Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings

WITNESS STATEMENT OF DEBORA MARGARET PICONE

I, Debora Margaret Picone AO of [redacted] in the State of New South Wales, Chief Executive Officer (**CEO**), Australian Commission on Safety and Quality in Health Care (**ACSQHC**) and [redacted], do solemnly and sincerely declare that:

1. I am authorised by ACSQHC to make this statement on its behalf.

2. I make this statement on the basis of my own knowledge, save where otherwise stated. Where I make statements based on information provided by others, I believe such information to be true.

BACKGROUND AND QUALIFICATIONS

3. I am the CEO of ACSQHC. I commenced in this role in March 2012. I am also an Adjunct Professor at the School of Health Sciences at the University of Tasmania. I commenced that role in 2012.

4. Prior to commencing my role as CEO of ACSQHC, I worked in the following roles at the following organisations in the New South Wales (NSW) health system:

   (a) Director-General, NSW Health, 2007 to 2011;

   (b) Chief Executive, South Eastern Sydney / Illawarra Area Health Service, 2004 to 2007;

   (c) Administrator, South Western Sydney Area Health Service, 2003 to 2004;

   (d) Deputy Director-General, NSW Health, 2000 to 2003;

   (e) Acting Chief Executive, New England Area Health Service, 1999 to 2000;

   (f) Chief Executive, Corrections Health (Justice Health), 1998 to 2000.

5. I held a range of other positions within NSW Health between 1975 and 1988, involving clinical, clinical leadership and management responsibilities. I also held a position as a Clinical Associate Professor at the University of Sydney between 2005 and 2012.

6. I have a Bachelor of Health Administration from the University of New South Wales; I am a registered General Nurse (1978) and hold a certificate in Renal Nursing (1984).

7. I was awarded a Member of the Order of Australia for service to public administration in New South Wales, particularly to health services management through the development of integrated health policies and strategies for the south western Sydney area, and to nursing education and administration.

8. I am an Officer of the Order of Australia, which was awarded for distinguished service to the community through the coordination of improvements to the safety and quality of health care.

9. I am a Distinguished Life Fellow of the Australian College of Nursing and a Life Member of the NSW Nurses and Midwives Association.

10. Attached to this statement and marked **DMP-01** is my curriculum vitae.

Current role

11. As CEO, I am responsible for the overall operation of ACSQHC.

12. I report to the Board of ACSQHC and am responsible for the leadership, strategic direction, governance and management of the organisation. This includes:

    (a) driving national health reform initiatives on all matters relating to safety and quality in health care;

    (b) establishing and maintaining strong and effective relationships with a range of safety and quality stakeholders, including State and Territory health departments and their inter-jurisdictional committee representatives;

    (c) engaging collaboratively with other key influencers in the health care sector;

    (d) providing strategic evidence-based advice to Commonwealth, State and Territory Ministers; and

    (e) representing the ACSQHC in a range of national and international forums.

13. My overall objective as CEO is to positively influence the quality and safety of health care delivered across all sectors of the Australian health care system in keeping with the ACSQHC's four priority areas:

    (a) Safe delivery of health care

    (b) Partnering with consumers

    (c) partnering with healthcare professionals

    (d) quality, value and outcomes.

ROLE OF THE ACSQHC

14. In 2006, the Council of Australian Governments (COAG) established ACSQHC to lead and coordinate national improvements in the safety and quality of health care. ACSQHC's permanent status was confirmed with the passage of the National Health and Hospitals Network Act 2011 (Cth) and its role was codified in the National Health Reform Act 2011 (Cth).

15. ACSQHC commenced as an independent statutory authority on 1 July 2011, funded jointly by Federal, State and Territory governments.

16. The organisational purpose of ACSQHC is to contribute to better health outcomes and experiences for all patients and consumers, and improve value and sustainability in the health system by leading and coordinating national improvements in the safety and quality of health care. Within this overarching purpose, ACSQHC aims to ensure people are kept safe when they receive health care and that they receive the health care they require.

17. The Board of ACSQHC, appointed by the Minister for Health, is responsible for governing ACSQHC and meeting its functions and responsibilities under legislation.

18. The primary functions of ACSQHC are set out in section 9 of the National Health Reform Act 2011 (Cth). In summary, these include:

    (a) developing national safety and quality health service standards (**National Standards**);

    (b) developing clinical care standards to improve the implementation of evidence-based health care;

(c) coordinating work in specific areas to improve outcomes for patients; and

(d) providing information, publications and resources about safety and quality.

19. ACSQHC works in four priority areas:

(a) safe delivery of health care;

(b) partnering with consumers;

(c) partnering with health care professionals; and

(d) quality, value and outcomes.

REGULATORY FRAMEWORK AND THE NATIONAL STANDARDS

20. The ACSQHC is responsible for the development of the National Standards and the assessment of these standards as part of the Australian Health Service Safety and Quality Accreditation Scheme. The scheme is the oversight framework for the assessment of all public and private hospitals and day procedure services in Australia.

The National Standards

21. The National Standards provide a nationally consistent statement of the level of care consumers can expect from health service organisations. The primary aims of the National Standards are to protect the public from harm and to improve the quality of health service provision.

22. The National Standards were developed by ACSQHC in collaboration with the Federal, State and Territory governments, private sector providers, clinical experts, patients and carers.

23. The second edition of the National Standards was endorsed by Health Ministers in June 2017 and released in November 2017. It was updated in May 2021 (the **second edition**).

24. The second edition contains eight National Standards, which are:

(a) Clinical Governance Standard;

(b) Preventing and Controlling Infections Standard;

(c) Comprehensive Care Standard;

(d) Blood Management Standard;

(e) Partnering with Consumers Standard;

(f) Medication Safety Standard;

(g) Communicating for Safety Standard; and

(h) Recognising and Responding to Acute Deterioration Standard.

25. Attached to this statement and marked **DMP-02** is a copy of the second edition of the National Standards.

Accreditation to the National Standards

26. All public and private hospitals, day procedure services and public dental practices are required to be accredited to the National Standards

27. To become accredited, a health service organisation must:

(a) implement the National Standards in their organisation;

(b) conduct routine self-assessments to determine if it is meeting the National Standards;

(c) participate in an on-site assessment by assessors appointed by the ACSQHC who assess the organisation's compliance with the National Standards every 3 years or annually where the organisation has elected to participate in limited or no notice surveys; and

(d) take steps to address any shortcomings identified by the assessors.

28. Following an assessment, a report is issued to the facility detailing its performance against the National Standards. The report includes compliance level ratings for each action that was assessed and commentary or recommendations on key findings.

29. The rating scale applied consists of:

(a) Met;

(b) Met with Recommendations;

(c) Not Met; or

(d) Not Applicable.

30. To meet accreditation requirements, all assessed actions must be met. Where an action is not rated as 'met', corrective action is specified.

31. The assessment of health service organisations against the second edition of the National Standards commenced in January 2019 (with some minor exceptions).

32. I discuss the nature of the assessments and their relevance to Launceston General Hospital from paragraph 46 below.

Broader regulatory framework

33. The broader regulatory framework within which health service organisations operate is a mix of legislation, regulations, administrative instructions, and internal policy and procedure.

Legislation

34. The legislation that underpins the operation of a health service organisation differs between each of the States and Territories. Some States and Territories include very specific legislative requirements for health service organisations, which may be the consequence of particular past issues or concerns in the jurisdiction. Other States and Territories take a broader or higher-level approach to the legislative obligations of health service organisations.

Regulations

35. Regulations sit below the legislation. These are generally very detailed. In my experience, regulations may go without updates for a significant period of time.

Administrative instructions

36. Next, administrative instructions (also known as "circulars") are often issued by State and Territory governments as a way to instruct health service organisations about their obligations. Governments issue these administrative instructions to both the public and private sectors. They are issued to the public sector because the States and Territories are the owner-operators of the relevant health service organisation (such as a public hospital) or what is called

the "system administrator". In the private sector context, they are issued by the State or Territory government as the sector regulator.

Policies and procedures

37. Finally, each health service organisation will have its own policies and procedures through which it implements the legislative, regulatory and administrative requirements.

Relationship with Child Safety Standards

38. The Royal Commission into Institutional Responses to Child Sexual Abuse developed a set of Child Safe Standards that articulate the ten essential standards of a child safe institution.[1]

39. In my experience, child safety and welfare is taken very seriously within health service organisations.

40. While the National Standards do not specifically address child safety, they apply equally to all patients – Adults, adolescents, children and babies. In relation to child safety, specific guidance has been prepared and is attached to this statement and marked **DMP-03**.

41. Various Child Safe Standards are reflected in the National Standards, for example, the Clinical Governance Standard[2] and Partnering with Consumers Standard provides as follows:[3]

> ***Child Safe Standard 1: Child safety is embedded in institutional leadership, governance and culture***
>
> **Action 1.01a** The governing body provides leadership to develop a culture of safety and quality improvement, and satisfies itself that this culture exists within the organisation
>
> **Action 1.06** Clinical leaders support clinicians to:
>
> a. Understand and perform their delegated safety and quality roles and responsibilities

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1 Royal Commission into Institutional Responses to Child Sexual Abuse, *Making Institutions Safe* (Report, 2017), 13.

2 Australian Commission on Safety and Quality in Health Care, National Safety and Quality Health Service (NSQHS) 'Partnering with Consumers Standard', *Standards* (Web Page) < https://www.safetyandquality.gov.au/standards/nsqhs-standards/partnering-consumers-standard>.

3 Australian Commission on Safety and Quality in Health Care, National Safety and Quality Health Service (NSQHS) 'Clinical Governance Standard' , *Standards* (Web Page) < https://www.safetyandquality.gov.au/our-work/clinical-governance/clinical-governance-standard>

b. Operate within the clinical governance framework to improve the safety and quality of health care for patients

Child Safe Standard 2: Children participate in decisions affecting them and are taken seriously

Action 1.13a The health service organisation has process to seek regular feedback from patients, carers and families about their experiences and outcomes of care

Child Safe Standard 3: Families and communities are informed and involved

Action 1.08d Involve consumers and the workforce in the review of safety and quality performance and systems

Action 1.14 The health service organisation has an organisation-wide complaints management system, and:

a. Encourages and supports patients, carers and families, and the workforce to report complaints
a. Regularly reviews and acts to improve the effectiveness of the complaints management system

Child Safe Standard 4: Equity is upheld and diverse needs are taken into account

Action 1.02 The governing body ensures that the organisation's safety and quality priorities address the specific health needs of Aboriginal and Torres Strait Islander people

Action 1.15 The health service organisation:

a. Identifies the diversity of the consumers using its services
b. Identifies groups of patients using its services who are at higher risk of harm
c. Incorporates information on the diversity of its consumers and higher-risk groups into the planning and delivery of care

Action 2.08 The health service organisation uses communication mechanisms that are tailored to the diversity of the consumers who use its services and where relevant, the diversity of the local community

Action 2.11a The health service organisation involves consumers in partnerships in the governance of, and to design, measure and evaluate health care

Action 2.11 b The health service organisation has processes so that the consumers involved in these partnerships reflect the diversity of consumers who use the service or, where relevant, the diversity of the local community

Child Safe Standard 6: Processes to respond to complaints of child sexual abuse are child focused

Action 1.11 The health service organisation has organisation-wide incident management and investigation systems, and:

- **a.** Supports the workforce to recognise and report incidents
- **b.** Supports patients, carers and families to communicate concerns or incidents
- **c.** involves the workforce and consumers in the review of incidents
- **d.** provides timely feedback on the analysis of incidents to the governing body, the workforce and consumers
- **e.** uses the information from the analysis of incidents into the risk management system
- **f.** Incorporates risks identified in the analysis of incidents into the risk management system
- **g.** regularly reviews and acts to improve the effectiveness of the incident management and investigation systems

Action 1.12 The health service organisation:

- **a.** uses an open disclosure program that is consistent with the Australian Open Disclosure Framework
- **b.** monitors and acts to improve the effectiveness of open disclosure process

Child Safe Standard 8: Physical and online environments minimise the opportunity for abuse

Action 1.29 The health service organisation maximises safety and quality of care:

- **a.** Through the design of the environment
- **b.** By maintaining buildings, plant, equipment, utilities, devices and other infrastructure that are fit for purpose

Action 2.11a The health service organisation involves consumers in partnerships in the governance of, and to design, measure and evaluate, health care

Action 2.12 The health service organisation provides orientation, support and education to consumers who are partnering in the governance, design, measurement and evaluation of the organisation.

Child Safe Standard 9: Implementation of the Child Safe Standards is continuously reviewed and improved

Action 1.07 The health service organisation uses a risk management approach to:

- **a.** Set out, review, and maintain the currency and effectiveness of policies, procedures and protocols

b. Monitor and take action to improve adherence to policies, procedures and protocols

c. Review compliance with legislation, regulation and jurisdictional requirements

Action 1.20 The health service organisation uses its training systems to:

a. Assess the competency and training needs of its workforce
b. Implement a mandatory training program to meet its requirements arising from these standards
c. Provide access to training to meet its safety and quality training needs
d. monitor the workforce's participation in training

Child Safe Standard 10: Policies and procedures document how the institution is child safe

Action 1.10 The health service organisation:

b. Identifies and documents organisational risks
c. Uses clinical and other data collections to support risk assessments
d. Acts to reduce risks
e. regularly reviews and acts to improve the effectiveness of the risk management system
f. reports on risks to the workforce and consumers
g. plans for, and manages, internal and external emergencies and disasters

42. It would be possible to embed the Child Safe Standards into the National Standards, in order to make them mandatory for accredited health service organisations. In my view, it would be preferable to do so. To date, however, ACSQHC has not received sufficient intelligence of breakdowns in child protection arrangements in health service organisations to warrant the specific inclusion of the Child Safe Standards in the National Standards. ACSQHC expects, as part of compliance with the National Standards, that health service organisations have the systems in place to keep children safe and manage the risk.

43. While compliance with the Child Safe Standards is not directly mandated by the National Standards, my understanding is that the Child Safe Standards have, or should have, been implemented by States and Territories.

44. I understand that the implementation of the Child Safe Standards within each State and Territory was the subject of negotiation within COAG (as is usual for

these processes). Because COAG processes are bilateral, they require each State and Territory to agree to do something. I do not know what processes Tasmania has agreed to follow to implement the Child Safe Standards (whether by legislative, regulatory or administrative means).

45. ACSQHC is actively monitoring the work of the Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings (**Commission**). In my view, to the extent this Commission identifies concerns in Tasmania, it may be fair to assume that other States or Territories are experiencing the same or similar problems. On that basis, the findings of the Commission may provide further insight to ACSQHC regarding whether there is a need to formally embed the Child Safe Standards into the National Standards.

ACSQHC ASSESSMENTS

The assessment process

46. As identified above at paragraph 27, health service organisations are regularly assessed against the National Standards, as part of the accreditation process. In practice, a team of independent assessors go into an organisation to check whether and how each National Standard is implemented in that organisation. The team spends time commensurate with the size of the health service organisation undertaking the assessment, in medium to large organisations this is usually 1 week. Depending on the size of the organisation, the team of assessors may number up to 15 individuals. An assessment of a smaller organisation, such as Launceston General Hospital (LGH), may only include a team of four or five assessors. In total, the process takes approximately three months (including preparation and reporting).

47. As part of the assessment, an organisation is assessed against a standardised dataset of hospital acquired complications (**HACs**), such as the number of infections acquired from a stay at a particular hospital and the number of medication errors. The risk of HACs can generally be reduced (though not necessarily eliminated) by clinical risk mitigation strategies. The HAC dataset sets out the rate and nature of HACs experienced by health service organisations of a similar kind and size.

48. Comparing the data on HACs at the organisation being assessed against a standard dataset is important, as it is an indicator of how an organisation is performing in the "real world" in comparison to its peers. For example, if a hospital has a high complication rate (such as a high rate of hospital acquired infections) that is generally a sign that the hospital is performing below standard. The comparison is also a very good indicator of the quality of governance within an organisation. Put another way, the organisation's HACs can paint a picture of what is really going on in an organisation.

49. Attached to this statement and marked **DMP-04** is a report which shows the performance of LGH against its peers as at the period ending 2020-21. The following observations are made:

Hand hygiene (HH)

At the hospital level, the HH compliance rates are consistently on or above the national benchmark of 80%.

At the department level, compliance rates are declining across several departments (some caring for higher infection risk patients). These departments include:

- Critical Care Unit
- Emergency Department
- Maternity
- Neonatal Care
- Oncology
- Peri-operative
- Renal (starting from a high base, >90%)

The compliance rate for medical practitioners consistently ranges from 61% to 74% (over the eight audit periods to June 2021), this is of concern.

Hospital-acquired Complications (HACs)

Across the 16 HAC categories, LGH's rates are consistently in the upper 50% when compared to its peers. The higher the rate, the worse the hospital is performing.

LGH's aggregate HAC rate was in the highest 10% from 2014-15 to 2018-19, before improving but still remaining in the highest 20-30%.

These individual HACs include delirium, healthcare-associated infections, gastrointestinal bleeding, surgical complications, respiratory complications, cardiac complications and renal failure.

Hospital Standardised Mortality Ratio (HSMR)

When assessed by the Commission's HSMR model, LGH has over the three years to 2020-21 performed consistently below the lower confidence bound, compared to peers nationally.

However, it would be recommended as an aspect of safety and quality improvement practices, that HSMRs are monitored periodically. Along with reviews undertaken to ensure the reliability of the underlying data and patient Casemix.

Sentinel Events

Sentinel events are a subset of adverse patient safety events that are wholly preventable and result in serious harm to, or death of, a patient.

LGH recorded 3 such events from 2018-19 to 2020-21.

SAB

LGH has met the current SAB national benchmark of 1 case per 10,000 patient days. However, LGH consistently sits above its peer aggregate SAB rate.

Emergency Department (ED) wait times

The proportion of ED presentations, seen in the recommended time, has been declining since 2015-16. The proportion of emergency, urgent and semi-urgent triaged presentations, were at or below 80% in 2015-16 and have declined to below 68% for emergency, 63% for urgent and 54% in recent years.

Observations of Launceston General Hospital

Assessment of Launceston General Hospital in 2022

50. The Tasmanian Health Service – North Region (which includes Launceston General Hospital) underwent assessment during the week beginning 4 April 2022. The Commission has not received a final report in regard to that assessment. At that assessment, three of the eight National Standards were assessed. They were the Partnering with Consumers, Preventing and Controlling Infection and Comprehensive Care Standards.

51. Of the 69 actions assessed, 62 were rated as "met" and seven were rated "met with recommendations". The majority of actions rated "met with recommendations" were in the Preventing and Controlling Infections Standard. A final report is yet to be received.

52. The last organisation-wide assessment of Launceston General Hospital took place in May 2018. The following actions were rated not met at initial assessment:

- **1.11.2** Participation of clinical workforce in regular performance reviews
- **1.2.2** Improving the S&Q of patient care
- **9.6.1** The clinical workforce is trained and proficient in basic life support
- **10.2.4** Taking action to reduce the frequency and severity of falls in the health service organisation
- **10.5.2** Monitoring the use of the screening tool to identify the proportion of at-risk patients that were screened for falls
- **10.5.3** Increasing the proportion of at-risk patients who are screened for falls upon presentation and during admission
- **10.6.1** Using a best practice assessment tool by the clinical workforce to assess patients at risk of falling
- **10.7.3** Reducing falls and minimise harm for at-risk patients.

53. In addition to these three standards, assessors were asked to review incident reporting and complaint handling, risk management and open disclosure systems. Assessors found that these systems were effective, were being used appropriately, and were being monitored. The assessors noted that training in open disclosure was directed to senior staff involved in these processes.

54. The next short notice assessment of Launceston General Hospital is being scheduled for mid-2022. The Clinical Governance Standard will be assessed at this time and Chris Leahy, Chief Operating Officer of ACSQHC will personally be attending this assessment as an observer. The Commission observes approximately 30 assessments each year as part of its program to improve the quality of assessments.

55. At the end of March 2022, 897 hospitals and day procedure services have been assessed to the NSQHS Standards. 282 (30%) health service organisations assessed met all actions from the Standards. The remaining 70% had actions that were met with recommendations (45%) or had at least one not met action at initial assessment (25%).

Other observations of Launceston General Hospital

56. I have observed and have been informed of a poor relationship existing between Launceston General Hospital and hospitals in the southern part of the State. I understand that this relationship reflects a historic rivalry between Hobart and Launceston. In my opinion, a preoccupation of this kind is present between many health services.

CHILD SAFEGUARDING

57. From a prevention perspective, it is critical for a health service organisation to have a child safe environment that prevents the opportunity for abuse.

58. The essential features of a child safe environment in a health care setting include:

    (a) clear principles and procedures concerning hospital design and layout – minimising non-essential exposure of children to people not authorised to provide their care – for example, ensuring that the unit is secure and that there are processes to approve all visitors;

    (b) a requirement that children are accommodated in a unit separate from adults;

    (c) as far as reasonably possible depending on the size of the hospital, a requirement that clinical staff treating children are trained in paediatrics;

    (d) appropriate background checks (such as a Registration to Work with Vulnerable People (**RWWVP**)) for all staff with access to children or to children's medical records (including non-clinical or ancillary staff such as catering and cleaning staff);

    (e) clear procedures for conducting examinations (in particular intimate examinations), including that all children are seen by at least two staff members; and

    (f) a reliable incident and complaints management system, which I discuss in more detail from **paragraph 644**.

59. In relation to requirements for children to be seen by more than one adult at any one time, I have observed that some healthcare workers consider this to

be onerous and unnecessary. But, in my view, if you are going to do a procedure on a child, you must have two people there. In these settings, curtains can be drawn and no one will know what is going on behind them. This is why a chaperone is so important.

60. I would expect to see these requirements detailed in various standards in a hospital setting, whether at the legislative, regulatory or administrative levels, or in internal hospital procedures.

INCIDENT AND COMPLAINTS MANAGEMENT

The role of the ACSQHC in relation to complaints management

61. The ACSQHC has published a guide for consumers called "Understanding My Healthcare Rights" which is a comprehensive guide to the healthcare rights patients can expect including access, respect, partnership, information, privacy and giving feedback. A copy of that guide is attached to this statement and marked **DMP-05.**

62. The ACSQHC does not have the authority to investigate complaints about health service organisations or practitioners unless requested to do so by the system regulator. The ACSQHC has no direct role in patient care. The role of the ACSQHC is to assist clinicians and health services improve the safety and quality of the care they provide.

63. The ACSQHC provides advice to consumers in relation to complaints about health service organisations, such as speaking to the Nurse Manager or lead clinician or contacting the organisation's consumer advocate or patient liaison officer. If a consumer does not receive a response (or a satisfactory response) they can contact their state and territory's health complaints commissioner. Complaints about specific registered health practitioners should be made to the Australian Health Practitioner Regulation Agency.

Incident management systems

64. Functioning incident management systems are a critical part of managing a health service organisation. Not only are they a record of all incidents, near-misses or complaints, they also act as a public health tool by providing

intelligence about the functioning of the organisation and allowing the organisation to identify areas for improvement.

65. All incidents (clinical and non-clinical) should be recorded in the organisation's incident management system. These systems are more commonly used for clinical incidents (such as treatment errors) but are also used for other non-clinical incidents (such as incidents of abuse). I do not consider that there are any issues, in principle, with using the same incident management system for clinical and non-clinical incidents.

66. While incident management systems will differ in practical ways between organisations, they generally feature similar processes. When making an entry, the person lodging the incident (**complainant**) will generally be required to describe the incident and provide all relevant information known at that time. The complainant would also allocate the incident a risk or seriousness rating – sometimes known as a severity assessment code (**SAC**). The SAC might be, for example, a score out of five which reflects the seriousness of the matter. The SAC used would depend on the relevant criteria used in that particular organisation. An incident involving child sexual assault would be considered an extremely serious matter.

67. Once an incident is submitted by the complainant, the relevant system will usually generate a management "tab" for that entry. All information gathered and decisions made after the initial entry are recorded against the management tab. The complainant may or may not have access to the management tab depending on how the system is configured and the local work processes.

68. That management tab may allow a reclassification of the SAC to be entered against the incident by a manager or reviewer. It is not unusual for management to assign a different SAC (higher or lower) to the incident than that assigned by the complainant. For example, following initial investigations (after the incident is entered into the system), management may consider the incident more or less serious based on new information. Further, the initial complaint may have been made in a high stress context, which may have resulted in an inaccurate assessment of severity (for instance, by a junior doctor during a difficult night shift without all the relevant information).

69. Importantly, any changes or additions to the management tab (including a reassessment of the SAC) should not, as a matter of best practice, remove or alter the original entry by the complainant. The purpose of the management tab is not to remove, obscure or rewrite the initial notification. Instead, it is an additive process that records new or more accurate information as it comes to light. This often occurs as the relevant manager reviews clinical notes or interviews other staff who witnessed the incident. In some instances, persons dealing with the incident may be making changes over a number of weeks. The work done by management in this regard should not be viewed suspiciously.

70. It is best practice for the system to preserve the original entry of the complainant as a permanent record. It should not be able to be destroyed, removed or otherwise amended (even for minor changes such as typos). I would be concerned if an incident management system was programmed in such a way that allowed for original entries to be destroyed, removed or altered.

71. I have sought advice in relation to the incident reporting system in use at the Launceston General Hospital — the Safety Reporting and Learning System. I am advised that entries made subsequent to the original entry are identifiable and that the system in use at Launceston General Hospital was developed not to allow changes to the original report once submitted. Incorrect information is changed by side notes to the report.

72. In some instances, a person or persons may decide not to report an incident because they want to maintain the reputation of the particular person or persons involved or the organisation at large. In these instances, persons who decide not to report an incident often believe it is the right thing to do, so that the community continues to have confidence in that organisation (such as the local hospital). An important safeguard against this instinct is to incorporate collective decision-making as part of risk management. Where a number of people are aware of an incident, a decision not to report the incident would necessarily involve those people collectively deciding not to report the matter or handle the complaint. Collective decision-making has become more common following the introduction of mandated complaints handling systems under the National Standards).

73. ACSQHC sometimes hears from junior medical officers, registrars and advanced trainees doing their specialty training that they are concerned that making a complaint against a senior officer might affect their ongoing career prospects. This is a concern because their boss signs off their training. In my view, this is not the norm but we still hear these kinds of sentiments from junior medical officers from time to time.

74. There is no central repository for clinical incident data which would allow the ACSQHC to compare the number of incidents that would be expected to be lodged in a given year, or what type or their spread.

75. The NSQHS Standards require health service organisations to meet the following actions:

> **1.11** The health service organisation has organisation-wide incident management and investigation systems, and:
>
> **a.** Supports the workforce to recognise and report incidents
>
> **b.** Supports patients, carers and families to communicate concerns or incidents
>
> **c.** Involves the workforce and consumers in the review of incidents
>
> **d.** Provides timely feedback on the analysis of incidents to the governing body, the workforce and consumers
>
> **e.** Uses the information from the analysis of incidents to improve safety and quality
>
> **f.** Incorporates risks identified in the analysis of incidents into the risk management system
>
> **g.** Regularly reviews and acts to improve the effectiveness of the incident management and investigation systems
>
> **1.12** The health service organisation:
>
> **a.** Uses an open disclosure program that is consistent with the Australian Open Disclosure Framework
>
> **b.** Monitors and acts to improve the effectiveness of open disclosure processes
>
> **1.14** The health service organisation has an organisation-wide complaints management system, and:
>
> **a.** Encourages and supports patients, carers and families, and the workforce to report complaints
>
> **b.** Involves the workforce and consumers in the review of complaints

c. Resolves complaints in a timely way

d. Provides timely feedback to the governing body, the workforce and consumers on the analysis of complaints and actions taken

e. Uses information from the analysis of complaints to inform improvements in safety and quality systems

f. Records the risks identified from the analysis of complaints in the risk management system

g. Regularly reviews and acts to improve the effectiveness of the complaints management system.

Responding to an allegation of child sexual abuse

76. Allegations of child sexual abuse are extremely serious and require a thorough response from more senior representatives of the organisation.

77. In my view, a best practice response to an allegation of child sexual abuse in a health service organisation is as follows:

(a) the matter is immediately escalated to the appropriate senior manager, such as a general manager (the exact position of that person will depend on the particular organisation);

(b) the senior manager immediately reports the matter to police (within the shortest possible time of receiving notice of the complaint);

(c) the senior manager takes an immediate administrative decision regarding the duties of the alleged offender, including whether they are to be suspended; and

(d) the senior manager initiates an open disclosure process with the victim and their family (I discuss open disclosure in more detail from paragraph 87).

78. Immediate referral to police is a critical part of the response. Whether or not the person has engaged in grooming or some form of child sexual abuse is not a matter that can be determined by senior management. Rather, that is up to the police. This is why the notification to police must happen very quickly.

79. Decisions about the continued presence of the alleged offender at the health service organisation must be guided by concerns for the safety of patients and families. This can be a difficult decision for organisations. In my view, it is very

inappropriate to allow an alleged offender to continue working in any capacity while a matter is being investigated. I consider the best course of action is to place the person on leave. At the very least, the alleged offender should not be left working with children until the matter has been dealt with by police.

80. These matters are addressed in more detail in the complaints handling manual of ACSQHC, which is attached to this statement and marked **DMP-06**.

Organisational culture

81. Proper incident management relies on reporting by staff. In that context, the culture of an organisation is critical to the effectiveness of an incident management system.

82. It is possible for organisational culture to discourage incident reporting – altogether or regarding incidents of a certain kind (for example, complaints concerning sexual abuse by staff). I am aware of such cultures presently existing in some health service organisations around Australia. For example, I recently questioned a very experienced senior doctor in a hospital outside Tasmania about a failure to record a certain incident in the hospital's incident management system. I explained to him that if he had done so, he would have received a more cohesive response to the incident. His reply was, in effect, "no one uses the incident reporting system, that's just a thing for nurses to report doctors".

83. This kind of culture of non-reporting was more common in the past, pre-2000. I have observed a general improvement in attitudes of health practitioners to incident reporting. In my experience, the majority of health practitioners understand the importance of proper incident management, and that a good complaints management system requires organisations to welcome complaints so that practices can be improved. The majority of people now see complaints handling and complaints management as a positive and useful thing. In particular, I have observed a positive attitude towards complaints and incident management among younger practitioners. In my experience, the best reporters are nurses.

Changing organisational culture

84. The culture of an organisation can be very deeply embedded. In some of the organisations I work with, the culture could be 10 years old or could be 150 years old. In these settings, achieving cultural change to address a problem is a long and sometimes difficult process.

85. In my experience, change is easier to achieve in a health care setting when health professionals see that what you are asking them to do is of benefit to the patient. Health practitioners are motivated by patient outcomes. If you can demonstrate to health professionals that a certain approach or process (for example, a robust complaints management system) will improve patient outcomes or reduce the stress on the organisation, they are more likely to participate and adopt the necessary organisational culture to achieve that outcome. In my experience, health professionals will also respond positively when they are provided with data about their performance as compared to their peers.

86. Change of this kind often begins by getting the support of a small group of, for example, senior doctors or senior nurses, to put out very simple messaging about the issue to the wider staff. That messaging can then be supported by data to substantiate why the change is required and the benefits it will produce. Eventually, this small group of "influencers" or "champions" becomes a larger group and the change gradually takes place.

OPEN DISCLOSURE

Overview

87. Health service organisations deal with very complex matters and systems. Mistakes do occur in these settings. Where a mistake occurs, a process of open disclosure is an important part of addressing and resolving the mistake.

88. Open disclosure involves an open discussion with a patient, their family and carers where an adverse event has resulted in harm to the patient while receiving health care. Fundamentally, it involves being honest with the patient and telling them when something has gone wrong.

89. The Clinical Governance Standard mandates the use of an open disclosure program consistent with the Australian Open Disclosure Framework (**the Framework**).[4] The Framework provides a nationally consistent basis for communication following unexpected healthcare outcomes and harm. Attached to this statement and marked **DMP-07** is a copy of the Framework.

90. The ACSQHC also has a number of Open Disclosure resources available on its website, including resources specifically designed for consumers, clinicians and health service organisations.[5]

91. The elements of open disclosure are:

    (a) an apology or expression of regret, which should include the words "I am sorry" or "we are sorry";

    (b) a factual explanation of what happened;

    (c) an opportunity for the patient, their family and carers to relay their experience;

    (d) a discussion of the potential consequences of the adverse event; and

    (e) an explanation of the steps being taken to manage the event and prevent recurrence.

92. These steps may happen over several meetings with the patient and their family.

93. Open disclosure is a very natural and normal process. Nine times out of ten, these steps happen automatically. For example, a nurse may realise that they gave a patient the wrong medication. In most instances, that nurse would go straight back to the patient and tell them what has happened, let the patient know that the mistake will not cause them any harm and apologise for the mistake.

94. In certain circumstances, people can be reluctant to engage in open disclosure. This is particularly so for doctors, who sometimes refuse on the basis of

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[4] Australian Commission on Safety and Quality in Health Care, National Safety and Quality Health Service (NSQHS) 'Clinical Governance Standard – Action 1.12', *Standards* (Web Page) < https://www.safetyandquality.gov.au/standards/nsqhs-standards/clinical-governance-standard/patient-safety-and-quality-systems/action-112>.

[5] Australian Commission on Safety and Quality in Health Care, 'Open disclosure', < https://www.safetyandquality.gov.au/our-work/clinical-governance/open-disclosure>, accessed at 23 May 2022.

medico-legal concerns. Over time, I have observed an improvement in the use of open disclosure. However, ACSQHC still estimates that about 20% of open disclosures still do not occur and 10% are performed poorly.

95. As a matter of best practice, the person responsible for the incident participates in the open disclosure process. This is appropriate in the context of clinical errors, such as a medication error. In the context of an incident that involves intentional harm or alleged criminal behaviour (such as child sexual abuse), you cannot ask the alleged offender to participate in open disclosure for obvious reasons concerning patient safety and the criminal investigation process. In those circumstances, the organisation steps in to work through the open disclosure process with the relevant patient or family.

96. In a really serious situation, such as an incident of child sexual abuse, I would expect the organisation's management and any relevant clinicians (aside from the alleged offender) to sit down with the family to explain the facts (as far as they are known). While the organisation's management cannot talk about whether the alleged offender is guilty or not, they can and should talk about what processes are being put in place to address the situation, what investigation is going to happen and when results of that investigation might be expected.

97. The best open disclosure is contemporaneous. Where an incident involves alleged criminal behaviour, I would expect open disclosure to occur at the same time the organisation is reporting the matter to police. In practice, this means that as soon as the senior manager has got off the phone with police, they should be taking steps to convene a meeting with the victim and their family, to explain (to the best of their ability) the nature of the issue and the steps taken by the organisation so far. The family should also be given an opportunity to ask questions. If the incident is serious, an organisation may have relevant community services involved in this process as well.

98. The timely conduct of open disclosure is critical in my view. In my experience, open disclosure fails when an organisation does not carry it out quickly and when, instead, the first time the victim and their family hear about the matter is on the front page of *The Mercury* or the TV news that night. Open disclosure can be extended to provide support to the patient or the family as may be required, such as grief counselling in the event of a death.

Supporting staff

99. In the context of a clinical or non-clinical incident, it is important to take steps to appropriately support staff who may be experiencing feelings of distress or guilt around the incident.

100. In instances of serious staff misconduct or criminal behaviour (including cases of child sexual abuse), staff will be experiencing distress for many reasons. The most common concern is that staff blame themselves for the incident, even where they cannot possibly be considered responsible. This is a particular risk for senior and experienced staff who consider they should have noticed the problem. I have observed this kind of significant distress among nursing staff and a visiting general practitioner in the context of significant and ongoing misconduct by one nurse over a number of years. During a meeting with nursing staff, one nurse expressed her sense of guilt over the issue, saying that she "should have known" what was going on.

101. The distress experienced by staff can be amplified in the context of small communities or where the alleged offender was a longstanding colleague and friend.

102. The steps an organisation may take to support their staff in these circumstances will depend in part on the nature of the incident. For example, if a matter is under police investigation, the organisation will need to be mindful of cutting across chains of evidence or hampering police efforts.

103. An important feature of the response is early communication. This may take the form of a meeting with senior management that (having regard to police activities):

(a) informs staff that a complaint has been made;

(b) advises staff of the nature of the complaint; and

(c) outlines the steps taken to address the complaint and the steps to be taken in the future.

104. At this point, it is also important to reassure the staff that they are not to blame for the alleged conduct of their colleague and to remind them of the steps being taken to address the harm. It is important, too, to make counselling and other support services available to staff at this time. Health service organisations

have policies and procedures about how to support staff in these situations. These services are in most instances provided by extramural specialists independent from the health service. These services are generally titled Employee Assistance programs.

Rebuilding trust within communities

105. From time to time a community may lose confidence in a health service organisation as the result of an error, series of errors or a failure to appropriately respond to an error. In such instances, it is important for the hospital to take steps to rebuild community trust.

106. An important step in rebuilding that trust is communication with the community. The shape of that process will often depend on the manner in which the organisation lost trust in the first place (for example, a high profile or preventable death, an incident of misconduct or some other incident). In many ways, the appropriate response takes on the character of open disclosure, but on a public scale. This includes:

(a) being open and honest about the fact that an incident has occurred;

(b) admitting fault for the error or set of circumstances as appropriate;

(c) making a very genuine apology to the affected persons and community;

(d) identifying what has been learnt from the error;

(e) advising the community about what is being done or will be done to address the problem; and

(f) demonstrating to the community that the organisation is following through with its promises.

107. Where the incident involves child sexual abuse, the health service must respect the family's concern around privacy or trauma for the child that might follow from publicity. This requires as far as possible to withhold the name of the patient and to have in place policies and procedures to guide staff.

108. Honesty in this process is critical to beginning to rebuild community confidence in the organisation. The organisation cannot promise that the incident will not happen again; rather the community needs to see that the organisation is

working to resolve the issue and take steps to prevent its recurrence. Over time, such steps will contribute to a slow re-building of trust within the community. However, organisations can often be left with a damaged reputation.

109. Often, the media play a significant role in contributing to the community response and reaction. For example, the Royal North Shore Hospital in Sydney suffered a storm of negative press when a woman suffered a miscarriage while waiting to be seen. The event triggered a large community reaction which was covered extensively in the media, to the point that activity at the Royal North Shore Hospital emergency department dropped by approximately 70%. A genuine apology and thorough response from the hospital can help alleviate a situation like this.

110. Often, organisations will struggle to regain confidence or trust where they are arrogant about an incident or attempt to ignore it.

111. A good example of a process taken by an organisation to rebuild trust was recently seen at the Perth Children's Hospital (**PCH**). In early 2021, a series of triage failures led to the death of a child from sepsis. Following the incident, ACSQHC undertook an independent inquiry into the PCH about the care and treatment that child received prior to her death, including matters such as emergency department staffing, and the roles and responsibilities of clinicians, management and the hospital's executive team. The resulting report made 30 recommendations, all of which have been accepted by the Child and Adolescent Health Service Western Australia.[6]

112. As part of the review, PCH was very honest about the incident, articulated what it had learned from the review, and articulated how things would change. In my view, that process of inquiry helped heal a lot of the staff and reduced the concerns the community had about the hospital.

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[6] Australian Commission on Safety and Quality in Health Care, *Inquiry under Part 14 of the Health Services Act 20016 (WA): Independent Inquiry into Perth Children's Hospital* (Report, November 2021).

I make this solemn declaration under the *Oaths Act 2001* (Tas).

Declared at Sydney, New South Wales
on 21 June 2022

[redacted]

Before me

[redacted]