



BRISBANE (3 November 2011)

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

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

I decided to release the report because:

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

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

The investigation set out to answer the following questions:

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

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



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

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

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

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

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

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

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

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



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

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

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For further information, please contact:

Leanne Robertson
Communications Manager
Tel: 3005 7042
lrobertson@ombudsman.qld.gov.au

Louise Crossen
Communications Officer
Tel: 3005 7049
lcrossen@ombudsman.qld.gov.au

ombudsman