Summary of Allegations, Findings and Recommendations of the Queensland Health Ethical Standards Unit Investigation into Events Surrounding the Alleged Sexual Assault of a Nurse in the Torres Strait.

This investigation deals with three substantive allegations investigated by the Ethical Standards Unit.

Allegation 1:

> **That unknown officers of Queensland Health improperly altered a security risk assessment document relating to departmental facilities in the Torres Strait and Northern Peninsula Health Service District thus minimising the apparent security risk to Queensland Heath staff members.**

The investigation has conducted numerous formal interviews and reviewed a quantity of email and other correspondence.

Findings – Allegation 1

Based on the information available to the investigation the following findings are made on the balance of probabilities:

- Sufficient evidence exists to determine that those tasked to assess and write the "Torres Strait Risk Assessment' tabled by the Minister for Health on 12 March 2008 to be the final version of the report.

- It has been established that that report tabled by the Minister for Health on 12 March 2008 has been in existence from 7 December 2006.

- There is no information or evidence available to support a finding that officers of Queensland Health inappropriately altered the risk rating in the report tabled by the Minister for Health on 12 March 2008 in order to protect the Minister for Health, the Premier or senior management of Queensland Health.

- There is sufficient information to determine that alterations to the draft risk assessment, as tabled in Parliament by the Mr Springborg did occur, but information available to this investigation indicates that this was done in the course of writing a balanced and sustainable interpretation of the circumstances facing the Torres Strait and Northern Peninsula Health Service District.

- No external influence was place upon report authors to provide the risk ratings contained in the report tabled by the Minister for Health on 12 March 2008.

- There is sufficient information and evidence to determine that a copy of the report tabled by Mr Springborg has been in the possession of Queensland Health since 13 November 2006.

- There is sufficient evidence to determine the District Workplace Health and Safety Officer had access to and saved report the copy of the report tabled by Mr Springborg in the format in which it was supplied outside of Queensland Health.

- No evidence is available indicating, or to support a finding, that the District Workplace Health and Safety Officer supplied copies of the report tabled by Mr Springborg outside Queensland Health.

- No allegation has been substantiated in relation to any subject officer.

- The investigation has made systemic recommendations in respect of procedures to ensure the independence of witnesses and to increase the capability of Queensland Health to manage historical electronic mail.

Allegation 2:

"That members of the Torres Strait and Northern Peninsula Health Service District (TSNPHSD) Executive failed to take appropriate action when they became aware of serious Workplace Health and Safety concerns impacting upon Health facilities within the Health Service District."

Findings – Allegation 2

There is substantial evidence that there has been a systemic failure by the Torres Strait and Northern Peninsula Health Service District to acknowledge and address workplace health and safety issues within the District over a long period of time. As such it is the finding of this investigation, that there is sufficient evidence for a decision maker to determine, on the balance of probabilities, that allegation 2 **is substantiated.**

Systemic Recommendations – Allegation 2

Recommendation 1:

It is recommended that as a mater of urgency all members of the TSNPHSD are provided full training about the requirements of the Workplace Health and Safety Act. This training should include all Senior Managers within the District including cluster managers and health centre managers. It is recommended that training should also be extended to all Remote Area Nurses and Health Workers

Recommendation 2:

It is recommended that training mentioned in recommendation 1 becomes a mandatory inclusion in yearly performance management reviews of the TSNPHSD executive and senior staff members.

Recommendation 3:

It is recommended that a further full audit of Outer Island Health Centres and accommodation units be undertaken by organisation independent of Queensland Health to assess the progress of rectifying workplace health and safety deficiencies. It is further recommended that this report is made available to Director General of Health for benchmarking purposes

Recommendation 4:

A full review, co-ordinated by the Queensland Health Office of Rural and Remote Health, be undertaken of the operation, resources and budgetary allocation to the Maintenance Department of the TNPHSD.

Recommendation 5:

A full review of the operation, structure and processes utilised by the TSNPHSD be undertaken, including structure, resources, work flow and records management with a view to improve efficiencies and accountabilities.

Recommendation 6:

It is recommended that a senior departmental officer examine this report and attachments to determine any appropriate action to be taken to address the performance of individual officers named in this report.

Allegation 3:

That members of the Torres Strait and Northern Peninsula Health Service District (TSNPHSD) Executive acted inappropriately and insensitively when notified of the alleged rape of a Nurse on Mabuiag Island on or around 5 February 2008

Findings – Allegation 3

Finding 1:

There is sufficient evidence to conclude, on the balance of probabilities, that members of the Torres Strait and Northern Peninsula Health Service District (TSNPHSD) Executive responded inappropriately and insensitively when notified of the alleged rape of a Remote Island Nurse on Mabuiag Island on or around 5 February 2008

Finding 2:

Further, there is sufficient evidence exists to find, on the balance of probabilities, that the repatriation of the remote area nurse from the outer islands as not managed or co-ordinated at a level cognisant with the seriousness of the events which had occurred.

Recommendations – Allegations 3

Recommendation 1:

The TSNPHSD should, as a matter of urgency, develop and implement standard operation procedures (SOPS) detailing roles and responsibilities of staff members when responding to critical incidents involving the safety, security and welfare of staff within the District.

Recommendation 2:

A senior departmental officer should consider the contents of this report in determining appropriate managerial action in respect of individuals named in this report. In particular, consideration should be given to requiring members of the District Executive to undertake re-familiarisation with Queensland Health's Code of Conduct and its implications.