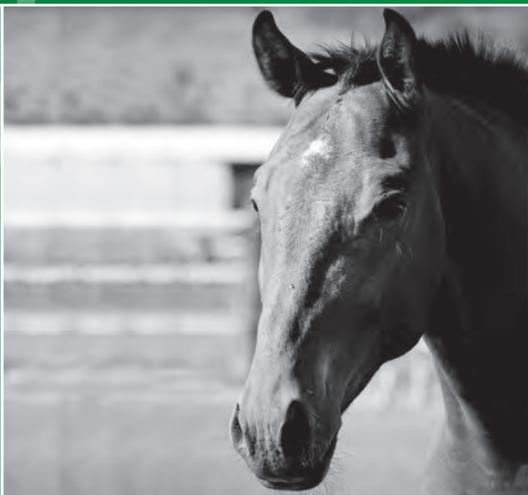




QUEENSLAND  
**ombudsman**

# The Hendra Virus Report



*An investigation into agency responses to Hendra virus incidents between January 2006 and December 2009.*

November 2011

# **Report of the Queensland Ombudsman**

## **The Hendra Virus Report**

An investigation into agency responses to Hendra virus incidents between  
January 2006 and December 2009

November 2011

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Queensland Ombudsman  
Level 17, 53 Albert Street  
Brisbane QLD 4000

GPO Box 3314  
Brisbane QLD 4001

Tel: 3005 7000

Fax: 3005 7067

Email: [ombudsman@ombudsman.qld.gov.au](mailto:ombudsman@ombudsman.qld.gov.au)

Web: [www.ombudsman.qld.gov.au](http://www.ombudsman.qld.gov.au)



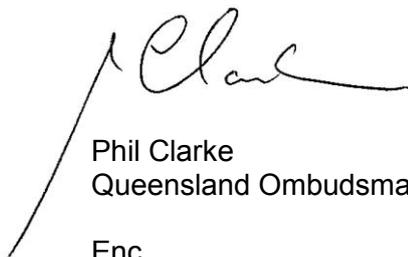
3 November 2011

The Honourable R J Mickel MP  
Speaker  
Parliament House  
George Street  
BRISBANE QLD 4000

Dear Mr Mickel

In accordance with s.52 of the *Ombudsman Act 2001*, I hereby furnish to you my report, *The Hendra Virus Report: An investigation into agency responses to Hendra virus incidents between January 2006 and December 2009*.

Yours faithfully



Phil Clarke  
Queensland Ombudsman

Enc

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## Foreword

This report presents the findings of an exhaustive investigation conducted by my Office into the administrative practices of a number of Queensland public sector agencies that responded to Hendra virus incidents that occurred in Queensland between 2006 and 2009. There was one Hendra virus incident detected in Queensland in 2010 and, to date, ten in 2011. This report does not consider those later cases in any detail although recent developments in practices are referred to throughout the report. The Hendra virus is a relatively new and serious disease that has killed both humans and horses in Queensland since it was first identified in the Brisbane suburb of Hendra in 1994.

My investigation, which was commenced as an own initiative investigation, examined the fairness, legality and effectiveness of actions taken and decisions made by a number of agencies that have concurrent and sometimes overlapping biosecurity, human health and other responsibilities for the identification, control, management and treatment of the virus.

This investigation has brought to light the difficult and complex issues that are faced by agencies when dealing with significant biosecurity incidents like Hendra virus. I acknowledge that officers who work in the responsible agencies during these periods are required to make difficult decisions every day, often with limited information and under significant pressure, and that their decisions have been subjected to a high level of scrutiny by this investigation. However, it is in the public interest that an independent body scrutinise decisions made by agencies which have responsibility for ensuring the safety and welfare of the community in such circumstances.

My investigation revealed systemic difficulties with a number of issues, including the processes around testing requested by private veterinarians, the existence of multiple and dated legislation addressing similar issues, which lead to inconsistent quarantine practices across the various responses, deficiencies in governance systems, delayed policy responses and incomplete communication plans. While much work has been done by the agencies concerned and the response systems are rapidly maturing, more work needs to be done as a matter of priority to prepare for the next Hendra incident.

In all, this report makes 74 recommendations to five agencies.

As the issues dealt with in the report are of significant public interest, I have decided to present the report to the Speaker for tabling in Parliament as provided for in section 52 of the *Ombudsman Act 2001*. I believe that the publication of this report will assist the agencies concerned to improve their practices and procedures and that publication is in the interests of those agencies and the general public, especially those involved in the equine industry or who otherwise own and care for horses.

I would like to thank all of the public sector officers, industry representatives, scientists, horse owners, and other stakeholders who assisted my investigation.

Finally, I would like to thank all of my staff, particularly Assistant Ombudsman Peter Cantwell and Senior Investigator Jessica Wellard, for their hard work and professionalism in conducting the investigation and preparing the report.



Phil Clarke  
Queensland Ombudsman.

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## Dictionary and abbreviations

|                                   |  |
|-----------------------------------|--|
| <b>2006 Peachester incident</b>   | The incident of Hendra virus identified in Peachester in June 2006   |
| <b>2006 Perkins Report</b>        | <i>Independent review of an Equine Case of Hendra Virus Infection at Peachester</i> , the final report of an investigation by Dr Nigel Perkins in relation to the 2006 Peachester incident                                   |
| <b>2007 needle-stick incident</b> | A needle-stick incident that occurred involving a QPIF officer in 2007   |
| <b>2007 Peachester incident</b>   | The incident of Hendra virus identified in Peachester in June 2007   |
| <b>2008 AAR Report</b>            | The internal ‘after action review’ report prepared by QPIF following the 2008 Redlands and 2008 Proserpine incidents (see also AAR)  |
| <b>2008 needle-stick incident</b> | A needle-stick incident that occurred involving a QPIF officer during the 2008 Redlands incident   |
| <b>2008 Perkins Report</b>        | <i>Independent review of Hendra virus cases at Redlands and Proserpine in July and August 2008</i> , the final report of an investigation by Dr Nigel Perkins in relation to the 2008 Redlands and 2008 Proserpine incidents |
| <b>2008 Proserpine incident</b>   | The incident of Hendra virus identified in Proserpine in July 2008   |
| <b>2008 Redlands incident</b>     | The incident of Hendra virus identified in Redland City in July 2008   |
| <b>2009 AAR Report</b>            | The internal ‘after action review’ report prepared by QPIF following the 2009 Cawarral incident  |
| <b>2009 Bowen incident</b>        | The incident of Hendra virus identified in Bowen in September 2009   |
| <b>2009 Cawarral incident</b>     | The incident of Hendra virus identified in Cawarral in August 2009   |
| <b>2009 payment</b>               | The ex gratia payment made by QPIF during the 2009 Cawarral incident   |
| <b>2009 Perkins Report</b>        | <i>Progress audit of Biosecurity Queensland’s response activities at Cawarral in August 2009</i> , the final report of an investigation by Dr Nigel Perkins in relation to preliminary aspects of the 2009 Cawarral incident |
| <b>AAHL</b>                       | The Australian Animal Health Laboratory, a Commonwealth Scientific and Industrial Research Organisation (CSIRO) facility in Geelong, Victoria  |
| <b>AAR</b>                        | An after action review conducted by QPIF following biosecurity incident responses  |
| <b>Acting CVO</b>                 | The acting Chief Veterinary Officer of QPIF during the 2009 Cawarral incident  |
| <b>Act of grace payment</b>       | A discretionary payment made by Commonwealth agencies under s.33 of the <i>Financial Management and Accountability Act 1997</i> (Cwlth)  |
| <b>APII</b>                       | Animal Industry, Policy and Investment, QPIF   |
| <b>AUSVETPLAN</b>                 | The Australian Veterinary Emergency Plan   |
| <b>AVA</b>                        | The Australian Veterinary Association  |

|  |   |
|--|---|
| <b>AWCR Trust</b>  | The Animal Welfare and Crisis Response Trust, established by the AVA during the 2008 Redlands incident  |
| <b>Biosecurity Bill</b>  | The Biosecurity Bill that was released for public consultation on 22 July 2011  |
| <b>Biosecurity Queensland or BQ</b>                            | The business unit in QPIF that is responsible for biosecurity responses, including responses to Hendra virus incidents  |
| <b>BSL</b>   | QPIF's Biosecurity Sciences Laboratory in Coopers Plains, Brisbane  |
| <b>BSPHU</b>   | Brisbane Southside Public Health Unit of QH   |
| <b>Callinan Report</b>   | The report by the Honourable Ian Callinan QC AC, titled <i>Equine Influenza: The August 2007 outbreak in Australia</i>  |
| <b>Cawarral property</b>                                       | A horse stud and nursery in Cawarral, near Rockhampton in Central Queensland and the site of the 2009 Cawarral incident   |
| <b>CCEAD</b>   | Consultative Committee on Emergency Animal Diseases   |
| <b>CDB</b>   | Communicable Diseases Branch of QH  |
| <b>CDDA Scheme</b>   | Commonwealth <i>Scheme for Compensation for Detriment caused by Defective Administration</i> , which facilitates the payment of ex gratia and other non-compulsory payments by Commonwealth Government agencies |
| <b>Chief Biosecurity Officer</b>                               | Chief Biosecurity Officer of QPIF   |
| <b>clinic owner</b>  | The owner and principal veterinarian of the Redlands clinic, which was the site of the 2008 Redlands incident of Hendra virus   |
| <b>companion horse</b>   | A horse that occupies the same paddock, enclosure or space as a suspect or highly suspect horse   |
| <b>CQPHU</b>   | Central Queensland Public Health Unit of QH   |
| <b>CVO</b>   | Chief Veterinary Officer of QPIF  |
| <b>DCP</b>   | Dangerous contact premises, as defined under the QPIF Quarantine Policy   |
| <b>DEEDI</b>   | Department of Employment, Economic Development and Innovation, the agency responsible for equine Hendra virus responses between April 2008 and the date of this report  |
| <b>DERM</b>  | Department of Environment and Resource Management   |
| <b>Director AWB</b>  | Director of Animal Welfare and Biosecurity, QPIF  |
| <b>Director-General or DG</b>                                  | As the context permits, the chief executive of the relevant government department   |
| <b>Director-General, Department of the Premier and Cabinet</b> | At the relevant time, Mr Ken Smith  |
| <b>DJAG</b>  | Department of Justice and Attorney-General  |
| <b>Doctor A</b>  | The PHMO from the CQPHU responsible for managing the QH response to the 2006 Peachester incident and the 2009 Cawarral incident   |

|                                 |   |
|---------------------------------|---|
| <b>Doctor B</b>                 | The PHMO from the BSPHU responsible for managing the QH response to the 2008 Redlands incident  |
| <b>Doctor C</b>                 | The PHMO from the TPHU responsible for managing the QH response to the 2008 Proserpine incident   |
| <b>Doctor D</b>                 | A doctor assisting Doctor A during the 2009 Cawarral incident   |
| <b>DPIF or DPI or DPI&amp;F</b> | The various acronyms that refer to the Department of Primary Industries and Fisheries, the agency responsible for equine Hendra virus responses between January 2006 and March 2008 collectively referred to in my report as QPIF |
| <b>EDIA Act</b>                 | <i>Exotic Diseases in Animals Act 1981</i>  |
| <b>EHU</b>                      | The Environmental Health Unit in QH   |
| <b>ELISA test</b>               | Enzyme Linked Immunosorbent Assay (Indirect ELISA) test   |
| <b>EMU</b>                      | The Emergency Management Unit in QPIF   |
| <b>encephalitis</b>             | An inflammation of the substance of the brain   |
| <b>endoscope</b>                | A slender tube used to examine the interior of a body cavity or hollow organ  |
| <b>EPA</b>                      | The former Environmental Protection Agency – now within DERM  |
| <b>equine</b>                   | A horse, or relating to a horse, as the context requires  |
| <b>equine herpes virus</b>      | A virus that causes mild respiratory disease and can cause abortion, stillbirths, deaths of newborn foals, and neurological disease in adult horses   |
| <b>equine morbillivirus</b>     | The virus now known as Hendra virus was initially called equine morbillivirus   |
| <b>euthanasia</b>               | The deliberate bringing about of the death of a horse suffering from an incurable disease or condition, by administering a lethal drug  |
| <b>euthanized vs euthanased</b> | An alternative spelling of <u>e</u> uthanased'. See euthanasia.   |
| <b>ex gratia</b>                | Latin for <u>a</u> ct of grace'. A payment made to a person by a government agency where there is no legal obligation to make such a payment.   |
| <b>Ex Gratia Decision-Maker</b> | Mr Robert Setter, the Acting Director-General of DPIF from March 2008, until appointed Director-General of DPIF in November 2008. He was then appointed Associate Director-General of DEEDI in March 2009.                        |
| <b>Executive Director</b>       | The Executive Director, Strategic Policy (Industry Development) of QPIF   |
| <b>exotic disease</b>           | A disease listed in the Schedule to the Exotic Diseases in Animals Regulation 1998  |
| <b>FA Act</b>                   | <i>Financial Accountability Act 2009</i>  |
| <b>FA&amp;A Act</b>             | <i>Financial Administration and Audit Act 1977</i>  |
| <b>first 2008 payment</b>       | The first ex gratia payment made by QPIF during the 2008 Redlands incident  |
| <b>FMA Act</b>                  | <i>Financial Management and Accountability Act 1997</i> (Cwlth)   |

|                                     |   |
|-------------------------------------|---|
| <b>fomite</b>                       | An inanimate object or substance that is capable of transmitting infectious organisms from one individual to another  |
| <b>Forbes Report</b>                | A Report by Mr Andrew Forbes of DLA Phillips Fox Lawyers, instructed by the Veterinary Surgeons Board in 2008 to investigate complaints from horse owners about the conduct of the clinic owner in response to the deaths of horses at the Redlands clinic          |
| <b>General Manager AIPI</b>         | General Manager of Animal Industry, Policy and Investment, QPIF   |
| <b>GP</b>                           | A general practitioner (medical doctor) who provides primary medical care for humans  |
| <b>Guidelines for Veterinarians</b> | The <i>Guidelines for veterinarians handling potential Hendra virus infections in horses</i> (various versions), QPIF's publicly available procedures for private and QPIF veterinarians to use when responding to potential Hendra virus infection in horses       |
| <b>HBMALG</b>                       | Horse Biosecurity and Market Access Liaison Group, an industry liaison group for the horse industry established by QPIF   |
| <b>Hendra virus</b>                 | A paramyxovirus spread from flying foxes to horses and then to humans that causes respiratory and neurological symptoms and frequently results in death. Hendra virus, formerly called equine morbillivirus, is a notifiable disease in Queensland.                 |
| <b>Hendra Virus Taskforce</b>       | An internal QPIF working group formed to review policies and procedures relating to Hendra virus responses  |
| <b>HeV</b>                          | The abbreviation for Hendra virus   |
| <b>HeV Expert Group</b>             | An internal QPIF group of officers formed in July 2008 to advise on QPIF's policy of destroying sero-positive horses  |
| <b>highly suspect case</b>          | A term used in the former Guidelines for Veterinarians (version 3 – 2009) to describe a possible Hendra virus case where a horse very closely matches the case definition and testing is necessary to confirm the presence of the primary diagnosis of Hendra virus |
| <b>incident</b>                     | A confirmed case or several confirmed cases of Hendra virus   |
| <b>index case</b>                   | The term 'index case' is used in different ways by different agencies and organisations. QPIF uses the term to mean the first identifiable case of Hendra virus, in any particular incident and this is the use that I have adopted in my report.                   |
| <b>infectious</b>                   | The ability of a person or animal to transmit a disease to other persons or animals   |
| <b>inspector</b>                    | A person appointed under s.4D of the Stock Act to carry out the functions of the Act  |
| <b>IP</b>                           | Infected premises   |
| <b>lavage</b>                       | To cleanse by flushing  |
| <b>LDCC</b>                         | A Local Disease Control Centre, formed by QPIF under the AUSVETPLAN during a biosecurity response   |

|  |  |
|--|--|
| <b>Manager, Strategy and Legislation</b> | The Manager, Strategy and Legislation of QPIF  |
| <b>Managing Director</b>                 | The Managing Director of Biosecurity Queensland, a division of QPIF  |
| <b>Minister</b>                          | As the context permits, the relevant Minister having responsibility for the government department  |
| <b>my officers</b>                       | Assistant Ombudsman Peter Cantwell LL.B (Hons), Solicitor and Senior Investigator Jessica Wellard M. Crim., Grad. Dip. Legal Prac, LL.B (Hons), BA (Psychology)  |
| <b>necropsy</b>                          | The examination of a body after death; an autopsy  |
| <b>Nipah virus</b>                       | A paramyxovirus causing a flu-like illness, pneumonia, and encephalitis in humans. Nipah virus is closely related to Hendra virus, but is not known to occur in Australia.   |
| <b>Ombudsman Act</b>                     | <i>Ombudsman Act 2001</i>  |
| <b>Operational Debrief</b>               | The internal debrief conducted by QH following its response to the 2008 Redlands incident  |
| <b>PAPR</b>                              | A powered air-purifying respirator   |
| <b>PCR test</b>                          | A polymerase chain reaction test used to detect the presence of Hendra virus genetic material  |
| <b>PHMO</b>                              | A Public Health Medical Officer working in a Public Health Unit of QH  |
| <b>PHU</b>                               | A Public Health Unit of QH   |
| <b>PPE</b>                               | Personal protective equipment  |
| <b>Principal Epidemiologist</b>          | The Principal Veterinary Epidemiologist for Biosecurity Queensland   |
| <b>private veterinarian</b>              | A veterinarian in private practice not employed by QPIF  |
| <b>Progress Report</b>                   | The report by QPIF tabled in Parliament in mid-2009 in response to the recommendations made in the 2008 Perkins Report   |
| <b>Proserpine property</b>               | A rural residential property in Proserpine, North Queensland, the site of the 2008 Proserpine incident   |
| <b>QH</b>                                | Queensland Health  |
| <b>QHC</b>                               | Queensland Horse Council   |
| <b>QHFSS</b>                             | Queensland Health Forensic & Scientific Services in Coopers Plains, Brisbane, the QH laboratory responsible for testing for Hendra virus   |
| <b>QH Guideline</b>                      | A QH document titled <i>Hendra Virus Infection – Queensland Health Guidelines for Public Health Units</i> that guides the response of QH officers to actual or suspected Hendra virus incidents  |
| <b>QPIF</b>                              | Queensland Primary Industries and Fisheries, a division of DEEDI responsible for equine Hendra virus responses. This term is also used when referring to actions by the former DPIF between 1994 and 2006, as well as to actions of DEEDI. |
| <b>QPIF legal unit</b>                   | An internal work group within QPIF which provided legal advice to QPIF officers  |
| <b>quarantine</b>                        | A strict isolation designed to prevent the spread of disease   |

|                                       |   |
|---------------------------------------|---|
| <b>Quarantine Policy</b>              | A QPIF policy titled <i>Hendra Response – Quarantine and Undertaking Management</i> that guides the response of QPIF officers to Hendra virus incidents                                     |
| <b>Queensland Health or QH</b>        | Department of Health  |
| <b>recrudescence or recrudescence</b> | To recur or to break out afresh, anything that has been dormant or inactive   |
| <b>Redlands</b>                       | Redland City, South East Queensland   |
| <b>Redlands clinic</b>                | A veterinary clinic and horse hospital in Redland City in South East Queensland. This clinic was the site of the 2008 Redlands incident.  |
| <b>SDCHQ</b>                          | State Disease Control Headquarters, a structure formed by QPIF under the AUSVETPLAN to facilitate responses to Hendra virus incidents   |
| <b>second 2008 payment</b>            | The second ex gratia payment made by QPIF during the 2008 Redlands incident   |
| <b>seroconvert</b>                    | To become sero-positive   |
| <b>serology</b>                       | The scientific study of the properties and action of the serum of the blood   |
| <b>sero-positive</b>                  | To test positive on serology to Hendra virus  |
| <b>SNT</b>                            | Serum neutralisation test. See VNT.   |
| <b>SP</b>                             | Suspected premises, that is a property suspected by QPIF of having a Hendra virus infection under the Quarantine Policy   |
| <b>stock</b>                          | Under the Stock Act, the term <u>stock</u> includes horses  |
| <b>Stock Act</b>                      | <i>Stock Act 1915</i>   |
| <b>suspect case</b>                   | A possible Hendra virus case where a horse shows a partial fit to the case definition in the Guidelines for Veterinarians, and testing is necessary to exclude the presence of Hendra virus |
| <b>TPHU</b>                           | Townsville Public Health Unit of QH   |
| <b>VES Trust</b>                      | The AVA's Veterinary Emergency Support Trust  |
| <b>VNT</b>                            | Virus neutralisation test   |
| <b>VS Act</b>                         | <i>Veterinary Surgeons Act 1936</i>   |
| <b>VSBS</b>                           | Veterinary Surgeons Board, a statutory board created under the VS Act to oversee veterinary practitioner registrations in Queensland  |
| <b>WHS Act</b>                        | <i>Workplace Health and Safety Act 1995</i>   |
| <b>WHSQ</b>                           | Workplace Health & Safety Queensland  |
| <b>WH&amp;S Review</b>                | QPIF's workplace health and safety incident prevention review in relation to a needle-stick incident that occurred during the 2008 Redlands incident  |
| <b>zoonoses</b>                       | Plural of zoonosis  |
| <b>zoonosis or zoonotic disease</b>   | A disease, such as Hendra virus, that can be transmitted from animals to humans   |

## 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,<sup>1</sup> 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',<sup>2</sup> in that it is a public authority established under an Act for a public purpose.<sup>3</sup> I therefore have power to investigate the administrative actions of the VSB.

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<sup>1</sup> Section 8(1), Ombudsman Act.

<sup>2</sup> Section 8, Ombudsman Act.

<sup>3</sup> Section 9, Ombudsman Act.

Under the Ombudsman Act,<sup>4</sup> 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

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<sup>4</sup> 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.<sup>5</sup> 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.<sup>6</sup>

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,

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<sup>5</sup> Section 25(2), Ombudsman Act.

<sup>6</sup> 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 recrudescence, 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.

## Chapter 1: Introduction

This chapter sets out the background to the investigation.

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 opinions formed and the recommendations made in this report are mine.

### 1.1 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 occurred. 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 have not to date 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 appears 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.

Throughout my report, I have used the term destroyed to refer to instances where QPIF used its statutory powers to euthanase horses that had recovered from Hendra virus. I consider this the appropriate term given that it is used in the legislation. For other instances, such as where private veterinarians euthanased ill horses that were subsequently determined to have Hendra virus, I have used the term euthanased.

I have not attempted to correct errors in quotes from documents or transcripts. All quotes in this report have been reproduced using the original words.

## 1.2 Own initiative investigation

Under s.12(a) of the *Ombudsman Act 2001* (Ombudsman Act), the Ombudsman can conduct investigations on the Ombudsman's own initiative.

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.

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 Tewanin 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.

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
- 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.

## Chapter 2: About the Ombudsman and investigations

### 2.1 Jurisdiction

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,<sup>7</sup> 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',<sup>8</sup> in that it is a public authority established under an Act for a public purpose.<sup>9</sup> I therefore have power to investigate the administrative actions of the VSB.

Under the Ombudsman Act,<sup>10</sup> 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.

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<sup>7</sup> Section 8(1), Ombudsman Act.

<sup>8</sup> Section 8, Ombudsman Act.

<sup>9</sup> Section 9, Ombudsman Act.

<sup>10</sup> Section 12, Ombudsman Act.

## **2.2 Agencies involved in responding to the Hendra virus incidents**

The government agencies to which my investigation related all have some legislative role or responsibility in relation to Hendra virus incidents.

### **Department of Employment, Economic Development and Innovation**

DEEDI has the primary role of managing biosecurity risks and equine issues during Hendra virus responses. This role is carried out by Biosecurity Queensland within DEEDI's business unit, QPIF.

Under the Stock Act, DEEDI has responsibility for controlling diseases in stock, including horses. A 'disease' is one prescribed under a regulation. Hendra virus is a prescribed disease under Schedule 1 to the Stock Regulation 1988.

In addition, Hendra virus is an exotic disease under the Schedule to the Exotic Diseases in Animals Regulation 1998. This means that DEEDI also has the responsibility for dealing with Hendra virus incidents under the EDIA Act.

Before March 2009, the agency that held the above responsibilities was the Department of Primary Industries and Fisheries (DPIF). Biosecurity Queensland was established as a business unit of DPIF in 2007.

In March 2009, DPIF was merged into DEEDI and, as mentioned above, one of its business units, QPIF (encompassing Biosecurity Queensland), now has these responsibilities.

For ease of reference, all actions taken by DPIF officers, Biosecurity Queensland officers or DEEDI officers are referred to in my report as actions by QPIF.

### **Queensland Health**

QH has responsibility for regulating public health concerns under the *Public Health Act 2005*. QH is responsible for all human health concerns during Hendra virus incidents, other than the workplace health and safety issues that are the responsibility of WHSQ.

### **Workplace Health and Safety Queensland**

WHSQ is a division of DJAG. Until March 2009, it was a division of the Department of Employment and Industrial Relations.

Under the *Workplace Health and Safety Act 1995* (WHS Act), WHSQ has responsibility for regulating occupational health and safety. Issues relating to the risk of Hendra virus infection within workplaces are the responsibility of WHSQ.

## **Department of Environment and Resource Management**

DERM is a support agency in a major biological incident. It has certain statutory responsibilities in relation to the safe disposal of potentially harmful material under the *Environmental Protection Act 1994*. Until March 2009, a separate agency, the EPA, fulfilled those functions.

DERM can have a role in relation to the disposal of horse carcasses, waste, and equipment during and after Hendra virus incidents.

## **Veterinary Surgeons Board**

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

A matter relating to a private veterinarian was raised in my investigation, and I considered the manner in which the VSB investigated the matter. The effectiveness of liaison between the VSB and QPIF was also relevant to my investigation.

## **Other agencies**

In my investigation, I also considered what role, if any, was held by local governments during Hendra virus incidents. For the sake of completeness, I sought submissions from a number of local governments that had experienced Hendra virus incidents in their local government areas.

Despite at least one local government choosing to convene Local Disaster Management Group meetings in relation to a local Hendra virus incident, I concluded that local governments would normally have no formal response role during Hendra virus incidents. Having said this, local governments are in a position to usefully disseminate information to local residents and greatly assist QPIF and other agencies to address public concerns.

## **2.3 Procedure for gathering evidence**

Section 25 of the Ombudsman Act provides as follows:

### 25 Procedure

- (1) Unless this Act otherwise provides, the ombudsman may regulate the procedure on an investigation in the way the ombudsman considers appropriate.
- (2) The ombudsman, when conducting an investigation:
  - (a) must conduct the investigation in a way that maintains confidentiality; and
  - (b) is not bound by the rules of evidence, but must comply with natural justice; and
  - (c) is not required to hold a hearing for the investigation; and
  - (d) may obtain information from the persons, and in the way the ombudsman considers appropriate; and
  - (e) may make the inquiries the ombudsman considers appropriate.

Neither I nor the former Ombudsman had to use any of the powers under part 4 of the Ombudsman Act to obtain evidence as all relevant departments, agencies and persons from whom information and/or documents were sought assisted my officers.

## 2.4 Standard of proof and sufficiency of evidence

The Ombudsman Act outlines the matters on which the Ombudsman must form an opinion before making a recommendation to the principal officer of an agency.<sup>11</sup> These include whether the administrative actions investigated are unlawful, unreasonable, unjust or otherwise wrong.<sup>12</sup>

Although the Ombudsman is not bound by the rules of evidence,<sup>13</sup> the question of the sufficiency of information to support an opinion of the Ombudsman requires some assessment of weight and reliability.

The standard of proof applicable in civil proceedings is proof on the balance of probabilities. This essentially means that, to prove an allegation, the evidence must establish that it is more probable than not that the allegation is true.

Although the civil standard of proof does not strictly apply in administrative decision-making (including the forming of opinions by the Ombudsman), it provides useful guidance.<sup>14</sup>

## 2.5 Procedural fairness

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.<sup>15</sup> 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.<sup>16</sup>

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

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

- 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.

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<sup>11</sup> Section 50, Ombudsman Act.

<sup>12</sup> Section 49(2), Ombudsman Act.

<sup>13</sup> Section 25(2), Ombudsman Act.

<sup>14</sup> See *Minister for Immigration and Ethnic Affairs v Wu Shan Liang* (1996) 185 CLR 259 at 282, and see also the discussion in Creyke, R. and McMillan, J. (2009) *Control of Government Action – Text, cases and commentary, 2nd edition*, LexisNexis Butterworths, Australia at 12.2.20.

<sup>15</sup> Section 25(2), Ombudsman Act.

<sup>16</sup> Section 26(3), Ombudsman Act.

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, 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.

My proposed report contained 82 proposed opinions and 78 proposed recommendations. This final report does not include the proposed opinions and recommendations unless I considered their inclusion necessary to clearly illustrate how I had formed my final opinions and recommendations. Where an agency responded to a proposed opinion or recommendation, the substance of their response is fairly set out within the body of the report if the proposed opinion or recommendation has been retained in original or amended form.

## **2.6 Responses received**

### **2.6.1 DEEDI**

In his response to my proposed report, the Director-General of DEEDI raised a number of initial concerns.

Specifically, he argued that procedural fairness had been denied to some of his officers in the conduct of my investigation. He alleged that:

- several officers who were interviewed raised concerns that no indication was given to them about how the information provided would be used
- many officers were particularly concerned that extracts from interviews had been presented verbatim in my proposed report without the appropriate context
- there was also concern about the lack of apparent basis for the weight that appears to have been given by me to evidence from one officer when compared with that given by another.

The Director-General also stated that any extracts from transcripts used in my investigation should have been checked for accuracy with the interviewee prior to being included in the report.

These concerns are without foundation for a number of reasons.

Firstly, the transcripts were checked for accuracy against the audio recordings of the interviews. They were accurate. The transcripts are therefore an additional record, in addition to the audio recording, of what the DEEDI officers told my officers at the time they were interviewed. I have not received any specific allegation that a comment attributed to a particular officer was not made at interview.

Secondly, each intended interviewee was provided with a written request for an interview. That request clearly set out details of the scope of the investigation. Interviewees were also provided with an information sheet which set out the manner in which the interview would be conducted and recorded. The information sheet also dealt with the officers' rights and obligations in relation to participating in the interview. The officers were also told, at interview, that they could inform my officers that, if they did not know the answer to a question, they could advise them of the answer at a later date if it was necessary to confirm any details. Accordingly, the responses provided by the interviewees are validly considered as evidence in my investigation and I am required to take the information provided into account. If DEEDI officers initially provided information to my officers that they wished to resile from, the Director-General had the opportunity to point out any such instances in his response to my proposed report and provide the necessary corrections.

Thirdly, interviewees were able to request a copy of the transcript of their interview if they wished, and several officers took advantage of this opportunity.

Fourthly, in relation to what advice was given to DEEDI officers (and others who were interviewed), each interviewee was provided, at interview, with an overview of my investigation and told that at the end of the investigation a report would be prepared. All interviews were recorded as was this explanation. Interviewees were provided with the opportunity to ask any questions, which could have included how the information they provided might be used. Without exception each interviewee consented to their interview being recorded for the purposes of this investigation. Each interviewee chose to fully cooperate with my investigation. At the conclusion of each interview, interviewees were asked if they had any concerns about how the interview had been conducted. No DEEDI interviewee expressed any concerns.

Fifthly, I have, as far as reasonably possible, attempted to extract and publish comments from DEEDI officers and other interviewees where relevant to demonstrate points made in my analysis. The views of officers differed in relation to certain points, as would be expected. Where possible, I have endeavoured to set out these differing views in relation to each issue.

Finally, the Director-General submitted that the way certain views had been attributed to easily identifiable officers had caused embarrassment and concern about their professional reputation. However, he did not identify the specific officers' concerns, citing a lack of time to prepare his response. The Director-General was provided with approximately seven weeks to prepare a response to my proposed report, which is considerably longer than the 28 day period that I would ordinarily provide. Nevertheless, he requested that officers to whom views are attributed in the final report be given an additional opportunity to again review and comment on these inclusions to ensure their comments made at interview accurately reflect their current positions before my final report is made public.

I have not provided this opportunity because I believe it unnecessary to do so. Nor am I required to do so by the principles of natural justice. The statements made to my officers are evidence and the veracity and usefulness of this evidence would be affected if I were to now, effectively, reconfirm evidence with officers which has already been given, and possibly, allow these officers to alter their positions. Nevertheless, in finalising my report, I have ensured statements are generally only attributed to identifiable individuals (identified by role) in the case of senior officers, and that other officers will generally not be identifiable.

The Director-General of DEEDI made further extensive submissions about the content of my proposed report. By way of background to his response, the Director-General submitted:

Hendra virus is a serious, albeit rare, disease that can transfer from animals to humans. There have been 13 primary cases of Hendra virus over 17 years in Queensland [accurate as at date of response]. While we have learned much about Hendra virus over the years, our knowledge is still evolving.

Each Hendra virus incident has been different, with different disease presentation, different circumstances on infected and surrounding properties and with each response conducted in an environment of increasing public awareness and concern.

There is no set pattern for how each incident will unfold. While core policies and procedures are in place, adaptability to changing circumstances is critical in an emergency response. Therefore, in assessing performance in relation to Hendra virus responses, as well as adherence to policies and guidelines, the concept of accountability must include the capacity to learn, adapt, with permission to improvise when the situation calls for it.<sup>17</sup> As demonstrated in the Canberra bushfires, processes that are too rigid or prescriptive run the serious risk of significant problems being missed, particularly in fast-moving incidents or when information is incomplete, or when the incident does not follow previous patterns.

This does not mean that DEEDI does not take its accountability obligations seriously. Rather, it reflects the practical experience of mounting any biosecurity response and the requirement to make decisions in often highly volatile situations with less than perfect information. Biosecurity is always concerned with pests and diseases; indeed, that is the whole point of the biosecurity function in government.

DEEDI acknowledges that, based on the recommendations contained in the Proposed Report, there are lessons to be learned, and the agency will be using the Report as part of its continuous improvement program for its biosecurity systems.

While DEEDI welcomes any learning, it is important to note that DEEDI is not called in until after Hendra virus is suspected or confirmed, meaning that infection and contact with other horses or humans has already occurred. There are no known cases where new infection has occurred once DEEDI became involved, illustrating that, overall, our responses to Hendra virus incidents have been successful in managing the disease and protecting the public.

The contextual information presented in this response is provided to inform the Ombudsman of the practical challenges faced when mounting a Hendra virus response. It is requested that any final findings be made after taking into account the broader considerations presented.

Specifically, DEEDI is concerned that the proposed report in places contains inaccuracies, quotes officers out of context, misunderstands the environment in which

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<sup>17</sup> Australian and New Zealand School of Government course "Emergency and Crisis Management" 2008, conducted by Herman B. ("Dutch") Leonard, Prof of Public Management, JFK School of Govt, Harvard University.

biosecurity responses take place, and misconstrues the evidence. The department strongly refutes certain suggestions that officers took actions for improper reasons (for example, the explanation of the basis for making ex gratia payments, or the reasons for utilising the Exotic Diseases in Animals Act). The body of the submission demonstrates why those conclusions and opinions should be withdrawn or modified.

The Director-General also submitted that:

A significant period of time has passed since the incidents in question took place, since DEEDI officers and others were interviewed, and since other elements of the investigation took place. As such, some opinions and recommendations made in the Proposed Report are not based on the latest information. This response highlights those areas where significant developments have occurred that perhaps may require further consideration.

...

The circumstances surrounding a Hendra virus response will always vary, so that no single prescription can be set down in advance. As such, the report should give more recognition to the practical challenges in the context of mounting an emergency response.

Finally, the report should acknowledge the commitment and dedication of DEEDI officers and many others in successfully responding to Hendra virus incidents, often under difficult circumstances. Given that there is no evidence that new infection has occurred once DEEDI became involved in a Hendra virus response, particular care should be taken to not imply that actions by DEEDI officers have exacerbated situations or increased disease risk on or around a particular property.

I note that the issue of whether new infections have occurred once QPIF officers became involved in responses is an entirely separate issue to whether the actions of QPIF officers have exacerbated situations or increased disease risk. If the actions of QPIF officers have increased disease risk, even if unwittingly, then this is rightly a matter which should be brought to the Director-General's attention for immediate rectification. My interest, from an administrative improvement perspective, is in ensuring that QPIF's response is as efficient and effective as possible.

However, as a general comment, nothing in my report comments adversely on the commitment or dedication of QPIF officers. Instead, I acknowledge that QPIF officers, and particularly those involved in the initial response to a biosecurity incident, perform a difficult task to the best of their ability.

### **2.6.2 The Minister and the Biosecurity Bill**

The Biosecurity Bill was released for public consultation on 22 July 2011. I have not undertaken a review of the Biosecurity Bill for the purposes of this investigation. That task properly fell outside my terms of reference.

The Minister advised that the proposed Bill is a major policy initiative undertaken by the Queensland Government in response to various biosecurity incidents including those involving the Hendra virus. The draft of the Bill has been prepared in consultation with various industry and interest group stakeholders.

The Minister stated that:

The Biosecurity Bill will provide a single cohesive regulatory framework for biosecurity in Queensland. It will comprehensively regulate responses to biosecurity incidents including emergency responses and access to compensation. In particular, the proposed legislation will replace both the *Stock Act 1915* (Qld) and the EDIA Act. I expect that the introduction of a single Act in Queensland concerning biosecurity will resolve concerns that you have expressed in the proposed report about there being alternative statutory regimes allowing for response to biosecurity issues.

The Minister advised that the proposed legislation is expected to be introduced into the Parliament in late 2011.

The Minister also made the following comments about QPIF's response to Hendra virus incidents generally:

I would like to refer to a number of factors concerning Hendra virus incidents and ask you to take them into consideration in preparing your final report.

Incidents of Hendra virus occur without warning, require an urgent response, and generate substantial public concern. Staff of the department responded quickly and effectively to the past incidents described in your proposed report, and with very considerable dedication. As Dr Perkins acknowledges in his report dated December 2008, (at page 11) they effectively controlled further spread of infection, in the face of the risks they encountered. They had to make decisions and judgments in very urgent timeframes, based on the state of knowledge of Hendra virus at the time, the information they had and the environment in which they found themselves.

As I have previously noted, I am not a veterinary surgeon nor a scientist. However, in my experience as a Minister with an important role to play in responding to Hendra virus, I would submit that each incident poses unique challenges. Depending on the time, place and environment at which an incident occurs, different issues arise to be dealt with, associated with clinical management of the disease and the impacts on individuals, families, businesses and communities.

Incidents of Hendra virus also evoke strong social, political and media concerns. Often the real risks to public health and safety, are significantly out of step with the level of public alarm that can be present. However, in an environment such as this, public confidence in the ability of governments, industry, professionals such as veterinarians and other relevant participants to respond, is essential.

I trust that the short chronology set out in this submission demonstrates that the Queensland Government has and will continue to be committed to learning from each incident and to progressively develop policies and procedures as more is learnt, including from your final report.

## 2.7 Identification of individuals

This report is about the responses of various government agencies to Hendra virus incidents.

In most instances, it was not necessary to identify individuals connected with my investigation and to the extent possible I have therefore deleted from this report:

- references to the names of most senior agency officers and instead referred to their position titles, for example the Chief Veterinary Officer
- references to the names of other agency officers and their position titles and instead referred to, for example, a QPIF veterinary officer or a public health doctor
- the names of those affected by Hendra virus incidents, with two exceptions (discussed below)
- the names of members of the public, private veterinarians and horse owners.

The 2008 Redlands incident and the 2009 Cawarral incident both led to the tragic deaths of private veterinarians involved in those incidents. As both of these veterinarians have been regularly named in the media, I did not consider it either appropriate or necessary to remove their names from my report.

I acknowledge that, given the amount of media attention that Hendra virus incidents have received, many other people involved in these incidents have also been identified in the media. Nevertheless, I do not consider it appropriate or necessary for me to identify them in my report.

## 2.8 Publication of report

When I provided various agencies and individuals with my proposed report, I advised that I was considering tabling my final report in the Parliament. The Directors-General of DEEDI, QH and DJAG were therefore provided with an opportunity to make submissions to me if they considered that my final report should not be made public.

While not expressing a concluded view about whether my final report should be made public, the Director-General of DEEDI requested that I take the following matters into consideration before reaching a final decision about whether to publish my final report.

Firstly, he argued that the age of the incidents under investigation and the passage of time since the commencement of my investigation necessarily reduced the public interest in tabling my report. The amount of media interest and related political comment in relation to Hendra virus incidents would suggest otherwise.

I acknowledge that my report relates to the response of Queensland Government agencies to Hendra virus incidents between January 2006 and December 2009. However, the adequacy of past responses and any identified areas for improvement remain, in my opinion, of significant public interest and a guide for future responses. In 2011 alone, there have been ten separate incidents of Hendra virus detected in Queensland.

Secondly, the Director-General argued that QPIF's response to biosecurity incidents depends on public cooperation, which is affected by public confidence. He stated that a diminution of public confidence in QPIF's response to Hendra virus incidents might affect public and stakeholder cooperation with future responses. The Director-General suggested that this may threaten the success of future biosecurity responses and adversely affect the public interest in effectively treating and responding to biosecurity threats.

I do not accept this argument. I have a statutory obligation to investigate the administrative practices and procedures of an agency and to make recommendations for the improvement of those practices and procedures. As an officer of the Parliament, I also have an obligation to report publicly in respect of matters of significant public interest. It would be possible to just as easily argue the contrary position, namely that public confidence is enhanced by my publication of this report and the opinions and recommendations it contains.

I have not said or implied in my report that the QPIF responses to the Hendra virus incidents that were considered were not effective in containing the virus. My analysis has related to the processes adopted by QPIF. Accordingly, I do not agree that my report is likely to lead to a significant diminution of public confidence in the ability of QPIF to contain and respond to biosecurity incidents such as Hendra virus.

Finally, as the Director-General also noted, there is a countervailing public interest in public awareness and disclosure of the issues addressed in my report. The public has an interest in ensuring that government agencies are functioning in an efficient and effective manner.

Many of the issues raised in my report are systemic matters that have application beyond responses to Hendra virus. My analysis may also be equally applicable to QPIF's response to biosecurity incidents other than Hendra virus, as well as to responses by other agencies in Queensland, and elsewhere.

Having considered the Director-General's comments, I have determined that the public interest in publishing my report outweighs the arguments raised in favour of not publishing my report. I have therefore resolved to table my final report in the Parliament.

## Chapter 3: Hendra virus in animals

This chapter contains an overview of the Hendra virus in horses and other animals. Information about Hendra virus in humans is set out in chapter 4.

It is important to note that not all of the information about Hendra virus in this chapter was known at the time of previous Hendra virus incidents and, where relevant, I have identified this in my report.

### 3.1 Description of Hendra virus in animals

This section provides background information about Hendra virus.<sup>18</sup>

#### 3.1.1 History of Hendra virus

Hendra virus is a zoonotic disease, that is, a disease that can transfer from animals to humans.

Hendra virus was first detected in September 1994 at horse stables in Hendra, Brisbane. The incident resulted in 20 horses becoming infected: 13 died and seven recovered from minor infection but were destroyed by QPIF. Two persons also became infected with the virus, and one, a Brisbane horse trainer, later passed away.<sup>19</sup>

This then unknown virus was subsequently called equine morbillivirus. It has now been reclassified as a member of the genus *Henipavirus* in the family *Paramyxoviridae*. The virus is commonly called Hendra virus after the Brisbane suburb in which it was first detected.

After the Hendra virus was identified, it was determined that the likely carrier of the virus was one or more species of flying fox, commonly known as fruit bats. Several species of flying foxes have been shown to carry antibodies to Hendra virus, suggesting that flying foxes play a role in the infection of horses.

In October 1995, the death of a Mackay man was traced back to an autopsy conducted on a horse that died of unknown causes in August 1994. It was determined by QPIF that this horse's death was in fact the first known case of Hendra virus.

In January 1999, a thoroughbred mare that died suddenly in Far North Queensland tested positive to Hendra virus. Then, in late 2004, two separate cases occurred in northern Queensland (Cairns and Townsville). One horse tested positive to Hendra virus. The other horse, which died suddenly, was presumed by QPIF to have been infected with the virus because the veterinarian who conducted the autopsy also became infected. The veterinarian survived the infection.

With the exception of two incidents, my investigation considered all incidents of Hendra virus occurring between January 2006 and December 2009. These incidents are described in more detail in section 3.3.

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<sup>18</sup> Much of this information is drawn from the QPIF website and the QPIF Guidelines for Veterinarians (Version 4.1 March 2011).

<sup>19</sup> The history of human Hendra virus infections is discussed further in chapter 4.

The first incident that did not form part of my investigation was a case that occurred in Murwillumbah, northern New South Wales, in October 2006 and was therefore geographically outside of my jurisdiction. This case involved a single horse and no human infection.

The second exception was the 2007 incident in Cairns. This case also involved a single horse without human infection occurring, and I did not receive any complaints or submissions about this incident. In view of the other investigations which I was conducting, I did not consider any useful purpose would be served by investigating this incident.

A further Hendra virus incident occurred in Tewantin on the Sunshine Coast in May 2010, after the investigation had been substantially advanced and the preparation of this report commenced. Therefore, I have not considered this incident in my report.

Between 1994 and April 2011, the date of my proposed report, there had been 14 Hendra virus incidents in Australia. All of these incidents had occurred at locations east of the Great Dividing Range, although it was presumed a Hendra virus incident could occur in any location that was populated by flying foxes and occupied by horses.

Since April 2011, there have been a further 16 Hendra virus incidents, ten in Queensland and six in New South Wales. One of those Hendra virus incidents in Queensland occurred west of the Great Dividing Range, at Chinchilla.

Hendra virus was previously considered an exotic disease, that is, a disease that occurred overseas but was not normally found in Queensland or Australia. It is now classified as an emerging disease.<sup>20</sup>

It is generally accepted that there will be future incidents of Hendra virus in Queensland. The QPIF website states:

Sporadic HeV infection in horses could occur in the future. However, Biosecurity Queensland workshops have ensured risk management measures and a high level of horse owner and veterinarian awareness will greatly reduce the likelihood of future cases.<sup>21</sup>

### 3.1.2 Hendra virus infection in horses

Hendra virus commonly presents with primarily respiratory or neurological signs, or a combination of both. The current QPIF Guidelines for Veterinarians state:<sup>22</sup>

#### 4.2. Case definition

There are no pathognomonic<sup>23</sup> signs that define HeV infection in horses. Horses that are infected with HeV have shown variable and often vague clinical signs.

There is, however, a range of clinical signs recorded from positive cases, including some signs that have been common to many positive cases. This necessitates applying professional veterinary judgement to ill horses to decide whether HeV may be

<sup>20</sup> QPIF *What are emergency animal diseases* [accessed at [http://www.dpi.qld.gov.au/4790\\_12934.htm](http://www.dpi.qld.gov.au/4790_12934.htm) on 19 August 2011].

<sup>21</sup> QPIF *Hendra virus: the initial research* [accessed at [http://www.dpi.qld.gov.au/4790\\_11112.htm](http://www.dpi.qld.gov.au/4790_11112.htm) on 1 April 2011].

<sup>22</sup> QPIF Guidelines for Veterinarians (Version 4.1 March 2011) at p.11.

<sup>23</sup> Specifically characteristic or indicative.

involved. Using the following list of clinical signs will help a veterinarian assign a case definition of exclusion case or suspect case.

HeV should be considered where there is acute onset of clinical signs, including increased body temperature, increased heart rate and rapid progression to death associated with either respiratory or neurological signs.

**Note: Based on the AAHL<sup>24</sup> research, an elevated temperature and heart rate should be considered as early warning of the possibility of HeV infection. Progression to include other symptoms, as mentioned below, increases the possibility of HeV infection.**

**The precautionary principle should be applied at the first indication of clinical illness and also when conducting invasive/aerosol-generating procedures of the respiratory tract and other high-risk procedures (e.g. endoscopy of the upper and lower respiratory tract, dentistry using power floats, necropsy, broncho-alveolar lavage and nasal lavage). The AAHL research suggests that an infected horse can excrete HeV in nasal or nasopharyngeal secretions from two days following exposure to HeV virus, up to and including the time of onset of clinical signs, and that a strongly symptomatic horse poses the greatest transmission risk to other horses and humans through body fluids. Appropriate infection control and general biosecurity measures must be applied to the sampling and management of such horses.**

A laboratory test is required to confirm whether a horse is actually infected with HeV.

HeV can cause a broad range of clinical signs in horses and, in particular, is recognised as causing neurological and/or respiratory signs. As outlined (see section 3.2 Epidemiology), HeV has an affinity for endothelial cells and causes systemic vasculitis. The organ/system where the greatest damage occurs would appear to contribute directly to the clinical signs seen.

Professional veterinary interpretation is required to assess if the case under investigation should be described as an exclusion or suspect case. The following signs will help in the assessment.

**Common clinical signs:**

- acute onset of illness
- increased body temperature
- increased heart rate
- discomfort/weight shifting between legs (both fore and hind limbs)
- depression
- rapid deterioration.

**Some other clinical observations that have been noted include the following.**

**Respiratory signs, including:**

- pulmonary oedema and congestion
- respiratory distress—increased respiratory rates
- terminal nasal discharge—can be initially clear progressing to stable white froth and/or stable blood-stained froth
- pulmonary involvement leading to terminal weakness, ataxia and collapse.

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<sup>24</sup> Australian Animal Health Laboratory.

**Neurological signs, including:**

- wobbly gait progressing to ataxia
- altered consciousness—apparent loss of vision in one or both eyes, aimless walking in a dazed state
- head tilting, circling
- muscle twitching—myoclonic spasms have been seen in acutely ill and recovered horses
- urinary incontinence
- recumbency with inability to rise.

**Other observations, including:**

- previous unexplained horse deaths (**Note:** This is important to check and has been a feature in a number of the incidents to date)
- facial oedema
- facial paralysis and/or a locked jaw
- spasms of the jaw, involuntary chomping
- muscle trembling
- altered gait, high stepping
- anorexia
- congestion of oral mucous membranes
- a high case fatality rate within 48 hours where there are multiple cases
- colic-like symptoms in some cases (generally quiet abdominal sounds on auscultation of the abdomen in pre-terminal cases)
- straining with difficulty passing manure
- stranguria (difficult urination)—seen in several terminal cases in both males and females (Hendra 1994); dribbling urine—seen in some terminal cases (Redlands 2008)
- hot hooves
- bad breath/halitosis
- delayed blood clotting times.

Proximity to flying foxes would support the above signs, though lack of sightings does not preclude HeV.

In most of the recorded infected cases, there has been strong presentation of clinical signs; however, occasional cases have demonstrated a much milder presentation of clinical signs.

From information about the confirmed cases to date, approximately 25% of horses can survive acute infection.

**In a paddock situation**, HeV disease in horses is more likely to occur as a single sick or dead horse. In paddock situations to date, the majority have involved one infected horse that went on to die without any companion horses becoming infected. However, on three occasions, one or more companion horses have become infected with HeV after close contact with the index case prior to or at the time of death.

**In a stable situation**, it appears that HeV has the potential to spread to other horses either through close direct contact with infectious body fluids or excreta, or through

indirect contact via contaminated fomites, including human-assisted transfer. Two events in stables (Hendra 1994 and Redlands 2008) and one event on a property comprising multiple small paddocks (Cawarral 2009) have resulted in multiple horses becoming infected. It should be noted that all these events appear to have arisen from a horse initially becoming infected in a paddock or outside yard.

Under the current Guidelines for Veterinarians, an 'exclusion case' is one where Hendra virus is one of a number of differential diagnoses being considered and testing is necessary to exclude Hendra virus.

A 'suspect' case is one where Hendra virus is a primary diagnosis. Testing is required to confirm the presence or absence of the virus. In either case the guidelines state that veterinarians should implement their HeV infection control procedures to investigate and sample these cases.

It is believed that the different presentations of Hendra virus (that is, primarily respiratory versus neurological) are due to its primary feature being vasculitis, where the virus attacks the blood vessels of the horse. The predominant clinical presentation of the virus may be a reflection of whether the greatest damage occurs in blood vessels in the neurological, respiratory or colic systems.<sup>25</sup>

The incubation period for Hendra virus in horses is believed to be between five and 16 days. Most horses die within 48 hours of initial clinical signs appearing.<sup>26</sup>

Approximately 75% of Hendra virus cases in horses are fatal.<sup>27</sup> Often, horses that survive show very mild signs of the virus for a few days and then appear to recover. There is a national policy that any horses that recover from Hendra virus are destroyed, because of a concern about recrudescence.<sup>28</sup>

Index cases (horses considered by QPIF to be the earliest confirmed cases of Hendra virus in any particular incident) have generally been horses living in paddocks or kept outside in areas attractive to flying foxes.<sup>29</sup> Companion horses were present in most incidents, and on only three occasions have these in-contact horses been infected.<sup>30</sup> Therefore, spread of the virus between horses appears to be uncommon in a paddock situation.<sup>31</sup>

Transmission between horses has occurred more easily in stables, with this method of transmission occurring in the Hendra (1994), Redlands (2008) and Cawarral (2009) situations.<sup>32</sup> In such situations, the Hendra virus could have been transferred between horses through direct contact, or through indirect contact with surfaces or contaminated equipment that can transfer infectious body fluids.<sup>33</sup>

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<sup>25</sup> QPIF Guidelines for Veterinarians (Version 4.1 2011) at p.5.

<sup>26</sup> QPIF Guidelines for Veterinarians (Version 4.1 2011) at p.6.

<sup>27</sup> QPIF Guidelines for Veterinarians (Version 4.1 2011) at p.6.

<sup>28</sup> Recrudescence is discussed in chapter 6 of this report.

<sup>29</sup> QPIF Guidelines for Veterinarians (Version 4.1 2011) at p.5.

<sup>30</sup> These incidents were Mackay 1994, Proserpine 2008 and Bowen 2009.

<sup>31</sup> QPIF Guidelines for Veterinarians (Version 4.1 2011) at p.5.

<sup>32</sup> QPIF Guidelines for Veterinarians (Version 4.1 2011) at p.6.

<sup>33</sup> QPIF Guidelines for Veterinarians (Version 4.1 2011) at p.6.

### 3.1.3 Flying foxes and Hendra virus

The natural host for Hendra virus has been identified as the flying fox (genus *Pteropus*, sub-order *Megachiroptera*). Hendra virus has been identified in flying foxes in both Australia and Papua New Guinea.<sup>34</sup>

Queensland has four native species of flying fox,<sup>35</sup> and viral material has been found in three of these species and antibodies found in all four species.

The method by which Hendra virus is passed from flying foxes to horses is not yet fully understood. Hendra virus has been found in the urine, placental material, aborted foetuses and birthing fluids of flying foxes.<sup>36</sup> Experimental studies of horses have also found the virus in respiratory secretions, saliva, urine and faeces.<sup>37</sup>

Flying foxes are known to regularly feed on flowering native trees, potentially bringing them into contact with horses in paddocks.

It is therefore assumed that horses infected with Hendra virus have come into contact with the excretions or birthing material of flying foxes. These infections are also known as 'spillover' events, where the virus has moved from one species to another.

The current Guidelines for Veterinarians state:<sup>38</sup>

The majority of incidents coincide with the period from mid/late pregnancy to early birthing of three of the four Australian flying fox species. This correlation does not necessarily indicate a causal association, but does suggest a biological or ecological basis for 'spillover' from flying foxes to horses.

The prevalence of infection in individual flying fox populations may vary from year to year, and a reliable method for predicting the high-risk period within this time is not available.

All properties with HeV cases reported some level of flying fox activity in the vicinity but not necessarily the presence of a roosting colony.

There is no evidence that flying foxes can pass Hendra virus directly to humans.<sup>39</sup> Tests on persons who have been in close contact with flying foxes have not produced any positive Hendra virus results. Each of the human infections of Hendra virus occurred after close contact with respiratory secretions or blood from infected horses.<sup>40</sup>

Further QPIF research with flying foxes will aim to identify how the infection is maintained in flying fox populations and how the spillover to horses occurs.<sup>41</sup>

<sup>34</sup> QPIF Guidelines for Veterinarians (Version 4.1 2011) at p.4.

<sup>35</sup> The grey-headed flying fox, black flying fox, little red flying fox and spectacled flying fox.

<sup>36</sup> QPIF Guidelines for Veterinarians (Version 4.1 2011) at p.4.

<sup>37</sup> QPIF Guidelines for Veterinarians (Version 4.1 2011) at p.4.

<sup>38</sup> QPIF Guidelines for Veterinarians (Version 4.1 2011) at p.5.

<sup>39</sup> QH *Topic: Hendra Virus Infection* [accessed at [http://access.health.qld.gov.au/hid/InfectionsandParasites/ViralInfections/hendraVirusInfection\\_fs.asp](http://access.health.qld.gov.au/hid/InfectionsandParasites/ViralInfections/hendraVirusInfection_fs.asp) on 1 April 2011].

<sup>40</sup> QH *Topic: Hendra Virus Infection* [accessed at [http://access.health.qld.gov.au/hid/InfectionsandParasites/ViralInfections/hendraVirusInfection\\_fs.asp](http://access.health.qld.gov.au/hid/InfectionsandParasites/ViralInfections/hendraVirusInfection_fs.asp) on 1 April 2011].

<sup>41</sup> QPIF *Research into Hendra virus: the story so far* [accessed at [http://www.dpi.qld.gov.au/4790\\_11599.htm](http://www.dpi.qld.gov.au/4790_11599.htm) on 1 April 2011].

### 3.1.4 Survival of Hendra virus in the environment

Hendra virus can survive for a short period of time outside a living host. The Guidelines for Veterinarians state:

It is possible that HeV may survive on fomites for a period of hours under mild climatic conditions, and that transfer to other horses from contaminated fomites through exposure to contaminated secretions/fluids may occur.<sup>42</sup>

Fomites are objects or substances that are capable of transmitting a virus from one organism to another. In relation to Hendra virus incidents, examples of possible fomites may be horse equipment such as bridles, veterinary equipment such as endoscopes, or even horse feed or stable walls.

One 2008 study suggested that the virus is unlikely to survive for longer than 48 hours in all but the most ideal conditions.<sup>43</sup> The study found that although Hendra virus could survive for more than four days at 22°C in pH-neutral flying fox urine, the virus was sensitive to both temperature and acidity changes. For example, the authors of the study found that the virus survived on mango flesh for between two hours and two days, depending on the pH and temperature of the mango. They concluded that in most cases, there would be a need for close contact between hosts for the virus to be transmitted through fomites.

### 3.1.5 Control of Hendra virus

Hendra virus is a 'notifiable disease' under both the Stock Act and the EDIA Act. Under both Acts, a person who suspects, diagnoses or confirms the presence of Hendra virus must inform QPIF as soon as possible.

Properties where confirmed cases of Hendra virus occur are usually placed under quarantine by QPIF and horses on those properties are likely to be subject to movement restrictions. Restrictions may also apply to neighbouring properties if there has been contact between horses, and to other properties that have received horses from the initial property or sent horses to the property and those horses subsequently became unwell.

QPIF has different powers of quarantine depending on whether the quarantine is imposed under the Stock Act or the EDIA Act. Whether statutory restrictions apply to human access and biosecurity practices, as well as horses, equipment and feed, depends on which Act is used. Generally, the movement of people on or off quarantined properties is not restricted although some biosecurity practices may be required when entering or leaving designated 'dirty' or 'hot' zones on the quarantined property.

Properties are usually removed from quarantine approximately 32 days after the last exposure to Hendra virus and when all test results are negative. Some properties may be placed into quarantine for shorter periods, depending on when a horse's last possible exposure to Hendra virus occurred.

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<sup>42</sup> QPIF Guidelines for Veterinarians (Version 4.1 2011) at p.6.

<sup>43</sup> Fogarty, R., Halpin, K., Hyatt, A.D., Daszak, P. & Mungall, B.A. (2008) 'Henipavirus susceptibility to environmental variables'. *Virus Research*, vol 132, pp.140-144.

### 3.1.6 Managing the risk of Hendra virus

The QPIF website provides information on precautions that can be taken to reduce the risk of horses contracting Hendra virus. These precautions include:

- placing feed and water containers under cover and away from trees that attract flying foxes
- not using horse feed that may attract flying foxes
- temporarily removing horses from paddocks where flying foxes are roosting or feeding, if possible
- keeping sick horses isolated from other horses, people and animals
- using appropriate protective equipment when caring for sick horses
- adopting regular hand-washing procedures
- seeking veterinary advice before bringing sick horses onto their property.

Similar information is also available from the WHSQ website.

### 3.1.7 Hendra virus infection in other animals

Experimental tests have shown that some other animals are susceptible to the virus.

In relation to the infection of other animals, the Guidelines for Veterinarians state:<sup>44</sup>

- Horses experimentally infected with the original virus isolate from Hendra (1994) did not transmit the virus to in-contact horses. Experimentally infected cats and guinea pigs were susceptible to HeV infection. In an experimental setting, a horse was infected following contact with the urine of an infected cat. It is not known whether urine from an infected cat can transmit infection to other animals or humans. Experimentally infected dogs, rabbits, chickens, rats and mice did not develop clinical disease, but some developed antibodies to HeV.
- Recent experimental studies in Canada (2010) showed that the response of pigs to inoculation with large doses of virus ranged from no clinical disease to severe interstitial pneumonia. The Canadian researchers are part of a global group collaborating on HeV and Nipah virus.
- This work has demonstrated that pigs can be infected using artificial means, but it does not confirm whether or not pigs can be infected naturally. However, pigs can be infected naturally with the closely related Nipah virus.
- Evidence of natural infection has not been found in any non-equine domestic species in contact with naturally infected horses; however, this potential exists and should be considered as part of the management of HeV incidents.

Therefore, experimental studies have shown that cats, guinea pigs and pigs can contract Hendra virus. However, despite testing conducted by QPIF during previous incidents, up until 2011 there had been no recorded cases of non-equine domestic animals contracting Hendra virus in a natural setting. In 2011, a domestic pet dog at a Queensland property identified as holding infected horses tested positive for Hendra virus.

It is clear that further research is needed to fully examine the infectivity of Hendra virus in species other than horses.

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<sup>44</sup> QPIF Guidelines for Veterinarians (Version 4.1 2011) at p.6.

## 3.2 Testing for Hendra virus in horses

This section discusses the different tests for Hendra virus, and outlines the procedures for testing horses.

### 3.2.1 Types of testing

There are three types of tests generally used to identify for Hendra virus:

- polymerase chain reaction tests (PCR)
- virus isolation tests
- serology tests
  - Enzyme Linked Immunosorbent Assay tests (ELISA)
  - virus neutralisation tests (VNT).

#### PCR testing

PCR tests detect genetic material specific to Hendra virus. The PCR test is generally the initial test done to check for the presence of Hendra virus genetic material. It can identify either live or dead virus, indicating present or recent infection.

The QPIF website states:

This test looks for direct evidence of the presence of Hendra virus. It is conducted when horses are initially suspected to have the virus. It is also used when monitoring horses during a Hendra virus incident to detect infection in other horses as quickly as possible.

Test results are usually reported the same day as the samples are received by the laboratory.

The PCR test can be conducted on a blood sample, nasal or oral swab, urine sample or tissue samples collected at post-mortem.

A positive result provides early evidence that the horse is infected.

There are two types of PCR tests relevant to Hendra virus: Taqman tests and gel-based tests.

The Taqman test is a real-time PCR test that is quick, robust and reliable. It simply provides confirmation of whether Hendra virus exists in a sample or not. Taqman PCR tests are used by the Biosecurity Sciences Laboratory (BSL), Queensland Health Forensic & Scientific Services (QHFSS) and AAHL to provide a relatively quick response to the possibility of Hendra virus in a sick horse. Taqman PCR tests take approximately four hours to conduct.

Gel-based tests are used to identify the strain of Hendra virus in a sample. They are used by AAHL for research purposes, and also periodically by BSL and QHFSS to confirm or obtain genetic sequencing.

If a positive PCR result is obtained, confirmation is then sought through a virus isolation test carried out at AAHL.

## Virus isolation testing

Virus isolation tests are generally used where a horse has returned a positive PCR test result, or where other factors are strongly indicative of Hendra virus. As this test involves the growth of live Hendra virus, it can only be conducted in a laboratory with a physical containment level of four (PC-4). In Australia, one such laboratory is AAHL in Geelong, Victoria.

Virus isolation tests involve attempting to grow a virus from blood or tissue samples, then isolating that virus and testing it to identify which virus it is. This test takes from several days to weeks to perform.

A positive virus isolation test is generally seen as definitive evidence of Hendra virus infection. However, a negative virus isolation test does not conclusively rule out Hendra virus, as the virus may no longer be alive, or there may be such small amounts of virus in the sample that it cannot be isolated.

## ELISA testing

A sero-positive horse is one which has survived an initial infection with Hendra virus and has developed antibodies to the virus. Such a horse is said to have seroconverted.

Serology tests look for antibodies to Hendra virus in horses that are infected with, or have recovered from, the virus. The most common test for seroconversion is the Enzyme Linked Immunosorbent Assay (Indirect ELISA) test. This test detects the presence of antibodies to Hendra virus in a blood sample.

In relation to this test, the QPIF website states:

This test looks for the presence of antibodies to Hendra virus. This test is used for monitoring horses that may have been infected, once antibody development has occurred.

Test results are usually reported within 24 hours of samples being received by the laboratory.

The ELISA test is conducted on a blood sample (serum).

It is a very sensitive screening test and false positives are not unexpected.

Any horses that have a negative result to this test on an ongoing basis are regarded as negative for Hendra virus.

When this test is used to monitor horses during a Hendra incident, successive tests will be conducted as antibodies take time to develop following infection.<sup>45</sup>

Because the ELISA test is sensitive and sometimes gives false positive results, a further VNT test is conducted on all positive ELISA results to establish whether the possible diagnosis of Hendra virus is correct.

It is important to understand that a horse may show a negative PCR result but a positive serology result, indicating that it has recovered from the virus and seroconverted.

<sup>45</sup> QPIF *Hendra virus tests* [accessed at [http://www.dpi.qld.gov.au/4790\\_14854.htm](http://www.dpi.qld.gov.au/4790_14854.htm) on 1 April 2011].

## **Virus neutralisation testing**

Positive or indeterminate ELISA test results are sent for a VNT. This test is also known as the serum neutralisation test (SNT).

The QPIF website states:

This is a specific test for the detection of antibodies to Hendra virus.

This test is conducted for monitoring horses during a Hendra virus incident once antibody development has occurred. It is used for the final round of testing before allowing movement restrictions to be lifted on suspect horses.

Test results are usually reported between one week and ten days after samples arrive in the laboratory.

The VNT test is conducted on a blood sample (serum).

**This is considered to be the definitive test to confirm that an animal has been exposed to Hendra virus.**

Following a positive VNT test, national policy requires that the subject horse be humanely euthanased.

This test only needs to be completed once for a definitive answer. [emphasis added]

This test involves mixing a blood sample from a Hendra-suspect horse with the live virus to see if the virus is killed by antibodies in the horse's blood. It is the definitive test of exposure in sero-positive horses.

These tests are also only conducted at AAHL in a PC-4 level of biosecurity containment.

### **3.2.2 Purpose of testing**

Testing for Hendra virus is conducted for one of four main purposes.

#### **Disease investigation**

Disease investigation testing is conducted during a suspected or actual Hendra virus incident. The submitting veterinarian must first have complied with the Guidelines for Veterinarians and have a reasonable suspicion that Hendra virus may be involved in a horse's illness or death.

Disease investigation tests may include PCR tests, serology tests or VNT tests as required.

Where tests are submitted for disease investigation, there is usually no charge to the submitter.

#### **Export screening**

Export screening is carried out where a horse is being exported from Australia and the import requirements of the other country stipulate testing for Hendra virus. This testing involves an ELISA test, with a further VNT test conducted if the ELISA test returns a positive or indeterminate result.

It is not considered necessary to conduct a PCR test for export screening, as this test is only useful to identify horses that currently have Hendra virus. Unless a horse was showing clinical signs of Hendra virus, PCR testing would be expected to be negative.

Export screening attracts a fee payable by the submitter.

### **Health testing**

Health testing involves a series of general tests conducted to confirm that an animal is healthy. For Hendra virus, health testing is generally carried out where a horse is being sent to a stud that requests certification of Hendra virus status before entry.

This testing is similar to export testing but generally also includes a PCR test. Health testing also attracts a fee payable by the submitter.

### **Surveillance testing**

Finally, surveillance testing is carried out on samples obtained for QPIF's research purposes. For Hendra virus surveillance testing, these samples may be from horses, flying foxes or other animals.

### **3.2.3 Testing fees**

*QPIF's Guidelines on Specimens accepted for Testing at Department of Primary Industries and Fisheries Veterinary Laboratories and Service Fee Exemptions* state:

[Testing fees] are broadly based on the principle that the level of fees applied is proportional to the degree of private benefit occurring to the owner of the animals from which samples have been taken.

Testing for notifiable diseases and specified diseases with a public health significance, such as Hendra virus, are considered to have a substantial public benefit and do not generally attract a service fee.

Testing for Hendra virus in the context of health and export testing attracts a fee under these guidelines.

### **3.2.4 Where tests are conducted**

There are three locations where tests for Hendra virus are performed on samples from Queensland horses:

- BSL (QPIF laboratory), Coopers Plains, Brisbane
- QHFSS (QH laboratory), Coopers Plains, Brisbane
- AAHL, Geelong, Victoria.

In 2006, all Hendra virus disease investigation tests were conducted at AAHL. Only ELISA testing for export screening was performed at BSL.

By 2008, QHFSS was able to perform PCR tests for disease investigation, as well as non-validated serology testing. Serology tests were therefore confirmed at AAHL.

BSL performed serology testing for export screening and health testing only. All other Hendra virus testing, including all VNT, was performed at AAHL.

During 2009, the capability to perform PCR tests was transferred from QHFSS to BSL. Since mid-2009, BSL has performed most disease investigation testing and QHFSS now provides back-up and confirmation testing. AAHL continues to perform all VNT testing, with confirmation of some other tests still sought from AAHL.

The QPIF policy *Hendra Virus (HeV) – Real-Time PCR*, dated 6 July 2009, states:

Only low risk cases for Hendra virus exclusion shall be tested in BSL. If the samples are considered high risk or are from a known Hendra virus infected property testing shall be referred to appropriate facilities (AAHL/QHSS). This determination shall be made by the Duty Pathologist in consultation with the BSL Laboratory Manager.

### 3.2.5 Testing procedure

While AAHL will only conduct Hendra virus testing on request from government veterinary laboratories, all three Biosecurity Queensland veterinary laboratories will accept samples for Hendra virus testing from non-government sources. The three laboratories are:

- Animal Disease Surveillance Laboratory, Toowoomba
- Biosecurity Sciences Laboratory, Coopers Plains
- Tropical and Aquatic Animal Health Laboratory, Townsville.

Samples are submitted for Hendra virus testing by private veterinarians or QPIF officers.<sup>46</sup> When submitting samples for testing, the submitter completes a submission form which includes providing the animal's clinical history, current clinical signs and also the differential diagnoses and tests requested.

QPIF officers reported that, in the case of horse samples received by QPIF laboratories, Hendra virus testing will always occur if requested by a veterinarian and the samples are suitable for testing. The only issue will be the priority assigned to the testing based on an assessment of the clinical history and other relevant information that has been provided on the submission form or by telephone discussion with the submitting veterinarian. Samples received in the late afternoon may not be tested until the next day if the testing is not assessed as urgent.

When testing was carried out by QHFSS, samples still had to be submitted to BSL. BSL officers would then repackage the samples and transport them to the nearby QHFSS facility, where QHFSS officers would carry out the testing requested by QPIF officers.

Where Hendra virus is listed on the submission form as a differential diagnosis (that is, one of a number of possible diagnoses), Hendra virus testing is conducted before any other tests are carried out.

Witnesses raised the issue of QPIF officers refusing to conduct Hendra virus testing with my officers. In some instances these cases related to non-equine samples. In response to my proposed report, the Director-General of DEEDI informed me that

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<sup>46</sup> My officers were told that if a sample was received from an individual, the laboratory would contact that individual to identify the relevant veterinarian for the purpose of interpreting and managing the case.

DEEDI has no evidence that a pathologist has refused to conduct testing on samples received for Hendra virus exclusion.

Chapter five considers the adequacy of QPIF processes and procedures for testing for Hendra virus in horses.

### 3.3 Summary of relevant Hendra virus incidents

The incidents that are the subject of my report occurred on six separate occasions and at five different locations. The incidents are unrelated except for the common elements of the responses. Although each had its peculiarities, which resulted in variations to the responses, a number of themes were common across the responses.

I have set out below a more detailed summary of each Hendra virus incident discussed in this report.

#### 3.3.1 Peachester 2006

The deceased horse, Clive, was an 18-year-old thoroughbred gelding living on a five-acre property at Peachester with one other mare. At the rear of the property were a number of trees that housed a semi-permanent colony of flying foxes.

On 12 June 2006, the owner noted that Clive appeared to be mildly depressed. A local veterinarian attended the horse on 13 June 2006, and provided initial treatment for sand colic. However, by the morning of 14 June 2006 Clive's condition had worsened significantly and the veterinarian considered other possible diagnoses, including Hendra virus.

The veterinarian took blood samples for analysis. She then returned to the clinic and contacted QPIF. Although advised that the clinical signs did not sound like Hendra virus, the veterinarian was told that she could submit samples for Hendra virus exclusion testing, which she did.

Clive died that afternoon.

The samples initially did not test unequivocally positive for Hendra virus on a PCR test,<sup>47</sup> but the longer virus isolation test identified the virus nine days after Clive had died. The property was placed into quarantine the following morning and testing carried out on samples from the companion horse and a neighbour's horse. Testing was also conducted on the private veterinarian, the property owner and others. All tests for both humans and horses were negative for Hendra virus.

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<sup>47</sup> There are three types of tests generally used to identify for Hendra virus:

- PCR tests
- virus isolation tests
- serology tests
  - ELISA tests
  - virus neutralisation tests (VNTs). See section 3.2 for further explanation.

### 3.3.2 Peachester 2007

The deceased horse, Titch, was kept in a paddock at Peachester with one other horse. This property adjoined the site of the 2006 Peachester incident.

On 2 June 2007, Titch showed signs of mild colic, but had no signs of respiratory distress and no discharge. His heart rate was elevated, but the private veterinarian noted that this could also have been attributed to nervousness. The veterinarian returned on 3 June 2007, at which time the horse appeared well.

The next day, Titch was reported to have stopped eating, although this has since been disputed by his owner. On 5 June 2007, the veterinarian noted that Titch appeared depressed and sedated with a wide-based stance. His temperature, lungs and heart rate were normal. Blood samples were taken for testing.

The veterinarian reported the case to QPIF on 5 June 2007, requesting Hendra virus exclusion testing.

Overnight there was heavy rain and Titch collapsed and could not rise. The private veterinarian euthanased him on 6 June 2007 and further blood samples were drawn. Other possible diagnoses were toxins from mushrooms and hepatitis.

A weak positive result for Hendra virus was obtained on the initial PCR test at QHFSS on 8 June 2007 and the property was placed into quarantine. A negative result was then obtained at AAHL on PCR testing conducted on 9 June 2007.

After discussions between the laboratories, AAHL issued a revised final report on 2 August 2007 reporting a positive PCR result but negative virus isolation test result. QPIF determined that the horse was positive for Hendra virus.<sup>48</sup>

### 3.3.3 Redlands 2008

The 2008 Redlands incident occurred at a local veterinary clinic which consisted of a specialist equine practice and a small-animal practice (Redlands clinic).

Over a period of six weeks from June 2008 there were eight horse deaths at the clinic that are relevant to my report. The deaths were discussed in a 2008 report by Dr Nigel Perkins, who was commissioned by QPIF to conduct an external review of its response (2008 Perkins Report).

The first three of these deaths are mentioned in the Guidelines for Veterinarians as possible Hendra cases.<sup>49</sup> The 2008 Perkins Report noted that the clinical histories of these horses fitted the case definition for suspect cases of Hendra virus, as they all had a sudden onset of clinical signs, a fever, rapid deterioration, and respiratory or neurological clinical signs. However, QPIF could not confirm whether these horses in fact died of Hendra virus as:

- the horses died before the Hendra virus incident was diagnosed at the Redlands clinic and consequently before QPIF became involved
- no autopsies were conducted on these horses by the clinic
- samples available from these horses were insufficient to obtain a test result.

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<sup>48</sup> I note that Titch's owner disputes that her horse died of Hendra virus.

<sup>49</sup> QPIF Guidelines for Veterinarians (Version 4 2010) at p.39.

As these deaths occurred at around the time of the 2008 Redlands incident and cannot be excluded as possible Hendra cases, I have included them in my discussion, in the order in which they occurred.

The first of them, Casemma, was a mare from a property near Jimboomba in Logan City. This property was home to a colony of flying foxes. Although appearing well on the evening of 5 June 2008, the following morning Casemma was depressed, fevered and reluctant to move. She was taken to the Redlands clinic for treatment but continued to deteriorate and died on 7 June 2008. No autopsy was conducted and only blood smears were retained. Although they tested negative to PCR tests, the smears were not considered optimal for such a test. Another horse on a non-adjointing paddock on Casemma's home property tested negative to Hendra virus.

The second horse, Loddy, was repeatedly admitted to the Redlands clinic in May and June 2008 for treatment of a variety of medical conditions.<sup>50</sup> He was discharged on 10 June 2008, but on 15 June 2008 was observed to be depressed, stumbling and fevered. He was re-admitted to the clinic on 16 June 2008 and died early the following day. An autopsy was not performed and only blood smears were retained by the clinic. Although they tested negative to PCR tests, the smears were not considered optimal for such a test. Other horses on Loddy's home property tested negative to Hendra virus.

The third horse, Noddy, underwent abdominal surgery at the Redlands clinic on 29 May 2008 and was discharged on 16 June 2008. On the morning of 23 June 2008 he was observed to be depressed and uncoordinated. His owners returned him to the clinic where he deteriorated, and he was euthanased by the clinic on 24 June 2008. At the time of his death, Noddy was observed to have foam coming from his nose and mouth. An independent investigator later formed an opinion that Hendra virus was discussed by clinic staff at this time and was dismissed as a possible cause of death. No autopsy was performed and only blood smears were retained by the clinic. Although they tested negative to PCR tests, these smears were not considered optimal for such a test. Complications arising from the abdominal surgery were advanced by the Redlands clinic as a possible alternative cause of death. Another horse on Noddy's home property tested negative to Hendra virus.

As stated above, whether these horses died from Hendra virus cannot now be established. The view expressed by QPIF is that it was possible they were Hendra cases, but it was impossible to definitively determine a cause of death. However, the owners of these horses maintain that the clinical signs were strongly indicative of Hendra virus.

In submissions to my Office, the Redlands clinic owner stated:

- clinics like his, regularly have horse deaths occurring, and these three deaths were not unusual
- he himself identified these deaths to QPIF only because they were recent
- the only relevant signs shown by the horses were fever and rapid progression to depression and death, but these signs are shown by almost every sick horse seen by the clinic
- the frothy discharge seen after Noddy's death was nothing more than a small quantity of pulmonary frothing oedema, which is extremely common in terminal horses after death.

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<sup>50</sup> The owner of the Redlands clinic believed that these medical conditions may have been an alternative cause of death.

This issue is discussed further in section 7.3.6.

The fourth horse to die at the Redlands clinic during the relevant period, Truly Gifted, is presumed by QPIF to be the index case.<sup>51</sup> This horse was a long-term resident of the clinic, and was generally housed in a small paddock. He was observed to be depressed and not eating on 26 June 2008, and his condition deteriorated. Truly Gifted was euthanased by the clinic between 26 and 28 June 2008<sup>52</sup> and an autopsy was performed. At the time of his death, Hendra virus was not considered a likely diagnosis by the clinic.

The fifth horse, Tamworth, was receiving treatment at the Redlands clinic for an eye condition. On 30 June 2008, he was observed to be depressed, uncoordinated and not eating. His condition slowly improved over the next few days. Although Hendra virus was not suspected by the clinic at the time, once other horses were known to have had the virus, Tamworth was tested and repeatedly showed positive results for serology tests. Although the horse appeared to have recovered, QPIF ordered his destruction on the basis of the risk that the virus might recrudesce.<sup>53</sup> Tamworth was destroyed by QPIF on 15 August 2008.

The sixth horse, JD, was undergoing treatment at the Redlands clinic for a nasal condition and was observed to be not eating and depressed on 4 July 2008. JD deteriorated over the following day and was euthanased by the clinic on the afternoon of 5 July 2008. Tissue and blood samples were retained by clinic staff and returned positive PCR results for Hendra virus when tested by QPIF on 8 July 2008.

The seventh horse, Rebel, had been treated at the Redlands clinic for a fractured jaw and discharged on 7 June 2008. He was re-admitted on 11 June 2008 for further treatment. On 6 July 2008, he was observed to be depressed, and he deteriorated the next day. His treatment continued until he returned positive Hendra results on 8 July 2008, when he was euthanased by the clinic, which also performed a limited autopsy.

On the morning of 7 July 2008, the owner of the Redlands clinic voluntarily closed the equine clinic and contacted QPIF to report the suspicious deaths. An initial quarantine was placed on the property by QPIF for another equine virus, equine herpes virus. Hendra virus exclusion tests were conducted that afternoon and a positive PCR result for Hendra virus was obtained on samples from a number of horses late that evening.<sup>54</sup>

QPIF revoked the previous quarantine and imposed a quarantine for Hendra virus from the morning of 8 July 2008.

Finally, the eighth horse, Barbie, had been admitted to the Redlands clinic on 23 June 2008 for treatment for a skin condition. Barbie had a temperature on 22 July 2008 but otherwise appeared normal. She became depressed and her condition deteriorated on 24 July 2008. A positive Hendra virus result was obtained on the evening of 23 July 2008 and Barbie was euthanased by QPIF officers the following day. A full post-mortem was completed by QPIF and AAHL pathologists.

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<sup>51</sup> That is, QPIF considers that this is the first horse to have been infected with the virus in this incident.

<sup>52</sup> There is some disagreement over whether Truly Gifted was in fact euthanased by the Redlands clinic on 26 or 28 June 2008. Official documents and media reports refer to different dates, although the clinic owner states that Truly Gifted was euthanased on 26 June 2008. I have not made an attempt to determine the exact date of Truly Gifted's death as I do not consider it to be significant for the purposes of my report.

<sup>53</sup> Recrudescence is discussed in section 8.2 of this report.

<sup>54</sup> The Redlands clinic owner has stated that test results did not come back until midday on 8 July 2008.

There were also two human infections of Hendra virus during the 2008 Redlands incident. A private veterinarian employed by the clinic, Dr Ben Cunneen, had been exposed to horses that later tested positive to Hendra virus. Dr Cunneen tested positive to Hendra virus on 15 July 2008 and spent several weeks in intensive care before passing away on 20 August 2008.

A private veterinary nurse also employed by the Redlands clinic had been exposed to horses that were subsequently found to have had Hendra virus. She tested positive to Hendra virus on 17 July 2008 and also spent several weeks in intensive care. She continues to experience ongoing ill-effects from her exposure to the virus.

### 3.3.4 Proserpine 2008

The 2008 Proserpine incident occurred at around the same time as the 2008 Redlands incident, although they are believed by QPIF to be unrelated. The 2008 Proserpine incident occurred on a private rural residential property.

The Proserpine property housed six horses, with four sharing one paddock and two in a neighbouring paddock. All infections occurred in the paddock occupied by the four horses. The closest flying fox colony was believed to be approximately six kilometres away, although flying foxes were observed to regularly fly over the property in the evenings.

The first horse, Dizzy, was found dead by the owners on 3 July 2008 after appearing healthy the day before. A private veterinarian attributed her death to misadventure or snake bite and she was buried on the property.

The second horse, Buddy, was noticed as unwell on 10 July 2008. The owner contacted a private veterinarian who was unable to visit the property until the next day. Buddy deteriorated and died the following morning. The private veterinarian performed a limited autopsy to collect samples and submitted these for Hendra virus exclusion testing. Buddy was then buried on the property in the same location as Dizzy.

A positive PCR result for Hendra virus was obtained from Buddy's samples on 14 July 2008 and the property was placed into quarantine by QPIF on 15 July 2008. Samples were taken from the remaining two horses in that paddock, as well as the two horses in the neighbouring paddock.

On 21 July 2008, the third horse, Dancer, was observed to be fevered and uncoordinated. It was decided that she should be euthanased by the owners, and a limited autopsy was performed by QPIF to collect samples for testing. Dancer was then buried in the same location as Dizzy and Buddy.

The final horse, Thomas, had returned negative PCR tests on 11 and 15 July 2008, but was observed to be depressed and high-stepping on 21 July 2008. He continued to show some signs of illness the next day, but then appeared to recover. Thomas was subsequently determined to be sero-positive to Hendra virus. He was destroyed<sup>55</sup> by QPIF on 4 September 2008 and a full autopsy was performed by AAHL and QPIF officers.

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<sup>55</sup> QPIF issued an order under the EDIA Act requiring Thomas's destruction.

The remaining two horses on the property did not test positive for Hendra virus at any time. No humans were infected with the virus, although the property owner, family members and the veterinarian underwent testing.

### **3.3.5 Cawarral 2009**

The first 2009 incident occurred at an equine nursery at Cawarral, just outside Rockhampton (Cawarral property).

On 27 July 2009, a private veterinarian, Dr Alistair Rodgers, was called to examine a horse named Steggles that was suspected of having suffered snakebite. During this examination, he performed an endoscopy on the horse. Steggles died the following day and was buried on the property. Hendra virus was not suspected at this time.

The second horse, Boots, a Shetland pony, died on 7 August 2009 after a short illness and was also buried on the property. A different veterinarian had examined the horse on 5 August 2009 and taken samples. Hendra virus was also not suspected as the cause of death.

A third horse, Princess, died suddenly on 8 August 2009 with clinical signs indicative of Hendra virus, and a private veterinarian notified QPIF. QPIF officers attended the property that afternoon and conducted a limited post-mortem before the horse was buried. Due to high suspicions of Hendra virus, the Cawarral property was placed into quarantine while samples were being tested.

Positive PCR results from samples taken from Princess were received on 10 August 2009, and samples from Boots subsequently also tested positive for Hendra virus. The Cawarral property was under quarantine until 12 October 2009. Horses on a number of other properties were also placed under quarantine or movement control at the time.

During the quarantine, one other horse, Winnie, initially tested PCR-positive and then recovered, testing sero-positive to Hendra virus. This horse was destroyed by QPIF on 24 August 2009 and an autopsy was conducted by AAHL.

Due to serious concerns about exposure to the Hendra-positive horses, QH provided post-exposure treatment to Dr Rodgers and the three workers from the property who were considered to be most at risk. Dr Rodgers became ill and was admitted to hospital. He was released from hospital after completing a course of treatment but was re-admitted showing signs of Hendra virus. Dr Rodgers was transferred to a Brisbane hospital for further treatment but passed away on 1 September 2009.

It was subsequently determined that the first horse that died, Steggles, must also have been a Hendra virus case, as this was the only horse to which Dr Rodgers had been exposed.

### **3.3.6 Bowen 2009**

The Bowen 2009 incident involved a small number of paddocked horses on a family property.

A horse was reported ill on 2 September 2009 and was treated for colic by a private veterinarian. The horse's condition deteriorated and it was euthanased by the private veterinarian the following day and buried on the property. Samples from the horse were forwarded for Hendra virus testing and positive PCR test results were detected on 8 September 2009. QPIF visited the property on 9 September 2009 and although the one horse remaining on the property did not show signs of Hendra virus, it was euthanased by the veterinarian at the owner's request.

Samples retained from a horse that had died on the property the previous month were tested and found to be positive for Hendra virus.

While some neighbouring properties with horses were placed into quarantine by QPIF, there were no horses left on the initial property and quarantine of this property was not required.

There were no human cases of infection in this incident.

## Chapter 4: Hendra virus in humans

This chapter discusses the nature of Hendra virus in humans.

### 4.1 Description of Hendra virus in humans

There have been seven recorded cases of Hendra virus in humans.<sup>56</sup> In all cases infection resulted from close contact with the bodily fluids of infected horses. Of the seven cases, five people are believed to have been exposed to the virus while performing autopsies, nasal lavages or endoscopies, while the other two had close contact with a dying horse. Hendra virus was not a confirmed or suspected diagnosis in any of these cases at the time of contact with the horse.

Of the seven recorded human infections, there have been four deaths. One of those deaths occurred 13 months after the initial infection. The remaining three persons did not survive their initial infections.

The first known human case of the virus occurred in the Brisbane suburb of Hendra in 1994, where two people were infected. A horse trainer died from the virus, while a stable worker survived an influenza-like illness that was later identified as Hendra virus.

The second death occurred in Mackay in 1995, when a male person developed severe encephalitis. It was later found that he had been exposed to Hendra virus during the autopsy of two horses 13 months earlier. At the time, the cause of death of the horses was unknown.<sup>57</sup> The male person had been hospitalised with aseptic meningitis shortly after the autopsies but his illness was not identified as Hendra virus at that time.

The next human case of Hendra virus occurred in North Queensland in 2004, where a private veterinarian performed an autopsy on a horse. She developed a mild influenza-like illness approximately seven days later, and recovered. This illness was subsequently diagnosed as Hendra virus, and the deceased horse was assumed to be a Hendra virus case.

The most recent human cases of Hendra virus infection occurred during the 2008 Redlands incident (two people) and the 2009 Cawarral incident (one person).

In the Redlands incident, a private veterinarian and a veterinary nurse employed at the same veterinary clinic developed acute influenza-like illnesses followed by encephalitis. They had both performed a nasal cavity lavage on a seemingly well horse in the days before it developed clinical signs of Hendra virus. The veterinarian, Dr Cunneen, had also performed an autopsy on another horse that was later found to have died of Hendra virus.<sup>58</sup> Dr Cunneen passed away five weeks later. The veterinary nurse survived the infection but continues to experience significant ill-effects.

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<sup>56</sup> There have been no confirmed reports of Hendra virus in humans arising from the 2011 Hendra virus incidents.

<sup>57</sup> The horse deaths in Mackay occurred before the Hendra incident in 1994, which was when Hendra virus was first identified.

<sup>58</sup> QH *Guidelines for Public Health Units, Hendra Virus Infection (formerly Equine Morbillivirus Infection)* [accessed at <http://www.health.qld.gov.au/cdcq/index/hendra.asp> on 1 April 2011].

The most recent human case of Hendra virus occurred during the 2009 Cawarral incident. Dr Rodgers passed away after contracting Hendra virus during an endoscopy on a sick horse that was later diagnosed with Hendra virus.

#### 4.1.1 Human-to-human transmission

The clinical notification criteria for Hendra virus in humans are listed in the QH document *Hendra Virus Infection - Queensland Health Guidelines for Public Health Units* (QH Guideline). Although not previously available to the public, the QH Guideline is now available on the QH website.<sup>59</sup>

The current QH Guideline states:

Acute illness following exposure to horses with suspected or confirmed Hendra virus infection.

Infection in humans has included:

- self-limiting influenza-like illness (two cases)
- influenza-like illness complicated by severe pneumonic illness contributing to death (one case)
- aseptic meningitis with apparent recovery, then death from encephalitis 13 months later (one case)
- acute influenza-like illness followed by encephalitis at seroconversion, followed by recovery (one case) and death (two cases).

However, the QH Guideline notes that the full spectrum of human clinical infection is unknown.

The incubation period for Hendra virus in humans is estimated as between five and 16 days, but could be up to 21 days.

The current QH Guideline states that there is no evidence of human-to-human transmission of Hendra virus, and notes that:

... Hendra virus does not appear to be very contagious. Serological testing in a large number of human contacts of the first three human cases was completely negative and serological testing of people who have close contact with bats has also failed to provide any evidence of infection.

All human infections have been acquired through close contact with the body fluid (especially respiratory secretions and blood) of Hendra virus infected horses. Direct contact with respiratory secretions or blood of infected animals seems to be necessary for transmission, although droplet transmission cannot be discounted. There has been no evidence of person-to-person or bat-to-person transmission.

Nevertheless, the QH Guideline advises that it is desirable to avoid close contact with body fluids/secretions of a symptomatic human case.<sup>60</sup> Consequently, the QH Guideline advises that standard, droplet and contact precautions should be taken against human-to-human transmission.<sup>61</sup>

<sup>59</sup> Refer <http://www.health.qld.gov.au/cdcg/index/hendra.asp>.

<sup>60</sup> QH *Guidelines for Public Health Units, Hendra Virus Infection (formerly Equine Morbillivirus Infection)* accessed at <http://www.health.qld.gov.au/cdcg/index/hendra.asp> on 1 April 2011].

<sup>61</sup> I note that such precautions are relatively standard for preventing the transmission of many diseases. A description of these precautions can be found at [http://www.health.qld.gov.au/chrp/ic\\_guidelines/sect2\\_elements.pdf](http://www.health.qld.gov.au/chrp/ic_guidelines/sect2_elements.pdf) [accessed on 15 June 2011].

Standard precautions involve hand-washing, protection from contact with the blood or body fluids of a person who is, or is suspected to be, infected (for example, by wearing gloves and masks), and routine environmental cleaning.

In addition to standard precautions, droplet precautions involve isolation, the routine use of surgical masks by staff, and the use of surgical masks by patients while they are in transit.

Where Hendra virus is confirmed or highly suspected in a person, the current QH Guideline also advises that the person avoid close contact with horses.

These precautions are only recommended where a person has had contact with a suspected or known Hendra-positive horse and shows signs of illnesses associated with Hendra virus. The QH Guideline does not recommend that any specific precautions be taken where a person has had contact with a suspected or known Hendra-positive horse but does not show any signs of illness.

## **4.2 Testing for Hendra virus in humans**

Human testing for Hendra virus is conducted by QHFSS. Further testing on human samples may also be conducted by AAHL.

### **4.2.1 Nature of tests**

QH has provided information to the general public about testing for Hendra virus in humans. I have commented on this further in chapter 13.

Generally, a combination of PCR and serological tests are used to test for Hendra virus in humans.

As discussed in section 3.2.1, PCR tests aim to identify the presence of virus matter. These tests are used where a person who has been exposed or potentially exposed to Hendra virus is unwell. A positive PCR test is considered by QH to be a conclusive indicator that a person has been infected with Hendra virus.

QHFSS also uses techniques to isolate the virus in human samples; however, because this process can take some weeks it is of limited use.

As with horses, serological testing examines a person's antibody response to Hendra virus. The Indirect ELISA test used for horses is not species specific and can also be used for human testing. However, this test is known for producing relatively high numbers of false positives and is therefore no longer used by QHFSS for human testing. Instead, human-specific serology tests are used to detect antibodies to Hendra virus in human samples (microsphere immunoassay, confirmed by specific immunofluorescent assay).

Where a positive serological result is obtained, this is considered to be a conclusive indicator of infection. Supplementary testing including a VNT test may be conducted by AAHL, as QHFSS does not conduct VNT testing. The test involves introducing the virus into the human blood sample and the amount of virus remaining after incubation shows whether antibodies are present. Alternatively, if an unknown virus is detected in the blood sample, the virus can be incubated in the presence of virus specific antibodies to determine the nature of the particular virus.

The current QH case definition for Hendra virus requires only one of the following for a diagnosis of Hendra virus to be confirmed in a human:

- isolation of the virus
- a positive PCR test
- detection of antibodies to Hendra virus by microsphere immunoassay, confirmed by specific immunofluorescent assay.

#### 4.2.2 When testing is carried out

Initial tests<sup>62</sup> on persons who have been exposed to an infected or potentially infected horse are generally carried out soon after a Hendra virus incident is identified, and usually involve only serological testing to detect antibodies to the virus. When conducted in the first few days after possible infection, serology test results are expected to be negative. The results of an initial serology test may be useful to aid interpretation of later serological tests, but are not essential.

Further serology tests will generally be carried out three and six weeks after exposure. However, not all people will require this course of testing, and QH will have regard to the timing of the first and second rounds of tests or any subsequent re-exposure by a person to an infected or potentially infected horse.

A person would only be expected to be positive to a PCR test during the initial stages of acute infection. For this reason, PCR testing is usually only conducted on people who are showing clinical signs of Hendra virus, as in the absence of clinical signs a person would be expected to be negative to this test. People who have contracted Hendra virus have all become unwell.

VNT or isolation testing is not considered necessary for a confirmed result in a human case, and is not carried out by QHFSS. Such additional testing may be carried out by AAHL if requested.

Neither a single negative serology test nor a single negative PCR test conducted early during the possible incubation period is conclusive evidence of a lack of Hendra virus infection. On the other hand, a single positive PCR test or a single positive serology test (microsphere immunoassay, confirmed by specific immunofluorescent assay) will be sufficient evidence of infection.

Because the incubation period for Hendra virus in humans could be as high as 21 days, testing may be done at both 21 days (three weeks) and approximately 42 days (six weeks) after exposure (two incubation periods).

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<sup>62</sup> Often referred to as 'baseline tests'.

Finally, it is important to note that this information refers to approximate testing timeframes which are subject to change as QH gathers further information about Hendra virus. The timeframes are only guidelines and may vary depending on an individual's circumstances and level of risk.

#### 4.2.3 Testing procedure

There is no QH policy specifically relating to testing, and the only procedures for testing are set out in the QH Guideline. The current QH Guideline states:

Human testing should be on the basis of exposure to known or suspected equine cases, or for a compatible human illness in consultation with an infectious diseases physician. Testing is not routinely recommended for those with nil or negligible exposures.

...

There have been no positive nucleic acid tests or seroconversions demonstrated in any asymptomatic human contacts followed up as part of any outbreak investigations to date.

This last paragraph explains that no person has tested positive to a PCR or serological test without showing clinical signs of Hendra virus.

The current QH Guideline also states:

Commence investigation immediately on notification of a confirmed human or equine case, or where notified by Biosecurity Queensland of heightened suspicion of infection in a horse on clinical/ epidemiological grounds.

Attempt to verify case(s) and establish time-line for results of laboratory testing if results are still pending.

...

The urgent priorities are to obtain a spreadsheet of all people who may have been in contact with the infectious horse/s (it is best to refer to horses by their common name/s to minimise confusion), then to:

- conduct assessment of exposure and current health status of those people
- provide information about Hendra virus
- counsel about risk
- provide advice about health monitoring
- refer any symptomatic people to appropriate care and
- facilitate recommended testing as indicated by level of risk.

There is no suggestion that people who have been in contact with the horse will be tested while awaiting the results of the tests on the horse.

The current QH Guideline also provides that testing is not routinely recommended for those with nil or negligible exposures, but may have to be undertaken in such situations so as to manage extreme anxiety. Furthermore:

For those with low exposures, the decision to test should be based on an understanding of what testing is (eg baseline screening is not proof of 'clearance') and that there have been no previous examples of asymptomatic seroconversion.<sup>63</sup> Testing does not take the place of self-monitoring for symptoms and appropriate investigation of illness.

I understand that QH's current position is that testing will be arranged for anyone exposed to a Hendra virus infected horse who wishes to be tested, whatever their level of exposure.

#### 4.2.4 Testing fees

Human testing for Hendra virus is only available where requested by a medical practitioner. QH does not charge a fee for human testing for Hendra virus where requested by a medical practitioner. Prioritisation of testing (that is, whether routine or urgent) occurs, informed by the QH Guideline.

#### 4.2.5 Treatment for Hendra virus

Three treatments have been trialled with people exposed to Hendra virus; however, because none has been registered for the purpose of preventing Hendra virus infection, they are considered experimental. Treatment is only offered to those who have had significant exposure to a horse known to have Hendra virus. The treatments are ribavirin, chloroquine and monoclonal antibodies.

##### Ribavirin

Ribavirin is an antiviral drug commonly used to treat hepatitis C. A test-tube laboratory study published in 2005 provided limited evidence suggesting that ribavirin may have some effectiveness in preventing Hendra virus,<sup>64</sup> and a preliminary clinical study in 2001 had previously suggested some effectiveness against the related Nipah virus.<sup>65</sup> However, by late 2009 results from a further study suggested that ribavirin may not be effective to treat Hendra virus in animals.<sup>66</sup>

##### Chloroquine

Chloroquine is a well-known anti-malarial drug. A single test-tube laboratory study in 2009 suggested that it may be effective against Nipah virus,<sup>67</sup> however, a study later that year questioned its effectiveness in responding to the related Nipah virus in ferrets.<sup>68</sup>

<sup>63</sup> Asymptomatic seroconversion refers to situations where a person's immune system creates antibodies in response to an infection without the person showing clinical signs. This has not been recorded in relation to Hendra virus.

<sup>64</sup> Wright, P.J. et al. *Archives of Virology* 2005 Mar;150(3):521–32. 'RNA synthesis during infection by Hendra virus: an examination by quantitative real-time PCR of RNA accumulation, the effect of ribavirin and the attenuation of transcription'.

<sup>65</sup> Chong, H.T. et al. *Annals of Neurology* 2001 Jun;49(6):810–3. 'Treatment of acute Nipah encephalitis with ribavirin'.

<sup>66</sup> While this study had not yet been published, QH was aware of the results of the study.

<sup>67</sup> Porotto, M. et al. *Journal of Virology* 2009; 83:5148–5155. 'Simulating henipavirus multicycle replication in a screening assay leads to identification of a promising candidate for therapy'.

<sup>68</sup> Pallister, J. et al. *Journal of Virology*, November 2009;83(22):11979–11982. 'Chloroquine Administration Does Not Prevent Nipah Virus Infection and Disease in Ferrets'.

## Monoclonal antibodies

One specific monoclonal antibody has been shown to protect ferrets from serious disease after exposure to Nipah virus.<sup>69</sup> This treatment has not been the subject of experimental trials on humans and is not registered in Australia. However, it may be used in exceptional circumstances following appropriate consideration of the potential risks and benefits and ethics committee approval.

Since at least 2008, some of these treatments have been offered, in varying combinations, to those who had developed Hendra virus or were at high risk of doing so. It is not known whether the treatments were effective in preventing or minimising infection.

Following analysis of all studies to date, ribavirin and chloroquine are no longer recommended by QH for treatment of persons at risk of developing Hendra virus infection.

Presently, there is no human vaccine available for Hendra virus.

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<sup>69</sup> Bossart, K. et al. *PLoS Pathogens* October 2009;5(10):1–11. 'A Neutralizing Human Monoclonal Antibody Protects against Lethal Disease in a New Ferret Model of Acute Nipah Virus Infection'.

## Chapter 5: Testing for Hendra virus in horses

This chapter considers the adequacy of QPIF processes and procedures for testing for Hendra virus in horses.

### 5.1 Access to testing

QPIF officers informed my officers that Hendra virus testing is available to all private veterinarians on request and free of charge where the purpose of testing is for disease investigation, rather than for health or export checks.

#### 5.1.1 Issues with access to testing

My officers were told by private veterinarians that between 1994 and 2006, it was difficult to obtain testing for Hendra virus. They were also told that the situation had recently improved.

One private veterinarian told my officers that QPIF's practice of declining to conduct requested tests had changed since the 2008 Redlands incident. Another private veterinarian stated:

And the PCR that they're testing now, the turn-around time is great. The reception is good at the [QPIF]. The response and the support you get is good. Now. Not before.

However, another private veterinarian who spoke to my officers reported they were still experiencing difficulties in this regard, and particularly with QPIF officers challenging the need for testing and discouraging or denying access to it. The private veterinarian also commented that the QPIF response to their inquiries varied depending on the officer to whom they spoke.

I understand that calls to the QPIF Business Centre can be directed to any one of 17 field veterinarians and five policy veterinarians, although some attempt is made to allocate calls to the local QPIF veterinarian.

My officers asked senior QPIF officers whether they thought private veterinarians would receive consistent responses to questions about testing regardless of the QPIF veterinarian they spoke to. One officer advised that there should be little disparity in the advice provided by different QPIF veterinarians.

At my request, QPIF conducted a review of samples submitted for Hendra virus testing between 2006 and 2010. QPIF was unable to identify any examples of testing being refused on submissions received by BSL (with the exception of one sample from a dog).<sup>70</sup>

QPIF's review did not consider any situations where private veterinarians contacted QPIF veterinarians to ask about Hendra virus testing and were dissuaded from submitting a sample.

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<sup>70</sup> This sample was initially rejected by QPIF for Hendra virus testing on the basis that dogs had not been infected experimentally, but Hendra virus testing was conducted several days later when a second dog from the same property died. Tests from both dogs were negative for Hendra virus.

The allegation that QPIF veterinarians have challenged diagnoses by private veterinarians is of concern.

Evidence was obtained during this investigation that it would be difficult for QPIF veterinarians to decide whether a horse's clinical signs were consistent with Hendra virus based purely on a verbal description.

I note that Hendra virus was not the primary diagnosis for most of the horses that died from it, and QPIF officers told my officers they were surprised when test results on the horses from Peachester, Proserpine and Redlands were positive for Hendra virus.

Further, several senior QPIF officers also told my officers that it was not usually possible to accurately identify a Hendra-positive horse from a list of clinical signs, because the clinical signs are so non-specific.

My officers asked Dr Deborah Middleton, a Veterinary Pathologist from AAHL, whether it is possible to tell from clinical signs alone whether a horse has Hendra virus, to which she replied:

No, I don't think it is and I think that's one of the problems ... The signs are very non-specific ... some of these animals have been suspected of having colic, you know just tummy upsets or snake bites or a whole range of other things, because they just look like horses that are a little bit flat you know, a little bit down, off their food, high temperature.

Dr Middleton also told my officers that the practice of having private veterinarians telephone QPIF veterinarians for approval for testing was wrong. In her view, exclusion tests for Hendra virus should be conducted for all horses along the eastern seaboard of Queensland which show clinical signs of an unknown illness.

Dr Perkins also expressed the view in his 2008 Perkins Report that:

It is important that Hendra virus testing be completed on all cases where it is deemed appropriate based on the initial investigation by a PVP.<sup>71</sup>

In view of the expert opinions in favour of testing being conducted on the recommendation of the treating private veterinarian, and the importance of that decision, I am of the view that this approach should be followed.

If QPIF remains concerned about private veterinarians seeking Hendra virus testing unnecessarily, it should take additional steps to ensure that private veterinarians are well informed about the limitations of tests and when it is appropriate to conduct them.

In my proposed report, I therefore formed the following opinion and made the following recommendations:

**Proposed opinion 1**

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

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<sup>71</sup> Private veterinary practitioner.

### Proposed recommendation 1

QPIF continue to provide advice and information to private veterinarians about Hendra virus, including in what situations testing is appropriate, and not discourage testing.

### Proposed 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.

### DEEDI's response

The Director-General submitted that requests for Hendra virus testing had never been discouraged. He stated that QPIF encouraged veterinarians to submit samples for testing where Hendra virus was suspected. The Director-General also submitted that laboratory records of calls and testing requests provide no evidence that any requests for Hendra virus testing made to the QPIF laboratory have been declined.

The Director-General further submitted that:

The purpose of the standard practice of private veterinarians telephoning a DEEDI veterinarian when Hendra virus is suspected is to assist the private veterinarian in assessing and managing the case, not to obtain approval to test for Hendra virus.

The urgency of testing is a factor that is likely to be discussed with a submitting veterinarian, depending on the clinical signs of the suspect horse and the potential risk as a result of human exposure. If there is any concern about human exposure, testing will be done on an urgent basis, including after hours.

The duty pathologist will also discuss with the submitting veterinarian which other diagnostic tests should be performed to elucidate a diagnosis. This decision is based on the animal's observed clinical signs and it is not surprising that, at times, there may be differing professional assessments.

As Hendra virus cases do not tend to present in a uniform manner, DEEDI considers that the expertise and judgement of the duty pathologist will play an important role in determining which tests are performed and the urgency in which they are undertaken. There have been occasions when the private veterinarian has disagreed with the duty pathologist's assessment of the urgency of a test, and this may have been interpreted as discouraging Hendra testing. However, to date, no samples that were not treated as urgent have tested positive for Hendra virus, indicating that DEEDI's current approach is sound.

Section 5.1.1 and proposed opinion 1 incorrectly imply that private veterinarians must seek approval for Hendra virus testing from Biosecurity Queensland officers and that DEEDI will not test for Hendra virus if requested. On the basis of the information provided above, it is requested that **opinion 1 be amended** to state:

*"Biosecurity Queensland's existing practice of conducting Hendra virus testing on the recommendation of the treating veterinarian in consultation with Biosecurity Queensland experts is reasonable."*

Further it is requested that the phrase –and not discourage testing” is removed from the end of recommendation 1 as it implies DEEDI currently discourages testing, which is not true. Accordingly, we submit that **recommendation 1 be amended** to read:

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

### **Ombudsman’s analysis**

In contrast to the information contained in QPIF’s response, a number of private veterinarians told my officers that they had experienced difficulty in arranging for Hendra virus testing due to QPIF officers in the past discouraging or denying access to the test. As I have stated earlier in the report, private veterinarians particularly commented on receiving differing advice depending on which QPIF veterinary officer they spoke to. QPIF officers agreed that this could very likely occur. Whether this is the current approach of QPIF officers is a different issue.

An absence of laboratory records identifying instances of samples not being tested for Hendra virus despite requests for such testing from private veterinarians does not surprise me as the issue raised by the private veterinarians relates to QPIF officers discouraging or denying access to the test before any samples were sent for testing.

The number of comments raised with my officers and the sources of those comments (some of which came from QPIF officers) in my view warrant the inclusion of the following opinion in my report.

However, I have taken the Director-General’s submissions into consideration in relation to my proposed recommendation 1, and the fact that some time has passed since interviews were conducted during my investigation. I have amended this recommendation slightly.

I confirm proposed opinion 1 as a final opinion:

#### **Opinion 1**

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

I confirm proposed recommendation 1 with an amendment as a final recommendation:

#### **Recommendation 1**

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

I confirm proposed recommendation 2 as a final recommendation:

#### **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.

### 5.1.2 Serology tests

The availability of serology testing in the absence of an identified Hendra virus incident is more complex.

One private veterinarian complained that while QPIF will conduct a PCR test on request, it will not do a further ELISA test even where the veterinarian believes one is warranted. This veterinarian considered that private veterinarians should decide whether serology testing should be conducted in the circumstances.

Another private veterinarian questioned QPIF's reporting of the Hendra virus status of horses which had been tested on a PCR test without serology testing being conducted.

Where samples are obtained from a sick horse for PCR testing, QPIF conducts the tests and may report that the horse is negative for the virus. However, during Hendra virus incidents, a horse is only determined to be negative for Hendra virus where it has had PCR tests plus at least two serology tests (including a VNT test) 21 days apart. The veterinarian therefore questioned whether QPIF could confidently tell horse owners that their horse had not been sick with Hendra virus unless such a variety of tests are conducted over a similar period of time in all suspect circumstances.

However, a senior QPIF officer told my officers that serology testing is not generally conducted because:

- at the time the horse is sick, it is unlikely to show any positive results on a serology test even if it does have Hendra virus
- if the horse recovers, it is likely that further samples would need to be collected one to two weeks later to conduct serology testing
- conducting serology testing in such situations would fail a cost benefit analysis and risk assessment
- such testing would generally only be conducted if QPIF strongly suspected that the horse had Hendra virus.

Where a horse exhibits clinical signs that may be indicative of Hendra virus but is not tested for the virus at the time, QPIF officers informed my officers that it has a policy of considering later testing for such horses on request, having regard to:

- the nature and severity of the clinical signs
- the time since the clinical signs were exhibited
- other circumstances that give rise to a suspicion of Hendra virus, such as the presence of flying foxes.

This is more consistent with the approach taken in the 2008 Redlands incident, where QPIF conducted serological testing on a horse that had recovered from a brief illness and subsequently identified this horse as being sero-positive.

I also understand that there would be no point conducting serology tests on a horse until approximately seven days after it had recovered from an illness, as until this time it may not have developed antibodies to Hendra virus. QPIF officers expressed the view to my officers that serology testing would rarely be needed in conjunction with PCR testing, as in most cases a private veterinarian would test for Hendra virus

at the time the horse was ill and therefore serology tests would be expected to be negative.

Further, a QPIF officer informed my officers that while there have been some false positive results on ELISA tests conducted on horses that had been ill but had recovered, subsequent VNT tests were not positive. Therefore, no horse has been found to have seroconverted with Hendra virus outside of a known Hendra virus incident.

Some QPIF officers also noted that there had been no positive serology (or PCR) results found on export or health tests for Hendra virus. However, I note that such requests for tests would not be likely to constitute a representative sample of horses across Queensland.

In the circumstances, 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. BSL officers told my officers that such further serology testing would still 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, if appropriate samples were submitted.

However, other QPIF officers told my officers that if extensive serology testing is conducted, it is statistically likely that some sero-positive horses would eventually be identified within the Queensland horse population.

This same reasoning was advanced by some senior QPIF officers as a reason not to conduct extensive serology testing, as QPIF did not have policies or procedures to cope with situations where a sero-positive horse was identified outside of a Hendra virus incident. Under current QPIF policy, such a horse would have to be destroyed even though the infection may have been some years ago and the horse may otherwise be healthy.

In my view, such arguments do not address the issue of the possibility of sero-positive horses existing within the broader horse population in Queensland and QPIF's capacity to respond to such scenarios. In my opinion, there is some scope for QPIF to conduct serology sampling of a cross-section of the Queensland horse population to determine whether in fact there are undiscovered sero-positive horses, in light of the view held by QPIF and QH that there is a serious health risk posed by such horses, justifying the immediate destruction of the horse. I have also identified a need for QPIF to consider the likelihood of such a scenario and develop any necessary policies to respond to this situation.

Finally, I note that if QPIF refuses to conduct serology testing but a private veterinarian remains of the view that such testing should be conducted, it is open to the veterinarian to submit the sample for Hendra virus testing as a health test, which attracts a small charge. While such testing would not be done urgently, it is arguable that there is no need for urgent testing of a potentially sero-positive horse as long as the horse is managed effectively.

It would not be appropriate for QPIF to charge the health testing fee if the test result was positive, consistent with the QPIF policy on fees for Hendra virus testing.

In my proposed report, I therefore formed the following opinions and made the following recommendations:

**Proposed opinion 2**

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

**Proposed opinion 3**

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

**Proposed recommendation 3**

QPIF consider 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.

**Proposed 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.

**Proposed recommendation 5**

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

**DEEDI's response**

The Director-General made the following submissions:

DEEDI already has considerable information about the prevalence of Hendra virus in the wider horse population. This information is gathered by submission of samples obtained in the following ways:

- to test horses that are already suspect' by other means, and
- through general exclusion' testing of samples submitted for unrelated health checks.

Since the beginning of 2008, DEEDI has processed 2474 samples. DEEDI is confident that this sampling approach yields the best possible indication of the prevalence of Hendra virus in the wider population because:

- 1815 of the submissions were from horses that exhibited clinical signs that warranted testing – the targeting of suspect horses greatly increases the sensitivity of the surveillance data, and
- the 659 exclusion' samples provides a picture of what is happening in a broader cross-section of the horse community.

The proposed report recommends that Biosecurity Queensland undertake testing for Hendra virus in the healthy horse population, to obtain an insight into the prevalence of the virus. It is strongly argued that such testing already occurs through the exclusion testing' on healthy horses that are being Hendra virus tested for reasons including pre-surgery, breeding, sale and export.

It is further argued that testing the broader healthy horse population would be an inefficient addition to what currently occurs. A large scale survey conducted in 1995

of 2000 horses from 160 properties found no evidence of unidentified infections. Given the continual screening through exclusion testing as outlined, it is questionable what additional information a repeat of such a survey would provide, particularly given the expense of such a survey.

It is submitted that it is more cost effective to screen a positively biased subset of the general population (i.e. horses showing signs consistent with infection). Given that it would be more likely to find Hendra virus in this group, if it is not found, there is a higher level of statistical confidence that cases are not being missed.

DEEDI also contends that there are higher priorities when it comes to Hendra virus research; priorities that are set according to an expert peer-reviewed process. The conduct of a general survey is not an identified priority at this time.

In summary, there would be no additional benefit in conducting a survey for Hendra virus prevalence in the broader horse population (as proposed in opinion 3). As indicated, DEEDI has a good understanding of the prevalence of Hendra virus based on current testing and data collection. DEEDI's targeted surveillance approach provides the most cost-effective way of detecting new cases, and informing risk management of the disease.

On the basis of the expert information provided above, it is submitted that **proposed opinion 3 and proposed recommendation 3 be withdrawn.**

### **Ombudsman's analysis**

The Director-General's submission only sought the withdrawal of my proposed opinion 3 and proposed recommendation 3.

I remain of the view that knowing the prevalence of Hendra virus in the wider horse population in Queensland would be beneficial to QPIF.

While it is inevitable that only limited resources will be available for research projects, I am concerned that the current testing program based on suspect horses and samples submitted for unrelated health testing does not provide a representative sample of the wider Queensland horse population. I note that the last large scale survey was over 15 years ago and that a number of Hendra virus incidents have occurred across Queensland since that time. A new large scale random survey of horses across Queensland may lead to an increase in scientific knowledge. However, I accept that an independent, expert peer-reviewed process is the best mechanism for determining the most suitable use of limited research funding.

I have therefore amended my proposed recommendation 3 slightly.

I confirm proposed opinions 2 and 3 as final opinions:

#### **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.

I confirm proposed recommendation 3 with an amendment as a final recommendation:

**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.

I confirm proposed recommendations 4 and 5 as final recommendations:

**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.

**5.1.3 Urgency of testing**

A related issue is the urgency with which Hendra virus testing is conducted by QPIF. QPIF advised my officers that Hendra virus testing, while generally provided within laboratory business hours, is available after hours where the duty pathologist, in consultation with a QPIF officer, believes urgent testing is warranted.

My officers were informed that there are no procedures to provide guidance to BSL officers when determining a level of urgency, and that duty pathologists rely on their expertise and experience, and err on the side of caution. The pathologists often also consult with the laboratory manager or QPIF veterinarians.

Generally, urgent testing is made available in situations where there is a significant risk to human health, where a large number of horses are potentially exposed, or where there are other situational factors that warrant expediting testing. In such cases, Hendra virus testing will be provided after hours or on weekends.

In all other situations, BSL advises veterinarians that Hendra virus testing will be conducted during normal business hours.

Some private veterinarians expressed dissatisfaction to my officers about the potential delay in conducting Hendra virus testing where tests are sent to QPIF in the late afternoon or on weekends.

I note that BSL is not open 24 hours a day. Further, in most cases testing for Hendra virus will not be considered urgent if a horse can be isolated until results come through and there has been no significant human contact with the horse during its illness. Private veterinarians should of course have adequate protective equipment to care for a horse until test results are available.

The information provided to me indicates that QPIF considers the urgency of testing in each case on its merits. I am satisfied that such an approach is reasonable.

However, it may assist QPIF to provide more information to private veterinarians about testing procedures, including the criteria used to determine if testing is urgent, so that private veterinarians can better understand this process.

I confirm proposed opinion 4 as a final opinion:

**Opinion 4**

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

I confirm proposed recommendation 6 as a final recommendation:

**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.

## 5.2 Accuracy of testing

Concerns were raised with my officers about the accuracy and reliability of Hendra virus tests, particularly the PCR test. These concerns mostly related to the lack of available data on accuracy and reliability to enable private veterinarians to conduct a risk assessment based on the test results and make informed decisions on the best course of action.

One private veterinarian argued that such information should be provided by QPIF in the same way that information on other tests is available on request from commercial laboratories.

QPIF officers advised my officers that the difficulty with validating tests and calculating false positive and false negative rates was due in part to the small sample size, as Hendra virus is relatively rare. Nevertheless, QPIF officers were confident in the current PCR tests.

During my investigation, I requested from QPIF the false negative and false positive rates and other confirmatory data for PCR and serological (ELISA and VNT) tests, including any differences between this data for tests run by BSL, QHFSS and AAHL. QPIF advised that while the ELISA test is known to have high specificity (low chance of a false positive) and sensitivity (96.5% and 94% respectively):

... definitive specificity and sensitivity data for the PCR test is yet to be compiled due to the limited number of known negative and positive samples tested. This is in part due to the PC4 requirements for working with known HeV positive samples. However all samples that have tested HeV positive at BSL have had that result confirmed by testing at QHFSS and AAHL indicating that the specificity ... of the HeV-PCR assay is high.

Given that Hendra virus is relatively rare, it is understandable that the development of testing tools will take time. It is reasonable for QPIF to use the available tests even without extensive data on false positive and false negative rates.

As data is accumulated, QPIF should consider making it available to private veterinarians.

### 5.3 Confirmation testing

A number of private veterinarians and other individuals specifically questioned the adequacy of QPIF testing, alleging that PCR tests conducted by AAHL were more reliable and that QPIF should be seeking confirmation from AAHL more frequently. Some people also claimed that it was negligent of QPIF not to seek to have results of PCR tests confirmed by AAHL.

QPIF was unable to provide my officers with any policy or procedure that described when confirmation testing would be sought. However, QPIF officers confirmed to my officers that the majority of Hendra virus testing is now done by its own laboratory, BSL. Negative test results are generally not sent to AAHL or any other laboratory for confirmation.

In a written response to my Office, the BSL Manager advised:

The Australian Animal Health Laboratory (AAHL) is the national reference laboratory for HeV testing. Accordingly, if tests indicate that a horse has a current (positive HeV-PCR reaction) or previous exposure (positive ELISA reaction) to HeV-infection, samples from that horse have to be sent to AAHL for confirmatory testing.

Confirmatory PCR testing may also be sought from QHFSS, particularly where human exposure has occurred.

A particular submission made to my officers by a number of horse owners and private veterinarians was that Hendra virus PCR tests conducted by AAHL are superior to tests run at BSL or at QHFSS.

Although in the past the different laboratories used different genetic primers to conduct the test, my understanding is that each laboratory now uses very similar tests. In addition to the tests conducted by BSL and QHFSS, AAHL conducts a broader range of tests using different genetic primers or aliquots. The samples which have tested positive to PCR tests at AAHL have also consistently been identified using the genetic primers used by BSL and QHFSS.

A specific allegation was made to my officers by several people that in previous Hendra virus incidents, certain tests run at BSL or QHFSS wrongly showed negative results while tests conducted on the same samples by AAHL were positive for Hendra virus. These allegations appeared to relate to either the 2006 or the 2007 Peachester incident.

In the 2006 Peachester incident, testing was not conducted at QHFSS or BSL but samples forwarded straight to AAHL. Therefore, there were no discrepancies between laboratories because the samples were tested only by AAHL. In this instance, the initial AAHL PCR test produced an indeterminate result for Hendra virus and initial serology tests were negative. However, when a virus isolation test was performed on these samples over several days, AAHL obtained a positive result for Hendra virus.

Therefore, I do not consider that the allegations are made out in this instance.

In the 2007 Peachester incident, PCR testing by QHFSS produced a positive result but PCR testing by AAHL initially showed negative results. After discussion between the laboratories, it was determined that the QHFSS PCR test was the more sensitive and the AAHL test had failed to detect the slightly different strain of virus. The reason for this failure was because AAHL was using a test based on the original 1994 strain of Hendra virus, whereas QHFSS was using a broader test that could detect other strains. AAHL then re-ran the PCR test using the genetic primers used by QHFSS and concluded that the sample was indeed positive for Hendra virus. I note in this instance that the horse did not test positive to a VNT test.

Therefore, the allegation that the tests conducted by AAHL were more accurate in this incident is not supported by the evidence.

I have also been told that QPIF is currently undertaking some research on strain diversity for Hendra virus, as a result of the discrepancies in PCR test results in the 2007 Peachester incident.

To further resolve this confusion, I requested from BSL and QHFSS a list of all Hendra virus tests since 2006 where the laboratory had obtained different results to those obtained by AAHL.<sup>72</sup> I did not identify any areas of concern in these test results. While there were slight discrepancies in results obtained by different laboratories in relation to some samples, these discrepancies related to the results of individual samples and not to the overall Hendra virus status of the horse. In summary, the laboratories in each instance agreed on whether the horse had Hendra virus or not, but in a few cases Hendra virus was identified in slightly different samples by different laboratories.

Overall, I am satisfied on the information provided to me that there have not been any instances where AAHL has reported positive results on PCR tests when negative PCR test results were obtained at BSL or at QHFSS.

However, I note that such an event is unlikely to occur because confirmatory testing is only sought from AAHL once BSL or QHFSS has obtained a positive result.

I was also told that confirmation testing may in fact not be required. A QHFSS officer told my officers that there is no scientific need to conduct confirmatory testing on PCR tests, because, being an RNA-based<sup>73</sup> test, it is very specific.

In relation to the argument that all negative tests from QPIF and QHFSS should be retested by AAHL, the Associate Director-General of DEEDI told one stakeholder by letter dated 7 December 2009:

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<sup>72</sup> As discussed in chapter 3, testing for Hendra virus was conducted at QHFSS until approximately June 2009, and from this time testing has been conducted at BSL.

<sup>73</sup> Ribonucleic acid.

I am advised that it is not realistic, practical or technically justifiable to perform expensive follow up virus isolation at AAHL on all of the 200 plus cases per year (averaged to date) submitted for testing. I understand this has a limited value in managing individual cases as, by the time a positive result is returned, the case would be resolved one way or another.

In the circumstances, given that all laboratories now use essentially the same PCR tests and the tests used by QPIF have been shown to be among the more sensitive, this approach appears to be a reasonable one.

I confirm proposed opinion 5 as a final opinion:

#### **Opinion 5**

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

### **5.4 The 2007 Peachester incident**

A specific complaint was received by my Office about Hendra virus testing in relation to the 2007 Peachester incident, which affected one horse in a paddock on a property in Peachester. I have discussed the background to this incident in chapter 3.

The horse involved, Titch, was euthanased by a private veterinarian on 6 June 2007 and samples were submitted for Hendra virus testing. After a weak positive PCR result was obtained by QHFSS on 8 June 2007, the property was placed into quarantine subject to further testing at AAHL.

Samples were sent to AAHL, which conducted further PCR tests as well as a virus isolation test. The PCR test showed a negative result on 9 June 2007, and a final report issued by AAHL on 26 June 2007 reported that the virus isolation test was also negative.

As a result of this discrepancy in testing, Titch's owner submitted to my Office that the horse did not have Hendra virus.

My officers were informed by a QPIF officer that the discrepancy in PCR results between laboratories was due to QHFSS and AAHL using different genetic primers that targeted different areas of the virus genome on their respective PCR tests. The genetic primers used by AAHL in this testing were those from the original 1994 Hendra virus incident, while QHFSS was using slightly different genetic primers. As the genetic structure of the virus had changed slightly since 1994, the genetic primers used by AAHL were unable to detect a positive result for the virus.

This was discovered during the conversations between the laboratories in July 2007 and resulted in AAHL repeating the PCR test in late July 2007 using the genetic primers that had been used by QHFSS. AAHL then issued a revised final report on 2 August 2007 which concluded that a single PCR test conducted on 31 July 2007 was positive for Hendra virus but that repeat virus isolation tests conducted on 11 July 2007 were negative.

My understanding is that BSL, QHFSS and AAHL now use the same genetic primers for the PCR Taqman test, but that AAHL also conducts other gel-based PCR tests using a range of different primers to sequence the strain of the virus.

Further submissions were received by my officers to the effect that QPIF documents suggest that a PCR test result is indicative only, and therefore should not be relied on, while other QPIF documents and the QPIF website state that a positive virus isolation or VNT result is required to be determinative of Hendra virus status. The lack of such a positive test on Titch was used to question whether this horse in fact died of Hendra virus.

My officers spoke to QPIF laboratory officers about this issue and were told that the test results were just one of a number of factors used to determine whether a horse is positive for Hendra virus. They also indicated that while a positive PCR result would be highly suggestive of Hendra virus, a negative virus isolation result would not discount that diagnosis as there may be insufficient virus in the particular sample.

My officers were told that at least three horses in other Hendra virus incidents were determined to have had the virus in the absence of a positive virus isolation test. These horses were Tamworth, Thomas and Winnie: the three sero-positive horses that were destroyed by QPIF.

In relation to the 2007 Peachester incident, my officers were informed that as Titch had succumbed to his illness he would not have had sufficient time to develop antibodies to Hendra virus and therefore a VNT test would not have assisted in the diagnosis.

The lack of a positive virus-isolation result was raised with my officers by Titch's owner, who said that, in her view, her horse's clinical signs did not fit within the case definition for Hendra virus.

I acknowledge that there were some key differences between Titch's clinical signs that were reported to me and the case definition in the Guidelines for Veterinarians. I note also that my officers were repeatedly told by QPIF officers that there is no one consistent presentation of Hendra virus.

In any event, the determination of whether a particular horse died of Hendra virus is a matter best decided by scientists and pathologists.

Titch has now been buried for a number of years and there are no tests that can be run to determine his Hendra virus status. No samples have been retained and exhumation of his body would not yield any useful results.

Although the test results and clinical signs in this case were initially different, I am unable to reach the view that QPIF's diagnosis of this horse as a Hendra virus case, which was supported by positive PCR test results reported by an independent laboratory (AAHL), was unreasonable or wrong.

I confirm proposed opinion 6 as a final opinion:

**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.

## 5.5 Other issues

During my investigation, a number of other issues relating to testing matters were raised with my officers. These issues included:

- whether sufficient information is sought on sample submission forms. It was suggested that QPIF should require the identification of the type of sample being submitted (for example, serum or EDTA<sup>74</sup>) to promote good testing outcomes
- whether the sample submission forms should also identify:
  - the specific location that the sample is from, rather than using outdated property codes
  - the specific veterinarian (or QPIF officer) who submitted the sample, rather than referring to a group of veterinarians (such as a clinic or QPIF as a whole)
- whether BSL should have a system to identify the above details to enable accurate and easy searching and reporting of results
- whether QPIF should provide more information to veterinarians about:
  - which type of blood samples (serum or EDTA) are preferred by which laboratory
  - whether submitting a non-preferred blood sample to a laboratory may produce a less accurate result
- whether non-preferred samples sent to one laboratory should be forwarded to another laboratory that prefers those samples to maximise testing accuracy
- whether Hendra virus status can be identified through a single nose swab
- whether QPIF should assist in the development of a rapid, stall-side test for Hendra virus
- whether QPIF should provide an information sheet when test results are made available to veterinarians or horse owners, explaining test accuracy data, the meaning of negative or indeterminate results, and information on any further tests that are required
- whether it is appropriate for QPIF scientists to deliberate on how to report the results of tests conducted by AAHL, and to independently determine whether to report AAHL results as positive or negative
- whether there is some uncertainty and inconsistency in the advice given by QPIF, QHFSS and WHSQ about whether Hendra virus samples being transported to the laboratory constitute dangerous goods, including the different situations where the samples come from either a horse that may have Hendra virus or a horse known to have Hendra virus.

Many of these issues are scientific matters. Others relate to minor matters or were not specifically pursued in my investigation.

In my view, it would be of benefit for the Director-General of DEEDI to consider whether QPIF should take any action to address these concerns.

The Director-General of DEEDI did not respond to my proposed recommendation.

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<sup>74</sup> Ethylenediaminetetraacetic acid.

Accordingly, I confirm my proposed recommendation 7 as a final recommendation:

**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'.

## Chapter 6: Overview of incident management

This chapter discusses the framework within which QPIF responds to incidents, and contains an overview of its response to the incidents the subject of my investigation.

### 6.1 Legislative and policy framework

QPIF's authority to respond to Hendra virus incidents is found under state legislation<sup>75</sup> and is guided by national policy on responding to biosecurity threats.

#### 6.1.1 Legislative framework for quarantines

QPIF has the power to quarantine properties during Hendra virus incidents under the Stock Act and the EDIA Act.

Section 14 of the Stock Act states:

##### 14 Quarantine

- (1) An inspector, on being satisfied that in any area stock is or is suspected to be infected, shall define the boundaries of the area in question, and (save with respect to holdings from the owners of which undertakings are accepted pursuant to subsection (2)) place it in quarantine by giving written notice to the owner either personally or by registered letter.
- (1A) The notice shall specify the species and the class or category of stock to which the notice shall apply and may specify the conditions for isolation or confinement of infected or suspected stock on the holding.
- (1B) On placing any area in quarantine the inspector may, in cases where the inspector considers it necessary or desirable so to do, affix in such place or places as the inspector deems fit a notice that such area is placed in quarantine.
- (1C) The quarantine continues until the area is released from quarantine by the chief executive.
- (1D) A person must not remove or introduce, cause to be removed or introduced, or assist or be in any way concerned in removing or introducing, stock into or out of the area without the chief executive's written authority.

Maximum penalty—1000 penalty units or 1 year's imprisonment.

...

- (4) The provisions of this section do not apply to any area in quarantine pursuant to the provisions of the *Exotic Diseases in Animals Act 1981*.

An infected property is one that is infected with a disease. The term 'disease' includes a disease prescribed under a regulation.<sup>76</sup> Hendra virus is a prescribed disease under Schedule 1 to the Stock Regulation 1988. Subsection 14(4) of the Stock Act makes it clear that section 14 does not apply to any area in quarantine under the EDIA Act.

<sup>75</sup> The two relevant statutes are the Stock Act and the EDIA Act.

<sup>76</sup> See definitions of 'infected' and 'disease' in Schedule 2 to the Stock Act.

QPIF can also place an area under quarantine for Hendra virus pursuant to s.9 of the EDIA Act, which provides:

### **9 Infected premises**

- (1) An inspector, on being satisfied that an exotic disease or animal pathogen is or is suspected to be present in any area, shall forthwith define the boundaries of the area in question and place it in quarantine by giving written notice to the owner.
- (1A) On placing an area in quarantine the inspector shall cause to be affixed in such place or places as the inspector considers appropriate a notice that the area is in quarantine.
- (1B) Subject to subsection (2), such quarantine shall continue—
  - (a) for a period of 96 hours from the giving of the notice; or
  - (b) until revoked by the Minister;whichever shall first occur.
- (2) Where an area has been placed in quarantine pursuant to subsection (1) the Minister may extend the period of quarantine by written notice given to the owner for such time as is specified in the notice.
- (2A) Notice of extension of quarantine shall be affixed in such place or places as the Minister considers appropriate.
- (3) Except with the permission of an inspector, a person shall not—
  - (a) enter or leave infected premises;
  - (b) cause, suffer, permit or allow any other person to enter or leave infected premises;
  - (c) bring, remove or cause, suffer, permit or allow any other person to bring or remove any animal, carcass, animal product, animal pathogen, biological preparation or property into or from infected premises;
  - (d) fail to close and secure against its being opened by any animal, any gate or door erected on the boundary of infected premises.

Maximum penalty—2000 penalty units or 2 years imprisonment.

Hendra virus is defined as an exotic disease under the Schedule to the EDIA Act.

Although the provisions in the Stock Act and EDIA Act are similar, there are some significant differences.

Firstly, under the Stock Act, a quarantine continues until the area is released from quarantine. However, under the EDIA Act, the quarantine continues for a period of 96 hours from the giving of the notice or until revoked by the Minister, whichever occurs first. The quarantine can also be extended by the Minister for a specified period.

Secondly, under the Stock Act, a quarantine only applies to stock. Under the EDIA Act, quarantine restrictions extend to people, animals, carcasses, animal products, animal pathogens, biological preparations and property (equipment).<sup>77</sup> I discuss this issue further in chapter 7.

Thirdly, there are differences in the compensation provisions of each Act, which I discuss in chapter 8.

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<sup>77</sup> Section 9(3), EDIA Act.

### 6.1.2 Legislative framework for undertakings

Under the Stock Act, instead of a property being placed under quarantine the chief executive may accept a written undertaking from the property owner that they will comply with the Act as if the property was under quarantine. There is no similar power under the EDIA Act.

Section 14 of the Stock Act relevantly states:

#### 14 Quarantine

...

- (2) The chief executive may accept from the owner of a holding that, but for this subsection, would be required to be placed in quarantine the owner's undertaking in writing that the owner will in respect of the holding and the stock thereon comply in all respects with the provisions of this Act applicable thereto or that would be applicable thereto were the holding placed in quarantine under subsection (1).
- (2A) For so long as it continues in force such an undertaking shall be deemed to have been entered into from time to time by and to oblige the owner for the time being of the holding and the owner for the time being shall be subject to and shall comply in all respects with such provisions and with all orders and directions made or given under this Act in respect of the owner's holding or the stock thereon.
- (2B) Such an undertaking may be expressed to be limited to a period specified therein or may be of indefinite duration and shall continue in force until—
- (a) the expiration of the period (if any) specified therein; or
  - (b) the chief inspector notifies the obligor for the time being in writing that the obligor is released from further obligation thereunder;
- whichever event is the first to occur.

I discuss QPIF's use of undertakings further in chapter 7.

### 6.1.3 QPIF policies and procedures

QPIF has a number of policies and procedures that relate to the management of Hendra virus incidents. The main policies and procedures relevant to QPIF's response include:

- *Hendra virus – Quarantine and Undertaking Management Policy (Quarantine Policy)*
- *Guidelines for Veterinarians*
- *Respiratory Management Program for zoonotic disease investigation and responses, chemical sprays, volatile or oxygen replacement gas exposures*
- *Risk Management Plan for Field Veterinarians*
- *Standard Operating Procedure: Personal protective equipment and personal disinfection for zoonotic diseases dated 6 August 2008*
- *Queensland Emergency Response Plan for Plant Pest and Animal Disease Emergencies*
- *Biosecurity Emergency Operations Manual.*

Not all of the policies were in place at the time of the various Hendra virus incidents I considered, and others remain in draft form or are unapproved. I have discussed this further in chapter 7.

The policies most relevant to responding to Hendra virus incidents are the Quarantine Policy and the Guidelines for Veterinarians. These policies prescribe QPIF's response and provide details on testing, quarantine and decontamination matters specific to Hendra virus.

#### **6.1.4 Australian Veterinary Emergency Plan**

The Australian Veterinary Emergency Plan (AUSVETPLAN) is a national framework jointly formulated by state and Commonwealth governments and industry, and contains technical response plans for dealing with emergency animal disease incidents.

Although each state and territory has operational responsibility for incidents within its borders and operates under its own legislation, AUSVETPLAN aims to ensure that there is a consistent response to biosecurity incidents by:

- providing policy and guidelines for the consistent management of an EAD<sup>78</sup> incident by appropriately trained personnel
- improving the technical validity of strategies to combat disease emergencies and improving deficiencies in technical knowledge
- assisting in identifying research priorities
- providing a focus for training
- providing guidelines for the development of standard operating procedures.<sup>79</sup>

The use of a joint plan also ensures interoperability to assist with cross-border outbreaks and the use of Commonwealth assets and services.

States and territories are responsible for:

- preparing operational plans that are consistent with AUSVETPLAN
- implementing the national strategy.

The AUSVETPLAN also sets out cost-sharing arrangements between state governments, the Commonwealth Government and industry for the cost of incident responses. However, the equine industry was not a participant until 2011 so cost sharing was not available in that industry during the incidents under review.

A number of response policy briefs sit under the AUSVETPLAN framework and guide the states in responding to diseases.

The response policy brief for Hendra virus states:

##### **Disease management**

During outbreaks, the most effective way to prevent further spread of disease is to quarantine infected equines. Due to the zoonotic potential of Hendra virus, personal

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<sup>78</sup> Emergency Animal Disease.

<sup>79</sup> Animal Health Australia, AUSVETPLAN *Summary Document*, Edition 3, p.18 (2008) [accessed at [http://www.animalhealthaustralia.com.au/programs/eadp/ausvetplan/ausvetplan\\_home.cfm](http://www.animalhealthaustralia.com.au/programs/eadp/ausvetplan/ausvetplan_home.cfm) on 28 January 2011].

protective equipment and adequate protocols are needed to protect people working near infected horses.

### **Australia's policy for Hendra virus infection**

Hendra virus infection is not an OIE-listed disease.<sup>80</sup> The disease has proven to be only mildly contagious outside its natural hosts. Relapse and serious infection in clinically recovered or partially recovered horses can occur.

The policy is to eradicate Hendra virus infection in terrestrial animals using:

- destruction and sanitary disposal of all horses or other terrestrial animals shown, through demonstration of antibodies, to be infected;
- disinfection of the immediate contaminated environment; and
- quarantine of all in-contact animals until repeated serological tests have proven freedom.

These strategies will be supported by:

- tracing and limited surveillance to determine the source and extent of infection and to provide proof of freedom from the disease; and
- a public awareness campaign to encourage cooperation from industry and the public.

Hendra virus is currently included as a Category 2 disease in the EAD Response Agreement. The costs of disease control would be shared 80% by governments and 20% by the relevant industries.

Other aspects of AUSVETPLAN are sometimes used to guide QPIF responses, such as the AUSVETPLAN operational procedures manual on the destruction of animals.

## **6.2 Structure of responses to incidents**

AUSVETPLAN contains two management manuals, which include guidelines for a management response structure, and the responsibilities of the Local Disease Control Centre (LDCC) and the State Disease Control Headquarters (SDCHQ).

When responding to a significant disease incident, QPIF will usually establish an LDCC in the area to manage the immediate response. An SDCHQ, most often in Brisbane, will also be set up to provide support and policy advice.

Such a management structure is not always required, and whether one is necessary will depend on the nature and severity of the incident. This structure was used in relation to the 2008 Redlands and Proserpine incidents and the 2009 Cawarral and Bowen incidents, but not the two Peachester incidents.

### **6.2.1 Local Disease Control Centre**

An LDCC is responsible for controlling the incident, tracing stock and equipment movements, destroying infected animals, decontaminating property, and liaising with the affected community about operational matters.<sup>81</sup>

<sup>80</sup> The need to fight animal diseases at global level led to the creation of the Office International des Epizooties through the international agreement signed on 25 January 1924. In May 2003, the office became the World Organisation for Animal Health but kept its historical acronym, OIE. The OIE is the intergovernmental organisation responsible for improving animal health worldwide.

<sup>81</sup> Animal Health Australia, *AUSVETPLAN Control centres management*, Part 1 (Version 3.1) p.21 (2008) [accessed at <http://www.animalhealthaustralia.com.au/programs/eadp/ausvetplan/management-manuals.cfm> on 28 January 2011].

An LDCC has three main units:

1. Planning Section – plans operations and provides specialist support to industry, public relations activities, epidemiologists and industry liaison
2. Operations Section – manages field operations including tracing, movement controls, management of the infected premises, and destruction, disposal and decontamination activities
3. Logistics Section – provides administrative and physical support to other parts of the response, including finance, human resources, and health and safety.

Responsibility for managing the LDCC falls to the:

- Local Controller, who has overall responsibility
- Site Supervisor, for each infected premises
- Infected Premises Operations Manager, who coordinates the site supervisors and oversees operations.

### **6.2.2 State Disease Control Headquarters**

An SDCHQ coordinates information, develops policies for a response and facilitates their implementation through the LDCC. The SDCHQ is also responsible for supporting the operational response of the LDCC by providing resources, coordinating technical advice, and liaising with stakeholders and the media.<sup>82</sup>

An SDCHQ has a number of functional areas, including:

- state/territory public relations, which provides community information, manages media issues and encourages early recognition and reporting. This section also communicates with key industry bodies
- sections that mirror the major sections of the LDCC, that is strategic planning, and provision of technical, legal and policy advice to the LDCC operational team.

An SDCHQ reports to the relevant Chief Veterinary Officer of the state or territory.

Although similar in structure, the SDCHQ is not intended to duplicate functions carried out by the LDCC or to assume operational responsibilities.<sup>83</sup>

### **6.2.3 Infected premises and dangerous contact premises**

Properties are defined under the Quarantine Policy according to their level of exposure to the virus.

Ssuspected Premises' (SPs) are properties where Hendra virus infection is suspected on the basis of clinical signs of the horses. Such properties are quarantined immediately to await the outcome of testing.

Infected Premises' (IPs) are properties where testing has indicated that a Hendra virus infection exists. Such properties are also quarantined immediately. The label

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<sup>82</sup> AUSVETPLAN Control centres management, Part 1 (Version 3.1) p.37.

<sup>83</sup> AUSVETPLAN Control centres management, Part 1 (Version 3.1) p.39.

Infectious Premises 1' or IIP1' is given to the property where Hendra virus is first identified in the incident. In some cases there may be other IPs.<sup>84</sup>

Dangerous Contact Premises' (DCPs) are properties that are close to an IP or have had contact with horses from an IP. There are several levels of DCPs.

- A DCP – High risk close contact property' is one where there has been close contact of the horses on this property with the horses on an IP. These are generally properties that the horses on the IP came from within approximately 30 days of the first known case, or those which have received horses from the IP within the last 30 days (of course, such movement would have occurred before the outbreak was discovered and the IP quarantined). DCP – High risk close contact' properties may include neighbouring properties to the IP where horses have had close contact over fences, or where horses have moved from the IP to this property. Such properties are quarantined.
- A DCP – High risk fomite property' is a property that now houses equipment that originated from an IP or that houses people who had access to an IP. The equipment includes anything that has been in contact with a known or suspected Hendra-positive horse or in contact with body fluids from a known or suspected Hendra-positive horse. This may include bridles, rugs, feed bins, personal clothing, veterinary equipment, etc. Such properties are usually quarantined and the equipment decontaminated or destroyed.
- A DCP – High risk trace forward property' is one where a high risk horse from the IP has moved onto this property before the Hendra virus infection was discovered. A high risk horse is one which has had close contact with a known or potentially infected horse in the 16 days before clinical signs appeared on the IP. Such properties are usually quarantined.
- A DCP – Low risk trace forward property' is one where a low risk horse from the IP has moved onto this property. A low risk horse is a horse that had no close contact with a known or suspected Hendra infected horse or with any potentially contaminated equipment, and which left the IP in the 21 days prior to the first confirmed or suspected case of Hendra virus. The owners of such properties are generally offered the opportunity to enter into an undertaking.
- A DCP – High risk trace back property' is a property that housed a known or suspected Hendra-positive horse in the 16 days before clinical signs occurred in that horse on the IP and where there was close contact between the known or suspected Hendra-positive horse and other horses on the property. Such properties are generally quarantined with time for the quarantine calculated from the date that the known or suspected horse left the property.
- A DCP – Low risk trace back property' is one where a known or suspected Hendra infected horse was present on the property during the 21 days prior to the onset of clinical signs in that horse, and either there was no close contact between that horse and other horses on the property, or where the only close contact occurred between 16 and 21 days before the onset of clinical signs in the horse when it would have been unlikely to have been infectious. Horses on such properties are generally monitored for illness but the property would usually not be subject to a quarantine or undertaking.

During an incident, DCPs are usually labelled DCP1', DCP2' and so on. There are usually a number of such properties during an incident.

<sup>84</sup> However, each Hendra virus incident between 2006 and 2009 only involved one property where the virus was identified.

### **6.2.4 Emergency Management Unit**

An Emergency Management Unit (EMU) was formed in 2008 to optimise the emergency preparedness of QPIF, and to integrate the Queensland biosecurity emergency management framework with the national biosecurity emergency management network and whole-of-government disaster management framework.

The EMU is located within the Biosecurity Queensland Control Centre, a dedicated eradication and emergency response centre within QPIF.

The EMU currently has a number of functional areas, including:

- logistics
- quality management systems
- training
- community and industry engagement

as well as specialist staff that look after animal, plant and invasive species.

The EMU currently consists of seven permanent QPIF officers.

My officers were told in 2009 that the role of the EMU in Hendra virus responses by QPIF was not yet settled. However, the Director-General of DEEDI has recently advised me that a major role of the EMU is preparedness for emergencies including the skilling of the Biosecurity Queensland workforce, and establishing systems that can be used in emergency responses.

## **6.3 Description of Hendra virus responses**

Each Hendra virus incident between 2006 and 2009 resulted in one or more properties being quarantined. Set out below is a brief description of the response by QPIF to each incident.

### **6.3.1 The 2006 Peachester incident**

The 2006 Peachester property was quarantined under the Stock Act on 24 June 2006, 10 days after the property owner's horse died of Hendra virus. The delay in quarantining the property was attributable to the time taken to obtain the virus-isolation test results. No signs were posted advising that the property had been quarantined.

Neither an LDCC nor an SDCHQ was established as part of QPIF's response.

The property was released from quarantine on 13 July 2006.

### **6.3.2 The 2007 Peachester incident**

After a sample taken from a horse on another Peachester property returned a weak positive PCR result, the property was placed into quarantine under the EDIA Act on 8 June 2007. Again, neither an LDCC nor an SDCHQ was established as part of QPIF's response.

The property was released from quarantine 96 hours later.

### **6.3.3 The 2008 Redlands incident**

The 2008 Redlands property was initially quarantined under the Stock Act on 7 July 2008 on suspicion of equine herpes virus. However, once a positive test result to Hendra virus was received, the initial quarantine notice was revoked and the property quarantined under the Stock Act on 8 July 2008 for Hendra virus.

An LDCC and an SDCHQ were then formed. The LDCC was located at a QPIF office in Yeerongpilly, Brisbane, while the SDCHQ was based at the QPIF head office in Brisbane.

Subsequently, responsibility for the LDCC was passed to the EMU which continued to manage the response until the quarantine was lifted.

The quarantine was lifted on 25 August 2008, 32 days (equivalent to two incubation periods) after the last horse tested positive to a PCR test for Hendra virus.

### **6.3.4 The 2008 Proserpine incident**

The 2008 Proserpine property was quarantined under the Stock Act on 16 July 2008, after a horse died of suspected Hendra virus on 11 July 2008. No signs were erected on the property and neighbouring properties were not quarantined.

An LDCC was established by QPIF officers from Rockhampton, Bowen and Mackay. The SDCHQ was already in place in response to the 2008 Redlands incident.

One horse which had shown signs of illness recovered and subsequently tested sero-positive to Hendra virus. This horse was destroyed by QPIF on 4 September 2008 and the quarantine was lifted on 12 September 2008.

### **6.3.5 The 2009 Cawarral incident**

The Cawarral property was placed into quarantine on 8 August 2009, after a horse had collapsed and died earlier that day. QPIF officers quarantined the property under the Stock Act on suspicion of Hendra virus. When the first positive result for the virus was obtained on 10 August 2009, a quarantine notice was placed on the main entrance to the property.

An LDCC was formed at the local Rockhampton QPIF office. An SDCHQ was also formed in the QPIF head office in Brisbane.

There were a number of DCPs in this incident, including neighbouring properties, and they, too, were quarantined. Although the IP at Cawarral was quarantined under the Stock Act, some DCPs were quarantined under the EDIA Act. At least five DCPs were the subject of undertakings under the Stock Act.

The quarantine notice was revoked and reissued on or about 20 August 2009 with further conditions attached. The quarantine was expected to be lifted in early October 2009, but because the final test results required further investigation it was not removed until 12 October 2009.

### **6.3.6 The 2009 Bowen incident**

A sick horse was euthanased by a private veterinarian on 2 September 2009 and samples submitted to QPIF for Hendra virus exclusion testing.

The samples returned positive PCR results and QPIF officers visited the property on 9 September 2009. However, because the owners had their private veterinarian euthanase the one remaining horse on the property, QPIF officers decided there was no need to impose a quarantine.

The response was organised by the LDCC which was already in place for the 2009 Cawarral incident. Similarly, the SDCHQ structure was also in place due to the Cawarral incident.

QPIF subsequently tested stored samples and determined that another horse had died of Hendra virus on that property a month earlier.

Three DCPs (neighbouring properties) which were identified during the incident response were quarantined and monitored under the Stock Act. The quarantines were lifted on 13 October 2009.

## Chapter 7: Analysis of QPIF response

This chapter contains an analysis of certain aspects of QPIF's response to the Hendra virus incidents considered in my report.

### 7.1 Use of legislation and policy

#### 7.1.1 Legislation

QPIF may quarantine properties under either the Stock Act or the EDIA Act. For example, the EDIA Act was used to quarantine the property in Peachester in 2007, while the Stock Act was used in most of the other incidents that were the subject of my investigation.

The following table shows the number of properties quarantined during each Hendra virus incident and the Act used to quarantine those properties.

| Incident        | IP <sup>85</sup> | DCPs <sup>86</sup>  |
|-----------------|------------------|---|
| 2006 Peachester | Stock Act        | No DCPs quarantined   |
| 2007 Peachester | EDIA Act         | No DCPs quarantined   |
| 2008 Redlands   | Stock Act        | No DCPs quarantined   |
| 2008 Proserpine | Stock Act        | No DCPs quarantined   |
| 2009 Cawarral   | Stock Act        | 4 DCPs quarantined under Stock Act<br>2 DCPs quarantined under EDIA Act |
| 2009 Bowen      | Not quarantined  | 3 DCPs quarantined under Stock Act                                      |

Therefore, in at least one instance, a combination of the two Acts was used. During the 2009 Cawarral incident, the IP was quarantined under the Stock Act while some DCPs were quarantined under the EDIA Act and others under the Stock Act.

QPIF officers were unable to explain to my officers why action was taken under one Act and not the other in any particular incident. For example, QPIF officers told my officers that the Stock Act was used to quarantine properties during incidents because, variously:

- QPIF officers, and particularly inspectors, are more familiar with the Stock Act
- Hendra virus is an endemic disease,<sup>87</sup> rather than an exotic disease, and therefore the EDIA Act is not the appropriate Act to use
- under the Stock Act a property owner can agree to enter into undertakings which have less of an impact on the owner than the property being quarantined
- a quarantine under the EDIA Act has to be renewed after 96 hours.

<sup>85</sup> Infected Premises.

<sup>86</sup> Dangerous Contact Premises.

<sup>87</sup> Schedule 8 of the Stock Regulation 1988 defines endemic disease as 'a disease that is intermittently or constantly present in a particular place or region'.

However, other QPIF officers said they would prefer to use the EDIA Act for a Hendra virus incident because:

- it has stronger powers of quarantine and facilitates a quicker response
- Hendra virus is listed as an exotic disease in the Schedule to this Act, so it can be used.

As discussed in chapter 6, the Acts have quite different quarantine powers. Section 14(1) of the Stock Act states:

- (1) An inspector, on being satisfied that in any area stock is or is suspected to be infected, shall define the boundaries of the area in question, and (save with respect to holdings from the owners of which undertakings are accepted pursuant to subsection (2)) place it in quarantine by giving written notice to the owner either personally or by registered letter.

Section 14(1A) of the Stock Act provides that the quarantine notice shall specify the species and the class or category of stock to which the notice shall apply and may specify the conditions for isolation or confinement of infected or suspected stock on the holding.

Under s.14(1D) of the Stock Act:

- (1D) A person must not remove or introduce, cause to be removed or introduced, or assist or be in any way concerned in removing or introducing, stock into or out of the area without the chief executive's written authority.

These provisions therefore appear to be directed to confining a species or stock on certain land and preventing stock from entering that area during the quarantine.

This is a quite limited power when compared to those under s.9(3) of the EDIA Act, which requires a person to seek the permission of an inspector before they:

- ...
- (a) enter or leave infected premises;
  - (b) cause, suffer, permit or allow any other person to enter or leave infected premises;
  - (c) bring, remove or cause, suffer, permit or allow any other person to bring or remove any animal, carcass, animal product, animal pathogen, biological preparation or property into or from infected premises;
  - (d) fail to close and secure against its being opened by any animal, any gate or door erected on the boundary of infected premises.

Under the EDIA Act, QPIF can therefore control the movement of people, animals and equipment onto and off the quarantined property.

Partway through the 2009 Cawarral incident, QPIF revoked the previous quarantine notice and issued an amended notice containing a number of further quarantine conditions it purported to impose under the Stock Act. These conditions were:

- (a) no movement of horses onto or off the property
- (b) no movement of horse equipment or farm equipment off the property
- (c) that gates to the property be secured
- (d) no movement of horse products (including waste) or horse feed off the property
- (e) that property owners maintain a register of everyone who enters the property

- (f) that human contact with horses be limited to an as needs' basis to care for the welfare of the horses
- (g) that people wash their hands or undertake disinfection procedures after having contact with horses
- (h) that horses be observed and signs of illness be reported to QPIF.

These conditions were imposed as a response to an alleged breach' of the previous quarantine notice by the removal of a vehicle off the property. A similar issue occurred during the 2008 Redlands incident, where QPIF also considered taking action against the clinic owner for an alleged breach' of the quarantine.

It is a fundamental administrative law principle that agency officers can only exercise authority over the activities of individuals where there is a clear statutory power to do so. In my view, s.14(1A), which provides that a quarantine notice may specify the conditions for isolation or confinement of infected or suspected stock on the holding, is insufficient authority for the imposition of most of the above conditions. It follows that QPIF would have been unable to take the threatened action against property owners for breaching' the quarantine conditions.

It also follows in my view that under the Stock Act, QPIF officers cannot prohibit property owners or workers from undertaking certain activities on quarantined properties, including providing basic or medical care to horses, or require them to do other activities such as maintaining registers and washing hands. In respect of the general conditions detailed above, I consider that QPIF officers only had statutory power to impose conditions (a)<sup>88</sup> and (c).

I confirm proposed opinions 7 and 8 as final opinions:

#### **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.

I confirm proposed recommendation 8 as a final recommendation:

#### **Recommendation 8**

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

As mentioned above, since 2006, different Acts were used for different purposes during Hendra virus incidents.

<sup>88</sup> However, condition (a) may be unnecessary given the prohibition on the movement of stock under s.14(1D) of the Stock Act.

Before August 2009, there was no QPIF policy as to which Act should be used to impose quarantines. On 27 August 2009, partway through the 2009 Cawarral incident, QPIF drafted and finalised its Quarantine Policy which now requires the Stock Act to be used to impose quarantines during Hendra virus incidents.

The question of which Act to use during an incident has been the subject of discussion among QPIF officers since at least 2008. The issue was discussed extensively among QPIF officers during the 2008 Redlands incident.

Despite this, QPIF did not have a consistent position until the finalisation of the Quarantine Policy in August 2009, some 12 months later and partway through the 2009 Cawarral incident.

The current Quarantine Policy dated 27 August 2009 provides:

## **5. STATEMENT OF POLICY**

A property may be initially quarantined on suspicion of HeV infection based on assessment of the clinical signs seen in a horse or horses. Quarantining in these circumstances aims to prevent the possible spread of disease by restricting the movements of horses onto and off the property and the movements of vehicles and equipment that have been in close contact with the affected horse(s) until laboratory results indicate HeV infection or not.

...

### **5.1 Quarantine and undertakings**

Quarantines are placed on properties under the *Stock Act 1915*, Section 14 (1) to contain the affected stock and other things and to reduce disease spread. The conditions of the quarantine will inform the property owner what activities and movements of animals are permitted. Under the *Stock Act 1915*, an inspector can quarantine a property. The property owner must comply with the stipulated conditions or face a penalty under legislation.

My primary concern with the policy is that there is no clear statement that the Stock Act is the only Act that should be used in response to Hendra virus incidents, and why. There is also no clear statement that the EDIA Act should not be used and an explanation provided for that view. I also note that Hendra virus remains listed in the Schedule to the EDIA Act.

To be effective, a policy should provide clear guidance for agency officers. The failure to mention the EDIA Act in the Quarantine Policy means that QPIF effectively has no policy to guide its officers in the exercise of a discretion. This is less than ideal, particularly when the discretion is the important matter of which piece of legislation will apply to a situation. A consistent approach will only be supported by a firm policy position or criteria that addresses both options and explains why one is preferred (if that is the agency's position).

Further, in my view, it is not good administrative practice for an agency to alternate between regulatory regimes under two Acts. The lack of a QPIF policy until August 2009 created a situation where this has occurred and the lack of detail in the current policy means that this remains possible.

QPIF intends to replace the Stock Act and EDIA Act, as well as other pieces of biosecurity legislation, with a proposed Biosecurity Act. A Biosecurity Bill was released for public consultation on 22 July 2011.

When the proposed Biosecurity Bill is enacted the issue may well be resolved. However, in the meantime greater clarity should be provided to QPIF officers as to the appropriate Act to adopt.

In my proposed report, I therefore formed the following opinions and made the following recommendation:

#### **Proposed 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.

#### **Proposed 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.

#### **Proposed recommendation 9**

QPIF amend the Quarantine Policy to:

- (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; and
- (c) explain 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.

### **DEEDI's response**

The Director-General of DEEDI responded that DEEDI had recently closely examined the interplay between the quarantine provisions in the Stock Act and the EDIA Act.

A firm view has now been formed that subsection 14(4) of the Stock Act and subsection 9(1) of the EDIA Act have the effect that:

- an inspector who is satisfied that Hendra virus is in an area or is suspected to be in an area must place the area in quarantine under the EDIA Act
- once placed in quarantine under the EDIA Act as required, the quarantine provisions in the Stock Act will not apply to the area.

As a consequence of forming this view, the current Quarantine Policy is under review.

DEEDI's view is that while the above provisions only directly concern the power to impose quarantine, and do not directly affect powers to destroy animals or owners' entitlement to compensation, it can be undesirable to use a patchwork of provisions from the two Acts for different purposes. As a result, Biosecurity Queensland is reviewing the Quarantine Policy (taking into account the desirability of using one Act

or the other) at least until the proposed Biosecurity Bill removes the existing overlaps and inconsistencies.

### **Ombudsman's analysis**

I have amended my proposed recommendation to take into account the review of the current Quarantine Policy.

I confirm proposed opinions 9 and 10 as final opinions:

#### **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.

I confirm proposed recommendation 9 with amendments as a final recommendation:

#### **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.

### **7.1.2 The use of undertakings**

During the 2009 Cawarral incident, the owners of several DCPs agreed to enter into undertakings in relation to the movement of horses which had been in contact with infected horses (in-contact horses) or the IP. The undertakings were given under the Stock Act as an alternative to full quarantine.

A number of reasons were given by QPIF officers for adopting this course, including:

- the imposition of further quarantines may lead to public concerns that the virus was spreading
- giving an undertaking avoids the adverse effect that a quarantine may have on any business being run on the property.

While I recognise that QPIF was trying to initiate a timely response in a practical manner, this approach has a number of deficiencies.

Firstly, QPIF's approach in imposing undertakings was to only restrict the movement of in-contact horses and not other horses on the property which have associated with in-contact horses and, consequently, could be carrying the virus.

Secondly, undertakings are personal guarantees given by the owner of the property. They are not binding on anyone else, including tenants, property workers or the owner of a horse on the property (including the owner of the in-contact horse).

Thirdly, legal advice was obtained by QPIF that it was doubtful any enforcement action could be taken against the owner if they breached their undertaking, unlike quarantines which were enforceable against anyone who breached the quarantine conditions. The QPIF legal unit therefore recommended that undertakings not be used.

Finally, one QPIF officer told my officers that during the 2009 Cawarral incident, the requirements for serving undertakings, locating owners and obtaining signatures, obtaining approval from SDCHQ and sending completed copies to the person giving the undertaking caused significant delays in having the undertakings in place. There were also difficulties in obtaining horse identification information to adequately describe the horse that was the subject of the undertaking. My officers were told that the last undertaking was not lawfully in place until approximately three weeks into the response, by which time at least one full incubation period had passed.

More than one QPIF officer expressed the view to my officers that it would have been more efficient to have quarantined the DCPs as soon as each was identified, which would have authorised officers to identify horses and do the necessary inspections.

As mentioned above, there was no QPIF policy on the use of undertakings in place at the start of the 2009 Cawarral incident. The Quarantine Policy, which now covers the use of undertakings, was not finalised until 27 August 2009, three weeks into the incident.

Accordingly in my proposed report, I formed the view that QPIF's use of undertakings despite receiving legal advice to the contrary was unreasonable. Further, undertakings made under the Stock Act were not sufficiently enforceable and do not seem appropriate for Hendra virus incidents in their present form.

I formed the following opinion in my proposed report:

**Proposed 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 acted contrary to legal advice it received that undertakings should not be used.

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

My understanding was that the proposed Biosecurity Bill would mean that the Stock Act would no longer be used to impose undertakings. However, as I was not aware of the proposed contents of the Biosecurity Bill at the time of writing my proposed report, I proposed making the following recommendation:

**Proposed recommendation 10**

QPIF review whether the use of undertakings is an appropriate means of controlling Hendra virus.

**DEEDI's response**

The Director-General of DEEDI made the following submissions in response to my proposed report:

In deciding what instrument to use in reducing the risk of spreading Hendra there were two options considered: quarantine and undertakings. Quarantine orders, while the preferred method, do have drawbacks in certain circumstances.

Quarantine orders can impact on people as there can be a stigma in having a property quarantined, which can have an impact on a person's business and their standing in the community. Where a person agists their horse, there are sometimes difficulties finding an agistment property where the property owner is prepared to have their property quarantined in order to hold the horse.

The use of undertakings tends to carry less of a stigma and can achieve the same biosecurity outcomes, but without the added angst of the people involved, which can adversely impact on a response. At times, undertakings can minimise the impact on the people affected and maintain their support and cooperation.

Legal advice was provided on the limitations of undertakings. However, the advice was not categorically that undertakings should not be used. Accordingly, a number of considerations were taken into account, including those noted above. It was decided that undertakings would achieve the desired outcome in certain circumstances.

Quarantine was to be used on infected properties. However, where tracings revealed that a horse could be at risk from Hendra virus and the owner was cooperative, it was judged that an undertaking was sufficient to manage the disease risk. Such horses were isolated from other horses, had diagnostic blood samples taken and were being monitored by the owner who was fully briefed on the signs of Hendra virus and the personal precautions to take.

Regular contact was made with the owner to monitor the situation. Should the horse have shown that it was infected then a quarantine would have been imposed. There was no evidence of people not complying with the undertaking. If the owner was not cooperative then a quarantine was imposed.

It is recognised that the use of undertakings has limitations, and a policy decision has been made to use quarantines in any future response.

However, the decision to use undertakings was not contrary to legal advice, as stated in proposed 11(d). The legal advice advised on the limitations of undertakings, but said the use of undertakings was a matter of judgement to be exercised under the circumstances.

It is therefore submitted that proposed opinion 11(d) be removed.

## Ombudsman's analysis

The Director-General's response does not contest that the use of undertakings during the 2009 Cawarral incident was not an appropriate response to the risks associated with Hendra virus incidents.

I acknowledge that QPIF's legal advice at the time did not categorically state that undertakings should not be used. However, the legal advice made it clear that:

- undertakings were probably not enforceable against the person who gave the undertaking even if they breached the undertaking
- undertakings cannot be enforced against third parties.

The legal advice I viewed did not state that the use of undertakings was a matter of judgment to be exercised under the circumstances. However, I have made one change to my proposed opinion as a result of the Director-General's submissions.

While there was no evidence of persons not complying with the undertaking, the undertakings were used on properties where no QPIF officers remained in attendance and therefore any breaches of the undertaking are unlikely to have come to QPIF's attention unless disclosed by the property owner. Given the purpose of the undertakings was to manage the risk of Hendra virus spreading to both animals and humans, I remain of the view that the use of undertakings which relied on the voluntary cooperation of property owners was unreasonable in the face of legal advice as to the serious and significant limitations applicable to undertakings when compared to the option of imposing quarantines.

I also note a policy decision has now been made to use quarantines in any future response as QPIF has recognised that the use of undertakings has limitations. On this basis, I have amended my proposed recommendation 10.

I confirm proposed opinion 11 with amendments as a final opinion:

### 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.

I withdraw proposed recommendation 10 and substitute the following final recommendation:

### **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.

My officers also found that during the 2008 and 2009 incidents, properties were placed under a verbal quarantine, by which quarantine conditions were purported to be imposed on a property without written notice. A number of internal QPIF emails and documents confirm that this occurred, and the use of verbal quarantines was confirmed to my officers by several QPIF officers involved in the response.

Under the Stock Act, a quarantine can only be imposed by giving written notice to the property owner. There is no provision for declaring or enforcing verbal quarantines.

My officers were told that one reason for the use of verbal quarantines was because QPIF had not yet prepared the paperwork for the quarantine and officers had difficulty in obtaining the necessary details for a quarantine notice.

However, in my view the process for preparing a quarantine notice or undertaking is not complicated.

It would be a better practice for an inspector to issue a quarantine notice on the spot on the basis of known information, and for that notice to be revoked and a more detailed notice issued once further information became available. Inspectors could be provided with a template notice for Hendra virus, as many of the quarantine conditions would not differ between incidents.

In my proposed report, I therefore formed the following opinion and made the following recommendation:

#### **Proposed 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.

#### **Proposed 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.

#### **DEEDI's response**

The Director-General made the following submissions in response to my proposed report:

The verbal quarantine orders referred to in the proposed report are more accurately described as verbal instructions issued to the property owners, advising them of a

positive detection of Hendra virus and that a quarantine order for their property was in the process of being prepared.

Such instructions were made in the context of advising property owners that they should consider their property to be quarantined and advising owners of what restrictions would apply under the quarantine order. This is considered to be reasonable advice to give to an owner under the circumstances when dealing with a serious disease. Most people can be expected to act responsibly when provided with such information. Conversely, it would be unreasonable and possibly negligent to not advise an owner of the situation.

Officers advise that in relation to the 2009 Cawarral incident, the written quarantine order was being prepared contemporaneously with the verbal instructions being provided to the property managers, and that the property (along with an adjoining DCP) were officially quarantined within hours of the verbal instructions being provided.

It is noted that the proposed Biosecurity Bill will require written notice to be given by inspectors to occupants where an emergency situation arises. It will however provide that where it is impracticable to give the written notice in the first instance, a verbal direction may be given but the inspector must, as soon as practicable thereafter, confirm that direction in writing.

DEEDI notes that Dr Nigel Perkins visited the 2009 Cawarral site within the first few days of the Hendra virus response and issued a preliminary report to the Managing Director, making specific comment in relation to how well the notification and quarantine issues were conducted.

DEEDI agrees that a process of immediately issuing a written quarantine notice using the information at hand and updating it subsequently is best practice where practicable, noting that an inspector may not be physically on the property at the start of the response in all cases.

It is therefore submitted that proposed opinion 12 be withdrawn, and that proposed recommendation 11 be amended to read as follows:

*“QPIF 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.”*

### **Ombudsman’s analysis**

The information provided by the Director-General in response to my proposed opinion and recommendation conflicts with evidence provided to my Office during the course of the investigation. QPIF officers gave evidence that when tracing processes identified new DCPs holding additional horses, QPIF officers decided not to issue a written quarantine order or obtain a written voluntary undertaking on at least three occasions. The QPIF officers instead chose to rely on a verbal agreement with the property owners that restrictions would be complied with.

I also note the Director-General agrees with my views on the best process for imposing quarantines quickly during Hendra virus incidents.

I confirm proposed opinion 12 as a final opinion:

### **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.

I confirm proposed recommendation 11 as a final recommendation:

### **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.

## **7.1.3 The preparation of policies and procedures**

Dr Perkins stated in his 2008 Perkins Report that many standard operating procedures and policies relevant to Hendra virus were in draft form, incomplete, or had not been reviewed recently. He made the following recommendation 3:

It is recommended that appropriate DPI&F operating procedures are completed or reviewed, identified in manuals and plans, and implemented right from the beginning of an emergency response, acknowledging that these will depend on the scale and activities of the response and the nature of the risks being encountered.

In mid-2009, a report was tabled in Parliament (Progress Report) which stated that QPIF accepted Dr Perkins' recommendation and implementation was in progress. The Progress Report referred to updating the Guidelines for Veterinarians, the *Biosecurity Emergency Operations Manual* and the respiratory management program. A specific community engagement plan was also to be developed.

My officers conducted a review of the status of QPIF's relevant policies, a number of which were in draft form or incomplete in 2009. Inquiries of QPIF in 2010 revealed that many still had not been finalised. As at the date of my proposed report, some of these policies were still being drafted or awaiting sign-off.

Further, the draft after action review report (2009 AAR Report) contained a list of the following resources that were developed during the response to the 2009 Cawarral incident:

- Induction documents and training records
- WH&S Risk assessments
- Property decontamination plan
- Examples of appropriately completed forms including:
  - Legal documents such as quarantine notices, undertakings, orders to destroy
  - Incident Action Plans
  - Attendance records – LCC, SCHQ and IP

- Situation Reports
- Contact lists – staff and clients on affected properties
- Rosters
- Audit checklists for WH&S re decontamination, autopsy and entry/exit procedures
- Plant and equipment register
- Register of Task/Resource Requests
- Equipment checklists
- Quarantine release plan
- Destruction/disposal hot debrief notes
- Equipment and procedures list for conducting autopsy on IP1
- Personal decontamination instructions to IP personnel
- Photo examples of Entry/Exit point set up
- SOP-IP induction documents including Site Supervisor work instructions
- Personnel Health Assessment Checklist for use prior to entering IP for work.

One QPIF officer said that one of the biggest issues he had to deal with during the 2009 Cawarral incident was that the policies that had been developed from Redlands and Proserpine were not available and so officers had to, in effect, start again.

Several policies and procedures were finalised in August 2009, during the Cawarral incident. This may have been a result of the policies being needed for the incident, or as a result of QPIF commissioning Dr Perkins to carry out a further audit of QPIF's response. For example, my officers were provided with an internal QPIF email dated 17 August 2009 showing that QPIF attempted to draft and gain rapid approval for the policy *Hendra virus outbreak response: Management of horses that are serologically positive*.

Further, in interviews conducted with QPIF officers in November 2009, my officers were told that steps had only recently been taken to prepare a comprehensive list of incomplete or missing policies and prepare drafts of those policies. This was 11 months after the 2008 Perkins Report was provided to QPIF, and two other Hendra virus incidents had occurred during this time. QPIF officers involved in responding to the 2008 Redlands and 2009 Cawarral incidents commented to my officers on the inadequacy of the policies available to guide them.

A list provided to my officers of the policies and procedures to be developed or reviewed by QPIF's Hendra Virus Taskforce as at 11 December 2009 contains the following:

#### Policies

- HeV response – management of positive horses
- HeV response – management of infected and other premises
- Reporting (release) of lab reports of emergency animal diseases
- HeV response – decontamination
- HeV exclusion
- HeV Disease strategy
- Policy on detailed disease investigation
- Responsibility of costs incurred
- PPE for zoonotic diseases for field operations
- Disposal of waste material including carcasses on IPs for zoonotic diseases

#### Standard operating procedures

- HeV – exclusion
- HeV – entry and exit procedures IPs – with appendix of template for developing site specific work instructions for future cases
- Procedures of samples submission for laboratory testing for IPs and DCPs
- Reporting (release) of lab results

- SOP of employment of private veterinarians and contractors – during a response and exclusion cases
  - Zoonotic risk assessment template
  - Imposition and revocation of quarantines and undertakings – Stock Act
  - HeV – decontamination
  - HeV response – Community and industry engagement
  - HeV response – induction DEEDI employees
  - HeV response – Induction persons other than DEEDI employees
  - Establishing registry – generic
  - Waste disposal on IPs
  - Development of a property disease management plan
  - Tracing
- Work instructions
- Hendra virus – sample of horses by Biosecurity Queensland officers for exclusion (non-invasive sampling only)
  - HeV – identification of horses on IPs

Not all of these policies had been completed at the date of my proposed report, despite over 15 months having passed since this list was prepared. Some policies are still being drafted, while a number are in draft form awaiting approval.

Therefore, I am not satisfied that QPIF adequately implemented Dr Perkins' recommendation within a reasonable time. I am also not satisfied that QPIF has acted reasonably or diligently in preparing and finalising policies and procedures to assist in responding to Hendra virus incidents.

In my view, many of the documents identified above should have been available as templates before the 2009 Cawarral incident occurred. Many were used in previous incidents, and QPIF should have had them ready to use in future Hendra virus incidents. With other documents, the need for such policies and procedures should have been clear to QPIF at least by the end of the 2008 Redlands incident, if not by the release of Dr Perkins' report in December 2008.

While I have not attempted to set out an exhaustive list of all the incomplete or delayed policies and procedures applicable to Hendra virus incidents, the examples above and elsewhere in my report make it clear that QPIF has repeatedly failed to prepare, finalise and approve adequate policies and procedures for Hendra virus incident responses.

Adequate, up-to-date policies and procedures are important because they provide guidance to officers to ensure that incidents are managed consistently and in a timely way. They are particularly important when managing events which have potential public and workplace health and safety risks, such as responding to a zoonotic disease like the Hendra virus.

Some QPIF officers told my officers that delays in finalising policies were due to a lack of resources, a cumbersome approval process and the low priority which was given to the task.

While I acknowledge that QPIF commenced an intensive review and drafting of Hendra virus policies and procedures through its Hendra Virus Taskforce, this task had still not been finalised by the date of my proposed report.

QPIF has not provided my Office with a firm date by which it has committed to finalising the outstanding policies and procedures. The Director-General of DEEDI did not respond to this section of my proposed report.

I confirm proposed opinion 13 as a final opinion:

### **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.

I confirm proposed recommendation 12 as a final recommendation:

### **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.

#### **7.1.4 Guidelines for Veterinarians**

A number of complaints were raised with my officers about QPIF's Guidelines for Veterinarians. These complaints were essentially that, since at least 2006:

- the Guidelines for Veterinarians and particularly the case definition for Hendra virus were inadequate
- the Guidelines for Veterinarians were not updated quickly once new information became available.

Having carefully considered a number of drafts of the Guidelines for Veterinarians, it seems that most of these inadequacies were rectified in the April 2009 version of the guidelines. QPIF has since released a further version of the guidelines dated May 2010, which took into account a number of suggestions from private veterinarians and the AVA and made significant further improvements. The current version was released in March 2011.

I therefore do not consider that it is necessary or justifiable for me to discuss this issue further. However, given that it has in the past taken up to nine months following one incident (the 2008 Redlands incident) to update the Guidelines for Veterinarians with relevant information (discussed further in section 7.4.4), I formed the following opinion and made the following recommendation in my proposed report:

#### **Proposed opinion 14**

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

#### **Proposed 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.

#### **DEEDI's response**

The Director-General acknowledged the need to provide up-to-date information to practitioners. However, he also stated that as a government agency, QPIF had the responsibility to ensure the information provided is scientifically valid. Specifically, he stated that:

The provision of incorrect or misleading information from a Government agency risks generating confusion, public hysteria, mistrust or complacency amongst the public and key stakeholders.

As such, DEEDI submits that **proposed opinion 14 be amended** to read:

***"It is important that the Guidelines for Veterinarians be updated promptly as soon as new scientifically valid/scientifically sound/scientifically based information becomes available."***

Similarly, DEEDI submits that **proposed recommendation 13 be amended** to read:

***"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 new relevant and scientifically valid information."***

#### **Ombudsman's analysis**

One of my concerns about the speed at which the Guidelines for Veterinarians were updated, and which is discussed at section 7.4.4 of my report, is the possibility that humans can contract Hendra virus from a seemingly well horse. This information was provided to QPIF as early as July 2008 by the BSPHU, and was not included in the Guidelines for Veterinarians until April 2009.

I do not accept that QPIF should wait to update the guidelines until the results of scientific studies are released, if there is sufficient information on which to identify a likely risk to public health and safety.

I confirm proposed opinion 14 as a final opinion:

#### **Opinion 14**

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

I confirm proposed recommendation 13 as a final recommendation:

### **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.

## **7.2 Issues relating to health and safety**

A number of health and safety issues relating to Hendra virus incident responses were raised with my officers. These issues related to the management by QPIF of its health and safety obligations, rather than any obligations on WHSQ or another agency or person.

### **7.2.1 Types of protective equipment**

The Australian Standard AS/NZS 1715:2009, *Selection, use and maintenance of respiratory protective equipment*, sets out the requirements for respiratory protection in the workplace. Particulate respiratory protection, which filters particles out of the air by use of a barrier, is generally used in Hendra virus incidents.

Particulate filters are rated according to their efficiency, with P1 filters providing the lowest efficiency and P4 the highest.

The mode of delivery is either non-powered (such as surgical masks) or powered (such as a 'hood' or 'space suit'). Powered filters, such as a powered air-purifying respirator (PAPRs) using a full face mask with a shield, can be used with either P2 or P3 filters.

While the levels of personal protective equipment (PPE) refer only to the respiratory protection provided, there are generally understood to be corresponding levels of other protective equipment (such as gloves and eye protection) that can also be worn in conjunction with the respiratory protection.

The two levels of protective equipment that are generally used in Hendra virus incidents are P2 and P3 levels. Both powered and non-powered respiratory protection are used.

#### **P2 equipment**

A P2 level of respiratory protection requires a P2 (N95) mask which must meet the requirements of AS/NZS 1715:2009. P2 masks can be either non-powered (that is, P2 disposable particulate filtering respirators (a type of surgical mask)) or powered (PAPRs with a P2 filter).

Surgical masks will not provide P2 protection for men with facial hair, because hair interferes with the seal of the mask against the skin. Men who are not clean-shaven must use a PAPR with a level P2 filter to achieve a P2 level of protection.

During a Hendra virus incident, a P2 mask is usually worn with disposable gloves, disposable overalls, rubber boots and some form of eye protection such as safety glasses or wrap-around sunglasses. The Guidelines for Veterinarians state that all such protective equipment should be impervious.

### **P3 equipment**

A P3 level of respiratory protection requires a full PAPR face-piece with level P3 filters.

During Hendra virus incidents, a P3 PAPR is usually worn with a full 'space suit' consisting of impervious overalls with long sleeves. The PAPR hood provides eye protection. Specialised non-cut gloves are also used.

#### **7.2.2 Policies and procedures**

QPIF does not have a specific health and safety policy for responding to Hendra virus incidents. Instead, its health and safety obligations and procedures are covered in a number of different documents, including a standard operating procedure for zoonotic diseases, a generic respiratory management policy, and the Guidelines for Veterinarians. My officers were informed that the Guidelines for Veterinarians were considered by QPIF to be a policy document for QPIF officers as well as for private veterinarians.

In addition, the Quarantine Policy provides some recommended hygiene precautions for persons in contact with horses exposed to Hendra virus.

QPIF's respiratory management policy, dated February 2009, is titled *Respiratory Management Program: For zoonotic disease investigation and responses, chemical sprays, volatile or oxygen replacement gas exposures*. It addresses the requirements for respirators or face masks when responding to Hendra virus incidents. It also briefly addresses other health and safety issues such as heatstroke and rest breaks.

A draft QPIF standard operating procedure dated 6 August 2008 and titled *Personal protective equipment and personal disinfection for zoonotic diseases* was provided to my officers. It identifies the types of PPE that should be worn when responding to a zoonotic disease including:

- disposable overalls
- rubber boots
- disposable latex or nitrile gloves
- respirators in accordance with QPIF's policy *Respiratory Management Program: For zoonotic disease investigation and responses, chemical sprays, volatile or oxygen replacement gas exposures*
- eye protection
- impervious aprons, where necessary.

Finally, a QPIF document titled *Respiratory Management: Respiratory Exposure to Zoonotic Disease and Airborne Contaminants: Identifying Hazardous Situations* addresses the dangers of respiratory secretions when dealing with sick horses.

#### **7.2.3 Correct use of PPE**

There is no QPIF procedure describing how to fit and remove PPE, and my officers were told by property workers involved in the 2009 Cawarral incident that QPIF officers did not do so in a consistent manner. They also said that the way QPIF

officers told them to use the equipment differed from advice provided by their private veterinarian.

In my view, 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.

One approach to consider is that of the Commonwealth Department of Health and Ageing which has produced a series of fact sheets titled:

- *How to fit and remove a P2 respirator*<sup>89</sup>
- *How to fit and remove PPE in the correct order*
- *Infection control precautions for severe respiratory diseases*<sup>90</sup>
- *How to fit and remove protective gloves.*<sup>91</sup>

I note that QPIF has now added a link on its website to at least some of these fact sheets. However, I am unsure whether the information in these fact sheets has been carefully reviewed by QPIF to ensure that no further steps are required in relation to zoonotic diseases such as Hendra virus.

In my proposed report, I therefore formed the following opinion and made the following recommendation:

#### **Proposed 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.

#### **Proposed 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.

### **DEEDI's response**

The Director-General made the following submissions in response to my proposed report:

DEEDI has been proactive in taking steps to educate the veterinary profession in relation to the risks posed from exposure to zoonotic disease. DEEDI has maintained an ongoing awareness campaign for veterinarians and horse handlers and the general horse community around Hendra Virus preparedness and precautions. In particular, since the incidents at Cawarral and Bowen in 2009, significant efforts have been made to promote awareness, risk reduction and support preparedness for future incidents.

DEEDI notes that the 2008 Perkins Report recommended that Biosecurity Queensland, the AVA, and Animal Health Australia (AHA) provide appropriate training – including PPE training – and awareness campaigns involving people with direct experience in Hendra cases to stakeholders. To implement these recommendations, six infection control workshops, in collaboration with the AVA and Workplace Health and Safety Queensland, have been delivered since 2009, from the

<sup>89</sup> [www.health.gov.au/in...nsf/Content/resources-1/\\$FILE/p2\\_mask.pdf](http://www.health.gov.au/in...nsf/Content/resources-1/$FILE/p2_mask.pdf).

<sup>90</sup> [www.health.gov.au/in...1/\\$FILE/infection\\_control\\_precautions.pdf](http://www.health.gov.au/in...1/$FILE/infection_control_precautions.pdf).

<sup>91</sup> [www.health.gov.au/in...nsf/Content/resources-1/\\$FILE/gloves.pdf](http://www.health.gov.au/in...nsf/Content/resources-1/$FILE/gloves.pdf).

Tablelands to Toowoomba with one more workshop scheduled for late August 2011 in Roma. It should be noted that a workshop scheduled for Bundaberg was cancelled due to a lack of nominations.

Furthermore, the Guidelines for Veterinarians set out recommendations for the need and type of PPE required when attending suspect or confirmed Hendra virus incidents. These Guidelines apply equally to DEEDI staff and private veterinarians. DEEDI also provides a number of other guidelines such as the Biosafety Policy that includes a table showing protection levels required for Low Risk, Medium Risk and High Risk animal diseases to officers to help private veterinarians form their own judgements in relation to the level of risk and level of PPE required in a given situation.

The Department has also developed a step-by-step, practical resource for veterinarians delivering advice on how to safely manage potential Hendra infections. The Veterinary practice pack is designed specifically for equine veterinarians and contains:

- a. Understanding Hendra Virus (HeV) – key HeV information booklet
- b. Reduce the risk: planning for a safe work environment fact sheet – how to deal with HeV safely, infection control procedures and personal protective equipment (PPE)
- c. Horse owner's fact sheet – information for horse owners waiting on HeV testing results
- d. Safely packing biological samples for HeV testing – poster for vet practices with step by step instructions on safely preparing samples and where to send them
- e. Equipment list and property entry procedure – weather-proof fold out designed for vets to take onsite when investigating a possible HeV case. This includes a step-by-step checklist of what is needed and how to proceed.

However, the Department cannot be responsible for delivering PPE training to veterinarians that are not in its employ, as it is not an accredited training organisation nor a manufacturer nor supplier of PPE equipment. The methods of fitting PPE vary depending on the brand of PPE utilised and the type of equipment. As such, DEEDI is not the appropriate entity to be providing direction, advice or training on how to fit and remove equipment as suggested in recommendation 15. Such training is most appropriately provided by the manufacturer, supplier or an accredited training organisation.

Instead, DEEDI's focus has been on connecting non-DEEDI veterinarians and horse industry stakeholders with PPE providers and trainers through the workshops described above and targeted communication activities (such as information distributed through the Horse Biosecurity Market Access Working Group to horse industry representatives).

...

The information provided demonstrates that DEEDI has gone to significant effort to educate private veterinarians, the horse industry, and employees about personal protection and preparedness for Hendra virus.

On this basis, DEEDI submits that **proposed opinion 16 be amended** to read:

***“QPIF’s written direction that PPE should be used in accordance with the manufactures instructions is reasonable.”***

DEEDI also submits that **proposed recommendation 15 be amended** to read:

***“QPIF continue to develop policies, procedures and publicly available fact sheets containing general advice on the protective equipment required for responding to zoonotic diseases such as Hendra virus.”***

### **Ombudsman’s analysis**

QPIF has an obligation to ensure that correct advice is given to its officers and other persons involved in Hendra virus responses regarding the correct usage of PPE. Incorrectly fitted PPE increases the risk of people being exposed to Hendra virus. As occurred during the 2009 Cawarral incident, property workers or owners will be instructed in the use of PPE by QPIF officers as a matter of course.

I remain concerned at the absence of any written direction on how to fit and remove PPE.

While manufacturers may make available instructions for the use of their products, I am also concerned that manufacturers may not provide any instructions as to the correct order in which to don PPE in relation to zoonotic diseases such as Hendra virus, and may not provide any directions as to the extent of protection required for Hendra virus.

In my view, the specific care required in relation to PPE for zoonotic diseases such as Hendra virus requires QPIF to provide written information to its officers and the public. I do not accept that it is impossible or inappropriate for QPIF to provide such guidance, particularly in light of the fact that the Commonwealth Department of Health and Ageing provides similar fact sheets to members of the public.

Finally, I note that the latest Guidelines for Veterinarians issued by QPIF in March 2011 do provide such step-by-step instructions on how to remove PPE. However, as these guidelines are specifically for veterinarians and not for horse owners, it appears that there is still a need for fact sheets. Obviously, the information in the guidelines could form the basis for such fact sheets where appropriate.

I confirm proposed opinion 16 as a final opinion:

#### **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.

I confirm proposed recommendation 15 as a final opinion:

#### **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.

### **7.2.4 Required level of PPE**

The Guidelines for Veterinarians provide that the minimum level of respiratory protection when investigating a suspect case is P2, and P3 for a highly suspect case.

One QPIF officer questioned the adequacy of the information in the guidelines. He told my officers that he was required to take a second blood sample from Winnie during the 2009 Cawarral incident after a positive PCR had been returned. At the time of taking the second sample he wore only P2 level protection. This level of protection was consistent with the guidelines because Winnie was not showing any clinical signs of disease at the time and she did not do so for several days. The officer stated:

One of my issues was that they had sufficient concern to go back and test Winnie and yet they sent me out with P2. Now at that stage Winnie was showing no clinical signs of disease and she didn't show signs of clinical disease for another couple of days. At the time that I had contact with the horse she was probably putting out her highest virus load and yet they sent me out with P2 and said that that was sufficient.

A number of other people told my officers that QPIF officers were wearing only P2 equipment during the 2009 Cawarral incident even when it was known that Winnie had tested PCR-positive and sero-positive for Hendra virus. This was confirmed by some QPIF officers. Indeed, QPIF officers tending Winnie reported wearing a P2 level of protection until the time of her destruction on 24 August 2009 (when P3 protection was used).

The Guidelines for Veterinarians current at the time provided that a horse was considered to be suspect if:

- its symptoms partially fit the case definition
- HeV is one of a number of differential diagnoses being considered
- sampling to test for HeV exclusion is necessary.

A horse was highly suspect if:

- its symptoms match the case definition very closely
- HeV is a primary diagnosis
- sampling is essential to confirm the presence or absence of HeV.

In my view, there is some force in the opinion that Winnie should have been considered a highly suspect horse from at least the time of her first positive PCR test. However, this is a matter for expert opinion. Consequently, I was of the view that there was sufficient doubt about the adequacy of the guidelines in this regard to warrant a review of the classification of suspect and highly suspect horses and the consequential PPE response.

I note that the Quarantine Policy, which was not finalised until after this time, states:

Apparently healthy horses with a PCR positive result but a negative VNT result must be resampled (blood and nasal swabs) and retested immediately. Full PPE should be worn for collection of these samples as a precaution.

How this policy interacts with the Guidelines for Veterinarians is unclear.

In my proposed report, I therefore formed the following opinion and made the following recommendation:

**Proposed opinion 17**

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

**Proposed recommendation 16**

QPIF review the adequacy of the Guidelines for Veterinarians, Quarantine Policy and related policies insofar as they concern the classification of suspect and highly suspect horses and the consequential PPE response.

**DEEDI's response**

The Director-General made the following submissions in response to my proposed report:

The current wording in proposed opinion 17 is confusing given that horses that test positive to Hendra virus are classified as a positive case of Hendra virus and the terms suspect or highly suspect do not apply. As such, DEEDI requests that **proposed opinion 17 be withdrawn**.

**Ombudsman's analysis**

The evidence from a QPIF officer and others who attended the 2009 Cawarral incident is that a PCR-positive horse was treated by QPIF officers who were only wearing P2 PPE after the PCR-positive results had been obtained. One reason given for this practice was the fact that clinical signs had not yet developed.

Following the drafting of my proposed report, an updated version of the Guidelines for Veterinarians has been published in March 2011 and these guidelines now use the terms exclusion case and suspect case. Under both categories it is stated that veterinarians should implement their Hendra virus infection control procedures to investigate and sample these cases.

However, given the focus of the guidelines on handling potential Hendra virus infection in horses and the repeated statements that Biosecurity Queensland will manage confirmed Hendra virus cases, there is no definitive statement on the level of PPE required for handling horses who are confirmed as Hendra virus positive.

After taking account of the new terminology used in the 2011 version of the Guidelines for Veterinarians, I have formed the following opinion.

I confirm proposed opinion 17 with amendments as a final opinion:

**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.

I confirm proposed recommendation 16 with amendments as a final recommendation:

### **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.

Finally, my officers were told about a number of problems with PPE:

- PPE being too small for an inspector involved in the 2008 Proserpine incident and resulting in exposed skin on his arm
- a similar incident occurring during the 2009 Cawarral incident, where a QPIF officer had not taped his gloves to his sleeves and a patch of skin was exposed
- during at least the first week of the 2009 Cawarral incident, the QPIF emergency response trailer containing equipment necessary to charge the P3 respirators was not available in Rockhampton
- concern about PAPR equipment failing during the Cawarral response, although my officers were told that this may have been due to the equipment being improperly decontaminated because officers did not know how to use it properly
- QPIF officers discovering that their overalls were not waterproof after assisting with the autopsy of a sero-positive horse.

A number of other health and safety issues were raised with my officers:

- that proper hydration was not managed well when using PPE during hot weather
- that there is a lack of information about the length of time officers can safely wear PPE
- that there is a concern that PPE is unsuitable for use in the Queensland climate and not of sufficient quality
- that not all QPIF officers have been trained in the use of PAPRs
- that not all QPIF officers have been provided with PPE training in responding to zoonotic diseases.

While I have not specifically investigated these issues, the fact that a number of PPE issues were raised with my officers suggests that further training (including practical training) is required for QPIF officers to be familiar with and comfortable in PPE, use PPE correctly and be able to train horse owners or property workers in contact with infected and potentially infected horses during Hendra virus incidents in the use of PPE.

This is consistent with feedback from QPIF officers that such training is needed.

In my proposed report, I formed the following opinion and made the following recommendation:

#### **Proposed opinion 18**

There is uncertainty among QPIF officers about the appropriate range of PPE available to them and the correct use of this PPE during Hendra virus incidents.

### Recommendation 17

QPIF:

- (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.

### DEEDI's response

The Director-General responded:

Departmental staff involved in animal biosecurity work all have an emergency response kit that includes respiratory gear. Respiratory gear was purchased for staff and distributed with respiratory training provided by the supplier (Protector All Safe) in 2009-10 with major sessions held at Brisbane, Toowoomba and Townsville covering 50 staff.

DEEDI reviews and updates its internal staff respiratory management program when needed as evidenced by its 2008 document titled "Respiratory management program for zoonotic disease investigation and responses, chemical sprays, volatile or oxygen replacement gas exposures". That document was available to staff from 2009. As approved in 2010, it now includes reference to the new model (the M98) respiratory masks purchased in 2010, adjustments and updates resulting from feedback.

Staff are informed that they need to be aware of a variety of environmental factors when attending a suspected or confirmed Infected Property (*IP*), including the risk of heat stress. As with many aspects of biosecurity responses, officers are required to exercise their own professional judgement before entering an IP. DEEDI always attempts to ensure that staff feel protected in such situations and makes it clear to officers if they have any concern about personal safety, they should not put themselves in a situation where they feel unsafe or at risk. This is supported in the DEEDI's Workplace Health and Safety Policy Statement that states "No task is so important that you should place yourself or others at risk. If is not safe, then you should not undertake the task until it can be done safely".

### Ombudsman's analysis

Over the course of the investigation I obtained clear evidence from QPIF officers that during Hendra virus incidents there was uncertainty about the correct use of PPE and there were concerns about unsuitable or inadequate equipment. I acknowledge new respiratory equipment has now been purchased for QPIF officers and relevant training may now have been provided.

However, QPIF must have an ongoing commitment to the regular provision of PPE and training in its use.

For this reason, I consider that it is still necessary to form the following opinion and make the following recommendation:

I confirm proposed opinion 18 with amendments as a final opinion:

### **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.

I confirm proposed recommendation 17 with amendments as a final recommendation:

### **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.

## **7.2.5 Inconsistent practices over PPE**

My officers were provided with a number of examples of situations where property or horse owners felt that inconsistent practices were adopted concerning the level and type of protective equipment provided. These examples included:

- property owners without PPE being asked to catch and hold horses for testing and assist QPIF officers who were wearing full P2 or P3 PPE
- at least two instances of owners of DCPs being forbidden from approaching their horses without PPE, after having fed and cared for their horses during the initial weeks of the incident without equipment as a result of being told by a different QPIF officer that they did not need it<sup>92</sup>
- a private veterinarian in one incident and a horse handler in another incident being asked to accompany QPIF officers to test a horse suspected of having Hendra virus, where the officers were in full PPE but no PPE was offered to the veterinarian or horse handler. In the incident relating to the horse handler, the horse handler accidentally touched fresh blood smears on a stable door during this testing
- a property owner of an IP being provided by QPIF with paper overalls which were not impervious to fluids, and being left to care for a suspect horse without goggles or disinfectant
- horse owners reporting that they were not shown how to use and safely remove PPE
- a horse owner who, in assisting a QPIF officer with the euthanasia and limited autopsy of a highly suspect Hendra horse, had to manhandle the horse carcass into a front loader for burial and ended up with blood-soaked jeans.

Concerns also arose from QPIF's practice of having officers generally don PPE at the gate of the property, and therefore wearing at least some protective equipment throughout the 'clean' zones of the property despite having told property owners that protective equipment was not necessary in these 'clean' areas. I have discussed this further in chapter 12. Similar concerns were raised by horse owners who saw QPIF

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<sup>92</sup> I also note that, consistent with my comments in section 7.1.1, such directions to horse owners would be inconsistent with QPIF's powers under the Stock Act.

officers disinfecting their boots on leaving their properties, but not taking other PPE precautions while on the properties.

In my opinion, these inconsistent practices on PPE requirements are both unnecessary and, assuming that the higher level of PPE protection in each case was warranted, could have exposed a number of horse and property owners to the risk of infection.

I note, however, there is no suggestion that any harm was suffered as a result of these inconsistencies.

In my proposed report, I formed the following opinion and made the following recommendation:

#### **Proposed 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.

#### **Proposed Recommendation 18**

QPIF:

- (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.

#### **DEEDI's response**

In response to my proposed recommendation 18, the Director-General stated that QPIF has engaged in extensive communication with horse owners and private veterinarians in relation to the possible risks of exposure to Hendra virus and steps that should be taken to minimise risk.

He further advised that:

In doing so, DEEDI has made a number of publications available to the public via information sheets contained on the QPIF website, contact with industry associations such as the Australian Horse Council and AVA as well as direct communication with over 100 veterinarians across Queensland.

DEEDI is constantly refining its message and methods of communication with industry.

DEEDI submits that **proposed recommendation 18 be amended** to acknowledge the communications that it already has in place in relation to PPE use.

#### **Ombudsman's analysis**

While I acknowledge that there has been an improvement in QPIF's communication with horse owners and veterinarians regarding the use of PPE, in my view there remains a need to ensure that QPIF officers adopt and communicate consistent practices about PPE requirements in future Hendra virus incidents. Whether QPIF's

current communication practices are adequate was not an issue within the scope of my investigation, which examined its communication processes between January 2006 and December 2009.

However, I have made one amendment to my proposed recommendation 18 in light of the Director-General's submissions.

I confirm proposed opinion 19 as a final opinion:

**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.

I confirm proposed recommendation 18 with an amendment as a final recommendation:

**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.

These examples also raise liability issues for QPIF in complying with its obligations under the WHS Act or as part of its broader duty of care. I discuss this issue further in sections 7.2.7 and 7.4.2.

### **7.2.6 Gathering temperature data**

The Quarantine Policy states in relation to every horse on IPs and DCPs:

HeV is present in nasal swabs and in blood around the time that the horse's temperature starts to rise. The temperatures of every horse should be taken daily if this is safe, reasonable and appropriate.

The policy provides, by way of example, that temperatures should be taken of all high risk horses that are stabled and not showing clinical signs of Hendra virus. It also states that temperatures should not be taken if the horse has to be caught in a paddock, as the data may be unreliable due to the horse's exertion.

However, there is no other guidance as to what constitutes safe, reasonable and appropriate circumstances in which to collect temperature data, nor does the policy state who should have responsibility for collecting the data. As discussed in section 7.2.7, there are potential liability issues for QPIF if it asks property owners or horse owners to collect such data.

I confirm proposed opinion 20 as a final opinion:

**Opinion 20**

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

I confirm proposed recommendation 19 as a final recommendation:

**Recommendation 19**

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

**7.2.7 Involvement of property owners**

In some Hendra virus incidents, QPIF officers have asked horse owners to assist them in obtaining samples for testing, carrying out autopsies, and euthanasing and burying horses.

If QPIF officers ask property owners or workers to assist them with any tasks, QPIF will be required to take reasonable steps to ensure their safety. This should include an induction or other instructions, and will also include the provision of adequate PPE.

It is possible that where property owners or property workers are asked to assist QPIF, there will be health and safety obligations under the WHS Act. For example, property workers might be considered to be workers' of QPIF for the purposes of the WHS Act if they are asked to obtain temperature data or conduct visual observations of horses for QPIF, whether or not a property is under quarantine.

Therefore, despite QPIF telling property owners that they remain responsible for the health and safety of their workers, QPIF may have some liability for the health and safety of these workers where the workers are carrying out any tasks at the request or direction of QPIF.

I note that the Guidelines for Veterinarians discuss the health and safety obligations of property owners and private veterinarians, but do not discuss QPIF's health and safety obligations during Hendra virus incidents.

In this regard, the AVA submission to my investigation stated:

However, the 2009 Review also notes that there appears to be uncertainty over the range of obligations and responsibilities that may exist on a premise that is under quarantine due to Hendra virus.' The Review concludes that there is a need for clarification of the various workplace health and safety obligations and responsibilities of people who may be involved in activities on an IP (a property that is under quarantine order authorised by relevant state legislation), and more particularly for those activities that may be unrelated to the control of Hendra virus. In the case of obligations and responsibilities for people who are not QPIF employees (farm owner, farm staff, private veterinary practitioners, industry labour), there appears to be a need for provision of advice and support to assist individuals to realise their responsibilities and to manage their own conduct to ensure minimisation of exposure risk or of other adverse events.'

The 2009 Review also points to text in the Guidelines on page 14 which implies that Biosecurity Queensland will accept responsibility for the management of all workplace health and safety risks on an IP.

Further, a QPIF officer told my officers that having QPIF officers on an IP wearing P3 equipment when having contact with a highly suspect or known positive horse could create another issue, because the property owners were only supplied with P2 by QPIF. In such a situation, there may be a perception that QPIF officers are giving inadequate advice or protection to property owners.

This issue would be further complicated if QPIF had assumed responsibility for the property owner's protection by issuing them with PPE and requiring them to follow certain procedures. In such situations, there could be some liability for QPIF if, for example, a property owner became infected as a result of wearing a lower level of PPE than required by the situation.

It is clear that this issue warrants further investigation by QPIF, perhaps in conjunction with WHSQ. In my proposed report, I therefore recommended that QPIF seek advice from Crown Law, and WHSQ if necessary, to determine what responsibilities and liability it may have to property owners and property workers in a quarantine situation, and whether its policies and procedures are adequate.

In response to my proposed report, the Director-General advised that DEEDI had commissioned advice to clarify the issues identified in my proposed opinion 21.

I confirm proposed opinion 21 with an amendment as a final opinion:

**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.

I confirm proposed recommendation 20 as a final recommendation:

**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.

### 7.2.8 Necessity of baseline blood tests for QPIF officers

In relation to Hendra virus and humans, baseline blood tests provide a starting sample against which QH can compare later levels of antibodies in a person's blood.

Several submissions to my investigation from QPIF officers suggested baseline blood tests should be organised by QH for QPIF officers before they enter a quarantine site. I was told that often QPIF officers were not tested until several days after entering the site.

One person told my officers that in:

... both incidents at Rockhampton and Redlands, DPI staff have entered quarantine sites without having their baseline bloods done and if we needed to react to that and those people got sick, there's no baseline testing to say that they didn't have antibodies or some conflicting blood results that was going to interfere with testing or, and so that's happened twice now. And I think Queensland Health probably need to not assume DPI's got it under control, because if this response happens in such a hurry and they have an influx of all these people, surely Queensland Health could have someone on site, in a van, and do seven people, all their bloods, get them all sorted and take it away. From then on, I understand the instructions are you've got to go and find your GP, you've got to go the doctor and get it done. But when these guys are all hauling in there to get it locked down and secure, some of them didn't do it for four days, and I believe in Rockhampton, a couple still haven't had it done, and where are the checks and where's the process? I think that's not good.

The QPIF induction document for staff involved in Hendra virus responses states that baseline blood tests will be taken by QH for all staff who have been into the dirty zone of an IP.

I was informed that QH officers only became aware of this QPIF policy part way through the 2009 Cawarral incident. The QH Public Health Unit (PHU) doctor told my officers:

Doctor A ...What's new in this protocol is a comment about DPI on page 11, public health unit supports Biosecurity Queensland, cause I had no idea that in the Redlands outbreak the public health unit was involved in testing DPI staff. I mean normally we don't get involved in, if DPI are trained in use of the PPE and are using PPE and don't have a breach in PPE, then by definition the risk is zero, I mean their PPE as you've described is extreme, it's extreme level of protection. So we found ourselves in a little bit of a muddle here by becoming aware that the DPI were expecting us to be contacting them, and we didn't know that, so I believe that Queensland Health needs to be written out of their protocols, because at the moment we are written into their protocols, we are written in their induction document that we will come if they're in the hot zone, we will contact them and arrange testing.

QO Officer But you didn't know that?

Doctor A At the start of this outbreak I did not know that, we discovered it very late in the week, in the first week.

QH officers also told my officers that in most instances, testing was most likely not necessary for QPIF officers provided that QPIF officers wore proper PPE on site and there had been no breaches of the protective equipment. Testing would only be required if QPIF officers developed clinical signs of Hendra virus.

However, most QPIF officers told my officers that they believed there was a need to have baseline blood tests taken before they went into the 'dirty' zone.

Therefore, there appears to be a lack of agreement between the two agencies or a lack of understanding among officers about whether baseline blood testing is required and who it is required for.

The current QH Guideline states that QH will assess the level of exposure and provide advice to QPIF staff who have been into the 'dirty' zone about what they need to do, including whether blood tests need to be taken. However, the current QH Guideline notes:

*PHU support for Biosecurity Queensland staff involved in outbreak response:*

Risk management for Biosecurity Queensland staff involved in the outbreak response is a workplace health and safety issue. However, as of November 2009, the Biosecurity Queensland Induction document for staff involved in incident response indicates that:

~~Contact details of staff who have been onto the hot zone of IP1 will be given to Qld Health. Qld Health will contact those staff and discuss their duties on IP1 and from this make an assessment on the level of exposure. Qld Health will advise staff what they will need to do. If required, blood tests will be taken. Blood samples will be taken by your usual doctor who Qld Health will also liaise with. Please ensure you notify the Logistics Manager if you attend the hot zone of IP1 and if you are not contacted by Qld Health."~~

Serological investigation of 298 people with variable exposure to horses associated with the original Hendra and Mackay outbreaks, and serologic testing of a large number associated with the Redlands and Cawarral outbreaks, indicate no evidence of asymptomatic seroconversion in humans, and no infection in outbreak response staff using appropriate PPE.

All Biosecurity Queensland staff involved in the outbreak response must have had appropriate training and use PPE accordingly. As a result, routine testing of Biosecurity Queensland staff involved in the response is **not** indicated. Testing can be advised if there is a significant breach of PPE when handling an infected horse or if there is a significant level of personal concern about potential exposure.

The concern that QPIF officers should be tested before going on to the property may also be based on a misunderstanding of testing procedures, as there is no urgency in conducting baseline serology tests.

Therefore, the issue appears to be one of both communication and different policy approaches towards whether baseline blood testing is necessary for QPIF officers. I recommend that QPIF and QH develop a common approach that has regard to current scientific knowledge as well as the understandable anxiety created for QPIF officers in responding to incidents of a zoonotic disease.

The Director-General of QH informed me that he supported the need for an agreed approach. No response was received from the Director-General of DEEDI in relation to this matter.

I confirm proposed opinion 22 as a final opinion:

#### **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.

I confirm proposed recommendation 21 with an amendment as a final recommendation:

#### **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.

### **7.3 Issues relating to quarantines**

A number of concerns were raised with my officers by property owners and QPIF officers about the quarantining of properties during Hendra virus incidents.

#### **7.3.1 When properties were quarantined**

Some concerns were raised over the timing of quarantine orders. Two properties (Redlands and Cawarral) were placed in quarantine on the day that Hendra virus was first suspected. However, the properties in the 2006 Peachester and 2008 Proserpine incidents were not quarantined until positive Hendra virus results were obtained by QPIF.

Under the former Guidelines for Veterinarians, different approaches to quarantines were specified for different categories of properties. For example, properties containing a highly suspect or confirmed horse were generally quarantined immediately, whereas those containing a horse that was merely suspect and undergoing exclusion testing were generally not quarantined until test results confirmed the infection.

The current Guidelines for Veterinarians state that the property will be quarantined by Biosecurity Queensland if it is assessed there is a strong suspicion of HeV or confirmation of HeV from sample results<sup>93</sup>.

It is reasonable for QPIF to tailor its approach to the particular circumstances.

<sup>93</sup> QPIF Guidelines for Veterinarians (Version 4.1 2001) at p.25.

### 7.3.2 Which properties were quarantined

A related issue concerns which properties are quarantined during an incident. A property worker in the 2009 Cawarral incident complained that his home property was quarantined although no horses or equipment had been moved from the IP to his home property before or during the incident. The reason given for his property being quarantined was that, before the incident was discovered, he had travelled from the IP to his home property where he fed and medicated his horses.

The property worker told my officers that:

- it was a one hour drive from the IP to his home property
- he had been told by QPIF officers that the virus was fragile, was purified by the sun and would not survive for long outside a horse
- he had been told there was no evidence that humans can give Hendra virus to horses and this had never been known to occur.

The property worker also observed that it seemed pointless to quarantine only his property, when the horses on his property had nose-to-nose contact over fences with horses on five surrounding properties, which could therefore also become infected.

The LDCC Controller told my officers that the quarantine was imposed on the worker's property because:

... he'd returned from the [IP] after a number of these events and administered medications and other things to horses on his property, including things like drenching type worming and those sorts of things to horses, where he had had his hands in animals' mouths and had returned from the [IP] without changing his clothes or washing himself or doing anything else.

The imposition of a quarantine in the 2009 Cawarral incident was inconsistent with the approach taken in the 2008 Proserpine incident, where the property owner's daughter owned horses on another property which was not quarantined, despite her having travelled back and forth to feed those horses.

Further, during the 2008 Redlands incident, I understand that the quarantine was imposed only on the IP despite horses having left the clinic before the incident. I have been informed that many of these horses were not quarantined on their home properties.

I am not suggesting that QPIF should have quarantined the daughter's property in the 2008 Proserpine incident, or the properties of all traced horses in the 2008 Redlands incident. Rather, I am questioning the inconsistent approach in the 2009 Cawarral incident, and whether this approach was justified by the scientific evidence. I have not been provided with any evidence to suggest that advances in scientific knowledge between the 2008 and 2009 incidents justified this change of approach.

The quarantine of the Cawarral worker's property may fit within the definition of a 'Dangerous Contact Premises – High risk fomite property' within the Quarantine Policy. However, this policy was drafted after the Cawarral incident commenced. I have been unable to identify any previous policy under which such a quarantine was prescribed.

In relation to why the worker's property was quarantined in the first place, one senior QPIF officer told my officers that in his view, QPIF's response was over the top but that it was better to over-react than under-react.

Now that the Quarantine Policy has been finalised, I would expect that a consistent approach will be followed by QPIF in all future Hendra virus incidents.

### 7.3.3 How properties were quarantined

An issue was raised with my officers about whether QPIF took adequate steps to prevent members of the public from inadvertently having contact with quarantined horses.

For example, in the 2008 Proserpine incident, the property owners felt that quarantine signs should have been placed along the boundary. Their main concern was that a public road ran alongside the property and at one point, the seroconverted horse Thomas was in a paddock adjacent to the road. The owners observed a member of the public approach the horse from the road and attempt to pat him, at a time when the horse was possibly infectious. Fortunately, a QPIF officer and a family member were present and stopped this from occurring.

A similar situation arose in the 2009 Cawarral incident, where the horse paddocks also bordered a public road. Early on, concerns were raised with QPIF officers by the property owner and his staff about the public and media being able to touch quarantined horses over the front boundary fence. There was also a concern that horses were often ridden down the front nature strip, which may have allowed them to have nose-to-nose contact with quarantined horses.

Local QPIF officers also expressed concern about this issue. Complaints by the property owner to the Mayor resulted in Rockhampton Regional Council workers delivering fencing equipment to the front gate of the property. However, the council workers refused to erect the fencing. A QPIF inspector was advised not to erect the fencing as the land was owned and controlled by the council. In the end, the fencing lay there untouched and the property owner erected his own reflective tape barrier around the boundary fence.

I understand that similar concerns were raised in relation to the 2009 Bowen incident, although in that case the concerns related to QPIF's failure to affix quarantine signs to a property adjoining the IP, which backed onto a public road.

Under the Stock Act, the inspector imposing a quarantine is authorised to erect quarantine signs on a property and to specify in the quarantine notice conditions for the isolation or confinement of infected or suspected stock. There is no blanket requirement that quarantine signs be erected, and this was not done in all incidents even though it could have assisted in preventing infected or suspected horses from having contact with humans or other horses.

The Quarantine Policy states that for high risk close contact properties, QPIF will:

Remove or prevent contact with IP horses (e.g. install double fencing, remove DCP horses from boundary paddock).

However, while the policy clearly states that this action applies only to properties that have close contact with horses on an IP, that is, neighbouring properties, the

example given in the policy suggests that the action is also meant to apply to horses on all high risk close contact DCPs. There is, however, no express requirement in the policy that any steps be taken to isolate horses on these DCPs.

I confirm proposed opinion 23 as a final opinion:

**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.

I confirm proposed recommendation 22 as a final recommendation:

**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.

### 7.3.4 Tracing

When incidents of Hendra virus are identified, QPIF generally undertakes a program of tracing and identifying other horses that may have had contact with the infected horse or property. Tracing refers to the activities undertaken by the QPIF response team to identify horse movements on and off the IP and DCPs within a relevant period (approximately 30 days before the first suspected case of Hendra virus is identified).

It was alleged that on three occasions during the 2008 Redlands incident horses were not traced or samples taken in a timely manner, and that QPIF's actions were inadequate.

My officers made inquiries of a senior QPIF officer, who stated that one of these instances was the result of human error. My officers were also told by QPIF officers that QPIF could only conduct tracing in response to information provided by the property and horse owners, and if all of the necessary information is not provided tracing may be compromised.

Despite there being a small number of errors in the tracing during the 2008 Redlands incident, I am not satisfied that QPIF's actions during this incident were unreasonable within the meaning of the Ombudsman Act sufficient to justify my forming an adverse opinion. I have seen no indication that QPIF refused to carry out traces once advised of relevant information.

However, further tracing issues arose during the 2009 Cawarral incident. Local QPIF officers told my officers that tracing was not done early in the incident, on a systematic basis, by experienced officers. Instead, early efforts relied on verbal accounts given to QPIF officers and the officers did not attempt to verify these. My officers were told by QPIF officers of instances where relevant information was not reported to the LDCC and QPIF officers did not speak to horse and property owners initially. The lack of an incident form or other procedures that enable QPIF officers to

regularly report back to the LDCC information provided by property owners was said to have contributed to these difficulties.

As a result, my officers were told that new tracing information was still coming to light on day 19 of the incident, and that systematic tracing began again on day 22. This led to undertakings still being obtained from property owners on 31 August 2009, three weeks after the incident was first discovered.

I accept that tracing may be complicated by various factors during an incident response, including by reliance on people's memories and willingness to provide information, and the accuracy of records kept by property owners of dates of entry to and exit from a property.

However, tracing is obviously an important part of an incident response and must be done efficiently and effectively and as soon as practicable.

The Quarantine Policy sets out what tracing should be done during an incident but it does not provide a timeframe for the tracing to be completed.

Having reviewed the processes adopted by QPIF to conduct tracing activities, in my proposed report I formed the view that QPIF's tracing activities during the 2009 Cawarral response were inadequate. I formed the following opinion and made the following recommendation:

#### **Proposed 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.

#### **Proposed 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.

#### **DEEDI's response**

The Director-General made the following submissions in response:

In all biosecurity emergency responses, tracing is prioritised and undertaken accordingly. Tracings to and from infected properties are given high priority. However the ability to quickly and accurately conduct tracing activities is largely dependent on the information provided by clients and the accuracy of their record-keeping. There are limited requirements for horse owners to keep records of movements and DEEDI officers are frequently required to commence tracing on the basis of very little (and frequently inconsistent) information. It is not uncommon for tracing to continue over several weeks as more information comes to hand.

In the Cawarral incident, tracing began from when the first officer arrived on the property following the suspicion of Hendra virus and continued when Hendra virus was confirmed. Furthermore DEEDI maintained regular contact with those horse owners involved in the tracing, on a daily basis for high risk horses.

DEEDI does have a standard template for information gathering that was used from the second week of the 2009 response. Prior to that, written notes were taken. As part of internal quality assurance, a review of tracing was undertaken by specialised tracing officers on 30 August 2009. This included interviews with the owners of the horses on the infected property. No significant tracing shortfalls were found.

Under the proposed Biosecurity Bill horse owners will be required to keep movement records which will help address the issues around the poor record-keeping by horse owners. Additionally tracing will be enhanced by a (computer-based) Biosecurity Surveillance, Incident, Response and Tracing (BIOSIRT) system which DEEDI is putting in place to help manage emergency responses.

The difficulties in tracing in the Cawarral incident were a result of poor record-keeping by horse owners and the difficulties of the owners in recalling horse movements, and not due to the timeliness of the response or poor record-keeping by DEEDI.

On the basis of the contextual information provided, DEEDI submits that **proposed opinion 24 be amended** as follows:

***“QPIF’s tracing activities during the 2009 Cawarral incident were reasonable.”***

### **Ombudsman’s analysis**

QPIF officers who were on the ground during the 2009 Cawarral incident informed my officers of delays in experienced officers conducting systematic tracing. I note QPIF’s advice that specialised tracing officers became involved in the response on 30 August 2009. However, this was at least 20 days after the incident response began. Based on evidence obtained from QPIF officers involved in the Cawarral response, I remain of the view that the failure to use experienced tracing officers and a standard form to gather information relevant to tracing activities earlier contributed to delays.

I have already accepted that tracing may be complicated by reliance on people’s memories and willingness to provide information, and the accuracy of records kept by property owners of dates of entry to and exit from a property. However, given the obvious importance of identifying other infected premises, evidence from QPIF officers that tracing had not been completed weeks after the response commenced concerns me. Therefore, I am not satisfied that tracing was completed efficiently and effectively and as soon as practicable.

QPIF’s claim that no significant tracing shortfalls were found following a review of tracing activities does not provide any indication as to what it considers would constitute a significant shortfall. Certainly the evidence provided to my officers was that new horses were being identified and new quarantines or undertakings imposed almost 20 days into the response. I cannot accept that this was reasonable or that these shortfalls were insignificant.

The Director-General submitted that any difficulties with tracing will be improved by the introduction of the computer-based Biosecurity Surveillance, Incident, Response and Tracing (BIOSIRT) system. However, the Director-General gave no timeline for when this system would be operational. My understanding, from interviews my officers conducted with QPIF officers, is that the introduction of BIOSIRT has been planned for a significant number of years and that it has still not been introduced. Therefore, in the absence of any clear timeline for delivery, I am unable to accept that the introduction of BIOSIRT in itself is sufficient to rectify any tracing deficiencies that may occur in the future. Until BIOSIRT’s implementation, QPIF must ensure that

existing systems are improved to ensure quick and accurate tracing activities in the event of another Hendra virus incident.

For these reasons, I have retained the opinion and related recommendation expressed in my proposed report.

I confirm proposed opinion 24 as a final opinion:

#### **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.

I confirm proposed recommendation 23 as a final recommendation:

#### **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.

I have commented generally in chapter 11 about the adequacy of some of QPIF's record-keeping systems.

### **7.3.5 Identification of horses**

During interviews, both QPIF officers and members of the public expressed concerns about issues relating to the identification of horses during incidents. Some of the problems described were:

- QPIF officers being confused over which blood sample came from which horse, due to a lack of, or poor, horse identity records
- delays in QPIF obtaining details needed to complete document requirements for quarantines and undertakings.

In one instance, a QPIF officer allegedly rang a horse owner and identified himself as the QPIF officer who had tested their horse that morning. The officer then proceeded to ask for details of the colour, brands and sex of the horse he had tested that morning.

QPIF officers also commented that some problems were compounded by:

- horses being identified by multiple names, that is, a stable name, a racing name and a pet name
- conflict between details provided by QPIF staff of horse identification and the identifying information provided by horse owners
- confusion about who lawfully owned agisted horses.

My officers were told by QPIF officers that initially during the 2009 Cawarral incident horse identification details were collected either inconsistently or not at all. After some time, QPIF officers began completing identification forms for each horse, showing features such as colour and distinguishing marks.

However, identification collars were not put on horses until approximately 25 August 2009, 17 days after the incident began. QPIF officers told my officers that on day 19 of the incident, they were still having difficulty with QPIF officers taking blood from horses at DCPs and not recording sufficient details to be able to identify them.

One QPIF officer told my officers that this situation cost QPIF a significant amount of time, and made its officers look incompetent.

My officers were told that the issue of horse identification became a very significant one when a horse (Winnie) returned a positive PCR test result and QPIF was not sure which horse the sample was obtained from. My officers were told that the issue was resolved by obtaining and testing further samples.

It seems that the difficulties experienced in the 2009 Cawarral incident in relation to horse identification were not isolated ones. A QPIF officer told my officers that the issue had been raised at a number of meetings, but a different approach had not been taken.

My officers confirmed that the issue of horse identification was also raised during the 2008 Proserpine incident, where QPIF officers did not adopt a method of identifying horses and there was confusion over which horses samples came from.

It seems that problems in identifying horses correctly and matching samples to the horses also arose in the 2008 Redlands incident, which again involved a large number of horses. The 2008 AAR Report commented on these deficiencies.

In my view, it is not satisfactory that QPIF is continuing to have problems with horse identification where this issue has been raised in relation to previous incidents.

QPIF should use a reliable identification system (for example, horse collars) from early in an incident response, so as to reduce its reliance on others for information about a horse's identity.

I confirm proposed opinion 25 as a final opinion:

**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.

I confirm proposed recommendation 24 as a final recommendation:

**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.

**7.3.6 Identifying the index case**

It has been alleged by a member of the public that the deaths of three horses at the Redlands clinic in June 2008 were due to Hendra virus. The owners of some of the horses are also of this view.

The deaths occurred before QPIF was notified about the 2008 Redlands incident.

The Guidelines for Veterinarians state:

Three horses have unresolved Hendra virus status from this incident—all died at [the Redlands clinic] in the month prior to the first confirmed case with clinical signs consistent with possible Hendra virus cases. Necropsies were not completed on the horses and only limited laboratory samples were available to allow further testing. The samples were negative for Hendra virus on the tests able to be undertaken.

In support of the belief that QPIF ignored evidence that these horses died of Hendra virus, the member of the public provided my Office with an analysis of departmental documents (obtained under freedom of information laws) and other material.

It is not the role of my Office to determine whether the horses died from Hendra virus, but I have considered QPIF's response to the 2008 Redlands incident during my investigation. In particular, I have had regard to whether there is any evidence to support the allegation that QPIF ignored evidence suggesting these horses died of Hendra virus.

I have also had regard to the fact that by the time this issue was raised with QPIF, the exhumation and testing of the horses would not have yielded any reliable results for Hendra virus. It follows that the health status of the horses could not be confirmed through further testing, as only blood smears had been retained by the commercial laboratory which were insufficient to give a conclusive result.

I have confirmed that in the early stages of the incident, QPIF did consider the possibility that the horses died of Hendra virus, and whether the first horse to die, Casemma, was the index case. Identification of the index case enables effective tracing of animals to determine the extent of the disease and contain all possible infections. The other horse considered as the possible index case was Truly Gifted, which was the first horse confirmed through testing to have died of Hendra virus.

Minutes from the QPIF HeV Expert Group teleconference on 11 July 2008 recorded the evaluation of the two possible index cases as follows:

- Two hypotheses were being investigated as per the report.
  - –Truly Gifted”, the index case for one of the hypotheses has been verbally confirmed by AAHL as positive on immuno-histochemistry. A couple of points that are not fully supportive of this hypothesis are being considered:
    - Current evidence indicates that the incubation period between –Truly Gifted” and the second horse in this hypothesis –Noddy” is very short (too short based on known incubation periods?).<sup>94</sup>
    - Also, this hypothesis relies on a spill over from a bat to –Truly Gifted” on the premise; however, the yard –Truly Gifted” has been held in for a long time does not support exposure to bats – no tree cover, not attractive to bats.
  - –Cassamma” is the index case for the second hypothesis. No samples are available from this horse and another 2 horses that died on the premises after –Cassamma” other than blood smears available from QML (rest of samples discarded according to normal QML policy). These have been sent to QHSS for testing. A negative result will not confirm absence of disease as these are not ideal samples for confirmation of HeV.<sup>95</sup>
    - Assuming –Cassamma” as the index case, incubation periods to subsequent horses that have died &/or are known positive fit within current knowledge.
    - Assumes –Cassamma” was exposed prior to entry to the premise and spread on the premise occurred post introduction.
    - A companion pony to –Cassamma” on their property of origin also got sick at about the same time and is still alive. This pony was sampled yesterday.

Having considered the possibility that the horses died of Hendra virus, QPIF decided that there was insufficient evidence to conclude that they had. A template email response used by the Chief Veterinary Officer (CVO) when responding to the question of whether the first three horses were Hendra virus cases stated:

The three horses were identified for further investigation by DPI&F because their cause of death had not been conclusively established. Having considered all of the available epidemiological information (not just clinical signs, but issues such as incubation periods, known contact with other horses etc) our position is that, while we cannot conclusively rule-out Hendra virus as the cause of death of these horses, we believe it is improbable that they were cases.

My officers also asked AAHL Veterinarian Pathologist Dr Middleton her view of the Hendra virus status of the horses. She advised that in her view, there was a high chance that they were Hendra cases based on their clinical histories and the proximity of their deaths to the known Hendra virus incident.

I have seen no evidence to suggest that QPIF had any motive for claiming that Truly Gifted was the index horse if this was not the case. There is no evidence that QPIF fabricated or altered material to make it more plausible that Truly Gifted was the index case, as was alleged by the member of the public.

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<sup>94</sup> In relation to this document, the Director-General of DEEDI advised me that this is an incorrect record as the second horse in this hypothesis was Tamworth. He also advised that knowledge subsequent to this teleconference confirmed that Truly Gifted had contact with Tamworth 2-3 days before Truly Gifted showed clinical signs, meaning that the incubation period fell within the known range.

<sup>95</sup> The Director-General of DEEDI advised me that subsequently identified laboratory results on Cassemma specifically commented that Cerebrospinal fluid (CSF) findings were not consistent with an acute infectious disease and thus supported Truly Gifted being the first case.

It appears that this comes down to a difference of opinion and is a matter for the experts to determine. I do not intend taking any further action in respect of these allegations.

### 7.3.7 „Clean“ zones and „dirty“ zones

During each Hendra virus incident, QPIF identifies two different zones on each IP:

- The dirty‘ or hot‘ zone is the area in which all infected or potentially infected horses are kept, including stables and paddocks. QPIF advised that anything situated in the dirty‘ zone at the time of the quarantine should not be removed without thorough disinfection.
- The clean‘ or cold‘ zone is the area where there is considered to be no risk of infection and where no precautions are recommended.

Concern was expressed by the property owner in the Cawarral incident that the area designated as the clean‘ zone was assumed by QPIF to not be contaminated even though it had not been tested or decontaminated. In particular, concerns were expressed about the patio area outside the house on the property, where property workers and QPIF officers regularly sat after attending to the horses.

My understanding is that a private veterinarian advised the property owner that there was no certainty that the patio was clean‘ and that it would need to be disinfected. The property workers and the private veterinarian undertook a lengthy process of disinfecting the entire patio area some days after the quarantine began, which included the spraying of disinfectant, use of a high pressure water cleaner and the owners discarding furniture that had been used on the patio.

The property owner complained to my officers that QPIF should have tested the furniture and other things on the patio to ensure that the area was in fact clean‘.

However, QPIF officers told my officers that the area had been designated as a clean‘ zone because it was away from the horses, and the nature of the disease was such that it did not survive in that environment. They also referred to research suggesting that the virus can only survive in environmental conditions for a few days, and only then in ideal conditions.<sup>96</sup>

Nevertheless, it is clear that there was a significant amount of concern among the property owners, workers and the private veterinarian that they were being put at risk of contamination.

My officers asked Dr Middleton whether she thought such disinfection processes were necessary. In her opinion, such processes were unnecessary as the virus is not highly transmissible. However, she recognised that as the virus can be fatal for human beings, the reality is that some people will be unwilling to accept any level of risk.

This incident again highlights the need for QPIF to provide clear information and instructions to property owners, including information about the nature of the disease. I have discussed this issue further in chapter 12.

<sup>96</sup> This was discussed in section 3.1.4.

### **7.3.8 Burial of horses**

In most cases, horses that were suspected to have died of Hendra virus were buried on the property where they died. Concerns have been raised about the burial of horses.

There is some uncertainty within QPIF and also among property owners who have been involved in Hendra virus incidents about issues relating to the burial of horses.

In the 2008 Redlands incident, there were delays in transporting and disposing of one horse after it was euthanased. I understand that the delays were due to difficulties in finding a new waste disposal contractor after the usual contractor refused to transport the carcass. These issues have since been rectified by QPIF.

In the 2008 Proserpine incident, the first three horses that died were buried in a gully on top of sleepers and sand, with sand then piled over the carcasses. The property owner's daughter told my officers that QPIF officers merely inquired about the burial location of the horses and did not inspect the burial site to assess its suitability until the fourth and final horse was to be destroyed. At this time, QPIF officers discovered that the site was not suitable for burials, and a different burial site was used for the fourth horse.

The daughter felt that QPIF should have inspected the burial site when Hendra virus was first identified, and ensured that subsequent horses were buried appropriately.

In the 2008 Perkins Report, Dr Perkins also expressed the view that the process adopted by QPIF in Proserpine was flawed. His report stated:

In this case it is considered unlikely that further action would have been warranted particularly exposing and reburial of horses after they had been buried. However, there was an opportunity for feedback on the site prior to the disposal of the second confirmed Hendra case and for selection of an alternative site if the original site had been deemed inappropriate.

In relation to disposal of carcasses, the Guidelines for Veterinarians now state:

#### **4.9. Carcass disposal**

If a carcass is held until the results of the investigation are known, the owner or person in charge remains responsible for the disposal. The owner or person in charge can dispose of the carcass using their normal methods if HeV is not diagnosed or not suspected.

Biosecurity Queensland will manage the disposal of a carcass that has tested HeV positive.

If a carcass is to be disposed of before results of the investigation are known, the owner or person in charge is responsible for the disposal. Both this person and the attending veterinarian have an obligation to ensure any potentially infectious animal does not pose a risk of infection to other animals or people and does not cause environmental contamination.

Where HeV is suspected or diagnosed, care will be required in the disposal of the carcass.

The Guidelines also provide information about how to safely dispose of a carcass. Much of this information was not in the Guidelines at the time of previous incidents.

I note also that AUSVETPLAN provides some guidance on the disposal of animal carcasses and associated waste.

However, the Guidelines for Veterinarians focus on the obligations of horse owners, rather than any actions that will be taken by QPIF to ensure compliance. QPIF does not appear to have issued any guidelines to its officers concerning their role in the burial of horses.

Several QPIF officers also told my officers that the EPA (now DERM) has a role to play in the disposal of carcasses of horses infected or suspected of being infected with Hendra virus. However, officers were unable to provide an explanation of what that role was.

It appears there is significant uncertainty, including among senior QPIF officers, about whether DERM approval is required to dispose of or bury carcasses in Hendra virus incidents. For example, several senior QPIF officers told my officers variously that:

- DERM approval was required to bury a horse at a particular location
- QPIF's obligation was only to advise DERM of the location of the burial site once the horse was buried
- DERM did not have any involvement unless the amount to be buried (the biomass) reached a certain limit which would not be triggered by a single horse.

QPIF officers were also unable to explain to my officers how a horse owner's obligation in the Guidelines for Veterinarians to ensure that a horse carcass does not cause environmental contamination fits with environmental protection legislation or another legal duty. For example, QPIF officers were unsure how carcasses of horses infected, or suspected of being infected, with Hendra virus and any equipment that has been in contact with such horses should be treated under the Environmental Protection Act 1994 and the Environmental Protection Regulation 1998.

I therefore sought information from the Director-General of DERM about this issue.

The Director-General of DERM advised that DERM's primary concern was in the disposal of regulated waste as described under Schedule 7 of the *Environmental Protection Regulation 2008*. Clinical waste is a regulated waste and would include any contaminated material including horse carcasses, needles, swabs and tissue.

The disposal of regulated waste, other than at the place of generation, is a notifiable activity which must be reported to DERM.

The storage, transport and off-site disposal of any clinical waste, including Hendra virus contaminated horse carcasses, must be managed in accordance with the Environmental Protection (Waste Management) Regulation 2000.

On-site burial of horse carcasses should be in accordance with the AUSVETPLAN which is administered by QPIF with DERM available to provide support or advice as needed to minimise the risk of causing environmental harm. There is no statutory requirement for QPIF officers to seek advice from DERM in relation to the on-site disposal of carcasses.

The Director-General of DEEDI did not make any submissions about this issue. However, given that QPIF officers were unable to properly describe QPIF's role in the disposal of horse carcasses during Hendra virus incidents and were uncertain about DERM's role, there is a need for QPIF to amend its policies and procedures and provide training to officers about this issue.

I confirm proposed opinion 26 as a final opinion:

**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.

I confirm proposed recommendation 25 as a final recommendation:

**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.

## **7.4 QPIF's response generally**

### **7.4.1 Staffing and training issues**

Complaints were raised with my officers about a number of issues relating to the training of QPIF officers. I have dealt with each issue in turn.

Firstly, complaints were raised by QPIF officers, including senior officers, as well as other people involved in incident responses that some QPIF officers were assigned to certain roles in an attempt to fill the role quickly, rather than with due regard to their experience, skills and training. One QPIF officer stated that, as a result:

... we have people sitting in frontline jobs sometimes that you should not put there.

This complaint was independently made by a number of QPIF officers in relation to several different Hendra virus incidents.

In my view, if this approach was adopted by QPIF then it would not be an appropriate biosecurity response. Rather than focusing on filling roles, an agency should ensure that an officer's skills, training and experience are appropriate to the responsibilities of the role.

Although I understand that QPIF currently has a first response unit, my officers were told that in practice the members of this unit are spread around Queensland and difficulties in moving them to the right location quickly mean they are often the second-response rather than the first ones on site once an incident is discovered. My

officers were also told that not all members of this unit have completed the training course required to undertake this role and most have had no practical training. One QPIF officer told my officers that the training that has been provided to first-response officers so far has consisted of approximately four days of classroom-based training over the past two years, without any practice component.

My officers were also advised by various QPIF officers that, in relation to the 2008 Redlands incident response:

- there was only one fully trained person on the response, and this was a person who was part of the Australian Rapid Response Team
- the LDCC Controller had previously received role-based training, but this was seven years previously
- other QPIF officers had extensive experience in emergency response, but had not had formal training
- although QPIF veterinary officers and inspectors from the South East Region had extensive training in PPE, not all those officers who participated in the response were from that region.

It is also relevant to note that QPIF officers reported that despite current efforts, attempts to implement a skills register were slow, hampered by the fact that existing records of training are spread over a number of recording areas.

My officers were told that there is currently no consistent centralised way of recording who had been provided with particular training or identifying future training needs. One officer stated that QPIF does not have a software package to do this, and data of attendance at previous training courses has not been captured by QPIF.

Secondly, a number of QPIF officers identified gaps in the emergency response training that has been provided. One EMU officer explained that many people are not aware that:

... the processes for emergency management ... are completely different to the day to day activities. ... This is what we offered up. Basically it was about systems and building redundancies into the processes that are there.

...

It's more about shoring up our obligations at the control centre and also about building some continuity into the structure because people roll into these roles and they roll out again and you need to be able to pick up and keep going.

A QPIF officer involved in the response to the 2009 Cawarral incident stated:

We don't get enough training, we hardly do any training. We're supposed to be a response agency for the purposes of when something is on, but yet we don't act like a response agency because we're at a hundred percent capacity for or above just doing our other duties: and to me it's, as an analogy, it's like, you know, sending your firefighters to go and paint houses, but drop everything when there's a fire on, then we get, we go out and we purchase the fire truck and then we all stand round and somebody decides that well, in some cases, that we should be trained in this so then we get trained in how to put out a fire.

...

We do have some [training], I won't say we don't have any, but we don't have enough. And there's still, there would be staff out there who are not comfortable and not confident in using the PPE. They are rolling out some training on part of the first response unit, which is being developed. There's also the rapid response team, which is a national team. One of the issues is that the people actually are trained to work in positions are not always appointed to positions. There's people who take on roles based on their management ... positions for normal staff, not that they have any necessary expertise or a lot of experience in emergency response.

When asked by my officers to describe what sort of training was required, QPIF officers nominated:

- an infected premises site supervisor course, which was relevant not only to Hendra virus incidents but to responses to every exotic disease. My officers were told that this training had not been provided by QPIF since early 2001 and most staff who completed the training have since left QPIF
- specialist P2 and P3 training in the use of protective equipment
- risk management training, as well as refresher courses on decontamination procedures and the use of PPE
- training on communication and coordination with different sections of QPIF that are involved in the response, such as the officers involved in field activities and staff at BSL.

This is consistent with the views of the EMU officer flown to Rockhampton 10 days into the 2009 Cawarral incident to assist with the local response. He stated that the response was not going as well as it could because of a lack of awareness on the part of staff about the procedures they should follow, and:

This is a very regimented system that we want them to follow and it's something that's completely foreign to them.

One officer also identified a gap in training for emergency responses, so that officers know how to perform their assigned role, and also know how their role relates to others' roles.

A senior QPIF officer told my officers that relevant officers routinely receive PPE training. My officers were told that specialist respiratory training had been provided in the past three years, and PPE training was generally transferrable across different biosecurity incidents. However, I note that this view was contrary to the views expressed by most other QPIF officers interviewed by my officers.

QPIF officers also expressed concern about the lack of training in responding to the zoonotic nature of Hendra virus.

In conducting his review of the early stages of the 2009 Cawarral incident response, Dr Perkins also noted the need for more training. In particular, he said that:

... very few people had received positional specific training, only a small number of people had received general training.

I have not attempted to audit the qualifications and training of QPIF officers involved in the incident responses to confirm these issues.

In response to my proposed report, the Director-General of DEEDI commented generally:

DEEDI has a training program in place to ensure that staff are trained in core emergency response skills, with many undertaking further more specialised training to fulfil the many roles that exist within a response.

However, the number of comments raised with my officers and the sources of those comments (some of which came from senior QPIF officers) in my view warrant the inclusion of the following amended opinion and recommendation in my report.

I confirm proposed opinion 27 with an amendment as a final opinion:

#### **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.

I confirm proposed recommendation 26 as a final recommendation:

#### **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.

My officers were told that many QPIF officers were required to respond to the 2008 Redlands incident while continuing to discharge their day-to-day duties. Others were required to leave their day-to-day roles but were not replaced. One QPIF officer stated:

There's always the issue of when you're involved in a response who looks after your day-to-day work, and that you get a backlog when you go back, and so in my experience, business continuity management planning has not been as good as I would like to see. Again, we're continually strapped for resources, and so really, it really puts us in difficult positions at times you know, because we want to throw the resources at these responses, and we typically do, but it comes at a cost.

The issue was also raised with my officers in relation to the 2009 Cawarral incident.

Dr Perkins commented in his 2008 Perkins Report that requiring QPIF staff to perform their ordinary duties meant that some response related tasks were not completed as quickly as desired.

I also note that business continuity planning was a recommendation made in both the 2008 and 2009 AAR Reports, as well as by the Auditor-General in his audit of QPIF in 2008. The Auditor-General's report stated:

#### **Workforce planning**

Biosecurity Queensland's responsibilities span across a number of primary industry related areas including animal welfare, use of agricultural and veterinary chemicals and

market access, as well as the protection of environmental and social amenities. In recent years Biosecurity Queensland has been responding to a number of consecutive, and at times concurrent, outbreaks of pests and diseases.

When an outbreak occurs, it is often an “all hands on deck” situation. Additional people are initially sourced from within Biosecurity Queensland and DPI&F, before external people are engaged.

Regular diversion of staff to emergency responses has a number of impacts including:

- reduced ability to meet the objectives of specific work programs
- rescheduling of functions such as surveillance, research and corporate activities
- deferral of training programs.

Biosecurity Queensland has arrangements in place to secure the assistance of technical staff who would be required in certain types of outbreaks. However there are no formalised arrangements to engage additional field staff, which can be a substantial requirement in an outbreak. The Biosecurity Group Business Plan for 2005-08 identified the need for a workforce plan, however currently no such plan is in place.

The Managing Director of Biosecurity Queensland (Managing Director) advised my officers that task alleviation and business continuity planning did occur during the Hendra virus incidents. However, the feedback I received from QPIF officers involved in the responses was that this remains an issue for them.

QPIF advised my officers that a Biosecurity Workforce Plan is currently under development. I note that it is now well over two years since the Auditor-General made his recommendation. In a recent follow up audit, the Auditor-General found that:

The Biosecurity Queensland Senior Leadership Team has endorsed a framework for the workforce plan. Though Biosecurity Queensland has committed to developing the plan through 2011-12, the weaknesses in the system identified during the original audit have yet to be addressed.<sup>97</sup>

In my proposed report, I formed the following opinion and made the following recommendation:

**Proposed 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.

**Proposed 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.

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<sup>97</sup> Auditor-General Report to Parliament No. 8 for 2011 at p.30.

## DEEDI's response

Although the Director-General of DEEDI did not directly respond to the proposed opinion and recommendation, he made the following general comment about business continuity during a biosecurity response:

When a response is actually underway, DEEDI places considerable importance on the health of staff and operates a strict fatigue management system. In order to sustain a response, people are drawn upon from all over the State and from other parts of the agency as needed. All staff are provided induction training and non-Biosecurity Queensland staff are encouraged to undertake basic emergency response training. DEEDI also prepares a communication and engagement strategy early in the response.

It is impractical to have a 'standing army' ready to respond to biosecurity incidents. Therefore, DEEDI builds preparedness activities into the day-to-day business of officers as much as possible and continually reprioritises other work once a response begins. The concept of conducting full 'normal business' alongside an emergency response is not feasible and DEEDI adopts a range of strategies to ensure critical business is sustained.

## Ombudsman's analysis

While it may be impractical to have a 'standing army' ready to respond to biosecurity incidents, formal arrangements can be developed for the redeployment of staff during biosecurity incidents. Given QPIF's past experiences of consecutive and at times concurrent biosecurity incidents, it is necessary for a workforce plan to be developed and implemented to reduce the pressure of competing priorities on staff responding to such incidents.

QPIF's response refers to non-Biosecurity Queensland staff being encouraged to undertake basic emergency response training. It is unclear which staff in particular this refers to. If it is intended that these non-Biosecurity Queensland staff will be called upon to assist with Hendra virus incident responses, then emergency response training should be compulsory and not optional.

Overall, the lack of any detail provided about what the Director-General stated was a range of strategies adopted to ensure critical business is sustained has made it difficult for me to undertake any assessment of the adequacy of those strategies. Therefore, I remain of the view that the following opinion and recommendation are necessary.

I confirm proposed opinion 28 as a final opinion:

### 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.

I confirm proposed recommendation 27 as a final recommendation:

**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.

**7.4.2 The use of private veterinarians**

In the 2009 Cawarral incident, QPIF engaged a private veterinarian to conduct a number of tasks.

Although the veterinarian performed tasks for both QPIF and for the property owner, QPIF only had a verbal agreement with the veterinarian about the tasks he would be doing and his pay rate. The distinction between work performed by the private veterinarian for QPIF and work performed for the property owner was unclear, and this had the potential to create confusion.

In this case, a written contract was not prepared until several weeks into the incident, and it was never signed. The exact terms and conditions of the veterinarian's employment and QPIF's expectations of him were therefore never settled.

In my opinion, the employment of a private veterinarian to perform work for QPIF without a written agreement about the scope and nature of this work, the rate of pay and appropriate conduct for a government contractor was both poor administrative practice and unreasonable.

In this regard, the AVA submission to my investigation stated:

It would be advantageous to clarify the responsibilities of personnel engaged on quarantined properties including individual OH&S responsibilities.

It is clear that, during a quarantine, the IP becomes a workplace of QPIF under s.9 of the WHS Act. QPIF therefore has obligations under that Act to provide a safe workplace for its employees, which will include private veterinarians who are employed by QPIF or contracted to QPIF to carry out certain tasks during a Hendra virus incident. QPIF will also have shared health and safety obligations for the area if the IP is a separate workplace for a private veterinarian employed by the property owner, as well as with the property owner if a business is conducted from the property.

If QPIF is not able to mandate requirements for PPE or limit the activities of property owners, private veterinarians or workers under the Stock Act, then QPIF's health and safety liability may require further consideration. For example, if the actions of the property owner or property workers inadvertently resulted in Hendra virus being spread over a larger than suspected area or led to lapses in quarantine procedures, this could affect the health and safety of QPIF officers. My investigators were told that QPIF officers proceed on the basis that a P2 level of PPE is all that is required in most instances, because they believe that the virus has been contained to certain areas and certain horses.

As QPIF officers are not on the IP all the time, QPIF does not currently seem to have a system for ensuring that quarantine measures are complied with or that risks arising from breaches are identified and addressed.

In my proposed report, I formed the following opinion and made the following recommendations:

#### **Proposed 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 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.

#### **Proposed 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.

#### **Proposed 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 various policies, procedures and practices in this regard.

### **DEEDI's response**

The Director-General of DEEDI made the following submissions in response:

In relation to the specific details contained in opinion 29, there were extenuating circumstances and actions taken by DEEDI to resolve a difficult situation that are not acknowledged in the proposed report.

The private veterinarian in question was one of three private veterinarians originally engaged to take blood samples from horses on the known infected premises and contact premises. Taking blood samples is a routine element of veterinarian work.

The private veterinarian was also engaged by the property owner for care and treatment of some of the horses held at the facility. Following the disease incident and subsequent media it was difficult for the owner to get other private veterinarians to attend at the property. In many ways the private veterinarian became a primary source of support for the property owner ...

Under the circumstances, it was decided that efforts would be made to continue using the private veterinarian to conduct routine procedures relating to the biosecurity response. After five days, DEEDI requested the private veterinarian to provide written details of his fee structure and asked him to commit to an employment contract. Verbal discussions about this possible arrangement began within the first few days of the response. The negotiations continued for many weeks due to the unwillingness of the private veterinarian to provide the requested information or to sign the documentation, each time indicating that he was considering legal advice regarding commitment to a written contract.

Nevertheless, a number of letters were sent to the private veterinarian confirming the conditions under which he would be paid, which included the provision of itemised invoices. The private veterinarian was paid for invoices submitted following the conclusion of the response although there remained a very small portion of the invoiced items that were unpaid due to the nature of the 'work' undertaken and the lack of authorisation of the work invoiced.

The private veterinarian was provided full instructions and information on the nature of the work prior to commencement of any tasks allocated to him. These instructions included the requirements for sampling and maintenance of samples, other observations required to be taken from the subject horses, WH&S inductions and site inductions regarding entry and exit and decontamination procedures including use of appropriate PPE.

The distinction between work performed for DEEDI and work performed by the private veterinarian for the owner was discussed many times from the first days of the response with both the private veterinarian and the owner. There were times when DEEDI had to provide specific advice to the private veterinarian not to perform some activities requested by the owner or initiated by the veterinarian himself due to the risks posed by the proposed activities.

There was considerable conflict between on-site staff and the private veterinarian and the relationship became increasingly difficult to manage. However, in the interest of supporting the property owner who had a relationship with the private veterinarian, the acting CVO intervened and again tried to have a work contact [sic] agreement signed by the private veterinarian. In the absence of a formal contract, all tasks were recorded and maintained as a record to substantiate approved activity undertaken by the private veterinarian on behalf of DEEDI.

Many discussions were held with the private veterinarian regarding WH&S, the provision of PPE, procedures related to entry and exit of the 'Hot' Zone on the Infected Premises, ancillary staff at the equine facility and their duties as well as his behaviours, including conducting high risk veterinary treatments or procedures on the subject horses at the property.

In summary, DEEDI made every effort to secure a written agreement from the private veterinarian at Cawarral. In the absence of a written agreement, DEEDI implemented a range of other mechanisms to ensure tasks were fully understood. It is reasonable to expect self-employed veterinarians to be responsible for statutory workplace health and safety obligations. But regardless of statutory obligations, DEEDI made every effort to ensure the private veterinarian was cognisant of on-site health and safety measures.

In light of these comments, DEEDI submits that **proposed opinion 29 be amended** to read:

***“DEEDI made every attempt to engage a private veterinarian to perform substantial ongoing work for DEEDI during the 2009 Cawarral incident and this constituted a reasonable administrative action in the circumstances.”***

DEEDI has commissioned the advice as outlined in proposed recommendation 29.

### **Ombudsman's analysis**

As I have noted earlier, QPIF officers made attempts to arrange a written agreement with the private veterinarian. However, I do not accept that it was reasonable for QPIF to fail to have a written agreement after several weeks had passed. The private veterinarian's alleged unwillingness to sign a contract within a short period of time should have, in my view, resulted in QPIF making other arrangements for the conduct of such routine procedures. By continuing to utilise the private veterinarian's services without a written agreement, QPIF may have exposed itself to financial and health and safety risks.

No documentation has been provided to me in support of claims that the private veterinarian was given full instructions and information concerning health and safety, the use of PPE and procedures for entering and exiting the IP. Records of such briefings or discussions should have been created at the time of the communication and evidence that the information has been adequately communicated to the veterinarian noted.

Therefore, while I acknowledge that there were some difficulties and sensitivities in relation to this issue, I am not satisfied that QPIF acted reasonably in its engagement of the private veterinarian.

I confirm proposed opinion 29 as a final opinion:

#### **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.

I confirm proposed recommendations 28 and 29 as final recommendations:

#### **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.

#### **7.4.3 The failure to report a notifiable disease**

During the course of my investigation, my officers received an allegation that QPIF failed to take action against the Redlands clinic for the clinic's failure to notify QPIF of the suspicion of Hendra virus within the timeframes prescribed by the EDIA and the Stock Act.

While I do not have jurisdiction over the actions of the Redlands clinic or any private veterinarians, I considered whether QPIF should have further investigated or taken action in relation to this matter.

The EDIA Act imposes an obligation on veterinarians to notify QPIF where they diagnose or suspect an exotic disease:

#### **8 Immediate notice of and separation of infected or suspected animal, carcass or animal product**

...

- (2) Every veterinary surgeon within the meaning of the *Veterinary Surgeons Act 1936* who diagnoses or suspects an exotic disease in any animal, carcass or animal product shall, as soon as possible after making that diagnosis or forming the suspicion, give notice of the diagnosis or suspicion to the nearest government veterinary officer by the quickest means of communication available to the veterinary surgeon.

There is also a requirement under s.27 of the Stock Act to notify a QPIF inspector of a diagnosed or suspected notifiable disease within 24 hours after making the diagnosis or forming the suspicion. Both Acts impose penalties for failing to notify QPIF within the required time.

Hendra virus is a notifiable disease under both Acts.

In June 2008, three horses died at the Redlands clinic from unknown causes. On the morning of 7 July 2008, QPIF was notified of the possibility of a notifiable disease (equine herpes virus). On 8 July 2008, test results identified the disease as Hendra virus.

At the time that the incident was notified to QPIF on 7 July 2008, there was no suggestion that the notification was tardy. After QPIF's incident response concluded, several complaints were made to the VSB about the conduct of the owner of the

Redlands clinic in response to the deaths.<sup>98</sup> The VSB instructed Mr Andrew Forbes from DLA Phillips Fox Lawyers to investigate the complaints.

In December 2008, Mr Forbes released his report into the complaints (Forbes Report) in which he concluded that on 24 June 2008 the Redlands clinic owner had discussed and suspected the possibility that the last of the three horses to die, Noddy, had been infected with and died of a contagious disease, possibly Hendra virus.

The Forbes Report also identified at least one other instance where equine herpes virus was clearly considered as at least a 'differential diagnosis' by clinic staff, by noting that all horses were vaccinated for herpes virus on 5 July 2008.<sup>99</sup> Equine herpes virus is also a notifiable disease under the Stock Act. While any failure to notify QPIF about this incident was not the focus of the Forbes Report, arguably these suspicions gave rise to an obligation to notify QPIF of the potential disease. Therefore, these suspicions may also have been something that QPIF should have considered in determining whether there had been a breach of notification obligations.

The VSB subsequently decided to take no further action against the Redlands clinic owner.

Nevertheless, it was the responsibility of QPIF to independently consider whether action should be taken against the Redlands clinic for a potential breach of the EDIA Act or Stock Act in failing to notify QPIF of suspicion of a notifiable disease.

My officers asked QPIF officers whether consideration was given to taking action against the Redlands clinic for the alleged failure to report a notifiable disease, either in respect of the suspicion of Hendra virus in relation to Noddy or the consideration of equine herpes virus in relation to the other horses.

In response, I was provided with a copy of an email from the CVO to the Manager, Strategy and Legislation, on 22 January 2009, attaching the Forbes Report and stating:

As a result of the VSB investigation of [the Redlands clinic], it would appear that we should consider whether we investigate a possible breach of the Stock Act in relation to notification of suspect notifiable disease - see page 7 of statement of reasons.

Pls give this some consideration asap. I suspect we could get asked about this now.

The CVO told my officers that:

I discussed the issue with [the Manager, Strategy and Legislation] and we decided not to pursue the matter.

However, he was unable to provide any written record of, or reasons for, this decision.

The Manager, Strategy and Legislation, told my officers that the decision not to pursue the matter was made by the Director of Animal Welfare and Biosecurity

<sup>98</sup> It is alleged by their owners that these horses died from Hendra virus. I have addressed this allegation in section 7.3.6.

<sup>99</sup> I note that the Redlands clinic owner disputes that vaccination occurred on 5 July 2008, and states that vaccination occurred on 7 July 2008 once equine herpes virus was suspected and had been notified to QPIF.

(Director AWB) and the CVO, and she was advised verbally by the Director AWB of the decision not to investigate the matter further. She stated that while she was keen to investigate both this issue and another issue relating to an alleged quarantine breach at the Redlands clinic, she was told that the CVO and Director AWB did not want the breaches investigated.

The Director AWB told my officers that, to her knowledge, the key reasons for not proceeding with the investigation were:

- there were concerns about fragmenting the relationship with the Redlands clinic, and QPIF being accused of ‘picking on’ it
- six months had passed between the time of the alleged offence and publication of the Forbes Report
- the delay in notification was not as serious as a complete failure to notify of a notifiable disease.

However, in the absence of any record of the decision not to take any further action, or of the reasons for the decision, I cannot be certain whether the decision was appropriate and reasonable in the circumstances.

I note that the Crime and Misconduct Commission observed in *The Volkels Case: examining the conduct of the police and prosecution*<sup>100</sup> that the Director of Public Prosecutions should ensure that reasons for a decision not to prosecute an individual be recorded. The report stated:

The purpose of such a document is twofold: to ensure accountability and transparency in the decision-making process, and to create a permanent record that will endure long after memories fade and personnel have gone.<sup>101</sup>

In my proposed report, I formed the following opinion and made the following recommendation:

### **Proposed 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.

### **Proposed recommendation 30**

In considering whether to prosecute for any statutory offence, QPIF officers make and retain a record of their decision not to prosecute, including their reasons for the decision and material on which they relied.

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<sup>100</sup> *The Volkels Case: examining the conduct of the police and prosecution*, Crime and Misconduct Commission, March 2003, p.44.

<sup>101</sup> *The Volkels Case: examining the conduct of the police and prosecution*, Crime and Misconduct Commission, March 2003, p.44.

## DEEDI's response

The Director-General of DEEDI made the following submissions in response to my proposed report:

DEEDI notes that section 27(2) of the Stock Act requires notification by a registered veterinarian or scientist within 24 hours of making a diagnosis or forming a suspicion of a notifiable disease. The EDIA does not specify a time frame in which to notify a suspected notifiable disease, other than that notification should occur as soon as possible after diagnosis or forming the suspicion.

At the time of the Redlands incident there was no suggestion that the requirements of either Act had not been met. The owner of the Redlands clinic voluntarily closed his clinic (as noted previously in the proposed report) and contacted the CVO early on 7 July 2008, indicating that he had a number of sick horses on his premises, but did not know what was wrong. DEEDI notes that at this time, the owner of the Redlands clinic had suspicion of another notifiable disease, namely Equine Herpes virus. A quarantine order was issued for Equine Herpes virus infection later that day. This was subsequently amended the following day upon confirmation of Hendra virus in samples obtained from the clinic on 7 July 2008.

Approximately six months after the emergency response, in about January 2009, DEEDI received a copy of the independent report commissioned by the Veterinary Surgeons Board (the Forbes Report).

The Forbes Report contained additional information that was not available to the former DPI&F at the time of the incident response, namely that the principal of the Redlands clinic had considered a possible diagnosis of Hendra virus earlier than 7 July 2008, the date on which he contacted QPIF with suspicion of an emergency animal disease.

Discussions were held within QPIF about pursuing further enquiry and the reasonableness of such action. It was determined for the reasons set out below, that further enquiry was not justified in the circumstances.

Factors that were considered in making the decision included:

- the decision of the Veterinary Surgeons Board not to pursue the matter of notification
- the substantial time between the event and the Forbes Report being published
- the fact that the owner of the Redlands clinic voluntarily closed his clinic and contacted former DPI&F on 7 July 2008, notifying that he had a number of sick horses on his premises
- the fact that the former DPI&F did not know with certainty when the owner of the Redlands clinic formed a suspicion substantial enough to warrant notification (bearing in mind that Hendra virus generates symptoms that are consistent with a number of other conditions, and the horses in question were already receiving veterinary treatment)
- considering Hendra virus as a possible differential diagnosis at a point in time does not necessarily constitute suspicion of disease
- veterinarians normally consider a range of possible causes when reviewing cases and subsequently make a provisional diagnosis
- there was no indication that the Redlands clinic had made a provisional diagnosis of Hendra virus at any time
- the fact that the Redlands clinic had already been subject to intense pressure and scrutiny both through the event itself, the media and the subsequent enquiry by the Veterinary Surgeons Board, and
- overall, there was considered to be little merit or public benefit in pursuing further enquiry into the matter.

Whilst the possibility of fragmenting relationships with [the Redlands clinic] was a concern, it was not the primary consideration underpinning the department's decision.

In relation to the decision not to investigate an alleged failure by the Redlands clinic owner to notify DPI & F under section 27(2) of the Stock Act, the Manager, Strategy and Legislation, concurred with the decision not to proceed with an investigation.

It is also not correct to say that the CVO was unable to provide reasons for this decision. The CVO is not aware of any request from the Ombudsman to provide reasons for this decision.

The former DPI&F made the decision that a preferable course of action would be to remind all veterinarians of their notification obligations. This decision was made in the context of former DPI&F estimates that fewer than 10 percent of veterinarians currently report suspicion of a notifiable disease, even when submitting samples for testing.

The Volkens case is not an apt comparison. Volkens concerned a decision not to prosecute a case, rather than a decision not to investigate. As a matter of usual practice, decisions (after investigation) as to whether to prosecute or take other regulatory action are made by prosecutors within DEEDI Legal, and documented with reasons and advices on evidence in a Legal Advice form. Prosecutors assess briefs of evidence provided by inspectors and clearly and comprehensively document decisions as to whether to prosecute.

The decision not to investigate this matter is a separate issue. Whilst DEEDI acknowledges that recording decisions (including decisions to take no action) and reasons for them can be improved, it does not accept that it failed to adequately consider whether or not to take any action against the Redlands clinic with regard to all possible breaches of the Acts. DEEDI submits that proposed **opinion 30(a) be withdrawn** accordingly.

It is submitted that proposed **recommendation 30 be amended** to refer to decisions to investigate, not decisions to prosecute.

### **Ombudsman's analysis**

The Director-General has provided a list of the factors which he said were considered when the decision was made in 2009 not to take any action against the Redlands clinic. While these reasons would support such a decision, none of these reasons appear in the documents provided by QPIF or were raised at interview with my officers.

My investigation was unable to identify any evidence that QPIF officers adequately considered the issue of whether to take any action against the Redlands clinic with regard to all possible legislative breaches. Three QPIF officers were questioned about the possibility of action being taken against the Redlands clinic: the CVO, the Manager, Strategy and Legislation, and the Director of Animal Welfare and Biosecurity. Each had the opportunity to disclose the reasons for the decision to take no action against the Redlands clinic for possible breaches of the relevant legislation.

I do not agree with the Director-General's statement that no request was made to the CVO about this issue. This matter was discussed during the CVO's interview with my officers, at which my officers requested that the CVO provide details of what consideration was given to this matter. The CVO was unable to provide any details at the time beyond stating that it was considered. That this issue was discussed is evidenced by an email sent to my officers by the CVO the following day stating:

You asked me yesterday about the issue of whether we considered taking any action in relation to failure to report a notifiable disease.

The following email trail shows that I did raise this issue following release of the VSB investigation.

I discussed the issue with [the Manager, Strategy and Legislation] and we decided not to pursue the matter.

However, as I noted in my proposed report, the CVO was unable during his interview or the following day to provide my officers with the reasons for this decision.

The Director-General has now provided me with the reasons for this decision. While I acknowledge this information, it was only provided a significant period of time after the event and in response to a proposed adverse finding against QPIF.

I also note inconsistencies between the evidence of the three QPIF officers questioned about this issue. The CVO said that he discussed the issue with the Manager, Strategy and Legislation and characterised the decision to not investigate as a joint decision, while the Manager, Strategy and Legislation told my officers that she was told not to investigate the issue due to a decision having been made by the CVO and the Director AWB.

Overall, I consider that QPIF is unable to provide adequate evidence regarding who made the decision not to take any action and the basis on which the decision was made at the time. My comments in relation to record-keeping in chapter 11 are also relevant in this regard.

The Redlands clinic owner made a number of submissions in response to my proposed report. He stated that Hendra virus was simply raised at the time during a general discussion and immediately discounted as a possible differential diagnosis. He submitted that it would be ludicrous to expect a practising veterinarian to report to QPIF every time the possibility of a notifiable disease crosses their mind. The clinic owner submitted that the role of a veterinarian is to refine signs and symptoms into a credible list of differentials, and there would be no obligation to notify QPIF unless and until a notifiable disease was on that credible list.

I acknowledge these submissions and do not disagree with the clinic owner's views. However, his submission is not directly relevant to the crux of this issue. I am not suggesting that he should have reported the notifiable disease, or that Hendra virus was a differential diagnosis for this horse. My point is that QPIF had a statutory obligation to consider any evidence that may suggest a veterinarian had failed to comply with an obligation to report a notifiable disease. In my opinion, the evidence gathered suggests that QPIF failed to do so adequately. What the outcome of such consideration would have been is not the point of my analysis of QPIF's processes.

Further, the Director-General's response to my proposed report refers to estimates that fewer than 10 percent of veterinarians currently report suspicion of a notifiable disease, even when submitting samples for testing'. This suggests to me a lack of enforcement of the legislation that has been continuing for some years. The fact that QPIF appears to be aware of the failure to comply with the legislation, and has taken no steps to remedy this, is concerning.

Finally, the clinic owner submitted that the conclusions in the Forbes Report were not accurate and should not be mentioned in my report. However, again it appears that this submission stems from a misunderstanding of the issue. My focus is on the adequacy of QPIF's processes of considering the issues raised in the Forbes Report, rather than the adequacy of the conclusions in the Forbes Report itself. For this reason, I consider it necessary and in the public interest to discuss the Forbes Report in my report as it illustrates a weakness in QPIF processes that requires rectification.

Overall, I am not satisfied that QPIF adequately considered the issue of taking action in relation to possible legislative breaches associated with the Redlands Hendra virus incident.

I confirm proposed opinion 30 as a final opinion:

#### **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.

I confirm proposed recommendation 30 with an amendment as a final recommendation:

#### **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.

The above opinion should not be interpreted as suggesting that I have formed a view on the substance of the allegation against the Redlands clinic owner, as I have not done so.

The above discussion is not the only example my investigation found of the failure to keep appropriate records of important decisions which were made during Hendra virus incidents. I have discussed this issue in chapter 11, and made a recommendation to address these record-keeping deficiencies elsewhere in my report. Consequently, it is unnecessary to make a further recommendation here.

#### **7.4.4 The issue of asymptomatic horses**

In November 2008, the Brisbane Southside Public Health Unit (BSPHU) of QH prepared a report (BSPHU Report) stating that it was likely that at least one person in the 2008 Redlands incident had become infected with Hendra virus from a horse that was not showing any clinical signs of illness.

A specific allegation was made to my officers that QPIF failed to advise veterinarians promptly of the risk of Hendra virus infection from horses before they began to show clinical signs of the virus.

QH officers informed my officers that they had in fact raised this issue with QPIF during an interagency teleconference on 28 July 2008. The minutes of this teleconference stated:

[PHMO] advised that for one of the human cases the only high risk exposure remembered/identified was nasal lavage on JD the day before onset of symptoms. Other human case had same exposure but also involved in PM on another horse. Other human contacts involved in lavage of JD remain well. Discussion around whether potentially changes advice to vets – complicated by lack of understanding of potential transmission pathways eg aerosol versus respiratory fluid exposure.

There is no mention of the possibility that people could be infected with Hendra virus from a seemingly well horse in either version of the Guidelines for Veterinarians released by QPIF in August or November 2008.

QPIF officers advised my officers that QPIF was first aware of this issue when Dr Perkins released his 2008 Perkins Report, in December 2008. This is contrary to the advice of the QH officers to my officers, and the minutes of the teleconference on 28 July 2008.

The relevant passages of the 2008 Perkins Report are as follows:

All confirmed human cases of Hendra virus to date appear to have been exposed while interacting with horses before they suspected Hendra virus. Prior to the Redlands cases it was suggested or assumed that human exposure to Hendra virus was most likely to occur as a result of very close contact with an obviously sick or dying horse or through performing invasive procedures such as a post-mortem on a Hendra case. These risks remain important.

...

It is also understood from discussions with the regional medical officer from QH that exposure to Hendra virus in one of the human cases of Hendra virus infection that occurred at Redlands is considered to have possibly occurred while performing procedures on a horse that was not at that time displaying clinical signs of illness that could be attributed to Hendra virus infection. Exposure in the other human case of Hendra virus infection may have occurred while interacting with infected horses after they displayed signs of illness attributed to Hendra virus infection.

Exposure from apparently healthy animals may occur if the animal was shedding infectious virus while in the incubation stage of the disease and not yet displaying signs of illness.

This information is considered to be very important for all people involved with horses (horse owners, carers, riders, farriers, dentists, veterinarians and others) since it indicates that there may be risks involved in interacting with horses that are not displaying obvious signs of disease. It is also very important to place this information in context to avoid alarming people unduly and to provide information on risks and risk management that allow people including veterinarians to be informed and to take suitable precautions. Hendra virus in horses is a rare disease. The risks of human infection appear to be very low for people who are engaged in routine horse handling and care. There may be certain procedures that are associated with elevated risk of exposure even in apparently healthy horses that could be incubating the disease. These are likely to include procedures that involve potential exposure to fluids or

tissues that may contain virus such as blood, nasal secretions, oral secretions and urine. People performing more invasive procedures such as surgery or post-mortem are considered to be at higher risk of potential exposure to fluids or tissues that may be infectious.

This issue has implications for the protective equipment worn by veterinarians when engaged in procedures which generate exposure to equine body fluids and reiterates the need for continued information and education of the general horse community and veterinarians.

It is suggested that effective and risk-based strategies are required for management of Hendra virus risk at all times and for all horses. ...

The first step in this process requires a paradigm shift that involves recognition and acknowledgement that all horses may present some level of exposure risk regardless of whether they present with clinical signs of disease or not. Different procedures and activities are likely to be associated with different exposure risks. Particular clinical signs may also indicate elevated exposure risk. In each case assessment of exposure risk should be followed with appropriate risk management or risk reduction procedures mainly based on PPE and general principles of hygiene and infection control and decontamination.

This approach is seen as the cornerstone of effective prevention or minimisation of exposure risk.

***It is recommended that efforts continue to be directed to effectively communicating exposure risk to all people who work with horses and to incorporate this information into various guidelines and other documents with a focus on early adoption of precautionary measures designed to minimise exposure risk at all times when interacting with horses. [emphasis in report]***

However, this information was not included in the Guidelines for Veterinarians or made publicly available until the next version of the guidelines was released in April 2009, despite QPIF officers advising my officers that it distributed this information during an infection control workshop for veterinarians in Malanda, North Queensland, in February 2009.

Dr Perkins told my officers that, in his view, this information should have been included in the Guidelines for Veterinarians before April 2009 because his report had flagged it as an issue.

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

I confirm proposed opinion 31 as a final opinion:

#### **Opinion 31**

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

In late 2008, Dr Middleton conducted a study investigating whether horses could shed Hendra virus before they showed clinical signs. The study, titled *Initial experimental characteristics of HeV (Redland Bay 2008) infection in horses*, concluded that seemingly well horses could shed Hendra virus before they developed clinical signs of the virus, and suggested that changes be made to the Guidelines for Veterinarians to highlight this.

QPIF received Dr Middleton's final report on 30 March 2009, and her findings were included in the next version of the Guidelines for Veterinarians released on 3 April 2009. The CVO also sent a communiqué to veterinarians at this time advising of Dr Middleton's findings and the updated Guidelines for Veterinarians.

Although QPIF took timely action to include the information in the Guidelines for Veterinarians once it received Dr Middleton's report, I am satisfied that the information had already been available to QPIF for approximately nine months and QPIF did not in my view take adequate or reasonable steps to act on the information.

In my proposed report, I formed the following opinion and made the following recommendation:

### **Proposed 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.

### **Proposed recommendation 31**

QPIF:

- (a) develop and implement a communication plan to ensure 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.

## **DEEDI's response**

The Director-General submitted:

As a general rule, DEEDI endeavours to ensure that information provided to the public is scientifically confirmed and accurate, so as not to propagate incorrect information and risk unnecessary public concern or complacency.

At the time, given that the information contained in the 2008 BSPHU Report went against what was previously held to be true, the former DPI&F decided to not release the information until it was scientifically verified. Officers recollect that this possible infection mechanism was discussed in various forums subsequent to the BSPHU report becoming available. However until verified by research conducted at AAHL, it remained a possible but not verified infection mechanism and as such was not included in official literature. It is noted that the relevant passage in the 2008 Perkins report states that infection through this mechanism "possibly occurred".

In hindsight, DEEDI acknowledges that, as a precaution, the information should have been made more widely available with the necessary caveats. Steps have since been taken to improve DEEDI's communication with the public about potential risks and how to minimise exposure.

However as pointed out earlier in this response, care should be taken in applying the lens of hindsight to past decision making in times of evolving knowledge.

In relation to my proposed recommendation 31, the Director-General submitted:

Following the 2008 Redlands incident, DEEDI recognised the need to improve communication practices. DEEDI has regularly revised and updated the Guidelines for Veterinarians and the Important Information for Horse Owners and has developed a Horse Biosecurity Communications Plan.

The Guidelines for Veterinarians and Horse Owners Information documents have undergone a comprehensive rewrite to include the most recent research information, and have been published on the agency's website.

DEEDI has gone to great effort to ensure that this information is received by relevant groups and was assisted in this task by the use of industry and stakeholder groups, publication on the DEEDI website and an extensive media campaign, made possible largely as a result of the media interest in Hendra virus.

As such, DEEDI submits that proposed **recommendation 31(a) be withdrawn**.

### **Ombudsman's analysis**

I acknowledge that the Director-General agrees that the information about the risk from asymptomatic horses should have been made available once it became known to QPIF officers in July 2008.

Although QPIF argues that care should be taken in applying hindsight to decision-making in times of evolving knowledge, in my view the obvious potentially life-threatening risks to veterinarians required that QPIF make this information available as soon as it was known. If QPIF was concerned about the unconfirmed nature of the information, appropriate caveats could have been applied. For this reason, I have not changed my proposed view that QPIF's conduct was unreasonable.

I confirm proposed opinion 32 as a final opinion:

#### **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.

I also note that a Horse Biosecurity Communications Plan has now been developed by QPIF. It remains vitally important that QPIF ensure the ongoing implementation of the plan.

I confirm proposed recommendation 31 with an amendment as a final recommendation:

**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.

**7.4.5 General comments on biosecurity responses**

Finally, my interviews with QPIF officers and members of the public identified a number of concerns about QPIF's responses to biosecurity incidents, including Hendra virus incidents. These concerns related to the extent to which the media, political interests and public perception drove decision-making.

From my review of each incident, it seems each one had a different response scope. Further, the scope of the QPIF response appeared to be increasing with each successive incident, in some cases out of proportion to the size of the incident. During my investigation, I have seen no evidence of any considered, risk-based assessment of the incidents which could have assisted QPIF in making decisions as to the extent of its response.

The failure to use a risk-based approach runs the risk that an incident response will:

- be inadequate or over-responsive
- waste resources
- dilute QPIF's resources such that it runs the risk of being unable to respond to other threats
- be based on irrelevant considerations.

I note that the Auditor-General raised a related issue in his 2008 report into the operation of the former Department of Primary Industries and Fisheries, noting the need for a risk management framework to identify and prioritise biosecurity threats, better inform decision-making and allocate a commensurate level of resources.

Similarly, a number of QPIF officers and members of the public expressed concern about QPIF's strategic capability in relation to biosecurity incidents, particularly in relation to its capacity to respond to more than one biosecurity incident at the same time.

I have not specifically investigated QPIF's strategic capability beyond its responses to Hendra virus incidents. However, I note that this concern is broadly consistent with the Auditor-General's 2008 report which stated:

Since its establishment in 2007, Biosecurity Queensland's capacity has been stretched in dealing with emergency responses to consecutive outbreaks. As a result deficiencies in corporate and governance systems have not been addressed in a timely manner.

The better prepared Biosecurity Queensland can be, the more likely it will be able to either prevent an outbreak or efficiently respond in a timely manner and eradicate the threat.

I consider it critical to the protection of Queensland's primary industries and environment that all systems are in place to prevent, detect and respond to biosecurity threats with the aim of eradicating a pest or disease.

Having mature systems in place will ultimately reduce the pressure on staff during emergency responses.

Some of the concerns expressed by the Auditor-General are similar to the opinions I have formed about QPIF in this report.

The Director-General should review the Auditor-General's recommendations in light of the comments and opinions in my report. In a recent follow up audit, the Auditor-General determined that his recommendation for the implementation of a formal risk management framework to prioritise threats and ensure resources were used effectively had only been partially implemented.<sup>102</sup>

In my view, QPIF needs to develop a framework within which it can make a risk-based assessment of the resources needed to respond to a particular Hendra virus incident while not expending resources disproportionate to those necessary to control the biosecurity risk.

In my proposed report, I formed the following opinion and made the following recommendation:

**Proposed opinion 33**

QPIF did not implement a risk-based assessment framework during Hendra virus incidents to enable it to:

- (a) identify and prioritise biosecurity threats
- (b) better inform decision-making
- (c) allocate a commensurate level of resources.

**Proposed recommendation 32**

QPIF implement a risk-based assessment framework during Hendra virus incidents to enable it to:

- (a) identify and prioritise biosecurity threats;
- (b) better inform decision-making;
- (c) allocate a commensurate level of resources.

**DEEDI's response**

The Director-General made the following submissions in response:

There is no single recognised risk framework that can account for every aspect of managing a biosecurity incident. Instead, DEEDI operates a multi-faceted approach to risk management during incidents like Hendra virus. There are processes in place for managing the risk of the disease itself, managing the risk to staff and people, managing the risks posed by the external environment (including managing public perception and expectations) and managing the financial risks.

Biosecurity Queensland has a well established practice for managing the disease risk during a Hendra virus incident. AUSVETPLAN, which is the national risk based plan for emergency animal diseases, is the basis of the disease response and has been formulated based on sound risk assessments pertaining to each disease.

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<sup>102</sup> Auditor-General Report to Parliament No. 8 for 2011 at p.32.

In managing the risks during a pest or disease incident, Biosecurity Queensland uses legislative implements such as quarantines to limit the spread, undertakes tracing and testing to determine the possible spread and takes action on positive cases to limit or remove future risks. This approach is used in the Hendra virus responses and there has been no spread of Hendra virus outside a property following Biosecurity Queensland involvement in an incident.

With regard to the workplace health and safety risks associated with a disease or pest, Biosecurity Queensland provides the most up-to-date information on the risks and how they can be managed, informs its staff and provides the equipment. Additionally, Biosecurity Queensland officers are trained to assess the risks involved with entering properties that informs the overall approach. Members of the public who may be exposed to risk are where possible informed directly or are informed through industry organisations, the media or internet.

In managing the risks posed by the external environment, DEEDI prepares a communications plan and community engagement plan for each significant response. Messages and strategies are based on an assessment of the risks associated with the public reaction to the response. This includes such things as direct engagement and community information sessions and information distribution points.

Responses can impose a large financial burden on the State. Consistent with national responses, DEEDI monitors expenditure and ensures that the State is not exposed to undue financial risk. Control measures are weighed against the costs of control and this is a factor in the decision making process.

DEEDI operates a series of control mechanisms to quickly identify, analyse and mitigate risk while a response is in progress. Biosecurity Queensland, establishes structures such as the state and local disease control centres, has forums where risk is monitored on a daily basis and decisions made to respond to the risk. In particularly complex responses, DEEDI forms a control group of key stakeholders whose prime purpose is to look over all aspects of the response and identify risks that need to be addressed.

More generally, Biosecurity Queensland operates within a national framework of biosecurity risk management and nationally cost-shared funding for emergency responses. The culture of biosecurity professionals includes a heavy emphasis on risk management.

The proposed report contains criticism of both under-responsiveness and over-responsiveness in community engagement. It is acknowledged that community engagement has been ramped up over successive incidents; however this is in response to community concern and expectation. Such community engagement is necessarily a core function of an emergency response agency.

DEEDI submits that proposed opinion 33 and proposed recommendation 32 do not reflect the practicality of emergency response, or the risk management systems that are in place and accordingly, submits that proposed **opinion 33** and proposed **recommendation 32 be withdrawn**.

DEEDI notes reference to the 2008 Auditor-General report and the need for a risk management framework for biosecurity. It should be noted that the risk framework referred to by the Auditor-General was in relation to establishing an overall investment framework for biosecurity which takes into account the relative risks across all biosecurity business. It does not, and was never intended, to provide a risk framework for dealing with individual responses.

### **Ombudsman's analysis**

There is evidence that QPIF has already recognised the need for a risk-based approach in relation to a range of issues. My recommendation is for the existing practices of individual QPIF officers to be extended and formalised into a framework which can guide officers and assist them to make consistent decisions.

QPIF officers who were involved in past responses to Hendra virus incidents raised with my investigators a desire to have a risk-based assessment framework to guide decision-making.

With limited resources of all types, including staff and finances, it is important that decisions about what resources to commit in response to individual Hendra virus incidents are based on sound reasons. A risk-based assessment framework will assist QPIF officers to accurately determine the resources needed in a particular incident both at an initial stage and as the response to the incident continues during the following weeks.

From the AUSVETPLAN, which I accept does guide the identification of biosecurity threats, it is apparent that the level of resourcing required for any particular emergency animal disease incident will depend on the nature and size of the outbreak. A risk-based assessment framework which guides QPIF officers in determining the level of resources required for a particular response will also assist in the prioritisation of biosecurity threats and other decision-making.

Without an extended and written risk-based assessment framework, there is also a risk that current corporate knowledge will not be captured and will eventually be lost due to staff turnover.

Therefore, I remain of the view that the following opinion and recommendation are justified.

I confirm proposed opinion 33 with an amendment as a final opinion:

#### **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.

I confirm proposed recommendation 32 with an amendment as a final recommendation:

#### **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.

## Chapter 8: Destruction of sero-positive horses

This chapter discusses the processes adopted by QPIF in destroying horses that survive a Hendra virus infection and subsequently test sero-positive to the virus.

### 8.1 The legislative basis for destruction

QPIF has the authority to destroy animals under the EDIA Act and the Stock Act.

The following is a brief explanation of the provisions that allow QPIF to destroy horses.

#### 8.1.1 Stock Act

The power to destroy stock<sup>103</sup> is contained in s.15 of the Stock Act:

##### 15 Stock may be destroyed in certain cases

- (1) The chief executive may order the destruction of any infected or suspected stock or any animal product thereof, or any carcass, or any articles or things used in connection with such stock, animal product or carcass, or any infected or suspected pasture or fodder, or the removal and destruction of animal pathogen or biological preparation, or the removal and disposal of soil, whenever in the chief executive's opinion such destruction or removal and disposal would tend to prevent the spread of disease or assist in the diagnosis of the disease.

...

- (2) Upon a failure in any respect to comply with the requirements of an order made under subsection (1) and without prejudice to any proceedings which may be taken upon such a failure, the chief executive may, after the expiration of 7 days from the date of such failure, direct in writing an inspector to enter upon the premises or holding in or upon which the stock, animal product, animal pathogen, carcass, article or thing, pasture or fodder ordered to be destroyed is or are situated and destroy or cause to be destroyed such stock, animal product, animal pathogen, carcass, article or thing, pasture or fodder specified in the order.

By definition, stock is considered to be infected' when it is infected with a disease, while suspected stock' is stock that is suspected of being infected.<sup>104</sup>

Animals can also be destroyed by a QPIF inspector under s.29(2):

##### 29 Powers of inspector

...

- (2) When any stock so impounded or quarantined are, or when any animal product, carcass, biological preparation or fodder so impounded or detained is found to be diseased, the chief executive may cause such stock, animal product, carcass, biological preparation or fodder to be destroyed.

<sup>103</sup> The definition of stock' in Schedule 2 of the Stock Act includes horses.

<sup>104</sup> Schedule 2 of the Stock Act.

Under this section an inspector can only destroy an animal found to be diseased and not one merely suspected of being so.

### 8.1.2 EDIA Act

Under s.22 of the EDIA Act, the Minister may order the destruction of any infected or suspected animal<sup>105</sup> whenever in the Minister's opinion such destruction or removal would tend to prevent the spread of an exotic disease.

Section 22(4) of the EDIA Act provides that an animal is taken to be suspected if:

- (a) the animal is an animal that is a host for an exotic disease or animal pathogen present, or suspected to be present, at an infected premises; and
- (b) the chief inspector reasonably believes it is necessary to destroy the animal to prevent or control the spread of the exotic disease or animal pathogen, having regard to—
  - (i) the animal's proximity to the infected premises; and
  - (ii) the ability of the disease or animal pathogen to spread and the way in which it spreads.

## 8.2 The policy basis for destruction

QPIF's practice of destroying horses even when they appear to have recovered from Hendra virus is based on the concept of recrudescence.

### 8.2.1 Sero-positivity and recrudescence

In relation to Hendra virus, recrudescence is understood as the reappearance of the virus after it has been inactive for some time. There are concerns that sero-positive horses may recrudescence.

When asked to explain the concept of recrudescence, QPIF advised my Office:

A fundamental aspect of recrudescence and relapse is that the agent remains asymptotically within the infected individual for a variable period of time, having not been eliminated by the individual's immune system.

The evidence that Hendra virus can recrudescence is somewhat limited. In the similar Nipah virus, both animals and humans have been shown to recover from an initial infection and then relapse after some time. Recrudescence of Nipah virus has generally proven fatal, although there is no evidence that recrudescence has resulted in the infection of other animals or humans.

Perhaps due to the relatively small number of identified infections, no similar research on Hendra virus recrudescence in horses has been conducted. There is only one known case of Hendra virus recrudescing in a person.

QPIF's Principal Epidemiologist advised my officers that there is no evidence showing that horses or humans who recrudescence with Hendra virus are infectious.

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<sup>105</sup> The EDIA Act refers to animals, while the Stock Act refers to stock. Horses fall within both definitions.

He also advised that there have been no studies examining the potential for sero-positive animals to infect others if they recrudescence. One reason for this is the animal welfare issues that will arise if animals have to be held for long periods of time in a secure biosecurity laboratory environment.

I discuss the relevance of this evidence and its application by QPIF in section 8.4.1 of this report.

### 8.2.2 The current QPIF policy

Since 2006, three horses are known to have recovered from Hendra virus infections and seroconverted. All were destroyed by QPIF due to concerns about the risk of recrudescence.

At the time of destruction of the horses in the 2008 Redlands and Proserpine incidents, there was no QPIF policy on destroying sero-positive horses.

There is now a QPIF policy titled *Hendra Virus Outbreak Response – Management of serologically positive horses* (Destruction Policy). This policy was finalised on 17 August 2009, part way through the 2009 Cawarral incident and shortly before the sero-positive horse Winnie was destroyed.

The Destruction Policy provides for the destruction of a horse in certain circumstances under the Stock Act:

Actions will be taken under the *Stock Act 1915* for the purposes of management of HeV seropositive horses in Hendra virus responses. ...

...

If a particular horse is identified as a risk horse for which euthanasia is recommended under the national policy, before deciding whether or not to order the destruction of the horse, the delegate must familiarise themselves with the content of these provisions and be reasonably satisfied that the prescribed requirements for destruction exist. This includes being satisfied that the risk horse meets the definition of infected stock or suspected stock under the *Stock Act 1915*. These definitions are found in the Schedule Dictionary of the Act.

...

If the delegate is satisfied that the requirements of section 15 of the *Stock Act 1915* are fulfilled, then the delegate may consider issuing an order for destruction of the horse. Before making that decision, however, the delegate must consider all matters relevant to making that decision, including any submissions the horse's owner may wish to make on the matter.

This policy therefore limits the destruction of sero-positive horses to occurring solely under the Stock Act.

### 8.2.3 The national policy

The national AUSVETPLAN sets out the disease response requirements for various disease outbreaks. I have described the AUSVETPLAN in chapter 6.

In relation to Hendra virus, the AUSVETPLAN states:

- The policy is to eradicate Hendra virus infection in terrestrial animals using:
- Destruction and sanitary disposal of all horses or other terrestrial animals shown, through demonstration of antibodies, to be infected;
  - Disinfection of the immediate contaminated environment; and
  - Quarantine of all in-contact animals until repeated serological tests have proven freedom.

In short, the AUSVETPLAN provides that sero-positive horses must be destroyed and disposed of.

While state authorities are not required by legislation to follow the national policy, QPIF officers advised that it is highly persuasive when considering whether a sero-positive horse should be destroyed.

The recommendations of the national Consultative Committee on Emergency Animal Diseases (CCEAD) also influence policy development on the subject. This cross-jurisdictional advisory committee is recognised within the Emergency Animal Disease Response Agreement, and is the key technical coordinating body between the Commonwealth, the states and territories, and industry for animal health emergencies.

The CCEAD consists of the Chief Veterinary Officers of each Australian state and territory government, as well as representatives from the Commonwealth Department of Agriculture, Farming and Fisheries and the Commonwealth Department of Health and Ageing. Veterinary and industry representatives are also members of the committee.

The CCEAD met by teleconference on 21 July 2008 (during the 2008 Redlands incident) to discuss the case of the horse, Tamworth, and whether changes were necessary to the CCEAD policy which required the destruction of sero-positive horses. Representatives from QH and AAHL were also involved in this meeting.

An internal QPIF reference group, the HeV Expert Group, met by teleconference on 15 July 2008 to prepare an options paper for submission to the CCEAD. The group canvassed three options for sero-positive horses:

1. euthanase as soon as possible, with two sub-options:
  - a. euthanase and dispose of without further action, or
  - b. euthanase and conduct a thorough post-mortem
2. monitor for a 12-month period, with two sub-options:
  - a. monitor for 12 months and then euthanase, or
  - b. monitor for 12 months, then release if results are negative
3. release back to owner.

The group recommended that option 2a or 2b be adopted, and strongly supported that this situation be used to add to the existing HeV knowledge for the benefit of future responses'.

The CCEAD considered the options during a meeting on 21 July 2008, the minutes of which recorded:

Historically recovered horses have been destroyed, resulting in emotive and sensitive public relations issues. Sound technical reasons for the final decision are desirable.

The latest evidence suggests that recrudescence in a recovered horse cannot be ruled out and thus has the potential to cause zoonotic spread of the disease to other horses or humans. Thus recrudescence may occur within 12 months, but cases of Nipah virus have relapsed after 2-3 years. The risk of zoonotic spread may have low probability but will have high consequences.

Participants (including DoHA representatives) agreed that the potential risk to horse handlers in managing recovered animals outweighed any gain in scientific knowledge from a study conducted on one animal.

Other issues raised included the potential effect on market access for Australia's horses if sero-positive animals are not euthanized and a view was expressed that primacy of this issue should remain with DoHA and not CCEAD due to the human health implications.

It was agreed to support option 1b in the paper allowing for the imminent euthanasia of the horse with thorough autopsy and comprehensive sampling with AAHL support. QDPI will inform the owner of the options and risks with the support of QLD Health and QLD Racing.

Consequently, the CCEAD resolved that there be no change to the AUSVETPLAN policy, and agreed that sero-positive horses should be destroyed because of the risk to human health.

The CCEAD also noted that:

... QDPI is to discuss euthanasia of the sero-positive horse with the affected horse owner, with the support of QLD Health and QLD Racing representatives, and report back to CCEAD [out of session].

### **8.3 Outline of previous cases**

This section contains a brief outline of the circumstances surrounding the destruction of the three sero-positive horses that were destroyed during the incidents the subject of my investigation.

#### **8.3.1 Tamworth**

The first occasion concerned Tamworth, a thoroughbred racehorse, which was admitted to the Redlands clinic on 17 June 2008 for the treatment of an eye condition. On 30 June 2008, Tamworth was observed to be depressed, uncoordinated and refusing to eat. Over the next few days, Tamworth's condition stabilised and then improved. The Redlands clinic was quarantined on 7 July 2008.

Blood samples and nasal swabs collected from Tamworth on 7 July 2008 tested negative to PCR tests but showed positive serology results. Further samples were taken on 10, 18, 21 and 23 July 2008, and all returned positive serology results and a mixture of positive and negative PCR results. QPIF therefore considered Tamworth to be sero-positive.

Consideration of an appropriate response began shortly after receipt of Tamworth's first positive serology result. On 9 July 2008, the CVO took steps to form the HeV Expert Group to consider what actions QPIF would take with regard to sero-positive horses.

The HeV Expert Group produced a draft options paper which was presented to the CCEAD meeting on 21 July 2008 (discussed in section 8.2.3 of this report). Both the CVO and the Director, Animal Welfare and Biosecurity (Director AWB) were present at this meeting. The minutes of the CCEAD meeting state:

...

AGREED on the advice of health authorities, and on the basis of human health risks, that the one recovered PCR positive horse be euthanized.

AGREED that a thorough autopsy with comprehensive sampling of this horse be undertaken.

NOTED that an AAHL representative would assist QDPI during the autopsies; ...

According to QPIF records, on or about 22 July the CVO met with Tamworth's owners to explain his intention to order Tamworth's destruction. This action would be consistent with the resolution of the CCEAD the previous day.

On 23 July 2008, the QPIF legal unit acknowledged that it had been asked by the Manager, Strategy and Legislation to provide:

... advice on whether the department is required to pay compensation to the owner of a horse infected with Hendra virus that the department intends to destroy.

An email from the CVO to the Director AWB and the Manager, Strategy and Legislation on 29 July 2008 also supports the view that by this time, a decision to destroy the horse had been made. The email states:

I think it is time to issue the destruction order for Tamworth. ...

On 31 July 2008, QPIF received a letter from solicitors acting for the Redlands clinic stating:

The [solicitors for Tamworth's owners] indicate that advice has been received from officers of the DPI & F that it is intended that "Tamworth" be euthanased. They further assert that their client owners do not consent to the horse being euthanased.

An email from the QPIF legal unit to Crown Law on 31 July 2008 stated:

I refer to our telephone conversation of today and confirm that [the Chief Biosecurity Officer]<sup>106</sup> intends to exercise his delegated power under s 15(1) of the *Stock Act 1915* (the Act) and issue a destruction order to the owners of a horse named "Tamworth" which is suspected of being infected with the Hendra virus.

However, a destruction order was not issued because of advice which QPIF received from Crown Law on 1 August 2008 that Tamworth's owners should be given an opportunity to make submissions before a decision on destruction was made.

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<sup>106</sup> The role of Chief Biosecurity Officer is distinct from the role of Chief Veterinary Officer. The former is the most senior policy and technical role within Biosecurity Queensland (as part of QPIF) across all programs. The latter role is a role which is generally carried out by the Chief Biosecurity Officer, and is a recognised decision-making role within state and national frameworks. During the 2008 Redlands incident, the one QPIF officer performed both roles. Therefore, in my report I have referred to actions taken and decisions made by the Chief Biosecurity Officer as actions or decisions by the CVO for clarity. During the 2009 Cawarral and Bowen incidents, the CVO was at an international animal health conference and the CVO and Chief Biosecurity Officer roles were held in an acting capacity by two separate QPIF officers. In those incidents, the decisions relevant to my investigation were made by the Acting CVO and I have referred to these decisions using this role description.

On the same day, a draft document was prepared by the CVO titled Reasons for the Destruction of Hendra Virus Infected or Suspected Horse, Tamworth". The document states:

**Reasons for the Decision.**

- I consider that the laboratory results performed on the horse, Tamworth, are valid and indicate that it has been infected with Hendra virus.
- Based on a documented previous case of HeV infection and documented records of infection with the closely related Nipah virus, there is a reasonable probability that HeV infection could recrudescence in a horse that appears to have recovered from disease caused by HeV infection.
- If the disease reappears in this horse it is likely to again shed virus and transmit infection to other horses or to associated people.
- Based on the advice received from relevant experts (in particular human public health experts) and CCEAD, as well as my own consideration of the issues, I have formed the view that the Horse, Tamworth, should be destroyed to mitigate against future risk to human and animal health posed by this animal.

A file note of a telephone call between the CVO and the QPIF legal unit in the late afternoon of 1 August 2008 stated:

[The CVO] wants to get Itr out Mon to give a few days, order then few days to destroy and lift quarantine early next wk.

QPIF obtained further advice from Crown Law on 4 August 2008 as follows:

I note from our discussion that the nominated decision maker, [the CVO], may have had a recent previous discussion with the owners of the horse and indicated that he intended to order that the horse be destroyed. ... As discussed, however, if it is the case that [the CVO] has indicated that he intends to make a certain decision, or words to that effect, we would recommend that it not be him who makes the decision or signs the show cause. This is because if he has made a statement to that effect the argument from the owners in a Judicial Review may well be that [the CVO] has effectively made the decision without first affording them natural justice and, therefore, apprehended bias would attend any decision he would make.

The CVO then decided that the Director AWB would make the decision about whether to destroy Tamworth. It seems that at about this time the CVO also nominated the Act under which destruction could occur.

An email from the QPIF legal unit to the Director AWB on 4 August 2008 stated:

After meeting with [the CVO] and [a QPIF legal officer] this afternoon, [the CVO] has instructed me to prepare a show cause letter to be signed by you regarding a proposed order to destroy under the Exotic Diseases in Animals Act.

Please find attached the draft show cause letter for your approval.

A file note prepared by a QPIF legal officer of a meeting on 4 August 2008 with the CVO states:

EDIA – OK with that.  
[The Director AWB] can be the decision maker.

[The CVO] expressly concern re having to show cause & issues surrounding his meeting w horse owners.

Discussed alternatives but recommended show cause to minimise possibility of legal challenge.

A file note dated 5 August 2008 then referred to a telephone conversation between the Director AWB and the QPIF legal unit:

In meantime, discussed ltr -> she's ok for it to go. It is based on [the CVO's] advice. Doesn't want to amend it. Is aware of attachments but hasn't yet read full articles. Was there for part of CCEAD meeting where Qld Health gave advice.

QPIF received a letter from the solicitors for Tamworth's owners (solicitors) on 5 August 2008 referring to test results from Tamworth and stating:

It may be that the horse did at some stage have a virus known as the Hendra virus but all of the evidence now points to the fact that the horse does not have the Hendra virus and it would seem, with respect, that there is no basis to order that this horse be euthanased.

Accordingly would you please confirm that there will be no direction to have the horse euthanased as we, on the evidence presented to date, do not see that there is any lawful basis to suggest that the horse should be euthanased.

A show cause notice was signed by the Director AWB and sent to Tamworth's owners on 5 August 2008. This letter stated:

I am writing to inform you that I am of the preliminary view that:

1. Tamworth is an infected animal within the meaning of the Act because:
  - a. Tamworth has tested positive to serological tests indicating past infection with Hendra virus.
  - b. Blood and nasal swabs from Tamworth also tested positive to the polymerase chain reaction (PCR) test for Hendra virus on at least one occasion. This test detects genetic material from the virus, thus indicating recent infection.
2. Destruction of Tamworth and his carcass would tend to prevent the spread of Hendra virus because:
  - a. Based on a documented previous case of Hendra virus infection and documented records of infection with the closely related Nipah virus, there is a reasonable probability that Hendra virus infection could recrudescence in Tamworth, a horse that appears to have recovered from the disease caused by Hendra virus infection.
  - b. If the disease reappears in Tamworth it is likely to again shed virus and transmit infection to other horses or to associated people.
3. I should order that Tamworth and his carcass be destroyed under s.22(1) of the Act because:
  - a. The reasons stated above.
  - b. Based on the advice received from relevant experts (in particular human public health experts) and the Consultative Committee on Emergency Animal Diseases (CCEAD), as well as my own consideration of issues,

such destruction would mitigate against future risk to human and animal health posed by Tamworth.

The Director AWB gave the owners 48 hours in which to make a submission regarding Tamworth's destruction.

Further test results were sent to Tamworth's owners on 7 August 2008, the date by which submissions were required.

Submissions from the solicitors were received by QPIF by letter dated 7 August 2008, arguing that:

- Tamworth was not currently infected with Hendra virus, as no recent tests had extracted live virus
- the show cause notice was premised on information that did not take Tamworth's current situation into account (that is, that he was not currently infected)
- there was no proper or adequate scientific data that Hendra virus infection could recrudescence
- Nipah virus and Hendra virus, while similar, are distinct viruses and knowledge about Nipah virus in pigs or humans cannot be equated with Hendra virus infection in horses
- studies into the effects of Hendra virus would be best served by keeping Tamworth alive for research purposes
- the statement 'If the disease reappears in Tamworth it is likely to again shed virus and transmit infection' was made without any factual scientific evidence
- the presence of sero-positive horses within the general equine population in Queensland and New South Wales would be guaranteed and that, therefore, to kill one sero-positive horse out of many would have no effect on the dynamics of Hendra virus infection and would destroy a potentially valuable research animal.

The solicitors also wrote to QPIF on 7 August 2008 offering to sell Tamworth to the State of Queensland for the purpose of scientific research. A payment of \$195,000 was requested, representing the market value of the horse, legal costs and veterinary fees.

QPIF provided further test results to the solicitors on 8 August 2008 and requested that any additional submissions be made by close of business that afternoon. This letter stated:

Since that time I have received new results of laboratory tests performed on Tamworth which indicate that he is still positive to a serum neutralisation test for Hendra virus.

The results of the laboratory tests referred to were contained in a report dated 5 August 2008 and faxed to QPIF that day. The results were not provided to Tamworth's owners at the same time as the show cause notice or shortly after.

The solicitors responded by letter dated 8 August 2008, stating:

We are instructed, with all due respect, that the correspondence of today's date is another example of misinformation and a scare campaign.

...

On our instructions the serum neutralisation test (SNT) detects antibodies made against a pathogen such as a virus. Antibodies are a response by the immune system against an infection by a pathogen. The SNT is NOT a test for the presence of the virus; it only indicates the body has been infected or exposed to the virus.

This is not a new fact and is not a matter that is in dispute.

... the SNT will remain positive for months to years with no virus present and the animal therefore not infectious.

...

On our instructions live virus has never been isolated from Tamworth (at least on the information provided to date) and as such any implication that Tamworth is currently infected with Hendra virus is made without any basis of fact.

An undated letter sent from the Director AWB to the solicitors at around this time stated that QPIF was not prepared to purchase Tamworth.

A file note of a conversation between the QPIF legal unit and the Director AWB on 11 August 2008 refers to the Director AWB reading the material and being ready to make a decision. An Order to Destroy the horse was signed on 11 August 2008 by the Director AWB.

The Director AWB, with the assistance of the QPIF legal unit, also prepared a statement of reasons for her decision, and this was dated 11 August 2008. I note that the content of this document is substantially different to the content of the statement of reasons previously prepared by the CVO.

At around this time, the Director AWB engaged in telephone discussions with a researcher who prepared a paper on Hendra virus. An email from the researcher on 12 August 2008 referred to a telephone call with the Director AWB the day before, and advised that no live virus had been found in autopsy samples taken from male person who died in 1995 from Hendra virus. The email also stated that a PCR positive result does not mean live virus will be found.

The decision to destroy Tamworth was communicated by telephone to the solicitors on 12 August 2008 and a copy of the Order to Destroy dated that day was served requiring Tamworth to be destroyed by 5.00pm on 14 August 2008.

The solicitors wrote to QPIF on 13 August 2008 requesting reasons for the decision to destroy Tamworth.

A further letter sent by the solicitors to QPIF on 14 August 2008 offered to place Tamworth in quarantine on his owner's property, at their expense, for a period of 12 months with all risks accepted by the owners.

QPIF responded by letter also dated 14 August 2008, stating:

I advise that having regard to the significant biosecurity concerns surrounding this matter, the department declines your clients' offer.

A file note prepared by a QPIF legal officer of a conversation on 14 August 2008 with the Director AWB records:

#### Issues

- list of material considered. She has considered materials not previously provided to owners including:
  - o internal report re symptoms → I said this is a relevant consideration & should be included
  - o other medical papers re nipar(?) virus → only delete if of interest only & didn't add to other papers provided to owners. [The Director AWB] said papers confirmed short disease.
  - o Statement includes details re [the Redlands clinic owner's] practice and procedures which puts vet in firing line. Said it could be removed re "business affairs" → I'll check.

The advice received from the QPIF legal officer was to attach any further material to the statement of reasons, and any argument about natural justice could be had at a later date.

Tamworth was destroyed on 15 August 2008 and an autopsy conducted by QPIF officers and veterinary pathologists from AAHL. Of the 24 samples taken at autopsy, nine showed positive PCR results. However, virus isolation tests were unable to culture any live virus from these samples.

The solicitors wrote to QPIF on 15 August 2008 repeating the request for a statement of reasons for the decision to destroy Tamworth.

A file note by a QPIF legal officer dated 15 August 2008 refers to a telephone call she and the Director AWB had with the author of a scientific paper on Hendra virus, stating:

... risk of getting HV from recovered horse – she believes is negligible.

The file note also noted that there was no positive PCR test result obtained on any nasal swab from Tamworth.

The Director AWB provided her statement of reasons to the solicitors on 4 September 2008. These reasons were:

#### **Reasons for the Decision**

I made my decision for the following reasons:

1. Medical evidence suggested to me that recrudescence of Hendra virus in "Tamworth" could not be ruled out because:
  - (a) There is one medically reported case of Hendra virus recrudescence in a human.
  - (b) Medical Literature on the closely related Nipah virus indicates recrudescence occurs in approximately 10 per cent of cases.
  - (c) Scientific knowledge in this area is incomplete.
2. I suspected "Tamworth" was a diseased animal within the meaning of that term in the EDIA because:
  - (a) "Tamworth" had been infected with Hendra virus.
  - (b) I could not rule out recrudescence of Hendra virus in "Tamworth".

3. "Famworth" was an infected animal within the meaning of that term under the EDIA because:
  - (a) Under s.5, Schedule 2 of the EDIA an animal suspected of being a diseased animal by an inspector is an infected animal.
  - (b) As Chief Inspector I suspected "Famworth" was a diseased animal within the meaning of that term in the EDIA.
4. Destruction of "Famworth" would tend to prevent the spread of the exotic disease Hendra virus because I could not rule out recrudescence of Hendra virus in "Famworth".
5. The necessity for humans working with animals potentially infected with Hendra virus to wear personal protective equipment indicated to me that there was a risk of humans being infected with Hendra virus if "Famworth" was not destroyed.
6. I found that, if "Famworth" was not destroyed, there was a risk of humans being infected with Hendra virus. I determined that if that risk materialised it could lead to single or multiple deaths. I determined that a single death would be a critical consequence of that risk materialising. I determined that multiple deaths would be a catastrophic consequence.
7. I weighed the unknown likelihood of Hendra virus recrudescence in horses against the critical to catastrophic consequences of it occurring. I therefore agreed with the recommendations of the CCEAD.
8. I took into account and agree with the submission that opportunity to acquire new scientific knowledge in relation to Hendra virus in recovered horses is desirable. However, I recognise and agree with the expressed opinion of medical experts at the CCEAD teleconference that the potential risk to horse handlers in managing recovered animals outweighs any gain in scientific knowledge from a study conducted on one animal. I support the view that primacy of this issue (Hendra virus infection) should remain with medical experts due to the human health implications.
9. After considering all the evidence before me, I determined that "Famworth" should be destroyed.

A further request for compensation by the solicitors on 3 November 2008 was declined by QPIF.

### **8.3.2 Thomas**

The second occasion on which QPIF destroyed a sero-positive horse was during the 2008 Proserpine incident, which occurred at approximately the same time as the Redlands incident.

Thomas was a five-year-old quarter horse-cross owned by the owner of the Proserpine property. Thomas was kept in a fenced paddock with three other horses: Dizzy, Buddy and Dancer. Another two horses were kept in a neighbouring paddock on the same property.

On 3 July 2008, Dizzy was found dead in a corner of the paddock, and was buried on the property that day. A private veterinarian suspected that the cause of death was snake bite.

On 10 July 2008, Buddy became unwell and died the next morning. Due to suspicions about the cause of death, QPIF was notified of the death by a private veterinarian and samples were collected for Hendra virus exclusion testing. Tests that were conducted on the remaining horses on 11 and 15 July 2008 showed no evidence of Hendra virus.

Dancer developed clinical signs suspected to be caused by Hendra virus, and was euthanased on 21 July 2008. Samples taken from her tested positive for Hendra virus. At this time, further samples were also taken from the one remaining horse, Thomas, which showed some signs of depression and high-stepping. These signs continued for a further day and Thomas then appeared to recover.

The sample taken from Thomas tested positive to serology tests. Further samples collected on 29 July and 18 August 2008 also showed positive serology results but negative PCR results. QPIF therefore determined that Thomas was a sero-positive horse.

Once Thomas had tested sero-positive, the possibility of his destruction was discussed by QPIF. An email from the CVO to the Managing Director and Acting Director-General of QPIF on 4 August 2008 stated:

[The Principal Epidemiologist] has now received verbal advice from AAHL that the SNT is positive for this horse, so we'll have another one to put down.

A further email from the CVO to the QPIF legal unit on 5 August 2008 stated:

This is another horse that appears to have recovered from Hendra, this time at Proserpine. The decision will be the same, ie to put the horse down.

I note that this was seven days before the decision was made by the Director AWB to destroy Tamworth, and before Thomas's owners had been given the opportunity to make submissions.

An email from the Director AWB to the CVO on 5 August 2008 stated:

Will this one [sic] in my name as well?  
[QPIF legal officer] is working on the other now so we may be able to use as a template

A letter was sent by express post to Thomas's owners on 12 August 2008 advising that the QPIF delegate was considering whether to order the destruction of Thomas under the EDIA Act. The letter provided 48 hours in which to respond.

I understand that Thomas's owners did not receive the letter until they collected it from the post office on 14 August 2008. They then rang QPIF and advised that they would respond by telephone the next day. It is not clear from QPIF's file whether Thomas's owners responded to this notice.

My officers were told that QPIF agreed to have further tests performed on Thomas and to provide the owners with the results before making a final decision about his destruction.

QPIF sent another letter by express post to Thomas's owners on Wednesday 27 August 2008 advising that the further test results showed Thomas to be positive for indirect ELISA and VNT tests. The letter also attached the test results, two further scientific studies, the Guidelines for Veterinarians, and an email which had been sent

to private veterinarians on 19 August 2008 from the CVO. Thomas's owners were given until Monday 1 September 2008 to make submissions to QPIF before a decision about whether to destroy Thomas would be made.

However, a file note dated 1 September 2008 stated that Thomas's owners only received the letter that morning and were upset that they were unable to make submissions by midday. During the day, there was some discussion between Thomas's owners and the Director AWB about the destruction of the horse, in which Thomas's owners made a submission to keep Thomas alive for research purposes. The owners were told by the Director AWB that there was no real benefit in studying Thomas while alive, and that an autopsy would yield more knowledge. Thomas's owners then confirmed that they did not require further time to make submissions.

The Director AWB wrote to Thomas's owners on 1 September 2008 advising that she had decided to exercise the power to destroy Thomas under s.22 of the EDIA Act, and attaching an Order to Destroy.

Thomas's owners subsequently signed a QPIF document authorising the destruction of Thomas.

Thomas was destroyed on 4 September 2008 and a full autopsy was performed by AAHL and QPIF officers at the Proserpine property. Of the 24 samples taken at autopsy, eight tested positive to PCR tests. No viable virus was cultured from any of these samples.

### **8.3.3 Winnie**

The third sero-positive horse, Winnie, was destroyed by QPIF during the 2009 Cawarral incident.

Winnie was a bay filly belonging to the owners of the Cawarral property. Quarantine was declared over the property on 8 August 2009 and a positive result for Hendra virus was found on 10 August 2009 on a sample from a horse that had died on the property.

Winnie had a slight temperature on 11 August 2009 when samples were collected from her. The results from these samples showed both positive PCR results and positive serology results. Subsequent samples showed negative PCR results, but consistently positive serology (ELISA and VNT) tests.

Given that she had been identified as sero-positive, QPIF decided to destroy her under the Stock Act. The Acting Chief Veterinary Officer (Acting CVO) sent a Notice of Intention to Destroy to Winnie's owners on 21 August 2009 by email. The owners subsequently signed an authorisation for her destruction.<sup>107</sup>

Winnie's destruction was scheduled for 24 August 2009. According to QPIF, on the morning of her destruction Winnie showed some signs of depression and it was not clear whether this was due to sedation or to a recrudescing of her clinical signs. If she had begun to show clinical signs of Hendra virus, Winnie would have been the first horse to have demonstrated recrudescence.

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<sup>107</sup> The signing of an authorisation for destruction appears to be carried out for QPIF's convenience, as it allows QPIF to destroy the horse inside of the statutory timeframes. However, as there is no statutory process for providing authorisation, whether the owners have signed such an authorisation or not is unlikely to have any bearing on compensation.

Winnie was destroyed that day and subsequent test results showed positive PCR results, but no live virus was isolated.

## 8.4 Analysis of QPIF response

Having provided a summary of the circumstances surrounding the destruction of each horse, I will now consider the appropriateness of QPIF's actions.

### 8.4.1 The basis for the decision to destroy the horses

According to the Notice of Intention to Destroy, the basis for the decision to destroy Tamworth was:

- evidence of Hendra virus recrudescence in one human case
- the ability of the closely related Nipah virus to recrudescence in approximately 10% of cases in Asia (of which approximately 18% are fatal)
- the recommendation by the CCEAD
- insufficient evidence to exclude the risk of recrudescence in a horse that has previously been infected with Hendra virus.

Similarly, the primary evidence cited as justifying the decision to destroy Thomas was:

- the human death that occurred in 1995 after the person had recovered from a Hendra virus infection 12 months previously
- the ability of the closely related Nipah virus to recrudescence in approximately 10% of cases in Asia (of which approximately 18% are fatal).

I can only assume that Winnie was destroyed for the same reasons as Thomas and Tamworth, as positive serology test results were the only information cited in the Notice of Intention to Destroy. No scientific studies were provided to Winnie's owners to support the decision for Winnie's destruction.

In the course of my investigation, I have considered the reasons given by QPIF for destroying the horses. I am satisfied that QPIF made the decision to destroy the sero-positive horses on the basis of expert advice and knowledge available at the time.

I confirm proposed opinion 34 as a final opinion:

#### **Opinion 34**

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

However, I note that:

- there have been no demonstrated cases of recrudescence of Hendra virus in a horse (which may be because QPIF routinely destroys sero-positive horses)

- there has only been one case of recrudescence of Hendra virus in a human, and although it is not clear whether that person was infectious before his death, there is no evidence that he infected anyone with Hendra virus when the virus recrudesced
- it is not clear whether the Nipah virus cases that recrudescence have the ability to shed the virus and infect others
- although PCR-positive tissues have been found in the sero-positive horses that were destroyed, no live virus has ever been cultured from these tissues.

There does not appear to be any research relating to recrudescence of Hendra virus in horses, and specifically the capacity of recrudescenced horses to infect other horses or humans.

The CVO explained the current state of research to my officers:

That is still an issue under scientific investigation, but you've seen some of the papers of – just over there this morning I saw you were reading through them, give an explanation as to why currently we consider them to be not disease free because, and the reasons are firstly, the first human case of Hendra virus – not the Vic Rail one, the one originally in Mackay. The person became infected in 1994, died one year later from the same infection in 1995. So it stayed dormant in the body, reproduced. Nipah virus which is a very closely related virus – 10% of cases recrudescence and come back later, and those horses that we did post-mortems on – Tamworth and the one up at Proserpine, six weeks after they were infected we were still finding PCR product in a number of organs of those horses, so there are still some scientific consideration as to whether that is infectious material or not, but the current scientific advice – certainly from people from AAHL is that you have to at this stage consider them infected.

There's a bit of debate as to whether that's actually...that is actually the virus replicating again and actually causing disease again or whether it's some other process. There's a bit of debate over that. Even to this stage I would have to, until I get more information, consider the animal infected.

However, in an interview with my officers, Dr Middleton stated that while she supported the decision to destroy Tamworth on the basis of knowledge at the time, in her view the decision should now be revisited. She stated:

So it's one of those situations where I've felt for some time that that decision could be revisited. I mean they may come to the same conclusion that on the balance of risk it is more sensible to euthanase these animals, but I think that as you get more knowledge you can say, 'Well actually we now think we're in a position to say, well, they could be reassessed every 12 months or you know ...', none of these things should ever be cast in stone I don't think, because it all depends on the knowledge base that you have at the time that you make your decision.

I confirm proposed recommendation 33 as a final recommendation:

**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 recrudescence, and if such recrudescence results in a risk of infection to other animals or people.

### 8.4.2 The decision about which Act to use for destruction

In each incident that required the destruction of a sero-positive horse, QPIF made a decision about whether the destruction of the horse would occur under the Stock Act or the EDIA Act.

Tamworth and Thomas were destroyed under the EDIA Act, and Winnie was destroyed under the Stock Act.

My investigation considered the basis on which the respective Acts were chosen.

#### Tamworth and Thomas

My officers were told by QPIF legal officers that the CVO made the decision about which Act to use to destroy the horses.

QPIF was unable to provide any record of the decision or the basis on which the decision was made. Therefore, my officers were required to interview the CVO and other senior QPIF officers on this subject to determine the reasons for the decision about which Act to use. As conflicting responses were obtained from interviews, my officers then reviewed relevant QPIF documents from July and August 2008 to determine the reasons why this decision was made.

It seems that a number of considerations were discussed in detail at the time that this decision was made, and in my view these considerations appear to have informed the decision about which Act would be used to destroy these horses.

The first consideration was the availability of compensation. On or about 23 July 2008, the QPIF legal unit was requested by the Manager, Strategy and Legislation to provide:

... advice on whether the department is required to pay compensation to the owner of a horse infected with Hendra virus that the department intends to destroy.

The legal advice received on 29 July 2008 was:

Section 15(1) of the Stock Act provides for both infected' stock and suspected' stock. The Dictionary in Schedule 2 defines suspected' as meaning suspected of being infected'. The Macquarie Dictionary defines suspect' as being to imagine to be guilty, false, counterfeit, undesirable, defective, bad, etc., with insufficient proof or with no proof.' You advise that Hendra Virus may hide' in an infected horse for some time despite testing negative for the disease. It is arguable, considering the known characteristics of the disease, that a horse known to have been infected by Hendra Virus at some point, but which no longer tests positive for the virus, may still carry the dormant virus and therefore may be suspected' of still being infected. In those circumstances, it may be the case that if the chief executive is of the opinion that the destruction of the previously infected horse would tend to prevent the spread of the disease and therefore he may order its destruction. [original emphasis]

...

No compensation is payable to the horse owner where the horse is destroyed by order of the chief executive under the Stock Act and not part of a disease eradication program unless the horse destroyed is after examination by a government veterinary officer, found to be free from the Hendra virus (section 17 of the Stock Act).

If the horse is found to be free from the Hendra virus, the amount of compensation payable is equal to its market value assessed pursuant to section 65 of the *Stock Regulation 1988* (the Regulation).

Therefore, if after post-mortem it is discovered that the horse is free from disease, the Department may be required to pay compensation (at market value) to the owner. Having regard to the characteristics of the Hendra Virus (that it can hide in its host and therefore prove difficult to find during testing), **it is arguable that testing the horse in question at post-mortem may result in a negative finding for Hendra Virus and therefore compensation may be payable to the owner.** [emphasis added]

...

The CVO responded to this advice by email dated 30 July 2008:

Thank you for the legal advice regarding destruction of a horse that has recovered from Hendra virus symptoms. A few points of clarification.

In the background, you state that the horse initially tested positive, but currently does not test positive. This is not quite correct. The horse was positive using a PCR test which detects viral genetic material, and it is true that this test is now negative. However the horse is strongly positive to serological tests which detect antibodies to Hendra virus, and will remain so, possibly indefinitely.

You say that compensation may be required to be paid if, after post-mortem, it is discovered that the horse is free from the disease. I would argue from a technical perspective that it will not be possible to determine whether the horse is free from disease. A post-mortem examination may be able to demonstrate virus infection in one or more parts of the body. However if none is detected, that does not mean that the horse does not continue to be infected, it just means that we did not detect the virus. It may still be present elsewhere in the body. There is sufficient evidence from our knowledge of previous cases of Hendra virus and the closely related, Nipah virus that a carrier state is likely.

Therefore I would argue that until further scientific evidence is discovered to the contrary, all sero-positive horses must be regarded as being infected, irrespective of post-mortem results.

The QPIF legal unit replied on 30 July 2008:

On the issue of compensation, it is payable under the Stock Act if ~~the~~ stock destroyed or carcasses are, after examination by a government veterinary officer, found to be free from disease." It is arguable whether compensation will be payable in this case and if the horse owners challenge a decision on compensation it will ultimately come down to the court considering all the evidence available including technical evidence on the nature of the disease and making a decision. Your argument may well prevail but there are no guarantees as to how a court will ultimately determine the matter.

An email on 4 August 2008 from a QPIF legal officer to the CVO stated:

Compensation

...

Accordingly, if there is concern regarding political pressure that may be applied to the Minister to declare an outbreak for the purposes of triggering the compensation provisions, this pressure will exist regardless of whether an order to destroy is made under the EDIA [Act] or the Stock Act because the compensation provisions apply to orders made under either legislation.

With respect to the Stock Act, I confirm my previous advice that there is no guarantee that a court will determine on the available evidence that the horse is not free from Hendra virus and compensation is not payable. It is arguable that compensation is payable at the rate of the market value of the horse.

An email from the CVO to a QPIF legal officer also on 4 August 2008 stated:

Feeling from DG and [the Executive Director] is that we should stick to the Stock Act for the order as its clearer regarding compensation and that is what we used previously.

I note that this was not ultimately the decision made.

The detailed discussions about compensation, at the time decisions were being made about the destruction of these horses, suggests to me that compensation was a consideration which the CVO took into account when deciding which Act to use to destroy the horses. This is consistent with an email from the CVO to Queensland Racing on 16 July 2008, in which the CVO asked Queensland Racing to quietly find out the rough value of this horse<sup>1</sup>.

The second matter that appears to have been considered by QPIF was whether there were avenues for reviewing a decision to destroy a horse. Legal advice provided to the CVO by the QPIF legal unit on 29 July 2008 first mentioned this issue:

... Please note that a person who is aggrieved by an original decision about an order to destroy under section 15(1) of the Stock Act may appeal to the Magistrates Court against the decision (section 36 of the Stock Act). If the original decision is about compensation then it may be appealed to the District Court (section 36A of the Stock Act). The appeal is by way of rehearing on the material before the original decision maker and any further evidence allowed by the court (sections 36(9), 36(11) and 36D(2)). The court may confirm or amend the original decision or make a substitute decision (sections 36(12) and 36E).

Crown Law advised on 1 August 2008 that an order to destroy the horse would be less open to challenge if made under the EDIA Act rather than the Stock Act, because the latter contains an additional right of appeal to the Magistrates Court.<sup>108</sup>

The CVO told my officers that the availability of review was the most relevant consideration when making his decision:

CVO We used the Exotic Diseases and Animals Act at Redlands, we used the Stock Act at Cawarral. The reason we used the Exotic Diseases and Animals – well in terms of, not in terms of the quarantine, it was actually more in terms of the destruction order, why we used the Exotic Diseases. There was a specific reason why we used the Exotic Diseases and Animals Act. Our legal section were very keen on us to use the Exotic Diseases and Animals Act for Redlands.

QO Officer For the destruction of the horse?

CVO For the destruction, yes. And that was primarily to stop legal action against the order. That was the main reason for that. But,

<sup>108</sup> Crown Law further advised that the decision to destroy a horse could be the subject of judicial review regardless of which Act the decision was made under.

personally, I've got a view that it's an endemic disease so we should just use the Stock Act.

A third consideration being discussed at the time was the statutory timeframes concerning the destruction of animals, which is discussed further in section 8.4.3. The time for destruction under the Stock Act is seven days after an order is issued, while the EDIA Act allows destruction after a 'nominated time'. I note that in an email on 4 August 2008 to the CVO, copied to the Acting Director-General, a QPIF legal officer stated that: 'It appears that the process under the EDIA may be quicker than that under the Stock Act'.

Which of these considerations was the most important in determining which Act to use is not clear on the evidence provided to me.

Dr Perkins was told by QPIF that the EDIA Act was chosen because of the different timelines in the Acts for destroying horses. Dr Perkins reflected this advice in the 2008 Perkins Report, where he stated:

The main reason identified for use of the Exotic Diseases in Animals Act (1981) to authorise destruction of the two sero-positive animals was because it provided the shortest possible time period from notification of the order to the time when the animals could be destroyed under the legislation. The Stock Act (1915) provides similar legislative authority to cause the destruction of an animal but involves a longer potential time interval from the notification of the order to the time when the animal could be destroyed under the legislation. Once the decision had been made to order destruction of the horses there was an intent to implement the destruction order in a timely manner to avoid dragging the process out any further than was necessary.

I note that Dr Perkins' statement in his report that compensation was not a factor in the decision reflected the advice provided to him by QPIF officers.

Notes of meetings between senior QPIF officers and the QPIF legal unit on 4 August 2008 show that issues of the availability of compensation and pressure to 'declare an outbreak' were relevant factors under consideration at the time. I note that under the EDIA Act, compensation would only be available if the Minister made a declaration under s.28 of that Act.

My officers discussed with QPIF officers at interview the considerations which were relevant to deciding under which Act to destroy sero-positive horses. The CVO and some other QPIF officers stated that Hendra virus should properly be considered an endemic, rather than an exotic, disease. Consequently, the Stock Act was the more appropriate Act to use in responding to Hendra virus incidents. However, this was not the Act chosen to destroy Tamworth in 2008, and therefore other considerations must have been relevant to that decision.

It is clear that there is little agreement among senior QPIF officers about the basis for the decision about which Act to use to destroy the sero-positive horses in the 2008 Redlands and Proserpine incidents. The absence of any record of the decisions, when the decisions were made, or the CVO's reasons for reaching the decisions, also means that there is no other material on which I can rely to form a view about the basis of the decisions.

On the evidence available to me, and in the absence of a contemporaneous record of the reasons for the decision, I am of the view that the decision to destroy Tamworth and Thomas under the EDIA Act was based on all the above reasons. I have not

been provided with any QPIF documents that record the most dominant or substantial considerations in the decision-making process.

Once again, the absence of records containing reasons for the decision made it necessary for my Office to interview QPIF officers and rely on emails in order to obtain a clearer picture of QPIF's decision-making process. This could have been avoided had QPIF officers kept both records of key decisions made and the reasons for these decisions.

Having reached the view that all three of the above considerations were taken into account, I am of the opinion that in deciding which piece of legislation to apply, the decision-maker should not have taken into consideration the availability of compensation and judicial review.

My opinion is based on the proposition that when exercising these statutory powers the State is, in effect, seizing private property from a citizen for public purposes, that is to protect the health and safety of the public. Where a decision is made by the State to deprive a person of their property for public purposes, the person should have the opportunity to challenge that decision, and in the event that the decision is implemented (whether after review or not), the person should be adequately compensated within the framework established by the applicable legislation.

In my view, a decision-maker should only have regard to which Act best meets their operational objective, in this case to protect the public and horse industry from disease. The decision-maker was entitled to take into account expert opinion, and QPIF's capacity under the EDIA Act or the Stock Act to take action in a timely way. However, in my view, issues concerning compensation and rights of review were irrelevant, and any consideration of such issues in deciding which statutory power to use constituted administrative action that was unreasonable and/or wrong within the meaning of s.49(2)(b) and (g) of the Ombudsman Act.

I would add that in my view, where the 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 the best avenue of review, and capacity to compensate the person affected by the decision.

### **Winnie**

During the 2009 Cawarral incident, the Acting CVO made the decision to destroy Winnie under the Stock Act.

When asked why the Stock Act was used for destruction, my officers were told that the Acting CVO thought the Stock Act was more appropriate as Hendra virus was an endemic disease, not an exotic disease.

This is an entirely different consideration to those factors which were used by the CVO in the 2008 Redlands and Proserpine incidents to select the Act to use to destroy the sero-positive horses.

## Summary

On the basis of this discussion, in my proposed report, I formed the following opinions:

### Proposed opinion 35

The decision about the statutory power to be exercised 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.

### Proposed 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.

### Proposed opinion 37

When determining which statutory power would be exercised 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 wrong within the meaning of the s.49(2)(g) of the Ombudsman Act.

### Proposed 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 which provides for the least intrusion on an individual's rights.

### Proposed opinion 39

The decisions about which Act to use to destroy horses in different Hendra virus incidents were made on different bases in almost identical circumstances. QPIF's failure to make decisions on consistent bases in like circumstances constituted administrative action that is unreasonable within the meaning of s.49(2)(b) of the Ombudsman Act.

## DEEDI's response

The Director-General made no submissions in relation to my proposed opinions 35 and 36.

In relation to my proposed opinion 37, the Director-General submitted:

The issue of which Act should be used for the destruction of animals is different to the issue of which Act should be used for quarantine (see comments on sections 6.1.1 and 7.1.1). Subsection 14(4) of the Stock Act, which makes the Stock Act quarantine provisions subject to any EDIA quarantine, do not affect destruction powers.

The decision about which Act to use for destruction was made in difficult circumstances. It was a high-pressure situation in which officers were subject to public concerns about public health risks posed by the virus. There was a clear

national destruction policy under AUSVETPLAN. There was a need to expedite action. It is true that the decision to destroy was delayed due to circumstances beyond the department's control, including the need to comply with procedural fairness requirements. As those circumstances further delayed the possibility of action, the more urgent the need for expeditious action became.

Section 8.4.2 makes a strong inference that the primary consideration for the CVO in making a decision about which Act to use was in relation to compensation entitlements. This inference is strongly rejected.

The CVO has stated, as acknowledged in the proposed report, that his preference, and original intent, was to use the Stock Act, regardless of compensation entitlements. There is clear evidence that the CVO received legal advice to the effect that compensation entitlements were less clear under the Stock Act, yet he retained a preference for using that Act until receiving further legal advice about judicial review provisions.

Seeking advice on and discussing compensation entitlements under legislation was reasonable in the light of the profile of the case and inquiries from agency executives. It was appropriate and prudent to know what the financial implications were of the decision to destroy the horses, so that agency executives could be accurately advised. However the CVO maintains that this was not a significant consideration in his decision-making.

It was reasonable for the CVO to be mindful of the timeframes for decision-making. Two people were critically ill in hospital with Hendra virus, and there were multiple pressures associated with disease management at the Redlands property, including the timeframe for release of quarantine. The CVO acted in good faith when making the decision to use the EDIA Act to destroy the horses.

The CVO has stated that the decision was primarily informed by the availability of judicial review in the context that it was an emergency biosecurity response. At the time legal advice was received, the decision-making process had extended over several weeks due to external factors such as the need to consult with owners about proposed destruction, and there was concern to prevent the possibility of further delays.

The proposed report also states that the decision-maker should not have taken into account the issue of judicial review. But the decision was made in the light of Crown Law advice on this particular matter (as acknowledged in the draft report) and there was no legal advice to the effect that this was not a relevant consideration. The decision was not unreasonable in all the circumstances set out above.

DEEDI also suggests that it is incorrect to infer that statutory timeframes were a significant consideration. While there may be a slightly shorter statutory time frame available under the Stock Act, the primary concern was the availability of judicial review.

In light of the above, DEEDI submits that **proposed opinion 37 be withdrawn**.

In relation to proposed opinion 38, the Director-General submitted:

Experience has led DEEDI to form the view that operational objectives may be best achieved through the use of a single set of statutory powers, rather than subjecting officers and members of the public to a patchwork of powers between the two Acts.

Subsection 14(4) of the Stock Act makes the Stock Act quarantine powers subject to EDIA Act quarantines. Where quarantines can only be imposed under the EDIA Act, the public interest in controlling the spread of the Hendra Virus may be best served by

solely utilising the powers of EDIA Act even if some of those powers may be more intrusive than their Stock Act counterparts.

In any event, the issue of choice of legislation will be overtaken by the draft Biosecurity Bill, which will become the sole Act dealing with such matters, and will resolve any ambiguity concerning which Act to use.

In relation to proposed opinion 39, the Director-General submitted:

The proposed report should recognise that the 2009 destruction decision was made in light of the experience and learnings from the 2008 response. Although the circumstances were similar to the previous response, the decision-maker held discussions with those involved in the previous response and took into consideration the issues that arose. It was apparent in the 2008 response that the use of different Act's during a response was not appropriate. It had become accepted that Hendra virus is endemic in Queensland, and that on this basis the Stock Act was the most appropriate legislation to be applied. This also supported the public message that precautions for Hendra virus should be taken at all times to decrease the risk of infection; as is the case with all endemic diseases. To continue operating as if the virus was exotic, would have hampered and confused the message.

Furthermore, there was a need to settle the uncertainty about which Act to use. Between the 2008 and 2009 responses, the Perkins Report was finalised. While this report did not make specific recommendations about which Act should be used in a Hendra response, it highlighted the complications associated with having two legislative instruments to work with. It was considered that both the Stock Act and the EDIA Act had shortcomings, but it was no longer appropriate to consider Hendra virus an exotic disease. The Stock Act was also meeting the operational needs of the response. As such, the Stock Act was used as the instrument for quarantine, and a policy document was drafted to reflect that the Stock Act would be used in Hendra responses (Hendra Response – Quarantine and Undertaking Management).

On this basis it is proposed that the use of the Stock Act in 2009 was not unreasonable and it is submitted that **proposed opinion 39 be withdrawn**.

### **CVO's response**

The CVO made the following submission:

In some cases, the reader could draw the conclusion that I lied to your investigators, which I can assure you, I did not. The primary example of this that concerns me is where I told your investigators that my primary consideration in using the Exotic Diseases in Animals Act for destruction of Tamworth was to prevent legal action against the Order. I suggest that the evidence presented in the report supports that this was my primary consideration, yet a contrary view has been taken.

### **Ombudsman's analysis**

I did not conclude that the CVO had lied to my officers, and I do not agree that my report implies that this occurred. However, I cannot be satisfied on the basis of oral evidence provided a significant time after a decision was made that the primary consideration was one out of three issues, when the documents relevant to this decision show that the remaining two issues were also the subject of significant discussion.

However, I have not, as suggested by the CVO, reached the view that the availability of judicial review was not considered by the CVO. What I have said is that I cannot determine whether this was the primary consideration. I also note that, even if it was

the primary consideration in the CVO's decision, I would remain of the view that the decision was made in error.

I also do not agree with the Director-General's submissions in response to my proposed opinion 37. While I accept that the decision about which Act to use was made in unusual and difficult circumstances, I have discussed elsewhere in my report that I do not accept there was critical urgency or urgent public health risks in destroying Tamworth and Thomas that would justify circumventing proper decision-making processes.

Further, the Director-General's submission that I have concluded that the availability of compensation was the primary consideration for which Act to use is incorrect. I have clearly stated above that I am unable to determine which was the primary consideration due to QPIF's failure to keep proper records and its officers having different recollections and understandings of events. However, it would be difficult to claim that this factor was not considered by QPIF at the time.

While compensation may have been a reasonable factor to consider, the proper time for such consideration was after the decision had been made about which Act to use. The consideration given to compensation before the decision was made, in the absence of any recorded reasons for the decision, leaves QPIF open to the implication that this was one of the bases for the decision.

Therefore, while acknowledging that the CVO states compensation was not a significant consideration in the decision, I maintain my view that compensation was one of the factors considered in reaching the decision about which Act to use.

In relation to the timeframes for destruction, the Director-General submitted that the CVO acted in good faith in making the decision to use the EDIA Act to destroy the horses. I have not suggested that there was any bad faith in making this decision. I have, however, questioned the reasonableness of the decision-making processes.

The Director-General's main submission appears to be that the availability of judicial review was the key factor in determining which Act to use to destroy the horses. He specifically stated that it is incorrect to infer that statutory timeframes were a significant consideration in the decision. However, this submission appears inconsistent with QPIF's advice to Dr Perkins in late 2008 that the timelines for destruction were the key reason for selecting the EDIA Act.

The CVO also submitted that the availability of judicial review was his primary consideration in selecting which Act to use for destruction. While the availability of judicial review may well have been the primary consideration, the absence of contemporaneous records means that the level of consideration given to the issues of compensation and timeframes for destruction is not clear. I do not accept (and I note that the CVO has not submitted) that these issues were not considered at all.

I also note that a request for legal advice from the QPIF Legal Unit to Crown Law on 4 August 2008 stated:

[The CVO] is concerned about any implications that making an order under the EDIA Act rather than the Stock Act will have on potential claims for compensation. Please provide your advice on whether you think compensation will be payable under Part 3 of the EDIA Act in circumstances where the Minister has not given notification of an outbreak under section 28.

Ultimately, there have been a number of substantial contradictions in relation to this issue. The CVO told my officers in 2009 that the availability of judicial review was the primary consideration, and this is consistent with the Director-General's current submission. However, the advice given by QPIF to Dr Perkins in 2008 contradicts this position. Other senior QPIF officers and QPIF legal officers also identified to my officers other factors that were considered at the time.

While I do not form the view that the CVO or any other QPIF officer misled my officers, in the absence of contemporaneous records of the decision I must balance recollections of the decision-making process some years later against the content of emails and legal advices received at the time the decision was made. On the basis of the evidence available to me, I am unable to conclude that the availability of judicial review was the only consideration in selecting the Act. The extent to which it was the primary consideration is therefore largely irrelevant to my finding.

Further, I maintain my view that limiting the availability of judicial review is an inappropriate basis for selecting a statutory power. Therefore, while the DEEDI submission requests that I find that the issue of compensation was not a primary consideration, I do not see that such a finding would alter my view that the basis for the decision was unreasonable and/or wrong.

Again, I comment that the absence of contemporaneous records of the reasons for the decision makes it difficult or impossible to determine the actual reasons for the decision at a later date, and leaves QPIF vulnerable to criticism.

The Director-General asserted that QPIF officers relied on legal advice about the availability of judicial review, and that there was no advice that this was not a relevant consideration. He argued that this legal advice meant that a decision made on this basis was reasonable.

However, reliance on legal advice is only one factor that may be relevant to determining whether a decision was reasonable. A decision does not become reasonable simply because a legal officer advises a particular course of action.

Legal advice is just that: advice, in response to specific information and/or questions. QPIF has not provided me with any evidence that QPIF officers briefed the QPIF legal unit or Crown Law to advise on which Act should be used, but simply asked about the consequences of using either Act.

I maintain my view that an approach which denies the owners of a sero-positive horse the opportunity to challenge a decision is not a reasonable basis for a decision within the meaning of s.49(2)(b) of the Ombudsman Act. While it may be a consideration that can be considered at law, I have a wider jurisdiction to examine the appropriateness and reasonableness of administrative decision-making in particular circumstances.

In relation to my proposed opinion 38, I acknowledge the Director-General's submission that an additional relevant consideration is which Act best achieves the public interest. However, I maintain my view that the selection of a statutory power with an objective of denying a person rights of judicial review, the time to consider or challenge a decision, or compensation (whatever the reason for such a denial) is not a reasonable course if another, less-intrusive statutory power is available.

In removing property from a person, an attempt to deny them the right to challenge a decision may be valid if there is an avenue for compensation available to them, so

that they could in effect be restored to the position they would previously have been in if the decision was later found to be wrong. Selecting a course of action that removes both a right of challenge and a right to any compensation does not appear to be in the public interest at all. I have no doubt that the public would object if all government decision-making was on such a basis.

I also do not accept any argument that there was a public health risk caused by Tamworth or Thomas remaining alive for a few days longer to enable an urgent judicial review application to be heard. As I discuss in sections 8.3.1 and 8.3.2, both horses were under quarantine and had been for a significant period of time prior to their destruction. While it may have been convenient to have the horses destroyed as soon as possible so that the quarantine was released, as far as I have been informed there was no additional public health risk that suddenly needed to be avoided.

Finally, in relation to my proposed opinion 39, the Director-General submitted that this opinion be withdrawn. I have considered the Director-General's submissions in this regard and agree that the proposed opinion should be withdrawn. As I have already reached the view that the decision-making in relation to the destruction of the horses in 2008 was significantly flawed, in light of the context provided by the Director-General in his response to my proposed report I have concluded that QPIF's decision to adopt a different approach in 2009 was not unreasonable.

I confirm proposed opinion 35 with an amendment as a final opinion:

#### **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.

I confirm proposed opinion 36 as a final opinion:

#### **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.

I confirm proposed opinion 37 with an amendment as a final opinion:

#### **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 s.49(2)(b) and (g) of the Ombudsman Act.

I confirm proposed opinion 38 as a final opinion:

**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.

My proposed report included a proposed opinion 39; however, this has been withdrawn.

My comments elsewhere in this report about the appropriateness of the Stock Act and of the EDIA Act to satisfactorily deal with the circumstances of Hendra virus should be taken into consideration by QPIF in:

- responding to Hendra virus incidents up to the date that the proposed Biosecurity Bill becomes law
- considering the adequacy of the powers and processes in the proposed Biosecurity Bill.

I confirm proposed recommendation 34 as a final recommendation:

**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.

### 8.4.3 Procedural fairness

In my investigation, I considered whether QPIF discharged its obligation to afford procedural fairness to the owners of the three horses that were destroyed.

In simple terms, procedural fairness, or natural justice, means that a person who might be adversely affected by an administrative decision (the affected person) must be given a fair hearing before the decision is made. However, there are generally considered to be three aspects of procedural fairness:

- the notice to the affected person must identify the critical issues and contain sufficient information for the person to be able to participate meaningfully in the decision-making process (the notice rule)
- the affected person is given a reasonable opportunity to speak or respond and also that the decision-maker genuinely considers the affected person's submission in making the decision (the fair hearing rule)
- the person making the decision must act impartially in considering the matter (the lack of bias rule).

Procedural fairness is required when legislation expressly provides that a decision-maker must observe procedural fairness or when the common law supplements any statutory procedures.

At common law, procedural fairness is required when a proposed decision may affect a person's rights, interests or legitimate (reasonable) expectations. So in cases where a decision may adversely affect any person, they must be given a reasonable opportunity to comment on the critical issues, and information or material that may be unfavourable to them, before the decision is made.

### **The notice rule**

I considered whether the owners of each horse were given sufficient information to enable them to participate meaningfully in the decision-making process. In order to meet the notice requirement, delegates should have provided to the owners all relevant material that was necessary for the delegates to rely on to justify their decision.

Both Tamworth's and Thomas's owners were provided with most of the information that was considered by the decision-maker. In Tamworth's case, some information was provided after the Notice of Intention to Destroy was issued, and two further scientific studies considered by the decision-maker were not provided to Tamworth's owners at all.

Winnie's owners were only provided with test results for their horse, an article by the CVO justifying Tamworth's destruction in 2008 and an extract from AUSVETPLAN, rather than the several scientific studies and extracts from the Guidelines for Veterinarians that were provided to the owners of Tamworth and Thomas.

Therefore, in both Tamworth's and Winnie's cases there were some departures from the strict requirements of procedural fairness, in that QPIF did not provide the owners with all of the information or evidence on which it intended relying to make its decision at the time that the notices were issued. However, I am satisfied that these were not substantial departures from what was required.

Further, no direct benefit can flow to the owners from any recommendation I might make given that the horses have been destroyed.

I am also unable to conclude that the provision of the additional information to the owners would have changed the outcome. However, I have included this discussion to:

- show QPIF where improvements in its administrative practice are required
- address concerns horse owners and members of the public may have with QPIF's practices
- provide guidance to QPIF and other agencies about the requirements of procedural fairness and the importance of strictly adhering to procedural fairness requirements where an individual's rights or interests are likely to be affected.

I confirm proposed opinion 40 with an amendment as a final opinion:

#### **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.

### **The fair hearing rule**

In each case, the owners were given an opportunity to make a submission to the decision-maker before their horse was destroyed. The issues for consideration are whether sufficient time was given to them and whether the decision-maker had an open mind.

In relation to the destruction of Thomas and Winnie, I have not identified any significant issues of concern in QPIF's process.

In relation to Tamworth's destruction, one issue merits discussion in my report. The relevant background to this decision is as follows.

The minutes from the CCEAD meeting on 21 July 2008 show the CCEAD expressed the view that Tamworth must be destroyed and directed QPIF to make arrangements to this end.<sup>109</sup> By this time, no notice had been given to Tamworth's owners that their horse was to be destroyed, and they had not been afforded an opportunity to respond.

It appears that a decision to destroy Tamworth was made by the CVO and communicated to his owners on or about 22 July 2008. The wording of the CVO's emails to the QPIF legal unit dated 23 July and 30 July 2008, as well as his conversation with Tamworth's owners about the pending destruction of their horse, indicate that by this time the CVO had decided to destroy Tamworth.

Crown Law advice received by QPIF on 1 August and 4 August 2008 recommended that the decision-maker be changed to avoid the perception that the CVO had already made up his mind.

Subsequently, in early August, QPIF replaced the CVO as the decision-maker and appointed the Director AWB to make the decision.

A show cause letter was then sent to Tamworth's owners on 5 August 2008 providing them with 48 hours to make submissions. It is clear that this show cause letter was signed by the Director AWB, but was based on the CVO's views.

The decision to destroy Tamworth was made on 12 August 2008 by the Director AWB after seeking submissions from Tamworth's owners. The statement of reasons prepared by the Director AWB in relation to this decision evidences an independent decision-making process.

Although the Director AWB ultimately reached the same decision as the CVO had reached, that is that Tamworth would be destroyed, it is clear that Tamworth's owners had the opportunity to seek legal advice and make submissions, and that the Director AWB engaged in an independent decision-making process. I also accept that the Director AWB understood her obligations as a decision-maker.

Therefore, in the circumstances I am of the opinion that Tamworth's owners were given a fair hearing before a decision was made to destroy the horse.

I agree with the advice provided by Crown Law that had QPIF proceeded to destroy Tamworth on the basis of the decision made by the CVO, then there might have

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<sup>109</sup> The Director-General of DEEDI has advised me that this is an incorrect record as CCEAD cannot direct a State to do a particular action. Instead he states that CCEAD only reaffirmed national policy.

been a breach of procedural fairness in relation to this decision because the CVO had arguably made the decision without having provided an opportunity for Tamworth's owners to make submissions.

In response to my proposed report, the CVO submitted:

While there is no adverse opinion stated in this section, the reader could draw the conclusion that my actions in relation to the destruction Order for Tamworth may have breached procedural fairness principles. While I did not debate this issue at the time that Crown Law advice was received on 1 August, I would submit that at the time my actions and thinking were mindful of striking a balance between procedural fairness and the public interest in terms of controlling an infectious disease.

...

During the Redland's incident I was mindful of the time period that had already passed and the need to exercise prudent disease control, as well as other considerations such as the need to release the property from quarantine in a timely manner. In trying to make the process as fair as possible I:

- a. Had the national policy on destruction of sero-positive horses reviewed as quickly as possible
- b. As soon as the policy had been confirmed by CCEAD I met the owner in person to explain the situation and advise of my intention to order the animal destroyed
- c. I prepared a Statement of Reasons to supply to the owner, as requested at the face to face meeting.

At this stage the process was transferred to the Chief Inspector on the advice of Crown Law. However I would submit that the owner was being given and would continue to have been given ample opportunity to submit contrary arguments. If I had continued the process I had commenced, my intentions were to continue to follow a procedurally fair process.

The subsequent process was very reasonable in the circumstances, followed internal and external legal advice, gave the owners good opportunity to have their say and gave them sound reasons for the ultimate decision. The transfer of decision-making to the Chief Inspector underlines the transparency and fairness of the process.

I request that the wording of section 8.4.3 be modified to remove the inference that I was not following a procedurally fair process.

### **Ombudsman's analysis**

I acknowledge the CVO's submissions and his intention to balance procedural fairness requirements with biosecurity requirements. However, the Crown Law advice at the time (and my perception from the contemporaneous documents) was that the CVO had already made a decision to destroy Tamworth before the show cause process was initiated. Whether the CVO had in fact reached a final decision to destroy Tamworth by this time is largely irrelevant, because the reasonable perception was that this had occurred.

The steps taken by the Director AWB as a result of the Crown Law advice were sufficient to cure any potential weakness in procedural fairness.

I confirm proposed opinion 41 with amendments as a final opinion:

**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.

I also have one comment to make about QPIF's overall process in relation to the destruction of Tamworth and Thomas in 2008.

Tamworth and Thomas were both destroyed under the EDIA Act, which allows destruction after a nominated period of time. This Act was at least in part selected by QPIF because of legal advice that it permitted destruction within shorter timeframes than the Stock Act.

Further, acting on legal advice, QPIF gave Tamworth's and Thomas's owners 48 hours to respond to a Notice of Intention to Destroy, before making the decision to destroy the horses and carrying out the destruction.

The relevant dates in each case were as follows:

**Tamworth**

- Tamworth first tested sero-positive on 8 July 2008.
- The Notice of Intention to Destroy was sent to Tamworth's owners on 5 August 2008.
- Submissions were due from Tamworth's owners by 7 August 2008.
- The Order to Destroy was signed on 12 August 2008.
- Tamworth was destroyed on 15 August 2008.

**Thomas**

- Thomas first tested sero-positive on 21 July 2008.
- Notices of Intention to Destroy were sent to Thomas's owners on 12 August and 27 August 2008.
- Submissions were due from Thomas's owners by 14 August 2008 and 1 September 2008.
- The Order to Destroy was signed on 1 September 2008.
- Thomas was destroyed on 4 September 2008.

Although QPIF argued that there was urgency in destroying the horses (sufficient to justify both providing a shortened period to respond to the notices and its use of the EDIA Act), its conduct is inconsistent with that view. Both horses first tested sero-positive some weeks before a Notice of Intention to Destroy was sent, and the time period from initial sero-positive test to destruction totalled approximately five to six weeks in each case.

My officers have not been provided with a reason for the sudden urgency for destruction at the end of the five to six week period. In each case, the horse was quarantined and had obviously been cared for in that situation for the entire period without significant difficulty.

Therefore, I query whether:

- there was in fact an urgent need to destroy the horses sufficient to justify the use of the EDIA Act over the Stock Act
- the shortened timeframe given to Tamworth's and Thomas's owners to make submissions was justified in the circumstances.

Providing the owners with a longer period to make submissions about the destruction of their horses may have permitted them to:

- consider the issues in detail, including the lengthy scientific papers with which they were provided
- seek adequate legal advice about the issues in the notice<sup>110</sup>
- seek expert veterinary advice about Hendra virus and sero-positive horses
- give careful consideration to their position and respond accordingly.

Further, the use of the Stock Act instead of the EDIA Act might have permitted the owners greater opportunity to challenge the decision to destroy their horses, or may have affected the availability of compensation (discussed in section 8.4.4).

In my proposed report, I therefore formed the following opinion:

#### **Proposed 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.

#### **DEEDI's response**

The Director-General of DEEDI submitted that, for the reasons he provided in relation to his submissions in respect of section 8.4.2, QPIF's conduct was not inconsistent with the urgency that had developed. He also stated that it was clear from the evidence that the CVO had attempted to act expeditiously despite other factors preventing this. The Director-General therefore requested that my proposed opinion 42 be withdrawn.

#### **Ombudsman's analysis**

I do not agree that the Director-General's submissions in relation to section 8.4.2 show that any urgency had developed. The legal advice that the Director-General appears to be referring to as the reason for delays in destroying the horses does not account for a significant portion of the delays, and nor does the need to provide procedural fairness to the owners of the horses (which took only 48 hours in either case).

While I acknowledge that QPIF wanted to release the quarantine on the relevant properties as soon as possible, this does not equate with there being an urgent need to destroy the horses such that the owners of the horses should be provided only with a minimal time to seek legal and veterinary advice and respond to the Notices of Intention to Destroy.

<sup>110</sup> Although Tamworth's owners did obtain legal advice, a longer time may have permitted them to seek more extensive advice or gather any necessary information to challenge the proposed decision.

Therefore, I see no reason for me to withdraw my proposed opinion.

I do not suggest that Tamworth and Thomas should have been destroyed earlier by QPIF. What I have concluded is that QPIF's conduct in destroying the horses was not consistent with there being an urgent need to destroy the horses at the time they were destroyed, sufficient to justify a curtailing of procedural fairness requirements or the selection of a statutory power that limited the availability of judicial review.

I confirm proposed opinion 42 as a final opinion:

**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.

I also note that QPIF's current Destruction Policy drafted on 17 August 2009 (after these incidents had been concluded) provides for destruction under the Stock Act, which allows a seven day period before destruction can commence once an Order to Destroy is signed. Therefore, QPIF clearly accepts at the present time that there is no urgent need to destroy quarantined, sero-positive horses within 48 hours.

However, despite this longer period, the policy still provides for a period of only 48 hours in most circumstances for owners to respond to a Notice of Intention to Destroy.

I confirm proposed recommendation 35 as a final recommendation:

**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.

**8.4.4 Compensation for sero-positive horses**

Tamworth and Thomas were destroyed under the EDIA Act and therefore compensation was not available to their owners unless the Minister declared an outbreak under that Act. I have discussed this issue further in section 8.4.5.

During the 2009 Cawarral incident, Winnie was destroyed under the Stock Act.

Section 17 of the Stock Act provides for an owner to be compensated where stock is destroyed, as long as the stock is found by a government veterinary officer to be free from disease' at the time it is destroyed. The amount of compensation payable for stock destroyed under the Stock Act may be up to the market value of the stock.<sup>111</sup>

The availability of compensation turns on the definition of free from disease'. Where stock can be shown to be infected with a disease, no compensation is payable.

The phrase free from disease' is not defined in the Stock Act and I have not been able to locate any judicial consideration of the phrase, despite it appearing in a number of pieces of legislation.

However, disease' is defined in the Stock Act to mean a disease, disorder, condition or other thing prescribed under a regulation or declared under the Act. Hendra virus is a prescribed disease under the Stock Regulation.

Therefore, it follows that for a sero-positive horse to be free from disease', it must be free from Hendra virus'.

A sero-positive horse carries antibodies to Hendra virus. However, antibodies do not necessarily indicate the presence of live virus. Antibodies can remain in an animal's body for a significant period of time after the animal has stopped showing clinical signs of a disease.

It is important to note that tests on the sero-positive horses that have been destroyed have been unable to culture live Hendra virus.

As the availability of compensation for a horse destroyed under the Stock Act depends on whether it is free from disease', it is a matter open to debate as to whether a sero-positive horse remains infected with Hendra virus.

One explanation of disease' is that the host is showing clinical signs of the virus. However, scientific studies have identified situations in which horses can infect others with Hendra virus before they begin showing clinical signs or symptoms of the virus.

On the other hand, the presence of antibodies may not be accompanied by any clinical signs. This results in a seemingly well horse.

The approach adopted by QPIF has been to presume that sero-positive horses remain infected with Hendra virus.

It has been suggested by QPIF officers that the possibility that a sero-positive horse can recrudescence with Hendra virus means that such a horse can never be considered free from disease'. One QPIF officer told my officers that the inability to culture the virus was of no significance:

... the virus is very difficult to culture, and then others will, are far more experienced than I, but basically it's a difficult virus to culture, so not necessarily. Just because you haven't cultured the virus doesn't mean there isn't live virus there.

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<sup>111</sup> Section 17, Stock Act.

This is also the view held by the CVO. An email from the CVO to the QPIF legal unit dated 30 July 2008 in regard to the destruction of Tamworth stated:

... I would argue from a technical perspective that it will not be possible to determine whether the horse is free from disease. A post-mortem examination may be able to demonstrate virus infection in one or more parts of the body. However if none is detected, that does not mean that the horse does not continue to be infected, it just means that we did not detect the virus. It may still be present elsewhere in the body. There is sufficient evidence from our knowledge of previous cases of Hendra virus and the closely related, Nipah virus that a carrier state is likely.

Therefore I would argue that until further scientific evidence is discovered to the contrary, all sero positive horses must be regarded as being infected, irrespective of post-mortem results.

On the CVO's interpretation, horses that test positive to antibodies but do not demonstrate clinical signs of the disease will nevertheless be regarded as being diseased indefinitely, even if it is never demonstrated that they are infected with the live virus.

QPIF has previously obtained internal legal advice on this issue. The QPIF legal unit provided the following advice to QPIF officers on 11 August 2009:

If cases are identified where it is decided it is necessary to make orders for destruction in respect of infected animals, orders can be made under either the *Stock Act 1915* (the SA) or the *Exotic Diseases in Animals Act 1981* (the EDIA).

...

Where animals are destroyed pursuant to orders under the SA, the owner has a right to compensation only where the animal's carcass is found to be free of disease. **Arguably, had the horse Tamworth been destroyed pursuant to the SA in 2008, the owners would have been entitled to compensation under the SA – that is to say, there is room for argument about the meaning of the phrase “free from disease”.** Tamworth had recovered from Hendra virus at the time of his destruction, but was destroyed under the EDIA on the basis that there was a possibility he might recrudescence. Whether or not the potential for recrudescence is enough to say that Tamworth was not free from disease is not clear. [emphasis added]

This issue was also considered at the time that QPIF was considering whether to destroy Tamworth during the 2008 Redlands incident. Advice from the QPIF legal unit at the time stated:

It is proposed that a horse be destroyed that initially tested positive for Hendra Virus but currently does not test positive.

You advise that Hendra Virus is able to hide in its host and may reappear at a later stage. ...

If a horse is found to be free from the Hendra virus, the amount of compensation payable is equal to its market value assessed pursuant to section 65 of the *Stock Regulation 1988* (the Regulation).

Therefore, if after post-mortem it is discovered that the horse is free from disease, the Department may be required to pay compensation (at market value) to the owner. Having regard to the characteristics of the Hendra Virus (that it can hide in its host and therefore prove difficult to find during testing), it is arguable that testing the horse in

question at post-mortem may result in a negative finding for Hendra Virus and therefore compensation may be payable to the owner.

Another email dated 30 July 2008 between QPIF legal officers stated:

Compensation – I think what [the CVO] is saying is similar to what we were saying ie compensation may be payable because the post-mortem will probably reveal that for the purposes of the Act, the horse is free from disease'. Maybe send [the CVO] an email explaining that the issue of compensation is arguable and will, if challenged, come down to our scientific evidence versus their scientific evidence.

QPIF ultimately determined that Tamworth should be destroyed under the EDIA Act. I have reached the conclusion in section 8.4.2 that the more limited availability of compensation was at least one factor considered in the decision to use the EDIA Act to destroy Tamworth.

QPIF has adopted the position that sero-positive horses are not free from disease' and therefore compensation is not payable for horses destroyed under the Stock Act. This position was applied to the destruction of Winnie during the 2009 Cawarral incident.

I have some concerns with this view. I am primarily concerned that QPIF is unable to prove conclusively that sero-positive horses are infected. All known tests for the presence of disease that have been used on sero-positive horses, such as virus isolation tests, have returned negative results. In relation to disease testing, QPIF points out that a negative result on such a test does not guarantee the absence of the virus, and that the tests are not yet validated.

I am concerned about whether it is reasonable for QPIF to deny compensation to owners of sero-positive horses on the basis of test results that fail to show the presence of any disease. It is arguable that the onus should properly lie on QPIF to prove that the horse was not free from disease'. It would be unfair to place that onus on the owner of the horse, as only government agencies have access to the necessary testing processes and scientific knowledge necessary to establish the presence or absence of disease.

Determining whether a sero-positive horse is free from disease' is, in my view, both a scientific and a legal question. While whether a horse has a disease may be a scientific determination, QPIF has not provided any information as to whether it has attempted to conduct any research that would support its view that sero-positive horses are able to recrudescence and therefore remain diseased'.

I question whether it is reasonable for QPIF to deny compensation to horse owners on the basis of an assumption.

Further, the issue of whether compensation should be payable is essentially a legal question and not a scientific one, albeit one based on scientific information. The issue of who should bear the burden of proving that the horse is either diseased' or free from disease', and to what standard this must be proved, are legal questions and cannot be resolved by QPIF scientists. While QPIF has sought some Crown Law advice on this issue as a result of a recommendation in my proposed report, the legal advice was based on the caveat of scientific advice provided solely by QPIF scientists. It is not clear to me whether an independent expert, or a Court, would agree with QPIF's view.

QPIF has adopted the view that compensation is not payable for sero-positive horses that are destroyed. That is one of two possible conclusions, the alternative conclusion being that such horses are not still diseased and therefore the Act anticipates compensation be paid on their destruction.

Finally, I am able to consider the reasonableness of a refusal to pay compensation under a legislative scheme, and not just the legality of such an action. While QPIF may obtain legal advice to the effect that it is legally able to avoid compensation, in my view if it cannot show that a sero-positive horse is diseased through any positive test results or strong scientific findings, then it is not reasonable for QPIF to refuse to pay compensation for destroying such a horse.

Although QPIF has recently sought Crown Law advice on this issue, I am not satisfied that this advice adequately deals with the issue of reasonableness.

Therefore, while I accept that QPIF scientists remain of the view that sero-positive horses are diseased, I do not accept that it is reasonable for QPIF to refuse to pay compensation for these horses in a situation where QPIF is not able to show that the horses are diseased.

It may be that future research will show that QPIF's current view is correct and sero-positive horses are in fact diseased. However, QPIF is required to assess the payment of compensation on the basis of known facts at the time it destroyed each individual horse under the Stock Act. On the basis of the information provided to me by QPIF and the state of knowledge at the time, I do not agree that it was reasonable for QPIF to decline to pay compensation for Winnie's destruction in 2009. While I do not assert that QPIF acted unlawfully in not paying compensation, as I have stated above, the issue of reasonableness is a separate issue entirely.

I also note that there is no indication that QPIF considered the issue of compensation in the case of Winnie in 2009, nor that it considered whether Winnie was free from disease'. There is also no evidence suggesting that QPIF advised Winnie's owners that compensation may be payable for destroyed stock under the Stock Act and that an application could be made to QPIF in relation to this issue.

In contrast to the EDIA Act, the Stock Act does not set out any process by which an owner may apply to QPIF for a determination of compensation. In the absence of any such process and any application by a horse owner, in my view QPIF should still, as a matter of fairness and on its own initiative:

- advise property owners and horse owners at the time a quarantine is imposed that:
  - QPIF has the ability to destroy stock in certain circumstances under the Stock Act
  - if stock is destroyed by QPIF, compensation may be payable for the destroyed stock under the Stock Act
- where it destroys a horse under the Stock Act, on receipt of autopsy results consider whether the horse was free from disease' at the time of destruction and therefore whether compensation is payable.

Finally, the resolution of this issue will also be relevant to the drafting of the proposed Biosecurity Bill. The seizing of private property for public purposes such as disease control is a serious issue and there should be certainty about whether and in what circumstances compensation for loss is available to affected individuals. I note again my comments in section 8.4.2 that where the state is depriving a person of their

property for public purposes such as disease control, unless compensation is specifically excluded by legislation the person should be adequately compensated for the loss.

The proposed Biosecurity Bill should, in my view, clearly set out the criteria on which compensation is payable for destroyed stock, including adequate clinical criteria to enable QPIF officers to determine whether compensation is payable. Obviously, clinical and legal advice may also be required to assist with this process.

In my proposed report, I formed the following opinion and made the following recommendations which were provided to DEEDI for a response:

#### **Proposed opinion 43**

QPIF's insistence 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, if not the better view
- (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.

#### **Proposed recommendation 36**

QPIF:

- (a) immediately seek external legal 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
- (b) in conjunction with this process and to inform the legal advice, seek clinical advice as to whether a sero-positive horse should be considered to be free from disease'
- (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.

#### **Proposed 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 in accordance with legal advice
- (b) if a claim is received, respond to the claim in accordance with the external legal advice.

### Proposed 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.

### DEEDI's response

The Director-General of DEEDI made a number of submissions in relation to my proposed opinion 43 and proposed recommendations 36 to 38.

The Director-General submitted that QPIF did not act unreasonably as suggested in proposed opinion 43, and that this opinion should therefore be withdrawn. He stated:

The department did not "insist" that compensation is not available to horse owners. It is difficult to identify, from the evidence cited, any conduct or exchange which would fairly justify the use of such a strong term.

The legal advice which is cited provided a balanced view on the compensation entitlements under the legislation. It was made clear in this advice that compensation would be dependent on the test results of the horse once destroyed, which is correct. Comments about whether a sero-positive horse might be "free from disease" were made with limited scientific information and understanding about the nature of the disease and the potential disease status of the animals in question. The legal advice in no way indicated that the 'better view' was that compensation would be available. It merely concluded that the availability of compensation would come down to scientific opinion.

The advice did not identify flaws in the information being provided by the CVO. Furthermore, there is no evidence from the related correspondence that the CVO was insistent that compensation not be available. The evidence shows that the CVO did no more than offer further scientific information to inform the legal advice. Evidence contained in the draft report supports the contention that the CVO, although having an opinion that the animal was "diseased", accepted that this could be argued scientifically.

Moreover, it follows that there is no basis on which the department should have sought external legal advice (opinion 43(b)).

In regard to proposed opinion 43(c), the Director-General submitted that:

- the determination that compensation was not payable turned on whether the animals were 'free from disease'.
- based on the scientific information explored above, it was reasonable to conclude that the destroyed animals were not free from Hendra virus, and thus not 'free from disease'.
- based on that conclusion, compensation was therefore not payable.

The Director-General also stated that:

- pursuant to the proposed recommendation 36, external legal advice has been sought from Crown Counsel on the issue of compensation under the Stock Act.
- the Principal Epidemiologist and the acting CVO briefed Crown Counsel about expert clinical matters in order to inform Crown Counsel's advice.
- proposed recommendation 36(b) has become otiose.
- s.17(2)(a) prohibited the State paying compensation under the Stock Act to the owners of sero-positive horses by order of the Stock Act.

The Director-General therefore requested that my proposed opinion 43 and proposed recommendations 36 and 37 be withdrawn.

### **CVO's response**

A response relevant to this section was also received from the CVO. He stated:

In other areas, your conclusions call into question my professional competence. The primary example of the latter is my explanation of the interpretation of the term "diseased". I am an animal health and biosecurity specialist, with post graduate qualifications in epidemiology, and 33 years of operational and policy experience at State and National levels. I am well respected in my field, yet my views seemed to carry little weight. As noted in DEEDI's response, separate legal opinion has now been received that supports my view.

### **Ombudsman's analysis**

While I accept that QPIF adopted the scientific view that sero-positive horses are not free from disease', I do not consider that there are any grounds for withdrawing my proposed opinion 43. On the legal advice available at the time, QPIF should have advised Winnie's owners that compensation may have been available under the Stock Act if they could show that Winnie was free from disease' at the time of destruction. The issue could then have been determined by a Court if necessary. It was unreasonable for QPIF to maintain that compensation was not payable, where the CVO accepted at the time that both positions could be argued scientifically'. No explanation has been provided for why Winnie's owners were not notified that compensation may be available under the Stock Act.

In response to my proposed report, the Director-General sought Crown Law advice about the correct interpretation of s.17(2) of the Stock Act. I have reviewed this advice in finalising my report.

I accept that a negative virus isolation test does not conclusively rule out infection with Hendra virus. I also note that as Ombudsman, it is not for me to determine whether a sero-positive horse is free from disease' in a scientific sense.

However, my concerns lie with the legal process of determining whether compensation is payable. Essentially, QPIF's argument is that since it cannot rule out the possibility of infection, it should not pay compensation. However, this ignores the issue of whether it is reasonable for QPIF to decline to pay compensation in the absence of positive proof that a sero-positive horse is diseased'.

I remain of the view that QPIF properly bears the onus of proving that a sero-positive horse is not free from disease'.

I am concerned about any advice obtained based solely on scientific evidence provided by QPIF. QPIF is the agency which would be required to pay compensation, if compensation were payable. Therefore, it may be that external advice should be sought on such scientific issues.

I am also concerned about any reliance being placed on the fact that a sero-positive horse is destroyed because it is suspected of being infected' under the Stock Act. It may be valid from a scientific perspective to argue that such a horse cannot then be regarded as being free from disease', because it has been destroyed due to being

ssuspected of being infected' under the same Act. However, I have some difficulties with this interpretation.

I note that private veterinarians are required to notify QPIF if they have a suspicion that a horse has a notifiable disease, such as Hendra virus. If the above reasoning is applied, any such horse about which a notification has been made is ssuspected of being infected' and could therefore be seized and destroyed by QPIF wwithout any compensation being paid and in the absence of any positive test result at all.

One further issue arises from this discussion. I originally proposed to recommend that QPIF seek legal advice on procedural issues relating to claims for compensation under the Stock Act.

The Director-General's response to my proposed report essentially submitted that such matters were a moot point, because QPIF had reaffirmed its view that sero-positive horses could not properly be considered free from disease'.

However, as a matter of good administrative practice, I do not accept that QPIF's processes in relation to the determination of compensation for the destruction of sero-positive horses are adequate.

The determination of whether compensation is available is clearly a matter which affects the rights and interests of the owner of a horse that has been destroyed by QPIF. As such, it seems to me that this would be a decision to which the principles of procedural fairness would apply.

QPIF's current approach appears to be that, since it has developed a policy position that compensation is not available for sero-positive horses, it does not have to take any positive steps when destroying sero-positive horses. I have difficulty with this approach. At a minimum, good administrative practice requires, in my view that:

- QPIF should inform owners of sero-positive horses of the provisions of the Stock Act and that compensation would be available if their horse was found to be free from disease'
- QPIF should provide owners with notice of its preliminary decision that their sero-positive horse was not free from disease', including the evidence on which this decision is based
- QPIF should then provide the owners with an adequate time to make submissions to it before a government veterinary officer makes a determination about whether the sero-positive horse was free from disease'. As the horse will already have been destroyed, there can be no urgency in making this determination and therefore a reasonable period of time (such as 28 days) should be provided
- The government veterinary officer must take into account any submissions made by the horse owner in making the final decision about whether a sero-positive horse was free from disease'. The decision should be advised to the horse owner in writing along with notice about any appeal rights either under the *Stock Act* or under the *Judicial Review Act 1991*.

To my knowledge, QPIF took none of these steps in relation to the destruction of Winnie under the *Stock Act* in 2009.

I emphasise again that the question of whether a horse is free from disease' at the time of its destruction is an entirely separate issue to whether QPIF could have or

should have destroyed the horse. The threshold for knowledge or suspicion under s.15 of the Stock Act is a different test entirely to the matter of compensation.

In light of my concerns about matters addressed in the Crown Law advice regarding the correct interpretation of s.17(2) of the Stock Act, I have therefore amended proposed recommendation 36.

For the same reasons, I have not withdrawn proposed recommendation 37.

Finally, the Director-General did not make any submissions about proposed recommendation 38.

I therefore confirm proposed opinion 43 with amendments as a final opinion:

#### **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.

I confirm proposed recommendation 36 with amendments as a final recommendation:

#### **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.

I confirm proposed recommendation 37 with an amendment as a final recommendation:

### **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.

I confirm proposed recommendation 38 as a final recommendation:

### **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.

## **8.4.5 The decision not to make a declaration under the EDIA Act**

Under s.28 of the EDIA Act, the Minister may, by notification, declare when an outbreak of a specified exotic disease started or ended in a specified area of the state:

### **28 Declaration of outbreak of exotic disease**

- (1) The Minister may, by notification, declare when an outbreak of a specified exotic disease started or ended in a specified area of the State.
- (2) A notification under this section is subordinate legislation.

Under the EDIA Regulation, Hendra virus is prescribed as an exotic disease.

Compensation under s.29 for destroyed animals is only payable where the Minister makes a notification under s.28. Section 29 states:

### **29 Compensation**

Subject to this part, compensation shall be paid to the owner of—

- (a) any animal or property which pursuant to an order made or given under the authority of this Act or the *Stock Act 1915* is destroyed during the period of the outbreak notified pursuant to section 28, for the purpose of controlling, eradicating or preventing the spread of an exotic disease specified in the notification; and
- (b) any animal which is certified by a government veterinary officer as having died during the period of the outbreak notified pursuant to section 28 of the exotic disease specified in the notification and which at the time of its death was situated in the area of the State notified in respect of that disease.

The amount of compensation payable is based on the market value of the animal.<sup>112</sup> As with the Stock Act, no compensation is payable under the EDIA Act for destroyed animals where the owner is convicted of doing an act or making an omission that causes or contributes to the spread of disease.<sup>113</sup>

During the 2008 Redlands incident, Tamworth was destroyed under the power contained in s.22 of the EDIA Act. However, Tamworth's owners were informed that compensation was not available to them because the Minister had not declared an outbreak under s.28'.

The power in s.28 of the EDIA Act is a discretionary power to be exercised by the Minister. I do not have any jurisdiction to investigate a decision made by a Minister, and therefore I will not comment on whether the Minister should have made a notification under s.28.

However, I do have jurisdiction to consider the appropriateness and correctness of advice provided by an agency to a Minister. In this instance, QPIF briefed the Minister during the 2008 Redlands incident and the CVO recommended that the Minister not make a declaration under s.28 as this incident did not constitute an outbreak' within the meaning of that term under the EDIA Act.

In summary, QPIF advised the Minister that:

- under s.28 of the EDIA Act, the Minister can declare whether an outbreak of an exotic disease occurred
- he should not declare an outbreak' under the EDIA because:
  - the Redlands incident was contained to one site and did not constitute an outbreak'
  - the Redlands and Proserpine incidents of Hendra virus were isolated incidents with no causal connection
  - QPIF successfully controlled the virus through the established process of quarantine and strict biosecurity controls'
  - the horses that had died or been euthanased at Redlands and Proserpine were assessed as being infected animals within the meaning of the EDIA Act
- it was the CVO's view that an outbreak' should be characterised as the situation where an infection spreads through animal populations from property to property, and therefore the CVO recommended that an outbreak of Hendra virus not be declared.

Advice received from QPIF legal officers at this time was that the CVO's interpretation of outbreak' might be legally defensible' but had not been tested. However, the advice given by QPIF to the Minister was that Legal is of the view that [the CVO's] view is defensible'.

When asked to confirm what would constitute an outbreak' under s.28 of the EDIA Act, the CVO explained to my officers:

There's nothing written down on this, but, the original intent was whether you're dealing with a fulminating exotic diseases outbreak where it's spreading – or it's got the potential to spread from property to property. Certainly not really intended for the sort of

<sup>112</sup> Section 30(2) states that the amount of compensation payable is the market value of the animal immediately before it was affected with the exotic disease.

<sup>113</sup> Section 31, EDIA Act.

situation [in Redlands in 2008] where you've got individual animals on an individual property that's not spreading or anything.

The term 'outbreak' is not defined in the EDIA Act or in corresponding regulations. Neither the second reading speeches nor the explanatory notes that accompanied the original enactment, nor the amendments to s.28 that occurred in 1994, provide any indication of Parliament's intended meaning or interpretation of the term.

The term appears in several places in the EDIA Act:

- the long title – 'An Act to provide for the control, eradication and prevention of exotic diseases in animals, the compensation of owners for loss or destruction of animals and property during outbreaks of exotic diseases, the establishment of an exotic diseases expenses and compensation fund and for related purposes'
- the heading to Part 2 – 'Outbreak of exotic disease'
- the heading to Part 3 – 'Compensation and other provisions relating to outbreaks of exotic diseases'
- the heading to s.28 – 'Declaration of outbreak of exotic disease'
- ss.28 and 29.

If a word is not defined in an Act, the preferred interpretation of the word will be its plain, ordinary and natural meaning.<sup>114</sup> However, this literal interpretation must also be consistent with the purpose of the Act.<sup>115</sup>

I have been unable to identify any relevant judicial consideration of the term. QPIF advised my officers that the Minister had never 'declared an outbreak' under s.28 of the EDIA Act.

In some cases, a dictionary may provide guidance as to the ordinary and natural meaning of a word. The Macquarie Dictionary defines 'outbreak' as an 'outburst' or a 'sudden and active manifestation'.<sup>116</sup>

QPIF advised the Minister that the term 'outbreak' meant a number of linked occurrences of the disease where there was evidence that the disease was spreading from property to property.

I was unable to find any legislative or other support for adopting QPIF's definition. A reading of the EDIA Act indicates that it was enacted primarily to control, eradicate and prevent exotic diseases in animals, and to compensate owners for loss or destruction of animals occurring during outbreaks. There is nothing in the EDIA Act to suggest that an outbreak of a disease only occurs if it has spread beyond one property.

Moreover, it must follow from QPIF's interpretation of 'outbreak' that there is no intention in the EDIA Act to compensate owners if the animals that are destroyed or that have died of an exotic disease, however many in number, are all located on one property.

It is difficult to accept that this is the interpretation that Parliament intended. The purpose of the Act appears to be to compensate animal or property owners for losses

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<sup>114</sup> *Amalgamated Society of Engineers v Adelaide Steamship Co Ltd (Engineers' Case)* (1920) 28 CLR 129.

<sup>115</sup> *Cooper Brookes (Wollongong) Pty. Ltd. v Federal Commissioner of Taxation* (1981) 147 CLR 297.

<sup>116</sup> Macquarie Concise Dictionary (5<sup>th</sup> edition) (2009).

suffered as a result of the occurrence of exotic diseases. A single property owner clearly is able to suffer loss. The application of compensation provisions in cases where four or five properties are affected, but not where one or perhaps two properties are affected, is illogical and unfair.

I also note that in the 2008 Redlands incident, although QPIF quarantined the Redlands clinic under the Stock Act, QPIF in fact relied upon a Part 2 power in the EDIA Act (the power of destruction in s.22) to respond to the Hendra virus incident while at the same time advising the Minister that an outbreak had not occurred for the purposes of the compensation provisions under Part 3 of the same Act. The heading of Part 2 of the EDIA Act is in fact Outbreak of exotic disease. This application of part of the EDIA Act to destroy the horse while denying that an outbreak had occurred under the same Act is inconsistent.

As I have noted in section 8.4.2, QPIF's decision to rely upon s.22 and destroy Tamworth under the EDIA Act was influenced at least partly by the fact that there is no right to claim compensation under the EDIA Act unless a notification of an outbreak has been made under s.28.

In summary, I consider that the advice given by QPIF to the Minister that an outbreak for the purposes of s.28 of the EDIA Act had not occurred because Hendra virus had not spread to other properties was based on a mistake of law and was wrong.

Further, the effect of the words used in s.28(1) is not to empower a Minister to determine whether an outbreak of an exotic disease has occurred. It seems clear that an outbreak of an exotic disease occurs whenever that exotic disease is identified. Section 28 of the EDIA Act merely allows the Minister to set limits on when the outbreak started and finished, and where the outbreak occurred, to enable compensation claims.

In relation to the 2008 Redlands incident, had the Minister decided to make a notification under s.28 of the EDIA Act, the owners of Tamworth may have been entitled to compensation for his destruction. The owners of the other horses that died of Hendra virus at the Redlands clinic within the notified period may also have been eligible for compensation.

While the decision about whether to make a notification is one for the Minister, in this situation I reached the view that the advice provided by QPIF officers to the Minister about the correct interpretation of s.28 and s.29 of the EDIA Act was based on a mistake of law and was wrong. I concluded that QPIF should therefore seek legal advice as to whether it should provide fresh advice and a fresh recommendation to the Minister to enable the Minister to properly consider the issue.

In my proposed report, I formed the following opinion:

**Proposed 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 wholly or partly on a mistake of law or fact, and/or was wrong, within the meaning of s.49(2)(f) and s.49(2)(g) of the Ombudsman Act.

I also made the following recommendations:

### **Proposed recommendation 39**

QPIF ensure that, if the proposed Biosecurity Act utilises 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.

### **Proposed 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 was wrong
- (b) seek legal advice as to whether the decision can, and should, be remade
- (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.

### **Minister's response**

As required under s.26(2) of the Ombudsman Act, I provided the Minister with an opportunity to make submissions on this section of my proposed report.

The Minister noted my discussion of the above matters, and that my proposed opinions and recommendations were directed towards QPIF, consistent with my jurisdiction.

The Minister further advised that he was not a lawyer, veterinary surgeon or scientist and accordingly had acted in good faith on the advice and recommendation contained in the briefing note provided to him by QPIF.

### **DEEDI's response**

The Director-General of DEEDI advised in response to my proposed report that QPIF had sought the legal advice from Crown Law in line with my proposed recommendation 40. He provided a copy of that advice, which I have reviewed.

The Director-General advised that he accepted that QPIF's advice to the Minister was based on a mistake of law, in that the Minister did not have the power to declare whether an outbreak occurred, but only when an outbreak started or ended.

The Director-General advised that QPIF would therefore provide fresh advice to the Minister.

In relation to QPIF's interpretation of the term outbreak, the Director-General submitted that:

- the term outbreak is so undefined that its meaning is a matter of interpretation
- the interpretation of the term given to the Minister was based on views which were honestly and reasonably held.

He submitted that in the circumstances, while QPIF conceded there was a mistake of law, I should not find that the administrative action was also wrong within the meaning of s.49(2)(g) of the Ombudsman Act. The Director-General submitted that

while a more detailed examination of the interpretation of outbreak' may differ from the QPIF view adopted in 2008, this view was adopted based on experience in biosecurity and disease control. QPIF's view in 2008 was influenced by its understanding of the history of the inclusion of compensation in the EDIA Act, as compensation has historically been paid only to owners of disease-free animals (as occurs in the Stock Act). However, to provide an incentive to owners to report exotic diseases, the compensation provisions were included in the EDIA Act.

The Director-General also stated that the definition of emergency animal disease' under the Emergency Animal Disease Response Agreement (EADRA) is instructive in interpreting the term outbreak' under the EDIA Act, and that the CVO's views were consistent with the EADRA definition, in that EADRA defines an endemic emergency animal disease as one that occurs in such a fulminant outbreak form (far beyond the severity expected), that an emergency response is required ...'

The Director-General therefore submitted on this basis that the CVO's interpretation of outbreak' was reasonable, especially as the CVO had raised with the CCEAD in 2008 whether the Hendra virus incident should be dealt with under the EADRA. He submitted that the advice to the Minister was made honestly, in good faith and on reasonable grounds. While conceding that the advice was based on a mistake of law, he argued that the advice was not wrong and that my proposed opinion 44 should be amended accordingly.

### **Ombudsman's analysis**

My proposed opinion stated in part that the advice provided to the Minister was based wholly or partly on a mistake of law or fact'. This is the wording used in s.49(2)(f) of the Ombudsman Act. The Director-General submitted that there was no mistake of fact. I agree that this is so. It was not my intention that my proposed report imply that a mistake of fact had been made. I was simply using the precise wording found in s.49(2)(f). To avoid confusion and to respond to the Director-General's concerns, I have removed references in my report to a mistake of fact' and adopted a shortened version of the reference to a mistake of law' only. Such a change does not alter the finding that I have reached.

In response to the Director-General's argument that the definition of emergency animal disease' is instructive in interpreting the term outbreak' under the EDIA Act, the issue to be determined is how a national agreement dating from 2002 has relevance in determining a provision of a Queensland Act that was inserted prior to 1995.

At interview, the CVO initially stated that the reason for the compensation provisions in the EDIA Act was due to the national EADRA; however, he later stated the compensation provisions had been introduced before he was involved with the issue so he did not have any direct knowledge of the intent behind the introduction of the provisions. I acknowledge that discussions at a national level could have been a factor that the CVO took into account in considering the meaning of the term outbreak'.

On the specific issue of the definition of an outbreak, the CVO stated that there was nothing written down about what was categorised as an outbreak; however, he understood the intent of the provisions relating to the declaration of an outbreak was to cover a sudden exotic disease outbreak where the disease was spreading or had the potential to spread from property to property.

I do not agree with the Director-General's assertion that the CVO's interpretation of outbreak was reasonable at the time that it was made. This is essentially a moot point anyway, as the interpretation was clearly based on a mistake of law and the issue of whether an outbreak had occurred was irrelevant to the exercise of the Minister's powers under s.28 of the EDIA Act.

I am satisfied that QPIF misinterpreted ss.28 and 29 of the EDIA Act and therefore gave incorrect advice to the Minister that he had the power to declare an outbreak of Hendra virus and that he should not do so as the virus was confined to one property. While I have not suggested that there was any bad faith or dishonesty in the advice given to the Minister, I am unable to conclude otherwise than that the advice was based on a mistake of law. On this analysis, it is clearly open to me to conclude that the interpretation was also wrong.

It seems to me that, under the EDIA Act, compensation would have been available for any horses that died of Hendra virus or were destroyed by QPIF during all Hendra virus outbreaks since the virus was included in the Schedule to the EDIA Regulation *if the Minister had made a notification of a start and end date and a location for the outbreak under s.28*. As a consequence of my conclusion that the advice given to the Minister about his power was wrong, I have identified two further issues that now require the Director-General's or Minister's attention.

Firstly, there is an argument that the Minister has a duty to consider exercising his discretion under s.28 to make a notification in respect of an outbreak of exotic disease, whenever such an outbreak occurs. There is no evidence that the Minister has done so in relation to any other outbreak of Hendra virus, nor in response to any other outbreaks of exotic diseases since the EDIA Act was enacted in 1981. Indeed, QPIF informed my officers that the Minister has never made a notification under s.28 of the EDIA Act. Therefore, QPIF and/or the Minister should seek legal advice about the effect of any previous failure to consider whether to make a notification under s.28 in respect of an outbreak of exotic disease, and whether the making of such a notification should now be considered.

Secondly, if the Minister chooses to make a retrospective notification of an outbreak under s.28 in relation to the 2008 Redlands incident of Hendra virus, any other incident of Hendra virus or any other outbreak of an exotic disease, this may enliven the compensation provisions under s.29 of the EDIA Act. However, s.30 of the same Act requires that applications for compensation be made within 90 days of the death or destruction of the animal during the outbreak. Obviously, such a time will now have passed for all previous outbreaks. QPIF and/or the Minister may need to seek legal advice on this issue, and whether s.30 would operate as a bar to a claim for compensation if the Minister now chooses to make a retrospective notification under s.28. If that were to be the case, I would expect that some form of ex gratia payment equal to the compensation amount which would have been available under the Act should be considered.

I also note that, although the Director-General submitted generally in his response to my proposed report that QPIF's current position is that Hendra virus is not an exotic disease and therefore should not be listed in the Schedule to the EDIA Regulation, Hendra virus was listed in the Schedule by Parliament at the time of all previous Hendra virus incidents. Therefore, it may not be reasonable or lawful for QPIF to advise the Minister to decline to make compensation available under the EDIA Act on the basis that Hendra virus is not an exotic disease. Of course, the Director-General is able to seek the immediate removal of Hendra virus from the Schedule if he

considers this an appropriate course of action, which will affect future compensation claims.

Although I have not directly adopted the Director-General's suggested amendments to my proposed recommendation 40, I have amended my recommendation slightly.

I confirm proposed opinion 44 as a final opinion:

#### **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.

I confirm proposed recommendation 39 as a final recommendation:

#### **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.

I confirm proposed recommendation 40 with amendments as a final recommendation:

#### **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.

It will be for the Minister to determine, on the basis of this advice received, whether any action needs to be taken to remedy any effect of this incorrect advice in respect of the destruction of Tamworth in 2008, as well as the deaths of other horses of Hendra virus. I reiterate that as Ombudsman, the *Ombudsman Act* provides that I am unable to question the merits of a decision made by a Minister<sup>117</sup> and this issue is a matter for determination by the Minister.

<sup>117</sup> Section 16(1)(b), Ombudsman Act.

#### 8.4.6 The failure to create a destruction policy

As stated in section 8.2.2, at the time of the 2008 Redlands incident QPIF did not have a policy on the destruction of sero-positive horses. This is perhaps attributable to the fact that the 2008 Redlands incident was the first Hendra virus incident since 1994 in which QPIF was required to destroy a sero-positive horse.

The lack of policies on a number of issues was highlighted by the 2008 Perkins Report, which recommended that QPIF prepare policies and procedures on various issues, including the processes surrounding the destruction of horses. The internal QPIF after action review (AAR), conducted following the 2008 Redlands and Proserpine incidents, also identified inconsistencies in legislation and policy use and recommended further work in this area.

It is also relevant to note that minutes of QPIF's Horse Biosecurity and Market Access Liaison Group (HBMALG) meeting on 4 December 2006 state:

Action Item 3. [The then-General Manager, Animal Biosecurity] is to provide HBMALG (07/01) with a Hendra virus policy statement in relation to sero-positive horses.

This suggests to me that QPIF was aware as early as 2006 of the need to prepare a policy in relation to sero-positive horses. The issue was raised again during the Redlands incident in August 2008 and again when the 2008 Perkins Report was released in December 2008.

However, a policy was not prepared until a considerable time later. During the 2009 Cawarral incident, QPIF officers had to seek advice once again from the QPIF legal unit about which Act to use to destroy Winnie because there was no settled policy position.

Minutes from a QPIF teleconference on 14 August 2009 (during the 2009 Cawarral incident) note that QPIF officers were working on policies for the destruction of horses that had positive serology results. While the preparation of such policies is desirable, my point is that this should have occurred when it was first discussed at the end of 2006 or, at the least, soon after the 2008 Perkins Report was released in December 2008, so that the policies were available if another horse required destruction.

The first evidence of a QPIF policy on the destruction of sero-positive horses is the policy finalised on 17 August 2009, seven days before Winnie was destroyed.

For the reasons outlined above, I am not satisfied that QPIF prepared this policy in a timely way. The Director-General of DEEDI made no submissions on this issue.

I confirm proposed opinion 45 as a final opinion:

#### **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.

## Chapter 9: Ex gratia payments

This chapter discusses three ex gratia payments made by QPIF arising from the Hendra virus incidents at Redlands and Cawarral.

### 9.1 Introduction

Ex gratia payments are a means by which government can provide compensation or other financial assistance despite there being no legal requirement or liability to do so. They are usually made where there is some moral obligation on the part of government to provide redress for loss or damage suffered by the recipient.

QPIF made two ex gratia payments as a result of the 2008 Redlands incident and one in relation to the 2009 Cawarral incident. This chapter focuses on QPIF's decisions to make the payments, how the amounts were calculated and the payment process. The following discussion should not be interpreted as a criticism of those who received the ex gratia payments, nor of any organisation which assisted in the distribution of these payments. No adverse opinions have been formed about these recipients.

The same senior officer, who is referred to in this chapter as the Ex Gratia Decision-Maker, approved all three payments.

### 9.2 Legislation

Ex gratia payments, and more broadly, special payments, are by their nature discretionary payments made under executive powers. Nevertheless, there are certain legislative requirements when making such payments.

The applicable law changed from 1 July 2009. Therefore, the law applicable to the 2008 Redlands incident and ex gratia payments was different to the law applicable to the 2009 Cawarral incident and ex gratia payment, although the content of those laws was substantially similar.

#### 9.2.1 The position in 2008

In 2008, ex gratia payments were governed by the *Financial Administration and Audit Act 1977* (FA&A Act). Section 106 of the FA&A Act provided that the accountable officer of a department may authorise special payments to be made from the departmental accounts.

The definition of 'special payments' in Schedule 3 to the FA&A Act included ex gratia payments and extra-contractual payments.

Section 41 of the Financial Management Standard 1997 stated:

- (1) Each accountable officer and statutory body must keep a record of the agency's special payments of more than \$5000 (**prescribed special payments**), including the following details about each payment—
  - (a) its date;
  - (b) the recipient;
  - (c) the reason for the payment;

- (d) the approval given.
- (2) The record may include other details the accountable officer or statutory body considers relevant.

Special payments would generally be approved by the Director-General of a department as the accountable officer.

Section 98A of the Financial Management Standard contained the requirement to publish details of the special payments made:

An agency's annual or final financial statements must disclose the following—

- (a) the classes of prescribed special payments made by the agency and the total amount of the payments for each class;
- (b) the classes of material loss and the total amount of the loss for each class.

Although QPIF had a *Financial Management Practice Manual* and related procedures at the time of making the 2008 ex gratia payments, these documents did not provide any guidance on when an ex gratia payment should be made or the procedures to be followed in making such a payment. Section 3.10 of the QPIF *Financial Management Practice Manual* stated:

Special payments are payments made in addition to those made in the ordinary course of departmental operations ...

...

Special Payments include:

- extra-contractual and ex-gratia payments where no legal obligation exists under the terms of the contract but a court might hold that obligation exists;
- ex-gratia payments other than contractors;
- ex-gratia compensation payments where the Government acts as its own insurer;
- extra-statutory and extra-regulatory payments which are within the broad interpretation of an act or regulation but go beyond the strict interpretation of its terms.
- Gifts and rewards (as per the FMPM Procedure 32 Special Payments)

The relevant QPIF *Financial Management Practice Manual Procedures* did not contain any additional information.

Under the FA&A Act, a chief executive of a department had the following broad obligation:

#### **12 Departmental accounts**

- (1) Each accountable officer, in respect of that officer's department, is to establish and keep or cause to be established and kept in accordance with the prescribed requirements such accounts as are necessary to—
  - (a) account in accordance with the financial management standards for public moneys, public property, other moneys, other property and other resources administered or controlled by the department; and

- (b) produce—
  - (i) financial statements required to be produced by this Act; and
  - (ii) other financial statements or information required to be produced by the prescribed requirements or the Treasurer.
- (2) Other than the consolidated fund accounts, the accounts established and kept by the under-Treasurer for preparing the consolidated whole-of-government statement for a financial year are departmental accounts of the treasury department.

In the former DPIF's annual report for 2008–09, which is referred to as the agency's final report since it was the last report before the former DPIF was merged into the new DEEDI in March 2009, the 2008 ex gratia payments are listed as \$0.200 million for Hendra virus response and support costs'.

### 9.2.2 The position in 2009

The *Financial Accountability Act 2009* (FA Act) came into force on 1 July 2009, repealing the FA&A Act.

Under s.72 of the FA Act, the accountable officer of a department may authorise special payments to be made from the departmental accounts.

Section 20 of the Financial and Performance Management Standard 2009 requires the accountable officer of a department to keep a record of the department's special payments of more than \$5,000 including date, recipient, reason and the approval given.

Special payments must also be separately identified in the notes to the department's annual financial statements under 'Other Expenses', pursuant to s.5 of Treasury's *Financial Reporting Requirements and Accounting Policy Guideline 5*.

DEEDI's Annual Report for 2009–10 refers to a total of \$27,000 in ex gratia payments being made in that financial year. No breakdown of the recipients of the payments was provided.

### 9.2.3 General obligations on chief executives

A similar obligation to that provided in s.12 of the FA&A Act exists in s.61 of the FA Act.

#### 61 Functions of accountable officers and statutory bodies

Accountable officers and statutory bodies have the following functions—

- (a) to ensure the operations of the department or statutory body are carried out efficiently, effectively and economically;
- (b) to establish and maintain appropriate systems of internal control and risk management;
- (c) to establish and keep funds and accounts in compliance with the prescribed requirements;

- (d) to ensure annual financial statements are prepared, certified and tabled in Parliament in accordance with the prescribed requirements;
- (e) to undertake planning and budgeting for the accountable officer's department or the statutory body that is appropriate to the size of the department or statutory body;
- (f) to perform other functions conferred on the accountable officers or statutory bodies under this or another Act or a financial and performance management standard.

### **9.3 The first 2008 ex gratia payment**

On 7 July 2008, quarantine was imposed on the Redlands clinic. The quarantine was extended on 24 July 2008, with a new calculated release date of 17 August 2008.

By letter dated 31 July 2008, the AVA wrote to QPIF requesting support for the Redlands clinic in meeting its biosecurity and animal welfare requirements. An ex gratia payment of \$150,000 was approved by the Ex Gratia Decision-Maker on 11 August 2008 and paid into an AVA trust fund that day (first 2008 payment).

#### **9.3.1 Documentation**

The following is a summary, in chronological order, of relevant written material concerning the nature of, and reasons for, the payment.

#### **25 July 2008**

An email was sent by the Managing Director of Biosecurity Queensland to the Ex Gratia Decision-Maker which in part stated:

- [The clinic owner] has said that he is experiencing financial difficulties as a direct result of the quarantine.
  - There are currently 36 horses at the Redlands clinic.
  - The quarantine has been extended by at least another 2-4 weeks because of the death yesterday of a horse from Hendra virus.
  - Yesterday, we made an offer of assistance of staff to help with the feeding and care of horses.
  - Today, [the clinic owner] presented a proposal for his vet clinic to care for the horses at a rate of \$150 per horse per day (to be paid by government). This equates to \$5,400 per day or \$37,800 per week.
  - We have made independent inquiries for the cost of the care of horses at veterinary hospitals - they range from \$27.50 per day to \$62 per day (most in the \$30 range).
  - We understand (via the Minister's office) that owners of the horses are being charged \$30 a day for the care of the horses during the quarantine period. (A client rang the Minister's office late today complaining about this).
  - Under the Stock Act (1915) we are not required to pay compensation for consequential losses as a result of a property being quarantined.
- ...
- Given the scale of his request this morning, government may wish to consider an ex gratia payment in light of the exceptional circumstances (ie a veterinary clinic with a large number of horses and an extended quarantine period).

- Our reading of the situation is that an outright rejection of [the clinic owner's] proposal will result in a negative and public reaction from him. Nevertheless, we are concerned at creating a precedent with any non-biosecurity related payments in the context of future disease incidents.
- We believe the actions outlined above relating to biosecurity and welfare are appropriate and we are continuing to work with [the clinic owner] on these matters.
- However, the issue around financial viability and any possible compensation may be best handled at a whole of government level given the precedents it may set.

## 26 July 2008

An email was sent by the Managing Director to the Ex Gratia Decision-Maker responding to a question from him about who assumes liability for the cost of looking after the horses if QPIF seizes them. The Managing Director then advised:

Issue is that we have to have a reasonable concern about welfare of animals and we aren't there yet.

## 28 July 2008

The CVO sent an email to the Ex Gratia Decision-Maker and other senior QPIF officers which stated:

Just spoke to [names deleted] from Legal. Very strong preference for an ex gratia [sic] to AVA... I've spoken to AVA now – [AVA official] is happy with this approach, but is talking to AVA National first.

Legal doesn't at all like the option of us taking over the horses – all sorts of liability issues. They were happy for us to make payment based on no. horses x no. days.

The CVO's email then went on to calculate the cost on this basis and suggested a total payment of \$50,400 based on payments made during the equine influenza outbreak.

## 29 July 2008

An email was sent at 8.04am from the Ex Gratia Decision-Maker to the Director-General, Department of the Premier and Cabinet, and the Minister, in which the Ex Gratia Decision-Maker advised, among other things:

- the Australian Veterinary Association and Queensland Horse Council have agreed to support [the clinic owner] through the quarantine.
- in real terms that will mean we will fund them to feed quarantined horses and tend to their vet needs
- quarantine likely for further 3 – 4 weeks assuming no further cases identified at the clinic
- our line is that we are not compensating the property or horse owners because of the quarantine – we are contracting peak bodies to manage the risk should the property owner or horses owners not meet their welfare obligations for whatever reason (in [clinic owner's] case that would be financial)
- we expect that ownwers [sic] would continue to meet normal vet costs and negotiations will determine what they are – difficult to estimate cost to us - assuming no further cases up to 150K is my guess.

...

The CVO later emailed the Managing Director, stating:

Did you notice in [the Ex Gratia Decision-Maker's] note to [Director-General, Department of Premier and Cabinet] that he envisaged spending up to \$150k?

### **30 July 2008**

On 30 July 2008, an email from the General Manager, Animal Industry, Policy and Investment of QPIF (General Manager AIPi) to the Ex Gratia Decision-Maker, the Executive Director, Strategic Policy Industry Development of QPIF (Executive Director), and others stated:

Last night I spoke with [the clinic owner] and [an AVA representative]

Following on from discussion yesterday regarding the potential for the AVA to work with [the clinic owner] on a way forward:

- [the AVA representative] rang [the clinic owner] yesterday and asked him to write to AVA outlining issues and proposed support
- [the clinic owner] sent this to AVA last night – but I am unaware of the contents. We could assume that this will be [the clinic owner's] wish list
- The AVA Corporate Services Manager will be talking with [the clinic owner] today about his proposal, then AVA will talk to us

### **31 July 2008**

A letter dated 31 July 2008 (and received by email at 5.09pm) was sent by the AVA to QPIF requesting support for the Redlands clinic. The AVA submitted, among other things:

... So far these thirty six horses have tested negative from infection, but they require constant supervision and observation. The continuing quarantine is causing a significant animal welfare issue. The horses have been monitored continuously by staff at Redlands who have observed strict biosecurity requirements.

The demands of complying with the quarantine order and the associated biosecurity conditions have placed a significant additional financial burden on the proprietor. The time and effort required to treat horses under quarantine conditions has significantly increased. Staff are required to observe onerous biosecurity measures.

This is especially the case when dealing with a zoonotic disease such as Hendra virus which imposes another layer of considerations which must be managed by Redlands to ensure compliance with the quarantine order and containment of the disease. Given the veterinary practice has been severely impacted the proprietors do not have the financial resources to continue to maintain the horses for the term of the quarantine.

The fact the Hendra virus is a zoonosis and therefore a danger to both horses and humans should be highlighted, and recognition given to the fact that Redlands is currently subject to quarantine for the protection of the surrounding human community not just the equine community. Since the quarantine order was imposed, the Redlands Clinic has borne a significant proportion of the cost of the protection of the local community.

The AVA is offering a range of support for the member and his staff, including:

- Offer of support to the members and their staff to assist with medical and personal costs arising from the outbreak through the AVA Benevolent Fund.
- Providing professional support and advice to the members through the Equine Veterinarians Australia.

- Access for the members, their staff and families to our 24 hour counselling service.

The AVA desires to provide additional support in protecting the welfare of the remaining horses subject to quarantine by providing for their ongoing care for the next four weeks of quarantine with the financial support of the Queensland Government.

We request that the Queensland Government consider making an ex gratia payment to the AVA Animal Welfare Trust. This is a separately constituted trust that was created to raise funds and make grants for the advancement of animal welfare. The trustees of the trust will then distribute this money to suitable organisations and individuals as required to maintain the welfare of the thirty six horses for the remaining duration of the quarantine period.

...

In our opinion in the case of horses potentially infected with a zoonotic disease, the costs of ensuring the welfare of the horse would exceed the base rate regular quarantine. The horses at Redlands have required constant ongoing clinical monitoring by qualified staff complying with comprehensive biosecurity requirements. This adds a significant further cost to the daily care of those horses. The costs of additional equipment, laundry bills, additional clinical monitoring and recording are an essential component of ensuring the welfare of the 36 horses.

...

We note that these funds will be used to maintain the minimum welfare of the subject horses and the costs of any veterinary treatments and testing unrelated to the Hendra Virus are to be met by owners of the horses and will be invoiced directly by the [Redlands clinic].

The letter requested a total ex gratia payment of \$166,320, calculated on the basis of \$165 per horse per day for 36 horses over 28 days.

### **1 August 2008**

The General Manager AIPI emailed the Ex Gratia Decision-Maker attaching the AVA letter and advising:

Issues:

We could negotiate a smaller amount with AVA based on actual costs to maintain the horses, but the timeframe (start date) is rubbery and the emphasis is on horse welfare and not on payment to keep the horses.

There is urgency for the Vet Practice and their clients to understand their financial positions. Apart from the precarious financial position of the Vet, some owners could make decisions about the fate of their horses depending on cost.

I recommend that the AVA proposal is supported, noting to AVA that the veterinary profession and horse owners have a collective responsibility to support the welfare of the horses.

The CVO also emailed a QPIF officer and stated:

Any moneys paid to [the clinic owner] will be from AVA, not DPI. DPI will not be (at least directly) paying for feeding of horses.

### 3 August 2008

An email from the Ex Gratia Decision-Maker to various QPIF officers advised that the Minister was meeting with the clinic owner on Monday (the next day) to determine what, if any, further support could be provided to the vet practice. The Ex Gratia Decision-Maker asked for these officers to meet with him at 9.00am the next day, having considered a number of issues including:

a risk and financial assessment of the AVA proposal, particularly in light of likely extension of quarantine and/or further cases and/or precedent. Is there a case for a lower payment; if so on what basis; and with a review at end week 3? Are there alternatives to AVA – QHIA?

...

does QRAA provide a means to provide loan payment to [the clinic owner] – consolidating existing loans into single 1 or 2 year interest free loan to see him through the quarantine?

does State Development have grants or support programs for businesses in financial crisis that might be made available?

An email from the Managing Director to the Ex Gratia Decision-Maker and other senior QPIF officers, stated, relevantly:

Another option to put into the mix is to pay a smaller grant immediately (say \$20K) while we negotiate the final amount with AVA. We put this idea forward earlier this week, but not sure where it got to.

I think we should also have another look at whether we can find another facility that will take the horses (recognising this is not an easy task) and won't help [the clinic owner's] immediate cash flow issues.

In terms of other organisations other than AVA and QHC – what about the RSPCA – we pay them to care for the animals. We can pay the going rate of around \$30 per day per horse, which comes out at around \$7500 a week.

An email from the Minister's media advisor to the CVO attached speaking notes for the Premier and stated:

[CVO], this is what I sent to premiers. Looks like we're still deciding how to siphon the money through ava, although as you said it won't be the 160k that they are asking for.

### 4 August 2008

An email from the Ex Gratia Decision-Maker to various QPIF officers suggested some outcomes to be achieved at the meeting later that day between the Minister and clinic owner:

Recognise extra ordinary nature of event

Recognise risk and welfare management of the horses

Recognise proposal from AVA and basis of their offer

**Offer \$150 000 ex gratia payment to AVA to support [clinic owner's] practice maintain highest levels of biosecurity and animal welfare through extended quarantine.**

Payment is not compensation; it recognises the uniqueness of the situation and the need for government support given mix and levels of risk to people and animals involved

...

**Purpose and duration of support is agreed to be:**

**Partnership between Australian Veterinarian Association and DPIF to support [the clinic owner's] veterinary [sic] practice maintenance of highest levels of biosecurity and animal welfare through extended quarantine period.**

Notes which were prepared for the meeting state that further support would be provided as follows:

In partnership with the Australian Veterinarian Association, Biosecurity Queensland will meet reasonable costs of animal welfare imposed on [the clinic owner's] business due to the extended quarantine period. This will be reviewed by 17 August. Support will end when quarantine is removed.

This support will enable the continued employment of clinic staff to provide day to day care for the horses, ensure full quarantine and biosecurity is in place, and monitor horses for any further spread of the virus.

...

The government is not in a position to compensate [the clinic owner] for loss of trade – that is a matter for his insurance and business continuity planning.

A media statement issued later that day by the Minister's office stated:

A one-off payment will be given to the Australian Veterinary Association – the peak veterinary professional body for Australia – which will work with the practice to respond to biosecurity and animal welfare management costs imposed on the business due to the extended quarantine period.

Mr Mulherin said extraordinary circumstances associated with the outbreak including the long quarantine time, the risk to human health and the welfare of the animals quarantined, led to the special assistance.

...

Government does not compensate business for loss of trade due to a disease outbreak or similar emergency situation. ...

## **5 August 2008**

An internal email from the Executive Director to the General Manager AIPI and another QPIF officer stated:

The confidential payment to the Australian veterinary Association animal welfare trust is for \$150,000 subject to confidentiality clause, no claim on insurance (if possible) and a report back to us on outcomes achieved.

## **6 August 2008**

An email was sent from a QPIF legal officer to a senior QPIF officer concerning the content of a draft deed of confidentiality in which the legal officer commented:

1. The nature of an ex gratia payment is to simply 'gift' money to a recipient without any obligation. Once the department starts placing obligations, even to report, on the AVA, it may change the nature of the payment such that it is no longer an ex gratia payment. The question may then be asked, if it is not an ex gratia payment in the true sense, is it compensation or alternatively a form of contractual arrangement? The Department must avoid any suggestion of the payment being made to compensate the [Redlands clinic] as it may start a [sic] undesirable precedent for the Department.

2. The nature of an ex gratia payment is that because there are no obligations attached to the gift, GST does not apply to the transaction. Once a supply arrangement is established ie the AVA is required to provide a service (such as a report) to the department in exchange for the payment, the transaction will no longer be "out of scope" and GST may apply.

## **7 August 2008**

The AVA trustees signed a deed establishing the Animal Welfare and Crisis Response Trust (AWCR Trust) and provided a copy of that deed to QPIF.

A memorandum from the General Manager AIPI to the Ex Gratia Decision-Maker sought his approval to provide a one-off special payment of \$150,000 to the AVA through its AWCR Trust.

## **8 August 2008**

An email to the AVA attached a deed of confidentiality (the 2008 Deed) and a letter from the Ex Gratia Decision-Maker in which he stated:

I am pleased to advise that a decision has been made to provide \$150,000 to support the work of the Animal Welfare and Crisis Response Trust in furtherance of supporting the AVA's desire to protect the welfare of the quarantined horses. This support will be delivered when we receive a signed copy of the attached Deed of Confidentiality.

A reference to the purpose of the payment can be found in paragraph A of the 2008 Deed as follows:

WHEREAS:

- A. The Department has proposed to provide the AVA with a special payment for the limited purpose of assisting persons to protect the welfare of horses affected by the quarantine at the [Redlands clinic] due to the recent discovery of Hendra Virus (HeV) (the Payment).

## **11 August 2008**

An ex gratia payment of \$150,000 was approved by the Ex Gratia Decision-Maker and made by QPIF to the AVA through its AWCR Trust. This amount was then paid by the AWCR Trust to the clinic owner on 14 August 2008.

### **20 August 2008**

An email from the Ex Gratia Decision-Maker to senior QPIF officers in response to the clinic owner's informal requests for a further payment stated:

your advice is sound; our focus is biosecurity maintenance and animal welfare, so if this is at risk due to his financial situation, our strategy is linked to AVA and how we support them to deliver those outcomes for the state. [Executive Director] can you get involved in determining what this means please.

### **21 August 2008**

A briefing note prepared by the General Manager AIPI stated:

- In response, the Government agreed to provide assistance to the AVA to manage the biosecurity risk and welfare of the horses in this exceptional circumstance.
- I emphasize that this is not business compensation to the veterinary practice involved, or to the owners of the horses. It is support for the responsible approach from the AVA as industry representatives with respect to maintaining the highest levels of biosecurity and animal welfare in this extra-ordinary situation.

### **29 August 2008**

The Ex Gratia Decision-Maker wrote in a letter to the editor of *The Australian* newspaper:

I'm writing to correct reports in The Australian claiming that the Department of Primary Industries and Fisheries in Queensland paid compensation to the [Redlands clinic], which was quarantined for Hendra virus.

The department has always been very clear about this – a one-off payment was provided to the Australian Veterinary Association to help ensure that required biosecurity and animal welfare standards were maintained at the [Redlands clinic] while it was under quarantine. It was not to support the owner's business.

### **30 September 2008**

A briefing note from a senior QPIF officer to the Minister stated:

However, the assistance provided to the Animal Welfare and Crisis Support Trust was for the sole purpose of assisting in managing the welfare of the horses in the extended quarantine period and did not in any way relate to the normal business practices of [the Redlands clinic] such as providing ordinary veterinary services and invoicing clients for these services.

### **25 November 2008**

An email from a senior QPIF officer to Dr Perkins, who had been engaged to review QPIF's response to the Redlands incident, stated:

- While the Stock Act 1915 does provide for compensation in particular circumstances, it does not compensate for loss of profits.

...

- Discussions about the welfare of the horses under quarantine at the [Redlands clinic] took place between DPI&F and AVA. It was determined that DPI&F would provide assistance to the AVA's Animal Welfare and Crisis Support Trust (the Trust). The assistance was provided for the sole purpose of assisting in managing the welfare of the horses involved in the extended quarantine period.
- The assistance in no way related to the normal business practices of [the Redlands clinic] such as providing ordinary veterinary services and invoicing clients for services or the costs of agistment (provision of shelter, feed and water).
- The horses quarantined at the [Redlands clinic] represented an extra-ordinary situation in that they were client-owned animals that had been admitted to a veterinary hospital for ongoing health care and the welfare of the animals in the clinic was the primary concern to DPI&F.
- The AVA established an Animal Welfare and Crisis Support Trust fund to provide support for the welfare concerns of the horses at the [Redlands clinic] and the AVA sought support from the state government.

### 9.3.2 Discussion

Based on the above material the stated purpose of the payment was not to compensate the clinic owner for loss of trade due to the imposition of the quarantine. However, there is very little information in the written material as to what the payment was actually for.

While the theme which runs through the documentation is that the payment was made to maintain biosecurity and meet the welfare needs of the horses, there is little detail as to what this entailed.

Perhaps the clearest statement is that of the Ex Gratia Decision-Maker, in his email on 29 July 2008, in which he said that QPIF will fund the AVA to feed quarantined horses and tend to their vet needs'. This advice is consistent with:

- the email dated 25 July 2008 from the Managing Director to the Ex Gratia Decision-Maker in which she said that QPIF had made an offer of assistance of staff to help with the feeding and care of horses
- the email from the CVO to a QPIF officer on 1 August 2008, in which he said that QPIF will not be (at least directly) paying for feeding of horses'.

However, this reason for the payment was contradicted by the email to Dr Perkins on 25 November 2008.

Consequently, my officers interviewed a number of people with a view to determining the precise purpose for which the payment was made.

### 9.3.3 Interviews

#### Ex Gratia Decision-Maker, QPIF

When asked by my officers about the purpose of the payments the Ex Gratia Decision-Maker said:

My understanding is that they were to cover off the basic attendance of care for the horses. So it's people on ground, in situ, ensuring that the horses who had to be walked or had to be, because they were corralled in, where it did so but in doing so obviously met the biosecurity obligations. So the issue of the daily maintenance of the

horse was not the issue in our situation. It was the daily care of the animal which was indeed quarantined, in fact locked down, and the existing carers were not there to maintain that in addition to the medical treatment, then that would be a risk.

As to the meaning of welfare of the animals' he stated:

The issue for me that we faced with the last couple of Hendra cases doesn't relate necessarily to the disease, it relates to the question of animal welfare. In the case of [the Redlands clinic] with a veterinarian with a large number of horses owned by other people confined in space for a particular medical reason the bringing in of quarantine over the top by government in order to manage the disease brought a range of additional requirements or expectations on both [the Redlands clinic] and the owners of the horses.

...

In each of those cases that was a matter of understanding the scale and scope of the problem, the scale and scope of the cost, looking to what tool could we use to ensure and mitigate that risk around animal welfare and at that point determine what would be the mechanism by which we would do it, who might we get to do it and what would be the appropriate scope and scale of it, i.e. how much would we pay and why.

When my officers asked the Ex Gratia Decision-Maker about his email of 29 July 2008, he said he was mistaken about the payment being for food for the horses and their veterinary care due to his incomplete understanding of the issue at the time.

When asked whether the clinic owner's financial position was a relevant consideration, the Ex Gratia Decision-Maker said:

This was the early advice that there was a financial risk ... and then there's a letter that [the Redlands clinic owner] sent which spelt out the nature of his concerns. Was that a key point to the decision to source funding? That was the key point to identify for me that there was a clear animal welfare risk here if indeed his capacity to maintain and service as he had been doing disappeared and we had to intervene in a way that mitigated that, that was my sole intention.

He was also concerned about the consequences for QPIF in the event that the Redlands clinic ceased trading:

Outside of that there was the ongoing management of the 60 horses<sup>118</sup> and as I said my view was based on [the clinic owner's] letter to us and advice we had through a couple of meetings there was a very high level risk that his capacity to pay his staff would end in which case that cost would then fall to the State and the issue was how we intervene to leverage that existing capability and minimise the risk around his financial situation.

### **Executive Director, QPIF**

The Executive Director was also involved in negotiating the payment.

The Executive Director told my officers that the payment was made in the interests of the welfare of the animals'. When asked what that meant, he said:

That meant that that payment was not to be, should not be seen as compensation to the [Redlands clinic] for the loss of earnings. It certainly was not meant to sort of take away the responsibility of those horse owners who had horses at the veterinary

<sup>118</sup> The Ex Gratia Decision-Maker was mistaken about the number of horses in quarantine (which was 36).

practice for the cost of the veterinary treatment that the horses had received or what you would expect them to have incurred irrespective of whether there was a quarantine or not ...

He also said:

... in this particular instance we had, the veterinary practice was receiving no income, there were a large number of horses on the property that needed to be fed and maintained, and there was a lot of pressure on the veterinary practice from some of the owners of the horses that were we're not subject to the quarantine' that they didn't believe that they should be paying for the maintenance and upkeep of their horses while they were under the quarantine of the veterinary practice.

...

... And I think the best thing that I can come to after analysing all those various options that we believed that an ex-gratia payment to the Australian Veterinary Association to take responsibility or do, take responsibility for the ongoing maintenance of those horses while they were subject to the quarantine arrangements.

The Executive Director further said, when discussing the second Redlands payment with my officers:

... we were very mindful of the fact that if there was to be any further extension of assistance it would have to be consistent with the arrangements made under the first round, which was to basically feed and maintain the animals while the quarantine lasted.

### **General Manager AIPI, QPIF**

The General Manager AIPI was also involved in the negotiations and made recommendations to the Executive Director and the Ex Gratia Decision-Maker about the payment. He told my officers:

So that the arrangement was that [the clinic owner] would still be charging the clients for that service and the intent of the ex gratia payment which as you're aware it wasn't paid to [the clinic owner], it was paid to the AVA, but the intent of that ex gratia payment was actually for the additional costs associated with maintaining the welfare of the horses because of the quarantine and because of the fact that they were dealing with an exotic disease which were substantial and the fact that the horses were being held in quite a confined environment and the additional costs were quite significant.

When asked what the additional costs would be in caring for horses in a quarantine situation, other than agistment costs, he said:

Yes well this is the big question. The likes of [the clinic owner] would have a fair idea ... about how much money is going out and how much money is coming in.

### **Chief Veterinary Officer, QPIF**

In relation to the purpose of the payment, the CVO told my officers:

[The payment] was actually to assist to ensure that the welfare of the horses was looked after, basically. It was the primary purpose, because the business was experiencing trouble in actually looking after the horses, because there were 37 or whatever horses left there. They were having financial difficulty and so there was real doubts about whether they would continue to be able to properly look after those horses.

## Redlands clinic owner

My officers also spoke to the owner of the Redlands clinic about the quarantine:

- |              |  |
|--------------|--|
| Clinic owner | We had 37 <sup>119</sup> horses here. Each one of those horses had to be examined at least twice a day and checked and assessed and monitored for what was going on.     |
| QO Officer   | Who did the testing?   |
| Clinic owner | The government vets came in and took the samples, yes, so they'd come in when there was samples to be collected because they were doing it as a disease control measure. |

And:

- |              |  |
|--------------|--|
| QO Officer   | So your vets were still trying to treat the horses for what they'd come in to be treated for? Were you still trying to give them care?   |
| Clinic owner | Well obviously they all had to you know I mean they were all in here for a reason, but the practicalities dictated that you could only give emergency, an essential treatment, you know because you just didn't want unnecessary exposure so they certainly weren't getting the sort of care that they would have gotten prior to the quarantine and we couldn't take the horses out of the stalls sort of thing you know they sort of had to be left in there so that's a pretty tough welfare issue for the horse you know, but any disease that affects humans I mean you've got to compromise a little bit with how it works.<br><br>So when you talk about the issue of compensation, I mean this is where the real thing comes in is that there's you know the best part of 40 horses here, that takes a lot of care and attention. The stalls have got to be cleaned every day, the horses have got to be examined and assessed and medicated. Someone has to pay for that and so it comes down to either I have to pay for it, the owners have to pay for it or the government has to pay for it. So it's very simple. |

### 9.3.4 Discussion

There are contradictory statements in the written and oral evidence obtained by my Office as to QPIF's purpose in making the first payment to the AVA's AWCR trust.<sup>120</sup> This absence of transparency in the process is of concern, particularly in relation to such a significant sum of public money.

Documentary evidence showing that the payment was to be used to maintain or enhance biosecurity measures at the Redlands clinic has not been provided. QPIF was unable to tell my officers exactly what the payment was to be used for.

I also note the press release from the Minister's office on 4 August 2008 which said:

<sup>119</sup> This office understands there were 36 horses under quarantine at the clinic.

<sup>120</sup> Although some documents and officers refer to payments being made 'to the AVA', all ex gratia payments were in fact made to one of two AVA trusts.

Biosecurity Queensland and Queensland Health have been working intensely with the Redlands Clinic since the outbreak first occurred in early July. This support has included providing:

- a full time, on-site biosecurity manager
- a full time vet to assist the practice
- ongoing monitoring and testing of horses
- assistance for the vet practice to relocate part of its business
- support for the owner to meet his commitment as official vet for the Ekka
- financial counsellor assistance
- necessary counselling and health assessment of the staff.

This suggests that QPIF had already been providing substantial biosecurity support before the AVA's request for funds. However, submissions made to me by the clinic owner disputed that a full-time veterinarian was provided. He also stated that the assistance for the vet practice to relocate part of its business' was simply permission for the practice to remove equipment already decontaminated, and the support in relation to the Brisbane Exhibition (Ekka) was simply giving the clinic owner permission to attend. The AVA similarly submitted that the above support from QPIF did not meet the day-to-day welfare needs of care of the horses.

It has been stated by senior QPIF officers, both in the documentation and in interviews with my officers, that the purpose of the payment was to maintain the welfare of the horses. While they were able to tell my officers what this did not mean – the provision of shelter, feed, water or veterinary services – not one QPIF officer could clarify what was to be funded from the ex gratia payment in order to maintain the welfare of the horses.

It was often stated that the payment was not to compensate the clinic owner for loss of trade due to the imposition of the quarantine. QPIF officers were clearly concerned about establishing a potentially costly precedent if the payment was described in that way.

There were also several references to the financial stress which the clinic owner was under due to the quarantine. While the quarantine was in place the Redlands clinic was unable to treat other animals with a consequential loss of income. Clearly, if the Redlands clinic ceased to remain commercially viable while the quarantine was in place then urgent action would have been needed. It is likely that QPIF would have had to find some alternative means for accommodating and caring for the quarantined horses.

The statements by the Ex Gratia Decision-Maker in his interview are consistent with other documents obtained from QPIF officers which refer to QPIF ensuring that the Redlands clinic continued to operate so that the clinic staff could care for the horses.

Notwithstanding the statements made by QPIF officers that the rationale for the ex gratia payment was animal welfare' purposes, QPIF was evidently equally concerned about the clinic's financial viability and what would happen if it ceased to operate.

No comment is made about whether it is appropriate for the government to provide money to a business in such circumstances. The issue is the transparency of the decision-making process which involved the expenditure of public funds.

It is open to conclude on the evidence that one of the purposes for which QPIF provided the ex gratia payment was to keep the business afloat. There may have

been good reasons for doing so. However, in my opinion, to describe the payment as being purely for biosecurity and animal welfare purposes is inaccurate and has the potential to mislead.

It was also incorrect to suggest that the payment was not, in effect, to cover the cost of keeping the horses. I note that the AVA's submission in response to my proposed report was that shelter, feed, water and veterinary services were examples of precisely the types of activities involved in managing the care and welfare needs of the horses that were to be supported by the ex gratia payment.

As the clinic owner said:

The stalls have got to be cleaned every day, the horses have got to be examined and assessed and medicated. Someone has to pay for that and so it comes down to either I have to pay for it, the owners have to pay for it or the government has to pay for it.

Finally, I am concerned with QPIF's decision not to accurately describe the payment because of the risk of creating a precedent, thus exposing QPIF to further claims. For a number of reasons, this is the wrong approach.

Documents that are created to record the reason for the expenditure of public funds should do so accurately. The same can be said in respect of public statements which are made concerning such expenditure. Apart from being a requirement of good public administration, this is also a statutory requirement under the *Public Records Act 2002*.

It is also unfair to incorrectly describe the reason for the expenditure of public funds with a view to denying future payments to people with claims of equal merit.

In my proposed report, I formed the following opinion:

#### **Proposed opinion 46**

The reason given by QPIF for making the first 2008 payment to the AVA in the sum of \$150,000, namely, to manage the biosecurity risk and the welfare of horses at the Redlands clinic, was misleading.

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.

#### **DEEDI's response**

In general, in relation to chapter 9 of my proposed report, the Director-General of DEEDI submitted:

DEEDI's main response to chapter 9 of the proposed report is that, in the Redlands case, animal welfare and the short-term financial viability of the [Redlands clinic] were inextricably linked. All options for ensuring the welfare of the animals at the [Redlands clinic] were considered, and ex gratia payments were considered only after all other options were exhausted. DEEDI emphatically rejects the conclusion and impression that relevant officers acted improperly.

DEEDI also strongly contests the conclusion that various public descriptions of the purposes of the payments were misleading.

As further context to the response to this chapter, DEEDI administers and enforces the *Animal Care and Protection Act 2001 (ACPA)*. The ACPA, section 17 binds the Crown and places a duty of care on those in charge of animals to:

- (a) provide the animal's needs for the following in a way that is appropriate—
  - (i) food and water;
  - (ii) accommodation or living conditions for the animal;
  - (iii) to display normal patterns of behaviour;
  - (iv) the treatment of disease or injury; or
- (b) ensure any handling of the animal by the person, or caused by the person, is appropriate.

The person in charge' may be the owner and, in the case of the Redlands incident, a veterinarian.

In an emergency response situation, it is important that animals are properly cared for both in terms of legislative responsibilities but also because sick or stressed animals are more susceptible to disease and compromised animals could complicate and exacerbate the disease incident. It is also important to recognise that where an animal's welfare is in doubt, the agency has the power (and arguably the responsibility) to seize that animal and provide for its welfare thereby assuming all costs, liability and responsibility for those animals.

This is important context when considering the actions and decision-making related to the welfare of animals at the [Redlands clinic].

In relation to proposed opinion 46, the Director-General submitted:

Considerations of the financial viability of the [Redlands clinic] were, in the circumstances of the Redlands incident, inextricably linked with considerations of animal welfare. A person's ability to fulfil their duty of care towards numerous large animals is intrinsically linked to their financial position, and the income of the clinic had been compromised as a result of agency actions. As the agency responsible both for animal welfare and for imposing the quarantine, the inability of the clinic to fund the care of the animals had significant implications for the agency.

The proposed report's conclusion ... that the evidence was contradictory as to the purpose of the first 2008 payment does not recognise the link between animal welfare and the financial viability of the [Redlands clinic]. The extracts of the transcript ... therefore do not contradict the other evidence. The conclusion that the immediate concern was the [Redlands clinic's] financial viability rather than animal welfare is not made out on the evidence. These were one and the same in the minds of those involved, under the circumstances at the time ...

It is clear in the letter from the AVA ... that support was needed to "protect the welfare of the remaining horses subject to quarantine", because of the "time and effort required to treat horses." It was reasonable for the Department to give significant weight to the opinion of the AVA as the expert professional and peak body for veterinary surgeons. It is also noteworthy that the AVA specifically suggested that the funds be paid to its Animal Welfare Trust', which had been created to make grants for animal welfare purposes.

If the claim had been solely for loss of trade or income, no moneys would have been paid (whether to the AVA or otherwise). The payment was only made because there was evidence from a number of parties that the welfare of the animals was an urgent issue, arising from the owners' and the [Redlands clinic's] financial situation. Evidence was provided as to why the ability to explore the [Redlands clinic] owner's financial position was limited ...

The proposed report does not take account of salient points from the evidence that provide important context to the evidence that is quoted. For instance, evidence that the ex gratia payment was not to take away from the responsibilities of horse owners was quoted, ... without the caveat that horse owners were not meeting these responsibilities ... This point gives further weight to the reason for and purpose of the payments.

As stated in verbal evidence, the ex gratia payments were payments of last resort made after a very exhaustive but time limited analysis of the issue'. Options such as insurance, industry assistance, loans, and other financial assistance options were all identified and explored as far as possible in the circumstances ...

Compensation is an ongoing issue for biosecurity responses, and as such, avoiding unnecessary precedent-setting is critical. Building expectations about compensation outside of statutory obligations has real operational implications for future responses.

It also undermines the established policy of biosecurity responses being a shared responsibility between government, industry and the community. As noted in the verbal evidence, the agency has to respond to the unique circumstances of each incident in the most appropriate way possible, without setting up expectations (such as government paying financial assistance) for all subsequent responses. Precedent-setting is therefore a very real consideration for biosecurity agencies, and should not be disregarded as an irrelevant factor in decision-making.

Biosecurity and animal welfare are linked in these cases, in that if welfare is not ensured, individual horse owners may be tempted to take precipitate action such as illegally removing their horse contrary to the quarantine order.

Accordingly, the department submits that the reason given for the payment was not misleading. The payment was explicitly for animal welfare and biosecurity purposes, as outlined in the AVA letter to the former DPI&F of 31 July. This payment was considered necessary and appropriate at the time. The proposed opinion that the administrative action was wrong is not borne out by the evidence at all. And the proposed opinion that the administrative action was unreasonable is also not borne out on the evidence as a whole. Accordingly, it is submitted that **proposed opinion 46 be withdrawn**.

### **Submissions by the AVA**

The AVA was also provided with an opportunity to comment on some of the content of the proposed report. In summary, the AVA submitted that:

- the clear purpose and intent of the involvement of the AVA was specifically and only to provide for the care and welfare of the horses caught up under quarantine orders. This was specifically required by the terms of the trusts which allocated the funds in both the 2008 and 2009 incidents
- the Hendra virus incidents were major veterinary crises affecting the welfare of the horses and the ability of the Redlands clinic owner and Cawarral property owner to care for the horses. The responsibility for care of the horses fell on these persons who were required through no fault of their own to operate and fund a quarantine centre with no right to government support
- the demands of this care increased and resources for the care of the horses were severely stretched. The quarantines lasted for lengthy periods
- action was required very quickly to provide for the care of the horses
- the AVA and the trustees took the action to involve the trusts on an emergency basis where no other material direct financial help or support to provide care for the horses was forthcoming from government or any other party.

In relation to the Minister's Press Release dated 4 August 2008 which stated that QPIF was providing 'substantial biosecurity support' to the Redlands clinic, the AVA submitted that although the implication of such a statement may be that the complete welfare needs of the horses were being attended to, this was not the case. The day-to-day welfare needs of the horses (shelter, feed, daily care and veterinary services) remained the responsibility of the clinic owner and placed extreme demands on them.

In relation to the claims by QPIF officers in interviews with my officers that the payments were not for the provision of shelter, feed, water or veterinary services, the AVA expressed the clear view (held by the trustees at the time) that these services were precise examples of the types of activities which were to be supported by the payments'.

It should be noted that in response to the proposed report, the AVA submitted that a recipient's financial viability' is not a relevant factor in the exercise of the trustees' powers. The AVA trustees advised me that they were solely concerned with animal welfare matters and not the viability of the Redlands clinic.

### **Submissions by the clinic owner**

The clinic owner also submitted that in his view, the welfare' of the horses meant the care, feeding, watering, health, husbandry and housing of the horses.

He also denied that the payment was compensation' for his business loss, stating the pittance provided in no way shape or form gave us any compensation'.

### **Ombudsman's analysis**

The Director-General of DEEDI has submitted that his officers' conduct in describing the first payment as for animal welfare and biosecurity purposes' was not misleading, because such concerns were inextricably linked with the financial viability of the Redlands clinic. Such an argument is not entirely consistent with what three senior QPIF officers told my officers in late 2009. Instead, my officers were provided with multiple conflicting explanations and it was impossible from the interviews to determine accurately just what the payment was for.

My difficulty is that the Director-General's submissions in response to my proposed report directly contradict the statements made by senior QPIF officers to my officers at interview. My officers were clearly told that the payments were not to fund the feed, shelter and veterinary care of the horses. The Director-General now appears to be submitting that the payments were to fund these matters, but that such matters were inextricably linked to the financial viability of the Redlands clinic. This is despite my officers being told by the Executive Director QPIF that the payments should not be seen as linked to the Redlands clinic's loss of earnings.

I also note that, in support of his submissions, the Director-General referred to the transcript of my officers' interview with one of his officers. However, no reference was made to the interviews with the two other senior QPIF officers, or the fact that statements made by all three officers were inconsistent.

The submissions now made by the Director-General in relation to the reasons for making the payment (to maintain the financial viability of the clinic) do not directly appear in the documents prepared by QPIF officers at the time the payments were made.

Further, it is clear from both the AVA's response and the clinic owner's response that both these third parties were operating under the impression that the payment was indeed to fund the feed, water, shelter and veterinary care of the horses under quarantine. This is inconsistent with both the statements made by QPIF officers to my officers in late 2009, as well as the current position of DEEDI.

Together, the above factors and the Director-General's submissions only reinforce my view that there was a lack of clarity and proper consideration about the nature and purpose of these ex gratia payments.

Arguments that the payments were necessary to protect the welfare of the animals may not be sustainable when viewed alongside the fact that some preliminary consideration was given to moving the horses from the Redlands clinic, which was assessed as costing significantly less than the \$165 per horse per day suggested by the AVA. However, it appears that this course of action was not taken, at least in part, because it would not assist the clinic owner's financial position. This suggests that a significant concern was to prevent the clinic from closing, not only to provide for the welfare of the horses (which could have been done through other means).

It seems abundantly clear after reviewing the submissions made to me in response to my proposed report that there was no shared understanding about the purpose of the payment.

Further, proof of the AVA's intention and purpose does not amount to proof of QPIF's intention and purpose. Therefore, I do not accept that the AVA's letter requesting the payment supports QPIF's arguments to the extent submitted by the Director-General.

It is difficult to reconcile the Director-General's submissions with the statements made by QPIF officers to my officers in 2009, as well as with statements made by QPIF in public records and also to Dr Perkins in the 2008 Perkins review. Such statements clearly and expressly stated that the payments were not to fund the feed, water, shelter and veterinary care of the horses. This is consistent with the fact that the clinic owner was attempting to charge the horse owners for this care. While I acknowledge that it was anticipated at the time that some horse owners would refuse to pay these bills, QPIF did not take any steps to prevent the clinic owner from issuing invoices to the horse owners. QPIF's failure to do so meant that, had any of the horse owners paid these bills, the Redlands clinic may have effectively been paid twice for the same service.

Nevertheless, a view that there was any intentional wrongdoing in relation to the making of the payments has not been formed. While there were certainly significant administrative deficiencies, there is insufficient evidence to suggest that any officer intentionally misled the public about the purpose of the payment. For this reason, proposed opinion 46 has been modified to refer to the reason for the payment as lacking clarity and being the subject of multiple inconsistent explanations.

Overall, QPIF's attempt to avoid setting what it saw as a precedent for the payments appears to have led to this position. QPIF was clearly able to make an ex gratia payment for any purpose it saw fit. What caused the difficulties, uncovered in my investigation, and led to my opinion 46 is the attempt by QPIF to avoid stating its true purpose for making the payments to avoid having it known to the public that payments were made to the clinic owner and that these payments were at least partly to cover the costs of caring for the horses under quarantine. Had the payments been

described as such in the first instance, this matter would not have been addressed in my report.

Despite the modification of proposed opinion 46, two further issues require attention.

Firstly, QPIF officers made specific statements to Dr Perkins that the payments were not to provide feed, water and basic care for the horses under quarantine. It now seems clear that this is exactly what the payments were intended to do. It is unclear why such incorrect statements were made to Dr Perkins. It is indeed regrettable that this occurred, as Dr Perkins then published such statements in his 2008 report. However, given that the statements made to Dr Perkins were vetted by senior QPIF officers, it is of concern that such errors occurred.

Secondly, the senior QPIF officers interviewed by my officers in 2009 provided a slightly different view of the purpose of the payments than that which has recently been provided by the Director-General of DEEDI. Given that these officers were the most directly involved in the decision-making process, and I have not found any evidence of an intention to mislead my officers, the only conclusion I can draw is that the purpose of the payments was not clear to the officers making the decision.

These issues further illustrate the lack of clarity and inconsistency involving an ex gratia payment of a considerable amount of public monies, where the circumstances called for absolute clarity.

The Director-General objected to the use of the word misleading in the proposed opinion 46, as he argued there was no proof of any intention to mislead. With respect, the Director-General has misunderstood the purpose in using this word. The word misleading was used in the proposed report to refer to the potential outcome of the process – that is, that people could (or would) be misled. It was not intended to imply that there was deliberate conduct on the part of QPIF officers to mislead anyone. However, to avoid any confusion or suggestion of impropriety and for the sake of clarity I have amended the opinion to describe the outcome of QPIF's actions in different terms.

The Director-General has also stated in his response that:

Biosecurity and animal welfare are linked in these cases, in that if welfare is not ensured, individual horse owners may be tempted to take precipitate action such as illegally removing their horse contrary to the quarantine order.

There was no indication that this occurred or was likely to occur in any incident of Hendra virus considered in my investigation. This issue has not been raised previously and I do not see the relevance of this argument to whether an ex gratia payment should be made.

It is clear to me that there were serious deficiencies in QPIF's actions in making the payment to the AVA's AWCR trust. Despite the Director-General's submissions, in light of these administrative deficiencies by QPIF I am unable to withdraw my proposed opinion 46.

I confirm proposed opinion 46 with amendments as a final opinion:

**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.

**9.3.5 Calculation of amount**

My concerns about the lack of transparency are heightened by the absence of any rigorous method by which the amount of the payment was calculated by QPIF.

The AVA calculated the sum it was seeking on the basis of a daily rate of \$165 to care for each horse that was under quarantine at the clinic. The amount per horse per day was taken from the April 2008 inquiry into the outbreak of equine influenza conducted by the Honourable Ian Callinan QC AC, titled *Equine Influenza: The August 2007 outbreak in Australia* (Callinan Report).

I have seen no evidence of any analysis by QPIF of the figures submitted by the AVA, nor any consideration of whether the AVA's proposal reflected costs which the ex gratia payment was intended to meet. There is also no evidence that QPIF officers gave consideration to the fact that the clinic owner was also charging the owners of the horses for the basic care of the horses during the quarantine.

Instead, it seems that QPIF presumed that the amount of the AVA's request was reasonable, without obtaining expert advice on the costs to maintain animals. Although the Callinan Report was relied on, no QPIF officers were able to describe for my officers how the daily rate in the Callinan Report was arrived at or the extent to which that applied to the quarantine scenario at the Redlands clinic.

In this regard, the Ex Gratia Decision-Maker told my officers:

I was of the view given the urgency around this that if Ian Callinan had determined that was the rate that would probably be useful as good information we had in terms of daily care, not coping with the zoonosis element component.

The obvious risk of this lack of analysis by QPIF is that the AVA's request could have been too high, or based on irrelevant information. There is also no evidence that QPIF considered whether the AVA's request made allowances for the amounts that the Redlands clinic would charge horse owners. While I note that the AVA and trustees have since advised my Office that they considered it unlikely that contributions would have been made by the horse owners, at the time QPIF was clearly aware that the clinic would charge the horse owners and clearly intended that this occur.

In addition, no evidence has been provided recording how QPIF calculated the amount of the ex gratia payment which was actually made.

In his email of 29 July 2008, the Ex Gratia Decision-Maker advised the Director-General, Department of the Premier and Cabinet and the Minister that it is difficult to

estimate cost to us - assuming no further cases up to 150K is my guess'. However, this statement was made before receiving the AVA's letter and there is no material which evidences how the Ex Gratia Decision-Maker arrived at his guess'. Internal estimates to that time were well short of this figure.

The Executive Director was asked whether QPIF tried to examine the Redlands clinic's records to determine an accurate daily rate to which he replied:

... one of the things that you're very mindful of is this is not a normal circumstance where you can go to a very exhaustive and rigorous process, that you're actually operating in all of these short time constraints, and I think these issues were mostly developed within a matter of a week or a few days, as distinct, which is not quite what you'd normally would consider a policy responses of Government in these circumstances, and that's the trade-off we have to operate in these circumstances.

The General Manager AIPi was asked whether the \$150,000 was a global calculation of the cost of keeping the horses, to which he replied:

That's right. See they came in and said \$165,000 I think it was in their letter and then we basically went into a meeting. The Minister was there, the Director-General, the AVA was there because essentially by that stage we were dealing with the AVA and not [the clinic owner] and there was a discussion where [the clinic owner] essentially and the AVA basically put the case and said look these are the circumstances that we're confronted with and the way that they worked it out was just the way that they worked it out, and the way that it was looked at from the perspective of the State government wasn't going through their figures with a fine tooth comb and saying well look you know the way you've worked this out is quite, is wrong, because there were all sorts of, I won't call them inconsistencies, but you could ask questions about well why did we ignore the time up until Tamworth died, why wasn't that included. ... why this, why that.

You could come up with a thousand different questions about why but at that time though the feeling was that a decision had to be made and essentially so one was made and it was ... for the \$150,000 and the agreement at the time I think was that that was providing the quarantine was lifted by a certain date and in fact then it wasn't and so we had to come back.

I recognise that QPIF was, understandably, under some pressure to make the ex gratia payment as soon as possible. However, this must be balanced with the need for public accountability and the prudent expenditure of public funds. I am concerned that QPIF arrived at an amount for the ex gratia payment without conducting sufficient inquiries into what would be an appropriate amount, and made inadequate records of its decision and reasons.

In my proposed report, I formed the following opinion.

**Proposed opinion 47**

In respect of the ex gratia payment by QPIF to the AVA 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.

## DEEDI's response

The Director-General made the following submissions:

The verbal evidence relied upon for this opinion has been taken out of context, and was not given on the issue of calculating the ex gratia amounts. This passage could be more accurately characterised as a discussion about the purpose of the ex gratia payment.

It was extremely difficult to get an assessment of daily costs for the maintenance of animal welfare in horses under a quarantine arrangement for a zoonotic disease. This was a unique situation, where normal veterinary maintenance costs were not informative. The costs of looking after horses in Equine Influenza was used as an indicator, but again, did not reflect the expenses in this unique situation. The amount paid was based on advice from the AVA, advice from the clinic owner, and conclusions drawn in the Equine Influenza report by the Honourable Ian Callinan QC AC. It was reasonable for the agency to place a degree of reliance on the advice of these sources of information, particularly the AVA as an expert peak professional veterinary body. In short there was an evidence based approach to estimate an appropriate ex gratia payment to be made to a professional, specialist body to ensure welfare of animals in quarantine was maintained.

Other contextual information about the amount paid has been excluded. Verbal evidence giving weight to why the final amount of \$150,000 was paid has been disregarded. Salient points include:

- The intensive nature of veterinary care in the circumstances, given it was a veterinary surgery and not a standard property, with associated animal care and feeding costs such as staff employment, medications, and intensive cleaning ...
- Horse owners were refusing to pay the ongoing basic boarding costs of horses while the property was under quarantine ... Moreover, it was evident that owners would not be willing to pay the additional costs associated with the [sic] maintaining the animals' welfare as a result of them being kept under quarantine.

The decision-making process surrounding the ex gratia payments was subject to extraordinary time and pressure circumstances which the proposed report gives only limited weight.

## Clinic owner's submissions

The clinic owner submitted that while the cost per day for the horses could be argued forever, the findings of the Callinan inquiry should be given some credibility and form a reasonable basis from which to move. He also noted that decisions had to be made quickly, and questioned whether it was fair for this Office to use the benefit of hindsight to criticise the decisions that were made at the time.

## Ombudsman's analysis

Having considered the Director-General's submissions, my views on the methodology for arriving at the amount of the payment have not changed. The only documented calculations which have been provided to me and which provide any sort of explanation for the amount of the first 2008 payment were those calculations performed by the AVA.

I do not accept the Director-General's argument that it was reasonable to rely solely or largely on information from the AVA and the clinic owner as to the appropriate

amount of the ex gratia payment. The AVA was requesting a payment on behalf of the clinic owner, and was therefore in a position of advocating for the clinic owner. It was not appropriate to treat an advocate for one party as an independent authority on whom QPIF could rely.

My comments here should not be taken as reflecting adversely on the reputation or integrity of the AVA, the trustees of any associated trust, or the clinic owner, but merely to highlight the lack of robustness in the QPIF process of making the payment. QPIF needed to carry out independent calculations and independent inquiries to satisfy itself that the amount of the payment was appropriate. An applicant for a payment, or advocate for an applicant, should not be relied upon for advice about quantum.

Finally, I am unsure as to why QPIF is of the view that it is difficult or impossible to calculate costs for an ex gratia payment. That is what an agency is required to do before expending public monies: to have a robust process of calculating the amount that should be paid. This could be done in a number of ways in relation to this payment, including by seeking financial records from the clinic to ensure that the amount paid was not inconsistent with the normal amount of money coming into the clinic, by paying the clinic directly on invoice for services rendered in caring for the horses under quarantine, or by actually calculating the cost of staff time and expenses in caring for the horses and paying this amount as a daily rate. This final approach was taken in relation to the 2009 payment, so I do not see why it was not possible in relation to the 2008 payment.

Overall, I am not satisfied that QPIF conducted sufficient independent calculations to satisfy itself that the amount requested by the AVA was reasonable, that this amount was necessary to achieve its stated purpose (which the Director-General now submits was to maintain the financial viability of the clinic), or even to satisfy itself about what the money would be spent on.

I confirm proposed opinion 47 with an amendment as a final opinion:

**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.

## **9.4 The second 2008 ex gratia payment**

The initial quarantine was due to conclude on 17 August 2008; however, it was extended to 25 August 2008.

On 22 August 2008, the clinic owner wrote to QPIF setting out his position. He wrote:

I believe we urgently need resolution to what is emerging as a potentially disastrous and damaging situation.

The AVA, in conjunction with the Queensland Government, has allocated our organisation some funds to help cover the costs of looking after the horses that are in quarantine at our veterinary clinic. We respect the issues that have surrounded the allocation of these funds and acknowledge that they have been a contribution, but have major disappointment at the way everything has been handled and the innuendo and disparaging remarks that are being made about us as a direct result of this methodology.

The facts are very simple. There has been an outbreak of a deadly disease in horses at our clinic that has been brought about by exposure to flying foxes, a protected wild animal. ... We have carried out all our obligations in good faith, reported the disease, and quite rightly, our facility has been placed in the strictest quarantine. This has occurred by virtue of the government of Queensland administering the various laws that are present in this state. These laws are not the governments, they are the laws of the people of Queensland and the government departments are only administering.

...

The situation is that the people of Queensland, acting through their elected government and administered by the government departments, have taken over our property and turned it into a quarantine station, purely to protect the people of Queensland. Our business functions as an equine veterinary facility. We admit horses for examination and treatment as a service provider to the owners of those animals. They are not our horses, they belong to other people. These horses are certainly entrusted to us and we certainly have a duty of care to apply best practice to them.

...

Therefore, I cannot in any way see that we are responsible at any level, for the care and costs of these horses.

...

The welfare of these animals is paramount and costs of maintaining this welfare have to [be] borne by someone.

As you are aware, we have been in negotiations over the last weeks discussing this. A commercial rate has been arrived at and a contribution made. This funding in no shape or form achieves even that commercial rate.

The situation is very clear. Someone has to pay to look after these animals, and administer the bio-security measures to control the disease. There can only be three possibilities, ourself, the Queensland people, or the owners.

...

Someone has to pay. I expect some support from the government. Either they have to contact owners and clearly explain the obligations of the owners under the legislation and point out that owners are responsible, not my wife and I, or I would expect the government, that is the people of Queensland through the government, to pay the daily agistment rate for each horse, for each day. ...

By letter dated 26 August 2008, the AVA applied to QPIF for another ex gratia payment of \$120,000 to cover the costs of the extended quarantine as well as an amount to cover additional daily costs since 24 July 2008.

In requesting this payment, the AVA stated:

The AVA Animal Welfare & Crisis Support Trust has received the funds remitted by the Queensland Government. On the 14 August 2008 these funds were applied in full by distribution to [the Redlands clinic], to assist in the care and maintenance of the horses for the four week period from 24 July 2008 to 20 August 2008.

We request that the Queensland Government consider making an additional ex gratia payment to the AVA Animal Welfare & Crisis Support Trust.

We would submit that given the quarantine has now been lifted and recognising the biosecurity risk has been successfully managed, that an appropriate additional ex gratia payment would be \$120,000.

...

The horses at Redlands required constant clinical monitoring by qualified staff complying with comprehensive biosecurity requirements. This necessitated significant additional costs to the daily care of those horses and the protection of those committed staff that have provided care to these horses. The costs of additional equipment, laundry bills, additional clinical monitoring and recording were an essential component of ensuring the welfare of the 36 horses and maintaining the strength of the quarantine measures.

...

The claim to recognise the additional burden of biosecurity costs of a Zoonotic Disease equates to \$55 per horse per day, which would result in a total cost of care and welfare of \$220 per horse per day. We maintain that this is a fair and reasonable reflection of the additional costs of maintaining the welfare of the horses during an outbreak of a Zoonotic Disease. We note that in the event that the proprietors and staff of [the Redlands Clinic] had declined to assist in dealing with this devastating event, the costs of contracting alternative service providers on a commercial basis to provide the necessary level of care to these animals would have far exceeded this amount.

As [the Redlands Clinic] has received the proceeds of the previous ex gratia payment, the trustees would propose to pay any additional funds made available by the Queensland Government to them. This includes both the component for basic care of the horses and the component proposed to recognise the additional burden they have borne of the biosecurity costs of a Zoonotic Disease.

Any additional ex gratia payment in no way reflects a contribution to the potential losses suffered by the business of [the Redlands Clinic] and we have not sought to support this application by reference to actual costs and expenses incurred by that business ...

The calculation of the amount requested by the AVA included an additional amount of \$55 per horse per day above the amount of \$165 per horse per day sought for the first 2008 payment.

By email dated 27 August 2008 to the Executive Director, the General Manager AIPI recommended:

Going back to the original meeting with the Minister, we committed to review the situation by 17 August, when we expected the quarantine to be released. The actual date was 25 August. If we made a contribution based on 17 - 25 August (inclusive), at the same \$ rate per day that applied for the first contribution, that would be \$48,600 --- near enough \$50,000.

My recommendation is to go with \$50,000 to AVA, aware that [the Redlands clinic] considers the contribution should be higher. How do you think we should progress this? Should I start the process for approvals for \$50,000?

The Executive Director confirmed that they should proceed as recommended.

By memorandum dated 28 August 2008, the General Manager AIPi sought the Ex Gratia Decision-Maker's approval to:

... provide additional support for the AVA's efforts to protect the welfare of the horses by providing a special payment (as defined in Schedule 3 of the Financial Administration and Audit Act 1977) of \$50,000 to the AVA through its AVA Animal Welfare and Crisis Response Trust.

The Ex Gratia Decision-Maker approved this amount and by letter dated 29 August 2008 advised the AVA of his decision. In doing so he stated:

When the Minister for Primary Industries met with AVA, an agreement was reached that the Department of Primary Industries and Fisheries would provide a one-off ex-gratia contribution of \$150,000 in anticipation of the quarantine being lifted on 17 August. It was also agreed that further assistance could be negotiated if the quarantine was further extended.

It seems clear that the second payment was calculated as an extension of the first payment. This was confirmed by the Ex Gratia Decision-Maker who told my officers:

There was no additional information that would have, that I would have, I don't recall considering anything else beyond we had an agreement to a date based on a formula, we had another period we always knew was coming, we now know that period, what does that translate.

In the circumstances, the same administrative deficiencies by QPIF which existed in respect of the first 2008 payment appeared to be present for the second 2008 payment.

Therefore, in my proposed report I formed the following opinions:

#### **Proposed opinion 48**

The reason given by QPIF for making the second 2008 payment to the AVA in the sum of \$50,000, namely to manage the biosecurity risk and the welfare of horses at the Redlands clinic, was misleading.

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.

#### **Proposed opinion 49**

In respect of the second 2008 ex gratia payment by QPIF to the AVA 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.

## **DEEDI's response**

The Director-General made the following submissions:

For the reasons given in relation to proposed opinion 46, the department submits that the reason given for the payment was not misleading. The proposed opinion that the administrative action was wrong is not borne out by the evidence at all. And the proposed opinion that the administrative action was unreasonable is also not borne out on the evidence as a whole.

The proposed report should give proper weight to the verbal evidence giving the context of the second payment, and the decision-making process surrounding it, including the rationale for why the amount requested was revised down for consistency with the first payment.

Accordingly, it is submitted that **proposed opinion 48 be withdrawn**.

The Director-General also submitted that his response to opinion 47 applied also to opinion 49. Furthermore, he stated that it was not necessary to develop a methodology for the second payment, as the situation was the same, and the pro rata amount was consistent with the first payment.

## **Ombudsman's analysis**

For the reasons described above in relation to my proposed opinions 46 and 47, I do not accept the Director-General's submission that proposed opinions 48 or 49 be withdrawn. However, I have made one amendment to my proposed opinion 48 in line with my comments above.

I confirm proposed opinions 48 and 49 with amendments as final opinions:

### **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.

## 9.5 The 2009 ex gratia payment

Quarantine was imposed on the Cawarral property on 8 August 2009 after the identification of a suspected case of Hendra virus in a horse. The quarantine was in place until October 2009. During this time, three workers from the Cawarral property were hospitalised for preventative treatment after being exposed to Hendra virus, and the property owner was also hospitalised due to unrelated medical conditions.

The Queensland Horse Council (QHC), an industry body comprising horse owners, wrote to QPIF on 3 September 2009 requesting financial assistance to avoid an animal welfare issue'. An amount of \$20,000 was sought to cover the costs associated with employing three stable-hands to assist with looking after the horses for approximately four weeks. The proposal was that the payment be made to the AVA's Veterinary Emergency Support Trust (VES Trust)<sup>121</sup> for distribution to the property owner. The AVA also wrote to QPIF on 8 September 2009 supporting that request.

An ex gratia payment of \$20,000 was approved by the Ex Gratia Decision-Maker on 21 September 2009. The amount was paid to the AVA's VES Trust and passed on by the VES Trust to the owner of the Cawarral property.

Although the quarantine was subsequently extended until 12 October 2009, no further payment was requested of or made by QPIF.

My officers asked the Ex Gratia Decision-Maker to confirm why the 2009 payment was made, and he said:

It was the requirement of the staff who were caring for the horses to go into hospital, they were on watch for Hendra, and leaving their post and the issue in that situation of maintaining a level of animal welfare at the property again was my recollection. I was less involved with the Cawarral response. I just said use the mechanism we've used, make sure the \$20,000 or whatever figure it was, it was not material in my view to challenge it, beyond was it a fair and reasonable response.

The Managing Director advised my officers that:

We believed that unless we intervened, the horses' welfare would be in jeopardy and that we were better off doing a pre-emptive payment rather than let the situation get to a point where we would have to come on to the property and take more extreme action.

I also note that the letter from the QHC to QPIF requesting the ex gratia payment specifically refers to animal welfare' issues. In an interview with my officers, the QPIF liaison officer stated:

... [I was told to] organise QHC to write a letter on behalf of [the Cawarral property owner] saying you know he's having, there's definite welfare and you know concerns about the property ...

An email from the Managing Director to the Ex Gratia Decision-Maker dated 2 September 2009 stated:

---

<sup>121</sup> The AVA Trust used in relation to the 2008 Redlands incident was restricted to assisting with the care and support of animals in the care and control of AVA members. The owner of the Cawarral property was not an AVA member and as a result the AVA's VES Trust was used to similar effect.

We understand that we will shortly receive a request from the QHC to provide assistance for the care and welfare of the horses on the property. While we don't know the likely figure that will be asked for, we don't expect it to exceed \$15,000. Given the circumstances outlined above, we support an ex-gratia payment because without it we are concerned the welfare of the horses will be put at risk. We can provide further advice on this assessment if you wish.

A QPIF legal officer's notes of a discussion with a senior QPIF officer on 27 August 2009 (several days before the QHC request was received by QPIF) also noted that the best method for the ex gratia payment was through the AVA and that the justification should mention animal welfare.

As with the 2008 payments, the purpose of the 2009 payment was said to be to meet animal welfare needs. It is noted that this was the same term used in the Redlands incident, in respect of which I have reached the opinion that reasons given by QPIF lacked clarity and were the subject of multiple inconsistent explanations. I was therefore concerned that the purpose of the Cawarral payment was also unclear.

However, the significant difference between the 2008 payments and the 2009 payment is that, in the latter case, there is specific information that those needs would be met by the employment of staff to feed the horses.

On this basis, I am satisfied that the 2009 payment was made for animal welfare reasons.

### 9.5.1 Calculation of the amount

The amount of the 2009 payment was derived from the following costings provided by the QHC:

QHC is seeking an ex gratia payment of \$20 000 to go to [the Cawarral property owner] to cover the cost of stable hands. This figure has been arrived at by the following:

|  |              |
|--|--------------|
| Estimated wages (\$30/hr x 6 hrs/day x 2 stable hands x 30 days) | \$10,800     |
| Estimated travel expenses  | \$2,000      |
| Meal Allowance (public service rates)                            | \$2,200      |
| Estimated accommodation  | \$2,000      |
| Estimated incidentals  | \$3,000      |
| <br>Total  | <br>\$20,000 |

A QPIF officer performed calculations and arrived at a figure of \$13,000. While the figures differ, it is noteworthy that an effort was made to determine the amount of the ex gratia payment by reference to specific costings. The Ex Gratia Decision-Maker also required QPIF officers to keep records of expenses incurred, including hours worked by the stable hands.

In the context of good administration, QPIF's approach to the 2009 payment is an improvement on its approach to the 2008 payments.

Nevertheless, in my opinion the transparency of the payment was inadequate for the following reasons:

- although QPIF considered the cost of providing additional labour to look after the welfare needs of the horses, this consideration was minimal

- the figure which the QPIF officer arrived at (\$13,000) was not adopted and there is no reason on the face of the material why it was not adopted
- there was no critical analysis by QPIF of the basis on which the QHC arrived at its figure of \$20,000
- the submission to the Ex Gratia Decision-Maker seeking his approval for the special payment contained no information concerning the purpose of the payment, other than it was for the welfare of horses, or the basis on which the figure of \$20,000 was calculated.

Furthermore, there was no evidence on the papers that the Ex Gratia Decision-Maker had regard to the amount and purpose of the 2008 payments when deciding on the amount of the 2009 payment.

Consistency is an important principle of good public administration. However, consistency does not mean that all cases should be decided the same way. Cases that are genuinely different should be treated differently where there is a rational reason for doing so. What is important is that there is an assessment of whether the cases are substantially similar, such as to justify similar treatment, or materially different such as to justify a departure from previous decision-making.

My concerns about the transparency of the decision are heightened by the disparity in the payments in these cases. When asked about the reasons for the difference the Ex Gratia Decision-Maker told my officers:

My response would again be that was for this circumstance with these number of horses, with these number of owners, for this circumstance, this was for this purpose for this circumstance. We've developed a, well in my mind we had quite separate cases developed for the outcome. In both cases for me it was about minimising the exposure, setting precedent and (b) ultimately minimising cost to State, with the best information available and ultimately to achieve a particular outcome which in both cases we've achieved.

The Executive Director put the disparity down to the different size of the operations:

I also think that we were very much aware that there was quite a different nature of the operation, and that there was, again I'd have to stand corrected, but I was led to believe that there was also offers of voluntary help at Cawarral, and therefore I think we were making sure, very mindful to try and restrict payments and that was the sort of conditions we put on there.

However, the General Manager AIPI explained that the reason a larger amount was not paid in the Cawarral incident was because it was not requested:

I think too the possibility of us actually having to take over the management of the property was less of a possibility at Cawarral. It wasn't an impossibility though because they nearly ran out of staff so that it was getting close but the simple answer to your question though is why didn't we consider a bigger amount at Cawarral. It's simply that we weren't asked for it. If we were though it would have been very difficult. I don't think, you know, we couldn't have considered an amount anything like what went to Redlands, but I've got no reason to have ever thought about what we would have done.

The absence of a transparent decision-making process means that it is difficult to properly scrutinise the 2008 and 2009 payments. The lack of comprehensive records, and the disparity between the payments, leaves QPIF vulnerable to criticism about the integrity of the process.

In my proposed report, I formed the following opinion:

**Proposed opinion 50**

In respect of the 2009 payment by QPIF to the AVA 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.

**DEEDI's response**

The Director-General made the following submissions:

The proposed report should reflect the verbal evidence that gives greater context to the 2009 payment, and the justification for the amount paid (in comparison to the 2008 payments). Relevant points include:

- The 2009 property was not a veterinary practice, and therefore had a different cost structure.
- The agency was reliant on the expertise of the peak body (Queensland Horse Council) in regard to the cost of caring for horses under the circumstances, including the cost of employing stable hands. QHC was supporting the horse owners through a situation where there were insufficient staff to care for the horses. It was reasonable for the agency to rely on such expertise in such a unique situation. There was no means for interrogating the costs outlined by the QHC, as they related to extraordinary circumstances, and employing reluctant individuals from other districts to undertake the work. The standard costs of employing such people were irrelevant.

Furthermore, the quantum of payment for the [Redlands clinic] was not informative of the costs being incurred in the specific circumstances of the Cawarral incident. This Cawarral case related specifically to the requirement to employ additional individuals to maintain the welfare of the animals.

Accordingly, the opinion that the administrative action was unreasonable is not appropriate on the whole of the evidence.

**Ombudsman's analysis**

Nothing in the Director-General's submissions alters my view that there was also inadequate consideration given to the 2009 payment. However, I have amended my opinion slightly to clarify that the payment was made to the AVA's VES Trust.

I confirm proposed opinion 50 with an amendment as a final opinion:

**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.

**9.6 Use of a third party trust fund to receive the payments**

All three ex gratia payments were paid by QPIF into one of two AVA trust funds. The trustees of the respective funds then transferred the money in full to the Redlands clinic owner in the case of the 2008 payments and the Cawarral property owner in the case of the 2009 payment.

The Managing Director's email to the Ex Gratia Decision-Maker on 25 July 2008 suggests that the impetus for making the first 2008 payment came in response to the Redlands clinic owner's request for funding. In her email she summed up the position and alerted him to a number of issues including:

- the Redlands clinic owner had said that he was experiencing financial difficulties as a direct result of the quarantine
- QPIF had offered the assistance of staff to help with the feeding and care of horses
- the clinic owner had presented a proposal for his vet clinic to care for the horses at a rate of \$150 per horse per day to be paid by government
- government may wish to consider an ex gratia payment
- outright rejection of the clinic owner's proposal would result in a negative and public reaction from him
- QPIF officers had concerns about creating a precedent with any non-biosecurity-related payments
- the issue of the clinic's financial viability and any possible compensation may be best handled at a whole-of-government level given the precedent it may set.

The events in July 2008 tend to support a conclusion that the concept of making the first 2008 payment to the AVA, rather than directly to the clinic owner, was initiated by QPIF:

- On 25 July 2008, the clinic owner presented a proposal for QPIF to pay him directly to care for the quarantined horses at his clinic.
- On the morning of 28 July 2008, the Executive Director expressed the view, that we need the Horse Industry Council and the AVA to be a part of the solution and not mere bystanders'.

- Approximately ten minutes later, the CVO emailed the Executive Director and the Ex Gratia Decision-Maker to confirm that he had spoken to the QHC and they were happy to cooperate. He also stated that the AVA President was not answering the phone.
- Approximately two hours later, a further email from the CVO to the Ex Gratia Decision-Maker, the Executive Director and other senior QPIF officers stated that he had now spoken with the AVA, which was happy with this approach.
- A file note of a meeting between the CVO, a senior QPIF officer and a QPIF legal officer on the same day listed three options, one of which was an ex gratia payment to the AVA or QHC. Neither of the two other options listed involved a payment directly to the clinic owner.
- The next day the Ex Gratia Decision-Maker advised the Director-General, Department of the Premier and Cabinet and the Minister that the AVA had agreed to support [the clinic owner] through the quarantine.

On 31 July 2008, two days after this conversation, QPIF received a letter from the AVA requesting an ex gratia payment to assist the clinic owner through the quarantine.

My officers were given a number of reasons why the payments were made to a third party trust fund, rather than directly to the clinic owner or, in respect of the 2009 incident, to the Cawarral property owner.

Firstly, the Executive Director confirmed that the payment was made in this way to avoid the perception that it was compensation for loss of income or trade. He said:

There's two things that were drawn, one is I don't think Government monitored, it was very concerned about precedent of directly paying monies to a veterinary practice. We saw that in this particular instance there was a vehicle that would, could ensure that monies were expended appropriately, and I, and without putting those obligations on the AVA, they were very much aware that this money was for the welfare of the animals, not [the clinic owner], and we believe that was probably more appropriate in the circumstances.

...

That circumstance could change quite differently, but even based on that experience, we used the same process for the Cawarral one.

Similarly, the CVO told my officers:

I mean it's just not realistic to be compensating for consequential loss. So basically we had to be very careful that we weren't seen to be, you know compensating for consequential loss in either of those cases.

Secondly, senior QPIF officers told my officers that in accepting the 2008 payments into its trust fund, the AVA assumed the risk for the horses' welfare in the event the clinic owner was unable to care for them. In this way, QPIF's risk of being left responsible for the welfare of the horses was minimised.

For example, the General Manager AIPI said that if [the clinic owner] had pulled out we would have expected the AVA to still maintain the welfare of those horses and they understood that responsibility'. Likewise, the Executive Director said:

... by going through the third party such as the Australian Veterinary Association, there is a lot of moral, so that if that in fact, what [the clinic owner] did was to actually go and buy himself a new car or do whatever ... and that those horses then were unfit, the AVA itself then has an obligation, would, in my expectation, would have had a moral responsibility to maintain those animals themselves.

Thirdly, it was suggested that the money paid for a service provided by the AVA. The Ex Gratia Decision-Maker said:

... The expectation was clearly linked to them ensuring that the welfare of the horses was maintained. That was the expectation. That would be their contribution to the partnership. I'd contribute dollars, they'd contribute the outcome. They then, through discussion it was clear they were going to, based in my view, an efficient way of using [the clinic owner's] capacity in order to ensure that. Which we had assessed through his letter and his advice from his accountant that he was a financial risk and was not going to be able to sustain it.

...

I was paying AVA to deliver a service.

... The payment was made to the AVA to ensure the biosecurity of the horses. Discussions with AVA indicated the tool they would use, the mechanism they would use would in fact be to leverage [the clinic owner's] capacity. So it would be a normal thing for us, no it's not. Our agreement was with AVA to deliver a range of ... welfare outcomes. The tools by which they used to do that was indeed that mechanism and hence that was the nature of advice from them, it wasn't our requirement that they do that.

In my view, QPIF's use of a third party through which to channel the ex gratia payments to the intended recipients was designed to avoid the suggestion that the payments were compensation for lost business. Clearly, in doing so, QPIF hoped to avoid setting a precedent for other potential claimants.

I do not accept the other bases which were given for the third party payments, that is, in accepting the payments to the trust funds the AVA assumed the risk of looking after the horses in the event that the clinic and/or property owner ceased doing so, and that the ex gratia payments were made to the AVA trust funds to deliver a service.

There is no evidence that the AVA would take on care of the horses in the event that the owners ceased doing so, and the AVA denies that it was under any obligation in this regard. It also seems unlikely that the AVA trust funds' trustees would pay the entire ex gratia payment to the recipients while retaining the risk for the ongoing care of the horses in such an event.

Similarly, there is no evidence of the payments being made in return for a service from the AVA. On the contrary:

- there was no formal, written agreement that any service be provided by the AVA
- the AVA did not agree that it had undertaken to perform any service
- the AVA did not take any steps to care for the welfare of the horses
- the AVA's trust funds passed on the amount of the ex gratia payments in full to the Redlands clinic owner and the Cawarral property owner respectively.

I have previously formed the opinions that the reasons given for the first 2008 payment – that it was to manage the biosecurity risk and the welfare of horses – lacked clarity and were the subject of multiple inconsistent explanations. I expressed my concern about QPIF's reasons for doing so, that is, to avoid a precedent which would thus expose QPIF to further claims.

It seems clear that QPIF's intention was that the 2008 payments be made to an AVA trust fund, which would then pay the money to the clinic owner. This was supported by submissions from the AVA to my Office which stated that to do other than to provide the funds to the clinic owner would have been to act in a manner contrary to the statements and representations contained in their correspondence with QPIF.

In my view, QPIF should not have made payments to an AVA trust in a situation where it had sought the agreement of the trustees to provide the funds to the clinic owner. Given my view is that QPIF's clear intention was that the payments be passed on to the clinic owner, the making of payments to the AVA trust appears to have been an attempt by QPIF to distance itself from the true reason for the payments, thereby potentially misleading not only people who may have wished to make like claims in the future, but also the general public.

In forming my opinion, I must emphasise that I am not suggesting that the payment was unlawful. Nor am I suggesting any wrongdoing or improper actions on the part of the AVA or its trustees. The AVA and the trustees clearly communicated to QPIF and my Office what they saw as the purpose of the 2008 payments and how they were intended to be managed.

However, openness and accountability in government and transparency in decision-making would have required QPIF to make the ex gratia payments directly to the Redlands clinic owner and the Cawarral property owner respectively, rather than QPIF's approach of using the AVA trust funds to pass on the payments to QPIF's intended recipients.

Further, I have similar concerns about the deeds of confidentiality concerning the ex gratia payments (described as special payments in the deeds), which were signed by the AVA, QPIF and the trustees of the relevant AVA trust funds. These documents were the only written agreements between the parties.

The deeds were in similar terms. For the first 2008 payment, the deed stated:

**WHEREAS:**

- A. The Department has proposed to provide the AVA with a special payment for the limited purpose of assisting persons to protect the welfare of horses affected by the quarantine at the [Redlands clinic] due to the recent discovery of Hendra Virus (**HeV**) (**the Payment**).
- B. In the course of negotiating the terms of the Payment the parties have entered into a range of discussion during which highly sensitive information has been exchanged (**the Confidential Information**).
- C. The Department wishes to ensure the Payment and the Confidential Information remains secret.
- D. The AVA and the Trustees acknowledge that the Payment and Confidential Information is regarded by the Department as secret and if disclosed to unauthorised persons may cause substantial damage to the Department.

- E. The AVA and the Trustees have agreed to keep the Payment and the Confidential Information secret on the terms set out in this Deed.

The deed contained nothing else about the purpose for which the payment was being made or the actions the trustees were required to take. The absence of any binding conditions on the trustees meant that there was no enforceable obligation on them to make any payments to the Redlands clinic owner or the Cawarral property owner. Indeed, it was open to the AVA trustees to simply not distribute the money for the time being, or to distribute it in any way they saw fit consistent with the terms of the trust.

Given my view that the payments were intended for the Redlands clinic owner and the Cawarral property owner, it is of considerable concern that QPIF chose to forward public money to a third party who was under no legal obligation to use it as intended.

One QPIF officer put similar concerns bluntly in saying to my officers in relation to the 2009 payment:

... and it did seem a very much of, you know, money in a brown paper bag, is [sic] handing over \$20,000 to the AVA, who's to say there's not someone dodgy in there who just goes well, this is all confidential, no-one knows about it, I'm just going to take it, there's not a leg to stand on.

The statement clearly identifies an obvious generic risk arising from the use of a third party to forward funds to an intended recipient when there is no legally binding obligation to do so.

In support of this possibility, the Ex Gratia Decision-Maker, when asked by my officers whether the AVA trustees could legally under the terms of the deed have kept the payment in their trust fund and used it for other purposes, rather than transferring the amount to the clinic owner, replied 'I guess that's possible'.

I understand that this approach was taken by QPIF because of internal legal advice to the effect that should conditions be placed on the payments they would cease to be ex gratia payments, and certain consequences would follow. No authority was given for this proposition however, and it is unnecessary for me to form a view one way or the other as to whether this advice was correct. If QPIF accepted that it was unable to place conditions on an ex gratia payment then it should have either:

- made the payments in a way other than by ex gratia payments, so that conditions on the use of the payments could have been imposed, or
- paid the ex gratia payments directly to the Redlands clinic owner and the Cawarral property owner so QPIF could ensure that the payments reached the parties for whom they were intended.

It should also be noted that, due to the methodology adopted by QPIF in making the payments to the AVA trusts, there was no agreement between QPIF and either property owner about what they would do with the money. Consequently, QPIF had no way of ensuring that the payments were spent on meeting costs associated with the quarantine.

My concerns in this regard should not be taken as a comment on, or criticism of, the integrity of the AVA, the trustees of the AVA trust funds, the Redlands clinic owner or

the Cawarral property owner. I have not formed any adverse opinion about any of these persons or entities.

It is also noted that the 2008 Deed contained a statement that the AVA and the trustees acknowledged that the confidential information (as defined in the deed) and the payment, if disclosed to unauthorised persons, may cause substantial damage to QPIF and should be kept secret.

No QPIF officer could adequately explain to my officers why releasing the information may have caused substantial damage to QPIF. The Executive Director told my officers:

Executive Director Now I suppose what it means is that, this Confidentiality Agreement I suppose, while we recognise it and that we had to acknowledge that a sum has been paid, the issue is I suppose about the detail and wanting some comfort that at the time, that that amount and to who it went, it might have gone to, was somewhat clouded given that the circumstances that applied at that time, recognising that sometime down the track that that issue tends to stand in a different context or light.

QO Officer Yes, yes. So ...

Executive Director Outside of emotional.

QO Officer Certainly. So I suppose the only thing is that when, I mean the Cawarral fund was made this year.

Executive Director Yes.

QO Officer So in your accounts that's going to show a \$20,000 payment. What do you think the Department's position might be I suppose when the Cawarral recipient finds out that they got \$20,000 and the Redlands recipient received \$200,000?

Executive Director I'm, I mean I think the issue for us more, more importantly is that there is now a clear pattern emerging, and I, and again when we did the Cawarral one, I was again acutely aware that we are by default setting precedents here.

QO Officer Yes, even though everyone says it's not a precedent?

Executive Director Even though everybody says it's a precedent, and of, all the circumstances are different and the quantum are quite different and the basis behind the costs ... but this is causing a significant issue for the agency is that we are going to have to be more clear and explicit in terms of how we handle these sorts of things in the future.

The secrecy provisions in the 2008 Deed were designed to further reduce what QPIF officers saw as the risk of creating a precedent for the payment of compensation. However, the principles of good administrative decision-making require decision-makers to consider previous cases when deciding whether to make ex gratia payments in the future.

Therefore, it makes no difference whether the exact amount or purpose of an ex gratia payment is public knowledge and that a person requests or expects QPIF to make a future payment in similar circumstances. Instead, QPIF has an obligation to

independently consider such issues and any similar circumstances irrespective of whether the person requesting the ex gratia payment is aware of them.

In my proposed report, I formed the following opinion.

#### **Proposed opinion 51**

In relation to the ex gratia payments:

- (a) QPIF intended the ex gratia payments which were made to the AVA 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 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) The conduct of QPIF in using the AVA as a vehicle to disguise the reason for the payments was misleading
- (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 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.

#### **DEEDI's response**

The Director-General made the following submissions:

The proposed report (p.170) refers to an email statement which is extracted to imply that ~~it~~ was QPIF's idea to make the payment to the AVA rather than directly to the Redlands clinic owner". Further context from the emails of that day have been excluded.

- Later that day, the Executive Director confirmed ~~we~~ need these organisations to help us come up with a solution and take some responsibility".
- A subsequent email from the Executive Director advised that a dedicated person was to be involved to work with the AVA and QHC on a solution that ~~may~~ at the end of the process involve an ex gratia payment – but not a starting point."

This contextual information clearly articulates the true intention behind the earlier email (as extracted in the report) that the industry organisations needed to be involved to develop a solution for the issues being raised by the veterinary clinic owner, consistent with the agency's shared responsibility policy.

The department submits that the proposed report be amended to reflect the true intention behind the Executive Director's email of 28 July 2008 (and the other events listed) as revealed by the contextual facts set out above.

The decision to pay the ex gratia funds to the AVA was based on a sound and justified decision-making process in the circumstances. Precedent-setting was a relevant consideration given the agency's long-term experiences with biosecurity responses and ongoing demands for financial assistance in similar circumstances. As stated above, compensation payments outside legislative obligations have been a recurring issue for biosecurity responses, and as such, precedent-setting has very real operational implications. As such the requirements of the Deeds of Confidentiality were based on very real considerations.

A number of considerations affected the decision-making. On this basis, options were explored for bringing some integrity to the payment to ensure it was expended in an appropriate manner. In this context, the AVA was a reasonable option given all surrounding circumstances:

- The veterinary clinic/property was in a situation that compromised the welfare of animals under a State Government-imposed quarantine;
- Options for assisting the clinic/property were explored, with ex gratia being the most viable option given the urgent nature of the situations;
- Legal advice was that conditions could not be applied to ex gratia payments, thereby limiting the agency's ability to ensure that the funds were expended on the intended purpose (animal welfare);
- The AVA was in a professional position to ensure that the funds were expended appropriately, and were also in a position to step in should this not occur.

As explored in verbal evidence, the payment to the AVA was not without expectations (as far as could be applied given legal advice being relied upon). Furthermore, it was reasonable to assume that given the professional status of the AVA, it would take its responsibilities in dealing with the money seriously.

The letter from the AVA (p.151) specifically states that the trustees of the AVA Animal Welfare Trust would distribute the funds as required to maintain the welfare of the horses. It was reasonable for the agency to give weight to this written commitment.

Accordingly, the proposed report should not find that the administrative action was unreasonable or wrong. In particular it is submitted that:

- **proposed opinion 51(a) be withdrawn**, as the finding that the agency intended the payments to be passed on to the property owners in full is not supported by the evidence;
- **proposed opinion 51(b) and (c) be balanced with a finding** that it was reasonable for the agency to be confident that its industry partner (the AVA) would ensure that the payments were used for the purposes of animal welfare;
- **proposed opinion 51(d) be withdrawn**, because there is no evidence at all to support the proposed opinion that the agency's conduct in using the AVA as a vehicle was intended to disguise the reason for the payments, and in any case the word disguise is unduly and unnecessarily inflammatory;
- **proposed opinion 51(e) be amended** to find that the agency's actions in entering into the confidentiality deed were reasonable;
- in any event, **proposed opinion 51 be withdrawn** because there is no basis for the conclusion that the action was wrong;
- **proposed opinion 51 be amended** to find that the agency's action in seeking to minimise the State's financial exposure was reasonable.

### **Submissions by the AVA**

I provided the AVA with an opportunity to respond to my proposed report. The AVA's submission set out relevant background information and clarified its views on the events associated with the ex gratia payments.

In relation to the issue of the 2008 Deed and the lack of any enforceable obligation on the AVA to make payments to the Redlands clinic owner and the Cawarral property owner, the AVA pointed out to me that to do so would have been inconsistent with statements and representations made to QPIF as to how the funds were intended to be dealt with by the AVA trustees.

In relation to the evidence obtained from a QPIF officer in relation to the 2009 payment and QPIF handing over \$20,000 to the AVA, quoted above, the AVA objected to that statement being included in my report on the basis that it reflected poorly on their association and/or the trustees. However, I did not include this evidence for the purpose of potentially embarrassing the AVA or casting aspersions on its officeholders.

### **Submissions by the clinic owner**

The Redlands clinic owner made the following submissions in response to my proposed report:

... I agree that transparency has to be paramount. I was certainly privy to a lot of the discussions and procedures at the time. I certainly strongly disagreed with the "back door" approach of going through the AVA as I felt it was not appropriate. I voiced these comments at the time, but was assured that this would be the only way that anything could be done as precedents could not be set.

...

The only thing I disagreed with was the methodology of involvement of the AVA, but at the time, it appeared to certain people to be essential for moving forward. I agree with your comments relating to transparency as I myself commented as such at the time. What needs to occur now is for proper guidelines to be developed to facilitate prompt action in the future so that no-one is forced to attempt to find some "devious" way of circumventing a system. ...

### **Ombudsman's analysis**

I acknowledge that the AVA's letter requesting the ex gratia payment states that the AVA trustees will distribute the funds as required to maintain the welfare of the animals. However, it is overwhelmingly clear from the evidence that QPIF officers knew, and intended, that the AVA trustees would provide the full amount of the payment to the clinic owner. I note in this regard the AVA's submissions on this matter, which I consider to hold significant weight.

I also note that the AVA clearly informed QPIF in writing as to how it had dealt with the first 2008 payment and how it intended to deal with the second 2008 payment, and no concerns were raised by QPIF. I believe it is difficult for QPIF to argue that it did not know what the AVA trustees intended to do with the payment, or to assert that there were no discussions about this matter or a clear intention among QPIF officers that a certain course of action be taken by the AVA trustees (as these QPIF officers told my officers at interview). Therefore, I do not accept the Director-General's assertions in relation to my proposed opinion 51(a).

In relation to whether QPIF could compel the AVA trustees to distribute the funds in a certain way, I am not suggesting that the AVA trustees should not have been relied on to act in a responsible manner. Again, I note the AVA's submission that to do other than transfer the payments to the intended recipients would have been inconsistent with statements and representations made to QPIF as to how the funds were intended to be dealt with by the AVA trustees. However, my point is that legally it may have been possible for the trustees to distribute the funds in another way.

However, the method adopted by QPIF constituted poor administrative practice in my view because, in light of my conclusion that QPIF intended the ex gratia payments be passed on to the Redlands clinic owner and the Cawarral property owner

respectively, QPIF paid a significant amount of public monies to a third party without a mechanism to ensure that the payments were passed on to the intended recipients. That the AVA acted in the manner intended does not absolve QPIF of this administrative deficiency.

Further, the Director-General again asserts that the AVA was an industry partner to QPIF. I am unconvinced by the claim that the AVA was an industry partner in relation to the ex gratia payments when it did nothing more than transfer the amounts of the ex gratia payments to the clinic owner and property owner respectively, and when the AVA trustees told me that they did not accept any obligation to perform any service for QPIF beyond this. The Director-General did not fully explain how the AVA became an industry partner of QPIF in relation to these payments. A general partnership in relation to horse issues may have existed, but that does not rectify the QPIF administrative deficiencies in relation to these payments.

In relation to my proposed opinion 51(d), the Director-General submitted that this opinion be withdrawn because he said there was no evidence that the use of the AVA was intended to disguise the intended recipients of the payment. With respect, I disagree. It is clear that QPIF officers determined that the payment would be made to the AVA trust so that QPIF could argue that it did not make any payment directly to the clinic owner in 2008. This is supported by the evidence given at interview by QPIF officers, as well as documents provided to my investigation. In light of my conclusion in my proposed opinion 51(a), I do not see any reason for withdrawing my proposed opinion 51(d).

However, I have taken into consideration the Director-General's submission in relation to the word disguise and have altered the wording of my final opinion slightly to avoid any inflammatory connotations. None were intended.

Similarly, I see no reason for withdrawing my proposed opinion 51(e). QPIF officers quite clearly informed my officers that a key concern of QPIF was to avoid creating what the officers saw as a precedent for future payments. There is no legal requirement that a deed of confidentiality be entered into in relation to an ex gratia payment. A public announcement of the payment to the AVA was made on 4 August 2008, four days before the 2008 Deed was forwarded to the AVA. Despite this announcement, QPIF's primary concern appears to have been to avoid having the ultimate recipient of and the purpose for the payment become public knowledge, so that a precedent would not be set. In the circumstances, I do not accept that the deed of confidentiality was a reasonable requirement.

Finally, in relation to my proposed opinion 51(f), I have taken into account the Director-General's submissions. QPIF does have an obligation to minimise the financial exposure of the agency in some respects. However, I do not agree that this extends to the mechanism that QPIF used to avoid the purpose of the payments becoming known or to put distance between QPIF and the intended recipients of the payments. By removing this opinion, I would essentially be agreeing that QPIF's actions in making the payments to a third party so that the payments could be passed on in full to the intended recipients were reasonable. I do not agree that this methodology was reasonable, no matter what the purpose of it.

I confirm proposed opinion 51 with amendments as a final opinion:

**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.

## 9.7 Reporting of the 2008 ex gratia payments

In 2008, there was an obligation in the *Financial Management Standard* for an agency to publish details of special payments made in its annual or final financial statements. It was compulsory for these details to include the classes of special payments and the total amount of special payments for each class, including ex gratia payments. All Queensland Government agencies were required to publish this information.

The Final Report<sup>122</sup> of the former DPIF for the period 1 July 2008 to 26 March 2009 records that \$345,000 in special payments were made during the relevant period. The notes to the Final Report state:

The 2008-09 amount includes payment of \$0.200 million for the Hendra virus response and support costs; and settlement of claim for legal and associated costs of \$0.142 million.

There was no actual requirement that the details of specific special payments be listed in the annual report. However, QPIF made a decision at the time to include this information.

Senior QPIF officers expressed surprise when told that the total amount of special payments was included in the financial statements of the annual report for each agency and could be downloaded off an agency's website. It seems that few people are aware of this requirement, particularly as many QPIF officers and third parties

<sup>122</sup> This is the final report of the former DPIF. Following a machinery-of-government change implemented on 27 March 2009, the former DPIF was abolished and its core functions were transferred to DEEDI. The report was prepared in accordance with the FA&A Act.

who were interviewed in my investigation were unsure of the amount of the 2008 payment.

Nor was the AVA aware of this requirement or that the amount of the 2008 payments had been reported in the relevant annual report.

Senior QPIF officers noted to my officers that the description of the payment in the annual report did not state the recipient of the payment, or its purpose. However, regardless of whether a department is required by law to include a description of the recipient or purpose of a special payment in its financial reports, I consider that any description given should be accurate.

In my proposed view, the description of the 2008 payments as being for Hendra virus response and support costs' was inaccurate and misleading. The 2008 payments were paid to the clinic owner, through the AVA trust fund. The payments were not part of the Hendra virus biosecurity response which was funded through QPIF's core business funding.

In my proposed report, I formed the following opinion:

**Proposed opinion 52**

QPIF's description of the 2008 payments in its 2008 Final Report was inaccurate and misleading. This constituted administrative conduct that was unreasonable within the meaning of s.49(2)(b) of the Ombudsman Act.

**DEEDI's response**

The Director-General of DEEDI submitted that the statement in the 2008 Final Report was not factually incorrect or misleading. The funds were used for Hendra purposes.

He did, however, state that:

It is regrettable that the report fails to clarify that the funds were for animal welfare and biosecurity purposes. It is therefore acknowledged that the annual report would have been more accurate if it had reflected this. But there is no basis for concluding that this reference in the annual report misled or was likely to mislead anyone. DEEDI rejects any implication that any officer intended to mislead.

DEEDI submits that **proposed opinion 52 be amended** to make clear that no officer intended to mislead anyone.

**Ombudsman's analysis**

I did not investigate the circumstances surrounding how this statement came to be included in the Final Report, and therefore do not agree that there is any implication in my report that any QPIF officer intended to mislead anyone. I have not sought any evidence to establish whether this was the case. My proposed opinion 52 was formed about QPIF as a whole, rather than any individual officer.

Given my views discussed above that the description of the payments as for animal welfare and biosecurity purposes' lacked clarity, I do not agree with the Director-General's contention that the description in the Final Report would have been improved had it stated this explicitly.

In any event, I remain of the view that public statements made about the expenditure of public monies must be accurate. The fact that there may not have been any intention to mislead does not alter this view.

However, in light of the Director-General's concerns about the word 'misleading', I have amended my proposed opinion to refer to the description in the Final Report as lacking clarity. Once again, my proposed report used the term 'misleading' to describe the outcome of the description in the final report, rather than to refer to any intention by a QPIF officer. I have removed this term to reflect the intention of my opinion.

I confirm proposed opinion 52 with an amendment as a final opinion:

#### **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.

## **9.8 Whole-of-government position on ex gratia payments**

It became clear during my investigation that there is a need for a whole-of-government position on ex gratia payments.

It is useful to consider both the current Queensland scheme as well as the Commonwealth scheme for discretionary payments.

### **9.8.1 The Commonwealth scheme**

In 2006, the Commonwealth Department of Finance and Deregulation issued a finance circular providing information to Commonwealth Government agencies on discretionary compensation mechanisms (Finance Circular).

The Finance Circular described four mechanisms for discretionary payments that are available to Commonwealth Government agencies:

- payments under the *Scheme for Compensation for Detriment caused by Defective Administration* (the CDDA Scheme)
- payments made under s.33 of the *Financial Management and Accountability Act 1997* (FMA Act) (act of grace payments)
- waiver, postponement or deferral of debts under s.34 of the FMA Act
- ex gratia payments.

It is relevant to note that the Commonwealth scheme uses the term 'ex gratia' differently to Queensland. This will be discussed further below.

Payments made under the Commonwealth scheme are discretionary, and are approved on the basis that there is a moral, but not legal, obligation to the person receiving them.<sup>123</sup>

I will briefly discuss each mechanism in turn.

<sup>123</sup> Finance Circular, p.2.

### 9.8.2 The CDDA scheme

The CDDA scheme, which was established in 1995, operates under the executive powers of the Commonwealth and generally applies to the circumstances of specific individuals. The scheme operates where individuals or other bodies have suffered losses due to the maladministration of agencies, but where there is no legal liability to compensate the person.

Under the CDDA scheme, there are specific criteria and limitations that apply to payments. The scheme provides guidance on determining:

- whether the agency's actions constituted defective administration
- the evidence available in considering whether defective administration occurred
- whether the defective administration caused detriment to the claimant
- the types of loss which are recoverable under the scheme
- whether the claimant's own actions contributed to the loss suffered
- the appropriate level of compensation
- interest and taxation implications
- funding and reporting requirements.

There is a formal claim form that must be completed by people wishing to access the CDDA scheme. Decisions under the scheme can be made by individual Ministers and can be delegated to agency officers.

CDDA payments are not capped and can cover economic, non-economic and property losses.

### 9.8.3 The act of grace payments

Act of grace payments are one-off or periodic payments made under s.33 of the FMA Act and generally apply to the circumstances of specific individuals. Section 33 of the FMA Act states:

#### **33 Finance Minister may approve act of grace payments**

- (1) If the Finance Minister considers it appropriate to do so because of special circumstances, he or she may authorise the making of any of the following payments to a person (even though the payment or payments would not otherwise be authorised by law or required to meet a legal liability):
    - (a) one or more payments of an amount or amounts specified in the authorisation (or worked out in accordance with the authorisation);
    - (b) periodical payments of an amount specified in the authorisation (or worked out in accordance with the authorisation), during a period specified in the authorisation (or worked out in accordance with the authorisation).

...
  - (3) Conditions may be attached to payments under this section. If a condition is breached, the payment may be recovered by the Commonwealth as a debt in a court of competent jurisdiction.
- ...

Such payments are used where the involvement of a Commonwealth Government agency has had an unintended outcome for a claimant, or where the application of Commonwealth legislation has had an unintended, anomalous or inequitable effect on the complainant in their particular circumstances. This includes situations where the agency has acted correctly, but where the effects on the complainant nevertheless justify some compensation. Therefore, payments are made where there is a moral obligation on the part of the government, but not a legal obligation.

Act of grace payments can cover both economic and non-economic losses. Section 33 of the FMA Act makes it clear that conditions may be attached to act of grace payments, and the agency can recover the money from the recipient if any of these conditions are breached.

Act of grace payments are not applicable:

- where the proposed payment would supplement another payment that has been explicitly capped by Parliament
- in some cases, where there is legislation that sets conditions for particular benefits, and the proposed payments would be applied to all or most beneficiaries on an ongoing basis, or for a significant period of time
- where the proposed payments would create a scheme that would replace case-by-case consideration of the merits of specific claims.<sup>124</sup>

Act of grace payments are not linked to potential legal claims, as most CDDA claims are. Act of grace payments usually relate to an amount or benefit that the claimant would have been entitled to receive, if the laws or policies in question actually operated in such a way as to include the claimant's particular circumstances.<sup>125</sup>

Attachment B to the Finance Circular provides guidance on:

- the circumstances in which act of grace payments will be available
- determining the amount of act of grace payments
- interest and taxation implications
- funding and reporting matters.

Decisions on act of grace payments can only be made by the Commonwealth Department of Finance and Deregulation.

#### **9.8.4 The ex gratia payments**

Ex gratia payments are made under the Commonwealth's executive power pursuant to s.61 of the Constitution and allow the government to deliver financial relief at short notice.

Payments are authorised by the Prime Minister or Cabinet on a case-by-case basis. The ex gratia payment mechanism is flexible and does not have the pre-set criteria of other discretionary schemes.

Ex gratia payments are generally used to provide assistance to a group of people rather than to assist an individual, although they can sometimes be used to assist a specific individual. These payments are generally not available to top up maximum

<sup>124</sup> Finance Circular, p.5.

<sup>125</sup> Finance Circular, p.33.

levels of other legislative payments, or where a person does not meet the conditions of a payment scheme set out in legislation.

Ex gratia payments are generally only considered if payments are not available under any other available scheme.

Attachment D to the Finance Circular sets out the process for obtaining approval for and implementing ex gratia payments. The circular also expressly states that conditions such as eligibility conditions can be attached to payments.

### **9.8.5 The Queensland position**

In Queensland, there is no whole-of-government policy on ex gratia or special payments and little information on the subject. Although it is generally accepted by agencies that people should be compensated for losses caused by government action or maladministration, I have been unable to locate any express policy statement about this.

On the whole, 'ex gratia payments' within the Queensland framework appear to be made in similar circumstances to 'act of grace payments' within the Commonwealth scheme, although I note that act of grace payments have a specific statutory basis within the Commonwealth scheme that is lacking in Queensland law.

As there are no procedures surrounding the making of ex gratia payments that apply to Queensland Government agencies, the Queensland position is not comparable to the Commonwealth scheme.

### **9.8.6 Review of Queensland agency policies**

My investigation of the circumstances surrounding the ex gratia payments made during Hendra virus incidents indicated that:

- there was confusion both among QPIF officers and QPIF legal officers about whether conditions could be attached to ex gratia payments
- there was a concern that if the payment became public knowledge, it would set a precedent requiring further payments to be made
- it would be inappropriate to have any guidelines for ex gratia payments because such payments were seen as being 'outside' of normal departmental processes
- there was a concern that creating a specific, publicly available framework for discretionary payments would result in the 'floodgates' being opened, meaning that the government would be overwhelmed by claims for ex gratia payments.

In view of these concerns, I considered whether it would be desirable to have a specific framework within which Queensland Government agencies could consider and make discretionary payments.

I wrote to the Directors-General of 11 Queensland Government departments in January 2010 requesting copies of their policies and procedures on special payments and details of any ex gratia payments made for the previous three financial years.<sup>126</sup>

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<sup>126</sup> I chose not to contact the Queensland Police Service or Queensland Treasury.

Responses from each department generally showed that:

- none of the departments had policies or procedures in place that provided guidance on assessing requests for an ex gratia payment
- existing policies and procedures dealt mainly with financial reporting matters, and a substantial portion of the information in almost all policies related to how to categorise a special payment for accounting purposes
- ex gratia payments were typically made for one of the following reasons:
  - reimbursements for expenditures
  - compensation for officers' equipment damaged during official business
- the majority of departments appeared to be operating under the assumption that conditions cannot be attached to ex gratia payments, without any legal authority or explanation being provided for this position
- some departments considered that GST may attach to special payments, while others do not
- some departments' special payments registers or other records failed to record the required detail or provide adequate descriptions of the ex gratia payments made.

Only two departments provided any guidance to decision-makers on the circumstances in which ex gratia payments would be available and the appropriate amounts of payments.<sup>127</sup> I note in this regard that most senior QPIF officers who dealt with the requests for ex gratia payments in relation to the 2008 and 2009 Hendra virus incidents told my officers that such guidance would have been of assistance.

It is clear to me that most Queensland Government departments have inadequate detail in their policies to provide even basic guidance to decision-makers when considering special payments.

### 9.8.7 Discussion

From my review of the Queensland framework, there is a clear need for guidance to be provided to Queensland Government agencies on:

- the situations in which discretionary payments may be appropriate
- how requests for discretionary payments should be received and processed
- the appropriate amount of discretionary payments and how such amounts can be calculated
- how to determine whether conditions should be attached to discretionary payments and examples of appropriate conditions
- common standards of service or administration against which claims of maladministration can be measured by an agency.

I have used the broader term 'discretionary payments', as there is a wide range of discretionary payment mechanisms in the Commonwealth scheme which have no equivalent in Queensland. The Queensland interpretation of 'ex gratia payments' also appears to be quite limited when viewed beside the Commonwealth scheme.

In my proposed report, I therefore formed the following opinion:

<sup>127</sup> Two of these departments now fall within one larger department due to machinery-of-government changes.

### **Proposed 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.

I also proposed making the following recommendations:

#### **Proposed recommendation 41**

The Under Treasurer consider the feasibility of the Queensland government developing a discretionary payment framework that provides for a range of payments to be made in different circumstances.

#### **Proposed recommendation 42**

Until such time as a discretionary payments framework is in force in Queensland, the Under Treasurer should issue detailed guidance to all state government agencies on:

- (a) the situations in which discretionary payments may be 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**

The Under Treasurer review each department's special payments register to ensure that all financial reporting requirements are being met.

Although I did not propose to make adverse comment about any agency or individual, I nevertheless provided this section of my proposed report to the Under Treasurer of Queensland Treasury for comment before finalising my report.

### **Treasury's response**

The Under Treasurer acknowledged my recommendations, but advised that:

... in line with Parliament's decision to introduce principles-based financial management legislation, it is Treasury Department's view that agencies should develop a discretionary payments framework appropriate to their circumstances.

In relation to my proposed recommendation 41, the Under Treasurer advised that the FA Act adopted a new, principles-based approach. This approach is seen as a more responsive approach to financial management, and its purpose is to reinforce that, within a broad accountability framework, agencies have discretion to design systems and processes tailored to their individual business needs.

The Under Treasurer also recognised the wide range of circumstances within which a special payment could be made given the range of services and functions undertaken by the Queensland Government.

He stated that it would therefore be difficult to develop a framework which considered all possible circumstances, and this was why accountable officers within each agency were given the authority to approve special payments. Treasury expects that each

agency will consider when a special payment may be appropriate in their business and to develop a process for the administration of such payments. This process is documented in the agency's *Financial Management Practice Manual* (FMPM) so that each agency has an agency-specific special payments framework.

In relation to my proposed recommendation 42, the Under Treasurer advised that the range of circumstances under which special payments could be made makes it impractical for Treasury to provide detailed guidance to agencies. He also stated that such a prescriptive approach would erode the accountability and flexibility provided to agencies by Parliament with the introduction of the principles-based legislation. The Under Treasurer further advised that individual agencies should be addressing the points raised in my proposed recommendation 42 in their individual FMPM.

Finally, in relation to my proposed recommendation 43, the Under Treasurer advised that Treasury's role is to set financial management policy, and not to audit whether those policies are complied with. He stated that this fell within the mandate of the Auditor-General, who is able to access the records of an agency at any time and assess their compliance with the prescribed requirements. Further, the Under Treasurer noted that any agency is able to request such an audit at any time.

### **Ombudsman's analysis**

The Under Treasurer made no comment on my proposed opinion 53.

I confirm proposed opinion 53 as a final opinion:

#### **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.

In relation to the Under Treasurer's submissions on my proposed recommendations 41 and 42, I make the following comments.

I recognise that the FA Act commenced after the 2008 payment was made. I also acknowledge that the payment method adopted for the 2009 payment was an improvement in terms of description and accountability. However, there is nothing in QPIF documents that suggests that the improvements made for the 2009 payment were due to the provisions of the FA Act.

I also note that the Under Treasurer's response to my proposed recommendation 41 fails to consider or address the Commonwealth scheme and whether it is appropriate for the Queensland context. Given that the Commonwealth Government is able to create a framework for the payment of several types of discretionary payments that applies across a large number of departments with a broad range of portfolios, I am unsure why the Under Treasurer considers a similar scheme would be inappropriate in Queensland.

In the circumstances, I am not satisfied that the Under Treasurer has adequately considered the applicability of a scheme similar to the Commonwealth scheme in Queensland, nor the advantages that such a scheme might bring in terms of enhanced accountability. I am also concerned about the intention to leave the onus on agencies to create their own accountability processes, given that the evidence

collected during my investigation suggests that agencies are not doing this adequately.

Finally, I comment that a framework does not have to cover all possible scenarios in which a discretionary payment could be made. Instead, it can set out principles to guide agencies in exercising this power.

For these reasons, I intend to confirm this recommendation, with minor amendments, so that Treasury can properly consider all matters raised in my report.

The Under Treasurer submitted that it would be impossible to provide guidance to agencies as I proposed to recommend in my proposed recommendation 42 and that agencies should therefore be left to determine discretionary payments themselves through their internal policies.

My point in relation to proposed recommendation 42 is that individual agencies do not appear to be addressing the points I raised in their individual FMPMs or policies. My review of the relevant policies of each agency has reinforced this, and my proposed report stated my preliminary view that this was not occurring.

I do not consider it adequate for the Under Treasurer to simply state that this should be occurring when presented with information from my Office that it is not in fact occurring. Treasury would have an interest in ensuring that each agency's policies and FMPM are adequate.

Further, if the Commonwealth is able to issue guidance to a diverse range of agencies on the availability of discretionary payments through its CDDA Scheme, it seems reasonable, in my view, to conclude that a similar scheme could be implemented in Queensland. I am not satisfied with the Under Treasurer's response in this regard.

In relation to proposed recommendation 43, I accept the Under Treasurer's observations about the respective roles of Treasury and the Auditor-General. I acknowledge that the Auditor-General is able to audit agencies' financial records and determine whether financial management policies have been complied with. Accordingly I withdraw proposed recommendation 43.

I confirm proposed recommendation 41 with an amendment as a final recommendation:

**Recommendation 41**

The Under Treasurer:

- (a) consider the feasibility of the Queensland Government developing a discretionary payments framework that provides for a range of payments to be made in different circumstances
- (b) prepare a submission to government in this regard.

I confirm proposed recommendation 42 with an amendment as a final recommendation:

**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.

## Chapter 10: Previous reviews and reports into Hendra virus responses

This chapter discusses previous reviews conducted by QPIF into its Hendra virus responses.

Between January 2006 and December 2009, QPIF conducted a number of reviews, both internal and external, into its handling of Hendra virus responses.

During my investigation, I considered whether QPIF has adequately implemented the recommendations made in these reviews. This also involved considering whether the recommendations were implemented in a timely fashion.

### 10.1 The 2006 Perkins Report

After the 2006 Peachester incident, QPIF appointed Dr Nigel Perkins of AusVet Animal Health Services (AusVet) to review its response to the incident.

Dr Perkins' final report to the Director-General titled *Independent review of an Equine Case of Hendra Virus Infection at Peachester* was dated 14 September 2006 (2006 Perkins Report).

The report was tabled in Parliament on 12 October 2006 and made the following four recommendations to QPIF:

1. It is recommended that a number of modifications be made to the Hendra virus guidelines in an attempt to clarify issues that have been identified during this review and to ensure that the Hendra virus guidelines remain as the main source of managing cases where animals may have been exposed to Hendra virus.
2. It is recommended that consideration be given to initiation of field research where appropriate at sites where Hendra virus cases have occurred in an attempt to continue to improve our understanding of the epidemiology of the disease and consequently prevention and control. Such research should be carefully planned and conducted only if there is perceived to be genuine potential for leveraging additional information out of a disease outbreak and if attendant risks associated with the work can be effectively managed. Consideration could be given to planning in advance of field projects that could be implemented rapidly on confirmation of a positive Hendra diagnosis in order to ensure that samples may be collected while events and risk factors associated with horse exposure may still be present and able to be explored.
3. It is recommended that the DPI&F web site and search engine be reviewed with a view to ensuring that the Hendra virus guidelines can be located easily by either clicking through the web site and by searching for key terms such as Hendra virus or Hendra guidelines.
4. It is recommended that DPI&F staff work with representatives from peak industry bodies to develop a mechanism that allows peak industry bodies to provide (and update) contact details (including after hours contacts) for individuals to be notified in the event of a confirmed animal emergency disease event.

My officers sought information from QPIF officers about the steps that QPIF had taken to implement each of these recommendations. The Managing Director recalled doing a brief implementation review at the time of the 2007 Peachester incident and

considered that these recommendations had been implemented, but was unable to provide any documents recording this review.

In relation to recommendations 1, 3 and 4, I have not attempted to investigate the Managing Director's claims as to whether these recommendations were implemented at the time. I have commented further on QPIF's actions in updating the Guidelines for Veterinarians and other publicly available documents in chapter 7.

My comments in chapter 12 about the QPIF website and communication with stakeholders suggest that recommendations 3 and 4 of 2006 may not have been implemented at the time of the 2008 Perkins Report, but some time later. However, I am satisfied that QPIF has finally taken steps to implement these recommendations and I do not intend to discuss these issues further.

QPIF's Principal Epidemiologist told my officers that research needed to be carried out close to the time of an incident to be of scientific value and there was little value in studying the Peachester flying fox colony some months after the incident. This was advanced as a reason why this aspect of the recommendation was not carried out some time after the 2006 Peachester incident.

This was not the reason given by the Principal Epidemiologist for not conducting research at the site of the 2007 Peachester incident. He told my officers that research was not conducted there because QPIF did not wish to further upset the owner of the property.

However, I note that there is no record of recommendation 2 being considered by QPIF, or dismissed for the reasons advanced by the Principal Epidemiologist.

Furthermore, not until 2009 was there any evidence of plans being prepared in advance of field projects that could be implemented rapidly on confirmation of a positive Hendra diagnosis' as recommended by Dr Perkins.

Dr Perkins stated in the 2008 Perkins Report that he considered the purpose of this recommendation to have been implemented, on the basis of the large amount of research that had taken place elsewhere since his 2006 review.

However, when interviewed by my officers, Dr Perkins confirmed that QPIF had not, before December 2008, conducted any research of the type specified in his recommendation.

In an interview with my officers, Dr Perkins elaborated on this:

... really the background of this is that there are a number of unknowns about Hendra virus that are worthy of research, and therefore in the prioritisation and funding of research, these things ought to be considered, and I'm very happy that they were. Not all of the ideas that were raised in the 2006 Report have actually been researched, but I mean that's almost never the case, you know the researcher will have a wish list a mile long and the funding body has a finite amount of money.

I am aware that field research is now being conducted by QPIF, some of it in collaboration with other agencies. I also note that the research proposed in recommendation 2 of 2006 was conducted soon after the 2009 Cawarral incident was identified, and has since been conducted at other sites. I am satisfied that QPIF has now implemented this recommendation.

However, I am not satisfied that QPIF gave adequate consideration to recommendation 2 at the time that it was made. I am satisfied that before 2009 no plans were prepared in advance by QPIF of field projects that could be implemented rapidly on the confirmation of a positive Hendra diagnosis.

In my proposed report, I formed the following opinion:

**Proposed opinion 54**

QPIF failed to:

- (a) make adequate records of its consideration 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.

**DEEDI's response**

The Director-General of DEEDI first submitted that the narrative contained in my proposed report did not acknowledge that Dr Perkins exonerated QPIF from any deficient or negligent action in the 2006 response.

He then stated that the implication that these recommendations were not implemented by the time of the 2008 Report is not correct. He advised that, as an example, the Guidelines for Veterinarians were reviewed in February 2007 and made available on the QPIF website, and that these guidelines took into account Dr Perkins' recommendations.

Further, the Director-General challenged my assertion that QPIF did not give consideration to the proposed field research (recommendation 2). He strongly contested statements made to my officers by Dr Perkins, and advised that specific incident-related field research has been carried out since 1995 (Cannon Hill post-1994, the retrospectively identified Mackay incident 1995, Trinity Beach 1999, Gordonvale 2004, Redlands 2008, Cawarral 2009 and Tewantin 2010). He also advised that field research at the site of the 2008 Redlands incident included environmental sampling and extensive analysis of horse-to-horse contacts.

The Director-General advised that while research does not take place for every incident of Hendra virus, it is conducted in line with the Perkins recommendation only if there is perceived to be genuine potential for leveraging additional information out of a disease outbreak and if attendant risks associated with the work can be effectively managed. He further advised:

The specific field research conducted in 2009 (as referred to in the proposed Report) was related to the interaction-behaviour between bats and horses that may exacerbate infection risk. This research was pursued in response to Recommendation 16 of the 2008 Perkins report.

Specifically, a workshop with the University of Queensland was held in April 2009 to explore the issue of interaction-behaviour between bats and horses that may exacerbate the risk of spill over Hendra virus infection from bats to horses. A project to progress real time research associated with spillover events during future

incidents commenced out of this workshop – as reflected by the agencies actions during the 2009 response.

Any conclusions drawn about the research undertaken by DEEDI or the former DPIF also needs to be considered in the context of the total national Hendra virus research effort at the time, such as that sponsored by the Australian Biosecurity Cooperative Research Centre for Emerging Infectious Diseases (AB-CRC), of which QPIF/DEEDI was a key partner. From 2003 onwards, Hendra virus was a major focus of the AB-CRC, and QPIF/DEEDI was a key research provider.

The former DPIF pursued Recommendation 3 of the 2006 Perkins Report in a timely manner, with the agency website updated to ensure Hendra virus information and guidelines can be located easily.

Recommendation 4 of the 2006 Perkins Report was also implemented in a timely manner. Prior to the Report being finalised, the Minister convened a Dialogue for Action Forum with the Thoroughbred and Racing Industry in May 2006. This led to the establishment of the Horse Biosecurity and Market Access Liaison Group, with individual industry members of the group being able to be contacted in the case of a biosecurity incident.

The Director-General also submitted that there is a difference between review recommendations not being considered and implemented, and QPIF not having maintained appropriate documentation of this consideration and implementation. Therefore, he submitted that proposed opinion 54 be amended to read:

QPIF failed to make adequate records of its consideration and implementation of the 2006 recommendations by Dr Perkins.

Finally, in relation to all the Perkins reviews, overall the Director-General of DEEDI submitted that such reviews should be considered only in their context at a point in time', as knowledge about Hendra virus changes rapidly. For this reason, he submitted that recommendations made at a particular point in time and in a particular context had the potential to become out of date, or might require changes to ensure they are relevant. Recommendations might also be superseded by improved knowledge or events.

The Director-General also submitted that recommendations presented to government do not take into consideration competing priorities, and are made in the absence of full knowledge of government action outside the specific activity for which the review is being conducted. He advised that there were a range of reasons why recommendations may not be fully implemented, including impracticalities, inconsistency with agreed operational policy, or resource constraints.

### **Ombudsman's analysis**

It is good administrative practice that a review is conducted following the implementation of a report's recommendations and the outcome of the review recorded. QPIF has not provided any evidence that an adequate review of the implementation of the recommendations was carried out or that any records were made of the outcome of such a review.

The Director-General accepted that QPIF failed to make adequate records of its consideration of the 2006 recommendations by Dr Perkins, and that it also failed to make adequate records of its implementation of those recommendations. I have amended my proposed opinion to reflect QPIF's position.

The third part of my proposed opinion relates to the development and implementation of research plans to enable a rapid research response to a confirmed Hendra virus incident. Dr Perkins advised my officers that he believed that research plans should be pre-arranged so that once a Hendra virus incident occurred, a team of researchers could be mobilised immediately to sample the nearby bat colonies. He had learned that no immediate attempt at such research was made at Peachester in 2007 or at Redlands in 2008. However, Dr Perkins noted that it was probably difficult at Redlands to identify which bat colony was the relevant one.

Dr Perkins' evidence in regard to the 2007 and 2008 incidents is consistent with the information provided by QPIF in its response; that is, there was no bat colony research conducted at Peachester in 2007 or at Redlands in 2008. Dr Perkins was aware that a quick mobilisation of researchers had occurred at Cawarral in 2009 and again this is supported by QPIF's response which refers to a project to progress immediate research commencing from a 2009 workshop at the University of Queensland.

It may be that Dr Perkins' intention for immediate research flowing from his second recommendation to involve sampling of nearby bat colonies was not understood by QPIF.

In any event, QPIF's response does not provide any evidence that QPIF developed and implemented plans to enable a rapid response to a Hendra virus incident until 2009. The mere fact that environmental sampling or other research was conducted at Redlands in 2008 does not demonstrate that Dr Perkins' second recommendation was complied with.

I consider that QPIF's response does not provide sufficient new information to require a change to my opinion except as noted earlier.

I confirm proposed opinion 54 with an amendment as a final opinion:

**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.

## **10.2 The 2008 Perkins Report**

After the 2008 Redlands and Proserpine incidents, QPIF again appointed Dr Perkins to conduct an external review of its responses to the incidents.

Dr Perkins' final report to the Director-General dated 2 December 2008 was titled *Independent review of Hendra virus cases at Redlands and Proserpine in July and*

*August 2008* (2008 Perkins Report). The report made 20 recommendations to QPIF and other organisations.<sup>128</sup>

In response to Dr Perkins' recommendations, QPIF stated on its website in early 2009:

Queensland Primary Industries and Fisheries has committed to consider all 20 recommendations put forward in the Perkins report on the response to Hendra virus in Proserpine and Redlands. Queensland Primary Industries and Fisheries will report back to Government on the implementation of the recommendations by mid-2009.

My officers were informed that an initial internal QPIF meeting to discuss the implications of Dr Perkins' recommendations was held on 9 December 2008, with the first working group meeting held on 15 January 2009. An agenda document for the meetings suggests that review meetings would be held monthly. QPIF could only produce one progress report to me, dated February 2009.

In relation to QPIF's implementation of Dr Perkins' recommendations, a submission from the AVA to my Office stated:

AVA is keen to ensure that the recommendations are adopted in a timely manner so that lessons learned from previous incidents will be taken on board to improve future government responses to disease outbreaks.

We do note however, that to our knowledge there has been no formal audit of the implementation of the 2008 recommendations made publicly available – (commentary on the status of the 2006 recommendations are contained at page 87 of the 2008 Report). Our view is that industry would have greater confidence in the Queensland Government's commitment to improving its capacity to respond to Hendra incidents if the implementation of the Perkins' recommendations were audited and the results made available to stakeholders.

QPIF provided a copy of an undated summary table to my Office (Progress Report), which I understand was prepared in approximately June 2009. In summary, QPIF fully accepted 12 recommendations, while the remaining eight were accepted in principle. Speaking notes prepared for the Minister in relation to the report stated:

Significant actions in response to 17 of the recommendations have been finalised or are in progress. The remaining 3 recommendations regarding quarantine notices, communication with horse owners about euthanasia decisions and procedures are yet to be progressed but will be pursued. When prioritising recommendations, it was considered most critical to progress the implementation of recommendations regarding improvements to the Guidelines, communications and operational procedures.

However, an internal review conducted by QPIF on 17 August 2009 clearly states that a significant number of the recommendations had not yet been implemented, or implemented fully.

I have set out in the following sections my comments on some of these recommendations. I have not attempted to address each recommendation of the 2008 Perkins Report as some are not important for my investigation. Other issues have been discussed elsewhere in my report.

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<sup>128</sup> The 2008 Perkins Report is available on the QPIF website, <http://www.dpi.qld.gov.au/home.htm>.

My decision not to address particular recommendations here should not be taken as approval of QPIF's actions in implementing those recommendations, or acceptance that the recommendations have been implemented.

### **Recommendation 2 of 2008**

Recommendation 2 of 2008 stated (in part):

It is recommended that specifications be developed for post-mortem preparation of suspect or positive Hendra cases for transport and disposal, for safe transportation of a prepared carcass from the site of death or euthanasia to the site of disposal and for disposal of the carcass.

QPIF accepted this recommendation in full and advised in the Progress Report that an operational procedure was being developed to provide guidance for the handling and safe transport of Hendra carcasses. It was envisaged that this operational procedure would be added to the Guidelines for Veterinarians. QPIF also discussed with its Horse Biosecurity and Market Access Liaison Group (HBMALG) the use of horse body bags and this was approved by the group.

Dr Perkins told my officers that, to his knowledge, the recommendation was the subject of attention from QPIF officers at the time of the 2009 Cawarral incident, when the QPIF officer was attempting to implement the recommendation. Although Dr Perkins did not put a timeframe on the implementation of his recommendations, he told my officers that he would have expected them to have been completed before then.

Much of this information is now included in the most recent draft of the Guidelines for Veterinarians. However, I am satisfied that QPIF did not implement this recommendation in a timely manner, as it was not finished by the time the next Hendra virus incident occurred eight months after the recommendation was made.

### **Recommendation 3 of 2008**

Recommendation 3 of 2008 related to the preparation of QPIF policies and operating procedures. I have considered this issue in chapter 7.

### **Recommendation 4 of 2008**

Recommendation 4 of 2008 stated:

It is recommended that procedures be reviewed to ensure that quarantine notices served on properties for the purposes of Hendra virus provide sufficient detail to cover expected activities and movements, the conditions under which they may be permitted or not permitted to occur and the role of DPI&F staff in performing, supervising, checking and approving activities related to the management of quarantine on the site.

This recommendation arose during the 2008 Redlands incident, as a result of Redlands clinic staff removing equipment from the property. Although this action was taken after seeking permission from a QPIF officer and the equipment was decontaminated before removal, it was later determined by QPIF that the removal of the equipment constituted a breach of the terms of the quarantine and permission should not have been given.

I agree with Dr Perkins' view that sufficient information must be provided to property owners at the time the quarantine is imposed to enable them to understand their obligations during quarantine.

The Progress Report stated that QPIF accepted the recommendation in principle, and noted that to assist property owners a separate biosecurity plan would be provided in addition to the quarantine notices. Changes to the quarantine notification procedures would also be considered in preparing the proposed Biosecurity Bill.

During interviews with my officers, QPIF officers questioned whether quarantine notices issued under the Act could contain the recommended information and conditions.

I do not understand the basis for this concern. The quarantine notices clearly allow QPIF to impose conditions about matters relevant to quarantine. It seems to me that the provision of a biosecurity plan to property owners would also assist in clarifying the requirements of a quarantine notice. Whether this is done within the quarantine notice or as an attachment to the notice is not material.

The issue again arose in relation to the quarantine conditions during the 2009 Cawarral incident.

Despite Dr Perkins' recommendation, the property owner in the 2009 Cawarral incident was provided with the same quarantine notices without the further recommended information. The initial quarantine notice simply stated that no horses could be moved onto or off the property. There were no conditions concerning the expected activities and movements, the conditions under which they may be permitted or not permitted to occur and the role of DPI&F staff in performing, supervising, checking and approving activities related to the management of quarantine on the site'. Although decontamination information and written guidelines were provided to the property owner, I have not seen any evidence that the property owner was provided with information about the role of QPIF officers in supervising and approving activities on site.

During the Cawarral incident, the property workers moved some hay from the infected property (though not from the dirty zone) to a nearby property. On investigation, QPIF officers realised that the conditions of the quarantine notice only applied to the movement of horses, rather than feed or equipment. It was decided to issue a warning to the property owners rather than to take action for a breach of quarantine.

There was no basis for either issuing a warning notice or taking action for a breach of quarantine as the movement of hay did not breach any conditions of the quarantine notice in place at the time.

QPIF subsequently revoked the original quarantine notice and issued a new notice which specifically included restrictions on the movement of tack, feed and other material that may have or had been in contact with horses without approval of a QPIF inspector.

Given that a period of seven months passed between when QPIF received the 2008 Perkins Report and the beginning of the Cawarral incident, I consider that QPIF had had sufficient time to amend or reissue the template quarantine notice and/or prepare the proposed information.

## Recommendation 8 of 2008

Recommendation 8 of 2008 stated:

It is recommended that procedures relevant to liaison officers appointed by DPI&F be reviewed and more information provided on the roles of liaison officers as conduits of information flow to and from relevant stakeholders. This should include review of induction and training, and information and other material they should have either available to them or access to during the response. Consideration should be given to the early appointment of liaison officers with communication roles that are independent of response activities.

The Progress Report stated that this recommendation was accepted in principle, subject to feasibility in the timeframe. It further stated:

- Liaison officers will be appointed for all significant biosecurity response. Just-in-time training for liaison officers is under discussion at the national level. These discussions include input from the Animal Health Australia as the peak industry/government body with responsibility for facilitating industry liaison officer training.
- The Horse Biosecurity and Market Access Liaison group (an initiative between government and the horse industry) provides an active forum for the development of the liaison officer role and the issue is under ongoing discussion through this forum.
- Biosecurity Queensland will review its appointment, induction and training procedures for industry liaison officers as informed by these processes, and learning's from After Action Reviews.

In its submission to my officers, the AVA stated:

A liaison officer was appointed subsequent to the 2008 Review and has been an excellent conduit between QPIF and the horse industry.

However, when asked by my officers, the QPIF horse industry liaison officer was unable to provide a copy of any role description or describe any role-specific training which she had been provided with before beginning her current role.

I agree with Dr Perkins that role descriptions, inductions and role-specific training would assist liaison officers in carrying out their role. This was acknowledged by the current liaison officer.

However, as it seems that such role descriptions and training have not been provided to the current liaison officer, I am not satisfied that QPIF has fully implemented this recommendation.

## Summary

The Progress Report was prepared by QPIF at least six months after the 2008 Perkins Report was presented to QPIF. In my opinion, there was sufficient time for QPIF to have substantially implemented all of the recommendations in the report.

It is relevant in assessing the adequacy of QPIF's response that a cost estimate QPIF officers prepared shows that many of the recommendations have no or minimal costs associated with their implementation beyond staff time. QPIF advised that staff time was not costed as the implementation of Dr Perkins' recommendations was considered to be core business of QPIF.

In addition to the recommendations discussed above, other recommendations were only implemented in part by the time of the Progress Report.

Therefore, in my view, QPIF's failure to implement all of the recommendations of the 2008 Perkins Report within a reasonable time was unreasonable administrative action. In my proposed report, I formed the following opinion:

**Proposed 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.

I also considered it necessary to propose the following recommendation.

**Proposed 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 accepted
- (b) take steps to ensure that all recommendations that were accepted have been fully implemented.

**DEEDI's response**

The Director-General of DEEDI made the following submission in response:

The conclusion that there was a failure to consider and implement the recommendations of the 2008 Perkins Report is not accepted.

In July 2009, Cabinet noted Biosecurity Queensland's progress in implementing the recommendations of the Hendra Review to enhance future response to the Hendra virus. The Government's Cabinet documents website from this time includes a table outlining the progress made on each of the 2008 Perkins Report recommendations. This is evidence that each of the recommendations had been duly considered, and implementation pursued where appropriate or possible.

It is therefore suggested that there was no failure to consider and implement' the recommendations within a reasonable time and that proposed opinion 55 should be withdrawn.

Given the comments at the beginning of the response to this chapter, the implication that all recommendations made by Dr Perkins in 2008 should be accepted now (in 2011) is contested. It is suggested that proposed recommendation 44 should be amended to read:

*"That DEEDI evaluate any recommendations made by Dr Perkins in the 2008 Perkins Report which had not been accepted to determine whether they remain relevant"*

Finally, the proposed report does not adequately reflect the conclusions presented by Dr Perkins that the former DPI&F had "responded rapidly and effectively" and that "the efforts of all individuals in response activities are acknowledged with special mention of the risks encountered and effectively managed by those individuals who were involved in managing suspect and confirmed cases".

## **Ombudsman's analysis**

The Cabinet report, which was reviewed in my investigation, notes that the implementation of a number of recommendations is in progress or yet to be progressed. This report was delivered to Cabinet at least six months after Dr Perkins made his recommendations to QPIF.

Further, as I noted in my proposed report, a number of the recommendations made by Dr Perkins had not been implemented at the time of the Cabinet report, and also had not been implemented by a significantly later stage of my investigation. In particular, recommendation 3 related to the preparation of policies and procedures and I note the Director-General did not provide any specific response in relation to this recommendation to support his general assertion that all the recommendations were implemented. As I discuss in section 7.1.3, I do not accept that this recommendation was fully implemented soon after it was made, or at any time within the next two years as policies remained undeveloped or in draft form in late 2010.

Therefore, I do not agree with the Director-General's contention that there are any grounds for withdrawing this proposed opinion. Nothing in the Director-General's submission provides support for his assertion that QPIF acted quickly and reasonably in implementing the 2008 recommendations. Merely reporting to Cabinet on which recommendations had been accepted and fully or partially implemented is not the same as having completed implementation of all of the recommendations.

I also consider that the Director-General has confused the issue of the effectiveness of QPIF's response to the Hendra virus incident with the effectiveness of its response to Dr Perkins' recommendations. Obviously, Dr Perkins could not comment in his report on how QPIF had responded to his recommendations because these recommendations had not yet been made. Therefore, I fail to see the relevance of Dr Perkins' conclusions about QPIF's biosecurity response to the present discussion.

Finally, I note that the Director-General has asserted that QPIF should have the opportunity not to accept or implement Dr Perkins' 2008 recommendations. This seems at odds with his assertion that QPIF had not failed to consider or implement these recommendations. I also note that at the time of preparing the Cabinet report, QPIF had accepted, or accepted in principle, each of Dr Perkins' recommendations. Therefore, the basis on which the Director-General may now wish to not implement recommendations previously accepted, or accepted in principle, is unclear. Nevertheless, I have slightly amended my proposed recommendation 44 to reflect his comments.

I confirm proposed opinion 55 as a final opinion:

### **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.

I confirm proposed recommendation 44 with amendments as a final recommendation:

#### **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.

### **10.3 The 2009 Perkins Report**

In August 2009, Dr Perkins was again appointed to review the initial stages of QPIF's response to the Hendra virus incident at Cawarral.

Dr Perkins submitted his report titled *Progress audit of Biosecurity Queensland's response activities at Cawarral in August 2009* to the Managing Director of QPIF on 3 September 2009 (2009 Perkins Report). The 2009 Perkins Report made three recommendations:

1. It is recommended that consideration be given to reviewing the level of support for Emergency Management Unit (EMU) activities to ensure that BQ staff received adequate training and support to underpin response capacity.
2. It is recommended that Queensland Primary Industries and Fisheries (QPIF) work with QH and with other stakeholders including AVA/EVA and horse industry groups such as QHC to address broad concerns about WH&S and management of human health risk during activities associated with investigation of a suspect case of Hendra virus and during response activities once a Hendra case has been confirmed. It is acknowledged that many of these concerns involve management of issues related to human health that are not the responsibility of QPIF.
3. It is recommended that QPIF staff initiate a debrief with QH staff that covers issues arising from the Cawarral response including in particular communications between QPIF and QH, and joint activities involving staff from QPIF and QH during a Hendra investigation or response.

During my investigation, no formal response or progress report was provided to my officers by QPIF. Despite this, in response to my proposed report the Director-General asserted that a progress report had in fact been prepared in the form of two briefs to the Minister in September 2009 and May 2010. I am disappointed that the first document was not previously provided to my officers, despite clearly falling within the scope of my document requests to QPIF and being in existence at the time of my requests.

I also note that a media statement by the Minister on 6 October 2009 after the release of the 2009 Perkins Report stated:

The Minister said the report made just three recommendations, which Biosecurity Queensland had already considered and would address.

“One relates to increasing the capacity of the Emergency Management Unit within Biosecurity Queensland and there are already plans in place to do this,” he said.

“The second recommendation relates to workplace health and safety matters during a response, many of which are not the responsibility of Biosecurity Queensland.

“However, once the current responses to Hendra virus incidents are concluded, Biosecurity Queensland will convene a meeting of relevant government agencies, the Australian Veterinary Association and horse industry groups to discuss workplace health and safety matters.

“Although the report found staff from Biosecurity Queensland and Queensland Health communicated at the local and policy level, the third recommendation is that process be formalised.

“The two agencies had already agreed to meet to debrief once the current Hendra incidents have been resolved.”

QPIF has now provided my officers with advice that these three recommendations have been implemented.

In response to my proposed report, the Director-General requested that I form an opinion that the actions taken by QPIF in response to Dr Perkins’ 2009 recommendations were reasonable. I do not intend to do so. The reason for my decision is that I have not audited QPIF’s response to these recommendations, and was not informed until 28 March 2011 that the recommendations were in fact implemented. This was less than one month before my proposed report was completed.

Finally, in his response to my proposed report the Director-General criticised my failure to acknowledge that Dr Perkins had assessed the QPIF response as positive, rapid and effective. While I agree that these were Dr Perkins’ conclusions, my analysis is focused not on the conclusions of Dr Perkins’ report, but on QPIF’s implementation, or failure to implement, his recommendations. Dr Perkins’ comments are already a matter of public record.

## **10.4 Other matters relating to the reviews**

A number of other concerns were raised with my officers in relation to the Perkins reviews.

### **10.4.1 Criticism of reviews**

One complaint was made to my officers that during his 2008 review, Dr Perkins should have investigated how Dr Cunneen became infected with Hendra virus. This criticism is unwarranted, as the terms of reference were focused on QPIF’s response to Hendra virus and did not allow Dr Perkins to investigate how Dr Cunneen became infected with the virus.

Furthermore, the issue of human infection in the workplace was not one for QPIF, but for WHSQ. Consequently, the circumstances of the death were not relevant to Dr Perkins’ review of QPIF actions.

I have discussed the WHSQ investigation into this issue further in chapter 14.

#### 10.4.2 Choice of external reviewer

Although my investigation did not initially consider the issue of Dr Perkins' appointment as independent reviewer, this matter was raised with my officers by several people.

Several members of the public have suggested to my officers that Dr Perkins and his company AusVet are regularly engaged by the state government. In particular, they have suggested that AusVet and/or Dr Perkins was involved in preparing a number of policies and procedures for QPIF, and particularly the Hendra virus policies and guidelines. For this reason, they claimed that Dr Perkins was not sufficiently independent to conduct the reviews.

As this allegation is related to the integrity of the external reviews conducted for QPIF, I considered this limited issue during my investigation.

At my request, QPIF provided me with a list of all work that Dr Perkins and AusVet have conducted for QPIF. The list does not support the allegation that Dr Perkins or AusVet carry out regular consultancy work for QPIF or that Dr Perkins or AusVet prepared any QPIF policies or procedures in relation to Hendra virus.

I am therefore satisfied, on the basis of the information available to me, that these allegations of bias are not made out. Given Dr Perkins' qualifications and experience, he seemed an appropriate person to conduct the reviews.

However, during my investigation I was provided with information regarding Dr Perkins' research work with the Rural Industries Research and Development Committee and various ABCRC<sup>129</sup> research projects. I understand that these ongoing or proposed research projects could be directly affected by QPIF participation and/or funding.

I was also provided with a draft paper for discussion and comment by Dr Perkins and a co-author that was provided to QPIF in about November 2009 regarding the development of a vaccine for Hendra virus. It was suggested that this discussion paper evidenced Dr Perkins' regular dealings with QPIF about research.

In February and April 2009, Dr Perkins attended workshops and was working with QPIF officers, academics and others on a series of research proposals for Hendra virus. These proposals included Dr Perkins taking a role in reviewing research pre-proposals. These research workshops were held (at least partly) as a way of implementing a recommendation made by Dr Perkins in his 2008 Report.

Dr Perkins informed my officers that while he has participated in a range of discussions of research needs and priorities for Hendra virus, he has never been directly involved in research projects on Hendra virus or received any funds intended for research on Hendra virus. Dr Perkins also advised that these discussions have mostly been general discussions about research needs and possible funding sources, and have not involved actual decisions about funding particular projects. He advised that his involvement in such discussions was as a scientist with interests in biosecurity and horses.

Dr Perkins further confirmed that he has never been involved in any decision-making processes about the expenditure of government funds on research activities, and nor

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<sup>129</sup> The Australian Biosecurity Cooperative Research Centre.

has he acted as an investigator on any research projects on Hendra virus funded by the government or received any funding from the Queensland Government for research on Hendra virus.

The Managing Director told my officers that the person undertaking reviews of Hendra virus responses needed to have experience in equine matters as well as epidemiology. She stated that Dr Perkins may be the only person within the industry in Queensland who has those skills.

I have not reached the view that the concerns expressed to my officers about Dr Perkins' involvement in Hendra virus research and a potential conflict of interest are made out.

However, in any event, it is not good administrative practice for an agency to repeatedly appoint a particular consultant without a transparent tender or selection process. The repeated appointment of the same consultant over time without an open tender and selection process may result in the perception that the agency is favouring a particular consultant, or that the consultant is in an ongoing commercial relationship and therefore not able to act impartially. Such a perception may be heightened if the consultant is involved in other work or research for the agency, even if this is only providing expert advice or input into research proposals that will be carried out by others.

I confirm proposed recommendation 45 as a final recommendation:

**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.

## **10.5 After action reviews**

QPIF policy provides that an internal AAR be conducted following each response to a biosecurity incident to identify learnings for QPIF so that it can improve its response capacity.

### **10.5.1 The 2008 AAR**

QPIF's Emergency Management Unit (EMU) conducted two operational AARs following the Redlands and Proserpine incidents, one for each response. In addition, a strategic AAR and a laboratory AAR were conducted. Results from the AARs were rolled into one AAR report (2008 AAR Report).

The draft 2008 AAR Report was distributed for comment on 19 December 2008. Comments were requested by 8 January 2009 so that the report could be finalised by 16 January 2009. The draft report was distributed to a number of people, including QPIF officers, QH officers and AAHL staff.

The draft 2008 AAR Report identified areas where the response had been effective, and also identified areas for improvement and made recommendations in relation to response coordination, communication, training, information technology systems, operational management, resourcing and business continuity.

In interviews with relevant QPIF staff, my officers were told that the recommendations in the 2008 AAR Report had not been properly addressed. This allegedly resulted in similar deficiencies occurring in QPIF's response to the 2009 Cawarral incident.

### 10.5.2 The 2009 AAR

The EMU also conducted an AAR after the 2009 Cawarral incident and prepared a report (2009 AAR Report). The 2009 AAR Report made recommendations in areas such as policy gaps, information technology systems, waste disposal, response coordination, communication, training, resourcing and business continuity.

A number of the issues that were raised in the 2008 AAR Report also arose during the 2009 Cawarral incident response. This was despite a progress report on the implementation of the 2008 AAR Report recommendations, dated 30 June 2009, listing many of the recommendations as having been implemented.

In fact, many of the recommendations made in the 2009 AAR Report were identical to the recommendations made in the 2008 AAR Report. It is also telling that the 2009 AAR Report states:

There are substantial similarities to the issues raised in the 2008 AAR following the HeV responses at [the Redlands clinic] and Proserpine.

In addition, one QPIF officer told my officers:

QPIF officer            When you look at these implementation plans, when you look at these after-action reviews, there is a lot of work that needs to be done. And you know until probably the last couple of years, you could probably write the after-action review before the incident. Because it was the same thing every time. You know, this needs to be fixed, this needs to be fixed, and it just hasn't been and again it's resource driven.

...

QO Officer              Are we going to ... put the Redlands and the Cawarral AARs side by side and see the same things?

QPIF officer            ... I wholly suspect that there will be a fair bit of overlap. We haven't managed to progress a lot of stuff. Again, resources, resource constraints, IT resource constraints as well, huge IT resource constraints. And we need IT resources during these responses, and in preparation. We are making headway, but it's slow going.

On the basis that these similar deficiencies were identified in the 2009 Cawarral incident, some seven months after the 2008 AAR Report was distributed, I consider that QPIF failed to fully and adequately implement the 2008 AAR Report recommendations.

In my view, QPIF should have promptly addressed the identified shortcomings in the Redlands response to ensure that they did not recur in future responses.

Further, my officers were advised that the implementation plan for the 2009 AAR Report is currently before the Hendra Virus Taskforce for action, but that the

taskforce was uncertain whether the implementation of this plan fell within its terms of reference and was in any event unlikely to adopt it. One QPIF officer told my officers:

I don't believe that has been discussed with them. There's been terms of reference developed and one of the terms of reference is progressing the key outcomes of the Hendra virus After Action Review. Obviously that hasn't been finalised. I don't believe the people that are on that taskforce at the minute have even been consulted about implementing this plan because quite honestly what they're looking at is these policies that are in here. I know that we're getting some good progress on this but ... it's quite an extensive document this implementation plan, I don't know how many tasks and it's enormous and these people I don't think have been fronted with this is where we think we're going, so what I've done as of yesterday is to ensure that the chair ... convenes a meeting in early January with all the players including those that are named as being you know the animal bio program, strategic communication and media, they're all in there. They need to come to the table and get some ownership of this thing. They may just reject it out of hand. I don't know. But at the minute it's been lobbed into this taskforce. I don't believe the taskforce has been consulted about implementing this extensive plan, some of which is going to require a considerable resource.

And:

QPIF officer            It's just one minute we've got the commitment and then we don't and I don't believe the, to answer your question, I don't believe this Hendra taskforce is the group to take this forward.

QO Officer             Are you intending to do an implementation plan on the after action report from Cawarral?

QPIF officer            Not at this stage no. My obligation so far is to get this thing completed. The implementation plan was the result of some discussions ... because we know there's a number of actions that need to be ticked off and it's not just in relation to Hendra. The implementation plan for Hendra will also tick off on a number of other obligations we have in relation to preparedness. The development isolation and a quality document I think but I don't think it's being sold at this stage. The email has gone out from [name deleted] to the right people ... that are listed as having some involvement that's been, talking to him this morning about it, because I got to bring it up again yesterday, there's just been deafening silence. There's been no buy-in at all.

The Director of Animal Biosecurity [name deleted] was away at the time this thing was sent out and I only became aware of that at the end of last week so I've actually forwarded it to him and said you know this thing's on the table, but I don't believe there's anybody actually read the document apart from to look at it and say this thing's in detail and there's a lot of work required here and there's also funding issues. So yes top marks to [name deleted] for putting it together and it's a quality document. It's there, it's in draft, it's there for discussion but the discussion is not happening. I personally think that the document must be actioned but I'm not sure who should do it.

The Chair of the Hendra Virus Taskforce, a now-retired QPIF officer who had been given the responsibility of implementing some of the recommendations from the 2008 Perkins Report, told my officers that in his view, the 2009 AAR Report was flawed because it did not prioritise the issues it dealt with. He stated that his priority was to amend policies and standard operating procedures, rather than to implement other recommendations. This officer also noted that the Hendra Virus Taskforce was not

able to allocate additional resources, which would be required if some of the AAR recommendations were to be implemented.

On the information available to me, I am not satisfied that there is a clear process for considering and implementing the recommendations and findings in the 2009 AAR Report.

In my proposed report, I formed the following opinion and made the following recommendation:

#### **Proposed opinion 56**

QPIF failed to fully and adequately 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.

#### **Proposed recommendation 46**

QPIF:

- (a) establish a process for evaluating and implementing the recommendations raised in the 2009 AAR Report and any outstanding recommendations from the 2008 AAR Report
- (b) set in place a timeline for the implementation of these recommendations
- (c) ensure all recommendations are implemented within six months of the date of this report.

#### **DEEDI's response**

The Director-General of DEEDI made the following submission to my Office:

It is noted that the After Action Review is an internal review of an emergency outbreak situation driven by people directly involved in the response. The making of a recommendation does not necessarily mean that it can or should be implemented. Many of the recommendations made are resource intensive, beyond current budgetary allocations and do not adequately take into account broader priorities or operational considerations of the agency.

On the basis that it may not be appropriate or possible for AAR recommendations to be implemented, it is suggested that **proposed recommendation 46** be amended to read:

***“DEEDI:***

- a) establish a process for evaluating and implementing, where appropriate, the recommendations raised in the 2009 AAR Report and any outstanding recommendations from the 2008 AAR Report.***
- b) set in place a timeline for the implementation of these agreed recommendations***
- c) ensure all accepted recommendations are implemented within 6 months of the date of this report.”***

#### **Ombudsman's analysis**

The Director-General's concerns are with the wording of my proposed recommendation 46.

While I agree that an agency must consider whether recommendations made to it are able to be implemented, the Director-General's response does not address the fact that it appears no such consideration was given to the AAR recommendations at all. I confirm proposed opinion 56 with an amendment as a final opinion:

**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.

I confirm proposed recommendation 46 with amendments as a final recommendation:

**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.

## 10.6 Other reviews

My investigation identified two further alleged examples of QPIF's failure to implement recommendations from reviews.

One QPIF officer told my officers about a report which was completed for QPIF during the equine influenza outbreak that raised issues about information technology systems. He stated that these same issues had arisen during every biosecurity incident since at least 2007 but had not been rectified by QPIF. However, as this report related to equine influenza I did not specifically investigate this issue in my investigation.

A further example was provided in relation to a needle-stick injury that occurred during the 2008 Redlands incident.

While performing the autopsy on the sero-positive horse, Tamworth, a QPIF officer received a needle-stick injury (2008 needle-stick incident). The incident resulted in the precautionary hospitalisation of the officer involved and no doubt caused significant stress to the officer and to her colleagues. This has been the subject of a WHSQ notification and I do not intend to comment further on the actual incident.

The following discussion therefore relates to the steps that QPIF took to provide a safe system of work for the officers involved, and does not consider matters relating to individual QPIF officers.

QPIF's WH&S incident prevention review (WH&S Review) in relation to the 2008 needle-stick incident stated:

### **Have previous incidents of a similar nature occurred recently?**

Yes, during Equine Influenza (EI) outbreak, December 2007.

Recommendations from an email from [name deleted], EI Health and Safety Manager, 21/12/07 following similar incident:-

- All vets to receive training in the SOP and are provided with the sharps containers
- More robust and effective sharps containers with a durable needle removal facility to be purchased
- That the containers be tested prior to the final purchase and distribution
- Ensure all vets are made aware of handling requirements
- Induction and training to highlight the need to follow the SOP

I will refer to the similar incident in 2007 as the 2007 needle-stick incident.

The WH&S Review states that the 2008 needle-stick incident occurred because a sharps disposal unit that was available was an inappropriate size, and the 'needle plus vacutainer holder' would not fit into the container. In addition, the QPIF officer involved had received no specific training for the Hendra response and her level of skill was unknown. It was assumed by QPIF that she had adequate skills based on her formal qualifications.

The WH&S Review did not determine whether a site induction or formal risk assessment was performed before Tamworth's autopsy, but indicates the possibility that these were not conducted. My review of the documents relating to the response to the 2008 Redlands incident indicates that inductions and risk assessments were only conducted consistently from approximately one month after the review started.

It seems to me that the 2007 needle-stick incident resulted in recommendations being made that, if implemented, could likely have prevented the 2008 needle-stick incident. Even acknowledging that there were multiple causes for the 2008 needle-stick incident, which I have not set out here, a review of the recommendations from the 2007 needle-stick incident certainly suggests that QPIF did not take sufficient actions in response to the recommendations.

When asked what steps it took to implement the recommendations arising from the 2007 needle-stick incident, QPIF stated:

... Biosecurity Queensland has had difficulty identifying the extent to which these recommendations were implemented. There appears to have been problems relating to the transferral of these recommendations into processes, procedures and operational activities following the emergency response. Responsibilities and roles for a number of key positions changed dramatically following the wind up of the response which contributed to the recommendations not being properly embedded into normal operations or carried through to preparedness for future responses.

In subsequent responses after action reviews have been used to carry forward learnings from the response into SOPs for operations and future responses. This should prevent this problem occurring in the future.

The recommendations arising from the 2008 needle-stick incident were to:

- develop a system to ensure that all staff and contract workers are inducted and trained in safe work procedures and risk management
- review sharps bins provided and develop a procedure to ensure purchase and supply of appropriate sharps bins
- train staff in carrying out risk assessments before commencing tasks
- provide adequate training to supervisors
- train staff in safe procedures for disposing of needles and sharps.

In addition, an improvement notice was issued by WHSQ on 22 September 2008 in relation to the incident. This notice required QPIF to:

... implement and maintain a safe system of work with appropriate control measures in place to prevent or minimise the risk of injury or illness to workers and others from the risk of skin laceration or needle-stick when disposing of used blood collection needles.

The date for remedying the contravention was 19 December 2008.

When asked what steps were taken to implement the 2008 recommendations, QPIF stated:

Following incident 2 a comprehensive incident prevention review was completed by [name deleted] (Workplace Health & Safety Coordinator BQ) on the 20/8/2008.

This report was presented to Workplace Health & Safety Queensland. Workplace Health and Safety Queensland were satisfied that the recommendations contained within the report would provide remedial actions to prevent further incidents.

A number of policies and procedures were prepared following the incident (these documents have been attached for your information).

The procedures are available for use and implementation in the next emergency management response if required. The procedures are currently being implemented within Biosecurity Queensland operations.

There have been discussions with Biosecurity Queensland veterinarians concerning the risk of needlestick injuries and sharps containers are included in the equipment list for veterinarians.

Sharps containers are freely available from laboratory stores for veterinarians. In addition, sharps containers were readily available at stores established for both the Cawarral and Tewantin HeV responses.

All of the sharps containers that Biosecurity Queensland uses have a needle removal facility. However, the standard is that needles not be removed, but intact needles and holders both be put into the sharps containers. This reduces the risk.

In addition, our WH&S Officer, [name deleted], has been testing various forms of vacutainer needles that lessen the risk of needlestick injury by having a flip-over needle guard. These were trialed at Cawarral, but were found to make the sampling of horses more difficult and thus increase risk.

Further, it is considered that our increased experience in wearing PPE has overcome some of the early practical difficulties of managing needle risk with fogged-up goggles, unfamiliar circumstances and not being sure of how horses will react.

**Actions that will be taken by DEEDI.**

1. The Chief Biosecurity Officer will take responsibility for auditing the systems to ensure they are fully implemented and functioning correctly.
2. An additional full time resource will be allocated for three months to assist the implementation of the remedial action required to ensure that all policy procedures, risk assessment systems, training and supervisory systems are fully implemented and effective.
3. Particular attention will be given to defining roles and responsibilities individually and operationally to ensure systems are maintained in the future.
4. A timeframe of 3 months will be set for full implementation.
5. The Manager WHS DEEDI and the Chief Biosecurity Officer will review the progress of the implementation of the systems on a monthly basis.
6. Additional actions recommended or required by the Ombudsman.

There is no point conducting internal reviews if the findings and recommendations are not acted upon. A theme that replayed repeatedly during my investigation was that QPIF failed to address issues that had been raised with it or to implement review recommendations.

I acknowledge that, since the commencement of my investigation, QPIF is now taking action to implement the recommendations arising from the 2008 needle-stick incident. I note that the response to my officers from QPIF expressing its intention to take action for full implementation within the next three months was received in late 2010, over two years after the recommendations were made. As at the date of my proposed report, the recommendations still had not been implemented. In my view, this delay is unacceptable.

I confirm opinion 57 as a final opinion:

**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.

I confirm recommendation 47 as a final recommendation:

**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.

I also intend to ensure that all of the issues raised in my report are addressed promptly and do not recur in relation to either a Hendra virus incident or another biosecurity situation.

To that end, in my proposed report, I made the following recommendation:

**Proposed 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 the reasons for not implementing them, if relevant.

**DEEDI's response**

No response was received in relation to this proposed recommendation.

**Ombudsman's analysis**

To ensure that full benefit is obtained from internal (or external) reviews, the outcomes of those reviews must be considered and improvements made to agency processes where appropriate or practicable. My overall impression of QPIF's response to Hendra virus incidents is that recommendations were repeatedly and consistently not considered, and those accepted were not implemented within a reasonable time. I consider this to be a serious flaw in QPIF's processes that warrants immediate attention from the Director-General.

I confirm recommendation 48 as a final recommendation:

**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.

## Chapter 11: Record-keeping and information management systems

This chapter discusses QPIF's record-keeping and the adequacy of its information management systems.

### 11.1 Record-keeping

The Public Records Act requires Queensland Government agencies to make and keep full and accurate records of all business activity. Section 7 of the Public Records Act provides:

- (1) A public authority must—
  - (a) make and keep full and accurate records of its activities; and
  - (b) have regard to any relevant policy, standards and guidelines made by the archivist about the making and keeping of public records.

This duty is reinforced by s.98(1)(h) of the *Public Service Act 2008*, which makes chief executives responsible for:

- (h) ensuring maintenance of proper standards in the creation, keeping and management of public records.

Public records include:

- emails sent or received in the course of business
- documents of decisions that were made or advice given
- documents setting out the process of arriving at a decision
- other documents required to be kept by legislation.

In addition, Principle 7 of *Information Standard 40: Recordkeeping*,<sup>130</sup> published by the Queensland State Archivist provides:

**Principle 7 - Full and accurate records must be made and kept for as long as they are required for business, legislative, accountability and cultural purposes.**

To meet this principle records must be:

- adequate;
- complete;
- meaningful;

Adequate record-keeping systems are essential to properly manage public records and make those records easily accessible.<sup>131</sup>

The *Best Practice Guide to Recordkeeping*,<sup>132</sup> endorsed by the Queensland State Archivist, further explains the concept of full and accurate records and more specifically adequate, complete and meaningful records this way:

<sup>130</sup> Queensland State Archivist (Queensland Government, Chief Information Office, Department of Public Works) *Information Standard 40: Recordkeeping* [accessed at <http://www.qgcio.qld.gov.au/qgcio/architectureandstandards/informationstandards/current/Pages/Recordkeeping.aspx> on 19 March 2009].

<sup>131</sup> Queensland State Archives Brochure 'An Introduction to Recordkeeping', p.2.

Records must be adequate for the purposes for which they are created and kept. To be complete, records should contain not only the content, but also the structural and contextual information necessary to document a transaction.

The record context represents all processes in which records participated. It should be possible to understand a record in the context of the processes that produced it and its relationship with other records. A record must be adequate to the extent necessary to:

- Facilitate action by employees (including agents and contractors) and their successors at any level
- Allow for the proper scrutiny of the conduct of business by anyone authorised to undertake such scrutiny
- Protect the financial, legal and other rights of the organisation, its clients and any other people affected by its actions and decisions.

In the context of biosecurity incidents, this means the records of those decisions must be detailed enough for supervisors and review bodies to be able to properly consider those decisions.

During my investigation, I identified a number of inadequacies in QPIF's record-keeping. These included:

- senior QPIF officers failing to keep adequate file notes of important discussions, including:
  - discussions about decisions to, or not to, exercise regulatory powers under the Stock Act or EDIA Act
  - discussions with people who received ex gratia payments from QPIF
- a failure to keep records of decisions made by QPIF officers, such as the decision to exercise regulatory powers under the Stock Act or the EDIA Act, or the name of the QPIF officer who made the decision and the date of the decision
- documents such as policies or contact lists being stored on individual officers' hard drives and therefore unavailable to other officers
- the lack of a system of version control for policies and procedures
- the publication of undated fact sheets with no way of determining whether a printed copy was current or had been superseded.<sup>133</sup>

A particular inadequacy identified was the inconsistent use of role-based emails.

My officers' own experience in seeking documents and information from QPIF is that there is no overarching system for storing QPIF records. For example, few emails are stored in a format accessible by other QPIF officers, with most emails only stored on officers' email accounts.

Although role-based emails were used for most of the 2009 Cawarral incident response, they were not used early on in the response or in many earlier responses. When the 2008 Redlands incident response was concluded, a QPIF officer requested that all QPIF officers involved in the response transfer all relevant documents and emails to a common-use folder. Such steps would have, at the least, ensured that the knowledge from the response was captured and available to QPIF officers in future

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<sup>132</sup> Queensland State Archivist (Queensland Government, Chief Information Office, Department of Public Works) (November 2006 – V1.04.00) *Best Practice Guide to Recordkeeping* [accessed at <http://www.archives.qld.gov.au/downloads/IS40BestPracticeGuidetoRKv1.03.00.pdf> on 19 March 2009].

<sup>133</sup> For example, in my investigation I was provided with three versions of the four-page document 'What is Hendra virus?' Only one was dated (October 2009), and all had different version numbers and different content.

years. However, not all officers involved in the response completed this task. This also meant that the emails of some key individuals, including senior QPIF officers with oversight roles, were not provided to my officers.

While a large proportion of emails would have been captured by a role-based email system during incident responses, QPIF may need to improve this system to ensure that it captures the emails of senior officers with oversight roles as well as relevant emails of all other officers.

QPIF's response to my investigation demonstrated the following inadequacies in QPIF's record-keeping practices. It is apparent that:

- there is no central repository of records of QPIF's responses to Hendra virus incidents, and documents are often retained on personal or shared drives<sup>134</sup>
- there is no standard QPIF filing system for records of biosecurity incidents
- some emails relating to biosecurity incidents were still kept on individual email accounts even after QPIF directed in 2008 that emails be copied into a shared folder at the end of an incident.

In my view, QPIF's practices do not comply with its obligations under the Public Records Act.

While the Director-General of DEEDI did not specifically respond to this opinion or recommendations in proposed form, he did state generally that:

While improvements are ongoing, DEEDI is working to ensure that IT, finance, record keeping, information management and HR systems are effective during a response. Role-based email accounts and the implementation of a corporate record keeping system has been a significant advancement in recent years.

I confirm opinion 58 as a final opinion:

#### **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.

I confirm recommendations 49 and 50 as final recommendation:

#### **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.

<sup>134</sup> Guidance provided to agencies by the Queensland State Archives states that email systems and personal or shared drives are not record-keeping systems. See Queensland State Archives brochure 'An Introduction to Recordkeeping', p.3.

### **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.

## **11.2 Information management systems**

Issues were also raised with my officers by QPIF officers and others about the lack of information management systems for use during incident responses.

My officers were told that the lack of a shared database to record response activities is causing difficulties for QPIF officers on the ground. I understand that in previous Hendra virus incidents, individual QPIF officers generally prepared their own spreadsheets for use during responses. One QPIF officer told my officers that there is no consistent system and information is captured (or not captured) by individual officers. The officer also stated that errors were made in spreadsheets due to QPIF officers working off different versions and cutting and pasting information to other versions of the spreadsheet.

This situation is not ideal, as it means that a document cannot be properly updated or that people may work from different versions of the document and therefore miss information. It also means that time is wasted in the early stages of an incident response developing and refining spreadsheets.

A senior QPIF officer involved in the 2008 Redlands incident stated that in each Hendra virus incident, a new database was developed. However, the officer expressed frustration that information was not in a single place and that it was difficult to access information and have confidence in its accuracy. This issue also arose in the 2009 Cawarral incident, where QPIF officers expressed frustration with not being able to access a single, up-to-date list of all the horses which were being tested, various identifying information and ownership details, the results of previous tests and when further tests were due. This information was necessary both for planning purposes and to liaise effectively with property owners.

My officers asked QPIF officers whether there were any database products available that would suit QPIF's purposes. One senior QPIF officer stated:

QPIF officer            And every time you come along and why can't we use the one we used for fire ants or why can't we use ones we used for Asian Honeybees but the thing is you start all over again and, and it comes up in every debrief you know the database, information control and the answer is we've got BIOSIRT<sup>135</sup> coming, which is getting closer but I'll believe it when it happens.

QO Officer              Do you know when BIOSIRT is due?

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<sup>135</sup> An information management system specifically designed for biosecurity responses.

- QPIF officer No. I've given up. Look I've heard any day now sort of thing like you know 2010 at the latest but yes, I've heard that with other things before ... I remember with the laboratory information management system that was, I was told in 2001 that they're coming out next week to test it and it's going to be finished in two weeks or something and nine years later it's still not done ... the Department doesn't seem to manage IT, they manage IT well in emails and systems internal systems but ...
- QO Officer But you're looking for a scientific database system?
- QPIF officer Yes, I don't know, just information gathering things, but yes it'll come up on every debrief you'll come [sic] will be the database.

My officers were told by several QPIF officers that the issue of inadequate information management systems has been raised internally within QPIF since at least the 2008 Redlands incident. QPIF officers also told me that the issue has repeatedly been raised in relation to other biosecurity responses.

Although several QPIF officers told my officers about the plans for QPIF to purchase a new system, BIOSIRT, the officers also reported that the new system was expected several years ago and had not yet arrived.

An adequate information management system is necessary to ensure that QPIF can respond in an organised and efficient manner to biosecurity incidents.

Although the Director-General of DEEDI did not respond to this section of my proposed report, elsewhere in his response he advised that DEEDI is putting in place a (computer-based) Biosecurity Surveillance, Incident, Response and Tracing (BIOSIRT) system to help manage emergency responses. No timeframe was provided for the implementation of this system.

I confirm opinion 59 as a final opinion:

**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.

I confirm recommendation 51 as a final recommendation:

**Recommendation 51**

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

## Chapter 12: Communication

This chapter concerns the way in which agencies communicated with each other and with stakeholders during and between Hendra virus incidents. I received a number of submissions about this issue. This chapter also considers the effectiveness of liaison arrangements between agencies involved in Hendra virus responses.

### 12.1 Communication by QPIF

#### 12.1.1 Communication with industry groups

The issue of QPIF's communication with industry stakeholders was discussed in both the 2006 and 2008 Perkins Reports. Dr Perkins made a number of recommendations to improve stakeholder communication, including that QPIF update its contact numbers for industry groups and engage with industry stakeholders about Hendra virus.

QPIF's approach to industry stakeholders has changed significantly since the 2006 Peachester incident. Since then, QPIF:

- has attempted to develop closer ties with horse industry groups, including through the secondment of a QPIF officer to the role of CEO of the QHC for a time
- has formed the HBMALG which meets several times a year to discuss issues relevant to the horse industry, including Hendra virus
- is assisting the racing and recreational horse industry groups to formulate biosecurity plans to enable them to minimise the risk of Hendra virus incidents<sup>136</sup>
- has begun using industry groups as a way of disseminating information to horse owners.<sup>137</sup>

In order to test the effectiveness of current communication with industry groups, my officers looked at how communication occurred during the four Hendra virus incidents in 2008 and 2009.

During the 2008 Redlands incident, QPIF held a Hendra virus briefing for industry groups one day after the virus was detected. Fact sheets on Hendra virus were also provided to industry stakeholders and information was sent to them during the incident for dissemination to members.

In the 2009 Cawarral and Bowen incidents, the Acting CVO issued updates on the incident responses. In total, QPIF provided a greater number of updates and provided these updates more often than in the 2008 Redlands incident.

However, two criticisms of QPIF's response in the 2009 Cawarral incident were raised with my officers.

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<sup>136</sup> I was informed by QPIF that it is adopting an approach of partnership and shared responsibility in relation to Hendra virus.

<sup>137</sup> The disparate nature of the horse industry has been identified by QPIF officers as a hindrance to effective communication with all members of the industry.

The first concerned QPIF's practice of posting new information and alerts only on its website, and not forwarding each alert to interested organisations so that they could inform their members.

Second, there was an absence of a single, streamlined means of communication. Several people, including QPIF officers, reported that there are several email lists used by QPIF for contacting stakeholders. Consequently, on occasions emails were not sent to all stakeholders.

In my view, having a streamlined means of communication that does not rely on a number of QPIF officers would be advantageous. In my proposed report, I therefore formed the following opinion and made the following recommendation.

#### **Proposed opinion 60**

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

#### **Proposed recommendation 52**

QPIF consider the adequacy of QPIF's current communication practices with industry groups.

#### **DEEDI's response**

In relation to communication during Hendra virus incidents generally, the Director-General made the following submission:

Biosecurity Queensland has a multilayered approach to communication and community engagement with a disparate group of stakeholders involved in Hendra virus. The approach includes using a range of tools to deliver targeted messaging to groups on issues of importance and relevance to them.

The availability and distribution of timely, accurate and consistent information is a key component for the success of a communications and community engagement plan both during a Hendra virus incident and in the promotion of prevention and preparedness messages outside of an incident.

Hendra virus incidents tend to trigger a large amount of media interest. There is often considerable apprehension among the horse industry and wider community surrounding such occurrences due to this disease having a high mortality rate in both horses and humans.

Since 2008, Biosecurity Queensland has placed strong emphasis on communication and community engagement activities as key elements of a response to Hendra virus. This is evident in the appointment of a dedicated horse industry liaison officer, a structured approach to all communication with stakeholders during an event and a strong prevention and preparedness focus outside of incidents. Biosecurity Queensland has developed a robust toolbox of Hendra virus communications and engagement resources. The tools and any associated documents are reviewed after each new Hendra virus case or when new information becomes available.

In relation to my proposed opinion 60, the Director-General submitted that:

Biosecurity Queensland has developed a structured approach to communicating with industry groups during a Hendra virus incident. This includes the following elements:

- Alert notification to key horse industry members, including Australian Veterinary Association (**AVA**) and Equine Veterinarians Australia (**EVA**) by SMS.
- Follow-up personal phone calls to key industry members to support initial alert.
- Electronically distributed Industry communiqué (from CVO, represents targeted industry messages relevant to the event)
- Electronically distributed CVO communiqué (represents targeted veterinary messages relevant to the event)
- Circulation of all media releases to key industry stakeholders
- Contact with local industry organisations in the location of the incident to provide information and support.
- Work with industry groups to plan information sessions which may include support from the industry liaison officer and DEEDI mobile offices.

The contact lists (both electronic and SMS) for industry groups are maintained centrally and are available on a shared folder which is accessible by approved administrative and policy staff. These lists are regularly updated to reflect changes in members and key contacts.

In addition to alerting key industry stakeholders if emergency situations pertaining to the horse industry arise, the contact details are utilised for regular information sharing regarding horse industry biosecurity issues.

In response to the comment regarding only posting new information and alerts on the department's website, since 2008, updates and all communiqués have been sent electronically to the previously identified communiqué lists (veterinarian and industry). Separate communiqués have been developed for both groups that reflect different information requirements. This change was made subsequent to feedback received by the department at the time.

Biosecurity Queensland worked with industry during the equine influenza outbreak (2007-2008) to develop and fund a portal to serve as a central site for information sharing and promote effective communication in the horse industry. This portal site is hosted by Queensland Horse Council (under agreement) and utilised to provide an effective communication methods for horse owners in Queensland and other ancillary industry members such as farriers, horse transporters, chiropractors, and horse dentists.

A new development in the portal is the Horse Owners Signal System (**HOSS**), a joint initiative with the Queensland Horse Council that promptly adopts and promulgates all communications from Biosecurity Queensland on new information and alerts regarding horse industry biosecurity issues. HOSS was used during the [sic] 2009 and 2010 with great efficiency.

In a further refinement, Biosecurity Queensland has developed a Hendra virus response Communication and Community engagement action strategy which describes the communications and community and industry engagement actions to be taken during a Hendra virus response. The strategy acknowledges the importance of established, consistent and agreed processes for communication with industry groups during a Hendra virus response. The strategy and supporting plans are reviewed after each Hendra virus response as part of a continuous improvement strategy.

It is submitted that **proposed opinion 60 be amended** to reflect recent progress in communication strategies with industry.

### **Ombudsman's analysis**

I am satisfied from QPIF's response that the current communication methods no longer rely on individual email lists of QPIF officers and I have adjusted my proposed opinion 60 accordingly.

QPIF's additional information about the progress it has made in improving its communication practices with industry groups is noted. My recommendation for QPIF to consider the adequacy of its current arrangements has therefore been amended to require QPIF to regularly review the adequacy of its communication methods.

I confirm proposed opinion 60 with amendments as a final opinion:

#### **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.

I confirm proposed recommendation 52 with an amendment as a final recommendation:

#### **Recommendation 52**

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

### **12.1.2 Communication with private veterinarians**

#### **Communication with veterinarians during incidents**

During my investigation, a number of complaints were received about QPIF's communication with private veterinarians during Hendra virus incidents in 2008 and 2009. Other concerns were raised in respect of the dissemination of information about Hendra virus generally.

The first concerned the sufficiency of information provided to private veterinarians during incidents. However, during the 2009 Cawarral incident, there was an improvement in the dissemination of information to veterinarians with the Acting CVO issuing regular communiqués to veterinarians via the AVA. With the exception of my comments below about communication solely with private veterinarians through the AVA, I do not consider it necessary to make any further comment about this issue.

Second, during the 2008 Redlands incident, the initial update was not sent to all private veterinarians using the VSB mailing list until 5 August 2008, nearly one month after the virus was detected. Until then, information had only been distributed to private veterinarians who were members of the AVA; and the CVO updates were not added to the QPIF website until three weeks into the incident.

The provision of information concerning Hendra virus during incidents, and generally, by means of the AVA was a common criticism, given that only approximately 40% of private veterinarians are members of that body. The same criticism was levelled at the dissemination of information about the updated Guidelines for Veterinarians distributed in April 2009, which was notified to private veterinarians through the AVA.

I note that Dr Perkins commented in the 2008 Perkins Report on some of these inadequacies in QPIF's communication processes. He specifically recommended that:

It is recommended that DPI&F work with the Australian Veterinary Association (AVA) to review and agree on procedures for timely reporting during a response of clinical signs, progression of disease and results of additional procedures such as post-mortem examinations.

... It is recommended that DPI&F and appropriate peak bodies consider options for improving the coverage rate to veterinarians and allowing sign-up for emergency animal disease information at any time. The VSB-QLD option only allows veterinarians to sign-on for communications on an annual basis. There may be an alternative option that allows veterinarians to sign-on at any time or to provide updates of changes in contact information. This could be achieved by adding functionality to a web site to allow individuals to sign-up for information.

In my view, it is not sufficient for QPIF to only communicate with private veterinarians through the AVA, since the AVA represents only approximately 40% of all veterinarians.

It was also suggested by some private veterinarians and members of the public that QPIF needed to advise all private veterinarians about a Hendra virus incident.

QPIF officers said that direct advice to private veterinarians was unnecessary as they would find out through the media. In addition, they considered that not all private veterinarians needed to know about a Hendra virus incident, since the chances of it spreading are remote, and many veterinarians do not treat horses.

Against this stance, I note:

- information obtained through the media may not be sufficiently detailed or accurate
- two major incidents have involved horses travelling from an infected area to other parts of the state, and to other states
- veterinarians who infrequently treat horses are the least likely to have up-to-date knowledge of equine diseases and proper PPE.

One private veterinarian told my officers that QPIF's ability to communicate with veterinarians has improved, and was acceptable during the 2009 Cawarral and Bowen incidents. However, most private veterinarians interviewed during my investigation commented that further improvements are needed.

QPIF's position is that veterinarians have an obligation to keep themselves up to date with the latest information on Hendra virus and should do so through the QPIF website and relevant email lists.

While it is reasonable to expect private veterinarians to take advantage of communication options provided by QPIF, in my view, it is first a matter for QPIF to establish and properly advise all veterinarians of these avenues.

Once QPIF has done so, the onus is then on private veterinarians to take reasonable steps to ensure they acquaint themselves with the information.

Dr Perkins agrees that once QPIF has provided adequate avenues for private veterinarians to receive information about biosecurity threats, it is the responsibility of veterinarians to use those avenues.

The AVA made the following submission to my investigation:

As part of the 2008 Perkins' review, AVA provided certain suggestions aimed at improvements to assist veterinarians respond to disease outbreaks more effectively. The most important recommendation identified by AVA was that QPIF provide certain information to the profession during future Hendra outbreaks to enable veterinarians to respond effectively to the threats and challenges posed by this virus.

It is our view that an informed veterinary profession which is presented with, and has access to, timely, up-to-date, accurate and relevant information is a key factor in successfully managing disease outbreaks.

In my view, all private veterinarians in Queensland should be advised promptly of all relevant information about a Hendra virus incident. Similarly, they all have an entitlement to receive up-to-date information about Hendra virus, as it becomes available.

Additionally, QPIF does not currently provide information about a Hendra virus incident or general information about Hendra virus to other people who may be exposed to the virus, such as farriers, veterinary nurses, horse contractors, horse transporters and horse exporters.

Having regard to the above concerns, in my proposed report, I formed the following opinion and made the following recommendation:

**Proposed opinion 61**

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

**Proposed recommendation 53**

QPIF review its current communication strategies with a view to developing and implementing a comprehensive, effective and reliable information network for private veterinarians and other people who have a higher risk of being exposed to Hendra virus.

**DEEDI's response**

The Director-General of DEEDI made the following submissions in response to my proposed report:

Biosecurity Queensland has developed a structured approach to communicating with private veterinarians during a Hendra virus incident. This includes the following elements:

- Alert notification to key horse industry members, including AVA and EVA by SMS.
- Follow-up personal phone calls to AVA and EVA senior officers to support the initial alert at both national and Queensland level.
- Electronically distributed CVO communiqué (represents targeted veterinary messages relevant to the event)
- Circulation of all media releases to AVA and EVA.

Following the 2008 response, and the associated Perkins Report, Biosecurity Queensland established procedures with the AVA and the Veterinary Surgeons Board (**VSB**) to ensure information about disease incidents, including Hendra virus, can be rapidly distributed. Due to privacy issues, contacting VSB registered veterinarians has been dependent on veterinarians volunteering their contact details for electronic notifications. Uptake of this service was initially limited, however, recent discussion with the VSB have demonstrated that this has improved significantly with 2010 out of 2800 registered veterinarian emails on record.

A Standard Operating Procedure (SOP – Chief Veterinary Officer Mailing List) has been developed to describe the actions and practices to be taken by Biosecurity Queensland staff when sending communiqués to private veterinarians on behalf of the CVO. This SOP also covers industry communications. The SOP includes details of how email contacts are to be shared between VSB and Biosecurity Queensland, where lists are to be stored on the server, and the process and record keeping requirements to support distribution. The SOP has recently been updated to include actions to be taken in the event of 'bounce back' received from old email addresses identified during the communication process. This is a regular occurrence with electronic communication processes.

Biosecurity Queensland is working with VSB to further refine and streamline the data sharing arrangements between the two parties.

The proposed report refers to DEEDI having an obligation to provide all veterinarians with information about Hendra virus as it becomes available. Biosecurity Queensland, through its communication and community engagement strategy, policies and procedures disseminates up-to-date and relevant information regarding Hendra virus to the veterinary profession. The report should recognise, however, that there is also a degree of professional responsibility that should be adopted by veterinary professionals in regards to ensure their clinical knowledge is continuously updated. This includes ensuring that their knowledge and awareness of diseases relevant to their profession, including Hendra virus, is current.

As outlined previously, Biosecurity Queensland uses a range of ways to communicate with veterinarians. Despite all best efforts and a range of communication tools applied, Biosecurity Queensland cannot guarantee that all veterinarians are contacted within an appropriate timeframe for a range of reasons, including out-of-date email addresses and contact numbers supplied to the Board.

As indicated above, Biosecurity Queensland has also worked with the industry to ensure ancillary professions are provided with relevant and up to date information.

It is submitted that proposed opinion 61 and the premise of proposed recommendation 53 are based on out-of-date information and can no longer be substantiated. It is not accurate to assert that current communication practices are inadequate. On this basis it is submitted that **proposed opinion 61 and proposed recommendation 53 be withdrawn.**

Elsewhere in his response, but relevant to this issue, the Director-General also submitted:

Biosecurity Queensland worked with industry during the equine influenza outbreak (2007-2008) to develop and fund a portal to serve as a central site for information sharing and promote effective communication in the horse industry. This portal site is hosted by Queensland Horse Council (under agreement) and utilised to provide an effective communication methods for horse owners in Queensland and other ancillary industry members such as farriers, horse transporters, chiropractors, and horse dentists.

A new development in the portal is the Horse Owners Signal System (**HOSS**), a joint initiative with the Queensland Horse Council that promptly adopts and promulgates all communications from Biosecurity Queensland on new information and alerts regarding horse industry biosecurity issues. HOSS was used during the [sic] 2009 and 2010 with great efficiency.

In a further refinement, Biosecurity Queensland has developed a Hendra virus response Communication and Community engagement action strategy which describes the communications and community and industry engagement actions to be taken during a Hendra virus response. The strategy acknowledges the importance of established, consistent and agreed processes for communication with industry groups during a Hendra virus response. The strategy and supporting plans are reviewed after each Hendra virus response as part of a continuous improvement strategy.

### **Ombudsman's analysis**

It appears that QPIF has improved the means by which it communicates information about Hendra virus incidents to private veterinarians. However, this does not change my view that QPIF's strategies in relation to previous Hendra virus incidents were inadequate.

This Office recently received a further complaint about QPIF's failure to communicate with all private veterinarians in relation to the 2011 Hendra virus incident at Kerry, in South East Queensland. A private veterinarian informed my officers that he was not notified about the Hendra virus update until four days after positive test results were obtained by QPIF and this could have resulted in his veterinary clinic accepting a horse that had been in contact with a positive Hendra case.

I have amended my proposed opinion and recommendation to take account of the improvements to QPIF's communications, while recognising that further steps may be needed. QPIF will need to take ongoing steps to ensure that its communication strategies remain adequate and relevant.

I confirm proposed opinion 61 with amendments as a final opinion:

#### **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.

I confirm proposed recommendation 53 with amendments as a final recommendation:

#### **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.

## Distribution of clinical signs

A private veterinarian has suggested to my officers that it would assist all veterinarians if there was a summary available of the clinical signs exhibited by each confirmed Hendra horse. The current *Guidelines for Veterinarians* contain information about the range of Hendra virus clinical signs, but not a summary of how the virus has presented in each infected horse.

The private veterinarian also expressed the view that this information should be distributed to veterinarians as soon as possible during Hendra virus incidents.

This issue arose during the 2008 Redlands incident, when a private veterinarian who operated a horse clinic near the Redlands clinic contacted QPIF requesting information on the clinical signs exhibited by horses that had died of the virus. He told my officers that he sought this information to enable him to make informed decisions and risk assessments about horses under his care. The information was sought as part of a substantial request to QPIF for information on Hendra virus matters.

QPIF required the veterinarian to make an application under the then *Freedom of Information Act 1992* and assessed the access charges payable at \$3,589.60. The charges were not paid and the information was never released.

QPIF officers later indirectly provided the private veterinarian with some of the information he requested, by providing summaries of clinical signs in epidemiological reports distributed to private veterinarians through the AVA and eventually through the VSB mailing list.

Dr Perkins then recommended the timely distribution of clinical signs in recommendations 9 and 10 of his 2008 Perkins Report:

It is recommended that management of the DPI&F web site consider the implementation of display of document tracking information on the web, flags or alerts to inform viewers when information has changed and for longer documents such as the guidelines for veterinarians, summary information to indicate the nature of the changes. Consideration should also be given to adding further information to the web site including for example FAQs, links to information on bats, and **descriptive summaries of past cases**. Other recommendations relating to flow of information to stakeholders are also relevant to the web site. [emphasis added]

It is recommended that DPI&F work with the Australian Veterinary Association (AVA) to review and agree on procedures for **timely reporting during a response of clinical signs, progression of disease and results of additional procedures such as post-mortem examinations**. [emphasis added]

The AVA's submission to my investigation confirmed that:

The reporting of clinical signs and progression of disease has always been highly sought after information by the veterinary profession. There has been some delay in the provision of this information to the veterinary profession in the past and it is hoped that the supply of this critical information will continue to be prioritised in future.

The delays referred to by the AVA are presumably the delays in reporting that occurred during the 2008 Redlands incident.

QPIF's approach to releasing information on clinical signs seems to have changed by the time of the 2009 Cawarral incident. The information provided to veterinarians

during that incident included a short summary of the symptoms and signs observed in each horse before its death.

The AVA informed me that the reporting of clinical signs and post-mortem results during the 2009 Cawarral incident was satisfactory.

However, the clinical signs that QPIF has now made available relate only to the horses that died in the 2009 Cawarral and Bowen incidents. Dr Perkins told my officers that his recommendation had only been partially implemented, because information about pre-2009 cases are not on the QPIF website and were not otherwise provided to private veterinarians.

Similarly, the AVA submitted to my investigation that:

Dr Perkins also suggested that further information be available to veterinarians. ... This type of information would be useful for veterinarians as it would provide an overall description of the particular case, rather than piecemeal snippets of information released throughout an outbreak. It would be highly useful to have individual Hendra case information collated and summarised for every known occurrence.

One possible reason for QPIF's apparent reluctance to fully implement this recommendation may be that many of these clinical signs are observed by the horse owner or a private veterinarian before QPIF becomes involved. The information therefore cannot be verified by QPIF.

Although it could be argued that the responsibility for compiling this information does not lie with QPIF, in my proposed view QPIF is undoubtedly best placed to gather this information during an incident response. I have no doubt that QPIF officers request information on clinical signs of the disease from veterinarians or horse owners during incidents to add to their knowledge of the disease and to identify the index case.

In my opinion, it is not unreasonable to require QPIF to provide this information to veterinarians. Where necessary, such information could be provided with the qualification that it was obtained from horse owners or private veterinarians and that QPIF cannot warrant the accuracy of the information.

In my proposed report, I formed the following opinion and made the following recommendations:

**Proposed opinion 62**

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

**Proposed recommendation 54**

QPIF:

- (a) collect information promptly on the observed clinical symptoms 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.

### **Proposed 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.

### **DEEDI's response**

The Director-General of DEEDI made the following submissions:

Biosecurity Queensland considers it is responsible to promote the fact that there are no pathognomonic signs (consistent indicative clinical signs) that define Hendra virus in horses. It is more important to convey that professional veterinary judgement should be applied to all sick horses to make a risk assessment regarding the possibility of Hendra virus being present.

The pathogenesis of Hendra virus infection in horses is vasculitis (inflammation of blood vessels) which can lead to variable and vague clinical signs. This is reflected in the diverse range of clinical signs in Hendra virus cases reported since 1994. Biosecurity Queensland believes it is more meaningful for vets to understand the underlying principles of any disease process and the resultant clinical expression this may lead to.

Biosecurity Queensland is concerned the provision of a definitive list of clinical signs for Hendra virus in horses needs to be done with caution. The absence of certain clinical signs could contribute to veterinarians limiting their consideration of Hendra virus.

Since 2009, Biosecurity Queensland has consistently advised the veterinary profession and horse owners to consider adopting protective measures around all sick horses, not just cases that fit a list of clinical signs considered to be Hendra virus. Biosecurity Queensland is concerned that the provision of a definitive list of clinical signs attributable to Hendra virus may lead veterinarians not to fully consider all clinical expressions of Hendra virus with the risk they may not adopt appropriate infection control precautions.

As a general comment regarding communication with veterinarians, Biosecurity Queensland respectfully submits that the perceived need to have real-time updates on what is happening during Hendra virus incidents appears based on the false notion that risk of exposure and infection is increased during a response and that veterinarians need to be more vigilant at that time. Biosecurity Queensland invests a lot of effort in communicating with veterinarians on the need to be considerate of Hendra virus in all their diagnoses and to take the appropriate personal protection at all times.

The Queensland Centre for Emerging Infectious Diseases (QCIED) [sic] has reviewed all equine Hendra virus cases to date and collated all available history and clinical aspects. Biosecurity Queensland intends to publish the material once outstanding issues (such as the deidentification of horses and owners) are resolved.

No submission was made about my proposed recommendation 55.

### **Ombudsman's analysis**

I acknowledge QPIF's concerns about the production of a definitive list of clinical signs for Hendra virus in horses. However, the response from DEEDI does not address the point I am making.

My proposed recommendations were not that QPIF produce a definitive list of clinical signs. My proposed opinion and recommendations were that, in addition to the information currently available in the Guidelines for Veterinarians, QPIF also provide case studies of how Hendra virus has presented in each horse that has been diagnosed with Hendra virus to date. Rather than narrowing the diagnostic picture for Hendra virus, in my view this would give private veterinarians and horse owners a clear picture of the varying ways that Hendra virus can present in a horse and contribute to the ability of private veterinarians to accurately assess the possibility of Hendra virus in a particular horse.

I note that QPIF's Queensland Centre for Emerging Infectious Diseases (QCEID) is now going to collate and publish clinical information regarding past equine Hendra virus cases. Therefore, it seems that DEEDI in fact accepts that this can and should occur.

My opinion and recommendations are unchanged.

I confirm proposed opinion 62 as a final opinion:

#### **Opinion 62**

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

I confirm proposed recommendations 54 and 55 as final recommendations:

#### **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.

#### **Communication about exposure risk and precautions**

Private veterinarians and veterinary nurses have a high risk of exposure to Hendra virus as they often treat unwell horses before Hendra virus is suspected or diagnosed. In most cases of human infection, infection has occurred when a private veterinarian/veterinary nurse was performing an invasive procedure (such as an

endoscopic procedure or an autopsy) on a sick or deceased horse before Hendra virus was suspected.

The CVO told my officers that the problem is that veterinarians will only wear PPE if they think a horse has Hendra virus, whereas in his view PPE should be worn whenever a veterinarian is treating a horse with an undiagnosed illness. He considered that a culture change is needed. The CVO gave an example of attending a suspect Hendra virus case after the 2008 Redlands incident with a private veterinarian. He said he was amazed to observe that the veterinarian had brought no PPE to wear while treating a horse that could have had Hendra virus.

Several QPIF officers likened the attitude shift needed among private veterinarians to the change seen in medical professionals in the 1980s with the rise of HIV/AIDS, when doctors and dentists began to wear gloves when examining patients.

In my view, there is a need for QPIF to communicate more effectively with private veterinarians about Hendra virus to help bring about this change in approach. Although QPIF has taken steps in this regard, further steps are clearly required.

In my proposed report, I formed the following opinion and made the following recommendation:

**Proposed opinion 63**

There is a need for QPIF to communicate more effectively with private veterinarians about Hendra virus and the precautions veterinarians must take when treating horses.

**Proposed recommendation 56**

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

**DEEDI's response**

As outlined in the response to proposed opinion 61 and proposed recommendation 53, Biosecurity Queensland can demonstrate that it does effectively communicate with private veterinarians about Hendra virus and the precautions veterinarians must take when treating horses.

After the then-Minister for Primary Industries and Fisheries held a Roundtable Forum on Hendra virus in September 2009 attended by the AVA, VSB, key horse industry members and other government agencies, it was identified that the most effective way to engage with private veterinarians about Hendra virus was to visit them at their practice to engage and inform all appropriate staff, in contrast to the approach involving regional seminars.

Subsequently, a targeted practical information pack was developed by the Biosecurity Queensland horse industry liaison officer focusing on key facts about Hendra virus, including the appropriate PPE required for the investigation of potential Hendra virus infection in horses (Veterinary Practice Pack).

During 2010, Biosecurity Queensland veterinarians visited over 100 private vet practices across Queensland to deliver the Practice Pack and all elements of the pack with veterinarians and their staff.

The Director-General also submitted:

It is submitted that proposed opinion 63 and the premise of proposed recommendation 56 are based on out-of-date information and can no longer be substantiated. It is not accurate to assert that current communication practices are ineffective. On this basis it is submitted that **proposed opinion 63 and proposed recommendation 56 be withdrawn.**

### **Ombudsman's analysis**

While QPIF has increased the extent of its communications with private veterinarians, I remain concerned as to the effectiveness of those communications. Private veterinarians are continuing to attend to sick horses where Hendra virus is suspected without adequate PPE.

However, I acknowledge that QPIF has taken significant steps towards educating private veterinarians, and that there is a shared responsibility for veterinarians to make the necessary changes in their practice to address the risk of Hendra virus infection.

I confirm proposed opinion 63 with an amendment as a final opinion:

#### **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.

I confirm proposed recommendation 56 with an amendment as a final recommendation:

#### **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.

### **Training for private veterinarians**

The issue of providing training for private veterinarians on Hendra virus procedures and the correct use of PPE for zoonotic disease response has also been raised with QPIF by a number of different stakeholders since at least 2008. In the 2008 Perkins Report, Dr Perkins made the following recommendation 15:

It is recommended that initiatives be progressed through the joint involvement of DPI&F and a range of industry bodies such as the AVA and Animal Health Australia (AHA), and accredited providers of safety training for the development of training and preparedness programs for veterinarians and that similar initiatives be progressed with appropriate industry bodies for all people who interact with horses. It is considered important that training is tailored to the needs of the relevant user, available to all relevant people, and that training may incorporate information relevant to biosecurity measures for other diseases in addition to Hendra virus.

This recommendation was accepted by QPIF in principle, although QPIF stated in its official response that the government will not be responsible for the training of private veterinarians and others because it is not an accredited training provider.

The QPIF report on the implementation of Dr Perkins' 2008 recommendations (Progress Report) stated that several infection control workshops had been held around Queensland in partnership with the AVA and WHSQ. The Progress Report also noted that information regarding infection control and PPE had also been provided to horse industry groups through the HBMALG for dissemination to their members.

A number of private veterinarians submitted to my officers that, as sole repository of information on Hendra virus, QPIF has an obligation to educate veterinarians and horse owners about the safe use of PPE when dealing with such biosecurity incidents.

One private veterinarian told my officers that only QPIF officers receive adequate PPE and Hendra virus response training, as no one else provides this training and there are no postgraduate practical courses on biosecurity or Hendra virus offered in Australia:

So you can't pay to get trained, unless you work for the DPI, these are the only vets that are trained at the moment ... The university has incorporated some biosecurity now, so graduates from now on ... It won't get anyone backwards.

I have been told that there are currently no continuing professional education requirements on private veterinarians that are linked to professional registration. The only obligations of that kind are through AVA membership and therefore only apply to approximately 40% of Queensland veterinarians.

If QPIF's goal is to have a trained and informed veterinary profession that is able to share responsibility for Hendra virus, then it may have to initiate and lead training in the short to medium term. Alternatively, QPIF may have to liaise with another training provider to do so.

The provision of training may also assist QPIF in dealing with the increasing number of situations where private veterinarians are refusing to take samples from horses that may have Hendra virus.

I appreciate that QPIF does not wish to take on a training role, which it sees as being a role for the commercial sector or a responsibility of private veterinarians. A senior QPIF officer told my officers that QPIF was working with the AVA to establish a network of equine practitioners who can provide advice and mentoring to private veterinarians attending possible Hendra virus cases, or who can attend those cases themselves if necessary. Obviously, a precursor to such a network will be the provision of training to these equine practitioners.

In the long term, there may not be any need for QPIF to take on the training of veterinarians in PPE and biosecurity matters, as I understand that QPIF is currently working with the University of Queensland and James Cook University to prepare and deliver a module on biosecurity to all veterinary students. Therefore, new graduates should already possess this information, although refresher courses may be necessary.

If QPIF does not wish to provide this training directly, then it could work with a variety of organisations (including WHSQ) to arrange for them to deliver the training. These organisations could include the AVA, but should not be limited to the AVA if this directly or indirectly excludes veterinarians who are not AVA members.

In my proposed report, I formed the following opinion and made the following recommendations:

**Proposed opinion 64**

As the government agency with expertise on Hendra virus, QPIF has a responsibility to ensure that training in Hendra virus procedures and the use of PPE is made available to all Queensland veterinarians.

**Proposed 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.

**Proposed recommendation 58**

QPIF continue to work with private veterinarians and horse owners to ensure that private veterinarians understand QPIF's limited role in obtaining samples for Hendra virus testing.

**DEEDI's response**

The Director-General made the following submissions:

In response to the 2008 Perkins Report recommendations regarding the provision of training (including PPE training), Biosecurity Queensland held infection control workshops in collaboration with the AVA and Workplace Health and Safety Queensland. The purpose of these workshops was to improve infection control awareness of veterinarians and encourage them to obtain the appropriate PPE training through accredited organisations.

Biosecurity Queensland cannot be responsible for the provision of PPE training to private veterinarians as it is not a registered training organisation. Significant effort has however been invested in connecting veterinarians and horse industry stakeholders with PPE providers and trainers through workshops (mentioned above) and targeted communications. PPE information was incorporated on the then-DPI&F website, included in the updated version of the Guidelines and the Veterinary Practice Pack. This information was also disseminated to members of the Horse Biosecurity Market Access & Liaison Group, which includes the Queensland Horse Council, the Queensland Performance Horse Industry Alliance, the racing industry, the AVA, and the Equine Veterinary Association.

Biosecurity Queensland has also reviewed and updated its internal respiratory management program and undertaken training for frontline Biosecurity Queensland responders.

The effectiveness of responses to future Hendra virus incidents depends on veterinary practitioner awareness and application of appropriate infection control principles. The AVA/Biosecurity Queensland/WHSQ infection control workshops, which include the appropriate selection and use of PPE, go some way to addressing this. However, the veterinary profession must also take a proactive role in ensuring that practitioners adopt appropriate hygiene and infection control behaviours.

The language of the Guidelines for Veterinarians, the Veterinary Practice Pack and the 'What is Hendra virus?' fact sheet has been amended to improve communication and understanding of the importance of infection control including PPE. A strong focus on precautionary measures is included in all the communications and they have all been published on the DEEDI website.

In 2010 Biosecurity Queensland mailed a copy of the Guidelines for Veterinarians to every registered veterinarian in Queensland and delivered Veterinary Practice packs to over 100 veterinary practices dealing with horses. These information packs contained specific information about the need for PPE and recommending that veterinarians undertake training in the use of PPE.

Biosecurity Queensland also communicates with veterinary science students through a structured biosecurity module at the University of Queensland which advises them of the importance of personal hygiene and infection control principles. A similar module is under consideration for the Veterinary School at James Cook University in Townsville.

The use of PPE is not unique to Hendra virus in the veterinary profession. It is noteworthy that training in the use of PPE is widespread and readily available to the veterinary community from the manufacturers and suppliers of PPE. These businesses are the best placed organisations to provide such training, given that each PPE product is slightly different and will vary in its application according to purpose, individual preference and requirement and intended usage. Biosecurity Queensland itself relies on training from PPE manufacturers to train departmental staff.

With specific regard to proposed opinion 64, it is not the Government's role to ensure veterinarians are trained in the use of PPE. Professional responsibility needs to be adopted, as with other workplace health and safety requirements, to ensure the workplace health and safety of themselves, their workers and others. It is incumbent on private veterinarians to be proactive in relation to their health and personal safety and that there is an important role for industry associations to communicate and educate their constituent members in relation to the risks of Hendra virus and steps that can be taken to limit risk of exposure.

Based on the evidence provided, the department considers that proposed opinion 64 does not reflect the current situation. As such, the department requests that proposed **opinion 64** and proposed **recommendation 57** be withdrawn.

### **Ombudsman's analysis**

I acknowledge that QPIF obtains its own PPE training from manufacturers and on the basis that sufficient information is now available to enable veterinarians to locate suitable training, I will amend proposed opinion 64 and recommendation 57.

I confirm proposed opinion 64 with amendments as a final opinion:

#### **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.

I confirm proposed recommendation 57 as a final recommendation:

**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.

I confirm proposed recommendation 58 with amendments as a final recommendation:

**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.

**12.1.3 Communication with property and horse owners about testing of horses**

Both the Quarantine Policy and Guidelines for Veterinarians provide some information on which horses should be tested and timetables for testing.

However, a number of property and horse owners involved in Hendra virus incidents complained to my officers about QPIF's communication in relation to the testing of horses. Some of the allegations made to my officers included that:

- QPIF had to be chased up for test results
- the testing regime was not properly explained and, as a result, people believed that the first round of testing could show if horses were free of the virus
- QPIF did not provide sufficient warning of when its officers would be arriving at a DCP to test the horses
- during the 2009 Cawarral incident, test results previously characterised as not positive were changed to not negative and the difference was not explained by QPIF
- during the last week of the 2009 Cawarral incident when the property owners were expecting the quarantine to be lifted, they were told by QPIF that two horses had shown toxic test results and the quarantine would have to be extended to allow for re-testing; however, no explanation was provided of what toxic meant.

A separate allegation raised by a number of horse owners related to the level of skill shown by different QPIF officers when drawing blood from horses for testing during Hendra virus incidents.

Although I did not investigate a number of these issues in depth, my proposed report stated that the number of issues raised with my officers justified my proposing to form the following opinion and proposing to make the following recommendation:

**Proposed opinion 65**

There is substantial concern amongst property owners and horse owners about QPIF's communication about testing issues.

### **Proposed 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 in advance of testing being conducted.

### **DEEDI's response**

In relation to the comments regarding inconclusive test results during the 2009 Cawarral incident, the Director-General submitted that:

- the results for two horses which were expected to be negative to Hendra virus were unable to be read, and as such QPIF was unable to provide advice to owners and further tests were undertaken
- the unreadability of the test results related to the nature of the blood sampled, not human error in the collection of the sample
- as soon as a definitive result was obtained, this was communicated to the horse owners.

### **Ombudsman's analysis**

The Director-General's response did not address all of the issues that I raised. Nor did he contest my proposed opinion or proposed recommendation.

My view remains that, whatever the reasons for additional testing, these reasons must be clearly communicated to property owners and horse owners.

I confirm proposed opinion 65 with an amendment as a final opinion:

#### **Opinion 65**

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

I confirm proposed recommendation 59 with an amendment as a final opinion:

#### **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.

Further, a number of horse owners complained that they did not receive written test results, but only oral advice. In one instance, a horse owner reported that the test results from a deceased horse were provided orally some weeks later, and that the written test results had not been provided even though it was several years since the tests had been conducted.

The QPIF policy *Hendra response – policy for distribution of laboratory results* was drafted on 2 September 2009 and covers the reporting of all laboratory results relating to Hendra virus incidents after a diagnosis of Hendra virus infection, or

determination that a death should be treated as if a formal diagnosis has been made'.

However, this policy only contains guidelines on when test results will be orally communicated and who will carry out this communication. There is no provision for written test results to be provided to horse owners. There is also no information provided on what test results mean, such as the meaning for an indeterminate or equivocal result, or whether a negative result on one test is definitive or further tests required.

QPIF officers state that the accepted approach is to provide written test results to the submitting veterinarian, who should then provide the results to the horse owner. However, in many cases the submitting veterinarian is a QPIF officer.

In my view, it is not unreasonable for a horse owner to receive written test results. This aids in transparency, and avoids any suggestion that QPIF is suppressing information.

Where a QPIF officer is the submitting veterinarian', horse owners should not have to apply to QPIF for these results under the *Right to Information Act 2009* or even by way of administrative release.

Further, to assist horse owners to understand the test results, information on how to interpret them and their reliability should be publicly available on the QPIF website. This should include information on when follow-up tests are required.

I also note that during the 2008 Redlands incident, QPIF's legal advice was that it should require Tamworth's owners to make an application under the then *Freedom of Information Act 1992* to obtain copies of test results on their horse which QPIF was proposing to destroy. In my proposed view, it is not appropriate to require horse owners to go through such a process to obtain information which they have a right to receive and which should be provided to them in the ordinary course of QPIF's business or in the process of providing procedural fairness while the decision on destruction was being made.

In my proposed report, I formed the following opinion and made the following recommendation:

#### **Proposed 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.

#### **Proposed 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) make information on how to interpret test results, and their reliability, publicly available on the QPIF website.

## **DEEDI's response**

The Director-General of DEEDI made the following submissions:

It is noted that where a private veterinarian submits samples for testing, the results are communicated to this veterinarian. The communication and interpretation of these results to the horse owner is at their discretion. It is also at their discretion whether a copy of the test report is provided to the owner. Under certain circumstances, such as a positive test result for Hendra virus, Biosecurity Queensland ensures that the owner gets a copy of the results, in consultation with the submitting veterinarian. Where a departmental veterinarian submits samples for testing, the agency will directly communicate with the horse owner.

The interpretation of laboratory results requires the professional judgement of a pathologist experienced in the laboratory tests being conducted. It is not appropriate for Biosecurity Queensland to provide general information on the interpretation of laboratory results. Such interpretation should be conducted by an appropriate expert, taking into account the specific circumstances of the case. Note that this type of information provision is not done for any other disease that Biosecurity Queensland deals with, including other zoonotic diseases.

## **Ombudsman's analysis**

It is clear from my investigation that merely providing test results to a horse owner, without any explanation or interpretation of those results, is not adequate. How test results are explained or interpreted for the benefit of horse owners is a matter for QPIF, but that does not alter the requirement that such explanation or interpretation be provided.

It is not clear from QPIF's response if it is now committed to providing written advice of test results to owners where a QPIF veterinarian submits the samples for testing. I do not believe that orally advising of the test results, whether positive, negative, indeterminate or otherwise, is sufficient.

Further, although the Director-General states that direct communication with horse owners will occur, he does not state that this occurred in relation to the previous Hendra virus incidents the subject of my report. Therefore, I see no reason to alter my proposed opinion or recommendation.

I confirm proposed opinion 66 as a final opinion:

### **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.

I confirm proposed recommendation 60 with amendments as a final recommendation:

**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.

Property owners in some incidents commented that the QPIF roster cycle meant that they were constantly dealing with new officers. One property worker stated that, during the 2009 Cawarral incident:

Witness                      It was quite confusing with the DPI especially because as we realised as time went on they only work x amount of days and then they have x amount of time off, so you are forever meeting new people who had new ideas and new explanations and you had to constantly repeat your stories to everybody.

QO Officer                    So you'd get different answers whenever you asked about this?

Witness                      In some cases yes.

This issue also arose during the 2008 Proserpine incident, where property owners were unhappy about the lack of continuity in QPIF officers and raised concerns that this approach may allow things to be missed by QPIF.

With the exception of these issues, it is relevant to note that I received almost entirely positive feedback about the local QPIF officers involved in the incident responses. One person stated:

As far as when they were here – I only saw good things. I only saw positive things. I saw them being vigilant and ... they gave a damn and were 100% on top of it. As far as I saw.

A number of people have suggested that a liaison officer be appointed as part of every QPIF response to Hendra virus. The value in this position was seen as the ability to communicate directly with property and horse owners and to provide them with a consistent and reliable contact during an anxious time.

One person involved in an incident told my officers:

... the DPI need to select a representative for the entire case and outline what their staff's responsibility is to us and their responsibility to the horses as well because it did feel like every day there was a new person in charge of the operation and it wasn't until the end when things sort of settled down and we were having people for a week and then we'd have another lot for a week and then the same people would come back again in a rotating shift, but in the beginning there was people all over the place.

The position of liaison officer was first recommended in the 2008 Perkins Report:

It is recommended that procedures relevant to liaison officers appointed by DPI&F be reviewed and more information provided on the roles of liaison officers as conduits of information flow to and from relevant stakeholders. This should include review of induction and training, and information and other material they should have either available to them or access to during the response. Consideration should be given to the early appointment of liaison officers with communication roles that are independent of response activities.

As a result, a liaison officer was appointed during the 2009 Cawarral incident to liaise with property owners and horse owners. People involved in this incident told my officers that having this liaison officer was helpful, although they were critical of the fact that the liaison officer initially focused on communicating with people at the DCPs rather than those at the IP.

It is clear that a liaison officer would be a valuable resource to communicate with property and horse owners during future Hendra virus incidents.

I confirm opinion 67 as a final opinion:

**Opinion 67**

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

I confirm recommendation 61 as a final recommendation:

**Recommendation 61**

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

Finally, one instance was brought to my attention about the notification of results to property owners. My officers were told that during the 2009 Cawarral incident, local QPIF officers were directed to provide incomplete information to the property owners about the test results of one horse, Winnie.

An email sent on behalf of the Acting CVO on 14 August 2009 stated:

This is a confirmation that the 25 horses on the [Cawarral] property are negative for PCR. Would you please inform [the property owner] and the owners of the horses of the **PCR results only**.

The attached test results clearly showed that there were also two positive ELISA results reported by AAHL to QPIF at the same time, but these were not reported to the property owner.

A further email from the LDCC Operations Manager to a QPIF officer stated:

Please note that only the PCR results are to be advised. Do not mention elisa. This will be addressed at a later time if significant.

Although it was suggested by QPIF officers and others that the SDCHQ instructed LDCC officers not to communicate positive PCR results, I have been unable to adequately match up test results with the knowledge of QPIF officers at the relevant

times to prove this allegation. However, I note that the 2009 AAR Report states that in one instance:

[LDCC] staff were tasked to provide negative results to an owner when [SDCHQ] were allegedly aware of a +PCR result. This resulted in lack of trust and lack of consideration issues.

It is not clear on the documents available to me whether such instructions were in fact given, or whether this report relates to the same instance that my officers were informed of. However, it is clear from the above email that the then Acting CVO instructed QPIF officers not to report two positive ELISA serology results to the owners of the horses at the time that these results were known to QPIF. One of these samples related to the horse that was destroyed 10 days later when it was confirmed to be sero-positive.

A situation where property or horse owners were unaware of a positive result on a horse could lead to the relaxing of PPE precautions, with potentially fatal consequences.

In circumstances where information relates to a person's rights, safety or property, in my view there is a general obligation for a government department or agency to provide full and complete information to the person, unless there are compelling reasons not to do so.

In my proposed report, I formed the following opinion and made the following recommendation:

**Proposed 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.

**Proposed recommendation 62**

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

**DEEDI's response**

The Director-General made the following submissions in response to my proposed report:

In regard to proposed opinion 68, Biosecurity Queensland submits that the reluctance to advise the property owner of the positive ELISA test results was reasonable. This test is regarded as a screening test, not a definitive serology test, as recognised in section 3.2.1 of the proposed report (page 26). ELISA can return false positive results, and as such a further VNT test is conducted to establish whether the possible diagnosis of Hendra virus is correct. The result of this individual test would not and did not affect the actions that Biosecurity Queensland took on the infected property.

This situation occurred on an infected premise where all the in-contact horses were considered possibly infected and full precautions were taken in all interactions with the suspect horses. This was overseen by Biosecurity Queensland until the final round of testing showed that the property was clear of Hendra virus. There was no

increased risk to staff or the owner of the property as implied on page 213 of the proposed report.

On the basis of the information provided, it is submitted that the decision not to provide the property owner with the positive ELISA result was made in good faith, and was not unreasonable. It is therefore requested that **proposed opinion 68 be withdrawn.**

### **Ombudsman's analysis**

Regardless of whether an ELISA test is a screening test, I do not accept that it is reasonable for the results of a positive ELISA test to be withheld from a horse owner. If tests can produce false positives then that is a matter that must be explained to the horse owner in writing at the time of releasing the test results or earlier.

Irrespective of whether this decision was made in good faith, I remain of the view that the owners of the horse had a right to be informed of test results on their horse. The failure to do so was, therefore, unreasonable in the circumstances, regardless of whether it actually increased the biosecurity risk at the property.

My opinion on this issue and the associated recommendation remain unchanged.

I confirm proposed opinion 68 as a final opinion:

#### **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.

I confirm proposed recommendation 62 as a final recommendation:

#### **Recommendation 62**

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

### **12.1.4 Communication with the general public**

Some concerns were raised about QPIF communication with horse owners and the general public about Hendra virus. One horse owner identified the need for a proactive approach to the education of horse owners, as all cases of Hendra virus have resulted in the potential exposure of horse owners to the virus before QPIF became involved.

Communication with horse owners who are not affected by a current incident can also raise awareness about Hendra virus and ensure that they have the necessary equipment and knowledge to care for sick horses without putting themselves at risk.

A senior QPIF officer confirmed to my officers that stakeholder communication was a key focus of QPIF. To this end, QPIF has coordinated and spoken at a number of recent Hendra virus seminars aimed at horse owners. Other seminars have been

organised by industry groups or individuals involved in previous Hendra virus incidents. I was told that there are further seminars planned.

QPIF has also issued a number of publications for horse owners and the general community about Hendra virus, current versions of which are available on the QPIF website.

During the 2009 Cawarral and Bowen incidents, QPIF implemented a community engagement strategy, which included:

- information packs to local schools
- an information stand at a local shopping centre
- brochures in stock and station agents and horse businesses
- visits to nearby properties that may have horses
- a community information centre
- a dedicated community engagement officer.

QPIF also included using a highly visible bus in popular locations and at horse events in the community to provide information about Hendra virus. The bus also contained information from QH about human health risks.

I was told that QPIF intends to conduct similar community engagement during future Hendra virus incidents.

The information provided to my officers clearly demonstrated the significant cost of community engagement in a biosecurity response, particularly when compared with the clinical elements of the response. This comparison raised questions among QPIF officers, who expressed the view that community engagement was not necessary for QPIF's biosecurity response to contain an incident.

In my view, there is a need for some community engagement because of the high level of public concern about Hendra virus incidents, particularly due to the misconceptions and myths that abound within the community about the virus.

The extent of that engagement and provision of information is a matter for QPIF to deal with on a case-by-case basis. The emergence of social media may well provide opportunities for QPIF to engage with the general public about Hendra virus or other biosecurity issues.

A specific concern raised with my officers was whether QPIF should be advising horse owners throughout Queensland of Hendra virus incidents, especially those in the immediate area. One horse owner complained to my officers that the only way that horse owners found out about Hendra virus incidents was through the media.

I do not consider that it is practicable or reasonable to expect QPIF to notify all horse owners throughout the state of a Hendra virus incident. A better approach is to ensure that the media is kept informed and properly briefed, and to provide up-to-date information on the QPIF website.

Horse owners who have questions about Hendra virus can then access the website or contact the QPIF Business Centre. They can also sign up on the website to receive notifications about Hendra virus from QPIF.

I confirm opinion 69 as a final opinion:

**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.

I confirm recommendation 63 as a final recommendation:

**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.

**QPIF website**

A number of people who made submissions to my investigation had concerns about the QPIF website.

I am satisfied that most of these concerns have now been addressed by QPIF.

However, it is relevant to note the AVA submission to my investigation:

A further way in which QPIF communicates with veterinarians is via its website which contains a range of information including guidelines, research, client information and other relevant advice. We note that although resources have been supplemented on the website since 2008, the presentation of this information is not ideally suited to accessing key information quickly. The adoption of more concise fact sheets and summary information on research and risk management would be both more useful and informative to veterinary practitioners.

I confirm opinion 70 as a final opinion:

**Opinion 70**

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

I confirm recommendation 64 as a final recommendation:

**Recommendation 64**

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

## **12.2 Communication by the VSB**

A number of matters were raised with my officers about whether the VSB has a role to play in communicating with veterinarians during biosecurity incidents. This issue arose in the context of criticism of QPIF for only communicating with private veterinarians through the AVA.

In particular, during the 2008 Redlands incident, it became apparent that QPIF did not have any way of communicating effectively with all veterinarians. Some QPIF officers quite clearly believe that this was the fault of the VSB, as the VSB did not immediately provide QPIF with contact details of all veterinarians in Queensland. This issue therefore requires some discussion and resolution.

I understand that although a database of veterinarians was developed by QPIF during the equine influenza outbreak in 2007, it was not kept updated by QPIF.

Some QPIF officers told my officers that in their view, the VSB should communicate with veterinarians about Hendra virus incidents because of the potential seriousness of these incidents and the high level of interest among equine veterinarians. The fact that the VSB is the only body which has a complete list of all veterinarians in Queensland was also considered relevant.

Currently, the VSB does not engage in regular communication with veterinarians. Although in the past the VSB sent twice-yearly newsletters to veterinarians, this has not occurred for several years due to resource constraints.<sup>138</sup>

At the time my investigation was commenced, there was some dispute between the VSB and QPIF about responsibility for communication with veterinarians during biosecurity incidents.

The QPIF position expressed to my officers was that the VSB has contact details for all veterinarians, and should at least provide those contact details to the department for the purposes of notifications of Hendra virus incidents and other communication about biosecurity matters. Some QPIF officers suggested that the VSB should send out immediate notifications about Hendra virus on behalf of QPIF or otherwise play an active role in ensuring that veterinarians are notified of Hendra virus incidents.

However, the VSB Registrar told my officers that emergency disease response is not part of the VSB's responsibilities. The Registrar's position was that the VSB is a compliance board and does not have any role to play in biosecurity responses. The Registrar noted that there is no requirement in the VS Act that the contact details of veterinarians be provided to QPIF, and to do so could raise privacy concerns.

Further, the Registrar noted that the VSB did not have the financial and human resources to play any significant role in responding to biosecurity incidents.

I agree with the VSB Registrar's views that the primary responsibility for communicating with veterinarians during biosecurity outbreaks such as Hendra virus incidents lies with QPIF. As the VSB Registrar noted, there is nothing in the VS Act which requires or permits the VSB to communicate with veterinarians about biosecurity matters.

The fact that the VSB has a database that allows it to communicate with veterinarians, and is the only agency with such a database, does not shift responsibility for such communication away from QPIF. Until recently, the VSB database did not contain veterinarians' email addresses or telephone numbers.

That said, given the serious nature of Hendra virus and the fact that many equine veterinarians are keen to receive information about incidents, it is in the interests of

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<sup>138</sup> I understand that the VSB registry has only two staff members, the Registrar and an administrative support person.

both agencies that an effective method is established for communicating with veterinarians about biosecurity concerns.

The 2008 Perkins Report considered issues relating to communication with veterinarians. Recommendations 11 and 12 stated:

It is recommended that DPI&F and the Veterinary Surgeons Board of Queensland (VSB–QLD) work together to develop procedures to ensure that a current list of email addresses for those veterinarians that have consented to have their email addresses used for emergency animal disease information, is provided to the DPI&F either as early as possible after confirmation of an emergency disease case to facilitate communication or on an annual basis after renewals have concluded.

It is recommended that DPI&F and appropriate peak bodies consider options for improving the coverage rate to veterinarians and allowing sign-up for emergency animal disease information at any time. The VSB–QLD option only allows veterinarians to sign-on for communications on an annual basis. There may be an alternative option that allows veterinarians to sign-on at any time or to provide updates of changes in contact information. This could be achieved by adding functionality to a web site to allow individuals to sign-up for information.

QPIF accepted both recommendations and advised my officers that implementation of these recommendations is in progress. The Managing Director told my officers in October 2009:

Our ideal state is that we want to be able to have emails and SMSs for every vet in Queensland that we can access and we're currently working for Vet Surgeon's Board to make this happen. The Vet Surgeon's Board have issues around privacy for their database because they, with their requirement under their legislation ... And it is something that I know the Minister is very interested in and he is willing to even, to look at legislative change to make sure we can have this happen. So it's a, this issue is ongoing, it's not resolved but we are working very hard to try and get a resolution. But if there is one area for full administrative improvement this is one of them.<sup>139</sup>

However, discussions between QPIF and the VSB did not appear to be progressing, despite the considerable time that had elapsed since Dr Perkins' recommendations and my officers seeking information from QPIF on the status of these discussions.

My proposed report noted it was clear that QPIF and the VSB needed to cooperate in resolving these issues to enable QPIF to communicate effectively with veterinarians about Hendra virus incidents.

I also noted significant concern among private veterinarians my officers spoke to about why QPIF did not contact all veterinarians during previous Hendra virus incidents. This concern is likely to intensify among veterinarians who have provided their contact details for this purpose if these details were not being used by QPIF.

The Registrar of the VSB advised my officers that the VSB does not have the capacity to enter additional information for 2,600 Queensland veterinarians into its database and that it had requested administrative support from QPIF to do so. At the time of my proposed report, this support had not yet been provided.

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<sup>139</sup> Although there was a view held by some QPIF officers at one stage that the VS Act should be amended to require the VSB to provide contact information for veterinarians for use in an emergency response, this has not yet been pursued. It was acknowledged that this would not ordinarily be the subject of legislation.

My view was that it was unreasonable for QPIF to expect the VSB to bear the costs of entering this information and keeping it up to date when the information was for the benefit of QPIF.

Having regard to the VSB's limited resources, I was of the view that QPIF needed to take the initiative by providing reasonable human and technological resources to the VSB for this purpose.

My proposed report highlighted the lack of progress in discussions between QPIF and the VSB for the development of procedures to collect and share electronic contact details of veterinarians. I proposed to form the following opinion and make the following recommendations to address this issue:

**Proposed 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.

**Proposed 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.

**Proposed 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; and
- (b) QPIF provides reasonable additional resources to assist the VSB to facilitate this recommendation.

**VSB's response**

The Registrar provided a response summarising the progress that had been made with QPIF towards enabling QPIF to utilise data collected and maintained by the VSB.

He advised that since December 2009, the VSB had generated regular communication with QPIF offering its full cooperation in the development of an IT proposal to enable the automated sharing of the electronic contact data held by the VSB. The Registrar also noted that improvements under the new *Information Privacy Act 2009* and initiatives undertaken by the VSB have led to the VSB recording such contact details for a majority of registered veterinarians.

Since receiving my proposed report, the VSB convened a meeting to again propose that QPIF fund an IT proposal to develop an automated data sharing system. As a result of that meeting, the Registrar advised that QPIF has now prepared a draft IT proposal for agreement and implementation. The Registrar further advised that the VSB would ensure that a memorandum of understanding was entered into with QPIF so that the data would be utilised solely for the purpose of emergency disease preparedness and response.

## **DEEDI's response**

The Director-General of DEEDI noted that with the recent changes to the *Information Privacy Act 2009*, the VSB is now able to provide some information from its register to State government agencies for the purpose of animal health emergency response and preparedness.

He further advised that:

Biosecurity Queensland continues to work with the VSB and has developed a case to support the implementation of an IT solution to ensure access to contact details of veterinarians registered with the VSB and to provide a streamlined and rapid system to notify vets about emergency animal disease response and preparedness information.

## **Ombudsman's analysis**

Since the commencement of my investigation there has been some action by both QPIF and the VSB towards the achievement of an email contact list for all Queensland veterinarians for biosecurity purposes, as envisaged by the 2008 Perkins Report.

However, given the lengthy delays to date and the latest advice only indicating that a case has been developed to support the implementation of the necessary IT solution, it is necessary for me to express the following opinion and make the following recommendations.

I confirm proposed opinion 71 with an amendment as a final opinion:

### **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.

I confirm proposed recommendation 65 as a final recommendation:

### **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.

I confirm proposed recommendation 66 with an amendment as a final recommendation:

**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.

It is important that these issues are resolved as soon as practicable so that an agreed system is in place before the next incident of Hendra virus.

**12.3 Inconsistent approaches between agencies**

An issue that was repeatedly raised with my officers is that QH and QPIF have different approaches during quarantines. Officers from both QPIF and QH told my officers that they were concerned about this. One QPIF officer told my officers:

It's about proportionate response. We go in boots and all and then someone else has got to come in from Health and say this thing's a rare disease and it's very hard to get and they look across at us and we're done up in P3. That's a very difficult message to sell. So there's some education, us, Queensland Health and Workplace Health and Safety need to get our heads together. We've done our stuff for good reason and with technical input from the right people and that's why our level's at this level, the fact that it doesn't meet yours, that's part of the education process.

I understand that the inconsistent approaches may stem from a different approach to quarantine adopted by each agency.

QH approaches Hendra virus incidents as a routine infection, and advises people that no protective equipment is needed or precautions required in dealing with people who may have been exposed to the virus, unless a person is unwell. To illustrate this point, my officers were told that, when visiting the IP during the 2009 Cawarral incident, QH officers did not wear any protective equipment when taking blood samples from property workers. QH also advises those involved in incidents that the virus has never been transmitted from person to person.

QPIF officers, on the other hand, approach Hendra virus incidents from the point of view of dealing with a quarantined property. QPIF divides a property into a clean' zone and a dirty' zone, and treats Hendra virus in much the same way as many other biosecurity incidents. This is despite a significant difference between Hendra virus and other biosecurity hazards, in that Hendra virus does not persist for long periods in the environment, is not airborne and has never been transported between properties other than through an infected horse.

By way of example, during the 2009 Cawarral incident QPIF officers parked their vehicles at the property gate and donned protective equipment. They then entered the property and remained in at least some of their protective equipment, even if they were speaking to the property owners within the clean' zone.

These different responses gave rise to the perception of unknown environmental contamination and heightened the anxiety of the property owner and property workers.

Not surprisingly, the owner of the Cawarral property stated:

... on the one hand we're getting biosecurity people and the DPI treating this as an unknown risk and on the other hand we're getting the Health Department telling us to don't worry about it, there is no risk. That's a mixed message that as a risk management specialist that I'm not prepared to tolerate.

Another property worker stated:

Witness                      Then they're sitting there and they're trying to tell us ... it's never been contracted from human to human and I said I can sort of believe that mate but I'll tell you what I'd have a lot more belief in what you're saying if you take that mask and suit off while you're talking to me.' They sat there with a suit on and a mask mate and talking to us on the verandah out there.

QO Officer                    In the clean ...?

Witness                      Yes, in the clean area.

Although this worker's recollection of QPIF officers wearing masks in the clean' zone was denied by the relevant QPIF officers, there is no doubt that QPIF officers remained in their overalls when in the clean' zone before entering the dirty' zone.

A QH officer told my officers:

But the other thing that I realised is that whereas I was dealing with very low risk contacts ... And telling them that the risk is almost negligible, this is a formality, it's extremely unlikely that you will become sick or infectious or seroconvert, that's not their impression.

If you look at the photographs of what was done at Proserpine ... photographs of men walking around in space suits and burying the horse with a loader and a digger and all the rest of it, people get freaked out by that. They are taking extreme, in many ways over-cautious, precautions (mandated by [WHSQ] by the way) and the contacts who are right there assume a number of things. One of them is that this is highly infectious, which is not true ... That this organism persists in the environment, which is not true and that they are at high risk of infection and death also not true and there's nothing I can do to convince them otherwise, whether I'm with them or not with them ... no matter how many times if I tell them that they're at low risk they will simply not believe that and they'll feel that they're not being taken seriously.

In light of the above discussion, in my proposed report, I formed the following opinion and made the following recommendation:

### **Proposed opinion 72**

The different approaches adopted by QPIF and QH to Hendra virus incidents may give 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.

**Proposed recommendation 67**

As part of ongoing communications between QPIF and QH in between incidents of Hendra virus, the agencies:

- (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.

My proposed report also noted that shortly before it was issued, QH, QPIF and WHSQ had finalised jointly developed advice on infection prevention for Hendra virus which is now available on the QH website.

**QH's response**

The Director-General of QH did not object to my proposed opinion. He supported my proposed recommendation 67, confirming that QH had worked with QPIF and WHSQ to jointly issue advice on infection prevention (now available on the QH website), an agreed interagency communication framework and a revised QH fact sheet for the general public.

**DEEDI's response**

The Director-General of DEEDI did not respond to my proposed opinion or recommendation.

**Ombudsman's analysis**

It appears that the various agencies have taken steps on their own initiative to work towards resolving the issue of different approaches between QPIF and QH giving rise to a perception of inconsistency between the agencies, leading people to be confused about the correct approach to Hendra virus incidents and eroding public confidence in the government's responses.

The documents referred to by the Director-General of QH make clear that there has been discussion between the two agencies, and involving WHSQ, as to their respective responses during incidents. The interagency communications framework places a firm focus on the coordination of communication to property owners and the general public. This should minimise the potential for inconsistent messages.

It will be necessary for the relevant agencies to review their responses and advice on an ongoing basis to ensure consistency in approach.

I confirm proposed opinion 72 with an amendment as a final opinion:

**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.

I confirm proposed recommendation 67 with an amendment as a final recommendation:

### **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.

## **12.4 Interagency communication**

This section considers how the three main agencies involved in Hendra virus incidents (QPIF, QH and WHSQ) have communicated during previous incidents.

### **Notification of Hendra virus cases**

There is no formal protocol between QH and QPIF for notification of possible or confirmed Hendra virus incidents.

The QH Guideline in place at the time of the 2007, 2008 and 2009 incidents stated:

... DPI&F to notify the Communicable Diseases Unit, Queensland Health who will notify the relevant local Public Health Unit where there is a confirmed or suspected case in a horse(s) or other animal(s) so that appropriate advice can be given to human contacts and their GPs.

There is no complementary QPIF procedure requiring its officers to notify QH in these circumstances.

Notification from QPIF to QH occurred very differently in each incident between January 2006 and December 2009.

In the 2006 Peachester incident, the private veterinarian contacted QH's Sunshine Coast Public Health Unit (PHU) on 15 June 2006, while confirmation testing was still being conducted by QPIF. The PHU contacted the CVO and then the property owner and veterinarian. I understand that there had been no previous contact between QPIF and QH in relation to this possible Hendra case.

At the start of the 2008 Redlands incident, QPIF officers notified the relevant PHU directly about the incident.

In relation to the 2008 Proserpine incident, the relevant Public Health Medical Officer (PHMO) told my officers that notification may have been provided by QPIF to the Communicable Diseases Branch (CDB) in Brisbane, and then passed on to him. However, I note that at this time there was already daily communication occurring between QPIF and QH at this level due to the earlier 2008 Redlands incident.

In relation to the 2009 Cawarral incident, a local QPIF officer contacted QH's Environmental Health Unit (EHU) in Rockhampton to advise of a highly suspect Hendra virus incident (QPIF officers were obtaining samples at the time). The Director of the EHU spoke to the property workers and then contacted the on-call PHMO. I understand that this communication method was also used in relation to initial test results. During interviews, one local QPIF officer told my officers that notifying the EHU was consistent with 'QPF policy'.

However, the relevant PHU was not satisfied with this method of notification. The PHMO told my officers that, ideally, notification should come through the relevant PHU and the unnecessary step of notifying the EHU should be avoided.

The EHU does not have a formal role in responding to Hendra virus. I understand that in this instance notification to the EHU occurred because of the work relationship between the Director of the EHU and the local QPIF officer.

It is clear to me that formal notification of a Hendra virus incident between QPIF and QH has occurred in a variety of ways.

The lack of a formal framework for notification between QPIF and QH is of particular concern in relation to the notification of suspect and highly suspect horses.

QH officers told my officers that they would prefer to be notified of all highly suspect horses from which samples are submitted for testing. Some also advised that they would prefer to be informed of all suspect cases also, since sometimes horse owners contact their local PHU to discuss possible Hendra virus cases where horses are undergoing testing.

QH conducted an internal debrief following its response to the 2008 Redlands incident (Operational Debrief). A recommendation from the Operational Debrief was:

Establish a protocol with DPIF for notifying sick horses and Hendra test requests. Process for providing contact details of people in contact with the sick horse needs to be tightened.

QPIF argued that to notify QH of exclusion testing for Hendra virus could result in a significant increase in the amount of information being provided to PHUs from QPIF.

In relation to the issue of communication, I note that the minutes of a joint QPIF and QH teleconference on 11 August 2009 stated:

The reporting channels between [QPIF] and QH need to be clarified especially out of hours and weekends. Also the process for receipt of hard copy confirmation. QH preference is that there be phone contact with the relevant Population Health Unit (PHU) followed by faxing of hard copies directly to the relevant PHU. Would also be good to formalise previously agreed protocol that [QPIF] head office notify QH Communicable Diseases Branch (CDB) ... of all highly suspect cases.

Although my discussion above relates only to QPIF and QH, I understand that it would also be beneficial for there to be a formal method of notification by QPIF to WHSQ where a Hendra virus incident arises in a workplace.

QPIF, QH and WHSQ met to discuss the issue of communication between agencies in December 2009, and a draft memorandum of understanding between the agencies has since been prepared that addresses the above issues.

In addition, three interagency working groups have been formed to address key communication, technical and incident management issues that have arisen in previous Hendra virus incidents. The outcomes of these meetings may also be relevant to other biosecurity matters that involve the agencies.

However, I am concerned that even after meeting in December 2009 the agencies had not concluded any formal agreement, despite having known that a communication protocol was required since late 2008. A formal agreement had still

not been finalised in June 2010. My understanding is that it was signed in January 2011 by the Director-General of DJAG, and is currently awaiting signature by the Director-General of DEEDI before being sent to the Director-General of QH for signature.

In my view, it would also be valuable for any agreement between the agencies to address issues of communication during Hendra virus incidents, in addition to the issue of notification of incidents. My officers have been advised that there is presently no agreement between QPIF and QH concerning communication between the two agencies once an incident of Hendra virus is confirmed. There are no guidelines in respect of the extent, and frequency, of communication so that the effectiveness of communication often depends on personal relationships between officers of the two agencies. One QH officer stated:

I think we should have formal agreed protocols. At the moment we have a good relationship but it's informal. So I have raised that a number of times that it should be formalised but it may not necessarily be one model because it depends on where the incident is, the scope of it and various other issues, because we obviously both have slightly different structures in terms of the head office and the regional and it's working out how the best way to integrate and get that to work is. But we should have at least have some proposed models that we can pick from and say this is what we're doing.

I note that the agencies have put in place some measures to maintain communication between Hendra virus incidents. One senior QH officer told my officers that there have been regular meetings (at least twice a year) for a number of years between QPIF and QH, at which the agencies discuss issues such as Hendra virus coordination and protocols. The Director-General of DJAG confirmed that WHSQ officers have attended these meetings since November 2010.

### **Interagency communication at a local and head office level**

The following issues were raised about interagency communication at a local level:

- senior QH officers noted the need for local QPIF officers to ensure that the information provided to people involved in a Hendra virus incident is consistent with the advice given by QH, or preferably that QPIF officers refer all human health matters to QH
- local QH officers in some incidents commented that they did not receive the QPIF situation reports and therefore were not receiving sufficient information
- QH officers reported that they had not received formal confirmation of test results in some incidents, despite these being requested
- local QH officers said they were not aware for the initial period of the 2009 Cawarral incidents that there was a QPIF local control centre, and had difficulty reaching local QPIF officers. It was suggested that it would be helpful to have a QH liaison officer in any future local control centre for Hendra virus, to ensure that QH officers can have input into decisions that affect them
- local QH officers reported having had no input into the community engagement strategy formulated by QPIF and were surprised to be given a copy of the strategy and told that they had to provide QH officers to contribute. This amounted to 160 hours of community engagement by QH officers over a three-week period.

Overall, interagency communication between the agencies at head office level during Hendra virus incidents appeared more effective.

However, the following issues were raised with my officers about interagency communication at this level.

Firstly, during the 2008 Redlands incident, QPIF and QH formed a control group on which both agencies were represented and held regular teleconferences. However, there was no agreement between the agencies about who had responsibility for these meetings, including who was to chair the meetings and responsibility for things like recording and actioning minutes. I understand that, after several meetings, QH took on this role on its own initiative and distributed minutes to participants.

Secondly, QH officers noted that although communication with QPIF worked smoothly during the 2008 Redlands incident, the CVO's absence during the 2009 Cawarral incident meant that it took the agencies longer to sort out liaison arrangements. This was because, as mentioned above, effective communication was largely built dependent on relationships between key people in each agency.

In relation to the above issues of interagency communication, I therefore proposed making the following recommendation:

#### **Proposed recommendation 68**

QPIF, QH and WHSQ enter into a memorandum of understanding within three months of the date of my report covering:

- (a) in relation to notification of suspect and highly 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.

#### **DJAG's response**

The Director-General of DJAG supported this recommendation and advised that he had signed this memorandum of understanding (MOU) in January 2011. He also stated that WHSQ, QH and QPIF have commenced interagency discussions on this recommendation and plan to incorporate the additional content in the draft multi-agency coordination standard operating procedure that will support the MOU.

#### **QH's response**

The Director-General of QH supported this proposed recommendation, with suggested amendments to take into account QPIF's changed method of categorising Hendra virus cases.

The Director-General further advised that the MOU between QH, QPIF and WHSQ has now been signed by all parties, and this MOU addresses many of the issues contained within my proposed recommendation 68. He further advised that any aspects outlined in my proposed recommendation that were not specifically covered in the MOU would be addressed in an accompanying interagency standard operating procedure, which was currently in an advanced draft form.

### **DEEDI's response**

The Director-General of DEEDI confirmed that the MOU had been signed recently, and that this MOU would be reviewed in the context of the specific proposals in my proposed recommendation 68.

### **Ombudsman's analysis**

Each of the relevant agencies has accepted my proposed recommendation 68.

Given that it took quite a significant period for QPIF, QH and WHSQ to finalise the MOU from when my officers were first informed that the MOU was being drafted, I consider it necessary to recommend that the proposed operating procedures be completed within three months of the date of my report.

I confirm proposed recommendation 68 with amendments as a final recommendation:

#### **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.

## **12.5 Involvement of local councils**

Most local councils are members of state government committees that respond to significant public health or environmental incidents occurring within their local government areas.

During both the 2009 Cawarral and Bowen incidents, local council officers were quoted in the media as saying that they might have a role to play in the Hendra virus response.

This is not strictly accurate. Although it is important for QPIF and QH to keep the relevant local council updated and to provide information to the council on the Hendra virus, there is no specific role for any local council to play in a response to a Hendra virus incident.

The perception that there may be a role for local councils to play may have been based on a misunderstanding of the nature of Hendra virus and whether it poses such a significant risk to public safety so as to trigger disaster management response plans.

During each of these incidents, it seems that any misconceptions were quickly cleared up through QPIF briefings with the respective councils. I have received no complaints from any of the local councils involved in the 2008 or 2009 incidents about the amount of information provided to them by QPIF.

I confirm opinion 73 as a final opinion:

**Opinion 73**

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

## Chapter 13: Human health concerns

This chapter discusses QH's responses to human health concerns during Hendra virus incidents since January 2006.

### 13.1 Policies and response structure

#### 13.1.1 QH Guideline

The procedure for managing human Hendra virus cases is contained in the QH Guideline. Although QH has published a number of versions of this guideline since 1994, only two versions are relevant to my investigation:

- the QH Guideline dated 12 September 2006, which was applicable to the 2008 Redlands and Proserpine incidents as well as the 2009 Cawarral incident (I will refer to this as the superseded QH Guideline)
- the QH Guideline published on 7 December 2009, and revised in April and May 2011, which is the current QH Guideline available on the QH website.<sup>140</sup>

As outlined in section 13.2, it is unnecessary to enter into a detailed discussion of QH's actions in relation to both the 2006 Peachester and the 2009 Bowen incidents.

#### Superseded QH Guideline

The superseded QH Guideline limited QH's investigation to confirmed cases of Hendra virus in humans, and people who have had direct contact with body fluids of a horse determined by QPIF to be a confirmed or highly suspect case of Hendra virus.

In those cases, the superseded QH Guideline stated:

*Definition:* People who have had direct contact with a horse or its body fluids, during its illness with possible or confirmed Hendra virus infection or at autopsy.

*Investigation:* ...

Follow-up all potential contacts to determine the level and type of contact between the animal and any human contacts.

...

If results confirm the horse as Hendra virus positive, arrange baseline (day 0) and follow-up serology (at least day 14) for each human contact.

Contacts should be kept under clinical surveillance for 2 weeks. Provide information to the contacts and to their GP.

The superseded QH Guideline did not provide any information about how testing was to occur, or the management of the people concerned.

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<sup>140</sup> <http://www.health.qld.gov.au/cdcg/index/hendra.asp> .

A draft updated QH Guideline was circulated on 22 July 2009 but was not approved or implemented by the time of the 2009 Cawarral incident.

### **Current QH Guideline**

The current QH Guideline also sets out processes for managing people who have been in contact with horses which are highly suspected of, or confirmed as, being infected with Hendra virus.

As with the superseded QH Guideline, the current QH Guideline limits investigation to highly suspect or confirmed human cases, and:

People who have had direct contact with respiratory secretions or body fluids of a horse determined by Biosecurity Queensland to be a confirmed or highly suspect case of Hendra virus infection – see *Guidelines for veterinarians handling potential Hendra virus infection in horses*.

In the event of a confirmed or highly suspect Hendra virus case in a horse, the current QH Guideline states:

#### *Site visit*

Where feasible, a medical officer with suitable expertise (public health physician or senior medical officer from local health service district) should make a visit to the property as soon as possible to provide information and support to key people e.g. owners and managers. This visit should complement and not delay the full public health response which includes the timely assessment of exposure and current health status of the entire range of people who may have been exposed to infected horses, including animal health practitioners, many of whom may not be on site. The timing of the site visit may also be influenced by Biosecurity Queensland activities on site, which may fully occupy property owners and managers. The site visit could include interviewing and conducting assessment of exposure and current health status if appropriate, and arranging blood collection on site if resources are available (eg staff from QH clinical services or private pathology providers). Note that public health nursing and medical staff are not expected to perform blood collection.

...

... contacts and other closely involved persons, such as family members, owners, and others with negligible contact, may require repeated reassurance and information.

As any existing mental health issues or personal stresses might be exacerbated by this event, contacts and closely involved persons should be promptly connected to appropriate counselling, or psychological care, preferably through their GP.

It is observed that the content and level of detail in the current QH Guideline relevant to the management of people who have been in contact with horses known or highly suspected to have Hendra virus has changed significantly from the superseded QH Guideline.

### 13.1.2 QH response structure

Within QH, responses to Hendra virus are generally managed at a local level by PHUs, which fall within regional services within the Division of the Chief Health Officer. The division also includes other units such as the EHU and the CDB.

PHUs respond to incidents of notifiable disease, such as Hendra virus, in accordance with QH policies. PHUs also provide specialist public health advice to clinicians, the public and other agencies.

Each region of Queensland is serviced by a PHU. Within each PHU, a PHMO is responsible for managing control and immunisation programs for communicable diseases and for providing expert public health advice to other parts of QH, general practitioners (GPs) and the public.

The PHUs work closely with the CDB in Brisbane, which is responsible for the surveillance, prevention and control of communicable diseases.<sup>141</sup> The CDB coordinates policy for communicable diseases, including Hendra virus, and participates in QH responses to communicable disease outbreaks of statewide significance.

When QPIF identifies a possible or confirmed case of Hendra virus it notifies QH, which handles the human health response. The relevant PHU generally manages the local response, including identifying people who have been in contact with the infected or potentially infected horses, providing information, and arranging testing where necessary. The CDB is responsible for strategic oversight, policy and media matters during Hendra virus incidents, and also communicates and coordinates with QPIF's SDCHQ.

## 13.2 Overview of QH's response

### 13.2.1 The Peachester incidents

QH's responses to the 2006 and 2007 Peachester incidents involved:

- assessing the possible exposure and risk of all persons involved
- determining whether testing was required
- arranging for people to be tested through their GPs
- providing information to the relevant GPs and arranging further testing where necessary.<sup>142</sup>

The responses were managed by the Sunshine Coast PHU. In the case of the 2006 Peachester response, the PHMO of the Sunshine Coast PHU was on leave at the time and Doctor A was temporarily relieving in this position. Doctor A was also in charge of the 2009 Cawarral incident response. This information is relevant to my discussion below of the 2009 Cawarral incident and my findings in that regard.

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<sup>141</sup> QH (May 2010) Communicable Diseases Branch [accessed at <http://www.health.qld.gov.au/ph/cdb/default.asp> on 1 April 2011].

<sup>142</sup> Three tests (in 2006) or two tests (in 2007) were requested for each individual.

Although I received a submission criticising QH's responses to the 2006 and 2007 Peachester incidents, I am satisfied from the evidence available to me that QH acted appropriately in both cases.

### **13.2.2 2008 Redlands incident**

The relevant PHU for the 2008 Redlands incident was the BSPHU led by Doctor B, a PHMO. The BSPHU managed the exposure assessment, follow-up and testing of 91 people during the incident.

The superseded QH Guideline was the applicable guideline at the time of this incident. As noted above, the superseded QH Guideline stated that people who had been in contact with an infected or potentially infected horse should be tested but did not specify how the testing was to be carried out.

On 8 July 2008, QH public health officers travelled to the Redlands clinic to provide staff with information about Hendra virus. Information on each staff member's exposure to infected and potentially infected horses was also gathered in interviews. QH engaged a private pathology laboratory to collect blood from staff at the clinic on the day for baseline testing.

Initially, QH did not have its own fact sheet for Hendra virus to provide to clinic staff, and a United States Center for Disease Control & Prevention fact sheet was provided instead. QH developed a fact sheet on 9 July 2008, two days after the incident was identified.

Clinic staff and horse owners who required testing but were not at the Redlands clinic on the morning of 8 July 2008, including those who lived interstate, were asked to organise testing through their GPs. The BSPHU contacted all of the relevant GPs to provide information and advice about testing for Hendra virus.

QH officers also arranged repeat blood testing for clinic staff at the site on 22 July 2008.

### **13.2.3 2008 Proserpine incident**

The QH response to the 2008 Proserpine incident was led by Doctor C, a PHMO at the Townsville Public Health Unit (TPHU). During this incident, the TPHU maintained contact with seven people who required testing – six members of the property owner's family and one private veterinarian.

I received extensive submissions about the QH response to this incident from a family member of the property owner. Most of these issues had already been raised with QH, and related to:

- QH's assessment of the exposure risk of those involved, and whether it was appropriate to assess all family members as having a low risk of infection on the basis of the information provided to QH
- whether testing was initially offered to family members or whether they had to ask for testing

- the length of time family members had to wait for blood samples to be obtained once they attended the local hospital and whether the PHMO provided adequate information to hospital staff about Hendra virus to enable testing to be conducted
- whether there was a lack of information about testing procedures available to the family
- whether a blood sample from one family member was mislaid by QH, with the subsequent reporting of that person's results delayed until the following Monday causing significant stress.

I have considered issues one, two and four in section 13.3.

In relation to issue three, I am satisfied on the basis of the information provided to me that Doctor C made genuine attempts to provide the necessary information to the local hospital.

I did not consider issue five in my investigation as this was the only instance identified to my officers where blood samples were allegedly mislaid by QH.<sup>143</sup> Therefore, even if the fact were to be established, the incident would have been an isolated one, and I do not believe it requires investigation.

While I acknowledge that the property owner's family is unhappy with some aspects of the QH response, overall I am satisfied that it was reasonable. Those aspects of the response that could have been improved are addressed in section 13.3.

#### **13.2.4 2009 Cawarral incident**

There was significant media interest in QH's response to the 2009 Cawarral incident, and it included criticism of the actions of the QH officers involved. For this reason, I intend to consider this response in some detail and a chronology is set out below.

The QH response to the Cawarral incident was managed by the Central Queensland PHU (CQPHU), which had officers based in Bundaberg and Rockhampton. The CQPHU at the time consisted of seven officers:

- a PHMO (Doctor A) based at Bundaberg
- a supernumerary assisting Doctor A while re-skilling (Doctor D) based at Bundaberg
- two public health nurses, based at Rockhampton and Wide Bay
- an immunisation nurse based at Rockhampton
- a public health officer for indigenous health<sup>144</sup>
- a data manager based at Rockhampton.

This team was responsible for all public health matters in the Central Queensland Region. None of the officers were relieved of their other duties during the Hendra virus response.

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<sup>143</sup> Some samples were delayed in transit from other states to Queensland. However, this delay was not attributable to QH.

<sup>144</sup> This position was vacant at the time of the 2009 Cawarral incident.

### **Saturday, 8 August 2009**

A QPIF officer contacted the Director of the local QH EHU in the early afternoon to advise of a suspected Hendra virus incident at a horse stud in Cawarral. One horse had died that morning and two horses had previously died of unknown causes. The Director of the EHU then contacted the on-call PHMO, who was from Brisbane Northside PHU due to a shared on-call roster that operated across several regions. Within two hours of being advised of the suspected incident, the on-call PHMO contacted the manager of the Cawarral property by email after being unable to make telephone contact. The PHMO provided the property manager with a QH fact sheet about Hendra virus in humans and asked her to provide a list of names of those people who had been on the property in the previous two weeks.

The QH fact sheet *Hendra Virus Infection*, dated 29 August 2008, stated:

#### **Transmission**

While Hendra virus does not appear to be very contagious, humans and horses are susceptible to the disease. All human infections have occurred following direct exposure to tissues and secretions from infected or dead horses. There is no evidence of human to human transmission.

The incubation period in humans has been estimated at 5-16 days.

...

#### **Treatment**

A person suspected to be infected with Hendra virus may need to be admitted to hospital for supportive care such as intravenous therapy and mechanical ventilation. It is not known whether antiviral treatments are effective against Hendra Virus infection.

...

In the meantime, samples taken from the recently deceased horse were sent by QPIF officers to Brisbane for testing.<sup>145</sup>

### **Sunday, 9 August 2009**

Doctor D contacted a QPIF veterinarian to confirm that test results would not be available until the following day. It was determined that, in line with the superseded QH Guideline which applied at that time, QH would not take any further action until the test results were available.

### **Monday, 10 August 2009**

The Cawarral property manager contacted the Brisbane Northside PHU early on Monday morning seeking information. I understand from media reports at this time that the property manager was concerned about property workers not being tested for Hendra virus until a positive Hendra virus test result was obtained from a horse.

When Doctor D arrived at work that morning, he returned the property manager's call and then confirmed by email the CQPHU's contact details. The property manager initially identified five people who had been in contact with the potentially infected

<sup>145</sup> These samples did not arrive in Brisbane until the morning of Monday, 10 August 2009. This delay in transporting the samples was not attributable to QH or QPIF.

horses and was advised that the test results for the horses were expected later that day.

An email from the QH Director-General's Office to Doctor A at 9.40am stated:

Simply FYI – Min's Office have this morning taken a call from a concerned MP's office regarding a report from a constituent about Hendra virus in Rockhampton.

The advice from the caller was that a large number of thoroughbreds have been tested for the virus (time period is unclear at this point, but given the nature of the call it would seem to be very recent) but that human tests were not carried out (or are still to be carried out – this point was unclear).

The caller has been in contact with the Department of Employment, Economic Development and Innovation (which has responsibility for the former Department of Primary Industries), but simply wanted to make health authorities aware of the concern that human testing has not occurred.

The caller also noted that ABC news was aware of the issue, so it may well come up on our radar if the concerns about human testing are referred our way.

A reply from the Senior Medical Officer in the CDB stated:

Our protocol is not to take samples from human contacts until a horse is confirmed with Hendra. My understanding is that the local PHU was contacting the owners over the weekend, assessing exposure/risk/other contacts and providing appropriate advice.

By mid-morning, there was significant media interest in the decision not to test humans until Hendra virus was confirmed in a horse.

At 11.46am, the property manager provided CQPHU with contact details for 26 people who had visited the property since 21 July 2009.

The first positive preliminary test result for the horse that died on 8 August 2009 was received at midday on 10 August 2009. These results were communicated verbally by a QPIF officer to the Director of the EHU in Rockhampton at 12.40pm. The Director EHU communicated these results to Doctor A, who notified the CDB and then unsuccessfully attempted to obtain written confirmation of these preliminary results. The test samples were also sent by QPIF to the QHFSS laboratory for confirmation testing, but the results of the confirmation tests were not available until late that afternoon.

At the time, the CQPHU was also dealing with a suspected case of meningitis in Rockhampton.<sup>146</sup>

While confirmation was being sought by QH, the media began reporting the positive Hendra virus result. An email from a QH Senior Public Affairs Officer to the Deputy Director-General of QH and Doctor A at 1.31pm states:

AAP/Brisbane Times is now reporting the confirmation of Hendra Virus.

If this is the case, could you please advise on what changes you would like made to the media statement?

In response, the Senior Medical Officer stated in a further email at 2.20pm:

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<sup>146</sup> Meningitis is a serious notifiable disease.

I have only 3<sup>rd</sup> hand information that the test is apparently positive.

An officer from QHFSS emailed Doctor A at 2.21pm advising that the results of the confirmation testing should be available at around 4.00pm that afternoon and the CQPHU would be advised of the results as soon as they were received.

By the time the CQPHU received notification of the preliminary and confirmation tests, confirmation of the positive preliminary test result had been widely reported in the media.

During this time, Doctor A held an outbreak control team meeting and briefed CQPHU staff who would be involved in the QH response. From 2.15pm, these staff began contacting people who were known to have been on the property. By 3.28pm there were more than 30 people on that list. Each person was contacted with the purpose of providing information, determining the nature of the person's contact with the property and horses, and assessing the person's individual risk for infection with Hendra virus.

An email from Doctor A to the Acting Deputy Director-General of QH at 3.28pm stated:

We now have more than 30 people on our list who are possible contacts of these horses. We provide information and advice, based on our assessment of risk (which in turn is based on a person's exposure to the horse/s). We recommend a blood test and throat swab, which are arranged through GPs (we speak with these GPs). If people are well, they do not need to alter their behaviour. If people who have been in contact with [sic] the confirmed horse become unwell with fever and respiratory or neurological symptoms, they are advised to seek medical advice.

That afternoon, the CQPHU also prepared a template fax message to the GPs of all people who had contact with the infected horses advising of potential exposure to Hendra virus. This fax included the following recommended actions for the GP to follow:

[The patient] should have baseline serology for Hendra virus and follow-up for evidence of seroconversion; plus a throat swab today for Hendra virus PCR. Follow-up tests should be done at about 21 days after the first specimen. If there is no illness and serology remains negative over this period, I would consider the outlook very good, despite our gaps in knowledge.

...

If [the patient] becomes unwell during the next three weeks with fever and respiratory or neurological symptoms, the possibility of Hendra virus infection should be considered. The PCR and serology should be repeated. If a diagnosis cannot be made (eg laboratory confirmation of influenza or other respiratory pathogen), advice should be sought from an Infectious Diseases Physician regarding the possibility of Hendra virus infection. ... After this time, the likelihood of subsequent illness being possibly related to Hendra virus infection diminishes, but a diagnosis should be considered, particularly if there is unexplained fever with respiratory or neurological symptoms. A similar process should be followed.

QH issued a media statement later that afternoon stating:

Queensland Health will follow up using established protocols for the management of humans exposed to horses with Hendra virus infection. This involves identifying people

who may have had contact with the horses, assessing their risk of exposure and providing information and advice, including blood testing where appropriate.

Hendra virus infection is rare in horses and in humans. There have only ever been six confirmed human cases of Hendra virus infection in Queensland.

All six acquired the infection through close contact with infected horses. There has been no evidence of person to person transmission of the Hendra virus.

Throughout the afternoon and evening, the CQPHU contacted people (from the list provided by the property manager) who had possibly had contact with infected horses, and obtained information about their exposure. There were now 36 people on this list. The CQPHU also obtained details of each person's GP.

All but two of these 36 people were contacted by the CQPHU between 2.15pm and 8.00pm that day. Of the 34 people who were contacted, 22 were excluded from testing or follow-up due to lack of contact with the sick horses. These people advised QH that they were happy not to be tested. Twelve were being tested, and some had already attended their GP for testing by the end of the day. Four people were identified who had significant exposure to the infected horses.

An email sent by a QH media adviser to senior QH officers and Doctor A at 8.07pm stated:

[Doctor A] did an 11<sup>th</sup> hour interview with ABC radio just before the 7pm news. It seems abc radio news had not seen our release.

They were running allegations we told a woman connected to the horses to go to her GP. I believe this actually related to earlier in the piece, before hendra was confirmed in the horses.

Doctor A responded at 8.41pm:

Thanks for this. Just to clarify your comments, I did advise [the property manager] and [a property worker] (the two there at the property today, later joined by the owner) and all others identified as being at some risk, to go to their GP for testing. This is a standard response, and appropriate, except perhaps where a large numbers [sic] of staff at one site might provide efficiencies in doing otherwise. It is not about a single point of testing. It is about ongoing care, managing anxiety (which can be considerable) and appropriate follow-up which includes repeat testing down the track. Our contacts today were quite dispersed and inviting them back to the property for testing would have been quite inappropriate. We have provided extensive information and have communicated with the involved GPs, who are the appropriate point of primary care.

## **Tuesday, 11 August 2009**

The concern expressed in the media about people being told to go to their GPs for testing continued the next day. The media reported that the property manager was refusing to leave the property until QH could provide assurances that Hendra virus would not be transmitted to her family members.<sup>147</sup> The property manager and other workers also questioned whether it was safe to require them to travel to their GPs for testing and whether this would place members of the public at risk.<sup>148</sup>

A media statement was prepared by QH Public Affairs Unit:

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<sup>147</sup> Taylor, A 2009, 'Hendra virus -How can I risk passing it on to my children?', *Morning Bulletin*, 11 August.

<sup>148</sup> Gregg, N and Miles, J 2009, 'Fears for 30 as Hendra virus hits', *The Courier-Mail*, 11 August.

People at the Cawarral horse stud near Rockhampton, and all others identified as being at some risk, were advised yesterday to go to their general practitioner for testing.

This is a standard response, and appropriate, except perhaps where a large numbers of staff at one site might provide efficiencies in doing otherwise.

It is not about a single point of testing. It is about ongoing care, managing anxiety (which can be considerable) and appropriate follow-up which includes repeat testing down the track.

The contacts yesterday were quite dispersed, and inviting them back to the property for testing would have been inappropriate.

We have provided extensive information and have communicated with the involved general practitioners, who are the appropriate point of primary care.

However, QH has been unable to confirm from its own records whether the media statement was ever released.

The CQPHU continued to have discussions with the people who had been in contact with the infected and potentially infected horses and their GPs during the day. By 11.00am, the CQPHU had developed a list of people who had visited the property and their GPs, details of each person's potential exposure to the horses, and the current status of their testing and health.

Sometime on 11 August 2009, the decision was made to have QH staff attend the Cawarral property to obtain blood samples rather than to require the property workers to travel to their GPs. I have discussed this decision further in section 13.3.6.

At 11.38am, Doctor A advised the owner of the property that a QH team from Rockhampton would shortly be arriving to take blood samples. A further email from the Acting Executive Director of Rockhampton Hospital at 12.10pm stated:

[name deleted] (infection control nurse from Pop Health) and 2 senior mental health clinicians, and a ED Nurse Practitioner are heading out to the property now. I have talked to the owner just now to arrange this.

...

They have taken the equipment necessary to do the testing, as per [Doctor A's] advice.

The visit by the QH team to the property resulted in eight people being tested. QH had arranged to test four people at the property, but when they arrived they found a further four people had arrived there requesting testing. Some of the people tested had previously been assessed by QH as not being at risk and had agreed with QH that they did not require testing. Others had agreed to visit their GPs for testing but had then heard that QH would be coming to the property. During the visit, tests were requested for a further six people. These people were all subsequently contacted by QH and tested as considered necessary by QH officers.

The five people judged to be at some risk of developing Hendra virus infection based on QH's assessment of their exposure were contacted on the evening of 11 August 2009 and offered post-exposure treatment. Information was provided to each person about the post-exposure treatment. One of the five provided information that indicated a lower level of risk than had previously been assessed, and it was agreed

between this individual and QH that treatment was not appropriate for this individual. The other four people, including a private veterinarian Dr Rodgers, were all requested to consider treatment and were given the contact details of a local infectious diseases expert and advised to make an appointment to see him early on 12 August 2009 to discuss whether they would undergo treatment.

### **Wednesday, 12 August 2009**

On the morning of 12 August 2009, Doctor A attempted to contact the property owner by telephone to arrange testing for the people who had not been tested at the property the previous day. The CQPHU also prepared a facsimile to all GPs and emergency departments in Rockhampton and surrounding areas. The facsimile provided information about Hendra virus, an update on testing and contact information if they had any questions.

On the afternoon of 12 August 2009, Dr Rodgers attended the Rockhampton Hospital to receive treatment.

At 5.15pm, initial negative results were received for the people tested at the property. Doctor A commenced notifying the people involved, advising that repeat testing would occur in three weeks or at the onset of any illness.

### **Thursday, 13 August 2009**

A QPIF officer contacted QH on 13 August 2009 to request testing of QPIF staff who had been working on the Cawarral property. The email advised that although the staff had observed the appropriate protocols and worn PPE, QPIF believed that this testing was necessary to meet its duty of care to the staff. QH agreed to do so.

The Cawarral property manager and two property workers were admitted to a Rockhampton hospital for post-exposure treatment.

### **Monday, 17 August 2009**

Dr Rodgers finished his course of post-exposure treatment and was released from hospital.

### **Tuesday, 18 August 2009**

Dr Rodgers was re-admitted to a Rockhampton hospital with symptoms consistent with Hendra virus and transferred to a Brisbane hospital.

### **Thursday, 20 August 2009**

Dr Rodgers was confirmed to have contracted Hendra virus.

### **Friday, 21 August 2009**

The Cawarral property manager and two property workers were transported to a Brisbane hospital as a precaution.

### **Wednesday, 2 September 2009**

Dr Rodgers passed away.

I have considered various aspects of QH's response to this incident in section 13.3.

### **13.2.5 2009 Bowen incident**

The PHU involved in the 2009 Bowen incident was the TPHU and the response was managed by Doctor C. Those people exposed to infected or potentially infected horses were provided with a choice of either seeking testing through their GPs who would be provided with QH support and information, or having QH visit them to take blood samples. Having reviewed a number of internal emails sent in relation to this incident, it is clear to me that the QH response to this incident was heavily influenced by the negative media coverage of its approach in the 2009 Cawarral incident of referring people to their GPs.

I wrote to the owners of the Bowen property to invite them to make any submissions about the response of QH to human health concerns during the 2009 Bowen incident. I did not receive any submissions about QH's response.

There were no significant issues that require comment in relation to QH's response to human health concerns in this case.

## **13.3 Analysis of QH's responses to Hendra virus**

This section of my report considers the reasonableness of QH's responses to the Hendra virus incidents.

While other concerns were raised with my officers by people interviewed in my investigation, I have included only those issues that warrant further discussion.

### **13.3.1 Communication with those affected**

A number of complaints were raised with my officers about the alleged lack of information in relation to testing, as well as QH's communication generally. In particular, a number of people involved in Hendra virus incidents complained that QH did not appear to take their concerns about Hendra virus seriously.

In relation to the 2008 Proserpine incident, a family member of the property owner was one of those who felt that QH officers did not take her concerns seriously. She stated that she felt that her family had to repeatedly request testing. She also said that QH did not provide information about testing procedures, and said she was not told that the first test was a baseline test that would be expected to be negative.

The PHMO from the TPHU who coordinated the QH response, Doctor C, disagreed with these complaints and had a different recollection.

From the material I have seen, I am unable to determine that QH did not provide adequate information or otherwise respond appropriately to this incident.

However, it is possible that QH did not communicate information effectively to the people involved in the incident. The fact that Doctor C was based in Townsville and could only communicate with the property owner and his family by telephone may not have been as effective as face-to-face communication. On-the-ground support from a local QH officer may have assisted in this regard.

I note generally that the understandably high levels of anxiety felt by people caught up in Hendra virus incidents may mean that verbal information is less likely to be understood and retained. Where a low assessment of an individual's risk conflicts with what that individual believes or their perceptions of a rigorous biosecurity response, the person may be less likely to accept information from QH that they are at a low level of risk.

It is also relevant to note that a Hendra virus incident will only be one public health concern facing a PHU at any one time. Various QH officers told my officers that there are many diseases more contagious than Hendra virus.

However, given the significant anxiety experienced by people affected by Hendra virus incidents, QH officers should recognise the need to allay these concerns irrespective of medical assessments of a person's level of exposure or public health risk.

In relation to the 2009 Cawarral incident, the information I have gathered shows that the CQPHU mostly responded well to people's concerns. CQPHU officers maintained contact with the 48 people who had been exposed to the infected horses, and I have been provided with extensive notes of those contacts. Counselling was also offered.

I am satisfied that Doctor A, Doctor D and other CQPHU officers expended significant effort and resources to assist people and respond to their concerns.

However, the efforts expended to reassure people affected by a Hendra virus incident may not always be successful. For example, during the 2009 Cawarral incident QH and QPIF officers went to the Cawarral property on 11 August 2009 to provide information and support to those at the property. In relation to this visit, one of the property workers told my officers:

- |            |   |
|------------|---|
| Witness    | I think it was to allay our fears that someone was going to be exposed to the Hendra virus and she was pretty much just telling us that it's extremely hard to catch and there was no risk to our staff by entering the dirty zone.   |
| QO Officer | Did it allay your fears?  |
| Witness    | Not at all.   |
| QO Officer | Is there anything you've learnt since then that might have helped at the time?  |
| Witness    | I think as we were getting more and more information through and more and more, we spoke to more and more people about all the questions we had we were starting to get answers for and the more answers you got the more safer you felt. But certainly not a lot. The day we had that meeting though our fears weren't allayed at all. |

In my view, it seems more likely that the lack of reassurance felt by people involved in the incident was a function of the nature of Hendra virus and people's anxiety and fears, rather than any failure by QH officers to provide reassurance.

This has been discussed internally within QH and recognised in the most recent *Hendra Virus Infection Queensland Health Guidelines for Public Health Units*.<sup>149</sup>

A Hendra virus outbreak can be an extremely stressful event for a horse/property owner, vet, or person in contact with an infected horse. Owners are likely to see Biosecurity Queensland staff perform elaborate infection control measures with maximum 'space suit' type PPE, and possibly euthanasia and post-mortem examinations of their horses and to have their horses isolated/quarantined for several weeks.

Therefore, contacts and other closely involved people, such as family members and owners, may require repeated reassurance and information even when they have had negligible exposure.

As any existing mental health issues or personal stresses might be exacerbated by such an event, contacts and closely involved persons should be promptly connected to appropriate counselling, or psychological care, preferably through their GP.

Further, a number of comments were made to me about the provision of post-exposure preventative treatment by QH. Treatment was made available to the four people judged to have the highest level of exposure in the 2009 Cawarral incident.

This discussion is not intended to focus on the clinical merits of treatment options or the actual care provided to patients. These are issues for QH and infectious disease physicians.

However, it is clear from my officers' conversations with those who received the treatment that they felt QH could have provided them with more information about the treatment. In particular, my officers were told that:

- the same information was not provided to each of the people involved, but rather it was left to filter down to a person from others involved or from that person's employer
- the information sheet provided to the workers on treatment was too complicated and difficult to understand and was more of an information sheet for doctors than for patients
- those receiving treatment did not properly understand the side effects or what it involved, including whether their immune system was compromised by the treatment
- those receiving treatment were under the impression that it would be provided in Brisbane and not in Rockhampton
- those receiving treatment commented on the anxiety and confusion they were experiencing and the fact that they had to make difficult decisions about treatment within short periods of time. In one instance, one of the people who received the treatment was told that they had 30 minutes to make a decision about travelling to Brisbane for observation.

Although the media at the time reported that the property manager was concerned that she had to record her own symptoms at the hospital because the nurses failed to do so, I consider this related to a patient's clinical care and I do not intend to comment on this matter.

During the majority of my investigation, the relevant QH fact sheet on Hendra virus effectively consisted of one page and contained little detail. At the time of the 2009

<sup>149</sup> Available at <http://www.health.qld.gov.au/cdcdg/index/hendra.asp>.

Cawarral incident, no other QH resources on Hendra virus, including post-exposure treatment, were available to the public.

My officers asked the Senior Director CDB whether more detailed written information is available to persons involved in an incident other than the fact sheet:

Senior Director Yes, I mean that's our main thing. As I said we have realised it's actually not sufficient for people who have been exposed, so they do need some extra written information as well that's a bit more detailed than that.

QO Officer So is that something that you're developing?

Senior Director Yes.

QO Officer Is that written information likely to involve or contain information on testing procedures and what results mean and things like that?

Senior Director Yes, so it would be a bit more detailed, exactly around that, so you know to try and get the message across that there's the baseline test and this is the timing of it. And we know when you need another test and what that means.

Additional documents and information have since been placed on QH's website about Hendra virus, including a revised fact sheet for the general public.

My proposed report expressed my opinion that such additional information will assist those who are involved in Hendra virus incidents to understand QH processes and aid in the recall of information.

I also noted that the availability of written information about testing for Hendra virus would be particularly useful.

My officers were also told that in each incident, some people declined further testing after receiving the results of the initial test. However, QH advised my officers that the initial test is considered to be a baseline test and is generally expected to be negative for people whose exposure to an infected horse occurred within the incubation period.

In my view, the fact that people declined further testing may suggest a lack of understanding on their part about the procedure for testing for Hendra virus. This in turn may suggest that further written information should be provided by QH during Hendra virus incidents.

I confirm recommendation 69 as a final recommendation:

**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.

**13.3.2 Confusion over transmissibility**

QH's advice is that there is no evidence to date of human-to-human transmission of Hendra virus; however, the potential for it to occur has not been ruled out. Consequently, when a person who has been exposed to an infected or potentially infected horse becomes ill, standard precautions are taken to guard against any possible human-to-human transmission.<sup>150</sup>

In my investigation, it became apparent that QH may not be effectively communicating this low likelihood of human-to-human transmission and the reasons for the use of standard, droplet and contact precautions when a person becomes ill.

My officers were provided with examples of people involved in the 2009 Cawarral incident receiving different or confusing advice about the transmissibility of Hendra virus. For example, the Cawarral property manager and property workers were initially reluctant to leave the Cawarral property because QH could not guarantee that they would not be able to transmit the virus to family members.

Cawarral property workers also told my officers that when QH nurses attended the property to obtain blood samples, the nurses did not wear gloves or use any other protective equipment. However, when the Cawarral property manager and property workers attended a QH hospital in Rockhampton to commence a course of post-exposure treatment, they said they were asked to put on gowns, masks and gloves in the public car park before entering the emergency ward in the hospital.

My officers were also told by two people who required testing in the 2009 Cawarral incident that there was confusion among private GPs and medical laboratories about the proper precautions for Hendra virus. The two otherwise well people who required testing said that they were asked to wait away from other patients, one at a GP's

<sup>150</sup> See section 4.1.1.

office and the other at a private medical laboratory. They also reported that nurses avoided contact with them for fear of infection.

My officers confirmed with a PHMO that there was no need to take such precautions:

- |            |  |
|------------|--|
| Witness    | There should not be. These are well people, not infectious. The precautions in terms of taking reference or follow up samples of blood would be the ordinary precautions that are taken for, in any blood testing. |
| QO Officer | So you wouldn't think there would be a need for masks and gowns?   |
| Witness    | No.  |
| QO Officer | ... It wasn't required in the Protocol or anything like that?  |
| Witness    | No.  |

While QH is not responsible for the actions of GPs or staff at private medical laboratories, QH has sole responsibility for providing information to them about Hendra virus. Any practices which are inconsistent with QH advice will result in people questioning that advice or the conduct of their GPs and other service providers. This in turn may lead to a decline in the public's confidence in private and public health practitioners to deal with the issue.

Confusion and anxiety about the transmissibility of Hendra virus will be compounded by the significant media discussion of the high mortality rate of Hendra virus and the uncertainties surrounding it. Public speculation about possible mutations of Hendra virus is also likely to heighten anxiety, although no mutations have been identified in the virus to date.

As QH is the agency responsible for managing human health risks from Hendra virus, I consider that it is QH's role to properly inform its officers, GPs, medical laboratories, hospitals and the public (whether through the media or by other means) about the transmissibility of Hendra virus and the necessary precautions for Hendra virus testing and treatment. This role includes ensuring as far as possible that there is consistency in advice given and precautions taken, so that those involved in incidents do not experience unnecessary anxiety or confusion.

Given the diverse range of responses to people who have been exposed to Hendra virus, it seems that further education of QH officers, private medical personnel and members of the public is required.

My proposed report therefore proposed the following opinion and recommendation:

**Proposed 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.

**Proposed 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's response**

The Director-General of QH expressed no issues with this proposed opinion. In relation to my proposed recommendation 70, the Director-General supported this proposal and noted that this approach will facilitate consistency and provide information to the public about the transmissibility of Hendra virus and the precautions which are necessary during a suspected or confirmed Hendra virus incident. He noted that advice for health care workers is already available on the QH website, and that QH has already revised its fact sheet for the general public to provide more comprehensive information.

The Director-General further advised that QH officers were currently working with laboratory staff to develop appropriate information sheets for people directly involved in incidents.

### **Ombudsman's analysis**

I note that the Director-General of QH has accepted this proposed opinion and recommendation and these actions have largely been implemented. I confirm proposed opinion 74 as a final opinion:

#### **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.

I confirm proposed recommendation 70 as a final recommendation:

#### **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.

### **13.3.3 Assessing risk of exposure**

I received complaints from a small number of people involved in incidents who believed that their level of risk was not assessed appropriately by QH. An assessment of level of risk is used to determine whether testing and/or treatment is required for a person who has had some exposure in a Hendra virus incident.

I have concerns about the process of exposure assessment adopted by QH.

Although QH officers used a risk assessment form in each of the incidents, they did not use the same form. I was unable to obtain any agreement from QH officers about the different levels of risk involved in an exposure assessment. One PHMO advised that the levels were nil, negligible, moderate and extreme. Other PHMOs spoke about low, medium and high risks, or categories of risk and no risk.

During the 2008 Redlands incident, the BSPHU prepared a one-page exposure assessment form for use in recording human exposures. There was no provision in the form for detailed information such as multiple exposures to multiple horses. The subsequent operational debrief recommended that a generic exposure history form be developed for novel or unknown diseases and routes of transmission.

It appears that the PHU involved in the subsequent incident responses developed its own exposure assessment form and its own method of determining risk. This could lead to the risk of exposure being assessed differently in different incidents. As exposure risk is one of the factors used to determine whether preventative treatment will be provided, my understanding is that using different risk levels and methods of assessing the risk of exposure could affect clinical outcomes for people exposed to infected horses.

The fact that exposure assessments are generally done at a local level, and the doctor performing the assessment may not have done so previously for Hendra virus, also means that there is a potential for inconsistency in assessments of exposure and risk across incidents in the absence of a standardised process.

The implementation update on the QH Operational Debrief noted that at 3 September 2009, a Hendra virus exposure form was being trialled in the current Hendra virus incident. My understanding is that the form is still being trialled but is near finalisation. It is not clear whether this form includes a standardised process for determining risk.

In my proposed report, I formed the following opinion and made the following recommendation:

**Proposed 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.

**Proposed 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.

**QH's response**

The Director-General of QH supported this proposed opinion and recommendation. He further advised that a standardised risk assessment process for assessing exposure to Hendra virus has been finalised and the relevant form available on the QH website.

The Director-General also advised that the risk assessment process and form will be reviewed in light of lessons learned during future incidents and/or where significant new evidence emerges. He advised that as an additional measure to facilitate consistency of approach, the QH Guideline now states:

People assessed to have medium exposures should be discussed promptly with an infectious disease physician (IDP) to reach consensus on exposure assessment. ... As the evidence base to inform the use of post-exposure prophylaxis (PEP) is rapidly evolving, the IDP involved should consult with other IDPs who have experience in Hendra PEP and knowledge of the current evidence base. Wherever possible, an expert panel of PHMOs and IDPs with appropriate experience should be convened as part of the incident management process to review all contacts identified as high and medium exposures and advise on provision of monoclonal antibody and logistic issues.

Finally, the Director-General advised that the exposure assessment process and form will be submitted for consideration for inclusion in the national guidelines for PHUs now available on the Commonwealth Department of Health and Ageing website.

### **Ombudsman's analysis**

I note that the Director-General supports my proposed opinion and recommendation, and I am pleased to see that he has already taken steps to implement my proposed recommendation.

I confirm proposed opinion 75 as a final opinion:

#### **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.

I confirm proposed recommendation 71 as a final recommendation:

#### **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.

The QH Operational Debrief noted that there was a need to understand the level of risk exposure arising from carrying out particular veterinary procedures. For example, the operational debrief referred to confusion over the risk to humans in conducting a nasal lavage.

While I accept that some terminology and procedures are commonly understood by both doctors and veterinarians, the specific nature of the procedures may be critical to understanding the concept of risk. For example, the veterinary nurse in the 2008 Redlands incident was exposed to Hendra virus through performing a nasal lavage.

While a doctor may understand the general concept of a lavage, they may not know information such as the size of the tube used, whether veterinarians generally wear gloves or a mask, or how much splashback commonly occurs.

Also, in the 2009 Cawarral incident, QPIF officers expressed concern about whether QH officers accurately understood how the activities of a farrier who treated an infected horse informed their assessment of his level of risk. A private veterinarian described for my officers exactly what a farrier's work involves:

A farrier tends to the horse's feet. Especially the front feet, horses graze down by their feet, blowing out crap and you know, right near their feet. When a farrier picks up their front feet, the horse leans over them and breathes right next to their ears and coughs all over their, that area. A farrier is probably more involved, even though he's working on the ground level, is more involved with a horse being very close to their face than most.

QPIF officers expressed concern about the farrier being assessed as having a low level of risk.

One solution may be for QPIF to nominate a QPIF veterinarian as soon as an incident of Hendra virus is discovered to provide information to the QH doctors assessing levels of risk about what particular veterinary procedures mean in terms of risk exposure.

QPIF officers also noted that QH has not communicated to them the process by which exposure risk is assessed, meaning that they do not know what information may be relevant to share with QH during an incident response.

I confirm opinion 76 as a final opinion:

**Opinion 76**

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

I confirm recommendations 72 and 73 as final recommendations:

**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.

**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.

### 13.3.4 When to test people

One other matter requires discussion, due to the number of submissions that my officers received on this issue.

A Sunshine Coast woman who lived on a property neighbouring the site of the Peachester incidents died suddenly, two months before the 2006 Peachester incident. The Coroner was unable to find a cause of death.

Following the 2006 Peachester incident, the woman's daughter contacted QH seeking testing of tissue samples from her mother's remains (or blood samples taken before her mother's death) for Hendra virus. She also contacted QPIF requesting that her mother's cat be exhumed and tested for the virus, as the cat had died just after her mother had passed away. The daughter also requested that QPIF test her mother's horses to confirm the absence of Hendra virus before they were moved to the daughter's property.

The relevant guideline at the time (a version of the QH Guideline dated 9 May 2005) required close contact with a known Hendra-positive horse before human testing would be undertaken.

However, a PHMO did investigate the daughter's concerns at the time. The PHMO obtained a copy of the Coroner's report and spoke with the deceased's GP. She also discussed the matter with the manager of QH's CDB and QPIF's Principal Epidemiologist, as well as taking into account information from the daughter about her mother's illness and the cat. The PHMO determined that there was no obvious transmission path between a Hendra case and her death, and there was no evidence of a sick horse at the time of the deceased's death. It was agreed by both QH officers and the QPIF officer that there was no evidence to suggest that the deceased died from Hendra virus, and this was conveyed verbally to the woman's daughter and in writing to the Coroner. After this time there was further contact between the PHMO and the daughter of the deceased woman which was facilitated by a QH Open Disclosure Consultant. A pathologist with expertise in Hendra virus then reviewed the post-mortem slides and found no evidence suggesting Hendra virus infection. These findings were then provided to the deceased's daughter.

Although claims have been made that QH refused the request to test stored samples from the deceased, my understanding is that there were no such samples that could be tested as Hendra virus tests cannot be performed on fixed specimens from a post-mortem.

QH's response to this unusual situation and request was not inconsistent with the superseded QH Guideline at the time, and I do not consider that QH's response was unreasonable.

The cause of the woman's death and QH's determination of medical issues are properly matters for the Coroner and medical experts to consider and determine as appropriate.

### **13.3.5 The number of tests provided**

Although the incubation period for Hendra virus is up to 21 days, QH generally recommends a final test at 42 days after a person was exposed to the virus to definitively conclude that they have not been infected. Whether testing is recommended depends on risk level (including the nature of contact with the horse or horses and use of protective equipment) and level of concern. The number of tests recommended may vary depending on when exposure occurred, or due to other factors on the basis of clinical judgment.

It is therefore not surprising that a different number of tests have been provided to people who had contact with infected or potentially infected horses in each incident. My officers were told that this caused some anxiety and confusion among the people being tested.

Having reviewed the evidence provided to me, I am satisfied that QH conducted an assessment of the number of tests required based on individual circumstances and the factors mentioned above.

QH advised my officers that the following general guidance accurately captures how the number of tests recommended would usually be determined.

If a person's last exposure to an infected or potentially infected horse occurred over 42 days ago and the person is otherwise healthy, one round of testing (serology) is sufficient to confirm that the person does not have Hendra virus infection.

If a person's last exposure to an infected or potentially infected horse occurred between 21 and 41 days previously, and the person is otherwise healthy, either one or two rounds of testing (serology) would be sufficient to determine whether the person had contracted Hendra virus. Testing is recommended at 21 days and 42 days after last exposure, but if the person is first seen at close to 42 days then a single test at 42 days may be the most appropriate option.

If a person's last exposure to an infected or potentially infected horse was more recent (that is, occurring in the past 20 days), and the person is otherwise healthy and their exposure was significant, two or three rounds of testing (serology) would likely be provided. Testing is recommended at baseline (when first seen), and then 21 days and 42 days after last exposure, but if the person is first seen at close to 21 days then two tests at 21 and 42 days may be the most appropriate option.

There may, of course, be situations where testing is not recommended for a person based on a clinical assessment of their individual exposure risk.

PCR testing would most likely only be conducted when a person with exposure to an infected or potentially infected horse became unwell during the incubation period.

Where contact with infected horses occurred after the Hendra virus incident was identified, the necessity of additional tests is likely to be determined on the basis of the nature of any further contact and whether protective equipment was used.

However, QH also advised that these are guidelines only and a treating doctor may choose to deviate from the guidelines depending on the circumstances.

I also received submissions criticising QH for changing its approach to the incubation period and number of tests required from incident to incident.

The QH approach to matters such as incubation periods and number of tests required changes as knowledge of the virus improves. It is entirely proper that this occur.

While I acknowledge that people have understandably high levels of anxiety about Hendra virus and that it may ease their anxiety somewhat to be provided with immediate and frequent testing, QH's approach is reasonable. However, in my proposed view some of this anxiety could be addressed if QH provided clear information to the public about testing procedures.

I have already proposed making a recommendation to this effect in section 13.3.1.

### **13.3.6 Referral of people to their GPs for testing**

During the 2009 Cawarral incident, substantial media attention was given to the advice initially provided by QH that people should attend their local GP for Hendra virus testing. The Cawarral property owner and property manager complained about being sent to their GPs for testing, and were concerned about the possibility that they might transmit the virus.<sup>151</sup> Following media reports of their concerns, a decision was made to send QH officers to the Cawarral property to obtain blood samples.

It appears that the decision to do so was made at the Minister's request. An email from the Minister's office to the QH Acting Deputy Director-General at 9.13am on 11 August 2009 stated:

It is requested that [Doctor A] and her team attend to the people on the property today and test them and provide advice on this please.

While the superseded QH Guideline applied at the time of the Cawarral incident, the revised draft QH Guideline had been circulated to Doctor A shortly before the incident was discovered.

In relation to the issue of whether to use GPs to carry out testing, the superseded QH Guideline stated:

If results confirm the horse as Hendra virus positive, arrange baseline (day 0) and follow-up serology (at least day 14) for each human contact.

Contacts should be kept under clinical surveillance for 2 weeks. Provide information to the contacts and to their GP.

Although the use of GPs is mentioned, it is not mandated. Nor is there any requirement that testing be carried out by QH officers.

Therefore, there was no specific requirement in the superseded QH Guideline about how testing was to be carried out.

The revised draft Guideline distributed for comment on 22 July 2009 did not change this position.

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<sup>151</sup> This dissatisfaction was later confirmed to my officers.

The approach of requesting that people visit their GP to obtain blood testing was the approach taken in several previous Hendra virus incidents, including the 2006 Peachester incident (managed by Doctor A), the 2008 Redlands incident<sup>152</sup> (managed by Doctor B) and the 2008 Proserpine incident (managed by Doctor C). I received submissions from people involved in these incidents who were satisfied with obtaining testing through their GP.

As the approach of using GPs to arrange testing for Hendra virus had been adopted in at least three previous Hendra virus incidents, I consider that senior QH officers would or should have known that this occurred. I have not seen any documents indicating that senior QH officers had expressed concern about this process or requested that it not occur.

Although during the 2008 Redlands incident the clinic workers were tested at the Redlands clinic, this was arranged because of the unusual situation where most of the people to be tested continued to work at the clinic. Attending a quarantined property to obtain blood samples for testing was not expressly required by the superseded QH Guideline.

Doctor A told my officers that she was not aware at the time of the 2009 Cawarral incident that on-site testing had occurred in the 2008 Redlands incident. I note that the situation in the 2009 Cawarral incident was significantly different, as only a handful of people who required testing remained on the Cawarral property.

I also note that in the 2009 Cawarral incident, the Acting Deputy Director-General, the Senior Director CDB and the Senior Medical Officer in the CDB were all notified at approximately 3.30pm on 10 August 2009 that the CQPHU's approach would be to refer people to their GPs for testing. I have not been provided with any written evidence to suggest that any of these officers believed that this approach was inappropriate, until the issue received significant media attention and the Minister and Premier became involved the following morning.

Finally, the Cawarral property manager raised concerns in the media that visiting a GP for testing might expose members of the public to Hendra virus. This concern may have been reinforced to some extent by incidents where some people without symptoms who attended GP clinics or medical laboratories for testing were allegedly isolated from other patients and required to wear protective gowns and masks.

It is unfortunate if this occurred. I note that such actions are not consistent with QH information that only standard precautions are to be taken, and only where a person is unwell.

The alternative to advising people to visit their GPs for testing is for QH officers to attend on-site to obtain blood samples, as occurred at the Redlands clinic, during the 2009 Bowen incident and ultimately at the Cawarral property. However, such an approach may be problematic if all affected people are not on the one property and available at the same time. There may also be instances where people may be reluctant to return to a quarantined property for testing.

Another factor that supports the use of GPs is that they can provide a holistic service to patients. The Senior Director CDB told my officers that the advantage of people being tested by their GPs is that:

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<sup>152</sup> Testing for some people was obtained through GPs; others were tested at the clinic.

... they're someone who actually knows the patient, so that when they do develop their cold symptoms, then you know they can go back to that person and actually get a proper diagnosis and get tested for everything else that it could be as well as the Hendra virus, so basically have a full assessment.

And the other advantage is that if that person does require you know extra psychological support then the GP, you know that's their bread and butter, that's what they do everyday is they support people who are sick, or who might be sick or anxious or worried, and they can do that and then refer onwards, to, you know, some sort of psychology or service if required. So you know they have far greater capacity and that's their day-to-day work with their patients, than having someone from Queensland Health coming in, especially if it's ... a rural place or whatever.

In the 2009 Cawarral incident, the CQPHU contacted each person's GP and provided them with information and advice about testing. In the circumstances, I do not consider that Doctor A's actions in requesting that people go to their GPs for testing were unreasonable.

I confirm opinion 79 as a final opinion:

#### **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.

However, having regard to the high level of anxiety triggered by incidents of Hendra virus, it was perhaps predictable that the approach would attract public criticism because it gave the appearance that QH was not taking sufficient responsibility for managing the incident.

It would have been preferable had the superseded QH Guideline contained sufficient, unambiguous guidance about the processes by which QH officers should arrange testing.

On 14 August 2009, the Director-General of QH directed that the superseded QH Guideline be revised, and a new version was produced, dated 18 August 2009. That version was similar to the current QH Guideline issued on 7 December 2009, which allows for site visits and the collection of blood samples at the site where this is appropriate.

I therefore do not consider it necessary to make any recommendations to QH on this issue.

### 13.3.7 Review of the Redlands and Proserpine responses

On 27 October 2008, QH conducted the operational debrief in relation to its response to the 2008 Redlands incident. The introduction to the document states that the aim of the debrief was:

To review the internal Queensland Health public health incident response performance during the 2008 Hendra outbreak in order to learn from that experience so that the response system and actions can be improved both in terms of agency preparedness and health service response capability.

The operational debrief was attended by QH officers, with QPIF participation at some stages.

Some people expressed their dissatisfaction to my officers about the scope of the operational debrief. It seems that expectations of wider participation may have been raised by a media article reporting statements attributed to the Senior Director CDB. The media report stated:

[The Senior Director CDB] said it was standard procedure to review a significant disease outbreak.

...

“We are looking at those who were exposed (including those who did not contract the virus), how it was managed, what support they received and the testing they received,” [the Senior Director CDB] said.

She said Queensland Health staff, clinic staff, horse owners and anyone who came into contact with the infected horses would be part of the inquiry.<sup>153</sup>

However, our review of the documents suggests that the operational debrief was largely internal, and although it involved some discussions with QPIF officers, it did not include input from any of the property or horse owners involved in the Redlands or Proserpine incidents.

My officers asked the Senior Director CDB about this media report:

Senior Director ... I didn't say that at the interview. So that was actually misquoted. ... So I did actually have, during that interview, one of the Queensland Health media people were sitting with me, and when that came out in the press I thought I don't think I said that, and you know I went back to him and said what did you think of this and his response was well I don't think you said that. I said well yes, I don't think I said it either.

QO Officer Was there a reason why people who weren't involved with Queensland Health during the outbreak at Redlands weren't included in the operational review?

Senior Director Just because it, you know it was never meant to be a broader review like that, it was you know an internal review around how our internal processes work, how our protocol worked, how we felt our communications with DPI and the media and you know all the

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<sup>153</sup> Berry, P 2008, 'Queensland Health launches Hendra review', AAP, 8 September.

external parties, so it was never meant to be you know a public review or whatever like that.

QH was unable to provide my officers with a transcript of the interview.

I note that the Senior Director CDB's assertion that QH intended the operational debrief to be an internal review is consistent with the fact that only QH staff attended the operational debrief, as well as the initial circulation of the operational debrief report.

While it is likely that expectations of a wider participation were raised by the media article, there is insufficient evidence for me to conclude that QH acted unreasonably by not consulting people affected by the incidents during the operational debrief.

Nevertheless, in my view a review of an incident response may have benefited from consulting with the people who were the subject of the incident response in order to identify communication gaps or other shortcomings.

The operational debrief identified a number of actions to improve QH's future responses. Many of these were minor matters and I do not intend discussing them here.<sup>154</sup> Some other issues are discussed in this chapter.

In September 2009, QH prepared an implementation status table summarising the actions taken in response to the operational debrief.

The table showed that not all of the recommendations in the operational debrief had been actioned, despite it being conducted 12 months earlier. Senior QH officers advised my officers that implementation was delayed by the H1N1 (swine flu) outbreak in 2009 which necessitated significant resources from the PHUs and the CDB.

QH has advised my officers that most of these recommendations have now been implemented, and the few remaining issues are under ongoing consideration.

### **13.3.8 Communication with veterinarians**

A submission to my investigation questioned whether QH has an obligation to communicate directly with veterinarians about zoonotic diseases such as Hendra virus.

It has been suggested that since veterinarians are more exposed to zoonotic diseases than the general public, QH has an obligation to contact private veterinarians directly to notify them of positive results to zoonotic diseases and instructions for personal protection, rather than relying on QPIF to do so.

In the past, QH has left all contact with veterinarians to QPIF, seeing communication with veterinarians as the role of QPIF which works with the AVA and other veterinary associations. However, QPIF manages the biosecurity and animal health aspects of an incident, rather than focusing on human health aspects.

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<sup>154</sup> The report of the Operational Debrief is available on the QH website at <http://www.health.qld.gov.au/ph/documents/cdb/hendradebrief.pdf>.

The Senior Director CDB told my officers:

... Biosecurity Queensland have a role in providing infection control to vets, but you know we also then have part of a role in informing that as well, so that's possibly a little bit of a grey area about who should actually give that infection control advice.

So the infection control advice to health care workers who are looking after a patient with Hendra virus is very clearly a Queensland Health responsibility, but in terms of you know what vets should be doing with sick horses more broadly you know requires DPIF, or that's partly their role because they advise on you know the symptoms in horses and that sort of stuff.

I agree with the Senior Director CDB that QPIF and QH both have a role in providing information to veterinarians. There is also clearly a role for WHSQ, as that is the agency that can provide expert advice on risk management and safe systems of work.

The AVA made the following submission to my investigation:

... documentation produced by QPIF incorporates an emphasis on precautionary based principles and encourages veterinarians and the horse industry to mitigate their risks through the adoption of appropriate risk management strategies. Similarly work with stakeholders such as Queensland Horse Council has seen further communication from that organisation in addition to public seminars and meetings specifically designed to raise awareness of Hendra health issues and risk management.

Workplace Health & Safety Queensland has demonstrated initiative in assisting with education and awareness campaigns for the veterinary profession and has liaised extensively with AVA and EVA to raise awareness of Hendra risk management throughout Queensland. We would like to see Queensland Health adopt a similarly high profile role in informing the community about Hendra risk and risk management.

I consider that the most effective way to provide information about Hendra virus to private veterinarians and other stakeholders, especially during an incident, is by the government agencies involved taking joint responsibility and a coordinated approach.

In my proposed report, I formed the following opinion and made the following recommendation:

**Proposed 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.

**Proposed 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.

I also noted that QH, QPIF and WHSQ along with the AVA published a document titled *Hendra Virus Infection Prevention Advice* (dated March 2011) on the QH website and that this goes some way to achieving this coordinated approach.

**DJAG's response**

The Director-General of DJAG supported this recommendation and advised that WHSQ has implemented an extensive engagement strategy with private veterinarians. This included participation in an interagency communications working group to promote coordinated communications during Hendra virus incidents.

The Director-General referred to a joint interagency Hendra virus communications framework, which was formulated in 2010 to provide an agreed and consistent process for the three agencies to follow when communicating with various stakeholders in Hendra virus incidents. He further advised that the three agencies have developed a web-based Hendra virus resource kit which includes six fact sheets (available on the WHSQ website), as well as Hendra virus prevention advice dated March 2011 (available on the QH website).

**QH's response**

The Director-General of QH expressed no issues with my proposed opinion or recommendation, and noted that the interagency communications framework aims to ensure coordination of communication to all relevant stakeholders.

**DEEDI's response**

The Director-General of DEEDI did not respond to this recommendation.

**Ombudsman's analysis**

I confirm proposed opinion 80 as a final opinion:

**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.

I confirm proposed recommendation 76 as a final recommendation:

**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.

**13.3.9 The issue of a coronial inquest**

Finally, I received a number of submissions from persons concerned that there had not been a coronial inquest into Dr Cunneen's death in 2008.

The holding of coronial inquests is governed by the *Coroners Act 2003*, which limits the circumstances in which a death can be investigated. Section 11 states:

## 11 Deaths to be investigated

...

- (2) A coroner must, and may only, investigate a death if the coroner—
  - (a) considers the death is a reportable death, whether or not the death was reported under section 7; and
  - (b) is not aware that any other coroner is investigating the death.
- (3) Also, a coroner must investigate a death if the State Coroner directs the coroner to investigate the death.
- (4) The State Coroner may direct a coroner to investigate a death if—
  - (a) the State Coroner considers the death is a reportable death; or
  - (b) the State Coroner has been directed by the Minister to have the death investigated, whether or not the death is a reportable death.

### *Example—*

The Minister might direct the State Coroner to investigate the death of a Queensland person that happened overseas, even though the death was investigated by a coroner overseas, if the Minister is concerned that the overseas investigation was not comprehensive enough.

The definition of a reportable death is contained in section 8:

- (1) A person's death is a **reportable death** only if the death is a death to which subsection (2) and subsection (3) both apply.
- (2) A death is a **reportable death** if—
  - (a) the death happened in Queensland; or
  - ...
- (3) A death is a **reportable death** if—
  - (a) it is not known who the person is; or
  - (b) the death was a violent or otherwise unnatural death; or
  - (c) the death happened in suspicious circumstances; or
  - (d) the death was a health care related death; or
  - (e) a cause of death certificate has not been issued, and is not likely to be issued, for the person; or
  - (f) the death was a death in care; or
  - (g) the death was a death in custody; or
  - (h) the death happened in the course of or as a result of police operations.
- ...
- (5) For subsection (3)(b), an unnatural death includes the death of a person who dies at any time after receiving an injury that—
  - (a) caused the death; or
  - (b) contributed to the death and without which the person would not have died.

### *Examples—*

- a person's death resulting from injuries sustained by the person in a motor vehicle accident many months before the death
- a person's death from pneumonia suffered after fracturing the person's neck or femur
- a person's death caused by a subdural haematoma not resulting from a bleeding disorder

The relevant Minister is currently the Attorney-General, Minister for Local Government and Special Minister of State.

I understand that clarification was sought from the Coroner in late August 2008 by solicitors for the owners of a horse that died during the 2008 Redlands incident as to whether an inquest would occur into the death of Dr Cunneen. A letter in response from the State Coroner dated 1 September 2008 stated:

Ben Cunneen's death is of course sad and regrettable. However I do not consider it "reportable" under the *Coroners Act 2003*. This assessment is based on advice that Mr Cunneen died of natural causes as a result of a known and identified disease. It is therefore not within any of the categories of reportable death set out in section 8 of the Act.

While I can well understand the concerns your client has, I am assured that the Department of Primary Industries, the Veterinary Board, the Infectious Diseases section of Queensland Health and the Chief Health Officer's office are looking into the public health risks highlighted by the case.

In the circumstances my office will therefore be taking no action in relation to the matter.

As deaths caused by Hendra virus are not reportable deaths, the State Coroner cannot conduct an inquest unless the Minister directs him to do so.

## Chapter 14: Workplace health and safety issues

This chapter discusses the role of WHSQ in Hendra virus incidents.

The current WHSQ website states that it is:

... responsible for improving workplace health and safety in Queensland and helping reduce the risk of workers being killed or injured on the job. WHSQ enforces workplace health and safety laws, investigates workplace fatalities, serious injuries, prosecutes breaches of legislation, and educates employees and employers on their legal obligations. WHSQ also provides policy advice on workers' compensation matters.<sup>155</sup>

Under the WHS Act, WHSQ has an obligation to investigate or intervene where a death, injury or other safety breach occurs at a workplace. A workplace is defined in s.9 of the WHS Act as a place where work is, or is to be, performed by a worker or a person conducting a business or undertaking.

Both a veterinary clinic and a private property at which a veterinarian is working are workplaces within the meaning of that term under the WHS Act.

### 14.1 Involvement of WHSQ in Hendra virus incidents

WHSQ officers advised my officers that they did not conduct any investigations of Hendra virus incidents before 2008, with one exception, even though some of those incidents involved the exposure or possible exposure of private veterinarians to Hendra virus on a client's property. However, my Office was advised that in some incidents before 2008, WHSQ officers gave advice to private veterinarians.

The one exception was an investigation conducted by the North Queensland region of WHSQ into the investigation of the infection of a private veterinarian near Cairns in late 2004. As a result of this investigation, improvement notices were issued to the veterinarian's employer.

WHSQ investigations were also conducted in respect of the 2008 Redlands incident and the 2009 Cawarral incident.

Since 2008, WHSQ has provided some guidance to private veterinarians about biosecurity risks such as Hendra virus. It advised my officers that the following actions have been completed:

- Engaged extensively with the Queensland branch of the Australian Veterinary Association (AVA) and the AVA speciality interest group Equine Veterinarians Australia (EVA).
  - Partnered the AVA in presenting one-day infection control workshops to veterinarians and veterinary nurses at Brisbane, Townsville, Malanda, Rockhampton and Toowoomba.<sup>156</sup>
  - Provided the AVA with a Hendra virus self-survey checklist for veterinarians for distribution to members.
  - Provided technical support for the development of AVA/EVA Hendra virus resources and provided articles for the AVA Queensland journal.

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<sup>155</sup> DJAG (2010) Fair and Safe Work Queensland, Workplace Health and Safety Queensland [accessed at <http://www.justice.qld.gov.au/corporate/our-department/about-us/fair-and-safe-work-queensland> on 1 October 2010].

<sup>156</sup> Subsequent workshops were held in Maroochydhore, Gatton and Mackay, with one further workshop planned for Roma.

WHSQ has published a paper titled *Managing Occupational Zoonoses in Veterinary Practice* in the April 2009 edition of the AVA Queensland newsletter.

WHSQ has also advised my officers that it has undertaken the following activities in relation to Hendra virus:

- published two safety alerts on Hendra virus on the WHSQ website for veterinarians and horse-related businesses
- provided technical support to QPIF for the development of Hendra virus resources, including revisions to the Guidelines for Veterinarians
- participated in the QPIF industry roundtable on Hendra virus on 23 September 2009
- delivered a paper on Hendra virus risk management at the Safety Institute of Australia's Visions conference in Townsville on 22 October 2009
- provided WHSQ Hendra virus safety alerts for QPIF community information displays and workshops
- hosted a one-day Hendra virus forum for veterinarians on 8 November 2009 and a half-day workshop for horse trainers on 9 November 2009 in Rockhampton
- participated in a cross-agency Hendra virus debrief with QPIF and QH on 9 December 2009 to progress enhanced interagency responses to future Hendra virus incidents.

Further, WHSQ advised that it was currently undertaking the following activities:

- providing small business program services to veterinary businesses on request
- conducting Hendra virus training for WHSQ inspectors in each region.

WHSQ has finalised its statewide Hendra virus intervention begun in January 2010, which involved five to 10 visits per region of horse-related businesses (with a focus on veterinary practices) to assess Hendra virus risk management, awareness and preparedness. The report of this audit is available on the WHSQ website and its findings have been presented to stakeholders including QPIF, QH and the AVA.

WHSQ has also participated in an interagency technical working group to develop best practice Hendra virus infection prevention advice. This advice has been published on the QH website.

WHSQ has also prepared a draft enforcement note for its investigators, setting out the criteria against which veterinary practices will be assessed for reasonable control of risks associated with Hendra virus. The checklist which forms part of the enforcement note and sets out the criteria against which veterinary practices will be assessed has been distributed to the veterinary industry via the AVA and is published on the WHSQ website.

I am satisfied that WHSQ is taking appropriate measures to provide information about reducing the risk of infection from Hendra virus in the workplace.

However, I note my comments in chapter 12 in relation to QPIF about the inadequacy of communicating with private veterinarians solely or mainly through the AVA.

In my view, it is essential that WHSQ ensures that information is made available to all private veterinarians within Queensland, whether through use of the VSB mailing list

or by another method. Further, I note that information on managing biosecurity risks may also be relevant to veterinarians who do not work with horses.

In my proposed report, I formed the following opinion and made the following recommendation:

**Proposed 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.

**Proposed 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.

**DJAG's response**

The Director-General of DJAG supported this recommendation, and advised that information on Hendra virus is made available on its website. He further advised that information on Hendra virus is included in the WHSQ electronic newsletter, and that WHSQ has provided QPIF with copies of its resources on Hendra virus to support community engagement during incidents. WHSQ has also developed an enforcement note to provide operational guidance to WHSQ officers and which requires the provision of information to private veterinarians involved in incidents. Finally, the Director-General committed to exploring ways to disseminate Hendra virus information to private veterinarians, including by working with QPIF to achieve this.

**Ombudsman's analysis**

I confirm proposed opinion 81 as a final opinion:

**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.

I confirm proposed recommendation 77 as a final recommendation:

**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.

**14.2 Adequacy of Redlands investigation**

The investigation conducted by WHSQ into the 2008 Redlands incident was the first investigation into Hendra virus conducted by WHSQ since the 2004 investigation referred to in section 14.1.

After conducting the investigation, WHSQ decided that a successful prosecution against the Redlands clinic was unlikely. This was due to a number of factors, including that WHSQ was satisfied that the sick horses may not have met QPIF's case definition for Hendra virus at the time of the incident, and that the employer took reasonable steps to manage the incident from the time that Hendra virus was first suspected on 7 July 2008 by notifying QPIF and closing the clinic.

An improvement notice dated 10 February 2009 was issued to the Redlands clinic requiring the owner to develop, implement and maintain safe systems of work to eliminate or minimise the risk of staff acquiring an infectious zoonotic disease. This requirement included the development of policies and procedures and the training and supervision of staff. WHSQ has confirmed that the requirement has been met.

However, I have a range of serious concerns about this investigation.

Firstly, my officers have identified a significant amount of relevant information that was not obtained by WHSQ during its investigation. There was a failure to follow up on comments made by the Redlands clinic owner and other witnesses, a failure to obtain documents from the clinic (such as training and induction documents and health and safety policies) relevant to the investigation and a failure to identify which autopsies were conducted by Dr Cunneen (a potential source of his infection with Hendra virus).

There also does not appear to have been any attempt to test the information provided by the clinic owner to WHSQ, such as through cross-checking with information from other sources or through confirmation by statements from other witnesses. A formal statement was obtained only from the veterinary nurse to accompany submissions from the Redlands clinic owner. However, no other formal statements were obtained, including no formal statement from the clinic owner, and it appears that WHSQ did not attempt to speak to any other clinic workers to confirm the information provided by the owner. WHSQ advised my officers that a statement from the obligation-holder (that is the clinic owner) would ordinarily be obtained.

Secondly, a number of issues were apparent from the documents that WHSQ did obtain, but were not sufficiently analysed during the investigation. For example, there was conflicting information on the file about the date on which Truly Gifted died, with discrepancies between the clinic owner's submission and blood test collection dates and times. Media statements and submissions made by the clinic owner and held on the WHSQ file were inconsistent with other information held by WHSQ, but little attempt was made to establish the accuracy of the information. Although the clinic owner submitted that such discrepancies were of little relevance, in my view this could not be determined by WHSQ without analysis.

Incorrect information was also provided by the clinic owner to WHSQ in relation to another horse. Although this information did not affect the outcome of the investigation, the errors could have been noted and corrected by WHSQ. Further, although WHSQ officers did ensure that the clinic had procedures specific to Hendra virus after the incident, the absence of procedures before the incident was not given significant consideration.

There are numerous other examples. A written submission and a number of clinical records were obtained from the clinic owner, but there is no evidence on file that this information was ever analysed. WHSQ failed to identify missing clinical records for two horses that were infected with Hendra virus. The missing records related to critical dates around when those horses first showed clinical signs of the virus.

Instead, it seems that the inspector received the documents, and the next day began drafting a memorandum proposing to take no further action. The clinic owner disputed the relevance of the missing records, and I do not suggest that these records were deliberately removed or that they contained any critical information. My point is that the WHSQ officers conducting the investigation should have noticed that the records were missing and requested the records. This should not be considered as a criticism of the actions of the clinic owner.

Similarly, the Forbes Report was placed on the WHSQ file in January 2009 but does not appear to have been analysed, despite the file remaining open until June 2009. The inspector's supervisor accepted that the report should have been analysed and brought to his attention during the investigation.

Consideration of this report would be relevant because both Dr Cunneen and the veterinary nurse may have been infected some time after Noddy's death on 24 June 2008 but before the 7 July 2008 notification to QPIF. Evidence that the clinic owner should have suspected the presence of Hendra virus when Noddy died was relevant to whether the clinic owner complied with his workplace health and safety obligations to Dr Cunneen and the veterinary nurse.

This is particularly the case when one possible way in which Dr Cunneen became infected was while allegedly performing an autopsy on Truly Gifted without protective equipment. This autopsy would have occurred on 26 June 2008 or shortly afterward.

The Forbes Report also identified that on at least two occasions veterinary nurses (including the veterinary nurse who contracted Hendra virus) may have collected urine from sick horses with their bare hands. If this occurred during the relevant period, it may have been a possible route of infection for the veterinary nurse. I note, however, the clinic owner's submissions to my investigation that this was not a policy or routine practice of the clinic.

Although the VSB took no action based on the Forbes Report, a potential workplace health and safety breach is a separate matter requiring investigation. There are two separate obligations, assessed by two different agencies and to which different standards of proof apply.

I am not, however, suggesting that WHSQ would have changed its decision had it considered the Forbes Report. I am merely expressing the view that WHSQ should have considered the information in the Forbes Report and, if necessary, reviewed its decision that no workplace obligation had been breached.

I am also not suggesting that the Forbes Report forms the basis of liability for the clinic owner or that I accept the conclusions in that report. My point is simply that WHSQ should have considered and/or investigated these matters further when the information became available to its officers.

The WHSQ officer who supervised the investigation commented to my officers that the investigation was assigned to an inexperienced inspector, who in hindsight may not have been the best choice for such a complex matter. The WHSQ officer advised that it was normally up to the inspector to scrutinise the information provided to WHSQ, but that this was not done in this case. It was submitted that the analysis of the matter was cut short to some extent when WHSQ accepted that the clinical signs shown by the horses were atypical, and therefore the risk of Hendra virus was unforeseeable. For this reason, WHSQ determined that no prosecution would occur,

but that an improvement notice would instead be issued to the clinic. Documents on the file do not evidence consideration of any other options.

A third significant issue with the WHSQ investigation is the number of errors that appeared on the file, both in relation to WHSQ's understanding of Hendra virus and its understanding of its jurisdiction and that of other agencies. For example, the WHSQ Investigation Complete Notification' dated 9 June 2009 stated:

This matter is to be NFA'd<sup>157</sup> due to the fact that the horses carrying the virus in this minor outbreak did not display what are the more usual symptoms. Further it seems nothing but appropriate that the Department of Primary Industries manage these sorts of things. It is that organisation which possesses the expertise.

However, a WHSQ Hot Issues Brief dated 21 August 2008 stated:

The DPI's jurisdiction is limited to the risk of animal transmission. The DPI does not have jurisdiction for preventing the spread of infection to humans.

This second statement is correct, as QPIF and WHSQ have distinct responsibilities in relation to the management of zoonotic disease incidents. While QPIF is responsible for biosecurity matters, WHSQ has responsibility for ensuring that employers, including QPIF and owners of veterinary clinics, provide safe working environments and safe systems of work for their employees.

Therefore, the statement in the document titled Investigation Complete Notification' reflects a misunderstanding of WHSQ and QPIF jurisdiction by WHSQ.

Although it is appropriate for WHSQ to coordinate its activities with those of QPIF and to obtain QPIF's advice and assistance on biosecurity issues relating to workplace health and safety, it cannot divest itself of its obligations under the WHS Act by relying on QPIF to respond to all aspects of a Hendra virus incident.

In addition, a WHSQ internal memorandum dated 30 April 2009 stated:

The Investigation Manager's review outlines that the virus that the above persons contracted was a mutation of the known virus and as such presented in infected animals with different symptoms.

Despite comments to that effect made to the media at the time of the 2008 Redlands incident by the clinic owner and others, the information I have obtained indicates that the virus was not a mutation of the known virus, although it did present different clinical signs from some of the previous cases. This information should have been available to WHSQ well before the date of this memorandum and therefore before the investigation was concluded, although it was likely not available at the time that WHSQ began its investigation.

Another example is the WHSQ Summary of Facts in relation to the 2008 Redlands incident, which states:

BRISBANE SOUTHSIDE POPULATION HEALTH UNIT (BSPHU) advised that throughout the virus epidemic, the horses did not display signs and symptoms common to the virus.

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<sup>157</sup> NFA' is generally used to refer to taking no further action.

The BSPHU is part of QH and therefore not the appropriate source for this information. In any future investigations into Hendra virus incidents, WHSQ should ensure that advice on matters relating to equine issues (such as clinical signs of disease in horses) is confirmed with QPIF and not QH.

The more concerning example is the number of errors that appear in the WHSQ 'no further action' memorandum dated 26 February 2009. Several factual errors were identified in the information in this memorandum. Further, the memorandum reports speculation about how Dr Cunneen and the veterinary nurse may have contracted the virus, but does not attribute the speculation to the correct agency (QH). Instead, a person reading the memorandum would assume that WHSQ had established these matters itself, when it did not make an attempt to do so and merely adopted the views of other agencies. The memorandum also fails to discuss any possible exposures for the veterinary nurse, although possible exposures for Dr Cunneen are discussed.

My review has also identified some instances where documents are not on the file, and where entries in the inspectors' notebooks were not entered into the electronic system.

It is also relevant to note that WHSQ relied heavily on information from QPIF and QH about the nature of the virus, the fact that the horses' symptoms presented differently to what had been seen previously, and the likely way in which Dr Cunneen and the veterinary nurse became infected. In particular, WHSQ relied on the opinion of QPIF officers that the 2008 Redlands incident was unforeseeable by the clinic owner and that the clinical signs shown by the horses did not comply with those recorded within the Guidelines for Veterinarians at the time. This then formed the basis of the WHSQ's decision not to prosecute the clinic owner in relation to the incident.

In the circumstances, it is understandable that WHSQ relied on QPIF and QH for some expert information relating to the Hendra virus. However, I do not consider that this negates WHSQ's obligation to independently test and verify information provided and independently assess whether any breach of the WHS Act has occurred.

There were some indications on the file that WHSQ officers recognised the need to obtain expert advice on whether the clinic owner should have considered Hendra virus before it was diagnosed. However, no formal advice was obtained and WHSQ officers were unable to explain why not.

One WHSQ officer identified a lack of experience and knowledge in relation to Hendra virus that in hindsight may have hindered the investigation. It seems to me that there was also a lack of investigative planning and the early determination about key issues may have unduly limited the remainder of the investigation.

In my proposed report, I formed the following opinion and made the following recommendation:

**Proposed 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.

### **Proposed 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.

### **DJAG's response**

The Director-General of DJAG provided the following submission in response to the relevant information I identified in my proposed report that was not obtained by WHSQ during its investigation:

The BSGC region of WHSQ agrees that in essence the information contained in the report is correct and do not disagree with the recommendation contained therein. An early decision was made not to proceed with a comprehensive investigation of the matter, based upon what has turned out to be incomplete, inaccurate and untested information obtained during the initial investigation phase. It is also acknowledged that the rate [sic] bio-hazardous nature fo [sic] this incident as unique to the Investigations Unit and in retrospect, warranted a far greater and in-depth expert assessment and analysis. Finally, as a backdrop to the investigation undertaken by WHSQ, when the outbreak of Hendra Virus at [the Redlands clinic] became apparent, there was genuine confusion at the local level, regarding which agency should take the lead role, having regard to technical expertise and experience. In hindsight, the investigation process would have been well served by an established structure (such as an MOU between relevant agencies), clearly outlining jurisdictional boundaries and roles in the event of such a scenario. WHSQ is confident, in the event of a future Hendra Virus incident, that BSGC's investigation response would address and meet with the expectations outlined in the Ombudsman's report recommendations.

In relation to the specific statement on the WHSQ 'Investigation Complete Notification' dated 9 June 2009, the Director-General advised that this was the opinion of an individual officer and did not reflect the position of WHSQ at the time with regard to its statutory responsibilities for Hendra virus incidents. He noted that other WHSQ investigations in 2004 and 2009 which resulted in the issuing of improvement notices reflected the correct view of WHSQ's role in such incidents.

Finally, in relation to proposed recommendation 78, the Director-General supported the recommended action and identified a number of steps that WHSQ has undertaken to implement this proposed recommendation. These steps included:

- the provision of Hendra virus training to inspectors who participated in the WHSQ Hendra virus audit program
- updating of the WHSQ enforcement note, which provides operational guidance to WHSQ inspectors on Hendra virus incident response and investigations
- the initiation of an internal review of the current investigations processes within WHSQ, which will examine a range of matters relevant to WHSQ investigation processes including the matters raised in my proposed report.

WHSQ also has an officer available to provide expert advice and training to investigating officers on technical matters relating to communicable diseases, including Hendra virus.

### **Ombudsman's analysis**

I acknowledge the Director-General's response. While it seems that the WHSQ investigation into the 2008 Redlands incident was deficient, there do not appear to be significant systemic problems within WHSQ in relation to Hendra virus investigations generally.

Further, the Director-General's acknowledgment of the deficiencies in the 2008 investigation and the initiation of an internal review of current investigative processes is welcomed.

In my investigation I also provided the Redlands clinic owner with the opportunity to comment on the above section of my proposed report. The clinic owner challenged the relevance of the above deficiencies, arguing that as the *Guidelines for Veterinarians* at the time did not describe the presentation of Hendra virus seen at the clinic, it was not useful for WHSQ officers to waste time conducting an investigation.

I do not share this view. WHSQ was obliged under the WHS Act to conduct an investigation of the matter, and has an obligation to conduct all investigations rigorously and effectively, regardless of whether others believe an investigation is justified.

It appears that the Director-General of DJAG shares the view that a WHSQ investigation was justified.

I confirm proposed opinion 82 as a final opinion:

#### **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.

I confirm proposed recommendation 78 as a final recommendation:

#### **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.

During an interview with my officers, the responsible WHSQ Regional Investigations Manager accepted that there were shortcomings in the WHSQ investigation of the Redlands clinic and viewed my investigation as a way of identifying and addressing those shortcomings and providing learnings for the future.

After issuing the improvement notice to the clinic, WHSQ advised my Office that an audit of the clinic had been conducted and the notice had been satisfactorily complied with.

As the incident occurred in 2008 and the investigation has now been concluded and enforcement action taken, it would be difficult to reopen the investigation. I also note that the time for taking prosecution action under the WHS Act has passed.<sup>158</sup> Therefore, unless a coronial inquest is held into the death (which would provide WHSQ with further time to bring a prosecution under s.165 of the WHS Act), there would be no purpose in me recommending that WHSQ review its decision or further investigate the matter in light of the findings of the Forbes Report.

Therefore, I considered whether improvements have been made to WHSQ practice since this time.

A WHSQ investigation was also conducted into the 2009 Cawarral incident, which resulted in the infection and death of Dr Rodgers.

Further, WHSQ has provided my officers with a draft enforcement note which sets out the operational guidelines for WHSQ inspectors responding to Hendra virus incidents. Although not finalised by the time of the 2009 Cawarral incident, this enforcement note was used by WHSQ inspectors to respond to that incident and has also been used successfully in relation to a subsequent incident. WHSQ informed my officers that the notice had not been finalised because it required input from QPIF and QH.

I have also reviewed the WHSQ investigation report for the 2009 Cawarral incident. This 31 page report is significantly more detailed than the 2008 investigation report, and reflects an adequate investigation was conducted.

Therefore, overall it appears that progress is being made in relation to WHSQ investigations into Hendra virus incidents.

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<sup>158</sup> Section 165 of the WHS Act requires proceedings for offences under the Act to be started within one year after the commission of the offence, or within six months after the offence comes to the complainant's knowledge. Where the breach of an obligation caused death and the death was investigated by a coroner, proceedings must be brought within two years of the coroner making a finding in relation to the death.



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