Review of Clinical Forensic Medical Services

(Health Support Queensland)

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November 2017

Contents

RECOMMENDATIONS

1. **A clear description of the service parameters (E.g. Case duration) should be developed and circulated to all the practitioners.**

2. **A new integrated case filing and management system should be implemented.**

3. **The security of the case data should be reviewed with particular reference to illegal access, offsite backup and the security of any files taken out of the office.**

4. **Explore of the cost-benefits of preparing a report for each examination conducted by the Unit and not performing alcohol read backs in sexual assault cases (accept in carefully selected cases).**

5. **Develop a rigorous set of Key Performance Indicators applicable to the Unit. This should be done in consultation with all stakeholders and the results should be reported regularly to the Executive Director of FSS.**

6. **Develop a feedback process for patients (particularly complainants of sexual violence) seen by the unit.**

7. **Establish a peer review process for reports produced by members of the Unit. Initially this will require the development of an agreed set of parameters by which reports are assessed and feedback provided.**

BACKGROUND

In August 2017, Health Support Queensland (Department of Health) requested a review of the measures of service provided by the Clinical Forensic Medicine Unit (CFMU). Appendix – Letter of Engagement

This report has been prepared for the Chief Executive Officer, Health Support Queensland.

Disclaimer and Limitations

In the conduct of this review, I am reliant on information by provided to me by others.

I have not performed a formal audit on all the data provided but have crosschecked much of the information where feasible. Whilst I have attempted to verify the accuracy of the information reported, it is possible that some errors could have occurred in the recording or transcription of this information. I would be happy to have this drawn to my attention and revise where required.

A considerable amount of patient information was accessed e.g. reports, medical notes. Any material that identifies individual patients has not been replicated in this report but will be held securely. All other data referred to can be provided as an Appendix if required.

All material will be held for 3 months from the date of submission of this report and will then be disposed of in a secure fashion.

PREAMBLE

The Clinical Forensic medical Unit (CFMU) is a component of Forensic and Scientific Services (FSS), which reports to Health Support Queensland (HSQ), which sits within the Queensland Department of Health. Most CFMU services are provided to other Government departments and agencies: Police, Office of Public Prosecutions (OPP) and Coroners.

The CFMU has its central office and administrative service in Brisbane. There are also some regional service hubs, the largest being South East Region (SER) based in Southport. The CFMU provides a comprehensive range of forensic services. These include cases of interpersonal violence, custodial medicine and clinical toxicology. Specifically:

- **Custodial medicine** – a health service to prisoners in police custody.

- **Biological sampling**. This includes Forensic Procedure Orders, Traffic blood samples and Disease Transmission Orders.

- **Assaults**. Complainants in cases of physical or sexual assault are examined for the purpose of medico-legal enquiry. Additionally, police or the OPP may seek an opinion on the basis of statements and photographs.

- **Medico-legal statements.** This included Coronial Statements (Reports and Form 1A) and statements at the request of OPP or police.

In my earlier report (March 2016) I focused on the services delivered by the Unit. The recommendations made in that report are as relevant today as they were then. With particular regard to services, there remain strong arguments to remove the responsibility of prisoner health services from the CFMU to a more appropriate body.

SERVICE DATA

Since February 2017, all service requests for CFMU services in Queensland have been directed to the Brisbane office. This centralised process of case reception and allocation replaces one in which cases were received directly by the regional office.

Upon receipt of a request for a service, a record is made of certain parameters of the case and the case is then allocated to an FMO for completion. Allocation of cases occurs via a daily meeting (including a teleconference facility). Once allocated, the FMO and the requesting authority are informed.

Upon completion of the case all relevant paperwork is entered into the database although the hardcopies may remain at regional offices. Typically the data captured for each case will include:

- Date of receipt
- Date of completion
- Turnaround time
- Subject's name and date of birth
- Requesting individual and agency
- Case type
- Time spent by FMO providing the service

Data is entered by the one of two administrative assistants at the Brisbane office. These are the only personnel who can enter or amend the data although all doctors can view the data if required. The files at both the Brisbane and Gold Coast offices are held in a compactus that is locked securely after business hours.

FMOs who have not completed a file within the expected time will be called by the Brisbane administration to assess activity and an expected completion date. Files remaining open after the expected closure date are brought to the attention of the Director of the CFMU. The director is provided with weekly and monthly reports on the service data including open files.

The current system of recording data is via Microsoft Excel Workbooks; a separate workbook is used for each type of case.

Comments

The process of centralised data collection and distribution is a sound one. Similarly, a single point of entry for all data (and any subsequent amendment) independent of the actual service provider has considerable benefits and safeguards.

There appear to have been a number of iterations of the data recording sheets kept by each practitioner whilst undertaking a case. These sheets allow the practitioner to record specific details of each case so that it can be entered into the centralised data collection process. A number of the parameters are not clearly defined. For instance, "Time spent on a case"

appears to have been variously interpreted as time with the patient or total time away from the office. Clearly this is significant as there is a large amount of travel time involved in some cases.

A new version of the data recording sheet was implemented in June 2017 but given this variance, it would be unacceptable to draw any conclusions on the duration of time spent on examinations. It would be a worthwhile exercise ensuring that all practitioners understand the definition of the various parameters required to be recorded.

The process of centrally recording the data, undertaken by the administrative assistants in the Brisbane office, is time-consuming, clumsy and open to errors. Further, the use of Microsoft Excel workbooks makes it technically difficult to produce reports and this process consumes a considerable amount of time. A new software database system is required. Such systems are in use and allow for efficient and accurate record information, the production of accurate reports and significantly reduce the workload on the administrative staff.

Another issue that warrants addressing is the security of the data. I am not in a position to be able to comment as to whether it could be illegally accessed or hacked but it is crucial that this data is as secure as possible. Inappropriate access of this personal data would cause a profound loss of trust in the service and personal damage to the vulnerable patients of the service. Further, an offsite backup system should be developed.

As I mention in the next section, I accessed 70 case files randomly selected from services provided by all the full-time practitioners employed by the CFMU. Each of these files was complete in their contents and all of the data relating to that file had been entered correctly. Further, I had the administrative staff analyse the case numbers and service times across a range of parameters using the Excel spreadsheets. I undertook the same task manually and there was an extraordinarily close approximation. (I suspect any variance related to the somewhat clumsy manual method used by myself.)

The only data that could not be readily checked was that of the time taken per case. This figure is totally dependent on the time given by the individual practitioner providing the service.

Recommendations

1. **A clear description of the service parameters (E.g. Case duration) should be developed and circulated to all the practitioners.**

2. **A new integrated case filing and management system should be implemented.**

3. **The security of the case data should be reviewed with particular reference to illegal access, offsite backup and the security of any files taken out of the office.**

DATA REVIEWED

The reviewer was able to access all the data required for this exercise through the centralised dataset. I also requested hard copies of selected files and these were obtained by the administrative assistants in Brisbane. No files were taken offsite and none of the medical practitioners were privy to the selection process or analysis.

Comparison of case numbers between FMOs is compounded by a number of uncontrollable variables. This combined with individual practice differences and skill sets means that caution must be exercised when analysing the data.

In an attempt to reduce the variables, the following processes were incorporated:

1. **Period of review.**

A six-month period of case-load was considered sufficient to develop a reasonable understanding of the data. In particular, it would also reduce the impact that more complex cases might make to turn around. The period chosen was 1 March-31st of August 2017. This allowed for a one month 'bedding down' of the new process of data collection and a month for any open cases to be completed.

2. **Staff.**

Only full-time staff caseloads were analysed; part time staff may be in training and their workloads could not be compared. Further, any absences by part-time staff are likely to have a greater impact on the case numbers.

Part of the analysis required a comparison between the two centres; Brisbane Metropolitan region and the South East region. Given that the latter has only two full-time staff it was decided to select two full-time staff from the Brisbane office of a similar seniority. A review of the case numbers of other three full-time practitioners in Brisbane indicates that their outputs are not dissimilar to the two Brisbane doctors included in the study.

Notwithstanding the above, one member of the Brisbane office has a significant workload unrelated to his case activities. [redacted] spends an unspecified but not in considerable amount of time (perhaps up to 50% of the working week) on administrative duties, teaching and meetings.

3. **Leave.**

The leave of each staff member used in this analysis was assessed to ensure that they had not had prolonged periods of absence from the office that might impact on caseloads.

4. Case selection.

The complete Queensland CFMU dataset for the six month period was provided and reviewed. Additionally individual case numbers for the four selected doctors were accessed. A summary sheet of the four FMOs over this period is included as an appendix. Dataset case details are not included as they contain patient identifiable data but can be accessed if required.

A review of the content of the case files was also conducted. Ten randomly selected cases completed by each of the seven FMOs at Brisbane and the two practitioners from SER were formally reviewed. The cases were selected by the administrative assistant in Brisbane and covered a range of examinations or opinions prepared by the practitioners over that period including sexual assaults and a range of traffic medicine cases. These cases were specifically examined for the quality of the report across a range of parameters.

Findings

- **Case completion times**

The Unit has developed a series of key performance indicators largely focused on turnaround times for requested services. Currently these include:

Coronial reports -	<30 days
Statements -	<10 days
Form 1A –	Same day
Clinical examinations –	<2hours

These timelines will vary if for instance not all required information is provided at the time of the request or a special request is made for an urgent response etc

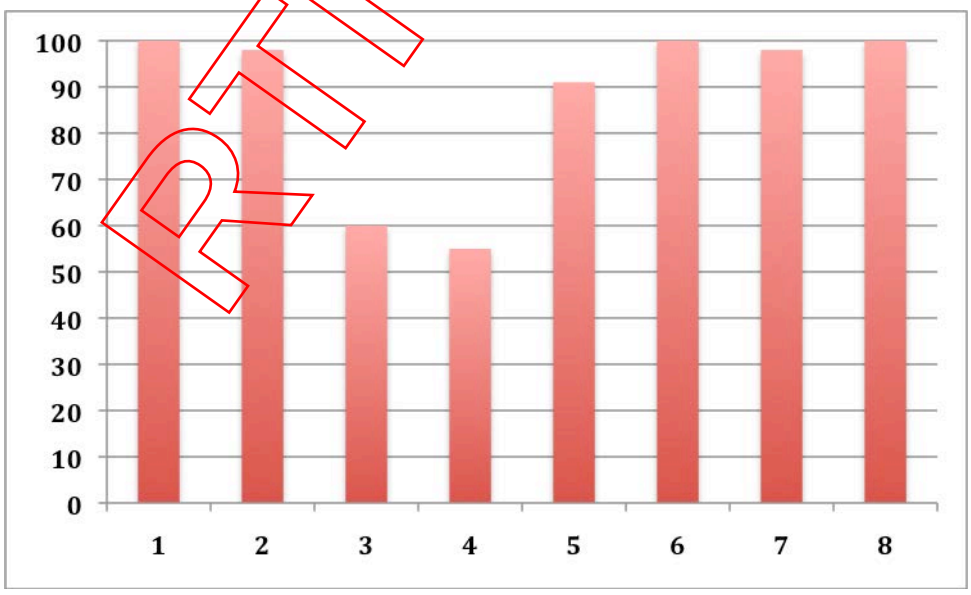
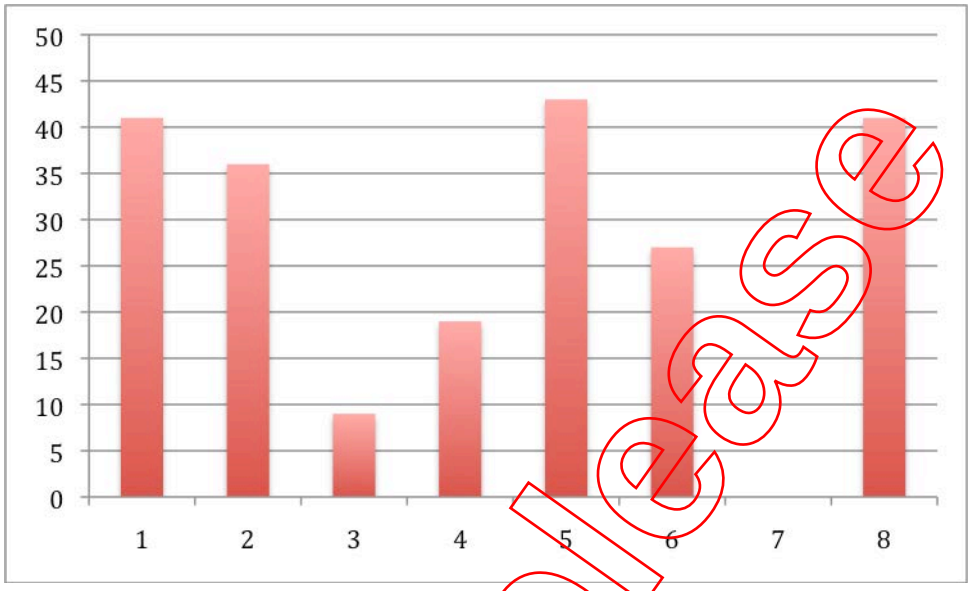


Table: Percentage of **office statements** completed within the 10 day "limit" by all the full time doctors at both regions.

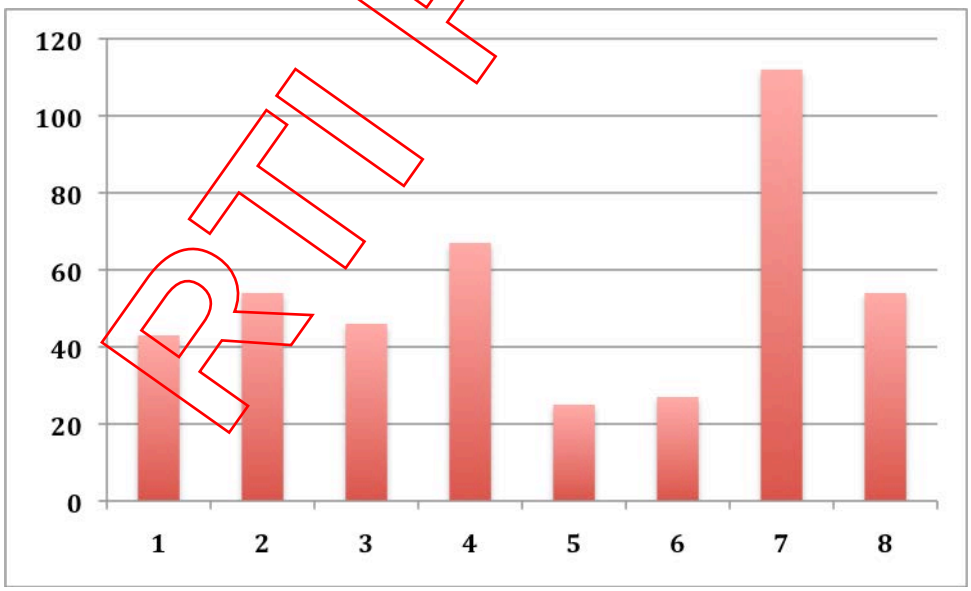
More than 90% of cases completed within the agreed turnaround time would be classed as a very acceptable outcome. In the case of the South East Region, less than 60% of cases were completed in this period.

- **Caseloads**

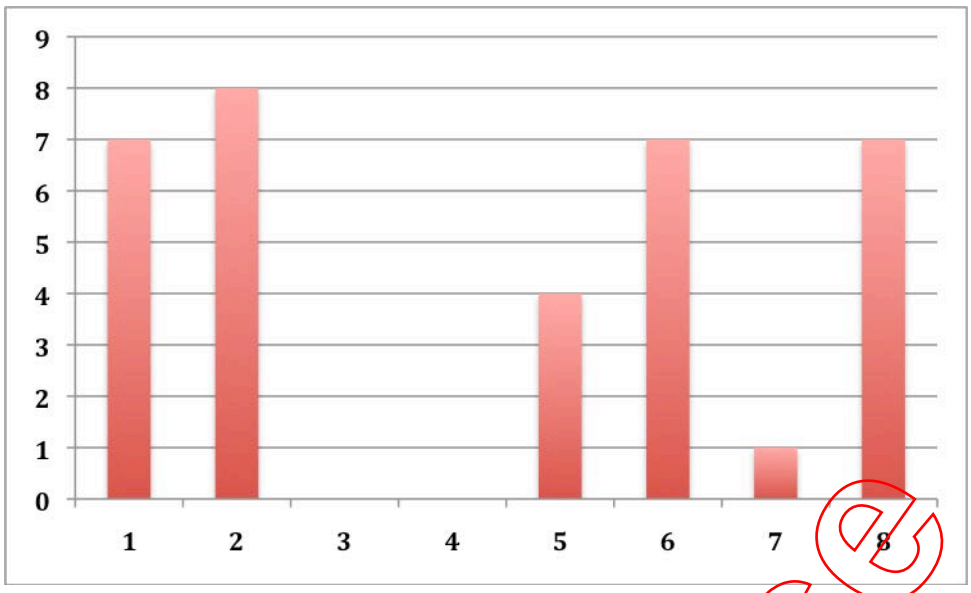
The following tables capture the case-loads of the doctors from the two services.



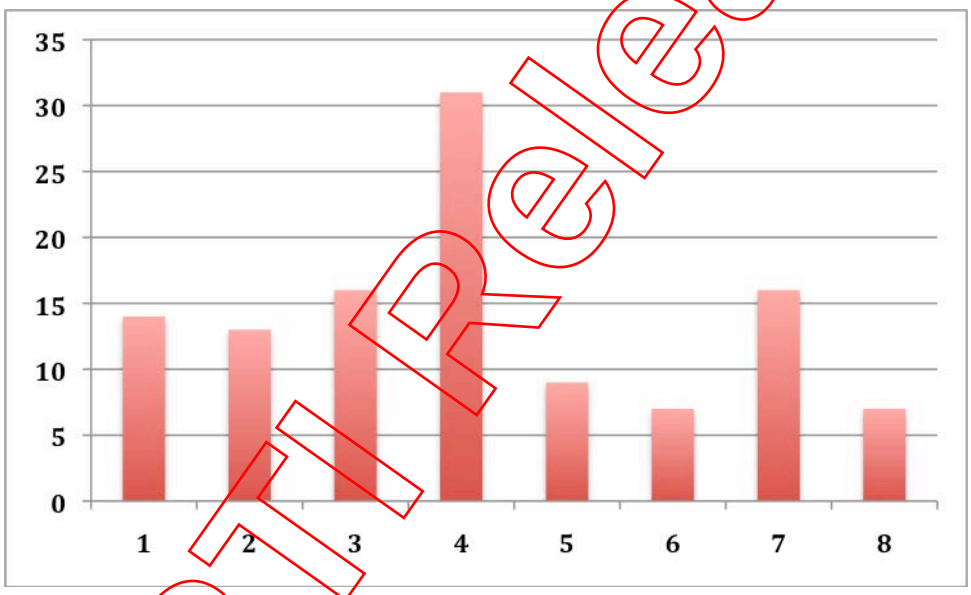
Graph: FORM 1A completed.



Graph: OFFICE STATEMENTS completed.



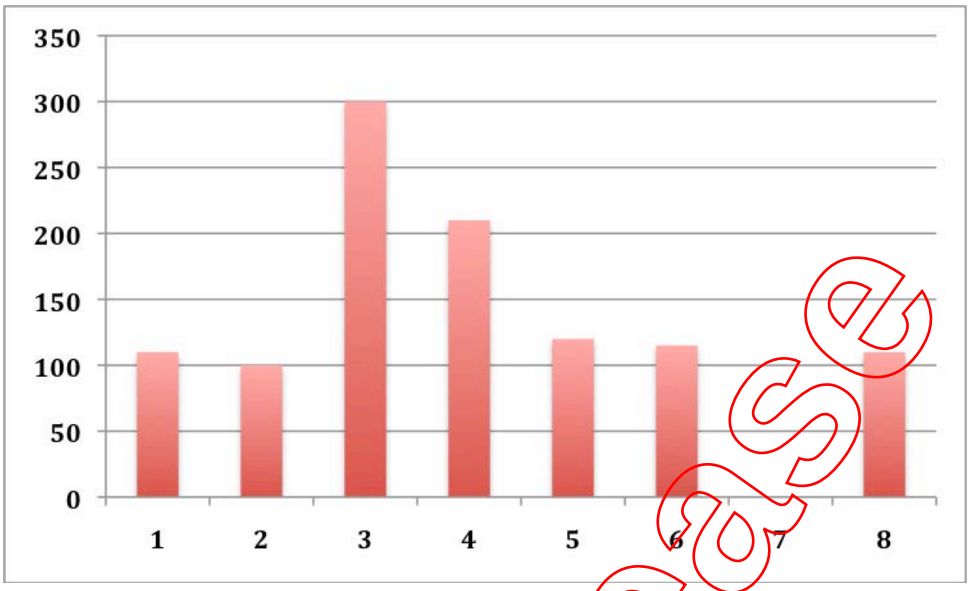
Graph: CORONIAL FILES completed.



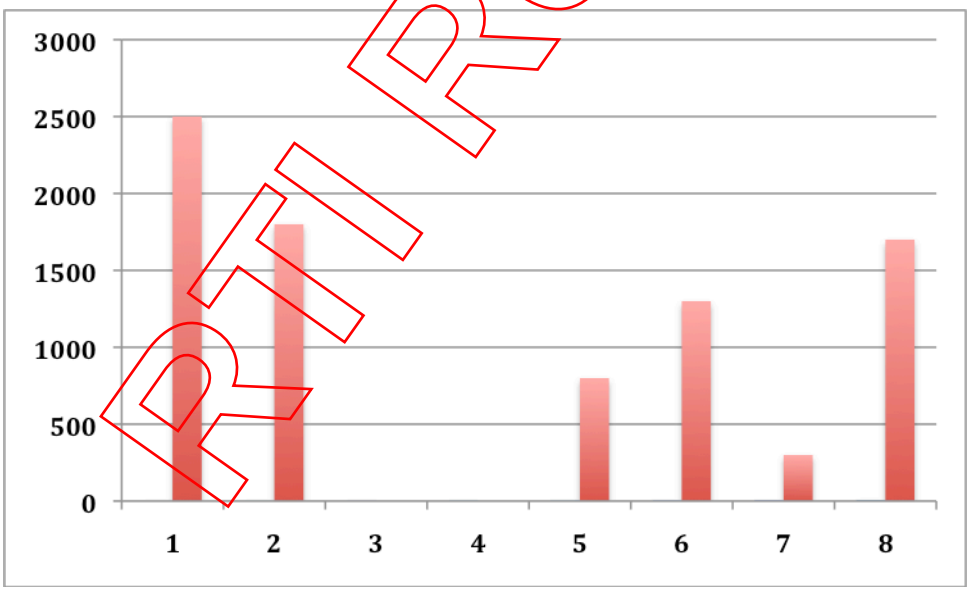
Graph: EXAMINATIONS completed

- **Case duration**

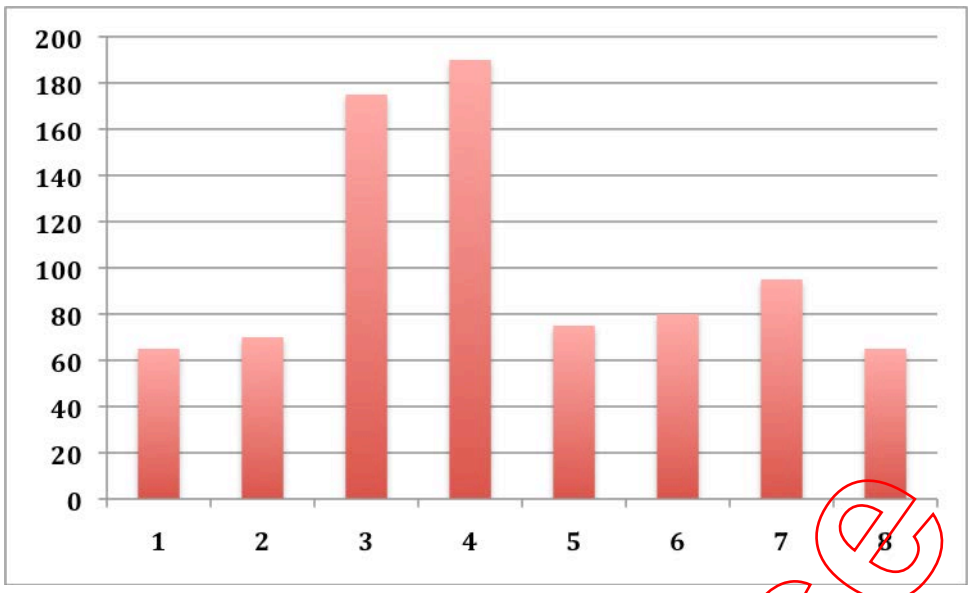
The duration required to complete a case may be a useful indicator of efficiency. The caseload accumulated over the six month period examined is likely to average out discrepancies in complexity of cases.



Graph: Duration (mins) to complete **Form 1A cases**



Graph: Duration (mins) to complete **Coronial files**



Graph: Duration (mins) to complete **office statements**

Comments

1. **Office Statements**

   A reason for low level of statements completed in the agreed time (< 10 days) by the SER practitioners might be a larger workload at that office. However as their caseload is at best equivalent to, and in many situations, less than the caseload per doctor at the Brisbane office. It is difficult to draw any other conclusion other than the efficiency or outputs of the South East Region practitioners are considerably less than those of the Brisbane practitioners.

2. **Outstanding cases**

   The number of outstanding (Incomplete cases) at the SER service over this period is nine times more than that of the Brisbane service. Some of these cases have been open for 3 to 4 months - well outside the accepted KPI of one month.

3. **Case duration**

   The time taken per case was significantly greater in the South East Region than in Brisbane. Assuming that the numbers provided by those practitioners is accurate,

REPORT QUALITY

Seventy case files, representing a range of types of cases, were randomly selected. This represented 10 cases of each of the five senior doctors at the South East region and the two senior doctors at the Brisbane office. They were reviewed across a range of parameters as follows:

PRESENTATION

- Letterhead
- Date of Report
- Timeliness
- Addressee
- Subject identification (Name & DOB)
- Author's identification - Name, address, appointments, qualifications.
- Jurat.

CONTENT

- Background (reason for consultation, location and timing of consultation, consent)
- History: Relevant current & past history, sources of information
- Examination: Overview of subject, extent of examination, findings & relevant negative findings
- Specimens: Type, handling & photography
- Expression: Grammar, clarity and accuracy

OPINION

- Impartiality
- Objectivity
- Scope
- Limitations
- Weighting

Findings

No major flaws were identified in any of the reports and generally they were of a good standard.

Comments

There were however a few issues that warrant mention as they have the potential to impact on the quality of this output and subsequent evidence in court.

1. There was no mention of photographs (taken or not taken, accessed or not accessed) in the majority reports;
2. No reference was made as to activities of sexual assault complaints before and after an assault; alcohol and drug consumption, Pre-existing injuries, washing or showering etc;
3. The extent of the examination was not captured i.e. what was and wasn't examined.
4. There was a paucity of general medical information that may be of relevance to the investigators and the court; medications, gynaecological history.
5. A number of the reports utilise the phrase 'consistent with the allegations'. This is a meaningless and potentially dangerous terminology;
6. It's unclear why an alcohol read-back was undertaken in many of the sexual assault cases. This might be a request of the police officer but its use is very limited. The range is potentially large making the ultimate result meaningless and generally no specific conclusion can be drawn about the impact on the individual with particular regard to the capacity to consent.
7. A failure to consider alternative explanations for injuries - other than what was provided by the complaint.

Many of the reports (almost exclusively those requested from practitioners in the South East region) appear to have taken a large amount of time to prepare and on many occasions, weeks or months passed between the date of request and the date of delivery. For instance, many of the reports were allegedly taking 6 to 7 hours to prepare with the turnaround times often months. The reports prepared by the Brisbane doctors, were generally addressed in less than 2 hours and almost without exception, were returned in the agreed turnaround time parameters.

Finally, (and I might be incorrect here) it appears that reports are only prepared if requested by police. This means that police do not have access to a report when investigating a crime or making a decision to prosecute. It also means that months and sometimes longer, has passed before of the report is prepared. In some cases police seek the report urgently because a court date has been set in the forthcoming weeks. This is particularly problematic if the practitioner is on leave at the time the request is made. There is a strong argument to prepare a report in every case in which a service has been provided.

A formalised process of reviewing one of the most important outputs of the office, medico-legal reports, should be initiated. Ideally this would include all reports from trainees, juniors and those not working in the Brisbane office. Further, there should be a process whereby reports of the full-time practitioners of the Brisbane office be reviewed by other senior practitioners on a regular basis. Consideration could also be given to utilising an outside resource for reviews.

Further discussion needs to be held regarding the benefits of producing a report in every case where a medico-legal examination was undertaken; physical and sexual assault forensic procedures etc. Considerations would include outcomes of discussions with stakeholders, the benefits of utilising a timely report in criminal investigations and preparations of briefs for court and the resultant costs such a program.

Consideration should also be given to revisiting the process of providing alcohol read backs in sexual assault cases. This is likely to be a historical activity that is being continued well past its use by date. Such a review should involve police and the Office of Public Prosecutions.

The Unit should agree and develop a set of parameters by which reports are reviewed. An important component of this is the timeliness of these reports. Ideally, the Unit should be required to regularly report on this process to the employing body.

Whilst not part of this review, consideration should also be given to developing a process for reviewing evidence given in court by practitioners of the service.

Recommendation

Explore of the cost-benefits of preparing a report for each examination conducted by the Unit and whether there is benefit from doing alcohol read backs in sexual assault cases.

SERVICES TO THE CORONER'S COURT

The Coroner's Court is a major client of the CFMU. At the request of the Court, the CFMU provides a range of expert advice and opinions. Essentially this takes two formats:

The Form 1A process.

This involves cases sent to the unit with a request to respond to specific questions raised by the Court. Addressing these issues allows the Coroner to make decisions regarding the need for an autopsy or initiate further investigation. Of the 5,500 reportable death cases that pass through the Court each year, approximately 1200 will be classified as a Form 1A of which 40-50% will be referred to the CFMU. *A same day response is required for this type of service.*

Coronial Reviews.

Frequently, the Coroner will seek independent medical advice from the Unit (or sometimes a specific medical specialist). This advice assists the Coroner in decision-making and may inform findings in a specific case. Generally these are complex matters requiring considerable research and are inevitably very time-consuming. *The turnaround time for these cases is less than one month.* There are approximately 100 such cases each year.

Findings

2. The Court was effusive of the services provided by the Unit in Brisbane. They saw the services as integral to the work of the Court and acknowledged their dependence on the service. Almost without exception, they praised the quality and timeliness of the service they were provided. It reflected a productive working relationship between the two services.

3. These comments were restricted to the services provided by the Brisbane office.
4. No coronial reviews were allocated to the Gold Coast unit in the period under review.

Comments

A strong professional relationship exists between the Coroners Office and the Unit. The Coroner is dependent on a high-quality, objective and timely service from the CFMU. In turn the CFMU is well-placed to provide advice on both urgent and non-urgent matters. The quality of the work provided by the Brisbane office has drawn strong plaudits from the Office of the Coroner.

PERFORMANCE MEASURES

The development of a rigorous set of performance measures is an important foundation of quality control and measurement of the outputs of the Unit. It can be distilled further into measurements across time (fluctuation in case numbers) between individuals (performance) and measures of output quality. Finally, it may provide a concrete measure whereby benchmarking can occur with other services.

The Unit has commenced such a program. Currently it is largely confined to measurements of services against time. This is focused on turn around times (case in-case out) and duration of service (a component of an efficiency measure).
There has also been some progress with the development of peer review of reports but more needs to be done in this field.

Comments

With the change in data collection proposed earlier, including clear definitions and an understanding of the measures, then the quantity issues are largely addressed. Discussions with stakeholders about their needs should be reflected in any new measures. Finally, the measures should be reported to the service line manager on a regular basis.

Developing quality measures of outputs is more challenging and time-consuming. A task for the Unit will be to develop quality issues around:

- **Consultations.** This may be best addressed through the construction of a voluntary feedback process by patients. Pathways for receiving complaints/compliments have been developed in other health entities and could be copied here. Ideally patients should have the option of sending responses anonymously. There should also be the option of sending such information to bodies such as a the Office of the Health Ombudsman or the Australian Health Practitioners Authority.

- **Reports.** It is vitally important that the Director has a clear understanding of the quality of the written outputs of the service. The process is time-consuming and laborious but ideally:

    - There is an agreed set of parameters by which reports are assessed;
    - Administrative staff can be tasked with undertaking some components of the review;
    - Trainees, junior practitioners and occasional providers should be obliged to submit drafts of all of their reports;
    - The senior practitioners develop a process to review a reasonable cross-section of their reports internally or externally;

- The major learnings of this process be transmitted to all practitioners;
- Input from stakeholders (E.G. the Office of Public Prosecutions and the Coroner) be sought.

- **Court.** A much more problematic goal is the assessment of evidence given in court by practitioners of the unit. Whether this is achieved by feedback from barristers (always difficult) or by having a member of staff attend as an observer, should be explored.

Hence an achievable goal for the Unit is to develop a structure whereby Key Performance Indicators and quality measures are utilised and become part of the life of the service. This may require a cultural change for some practitioners.

Recommendations

1. **Develop a rigorous set of Key Performance Indicators applicable to the Unit. This should be done in consultation with all stakeholders and the results should be reported regularly to the Executive Director of FSS.**

2. **Develop a feedback process for patients (particularly complainants of sexual violence) seen by the unit.**

3. **Establish a peer review process for reports produced by members of the Unit. Initially this will require the development of an agreed set of parameters by which reports are assessed and feedback provided.**

APPENDIX 1

TERMS OF REFERENCE

Purpose and Scope[1]

The purpose of the consultancy is to examine the services provided by the Clinical Forensic Medical Unit (CFMU) and determine standardised measures for the productivity and quality of these services to ensure the consistent delivery of clinical forensic medicine services in Queensland along with any other matter as specified in this Terms of Reference (ToR).

Please include, and report on, the following:

1. Current productivity and quality for all clinicians at CFMU, for;
    a. office requests
    b. Form 1A outputs
    c. Form A reviews (coronial reviews)
    d. examinations
2. Recommended standardised measures for;
    a. office requests
    b. Form 1A outputs
    c. Form A reviews (coronial reviews)
    d. examinations

The aim of this consultancy is to;

- determine the validity of this feedback and examine current performance using existing data
- determine the validity of the data currently being collected
- develop a set of standard measures to monitor performance
- recommend any operational and clinical improvements required.

[1] Copied from Letter of Consultant Engagement.

APPENDIX 2

CONSULTATIONS

In the preparation of this report, consultations were conducted with the following:

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