IN THE HIGH COURT OF AUSTRALIA
BRISBANE REGISTRY

No. B11 of 2012
B25/2011

BETWEEN

JAYANT MUKUNDRAY PATEL
and
THE QUEEN

Appellant/Applicant
Respondent

10 **APPELLANT'S SUBMISSIONS**

Part I: Certification that the submissions are in a form suitable for publication on the internet

1. We certify that the submissions are in a form suitable for publication on the internet.

Part II: A concise statement of the issues the Appellant contends that the appeal presents

2. There are two issues presented by this appeal:
   a. Whether the appellant was convicted under the wrong provisions of the *Criminal Code 1899* (Qld), in particular by incorrect reliance on a breach of s.
20 288 as a pre-requisite to his conviction; and
   b. Whether there was a miscarriage of justice in the way the trial was conducted.

Part III: Section 78B of the *Judiciary Act 1903* (Cth)

3. The appellant has considered whether any notice should be given in compliance with s. 78B of the *Judiciary Act 1903* (Cth). No such notice is required.

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Part IV: Citation

4. The proceeding at first instance was a trial by jury. The appeal was *Patel v R; ex parte A-G (Qld)* [2011] QCA 81.

Part V: A brief statement of the factual background to the appeal

5. The appellant, Dr Patel, appeals against his convictions for the manslaughter of three patients of the Bundaberg Base Hospital (Mr Morris, Mr Phillips and Mr Kemps), and for unlawfully doing grievous bodily harm to another (Mr Vowles).

6. The convictions of the appellant occurred on the 58th day of the trial. The Crown called its final witness on Day 39. Dr Patel elected not to give evidence.

7. The Crown, by its most senior prosecutor, Mr Martin SC, opened its case on the basis that it was intending to prove a contravention, in each case, by the appellant of s. 288 of the Code. By Day 40, the Crown was represented by the Solicitor-General, Mr Sofronoff QC, who argued that s. 288 was irrelevant to the Crown case. The trial judge decided on Day 41 that the case could only proceed by means of s. 288. This ruling was made on Day 40. On Day 42, the trial judge decided that "a decision to operate" could fall within s. 288. The first issue in the appeal considers the correctness of each of these rulings.

8. In relation to the claim that there was a miscarriage of justice, the Crown opened a very broad case against the accused. Its first set of particulars was delivered in relation to Mr Morris on Day 6. Particulars involving very similar broad and alternative allegations were then delivered in relation to the other three cases throughout the trial. These particulars, *inter alia*, alleged that Dr Patel had not conducted the operations in good faith and knew that they were unnecessary (and therefore not for the patients' benefit).

9. On Day 10, the defence's application to discharge the jury was dismissed.

10. As is developed below, the trial judge made repeated serious criticisms of the particulars throughout the trial. His Honour found them incomprehensible and incoherent and likened them to a civil pleading that should be struck out as disclosing no cause of action. He referred to the trial more than once as a "mud-slinging" exercise.

11. Crucially, his Honour identified that it would be acceptable if the Crown delivered narrower and coherent particulars by the time that addresses to the jury were made.

12. On Day 43, with the encouragement of the trial judge, the Crown delivered revised particulars identifying a much narrower case. The trial judge described them as a "vast improvement" and as the first comprehensible particulars that had been delivered. By this stage all of the Crown evidence had been called.

13. On Day 44, the defence applied for the discharge of the jury on the basis that much irrelevant and prejudicial evidence had been heard by the jury before the revised particulars were delivered. The trial judge dismissed the application.

Part VI: The Appellant's argument

Introduction

14. Dr Patel obtained a grant of special leave in relation to ground two of the notice of appeal.[1] The second issue concerns the miscarriage of justice. The special leave application in relation to the second issue was referred to the expanded court to be agitated on the appeal.[2]

15. Both issues are addressed in these submissions.

16. If either ground is decided favourably to Dr Patel then his conviction ought to be quashed and an order made for a new trial.

The First Issue: s. 282, s. 288 of the Code

A. The Case on which the Appellant was convicted

17. Dr Patel was tried and convicted in each of the four cases only on the basis that a contravention of the duty in s. 288 was essential to a conviction. The case put to the jury was that unless there was a breach of s. 288 involving a culpable degree of criminal negligence they could not convict the accused.

18. Section 288 was the wrong section to apply and had nothing whatsoever to do with the crimes of which the accused was found guilty. The wrong law was applied by the trial judge and the Court of Appeal, and Dr Patel was deprived of a trial according to law, under relevant and applicable provisions. In particular, the availability of an exculpatory provision, s. 282, which was directly applicable to this unique case, was not even put to the jury to consider.

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[1] *Patel v The Queen* [2012] HCA Trans 019
[2] *Patel v The Queen* [2012] HCA Trans 019

19. In each of the four cases, Dr Patel was convicted of a decision to operate which was criminally negligent. He was not convicted of performing incompetent surgery. The trial judge summed up the case in these concise terms:

> *"It is critical to appreciate that this trial is not about botched surgery.*
>
> *Instead, it is about surgery performed competently enough....*
>
> *It is not how the accused performed the surgery that matters in these four cases.*
>
> *What matters is his judgment in deciding to commend the surgery to a patient and, having obtained the patient's consent, in taking the patient to theatre to perform it.*
>
> *The prosecution contends that the operations were unnecessary or inappropriate.*
>
> *Removal of Mr Morris's sigmoid colon is said to have been inappropriate, mainly because the bleeding problem that the surgery was to address was sourced in his rectum.*
>
> *The surgery on Mr Vowles is said to have been inappropriate because, contrary to what the accused supposed, Mr Vowles did not then have colon cancer.*
>
> *With both Mr Phillips and Mr Kemps, the primary contention is that the patient's health was too precarious for an oesophagectomy."*[3] [underlining added]

20. The case put to the jury was in each case that in order to convict they had to find that the prosecution had established beyond reasonable doubt a contravention of the duty in s. 288.[4]

B. Sections 282 and 288

21. The defence in s. 282 was not addressed by the trial judge and the jury was not asked to consider this exculpatory provision. The incongruity of this is revealed by a plain reading of each of s. 288 and s. 282. On a plain reading, s. 288 does not deal with a decision to operate anterior to the surgery. By contrast, on a plain reading, s. 282 does deal with a decision to operate in addition to the performance of the surgery.

22. Section 288, which is contained in Chapter 27 of the Code, entitled "Duties Relating to the Preservation of Human Life", provides:

> *"It is the duty of every person who, except in a case of necessity, undertakes to administer surgical or medical treatment to any other person, or to do any other lawful act which is or may be dangerous to human life or health, to have reasonable skill and to use reasonable care in doing such act, and the person is held to have caused any consequences which result to the life or health of any person by reason of any omission to observe or perform that duty".* [underlining added]

[3] T 52.59 L49 – T 52.60 L50
[4] T52.65 L3-11

23. Chapter 27 contains five sections. Each follows a structure similar to s. 288; that is, imposing a duty upon a person in certain particular circumstances and deeming causative consequences for the results of failing to perform that duty.

24. By contrast, s. 282, which is contained in Chapter 26 of the Code, is an exculpatory provision that obviously had a special and unique application to the case put against the accused. On a plain reading it applies to a decision to operate. At the relevant time it provided:

> *"**282** A person is not criminally responsible for performing in good faith and with reasonable care and skill a surgical operation upon any person for the patient's benefit, or upon an unborn child for the preservation of the mother's life, if the performance of the operation is reasonable, having regard to the patient's state at the time and to all circumstances of the case".* [underlining added]

C. The Legal Position Contended by the Crown at Trial

25. That section 282 does deal with a decision to operate and that s. 288 does not is not only the plain meaning of the provisions but was also submitted as the correct legal position by the Crown to the trial judge. Although the prosecution case was conducted by Mr Martin SC, Mr Sofronoff QC SG addressed the trial judge on this particular issue on Day 40 of the trial, after the prosecution witnesses had all been called.[5] The Crown, by the Solicitor-General, made correct and responsible submissions on this issue. The trial judge delivered Ruling No. 3 on Day 42 of the trial.[6] His Honour erred in Ruling No. 3 because he reasoned, incorrectly, that a distinction between s. 282 and s. 288 was that s.282 dealt with cases where the patient had not consented but s.288 dealt with cases where there was consent.[7] The Court of Appeal correctly reasoned that s. 282 was not limited to cases where there was no effective consent to an operation.[8] This was not an answer, however, to the correctness of the Crown's position as submitted by the Solicitor-General.

D. Rulings No. 3 and No. 4 at Trial

26. In Ruling No. 3, the trial judge reasoned clearly and correctly that s. 282 did cover a decision to operate:

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[5] Mr Sofronoff's written submissions were marked "W" for identification
[6] Ruling No. 3: *R v Patel* [2010] QSC 198
[7] Ruling No. 3: *R v Patel* [2010] QSC 198 at p 8.2 per Byrne J
[8] Court of Appeal reasons at [35]

"First, s. 282 deals not only with reasonable skill and care in performing the surgery – as does s. 288 – but also with the reasonableness of performing the procedure at all – something s. 288 does not touch, probably because it assumes consent".[9] [underlining added]

27. The trial judge decided, in Ruling No. 3, based upon his erroneous reasoning about s.282 only covering non-consensual cases, that:

"The prosecution must be confined to the case opened more than two months ago, which means that the accused's criminal responsibility depends upon proof of a contravention of the duty which s. 288 imposes."[10]

28. In Ruling No. 4, delivered two days later, on Day 42 of the trial, the trial judge ruled inconsistently with the reasoning quoted at paragraph 26 above that s. 288 did extend to the prosecution case which involved a wrong decision to operate.[11]

29. If the trial judge had not altered his reasoning in the two days between Ruling No. 3 and No. 4 there would have been a very serious consequence for the prosecution case, *viz* it could not have proceeded and gone to the jury under s. 288 and the jury would have had to have been discharged.

E. The Correct Way that should have been applied

30. The correct way to proceed, and the law which should have been put to the jury, was that submitted by the Crown, through the Solicitor-General on Day 40, and reflected in the written submissions which were summarised by the trial judge in Ruling No. 3 at page 4, involving these elements on the manslaughter charges:

a. the operation caused the death;
b. the death is an unlawful killing unless authorised, justified or excused by law;
c. the death was not an event that occurred by accident: s. 23; and
d. the defence under s. 282 is negatived by the prosecution.[12]

31. The position was put succinctly in the written submissions of the Crown, by the Solicitor-General:

" Consequently, the Crown submits, that in respect of these charges where the accused is alleged to have unlawfully killed a patient by undertaking the surgery, s. 288 is irrelevant. The Crown will need to prove a positive act (the surgery) which caused the death of the patient. If the facts raise a defence under s. 282, as

[9] Ruling No. 3: *R v Patel* [2010] QSC 198 at p. 8.8 per Byrne J
[10] Ruling No. 3: *R v Patel* [2010] QSC 198 at p. 14.4 per Byrne J
[11] Ruling No. 4: *R v Patel* [2010] QSC 199 at pp. 13-15 per Byrne J
[12] Ruling No. 3: *R v Patel* [2010] QSC 198 at pp. 4-5 per Byrne J

they appear to do, then the Crown will have to negative that defence. It will seek to do so by proving that the performance of the surgery was not reasonable."[13]

32. This submission was entirely correct and responsibly put and the trial judge and the Court of Appeal erred in deciding that s. 288 had any relevance to the case.

F. A Summary of the Reasons why s. 288 was irrelevant

33. There are a number of reasons why the trial judge and the Court of Appeal ought to have found that s. 288 was irrelevant to a case that the decision to operate, in each of the four cases, was criminally negligent.

34. First, the plain meaning of the text of s. 288 is that it deals with the performance of surgery or administering surgical or medical treatment. The words "*in doing such act*" clearly support this. One is not confronted with an ambiguous provision. It is perfectly plain. Historical development of this part of the Code does not support a contrary argument. But in any event, historical or common law considerations do not take precedence over the plain meaning of the text: *R v Barlow*;[14] *R v LK*.[15]

35. Secondly, reading the Code coherently, as a whole, makes it clear that when the Code intends to refer to a decision to operate it does so, as in s. 282, and that no such intention is revealed in s. 288. This difference is particularly significant when it is considered that each of s. 282 and s. 288 is dealing with a very similar subject matter.

36. Thirdly, the interpretation adopted by the trial judge and Court of Appeal fails to give any appropriate significance to the words "*or to do any other lawful act*" in s. 288. The section is premised upon the decision to operate, logically anterior to the performance of the surgery, being lawful. It does not make sense that the section could be attempting to cover criminally reprehensible decisions to operate as they, by definition, could not be lawful.

37. Fourthly, if there is any ambiguity in s. 288 on this subject, and it is submitted that there is none, such ambiguity, given it is a penal provision, ought to have been resolved in favour of the most lenient construction: *Deming No 456 Pty Ltd v Brisbane Unit Development Corporation Pty Ltd*;[16] *Chew v R*.[17] At the very least, the

[13] These submissions were marked "W" for identification
[14] (1997) 188 CLR 1 at 18-19 per McHugh J
[15] (2010) 241 CLR 177 at [97] per Gummow, Hayne, Crennan, Kiefel and Bell JJ
[16] (1983) 155 CLR 129 at 145 per Mason, Deane and Dawson JJ
[17] (1992) 173 CLR 626 at 632 per Mason CJ, Brennan, Gaudron and McHugh JJ; at 642 per Dawson J

trial judge ought to have recognised that his own view was that s. 288 was plain or at least ambiguous and applied the most lenient interpretation. He did not do so.

38. Finally, the trial judge (in Ruling No. 4) and the Court of Appeal were influenced in their reasoning that s.288 applied to a decision to operate because otherwise bizarre consequences would ensue, namely that a wanton and criminal decision to operate, where the surgery was performed correctly, would go unpunished. The Court of Appeal assumed that in extreme, hypothetical cases, the Code would provide no response.[18] This reasoning was fundamentally incorrect for two reasons:

a. it assumed the correctness of the trial judge's rejection of the Crown's argument in Ruling 3. The Crown's argument, as summarised above, correctly would have accommodated the criminality of such cases; and

b. secondly, it is not a correct principle of interpreting the Code, in any event, to strain unreasonably the meaning of a plain provision to make it accommodate extreme, hypothetical examples of medical misconduct. If there were a lacuna in the Code (and it is submitted there is not), this is not a reason to distort the quite plain meaning of s. 288. Both the trial judge and the Court of Appeal erred in this important respect.

G. The Inapplicability of the Proviso

39. The appellant, in being convicted of an offence by reason of a contravention of the duty in s. 288, and without the jury having drawn to its attention for consideration the applicable exculpatory provision under s. 282, did not have a trial according to law. Quite simply and bluntly he was tried under the wrong legal provisions.

40. For this reason his conviction should be quashed. Any accused is entitled to a trial under the correct legal provisions of the Code correctly explained to the jury: *Mraz v The Queen*;[19] *Nudd v R*;[20] *Handlen v The Queen*.[21]

41. The Court of Appeal erred in deciding that s. 288 could apply to the decisions to operate. However, it went on to reason that even if s. 288 was not the correct provision, Dr Patel's appeal should be dismissed because proof of a breach of duty under s. 288 necessarily implied that Dr Patel's conduct in performing each operation at all was unreasonable having regard to all of the circumstances of the case. In other

[18] Court of Appeal reasons at [16], [42], [41]
[19] (1955) 93 CLR 493 at 514 per Fullagar J
[20] (2006) 225 ALR 161 at 163 per Gleeson CJ
[21] (2011) 86 ALJR 145 at [42] – [47] per French CJ, Gummow, Hayne, Crennan, Kiefel and Bell JJ

words, the guilty verdicts obtained via s.288 necessarily meant that a defence under s. 282 could not have been made out.[22]

42. The Court of Appeal was influenced by reasoning that the trial judge had directed the jury under s. 288 in terms that required criminal negligence consistently with cases such as *R v Bateman*[23] and the decision of this Court in *Callaghan v The Queen*[24] in the terms quoted at paragraphs [20], [21], [23] and [24] of the Court of Appeal's reasons.

43. The Court of Appeal erred in this reasoning for four reasons.

44. First, the only means by which it could even be conceivable that an accused's conviction by means of incorrect legal provision could be upheld would be by invoking the proviso in s 668E(1A) of the Code. That required specific consideration of the question whether the Court of Appeal considered that "*no substantial miscarriage of justice has actually occurred*". The Court of Appeal did not refer to the proviso or provide reasons why it specifically applied. But even if it had, the proviso should not have been found to apply for the reason that the wrong law was applied which was capable of affecting the accused's position: *Handlen v The Queen.*[25] It is orthodox that the proviso may apply even where the appellate court is persuaded to the requisite standard of the appellant's guilt.[26]

45. Secondly, and further to the above, the accused had a trial conducted under an incorrect provision and was deprived of an opportunity to make decisions as to how he conducted his defence under the correct provisions. An obvious problem was that he was denied the opportunity to make an informed decision to give evidence knowing that s.282 was an exculpatory provision which he may seek to avail himself of by giving evidence. The closing words of s. 282 are broad: "... *having regard to...all circumstances of the case.*" Such words are not found in s.288 which serves a different purpose. Under s.282 it would be relevant for an accused to give evidence of a potentially broad range of matters including his experience, his level of appreciation of the imperatives that applied to each patient and his own skills, the influence upon him of the culture of practice at the Bundaberg Base Hospital and the wishes of the patients.

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[22] Court of Appeal reasons at [44]
[23] [1925] 19 Cr App R 8
[24] (1952) 87 CLR 115 at 123-124 per Dixon CJ, Webb, Fullagar and Kitto JJ
[25] (2011) 86 ALJR 145 at [47] per French CJ, Gummow, Hayne, Crennan, Kiefel and Bell JJ
[26] *Weiss v The Queen* (2005) 224 CLR 300 at 317 per Gleeson CJ, Gummow, Kirby, Hayne, Callinan and Heydon JJ

46. Thirdly, it was relevant for the jury to be instructed to consider s.282 whether Dr Patel gave evidence or not. It is anomalous that he was convicted without the relevant avenue of defence being brought to the jury's attention.

47. Fourthly, the Court of Appeal reasoned that because a higher standard of criminality had to apply to establish a breach of s. 288 because of *R v Bateman* this meant s. 282 could not succeed. This involved erroneous analysis. An accused could well choose not to give evidence if faced with a s. 288 case and take the chance that the Crown would not discharge the difficult task of proving morally reprehensible negligence but might, under a correctly run trial, have been more inclined to give evidence if s. 282 had been applied.

48. For these reasons, the convictions of the appellant should be quashed.

The Second Issue: Miscarriage of Justice

Introduction

49. The second major issue in the appeal is that which concerns whether there was a miscarriage of justice. The appellant requires a grant of special leave in order to appeal on this ground.

50. A chronology which deals with the progress of the trial is delivered with these submissions.[27] That chronology is an important adjunct to these submissions as it assists in explaining the manner in which the trial went off the rails.

51. The miscarriage of justice is in this case one that occurred by an accumulation of significant errors in the trial process. They are addressed separately below but it is emphasised that the cumulative effect of such errors on the trial and particularly on the jury needs to be at the forefront of consideration. The fact that a combination of errors, including errors by the trial judge can lead to a miscarriage of justice, is orthodox law.[28] Because many references to the transcript are involved, covering the course of the trial, these have been set out in **Schedules A, B and C** as explained below.

[27] Part IIB of the chronology
[28] *Nudd v R* (2006) 225 ALR 161 at 168-169 per Gleeson CJ

H. The Inadequacy of Particulars, the Dramatic Change in the Particulars and Dramatic Narrowing of the Crown Case

52. The trial proceeded in a highly unorthodox manner in relation to the particulars provided by the Crown.

53. This was a complex trial involving serious charges concerning four patients of Dr Patel and evidence admitted relating to another patient, Mr Grave, whose case was not the subject of a charge. The evidence was highly technical and scientific in places, and apt to be confusing. There were different operations involved and the medical histories of each of the four patients involved different, specific, and technically difficult issues. The case took place after two highly public commissions of inquiry had been conducted concerning events related to the accused and where the accused had received much adverse attention in the media. It was, in short, a trial that called for an emphasis on clarity and precision with the Crown case.

54. To the contrary, what occurred was that the Crown ran a confused, broad-ranging and legally incoherent case, and much prejudicial evidence was admitted against Dr Patel on that case. After the Crown had called all of its witnesses it dramatically narrowed its case by delivering revised particulars in relation to each of the four cases.

55. The trial judge erred in dismissing an application brought by the defence on Day 44 that the jury ought to be discharged. His Honour's reasons were inadequate and did not address the salient problem which was the prejudicial and unfair nature of the trial which had been permitted to occur.

56. By Day 44, the unfairness to the accused in what had occurred was irretrievable, but even by Day 10, when the first application for discharge of the jury was made, the trial judge erred in not acceding to it. By acceding to a correct application on Day 10 the trial judge would not have been confronted with the extra difficulty that presented itself on Day 44, that the trial had been running for a very long time.

57. The importance of the particulars in a criminal trial as defining the issues is clear from the authorities. But what occurred here was a dramatic shifting of the case, occurring late, after all the Crown witnesses had given evidence. The authorities on this include *S v The Queen*.[29] That is, where there is uncertainty about precisely what is charged ordinarily those difficulties will be avoided by ordering particulars and appropriately confining the evidence in the offences charged:

[29] (1989) 168 CLR 266 at 286-287 per Gaudron and McHugh JJ

> *"However, when a trial proceeds without an order averting those difficulties, the question is whether there is a blemish on the trial amounting to a substantial miscarriage of justice".*[30]

As stated by McHugh J in *KRM v The Queen*,[31] referring to the context of

> *"...an adversary system of criminal justice where an accused person is entitled to be given as high a degree of particularity concerning a criminal charge as the subject matter will bear. An accused person "is entitled to be apprised not only of the legal nature of the offence by which he is charged but also of the particular act, matter or thing alleged as the foundation of the charge."*[32]

10 McHugh J was quoting from the judgment of Dixon J (as his Honour then was) in *Johnson v Miller*.[33]

58. In *Johnson v Miller*, Evatt J said:

> *"It is an essential part of the concept of justice in criminal cases that not a single piece of evidence should be admitted against a defendant unless he has a right to resist its reception upon the ground of irrelevance, whereupon the court has the right and the duty to rule upon such an objection. These fundamental rights cannot be exercised if, through a failure or refusal to specify or particularise the offence charged, neither the court nor the defendant (nor perhaps the prosecutor) is as yet aware of the offence intended to be charged."*[34]

20 59. The present case involved a greater vice than a failure to particularise the case. It involved the replacement of broad, wide-ranging particulars, repeatedly described by the trial judge as confusing, incomprehensible, embarrassing and legally incoherent,[35] with revised and narrowed particulars which the trial judge described as a "vast improvement" and as being comprehensible for the first time.[36] There was the further fundamental problem that the trial judge encouraged the prosecution to narrow its case by the time it addressed the jury, seriously underestimating the effect that highly prejudicial evidence – admitted on the basis of the case opened, and on the basis of the original particulars – would have on the jury.

60. The trial judge made the following comments (these are not exhaustive):

30 a. Day 6.5: *"...well, judging by this morning's particulars [in relation to Morris] it [the trial] is about to become considerably more difficult*";

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[30] (1989) 168 CLR 266 at 287 per Gaudron and McHugh JJ, applying *Johnson v Miller* (1937) 59 CLR 467 at 480, 481 per Latham CJ; at 486 per Dixon J; at 497-498 per Evatt J; and at 501 per McTiernan J
[31] (2001) 206 CLR 221
[32] *KRM v The Queen* (2001) 206 CLR 221 at 229 per McHugh J
[33] *Johnson v Miller* (1937) 59 CLR 467 at 489
[34] (1937) 59 CLR 467 at 497 per Evatt J
[35] See the Chronology of the Trial at days 6, 7, 12, 20, 22, 27, 38 and 39
[36] See the Chronology of the Trial at day 43

b. Day 7.77: "*So far it looks to me – I haven't counted the number of alternative cases pleaded but it would be at least a dozen, wouldn't it?*";

c. Day 9.4: the trial judge accepts that in this case every little "*piece of mud*" is being thrown at the accused but expresses optimism that the case will be "*pared back by the time it goes to the jury to a digestible case capable of rational assessment...*";

d. Day 12.3: the trial judge reads particulars for the Phillips case and exclaims "*Oh, dear*";

e. Day 20.80: the trial judge, in referring to the Crown case says "*I am completely befuddled*"; the trial judge goes on to say, at Day 20.82, "*The idea that the case could go to the jury as a disconnected set of complaints or criticisms about what is being done is not only unappealing but very likely to be erroneous in law...*";

f. Day 22.6: the trial judge says "*How much more complicated can the case be made?*";

g. Day 26.80: the trial judge raises serious concerns about the large litany of complaints being made against Dr Patel;

h. Day 26.83: the trial judge refers to the "*myriad number of alternative cases that have been propounded*";

i. Day 26.84: the trial judge refers to the optimism of the Crown that by the time the evidence is concluded the range of alternative cases will be narrowed;

j. Day 30.4: the trial judge says "*...It is not a third Commission of Inquiry. A man is standing trial on very serious charges on the footing that he is criminally responsible for these consequences. The idea that we should have roving investigations into every little thing that he is said to have done imperfectly is most unattractive...*";

k. Day 35.57: the trial judge refers to his presumption that by the time the case goes to the jury there will be different particulars identifying the act or omission which is said to be negligent with a relevant cause;

l. Day 36.25: the trial judge says: "*We keep hearing a great deal of criticisms, and at the moment I remain, as I have been for many weeks, concerned that this may be putting a fair trial at risk*";

m. Day 39.63/64: the trial judge expresses serious criticisms of particulars handed up in relation to Mr Vowles on the basis that they allege a lack of good faith by Dr Patel as distinct from incompetence;

n. Day 39.66: the trial judge says that if the particulars were a civil pleading they would be struck out as not disclosing a reasonable cause of action;

o. Day 42.7: the trial judge refers to the fact that a welter of prejudicial material has been thrown at the jury;

p. Day 42.10: the trial judge says that the Crown has thrown "*every little piece of mud in the hope that some will stick*";

q. Day 43.3: revised particulars handed up. The trial judge describes them as a "*vast improvement*" (after the Crown has called all of its witnesses);

r. Day 43.19: the trial judge says the trial is no longer "*just a mud-slinging exercise*";

s. Day 43.22: the trial judge notes that for the first time defence counsel has particulars on all 4 cases that are "*comprehensible particulars that make sense*";

t. Day 44.15: the trial judge refers to original particulars, which were in place until end of the Crown's evidence and says "*I do not even find looking at them an appealing exercise they are so bad*".

61. It must be emphasised that, although a criminal trial is adversarial, and the Crown and defence counsel have respective duties, it is ultimately the trial judge who must hold the balance between the contending parties and ensure the trial is conducted fairly.[37] The learned trial judge failed to discharge his duty.

62. Lord Bingham (when he was Lord Chief Justice), in delivering the judgment of the Court of Criminal Appeal in *R v Carr*[38] made a relevant statement about the pernicious effect of the prosecution changing the nature of its case in the course of a case:

> *"...it seems to us anomalous and wrong that a case against a defendant should be spelled out with less particularity when he stands in the dock accused of murder than when he resists a claim for compensation. Secondly, we think it unfortunate, the prosecution having apparently nailed its colours to one version of events in opening, namely that the deceased was felled by a karate kick, that the prosecution sought, and the judge permitted, departure from that position in the course of the case, at any rate without making sure that the defendant was in no way prejudiced...The defendant was entitled to know how the case was put so that he could make judgments on the cross-examination of prosecution witnesses and the marshalling and deployment of his own evidence. It put him at a serious disadvantage when he was denied a clear statement of the case he had to meet."*

63. It becomes entirely artificial to focus upon whether the defence counsel objected to evidence when the case being run was so broad and confusing, as the trial judge repeatedly recognised and emphasised, that it would have made the evidence that went in either relevant to some convoluted, alternative allegation or it would not have been possible for the trial judge to make a sensible decision about it, confused and "befuddled" as he expressed himself to be with what the case was. His Honour

[37] *Libke v The Queen* (2007) 230 CLR 559 at [72] and [85] per Hayne J; at [133] per Heydon J; and at [35] per Kirby and Callinan JJ

[38] (2000) 2 Cr. App R 149 at 156-157

conceded as much by commenting that the judge who ruled on issues of admissibility pre-trial would not have been assisted in that task by having the original particulars.[39]

64. By Day 10, when the first discharge application was made, this problem had become acute. The trial judge erred in letting the trial proceed before a jury when he:

a. did not understand the Crown case and found it incomprehensible;

b. appreciated that it contained a "myriad" of alternatives as he described it;

c. encouraged the Crown to conduct the case on the basis that the incoherent, unintelligible case should continue and ultimately be narrowed to something sensible at the time of the address to the jury;

d. in doing so, severely overestimated the ability and propensity of a jury not to be prejudiced by much graphic, prejudicial evidence, adverse to Dr Patel.

65. The original particulars were delivered in relation to each of the four cases at various stages during the trial and remained thereafter on test until Day 43 when they were replaced with revised particulars.

66. The first set of the original particulars was delivered in relation to the case concerning Mr Morris. These led to the application to discharge the jury on Day 10. Subsequent particulars followed in identical format save for those relating to Mr Kemps which contained more allegations and permutations.

67. By reference to the original Morris particulars[40] some of the many allegations made against Dr Patel included:

a. that Dr Patel in fact knew that the surgical procedure was dangerous to the health and life of Mr Morris and proceeded to perform it (para 15);

b. that Dr Patel knew that the surgical procedure was unnecessary (para 7);

c. that the actual surgical procedure was performed without reasonable skill or reasonable care (para 21);

d. that the post-operative care of the patient was undertaken without reasonable skill or care (para 22);

e. that the accused did not perform the surgical procedure on Mr Morris in good faith (para 26);

f. that the surgical procedure was not for the patient's benefit (para 27).

68. The original particulars delivered in relation to Mr Phillips, Mr Kemps and Mr Vowles contained negative allegations.

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[39] T44.4 L48-52

[40] These particulars were marked "K" for identification

69. The revised particulars delivered on Day 43 narrowed the cases to a case that in each case it was the decision to operate that was criminally negligent. Allegations of a lack of good faith, performing an operation not for the patient's benefit, incompetent post-operative care, and bungled surgery were no longer proceeded with.

70. However, the majority of evidence heard by the jury concerned matters that were no longer relevant once the revised particulars superseded the original particulars.

71. A fundamental problem with the trial judge's approach on each of Days 10 and 44 in failing to discharge the jury, is that:

a. he recognised that he found the Crown case as revealed in the original particulars legally incoherent and embarrassing – he described the particulars as of a kind that should be struck out if they were a civil pleading as not disclosing a reasonable cause of action;

b. the trial judge's criticisms of the particulars were seriously expressed and repeatedly made – his concerns cannot be relegated in significance to an "off the cuff" remark or momentary frustration – the trial judge permitted a case which he found confusing and incoherent to continue to proceed in front of a jury. It is an obvious proposition that if a very experienced Supreme Court Judge found the Crown case incoherent, a jury had no chance of understanding what was relevant. The summing up by the trial judge could not realistically have removed from the jury's perception all the adverse and prejudicial evidence that had been admitted against Dr Patel.

72. It was a fundamental error in the trial process for the trial judge, in refusing the application to discharge the jury on Day 10, to allow an unintelligible and incoherent case to proceed on the basis that it was open to the Crown to narrow its case to a more "digestible" form by the time of the address.

73. By permitting, and indeed encouraging, the Crown to proceed in this manner, the trial judge denied the accused what he was entitled to, namely:

a. a trial based on comprehensible particulars;

b. further, and just as importantly, a trial based on particulars that would not change dramatically during the trial.

74. It is so obvious that it goes without saying that the conduct of the accused's defence and delicate questions of whether to object and how to cross-examine can only be based upon the particulars provided by the Crown. This process is not meant to be iterative or ambulatory and the revised version of the case, which had been

dramatically narrowed, changed the context in which the accused would have had to make relevant decisions. Importantly, the case under the original particulars was not just one that changed dramatically. It was, as the trial judge described it, a "mud slinging exercise".

I. Prejudicial and Irrelevant Evidence in Relation to the Four Patients: Morris, Phillips, Kemps and Vowles

75. Due to the unsatisfactory way in which the trial proceeded under the original particulars, much evidence was heard by the jury which was prejudicial and which became entirely irrelevant or was of a kind where its prejudicial value outweighed any negligible probative value that it may have had.

76. Examples are set out below. So much evidence, in terms of quantity, fits into these categories that transcript references have been collected in **Schedule A** to these submissions.

77. There are three subjects about which the jury heard significant evidence in terms of prejudicial effect and sheer volume of irrelevant and prejudicial material. They were:

a. evidence of incompetent surgery – the trial judge's direction to the jury that this was not a case about "*botched surgery*" and that "*it is not how the accused performed the surgery that matters*" was quite unrealistic given that the course of evidence demonstrated that this did matter and was important. Indeed, as late as its closing address the Crown was addressing the jury about poor surgery and poor post-operative care of patients by Dr Patel;

b. evidence of incompetent post-operative care by Dr Patel – this was irrelevant and prejudicial;

c. evidence of bad or unprofessional conduct by Dr Patel calculated to call his integrity and professionalism into question; and

d. emotive and graphic evidence concerning the pain and suffering endured by patients, allegedly caused by Dr Patel, and distress to their families.

78. Examples are set out in **Schedule A**.

J. The Ventilator Evidence

79. **Schedule A** to these submissions details a great deal of prejudicial evidence. The evidence that Dr Patel caused, or agitated for, the premature turning off of a ventilator on a brain dead patient because he needed it to perform the operation on Mr Kemps and then go on holiday is only one example of gravely prejudicial evidence. The Court of Appeal addressed this at [132] by reasoning that its prejudicial effect could be explained away because it was a relatively small body of evidence. This was incorrect reasoning. In fact, eight witnesses gave evidence concerning this topic so it can be expected to have drawn the jury's attention as a significant event. Those witnesses were Nurse Brennan, Nurse Tapiolas, Nurse Stumer, Nurse Zwolak, Nurse Doherty, Nurse Gaddes, Nurse Boisen and Dr Carter.

80. Further, this subject featured in the Crown's opening and closing address.

81. It is also obvious that prejudicial effect is not to be gauged, in any event, by the space occupied in the transcript.

82. The reaction of the trial judge to this evidence, during legal argument, was telling but unfortunately was not effective in dealing with the evidence. His Honour described the evidence in terms as "*well, that's pretty nasty stuff before a jury*" (T44.5 L1-30). Unfortunately, the Crown referred to this evidence in its closing address.[41]

K. The Unsatisfactory and Unfair Case put in relation to Mr Kemps

83. In his summing up to the jury the trial judge was very clear (at T52.59 L50 to T52.60 L50) as to what the final case was about. He identified the Crown case as:

a. not being about botched surgery;
b. being about surgery performed competently enough where mistakes did not adversely affect patients;
c. being one where it did not matter how the accused performed the surgery in the four cases;
d. being one concerned with the decision to operate and then to undertake the operation;
e. being that the operations were unnecessary or inappropriate;
f. being, in relation to Mr Kemps, that the patient's health was too precarious for an oesophagectomy.

[41] T48.3 L30-40

84. This clarity came too late to prevent a miscarriage but it is a clear summary.

85. But when the trial judge summed up the detail of Mr Kemps's case he, confusingly, left open another case to the jury which was that Dr Patel should have performed the second operation (to attempt to stop the surgical bleeding) sooner than he did. He called this the "second case" (T52.136 L43-50 and at T52.138 L47).

86. The second case was described by the trial judge as follows :

> *"This second case is that the decision to operate on another patient rather than re-open Mr Kemps to attend to his bleeding at the end of the oesophagectomy – or well before the Accused did, at any rate – renders the Accused criminally responsible for the death."*
>
> (T51.240 L1-20)

87. This was inconsistent with the simple case summed up to the jury earlier in relation to Mr Kemps, and was confusing.

88. On the second case, Dr Patel could only be liable if the patient died because of his delay in proceeding with a second operation. This becomes a form of decision not to operate in a timely way rather than a decision to operate. Further, this case raises issues of "botched surgery" contrary to what the judge had earlier submitted. As **Schedule A** demonstrates, there was evidence that it was incompetent surgical procedure not to identify and stop the source of bleeding.

89. Thus, the jury, on the second case for Mr Kemps, would have had to be satisfied beyond reasonable doubt that if Dr Patel had operated sooner (for a second time) a competent surgeon would have stopped the bleeding and prevented death. The expert evidence was that a competent surgeon in dealing with the bleeding would have used "packing" to stop it. So the case, contrary to what the trial judge had indicated clearly earlier, did conflate and confuse notions of a decision to operate with issues of botching surgery.

L. The Oregon Order

90. The Oregon Order ought not to have been admitted on the final case put to the jury. The trial judge summed up the use which the jury could make of the order at T52.58 – T52.59.

91. A use the trial judge addressed to which the order could be relevant was whether it gave the accused "reason to reflect, before commending major surgery to patients, on any pertinent deficiencies there may have been in his knowledge and aptitude".

92. There are three fundamental problems with this line of reasoning. First, it was not possible for the prosecution to prove beyond reasonable doubt that Dr Patel had not privately reflected on what implications the Oregon Order had on his knowledge or aptitude.

93. Secondly, the Oregon Order is equivocal. It was tendered merely as a document. It fell to be interpreted according to its terms. One plainly available interpretation of it was that it referred to situations where Dr Patel had made "surgical errors" in the course of performing surgery (see clause 2.3 of the Order). If this was correct then it had no relevance at all to a case which did not concern incompetent surgery, and was prejudicial in effect.

94. Thirdly, given the prejudicial effect of the Oregon order and its essential irrelevance, it behoved the Crown to address the jury about its interpretation in accurate terms. It did not do so. In the Crown's closing address, it was put to the jury that the Oregon order meant that Dr Patel:

    a. had a "*history of gross negligence*"[42] which he knew about; and
    b. had engaged in conduct in Oregon which involved "*gross repeated acts of negligence and so on.*"[43]

95. This was overreaching and inaccurate. The relevant passage of the Oregon order at paragraph 2 referred to "*gross or repeated acts of negligence…*". Thus, on a proper construction the Oregon order may have only referred to repeated acts of negligence that were not gross but were relatively minor but accumulated. The Crown called no actual evidence from anyone at Oregon about this subject. The misstatement of the effect of the order was significant and not corrected.

M. The Evidence Relating to Mr Grave

96. The evidence adduced and admitted in relation to Mr Grave was irrelevant on the final issue which concerned, in each of the four cases, whether the decision to operate was criminally negligent.

97. If it had any relevance this was outweighed by its prejudicial effect.

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[42] T48.7 L40-50
[43] T49.7 L1-8

98. The guiding proposition must be that each patient had to be assessed by Dr Patel based upon the particular conditions affecting that patient. The case as summed up against him was that the health of each of Mr Phillips and Mr Kemps was too precarious to permit an oesophagectomy to occur (T52-60 L42-44). Mr Grave's condition related particularly to him and could not be properly relevant, except in a prejudicial way, to this issue.

99. Further, the evidence admitted in relation to Mr Grave was admitted when the broad, incoherent case was being run, and evidence was admitted tending to prove surgical incompetence by Dr Patel and unprofessional and incompetent post-operative treatment of Mr Grave, none of which had any bearing on the final case.

100. Some of this evidence relating to Mr Grave is summarised in **Schedule B.**

N. The Volume of Irrelevant and Prejudicial Evidence

101. An important issue, one of the cumulative factors going to the miscarriage of justice, is that a disproportionately large amount of evidence heard by the jury in a long trial, which was highly technical, was ultimately irrelevant as it concerned operative technique or post-operative treatment and suffering of patients. The sheer volume of this evidence could not sensibly be treated as not having weighed on a jury of lay people. While a lay person might have understood that the ultimate case was only about a "decision to operate", it is very difficult to think that he or she would not be fortified in reaching a guilty verdict by the welter of other prejudicial evidence heard. The jury, of course, had not been present when the trial judge repeatedly expressed to counsel his confusion about the Crown case. The jury had no reason to think that it was other than required of them to pay close attention to the detail of the prejudicial evidence.

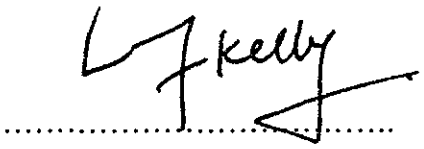
102. The quantity of the evidence is indicated by the transcript references in **Schedule C.**

Part VII: The applicable legislative provisions as they existed at the relevant time

103. Sections 282 and 288 of the Code as in force at the relevant time are attached in **Schedule D**. Also attached in **Schedule D** is a copy of the legislation under which s. 282 was amended in 2009.

Part VIII: The precise form of orders sought by the Appellant

104. That the convictions of the appellant be quashed and that there be a new trial.



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9 March 2012

SCHEDULE A

A. Mr Morris

- Evidence that Dr Patel was responsible for the malnourishment of Mr Morris and that the eventual malnutrition of Mr Morris in his post-operative state was a cause of his death.
- Extensive evidence dealing with the gradual and very painful decline in Mr Morris' health over some weeks post-operatively including detailed evidence of his pathetic state in extremis (Crown's opening (T1-51 L50-60); Dr Britten (T4.63 L1- T4.63 L50); Dr Smallberger (T7.40 L19-23); Dr Collopy (T8.62 L30-50; T8.65 L8-25; T8.68 L3-5, T8.70 L25-40); Dr Chikolwa (T4.2 L58-; T4.13 L50); Dr Britten (T4.62 L10- T4.65 L60); Dr Igras (T4.73 L20-; T4.82 L59); Ms Whitfield, the daughter of Mr Morris (T5.40 L1-; T5.43 L30); Dr Smallberger (T7.39 L3- T7.40 L25); Dr Collopy (T8.51 L45- T8.66 L30)).
- Evidence concerning Mr Morris' aspirating vomit and faecal matter into his lungs, a causal factor of his death due to the mispositioning of a nasogastric tube that was coiled in his oesophagus rather than being in his stomach (T4.76 L42-50; T4.77 L30), the mispositioning of the tube being attributable to the fault of Dr Patel (Dr Igress T4.79 L46-55; T4.80 L9-18).
- The inadequate creation of a stoma for Mr Morris' bowel, indicating surgical incompetence by Dr Patel; evidence that the stoma failed due to compression of the bowel due to surgical error. (Ms Logan, stomal therapist (T7.55 L43-; T7.62 L35); Dr Collopy, expert colo-rectal surgeon (T8.37 L20-T8.41 L43; T8.72 L1-48; T8.73 L47-52)).
- The occurrence of an obstruction of the colostomy which was not detected or attended to by Dr Patel competently (Dr Igress (T4.78 L20-35); Dr Collopy (T8.40 L28-30; T8.43 L25-40; T8.44 L50-; T8.45 L60; T8.68 L1-5; T8.68 L19-22)).
- There was an event of wound dehiscence post-operatively (Dr Igras T4.44 L13-T4.45 L40).
- During an operation to repass the wound Dr Patel failed to take the opportunity to review the problems with the stoma and address and fix the bowel blockage (Dr Collopy T8.43 L10-30; T8.58 L40-T8.59 L20; T8.60 L25-27; T8.62 L30-50; T8.65 L8-25).

B. Mr Phillips

- Inability of Dr Patel to obtain the insertion of a central venous line during the operation; evidence that he tried and failed to obtain central venous access, indicating surgical incompetence. The failure to obtain a central venous line was a "bread and butter issue" for a surgeon (Dr Allsop (T34.23 L28-T34.24 L20); Ms Heidke, registered nurse (T13.26 L50-T13.27 L10)).
- Dr Patel could not originally find the jugular vein during the operation.
- Dr Patel inadvertently tore the oesophagus during the operation, evidence going to "botched surgery".
- Dr Patel caused considerable blood loss during the operation by opening a cut in the jugular vein.
- Dr Patel caused significant bleeding during the operation in the abdomen.
- Mr Phillips experienced significant bleeding post-operatively.
- It was not competent that the oesophagus was torn (Dr Allsop T34.35 L26-40). This contravened principles of cancer surgery (Dr Jamieson T36.13 L37-46).
- The piece of oesophagus taken out was divided out into two pieces – this was contrary to the principles of cancer surgery endangering the patient because of cancer cells possibly "spilling" (Dr Jamieson T36.13 L15-30).
- The operation should not have been proceeded with once a central venous line could not be established (Dr Jamieson T36.15 L 28-32).
- Evidence of the decline of Mr Phillips after the operation to death was given (Ms Cree (T13.33 L35-60); Dr Miach (T14.51 L20-27); Ms Boisen (T20.32 L52-T20.34 L20)).
- Post-operative evidence that Mr Phillips' pupils became unresponsive and something was drastically wrong with his brain (Dr Miach T14.55 L30-48).
- There was criticism by Dr Miach, a senior specialist at the hospital, directly challenging the accuracy of Dr Patel's post-operative notes (Dr Miach T14.59 L48-60).
- It was put by the Crown to a witness or witnesses implicitly that the Oregon order meant that Dr Patel had committed in Oregon "gross and repeated acts of negligence" (T17.71 L32-40), it being implicit that this could refer to surgical, operative error. In fact this is a misstatement of the Oregon Order which refers to "gross or repeated acts of negligence".

- Evidence was given by Ms Stumer and Ms Hoffman, nurses, to the effect that Dr Patel had given misleading and false information to Mr Phillips' mother and sister that Mr Phillips' condition was improving (T19.72 L10-27; T20.53 L10-20; T20.67 L22-29; T20.74 L38-42).
- Evidence was given that Dr Patel resisted and obstructed attempts to transfer patients to Brisbane when there were limits on the capabilities of the Intensive Care Unit in Bundaberg (Ms Byrne (T20.24 L10-15); Ms Boisen (T20.32 L22-50); Ms Hoffman (T20.49 L20-30; T20.54 L15-20)).
- Evidence was given that Dr Patel gave orders about the post-operative care of patients that conflicted with the advice of other doctors (Ms Boisen T20.34 L50-; T20.35 L1).
- Evidence was given by Nurse Hoffman that Dr Patel was angry at Nurse Hoffman for telling the truth about Mr Phillips' declining condition to Mr Phillips' family (T20.53 L17-23).
- Evidence was given by Nurse Hoffman that Dr Patel conducted himself in a dysfunctional way in the Intensive Care Unit (T20.54 L25-35).
- Evidence was given that if Dr Keating had known about the Oregon order he would not have employed Dr Patel at the hospital (T23.21 L48-52).
- Evidence was given that Dr Patel screamed at nurses because they had told the truth about Mr Phillips' declining condition to Mr Phillips' mother and embarrassed Dr Patel (T24.7 L38 – T24.8 L2).

C. <u>Mr Kemps</u>

- The widow of Mr Kemps was called and she gave evidence that Dr Patel told her that the surgery on Mr Kemps was a great success when he died the next day (T28.18 L40-42).
- Evidence was given that Dr Patel misled the relatives of Mr Kemps about the operation and that his notes were not an accurate record of his conversation with Mr Kemps' relatives (Mrs Kemps T28.17 L39-53; T28.18 L40 – T28.19 L60).
- Evidence was given by relatives of Mr Kemps to the effect that Dr Patel said things indicating he could not find the source of the bleeding in Mr Kemps (that bleeding caused his eventual death) (Mrs Kemps T28.20 L1-20; Mr Bernard Kemps T28,30 L20-T28.31 L10); (Dr Berens T31.8 L40-T31.9 L22).

- Graphic evidence was given by an operating theatre nurse that, during the operation, there were blood clots all over the floor, and footprints of blood through the operating theatre (Nurse Law T28.62 L1-17).
- Graphic evidence given by Nurse Zwolak in relation to Dr Patel's second operation on Mr Kemps that blood poured out of him and "we scooped up kidney basin after kidney basin out of the patient" (T30.35 L33-50).
- Evidence given by Nurse Evans that Dr Patel had a very uncaring look about him when she confronted him about the death of Mr Kemps (T28.56 L1-22).
- Eight witnesses gave evidence concerning the topic of the alleged improper conduct of Dr Patel in urging (in a heated and petulant manner) for a brain dead patient to have the ventilator turned off and therefore killed, without following proper protocols or established procedures, with one witness giving evidence that Patel said he needed to get the operation done so he could go on holiday (Nurse Tapiolas (T29.38 L30-L10); Nurse Stumer (T29.55 L20 – T29.56 L18); Nurse Zwolak (T30.34 L40-50); Nurse Doherty (T30.63 L38-52); Nurse Gaddes (T30.70 L30-50); Nurse Brennan (this is highly prejudicial) (T32.16 L42 – T32.18 L20); Nurse Boisen (T32.25 L20-48); Dr Carter (T33.3 L10-20) (Dr Carter described Dr Patel as having a tantrum).
- Evidence was given that staff ceased giving blood products to Mr Kemps as it had become futile (Dr Zia T30.30 L28-30).
- Evidence was given that the bleeding of Mr Kemps which Dr Patel was unable to stop in the second operation had been caused by the surgery of Dr Patel in the first operation (Dr Zia T30.28 – T30.30).
- Evidence was given that Dr Patel said loudly and unprompted, that the bleeding of Mr Kemps was not as a result of his surgery (Nurse Zwolak T30.35 L50-53). The expert evidence was that the bleeding was caused by the surgery and that it was incompetent and unrealistic for him not to recognise it as such and do something about it earlier.
- Very prejudicial evidence was given that Dr Patel told medical staff in the operating theatre to remain "tight lipped" and not to discuss what had happened with Mr Kemps (Nurse Zwolak T30.36 L3-15).
- Evidence was given that Dr Patel directed operating theatre staff to move Mr Kemps to the ICU even though the patient was unstable (suffering from

surgical bleeding) and started on an operating on another patient ignoring advice that the patient was bleeding too much (Nurse Goatham (T30.47 – T32.48); Nurse Doherty (T30.65 – T30.67); Nurse Gaddes (T30.72 L20-30); Dr Berens (T31.7 L18-33)).

- Evidence, including expert evidence, was given that:
    - no packing was done to stop the bleeding of Mr Kemps which would have been the normal thing to do (Dr Kariyawasam T31.39 L40-55);
    - that Dr Patel was incompetent by attempting to analyse the blood loss from Mr Kemps by looking at the drain collecting the blood which was an unreliable indicator (Dr Allsop T34.55 L10-40);
    - that he gave up looking for the source of the bleeding (Dr Berens T31.8 L40 – T31.9 L20);
    - that he failed to recognise that the bleeding had been caused by his surgery and to do something about it earlier (Dr Allsop (T34.56 L30 - 34.57 L30); Dr Jamieson (T36.46 L40-52)). He should have kept Mr Kemps in the operating theatre and re-opened him earlier (Dr Jamieson T36.42 L40 - T36.43);
    - that he took too long to conduct the second operation on Mr Kemps and that it was the singular function of the surgeon to control the bleeding he should have used the packing technique to arrest the bleeding (Dr Allsop (T34.59 L18 – T34.61); Dr Jamieson (T37.30 L1 – T37.31 L22)). He should have been able to find the source of the bleeding (T36.44);
    - that he should not have operated on another patient while the bleeding situation with Mr Kemps was unresolved (Dr Allsop T34.62 L31-50);
    - that Dr Patel's protest that he had not caused the bleeding in the surgery was wrong and a claim not connected with reality (Dr Allsop T34.66 L40 – T34.67 L1).
- The histology report, examined after the death of Mr Kemps, showed that not all of the cancer had been removed, contravening basic principles of cancer surgery (Dr Jamieson T36.37 L1-20).
- Dr Patel had erred in the first operation on Mr Kemps by not cutting out enough of the oesophagus (Dr Jamieson T36.40 L29-50).

- Evidence was given that Patel said, gratuitously that he had brought a lot of money to the hospital by increasing activity (Nurse Gaddes T30.75 L1-3).
- Evidence was given that Patel, as the head of the surgical team, should have referred the death of Mr Kemps to the coroner and did not do so (Dr Berens (T31.11 L30-40); Dr Carter (T33.4 L40-43)).
- Evidence was given that Patel gave Mrs Kemps wrong information about the second operation and said that the cause of the bleeding was not surgical and it was not his fault (Dr Kariyawasam T31.44 L1-5).
- Dr Carter, an anaesthetic specialist, described Dr Patel as having put on a tantrum when he learned that a brain dead patient's ventilator had not been switched off to allow Dr Patel to operate on Mr Kemps (T33.3 L10-20).

D. <u>Mr Vowles</u>

- Evidence was given relating to post-operative difficulties with the stoma surgically created by Dr Patel (Mr Vowles T38.11 L28-50).
- Dr O'Loughlin, a specialist surgeon, was later able to fix the stoma problem in circumstances where Dr Patel had attempted to fix it and failed (Mr Vowles T38.13 L10-28).
- A stoma nursing specialist gave evidence that the stoma created by Dr Patel was deteriorating and needed revision (Nurse Logan T38.32 L33-40).
- Evidence was given that the post-operative condition of the stoma deteriorated and needed revision (Nurse Logan (T38.32 L40-47); Dr Kariyawasam (T39.25 L17-33)).
- The post-operative performance of the stoma caused a lot of problems including:
    - effluent not adequately discharging into the colostomy inflaming Mr Vowles' skin;
    - soiled linen due to an inadequacy of flow of effluent from stoma into colostomy;
    - this was described as an "horrendous time for the family and him" (Nurse Logan T38.34 L40-60).
- Evidence was given that it was a poor great ileostomy and that the problems resulted from incompetent surgery causing irritation and ulceration of the surrounding skin (Dr O'Loughlin T39.31 L40-55).

- Evidence was given that the opening of the ileostomy was too narrow and constricted (Dr O'Loughlin T39.31 L48-50).
- Expert evidence also given that Dr Patel should not have attempted to fix the ileostomy when he did and that an experienced surgeon would have waited (Dr O'Loughlin T39.32 L40-60).

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SCHEDULE B

E. Mr Grave

- Evidence was given that Dr Patel inadvertently put a hole in his oesophagus during the operation (Dr Igras T23.63 L1-9).
- Mr Grave had many post-operative complications and Dr Patel resisted having him transferred to Brisbane where he ultimately had to be transferred (Dr Keating (T23.27 L1-30); Nurse Hoffman (T24.37 L28 – T24.39 L60)).
- Evidence was given by Mr Grave's daughter that Dr Patel told her and her mother that the operation on Mr Grave had been straightforward (Ms Davon, the daughter of Mr Grave T24.31 L50-60). This was inconsistent with other evidence of a graphic nature of Mr Grave bleeding and of a need for subsequent surgical repair (Ms Davon T24.32 – T24.33) and post-operative complications (Dr Cook T26.55 L30 – T26.56 L10).
- Mr Grave's daughter gave evidence that her father could not speak properly after the operation and never recovered his voice before he died (Ms Davon T24.33 L50 – T24.34 L5).
- Mr Grave needed four visits to the operating theatre with two being necessary to deal with wound dehiscence (Nurse Hoffman T24.37 L1-18). Expert evidence was given by Dr Jamieson that wound dehiscence is uncommon (Dr Jamieson T36.29 L40).
- There was evidence that Dr Patel refused or failed to co-operate with Brisbane-based surgeons so as to delay or obstruct the transfer of Mr Grave to Brisbane. Dr Patel was said to have resisted Mr Grave's transfer to Brisbane when Mr Grave was getting sicker and that this was the opinion of the Intensive Care Unit staff in Bundaberg (Dr Joiner (T28.6); Nurse Hoffman (T24.39 – T24.41)).
- The widow of Mr Grave gave evidence that after the operations on Mr Grave, Dr Patel said that everything would be fine when the opposite turned out to be the case (Mrs Grave T27.4 L26-30).
- Dr Joiner gave evidence that Dr Patel threatened to resign if Mr Grave was transferred (Dr Joiner T28.6 L30-52). Evidence casting Dr Patel in an unprofessional light, not interested in the ultimate welfare of his patient.

SCHEDULE C

F. **Mr Morris**

- Dr Chikolwa gave evidence of seeing Mr Morris on 13 June and 14 June; that his liver function was raised (T4.4); there was evidence of dehydration (T4.7); there was evidence of fluid in his abdomen (T4.8); and he had swollen legs (T4.9).
- Dr Chikolwa gave evidence that Mr Morris did not have much longer to live (T4.12).
- Dr. Igras gave evidence concerning the repair of abdominal wound dehiscence (T4.44); of clotted blood on a pad after wound dehiscence operation (T4.46); of a build-up of fluid in the peritoneal cavity (T4.48); of oxygen, ventolin and Atrovent treatment (T4.72); of medical emergency with the patient in extremis and in a peri-arrest state (T4.74); of nasogastric feeding and a distended abdomen (T4.76); of post -operative wound dehiscence, respiratory compromise and acute respiratory distress (T4.78); of resuscitation equipment being set up, difficult intubation and faecal vomiting (T4.79-80); and of a discussion with Mr Morris's family, who wanted maximum effort to keep him alive until the arrival of his daughter (T4.82).
- Dr Britten gave evidence of Mr Morris's post-operation condition (T4.59-70), including evidence of the patient being in a lot of pain and needing increased pain relief; experiencing penile swelling; and his bowels not working well (T4.62); of ongoing distress and abdominal distention (T4.63); and of poor nutrition and poor nourishment (T4.65).
- Mrs Whitfield (the daughter of Mr Morris) gave evidence of Mr Morris's post-operative condition and the pain he was in (T5.39-43).
- Ms Andrews (a dietician) gave evidence of Mr Morris's post-operative condition (T7.4-11).
- Mr Mitchell (a nurse) gave evidence concerning post-operative care of Mr Morris (T7.28-32).
- Dr Smalberger gave evidence that Mr Morris was in ICU and critically ill; was premorbid and his respiratory function was supported by a ventilator (T7.39); and evidence of summary of notes leading up to Mr Morris's death (T7.40-41).
- Ms Barbara Logan (a stomal therapist) gave evidence of Mr Morris's post-operative condition and treatment concerning the stoma (T7.55-63); and evidence

of the fact that Ms Logan only saw Mr Morris post-surgery (T7.55)

- Dr Collopy gave evidence concerning Mr Morris's post-operative condition (from T8-37), including evidence of a dark appearance of the stoma as a result of the opening not having been made large enough (T8.39); of problems with the stoma (T8.39-42); of no review of the stoma in the second operation to overcome the retraction element; a failure to fix a partial blockage associated with the stoma; the presence of the blockage being an error of surgery (T8.43); of Dr Patel's attempt to fix the dilated stoma as not being an effective solution (T8.45); of the patient becoming increasingly unwell, with shortness of breath, pulse rate increasing and showing signs of stress (T8.51); of minimal fluids being accepted and the patient getting weaker (T8.52); of a distended abdomen and pain requiring morphine (T8.54); of the stoma beginning to function properly where it should have been doing so beforehand (T8.57).
- Dr Collopy also gave evidence that a coiled tube in the oesophagus runs the risk of the patient vomiting and further runs the risk of the patient inhaling fluid down the tube (T8.59); that the tube had not reached the stomach as at 12 June and was still inappropriately place for nasogastric feeding, suggesting that there was still obstruction of stoma; and that liver function was worsening (T8.60); that Mr Morris was pushing fluids down a nasogastric tube that was in his oesophagus, so that there was no wonder he was nauseous (T8.62); evidence of feculent vomit going into his lungs, linked to mispositioning of the nasogastric tube (T8.65); evidence that nutrition issues were not adequately addressed before or after surgery; that nutrition was a significant issue with respect to the end of Mr Morris's life and the surgeon was responsible for nutrition (T8.70); evidence that a reason that Dr Patel's conduct was well below the acceptable standard was the failure in the postoperative management of the stoma and the failure to address nutritional requirements (T8.73); and evidence on the subject of postoperative management of care as well as surgical errors in procedures conducted after 23 May (T8.37-67).
- Dr Woods gave evidence that post-operatively, the patient did not have decent oral intake for most of the post-operative course (T27.26); that the failure to deal with the patient's nutrition post-operatively was below the standard of competence to be expected of a surgeon (T28-29); and that the ultimate cause of death was

aspiration of vomit (T27.41).

- Mr Grave had many post-operative complications and Dr Patel resisted having him transferred to Brisbane where he ultimately had to be transferred (Dr Keating (T23.27 L1-30); Nurse Hoffman (T24.37 L28 – T24.39 L60)).

G. Mr Phillips

- Ms Sharon Cree gave evidence concerning the postoperative care and problems experienced by the patient in ICU (T13.33-40).
- Dr Miach gave evidence of a significant loss of blood after surgery, and that the patient's blood pressure was unstable (T14.35); of a high potassium level (T14.38); of very high potassium levels in the patient at death and that bleeding contributes significantly to high potassium levels (T14.44); evidence that Dr Patel was in charge of the patient after surgery (T14.50); that the patient was in a parlous condition with unstable blood pressure and getting adrenaline; things were deteriorating (T14.51); that pupils were unresponsive, being a symptom that there is something drastically wrong with the brain (T14.55); that the patient's circulation is marginal and he is shutting down (T14.56); that Dr Patel notes the patient is stable haemodynamically; Dr Miach is critical of this assessment and finds that on the data, the patient is haemodynamically unstable (T14.59); that the patient's eyes are nonreactive, which is serious; it is likely he had a haemorrhage inside his brain (T14.61); that the immediate cause of death was probably hyperkalemia - the fact that his potassium went very high - that was the final straw (T14.67).
- Dr Carter gave evidence that ECG readings showed the patient's heart was being poisoned by potassium (T17.32).
- Ms Goatham (a nurse) gave evidence on the topic of the operation and post-operation period (T19.23-28).
- Ms Yeoman gave evidence as to post-operative procedures (T19.30-34).
- Ms Boisen (a nurse) gave evidence that Dr Patel told her that the ICU was a Third World country unit. Dr Patel was unhappy that his patients were to be transferred out of the unit (T20.32).
- Ms Hoffman (a nurse) gave evidence that she told Dr Patel that the ICU was only

capable of keeping patients for 24-48 hours; he said he would be keeping patients in Bundaberg (T20.49); evidence that Dr Patel told the family the patient was stable when in fact he was not stable; that Dr Patel was upset with the nursing staff that they were telling the family that he was unstable; and evidence of conflict between Dr Patel and other doctors caring for the patient (T20.53); that Dr Patel would not talk to her directly; this affected the way in which she would treat his patients, and it was a very dysfunctional way to operate in an intensive care unit (T20.54).

- Ms Cooper (a nurse) gave evidence as to post-operative care. She gave evidence that Dr Patel threatened to walk out if the patient's next of kin were notified; and that Dr Patel screamed at her (T24.7).

H. Mr Kemps

- Ms Evans (a nurse) gave evidence of a conversation with Dr Patel after the patient had died; he said that people don't usually survive that surgery; he walked out of the office with a very uncaring look about him (T28.56).
- Ms Law (a nurse) gave evidence of assisting in the operation; of the drain from the wound filling rapidly; of the patient being brought back into theatre for the second operation, referring to a large number of sponges; and blood everywhere; blood all over the floor, all over the linen; footprints of blood all through the theatre; Dr Patel was agitated saying "This isn't my fault" (T28.58-62).
- Ms Tapiolas gave evidence recalling a heated discussion between Dr Patel and Dr Carter regarding a patient who was finally taken off ventilation (T29.38-39); and evidence of the patient getting sicker and sicker and everyone was just there trying to keep him alive (T29.43).
- Ms Stumer (a nurse) gave evidence regarding a patient, Mrs Turton, who was displaying signs of brain death; she asked Dr Patel if she could have brain death testing done; he said it was not necessary (T29.55).
- Dr Zia gave evidence regarding the second operation; the cause of the bleeding was surgery; vivid evidence was given of the patient's demise (T30.28-29).
- Ms Zwolak (a nurse) gave evidence that Dr Patel was upset that there was a possibility that the operation may not proceed because of insufficient beds in the

ICU; he referred to a brain stem injury that should be turned off (T30.34); and graphic evidence of the second operation - blood poured out of him; they scooped kidney basin after kidney basin of blood out of the patient; Dr Patel said that "*This was not from my surgery*;" Dr Patel yelled and continued to yell "*Get the family.*" (T30.35); Dr Patel told the junior doctors to keep tight lipped (T30.36); afterwards Dr Patel said to her that the day was the worst day of his life (T30.37).

- Ms Goatham (a nurse) gave evidence that Dr Patel came back to theatre after the first operation; he became very upset and irritated that the patient was still there; she felt that he was saying that she was deliberately trying to hold up the theatre; they tried to explain to Dr Patel that the patient was too unstable to transfer (T30.47).
- Ms Doherty (a nurse) gave evidence regarding a clinically brain dead patient and no bed in ICU for the patient; Dr Patel was angry because he could not proceed with his case (T30.63); and evidence of significant bleeding at the end of the first operation; Dr Patel returned to theatre and snapped; he was angry that the patient still on the theatre table (T30.65-67).
- Mr Bondarenko (a nurse) gave evidence of a telephone call with Dr Patel; he told Dr Patel the ICU was full; Dr Patel became angry and asserted that the brain dead patient was supposed to be switched off and the bed available for his patient (T30.70); evidence of blood flowing freely into a drain; Dr Patel says "That's what drains are for" (T30.72); and evidence of Dr Patel saying that the community is lucky to have him and that he has brought a lot of money to the hospital (T30.75).
- Dr Berens gave evidence that he thought the case should have been referred to the coroner; the surgical team was responsible for such a referral; they didn't do so and "made it a natural death cause" (T31.11).
- Dr Athanasiov gave evidence of involvement in the second procedure; he recalls Dr Patel saying "Maybe they're right, maybe we shouldn't be doing oesophagectomies here." (T31.68).
- Ms Maresse – (a retired nurse) gave evidence that after the second procedure, Dr Patel said to Mrs Kemps that he hadn't been able to stop the bleeding but it's nothing that happened in the surgery - it must be some underlying cause (T31.77).
- Dr Cresswell gave evidence that after hearing of the death of Mr Kemps, Dr

Cresswell informed Dr Patel's team that the case needed to be discussed with the coroner (T31.79).

- Dr Risson gave evidence of Dr Patel saying "Maybe I should start thinking about not doing these type of procedures any more" (T32.11).
- Mr Brennan (a clinical nurse) gave evidence that he had been given instructions that Dr Patel wanted a patient's ventilator or life support turned off that night after some family had arrived; there were certain protocols which had not been followed in regard to this issue; he was concerned that the patient had only been in ICU for 24 hours and it was not normal to withdraw treatment so soon; and Dr Joiner did not want the ventilator turned off (T32.17); and evidence that Dr. Patel had planned an oesophagogastrectomy for the morning; Mr. Brennan told him that the ICU was full and the operation might have to be postponed; Dr. Patel became quite angry and demanded to know why the patient with the cerebral bleed had not been turned off the ventilator as he had instructed; Dr. Joiner had instructed that in the absence of the correct procedures the ventilator was not to be turned off; and Dr. Patel said he had to perform the operation that morning and he was due to be on leave in a day or two (T32.18).
- Ms Boisen (a registered nurse) gave evidence that Dr. Patel was talking of a patient who was on a ventilator; he had expected that ventilator support would have been withdrawn overnight; after a meeting between Dr. Carter and the patient's family the ventilator support was withdrawn; as the patient's family was walking along a corridor in one direction, Dr. Patel was walking in the opposite direction and said that they could now go and do the proposed oesophagectomy (T32.25).
- Dr Carter gave evidence of a conversation with Dr. Patel; he inquired why the patient on the ventilator was still on the ventilator when he had requested that she be turned off; his manner was compared to that of a child having a tantrum; Dr. Carter saw the family and told him that the prognosis was very very poor and nothing was to be gained by leaving her on a ventilator; he then made the decision to turn the ventilator off (T33.3); evidence that after the death of Mr Kemps, Dr. Carter gave some thought to the issue of whether there should be a report to the coroner and says that he was surprised that that had not happened (T33.4); evidence that he looked into the medical literature for expected survival

rates for oesophagectomies of the sort that Dr. Patel was performing and found that there should be a 90% survival rate; consideration was given to referring the matter to the coroner and having an autopsy; the key reason as to why the matter was not referred to the coroner was that it was close to Christmas and the funeral would therefore need to be postponed until after Christmas (T33.5).

- Dr. Allsop gave evidence that in the context of Dr. Allsop's assessment of what constitutes a "good surgeon", Dr. Allsop was of the view that Dr. Patel did not have the relevant skills (T34.50); evidence commenting on the statement attributed to Dr. Patel that "I haven't been able to stop the bleeding, but ...it was nothing that happened in surgery. It must have been some underlying medical cause." – this demonstrated a complete disconnection with surgical reality; an incomprehensible statement and he couldn't believe that he [Dr. Patel] believes it (T34.60).

I. Mr Vowles

- Mr Vowles gave evidence that Dr. Patel said he was unable to construct the stoma any better; that was the best he could do because there was too much scar tissue (T38.12); after receiving correspondence from Queensland Health, he saw Dr. O'Loughlin and went to Brisbane for a revision of the ileostomy. The stoma was repositioned and there has been no problem with it since (T38.13).
- Ms. Logan (a stomal nurse) gave evidence concerning the postoperative deterioration of the ileostomy by Dr. Patel and further revision of the ileostomy in June 2005 at the Royal Brisbane Hospital (T38.32-33); and evidence that between the performance of the operation and the first revision, the performance of the stoma caused many problems because of effluent running onto the skin; extra linen would have been required at home which was soiled; and this was "*a horrendous time for the family and him.*" (T38.34).
- Dr. O'Loughlin gave evidence that the main issue was an ileostomy causing a great deal of trouble; the ileostomy was unsatisfactory in that it was below the level of the skin or flush with the level of the skin; it was inflamed and ulcerated because the effluent was very irritant (T39.31); evidence that in respect of the revision of the ileostomy by Dr. Patel, at that point in time it would be difficult to

improve on that stoma; experienced surgeons will try and avoid re-operating on patients because of risks; a successful ileostomy is fashioned such that it is in the form of a spouse so that it protrudes beyond the level of the abdomen (T39.32).

- Ms Jones (a specialist stomal therapy nurse) gave evidence in respect of postoperative condition of the stoma; a description of the stoma before the revision done by Dr. O' Loughlin; the stoma would have been difficult to manage; further evidence in respect of the revision was performed by Dr. O' Loughlin; and that the stoma was protruding which meant that an appliance could remain secure and seal well (T39.57-58).

10

SCHEDULE D

Queensland

Criminal Code Act 1899

Reprinted as in force on 1 July 2009

Reprint No. 7A

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purpose of maintaining good order and discipline on board the vehicle, such force as the person or such person acting by his or her authority believes, on reasonable grounds, to be necessary, and as is reasonable under the circumstances.

282 Surgical operations

A person is not criminally responsible for performing in good faith and with reasonable care and skill a surgical operation upon any person for the patient's benefit, or upon an unborn child for the preservation of the mother's life, if the performance of the operation is reasonable, having regard to the patient's state at the time and to all circumstances of the case.

282A Palliative care

(1) A person is not criminally responsible for providing palliative care to another person if—

(a) the person provides the palliative care in good faith and with reasonable care and skill; and

(b) the provision of the palliative care is reasonable, having regard to the other person's state at the time and all the circumstances of the case; and

(c) the person is a doctor or, if the person is not a doctor, the palliative care is ordered by a doctor who confirms the order in writing.

(2) Subsection (1) applies even if an incidental effect of providing the palliative care is to hasten the other person's death.

(3) However, nothing in this section authorises, justifies or excuses—

(a) an act done or omission made with intent to kill another person; or

(b) aiding another person to kill himself or herself.

Chapter 27 Duties relating to the preservation of human life

285 Duty to provide necessaries

It is the duty of every person having charge of another who is unable by reason of age, sickness, unsoundness of mind, detention, or any other cause, to withdraw himself or herself from such charge, and who is unable to provide himself or herself with the necessaries of life, whether the charge is undertaken under a contract, or is imposed by law, or arises by reason of any act, whether lawful or unlawful, of the person who has such charge, to provide for that other person the necessaries of life; and the person is held to have caused any consequences which result to the life or health of the other person by reason of any omission to perform that duty.

286 Duty of person who has care of child

(1) It is the duty of every person who has care of a child under 16 years to—

(a) provide the necessaries of life for the child; and

(b) take the precautions that are reasonable in all the circumstances to avoid danger to the child's life, health or safety; and

(c) take the action that is reasonable in all the circumstances to remove the child from any such danger;

and he or she is held to have caused any consequences that result to the life and health of the child because of any omission to perform that duty, whether the child is helpless or not.

(2) In this section—

person who has care of a child includes a parent, foster parent, step parent, guardian or other adult in charge of the

child, whether or not the person has lawful custody of the child.

288 Duty of persons doing dangerous acts

It is the duty of every person who, except in a case of necessity, undertakes to administer surgical or medical treatment to any other person, or to do any other lawful act which is or may be dangerous to human life or health, to have reasonable skill and to use reasonable care in doing such act, and the person is held to have caused any consequences which result to the life or health of any person by reason of any omission to observe or perform that duty.

289 Duty of persons in charge of dangerous things

It is the duty of every person who has in the person's charge or under the person's control anything, whether living or inanimate, and whether moving or stationary, of such a nature that, in the absence of care or precaution in its use or management, the life, safety, or health, of any person may be endangered, to use reasonable care and take reasonable precautions to avoid such danger, and the person is held to have caused any consequences which result to the life or health of any person by reason of any omission to perform that duty.

290 Duty to do certain acts

When a person undertakes to do any act the omission to do which is or may be dangerous to human life or health, it is the person's duty to do that act: and the person is held to have caused any consequences which result to the life or health of any person by reason of any omission to perform that duty.

Queensland

Criminal Code (Medical Treatment) Amendment Act 2009

Act No. 33 of 2009

Queensland

Criminal Code (Medical Treatment) Amendment Act 2009

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Criminal Code (Medical Treatment) Amendment Act 2009

Act No. 33 of 2009

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an Act to amend the Criminal Code to ensure the lawfulness of particular medical matters

[Assented to 5 September 2009]

The Parliament of Queensland enacts—

1 Short title

This Act may be cited as the *Criminal Code (Medical Treatment) Amendment Act 2009*.

2 Code amended

This Act amends the Criminal Code.

3 Replacement of s 282 (Surgical operations)

Section 282—

omit, insert—

'282 Surgical operations and medical treatment

'(1) A person is not criminally responsible for performing or providing, in good faith and with reasonable care and skill, a surgical operation on or medical treatment of—

(a) a person or an unborn child for the patient's benefit; or

(b) a person or an unborn child to preserve the mother's life;

if performing the operation or providing the medical treatment is reasonable, having regard to the patient's state at the time and to all the circumstances of the case.

'(2) If the administration by a health professional of a substance to a patient would be lawful under this section, the health professional may lawfully direct or advise another person, whether the patient or another person, to administer the substance to the patient or procure or supply the substance for that purpose.

'(3) It is lawful for a person acting under the lawful direction or advice, or in the reasonable belief that the advice or direction was lawful, to administer the substance, or supply or procure the substance, in accordance with the direction or advice.

'(4) In this section—

health professional has the same meaning as in the *Health Services Act 1991*, section 60.

medical treatment, for subsection (1)(a), does not include medical treatment intended to adversely affect an unborn child.

patient means the person or unborn child on whom the surgical operation is performed or of whom the medical treatment is provided.

surgical operation, for subsection (1)(a), does not include a surgical operation intended to adversely affect an unborn child.'.

4 Insertion of new pt 9, ch 85

Part 9—

insert—

'Chapter 85 Transitional provision for the Criminal Code (Medical Treatment) Amendment Act 2009

'722 Retrospective application of amendment

'(1) This Code as amended by the *Criminal Code (Medical Treatment) Amendment Act 2009*, section 3 applies to proceedings for an offence—

(a) started but not finished before 19 August 2009; or

(b) started after 19 August 2009, whether the act or omission constituting the offence happened before or after 19 August 2009.

'(2) Subsection (1) does not apply to proceedings for an appeal against a conviction or sentence that happened before 19 August 2009.'.