Executive summary

Background

Hendra virus, formerly known as equine morbillivirus, is a serious disease that has killed both humans and horses in Queensland. Spread by flying foxes, Hendra virus was first identified in 1994 in the Brisbane suburb of Hendra. Since that date, 22 Hendra virus incidents have been identified in Queensland and several in New South Wales. In 2011 alone, there were ten separate incidents of Hendra virus detected in Queensland.

Occurrences of Hendra virus are commonly called ‗outbreaks'. However, under the *Exotic Diseases in Animals Act 1981* (EDIA Act) the Minister may make a declaration as to when and where an outbreak of an exotic disease such as Hendra virus occurs. Therefore, to avoid any confusion, I have not used the term ‗outbreak' in my report to refer to the occurrences of Hendra virus. I have instead referred to Hendra virus ‗incidents'.

The former Ombudsman had originally intended to examine only the Queensland Primary Industries and Fisheries' (QPIF) response to Hendra virus incidents within a broader regulatory investigation of QPIF as part of my Office's ongoing regulatory audit program. However, for several compelling reasons, a decision was made to conduct an own initiative investigation into how various government agencies had responded to particular Hendra virus incidents.

Firstly, while conducting the regulatory investigation, we received detailed submissions from a number of persons about the responses of QPIF and other agencies to Hendra virus incidents which raised concerns about significant issues that could not have been properly examined in a broad investigation.

Secondly, it was in the public interest for this Office to investigate whether the relevant government agencies responded, or were able to respond, quickly and effectively to such incidents. The deaths of two veterinarians as a result of exposure to the virus in circumstances which to date have not been the subject of a coronial inquest also influenced the decision to investigate.

Thirdly, we were aware that several of the agencies involved had conducted internal reviews, and in some cases had commissioned external reviews, of their handling of particular Hendra virus incidents. However, it appeared that these reviews had narrow terms of reference and that none of the reviews had properly examined the level of coordination of responses across agencies.

This investigation was therefore commenced in late August 2009.

I commenced duty as Queensland Ombudsman on 10 January 2011. Mr David Bevan was Queensland Ombudsman from 16 September 2001 to 17 September 2010. This investigation was commenced by Mr Bevan as Ombudsman and was an ongoing investigation at the time of my appointment.

The government agencies

By letter dated 21 August 2009, the former Ombudsman informed the Director-General of the Department of Employment, Economic Development and Innovation (DEEDI) of his intention to conduct an investigation into how various government

agencies had responded to particular Hendra virus incidents. The former Ombudsman separately notified the Director-General of Queensland Health (QH) by letter of the same date.

He also gave notice of the investigation to:

- the Director-General of the Department of Justice and Attorney-General (DJAG) (in relation to Workplace Health & Safety Queensland (WHSQ)) on 8 September 2009
- the Registrar of the Veterinary Surgeons Board of Queensland (VSB) on 29 September 2009
- the Under Treasurer of Queensland Treasury on 12 February 2010
- the Director-General of the Department of Environment and Resource Management (DERM) (in relation to the Environmental Protection Agency (EPA)) on 1 June 2010.

Issues for investigation

The principal objectives of the investigation were to:

- determine whether the various Queensland government agencies had complied with their legislative responsibilities when responding to Hendra virus incidents between January 2006 and December 2009
- determine whether their responses were effective
- identify how their responses could be improved.

The investigation specifically focused on six incidents of Hendra virus in Queensland that occurred between June 2006 and October 2009:

- On 14 June 2006, in Peachester on the Sunshine Coast hinterland, a deceased horse was suspected by a private veterinarian to have died of Hendra virus. Subsequent testing eventually confirmed the cause of death to be Hendra virus and the property was quarantined under the *Stock Act 1915* (Stock Act) from 24 June 2006 to 13 July 2006. No other horses or persons were infected with the virus in this incident.
- On 6 June 2007, on a neighbouring property in Peachester, a horse was euthanased by a private veterinarian after contracting an unknown illness that was suspected to be Hendra virus. Subsequent tests eventually showed some positive results for the virus. Again, no other horses or persons were infected with the virus. The property was quarantined under the EDIA Act from 8 June 2007 to 12 June 2007.
- On 7 July 2008, a veterinary clinic in the Redlands was placed into quarantine under the Stock Act on suspicion of equine herpes virus after the unexplained deaths of three horses. Further testing identified that Hendra virus was responsible for these deaths, and the clinic was quarantined under the Stock Act from 8 July 2008 for Hendra virus. A further horse was euthanased after becoming ill with the virus, while another horse recovered from the virus but was destroyed by QPIF. A private veterinarian and a veterinary nurse who both worked at the clinic were infected with the virus. The veterinarian later passed away in hospital. The quarantine was lifted on 25 August 2008.

- Also in July 2008, Hendra virus was detected in Proserpine, North Queensland. Three horses from the same paddock died between 3 July 2008 and 15 July 2008, with the cause of death of the latter two horses subsequently identified as Hendra virus. The property was placed into quarantine under the Stock Act on 16 July 2008. A fourth horse recovered from the virus but was destroyed by QPIF before the quarantine was lifted on 12 September 2008.
- On 8 August 2009, a horse died suddenly of a suspicious illness in Cawarral, near Rockhampton. The property was placed into quarantine under the Stock Act that afternoon. Two horses had previously died of unknown illnesses on 28 July 2009 and 7 August 2009. It was identified that all three horses had died from Hendra virus. Another horse subsequently contracted the virus and recovered, but was destroyed by QPIF. A private veterinarian who attended the property also contracted the virus and later passed away in hospital. The quarantine was lifted on 12 October 2009.
- In September 2009, a horse died suddenly on a property in Bowen. Samples from the horse tested positive to Hendra virus and a horse that had died on the property some time earlier was also identified as having died of Hendra virus. The one remaining horse on the property was euthanased by the owners and no other horses or humans were infected with the virus. As there were no horses remaining on this property, a quarantine was not required.

The investigation did not assess the incident of Hendra virus detected at Tewantin on the Sunshine Coast in May 2010 or the ten incidents recently detected at Beaudesert, Mt Alford, Park Ridge, Kuranda, Chinchilla, Logan Reserve, Hervey Bay, Boondall, the Gold Coast and Beachmere in 2011. My officers had already gathered sufficient information for the purposes of this report and it was not necessary to consider those incidents. However, where appropriate, any recent updates are reflected in my report.

This report details the outcome of my investigation.

Role of Ombudsman

The Ombudsman is an officer of the Queensland Parliament empowered to investigate complaints about the administrative actions of Queensland public sector agencies.

As Queensland government departments are ‗agencies' for the purposes of the Ombudsman Act,[1] it follows that I may investigate the administrative actions of the following:

- QPIF, within DEEDI
- QH
- WHSQ, within DJAG.

Information was also obtained from DERM and Queensland Treasury.

The VSB is a statutory board created under the *Veterinary Surgeons Act 1936* (VS Act). As such, it also falls within the definition of an 'agency',[2] in that it is a public authority established under an Act for a public purpose.[3] I therefore have power to investigate the administrative actions of the VSB.

[1] Section 8(1), Ombudsman Act.
[2] Section 8, Ombudsman Act.
[3] Section 9, Ombudsman Act.

Under the Ombudsman Act,[4] I have authority to:

- investigate the administrative actions of agencies on complaint or on my own initiative
- make recommendations to an agency being investigated about ways of rectifying the effects of its maladministration and improving its practices and procedures
- consider the administrative practices of agencies generally and make recommendations, or provide information or other assistance to improve practices and procedures.

If I consider that an agency's actions were unlawful, unreasonable, unjust or otherwise wrong, I may provide a report to the principal officer of the agency. In my report, I may make recommendations to rectify the effect of the maladministration I have identified or to improve the agency's policies, practices or procedures with a view to minimising the prospect of similar problems occurring.

My jurisdiction extends only to the administrative action of an officer of an agency. Accordingly, I have no jurisdiction to form an opinion or make a recommendation in relation to an action or decision of a person who is not an officer of an agency.

Similarly, the actions of the Australian Veterinary Association (AVA) or other professional bodies that were not created by Queensland statute for a public purpose are not within my jurisdiction. Accordingly, nothing in my report should be taken as commenting adversely on the actions of the AVA, or the trustees of any trust established by the AVA.

Public report

The Ombudsman Act provides that I may present a report to the Speaker for tabling in the Parliament, as I consider appropriate, on a matter arising from the performance of my functions. I have decided to report to Parliament on my investigation for the following reasons:

- the amount of recent media interest and related commentary indicates that this is a matter of considerable public interest
- the adequacy of past responses and any identified areas for improvement remain a guide for future responses
- the public have an interest in ensuring that government agencies are functioning in an efficient and effective manner
- lessons from this report may be of benefit to other government agencies.

Investigative process

The investigation has been conducted informally, that is, without the use of coercive investigation powers.

During the investigation my officers:

- obtained and examined relevant documents from each agency
- conducted recorded interviews with people affected by the incidents and with members of the horse industry

[4] Section 12, Ombudsman Act.

- conducted recorded interviews with private veterinarians, and officers of the relevant agencies
- obtained and examined relevant internal and external reviews conducted by the agencies into their responses to the incidents
- consulted technical experts
- conducted visits to the sites of the 2008 Redlands and 2009 Cawarral incidents.

These inquiries and activities covered every material aspect of the responses of the various agencies to the six nominated incidents between 2006 and 2009.

Proposed report

The terms 'procedural fairness' and 'natural justice' are often used interchangeably within the context of administrative decision-making. The rules of procedural fairness have been developed to ensure that decision-making is both fair and reasonable.

The Ombudsman must also comply with these rules when conducting an investigation.[5] Further, the Ombudsman Act provides that, if at any time during the course of an investigation it appears to the Ombudsman that there may be grounds for making a report that may affect or concern an agency, the principal officer of that agency must be given an opportunity to comment on the subject matter of the investigation before the final report is made.[6]

This report was completed as a proposed report in April 2011.

To satisfy my obligations, I provided sections of my proposed report to the following principal officers:

- the Director-General of DEEDI, Mr Ian Fletcher
- the then Director-General of QH, Mr Michael Reid
- the Director-General of DJAG, Mr Philip Reed
- the Registrar of the VSB, Mr Wayne Murray
- the Under Treasurer of Queensland Treasury, Mr Gerard Bradley.

I received responses from each agency, and where appropriate have referred to these responses throughout this report.

Section 55(2) of the Ombudsman Act provides that I must not make adverse comment about a person in a report unless I give that person an opportunity to make submissions about the proposed adverse comment. The person's defence must be fairly stated in the report if the Ombudsman still proposes to make the comment.

I issued six notices of proposed adverse comment under s.55 of the Ombudsman Act to current and former QPIF officers and allowed them time in which to make a submission in response. Two of these officers provided responses and these were taken into account in finalising my report. Three other recipients advised that they did not intend to provide an individual response beyond the submissions made by the Director-General of DEEDI. The remaining recipient chose to not provide a response.

Out of an abundance of caution, I also wrote to a number of people, agencies and organisations offering them the opportunity to comment on sections of my report,

[5] Section 25(2), Ombudsman Act.
[6] Section 26(3), Ombudsman Act.

even though I did not, in my opinion, make any adverse comment in relation to them. I received responses from each of these recipients and have taken these submissions into account in finalising my report.

Under s.26(2) of the Ombudsman Act, I am required to consult with a Minister where an investigation relates to a recommendation made to that Minister. I therefore sought submissions from the Minister for Agriculture, Food and Regional Economies (formerly the Minister for Primary Industries and Fisheries). His response dated 3 June 2011 was considered in finalising my report.

Outcomes of this investigation

In this report, I formed 78 opinions and made 74 recommendations about the responses of various Queensland government agencies to Hendra virus incidents between 2006 and 2009.

The key outcomes of the investigation are:

Testing

- Private veterinarians are best placed to make decisions about whether samples taken from horses should be tested for Hendra virus.

Legislation and compensation

- There was dated and overlapping legislation that addressed similar issues which lead to inconsistent quarantine practices across the various responses.
- QPIF's choice of legislation to be used for the destruction of horses believed to be infected with Hendra virus was made after inappropriate weight was given to certain considerations.
- QPIF gave advice to its Minister about the meaning of the word 'outbreak' of Hendra virus which was based on a mistake of law and this may have affected the ability of horse owners to seek compensation. Fresh advice is required to be given to the Minister.

Quarantine and PPE

- In some incidents, QPIF engaged in administrative action that was contrary to law in relation to the imposition of quarantines.
- Some QPIF officers responding to particular Hendra virus incidents were uncertain as to the correct selection and use of Personal Protective Equipment (PPE).

Policies and procedures

- Over the course of multiple Hendra virus incidents, QPIF failed to create and finalise policies and procedures to guide its officers in their responses to future incidents.

Multiple agencies

- Improved coordination was required between the agencies responding to Hendra virus incidents.

Incident response

- QPIF staff expressed concern about the levels of staff training and the procedures for selecting personnel for Hendra virus incident responses.

Ex gratia payments

- Three ex gratia payments totalling $220,000 were made to two parties without developing a methodology to determine the appropriate amount to be paid and without adequate records of the reasons for the payments.
- A suitable discretionary payments framework is not currently in force in Queensland Government agencies.

Recommendations from past reviews

- When reports were commissioned reviewing agency responses to particular Hendra virus incidents, there was a failure to appropriately consider and implement the recommendations contained in those reports.

Record-keeping

- QPIF failed to comply with its obligations under the *Public Records Act 2002* resulting, on many occasions, in the key decisions of senior officers not being supported by adequate records. Other important records were not appropriately managed and stored.

Communication

- A coordinated approach is required from QPIF, QH and WHSQ in communicating with private veterinarians and the public about the risk of human infection from Hendra virus.

Human health

- Better communication was required from QH to persons involved in Hendra virus incidents, including medical practitioners.

WHSQ

- The investigation into the Hendra virus incident at Redlands in 2008 was inadequate and, in the future, consideration should be given to the skills, experience and training of investigators assigned to investigations.

Post report action

Section 51(2) of the Ombudsman Act provides that:

> 51 Action after report making recommendations
>
> …
>
> (2) The ombudsman may ask the agency's principal officer to notify the ombudsman within a stated time of -
>
> (a) the steps taken or proposed to be taken to give effect to the recommendations; or
> (b) if no steps, or only some steps, have been or are proposed to be taken to give effect to the recommendations, the reasons for not taking all the steps necessary to give effect to the recommendations.

I have asked the principal officers of each agency to whom recommendations have been directed to advise me of the steps taken, or proposed to be taken, to give effect to the recommendations by 16 December 2011.

Opinions

All opinions relate to QPIF unless otherwise indicated.

Opinion 1

Hendra virus testing should be conducted on the recommendation of the treating private veterinarian.

Opinion 2

It is reasonable for QPIF to adopt an approach of not generally conducting serology testing on horses that have been ill but have recovered, and had samples tested PCR-negative for Hendra virus. However, a reasonable approach would still require further testing to be conducted where the clinical signs of the horse were suggestive of Hendra virus or where the cause of the horse‘s illness remained unknown after other investigations.

Opinion 3

It would be beneficial for QPIF to know the prevalence of Hendra virus in the wider horse population in Queensland.

Opinion 4

QPIF‘s current approach of considering the urgency of Hendra virus testing in each case on its merits is reasonable.

Opinion 5

QPIF‘s current approach of only seeking confirmation testing from AAHL for positive PCR tests for Hendra virus is reasonable.

Opinion 6

Despite initially differing test results and clinical signs, QPIF‘s diagnosis of Titch as a Hendra virus case (supported by positive PCR test results reported by an independent laboratory) was not unreasonable or wrong.

Opinion 7

The Stock Act only allows for imposition of conditions relating to the movement of stock.

Opinion 8

The imposition of conditions (b), and (d) to (h) on the amended quarantine notice served on the Cawarral IP in purported exercise of a power under s.14(1A) of the Stock Act constituted administrative action that was contrary to law within the meaning of s.49(2)(a) of the Ombudsman Act.

Opinion 9

QPIF's failure until August 2009 to have a policy on which Act to use to quarantine properties during Hendra virus incidents created a situation where QPIF officers were able to alternate between two regulatory regimes under two Acts.

Opinion 10

The current Quarantine Policy is inadequate in that it does not:
(a) accurately describe the range of powers that QPIF has to implement quarantines under both the Stock Act and the EDIA Act
(b) clearly state if there is a preference for the use of one Act over the other
(c) explain the reason for the preference for one Act over another.

Opinion 11

QPIF's use of undertakings during the 2009 Cawarral incident was not an appropriate response to the risks associated with Hendra virus incidents because:
(a) the undertakings were probably not enforceable and did not bind property workers, horse owners or tenants
(b) the undertakings did not apply to the movement of horses which had been in contact with an in-contact horse on the DCP
(c) the use of undertakings lead to unacceptable delays in responding to the threat of Hendra virus
(d) QPIF failed to act in accordance with legal advice which identified serious and significant limitations applicable to the use of undertakings.

This constituted administrative action that was unreasonable within the meaning of s.49(2)(b) of the Ombudsman Act.

Opinion 12

The actions of QPIF officers in purporting to orally impose a quarantine, that is, without serving a written notice on the owner of the property under s.14 of the Stock Act, constituted administrative action that was contrary to law within the meaning of s.49(2)(a) of the Ombudsman Act.

Opinion 13

QPIF has failed to prepare, finalise and approve the necessary policies and procedures prescribing the department's response to Hendra virus incidents, despite:
(a) there being a number of such incidents since 1994, in particular, the 2008 Redlands and 2009 Cawarral incidents which required significant responses from QPIF
(b) Dr Perkins recommending in his 2008 Perkins Report that policies and procedures be given further attention
(c) the absence of policies and procedures being noted in the 2008 AAR Report which was circulated to a number of senior QPIF officers in early 2009
(d) the issue of policies and procedures being repeatedly raised with QPIF at the start of my investigation and throughout late 2009 and 2010.

This failure constituted administrative action which was unreasonable within the meaning of s.49(2)(b) of the Ombudsman Act.

Opinion 14

It is important that the Guidelines for Veterinarians be updated promptly as soon as new information becomes available.

Proposed opinion 15 was withdrawn.

Opinion 16

The absence of any written direction concerning the recommended method of fitting and removing PPE increases the risk of people being exposed to Hendra virus.

Opinion 17

There was sufficient doubt about the adequacy of the Guidelines for Veterinarians in relation to whether a horse that had tested positive to Hendra virus was classified as a highly suspect' horse to warrant a review of the classification of suspect and highly suspect horses and the consequential PPE response.

Opinion 18

In past Hendra virus incidents, there has been uncertainty among QPIF officers about the appropriate range of PPE available to them and the correct use of PPE.

Opinion 19

There is a perception among some property and horse owners involved in previous Hendra virus incidents that QPIF officers are adopting inconsistent practices about PPE requirements.

Opinion 20

The Quarantine Policy does not provide adequate guidance to QPIF officers about the collection of temperature data.

Opinion 21

There was a need to clarify QPIF's workplace health and safety obligations:
(a) in respect of property and horse owners and others who assist QPIF during Hendra virus incidents
(b) where QPIF issues property and horse owners with PPE and requires them to follow certain procedures during Hendra virus incidents.

QPIF and QH

Opinion 22

There is currently no consistent understanding and agreement between QPIF and QH about the necessity of blood tests for QPIF officers involved in Hendra virus responses, and when and how these tests will be carried out.

Opinion 23

The Quarantine Policy is not clear with regard to the steps that should be taken to ensure that infected or suspected horses on the IP and DCPs do not have contact with people or other horses.

Opinion 24

QPIF's failure to quickly and accurately conduct tracing activities during the 2009 Cawarral incident constituted administrative action that was unreasonable within the meaning of s.49(2)(b) of the Ombudsman Act.

Opinion 25

QPIF's failure to have implemented a process for the accurate and efficient identification of horses by the time of the 2009 Cawarral incident constituted administrative action that was unreasonable within the meaning of s.49(2)(b) of the Ombudsman Act.

Opinion 26

There is a need for QPIF to amend its policies and procedures and provide training to officers on issues relating to the disposal of horse carcasses during Hendra virus incidents.

Opinion 27

There is sufficient concern among QPIF officers about training and personnel selection procedures that were used during past Hendra virus incidents to warrant a review of the effectiveness of such training and procedures.

Opinion 28

A workforce plan is necessary for QPIF to ensure that it has sufficient capacity to respond to biosecurity incidents such as Hendra virus at the same time as maintaining adequate day-to-day conduct of QPIF's business.

Opinion 29

QPIF engaged a private veterinarian to perform substantial ongoing work for QPIF during the 2009 Cawarral incident:
(a) without entering into a written agreement concerning the scope and nature of the work to be performed
(b) without clearly distinguishing between work to be performed for QPIF and work to be performed for the property owner
(c) without entering into a written agreement concerning terms and conditions, pay rates or related matters
(d) without specific written agreement about statutory or workplace health and safety obligations.

This constituted administrative action that was unreasonable within the meaning of s.49(2)(b) of the Ombudsman Act.

Opinion 30

In respect of the alleged failure by the Redlands clinic owner to advise QPIF of a suspected outbreak of either Hendra virus or equine herpes virus within the timeframes prescribed by the EDIA and the Stock Act, QPIF officers failed to:
(a) adequately consider the issue of whether to take any action against the Redlands clinic with regard to all possible breaches of the Acts
(b) record the decision to take no action
(c) record the reasons for the decision to take no action.

This failure constitutes administrative action that is unreasonable within the meaning of s.49(2)(b) of the Ombudsman Act.

Opinion 31

QPIF first became aware of the risks of humans contracting Hendra virus from asymptomatic horses on or before 28 July 2008.

Opinion 32

QPIF's failure to inform veterinarians and the public that people could be infected with Hendra virus from asymptomatic horses:
(a) within a reasonable time after QPIF officers were provided with this information by QH officers on 28 July 2008, or
(b) within a reasonable time after receiving Dr Perkins' report in December 2008

constituted administrative action that was unreasonable within the meaning of s.49(2)(b) of the Ombudsman Act.

Opinion 33

QPIF did not implement a risk-based assessment framework during Hendra virus incidents to enable it to:
(a) prioritise biosecurity threats
(b) better inform decision-making
(c) allocate a commensurate level of resources.

Opinion 34

QPIF made the decision to destroy the sero-positive horses after having regard to the available expert advice and available information.

Opinion 35

The decision about which Act to use to destroy Tamworth and Thomas was made taking into account, among other things, the following considerations:
(a) the availability of compensation under the Acts
(b) the availability of judicial review under the Acts
(c) the timelines for destruction under the Acts.

Opinion 36

QPIF's failure to keep records of the reasons for the decision about which Act to use to destroy Tamworth and Thomas constituted administrative action that was unreasonable within the meaning of s.49(2)(b) of the Ombudsman Act.

Opinion 37

When determining which Act would be used to destroy Tamworth and Thomas, QPIF's consideration of:
(a) the availability of compensation under the EDIA and Stock Acts
(b) the availability of judicial review under the EDIA and Stock Acts

constituted administrative action that was unreasonable and/or wrong within the meaning of the s.49(2)(b) and (g) of the Ombudsman Act.

Opinion 38

Where a departmental decision-maker is faced with a choice of legislation, either of which can be used to achieve the decision-maker's operational objectives, preference should be given to the statute that provides for the least intrusion on an individual's rights.

Proposed opinion 39 was withdrawn.

Opinion 40

In relation to the destruction of Tamworth, Thomas, and Winnie, although there were some departures from the strict requirements of procedural fairness in relation to the notice rule, these were not substantial departures from what was required.

Opinion 41

The owners of Tamworth, Thomas and Winnie were given a fair hearing on the issue of the destruction of the animals before the decisions to destroy the animals were made.

Opinion 42

In relation to the destruction of Tamworth and Thomas, QPIF's conduct was not consistent with there being an urgent need to destroy the horses, sufficient to justify the use of the EDIA Act over the Stock Act or the shortened timeframes in the notices.

Opinion 43

QPIF's position that compensation is not available to owners of destroyed sero-positive horses was unreasonable within the meaning of s.49(2)(b) of the Ombudsman Act, in that:
(a) internal QPIF legal advice was that the contrary view was at least arguable
(b) QPIF failed to seek any external legal advice on this issue
(c) QPIF failed to inform horse owners that compensation may be payable where it destroyed sero-positive horses under the Stock Act.

Opinion 44

QPIF's advice to the Minister that an outbreak of Hendra virus for the purposes of s.28 of the EDIA Act had not occurred because the virus had not spread to other properties was based on a mistake of law, and was wrong, within the meaning of s.49(2)(f) and s.49(2)(g) of the Ombudsman Act.

Opinion 45

QPIF failed to prepare a policy or procedure on the destruction of sero-positive horses within a reasonable time. This failure constituted administrative action that was unreasonable within the meaning of s.49(2)(b) of the Ombudsman Act.

Opinion 46

The reason given by QPIF for making the first 2008 payment to the AVA's AWCR trust in the sum of $150,000, namely, to manage the biosecurity risk and the welfare of horses at the Redlands clinic, lacked clarity and was the subject of multiple inconsistent explanations.

This constituted administrative action that was unreasonable and/or wrong within the meaning of s.49(2)(b) and s.49(2)(g) of the Ombudsman Act.

Opinion 47

In respect of the ex gratia payment by QPIF to the AVA's AWCR trust in the sum of $150,000, QPIF failed to:
(a) develop a methodology by which the sum was calculated
(b) keep adequate records of its reasons for the amount of the payment
(c) conduct an analysis of the AVA's method of calculating the amount sought.

This constituted administrative action that was unreasonable within the meaning of s.49(2)(b) of the Ombudsman Act.

Opinion 48

The reason given by QPIF for making the second 2008 payment to the AVA's AWCR trust in the sum of $50,000, namely, to manage the biosecurity risk and the welfare of horses at the Redlands clinic, lacked clarity and was the subject of multiple inconsistent explanations.

This constituted administrative action that was unreasonable and/or wrong within the meaning of s.49(2)(b) and s.49(2)(g) of the Ombudsman Act.

Opinion 49

In respect of the second 2008 ex gratia payment by QPIF to the AVA's AWCR trust in the sum of $50,000, QPIF failed to:
(a) develop a methodology by which the sum was calculated
(b) keep adequate records of its reasons for the amount of the payment
(c) conduct an analysis of the AVA's method of calculating the amount sought.

This constituted administrative action that was unreasonable within the meaning of s.49(2)(b) of the Ombudsman Act.

Opinion 50

In respect of the 2009 payment by QPIF to the AVA's VES Trust in the sum of $20,000, QPIF failed to:
(a) develop a methodology by which the sum was calculated
(b) conduct an analysis of the AVA or QHC's method of calculating the amount sought
(c) have sufficient regard to the amount and purpose of the ex gratia payments made in the 2008 Redlands incident when determining the sum
(d) keep adequate records of its reasons for the amount of the payment.

This constituted administrative action that was unreasonable within the meaning of s.49(2)(b) of the Ombudsman Act.

Opinion 51

In relation to the ex gratia payments:
(a) QPIF intended the ex gratia payments which were made to the AVA trusts in 2008 and 2009 to be passed on to the owner of the Redlands clinic and the Cawarral property owner in full
(b) QPIF could not compel the AVA trusts to pass the funds to the intended beneficiaries, that is, the Redlands clinic owner and the Cawarral property owner
(c) QPIF could not ensure that the funds were used for purposes associated with meeting the cost of the quarantines
(d) QPIF made the payments to the AVA trusts in situations where it knew and intended that the AVA trusts would pass the payments on to the Redlands clinic owner and Cawarral property owner in full, although QPIF did not want to be seen as making a direct payment to the eventual recipients
(e) the requirement in the deeds of confidentiality that the parties keep information in relation to the ex gratia payments confidential was designed to reduce the risk of creating what QPIF saw as a precedent for the payment of compensation
(f) the ex gratia payments were made via the AVA trusts for the purpose of reducing QPIF's financial exposure to further applications for ex gratia payments.

This conduct constituted administrative action that was unreasonable and/or wrong within the meaning of s.49(2)(b) and s.49(2)(g) of the Ombudsman Act.

Opinion 52

The description of the 2008 payments in the DPIF Final Report lacked clarity. This constituted administrative conduct that was unreasonable within the meaning of s.49(2)(b) of the Ombudsman Act.

Queensland Treasury

Opinion 53

Good public administration requires Queensland to have a discretionary payments framework that provides for a range of payments to be made in different circumstances.

Opinion 54

QPIF failed to:
(a) make adequate records of its consideration and implementation of the 2006 recommendations by Dr Perkins
(b) adequately review the implementation of the 2006 Perkins Report, and record the outcome of that review
(c) develop and implement plans under recommendation 2 for the conduct of research to enable a rapid response in the event of a confirmed Hendra virus incident until 2009.

This constituted administrative action that was unreasonable within the meaning of s.49(2)(b) of the Ombudsman Act.

Opinion 55

QPIF's failure to consider and implement (where appropriate) the recommendations of the 2008 Perkins Report within a reasonable time constituted administrative action that was unreasonable within the meaning of s.49(2)(b) of the Ombudsman Act.

Opinion 56

QPIF failed to consider and implement the recommendations made in the 2008 AAR Report. This failure constituted administrative action that was unreasonable within the meaning of s.49(2)(b) of the Ombudsman Act.

Opinion 57

QPIF:
(a) failed to implement the recommendations arising from the review of circumstances surrounding the 2007 needle-stick incident
(b) failed to consider and commit to implementing the recommendations arising from the review of the 2008 needle-stick incident until prompted by my investigation over two years later
(c) had not finalised the implementation of these recommendations by the date of my proposed report.

These failures constituted administrative action that was unreasonable within the meaning of s.49(2)(b) of the Ombudsman Act.

Opinion 58

QPIF's failure to comply with its obligations under the Public Records Act constitutes administrative action that is unreasonable within the meaning of s.49(2)(b) of the Ombudsman Act.

Opinion 59

QPIF's failure to have an adequate information management system introduces an additional risk to the effective management of biosecurity incidents such as Hendra virus.

Opinion 60

It is advantageous for QPIF to have a streamlined method of communication with industry groups that does not rely on individual email lists of QPIF officers.

Opinion 61

The means by which information concerning Hendra virus incidents was communicated to private veterinarians and other people who have a higher risk of being exposed to the virus was inadequate during previous Hendra virus incidents.

Opinion 62

QPIF should provide private veterinarians with prompt information on the clinical signs of horses infected with Hendra virus.

Opinion 63

QPIF has recently taken steps to communicate more effectively with private veterinarians about Hendra virus and the precautions veterinarians must take when treating horses.

Opinion 64

As the government agency with expertise on Hendra virus, QPIF should encourage Queensland veterinarians to undertake training in Hendra virus procedures and the use of PPE.

Opinion 65

There is substantial concern among property owners and horse owners in relation to QPIF‘s communication about testing.

Opinion 66

Horse owners have a right to be provided with test results on their horses, in writing, along with information on how to interpret these test results.

Opinion 67

The use of a liaison officer assists QPIF to respond effectively to Hendra virus incidents.

Opinion 68

QPIF‘s decision not to immediately inform the Cawarral property owner about a positive ELISA result on the horse Winnie during the 2009 Cawarral incident constituted administrative action that was unreasonable within the meaning of s.49(2)(b) of the Ombudsman Act.

Opinion 69

There is a need for community engagement because of the high level of public concern about Hendra virus incidents, however, the extent of engagement is a matter for QPIF to determine on a case by case basis.

Opinion 70

QPIF has addressed the majority of issues about its website; however, improvements can still be made.

QPIF and VSB

Opinion 71

QPIF should work with the VSB and provide necessary human and technological resources to the VSB to allow QPIF to effectively communicate with veterinarians regarding biosecurity incidents.

QPIF and QH

Opinion 72

The different approaches previously adopted by QPIF and QH to Hendra virus incidents may have given rise to a perception of inconsistency between the agencies, leading people to be confused about the correct approach and eroding public confidence in the government‘s response.

Opinion 73

QPIF provided adequate information to the relevant local councils to keep them informed about Hendra virus incidents.

QH

Opinion 74

The diverse range of responses by both public and private medical practitioners to people who had been exposed to Hendra virus indicates that further education may be required in this regard.

QH

Opinion 75

There is the potential for inconsistency in assessing risk of exposure to the Hendra virus where:
(a) exposure assessments are generally done at a local level
(b) there is no standard exposure assessment form or process
(c) the doctor performing the assessment may not have done so previously for Hendra virus.

QH

Opinion 76

There is concern among QPIF officers as to whether QH officers adequately understand the levels of risk associated with particular veterinary procedures.

Proposed opinions 77 and 78 were withdrawn.

QH

Opinion 79

Doctor A's actions in advising people to go to their GPs for testing were not unreasonable in the circumstances, as:

(a) this approach was not discouraged by the superseded QH Guideline
(b) an alternative approach (and the approach ultimately adopted) was not suggested in the superseded QH Guideline
(c) this approach:
    (i) was generally consistent with the approach taken in previous Hendra virus incidents
    (ii) was not countermanded by Doctor A's supervisors
    (iii) was consistent with QH's view that Hendra virus cannot be easily transmitted from person to person and is unlikely to be transmitted by a person without symptoms.

QPIF, QH and WHSQ

Opinion 80

The most effective way to provide information about Hendra virus to private veterinarians and other stakeholders, especially during a Hendra virus incident, is by the government agencies involved in responses to take joint responsibility and a coordinated approach.

WHSQ

Opinion 81

WHSQ should not communicate information about managing biosecurity risks and health and safety to private veterinarians solely or largely through the AVA, but through broader means of communication.

WHSQ

Opinion 82

The WHSQ investigation into the 2008 Hendra incident was inadequate, in that:
(a) the investigation failed to request relevant documents or information
(b) the investigators failed to analyse or test the information obtained
(c) the file showed a number of errors and misinterpretations
(d) a number of issues were not pursued by WHSQ.

These failures constituted administrative action that was unreasonable within the meaning of s.49(2)(b) of the Ombudsman Act.

Recommendations

All recommendations relate to QPIF unless otherwise indicated.

Recommendation 1

QPIF continue to provide advice and information to private veterinarians about Hendra virus, including in what situations testing is appropriate.

Recommendation 2

QPIF inform private veterinarians that final decisions about whether to take samples and submit them for Hendra virus testing are to be made by the private veterinarian with reference to the Guidelines for Veterinarians.

Recommendation 3

QPIF refer to an independent expert peer-review panel the question of conducting research on a representative cross-section of the Queensland horse population to identify whether it contains horses that are sero-positive for Hendra virus.

Recommendation 4

QPIF consider how it will approach the issue of horses that are sero-positive for Hendra virus being identified outside of a Hendra virus incident and develop appropriate policies and procedures in this regard.

Recommendation 5

QPIF should not charge health testing fees for Hendra virus tests if the test result is positive.

Recommendation 6

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 7

QPIF should consider:
(a) the adequacy of its sample submission forms for Hendra virus samples
(b) the adequacy of its recording and reporting systems for Hendra virus samples
(c) whether further information should be provided to private veterinarians or horse owners about submitting Hendra virus samples
(d) the adequacy of making a determination about whether a horse has Hendra virus through analysis of a single sample such as a nasal swab
(e) the effect of non-preferred samples on testing accuracy
(f) whether it is appropriate for QPIF scientists to deliberate on how to report the results of tests conducted at other laboratories
(g) whether there is adequate certainty in the advice given by QPIF, QHFSS and WHSQ about whether Hendra virus samples being transported to the laboratory constitute _dangerous goods'.

Recommendation 8

QPIF review its Quarantine Policy and consider whether the use of the Stock Act provides adequate powers to control Hendra virus.

Recommendation 9

As part of the current review of the Quarantine Policy, QPIF should ensure the policy:
(a) accurately describes the range of powers that QPIF has to implement quarantines under both the Stock Act and the EDIA Act
(b) clearly states if there is a preference for the use of one Act over the other
(c) explains both the reasons for this preference for the use of one Act, and the reasons why the other Act will not or should not be used.

Recommendation 10

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 11

QPIF cease the practice of purporting to orally impose a quarantine without serving a written notice on the owner of the property under s.14 of the Stock Act, and instead develop a process whereby it:
(a) issues a quarantine notice at the time of the initial visit on the basis of the information known at the time
(b) if necessary, revokes the notice and issues a more detailed notice as soon as further information becomes available.

Recommendation 12

The Director-General of DEEDI allocate the necessary resources to ensure that, within six months of the date of this report:
(a) all policies and procedures relevant to Hendra virus incident responses are prepared and finalised, or reviewed where necessary
(b) these policies and procedures are made available to QPIF officers and officers are provided with adequate training to implement these policies and procedures.

Recommendation 13

QPIF ensure that any necessary changes to the Guidelines for Veterinarians are made within not more than three months of when QPIF becomes aware of relevant new information.

Proposed recommendation 14 was withdrawn.

Recommendation 15

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 16

QPIF review the adequacy of the current Guidelines for Veterinarians, Quarantine Policy and related policies insofar as they concern the classification of horses potentially exposed to Hendra virus and the consequential PPE response to ensure the required level of PPE is clear in the case of a horse testing positive to Hendra virus without any clinical signs.

Recommendation 17

QPIF take ongoing and regular steps to:
(a) ensure that all officers wear the appropriate PPE when responding to a Hendra virus incident
(b) reinforce with officers the importance of wearing appropriate PPE, and provide training for officers if necessary
(c) have appropriate systems in place to monitor compliance with PPE requirements.

Recommendation 18

QPIF continue to:
(a) 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
(b) publish these guidelines on its website
(c) provide training to QPIF officers in the content of these guidelines
(d) explain the guidelines, both orally and in writing, to property and horse owners during Hendra virus incidents.

Recommendation 19

QPIF review and amend the Quarantine Policy to provide adequate guidance to QPIF officers about the collection of temperature data.

Recommendation 20

QPIF:
(a) seek advice from Crown Law, and WHSQ if necessary, to clarify QPIF's workplace health and safety obligations in respect of:
    (i) property and horse owners and others who assist QPIF during Hendra virus incidents
    (ii) property and horse owners to whom QPIF has issued PPE and who QPIF requires to follow certain procedures during Hendra virus incidents
(b) consider whether its policies and procedures adequately describe and meet such obligations
(c) amend its policies, procedures and practices, where necessary, to reflect the advice received.

QPIF and QH

Recommendation 21

QPIF and QH:
(a) develop an agreed approach to the testing of QPIF officers involved in incident responses
(b) make appropriate changes to their respective policies and procedures
(c) provide information and training on this approach to officers of the agencies that are involved in incident responses.

Recommendation 22

QPIF provide clear guidance to officers about:
(a) the steps to be taken to ensure that infected or suspected horses on the IP and DCPs do not have contact with people or other horses
(b) the circumstances in which quarantine signs should be placed on properties.

Recommendation 23

When conducting tracing, QPIF:
(a) commence, and adequately resource, tracing activity as soon as practicable
(b) use a standard questionnaire to obtain written and oral information from property owners and horse owners
(c) develop systems to accurately record data
(d) maintain contact with horse owners in case new information comes to hand.

Recommendation 24

QPIF:
(a) adopt a method for the accurate and efficient identification of horses, for example by affixing unique QPIF identifiers to all horses being tested during Hendra virus incidents
(b) provide training to officers responsible for collecting blood samples to ensure that sufficient details are recorded about the identity of the horses at the time of testing.

Recommendation 25

QPIF:
(a) consider whether it should amend its policies and procedures to require its officers to assess the adequacy of a proposed burial site before any horse that is highly suspected or known to have Hendra virus is buried on a property
(b) in any event, amend its policies and procedures to detail the roles and responsibilities of QPIF, DERM and horse owners in relation to the disposal of horse carcasses during Hendra virus incidents.

Recommendation 26

QPIF conduct a review of current levels of officer training and personnel selection procedures during Hendra virus incidents and develop additional processes where necessary to ensure that:
(a) sufficient officers have the necessary training, experience and skills, including regular refresher courses, to enable QPIF to respond effectively to incidents
(b) officers are selected for response tasks based on training, experience and skill
(c) information regarding the training, experience and skills of QPIF officers is adequately recorded and used by QPIF.

Recommendation 27

QPIF review its business continuity plan to ensure that biosecurity incident responses such as Hendra virus responses:
(a) do not adversely affect the day-to-day conduct of QPIF‘s business, other than in exceptional circumstances
(b) are not adversely affected by a requirement for officers to also maintain day-to-day business operations.

Recommendation 28

When engaging non-agency personnel to assist QPIF during a quarantine, QPIF enter into a written agreement with any person engaged which, at a minimum, specifies the nature and scope of the person's duties and responsibilities, and the terms and conditions on which they are engaged.

Recommendation 29

QPIF:
(a) seek advice from Crown Law, and WHSQ if necessary, about the health and safety implications of its level of control over the conduct of private veterinarians, property owners and property workers during Hendra virus incidents, under both the Stock Act and EDIA Act
(b) carefully consider the adequacy of its current policies, procedures and practices in this regard.

Recommendation 30

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 31

QPIF:
(a) 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
(b) regularly (at least every six months) review the content of the Hendra virus materials for accuracy and completeness.

Recommendation 32

QPIF implement a risk-based assessment framework during Hendra virus incidents to enable it to:
(a) prioritise biosecurity threats
(b) better inform decision-making
(c) allocate a commensurate level of resources.

Recommendation 33

QPIF:
(a) review its policy on destroying sero-positive horses
(b) if necessary, ensure that this review forms part of any reconsideration of the national policy
(c) consider participating in any research designed to establish whether sero-positive horses can recrudesce, and if such recrudescence results in a risk of infection to other animals or people.

Recommendation 34

In drafting the proposed Biosecurity Bill, QPIF take into account the comments in my report when considering the adequacy of the proposed powers and processes to respond to Hendra virus incidents.

Recommendation 35

QPIF review and amend its Destruction Policy to comply with procedural fairness requirements when considering the destruction of sero-positive horses, including:

(a) providing all relevant documents and information to the horse owner at the time the notice is provided
(b) advising horse owners that the national and QPIF policy is to destroy all sero-positive horses
(c) ensuring that the time period for making submissions does not commence until the notice is received by and brought to the attention of the horse owners
(d) unless there is a verifiable biosecurity risk that justifies a departure from the principles of procedural fairness stated above, providing adequate time (which will be a period of at least seven days) for the horse owners to make submissions to QPIF and seek any necessary legal or veterinary advice.

Recommendation 36

QPIF:

(a) seek independent clinical advice as to whether a sero-positive horse can be considered to be ‗free from disease'
(b) obtain further external legal advice, based on the independent clinical advice, as to:
    (i) the correct interpretation of the availability of compensation under the Stock Act in previous incidents where QPIF has destroyed a sero-positive horse
    (ii) how and when QPIF should determine the market value of a sero-positive horse
    (iii) the level of proof and amount of scientific evidence required by QPIF to show that a sero-positive horse was not ‗free from disease' at the time of its destruction
    (iv) the procedure by which QPIF should receive and assess claims for compensation in the absence of statutory guidelines
(c) in light of the legal and clinical advice received, review and make appropriate amendments to its policies and procedures regarding the payment of compensation in Hendra virus incidents.

Recommendation 37

QPIF:

(a) write to the owners of Winnie to inform them that:
    (i) compensation may be payable for the destruction of a sero-positive horse if the horse was free from disease at the time it was destroyed
    (ii) they are able to submit a claim to QPIF for compensation which will be properly assessed
(b) respond to any claim received accordingly.

Recommendation 38

QPIF develop clear legal authority and clinical criteria in the proposed Biosecurity Bill to ensure that sufficient guidance is provided to the public and to QPIF officers on the circumstances in which compensation is payable to individuals whose stock is seized and destroyed by QPIF for purposes such as disease control.

Recommendation 39

QPIF ensure that, if the proposed Biosecurity Act eventually uses the term ‗outbreak' or a similar term as the basis for determining whether compensation is payable:
(a) the Act includes a definition of the term, or
(b) QPIF develop a policy and publish guidelines or a list of relevant factors which will be considered by QPIF to assist in determining whether an outbreak has occurred or when an outbreak started or finished.

Recommendation 40

QPIF:
(a) advise the Minister that QPIF's 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
(b) seek legal advice as to the further legal issues raised in my report, including whether a retrospective notification can be made and the effect of a retrospective notification of the operation of s.30 of the EDIA Act
(c) provide fresh advice and a fresh recommendation to the Minister about the application of s.28 and s.29 of the EDIA Act in relation to the 2008 Redlands incident and other relevant incidents of Hendra virus and exotic diseases.

Queensland Treasury

Recommendation 41

The Under Treasurer:
(a) 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
(b) prepare a submission to government in this regard.

Queensland Treasury

Recommendation 42

Until such time as a discretionary payments framework is in force in Queensland, the Under Treasurer should issue guidance to all Queensland government agencies on:
(a) the situations in which discretionary payments may be appropriate, such as the principles relevant to determining whether a discretionary payment is appropriate
(b) how requests for discretionary payments should be received and processed
(c) the appropriate amount of discretionary payments and how such amounts can be calculated
(d) how to determine whether conditions should be attached to discretionary payments and examples of appropriate conditions
(e) common standards of service or administration against which claims of maladministration can be measured by an agency.

Proposed recommendation 43 was withdrawn.

Recommendation 44

Within two months from the date of my report, QPIF:
(a) evaluate any recommendations made by Dr Perkins in the 2008 Perkins Report which have not yet been fully implemented
(b) reach a decision, duly recorded, as to whether to implement these recommendations. Where this decision differs from the decision noted in the Cabinet report of June 2009, the reasons for this different approach should be clearly recorded
(c) take steps to ensure that all recommendations that are accepted have been fully implemented.

Recommendation 45

The Director-General of DEEDI consider conducting an open selection process when appointing an external reviewer of QPIF's response to future Hendra virus incidents.

Recommendation 46

QPIF:
(a) establish a process for evaluating and implementing, where appropriate, the recommendations made in the 2009 AAR Report and any outstanding recommendations from the 2008 AAR Report
(b) set in place a timeline for the implementation of the accepted recommendations
(c) ensure all accepted recommendations are implemented within six months of the date of this report.

Recommendation 47

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 48

Where QPIF undertakes or receives recommendations from an internal or external review of its response to biosecurity incidents, QPIF develop a process to ensure that:
(a) any recommendations are fully considered at a senior level in a timely fashion
(b) a decision about whether to implement the recommendations is made within a reasonable time
(c) any recommendations accepted for implementation are then implemented in a timely fashion
(d) it makes and keeps appropriate records of the consideration given to the recommendations and, if relevant, the reasons for not implementing them.

Recommendation 49

QPIF:
(a) adopt a consistent approach from the start of a Hendra virus incident response regarding the use of role-based email accounts
(b) ensure that all information and emails relating to a Hendra virus incident response are captured and stored by QPIF in a single location.

Recommendation 50

QPIF take the following actions to ensure that officers comply with the requirements of the Public Records Act:
(a) provide regular training to officers, including senior officers, on its record-keeping systems and on QPIF's record-keeping obligations
(b) regularly monitor its officers' compliance with record-keeping obligations.

Recommendation 51

QPIF develop and implement a comprehensive information management system to assist in the management of Hendra virus and other biosecurity responses.

Recommendation 52

QPIF regularly review the adequacy of its communication practices with industry groups.

Recommendation 53

QPIF:
(a) review its current communication strategies to ensure that its strategies present a comprehensive, effective and reliable information network for private veterinarians and other people who have a risk of being exposed to Hendra virus
(b) ensure that private veterinarians are urgently notified of Hendra virus incidents through the VSB mailing list once a Hendra virus incident is confirmed.

Recommendation 54

QPIF:
(a) collect information promptly on the observed clinical signs from private veterinarians, horse owners and QPIF officers for each confirmed Hendra-positive horse, including information about the progression of the disease over time
(b) collate the information for each horse without interpretation
(c) distribute the information to private veterinarians within a reasonable time during each Hendra virus incident
(d) publish the information for each horse on the QPIF website within a reasonable time during each incident.

Recommendation 55

QPIF collate and distribute to private veterinarians (including by publishing the information on its website) any information in its possession about the observed clinical signs of the horses that have died of Hendra virus between 1994 and the date of my report. This information should be reported for each relevant horse individually.

Recommendation 56

QPIF continue to work with WHSQ, the AVA and the VSB to identify ways of effectively communicating to private veterinarians about the necessary PPE to protect against Hendra virus.

Recommendation 57

QPIF, either alone or in conjunction with other organisations, ensure that training in Hendra virus procedures and the correct use of PPE for zoonotic disease response is made available to all Queensland veterinarians.

Recommendation 58

QPIF continue to work with private veterinarians and horse owners to better explain QPIF's limited role in responding to suspected Hendra virus incidents prior to private veterinarians obtaining initial samples for Hendra virus testing.

Recommendation 59

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 60

QPIF:
(a) provide written test results, to either the owner's private veterinarian (where the veterinarian submitted the samples for testing) or the horse owner personally, for all horses that are tested for Hendra virus during a Hendra virus incident
(b) amend the relevant QPIF policies and provide training to QPIF officers in support of this requirement
(c) provide information explaining or interpreting test results, and detailing their reliability, to horse owners with similar general information made publicly available on the QPIF website.

Recommendation 61

QPIF continue to appoint a liaison officer, where required, by future Hendra virus incidents.

Recommendation 62

QPIF immediately and fully inform horse owners and/or their private veterinarians of the results of Hendra virus tests on their horses.

Recommendation 63

QPIF continue to provide information to the community during Hendra virus incidents, with the extent of that engagement determined by QPIF on a case by case basis.

Recommendation 64

QPIF consider the AVA's suggestions when next reviewing its website content on Hendra virus.

VSB

Recommendation 65

The VSB amend its annual registration forms to make it a condition of registration that all veterinarians provide email addresses and mobile telephone numbers for the purpose of distributing information about emergency biosecurity incidents.

QPIF and VSB

Recommendation 66

QPIF and the VSB enter into a formal arrangement whereby:
(a) the email addresses and other relevant contact details for all veterinarians are made available for immediate use by QPIF officers during an emergency biosecurity incident. This arrangement should take into account any reasonable privacy concerns of veterinarians
(b) QPIF provides reasonable additional resources to assist the VSB to facilitate this recommendation within six months of the date of my report.

QPIF and QH

Recommendation 67

As part of ongoing communications between QPIF and QH in between incidents of Hendra virus, the agencies continue to:
(a) discuss their respective responses during incidents
(b) ensure that each agency's response is consistent with the known levels of risk
(c) minimise the potential for inconsistent messages to be provided to property owners and the general public.

QPIF, QH and WHSQ

Recommendation 68

QPIF, QH and WHSQ revise their current memorandum of understanding and create any accompanying interagency standard operating procedures within three months of the date of my report covering:
(a) in relation to notification of exclusion or suspect Hendra virus cases:
    (i) the information to be provided by one agency to the other when testing occurs
    (ii) when and how this information will be provided
    (iii) the officers or departmental units responsible for providing or receiving this information
(b) in relation to responses to Hendra virus incidents:
    (i) the information to be provided by one agency to the other
    (ii) when and how this information will be provided
    (iii) the officers or departmental units responsible for providing or receiving this information
(c) ongoing communication about relevant matters between Hendra virus incidents.

QH

Recommendation 69

QH develop detailed information sheets for people who are involved in Hendra virus incidents, including information on:

(a) testing procedures, such as how many tests will generally be provided in different situations, the basis on which decisions about testing are made and who will take the blood samples
(b) how test results are interpreted
(c) the symptoms of Hendra virus and what self-monitoring for symptoms involves
(d) the incubation period for Hendra virus
(e) the transmissibility of Hendra virus from person to person, and any precautions that should be taken both when a person is well and if a person becomes unwell. This information should include advice about people adopting the same precautions (that is, standard and droplet precautions) that are adopted by QH officers if a person becomes unwell during the incubation period and needs to attend a hospital or clinic for further testing
(f) the treatment for Hendra virus, including length, side effects, risks and expected clinical monitoring.

QH

Recommendation 70

QH provide:

(a) information to QH officers, GPs, medical laboratories and hospitals during Hendra virus incidents about the precautions which are necessary when testing for and treating Hendra virus, to ensure as much as possible a consistent approach
(b) information to the public (whether through the media or by other means) about the transmissibility of Hendra virus and the precautions which are necessary during a suspected or confirmed Hendra virus incident.

QH

Recommendation 71

QH finalise a standard risk assessment process and corresponding exposure assessment form for exposure to infection from Hendra virus within 28 days of receiving my report.

Recommendation 72

As soon as an incident of Hendra virus is identified, QPIF nominate a QPIF veterinarian who can provide information to the QH officers assessing levels of risk about what particular veterinary procedures mean in terms of risk exposure.

QH

Recommendation 73

QH formally communicate to QPIF the process by which exposure risk is assessed and what information about people's exposures to horses QPIF officers should share with QH during incident responses.

Proposed recommendations 74 and 75 were withdrawn.

QPIF, QH and WHSQ

Recommendation 76

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.

WHSQ

Recommendation 77

WHSQ ensure that information on managing biosecurity risks in the workplace is made available to all Queensland veterinarians, including by working with QPIF where necessary to formulate or distribute this information.

WHSQ

Recommendation 78

In investigating workplace incidents, WHSQ should give adequate consideration to:
(a) the skills, experience and training of the investigator assigned to the investigation
(b) the need for any expert advice on technical matters that arise during an investigation
(c) its statutory obligations to investigate matters.