



## MEDIA RELEASE

### Queensland Ombudsman releases report on Hendra virus

Thursday 3 November 2011  
For immediate release

Queensland Ombudsman Phil Clarke today released his report into the handling of Hendra virus incidents in Queensland from 2006 to 2009.

The *Hendra Virus Report* details systemic failures across several government agencies, including:

- outdated and inconsistent policies and procedures
- dated and overlapping legislation addressing similar issues which lead to inconsistent quarantine practices
- inadequate communication with vets and horse owners
- inadequate frameworks for ex gratia payments and compensation
- failure to implement recommendations contained in previous internal and external reviews
- inadequate training and resources for agency staff, contractors and property owners
- inadequate records of decisions.

State government agencies have important roles in responding to Hendra virus incidents, including:

- managing biosecurity risks
- controlling diseases in stock, including horses
- regulating public health concerns
- regulating the safe disposal of potentially harmful material
- managing workplace health and safety issues
- communicating with vets, horse owners and members of the public.

The investigation primarily focused on the administrative actions of Queensland Primary Industries and Fisheries, and to a lesser extent, Queensland Health and Workplace Health and Safety Queensland.

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The report details an exhaustive two-year investigation into the handling of six Hendra virus incidents between 2006 and 2009. In 2010-2011, a further 11 Hendra virus incidents were detected in Queensland. This report does not consider the later incidents in any detail as the Ombudsman's investigation had already provided sufficient evidence for this report.

The Ombudsman's investigation involved more than 50 interviews with senior government officers, private veterinarians and people affected by Hendra virus incidents. The investigation also examined thousands of pages of internal government documents and emails, consulted scientific experts and conducted site visits.

Mr Clarke made 74 recommendations, some of which were designed to rectify "systemic failures".

"I found evidence that systemic failures hampered the way government agencies responded to Hendra virus incidents," he said.

"The lessons from this investigation will help government agencies respond more effectively in future. My recommendations are designed to improve the way the public sector manages Hendra incidents and other significant biosecurity threats.

"An important part of my role is to help public agencies improve their administrative practices. This investigation revealed numerous systemic issues that have application beyond the response to the Hendra virus."

The agencies concerned have already made significant progress, as demonstrated by improved communication and coordination during the most recent Hendra virus incidents. However Mr Clarke said there was still room for significant improvement.

"While much work has been done by the agencies concerned and the response systems are rapidly maturing, more needs to be done as a matter of priority before the next Hendra incident," he said.

"We need an effective, timely and coordinated approach to the management of Hendra virus in Queensland. Full implementation of my recommendations will aid that process."

The Queensland Ombudsman is an independent officer of the Parliament and is not answerable to the government of the day.

The Ombudsman ensures public agencies make fair and balanced decisions for Queenslanders by investigating complaints and conducting own-initiative investigations to tackle broader, systemic concerns.

The Ombudsman has jurisdiction over state government agencies, local councils and universities.



However, under the Ombudsman Act, the Ombudsman has no jurisdiction to investigate or express any opinions in relation to any decision or action of government Ministers, private veterinarians or private industry bodies.

The Hendra Virus Report has been tabled by the Speaker and is available at:  
<http://www.ombudsman.qld.gov.au/>

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**3 November 2011**

## **Hendra Virus Report: FAQs**

### **What is Hendra virus?**

Hendra virus, formerly known as equine morbillivirus, is a serious disease that has killed humans and horses in Queensland. The virus was first identified in the Brisbane suburb of Hendra in 1994. Since then, there have been 22 Hendra virus incidents in Queensland.

### **Why did the Ombudsman decide to investigate the government's response to the Hendra virus?**

A number of state government agencies play an important role in responding to Hendra virus incidents, including:

- managing biosecurity risks
- controlling diseases in stock, including horses
- regulating public health concerns
- regulating the safe disposal of potentially harmful material
- managing workplace health and safety issues
- communicating with vets, horse owners and the general public

As part of a routine audit of Queensland Primary Industries and Fisheries (QPIF) in 2009, the then Ombudsman decided to examine QPIF's response to a number of Hendra virus incidents.

This led to a broader investigation that examined how various government agencies had responded to Hendra virus incidents.

### **What were the main objectives of the investigation?**

The investigation set out to answer the following questions:

- Did Queensland government agencies comply with their legislative responsibilities when dealing with Hendra virus incidents between January 2006 and December 2009?
- Were their responses effective?
- How could they have improved their responses?



## **Who are the key players?**

### **Queensland Primary Industries and Fisheries (QPIF)**

QPIF is part of the Department of Employment, Economic Development and Innovation (DEEDI). QPIF is the primary response agency for managing biosecurity risks and controlling diseases in livestock.

### **Queensland Health (QH)**

QH is responsible for handling public health concerns.

### **Workplace Health and Safety Queensland (WHSQ)**

WHSQ is part of the Department of Justice and Attorney-General (DJAG). WHSQ is responsible for regulating occupational health and safety related to Hendra virus incidents.

### **Environmental Protection Agency (EPA)**

The EPA is part of the Department of Environment and Resource Management (DERM). It is a key support agency during a major biological incident and is responsible for regulating the disposal of horse carcasses and other waste during and after Hendra virus incidents.

### **Veterinary Surgeons Board (VSB)**

The VSB is responsible for the registration and regulation of veterinarians in Queensland.

## **Who did the Ombudsman speak to as part of the investigation?**

Investigators interviewed private veterinarians, government officers and members of the public affected by the Hendra virus incidents. The investigation also examined thousands of pages of internal government documents, relevant internal and external reviews, consulted scientific experts and conducted site visits.

## **What investigative powers does the Ombudsman have?**

When investigating the administrative actions of public sector agencies, the Ombudsman must consider whether their actions are:

- unlawful, unreasonable or unjust
- based on irrelevant considerations
- based on a mistake of law or fact
- wrong.





The Ombudsman is empowered to make recommendations to the principal officer of an agency that action be taken to rectify maladministration to improve the agency's policies, practices or procedures to minimise the prospect of similar problems reoccurring.

The Ombudsman has jurisdiction over QPIF, QH, WHSQ, DERM and the VSB. However, under the Ombudsman Act, the Ombudsman has no jurisdiction to investigate or express any opinions in relation to any decision or action of government Ministers, private veterinarians or private associations.

### **How can the Ombudsman ensure the agencies will implement his recommendations?**

The Ombudsman will monitor implementation of the recommendations over the next 12 months.

### **How did the Ombudsman decide on the scope of this investigation?**

The investigation focused on six Hendra virus incidents in Queensland between 2006 and 2009.

In 2010-2011, a further 11 Hendra virus incidents were detected in Queensland. This report does not consider these later incidents in any detail as there was already sufficient evidence for the draft report which was well advanced. However changes to departmental practice have been identified in the report.

### **Why did the Ombudsman decide to table a public report on this investigation?**

If the Ombudsman considers it appropriate, a report may be presented to the Speaker for tabling. The report was made public for the following reasons:

- the proper management of Hendra virus incidents is a matter of public interest
- it is in the public interest to report on serious concerns raised about the decisions and actions of government agencies
- the lessons from this report will provide guidance to other government agencies
- the matter has been the subject of numerous media reports.

### **What were the key findings of the investigation?**

The investigation uncovered evidence of systemic failures that hampered agency responses to Hendra virus incidents.



The Ombudsman identified a number of issues, including outdated policies and procedures; dated and overlapping legislation that lead to inconsistent quarantine practices; inadequate training and resources for staff; inadequate record-keeping, delays in implementing recommendations from previous reviews and incomplete communication plans.

The Ombudsman also identified inconsistencies in ex gratia payments to two parties totalling \$220,000. He found that no adequate methodology was used to determine the appropriate amount for the ex gratia payments and no adequate reasons given for inconsistencies.

### **What are some of the Ombudsman's recommendations?**

The Ombudsman made 74 recommendations to five agencies covering a wide range of issues. The report details all opinions and recommendations.

Examples of recommendations:

#### **Quarantine and testing**

- QPIF amend its Guidelines for Veterinarians to provide more information about Hendra virus testing procedures, including the criteria used to determine if testing is urgent. (Recommendation 6)
- QPIF review its Quarantine Policy and consider whether the use of the Stock Act provides adequate powers to control Hendra virus. (Recommendation 8)
- QPIF ensure all relevant officers are aware of its policy decision to use quarantines rather than undertakings in any future response to Hendra virus incidents. (Recommendation 10)
- The Director-General of DEEDI allocate the necessary resources to ensure that, within six months of this report: all policies and procedures relevant to Hendra virus incident responses are prepared and finalised or reviewed where necessary; these policies and procedures are made available to QPIF officers and officers are provided with adequate training to implement these policies and procedures. (Recommendation 12)
- QPIF advise the Minister that its previous advice and recommendation relating to the interpretation of 'outbreak' in s.28 of the EDIA Act during the 2008 Redlands incident were based on a mistake of law and were wrong. (Recommendation 40 (a))
- QPIF review its policies and procedures and provide necessary training to officers to ensure that adequate information about testing is provided to property owners and horse owners to enable them to fully understand the testing regime before testing is conducted (Recommendation 59)
- QPIF immediately and fully inform horse owners and/or their private veterinarians of the results of Hendra virus tests on their horses (Recommendation 62)

### **Personal protective equipment (PPE)**

- QPIF continue to develop policies, procedures and publicly available fact sheets containing advice on the protective equipment required for responding to zoonotic diseases such as Hendra virus, and direction on how to fit and remove this equipment. (Recommendation 15)
- QPIF take ongoing and regular steps to ensure all officers wear the appropriate PPE when responding to a Hendra virus incident, reinforce with officers the importance of wearing appropriate PPE, and provide training for officers if necessary, and have appropriate systems in place to monitor compliance with PPE requirements. (Recommendation 17)
- QPIF continue to prepare clear and detailed guidelines for members of the public on the PPE requirements when dealing with horses which are, or are suspected of being, infected with Hendra virus, publish these guidelines on its website, provide training to QPIF officers in the content of these guidelines, and explain the guidelines, both orally and in writing, to property and horse owners during Hendra virus incidents. (Recommendation 18)

### **Communication and policy**

- In considering whether to investigate the possibility of any statutory offence, QPIF officers make and retain a record of their decision not to investigate, including their reasons for the decision and material on which they relied. (Recommendation 30)
- QPIF implement the recently developed Horse Biosecurity Communication Plan so that critical information regarding Hendra virus is distributed to private veterinarians and other relevant people in a timely and comprehensive way, and regularly (at least every six months) review the content of the Hendra virus materials for accuracy and completeness. (Recommendation 31)
- QPIF implement a risk-based assessment framework during Hendra virus incidents to enable it to prioritise biosecurity threats, better inform decision-making and allocate commensurate resources. (Recommendation 32)
- QPIF review its policy on destroying sero-positive horses; if necessary, ensure that this review forms part of any reconsideration of the national policy; and consider participating in any research designed to establish whether sero-positive horses can recrudescence, and if such recrudescence results in a risk of infection to other animals or people. (Recommendation 33)
- The Under Treasurer consider the feasibility of the Queensland Government developing a discretionary payment framework that provides for a range of payments to be made in different circumstances; and prepare a submission to government in this regard. (Recommendation 41)





- The Director-General of DEEDI ensure that the recommendations arising from the reviews of the needle-stick incidents in 2007 and 2008 are immediately implemented. (Recommendation 47)
- QPIF develop and implement a comprehensive information management system to assist in the management of Hendra virus and other biosecurity responses. (Recommendation 51)
- QPIF regularly review the adequacy of its communication practices with industry groups. (Recommendation 52)
- As part of ongoing communication between QPIF and QH in between incidents of Hendra virus, the agencies continue to discuss their respective responses during incidents, ensure that each agency's response is consistent with known levels of risk and minimise the potential for inconsistent messages to be provided to property owners and the general public. (Recommendation 67)
- QH, QPIF and WHSQ take joint responsibility and a coordinated approach in providing information to private veterinarians on reducing the risk of, and consequences of, human infection with Hendra virus, particularly during Hendra virus incidents (Recommendation 76)

### **What response has the Ombudsman had from the agencies concerned?**

The key agencies responsible for responding to Hendra virus incidents have made significant progress in recent years, much of it in line with 000 recommendations made in this report. However more work needs to be done as a matter of priority. An effective, timely and coordinated approach to the management of Hendra virus in Queensland is essential. Full implementation of the recommendations in this report will aid that process.

### **How will this report help Queenslanders affected by the Hendra virus?**

The Ombudsman made 74 recommendations designed to improve the way the public sector manages Hendra virus and other biosecurity incidents.

**<END>**



BRISBANE (3 November 2011)

## **Statement from Queensland Ombudsman Phil Clarke on the release of the *Hendra Virus Report***

This morning I provided the Speaker of the Parliament with a copy of the *Hendra Virus Report*. This report presents the findings of an exhaustive investigation into the way Queensland government agencies responded to Hendra virus incidents between 2006 and 2009.

I decided to release the report because:

- it concerned a matter of considerable public interest
- the lessons from this report will provide guidance to government agencies
- the matter has been the subject of numerous media reports.

As part of a routine audit of Queensland Primary Industries and Fisheries, the former Ombudsman decided to examine QPIF's response to Hendra virus incidents. This led to a broader investigation that looked at how various agencies had responded to Hendra virus incidents between 2006 and 2009.

The investigation set out to answer the following questions:

- did Queensland government agencies comply with their legislative responsibilities when dealing with Hendra virus incidents between January 2006 and December 2009?
- were their responses effective?
- how could they have improved their responses?

Ombudsman investigators interviewed private veterinarians, government officers and people affected by the Hendra virus responses. The investigation also examined thousands of pages of internal agency documents, examined relevant internal and external reviews, consulted scientific experts and conducted site visits.



There have been 11 further Hendra virus incidents in Queensland over the past two years. By the time these incidents occurred, the investigation was in its final stages and sufficient evidence had been gathered to proceed with the report. I believe the lessons from this investigation will help public agencies manage future Hendra virus and biosecurity incidents more effectively and that the findings will benefit government agencies and the wider community.

This investigation underlines the key role the Ombudsman plays in highlighting systemic concerns, identifying areas for improvement and helping agencies improve the way they carry out their responsibilities.

Following established practice, a draft report containing my proposed opinions and recommendations was made available to the agencies and other stakeholders for comment. The final report includes information about the responses received from agencies and others on the draft report and my final opinions and recommendations.

I concluded that systemic failures hampered the government's response to Hendra virus incidents. My investigation found:

- outdated and inconsistent policies and procedures
- dated and overlapping legislation which lead to inconsistent quarantine practices
- inadequate training and resources for agency staff
- inadequate records of decisions
- failure to implement recommendations from previous internal and external reviews
- inadequate communication
- inadequate frameworks for ex gratia payments and compensation.

I have made 74 recommendations to five agencies to rectify these failures.

The key agencies responsible for responding to Hendra virus incidents have made significant progress in recent years, much of it in line with recommendations made in this report.

However more work needs to be done as a matter of priority. An effective, timely and coordinated approach to the management of Hendra virus in Queensland is essential.



Full implementation of the recommendations in this report will aid that process.

This matter is of ongoing interest and I will monitor the implementation of my recommendations.

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