician' form was completed, including details of the proposed investigation. The form noted as concerns Dr Gayed's performing an endometrial ablation on a pregnant patient and conducting high-risk surgery despite colleagues' and the patient's advice. The form noted that the second procedure was 'poorly performed with subsequent post-operative internal bleeding requiring re-operation and ICU admission'. The form rated concern about Dr Gayed to be Level 2. The form noted that 'Dr Gayed is under suspension until completion of investigation. Open Disclosure with involved patients is organized'.[388] The form was updated with a progress report on 9 February 2016 to note that meetings 'with Dr Gayed to investigate the incidents have already started' and that he had requested time to respond to the allegations in writing.[389]

1149. On 9 February 2016, a risk assessment was conducted. The assessment noted a high risk to patient safety, quality of care and the reputation of the organisation and recommended that Dr Gayed be suspended.[390]

1150. On 9 February 2016, the Chief Executive of the Hunter New England Local Health District approved the creation of a Service Check Record to show that there was alleged misconduct with the finding still pending. The reasons for the creation of the Service Check Record were that:

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[386] Minutes of Obstetrics & Gynaecology Meeting, Manning Base Hospital, 8 February 2016 (Tab 4.a.35.5, HNELHD documents).
[387] Letter from Dr Osama Ali, Deputy Director Clinical Services, Manning Rural Referral Hospital, to Dr Emil Gayed, 8 February 2016 (Tab 4.a.40, HNELHD documents).
[388] Hunter New England Local Health District, Management of Complaint or Concern about a Clinician, Emil Gayed, 8 February 2016 (Tab 4.a.53, HNELHD documents).
[389] Hunter New England Local Health District, Management of Complaint or Concern about a Clinician, Progress Report, 9 February 2016 (Tab 4.a.53, HNELHD documents).
[390] Hunter New England Local Health District, Risk Assessment, Emil Gayed, 9 February 2016 (Tab 4.a.57, HNELHD documents).

> Allegations regarding Dr Gayed's clinical ability and patient safety have been raised. A risk assessment was undertaken and the decision was made to suspend Dr Gayed's privileges while an investigation is conducted.

1151. The Service Check Record further noted that:

> This decision is in accordance with Section 4.3 of the Service Check Register Policy requiring creation of a record when 'There is alleged misconduct and a decision has been made to take administrative action to mitigate any immediate or ongoing risks relating to the alleged misconduct while any investigation or other action is ongoing'.[391]

1152. The action taken to create a Service Check Record was consistent with the relevant Policy Directive PD2013_036, 'Service Check Register for NSW Health'.[392]

1153. On 10 February 2016, Mr DiRienzo wrote to Dr Gayed to inform him that a Service Check Record had been approved and created due to the allegations made against him on 8 February 2016 that were pending investigation.[393]

1154. On 19 February 2016, Dr Gayed made a presentation to 'medical administration and other clinicians'.[394] The presentation was supported by a letter of 18 February 2016 to Dr Ali containing detailed notes in response to the concerns raised by Dr Roberts. Dr Gayed stated:

> I was shocked to be notified of the meeting on 8th February where I did not know the details of the concerns prior to the meeting and then to be suspended was devastating. I have provided straightforward and honest answers to the issues raised and fully recognise that I could have done better in managing a number of these cases. I am always seeking to improve my skills and learn from my peers.[395]

1155. On 24 February 2016, Dr Gayed made a statutory declaration to correct a detail in his letter of 18 February 2016 regarding payments made in relation to the termination.[396]

1156. On 24 February 2016, the terms of reference for an 'Investigation of a Complaint or Concern about a Clinician' pursuant to Policy Directive PD2006_007[397] and

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[391] Brief from Mr Peter Reay, Human Resources Manager, Hunter New England Local Health District to Mr Michael DiRienzo, Chief Executive, Hunter New England Local Health District, 'Application for Approval to Create a Service Check Register Record', 9 February 2016 (Tab 4.a.29, HNELHD documents).
[392] NSW Health, Policy Directive PD2013_036, 'Service Check Register for NSW Health', 31 October 2013, p 6 (Tab 45, Policies on the management of incidents, complaints and disciplinary processes 1990–2016).
[393] Letter from Mr Michael DiRienzo, Chief Executive, Hunter New England Local Health District, to Dr Emil Gayed, 10 February 2016 (Tab 4.a.45, HNELHD documents).
[394] Dr Emil Gayed, Presentation Made to Medical Administration and Other Clinicians, 19 February 2016 (Tab 4.a.35.15, HNELHD documents).
[395] Letter from Dr Emil Gayed to Dr Osama Ali, Deputy Director Clinical Services, Manning Rural Referral Hospital, 18 February 2016 (Tab 4.a.35.15, HNELHD documents).
[396] Statutory Declaration, Emil Shawky Gayed, 24 February 2016 (Tab 4.a.43, HNELHD documents).
[397] NSW Health, Policy Directive PD2006_007, 'Complaint or Concern about a Clinician—Principles for Action', 30 January 2006 (Tab 28, Policies on the management of incidents, complaints and disciplinary processes 1990–2016).

Guideline GL2006_002[398] were drafted. The 'Review of Concerns Relating to Dr Email Gayed at the Manning Regional Referral Hospital' concerned six patients. The terms of reference noted that, once the investigation report had been submitted, the Hunter New England Local Health District would:

- request a 'written response to the report from the clinician';
- report 'any finding that there may be unsatisfactory professional conduct to the NSW Medical Council and AHPRA [Australian Health Practitioner Regulation Agency]';
- report 'any finding that there may be impairment to the NSW Medical Council and AHPRA';
- deal 'with the other findings and make recommendations in accordance with NSW Health and Hunter New England Local Health District policies'.[399]

1157. On 24 February 2016, Dr Ali, then Acting Director of Clinical Services at Manning Hospital, wrote to Dr Gayed to inform him that a review team had been established in accordance with NSW Health policy directives. Dr Ali informed Dr Gayed that the review team would consist of Dr Osama Ali (Acting Director of Clinical Services, Manning Hospital), Ms Jodi Nieass (Acting General Manager, Manning Hospital), Dr Nigel Roberts (Director of Obstetrics and Gynaecology, Manning Hospital), Peter Reay (Human Resources Manager, Greater Metropolitan Health Services) and Professor Henry Murray (Area Director of Obstetrics and Gynaecology). Dr Ali also informed Dr Gayed that his appointment as a Visiting Medical Officer would remain suspended while the investigation was being finalised.[400]

1158. On 24 February 2016, Mr DiRienzo wrote to the Medical Council to note that he wished 'to notify AHPRA via your organization and the HCCC, that HNE Health is investigating a concern about Dr Emil Gayed who works as a Visiting Medical Officer in the Hunter New England Local Health District'. Mr DiRienzo noted:

> The concern relates to allegations that his skill, judgment and care exercised in the practice of obstetrics and gynaecology is significantly below the standard reasonable expected of a practitioner of an equivalent level of training or experience. …
>
> An investigation into the matters raised has commenced. The clinician has been suspended from duties at Manning Rural Referral Hospital. He has been informed that the investigation is to take place and that HNE Health is informing AHPRA of this matter.

[398] NSW Health, Guideline GL2006_002, Complaint or Concern about a Clinician—Management Guidelines', 30 January 2006 (Tab 29, Policies on the management of incidents, complaints and disciplinary processes 1990–2016).
[399] Hunter New England Local Health District, Investigation of a Complaint or Concern about a Clinician, Review of Concerns Relating to Dr Emil Gayed at the Manning Regional Referral Hospital, 24 February 2016 (Tab 4.a.58, HNELHD documents).
[400] Letter from Dr Osama Ali, Acting Director Clinical Services, Manning Hospital to Dr Gayed, 24 February 2016 (Tab 4.a.35.4, HNELHD documents).

> HNE Health recommends that the NSW Medical Council imposes restrictions on this practitioner to minimize risks to patient safety pending the completion of the investigation.[401]

1159. Mr DiRienzo's letter of 24 February 2016 was forwarded by email to the HCCC on 29 February 2016.[402]

1160. On 26 February 2016, Dr Ali wrote to Dr Gayed to provide a summary of the outcome of the review.

1161. The letter concluded:

> Due to the significance and risk to patient safety of the above findings it is proposed to recommend to the Chief Executive, via the relevant approval process, the termination of your contract as a Visiting Medical Officer with Hunter New England Local Health District. Your appointment as a Visiting Medical Officer will remain suspended until further notice while the investigation is being finalised.[403]

1162. The letter requested that Dr Gayed respond in writing by 4 March 2016 'with respect to any appeal against the findings of the Review Team and to the proposal to terminate your contract for the reasons identified above'.[404]

1163. On 28 February 2016, Dr Gayed wrote to Dr Ali to resign from his Visiting Medical Officer position. Dr Gayed noted concern that Dr Roberts and Professor Murray may have a conflict of interest in their assessment of his practice. Dr Gayed also stated that his performance was above average and in obstetrics it was excellent. He stated:

> [I have had] No Foetal Injuries, No Fetal Death, caused by delay or deficiency, Never delivered a Dead baby at time of Caesarean Section and Very Low Maternal morbidity. … In my whole career I have never had an Obstetric Claim nor substantiated complaints.[405]

1164. This statement by Dr Gayed is inaccurate. As discussed above, in December 2005, Dr Gayed delivered a baby who was declared deceased immediately after a caesarean section. Further, there were many concerns expressed at three hospitals, including a finding of unsatisfactory professional conduct and suspensions and restrictions imposed on him.

1165. On 4 March 2016, Dr Gayed wrote to Dr Ali to respond to the letter of 26 February 2016 informing him of the preliminary findings of the review team. This response

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[401] Letter from Mr Michael DiRienzo, Chief Executive, Hunter New England Local Health District, to the Medical Council of NSW, 24 February 2016 (Tab 4.a.38, HNELHD documents).
[402] Email from Ms Karen Kelly, Executive Director, Greater Metropolitan Health Service, to Health Care Complaints Commission, 29 February 2016 (Tab 4.a.38, HNELHD documents).
[403] Letter from Dr Osama Ali, Acting Director Clinical Services, Manning Hospital, to Dr Emil Gayed, 26 February 2016 (Tab 4.a.44, HNELHD documents).
[404] Letter from Dr Osama Ali, Acting Director Clinical Services, Manning Hospital, to Dr Emil Gayed, 26 February 2016 (Tab 4.a.44, HNELHD documents).
[405] Letter from Dr Gayed to Dr Osama Ali, Deputy Director Clinical Services, Manning Rural Referral Hospital, 28 February 2016 (Tab 4.a.59, HNELHD documents).

includes detailed comments on each of the cases that had been raised as being of concern. In this letter Dr Gayed stated:

> With respect to the bias rule, the persons interviewing me and making findings potentially very serious to my career, must be disinterested in the matter at hand. On any objective review of the matter, Dr Roberts could not be said to be disinterested in the allegations, given his role in actively investigating and preparing the allegations, and being involved/part of the review team.
>
> It is evident that the findings made with respect to these allegations are tainted by bias and should be disregarded by the decision maker. Accordingly, I request that an independent expert should be appointed to conduce a fresh review of the cases the subject of this investigation.[406]

1166. Attached to Dr Gayed's correspondence of 4 March 2016 is a report from an obstetrician and gynaecologist who stated that for 10 years he had been a locum obstetrician gynaecologist for short periods at Manning Hospital. He discusses the cases that were the subject of the review briefly and concludes:

> I believe that only one patient justified a review of some sort. A clinical meeting at the hospital, common practice in most hospitals, would be the forum where this patient's management ordinarily, would have and should have been respectfully considered. I also believe none of the other reported cases should have been referred for a peer review. The other cases could have been considered at a local hospital meeting, but certainly Dr Roberts should have had a respectful discussion with Dr Gayed about his concerns.
>
> In my overview of these cases, I have cause to suspect that there are other non-medical reasons for the actions taken by the Director of Obstetrics and Gynaecology at MBH. I consider that there has been a miscarriage of justice and due process in the termination of Dr Gayed's appointment as a VMO to MBH.[407]

1167. On 8 March 2016, Dr Ali wrote to Dr Gayed to acknowledge receipt of his response to the findings of the review team. Dr Ali informed Dr Gayed that 'the Health District has accepted your resignation submitted on 28th February 2016' and that the resignation had been deemed effective from that date. Dr Ali further informed Dr Gayed that the local health district had notified the Medical Council of the allegations.[408]

1168. The review team provided a report to the Executive Director Greater Metropolitan Health Services and the Director of Clinical Governance on 5 April 2016.[409]

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[406] Letter from Dr Gayed to Dr Osama Ali, Deputy Director Clinical Services, Manning Rural Referral Hospital, 4 March 2016 (Tab 4.a.35.16, HNELHD documents).
[407] Letter from Gordon R Campbell, 'To whom it may concern', 2 March 2016, attached to letter from Dr Emil Gayed to Dr Osama Ali, 4 March 2016 (Tab 4.a.35.16, HNELHD documents).
[408] Letter from Dr Osama Ali, Deputy Director Clinical Services, Manning Hospital, to Dr Gayed, 8 March 2016 (Tab 4.a.47, HNELHD documents).
[409] Hunter New England Local Health District, Review Team, Confidential Review Report, 5 April 2016 (Tab 4.a.35.14, HNELHD documents).

1169. On 7 April 2016, the Chief Executive of Hunter New England Local Health District wrote to Dr Gayed to notify him formally of the final decision of the Hunter New England Local Health District with respect to the review.

1170. He notified Dr Gayed that 'due to the seriousness of the allegations substantiated had you not resigned with effect from 28 February 2016 the Health District would have proceeded to terminate your employment contract as a Visiting Medical Officer' and that his entry would be retained on the Service Check Register.[410]

1171. On 7 April 2016, the Chief Executive of Hunter New England Local Health District also notified the Medical Council of the actions it had taken in relation to Dr Gayed. This letter was copied to both the HCCC and the Australian Health Practitioner Regulation Agency.[411]

1172. On 11 April 2016, the Chief Executive of Hunter New England Local Health District approved the creation of a Service Check Record that noted a finding of substantiated misconduct against Dr Gayed.[412]

1173. In my view, Hunter New England Local Health District took appropriate action, in accordance with the policies, to suspend Dr Gayed on 9 February 2016.

10. Summary of action taken by Medical Council in response to notification

1174. Following the notification from Hunter New England Local Health District on 1 April 2016 the Medical Council held urgent proceedings pursuant to s 150 of the *Health Practitioner Regulation National Law* (NSW) (**National Law**) to determine whether action should be taken either to suspend or impose further conditions on Dr Gayed's registration.

1175. The Medical Council imposed conditions on Dr Gayed's registration with effect from 7 April 2016, additional to those already in effect. The delegates specified that the additional conditions would have effect until the complaints were disposed of or the conditions were removed by the Medical Council. The conditions were, in summary:[413]

- Not to perform a laparotomy for any reason;
- To practice under category B supervision in accordance with the Medical Council's Compliance Policy-Supervision, except when consulting in his consulting rooms;

[410] Letter from Mr Michael DiRienzo, Chief Executive, Hunter New England Local Health District, to Dr Emil Gayed, 7 April 2016 (Tab 4.a.48, HNELHD documents).
[411] Letter from Mr Michael DiRienzo, Chief Executive, Hunter New England Local Health District, to Dr Emil Gayed, 7 April 2016 (Tab 4.a.48, HNELHD documents).
[412] Brief from Mr Peter Reay, Human Resources Manager, Hunter New England Local Health District, to Mr Michael DiRienzo, Chief Executive, Hunter New England Local Health District, 'Application for Approval to Create a Service Check Register Record', 11 April 2016 (Tab 4.a.50, HNELHD documents).
[413] Tab 357 Medical Council files.

- Not to perform any procedures in an operating theatre without prior written approval of his Medical Council-approved supervisor. The practitioner is to maintain and submit to the Medical Council of NSW on a monthly basis (within 7 days of each calendar month) a log of all procedures undertaken or proposed to be undertaken in an operating theatre;
- To authorise and consent to any exchange of information between the Medical Council and Medicare Australia for monitoring compliance with these conditions;
- To authorise Medical Council to notify current and future places in Australia where he works as a medical practitioner of any issue arising in relation to compliance with the conditions;
- By no later than 14 days of receipt of the written reasons for this decision, to provide proof that he has given a copy of the conditions to all employers, accreditors and the director of any hospital at which he has VMO rights;
- To advise the Medical Council in writing at least seven days before changing the nature or place of his practice.

1176. The Medical Council notified the new conditions to the Australian Health Practitioner Regulation Agency and provided a notice of decision to Dr Gayed and his solicitor, the Medical Council of New Zealand, the HCCC and Dr Gayed's employers, being Mayo Private Hospital and Warringah Day Surgery,[414] but not Manning Hospital or Hunter New England Local Health District. (The legislation required that notice be given by the Medical Council to employers including entities that had appointed the practitioner of any imposition or alteration or removal of conditions: s 176BA of the National Law).

1177. On 8 April 2016, the Medical Council referred the matter to the HCCC for investigation as a complaint under s 150D of the National Law.[415] On 28 April 2016, the Medical Council and the HCCC consulted and the matter was referred for investigation.[416]

11. Compliance with appointment policies

1178. The relevant policies are set out in chapter 2 of this report.

1179. Dr Gayed's credentials should have been checked as part of his initial appointment. There are no documents indicating that happened; however, his clinical privileges were consistent with his qualifications, experience and registration. Further, Dr Gayed had available evidence of continuing medical education.

1180. There are no documents indicating that 'structured reference checking' occurred; however, Dr Gayed had positive references available to him.

[414] Tabs 358, 359, 366, 367 and 368 Medical Council files.
[415] Tabs 362, 369 Medical Council files.
[416] Tab 369, p 6043 Medical Council files.

1181. The area health service should have checked with Cooma Hospital, the Medical Board and/or the HCCC before reappointing Dr Gayed in 2003, 2006 and 2011. There are no documents indicating it did so. I conclude that those checks were not made. These are serious omissions. The policies requiring this information to be acquired as part of consideration of reappointing Visiting Medical Officers are significant elements of a system designed to identify concerns about practitioners who work across various private and public health facilities.

1182. I have concluded that Dr Wills minimised concerns about Dr Gayed and paid little regard to the experience of Mona Vale Hospital (see section 4). The additional material available from Cooma Hospital, the Medical Board and HCCC may have persuaded Dr Wills or his managers to scrutinise Dr Gayed's performance more thoroughly.

1183. On each occasion the relevant area health service was informed by the Medical Board that conditions had been imposed on Dr Gayed's registration, there were delays in reflecting those conditions in his clinical privileges. The most significant was in 2001, when some 16 months elapsed after the area health service was told that Dr Gayed's registration was conditional on him not performing microsurgery.

1184. Dr Jenkins is of the view that microsurgery is rarely performed by obstetricians and gynaecologists and, while it is unsatisfactory that the delay occurred in that condition being reflected in his clinical privileges, practically, it is unlikely that he would have needed to perform microsurgery during that period.

1185. It has to be said that Dr Gayed provided at best misleading information on his applications in 2003, 2006 and 2011—in particular, in completing the form in 2011, by stating that his registration was 'full' when it was conditional.

1186. From 2005, the relevant policy required regular performance reviews. There is no indication that Dr Gayed was subject to any performance reviews, let alone regular performance reviews. These reviews, when performed regularly, are another significant element of the system. They are critical to identifying underperforming practitioners.

12. Compliance with conditions of appointment

1187. My terms of reference require me to report on the local health district's compliance with any conditions imposed on his appointment.

1188. No conditions were imposed on Dr Gayed's appointment at Manning Hospital.

13. Variation or withdrawal of Dr Gayed's clinical privileges

1189. My terms of reference require me to report on the local health district's variation or withdrawal of clinical privileges. There was no variation or withdrawal of Dr

Gayed's clinical privileges until 8 February 2016, when his appointment as a Visiting Medical Officer was suspended.

14. Consistency of clinical privileges with registration conditions

1190. My terms of reference require me to report on the consistency of Dr Gayed's clinical privileges with any registration conditions.

1191. On each occasion the Hunter New England Area Health Service was informed by the Medical Board that conditions had been imposed on Dr Gayed's registration, there were delays in reflecting those conditions in his clinical privileges. In 2001, some 16 months elapsed, and in 2008 three months elapsed, before his clinical privileges were consistent with his registration.

15. Reporting to the Medical Council

1192. My terms of reference require me to identify whether the local health district appropriately reported to the Medical Council notifiable conduct under the National Law.

1193. On 24 February 2016, Mr DiRienzo of Hunter New England Local Health District notified the Medical Council and the HCCC that the local health district was investigating a concern relating to Dr Gayed based on his treatment of six patients and had suspended him from Manning Hospital. The letter recommended that the Medical Council impose restrictions on Dr Gayed to minimise risks to patient safety pending the completion of the investigation.[417]

1194. In my view, it was appropriate for the local health district to make that notification.

16. A further audit?

1195. My terms of reference require me to advise whether any further audit or review of clinical outcomes should be considered. I am informed that, following Dr Gayed's suspension, the Hunter New England Local Health District conducted a number of Clinical Management Reviews. As a result, Lookbacks 1, 2 and 4 have been completed, with Lookback 3 currently underway.

1196. The first two Lookbacks concerned, first, the investigation of concerns relating to abnormal pathology prior to endometrial ablation being performed by Dr Gayed and, secondly, the investigation of concerns relating to patients with a diagnosis of carcinoma under the care of Dr Gayed.

[417] Letter from Mr Michael DiRienzo, Chief Executive, Hunter New England Local Health District, to the Medical Council of NSW, 24 February 2016 (Tab 4.a.38, HNELHD documents).

1197. Lookback 4 was an investigation of concerns relating to patients who had an endometrial ablation and a concurrent coding of leiomyoma (fibroid) under the care of Dr Gayed.

16.1 Lookback 3

1198. As indicated earlier, a public inquiry line was established by Manning Hospital for women who wished to request advice or a review of their treatment. The volume of women presenting triggered the commissioning of Lookback 3, which, at the time of writing this report, had not yet been completed.

1199. Between 25 June 2018 and 31 October 2018, the hospital public inquiry line received 199 calls from women about the treatment they had received by Dr Gayed. An expert team was established and it was determined that, as at 30 November, 176 patients required a risk assessment. Of those who did not require a risk assessment, 16 women had not been treated by Dr Gayed and others were not the subject of a report for various reasons, including no additional risk related to Dr Gayed's care.

1200. Ultimately, individual reports about the care provided by Dr Gayed to individual patients were prepared by Dr Roberts. The reports concerned 300 procedures.

1201. The local health district identified a limitation affecting the scope of its review, being that Dr Gayed was employed under a Visiting Medical Officer contract and he maintained private medical records. The local health district requested access to those records through his defence organisation; however, no information was provided. Thus, the reviewer did not have access, among other matters, to any intra-operative photographs, medical imaging and pathology results.

1202. Dr Jenkins reviewed 176 reports drafted by Dr Roberts.

1203. Dr Jenkins has provided me with his opinion as to the standard of treatment the relevant patients received from Dr Gayed. On the basis of his opinion, I have referred 50 patients to the HCCC for investigation. I understand that four of those have been referred to the HCCC for investigation.

1204. Five of those 50 women have been the subject of an IIMS report made at or around the time of the treatment and which has been produced to me.

1205. In respect of the other 45 women, I have not been provided with any written material by the Hunter New England Local Health District indicating that there were any concerns about their treatment at or around the time of the treatment.

1206. In relation to the IIMS reports which were provided to me in November 2018, and based on Dr Jenkins' opinion, I have referred one patient to the HCCC.

1207. I have provided the HCCC with Dr Jenkins' reports on each of those women.

1208. My conclusions below address my observations on the limited documents available concerning Dr Gayed's treatment in light of the large number of women whose treatment now warrants investigation.

17. Observations made by other health professionals

1209. Dr Walkom was a Visiting Medical Officer obstetrician and gynaecologist at Manning Hospital. He told me that he has had a few patients over the years who have asked for a 'second opinion' following Dr Gayed's surgery. He recalled two events: the first, where the ureter was cut, he described as something that 'could have happened to any surgeon'; and the second was an unsuccessful termination. Dr Walkom was, however, critical of Dr Gayed performing a laparotomy on a patient (see section 7.9).

1210. Overall, he said that Dr Gayed was not an 'outlier' among Visiting Medical Officers in Morbidity and Mortality meetings.

1211. He referred to the minutes of the Medical Staff Council meeting on 18 July 2018 which recorded that there was 'common knowledge with in the Hospital of problems' with Dr Gayed. He told me that that was a reference to Dr Gayed taking a long time in theatre.

1212. Dr Walkom told me that, on a number of occasions, he went to Dr Wills, as there had been 'talk' about Dr Gayed, and asked him 'what was being done'. Each time, he was told that the Medical Board was 'keeping an eye' on Dr Gayed and it was not really 'our concern'.

1213. Dr Wills told me that Dr Walkom did not speak with him about clinical concerns about Dr Gayed and told him nothing which could be investigated. That is not inconsistent with what Dr Walkom told me.

1214. Dr Wills told me that there were no specific issues raised with him by Dr Gayed's peers or nursing staff. He said there was no more chatter about Dr Gayed than anyone else.

1215. Dr Ali was an Emergency Department Career Medical Officer from 2007 until March 2018, when he became Acting Director Medical Services. He told me that he knew nothing about Dr Gayed's competence until February 2016, when he participated in Dr Roberts' review. He said he was not in a position to hear anything, as he had only worked in the Emergency Department. He said he never had a problem with admitting a patient or referring a patient to Dr Gayed.

1216. Dr Bourke, an anaesthetist at Manning Hospital, worked with Dr Gayed infrequently, probably less than once a month from 2013 to 2016.

1217. During that time, his impression was that Dr Gayed had higher levels of complication rates than his peers and that his patients required greater pain relief then would be expected. He had discussions with colleagues, anaesthetists and

nursing staff who shared his concerns. He did not document any of these matters and was not aware that anyone to whom he spoke recorded their concerns. Dr Bourke emphasised that he only worked infrequently with Dr Gayed.

1218. He was of the view that, because Dr Gayed had been a Visiting Medical Officer at the hospital for so long, staff had become desensitised to him and his performance. They were aware that there were visits from the 'Colleges' and that they had imposed limits on Dr Gayed. However, Dr Gayed's performance was no different after those visits.

1219. For Dr Bourke, his concerns culminated with Dr Gayed's treatment of a patient (see section 7.9). She had significant complications and Dr Gayed's treatment was 'beyond the spectrum'. That was the first occasion he addressed concerns to Dr Wills about Dr Gayed. At Dr Wills' request, he documented his issues (the document has not been provided to the inquiry) and met with Dr Roberts, Dr Wills and an anaesthetist colleague who shared his views.

1220. He believed that Dr Wills and Dr Roberts agreed that his concerns were well founded; however, they told him that there was no 'paper trail' of other issues with Dr Gayed being raised.

1221. Dr Bourke understood the difficulties posed where no other issues were documented; however, he expected a formal review to be undertaken. He considered Dr Roberts' response in suspending Dr Gayed in February 2016 to be timely and welcome.

1222. Dr Bourke told me that in the last six months of 2015 he was told of concerns by nursing staff about Dr Gayed's vision. It was thought that he might have an impairment. He relayed this information to Dr Roberts and Dr Wills at the meeting.

1223. Dr Campbell is the senior staff paediatrician at Manning Hospital. He worked with Dr Gayed from 2002 until 2017. He made a submission to the inquiry that Dr Gayed was well regarded professionally and at no perinatal Morbidity and Mortality meeting did he recall his management of obstetric patients being subject to significant criticism. He submitted that on only two occasions was he critical of Dr Gayed's decision to perform elective caesarean section deliveries after hours.

1224. Mr Michael de Wright has been Nurse Manager of the Perioperative Unit at Manning Hospital since 2012. Prior to that he was Nursing Unit Manager in the same area. He told me that the main issue for nursing staff was Dr Gayed's eyesight. Mr de Wright said that there was talk about this issue; however, it was never the subject of an IIMS report or a written report. He had some nurses speak with him but not in a formal manner.

1225. Mr de Wright obtained a report from the data recording 'booked into theatre' which revealed unplanned return to theatre rates of the three Visiting Medical Officers from 2000 to 2018. Dr Gayed had only three, which was low compared with the other two. He believes that, as there were no clinical complications from

Dr Gayed's eyesight, such as would be revealed by that data, there were no formal reports or IIMS reports about that issue.

1226. He said there was a 'general feeling' that Dr Gayed was not a 'very good surgeon' and there was not 'a great deal of confidence in him'. That seemed to be largely based on the mistakes he made because of his eyesight. Mr de Wright referred to the 2008 'list', which is set out in section 4.9, as indicative of the concerns. He also said that staff were aware that he was subject to clinical reviews. However, on clinical indicators he was no different from the other Visiting Medical Officers.

1227. He described the lessons learned from what is now known about Dr Gayed as the need for governance structures such as the appointment of a Director; and well-organised Morbidity and Mortality meetings. He referred to the difficulty for Dr Ali and Dr Wills, as Directors of Clinical Services, to review obstetrics and gynaecology cases when each was an emergency career medical officer. In addition, he believed that the IIMS should be better used to capture concerns such as Dr Gayed's eyesight.

1228. Ms Sharron Brown, currently Clinical Nursing Unit Manager Operating Theatres, Manning Hospital, has worked at the hospital since 1997. She told me that the main concern of nurses about Dr Gayed was his vision. She was aware that Dr Gayed was being reviewed by the Medical Board and assumed that he was 'OK' because there was no change after the reviews. She told me she had a discussion with Dr Gayed concerning a patient (section 6.9) and the difficulty Dr Gayed had in controlling bleeding. Dr Gayed wrote to her acknowledging the bleeding and explaining that his vision was 'quite good since the successful cataract surgery'.

1229. She told me that, generally, the nurses' concerns were not recorded in IIMS.

18. IIMS and information provided by the Hunter New England Local Health District

1230. My terms of reference relate to the response of Hunter New England Local Health District to concerns about Dr Gayed.

1231. As set out in the introduction to this chapter, I sought information from the local health district and documents were provided over the course of the inquiry.

1232. I have been advised by Hunter New England Local Health District of the processes it followed in searching for IIMS reports concerning Dr Gayed.

1233. I am told that there are 'well known' limitations to searching the IIMS. These limitations include:

(a) The system cannot be searched by clinician name as there is no field for 'staff name' in clinical or complaint incident categories.

(b) IIMS does not search free text fields so, despite Dr Gayed being mentioned by name in the free text field incident description, a search on 'Gayed' did not identify clinical or complaint IIMS records.

(c) Searching IIMS by patient name and/or medical record number (MRN) has the potential to miss reports, as the minimum data set for clinical incidents does not include patient identifiers (name, MRN or date of birth).

(d) The IIMS cannot be searched by location, as the location tree has many layers and Dr Gayed's patients may have been located in multiple wards, departments and facilities. The search can be conducted at the local health district level, but, without additional information to refine the search, identifying incidents relating to Dr Gayed is not achievable.

1234. I am told that during the course of my Inquiry more IIMS reports were identified by the local health district after more patient identifiers became available. This primarily occurred as a result of other reviews being carried out by the local health district.

1235. I accept the fact that Dr Gayed was not named as the clinician responsible and without, until recently, patient details, the local health district's capacity to identify all IIMS reports was significantly reduced.

1236. I understand that the current NSW Health Policy Directive PD2014_004, 'Incident Management Policy', published 10 February 2014, states that the notifier 'must not include identifiable details such as staff names' when recording the incident notification in the IIMS (PD 2014_004, p 8). The IIMS Data Management Guidelines published in January 2013 also indicate that public health organisations have a duty to 'Ensure that information entered into IIMS does not contain any potentially identifying or sensitive data, and rectify any breaches' (section 4.1, under the heading 'Privacy and Security of Data').

1237. Prior versions of the Incident Management Policy did not explicitly prohibit staff names from being included in IIMS. However, the NSW Policy Directive PD2005_404, 'Incident Information Management System (IIMS)', published 27 January 2005, which outlined the statewide deployment of the New South Wales IIMS, indicates that the purpose of IIMS is to manage systems issues rather than individual performance issues. Appendix 2 of the policy states that 'concerns about individual clinicians are not documented in IIMS'. The policy indicates that these concerns should be managed separately from the incident management processes, in accordance with the 'Guideline on the Management of a Complaint or Concern about a Clinician 2004'.

1238. I am informed that the Clinical Excellence Commission has a key role in routinely reviewing the clinical form within IIMS for serious incidents; however, it does not have responsibility for the regular review of the other notifications forms within IIMS.

1239. I understand that the Guideline on the Management of a Complaint or Concern about a Clinician referred to in this chapter is designed to be the method by which concerns about a clinician are raised. The IIMS serves different functions. It is beyond my inquiry to opine on the operation of the complete IIMS.

1240. The local health district tells me that it has considered the limited reporting of significant clinical outcomes of Dr Gayed's management and has 'resolved to work with the Gynaecology Stream to identify a list of mandatory incident reporting for gynaecological procedures. A process similar to the notification of obstetrics trigger IIMS will be developed and piloted at Manning Hospital'.

1241. In any event, I am of the view that the health system should have in place governance processes by which IIMS can be monitored at a local health district level to ensure that issues of patient safety relative to a particular clinician can be identified.

1242. It seems that the processes in place did not identify that aggregate reviews were not taking place or, if they were, were not documented.

1243. It is of concern that the response of the Hunter New England Local Health District to my request for an explanation of the meaning of an aggregate review was to indicate that 'at that time' there were no documents evidencing those reviews.

1244. I have been provided with nine IIMS reports covering the period 2011 to 2016 in which an aggregate review was recorded as 'undertaken'. That accounts for many of the IIMS reports I have been given. No documents have been provided to me indicating that that occurred. I infer that over that five-year period there was no requirement that the fact and results of aggregate reviews be documented. If that has not been remedied, it should be.

1245. The need for improved governance processes is also supported by the two occasions in 2012 when it was recorded that an investigation took place. If it did, no records were provided to me. Finally, there was reference in 2011 that relevant IIMS report be referred to the Medical Director. Again, if that happened, no records were provided to me.

19. Conclusions

1246. In most years from 1999 to 2016 there was a complaint or concern raised about Dr Gayed's clinical treatment of a patient. They were expressed by nursing staff, anaesthetists and other medical practitioners as well as, more recently, patients themselves. They were identified by the reviews of Dr Roberts and the reviews conducted as part of this inquiry by Dr Jenkins.

1247. Those concerns continued notwithstanding:

(a) the findings of a Professional Standards Committee in 2001 and the conditions imposed on his practice;

(b) the assessments by the Medical Board and Medical Council at various times over a decade and the imposition of further conditions on his registration; and

(c) the effective termination of his contract at three hospitals: Cooma in 1999, Delmar in 2007 and Mona Vale in 2007.

1248. Of most concern is that a repeated theme has been the unnecessary removal of organs, unnecessary or wrong procedures, perforations of organs and reluctance to transfer to tertiary facilities.

1249. Dr Gayed remained at Manning Hospital from 1999 until early 2016 notwithstanding that, by that time, at Manning Hospital alone, there had been 50 women whose treatment, according to advice by Dr Jenkins, which I accept, warrants a complaint to the HCCC and many more who had complained directly to the HCCC.

1250. Most of these 50 women I have referred to the HCCC—that is, 30 in number—were treated between 2011 and 2015.

1251. The health system failed each of these women.

19.1 What went wrong

1252. First, Dr Gayed was a Visiting Medical Officer in obstetrics and gynaecology. He saw patients in his private rooms, where he carried out assessments, examined patients and made diagnoses. He booked women in for surgery at Manning Hospital. They often returned to his private rooms and some were encouraged not to attend Manning Hospital after complications arose. His medical records were not available to the hospital; nor were any test results. It follows that the extent to which oversight could have occurred, if there was a view it should have, was limited.

1253. I am concerned about a situation in which a public hospital provides facilities for a Visiting Medical Officer obstetrician gynaecologist to practise without the hospital having the capacity to ensure that those female patients are being cared for at the standard expected in a public hospital.

1254. In my view, the public health system should have sufficient information about patients receiving procedures in its hospitals and using its ancillary staff to be satisfied that the procedures are being performed to an appropriate standard.

1255. Secondly, mechanisms for oversight were not used. There was a requirement for regular performance reviews of Visiting Medical Officers. This did not occur with Dr Gayed.

1256. There were no clinical supervision plans of him as required by policy.

1257. Aggregate reviews of incidents recorded on the IIMS were not completed or not documented.

1258. The doctors did not record concerns on the IIMS at all and the nurses did so selectively.

1259. There was no evidence available to me that, before the arrival of Dr Roberts, there was any review of the IIMS undertaken to enable any pattern to be detected or reviews followed up.

1260. Thirdly, senior staff were not available to provide supervision and monitoring. There was no Director of Obstetrics and Gynaecology until April 2015. It is no coincidence that IIMS reports and other complaints escalated from mid-2015. Dr Bourke told me that there were discussions among colleagues and no reporting because 'there was no-one to report to'.

1261. The Director of Clinical Services was a Career Medical Officer Emergency Department doctor who responded to IIMS reports concerning Dr Gayed. I have documented the occasions on which Dr Wills was unduly favourable to Dr Gayed, did not follow policy and minimised the seriousness of concerns raised.

1262. Fourthly, the hospital was reliant on Dr Gayed providing most of the obstetrician and gynaecologist services.

1263. Local health districts need to identify these circumstances, particularly in regional, rural and remote areas, and ensure there is external oversight of the performance of medical practitioners providing such services.

1264. Fifthly, the indicators in place, Morbidity and Mortality meetings and various 'trigger' events were not sufficiently sensitive or effectively monitored to detect Dr Gayed's poor performance.

1265. Sixthly, there was an attitude which prevailed that what occurred outside Manning Hospital with Dr Gayed was irrelevant to the experience of Manning Hospital. Hence:

(a) Following the report of the Professional Standards Committee in 2001, the Mid North Coast Area Health Service did not carry out a review of Dr Gayed's clinical privileges or a risk assessment as to Dr Gayed's continued appointment at the hospital.

(b) The area health service / local health district did not make any inquiries of previous places of employment, the Medical Board / Medical Council or HCCC when Dr Gayed reapplied for appointment as a Visiting Medical Officer in 2003, 2006, 2007 and 2011.

(b) The local health district did not carry out a review of Dr Gayed's clinical privileges after it was notified by the Director of Clinical Governance at Northern Sydney and Central Coast Area Health Service of its effective suspension of Dr Gayed.

(d) After that notification, the local health district did not have Dr Gayed's performance reviewed by one or more clinicians who were of the same speciality and did not have an appointment at or work as a staff specialist at Manning Hospital. Such a review would have avoided any conflict or bias towards a Visiting Medical Officer who carried a large burden of the roster of the hospital and was a colleague of many at Manning Hospital.

1266. With the appropriate leadership, both within the hospital and the local health district, this attitude should not have prevailed.

1267. Finally, staff relied too heavily on the Medical Board providing oversight and imposing conditions on or correcting Dr Gayed's performance. They believed that, because Dr Gayed's performance did not change after intervention by the Medical Board, his performance was satisfactory.

1268. Staff became desensitised to his poor performance.

1269. Dr Wills told me that he relied on the Medical Board / Medical Council to determine whether Dr Gayed was fit for practice and did not consider that to be his role. He said he made statements and gave evidence based on his experience of Dr Gayed alone.

1270. Dr Wills was entitled to rely upon the Medical Board / Medical Council for it to carry out its regulatory functions. The Medical Board / Medical Council was the only body with overall knowledge of performance concerns of Dr Gayed from his public and private appointments and private practice. It assessed his performance from time to time and had the benefit of the views of those assessors.

1271. However, the responsibility of the Medical Board / Medical Council did not relieve the hospital from properly reviewing Dr Gayed's performance on a regular basis by a clinician with the same expertise. That was not done.

1272. Hunter New England Local Health District told me that there are now a number of mechanisms in place which should identify a practitioner with similar problems. I am told that some of these processes were in place during the time Dr Gayed was working at Manning Hospital.

1273. I have not considered current practices and procedures at Manning Hospital in respect of the above matters.

20. Recommendations

1274. I recommend that governance processes of Hunter New England Local Health District be reviewed to ensure that IIMS reports are monitored at a local health district level to enable issues of patient safety relative to a particular clinician to be identified and to ensure that relevant staff have undertaken the reviews and investigations which the IIMS records as to be or having been undertaken.

1275. I recommend that public hospitals which have arrangements with Visiting Medical Officers to undertake procedures on their private patients, using public facilities, should establish mechanisms to ensure access to sufficient information about those patients to be satisfied that the procedures are being performed to an appropriate standard.

1276. The hospital was reliant on Dr Gayed providing most of the obstetrician and gynaecologist services. Local health districts need to identify these circumstances, particularly in regional, rural and remote areas, and ensure there is external oversight of the performance of medical practitioners providing such services.