Health Service Investigation
Townsville Hospital and Health Service

Townsville University Hospital

Urology Services

Final Report

10 August 2026

Contents

Executive Summary 9
Summary of Findings 9
Summary of Recommendations 13
Section 1 - Overview of the Investigation and structure of the Report 18
1.1 Establishment of the Investigation 18
1.2 Scope and purpose of the Investigation 18
1.3 Observations regarding the TOR 19
1.4 Approach of the Investigators in responding to the TOR 20
1.5 Structure of the Report 21
Part A - Investigative settings and procedural background 22
Section 2 - The Investigators 22
2.1 The appointment of the Investigators 22
2.2 The management of conflicts of interest 23
Section 3 - Investigative Methodology 25
3.1 Overview 25
3.2 Information / evidence gathering and analysis 25
3.3 Specific issues informing the investigative methodology 28
Section 4 - Consultation process including natural justice 30
4.1 Overview 30
4.2 The scope of natural justice obligations 30
4.3 Approach adopted in this Investigation 31
4.4 Observations regarding the Consultation process 33
4.5 Conclusion 35
Part B - Evidence analysis and review 36
Section 5 - The Institutional Setting 36
5.1 Geographical and service characteristics 36
5.2 Governing body 37
5.3 Strategies and plans 38
5.4 Executive governance – executive roles 39
5.5 Executive governance – committee roles 40
5.6 Summary of Committee Roles 41
5.7 Organisational structure 41
Section 6 - Framing Concepts 44
6.1 Defining Urology Services 44
6.2 Defining Clinical and Corporate Governance 47
6.3 Definition of a cluster of adverse clinical incidents 47
6.4 Defining Disrupted Care 48
Section 7 - Chronology of Key Events 51
7.1 Overview 51

7.2 Clinical incident clusters 53
7.3 Governance and Leadership Responses 56
7.4 Urology Outpatient Process and Risk Analysis 57
7.5 AcciMap Analysis: Townsville Urology Services 58
7.6 Management of clusters of adverse clinical incidents 62
7.7 Issues of concern 63
Part C - Responding to the TOR 67
Section 8 - Governance: Policies, Procedures, Standards and Processes 67
8.1 Overview 67
8.2 Applicable Statewide Policies, Procedures, Standards and Codes 73
8.3 Appropriateness of policies and procedures 80
8.4 Compliance with existing policies, procedures and standards 89
8.5 Processes from initial referral to diagnosis and treatment 90
8.6 Demand and Capacity for Urology Services 93
8.7 Summary of conclusions 99
Section 9 - Clinical governance and incident management 105
9.1 Overview 105
9.2 Statewide requirements for clinical governance 112
9.3 THHS compliance with Clinical Incident Management Guidelines 115
9.4 Previous reviews of clinical governance 116
9.5 The Investigators approach to reviewing clinical incidents 118
9.6 Reviews of adverse clinical incidents 119
9.7 Identification of Systemic Issues 127
9.8 Advice provided to regulators 130
9.9 Findings related to THHS implementation, monitoring and evaluation from previous reviews or analyses 131
9.10 Actions and findings relating to the THHS management of clusters 133
9.11 Summary of conclusions 148
Section 10 - Adequacy of Oversight of the TUH executive, HSCE and/or the Board 151
10.1 Overview 151
10.2 Hospital and Health Boards Act 2011 (Qld) 155
10.3 Good Practice Guide for Hospital and Health Boards 157
10.4 NSQHS Standards and User Guide 158
10.5 Identified issues of concern 160
10.6 Adequacy of oversight by the TUH Executive, HSCE and Board 162
10.7 The roles of the HSCE, COO and the EDCG 187
10.8 Oversight of issues of concern by the Board 188
Section 11 - Complaints and Culture 198
11.1 Overview 198
11.2 Queensland Government Patient Complaint Policies 201
11.3 Patient complaints management in the TUH Urology Service 202

11.4 QH Staff Complaint Policies 208
11.5 Staff complaints relating to the delivery of urology services 210
11.6 Pathways for escalating systemic patient safety concerns 217
11.7 Findings and Recommendations 218
Section 12 - Embedding a Robust Approach to Delivery of Urology Services 222
12.1 Overview 222
12.2 Urology Service Progress - August to December 2025 223
12.3 Updated Audit Results 232
12.4 Summary 233
12.5 An approach to be considered by THHS 233
Section 13 - Statewide Learnings 235
13.1 Overview 235
13.2 Matters identified through this Investigation 236
13.3 Matters related to the Closed Loop Radiology program of work 237
13.4 Findings and Recommendations 238
Annexure A - Terms of Reference 240
Annexure B - AcciMap of TUH Organisational Process 242
Annexure C - AcciMap Methodology 243
Annexure D - Witness Interview Details 244
Annexure E - Severity Assessment Code (SAC) Case Sample Summary 247
Annexure F - Relevant materials considered by the THHS Board and Committees 275
Annexure G - Riskman Complaints Review Summary 297
Annexure H - Never Lost Pathway 331

Glossary of Abbreviations, Acronyms, and Terms

Defined Term	Meaning
AcciMap	Accident Mapping
ACHS	Australian Council on Healthcare Standards
ACSQHC	Australian Commission on Safety and Quality in Health Care
APCLG	Access to Planned Care Leadership Group
BARC	Board Audit and Risk Committee
Board	THHS Board as constituted during the relevant period
BSQC	Board Safety and Quality Committee
Bulk Check Out	The practice of Bulk Check Out of outpatients which ceased on 18 December 2023 following a memorandum issued by COO 2
CEQ	Clinical Excellence Queensland
CIR	Clinical Incident Review
Cluster/s	Cluster of adverse clinical incidents as described in Section 6.3
CMO	Chief Medical Officer role
COO	Chief Operating Officer role
COO 1	Chief Operating Officer (November 2018 to January 2025)
COO 2	Acting Chief Operating Officer (December 2023)
COO 3	Chief Operating Officer (February 2025 to present)
CPC	Clinical Prioritisation Criteria
Disrupted Care or DC	Disrupted Care, which is the term applied to describe this cohort, but which includes patients who are lost to care or where their treatment is delayed
DMSCGDH	Director Medical Services Clinical Governance and Digital Health
Draft Report	Initial draft of the Report which was provided to THHS and the Board for natural justice consultation on 27 February 2026
EARCC	Executive Audit, Risk and Compliance Committee
ECGC	Executive Clinical Governance Committee
EDCG	Executive Director Clinical Governance
EDDHK	Executive Director Digital Health and Knowledge
EDNMS	Executive Director Nursing and Midwifery Services
EDPSQ	Executive Director Patient Safety and Quality
EMR	Integrated Electronic Medical Record
ESIS	Elective Surgery Services Implementation Standard
ESM	Enterprise Scheduling Management
ESU	Ethical Standards Unit
FTE	Full-time Equivalent
GP	General Practitioner
GPSI	General Practitioners with Special Interest

Defined Term	Meaning
HBCIS	Hospital Based Corporate Information System
HHB Regulation	*Hospital and Health Boards Regulation 2023* (Qld)
HHBA	*Hospital and Health Boards Act 2011* (Qld)
HHS	Hospital and Health Service
HHS Board	Hospital and Health Board as defined in the HHBA
HIU	Health Improvement Unit, Queensland Health
HOA	*Health Ombudsman Act 2013* (Qld)
HR Act	*Human Rights Act 2019* (Qld)
HSCE	Health Service Chief Executive role
Investigation	This Health Service Investigation
Investigators	Health Service Investigators
IP Act	*Information Privacy Act 2009* (Qld)
Lead Investigator	Professor Michael Cleary
LTS	Lost to service
MDT	Multidisciplinary team
Natural Justice Response	Submissions, correspondence and information received as part of the natural justice consultation process from consulted parties
NDSSG	Nursing Director Surgical Service Group
NQRH	North Queensland Referral Hub
NSQHS Standards	National Safety and Quality Health Service Standards
OHO	Office of the Health Ombudsman
OPD	Outpatient Department
PACS	Picture Archiving and Communication System
PDAR	Post Discharge Appointment Request
PHO	Principal House Officer
PID	Public Interest Disclosure
PID Act	*Public Interest Disclosure Act 2010* (Qld)
Previous CMO	Chief Medical Officer (2022 to 2026)
Previous HSCE	Health Service Chief Executive (2018 to 2026)
PSC	Patient Safety Committee
PSQ	Patient Safety Queensland
QH	Queensland Health
RATP	Risk Assessment Treatment Plan
Relevant period	1 January 2022 to 31 July 2025
Report	This Health Service Investigation Report prepared under section 199 of the HHBA
RFI	Request for Information
SAC	Severity Assessment Code

Defined Term	Meaning
SMO	Senior Medical Officer
SOSIS	Specialist Outpatient Service Implementation
SRG	Service Related Group
SSG	Surgical Service Group
THHS	Townsville Hospital and Health Service
TOR	The Terms of Reference for the Investigation
TUH	Townsville University Hospital
Updated Draft Report	Revised draft of the Report which was provided to THHS and the Board for natural justice consultation on 5 June 2026
VMO	Visiting Medical Officer
We, us or Investigators	Persons appointed under Part 9 of the *Hospital and Health Boards Act 2011* to conduct the Investigation. Given the varied involvement and participation of the abovementioned Investigators throughout the Investigation, references to the plural "Investigators" throughout this Report includes a reference to the singular and vice versa.

Acknowledgement

The Investigators would like to recognise the assistance and the positive approach of staff from both the Townsville Hospital and Health Service and Queensland Health during their interactions with the Investigators. These interactions identified to the Investigators that staff were looking to improve the safety, quality and efficiency of the services provided to patients who are connected to or receive urology services at Townsville University Hospital, Townsville Hospital and Health Service.

Further, the Investigators acknowledge the patients of the Townsville Hospital and Health Service urology services whose experiences are referred to in this Report and the impact these matters had on them and their families. The Investigators note the acknowledgements made by the Board, the former Health Service Chief Executive and former Chief Operating Officer in their Natural Justice Responses and during the Investigation, as follows:

> The Board's members live and work in the Townsville community. They understand, with gravity, that Disrupted Care has meant that patients and their families have suffered delayed diagnoses of potential malignancies, prolonged uncertainty about cancer outcomes, disruption to treatment pathways for conditions that do not wait, and the anxiety that accompanies each of those experiences for patients and for those who love them. The Board does not minimise those experiences. It is profoundly sorry for them.
>
> ...
>
> It must be recognised and remembered that there were patients and families at the heart of the events under review who did not receive the timely access to care that we endeavoured to provide. Whilst I have outlined that considerable work was being done by THHS at the time to identify and address underlying issues impacting outpatient urology services, this Investigation is a welcome opportunity to revisit and learn from events in order to make important improvements.

It is against this background, with the abovementioned matters front of mind, that the Investigators prepared this Report and now submit this Report to the Director-General of Queensland Health in accordance with the Terms of Reference for this Investigation.

We acknowledge the Traditional Custodians of the land on which care is delivered, the Wulgurukaba and Bindal peoples. We pay our respects to Elders past, present, and emerging, and recognise the enduring connection of Aboriginal and Torres Strait Islander peoples to land, waters, and community. We acknowledge that sovereignty was never ceded and that First Nations peoples continue to contribute invaluable knowledge, resilience, and leadership to the health and wellbeing of our region.

We affirm a commitment to gender inclusivity. We recognise and respect the diversity of gender identities and expressions among staff, patients, and community.

Executive Summary

1. In July 2025, concerns emerged regarding patients experiencing "Disrupted Care" within urology outpatient services at Townsville University Hospital (**TUH**), which is part of the Townsville Hospital and Health Service (**THHS**). The concerns arose following a patient who experienced Disrupted Care and subsequently suffered a serious adverse event.

2. On 28 September 2025, the Director-General of Queensland Health (**QH**) formally commissioned a Health Service Investigation (**Investigation**) under Part 9 of the *Hospital and Health Boards Act 2011* (Qld) (**HHBA**) into the administration, management, and delivery of public sector health services, including clinical governance, in relation to urology services at TUH.

3. The Investigation covered the period 1 January 2022 to 31 July 2025 (the **relevant period**). The Terms of Reference (**TOR**) required the Health Service Investigators (**Investigators**) to assess governance arrangements (including policies, procedures, standards, and processes), clinical governance and incident management, adequacy of oversight by the TUH executive, the Health Service Chief Executive (**HSCE**) and the Board, complaints handling and culture, effectiveness of remedial measures taken during or after the relevant period, and to provide recommendations for strengthening both local and statewide systems of care.

4. In responding to the TOR, the Investigators have conducted a detailed and comprehensive information gathering process, producing a high volume and complex body of evidence from which to reach conclusions, findings and make recommendations. A total of 3,475 documents have been received by the Investigators and a total of 37 interviews have been conducted. The Investigators have also undertaken an extensive consultation process with affected parties (the **Consultation**). This was undertaken across a four-month period with a total of 22 parties consulted, with some of these parties consulted across a two-stage process. The two-stage process was necessary to enable these parties to consider the key evidence and analysis of the same by the Investigators and then provide those same parties with the opportunity to respond to the revisions and refinements to drafts of this Health Service Investigation Report (**Report**) which had been made as the Consultation process progressed.

5. This extensive and comprehensive evidence gathering and Consultation process was necessary considering the significance and gravity of the subject matter of this Investigation and the potential impact on the affected parties and the broader community.

6. Against this background, a summary of the views of the Investigators, along with the conclusions and findings reached and recommendations that have been made by the Investigators in responding to the TOR, is set out below.

Summary of Findings

7. The Investigators conclude that clusters of adverse clinical incidents (**clusters**) in urology services at the TUH after the first cluster was identified could have been mitigated.

8. The Investigators further consider that the oversight of the urology service by the Board, previous HSCE, COO 1 and the EDCG was not sufficient and that this represented a departure from what would reasonably be expected of the Board, previous HSCE, COO 1 and the EDCG across the relevant period.

9. Despite the THHS identifying information as to the variation in outpatients processes from as early as August 2022, THHS did not appear to appreciate the seriousness of the emerging patient safety risks until Cluster 9 arose in 2025. The Investigators found that this was due to several factors including that no detailed analysis was undertaken to understand the underlying causes of patients experiencing Disrupted Care. The Investigators consider that the visual representation of the clusters through the utilisation of the AcciMap clearly demonstrates how the clusters were linked.

10. The THHS executive hold explicit accountabilities relating to the provision of safe high-quality care, risk identification, operational performance, and clinical governance. Their role descriptions emphasise leadership in patient safety, risk management, and the maintenance of systems that ensure safe service delivery.

11. The Investigators consider that some of the executive roles such as those of the HSCE, Chief Operating Officer (**COO**) and Executive Director Clinical Governance (**EDCG**) were interdependent and were akin to the "three sides of an equilateral triangle" in relation to clinical governance. The Investigators found that their collective assessment and management of the clusters fell below the standard reasonably expected. This was manifest in action plans that did not address underlying causes, lacked change management rigour, and failed to prevent recurrence of the clusters.

12. The Board as the central governance authority under the HHBA received large volumes of information and demonstrated concern about issues raised. However, its oversight was inhibited by unfiltered reporting, "managerial board papers", and an information environment that obscured strategic risk signals. The Investigators note that this hindered the Board's ability to "join the dots" and recognise the true scale of the patient safety risks.

13. Although the Board complied with procedural expectations by reviewing clusters, receiving briefings, and seeking assurances, it did not escalate concerns or seek external advice at the points where this could have been considered. This is particularly relevant after Clusters 6 and 7 occurred in December 2023 and certainly by the time Cluster 8 occurred in April 2024. The Investigators consider that earlier escalation to QH or external advice could have mitigated the risks associated with subsequent clusters.

14. The Board Safety and Quality Committee (**BSQC**) fulfilled its formal responsibilities but similarly relied on internal briefings and did not recommend external advice in relation to Cluster 6. The committee, although recognising the seriousness of incidents and having considered seeking external advice, continued to operate within an information environment that lacked strategic clarity.

15. The Board and its committees sought detailed internal briefings from THHS and accepted their assurances without external validation. The Investigators note that this created governance risk, particularly given the complexity of the issues and the fact the Board did not hold expertise in relation to urology services or outpatient management (and nor should they, as a governing body). The Board's desire for assurance reflected genuine concern, yet the absence of external validation contributed to prolonged, systemic, blind spots.

16. Across the relevant period, THHS leadership and governance structures did not adequately assess or manage the clusters. The previous HSCE, COO 1 and EDCG did not undertake the level of analysis or corrective action reasonably expected of their roles, and the Board did not exercise sufficient strategic oversight or consider escalating their concerns. These failures collectively contributed to prolonged patient safety risks and repeated clusters of patients who experienced Disrupted Care.

17. The specific findings and recommendations reflecting the above position are below.

Key Findings and Recommendations – Consolidated Summary

<u>Section 8: Governance - Policies, Procedures, Standards and Processes</u>

(a) With respect to the policy and procedure framework within the THHS, the Investigators considered that the THHS had an established policy framework in place that was consistent with national accreditation requirements as per the National Safety and Quality Health Service Standards (**NSQHS Standards**).[1] However, in the delivery of urology services, for most of the relevant period

[1] Australian Commission on Safety and Quality in Health Care, *National Safety and Quality Health Service Standards,* Second Edition, May 2021. Electronic copy available at: https://www.safetyandquality.gov.au/standards/nsqhs-standards.

TUH lacked detailed operational procedures and work instructions as required under the QH Specialist Outpatient Service Implementation Standard (**SOSIS**).[2] This absence of localised procedural guidance contributed to variability in administrative practice within the delivery of urology services. Despite current alignment with SOSIS, it was noted that the THHS had only developed relevant operational procedures in the period late 2024 to 2025.

(b) Non-compliance by staff with established policies, procedures, standards and directions relating to the delivery of urology services impacted adversely on patient care. This was apparent in relation to the tracking of patients from referral through to diagnosis and treatment. Administrative and nursing teams attempted to mitigate the risks that they identified, however, local resourcing and systemic constraints limited their ability to achieve sustainable improvements.

(c) Demand for urology services within the THHS exceeded available capacity. This was driven primarily by workforce shortages. The THHS Board and Executive were aware of these pressures and had developed Risk Assessment Treatment Plans (**RATP**s) in response to the risks that this presented. Despite these activities, the recruitment to vacant specialist urologist positions remained unresolved within the TUH.

(d) The sustained discrepancy between demand and capacity affected THHS's ability to provide timely care to urology patients who are connected to or receive urology services. Addressing capacity concerns will also require attention to be given to infrastructure requirements such as operating theatre access, clinic space and equipment availability.

(e) The Investigators identified processes that fell below expected standards in the urology outpatient area. The Investigators also noted that concerns raised by staff and which related to both the resourcing and procedural requirements within the urology outpatient area were not consistently acted upon, and in some instances, remedial actions were delayed.

Section 9: Clinical governance and incident management

(f) When adverse clinical incidents were identified that related to patients experiencing Disrupted Care, THHS responded to these matters in a timely manner and the case reviews and actions by the THHS were professional and detailed and patient focused. However, their response did not include a detailed analysis that identified the broader range of underlying causes of incidents and, in not doing so did not fully mitigate the risk of future incidents of patients experiencing Disrupted Care.

(g) The Investigators note that once the impacted patients had been identified that there was a proactive management arrangement put in place to ensure that the patients received follow up care and treatment.

(h) With respect to the reviews undertaken by the THHS of the various adverse clinical incidents, an assessment of underlying systemic issues was not undertaken as comprehensively as the Investigators considered would be required. For example, the THHS did not use the standard analytical methodologies to investigate the adverse clinical incidents and the underlying causes for patients who experienced Disrupted Care. The Investigators note, however, that process mapping was undertaken in relation to Cluster 1, but not in relation to urology. Overall, this limited the organisation's ability to understand why patients who were connected to or received urology services experienced Disrupted Care and how systemic vulnerabilities contributed to these risks.

Section 10: Adequacy of Oversight

(i) At the governance level, the previous HSCE, each COO and EDCG provided their considered advice to the Board in relation to the causes and treatments for patients who are connected to or receive urology services experiencing Disrupted Care.

[2] QHT.001.001.0019 Queensland Health, *Specialist Outpatient Services Implementation Standard*, Document Number QH-IMP-300-1, 22 March 2023. Electronic copy available at: https://www.health.qld.gov.au/__data/assets/pdf_file/0029/164756/qh-imp-300-1.pdf.

(j) The Investigators appreciate that the Board voiced concerns about the delivery of urology services including the recurrent nature of patients experiencing Disrupted Care. The Board relied on the advice from the previous HSCE, COO and EDCG. The Investigators consider that the THHS did not formally escalate concerns to QH in a timely manner nor did the THHS obtain external advice to assist them to better understand the underlying factors that led to patients experiencing Disrupted Care. The delay in escalating the matter contributed to delays in recognising the breadth of systemic issues. In this way, the Board's oversight in relation to the issues of concern relevant to urology services was inadequate.

(k) Overall, the Investigators formed the view that the assessment and management of the clusters represents a departure from good practice, specifically what would reasonably be expected of the previous HSCE, COO 1 and EDCG. Sufficient information about the serious nature of the patient safety risk was before the HSCE and the EDCG as well as COO 1 but notwithstanding this, the previous HSCE, COO 1 and EDCG's assessment of the underlying causes was below the level reasonably expected of these executives and that the action plans that were developed did not comprehensively address the underlying causes of the clusters nor consider implementation actions and the monitoring of the effectiveness of the same.

Section 11: Complaints and culture

(a) The Investigators considered that the formal patient complaint management processes within THHS were appropriate. Having considered the rate of urology services related patient complaints, the Investigators considered that the year-on-year increase in complaints is significant and should have triggered a more detailed analysis of the complaint profile by the THHS.

(b) The Investigators noted that THHS did not have a public facing patient complaints management policy and have been advised that the Board has since directed that this be developed.

(c) Staff complaints, including Public Interest Disclosures (**PID**s), were managed in accordance with the relevant QH policy. The Investigators noted instances of inaction with respect to staff concerns when these were escalated through management channels. The THHS reported that they had not received any PIDs relating to the delivery of urology services, however QH's Ethical Standards Unit (**ESU**) confirmed that a relevant PID had been raised during the relevant period. Similarly, the THHS reported that they received no Patient Safety Net complaints, however, one was subsequently identified by the Investigators.

(d) While formal mechanisms existed for escalating systemic patient safety concerns, some staff reported that they chose not to use them due to a belief that their concerns would not be heard or acted upon.

Section 12: Embedding a robust approach

(a) In response to patients who are connected to or receive urology services experiencing Disrupted Care, the THHS has undertaken a remediation program. This includes the appointment of additional temporary urologists, operational and production planning, process mapping and follow-up of patients identified through their clinical audit processes who potentially experienced Disrupted Care. This activity is ongoing. QH and the Health Improvement Unit (**HIU**) have played a significant role in supporting this work. Workforce stabilisation remains a critical priority.

Section 13: Statewide learnings

(a) The Investigators identified several learnings with potential state-wide applicability. These include the development of a Cluster Adverse Clinical Incident Review (**CIR**) Guideline and Toolkit, strengthening the SOSIS, advancing service and workforce planning for urology, considering the development of “never lost pathways” for high risk clinical services and encouraging Hospital and Health Boards (**HHS Board**s) to consider the circumstances in which external advice should be sought.

Summary of Recommendations

18. Noting the above key observations, findings and conclusions, the Investigators have made 27 recommendations. Some of the recommendations have sub-components. Of the recommendations, seven are for consideration by QH. The Investigators have also made three recommendations that are related to the Statewide Urology Taskforce and two recommendations that relate to the Closed Loop Radiology program of work being coordinated by QH. These are detailed in Section 13 of this Report.

19. Of the Recommendations made by the Investigators, there are 10 that are a priority. These are Recommendations 1, 5, 6, 7c, 8a, 8c, 13, 14b, 27a, and 27b.

20. The Priority Recommendations and the Statewide Recommendations are specifically identified in the below tabular listing of recommendations.

21. The table below presents a summary of the Recommendations from the Investigation.

Table 1: Summary of Recommendations

Recommendation No.	Recommendation
Detailed in Section 7	
Recommendation 1	(Priority) That the THHS reviews the Accident Mapping (**AcciMap**) and AcciMap Analysis developed by the Investigators and consider the further activities that would assist the THHS to mitigate the risks of patients experiencing Disrupted Care.
Recommendation 2	(Statewide) That QH consider developing a Cluster Adverse CIR Guideline and Toolkit to assist Hospital and Health Services (**HHS**) to respond to clusters of adverse clinical incidents. In so doing, QH may need to consider the structure, functioning and resourcing of HHS clinical governance teams.
Detailed in Section 8	
Recommendation 3	(Statewide) That QH consider strengthening the SOSIS and confirming that compliance with the standard is mandatory for HHSs.
Recommendation 4	That the THHS establish a robust internal policy governance process to ensure that internal policies, procedures, and standards are maintained and align with the SOSIS as they relate to the delivery of urology services.
Recommendation 5	(Priority) That the THHS Chief Medical Officer (**CMO**) ensure that professional standards are complied with in the delivery of urology services as they relate to the follow up, endorsement and actioning of radiology and pathology investigations undertaken in the public and private sector for patients who are connected to or receive urology services
Recommendation 6	(Priority) That the THHS review the resource requirements within urology outpatients to ensure that the changes identified in the memorandum relating to the Bulk Check Out process circulated on 18 December 2023

	(**Bulk Check Out**) and the implementation of QH Refer are resourced, operationalised effectively and are sustainable.
Recommendation 7	a) (Statewide) That QH consider further developing the reporting of information collected as part of the Smart Referrals Workflow Solutions to ensure that outpatient services are aware of delays in the triage and categorisation of outpatients referred to the respective HHSs. b) That the THHS expand the resourcing of urology services to allow the development and maintenance of work instructions and clinical care pathways such as a service model, patient pathways for planned and unplanned care, a urology operational plan and production plan, the partly completed one relating to bladder cancer guidelines and guidelines for patients with a cancer diagnosis. c) (Priority) That the THHS CMO ensure that professional standards are complied with in the delivery of urology services as they relate to the triaging and categorisation of new GP outpatient referrals.
Recommendation 8	a) (Priority) That the TUH establish dedicated Urology Case Coordinator and Nurse Navigator roles within urology services that will work with the medical officers so that the medical staff can focus on the provision of specialist care. b) (Statewide) That the THHS HSCE works with the QH and the HSCE from the Cairns and Hinterland HHS to progress workforce and service planning for the delivery of urology services with a focus on Northern Queensland. This may include consideration of: i. Strengthening the training pipeline, increasing intake, and incentivising regional placements which will be critical to building sustainable capacity. ii. Consideration of workforce demographics, including gender imbalance and ageing. iii. Expanding specialist capacity to address regional gaps and reduce reliance on outsourcing. iv. Consideration of establishing Career Medical Officer roles within urology services. c) (Priority) That the THHS progress the sourcing of an additional 2.0 Full-Time Equivalent (FTE) urologists (noting that there are 3.5 FTE funded and 1.7 FTE vacant positions). The recruitment activity is a priority and must include a Clinical Director for urology services. Recruitment should coordinate and actively engage with the specialist college and society with the active support of QH.
Recommendation 9	(Statewide) That QH consider developing an overarching policy guideline for HHSs in relation to the operationalisation and management of Multidisciplinary Teams (**MDT**s) within HHSs.
Detailed in Section 9	
Recommendation 10	That the THHS formalises a detailed summary of the clinical review methodology used for the clinical audit (triggered by Cluster 10) of patients who are connected to or receive urology services and had

	experienced Disrupted Care, including their process for Open Disclosure, and provides this to QH.
Recommendation 11	That the THHS apply resource and scheduling interventions to target the Severity Assessment Code (**SAC**) 2 cohort of patients identified during the clinical audit (triggered by Cluster 10) of patients who are connected to or receive urology services, with a parallel, scalable process to reduce the SAC 3 backlog.
Recommendation 12	That the THHS ensure that current and future SAC 1 incidents identified through the current clinical audit (triggered by Cluster 10) are reviewed in such a way as to identify and mitigate underlying causes of patients experiencing Disrupted Care.
Recommendation 13	(Priority) That the THHS urgently obtain an independent review of the original SAC 2 cases identified through the current clinical audit (triggered by Cluster 10) of patients who are connected to or receive urology services to determine if any of these cases should be reclassified as SAC 1 cases pending clinical review. This is based on the Investigators' review of the SAC data where it appears that some SAC 2 cases should have initially been classified as SAC 1.
Recommendation 14	a) That the THHS resource and support urology services to undertake the appropriate levels of clinical and administrative audits. These audits must be monitored through the THHS governance structure so that the THHS BSQC can be assured that appropriate audits are in place and ongoing. b) (Priority) That the THHS work to establish a “Never Lost Pathway” within urology services. c) (Statewide) That QH consider the opportunities to develop a “Never Lost Pathways” for high risk clinical conditions within its digital framework, and particularly those related to cancer care as a system-wide patient safety initiative.
Recommendation 15	That the THHS confirm that appropriate notifications have been provided to the Australian Council on Healthcare Standards (**ACHS**), the Office of the Health Ombudsman (**OHO**) and the Coroner following the clusters of patients experiencing Disrupted Care who are connected to or receive urology services and provide this confirmation to the THHS Board.
Recommendation 16	That the THHS consider how to further progress the THHS Clinical Engagement Strategy as part of the support for urology services.
Recommendation 17	The urology services RATPs be updated and streamlined to include responses to the issues identified in this Report.
Recommendation 18	That the THHS review the information flows and reporting through Patient Safety Net to confirm that matters raised through this process are logged in line with the relevant policies and procedures in a way that facilitates local management.
Recommendation 19	That the THHS reviews the findings for each of the clusters and consider if there are gaps that exist within the model of urology services that have

	not been addressed through the work that the THHS has undertaken since July 31, 2025.
Detailed in Section 10	
Recommendation 20	That the THHS Board consider the circumstances where the THHS should seek external advice when complex matters are presented to the Board. This should be a component of a formal decision-making framework. By detailing its approach, the Board will provide assurance that its governance processes are robust, transparent, and resilient. This will strengthen the organisation's capacity to anticipate and mitigate future risks, while strengthening public confidence in the integrity of THHS decision-making.
Recommendation 21	(Statewide) That QH provide formal advice to HHSs and their Boards in relation to the circumstances where HHSs should notify QH and/or the Minister's Office about complex matters that they are considering and/or that may have Statewide significance.
Recommendation 22	That the THHS formally identify the circumstances that would require them to seek external advice or escalate complex matters to QH. The Investigators are of the opinion that this should be placed in a formal decision-making framework and provided to the Board for review.
Recommendation 23	That the THHS Board consider what circumstances would require it to escalate risks when complex matters are presented to the Board Audit and Risk Committee (**BARC**) and include details of this principle in the THHS Risk Management Framework.
Detailed in Section 11	
Recommendation 24	That the THHS review the processes in place to support thematic assessment of patient complaints in the delivery of urology services to identify changes to complaint profiles and implement appropriate actions to address underlying issues.
Recommendation 25	That the THHS ensures that when patient safety concerns are raised, they are appropriately reviewed and clinical audit teams are empowered to conduct retrospective reviews, supported by digital systems that provide transparent and accessible data.
Recommendation 26	That the THHS reaffirms for executive staff, best practice arrangements for receiving and responding to issues and concerns relating to patient safety when these are raised by staff, such as those raised in relation to the delivery of urology services. That the THHS ensure that patient safety and quality is an item on the agendas in key operational performance meetings across the health service and that safety discussions are facilitated through these forums. That the THHS consider implementing a professional development program for executives and managers that provides guidance on how to

	receive and respond to patient safety concerns while encouraging staff to speak up for patient safety.
Detailed in Section 12	
Recommendation 27	a) (Priority) That the THHS approach QH and request further support from the QH Deputy Director-General, Workforce Division with respect to medical recruitment as this remains a key risk for the delivery of urology services. This supports an earlier recommendation relating to service and workforce planning. b) (Priority) That the THHS, in collaboration with QH HIU, consider establishing a dedicated innovation focused team to explore, plan and introduce appropriate service models pending the recruitment of additional specialist staff and noting the existing pressures on specialist urologists in terms of supervision. This may include consideration of the following: i. Enhance and formalise a networked hub-and-spoke model supported by visiting urologists from larger centres who provide scheduled fly-in fly-out clinics, block-time surgical lists, and virtual participation in MDT meetings; ii. Expansion of tele-urology consultations via telehealth, supported by local nurse practitioners and general practitioners (**GP**s) who perform physical assessments, diagnostics, and follow-up. iii. Establishing high volume / lower-complexity clinics led by nurse practitioners, General Practitioners with Special Interest (**GPSI**) or Career Medical Officers. iv. Expanding procedure-focused task delegation, where non-urologist clinicians are trained to perform selected procedures. v. For high-complexity surgical care, THHS expand access to the private sector's robotics and theatre platforms to enable urologists to undertake robotic prostatectomy and nephrectomy in block sessions. vi. Across cancer and stone disease, implement integrated Never-Lost Pathways to ensure patients move predictably through the system. This could be nurse-led with specialist oversight. vii. Workforce attraction and retention initiatives including registrar rotations, joint public-private appointments, supervised international medical graduate pathways, and targeted incentives to attract and retain urologists in North Queensland. While these strategies will take time to mature, they provide the foundation for a sustainable future workforce.

Section 1 - Overview of the Investigation and structure of the Report

1.1 Establishment of the Investigation

22. The THHS offers a wide range of general and specialist health services, including urology services. TUH is the largest health facility in northern Queensland and is a key operational element of the THHS. It is designated a tertiary hospital because it provides the highest level of specialist and critical care services in northern Queensland.

23. It functions as the region's major trauma centre and cancer centre, supports a large referral catchment, and operates as a major teaching and research infrastructure in association with James Cook University. Its service profile, critical care capability, and statewide referral role aligns with the criteria used in the Clinical Services Capability Framework used to define health service capabilities in Queensland.[3] The institutional arrangements of TUH, including information on services provided and detail on the geographical characteristics of the service, are considered under Section 5 of this Report.

24. In July 2025, concerns over patients experiencing Disrupted Care prompted a preliminary review of urology outpatient services. This followed a patient experiencing Disrupted Care who suffered a serious adverse event.[4]

25. In September 2025, this Investigation was established and commenced by the Director-General, QH. At this time, the Director-General also established a Statewide Urology Taskforce to consider operational opportunities to support patients requiring urology services within the Queensland Public Hospital System, particularly those offered at TUH.

1.2 Scope and purpose of the Investigation

26. The purpose and scope of the Investigation, as prescribed by the TOR, is for the Investigators to investigate matters relating to the administration, management and delivery of public health services, including overall clinical governance in relation to urology services at TUH, THHS within the relevant period focusing on several areas comprising, in summary form, the following:

(a) **Governance** matters, across a broad range of areas including the consideration of the appropriateness of relevant administrative and clinical policies; procedures and standards and compliance with the same; the identification of and response to systemic issues; and the adequacy of TUH executive, the THHS HSCE and the THHS Board's (**Board**) oversight of these matters;

(b) **Culture and complaints**, identifying complaints and concerns received within THHS about the delivery of urology services, including PIDs (within the meaning of the *Public Interest Disclosure Act 2010* (Qld) (**PID Act**)) as well as complaints from staff, health practitioners and patients, and assessing the adequacy of the THHS complaints management process;

(c) **Embedding a robust approach to the delivery of urology services** by identifying and assessing the effectiveness and sustainability of any measure implemented by TUH/THHS staff during or after the relevant period to respond to the matters identified above; and

(d) **Statewide learnings**, identifying and reporting on any practices or learnings derived from this Investigation which could be implemented state-wide that are relevant to improving and strengthening system safety and local or state-wide policies, procedures and/or standards.

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[3] Queensland Health, *Clinical services capability framework,* last updated 25 June 2024. Webpage can be accessed here: https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/service-delivery/cscf.
[4] WIT.002.001.0023 Transcript of interview – Witness Q and Witness B, paragraph 68.

27. The drafting contained in the TOR affords a broad scope to the areas and matters which fall within the ambit of matters to be considered by the Investigators when responding to the TOR. In particular, this drafting of the TOR includes the use of the term "urology services" as opposed to "urology department" and the inclusion of connective phrases such as "in relation to". This drafting is contained within an already broad array of matters and issues that must be investigated and considered by the Investigators over a three-and-a-half-year period to respond to the TOR.

28. This has required the Investigators to identify, analyse and evaluate a broad array of information and evidence and interpret the same in order to understand what occurred at THHS within the relevant period and what conclusions, findings and recommendations can be made in responding to the TOR. A complete copy of the TOR is included in Annexure A.

1.3 Observations regarding the TOR

29. There are several observations regarding the nature and scope of the TOR which, while discussed throughout the Report, are necessary to identify at the outset, being:

(a) the Investigators note that the TOR are system-level focussed and as such the Investigators have directed their focus towards analysis through that lens. While individual actions and accountability have been expressly considered, this has been undertaken with a view as to how individuals operated within the system in line with the TOR;

(b) throughout the Report, it has been necessary to refer to occupational/position titles. The Investigators have identified through the factual setting and context whether the reference pertains to the individual holding the cited position during the relevant period or more generally to the specific responsibilities associated with it, irrespective of the individual occupying the cited position. Additionally, during the relevant period there have been changes in persons holding specific positions, including at a Board and Executive level. These changes are identified in the Glossary of Abbreviations, Acronyms and referenced in the Report;

(c) in terms of the relevant period, which is 1 January 2022 to 31 July 2025, the Investigators included information relating to patients who were under the care of or receiving treatment from urology services during the relevant period. Documents and information (for example audits, Riskman Reports and complaints) which were created after 31 July 2025 have been included where they concern patients who were under the care of or receiving treatment from urology services during the relevant period and/or are otherwise connected to the relevant period and/or responsive to 3.2 of the TOR;

(d) elements of the TOR for this Investigation refer to TUH. The Investigators noted that TUH exists as a physical entity and that there is no specific governance structure for TUH, as the Service Groups within the hospital report to the THHS COO. As such, the Investigators consider that where the term "TUH" is used, this relates to structures or activities that are undertaken within the physical facility as part of the THHS;

(e) elements of the TOR for this Investigation refer to the TUH executive, as exemplified in TOR 3.1(e). In further considering the TOR, where TUH is referred to, the Investigators noted that there is no executive lead for the TUH and that business units within the physical structure, that is the TUH, report directly to the THHS COO. As such, the Investigators have applied the following in responding to the TOR where TUH is referred to:

(i) where there is reference to physical or organisational unit that is located within the TUH, this is identified as a component of the TUH. For example, urology services are a component of the TUH; and

(ii) where the TOR refers to executive, governance or management structures within the TUH, these are interpreted as relating to the THHS executive, governance and management structures.

(f) with respect to the TUH executive, this is therefore considered to be the THHS Executive for the purpose of responding to TOR 3.1(e). The Investigators have interpreted the THHS executive as per the information contained on the THHS website.[5] The THHS have provided the Investigators with information as to other officers it sees as relevant to the Investigation. This information has been considered by the Investigators.

1.4 Approach of the Investigators in responding to the TOR

30. The purpose and scope of the Investigation, combined with matters identified in the above observations, has necessitated the adoption of several specific steps and/or approaches to enable the Investigators to conduct the Investigation in a manner which responds to the TOR, being:

(a) the identification, analysis and examination of a broad range of clinical, factual, operational and administrative information across a significant temporal period. This has caused a high volume of varied and complex information to form the body of relevant evidence for this Investigation from which findings, conclusions and recommendations have been made;

(b) the consideration of the level and form of analysis and synthesis of the body of relevant evidence in order to identify and understand the clinical, operational and decision-making settings, as well as relevant points of intersection within these settings in order to understand the events occurring at THHS and in turn respond to the specific items contained within the TOR;

(c) in this connection, this required the Investigators to consider how to discuss and present the evidence, outcomes of the examination, and analysis of the evidence in a manner that could be clearly and easily understood, was transparent and robust while simultaneously allowing for the presentation of identified specific issues of concern and systems issues across a 3.5 year period. In these circumstances, the Investigators used several measures to present the evidence and the analysis of the same:

(i) the development of "framing concepts" being the identification and application of specific definitions such as "clusters" and "Disrupted Care" to assist in the interpretation and analysis of the body of relevant evidence;

(ii) a diagrammatical representation of key parts of the relevant evidence (in the form of the identified clusters of Disrupted Care) and the placement of this evidence (the clusters) within relevant clinical and operational settings across the relevant period as an aid to assist in understanding what had occurred at THHS in the delivery of urology services. It was considered that the most effective, patient-focused mechanism to present this evidence was through an AcciMap;

(d) a detailed and robust Consultation process with individuals, the THHS and the Board. A total of 22 parties were separately consulted. Some of the parties involved in the Consultation process (the parties subject to item 3.1(e) of the TOR) undertook a consultation process involving the release of an initial draft or extracts of (with necessary redactions) the Report (**Draft Report**) followed by the release of a revised draft (with necessary redactions) of the Report (**Updated Draft Report**) and all footnoted documents (or extracts of the same). The two phase process was

[5] https://www.townsville.health.qld.gov.au/about-us/our-executive/

considered necessary to allow for concurrent consultation processes to be undertaken across this cohort of consulted party and in order to afford these parties with the capacity to examine the defined terms and the AcciMap along with other relevant evidence at first instance, followed by a further opportunity to respond to revisions in the Updated Draft Report including those made pursuant to comments and feedback from consulted parties provided in the first phase of Consultation.

1.5 Structure of the Report

31. Noting the broad array of matters falling within the scope of the TOR, the complexity and volume of the relevant body of evidence, and the specific steps and measures identified and adopted by the Investigators, this Report has been structured in three parts, with specific Sections contained within these parts, in responding to the TOR as set out below.

Part A – Investigative background and procedural settings

32. Under this **Part A**, the following issues are covered in the specific sections of the Report:

(a) Section 2 - Investigators – appointment; conflict of interest and bias issues;

(b) Section 3 - Investigative methodology;

(c) Section 3.3 - Specific issues informing the investigative methodology; and

(d) Section 4 - Consultation process including natural justice.

Part B – Measures and approaches adopted in evidence evaluation and synthesis

33. Under this **Part B**, the following issues are covered in the specific sections of the Report:

(a) Section 5 – Institutional Settings;

(b) Section 6 - Framing concepts; and

(c) Section 7 – Chronology of key events and the AcciMap.

Part C – Responding to the TOR

34. Under this **Part C**, the following issues are covered in the specific sections of the Report:

(a) Section 8 – Governance: Policies, Procedures, Standards and Processes (responding to TOR 3.1 (a));

(b) Section 9 – Clinical Governance and Incident Management (responding to TOR 3.1 (b) – (d));

(c) Section 10 – Adequacy of Oversight – TUH Executive, HSCE and/or the Board (responding to TOR 3.1(e));

(d) Section 11 – Complaints and Culture (responding to TOR 3.1 (f) – (g));

(e) Section 12 – Embedding Robust Approach to Delivery of Urology Services (responding to TOR 3.2); and

(f) Section 13 – Statewide Learnings (responding to TOR 3.3).

Part A - Investigative settings and procedural background

Section 2 - The Investigators

2.1 The appointment of the Investigators

35. On 28 September 2025, the Director-General formally commissioned the Investigation under Part 9 of the HHBA into urology services at TUH.

36. On 1 October 2025, the Director-General of QH appointed Professor Michael Cleary PSM (**Lead Investigator**), Dr Malcolm Lawson and Ms Sarah Black under section 190(2) of the HHBA (collectively, the Investigators) to conduct the Investigation under Part 9 of the HHBA.

37. The expertise that the Investigators bring to this Investigation is set out below.

Professor Michael Cleary PSM

38. Professor Cleary is a senior medical leader, holds a Professorship of Medicine at the University of Queensland and serves as Adjunct Professor within the School of Public Health Medicine at Queensland University of Technology. His medical foundation was established with a Bachelor of Medicine, Bachelor of Surgery from the University of Queensland in 1983, followed by advanced qualifications including a Master of Health Administration from the University of New South Wales in 1993 and is a graduate from the Australian Institute of Company Directors in 2018 and 2022.

39. Clinically, Professor Cleary is a Fellow of the Australasian College for Emergency Medicine, awarded in 1989, and has contributed extensively to trauma and critical care education. He has served as an instructor in multiple internationally recognised programs, including Early Management of Severe Trauma, Pre-Hospital Trauma Life Support, and Care of the Critically Ill Surgical Patient. His expertise extends to disaster medicine, having completed his certification through the Emergency Management Institute in 1994, equipping him to lead in high-stakes environments where resilience and rapid decision-making are paramount.

40. In the field of medical administration, Professor Cleary is a Fellow of the Royal Australasian College of Medical Administrators (**RACMA**). His leadership includes his tenure as President of RACMA, where he collaborated with the Australian Commission on Safety and Quality in Health Care (**ACSQHC**) to develop and establish national clinical governance guidelines. He is formally trained in Root Cause Analysis, HEAPS Review, and Open Disclosure.

41. Additionally, Professor Cleary has held Senior Executive Positions within QH across a decade, including as Director-General for a period of 18 months. Relevantly, Professor Cleary's experience and expertise in this capacity extends to:

    (a) leading the development and implementation of the HHBA reforms and related arrangements over a four-year period, which included:

        (i) oversight of the development and implementation of the HHBA including drafting instructions and Cabinet authorisation processes and implementation across a two year period; and

        (ii) oversight of supporting processes including preparing explanatory notes and materials for parliamentary committee consideration.

42. Professor Cleary oversaw the development and implementation of the original elective surgery and outpatient guidelines and the CIR guidelines in Queensland.

Ms Sarah Black

43. Ms Black is an accomplished healthcare executive and holds advanced qualifications including a Master of Leadership, a Master of Advanced Practice in Emergency Nursing, and a Graduate

Diploma in Health Industry Management. Ms Black is a senior practitioner in clinical governance and has extensive experience in this area which includes clinical governance at MNHHS, Royal Brisbane Hospital.

44. Ms Black has had a demonstrated career pathway in strategic leadership, clinical governance, and service improvement across complex health systems. Her career includes senior executive roles within the public, private and not-for-profit sectors. She has led emergency services, clinical governance, operational and patient flow portfolios.

45. Additionally, she has overseen statewide nursing operations and aeromedical service delivery.

Dr Malcolm Lawson

46. Dr Malcolm Lawson is a senior clinician currently holding the position of Acting Director of Urology at the Princess Alexandra Hospital. Additionally, he is one of the Senior Renal Transplant Surgeons in the Queensland Kidney Transplant Service (**QKTS**). His undergraduate degree was a Bachelor of Medicine, Bachelor of Surgery from the University of Queensland in 1994. He went on to complete advanced training in Urology receiving a FRACS (Urol) in 2007. Following completion of training in Australia, Dr Lawson undertook a combined fellowship in Urology and Renal Transplant at Beaumont Hospital, Dublin, Ireland in the Urology and National Kidney Transplant departments.

47. Clinically, Dr Lawson works in Urology both publicly and privately at Greenslopes Private Hospital. He has been a Senior Consultant in a major tertiary urology department for many years and is now the Acting Director of that unit. In Renal Transplant, he works as both a donor and recipient surgeon in the QKTS, based at Princess Alexandra Hospital and Queensland Children's Hospital. He is the Queensland lead surgeon on the Australia and New Zealand Paired Kidney Exchange program.

2.2 The management of conflicts of interest

48. Throughout the Investigation, conflicts of interest were carefully considered and managed as appropriate. Where necessary, appropriate management plans were put in place to ensure the integrity of the Investigation. Details of these matters are set out below, including information regarding how conflicts of interests were managed throughout the Investigation and specific conflict of interest information applicable to each of the Investigators.

49. In summary form, the mechanisms and steps taken by the Investigators to manage conflicts of interest throughout the conduct of the Investigation included:

(a) the completion on appointment and the ongoing review and amendments (where necessary) of the conflict of interest declaration form provided to QH;

(b) receipt of information in October 2025 in relation to the management of conflict of interest issues;

(c) ongoing disclosures and the checking and assessment of conflict of interest issues as factual matters developed throughout the course of the Investigation;

(d) receiving advice and, where necessary to do so, the preparation and implementation of a conflict of interest management plan;

(e) advice from the Deputy Queensland Integrity Commissioner and the preparation of a section 40F statement under the *Integrity Act 2009* (Qld) and submission of the same to QH;

(f) managing the associated concerns regarding apprehended bias arising from these actual or perceived conflicts of interest; and

(g) briefing to the Lead Investigator of any perceived or actual conflict of interest as deemed necessary and appropriate.

50. Details of the mechanisms and steps applicable to each of the Investigators are detailed in the table below.

Investigator	Conflict issues and management steps
Professor Michael Cleary	Professor Cleary was appointed as the Lead Investigator for the Investigation. As the Lead Investigator, Professor Cleary was actively involved in all aspects of the Investigation from the commencement through to the completion of the Investigation. Professor Cleary was appointed to the Metro North Board on 1 April 2026. Accordingly, in accordance with guidance from the Deputy Queensland Integrity Commissioner, Professor Cleary maintained a leave of absence from 1 April 2026 until the completion and conclusion of the Investigation.
Doctor Malcolm Lawson	Dr Lawson's participation in the Investigation was as the Urology specialist, providing expert clinical opinion and advice in accordance with his role as the subject matter expert within the Investigation. In late March 2026, a conflict of interest/bias issue was raised. The issue arose in connection with Dr Lawson being previously consulted on a urology case review report prepared by THHS. When this matter was identified, Dr Lawson's participation in the Investigation was paused, with Dr Lawson's recommencement on 5 June 2026 after the matter had been considered in detail.
Ms Sarah Black	Ms Black's participation in the Investigation was as the expert in clinical governance, providing expert clinical governance opinion and advice in accordance with her role as the subject matter expert within the Investigation. In late February 2026, for potential conflict of interest reasons, Ms Black ceased her involvement in the Investigation.

Section 3 - Investigative Methodology

3.1 Overview

51. The Investigators have adopted and embedded the following principles in the design and structure of the investigative methodology for this Investigation:

    (a) the Investigation is to be a comprehensive, detailed and fair process, acknowledging the significance and importance of the subject matter of this Investigation and the potential impact on staff and the community; and

    (b) acknowledging the significance and importance of the subject of the Investigation and undertaking a confidential process to ensure robustness and integrity in the responses obtained from consulted parties.

52. Applying these principles, the Investigators have adopted a comprehensive investigative methodology which has included extensive and detailed evidence gathering steps and processes.

53. The investigative methodology adopted and applied in this Investigation has essentially comprised of:

    (a) information and evidence gathering activities; analysis and review of the relevant information; and the presentation of the evidence and evidence analysis;

    (b) forming observations, findings, and recommendations;

    (c) undertaking Consultations with affected persons and entities in order to discharge natural justice requirements; and

    (d) drafting this Report.

3.2 Information / evidence gathering and analysis

3.2.1 Request for Information process

54. The Investigators, in addressing the TOR and exercising statutory powers under Part 9 of the HHBA, requested certain information, data and documents through the issuing of several RFIs.

55. In conducting this Investigation, the Investigators have undertaken robust and thorough information and evidence gathering processes to satisfy the matters set out in the TOR. The information and documents obtained through the RFI process were extensive and obtained from a range of different sources including clinical governance and patient safety records; Board, Board Committee and other Committee minutes, agendas and papers; policies and procedures; and data.

56. One aspect of the RFI process as it related to the documents provided by THHS was the redaction of information contained within responsive documents. In many instances, there was a high level of redaction applied across the responsive documents. The Investigators acknowledge that THHS subsequently released responsive documents without or with limited redactions applied. The Investigators highlight this issue to provide context to the forthcoming summary, which includes references to redacted information in documents responsive to RFIs.

57. In summary, the Investigators issued the following RFIs:

    (a) on 15 October 2025, RFI No. 1 was issued to THHS seeking documents across 12 categories of information holdings. On 21 October 2025, the Investigators also issued RFI No.2 to THHS seeking contact information for witnesses and other staff information.

(b) THHS provided responsive documents on a rolling basis as follows:

(i) **Tranche 1** - on 27 October 2025, THHS provided 40 responsive documents inclusive of the covering response letter and advised that documents were not held with respect to three subcategories of information sought;

(ii) **Tranche 2 -** also on 27 October 2025, THHS provided 290 responsive documents inclusive of the covering response letter;

(iii) **Tranche 3 -** on 29 October 2025, THHS provided 96 responsive documents, inclusive of the covering response letter;

(iv) **Tranche 4 -** on 30 October 2025, THHS provided 23 responsive documents, inclusive of the covering response letter;

(v) **Tranche 5** - on 31 October 2025, THHS provided 65 responsive documents, inclusive of the covering response letter;

(vi) **Tranche 6** - on 4 November 2025, THHS provided 49 responsive documents, inclusive of the covering response letter;

(vii) **Tranche 7** - on 6 November 2025, THHS provided 285 responsive documents, inclusive of the covering response letter;

(viii) **Tranche 8** - on 7 November 2025, THHS provided 19 responsive documents, inclusive of the covering response letter;

(ix) **Tranche 9** - on 12 November 2025, THHS provided 51 responsive documents, inclusive of the covering response letter;

(x) **Tranche 10** - on 15 November 2025, THHS provided 14 responsive documents, inclusive of the covering response letter;

(xi) **Tranche 11** - on 20 November 2025, THHS provided 387 responsive documents, inclusive of the covering response letter;

(xii) **Tranche 12** - on 24 November 2025, THHS provided 39 responsive documents, inclusive of the covering response letter;

(xiii) **Tranche 13 -** on 28 November 2025, THHS provided 490 responsive documents, inclusive of approximately 160 new documents and otherwise consisting of unredacted versions of documents that were provided in redacted format in previous tranches; and

(xiv) **Tranche 15 -** on 18 December 2025, THHS provided a further 17 responsive documents subsequently identified to be of assistance to the Investigation, inclusive of 11 documents on behalf of the Board and the covering response letter.

(c) THHS also provided responsive documents on behalf of the Board on a rolling basis as follows:

(i) **Tranche 1** - on 12 November 2025, THHS provided 92 responsive documents inclusive of the covering response letter. Unredacted copies of some of these documents were later provided in Tranche 13, referenced above;

(ii) **Tranche 2** - on 12 November 2025, THHS provided 31 responsive documents inclusive of the covering response letter. Unredacted copies

of some of these documents were later provided in Tranche 13, referenced above;

(iii) **Tranche 3** - on 12 November 2025, THHS provided 51 responsive documents, inclusive of the covering response letter. Unredacted copies of some of these documents were later provided in Tranche 13, referenced above; and

(iv) **Tranche 4** - on 13 November 2025, THHS provided 57 responsive documents, inclusive of the covering response letter. Unredacted copies of some of these documents were later provided in Tranche 13, referenced above.

(d) On 3 December 2025, the Investigators issued RFI No.5 to THHS seeking documents in response to two categories. THHS provided the following in response:

(i) **Tranche 14** - on 5 December 2025, THHS provided 486 responsive documents, inclusive of the covering response letter.

(e) On 30 October 2025, the Investigators issued RFI No.3 to the Workforce Division of QH seeking documents in response to three categories. On 6 November 2025, in response, QH provided four documents.

(f) Also on 30 October 2025, the Investigators issued RFI No.4 to the QH HIU seeking documents in response to seven categories. On 25 November 2025, in response, QH provided 17 documents and two emails, totalling 19 documents.

(g) Also on 3 December 2025, the Investigators issued RFI No.6 to the QH HIU in response to one category. On 4 December 2025, QH provided five documents under the cover of one email, totalling six documents.

3.2.2 Interviews

58. The Investigators conducted 37 interviews throughout the Investigation, producing more than 60 hours of interviews and related transcripts. Details of these interviews are set out at Annexure D to this Report. In accordance with the TOR, the names of witnesses have been kept confidential and are referred to in a de-identified form.

59. The Investigators also received extensive documents from witnesses, provided voluntarily, on request and through the natural justice process. The Investigators received approximately 717 additional documents from witnesses.

60. The documentary evidence gathered during the Investigation is set out in the table below. This table demonstrates the high volume and breadth of documentary evidence gathered, reviewed, and analysed as part of the Investigation.

Table 2: Documentary Evidence

Source	Number of documents*	Approximate Pages
THHS	2,716	Over 28,000 pages (63 of these documents are audio files. They do not contribute to the total page count but do contribute to the total document count.)
QH	42	Over 300 pages

Witnesses	717	Over 2,700 pages

*Note: Some documents provided were duplicates. Where a document was duplicated, it was counted once in the final document total.

3.2.3 Information and evidence provided by whistleblowers under the *Public Interest Disclosure Act 2010* (Qld)

61. The Investigators interviewed and received information and evidence from two persons who had made PIDs under the PID Act. Information provided by the whistleblowers also assisted the Investigators in identifying and requesting further information and documents which was subsequently provided under the RFI process.

3.2.4 Limitations

62. There are a number of limitations as regards certain aspects of the investigative methodology which are necessary to highlight:

(a) the Investigators have been informed by and have based their conclusions, findings and recommendations based on the information presently before them as provided predominantly by THHS, the Board and specific individuals through the RFI process;

(b) in some instances, some of the consulted parties provided information and documents at a late stage. This has, in some circumstances, limited the time in which the Investigators had to consider the information and documents; and

(c) not all relevant documents or records were accessible within the time limit of the Investigation. In some cases, information was incomplete or redacted.

3.3 Specific issues informing the investigative methodology

63. The TOR, as drafted, presents a broad scope of matters to be considered to satisfy the TOR. Consequently, the body of relevant evidence is of a high volume and complexity and covers a range of varied clinical, operational and decision-making settings across a three and a half year period.

64. In these circumstances it has been necessary for the Investigators to adopt a number of measures and/or approaches to respond to the TOR. These include:

(a) as previously highlighted, given the broad scope of the matters to be considered in responding to the TOR and the high volume and complex nature of the relevant body of evidence, the Investigators have used key definitions or "Framing Concepts" including for concepts such as "clusters" and "Disrupted Care". The Investigators have also used an AcciMap to provide a diagrammatic expression of the relevant evidence and analysis of the same. These matters are discussed in detail at Part B of this Report;

(b) a number of the consulted parties raised the issue of "hindsight bias" and asserted that the Investigators have inappropriately assessed the issues the subject of this Investigation with the benefit of hindsight and as such at a higher standard than what would have applied at the time when these issues were occurring at THHS. The Investigators do not accept this position. Contrary to these assertions, the Investigators have carefully considered the evidence before them and exercised their judgment through the lens of what would be a reasonable response to the issues presented by this evidence at the time these issues were occurring. While the Investigators have acknowledged in this Report that the Investigators have had the benefit of hindsight, this does not mean that the assessment has been undertaken on a hindsight basis;

(c) the natural justice process has comprised of a two-stage process for some of the consulted parties. This was considered necessary to enable concurrent consultations to occur and for consulted parties to have the capacity to consider the cluster analysis and AcciMap and then for some of those parties to consider a further revised draft, being the Updated Draft Report, once comments and feedback on the same had been considered and incorporated into the Draft Report as necessary. These matters are further considered below in a standalone Section.

Section 4 - Consultation process including natural justice

4.1 Overview

65. The Investigators confirm that the Investigation has been conducted in accordance with the principles of natural justice.

66. At the outset, the Investigators acknowledged the significance and gravity of the issues and circumstances in focus in this Investigation and, consequentially, undertook a detailed consultation process. Consistent with this approach, in addition to the consultation process being a vehicle for the discharge of natural justice, as part of the consultation process, the Investigators also invited the consulted parties to comment on the accuracy of information provided and to provide further relevant information to inform the Investigation, particularly given item 3.2 of the TOR (collectively referred to as the **Consultation**).

67. Reflective of this approach, the Investigators described the purposes of the Consultation, in correspondence with each of the consulted parties, in the following terms:

    (a) to afford [the consulted parties] an opportunity to comment on the accuracy of the information, observations and comments in the Draft Report[s];

    (b) to afford natural justice; and

    (c) to invite [the consulted parties] to provide further relevant information including as regards measures taken to respond to the issues related to the delivery of urology services pursuant to paragraph 3.2 of the TOR.

68. The importance of the Consultation process is also reflected in the steps that were taken by the Investigators.

69. A total of 22 parties were separately consulted. Some of the parties involved in the Consultation process undertook a consultation process involving the release of an initial draft or extracts of the Report (**Draft Report**) (with necessary redactions) followed by the release of a revised draft (with necessary redactions) of the Report (**Updated Draft Report**) and access to the majority to footnoted documents (or extracts of the same). The two-phase process was considered necessary to allow for concurrent consultation processes to be undertaken and in order to afford these parties with the capacity to examine the defined terms and the AcciMap along with other relevant evidence at first instance, followed by a further opportunity to respond to revisions in the Updated Draft Report including those made pursuant to comments and feedback from consulted parties provided in the first phase of Consultation.

70. This Section discusses the method by which the Investigators conducted the Consultation process, as well as the main issues raised throughout the Consultation process.

4.2 The scope of natural justice obligations

71. Set out below is a summary of the approach adopted by the Investigators, including a summary of the key principles regarding natural justice and the practical application of the same in the conduct of this Investigation.

72. The overarching requirement in the discharge of natural justice obligations is that the Investigators do what is reasonable and necessary to avoid an affected party experiencing practical injustice. The specific content of that overarching requirement is context-dependent and is influenced by the totality of the circumstances, including the applicable statutory settings.

73. The Investigators were especially cognisant that the following natural justice principles as relevant to the present Investigation:

    (a) **Disclosure**: affected parties must be provided with information that adversely affects their rights and interests and which is credible, relevant and significant.

(b) **Opportunity to respond**: affected parties must be given a reasonable opportunity to present their case, to address the issues relevant to their rights and interests, and in that sense, to respond to the case made against them. This includes providing affected parties with reasonable time to prepare their respective cases.

(c) **Proper consideration**: once affected parties have provided their responses, the Investigators are required to properly consider those responses and any evidence or additional material provided by affected parties.

74. However, the Investigators are also mindful that during the Investigation, natural justice did not require, contrary to the assertions of some of the consulted parties, that the Investigators:

(a) provide to consulted parties information or materials which do not adversely affect their rights and interests and/or which are not credible, relevant and significant;

(b) give consulted parties the opportunity to comment on every nuance of what the Investigators were considering in relation to the Investigation;

(c) disclose to consulted parties every piece of information and every document that the Investigators received in the course of the Investigation and/or every document footnoted in the Draft Report/Updated Draft Report (or extracts of the same) so as to enable a review of the Investigation;

(d) provide to consulted parties information which is a summary of information already included in the Draft Report;

(e) attend forums such as a "without prejudice conference" or "mediation" between consulted parties; or

(f) interview certain persons.

4.3 Approach adopted in this Investigation

75. As referred to above, the Investigators undertook a detailed Consultation which for some of the Consultation, comprises a two-stage natural justice process.

76. As also referenced above, the Consultation involved the Investigators consulting with 22 individuals and organisations. The Investigators received substantive responses from 15 parties (including preliminary, supplementary, and updated responses). Seven parties did not respond or advised that they did not wish to participate in the Consultation process.

77. The Consultation process spanned a period in excess of four months.

78. In undertaking the Consultation, the Investigators either provided the relevant consulted party with extracts and information (in schedules) or a copy of the Draft Report/Updated Draft Report (with necessary redactions). In both of these instances, the supporting documents were also provided, with necessary redactions.. The schedules which were provided to some individuals contained extracts of the Draft Report/Updated Draft Report which were relevant to their rights/interests. The schedules were extensive and footnoted documents were also provided to some parties upon request. In many instances, the schedules provided to these individuals was more than 100 pages, in addition to supporting documents and information.

79. Concurrently, the Investigators provided the Board and the THHS with a redacted copy of the Draft Report in late February / early March 2026. The Investigators considered that natural justice was best served by the Draft Report, as opposed to extracts of the same, being provided to the THHS and the Board.

80. The Investigators invited the consulted parties to comment.

81. Some individuals requested additional documents and the Investigators provided the requested documents (with necessary redaction). The Investigators informed the consulted parties that redactions were applied to these documents (and to the Draft Report and extracts of the same) in this first stage of the natural justice process for three reasons being that because the information that was the subject of the redactions was irrelevant; was subject to the requirements of the PID Act (including those regarding reprisals and confidentiality) or the redacted information contained adverse information as it related to other parties who had not yet responded to this information. Here, in redacting this third category of information, the Investigators were particularly cognisant that it is well-established in Australian law that reputation is a recognised interest and that circulating material which may harm a party's reputation engages natural justice considerations.[6] During the first stage of the natural justice process, the Investigators advised the parties that they would consider whether to supply unredacted materials (including some parts of the Draft Report then subject to redactions) as the natural justice process continued.

82. After the Draft Report was provided at this first stage, some of the consulted parties separately requested a complete and unredacted copy of the Draft Report, along with numerous unredacted documents, including all the documents referenced in footnotes.

83. Although the Investigators considered that natural justice may not have strictly required that all of these requested documents be provided, the Investigators took a broad view and adopted the approach of carefully considering each request for documents/information and providing them to the requesting party where appropriate. By way of example, the Investigators highlight that:

(a) across a two-week period in March, the Investigators provided one of the consulted parties with an Excel spreadsheet identifying all 294 THHS-sourced documents referenced in the consultation material, and a further 86 documents in two tranches accompanied by detailed schedules explaining the status and basis for treatment of each document (i.e. release status and the basis of applying redactions). This included, among other documents, 29 redacted transcripts of witness interviews;

(b) between mid March to early April 2026, the Investigators provided to another consulted party an Excel spreadsheet identifying all 294 THHS-sourced documents referenced in the consultation material, and a further 82 additional documents accompanied by detailed schedules explaining the status and basis for treatment of each document. This included 14 redacted transcripts of witness interviews as well as all the additional documents referenced in footnotes of the consultation material which had not previously been provided to that consulted party; and

(c) further to these instances, between 25 February 2026 and 26 June 2026, the Investigators provided to some consulted parties either copies or an Excel spreadsheet identifying all THHS-sourced documents referenced in the consulted materials, and either extracts of documents or copies of additional documents accompanied by detailed schedules explaining the status and basis for treatment of each document.

84. In addition to the request for supporting documents, the Investigators received other requests from some of the consulted parties during the Consultation. The Investigators considered these requests but formed the view that it was not necessary to provide this information. As some of the consulted parties asserted that these requests were necessary in order to natural justice, it is important to identify these requests, which included: requests for (among others):

(a) audio recordings of witness interviews;

(b) summary information, including summary boxes at the commencement of each section of the Draft Report, and the Executive Summary to the Report;

[6] *Ainsworth v Criminal Justice Commission* (1992) 175 CLR 564.

(c) that specific persons be interview, noting that these persons were expressly advised that they could provide written responses and/or any other information these persons considered relevant;

(d) that the consulted party be advised of the "case against" them, notwithstanding that this consulted party had received high volumes of information and documents (with redactions) under the Consultation;

(e) the opportunity to adduce expert evidence; and

(f) further and better particulars of the findings including the identification of "trigger points", "counterfactuals" and "causation".

85. The Investigators received responses from consulted parties across the period of March to May 2026.

86. After carefully considering each of these responses, the Investigators finalised the first stage of the natural justice process and commenced the second stage of the natural justice process as relevant. This stage entailed the Investigators revising the Draft Report to incorporate amendments arising from the responses the Investigators had received and making available to the consulted parties a copy of the Updated Draft Report (with any necessary redactions still applied) or extracts of the same where relevant to the parties.

87. That Updated Draft Report was provided to the THHS and to the Board on 5 June 2026. Those parties were also supplied with additional documents that had not previously been provided, as well as a schedule explaining redactions applied in previously disclosed documents, including the basis for those redactions and whether previous redactions remained or had been removed.

88. Further, the Investigators also revised some of the schedules initially provided to some of the individual parties. The Investigators then provided the relevant individual parties with those revised schedules containing updated potentially adverse information, and in some instances also provided additional relevant documents or extracts.

89. The Investigators invited the consulted parties to whom additional material had been supplied to provide further comments on that material.

90. Throughout the Consultation, the Investigators endeavoured to ensure that the parties had sufficient time to review, consider, and respond to the contents of the Updated Draft Report. The Investigators carefully considered extension requests made by the parties and granted extensions when appropriate. The Investigators granted those parties extensions which translated into these two parties having a period of four weeks to provide a response.

91. The Board and the THHS ultimately provided their responses to the Updated Draft Report on 6 July 2026. The individual consulted parties provided their responses on various dates in early July 2026.

4.4 Observations regarding the Consultation process

92. The Investigators wish to express their gratitude for the assistance provided by the consulted parties who engaged with the Investigators during the Consultation.

93. Multiple submissions were provided by several parties which the Investigators carefully considered. Those submissions were highly detailed, and in several instances, exceeded 80 pages in length and annexed more than 100 documents. The Investigators are grateful for those parties' engagement.

94. That assistance was particularly valuable in light of several matters relevant to the Consultation, and about which the Investigators make the following observations:

(a) the Investigators consulted 22 separate parties during the Consultation. Several were consulted on multiple separate occasions. Reflecting the volume of the information and documentary evidence received by the Investigators, as well as the complexity of the issues which the Investigators were required to identify and evaluate, it was necessary for these parties to be consulted on several occasions and be afforded adequate time to provide a response;

(b) several of the consulted parties were legally represented from the initial stages of the Investigation and Consultation and remained represented throughout. In particular, the Investigators note that the Board, the THHS, and three individuals were separately represented during the Consultation;

(c) as explained earlier, the Investigators were highly motivated to ensure that potentially affected parties had the opportunity to properly respond to potentially adverse information contained in the Draft Reports. This was done not only to afford those parties natural justice, but also to ensure the content of the Draft Reports was accurate;

(d) as a result of the matters identified above, the Investigators acknowledge that the Consultation was lengthy. Nevertheless, the Investigators remain of the view that this length of time was necessary given: the volume and complexity of the evidence, including the adverse information; the number of parties involved in the Investigation; the relevant issues under consideration; the complexity of the materials; the necessity to appropriately undertake the two-stage natural justice process for some of the consulted parties and the time taken to review and consider detailed submissions and annexed documents. Further, on multiple occasions the Investigators extended dates for when responses were due;

(e) some consulted parties pressed the Investigators for materials and information which, in the Investigator's opinion, was not necessary for several reasons, including that these requests went beyond the scope of what natural justice required of the Investigators. These requests appeared to be premised on the assumption that the Consultation process was a means by which affected parties could review the Investigation by requesting all evidence and information relied upon by the Investigators. While the Consultation was an opportunity to allow consulted parties to assess the accuracy of the information, provide further information to inform the Investigation and answer potentially adverse comments, it was not a means by which the Investigation process, by reference to accessing every document footnoted in the Draft/Updated Draft Report, as a whole was to be reviewed by the consulted parties;

(f) throughout the Consultation, some of the consulted parties made repeated assertions regarding redactions. These assertions included that the consulted party was entitled to be provided with access to redacted information, notwithstanding having been advised that the redactions were made for several reasons. The reasons provided by the Investigators were firstly on the basis of relevance, that is, that no natural justice obligation had arisen in relation to the information; secondly, there being concurrent Consultation processes ongoing with the redactions unable to be disclosed at that point in time until those Consultations were completed due to concerns for reputational harm (see *Ainsworth v Criminal Justice Commission* [1992] HCA 10); and thirdly, due to requirements of the PID Act. These claims were asserted on numerous occasions, with one consulted party asserting that there was no "lawful basis" to apply these redactions, notwithstanding the above explanation provided by the Investigators;

(g) some of the consulted parties repeatedly agitated the same or similar natural justice concerns and requests for information which had already been dealt with. The language and tone of the correspondence was regrettably, at times, aggressive and threatening. Many of the requests and natural justice concerns were inaccurate, particularly in circumstances where the matters in issue had already been responded to by the Investigators. In the Investigators' opinion, this conduct was unnecessary,

and on one view could be said to be directed towards delaying and/or otherwise impeding the Investigation; and

(h) in this connection and by way of example, one of the consulted parties breached express confidentiality obligations (which had been made very clear to them and put matters beyond doubt) by disclosing confidential communications to other parties during the Consultation period. This party then sought to engage in this conduct on a subsequent occasion. The Investigators view this conduct as unhelpful to the Investigation process.

4.5 Conclusion

95. In conclusion, as stated above, the Investigators have conducted a detailed and lengthy Consultation spanning across a four month period, with 22 parties separately consulted and some of these parties being consulted across a two stage process.

96. The Investigators acknowledge and are grateful for the submissions received by the consulted parties as part of the Consultation process. Some of the consulted parties provided submissions in excess of 100 pages with over 70 supporting documents. These submissions were carefully considered by the Investigators in revising and finalising this Report.

97. Ultimately, while the Consultation process is necessary to discharge legal requirements in the form of natural justice, it has been a process to enable the Investigation to be informed by necessary, accurate and up to date information and as such the Consultation process has provided rigour and robustness to the Investigative methodology, as reflected in this Report.

Part B - Evidence analysis and review

Section 5 - The Institutional Setting

98. As is the case in any investigation, it is necessary to examine and consider the context and circumstances in which the matters for investigation arose. This includes, for present purposes, understanding the context and settings in which THHS and the TUH operate.

5.1 Geographical and service characteristics

99. The THHS region is geographically expansive. The region serviced by the THHS includes communities in Townsville, Cardwell, Richmond, Home Hill and Magnetic and Palm Island.[7]

100. As the region's largest local employer, THHS employs 7,699 staff across its 17 facilities, which is comprised of:

(a) 15 hospitals and community health campuses; and

(b) two residential aged care facilities.[8]

101. Across its 17 facilities, the THHS offers a range of health services that include but are not limited to: emergency, primary health and acute care, medical imaging, maternity, aged care, allied health, urology, palliative, mental health, intensive care, neonatal and offender health care services. The service capabilities of most facilities within the THHS are like those in any rural or remote health service in Australia, being limited to low-to-moderate inpatient and ambulatory care services.

102. The THHS's service capabilities are more limited than their metropolitan or urban counterparts, which necessitates reliance on referral and transfer processes to its tertiary health service, the TUH (formerly known as the Townsville Hospital) to ensure appropriate care is delivered, particularly for more complex cases.[9]

103. Notably, TUH is the tertiary referral hospital for north Queensland. This means it has the additional responsibility for providing specialist care to people beyond the THHS geographic region. TUH is also a teaching hospital for James Cook University and TAFE Queensland North.[10]

104. The Figure below provides a high-level overview of key facilities within the THHS region.

[7] State of Queensland (THHS), *Health Service Plan 2018 – 2028*. January 2018. Electronic copy available at: https://cdn.townsville.health.qld.gov.au/tgh/documents/health-service-plan.pdf.
[8] Queensland Health, *Clinical Services Capability Framework, Fact Sheet 2 – Explanation of service levels*. Electronic copy available at: https://www.health.qld.gov.au/__data/assets/pdf_file/0021/444423/cscf-fs-2-service-levels.pdf; State of Queensland (THHS), *THHS (Townsville HHS) Health Service Plan 2018 – 2028*, January 2018, pages 11 and 16-19. Electronic copy available at: https://cdn.townsville.health.qld.gov.au/tgh/documents/health-service-plan.pdf; State of Queensland (THHS), *Annual Report 2024-2025*, page 21. Electronic copy available at: .https://cdn.townsville.health.qld.gov.au/tgh/documents/thhs_2425_annual_report.pdf.
[9] State of Queensland (THHS), *Health Service Plan 2018 – 2028*. January 2018. Electronic copy available at: https://cdn.townsville.health.qld.gov.au/tgh/documents/health-service-plan.pdf.
[10] State of Queensland (THHS), *Health Service Plan 2018 – 2028,* page 11. January 2018. Electronic copy available at: https://cdn.townsville.health.qld.gov.au/tgh/documents/health-service-plan.pdf.

Figure 1: Locations of health services delivered by THHS



5.2 Governing body

105. The THHS operates as an independent statutory body under the HHBA. The THHS is governed by the Board which is in control of the service. As set out in its Annual Report for 2024-25, THHS oversees healthcare delivery across a 148,000 km² catchment in northern Queensland, serving over 250,000 residents and provides tertiary services to 670,000 people across the region.[11]

5.2.1 The Board

106. The Board is the governing body responsible for the overall direction of the health service. Appointed under the HHBA, the Board sets strategic priorities, monitors performance and compliance with legislative and regulatory requirements.[12] The Board has a role in providing oversight of both corporate and clinical governance and holds the HSCE accountable for the delivery of safe, effective, and sustainable care. The Board also has a role in engaging with government and community stakeholders, and to ensure that the health service remains responsive to local needs while meeting statewide obligations. The Board is in control of the service.[13]

107. The Board is supported by five committees which are the Executive Committee, the Board Finance Committee, the BARC, the BSQC, and the Stakeholder Engagement Committee.

108. Supported by specialist committees such as the BSQC and BARC, the Board holds the HSCE accountable for the overall performance of the THHS and receives updates on risk mitigation treatment action plans as developed by the Executive. The THHS advised the Investigators that "some risks cannot be managed entirely and so are managed in accordance with the Board's risk appetite".[14]

5.2.2 Board Safety and Quality Committee

109. The HHBA and HHB Regulation require every HHS Board in Queensland to establish a Quality and Safety Committee.

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[11] State of Queensland (THHS), *Annual Report 2024-2025*, page 45. Electronic copy available at:https://cdn.townsville.health.qld.gov.au/tgh/documents/thhs_2425_annual_report.pdf.
[12] State of Queensland (THHS), *Annual Report 2024-2025*, pages 14-17. Electronic copy available at:https://cdn.townsville.health.qld.gov.au/tgh/documents/thhs_2425_annual_report.pdf.
[13] *Hospital and Health Boards Act 2011* (Qld) section 22.
[14] The THHS' Natural Justice Response.

110. In the THHS, this committee of the Board is referred to as the BSQC. The BSQC provides focused oversight of patient safety, quality of care, and clinical risk. It meets bi-monthly and reviews reports authored by executive and professional leaders, including the EDCG, and aims to ensure that systems are in place to monitor clinical outcomes and incidents and supporting continuous quality improvement. The functions of this committee include acting as a monitoring mechanism for clinical governance, ensuring that clinical risks are escalated appropriately to the Board. It also plays a critical role in aligning clinical governance with corporate governance, ensuring that safety and quality considerations inform strategic decision-making.

5.2.3 Board Audit and Risk Committee

111. The HHBA and HHB Regulation require every HHS Board in Queensland to establish an Audit Committee. In the THHS this committee of the Board is referred to as the BARC. The BARC's obligation reflects the broader governance expectations set out in the *Financial and Performance Management Standard 2019* (Qld)[15] (**FPMS**).

112. The BARC is a statutory safeguard designed to provide advice to the Board about financial accountability, risk management, and to ensure that compliance frameworks are robust and effective.

113. The Committee's role is advisory. It supports the Board by reviewing financial statements, monitoring internal controls, and overseeing enterprise risk management systems. It does, however, approve and evaluate internal audit plans, consider audit findings, and liaise with the Queensland Audit Office.[16]

114. Through these functions, the Committee ensures that issues affecting financial integrity or compliance are identified, escalated, and addressed in a timely manner.

115. The BARC is a critical element of the governance framework, ensuring that Boards can demonstrate accountability to both the Minister for Health and the community they serve.

5.3 Strategies and plans

116. The THHS has published a suite of strategies and plans[17] which meet the requirements of the HHBA, the HHB Regulation and the Service Agreement with QH. This includes a Strategic Plan, an Operational Plan, a Network Protocol, and a Clinical Engagement Strategy.

117. The THHS's strategic priorities for the health service are outlined in the Strategic Plan and relate to enhancing patient outcomes, improving staff experience, optimising patient experience, and delivering better care. Strategies include early intervention, the delivery of culturally appropriate services, virtual care models, and infrastructure expansions. Governance reforms focus on safety, quality, and resource allocation, while accountability measures track performance in areas such as patient access, staff development, and cost efficiency.

118. The THHS Operational Plan notes that key challenges include demand exceeding capacity, workforce retention, financial sustainability, and unequal health outcomes. To address these matters, the THHS is leveraging partnerships, optimising productivity, and prioritising health equity. Actions such as telehealth expansion, geriatric hospital-at-home services, and a rural surgical service established by THHS are designed to improve service access and efficiency.

[15] Financial and Performance Management Standard 2019 https://www.legislation.qld.gov.au/view/html/inforce/current/sl-2019-0182.
[16] *Hospital and Health Boards Regulation 2023* (Qld), r 47.
[17] Electronic copies of these strategies and publications can be found on the THHS website, available at: https://www.townsville.health.qld.gov.au/about-us/strategies-and-publications/.

119. The THHS Clinical Engagement Strategy 2025-2028,[18] is a requirement under the health portfolio legislation[19] and is based on three core principles:

(a) communicate for a culture of shared information;

(b) consult to involve clinicians in decisions; and

(c) collaborate for innovation to foster improvement.

120. The strategy outlines how this is achieved through regular communication channels.

121. Together these and other THHS strategies and plans frame the Board's vision for the THHS.

5.4 Executive governance – executive roles

122. Effective governance in the THHS requires alignment between strategic leadership, operational delivery, and clinical assurance. Within THHS, and relevant to this Investigation, this alignment is achieved through the interplay between the HSCE, the COO, the EDCG, supported by the other members of the THHS executive including the CMO, the Executive Director Nursing and Midwifery Services (**EDNMS**), Executive Director Allied Health, Executive Director Infrastructure Program Delivery and the Chief Financial Officer. Together, these officers have a responsibility to ensure that the health service delivers safe and effective care while maintaining accountability to government and the community. The Investigators have summarised the roles that are relevant to this Investigation below.

123. Many of the officers have held these executive roles for the duration of the relevant period. Where different officers have held roles at various times, the delineation between those individuals is set out in the defined terms. It is acknowledged that some roles may have been acted in by various individuals for short periods of time to account for leave or other reasons. Roles are only delineated where it is relevant for the purposes of the Report.

5.4.1 Health Service Chief Executive

124. The HSCE is the most senior executive and is appointed by the Board, is accountable to the Board, and is subject to direction by the Board in managing the HHS. The HSCE provides strategic leadership across the service, ensuring that hospital and community health programs meet the needs of the population. This role encompasses responsibility for ensuring that safe and high-quality care is provided while maintaining financial and operational performance and compliance with Service Agreements negotiated with QH. The HSCE is ultimately accountable for both the clinical and corporate performance of the organisation.

125. The previous HSCE advised the Investigators that there are 10 direct reports that provide information to them on a range of clinical and operational matters. In relation to the delivery of urology services, they receive information from the COO, the EDCG and the CMO.[20]

5.4.2 Chief Operating Officer

126. The COO is responsible for the day-to-day delivery of services across hospitals and community health facilities. The COO translates strategic priorities into operational outcomes, ensuring that patient flow, resource allocation, and service performance targets are met. This role requires close oversight of operational managers across specialties, driving efficiency and consistency while responding to patient demand. COO 1 advised Investigators that the role is supported by professional leads such as the CMO, EDNMS and Chief Allied Health Officer. The COO is

[18] THHS, *Clinician Engagement Strategy 2025-2028*, page 2. Electronic copy available at: https://cdn.townsville.health.qld.gov.au/tgh/documents/clinician_engagement_strategy_2025-2028.pdf.
[19] s.40(1)(a) of the HHBA.
[20] Consulted Parties' Natural Justice Response.

responsible for ensuring that the health service runs smoothly and safely, balancing operational pressures with the need for innovation and service redesign.

5.4.3 Executive Director Clinical Governance

127. The EDCG provides advice to the HSCE on all clinical governance issues, contributes to the design and delivery of the broader organisation's strategic plan, and develops, implements and monitors systems and processes to improve the quality of patient care. This role is dedicated to embedding a culture of transparency, accountability and evidence-based service. The EDCG, with the HSCE, commissions investigations into adverse events and oversees systems that support risk management and compliance with NSQHS Standards. By working closely with clinicians and managers, the EDCG role ensures that clinical risks are identified, lessons are learned from research, audits, complaints and compliments, and adverse events, and improvements are implemented. The EDCG advised Investigators the role holds no operational authority.[21]

5.4.4 Chief Medical Officer

128. The CMO provides leadership and oversight of medical practice across the THHS. This role ensures that medical services are delivered in line with professional standards, regulatory requirements, and patient safety expectations. The CMO is responsible for oversighting, credentialing and determining the scope of clinical practice of medical staff, workforce planning for medical specialties, and supporting clinical innovation. Working closely with the EDCG, the CMO ensures that medical governance is aligned with broader clinical governance frameworks and provides assurance to the HSCE that the medical practice is safe, effective, and sustainable.

5.4.5 Executive Director Nursing and Midwifery Services

129. The EDNMS provides leadership and oversight of nursing and midwifery practice across the THHS. This role ensures that nursing and midwifery services are delivered to the highest professional and ethical standards, with a strong focus on patient safety, workforce capability, and continuous improvement. The EDNMS is responsible for workforce planning, professional development, and embedding evidence-based practice across nursing and midwifery teams. By working closely with the EDCG, the EDNMS ensures that nursing and midwifery governance contributes directly to the overall clinical governance framework and provides assurance to the HSCE that care is safe, compassionate, and effective.

130. In summary, the executive roles aim to ensure THHS delivers safe and quality healthcare that optimises patient outcomes within a model of person-centred care. They encourage learnings from adverse events and promote a culture of transparency, accountability and evidence-based service.

5.5 Executive governance – committee roles

131. Governance within the THHS is supported by a network of committees that aim to provide oversight, assurance, and accountability across both corporate and clinical domains. These committees have a role in ensuring that strategic priorities are translated into safe, effective care, and that risks are identified and managed appropriately. Two committees are central to this framework:

(a) the Executive Clinical Governance Committee (**ECGC**); and

(b) the Patient Safety Committee (**PSC**).

[21] Consulted Parties' Natural Justice Response.

5.5.1 Executive Clinical Governance Committee

132. The ECGC operates at the executive level, providing leadership and coordination of clinical governance across the THHS. Chaired by the EDCG, the Committee brings together medical, nursing, and allied health leaders to oversee patient safety systems, clinical audits, and compliance with national standards. The previous HSCE advised Investigators that they would also attend these meetings.[22] The Committee is structured to function as the operational engine of clinical governance. In its role, the Committee identifies emerging system-level risk, issues and opportunities impacting on clinical safety and quality, and provides strategic advice in relation to these.

5.5.2 Patient Safety Committee

133. The PSC is structured to provide a more focused forum for reviewing incidents and emerging risks related to patient care. It has a role in examining trends in adverse incidents, identifying systemic issues, and recommending improvements to clinical practice and processes. The PSC advises and makes recommendations to the ECGC. The EDCG and CMO are members of the Committee. By concentrating on patient safety at a granular level, the committee aims to support the ECGC. In this regard, the committee is required to provide assurance that clinical risks are being managed and that patient outcomes are continually improving.

5.6 Summary of Committee Roles

134. In summary, the committee roles are structured to form a layered governance structure that integrates strategic oversight, executive leadership and frontline assurance across the health services, and, in support of the urology services.

135. The Board's role is to set the direction and hold the HSCE accountable for the delivery of safe, effective and sustainable care. The BSQC plays a critical role and is structured to provide assurance to the Board on clinical governance within the health service.

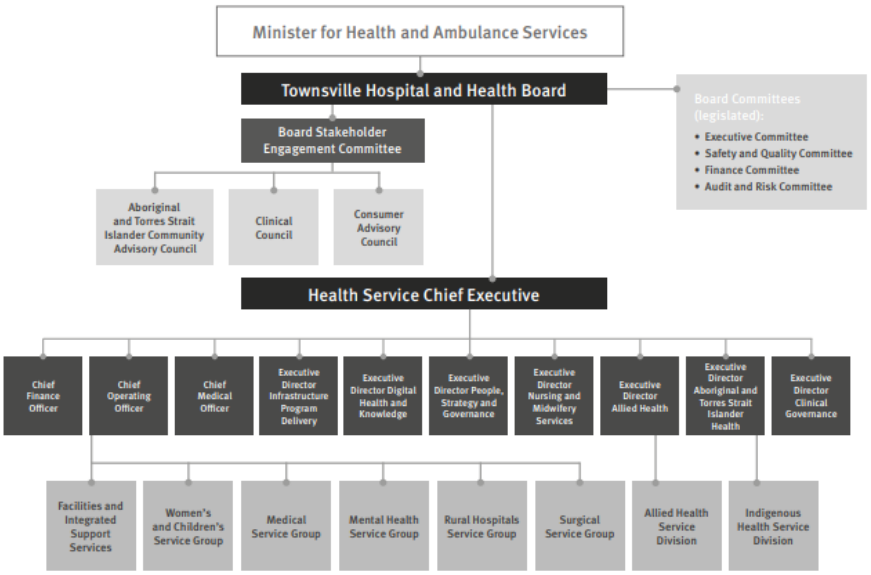
5.7 Organisational structure

136. As detailed earlier in the Report, the THHS is established as a statutory body by the HHBA. Accordingly, THHS is independently governed by a Board (appointed by, and accountable to, the Minister for Health and Ambulance Services) and is operationally managed by the HSCE who reports to the Board.[23]

137. The relationship between the Board and HSCE, and the broader organisational structure of THHS, is represented in the Figure below.[24]

[22] Consulted Parties' Natural Justice Response.
[23] *Hospital and Health Boards Act 2011* (Qld) section 7.
[24] State of Queensland (THHS), *Annual Report 2024-2025*, page 20. Electronic copy available at: https://cdn.townsville.health.qld.gov.au/tgh/documents/thhs_2425_annual_report.pdf.

Figure 2: THHS organisational structure



138. As prescribed by the TOR, this Investigation focuses on urology services at the TUH. Urology services sit under the Surgical Service Group (**SSG**) within the THHS and are provided in Surgical Ward 2 of the TUH.[25] The organisational structure for the SSG is represented in the Figure below.

139. There are six service groups across the THHS where operational oversight is provided by the COO.

140. The role of the Surgical Service Group Director (**SSGD**) represents a single point of accountability for achieving the outcomes expected within the clinical service group and is a key member of the management team. The officer has direct responsibility for managing the relevant clinical services, clinical governance, specific risks, human resources (**HR**) related issues, resourcing and the implementation of effective processes. They manage the clinical operations and establish business and clinical governance frameworks to promote transparent decision-making and optimal allocation of resources. This role also manages the Service Group's operational plan.[26]

[25] State of Queensland (THHS), *Annual Report 2024-2025*, page 23. Electronic copy available at: https://cdn.townsville.health.qld.gov.au/tgh/documents/thhs_2425_annual_report.pdf; State of Queensland (THHS), *Annual Report 2015-2016*, page 31. Electronic copy available at: https://cdn.townsville.health.qld.gov.au/tgh/documents/thhs-annual-report-2015-16.pdf; THHS, Surgical Services. Webpage can be accessed here: https://www.townsville.health.qld.gov.au/services/services-a-z/surgical-services/.

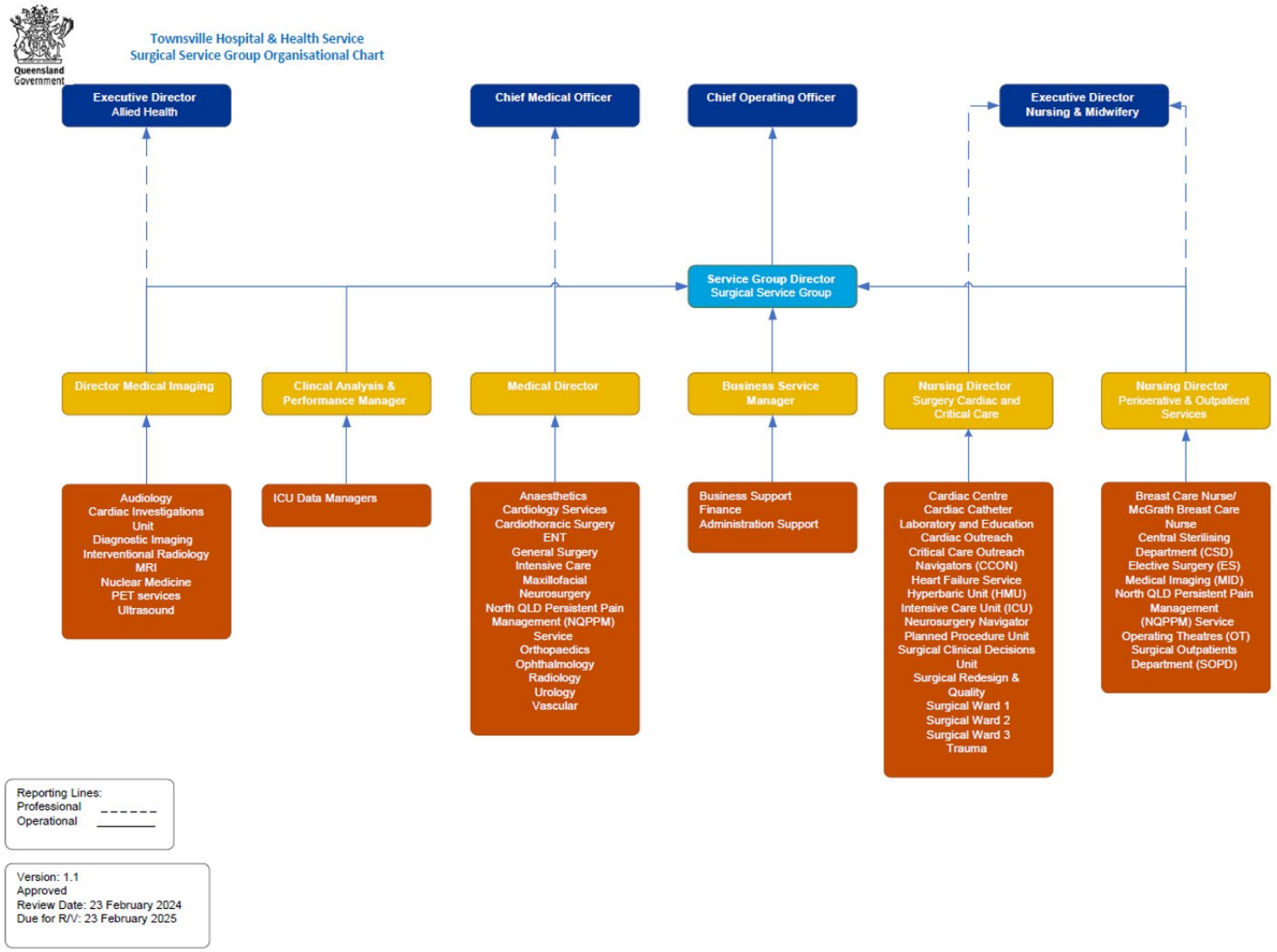
[26] THS.001.001.0736, Role Description of Service Group Director - Surgical, last updated June 2023.

PART A

PART B

PART C

Figure 3: Management structure THHS SSG



PART A

PART B

PART C

Section 6 - Framing Concepts

141. The scope of the Investigation is prescribed in the TOR which frames the Investigation by reference to several areas of concern. It became clear to the Investigators that these areas of concern and the factual circumstances related to the TOR were extremely complex and difficult to portray in a simplified manner.

142. It was therefore necessary for the Investigators to define certain concepts that would allow the Investigators to best portray the circumstances relating to the management of urology services in TUH as per the TOR. These concepts were not threshold concepts for the Investigation but rather concepts that assisted the Investigators to better describe the circumstances central to this Report. Reflective of the central nature of these concepts, the Investigators have referred to these as "Framing Concepts".

143. To be clear, the Investigators considered the TOR as the basis for their inquiries and did not rely on the framing concepts as set out below but rather used these framing concepts in the formulation of the Report.

144. The key framing concepts included:

(a) the definition of a urology service which had to allow for consideration for the services in THHS, as well as matters that might be of a statewide significance;

(b) clarifying the nature of clinical and corporate governance;

(c) defining Disrupted Care which captures the clinical impact on patients of administrative and other similar activities which are factually described in this Report; and

(d) defining clusters as described in this Report.

6.1 Defining Urology Services

145. The Investigation is in relation to "urology services", as distinct from the "urology department", and is not specifically defined in the TOR. As such, it is important, not only in respect of the scope of the Investigation, but also for clarity and consistency purposes, to consider and define what is considered to fall within the ambit of "urology services". Given the TOR requests that the Investigators consider under TOR 3.1 (a)(i), the use of multidisciplinary teams and under TOR 3.3, Statewide Learnings, it was also necessary to consider urology services in a broader sense.

146. Urology, as a discipline, spans the management of conditions affecting the urinary tract and the male reproductive system, ranging from benign disorders such as kidney stones and urinary tract infections to complex malignancies and end-stage organ failure.

147. A reference to "urology services" is not restricted to services provided by a single department, being the urology department. Rather, it is a reference to services that are delivered by an integrated clinical ecosystem that brings together multiple specialties to deliver patient-centred care in connection with urological concerns or conditions. Urology services in a HHS will be structured to meet the needs of the community and will therefore vary in size and scope.

148. Therefore, urology services work collaboratively with associated services such as nephrology, transplantation, medical oncology, radiation oncology, palliative care, radiology, pathology, and operating room services, each contributing specific expertise to the patients. For example, the North Queensland Kidney Transplant Service is based within the Medical Service Group and works collaboratively with the Urology Service.

149. Further information regarding the scope of matters falling with the ambit of "urology services" and which informed the scope of the matters considered by the Investigators in conducting this Investigation are detailed below.

6.1.1 The Urology Department

150. Notwithstanding the above, at the centre of the delivery of urology service is the urology department, staffed by surgeons, registrars, specialist nurses, registered nurses, and allied health professionals. Its mandate is broad and includes diagnostic evaluation, medical and surgical management, and long-term follow-up of patients with urological conditions. The department's access to outpatient clinics, procedure rooms, and surgical theatres capable of supporting minimally invasive, robotic, and open surgical techniques is essential. Beyond the technical aspects, the urology department must promote a culture of multidisciplinary collaboration, recognising that most urological conditions intersect with other clinical specialties.

151. The urology department's clinical portfolio includes oncological urology (prostate, bladder, kidney, and testicular cancers), functional urology (incontinence, pelvic floor disorders), stone disease, andrology, and specialised surgery. Each area requires close coordination with other clinical departments to ensure that patients receive comprehensive care tailored to their condition. Relevant specialty links are detailed below.

6.1.2 Nephrology

152. Many urological patients present with impaired renal function, either because of obstruction, chronic infection, or systemic disease. Nephrologists provide expertise in medical management of chronic kidney disease, dialysis, and optimisation of renal function prior to and following surgical interventions. For example, a patient undergoing partial nephrectomy for a renal tumour may require nephrology input to assess baseline kidney function and to plan postoperative monitoring. Similarly, patients with recurrent stone disease may benefit from metabolic evaluation and preventive strategies led by nephrologists.

153. The integration of nephrology ensures that surgical decisions are made with a full understanding of long-term renal outcomes, balancing symptom relief with preservation of kidney function.

6.1.3 Transplantation

154. For patients with end-stage renal disease, transplantation represents the gold standard of care. A comprehensive urology service must therefore be closely aligned with the transplant program. Urologists play a role in donor nephrectomy, surgical implantation of the graft (noting this is provided by transplant surgeons in the TUH), and management of urological complications post-transplant, such as ureteric strictures or bladder dysfunction. Collaboration with transplant surgeons, immunologists, and nephrologists is essential to ensure an optimal patient outcome.

6.1.4 Medical oncology

155. Urological cancers often demand systemic therapy beyond surgery. Medical oncology provides expertise in chemotherapy, immunotherapy, and specialised targeted agents. For example, advanced bladder cancer may require neoadjuvant chemotherapy before cystectomy, while metastatic prostate cancer is increasingly managed with novel hormonal agents and immunotherapies.

156. The partnership between urology and medical oncology ensures that patients receive evidence-based, guideline-driven care across the disease spectrum. The Genitourinary/Urology MDT serves as the forum where urologists and oncologists jointly review cases, integrating surgical options with systemic therapies to craft individualised treatment plans.

6.1.5 Radiation oncology

157. Radiation oncology is another critical pillar. Many urological malignancies, particularly prostate cancer, can be treated with radiation either as a primary modality or in combination with surgery and systemic therapy. Radiation oncologists bring expertise in techniques such as stereotactic radiotherapy, and brachytherapy.

158. Close collaboration between urology and radiation oncology allows patients to weigh the relative benefits and side effects of surgery versus radiation, ensuring informed decision-making. Furthermore, radiation therapy plays a role in palliation, offering symptom relief for bone metastases or local tumour control.

6.1.6 Palliative care

159. A truly comprehensive service must recognise that not all patients will be cured. Palliative care provides holistic support for those with advanced disease, focusing on symptom management, psychosocial support, and end-of-life planning. Integration of palliative care into the delivery of urology service ensures that patients with incurable cancers or progressive renal failure are not abandoned but continue to receive compassionate, dignified care.

160. Palliative specialists work alongside urologists, oncologists, and nephrologists to manage pain, while also addressing emotional and spiritual needs.

6.1.7 Radiology

161. Radiology underpins almost every aspect of urological care. From ultrasound and computed tomography (**CT**) scans to magnetic resonance imaging (**MRI**) and nuclear medicine, imaging provides the diagnostic clarity needed to guide treatment. Radiologists collaborate with urologists to stage cancers, identify stones, evaluate renal function, and plan surgical approaches.

162. Interventional radiology adds further value, offering minimally invasive procedures such as nephrostomy tube placement, embolisation for bleeding, or targeted biopsies. The radiology department's integration ensures that patients benefit from rapid, accurate diagnostics and therapeutic interventions that complement surgical care.

6.1.8 Pathology

163. Pathology provides definitive tissue diagnosis. Tissue obtained from biopsy or surgery must be analysed to determine cancer type, grade, and stage, which in turn dictates treatment strategy.

164. Pathologists also contribute to transplant medicine through histocompatibility testing and monitoring for rejection.

165. The role of pathology services is not merely diagnostic but also prognostic, guiding clinicians on expected disease behaviour and informing decisions about adjuvant therapy. Regular communication between urologists and pathologists ensures that surgical specimens are interpreted in clinical context, enhancing the precision of care.

6.1.9 Operating room services

166. Finally, the operating room services form a practical foundation of the delivery of urology services. A comprehensive service requires access to surgical theatres equipped for open, laparoscopic, and robotic procedures (noting this is undertaken in collaboration with the Mater Hospital in Townsville). The anaesthetic staff, perioperative nursing staff, and sterile processing teams are integral components that ensure patient safety and surgical efficiency.

167. Operating room services must be flexible enough to accommodate complex multidisciplinary procedures, such as combined urology-transplant surgeries.

6.1.10 Multidisciplinary model

168. The strength of a contemporary urology service lies in its ability to integrate these diverse departments into a cohesive model of care. Multidisciplinary clinics serve as the operational nexus, where specialists from urology, nephrology, oncology, radiology, and pathology convene, to discuss cases and align treatment strategies. Shared electronic health records, coordinated scheduling, and joint research initiatives further reinforce collaboration.

6.2 Defining Clinical and Corporate Governance

169. Consideration of these two areas is implicit within the TOR. The governance arrangements of a health service established under the HHBA arrangements can be said to be built on these two complementary pillars. While each addresses a different form of accountability, corporate and clinical governance operate in conjunction and on an interconnected basis in practice.

170. Clinical governance[27] is the set of relationships and responsibilities established by a health service organisation between its department of health (for the public sector), governing body, executive, clinicians, patients, consumers and other stakeholders to ensure good clinical outcomes. It ensures that the community and health service organisations can be confident that systems are in place to deliver safe and high-quality health care and continuously improve services.

171. Clinical governance is an integrated component of corporate governance of health service organisations. It ensures that everyone – from frontline clinicians to managers and members of governing bodies, such as boards – is accountable to patients and the community for assuring the delivery of health services that are safe, effective, integrated, high quality and continuously improving.

172. Each of the TOR has elements that relate to these two pillars. For example, under TOR 3.1 (f) and (g) which relate to complaints management, patient complaints form part of clinical governance while staff complaints form part of corporate governance.

6.3 Definition of a cluster of adverse clinical incidents

173. A further framing concept relevant to the Investigation is the consideration of a definition for a "cluster of adverse clinical incidents" (i.e. a cluster).

174. Given the scope of the matters required to be considered under the TOR, it has been necessary for the Investigators to examine these issues by reference to clusters. This has been necessary on a factual level, i.e. that is because there has been clusters of adverse clinical incidents, but also because the Investigators considered a "cluster" based approach best assists in the identification and then the analysis of connected adverse clinical incidents, and through this connection, a mechanism that best allows for the consistent identification of system level issues and concerns and the structured analysis of the same in the delivery of urology services. This is not to say the scope of the Investigation is constrained by the definition of a cluster, as the scope is instead contained within the TOR.

175. THHS has used varied terminology throughout the relevant period such as "clusters", "bundles", "streams" and "cohorts" to describe groups of adverse clinical incidents detailed in Section 7.2 of this Report. The Investigators have used the term "cluster" in this Investigation. THHS undertook a "cluster analysis" for one group of SAC incidents which were considered and analysed as a group of related incidents.[28]

176. A definition of a cluster is a framing concept for the Investigation and a concept that allows the Investigators to provide a structured analysis of the incidents in the TUH that relate to patients that experienced Disrupted Care who are connected to or who receive urology services.

177. It was noted that QH does not have a published definition of a "cluster of adverse clinical incidents". It is also noted that there are no national or international agreed definitions for a "cluster of adverse clinical incidents".

[27] Australian Commission on Safety and Quality in Health Care, *National Safety and Quality Health Service Standards,* Second Edition, May 2021. Electronic copy available at: https://www.safetyandquality.gov.au/sites/default/files/2021-05/national_safety_and_quality_health_service_nsqhs_standards_second_edition_-_updated_may_2021.pdf.
[28] THS.001.001.1476 THHS, *Multi Incident Analysis Review Report*, 25 March 2025.

178. Within Australia, the South Australian Department of Health[29] refers to three to five clinical incidents as forming a cluster, while in Victoria, Safer Care Victoria[30] refers to three or more clinical incidents as forming a cluster.

179. The Investigators have drawn on the definitions used in South Australia and Victoria to define a cluster as three or more clinical incidents with similar characteristics, occurring within a defined timeframe and service context, in a pattern that suggests a potential common contributory factor or systemic issue rather than unrelated, isolated incidents.

180. The Investigators consider the key features of a cluster include: [31]

(a) multiplicity of incidents: at least three clinical incidents are identified;

(b) similarity of characteristics: the incidents share one or more of the following:

(i) same or similar harm type (e.g. delayed diagnosis, medication error, deterioration not recognised); or

(ii) same or similar clinical process or pathway (e.g. referral, triage, escalation, discharge, follow-up); or

(iii) same or similar patient cohorts (e.g. specialty, diagnosis, age group, risk profile); and

(c) temporal proximity: the incidents occur within an agreed timeframe relevant to the risk sufficient to indicate a plausible relationship rather than a random occurrence;

(d) service or process proximity: the incidents involve the same service, team, or functional unit, or the same or substantially similar workflow, protocol, or enabling system (e.g. the same booking, triage, or clinical information system); and

(e) signal of systemic risk: on preliminary review, the pattern of incidents reasonably suggests a non-random aggregation, indicating one or more shared contributory factors, latent conditions, or governance gaps that warrant aggregated analysis.

181. The above definition is used in the Report to define clusters to ensure the terminology is consistent. This has allowed the Investigators to identify and consider a series of clusters that occurred in the delivery of urology services at TUH and to examine these matters on a structured and consistent basis.

6.4 Defining Disrupted Care

182. The Investigators were required to evaluate and respond to both the clinical and administrative elements which may have impacted patient care. The Investigators were conscious that a definition which is responsive to all relevant factors was not available to them.

183. The Report sets out a series of cases where individuals receive care at TUH and experience a disruption to that care. The Investigators chose to use the term "Disrupted Care" to describe the care that these patients received for the purposes of this Investigation. This allowed the Investigators to consider the care patients received in a more holistic sense.

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[29] SA Health, How to Conduct a Cluster Incident Review Guideline, Version 1.0, Approval date: 15 April 2024, PDS Reference No: G0205. Electronic copy available at:https://www.sahealth.sa.gov.au/wps/wcm/connect/2bbe2816-9885-46d1-b737-31ae5dbc6a84/How+to+Conduct+a+Cluster+Incident+Review+Guideline.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-2bbe2816-9885-46d1-b737-31ae5dbc6a84-o.BVLiF.

[30] Victorian Government, *Adverse Patient Safety Event Policy*, Safer Care Victoria, July 2023. Electronic copy available at: https://www.safercare.vic.gov.au/sites/default/files/2019-08/Policy%20-%20Adverse%20Patient%20Safety%20Events.pdf.

[31] Tsatsoulis, C., & Amthauer, H. A. (2003). Finding clusters of similar events within clinical incident reports: A novel methodology combining case-based reasoning and information retrieval. *Quality and Safety in Health Care*, 12(Suppl II), ii24–ii32. Electronic copy available at: https://pmc.ncbi.nlm.nih.gov/articles/instance/1765772/pdf/v012p0ii24.pdf.

184. Patients in hospital systems can experience Disrupted Care[32] when follow-up is missed, when transitions are poorly managed, and when systemic barriers prevent continuity or result in lengthy delays to care. There are six common causes of patients experiencing Disrupted Care: missed follow-up, poor transitions of care, administrative gaps, access barriers, digital disengagement, and clinical oversight. Each represents a point where patients disengage or are overlooked, with risks ranging from unbooked reviews to fragmented care across public and private boundaries.

185. These causes can be mapped against the elements of the National Model Clinical Governance Framework (2017),[33] identified as one of the key policy documents used as background to this Report. This Framework was in place during the period when the clusters occurred. Key considerations include:

(a) **Missed Follow-Up**: patients may have been seen and not provided with a scheduled review or fail to attend booked appointments. The absence of robust recall systems for chronic or high-risk conditions such as cancer surveillance means that this disruption can go unnoticed;

(b) **Poor Transitions of Care**: discharge summaries may not reach GPs or community providers, leaving primary care teams unaware of diagnoses or treatment plans. Inadequate handovers between departments or facilities, and fragmentation across public/private/regional boundaries;

(c) **Administrative Gaps**: gaps in patient records such as the inclusion of incorrect contact details, duplicate entries, mismatched identifiers, lost/misplaced booking forms or delayed entries into electronic medical systems can prevent referrals from being actioned, triaged correctly or appropriate care being provided. Administrative lapses are often invisible until adverse outcomes occur, making them a silent contributor to patient risk;

(d) **Access Barriers**: structural barriers such as long waitlists, delayed specialist appointments, geographic isolation, and financial or transport constraints limit patient engagement. Language and cultural mismatches, particularly affecting First Nations patients, further exacerbate disengagement;

(e) **Digital Disengagement**: patients without access to My Health Record, SMS/email reminders, or portals for tracking appointments are more likely to disengage. Digital exclusion disproportionately affects older patients, those in rural areas, and communities with limited digital access or literacy. This undermines system-wide efforts to modernise care pathways and creates gaps in follow-up; and

(f) **Clinical Oversight**: busy clinics may deprioritise lower-risk patients, while complex cases requiring multidisciplinary review can be overlooked leading to missed appointments and disengagement.

186. For completeness, the THHS have used terms including "Lost to Service", "Lost to Care", "Delayed to Care" and "Lost to Follow Up" at various points in their documents. Where the THHS has used these terms in its documents, the Investigators have retained the terminology. THHS

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[32] Tong Ching Yi Michelle et. al. (2023) "A scoping review on the factors associated with the lost to follow-up (LTFU) amongst patients with chronic disease in ambulatory care of high-income countries (HIC)" *BMC Health Services Research* 23:883. Electronic copy available at: https://link.springer.com/content/pdf/10.1186/s12913-023-09863-0.pdf; Harry Collin et al, "Determinants of Nonattendance in a Urology Outpatient Clinic: A 5-Year Retrospective Study in a Tertiary Metropolitan Hospital" (2025) *ANZ Journal of Surgery* 0:1–8. Electronic copy available at: https://gecko.healthinfonet.org.au/uploads/resources/51539_51539.pdf.

[33] Australian Commission on Safety and Quality in Health Care, *National Model Clinical Governance Framework,* 2017. Electronic copy available at: https://www.safetyandquality.gov.au/sites/default/files/migrated/National-Model-Clinical-Governance-Framework.pdf. The Investigators note this has recently been replaced by the June 2026 version which is available at: https://www.safetyandquality.gov.au/resources/2026-national-model-clinical-governance-pdf

advised the Investigators that clinical decision-making is a contributing factor to what the Investigators have defined as Disrupted Care.[34]

187. A consulted party also provided the following definitions to the Investigators:

(a) "Lost to Service" is defined to be when the patient was not on any waitlist, and there was no visibility of their care; and

(b) "Delayed to Care" is defined to be when the patient is waitlisted and not scheduled within the specialists' recommended timeframe.

188. Due to the systems-based analysis required in this Investigation, the definition of Disrupted Care is focused on the reasons contributing to patients becoming "Lost to Service", "Lost to Care", "Delayed to Care" and "Lost to Follow Up".

189. However, essentially, the Investigators consider that in a contemporary health service with comprehensive information systems in place, such as the THHS, and where individual patients are recorded in those digital systems, the differentiation between terms such as "Lost to Service", "Lost to Care", "Delayed to Care" and "Lost to Follow Up" is to a degree artificial as all patients will be recorded within the information systems used by a health service and have a digital footprint within those systems.

190. The term Disrupted Care is used throughout the Report to account for patients whose care was disrupted.

[34] THHS Natural Justice Response.

Section 7 - Chronology of Key Events

7.1 Overview

191. Over the period from January 2022 to 31 July 2025, there were a series of patient safety incidents relating to the delivery of urology services at TUH. These are detailed in the SAC reports provided to the Investigators by the THHS and which are examined in detail in Section 9.6 of this Report.

192. These SAC reports detail several varied but interconnected issues of concern that relate to the delivery of urology services across TUH and which are related to broader TUH systems and processes. For this reason, it has been important to set out a chronology of events in detail to accurately represent what happened within the TUH and urology services. In doing so, the definition of a cluster, as outlined in Section 6.3 of this Report, has been used to identify the relevant events.

193. In providing the chronology of key events, the Investigators acknowledge that:

(a) the chronology has been prepared with the benefit of hindsight;

(b) the dates cited for the clusters are based on the information available to the Investigators and signify the best available evidence. The identification, quantification and management of the clusters by THHS was a dynamic and evolving process over the relevant period and the Investigators have made every effort to anchor the events and numbers of patients to a point in time demonstrated by documentary evidence before them;

(c) further, while this Investigation is focused on the clusters, the Investigators acknowledge these incidents did not occur in isolation and several events occurred during the relevant period which would have warranted attention and responses by THHS. For example, including but not limited to, the COVID-19 pandemic, coordinated health responses in relation to weather events, and other health projects that are unrelated to the TOR; and

(d) some of the issues that have been identified in this Report are not unique to THHS and have posed challenges to other health services. In some cases, these have been recognised by QH as statewide issues and are acknowledged as such in this Report.

194. The Investigators have considered the information provided to them by THHS and by staff interviewed as part of the Investigation process. Following an analysis of the evidence, the Investigators utilised the AcciMap methodology to visually represent this analysis and to present the sequencing of relevant events to inform the Report.

195. The AcciMap methodology was used for this purpose as it allowed the Investigators to consider and map how and why an adverse incident occurred by examining contributing factors across an organisation rather than focusing solely on the actions of frontline staff. As such, the AcciMap shows the Investigators' consideration of how decisions were made, the level of executive oversight in decisions, organisational processes, and policy settings combined to create the circumstances in which the incidents took place.

196. This process is described in Annexure C of this Report.

SUMMARY: Key observations, findings, and conclusions in relation to the Chronology of Key Events

(a) The Investigators have utilised an AcciMap methodology to visually represent their analysis of the material provided to them and present potential issues of concern which contributed to clusters of patients who experienced Disrupted Care.

(b) The clusters of patients who experienced Disrupted Care related to the urology service included:

(i) **Cluster 1** (July 2022): eight outpatients were identified as being involved in clinical incidents, several of which experienced Disrupted Care, including two urology patients. The incidents relating to urology patients were identified as being related to delay to follow up of critical results and outpatient scheduling.

(ii) **Cluster 6** (November 2023): 157 urology patients were initially identified as experiencing Disrupted Care. This cluster was identified through incident reporting after a patient complaint was received regarding a long wait for a follow up for urology services. This cluster occurred because of ineffective rebooking and auditing processes, which the THHS attributed to human error. The Investigators consider the cause was related to a range of factors beyond solely human factors including workload, lack of formal procedures, inconsistent work practices in the delivery of urology services, and the use of paper booking forms.

(iii) **Cluster 7** (November 2023): 23 urology patients were identified who were outsourced to a private radiology service for a complex medical imaging procedure (MRI guided prostate biopsy) that experienced Disrupted Care. This cluster occurred because of several factors including the shortage of specialist needles needed for the procedure and the lack of detailed procedures relating to the outsourcing of specialist radiological investigations such as MRI guided prostate biopsies within THHS.

(iv) **Cluster 8** (December 2024): 32 patients with bladder cancer experienced Disrupted Care. Three of the 32 cases were highlighted as having prolonged bladder cancer journeys resulting in unexpected outcomes and patient harm. A clinical audit identified that these urology patients experienced Disrupted Care because they had atypical pathology and were either not reviewed when receiving urology services and/or not referred to cancer services.

(v) **Cluster 9** (March 2025): 24,544 outpatients potentially experienced Disrupted Care, including 655 urology patients. A subsequent administrative audit of 21,091 paper booking forms identified that a proportion of appointments did not have associated clinical documentation, the plan of care on the booking form was different to the plan of care included in the EMR, and where there was a plan of care, it was at times not actioned.

(vi) **Cluster 10** (September 2025): This cluster represents a subgroup of urology patients identified in Cluster 9. The separation is because of distinct underlying causes, with this cluster instead occurring because of changes to and digitisation of the rebooking process not being effectively implemented. The initial number of patients who experienced Disrupted Care was identified to be 175 but this was increased to 576 patients following an expanded audit, which identified 254 SAC incidents.

(c) To collate issues of concern, the Investigators reviewed the various clusters that relate to the delivery of urology services. Several issues were also identified during the Investigators' site visit and witness interviews that potentially impacted on patient outcomes. These include:

(i) patients experiencing Disrupted Care due to fragmented processes, for example, patients being placed on the outpatient review waiting list after an outpatient appointment where there was a large backlog of patients requiring review;

(ii) high outpatient cancellation rates without active recovery of care and growing wait lists for both new and reviewed outpatients which impacted on the THHS's ability to provide care;

(iii) incomplete documentation in the EMR and ESM which limited the ability of staff to manage workflows; and

(iv) technology gaps and a lack of integration of information systems where staff had to "cut and paste" text from one system into an alternate system for action e.g. GP referral systems into ESM and EMR into ESM.

(d) Through this process the Investigators identified 25 issues of concern, categorised as follows:

(i) Operational Management in the Work Unit: 12 issues of concern identified;

(ii) Clinical Governance: seven issues of concern identified; and

(iii) Corporate Governance: six issues of concern identified.

(e) In evaluating the clusters, identifying the issues of concern and making recommendations, the Investigators acknowledge that:

(i) the chronology has been prepared with the benefit of hindsight;

(ii) the identification, quantification and management of the clusters by THHS was a dynamic and evolving process over the relevant period. The dates cited for the clusters is based upon the best evidence available to the Investigators;

(iii) the clusters did not occur in isolation. Several events occurred during the relevant period which may have warranted attention and responses by THHS; and

(iv) some of the issues identified are not unique to THHS and have posed challenges to other HHSs.

7.2 Clinical incident clusters

197. The clusters of patients who experienced Disrupted Care were identified by the Investigators through analysis of the information gathered and are represented graphically in the AcciMap.

198. The specific clusters of patients experiencing Disrupted Care related to urology patients are summarised below. Other clusters of patients who experienced Disrupted Care are included in the AcciMap for completeness.

199. It has been necessary to reflect all the identified clusters to represent the systems-based issues which can only be fully understood by reference to all the clusters. The Investigators acknowledge that some of the clusters do not include urology service patients, however, all clusters and the events arising from them and impacting upon them are connected to systems issues in the delivery of urology services. It is only through this lens that Investigators were able to understand the complexity of the systems issues affecting outpatients at TUH. The other clusters have not been summarised below as although the patients in these clusters experienced Disrupted Care, these patients were not connected to urology services.

200. The Investigators note that Clusters 1 and 9 are mixed clusters relating to both urology and non-urology patients. For these mixed clusters, the urology patients were the focus of the analysis, however, due to the consistent themes across the clusters it would have been misrepresentative of the way the clusters were managed and the responses taken to not include the non-urology patients. THHS dealt with the urology and non-urology patients in Clusters 1 and 9 collectively and did not differentiate clinical streams in their findings relating to these clusters.

(a) **Cluster 1 (July 2022)**: eight outpatients were identified by THHS as being involved in clinical incidents, several of which experienced Disrupted Care, including two

urology patients.[35] The clinical incidents were categorised as ranging from SAC 1 to SAC 4 and the urology patients were categorised SAC 3 and SAC 4.[36] The issues and themes of the incidents relating to urology were identified in a cover note to the Board on clinical incident trends in variation in outpatient processes as being related to delay to follow up of critical results and outpatient scheduling.[37] The issues and themes identified for the remaining outpatients experiencing Disrupted Care were triage, scheduling and follow up of results.[38]

(b) **Cluster 6 (November 2023)**: 157 urology patients were initially identified as experiencing Disrupted Care.[39] This cluster is referred to by TUH as the "Bundle Stream" and/or the "Urology Bundle"[40], where patients experienced Disrupted Care because rebooking and auditing processes did not occur effectively and patients were not placed on the Outpatient Department (**OPD**) review waiting list or rebooked for follow up outpatient care in accordance with their clinical plan.[41] This cluster was identified through incident reporting after a patient complaint was received regarding a long wait for a follow up for urology services.[42] The EDCG advised that THHS identified the cause as human error.[43] It is the Investigators' view that the cause was related to a range of factors including workload, lack of formal procedures, inconsistent work practices in the delivery of urology services, human factors as well as the use of paper booking forms for a manual rebooking process, where a bundle of paper booking forms were found to have not been acted upon.[44]

(c) **Cluster 7 (November 2023)**:[45] 23 urology patients were identified who were outsourced to a private radiology service for a complex medical imaging procedure (MRI guided prostate biopsy) that experienced Disrupted Care.[46] This cluster was identified through an incident report after receiving a patient complaint.[47] This cluster was due to several factors including:

(i) a shortage of available specialist devices, which was initially identified in March 2023[48] and not acted on until November 2023 (specialised needles are needed for the procedure);[49] and

[35] THS.001.001.2042 THHS, *Executive Clinical Governance Committee Endorsed Meeting Minutes,* 28 July 2022, page 12; WIT.003.001.0004, *Lost to follow up risk submission,* 6 November 2025, page 1; WIT.003.001.0006 THHS, *ief med and Quality Committee: Clinical Incident Trends in Variation in Outpatient Processes,* 24 August 2022, page 2.
[36] WIT.003.001.0006 THHS, *Board Safety and Quality Committee: Clinical Incident Trends in Variation in Outpatient Processes,* 24 August 2022, page 1-2; THS.001.001.1689 THHS, *Board Safety and Quality Committee Meeting Minutes,* 24 August 2022, page 3-4.
[37] WIT.003.001.0006 THHS, *Board Safety and Quality Committee: Clinical Incident Trends in Variation in Outpatient Processes,* 24 August 2022, page 229-230.
[38] WIT.003.001.0006 THHS, *Board Safety and Quality Committee: Clinical Incident Trends in Variation in Outpatient Processes,* 24 August 2022, page 230.
[39] THS.001.001.1735 THHS, *Board Safety and Quality Committee: Briefing Note,* 22 April 2024, pages 1-2; WIT.003.001.0001 Transcript of Interview – Witness Q, paragraph 29; WIT.003.001.0004, *Lost to follow up risk submission,* 6 November 2025, page 2.
[40] THS.001.001.1734 Board Safety and Quality Committee, *Briefing Note: Patient Safety Report,* meeting date 19 February 2024, presented to Board on 4 March 2024, page 11.
[41] THS.001.001.0047 THHS, *Board Executive Committee Urology and Outpatient Processes Update,* 15 January 2024, page 7.
[42] WIT.003.001.0001 Transcript of Interview – Witness Q, paragraph 29; THS.001.001.0047 THHS, *Board Executive Committee Urology and Outpatient Processes Update,* 15 January 2024, page 2; THS.001.001.1699 THHS, *Board Safety and Quality Committee Meeting Minutes,* 13 December 2023, page 4-7.
[43] Consulted Parties' Natural Justice Response.
[44] WIT.003.001.0004, *Lost to follow up risk submission,* 6 November 2025, page 2; THS.001.001.1312 Email sent on 14 December 2023; WIT.002.001.0003 Transcript of Interview - Witness AE, paragraphs 19-29.
[45] THS.001.001.1735 THHS, *Board Safety and Quality Committee: Briefing Note,* 22 April 2024, pages 1-2; THS.001.001.1699 THHS, *Board Safety and Quality Committee Meeting Minutes*, 13 December 2023, page 6.
[46] THS.001.001.1734 Board Safety and Quality Committee, *Briefing Note: Patient Safety Report,* meeting date 19 February 2024, presented to Board on 4 March 2024, pages 1 and 11.
[47] THS.001.001.1699 THHS, *Board Safety and Quality Committee Meeting Minutes*, 13 December 2023, page 5-6.
[48] THS.001.001.1660 Email dated 15 March 2023.
[49] THS.001.001.1699 THHS, *Board Safety and Quality Committee Meeting Minutes*, 13 December 2023, page 6; THS.001.001.1660 Email sent on 15 March 2023; THS.001.001.1655 Email sent on 26 October 2023.

(ii) a lack of detailed procedures relating to the outsourcing of specialist radiological investigations within THHS (MRI guided prostate biopsies).[50]

(d) **Cluster 8 (December 2024)**: 32 patients with bladder cancer experienced Disrupted Care.[51] Three of the 32 cases were highlighted as having prolonged bladder cancer journeys resulting in unexpected outcomes and patient harm.[52] These urology service patients experienced Disrupted Care because they had atypical pathology and were either not reviewed when receiving urology services and/or not referred to cancer services.[53] This was identified through a clinical audit of pathology results.[54] There was no or limited documentation in the medical records outlining the care planned for these patients as team meetings between medical and nursing staff at the end of the urology outpatient clinic were not being held. This occurred around the same time as the process changes outlined in the Bulk Check Out memorandum circulated in December 2023, but was unrelated.[55]

(e) **Cluster 9 (March 2025)**:[56] An audit was conducted of 24,544 outpatients potentially experiencing Disrupted Care over the period 2021 to 2025,[57] including 655 urology patients within the SSG. This data was unvalidated at the time. This audit was subsequently refined by the THHS using a validated dashboard. A subsequent administrative audit of 21,091 paper booking forms covering appointment dates from January to September 2025 was initiated by COO 3 but had not been formally validated.[58] This aimed to review the plan of care documented on paper booking forms against the plan of care in the EMR.[59] As of December 2025, a total of 21,019 booking forms had been audited, including 529 paper booking forms from Urology patients.[60] The results of the SSG paper booking form audit demonstrated that a proportion of appointments did not have clinical documentation associated with them, the plan of care on the paper booking form was different to the plan of care included in the EMR, and where there was a plan of care, it was at times not actioned.[61]

(f) **Cluster 10 (September 2025)**:[62] This cluster was identified through incident reporting following a complaint from a patient's GP.[63] In this cluster, patients experienced Disrupted Care because the rebooking process which was supposed to have moved to a fully electronic process, with medical staff making specific entries in the EMR so that administrative staff could enter the patient rebooking details into ESM as either a rebooked patient or by adding them to the OPD review waiting list, was not effectively implemented in the delivery of urology services following an instruction issued by COO 2 in December 2023.[64] Cluster 10 represents a subgroup of patients identified in Cluster 9. The initial number of patients identified through an audit was 175. The number of patients who experienced Disrupted Care increased to 576

[50] THS.001.001.2068 THHS, *Surgical Service Group Performance and Accountability Meeting,* 21 March 2023, pages 17 - 44.
[51] WIT.003.001.0001 Transcript of Interview – Witness Q, paragraphs 43-55; WIT.001.001.0038, *Proposal to Improve Bladder Cancer Delays,* 5 December 2024.
[52] THS.001.001.1770 Board Safety and Quality Committee, *Briefing Note*: *THHS Patient Safety Report*, 14 April 2025, page 2.
[53] THS.001.001.0301 THHS, *Multi Incident Analysis Report,* 25 March 2025, page 3.
[54] WIT.001.001.0038, *Proposal to Improve Bladder Cancer Delays,* 5 December 2024; THS.001.001.0301 THHS, *Multi Incident Analysis Report,* 25 March 2025, page 1.
[55] THS.001.001.1718 - Email, sent on 18 December 2023.
[56] WIT.002.001.0036 Transcript of Interview – Witness L, paragraphs 25-29.
[57] WIT.002.001.0036 Transcript of Interview – Witness L, paragraphs 25-29; THS.001.001.2260 THHS, *Outpatient Planned Care Steering Group,* 26 March 2025, page 93.
[58] WIT.001.001.0236 – Email, sent on 17 October 2025; WIT.001.001.0237 THHS, *Outpatient Waitlist Clinical Audit – Reporting Schedule,* 1 August 2025, page 1; WIT.004.001.0017 Email, sent on 23 December 2025.
[59] WIT.004.001.0017 Email, sent on 23 December 2025.
[60] WIT.004.001.0019, *Results Summary, SSG Clinic Clip Audit,* 23 December 2025, pages 1-3; WIT.004.001.0017 Email, sent on 23 December 2025.
[61] WIT.001.001.0064 - Email, sent on 3 November 2025; WIT.002.001.0028 Transcript of Interview – Witness I, paragraph 12.
[62] WIT.003.001.0001 Transcript of Interview – Witness Q, paragraphs 56-65, 75-80; THS.001.001.2277 THHS, *Board Safety and Quality Committee Urology Services Action Plan Update,* 8 December 2025, pages 1-2; THS.001.001.1524 *Urology Audit Excel*, dated 17 November 2023. The Investigators note that as per document THS.001.001.1524, the initial number of patients audited was 175. This initial audit was conducted before it became apparent that there was a broader issue, which led to the audit of 576 patients and identification of 254 clinical incidents.
[63] THS.001.001.1302 Initial Patient Safety Review Document, 2 September 2025.
[64] THS.001.001.1718 - Email, sent on 18 December 2023; THS.001.001.0835, Memorandum dated 18 December 2023.

patients when the audit was expanded. Of that number, 254 of the patients were associated with SAC incidents.[65] As set out later in this Report, this audit data was provided by the THHS and was ongoing.

201. In considering both Clusters 9 and 10, the Investigators had regard to section 3.2 of the TOR and therefore, the effectiveness of any measure identified or implemented by THHS during or after the relevant period to respond to issues related to the delivery of urology services. Cluster 9 comprises of audits undertaken after the relevant period but which relate to patients who were under the care of or receiving treatment from the urology service in the relevant period. The audits were measures employed by THHS to assess compliance with outpatient booking procedures which was an issue related to the delivery of urology services within the relevant period. Cluster 10 consists of a subgroup of patients from Cluster 9 which was identified after 31 July 2025, but an analysis of this sub-group of patients showed they had contact or care prior to 31 July 2025. This analysis was based on detailed patient-level data provided to the Investigators by THHS. Cluster 10 is separated from Cluster 9 because the underlying cause of the cluster is considered by the Investigators to be different to those considered in relation to Cluster 9, in that Cluster 10 relates to specific processes that were in place in the TUH and the THHS urology outpatient area.

202. The Investigators note that the issues relating to patients that experienced Disrupted Care who are connected to or receive urology services were generally identified from patient complaints, clinical incidents and clinical reviews that then triggered an audit that subsequently documented SAC incidents within the delivery of urology services.

203. It is considered that these clusters occurred because of a weakness in governance arrangements as had the underlying causes been identified earlier, effective mitigations could have been put in place by the THHS.

204. The AcciMap demonstrates the Investigators' consideration of the various clusters, the related underlying causes and the responses to each cluster by reference to a range of factors including the escalation of Disrupted Care cases, governance and leadership responses, causes of patients experiencing Disrupted Care, urology outpatient process and a risk analysis. This in turn enabled the Investigators to effectively represent the clusters and the issues presented by each cluster on a systemic basis. These issues are outlined in detail below.

7.3 Governance and Leadership Responses

205. There were a series of concerns relating to patients who are connected to or receive urology services that were raised through THHS governance structures.

206. The THHS clinical governance committees considered and sought to respond to the various adverse clinical incidents. In particular, the ECGC and PSC considered the proposed response to issues that they had identified as leading to the adverse clinical incidents. The committees escalated matters to the previous HSCE appropriately. The extensive consideration given to these matters is outlined in Annexure F and in more detail in each section of this Report. Further detail on the actions taken by the previous HSCE in response to each cluster are considered at Section 9.10.

207. Leadership changes occurred during the relevant period, with key staff, including the COO, transitioning to new acting roles, and with other staff stepping back from roles and governance committees relating to outpatient care.[66] THHS also introduced QH Refer to replace paper documentation for internal patient referrals to improve the efficiency of patient flows in October 2025, which complicated the operating environment.[67]

[65] THS.001.001.2309 SAC 1,2,3 Audit Excel, 1 August 2025.
[66] THS.001.001.2262 Outpatient Planned Care Steering Group, *Meeting Book,* 27 February 2025, page 3.
[67] THS.001.001.2227 Access to Planned Care Leadership Group, *Meeting Book*, 19 July 2024, page 9.

208. In late 2025, a statewide Urology Taskforce was established by the Director-General.[68]

209. The Acting HSCE (**A/HSCE**) for the THHS informed the Lead Investigator on 14 October 2025 that across the timeline, the multiple clusters highlighted recurring issues and themes, including:

(a) outpatient booking process weaknesses, including administrative errors, with paper booking forms called "bundles" not actioned by administrative teams because of workloads and associated gaps in clinical and administration documentation resulting in patients experiencing Disrupted Care; [69]

(b) operational weaknesses, including for example the cessation of Bulk Check Out practices.[70] The implementation of this change was undertaken without a full understanding of its broader procedural impact, resulting in a new group of patients experiencing Disrupted Care; [71]

(c) inefficient processes, including for example, radiology reporting delays and radiology outsourcing processes relating to MRI guided prostate biopsies not being monitored and managed resulting in patients experiencing Disrupted Care;[72] and

(d) clinical governance concerns such as repeated SAC 1 incidents, escalating patient safety risks identifying patients experiencing Disrupted Care.[73]

7.4 Urology Outpatient Process and Risk Analysis

210. The Investigators have briefly detailed the urology outpatient processes in this section to provide background to the risk analysis. The outpatient process is discussed in detail in Section 8.5.

211. The urology service workflow is a complex, multi-stage process designed to deliver timely care to patients requiring specialist intervention. It begins with referrals from diverse sources including other hospitals, GPs, and emergency departments (**ED**s). These feed into a structured intake and triage system.[74] This triage process categorises patients by clinical urgency and ensures that pre-appointment investigations are completed.

212. Scheduling and appointment management is facilitated through the ESM system, which manages outpatient appointment scheduling and procedure scheduling.[75] Reminder systems aim to reduce failure-to-attend rates and optimise throughput.[76] The Investigators consider that clinical care in outpatients involves multidisciplinary collaboration, accurate electronic documentation, and patient education.

213. The follow-up phase after an outpatient appointment is critical in preventing patients from experiencing Disrupted Care. Structured protocols, audits, and escalation pathways are also

[68] WIT.002.001.0030 Transcript of Interview - Witness E, paragraphs 57-58; QHT.001.001.0009 Draft Statewide Urology Services Taskforce, Terms of Reference Version 3, September to October 2025.
[69] THS.001.001.1718 Email, sent on 18 December 2023; THS.001.001.1699 THHS, *Board Safety and Quality Committee Meeting Minutes*, 13 December 2023; THS.001.001.1312 Email, sent 18 December 2023; THS.001.001.1327; THS.001.001.1336 Email, sent on 28 October 2024.
[70] THS.001.001.1699 Board Safety and Quality Committee, *Meeting Minutes*, 13 December 2023.
[71] THS.001.001.2261 Outpatient Planned Care Steering Group, *Meeting Book* 26 June 2025, page 6; THS.001.001.1718 Email, sent 18 December 2023.
[72] THS.001.001.2106 Executive Clinical Governance Committee, *Patient Safety Briefing Note,* 17 January 2025. WIT.002.001.0023 Transcript of Interview - Witness B and Q, paragraphs 102-103, 134-135.
[73] THS.001.001.2226 Access to Planned Care, *Meeting Book*, 14 August 2024; THS.001.001.2261 Outpatient Planned Care Steering Group, *Meeting Book*, 26 June 2025; THS.001.001.2235 Outpatient Planned Care Steering Group, *Meeting Book,* 19 December 2024; THS.001.001.2244 Outpatient Planned Care Steering Group, *Meeting Book,* 24 January 2025.
[74] THS.001.001.0283 THHS, *Procedure: Outpatient Referral Management,* Procedure Number: THHSSUP251652v1, effective from 31 March 2025.
[75] THS.001.001.0281 THHS, *Procedure: Outpatient Clinical Management,* Procedure Number: THHSCLI241627v1, effective from 16 October 2024; THS.001.001.2131 Access to Planned Care Leadership Group, *Meeting Book,* 2 May 2024, page 15.
[76] THS.001.001.0281 THHS, *Procedure: Outpatient Clinical Management,* Procedure Number: THHSCLI241627v1, effective from 16 October 2024; THS.001.001.2131 Access to Planned Care Leadership Group, *Meeting Book,* 2 May 2024, page 15-16.

used to safeguard high-risk cases. Despite these measures, challenges can lead to delays and missed care opportunities as was identified in THHS.[77]

214. At the time that the Investigators undertook a site visit to facilities that delivered urology services at TUH on 3 November 2025, the care pathway exhibited process fragmentation that could result in patients being lost to follow-up and delayed in care delivery. This care pathway was in place during the relevant period. Key contributing factors include complex referral chains, inadequate tracking and capacity constraints.[78] These factors contributed to patients who are connected to or who receive urology services in TUH experiencing Disrupted Care.

215. The THHS could not provide a process map that documented the outpatient care pathway for urology patients during the relevant period at the time that the Investigators undertook a site visit to facilities that delivered urology services. As described by staff in urology outpatient services during the Investigators' site visit, the pathway that patients had followed during the relevant period was considered to be fragmented, which could lead to patients experiencing Disrupted Care.[79]

216. Several issues were identified during the Investigators' site visit that potentially impacted on patient outcomes during the relevant period. These included:

(a) patients experienced Disrupted Care due to fragmented processes, for example, patients being placed on the outpatient review waiting list after an outpatient appointment where there was a large backlog of patients requiring review;[80]

(b) high outpatient cancellation rates without active recovery of care and growing waiting lists for both new and reviewed outpatients, which disrupted the continuity of care;[81]

(c) incomplete documentation in the EMR and ESM which limited the ability of staff to manage patient follow up[82]; and

(d) technology gaps and lack of integration of information systems where staff had to "cut and paste" text from one system into an alternate system for action e.g. GP referral systems into ESM and EMR into ESM.[83]

7.5 AcciMap Analysis: Townsville Urology Services

7.5.1 AcciMap Analysis Techniques

217. Systems-based investigation methods have become increasingly central to contemporary patient-safety practice, particularly when analysing complex or high-severity clinical incidents. Among these approaches, AcciMap has emerged as a robust and validated framework that enables users to map their understanding of how adverse incidents arise within complex sociotechnical systems such as healthcare.[84] A summary of this methodology is contained in Annexure C.

218. Unlike traditional methodologies that tend to focus on proximal factors or solely the actions of individuals, AcciMap provided a structured way for the Investigators to map how decisions, constraints, and systemic conditions across multiple levels within an organisation interacted to

[77] THS.001.001.2131 Access to Planned Care Leadership Group, *Meeting Book,* 2 May 2024, page 14.
[78] WIT.001.001.0088 THHS Digital Health Branch, *Smart Referrals Overview*, dated 19 January 2026; WIT.002.001.0018 Transcript of Interview – Witness AA, paragraph 130; WIT.002.001.0033 Transcript of interview – Witness AK, paragraph 36-38.
[79] Information obtained by Investigators during site visit at Townsville University on 3 November 2025.
[80] Information obtained by Investigators during site visit at Townsville University on 3 November 2025.
[81] Information obtained by Investigators during site visit at Townsville University on 3 November 2025.
[82] Information obtained by Investigators during site visit at Townsville University on 3 November 2025.
[83] WIT.002.001.0021 Transcript of Interview - Witness U, paragraphs 41-45; WIT.002.001.0013 Transcript of Interview – Witness AG, paragraphs 20-32.
[84] Rasmussen, J. (1997). "Risk management in a dynamic society: a modelling problem." Safety Science, 27(2-3), 183-213; Salmon, P. M., et al. (2020). The big picture on accident causation: A review, synthesis and meta-analysis of AcciMap studies. *Safety Science, 126*, 104650. Electronic copy available at: https://doi.org/10.1016/j.ssci.2020.104650; QHT.003.001.0001 *Best practice guide to clinical incident management*, Second edition, January 2023, page 12.

shape the circumstances in which the clusters occur. AcciMap was utilised in this Investigation because it enabled a structured depiction of contributory factors to the clusters, as identified by the Investigators, across all levels of the organisation from frontline clinical work through to operational management, governance, and policy settings. This multi-layered mapping provides a useful means of presenting a more complete picture of system vulnerabilities identified through the Investigators' detailed analysis and a stronger foundation for meaningful, system-level improvement.

7.5.2 Decision to use AcciMap to Represent the Clusters

219. As the timeline of the clusters became clear to the Investigators, they then undertook the task of considering how to best depict the series of events and their analysis of what occurred in THHS in relation to urology services in the relevant period. In developing the AcciMap, the Investigators had regard to the TOR, namely the parameters of the relevant period and scope of information that should be included. The Investigators' analysis of the THHS clusters identified critical themes that pointed to organisational safety activities requiring development. The AcciMap was selected to represent those themes and their interrelationships.

220. The AcciMap shows an executive level narrative of the systemic, multi-layered process that led to patients experiencing Disrupted Care in the delivery of urology services. The Investigators' analysis is visually represented at Figure 4 below.

221. The AcciMap was used to depict the clusters that occurred and was constructed based on the detailed assessment of the evidence undertaken by the Investigators as outlined in later sections of this Report and as per the TOR.

222. The AcciMap visually demonstrates the Investigators' findings that patients experiencing Disrupted Care was not the result of isolated human errors but rather cuts across matters of corporate governance, clinical governance, operations, processes, leadership, and technology. The vertical hierarchy of the AcciMap is macro to micro to identify potential links to the clusters across levels. The Investigators were of the view that these conditions were magnified by workforce limitations.

223. In producing the AcciMap, the Investigators were also conscious of considering external factors such as workforce limitations, equipment, information systems and the Statewide urology taskforce.

224. The AcciMap developed by the Investigators for TUH urology services assisted the Investigators in producing a visual representation of a complex series of clusters and the recurring themes and system behaviours that had been identified but were not otherwise visible when incidents were analysed individually.

225. These insights were then aligned chronologically to construct a unified system-level timeline. The timeline integrates clinical events with operational pressures, staffing patterns, and governance decisions, providing a clear view of how clusters emerged, evolved, and intersected over time.

226. The underlying causes of patients experiencing Disrupted Care in the delivery of urology services as presented in the AcciMap can be grouped into four domains. These are detailed below:

(a) corporate governance: limited strategic oversight of patient care processes resulted in diluted ownership of issues and concerns;

(b) clinical governance: escalation pathways were clear but not used effectively, unit based audits were irregular, and feedback loops were not consistently used to drive corrective actions;

(c) operations and process: process-level controls were weak at key junctures, including referral acceptance, diagnostic result review, appointment scheduling, and discharge

planning, workflows depended on manual transitions, responsibilities for closing the loop on referrals and appointment scheduling were either absent, outdated, or inconsistently applied; and

(d) workforce and technology: staffing variability and limited training for the management of complex pathways and limited digital solutions for patient tracking created vulnerabilities.

7.5.3 Summary

227. The Investigators considered a range of reasons why patients who are connected to or receive urology services experienced Disrupted Care.

228. Within this context, regional hospitals face heightened risks due to reliance on shared care models and workforce shortages in subspecialties. These systemic weaknesses increase the likelihood of patients falling through gaps, particularly in rural and First Nations communities where geographic, cultural, and financial barriers compound the problem.

229. The Investigators noted that there were recommendations in 2024 from senior clinical staff that process mapping be undertaken to better describe the underlying causes of patients experiencing Disrupted Care. This advice was discounted at the time and as such the opportunity to better understand the underlying causes of the problems was lost.

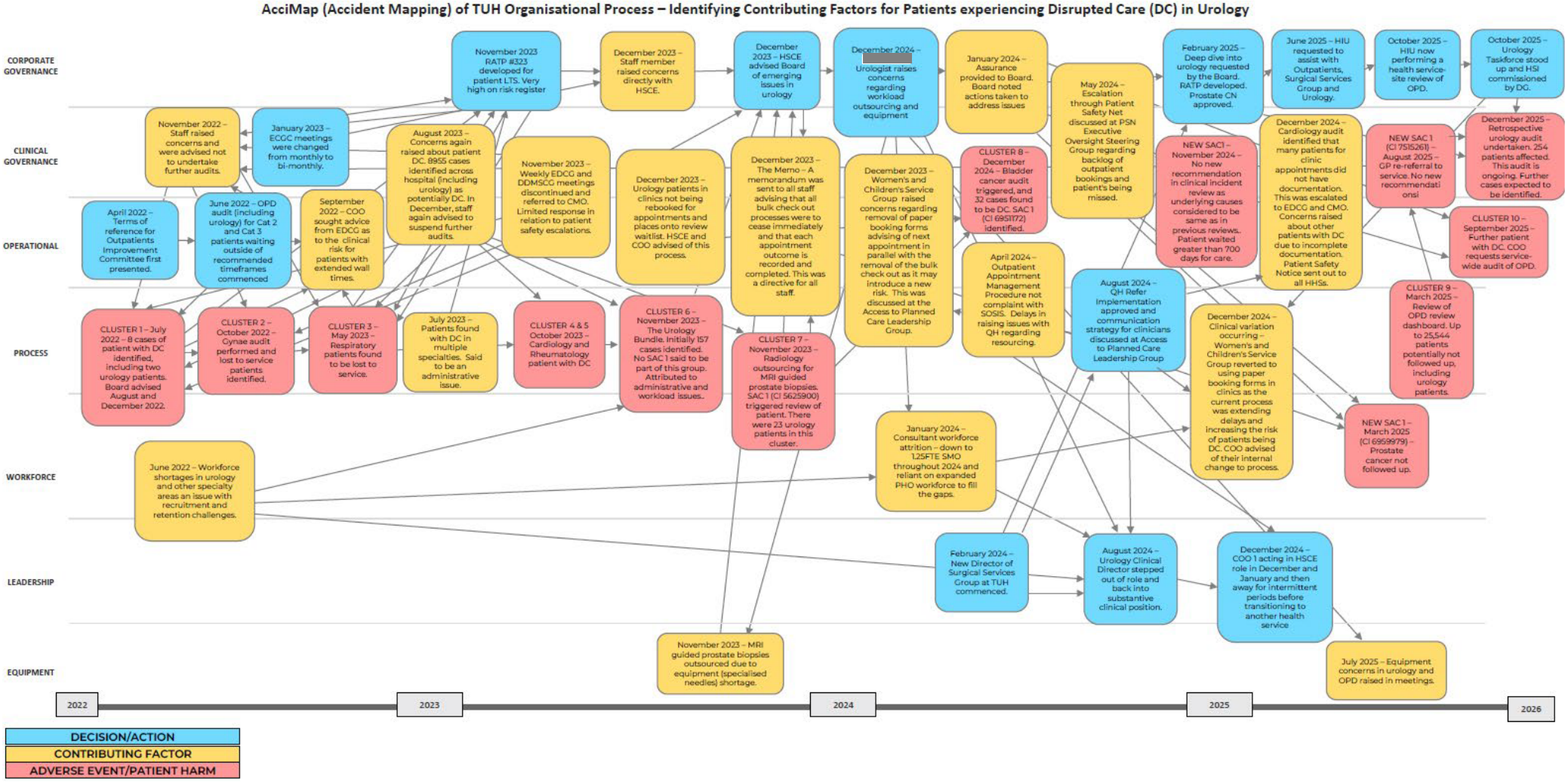
230. The Board advised that it:

> accepts that the AcciMap identifies what appear to be genuine systemic failures in the delivery of urology services at TUH.[85]

Recommendation 1	(Priority) That the THHS reviews the AcciMap and AcciMap Analysis developed by the Investigators and consider the further activities that would assist the THHS to mitigate the risks of patients experiencing Disrupted Care.

[85] The Board's Natural Justice Response.

Figure 4: AcciMap of factors contributing to urology patients experiencing Disrupted Care



7.6 Management of clusters of adverse clinical incidents

231. Health systems increasingly recognise that clusters require a structured and coordinated response, as they often signal deeper system vulnerabilities rather than isolated clinical errors.

232. Contemporary patient safety policy emphasises early detection of patterns of harm, the use of systems-based investigation methods, and the need for consistent governance oversight across services.[86]

233. Several authoritative frameworks and toolkits now guide how health organisations should identify, analyse, and respond to clusters. Together they form a foundation for executive level decision-making.

234. Across Australia, SA Health provides one of the most explicit frameworks through its Cluster Incident Review Guideline.[87] This outlines a structured methodology for recognising and analysing clusters of patient-safety incidents. This guideline defines what constitutes a cluster, establishes triggers for escalation, and provides a consistent approach for synthesising findings across multiple, related, incidents. It reinforces the principle that clusters often reflect systemic issues such as workflow design, communication processes, or resource constraints that require coordinated organisational action rather than isolated corrective measures.

235. Internationally, National Health Service (**NHS**) England's Patient Safety Incident Response Framework[88] and its associated Learning Response Toolkit[89] offer a comprehensive suite of methods for responding to patterns of harm. These resources support the use of systems-based investigation models, including AcciMap and provide a structured approach to thematic reviews, cluster analyses, and broader learning responses.

236. Safer Care Victoria's Adverse Patient Safety Event Guideline[90] reinforces the need for a structured, statewide approach to identifying and responding to patterns of harm. It highlights the importance of early detection, consistent classification, and the use of system-level analysis to understand recurring risks. This framework supports health services to move beyond incident-by-incident review and instead examine the broader organisational and environmental factors that contribute to repeated adverse outcomes.

237. At a national level, the ACSQHC provides some foundational guidance through its Incident Management and Sentinel Events framework.[91] While not cluster-specific, it establishes the principles and expectations for incident management in Australia, including the need for trend analysis, thematic review, and the identification of recurring risks.

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[86] Australian Commission on Safety and Quality in Health Care, *Australian Safety and Quality Framework for Healthcare*, December 2010. Electronic copy available at: https://www.safetyandquality.gov.au/sites/default/files/migrated/Australian-SandQ-Framework1.pdf.
[87] SA Health, *How to Conduct a Cluster Incident Review Guideline*, 15 April 2024. Electronic copy available at: https://www.sahealth.sa.gov.au/wps/wcm/connect/2bbe2816-9885-46d1-b737-31ae5dbc6a84/How+to+Conduct+a+Cluster+Incident+Review+Guideline.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-2bbe2816-9885-46d1-b737-31ae5dbc6a84-o.BVLiF.
[88] NHS England. *Patient Safety Incident Response Framework,* 23 July 2024. Electronic copy available at: https://www.england.nhs.uk/publication/patient-safety-incident-response-framework-and-supporting-guidance/#heading-1.
[89] NHS England, *Patient safety learning response toolkit*, 16 August 2022 (updated 3 March 2025). Electronic copy available at: https://www.england.nhs.uk/publication/patient-safety-learning-response-toolkit/.
[90] Victorian Government, Safer Care Victoria, *Adverse Patient Safety Event Guideline,* July 2023. Electronic copy available at: https://www.safercare.vic.gov.au/sites/default/files/2023-07/Adverse%20Patient%20Safety%20Event%20guideline_Safer%20Care%20Victoria_2.pdf.
[91] Australian Commission on Safety and Quality in Health Care, *Incident Management and Sentinel Events Review Framework*. Electronic copy available at: https://www.safetyandquality.gov.au/our-work/indicators-measurement-and-reporting/incident-management-and-sentinel-events.

238. QH's Clinical Incident Management Guideline[92] provides statewide direction for incident classification, review, and escalation, and the Statewide Patient Safety Notification System[93] ensures that serious or patterned incidents receive consistent scrutiny at a statewide level.

239. These policies and toolkits demonstrate a clear and maturing consensus that clusters must be managed through structured, systems-based processes that emphasise early detection, rigorous analysis, and statewide learning.

240. It is noted that the QH does not have a Cluster Adverse CIR Guideline or Toolkit.

241. Over the period from 2022 to 2025, the Investigators identified several clusters of patients who experienced Disrupted Care.

242. Several of the patient clusters, as detailed in the AcciMap, involve urology services or are relevant to urology services because the concerns relate to the systems and processes in place across TUH and therefore could have affected the delivery of urology services.

243. Over this period, the Investigators identified 10 separate patient clusters. The latest cluster, referred to as Cluster 10, is the subject of a detailed analysis by the Investigators.

244. It is the view of the Investigators, having regard to the number of clusters that arose in the THHS over the relevant period, that the THHS should have appreciated that such a large number of clusters represented a systemic risk to the organisation.

Recommendation 2	(Statewide) That QH consider developing a Cluster Adverse CIR Guideline and Toolkit to assist HHSs to respond to clusters of adverse clinical incidents. In so doing, QH may need to consider the structure, functioning and resourcing of HHS clinical governance teams.

7.7 Issues of concern

7.7.1 Issues of Concern Identified by Investigators

245. The TOR require the Investigators to consider whether "issues of concern" were identified and escalated, whether appropriate actions were taken and whether there was adequate oversight regarding these issues of concern. As such, it has been necessary to set out what the Investigators consider to be the issues of concern relating to the delivery of urology services at TUH during the relevant period.

246. To collate these issues of concern, the Investigators have reviewed the various clusters that relate to urology services. In doing so, they considered the information provided by the THHS relating to CIRs,[94] briefings and meeting records, as well as information provided during witness interviews.

247. Through this process, the Investigators identified issues of concern, categorised as follows:

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[92] Queensland Health, *Clinical Incident Management Guideline,* 1 July 2024, Guideline number: QH-HSDGDL-0322. Electronic copy available at: https://www.health.qld.gov.au/system-governance/policies-standards/health-service-directives/patient-safety/clinical-incident-management.
[93] Queensland Department of Health, *Patient Safety Notification System,* Guideline number: QH-HSDGDL-032-3:2013, effective from 1 March 2024. Electronic copy available at: https://www.health.qld.gov.au/system-governance/policies-standards/health-service-directives/patient-safety/patient-safety-notification-system.
[94] THS.001.001.0276 THHS, *Clinical Incident Management Procedure,* Procedure Number: THHSCLI140740v12, effective from 27 June 2024, pages 1-4; Queensland Health, *Clinical Incident Management Guideline,* 1 July 2024, Guideline number: QH-HSDGDL-0322. Electronic copy available at: https://www.health.qld.gov.au/system-governance/policies-standards/health-service-directives/patient-safety/clinical-incident-management.

(a) Operational Management in the Work Unit: 12 issues of concern:

(b) Clinical Governance: seven issues of concern; and

(c) Corporate Governance: six issues of concern (based on an assessment at the time the cluster was reported).

248. The issues of concern identified by Investigators are outlined below, including the relevant clusters that each issue relates to:

(a) Operational Management relating to the work unit:

(i) human factors in Clusters 1, 6, 7, 9 and 10;

(ii) variation and noncompliance with local rebooking processes (when a specific procedure is not in place) in Clusters 1, 6, 8, 9 and 10;

(iii) variation and noncompliance with administration procedures (not compliant with SOSIS) (Outpatient Appointment Management Procedure) in Clusters 6 and 9;

(iv) noncompliance with procedures in place in Clusters 8, 9 and 10;

(v) lack of Clinical Management Guidelines for high risk patients in Cluster 8;

(vi) use of Bulk Check Out process in Clusters 1 and 6;

(vii) clinical practice variation in Clusters 7 and 8;

(viii) medical leadership and accountability in Clusters 8, 9 and 10;

(ix) workforce constraints (administration/nursing/medical) in Cluster 1 (medical), 6 (administration), 7 (medical), 8 (medical), 9 (medical and administration) and 10 (medical and administration);

(x) limited development of operational procedures in Cluster 8;

(xi) poor change management e.g. lack of effective consultation in Cluster 6, 7 and 8; and

(xii) governance structure not providing clear accountability for actions in Cluster 6 onwards.

(b) Clinical Governance:

(i) failure to undertake a detailed analysis to identify the underlying causes and process failures in Cluster 6 onwards;

(ii) limited understanding of the underlying causes of events in Cluster 6 onwards;

(iii) incomplete action in relation to clinical staff escalations in Cluster 6;

(iv) limited management of CIRs by assuming that actions from initial reviews applied across new incidents. Namely, the completion of these was managed as a compliance exercise, and in that sense, as a necessary transaction, rather than a process for identifying system improvement opportunities in Cluster 8;

(v) limited awareness of Patient Safety Net escalations in Cluster 9;

(vi) limited engagement with "look back" processes to identify all affected patients despite recommendations to do so in the context where affected patients could have potential malignancies from Cluster 1 onwards; and

(vii) limited actions to address closed loop reporting including results not being reviewed following a procedure (when performed) by the ordering clinician, patients not being rebooked for OPD appointment following outsourced procedures and to identify all patients affected by an incident or process failure in Cluster 7.

(c) Corporate Governance:

(i) limited tracking and management of outsourcing for procedures in Cluster 7;

(ii) limited recognition of the seriousness or significance of the clinical impacts of the adverse events where patients involved presented with actual or potential cancer or organ insufficiency in Clusters 7 and 8;

(iii) limited recognition of the importance of identification of the underlying cause for clinical incidents in Clusters 6 and 8;

(iv) limited recognition of the impact of executive movements and a series of officers in acting positions, at a time when clusters were being actively managed in Clusters 6, 7, and 8;

(v) limited recognition of the interconnectedness of the clinical incidents in Cluster 6 onwards; and

(vi) limited recognition of the importance of seeking external advice in relation to the assessment and management of clusters that were of a serious nature.

7.7.2 Issues of Concern Identified by THHS

249. Of the issues of concern identified by the Investigators, the THHS identified similar issues in their reviews of the cluster CIRs. The following is a list of the issues of concern identified by the THHS.

250. The THHS principally identified issues relating to operational management in the work unit.

(a) Operational Management relating to the work unit:

(i) human error – Clusters 1, 6, 7, 9 and 10;

(ii) breakdown in the local rebooking processes (when specific procedure not in place) – Clusters 1, 6, 8, 9 and 10;

(iii) breakdown of administration procedures (not compliant with SOSIS) (Outpatient Appointment Management Procedure) – Clusters 6 and 10;

(iv) lack of Clinical Management Guidelines for high risk patients – Cluster 8;

(v) noncompliance with procedures in place – Clusters 8, 9 and 10;

(vi) use of the Bulk Check Out process – Clusters 1 and 6;

(vii) medical leadership and accountability – Clusters 8, 9 and 10; and

(viii) workforce constraints – administration/nursing/medical – Cluster 1 (medical), 6 (administration), 7 (medical), 8 (medical), 9 (medical and administration) and 10 (medical and administration);

(b) Clinical Governance:

(i) limited actions to address Closed Loop Reporting including results not having been reviewed following the procedure (when performed) by the ordering clinician and patients not being rebooked for OPD appointment following outsourced procedures – Cluster 7; and

(c) Corporate Governance:

(i) limited tracking and management of outsourcing for surgery and procedures – Cluster 7.

251. The Investigators note that in several papers presented to executive and Board committees the THHS describes issues of concern as “unwarranted variations“ or “variations”. The Investigators have retained this terminology in this Report where it was used by the THHS.

7.7.3 Summary of Issues of Concern Underpinning Clusters

252. Based on this thematic analysis, the Investigators have formed the view that if the review of Cluster 6 in November 2023 had been more comprehensive and included a methodology that examined the underlying causes of adverse incidents, and had the actions flowing from this, had a stronger change management focus then subsequent clusters (particularly Clusters 9 and 10) may have been avoided.

253. The Investigators also observe that the THHS may have underestimated the risks associated with outpatient services and viewed them as lower risk service areas. The Investigators observe that THHS did not seek to identify patterns across clusters.

254. COO 1 agreed that workforce issues, outpatient booking process weaknesses, gaps in documentation and administrative errors led to some urology patients being delayed to care, and in some instances potentially lost to service. They noted this was a key concern of the THHS from 2022 onwards and was the impetus behind the considerable body of work they initiated during 2022 – 2024.[95]

[95] Consulted Parties' Natural Justice Response.

Part C - Responding to the TOR

Section 8 - Governance: Policies, Procedures, Standards and Processes

8.1 Overview

255. In this section, the Investigators have addressed TOR 3.1(a)(i) - (vi) which requires the Investigators to review relevant clinical and administrative policies and procedures and standards relating to the delivery of urology services at TUH, THHS, from initial referral to diagnosis and treatment during the relevant period and considering:

(a) whether appropriate policies and procedures were in place, including in relation to:

(i) the management of urology patient outpatient waitlists;

(ii) management of external diagnostic testing;

(iii) monitoring and reporting these results and use and functionality of the Outpatient Dashboard; and

(iv) use of MDTs;

(b) whether there was compliance with existing policies, procedures, and standards;

(c) the extent of any non-compliance with the policies, procedures, and/or standards, including whether this had any impact on the quality of care provided to patients;

(d) the efficiency of processes from initial referral to diagnosis and treatment;

(e) the extent the demand for urology services at TUH exceeded the capacity of TUH and the impact of this on times between reviews;

(f) any processes that fell below expected standards and/or were not consistent with or in compliance with required policies, procedures, and standards, as identified by the Investigators;

(g) whether issues of concern were identified and escalated effectively; and

(h) whether appropriate actions were taken to address any issues of concern.

256. Accordingly, while the issues canvassed in this section are varied, they are inherently interconnected and warrant collective discussion to draw meaning. To assist the reader to navigate this assessment, the Investigators take this opportunity to explain the approach that they have taken in this section of the Report.

257. For the Investigators to assess the relevant clinical and administrative policies and procedures and standards relating to the delivery of urology services at TUH, in this section, the Investigators have examined the following:

(a) the Investigators assessed the appropriateness of TUH policies, procedures and guidelines, in place during the relevant period, that related to the management of urology outpatient waitlists; the management of external diagnostic testing; the monitoring and reporting of these results, the use, and the functionality of the Outpatient Dashboard; and use of MDTs against the statewide requirements. These are set out in Sections 8.2 and 8.3 of this Report;

(b) the Investigators assessed compliance with existing policies, procedures, and standards by reviewing various incident reports, through witness evidence and by

visiting operational areas within the TUH to observe firsthand the management of clinical and administrative activities. The Investigators understood compliance to mean the extent to which TUH staff were compliant with and followed TUH and THHS policies and procedures during the relevant period. Areas of non-compliance were identified and set out in Section 8.4 of this Report;

(c) the Investigators assessed efficiency of processes from referral to diagnosis and treatment. The Investigators relied on their experience with respect to the provision of health services and compared this to the arrangements that were in place in TUH, THHS during the relevant period. Where processes fell below expected standards this is set out in Section 8.5 of this Report;

(d) with respect to assessing the extent of demand for urology services at TUH against the capacity of TUH, the Investigators first established Statewide workforce levels for urology services to benchmark against. The Investigators also considered outpatient waiting list data, the elective surgery waiting list data and the QH performance indicators and workforce benchmarks, respectively. This is set out in Section 8.6 of this Report; and

(e) with respect to whether concerns were identified and escalated effectively and whether appropriate actions were taken, this was assessed by the Investigators by reviewing incident reports, information recorded in Riskman and witness evidence. This information is set out in Section 11 of this Report where complaint management is discussed in detail.

SUMMARY: Key observations, findings, and conclusions in relation to the policies, procedures, standards and processes relating to the TUH urology service

Appropriate policies and procedures in place

<u>Management of outpatients</u>

(a) The Investigators identified the key Statewide standards relating to the management of outpatient waiting lists as:

(i) Specialist Outpatient Services Implementation Standard (**SOSIS**);

(ii) Elective Surgery Services Implementation Standard (**ESIS**);

(iii) Specialist Outpatient Services (**Policy**); and

(iv) Provision of Diagnostic Imaging Reports (**Guideline**).

(b) With respect to the management of urology outpatient waitlists, the THHS policies and procedures relating to outpatient services were compared with the relevant elements of the SOSIS. This assessment demonstrated that the current overarching policy is compliant and is supported by relevant procedures.

(c) Despite current compliance, the THHS had only developed relevant operational procedures in the period late 2024 to 2025. This is despite SOSIS having been in place since 2016, a PricewaterhouseCoopers (**PwC**) Failure to Attend (**FTA**) Internal Audit dated June 2023 identifying misalignment with SOSIS compliance, and a Draft RATP for Lost to Service dated June 2023 further underscoring the risk. Further, a subsequent Waitlist Management Internal Audit by Scyne Advisory in March 2024 was consistent with the findings of the PwC FTA Internal Audit from June 2023 and identified deviations from the SOSIS standard.

Management of diagnostic testing

(a) To the Investigators' knowledge, there are no QH standards specifically relating to management of external diagnostic testing including monitoring and reporting test results within urology services.

(b) With respect to the management of internal diagnostic testing, this was assessed against the processes embedded in the EMR. The system is designed so that diagnostic information flows directly into the patient record in real time, supporting clinical decision-making. The results viewer (PowerChart) is the primary location where clinicians view and acknowledge results. Within TUH, during the relevant period, there was a low level of digital endorsement through EMR, in the order of 65%, for digital result acknowledgement. It was also noted that of the relevant witnesses interviewed none were able to detail how the THHS was addressing this low level of compliance.

(c) With respect to requests directed to private radiology services by the Medical Imaging Service (**MIS**), these requests are recorded in the THHS radiology information system, however, the referrals for specialised procedures are not actively managed. Where requests are directed to private radiology services by staff directly, they are not tracked through the THHS radiology information system.

(d) Monitoring and reporting of private outsourcing results represents an area where report tracking was recognised as being problematic. This is an area of concern statewide and the subject of a review being led by QH.

(e) There were rudimentary systems in place to ensure that private test results are reviewed and endorsed by clinical staff. The processes that they had in place to track private results was not considered to be robust by the Investigators. This arrangement has and continues to lead to patients experiencing Disrupted Care.

(f) The Investigators also note the statewide work being undertaken in relation to closed loop results reporting and that THHS is participating in this activity.

(g) The management of diagnostic testing was problematic as there is suboptimal use of the EMR results reporting and validation function. Separately, there are patients referred for investigations privately who do not have their requests tracked, recorded in, or reported on through the EMR.

Outpatient Dashboard

(a) The Outpatient Dashboard draws on linked data from the EMR and Hospital Based Corporate Information System (**HBCIS**) via the QH enterprise data warehouse. It provides, amongst other functions, a reporting capability that identifies patients that are potentially experiencing Disrupted Care.

(b) The Outpatient Dashboard is part of a suite of tools used by the TUH and the reporting functionality is developed locally so that TUH is positioned to respond to local issues.

(c) The Outpatient Dashboard was demonstrated to the Investigators and was considered to provide the THHS with the necessary reporting functionality.

Use of MDT

(a) To the Investigators knowledge there are no QH standards specifically relating to the use of MDTs within urology services. However, there are national guidelines which provide a framework for MDTs.

(b) THHS has an MDT framework (March 2024) in place and a Genitourinary/Urology MDT in operation. The THHS policy is consistent with the NSQHS Standards.

(c) THHS Cancer Services have a Genitourinary/Urology MDT in place to review the management of patients with urological disease. From the information provided to the Investigators, the attendance by urologists at this Genitourinary/Urology MDT was consistent but has decreased over time reflecting the decrease in urology medical officers.

(d) The Investigators consider that the policy framework in place in relation to MDT management at the TUH was appropriate. Attendance at the relevant MDT of staff from urology services will be important to maintain.

Compliance with policies, procedures and standards

(a) The Investigators focused their assessment on the issues of concern when assessing staff compliance with existing policies, procedures, and standards within urology services at TUH and whether this had any impact on the quality of care to patients.

(b) Assessing compliance against the relevant THHS procedures was difficult as many of the key procedures had only been recently finalised and implemented and had not been reviewed since their implementation.

(c) As such the Investigators considered that the information that they obtained through witness evidence during the operational site visit to the urology outpatient area on 3 November 2025 in conjunction with other evidence to be a guide to compliance during the relevant period. During this visit, the Investigators were able to observe the process flows in the work area and received evidence that those process flows had remained largely unchanged from those that were in place during the relevant period.

(d) There had been a level of non-compliance from some medical staff with respect to categorisation of new GP Outpatient Referrals within five working days as required by SOSIS and non-compliance with the requirement to document care plans in the EMR as advised in the Bulk Check Out memorandum in December 2023 to cease Bulk Check Outs.

(e) Staff also advised that there had been a variable level of completion of the Post Discharge Appointment Request (**PDAR**) form in the service as was required after the QH Refer system was implemented. Staffing limitations were said to have contributed to these discrepancies. The Investigators consider this posed a risk.

Process from initial referral to diagnosis and treatment

(a) Within the THHS, the referral process is managed through the North Queensland Referral Hub (**NQRH**) which coordinates patient referrals across the THHS as well as specialist referrals from adjacent HHSs. The NQRH approach to managing referrals was comprehensive and mitigated risks of patients experiencing Disrupted Care or having their care significantly delayed.

(b) The Investigators noted that:

(i) during the relevant period, the medical staff working in urology services could not actively manage the volume of new referrals received from NQRH in accordance with the QH or THHS policies and procedures and that consequently some Category 1 patients were significantly delayed in receiving care. These requirements relate to a professional standard;

(ii) urology services did not have defined (and documented) pathways in place for patients presenting with haematuria, a pathway for specialised clinics (e.g. the Flexible Cystoscopy Surveillance Clinic, the Continence Clinic, Registrar Review Clinic) or for Stent Tracking; and

(iii) the rebooking process for patients attending the outpatient's area for urology services was not functioning at a high level.

(c) The information was gleaned from the site visit and discussions with staff from urology services and with executives from THHS. This information did not provide the Investigators with the sense that there were systematised patient flow processes in place during the relevant period in the urology service that would support the delivery of urology services. Staff indicated that there had previously not been resourcing available to assist with this work.

(d) There were changes to the rebooking process for patients attending the outpatient's area for urology services. Despite a directive issued by COO 2 in December 2023 to cease the Bulk Check Out process and to transition the Service to fully electronic workflows, paper based booking forms continued to be used within the urology service for almost two years. This led to a workload issue delaying data entry into ESM and created the risk that the booking forms could be lost or misplaced resulting in patients experiencing Disrupted Care. In the circumstances, the net effect was that patients were not booked and experienced Disrupted Care. The Investigators note that the use of the booking form was considered by the THHS as being an underlying cause for patients who are connected to or who receive urology services that experienced Disrupted Care in Cluster 6. The continued use of this booking form in the department where it was identified as being a risk was a concern for the Investigators. This variation in practice continued until November 2025.

(e) The Investigators did not consider the implementation of the change management process to be effective. With respect to the paper based booking forms, the continued use of these presented a risk that they may be lost or misplaced resulting in patients experiencing Disrupted Care, as occurred in Cluster 6.

(f) A new electronic form had been created in the EMR for medical staff to complete which included the specific information that administrative staff required to undertake the rebooking process. This represented a positive and secondary corrective action.

(g) The Investigators were informed of difficulties being experienced with the use of the PDAR form. The inconsistent completion of the PDAR form for inpatient or outpatient interventions, surgical procedures and patient discharges resulted in a new group of patients experiencing Disrupted Care. This reflects the effectiveness of the change management processes associated with the introduction of this new electronic form. THHS has advised that there has been corrective action taken in relation to this workflow including an audit that found no patients suffered from adverse outcomes.

(h) The Investigators found that there was a variability in the efficiency of the services provided to THHS urology patients:

(i) with respect to the initial categorisation, delays in categorisation resulted in patients being delayed to their initial appointment. Although constraints relating to the medical workforce existed, the THHS had visibility of this issue and could have considered some form of risk mitigation;

(ii) the NQRH has access to data that demonstrates delays in internal processes within urology OPD as it relates to new referrals that would assist in the management of the referral process. This relates to time to triage and categorise outpatient referrals;

(iii) an area of inefficiency related to the need to "cut and paste" information from various systems which are logically connected to the patient's journey, including from QH Refer, GP referral systems and EMR clinical module into ESM. This presents a risk to the organisation if the transcribing of information is not completed with a high degree of accuracy; and

(iv) at an operational level, a deficiency was identified in the process controls (procedures and guidelines) within the Urology Outpatients area. Although staff in the area are aware of the need to have operational procedures and guidelines in place they had not previously been resourced to develop these. Examples include the bladder cancer clinical pathway, procedures relating to the cystoscopy service and procedures relating to the management of high-risk patient cohorts such as those patients with abnormal histology.

(i) Since the site visit the Investigators have noted that COO 3 has progressed work on describing patient flows through the urology service. This work is ongoing and is presented in Section 12 of this Report.

Demand and capacity for urology services

(a) Resourcing of the urology services was a theme that came through during interviews with staff.

(b) In summary the TUH had a shortfall of 1.7 FTE for urologists (Approved FTE 3.5 and occupied FTE 1.8).

(c) When assessed against the combined drainage population, Cairns Hospital and TUH collectively have a workforce ratio (approximately 1.6 to 2.0) below the commonly referenced benchmark of 2.2 to 2.3 urologists per 100,000, which is not sufficient to meet potential future clinical demand.

(d) Specifically for TUH, the estimated shortfall in urologists is estimated to be 2.0 FTEs (including the current urology vacancies at TUH).

(e) It is the view of the Investigators that the level of staffing in the Urology Outpatient Service was below the level that would be reasonable and necessary for the service to operate efficiently and safely. This may have been as consequence of challenges with medical recruitment.

(f) The Investigators note that the waiting list data for THHS as at 26 September 2025 was:

(i) 125 Category 1 urology patients who needed to be seen were long wait (on a waitlist of 135);

(ii) 307 referrals to urology needed to be reviewed, of which 271 had waited longer than five days;

(iii) 23 Category 1 urology patients who need surgery are long wait (on a waitlist of 103); and

(iv) a significant number of patients are overdue for appointments, with 25% of the total THHS patients waiting outside of time as identified by the OPD Waiting List audit.

(g) It is noted that the workforce constraints and the non-compliance with the policies, procedures and standards in the delivery of urology services had an impact on the quality of care provided to patients. This resulted in patients experiencing Disrupted Care as detailed in Section 9 of this Report.

(h) Addressing workforce constraints will require a combination of targeted recruitment, strengthened training pathways, and redesigned models of care. Opportunities exist to expand trainee positions, develop extended scope nursing roles, and implement shared care pathways with GPs and general surgeons.

8.2 Applicable Statewide Policies, Procedures, Standards and Codes

258. The Investigators identified the following standards and policies which are relevant to urology services and are expected to be met by all HHSs. These standards represent the overarching policies that HHSs align with when developing their local policies and procedures relating to the management of outpatient waiting lists, management of external diagnostic testing including monitoring and reporting test results, the use and functionality of the TUH THHS Outpatient Dashboard and the use of MDTs within the service:

(a) SOSIS;[96]

(b) ESIS;[97]

(c) Specialist Outpatient Services (Policy);[98] and

(d) Provision of Diagnostic Imaging Reports (Guideline).[99]

259. To the Investigators' knowledge there are no QH standards specifically relating to: management of external diagnostic testing including monitoring and reporting test results, the use and functionality of outpatient dashboards or the use of MDTs within urology services.

260. Further to the standards above, the Investigators have considered the following codes which are the professional standards that set out the requirements for clinicians in their clinical practice and relevantly, require compliance with all relevant standards and policies as outlined in Section 8.2.3 onwards:

(a) National Code of Conduct for Health Care Workers (Queensland);[100] and

(b) Good Medical Practice: A Code of Conduct for Doctors in Australia.[101]

261. Each of these standards, policies and codes are summarised below so that the reader can identify their key elements.

8.2.1 Specialist Outpatient Service Implementation Standard

262. The SOSIS[102] is a comprehensive document developed by QH. It was first issued in 2016 and was applicable during the relevant period. It sits under the recently developed Specialist

[96] QHT.001.001.0019 Queensland Health, *Specialist Outpatient Services Implementation Standard*, Document Number QH-IMP-300-1, 22 March 2023. Electronic copy available at: https://www.health.qld.gov.au/__data/assets/pdf_file/0029/164756/qh-imp-300-1.pdf.
[97] Queensland Health, *Elective Surgery Services Implementation Standard,* Document Number QH-IMP-342-1:2017, 6 November 2017. Electronic copy available at: https://www.health.qld.gov.au/__data/assets/pdf_file/0027/397440/qh-imp-342-1.pdf.
[98] Queensland Health, *Specialist outpatient services Department of Health Policy*, 4 April 2025. Electronic copy available at: https://www.health.qld.gov.au/__data/assets/pdf_file/0027/396117/qh-pol-300.pdf.
[99] Queensland Health, *Provision of Diagnostic Imaging Reports*, Document Number: QH-GDL-017-2015, 30 November 2016. Electronic copy available at: https://www.health.qld.gov.au/__data/assets/pdf_file/0029/147386/qh-gdl-017.pdf.
[100] Queensland Health, *National Code of Conduct for Health Care Workers* (Queensland), 1 October 2015. Electronic copy available at: https://www.careers.health.qld.gov.au/__data/assets/pdf_file/0027/188442/national-code-conduct-health-workers.pdf
[101] Medical Board AHPRA, *Good medical practice: a code of conduct for doctors in Australia,* 1 October 2020. Electronic copy available at: https://www.medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx.
[102] QHT.001.001.0019 Queensland Health, *Specialist Outpatient Services Implementation Standard*, Document Number QH-IMP-300-1, 22 March 2023. Electronic copy available at: https://www.health.qld.gov.au/__data/assets/pdf_file/0029/164756/qh-imp-300-1.pdf.

Outpatient Service Policy (2025)[103] and is aligned with the Provision of Diagnostic Imaging Reports.[104]

263. Specialist outpatient services are designed for the assessment and management of conditions requiring specialist expertise beyond the capabilities of primary healthcare or community settings. These services include the investigation, diagnosis, treatment, and management of complex healthcare conditions in non-admitted settings. The SOSIS applies to all employees, contractors, and consultants within Queensland HHSs, departmental divisions, and commercialised business units involved in providing specialist outpatient services. It covers both new and review appointments. In cases where non-admitted procedural services cannot be managed within the SOSIS framework, existing guidelines such as the ESIS are referenced.

264. The provision of specialist outpatient services in Queensland public HHSs must align with the National Healthcare Agreement[105] and HHS Service Agreements. Key principles include:

(a) patient and carer-centred care;

(b) equitable and transparent service delivery;

(c) proximity of care to the patient's residence;

(d) timely treatment within clinically recommended time limits;

(e) continuity of care with the same clinician or team whenever possible;

(f) coordinated care, follow-up, and discharge planning;

(g) development of agreed care pathways and treatment plans in partnership with patients;

(h) empowering patients to make informed decisions about their care;

(i) transparent record-keeping and reporting;

(j) effective communication with patients, referring practitioners, and GPs;

(k) consideration of hardship and extenuating circumstances; and

(l) collaboration with private service providers.

265. With respect to the above principles, the Investigators consider that the principles identified in (d), (f), (g), (i), (j) and (l) to be most relevant.

Eligibility

266. Specialist outpatient services are available to patients who meet the following criteria:

(a) possession of a valid referral;

(b) patients require specialist assessment and management beyond primary healthcare capabilities; and

[103] Queensland Health, *Specialist outpatient services Department of Health Policy*, Document Number QH-POL-300, 4 April 2025. Electronic copy available at: https://www.health.qld.gov.au/__data/assets/pdf_file/0027/396117/qh-pol-300.pdf.
[104] Queensland Health, *Provision of Diagnostic Imaging Reports*, Document Number: QH-GDL-017-2015, 30 November 2016. Electronic copy available at: https://www.health.qld.gov.au/__data/assets/pdf_file/0029/147386/qh-gdl-017.pdf.
[105] QHT.001.001.0019 Queensland Health, *Specialist Outpatient Services Implementation Standard*, Document Number QH-IMP-300-1, 22 March 2023, page 4. Electronic copy available at: https://www.health.qld.gov.au/__data/assets/pdf_file/0029/164756/qh-imp-300-1.pdf.

(c) the referral must meet the minimum thresholds specified in the Clinical Prioritisation Criteria (**CPC**)[106] or local referral guidelines. Eligible patients include Medicare beneficiaries, compensable patients, private patients referred to HHS staff specialists, and Medicare-ineligible patients at the discretion of the HHS. Medicare-ineligible patients may be guided to private facilities.

Access

267. Access to publicly funded specialist outpatient services requires patient registration on the corporately endorsed specialist outpatient waiting list of a HHS. HHSs are responsible for providing services to their geographic catchment population as defined in their Service agreements with QH. Patients outside the catchment area may be accepted if the service is unavailable locally or closer to their residence. Vulnerable population groups are prioritised according to relevant policies. HHSs must monitor demand and capacity to ensure timely access to services and investigate alternative arrangements if capacity is insufficient.

Service Continuity

268. HHSs must maintain continuity for services agreed upon in their Service Agreements. If services are suspended or discontinued for more than 30 days, the HHS must notify the QH and impacted services within five business days. Patients on the waiting list for discontinued services must be treated elsewhere within clinically recommended timeframes. Outreach services, which are delivered outside the HHS area, must ensure reliable delivery within recommended timeframes.

Duty of Care

269. Once a referral is received, the HHS assumes a duty of care toward the patient, which includes providing clinically appropriate care within recommended time limits, maintaining communication, and responding to changes in the patient's condition. The duty of care continues until the patient completes their initial consultation or treatment.

Referral Management

270. Access to specialist outpatient services is granted through written referrals from recognised sources, including GPs, medical officers, nurse practitioners, midwives, and allied health practitioners. Referrals must contain adequate information for safe transfer of care and comply with CPC or local guidelines. Internal referrals are accepted only for Category 1 patients and must meet specific criteria. Associated care referral requests are exempt from the 30-day rule and are categorised based on clinical urgency.

Waiting List Registration and Management

271. All referrals must be entered into a corporately endorsed referral management system and recorded on a waiting list management system. Patients are categorised based on clinical urgency, with three defined categories:

(a) category 1: appointment required within 30 days;

(b) category 2: appointment required within 90 days; and

(c) category 3: appointment required within 365 days.

272. Patients are classified as either "ready for care" or "not ready for care". "Not ready for care" status may be applied for clinical, personal, or staged reasons, with specific thresholds for

[106] Queensland Health, *Clinical prioritisation criteria,* last updated 4 December 2024. Webpage can be accessed here: https://www.health.qld.gov.au/cpc.

deferment periods. HHSs must conduct regular audits to ensure accurate waiting list records and remove patients who no longer require care.

Booking and Scheduling Management

273. Appointments are prioritised based on clinical urgency and scheduled within recommended timeframes. Patients within the same urgency category are seen in the order they are placed on the waiting list, considering factors such as acuity, comorbidities, and social circumstances. Standby patients may be identified for short-notice appointments, and processes are in place to manage hospital-initiated and patient-initiated cancellations. Patients who fail to attend confirmed appointments or decline offers twice may be removed from the waiting list.

Transferring and Outsourcing Patients

274. HHSs must monitor waiting times and take action to ensure timely treatment. Internal options, such as increasing clinic capacity or transferring care within the same HHS, should be explored before considering external options like transferring patients to other public facilities or outsourcing to private providers. Transfers and outsourcing must prioritise patient interests and ensure treatment within recommended timeframes. Patients must provide consent for outsourcing and their clinical records must be appropriately managed.

Removals and Discharge

275. Patients may be removed from the waiting list for various reasons, including completion of treatment, patient request, or failure to meet eligibility criteria. Discharge or transfer of care occurs when the single course of treatment is completed, or another provider can better manage the patient's care. Discharge planning begins at the initial consultation and includes providing a summary to the referring practitioner.

Validation of Waiting Lists

276. HHSs must maintain accurate records of waiting list information, including changes to clinical urgency categories, ready-for-care status, and appointment dates. Regular administrative and clinical audits are conducted to ensure the accuracy of waiting lists and remove patients who no longer require care.

Communication Requirements

277. Effective communication is essential for ensuring patient safety and collaborative care. HHSs must provide patients with information about their rights, responsibilities, appointment details, and waiting list status. Referring practitioners and GPs must be kept informed about patient progress, changes in urgency categories, and discharge or transfer of care. Special considerations are made for patients from Queensland Corrective Services to ensure security and confidentiality.

Reporting Requirements

278. HHSs are required to monitor and report on various metrics, including waiting times, cancellations, failure-to-attend rates, and removal reasons. Regular reviews and analyses of waiting lists help identify capacity issues and ensure sustainable waiting times.

Cancellations

279. Hospital-initiated cancellations must be promptly communicated to patients and new appointments must be scheduled as soon as possible. Patients should not experience multiple hospital-initiated cancellations that result in delays beyond clinically recommended timeframes.

280. In summary, the SOSIS establishes business rules and processes for ensuring equitable access to specialist outpatient services within the Queensland public hospital system. It provides best practice waitlist management and scheduling processes to facilitate timely treatment for patients

within clinically recommended timeframes. The standard complements professional self-regulation and clinical judgment, which are integral to healthcare delivery. It is noted that HHSs have a duty of care to patients once a valid referral is received, must keep accurate records, must audit their waiting lists and must manage service demands.

8.2.2 Elective Surgery Implementation Standard

281. The ESIS[107] issued by the QH provides a structured framework for managing elective surgery services in public hospitals across Queensland. It aims to ensure equitable access to elective surgery and best-practice waitlist management, enabling treatment within clinically recommended timeframes. The standard complements professional self-regulation and clinical judgment, which remain essential components of healthcare delivery. The key points are:

(a) Elective surgery refers to planned surgical procedures scheduled in advance following a specialist clinical assessment. Patients requiring such procedures are placed on an elective surgery waiting list. The standard applies to all patients registered on elective surgery waiting lists at Queensland public hospitals, referred to as HHSs. Compliance is mandatory for all employees, contractors, and consultants involved in elective surgery services.

(b) Certain services are excluded from the standard, including emergency surgery, elective caesareans, medical inductions of labour, procedures not publicly funded in Queensland and surgeries excluded from the national definition of elective surgery. However, the standard may serve as a guide for managing out-of-scope services unless other guidelines apply.

(c) Elective surgery services must align with the National Healthcare Agreement and HHS Service Agreements. Key principles include patient-centred care, equitable and transparent service delivery, treatment within clinically recommended time limits, continuity of care, informed decision-making, and effective use of resources. Transparent record-keeping and timely communication with patients and practitioners are also emphasised.

(d) Eligible patients must be referred via a valid referral, registered on an elective surgery waiting list, and have a condition requiring surgery that cannot be managed by a primary healthcare practitioner. Medicare-eligible patients, compensable patients, and private patients referred to HHS staff specialists or Visiting Medical Officers (**VMO**) are included. Medicare-ineligible patients may be treated at the discretion of the HHS, provided that payment arrangements are in place.

(e) Access to publicly funded elective surgery is contingent on registration on an HHS elective surgery waiting list. HHSs must accept referrals from outside their geographic catchment if the required service is unavailable locally. Disputes regarding service provision should be escalated to the HSCE or QH.

(f) Patients may only be registered on an elective surgery waiting list after the listing surgeon confirms the need for surgery, the patient's readiness, and informed consent is obtained. Registration must include detailed information such as patient identification, procedure details, urgency category, and consent status.

(g) Patients should be treated in the order they were added to the waiting list within their urgency category. At least 60% of patients in each category must be treated in waiting time order.

PART A

PART B

PART C

[107] Queensland Health, *Elective Surgery Services Implementation Standard,* Document Number QH-IMP-342-1:2017, 6 November 2017. Electronic copy available at: https://www.health.qld.gov.au/__data/assets/pdf_file/0027/397440/qh-imp-342-1.pdf.

(h) Hospitals must notify patients of cancellations, reschedule surgeries promptly, and ensure patients are treated within clinically recommended time limits. Urgent category 1 patients should not be postponed without executive approval.

(i) Patients who cancel or decline surgery dates twice may be removed from the waiting list unless extenuating circumstances apply. Written notification of removal must be sent to the patient, treating surgeon, and referring practitioner.

(j) Patients may be transferred to another public hospital if it offers shorter waiting times or has the required clinical capability. Waiting times accrued at the original hospital must be carried over.

(k) Patients may be outsourced to private facilities under locally negotiated or state-wide contracts. Outsourced patients are reported as removed from the waiting list but must still be treated within clinically recommended timeframes.

(l) HHSs must conduct regular administrative and clinical audits to ensure the accuracy of waiting lists. Audits should verify patient readiness for surgery, urgency categorisation, and contact details.

282. In summary, the ESIS provides a robust framework for managing elective surgery services in Queensland public hospitals by prioritising access based on clinical appropriateness through the efficient management of elective surgery waiting lists.

8.2.3 National Code of Conduct for Health Care Workers (Queensland)

283. The National Code of Conduct for Health Care Workers (Queensland)[108] was implemented on 1 October 2015 and is referenced in section 5 of the *Health Ombudsman Regulation 2024* (Qld).

284. It requires that health care workers, deliver services safely and ethically, maintaining competence in their field, avoiding practices outside their qualifications, and prescribing treatments that meet client needs. They must recognise their limitations, refer clients to other providers when necessary, and encourage clients to seek additional opinions. Workers must also understand potential adverse interactions between treatments and medications and provide culturally sensitive care.

285. Health care workers must obtain appropriate consent before commencing treatment, ensuring compliance with jurisdictional laws. They must respect clients' rights to make informed health care decisions, avoid dissuading clients from seeking medical treatment, and collaborate with other health providers in the clients' best interests.

8.2.4 Good Medical Practice: A Code of Conduct for Doctors in Australia

286. The purpose of the Good Medical Practice Code[109] is to describe what is expected of all doctors registered to practice medicine in Australia. It sets out the principles that characterise good medical practice and makes explicit the standards of ethical and professional conduct expected of doctors by their professional peers and the community. The code was developed after wide consultation with the medical profession and the community and is intended to support doctors in providing good medical care and fulfilling their professional roles, as well as informing the community about what they can expect from doctors. The code complements the Australian

[108] Queensland Health, *National Code of Conduct for Health Care Workers* (Queensland), 1 October 2015. Electronic copy available at: https://www.careers.health.qld.gov.au/__data/assets/pdf_file/0027/188442/national-code-conduct-health-workers.pdf.
[109] Medical Board AHPRA, *Good medical practice: a code of conduct for doctors in Australia*, 1 October 2020, at subsection [1.1]. Electronic copy available at: https://www.medicalboard.gov.au/codes-guidelines-policies/code-of-conduct.aspx.

Medical Association Code of Ethics[110] and aligns with the values of the Declaration of Geneva[111] and the International Code of Medical Ethics.[112]

287. It covers key areas such as professionalism, providing good care, working with patients, maintaining patient safety, and ensuring doctors' health. The code emphasises the importance of effective communication, trust, cultural safety, and respect in the doctor-patient relationship. It also addresses the responsibilities of doctors in teaching, supervising, and conducting research. This comprehensive guide aims to support doctors in delivering high-quality medical care and maintaining the trust and respect of the community.

288. The principles of good patient care, as outlined in the guideline, include the following:[113]

(a) making the care of patients a practitioner's primary concern and working in partnership with them;

(b) comprehensively assessing patients by considering their history, views, conducting appropriate physical examinations and by formulating and implementing a suitable management plan, including investigations, diagnosis, treatment, and advice;

(c) facilitating coordination and continuity of care, ensuring seamless transitions between different healthcare providers;

(d) referring patients to other practitioners when it is in their best interests and by consulting and taking advice from colleagues when appropriate;

(e) recognising and respecting patients' rights to make their own decisions and supporting their right to seek a second opinion. Providing information in a way patients (or their legal guardians) can understand before obtaining consent;

(f) communicating effectively with patients, providing clear information about their condition and treatment options, and ensuring they understand the information provided;

(g) recognising and working within the limits of their competence and scope of practice and ensuring they have adequate knowledge and skills to provide safe clinical care;

(h) considering the balance of benefit and harm in all clinical management decisions and only recommending treatments with a reasonable expectation of clinical efficacy and benefit for the patient;

(i) taking steps to alleviate patient symptoms and distress, whether a cure is possible;

(j) making responsible and effective use of available healthcare resources; and

(k) ensuring that their personal views do not adversely affect the care of their patient or the referrals they make.

[110] Australian Medical Association, *Code of Ethics 2004*, editorially Revised 2006, revised 2016. Electronic copy available at: https://www.ama.com.au/articles/code-ethics-2004-editorially-revised-2006-revised-2016.
[111] World Medical Association, *Declaration of Geneva*, Adopted by the 2nd General Assembly of the World Medical Association, Geneva, Switzerland, September 1948. Electronic copy available at: http://wma.net/policies-post/wma-declaration-of-geneva/.
[112] World Medical Association, *International Code of Medical Ethics,* Adopted by the 3rd General Assembly of the World Medical Association, London, England, October 1949. Electronic copy available at: https://www.wma.net/policies-post/wma-international-code-of-medical-ethics/.
[113] Medical Board AHPRA, *Good medical practice: a code of conduct for doctors in Australia*, 1 October 2020. Electronic copy available at: https://www.medicalboard.gov.au/codes-guidelines-policies/code-of-conduct.aspx.

8.3 Appropriateness of policies and procedures

289. As set out above, the Investigators are required to assess the appropriateness of TUH and THHS's policies and procedures relevant to the delivery of urology services including in relation to:

(a) the management of urology patient outpatient waiting lists;

(b) management of external diagnostic testing including monitoring and reporting of these results;

(c) use and functionality of the Outpatient Dashboard; and

(d) the use of MDTs.

290. The Investigators have assessed the following policies and procedures against the requirements of the Statewide policies, procedures and standards set out above in Section 8.2:

(a) THHS Outpatient Services Policy (February 2024);[114]

(b) Fail to Attend Specialist Outpatient Services Procedure (Version 2 February 2024);[115]

(c) Review Waiting list – Specialist outpatient services (Version 2 – May 2024);[116]

(d) Outpatient Appointment Management Procedure (Version 2 - June 2025);[117]

(e) Outpatient Clinic Management (Version 1 – October 2024);[118]

(f) Outpatient Waiting list Clinical Audit Process (Version 1 – September 2024);[119]

(g) Outpatient Referral Management (Version 1 – March 2025);[120]

(h) Outpatient Treat in Turn Management (Version 1 - June 2025);[121] and

(i) Outsourcing Public Elective Surgery Patients to Private Providers (Version 2 - August 2024).[122]

291. The Investigators noted that COO 1 advised that from 2023 onwards, THHS produced a suite of policies and procedures which collectively governed outpatient management (including the management of appointments and waitlists).[123] During 2024, these policies and procedures were

[114] THS.001.001.0278 State of Queensland (THHS), *Outpatient Services Policy*, Policy Number THHSCOR171163v6, effective from 2 December 2024.
[115] THS.001.001.0275 State of Queensland (THHS), *Fail to Attend Specialist Outpatient Services Procedure*, Policy Number THHSCLI211503v2, effective from 29 February 2024.
[116] THS.001.001.0279 State of Queensland (THHS*), Review Waitlists - Specialist Outpatient Services*, Policy Number THHSCLI211505v2, effective from 11 June 2024.
[117] THS.001.001.0285 State of Queensland (THHS), *Outpatient Appointment Management*, Policy Number THHSCLI241626v2, effective from 26 June 2025.
[118] THS.001.001.0281 State of Queensland (THHS), *Outpatient Clinic Management*, Policy Number THHSCLI241627v1, effective from 16 October 2024.
[119] THS.001.001.0282 State of Queensland (THHS), *Outpatient Waiting list Clinical Audit Process*, Policy Number THHSCLI241628v1, effective from 15 October 2024.
[120] THS.001.001.0282 State of Queensland (THHS), *Outpatient Waiting list Clinical Audit Process*, Policy Number THHSCLI241628v1, effective from 15 October 2024.
[121] THS.001.001.0286 State of Queensland (THHS), *Outpatient Treat in Turn Management*, Policy Number THHSSUP251665v1, effective from 9 September 2025.
[122] THS.001.001.0280 State of Queensland (THHS), *Outsourcing Public Elective Surgery Patients to Private Providers,* Procedure Number THHSCOR211501v2, effective from 7 August 2024.
[123] Consulted Parties' Natural Justice Response.

further expanded to include the Outpatient Management Procedure (Version 1) which took effect on 16 October 2024, was published on the intranet and distributed to all staff on the same date.

292. There is no specific requirement that the Investigators are aware of for HHSs to have a policy or procedure for the management of external diagnostic testing including monitoring and reporting of these results. THHS did not provide a detailed policy or procedure of this nature to the Investigators however, the Investigators note for completeness that TUH was documenting this via internal workflow documents which are discussed in more detail in relation to Cluster 7 and again in Section 12. There is also a body of work being undertaken after a patient safety notice released by QH on 17 October 2025 in relation to external management of diagnostic testing and results.[124]

293. The Investigators received a presentation on the function and capability of the THHS Outpatient Dashboard during their site visit. During that presentation, the subject matter expert provided advice that THHS has a suite of dashboards operational during the relevant period and which were developed to support staff. These were based on the information contained in the EMR and other administrative information systems.[125] These dashboards are accessed through a single intranet site. Each dashboard has technical materials appended to the website for the specific dashboards explaining how the dashboards are constructed and the source of the data presented.

294. The Investigators could not identify a mandatory requirement for HHSs to develop policies or procedures on the use of MDTs within QH as it relates to urology services. However, there are national guidelines which provide a framework for MDTs and which are discussed below.

8.3.1 Management of urology patient outpatient waitlists

THHS Outpatient Services Policy (February 2024)

295. THHS Outpatient Services Policy establishes the framework for delivering safe, effective, and compliant non-admitted care across all THHS facilities. It mandates that outpatient services be provided in line with the Specialist Outpatient Services Implementation Standard, the National Healthcare Agreement,[126] and the *Human Rights Act 2019* (Qld) (**HR Act**).

296. The policy applies to all staff, contractors, and volunteers engaged in outpatient care, covering services delivered in hospital clinics, community settings, and patients' homes. Compliance is compulsory.

297. Key principles include adherence to national and state service agreements, prioritisation of patient access, and alignment with Standard 5: Comprehensive Care of the NSQHS Standards. Service Group Directors hold responsibility for implementation, including audit of waiting lists, minimisation of cancellations, resource optimisation, and management of patients awaiting care.

298. Risk management is embedded through monthly monitoring of access targets, patient waiting lists, and complaints processes. The outpatient services are overseen by the Outpatient Planned Care Steering Group.

299. Governance oversight of this policy is provided by the Board with delegated authority to the HSCE. It was noted that the policy was due for review in March 2025.

300. The following procedures that are in place within the TUH and relate to outpatient management.

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[124] QHT.001.001.0048 Patient Safety Notice 32/2025, issued on 17 October 2025.
[125] Demonstration to Investigators by BPIO on 6 November 2025. WIT.002.001.0018 Transcript of Interview – Witness AA, paragraphs 18-19.
[126] Australian Government, *National Health Reform Agreement (NHRA), 2020-25*. Electronic copy available online: https://www.health.gov.au/our-work/national-health-reform-agreement-nhra?language=en.

Fail to attend Specialist Outpatient Services Procedure (Version 2 February 2024)

301. The "Fail to Attend Specialist Outpatient Services" procedure at TUH establishes guidelines for managing FTA appointments, aligning with the SOSIS.[127] It aims to optimise clinic resources, improve patient safety, and enhance communication with patients and referring practitioners. Fail to attend events are to be documented in the EMR and EMS. Patients who miss or cancel two confirmed appointments may be removed from the waitlist, with written notification provided. Specific processes address paediatric, correctional facility, and rural/remote patients. Regular audits are required.

Review Waiting list – Specialist outpatient services (Version 2 – May 2024)

302. The procedure titled "Review Waitlists - Specialist Outpatient Services" outlines the management of review appointments for specialist outpatient services at TUH.[128] It aligns with the SOSIS. It aims to optimise clinic resource utilisation and improve patient safety and outcomes. Key processes include maintaining a "just in time" booking approach, utilising the ESM for waitlist management, conducting regular administrative audits, and ensuring clinician oversight for long-wait patients. The procedure was endorsed by THHS leadership and supports compliance with THHSCOR171163 Outpatient Services policy.

Outpatient Appointment Management Procedure (Version 2 - June 2025)

303. The "Outpatient Appointment Management" procedure outlines the THHS approach to managing outpatient services in alignment with the SOSIS.[129] It aims to optimise clinic resource utilisation, enhance patient safety, and improve communication with patients and referring practitioners. The procedure details clinical and administrative requirements for scheduling, actioning, and monitoring appointments using the ESM and EMR. It emphasises cultural considerations for Aboriginal and Torres Strait Islander patients and includes protocols for managing failed appointments, cancellations, and rescheduling. It requires regular audits to ensure compliance and data accuracy.

Outpatient Clinic Management (Version 1 – October 2024)

304. The "Outpatient Clinic Management" procedure outlines the management of outpatient clinic templates and schedules within the THHS.[130] It aligns work practices with the SOSIS. It aims to optimise clinic resources, improve efficiency, and enhance service capacity visibility. The procedure details processes for planned and temporary clinic changes, approval responsibilities, and the use of the ESM system for appointment scheduling. Special considerations include equitable access for Aboriginal and Torres Strait Islander patients. Monitoring and auditing strategies are required to ensure efficient clinic capacity management.

Outpatient Waiting list Clinical Audit Process (Version 1 – September 2024)

305. The "Outpatient Waitlist Clinical Audit Process" procedure outlines the systematic approach for auditing patients awaiting Specialist Outpatient Care within THHS.[131] It ensures clinical oversight and compliance with the SOSIS. Audits are undertaken to assess patient needs, clinical status changes, urgency categories, and readiness for care. Escalation protocols are established for patients experiencing clinical deterioration, with documentation in Riskman for incidents of delayed care. The procedure emphasises the use of monthly audits, tiered reviews for long-wait

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[127] THS.001.001.0275 State of Queensland (THHS), *Fail to attend Specialist Outpatient Services Procedure*, Policy Number THHSCLI211503v2, effective from 29 February 2024.
[128] THS.001.001.0279 State of Queensland (THHS), *Review Waitlists - Specialist Outpatient Services*, Policy Number THHSCLI211505v2, effective from 11 June 2024.
[129] THS.001.001.0285 State of Queensland (THHS), *Outpatient Appointment Management*, Policy Number THHSCLI241626v2, effective from 26 June 2025.
[130] THS.001.001.0281 State of Queensland (THHS), *Outpatient Clinic Management*, Policy Number THHSCLI241627v1, effective from 16 October 2024.
[131] THS.001.001.0282 State of Queensland (THHS), *Outpatient Waiting list Clinical Audit Process*, Policy Number THHSCLI241628v1, effective from 15 October 2024.

patients, and collaboration between clinical auditors and the Waitlist Management Team. The process aligns with relevant policies and supports patient safety and timely care delivery.

Outpatient Referral Management (Version 1 – March 2025)

306. The THHS "Outpatient Referral Management" procedure outlines the process for managing patient referrals to specialist outpatient services, ensuring alignment with the SOSIS. The procedure aims to optimise clinic resource utilisation, enhance patient safety, and improve communication with patients and referring practitioners.[132] It mandates a structured referral process, including intake, clinical review, categorisation, acceptance, and waitlist management, with defined time limits and responsibilities. Compliance is monitored through dashboards and audits, with escalation protocols for unresolved issues. The procedure supports efficient referral processing and adherence to CPC.

Outpatient Treat in Turn Management (Version 1 - June 2025)

307. The "Outpatient Treat in Turn" procedure outlines the management of waitlists and patient appointments for outpatient services within the THHS.[133] It aligns with the SOSIS. It aims to ensure equitable access, improved patient experience, reduced waiting time breaches, and enhanced transparency in referral and booking processes. Referrals are triaged using the Smart Referrals Workflow Solution and categorised by clinical urgency. Appointments are allocated based on Treat by Date, prioritising category 1 patients, and ultra-long wait patients. Monitoring and audit strategies are required to ensure compliance with the 70-85% treat-in-turn benchmarks.

Outsourcing Public Elective Surgery Patients to Private Providers (Version 2 - August 2024)

308. This THHS procedure governs the outsourcing of public elective surgery patients and establishes a standardised, transparent framework for transferring eligible patients from the public elective surgery waiting list to private providers, either directly or through the statewide Surgery Connect program.[134] The intent is to ensure timely access to surgery, maintain equity, and support demand management across the health service.

309. The process begins with the generation and auditing of specialty waitlists to identify patients suitable for outsourcing based on clinical criteria, surgeon availability, and approved procedure types. A structured clinical review confirms suitability, supported by defined inclusion, consideration, and exclusion criteria relating to age, BMI, anaesthetic risk, comorbidities, social supports, and procedural complexity.

310. Once identified, patients are contacted, informed of the outsourcing process, and consent is obtained to transfer their information to private facilities. Staff must verify patient details across HBCIS and EMR, cancel any preadmission appointments, and compile a comprehensive patient pack containing all relevant clinical and administrative documentation. Outsourcing activity is tracked through spreadsheets and recorded in HBCIS using designated outsourcing codes.

311. Finance approval is required for all directly outsourced cases, with weekly submission of patient lists to the SSG for endorsement. Following surgery, private providers return clinical documentation for scanning into the patient record, and waitlist entries are updated to reflect treatment or returned to the public list. Returned patients are managed through defined administrative steps, including reinstatement to the THHS waitlist and notification of finance.

[132] THS.001.001.0283 State of Queensland (THHS), *Outpatient Referral Management*, Policy Number THHSSUP251652v1, effective from 31 March 2025.
[133] THS.001.001.0286 State of Queensland (THHS), *Outpatient Treat in Turn Management*, Policy Number THHSSUP251665v1, effective from 9 September 2025.
[134] THS.001.001.0280 State of Queensland (THHS), *Outsourcing Public Elective Surgery Patients to Private Providers,* Policy Number THHSCOR211501v2, effective from 7 August 2024.

312. The procedure also outlines the separate pathway for Surgery Connect, which applies minimum wait time thresholds and uses a dedicated referral and documentation system (SCAN). Ophthalmology was the only specialty utilising this program in Townsville.

313. Overall, the procedure provides a detailed operational framework that supports consistent decision making, ensures appropriate patient selection, maintains governance oversight, and facilitates efficient coordination between THHS and private providers to improve elective surgery access.

8.3.2 THHS assessment of internal outpatient procedures

314. Assessing internal procedures within a HHS can be a complex process. However, the Investigators note that the THHS has undertaken reviews of outpatients' procedures within the THHS. This included a suite of reports presented to the Access to Planned Care Leadership Group (**APCLG**) in August 2023.[135] The catalyst for these activities included the identification of a bundle of unprocessed booking forms found within the SSG (referred to as Cluster 6 within this Report), and that patients had exceeded clinically recommended wait times without any clinical oversight or reconciliation of their position on the waitlist.

315. A summary of these reports is as follows:

(a) the PwC FTA Internal Audit Report[136] dated June 2023 confirmed that a lack of a risk-based approach to managing outpatient care was systemic. The Investigators noted that the audit report identified that over a 12 month period, THHS recorded more than 38,000 FTA clinic appointments. The audit report also noted that local procedures were outdated, misaligned with the SOSIS, and inconsistently applied across clinics. The audit report identified widespread operational non-compliance, including failures to document follow up actions, inconsistent use of Not Ready for Care categories, and repeated rebooking of patients after consecutive FTAs without addressing underlying barriers to attendance. The audit highlighted that THHS did not have a bookings management procedure in place which was a core SOSIS requirement;

(b) the Draft RATP for Lost to Service[137] presented to the APCLG in June 2023 and endorsed by the Executive Audit, Risk and Compliance Committee (**EARCC**) in October 2023 further underscores the risks associated with outpatient services. This material identified that review appointments were not reliably tracked, due dates were often missing, and many specialties relied on manual spreadsheets or local logs rather than structured, system supported workflows. There was no automated mechanism to detect overdue reviews or missed follow up. The assessment explicitly acknowledged the potential for permanent harm due to delays beyond clinically recommended timeframes;

(c) the Scyne Advisory Waitlist Management (Outpatient Department) Internal Audit Report of March 2024[138] identified several positive factors in THHS' waitlist management processes, including the work of the Outpatient Working Group (established with the Board's support), dashboards containing waitlist and capacity information, and effective Service Group reporting and communication. It also identified the following deviations from the SOSIS standard and was consistent with the findings of the June 2023 PwC FTA Internal Audit Report mentioned above; and

[135] THS.001.001.2143 THHS, *Access to Planned Care Leadership Group,* 3 August 2023.
[136] THS.001.001.2143 THHS, *Access to Planned Care Leadership Group,* 3 August 2023, page 10.
[137] THS.001.001.2143 THHS, *Access to Planned Care Leadership Group,* 3 August 2023, page 66.
[138] THS.003.001.0050, THHS, *Waitlist Management (Outpatient Department) Internal Audit Report - Final,* March 2024, page 19-20.

Figure 5: Extract from the Scyne Advisory Waitlist Management Internal Audit Report

SOSIS Requirement	Current process aligned to SOSIS?	Deviation documented?	Comments
3.4.1 Outreach and visiting services	X	X	Patients that are seen via outreach services have been placed on the THHS waitlist, whereas per SOSIS, the patient must be placed on their local HHS waitlist.
3.9.3 Appointment scheduling process	X	X	SOSIS states that a patient must confirm or respond to the offer on an appointment, however currently at THHS a patient is not required to confirm their appointment.
3.9.6 Management of failure to attend (FTA) for a confirm appointment 3.10.2 Management of patient-initiated cancellations 3.12.1 Removing patients from the specialist outpatient waiting list or scheduling system	X	✓	SOSIS requires that patients are removed from the waitlist following 2 FTA or patient-initiated cancellations (for Cat 2 and 3), however at THHS these patients are not automatically removed, rather treating specialists are consulted. Refer to **Finding 3.3** Deviation is documented in the 'Fail to Attend Specialist Outpatient Services' Procedure
3.11.5 Outsourcing patients to private facilities	X	X	SOSIS states that patients who have been outsourced should be removed from the waitlist following confirmation that they have attended their appointment. Currently at THHS there is no documented process to confirm that patients have attended their appointment with the outsourced facility, resulting in a risk that these patients remain on the waitlist. Refer to **Finding 3.3**
3.13.1 Clinical audits	X	X	SOSIS states the requirements for performing clinical audits. At THHS, clinical audits are not undertaken consistently, nor documented appropriately. Refer to **Finding 3.4.**
3.13.1 Administrative audits	X	X	SOSIS states the requirements for performing administrative audits. At THHS, the current methodology used to select records to be audited does not align to the SOSIS requirements. Refer to **Finding 3.4.**
3.15 Reporting requirements	X	X	Section 3.15 of SOSIS recommends minimum metrics that should be reported and monitored by the HHS. Internal Audit noted the below metrics were not being reported: • Number of patients removed by specialty including all removal reasons, removals where treatment was not required, removals where treatment was provided elsewhere; and • Hospital initiated cancellation rates. Refer to **Finding 3.2 and 3.3.**

SOSIS requirements in detail including alignment and deviations is further outlined in **Appendix A**.

(d) This Report also found that:

(i) in relation to the review of requirements outlined in SOSIS for key processes (item 3.5) the root causes were identified as *"Ineffective governance and oversight of waitlist management across the Health Service for consistency of process, compliance with requirements and maintaining robust and cohesive policy/procedural framework with alignment to the SOSIS requirements"*;

(ii) in relation to quality assurance processes to ensure that patients are added to the review waitlist in line with the clinician's direction (item 3.6), the root causes were identified as *"Reliance on paper slips being provided following an appointment and lack of application of the digital workflow"*; and

(iii) this Report was considered and endorsed by BARC on 20 March 2024 who escalated it to the Board on 8 April 2024.[139] The Board discussed and noted the paper.[140]

316. The Investigators consider that the FTA Internal Audit Report demonstrates that in June 2023, local procedures were outdated and misaligned with SOSIS, that digital systems did not support

[139] THS.001.001.1846, THHS, Board Audit and Risk Committee, *Internal Audit Report - Waitlist Management (Outpatient Department),* 20 March 2024; THS.001.001.1848, THHS, Board Audit and Risk Committee, *Internal Audit Report - Waitlist Management (Outpatient Department), 20 March 2024 (Version included in Board papers 2024 04 08),* 20 March 2024.
[140] THS.001.001.1813, THHS Board, *Meeting Minutes,* 8 April 2024, page 10.

safe outpatient workflows, that operational practice varied widely across TUH with manual workarounds and that inconsistent documentation undermined service reliability.

317. The Investigators note the comments from the COO 1 with respect to the FTA Internal Audit Report in that the THHS actioned matters relating to the FTA patient cohort identified in the audit. This included tracking the THHS' FTAs to ensure Service Group leadership members were focussed on reducing numbers, Business Practice Improvement Officer (**BPIO**) discussions with administration team leaders and staff in February 2023 regarding SOSIS requirements and procedures to call patients to confirm appointment attendance, a pilot on 9 May 2023 which was conducted in urology reviewing FTAs and waitlists which included a number of additional quality improvement processes. During the pilot, a total of 917 calls were made to urology patients (47 cancelled, 603 confirmed and 267 not confirmed). Of those 47 opened slots, 14 new patients were given appointments and 33 were given review appointments.[141]

318. This activity had a positive impact with the COO 1 advising that "*the Data provided by the BPIO to the Access to Planned Care Senior Leadership Group in September 2023 on FTA rates by specialty demonstrated the effectiveness of the pilot and new processes, showing a clear downward trend in Urology from 16.6% in late 2022 to 7.5% in August 2024, which was lower than the State average*."[142] The Investigators were unable to confirm this data from the APCLG meeting minutes.

319. The Investigators note that the THHS has undertaken activities over the subsequent period to develop local procedures that align with the SOSIS.

320. The Board advised in July 2026 its view that in respect of the PwC FTA Audit Report and the Scyne Advisory Waitlist Management cited above that *"none detected the systemic failure now identified by the Investigators."*[143] The Investigators do not agree with this position on the basis set out above.

Observations regarding the management of urology patient outpatient waitlists

321. With respect to the management of urology outpatient waitlists, the TUH policies and procedures relating to outpatient services were compared with the relevant elements of the SOSIS. This assessment demonstrated that the TUH had developed a compliant overarching policy supported by relevant procedures.

322. It was noted that although the SOSIS had been in place since 2016, that the TUH had only developed relevant operational procedures during the period from late 2024 to 2025. The PwC FTA Internal Audit Report dated June 2023 identified that there was insufficient governance and oversight of outpatient activities and procedures. In accordance with finding 3.2 in recommendation 3 of that internal audit report, which was accepted and endorsed by THHS, it was recognised that there was a need for a procedure relating to the management of outpatients.[144]

323. It is noted by the Investigators that in May 2024, the THHS recognised that the draft Outpatient Appointment Management Procedure (Version 1) was required to guide outpatient practices.[145]

324. This procedure was discussed at the ECGC and at that time. COO 1 was to progress work to develop a revised procedure including the relevant resourcing considerations. A draft of the procedure was circulated for consultation via the APCLG in May 2024.[146] The procedure was endorsed by the APCLG in August 2024 noting that further consultation was required. [147]

[141] Consulted Parties' Natural Justice Response.
[142] Consulted Parties' Natural Justice Response.
[143] The Board's Natural Justice Response.
[144] THS.001.001.2143 THHS, *Access to Planned Care Leadership Group,* 3 August 2023, page 10.
[145] THS.001.001.2225, THHS, *Access to Planned Care Leadership Group,* 12 June 2024, page 8.
[146] THS.001.001.2225, THHS, *Access to Planned Care Leadership Group,* 12 June 2024, page 8.
[147] THS.001.001.2207 THHS, *Access to Planned Care Leadership Group,* 5 September 2024, page 6.

Version 1 of the procedure was published in October 2024.[148] Concerns were expressed with respect to the resourcing required to operationalise the procedure.[149] Resourcing matters were subsequently addressed by COO 3 and a revised procedure (Version 2) published in June 2025.[150]

325. Although staff raised resourcing concerns with the Investigators during their interviews, the COO 1 advised that no one had specifically raised resourcing concerns with them after being invited to do so and that as such they did not consider that it was necessary to raise resourcing with QH as had been noted in minutes of the APCLG on 19 December 2024.[151]

326. The Investigators note that although the procedure was published in October 2024, it was not fully operationalised until June 2025. The Investigators consider that there was a significant period between when the procedure was first circulated (May 2024), when the initial procedure was published (October 2024) and when the procedure was fully operationalised within the THHS (June 2025).This was the first time that a procedure was introduced to clarify the relevant processes that should apply in TUH. The Investigators regard this procedure as a critical response to patients experiencing Disrupted Care in relation to Cluster 6 where the development of this procedure was identified as key element of a series of corrective actions to be taken by the THHS.

327. The COO 1 advised that the process although not incorporated into a centralised procedure until October 2024, that staff were applying the relevant processes in outpatient management. Further:

> the absence of a single centralised procedure before that date [did] not mean that appropriate processes were not already in place.[152]

328. Compliance with the SOSIS by THHS was variable as demonstrated by the delay in operationalising an Outpatient Appointment Management procedure until June 2025.

Recommendation 3	(Statewide) That QH consider strengthening the SOSIS and confirming that compliance with the standard is mandatory for HHSs.

8.3.3 Management of diagnostic testing (internal and external)

329. Within urology services, radiology requests can progress through four separate pathways:

(a) requests through the EMR where studies are undertaken locally, are therefore tracked and visibly reported in the EMR;

(b) requests through the EMR where studies are outsourced by the radiology department and therefore only the request is visible in the EMR as the report, when returned from the private provider, is stored as correspondence;

(c) requests outsourced through contract arrangements where studies are undertaken privately and therefore neither the request nor the results are visible in the EMR. Although inconsistent, reports may be added recorded in the EMR and stored as correspondence; and

[148] THS.001.001.0298, THHS, Outpatient Appointment Management Procedure, Procedure Number THHSCLI241626v1; THS.001.001.0669, Cl [redacted] SAC 1 Case Review - Recommendation 1 Closure, dated 5 December 2024.
[149] THS.001.001.2207 THHS, *Access to Planned Care Leadership Group,* 5 September 2024, page 8; THS.001.001.2235 THHS, *Outpatient Care Planned Care Steering Group,* 19 December 2024, page 10.
[150] THS.001.001.2242 THHS, *Outpatient Planned Care Steering Group*, 21 May 2025, page 15; THS.001.001.0285 THHS, *Outpatient Appointment Management Procedure*, Procedure Number THHSCLI241626v2.
[151] Consulted Parties' Natural Justice Response.
[152] Consulted Parties' Natural Justice Response.

(d) requests directly to private providers where studies are undertaken privately and therefore neither the request nor the results are visible in the EMR. Although inconsistent, reports may be added to the EMR as the report is stored as correspondence. [153]

330. With respect to the management of internal diagnostic testing, this was assessed against the processes embedded in the EMR. The system is designed so that diagnostic information flows directly into the patient record in real time, supporting clinical decision-making. The results viewer (PowerChart) is the primary location where clinicians view and acknowledge results. Within TUH, during the relevant period, there was a low level of digital endorsement through EMR, in the order of 65%, for digital result acknowledgement.[154] It is also noted that of the relevant witnesses interviewed, none were able to detail how the THHS was addressing this low level of compliance.[155]

331. With respect to requests directed to private radiology services by the MIS, these requests are tracked through the THHS radiology information system.

332. Where requests are directed to private radiology services by staff directly, they are not tracked through the THHS radiology information system.[156]

333. In 2023, the MIS had formal arrangements in place to contract out reporting of diagnostic imaging performed at THHS facilities. These formal arrangements related to the reporting of unreported studies.

334. There were also arrangements in place to outsource specialised procedures, including MRI guided prostate biopsies. It is noted that for these studies there was no medical imaging report provided by the private radiology service to the THHS and that the related pathology results were provided to the requesting clinical team. The Investigators understand that there were no formal agreements in place with the provider in relation to these specialised procedures. The MIS did however monitor procedures so that they could validate accounts from the private providers.[157]

335. Monitoring and reporting of private outsourcing results represents an area where report tracking was recognised as being problematic.[158] This is an area of concern statewide and the subject of a review being led by QH which is taking the lead with this work.[159]

336. The Investigators note the statewide work being undertaken in relation to closed loop results reporting and that THHS is participating in this activity. Further, the previous HSCE advised Investigators in April 2026 that closed loop is now in effect with patients remaining "*open to their care episode*" until documented advice is made by the clinical staff in the EMR.[160]

8.3.4 Outpatient Dashboard

337. With respect to the Outpatient Dashboard, this draws on linked data from the EMR and HBCIS via the QH enterprise data warehouse. The reporting functionality is developed locally so that TUH is positioned to respond to local issues.[161] It is assumed by the Investigators that the integrity of the Dashboard was confirmed by the TUH. The Dashboard was part of a suite of

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[153] WIT.002.001.0008 Transcript of interview – Witness G, paragraphs 70-82.
[154] WIT.001.001.0207 Audit, *Medical Imaging critical results and adverse outcomes notification pathways,* dated October 2025; WIT.002.001.0019 Transcript of Interview – Witness Z, paragraphs 70-73.
[155] WIT.002.001.0008 Transcript of Interview – Witness G, paragraphs 70-82.
[156] WIT.002.001.0008 Transcript of Interview – Witness G, paragraphs 47, 70-82; THS.001.001.0166 - Board Safety and Quality Committee, *Cover Note: Medical Imaging Department Patient Flow - Implementation Progress Update,* 19 February 2024; THS.001.001.0763 THHS, *Process for Outsourcing Medical Imaging Requests*, review date 2 March 2021.
[157] WIT.007.001.0041 *MID Process: Outsourcing Medical Imaging Orders*, 13 February 2024.
[158] WIT.002.001.0008 Transcript of Interview – Witness G, paragraphs 70-82; THS.001.001.0166 - Board Safety and Quality Committee, *Cover Note: Medical Imaging Department Patient Flow - Implementation Progress Update,* 19 February 2024.
[159] QHT.001.001.0048 Patient Safety Notice 32/2025, issued on 17 October 2025.
[160] Consulted Parties' Natural Justice Response.
[161] WIT.002.001.0016 Transcript of Interview - Witness F.

tools used by the TUH during the relevant period. It provides, amongst other functions, a reporting capability that identifies patients that are potentially experiencing Disrupted Care. The Dashboard was demonstrated to the Investigators during the site visit on 3 November 2025 and was considered to provide the THHS with the necessary reporting functionality.[162]

8.3.5 Use of MDTs

338. With respect to the use of MDT, these are a core component of safe, effective, and patient-centred care across QH. The NSQHS Standards[163] underpin the application of MDT practices in HHSs. At the operational level, each HHS implements local models of care, MDT meeting procedures, and specialty-specific protocols. THHS has an MDT framework (March 2024) in place and a Genitourinary/Urology MDT in operation.[164] The THHS policy is consistent with the NSQHS Standards.

339. The Investigators considered that the policy framework in place in relation to MDT management at the TUH was appropriate. Attendance at the relevant MDT of staff from urology services will be important to maintain.

8.4 Compliance with existing policies, procedures and standards

340. In assessing staff compliance with existing policies, procedures, and standards within urology services at TUH during the relevant period, and whether this had any impact on the quality of care to patients, the Investigators have focused their assessment of this on the issues of concern.

341. Assessing compliance against the relevant THHS procedures was difficult as many of the key procedures had only been recently finalised and implemented and had not been reviewed since their implementation.

342. For example, a key procedure, the Outpatient Appointment Management Procedure (Version 2)[165] which was identified as being required in response to the "Urology Bundle Cluster" in 2024 was only fully operationalised in June 2025. The previous version of the procedure (Version 1) had been published but had not been fully operationalised by the THHS.

343. As such the Investigators considered that the information they obtained through witness evidence during the operational site visit to the urology outpatient area on 3 November 2025 to be a guide to compliance during the relevant period. During this visit, the Investigators were able to observe the process flows in the work area and received evidence that those process flows had remained largely unchanged from those that were in place during the relevant period. The Investigators noted that there had been a level of non-compliance from some medical staff with respect to categorisation of new GP Outpatient Referrals within five working days as required by SOSIS and non-compliance with the requirement to document care plans in the EMR as advised in the Bulk Check Out memorandum in December 2023 to cease Bulk Check Outs.[166] Staff also advised that there had been a variable level of completion of the PDAR form in the clinic as was required after the QH Refer system was implemented. Staffing limitations were said to have contributed to these discrepancies.

344. The Investigators also reviewed various urology service incident reports relevant to urology patients in the relevant period. These CIR reports are identified in Section 9.6 and discussed in

[162] WIT.002.001.0013 Transcript of Interview – Witness AG, paragraphs 20-34.
[163] Australian Commission on Safety and Quality in Health Care, *National Safety and Quality Health Service Standards,* Second Edition, May 2021. Electronic copy available at: https://www.safetyandquality.gov.au/publications-and-resources/resource-library/national-safety-and-quality-health-service-standards-second-edition.
[164] THS.001.001.0659 Executive Clinical Governance Committee, *Briefing Note - Multidisciplinary Teams Project Update,* 28 September 2023; THS.001.001.0657 Mapping Core Optimal Care Pathway MDT Attendance Requirements to THHS Cancer MDT; THS.001.001.0656 THHS, *Multidisciplinary team meeting framework*, March 2024, Draft v1.7.
[165] THS.001.001.0285 THHS, *Outpatient Appointment Management Procedure*, Procedure Number THHSCLI241626v2..
[166] THS.001.001.1718 Email, sent on 18 December 2023.

Section 9.10 and include the identification of breakdowns in relation to clinical processes, clinical communication and patient flow.

8.5 Processes from initial referral to diagnosis and treatment

345. There were no formal descriptions of patient flows through urology services provided to the Investigators prior to their site visit. The details of patient flows during the relevant period were identified by the Investigators during the site visit to TUH Urology Outpatient Service during the week of 3 November 2025. This was by way of discussions with staff from urology services and discussions with executives from THHS. The information gleaned from this visit and these discussions did not provide the Investigators with a sense that there were systematised patient flow processes in place in the delivery of urology services during the relevant period.

346. During witness interviews, information was obtained that indicated that staff had recognised the need for patient flow documentation to be in place, however, there had not previously been resourcing available to assist with this work.[167]

347. Since the site visit, the Investigators note that COO 3 has progressed work on describing patient flows through urology services. This work is ongoing and is presented in Section 12 of this Report.

348. The process for planned care in urology services from initial referral to diagnosis and treatment during the relevant period included the following steps:[168]

(a) the process begins with referrals, which can originate from various sources, including GPs through the GP Smart Referrals system, private specialists, and inter-hospital transfers from outside the catchment area;

(b) referrals into Townsville Smart Referral Workflow Solution are accepted via facsimile, email, letter, GP Smart Referrals system, QH Refer or redirected from another HHS' Smart Referral Workflow Solution;

(c) once received, referrals are processed within the NQRH, where the administration team ensures that they are allocated to the appropriate specialty; and

(d) following this, nurses, health professionals and medical officers in the relevant clinical areas such as urology services, review the referrals to categorise patients based on their needs, following a review of the referral ensuring to review to CPC where appropriate and comply with SOSIS. Referral types include new referrals, upgrades for urgent care and continuing care for ongoing management.

349. Within the THHS during the relevant period, the referral process was managed through the Smart Referral Workflow Solution under NQRH ownership which coordinates patient referrals across the THHS as well as specialist referrals from adjacent HHSs.[169] The NQRH Referral and Intake Management Standard outlines the framework for managing referrals across five North Queensland HHSs.[170] It defines the processes, roles, and responsibilities for ensuring timely, safe, and efficient referral management to improve patient outcomes and healthcare delivery. The document establishes performance measures, reporting mechanisms, and assists with governance structures to monitor and address referral management challenges. The NQRH staff provided details of their workflows, internal arrangements, and performance indicators.[171] The NQRH approach to managing referrals was comprehensive and mitigated the risks of patients experiencing Disrupted Care or having their care significantly delayed. The key modules used

[167] Information obtained by Investigators during site visit at Townsville University on 3 November 2025.
[168] Information obtained by Investigators during site visit at Townsville University on 3 November 2025.
[169] WIT.002.001.0013 Transcript of Interview – Witness AG, paragraph 11.
[170] THS.001.001.0752 North Queensland Referral Hub, *Referral Intake and Management Standard,* approved 6 March 2023.
[171] WIT.002.001.0013 Transcript of Interview – Witness AG, paragraphs 11, 20-32 and 49.

by the information system and that underpins workflows was the Smart Referrals Workflow Solutions.

350. At the time that the Investigators attended TUH as part of a site visit to facilities delivering urology services during the week of 3 November 2025, it was noted that, during the relevant period, the medical staff working in urology services were not able to actively manage the volume of new referrals received from NQRH in accordance with the QH or THHS policies and procedures and that as a consequence some Category 1 patients were significantly delayed in receiving care. These requirements relate to a professional standard.[172]

351. At the time that the Investigators attended TUH as part of the site visit to facilities delivering urology services it was noted that, during the relevant period, urology services did not have defined (and documented) pathways in place for patients presenting with haematuria, a pathway for specialised clinics (e.g. the Flexible Cystoscopy Surveillance Clinic, the Continence Clinic, Registrar Review Clinic) or for Stent Tracking.

352. The rebooking process for patients attending the outpatients area for urology services was not functioning at a high level at the time that the Investigators undertook their site visit reflecting practices that occurred during the relevant period.

353. The process that was supposed to be in place in the outpatient area during the relevant period is outlined below:[173]

(a) following a clinical interaction with a medical officer, the medical officer entered a formal note into the EMR outlining a treatment plan and a date for review; and

(b) administration and nursing staff arrange the follow up as indicated including placing patients on the review waiting list in ESM.

354. The process that had been in place for the preceding 18 months was more variable as follows:

(a) following a clinical interaction with a medical officer a formal note is entered into the EMR;

(b) the booking form was completed and handed to staff (noting that the form was meant to have been progressively taken out of service and replaced with a fully electronic process after the December 2023 memorandum requiring cessation of the Bulk Check Out process);

(c) administration and nursing staff in urology services continued to use the booking forms that led to a workload issue delaying data entry into ESM and created the risk that the booking forms could be lost or misplaced, resulting in patients experiencing Disrupted Care. In the circumstances, the net effect was that patients were not booked and experienced Disrupted Care. The Investigators note that the use of the booking form was considered by the THHS as being an underlying cause for Disrupted Care for patients who were connected to or who received urology services in Cluster 6. The continued use of this booking form in the department where it was identified as being a risk was a concern for the Investigators; and

(d) a team meeting between medical and nursing staff at the end of the urology outpatient clinic was apparently discontinued sometime after the Bulk Check Out memorandum was circulated in December 2023 but which was unrelated to the cessation of the Bulk Check Out process. This resulted in the discussions between the medical and nursing staff where patient care was planned not occurring. This created a new risk

[172] Medical Board AHPRA, Good medical practice: a code of conduct for doctors in Australia, 1 October 2020, subsection 10.5, https://www.medicalboard.gov.au/codes-guidelines-policies/code-of-conduct.aspx.
[173] WIT.001.001.0088 THHS Digital Health Branch, *Smart Referrals Overview*, dated 19 January 2026; WIT.002.001.0021 Transcript of Interview – Witness U, paragraphs 31-35.

resulting in patients experiencing Disrupted Care in particular patients requiring more urgent follow-up.

355. The Investigators did not consider the implementation of this change in process following Cluster 6 to be effective and noted that some medical staff did not change their work practices following the Bulk Check Out memorandum requiring that they make changes to their process in December 2023. They continued to use paper booking forms and did not enter the required information into the EMR. This created risk as there was potential for advice to flow through two pathways, one which was digital and included entries being made in the EMR and one which utilised paper booking forms. With respect to the paper based process, the booking forms were at risk of being lost or misplaced resulting in patients experiencing Disrupted Care as occurred in Cluster 6.

356. The Investigators noted that a new electronic form had been created in the EMR for medical staff to complete which included the specific information that administrative staff required to undertake the rebooking process. This represented a secondary corrective action. This was being introduced in the delivery of urology services around the time of the Investigators site visit in November 2025.

357. The Investigators during their site visit to the urology outpatient area were able to speak with a range of staff including junior medical staff. The junior medical staff that attended the clinic detailed the difficulties that had been experienced with the use of the PDAR form. The junior medical staff explained that for patients requiring urological interventions (in outpatients) and surgery interventions undertaken at TUH, that a PDAR form was required to be completed to ensure follow-up care is planned and scheduled. At the time that the Investigators attended the urology outpatient area the junior medical staff indicated that the use of the PDAR form had been variable during the relevant period. This was due to the inconsistent completion of the PDAR form when surgical procedures were undertaken and the patient was discharged. This resulted in a new group of patients experiencing Disrupted Care.[174] The Investigators considered that this reflects the effectiveness of the change management processes associated with the introduction of this new electronic form.

358. The THHS advised Investigators in July 2026 that:

> an audit of PDARs was undertaken to confirm appropriate post-surgical follow-up and continuity of care for elective surgery patients. The audit covered January 2022 to the current period. A total of 6,409 episodes of care or encounters were reviewed. There were no identified SAC 1 or SAC 2 incidents within this cohort of patients.[175]

359. While in hospital, patients receive ongoing care that is provided by a MDT comprising allied health professionals, doctors and nurses.

360. When a patient's treatment and care have been completed, they are discharged from hospital. Patients may be discharged to other hospitals for care, to their GPs for community-based follow-up, to their homes for recovery, or to community or ambulatory care services for additional support. Follow-up care is documented using the EMR.

361. The Investigators note for completeness that there were a range of routine administrative audits undertaken in the relevant period, in the outpatients department, including urology services. Their purpose was to ensure that patient data is accurate and up to date and is consistent with the Outpatient Waiting List Clinical Audit Process (Version 1 – September 2024).[176]

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[174] Information obtained by Investigators during site visit at Townsville University on 3 November 2025; WIT.002.001.0013 Transcript of Interview – Witness AG, paragraphs 68-73; WIT.002.001.0010 Transcript of Interview - Witness O, paragraphs 46-92.
[175] THHS Natural Justice Response.
[176] THS.001.001.0282 State of Queensland (THHS), *Outpatient Waiting list Clinical Audit Process*, Policy Number THHSCLI241628v1 , effective from 15 October 2024.

8.6 Demand and Capacity for Urology Services

8.6.1 Overview

362. The Investigators sought to assess demand and capacity with respect to the delivery of urology services provided through THHS, as part of the Investigation and as per the TOR, from a practical perspective. Resourcing of urology services was a theme that came through during interviews with staff.[177] After consideration, the Investigators determined that population-based workforce requirements represented the most practical way to summarise the mismatch in demand and capacity in the delivery of urology services at TUH, THHS.

363. In undertaking this assessment, the Investigators sought information from the System Policy and Planning Division, Health Workforce Division and the HIU within QH. This information is outlined below.

364. In considering the demand for and capacity to meet the need for urology services within TUH, THHS the Investigators also considered key operational performance indicators relating to the delivery of urology services, including waiting list data.

365. The Investigators had to establish Statewide workforce levels for urology services to compare against. As such an analysis of the urology workforce was the critical determinant in assessing the capacity of TUH to respond to clinical needs. Workforce planning data together with the activity profile generated by these specialist services informed this.

8.6.2 Urology Workforce Benchmarks – Australia (2025)

366. The urology workforce in Australia is provided as background to the urology workforce in Queensland and Townsville.[178] It is characterised by modest growth, an ageing profile, and regional gaps. Data from New South Wales (**NSW**), the most detailed available, provides a useful benchmark. [179]

367. The most recent benchmark indicates Australia has around 596 practicing urologists in 2025, which equates to 2.2–2.3 urologists per 100,000 population. This figure is lower than international norms, with regional distribution being uneven and metropolitan centres being better staffed than rural and regional hospitals. Acknowledging the differences between the medical systems, by way of comparison, this is below the levels in the USA which are 3.3 - 3.6 urologists per 100,000 population and Europe where there are three-to-four urologists per 100,000 population.[180]

368. The Commonwealth has undertaken national workforce modelling that includes urology as part of the broader surgical specialties, but it has not produced a dedicated “urology-only” pipeline strategy.

369. In 2019, NSW reported 128 clinical urologists, with an average age of 51.5 years and weekly hours of 45.7. Female representation remained low at 11.7%. The training pipeline showed stagnation, with 35 trainees and no growth between 2015 and 2019.

370. National projections from QH’s, Future Health Workforce reports indicate stable demand growth of 1.4–1.5% annually through 2030–2035. Retirement risk is significant, with 22% of urologists aged 60 and above, particularly in non-metropolitan areas. Without expansion of the training

[177] WIT.002.001.0015 Transcript of Interview - Witness H; WIT.002.001.0011 Transcript of Interview - Witness P; WIT.002.001.0002 Transcript of Interview - Witness W paragraphs 54, 97-101.
[178] Australian Government, Department of Health, Disability and Ageing, *Summary Statistics, Medical Profession*, last updated 18 September 2025. Webpage can be accessed here: https://hwd.health.gov.au/resources/data/summary-mdcl.html#. QHT.001.001.0005 Workforce data provided by Queensland Health on 6 November 2025; QHT.001.001.0003 Workforce data provided by Queensland Health on 6 November 2025.
[179] QHT.001.001.0005 Workforce data provided by Queensland Health on 6 November 2025; QHT.001.001.0003 Workforce data provided by Queensland Health on 6 November 2025.
[180] QHT.001.001.0005 Workforce data provided by Queensland Health on 6 November 2025; QHT.001.001.0003 Workforce data provided by Queensland Health on 6 November 2025.

pipeline, shortages are likely to emerge, especially in regional centres where recruitment is already constrained.

371. Regional hospitals also rely on dual public-private coverage to maintain service delivery. Recruitment pressures are acute, with regional hospitals frequently dependent on private partnerships to sustain subspecialty coverage.

372. In summary, the urology workforce profile nationally highlights several risks which include that:

(a) without expansion, the specialist training system will not meet projected demand;

(b) there is a reliance on dual public private models which leaves regional hospitals exposed to turnover and locum dependence;

(c) recruitment and retention challenges exist in regional areas which risks widening disparities in access to urology services; and

(d) retirement risk is concentrated in non-metro areas, compounding regional shortages.

8.6.3 Urology Workforce Queensland (November 2025)

373. The workforce profile for urology in Queensland (including the public and private sectors), updated in November 2025[181], provides a view of the specialty's current state and future trajectory. This information was provided by the Health Workforce Division within QH. As of 2023, Queensland had 103 registered urology specialists, with only four new Fellows entering practice in 2024.

374. The Queensland workforce is heavily skewed towards private practice, with two-thirds of specialists working outside the public system and only one-third employed in public hospitals. Gender variation remains pronounced, with 12% of specialists being female. The age profile is concerning with half of the workforce being aged 60 or older, 16% intending to retire by 2024 and 48% intending to retire by 2034. Taken together, these factors point to a future risk to service delivery.[182] QH modelling projects a shortfall of 16 specialists by 2028, equating to a 13% deficit against demand.

375. Workforce distribution is uneven, with 83% of specialists located in major cities and only 17% in regional areas. This distribution leaves rural and remote communities less well served, with 35% of Queensland's population living outside metropolitan centres.[183]

376. Training capacity is modest, with 20 trainees in 2023 and three new entrants in 2024. The Royal Australasian College of Surgeons Surgical Education and Training provide a structured training pathway, however, intake remains limited. Gender balance among trainees is more equitable (55% male, 45% female). Overall, numbers appear insufficient to offset projected retirements.

377. Fourteen accredited training sites exist in Queensland. These are concentrated in metropolitan centres with limited regional exposure. Workforce mapping data shows the key elements in the urology workforce to be 32.09 Principal House Officer (**PHO**) FTE, 19.58 Registrar FTE, and 34.47 Senior Medical Officer (**SMO**) FTE statewide. Metro North and Metro South dominate capacity. Regional HHSs report significant gaps between approved and occupied positions. This

[181] QHT.001.001.0003 Queensland Health, *Medical Workforce Profile,* November 2025; Queensland Health, *Workforce gap analysis.* Webpage can be accessed here: https://www.health.qld.gov.au/system-governance/strategic-direction/plans/workforce-gap-analysis.
[182] QHT.001.001.0003 Queensland Health, *Medical Workforce Profile,* November 2025; Queensland Health, *Workforce gap analysis.* Webpage can be accessed here: https://www.health.qld.gov.au/system-governance/strategic-direction/plans/workforce-gap-analysis.
[183] QHT.001.001.0003 Queensland Health, *Medical Workforce Profile,* November 2025; Queensland Health, *Workforce gap analysis.* Webpage can be accessed here: https://www.health.qld.gov.au/system-governance/strategic-direction/plans/workforce-gap-analysis.

reliance on VMOs and private contracts creates fragility in service delivery, particularly outside metropolitan areas.

378. Queensland has 1.9 registered urologists per 100,000 Estimated Resident Population, broadly comparable to the national average of 1.8. However, distribution is heavily skewed towards metropolitan areas.

379. The combined evidence underscores systemic risks. Workforce shortages are projected to worsen by 2028, with geographic distribution creating challenges in regional and remote communities. Heavy reliance on private practice and VMOs limits resilience in the public sector, while equity concerns persist, particularly for First Nations patients and regional populations.

380. Training pipeline constraints, with low intake and limited regional placements, further compound the challenge. Without intervention, Queensland risks widening disparities in access to urology care, with metropolitan centres continuing to absorb demand.

381. To better inform the workforce profile in north Queensland, a limited assessment of the urology specialist workforce and activity levels across Cairns and Townsville was undertaken.

8.6.4 Drainage population

382. The Investigators consider that Cairns Hospital and TUH function as the two principal urology hubs for north Queensland. Together, they provide care to a combined drainage population of approximately 510,000 people. Cairns Hospital supports a population of approximately 260,000 people,[184] while THHS supports a population of approximately 250,000 people.[185] These data represent the populations that rely on these hospitals for secondary and much of their tertiary urological care.

8.6.5 Service Demand[186]

383. The System Policy and Planning Division provided an overview of the relevant activity to the Investigators.

384. The Division identified that in North Queensland there was an average of 6,500 public inpatient separations per year for urology Service Related Groups (**SRG**) (2021/22 – 2023/24). The majority (83%) of public inpatient separations occur at Cairns Hospital (30.7%), TUH (30.8%), and Mackay Hospital (21.6%).

385. Two Enhanced Service Related Groups (**ESRG**s) within the Urology SRG (Cystourethroscopy and TURP) are exclusively provided at these three hospitals. The other ESRGs that make up the Urology SRG (Other Urological Procedures, Other Non-procedural Urology, Urinary Stones and Obstruction, Male Sterilisation) were provided across 33 public facilities in North Queensland.

386. An additional 600 inpatient separations are publicly contracted to a private provider per year. Most of the publicly contracted activity (75%) occurred in Cairns and Hinterland HHS.

387. In North Queensland, there was an average of 10,000 public outpatient visits per year for Urology QTier2 Code 20.36 (classification system for non-admitted patient services) (2021/22 – 2023/24). This activity occurred at Cairns Hospital, TUH (including in community), and Mackay Hospital.

[184] ABS, Estimated Resident Population as at June 2023 (preliminary), disaggregated by age, sex, and SA2 (ASGS 2021- Ed 3). Webpage can be access here: https://www.abs.gov.au/statistics/people/population/regional-population/latest-release; QGSO ERP 2025 ; https://www.qgso.qld.gov.au/statistics/theme/population/population-estimates/regions.
[185] ABS, *Estimated Resident Population as at June 2023 (preliminary),* disaggregated by age, sex, and SA2 (ASGS 2021- Ed 3). https://www.abs.gov.au/statistics/people/population/regional-population/latest-release.
[186] QHT.002.001.0004 Email, sent 14 January 2026.

8.6.6 Patient Flows

388. The System Policy and Planning Division also provided advice in relation to patient flows.

389. In 2023/24, most of North Queensland resident public inpatient demand for urology SRG was serviced in North Queensland (97.3%), with 2.7% of public inpatient separations outflowing to other HHSs. An additional 223 separations were demand inflowing form other HHSs (similar number to the outflowing separations).

390. In 2023/24, public inpatient and outpatient self-sufficiencies for North Queensland HHSs were:[187]

(a) Cairns and Hinterland HHS: 94% inpatient, 82% outpatient;

(b) THHS: 95% inpatient, 98% outpatient;

(c) Mackay HHS: 91% inpatient, 89% outpatient;

(d) Northwest HHS: 62% inpatient, 0% outpatient with most residents flowing to THHS (inpatient 35%, outpatient 98%); and

(e) Torres and Cape HHS: 32% inpatient, 0% outpatient with most residents flowing to Cairns and Hinterland HHS (62% inpatient, 81% outpatient).

391. The self-sufficiencies indicate THHS primarily supports THHS residents and North West HHS residents, while Cairns and Hinterland HHS primarily supports Cairns and Hinterland HHS residents and Torres and Cape HHS residents. Mackay is largely self-sufficient.

8.6.7 Estimated Resident Population[188]

392. The System Policy and Planning Division were able to validate the assessment of drainage populations for the Investigators. This is outlined below.

393. North Queensland, defined as the combined geographical catchment of Cairns and Hinterland, Townsville, Mackay, North West, and Torres and Cape HHSs, had an Estimated Resident Population of approximately 763,500 people as at June 2023. This is made up of an Estimated Resident Population as follows:

(a) Cairns and Hinterland: 270,522;

(b) Townsville: 248,358;

(c) Mackay: 189,643;

(d) North West: 28,844; and

(e) Torres and Cape: 26,127.

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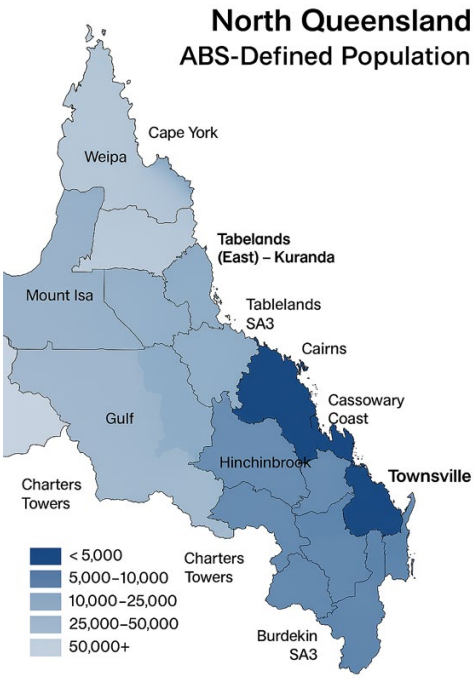
[187] QHT.001.001.0003 Queensland Health, *Urology Medical Workforce Profile,* updated November 2025; QHT.001.001.0004 Royal Australasian College of Surgeons, *Activities Report,* 2024; QHT.001.001.0005 Medical Advisory and Prevocational Accreditation Unit and Workforce Strategy Branch – Health Workforce Division, *Joint Response to Request from Lead Investigator,* dated 6 November 2025.

[188] Estimated Resident Population as at June 2023 (preliminary), disaggregated by age, sex, and SA2 (ASGS 2021- Ed 3). Australian Bureau of Statistics (ABS) source data rebased by Queensland Government Statistician's Office (QGSO) – March 2025. Published by Statistical Services Branch, Queensland Health, March 2025; QHT.002.001.0004 Email, sent 14 January 2026.

394. When Mackay is excluded, because of its level of self-sufficiency with respect to urology services, this leaves a population of 573,851 that is served by Cairns Hospital and TUH with respect to urology services.[189]This is graphically represented below.

395. Across the two centres, the estimated combined urology workforce is between nine and eleven specialists (depending on the locum workforce). Cairns hosts approximately five to six urologists across its public and private services, while Townsville has an estimated four to five.[190] The availability of specialist time to the public system is lower than the headline numbers suggest.

Figure 6: North Queensland population distribution



396. When assessed against the combined drainage population, this equates to a workforce ratio of approximately 1.6 - 2.0 urologists per 100,000 population. This is below the commonly referenced benchmark of 2.2 - 2.3 urologists per 100,000. If a target level of 2.5 is applied to consider future workforce needs, then Northern Queensland is likely needing a minimum of three to five additional urologists (includes the current vacancies at TUH) to meet potential future clinical demands.

8.6.8 Performance metrics, operational activity profile and waiting lists

397. The Investigators reviewed a series of documents provided by QH HIU who had been supporting the THHS with respect to their urology service during the relevant period and in relation relevant performance measures[191]. This included the following:

(a) Preoperative Services Site Review plan (July 2025);[192]

[189] QHT.002.001.0004 Email, sent 14 January 2026.
[190] QHT.001.001.0003 Workforce data provided by Queensland Health on 6 November 2025.
[191] Some of the data below falls outside the date range of the relevant period prescribed by the TOR. However, this information was used to inform the Investigators' understanding of 3.1(v) and in responding to 3.2 of the TOR.
[192] QHT.001.001.0030 THHS, *Perioperative Services Site Review,* July 2025.

(b) Waiting List data extracted from the QH Specialist Outpatient Data Collection (26 September 2025);[193]

(c) OPD Waiting list audit (31 July 2025);[194]

(d) Statewide urology Service Taskforce TOR (1 October 2025) [195]; and

(e) Email correspondence relating to patient delays from Northwest HHS (July 2025).[196]

398. A summary of these materials is outlined below.

399. The Preoperative Services Site Review plan (July 2025) related to a review of the current processes across perioperative services, particularly theatre utilisation, elective surgery waitlist management, models of care impact on quality, safety and efficiency including urology services.

400. Waiting List Data (as at 26 September 2025):

(a) category 1 patients in urology who need to be seen – 135 on the wait list of which 125 were long wait;

(b) referrals to urology who need to be reviewed – 307 of which 271 had waited longer than five days; and

(c) numbers of Category 1 urology patients who are requiring surgery – 103 on the wait list of which 23 were long wait.

Figure 7: THHS Urology Waiting List data as at 26 September 2025

Urology - as of 26/9/25

Outpatient - New	Wait List	Long waits	Maximum Days Wait	Total Booked
Total	813	536		23
Cat 1	135	125	184	19
Cat 2	336	305	684	2
Cat 3	342	106	752	2

Outpatient - Review	Wait List	Long waits		Total Booked
Total	1,390	644		1,035

Smart Referrals			
Total referrals waiting categorisation	Referals waiting > 5 days to be categorised	Referals waiting > 30 days to be categorised	Maximum Days Wait
307	271	169	88

* There are an additional 14 referrals waiting for clinical review (nurse) that are not included in the categorisation numbers above.

Elective Surgery	Wait List	Long waits	Maximum Days Wait	Total Booked
Total	344	154		54
Cat 1	103	23	130	38
Cat 2	147	97	581	15
Cat 3	94	34	748	1

[193] QHT.001.001.0016 Email, sent on 26 September 2025
[194] THS.001.001.1294 THHS, *Outpatient Waitlist Clinical Audit – Reporting Schedule,* 31 July 2025.
[195] QHT.001.001.0009 Draft Statewide Urology Services Taskforce, *Terms of Reference Version 3,* September to October 2025.
[196] QHT.001.001.0011 Email, sent on 10 July 2025.

401. OPD Waiting List audit:[197]

(a) this document outlines the Outpatient Waitlist Clinical Audit process, detailing methodology, findings, and a proposed reporting schedule for patient waitlists;

(b) Background and Methodology: the Outpatient Waitlist Clinical Audit Procedure mandates audits for patients waiting beyond clinically recommended time limits for outpatient appointments. Each service group has an accountable officer for clinical oversight, who can delegate auditing responsibilities. Audits involve contacting patients to assess their ongoing need for care and any changes in clinical status. A small sample of 41 patients was audited from the ESM Waitlist Dashboard, focusing on those waiting outside of time without scheduled appointments;

(c) Findings: the audit revealed that a significant number of patients are overdue for appointments, with 25% of the total THHS patients waiting outside of time. The audit showed low compliance with clinical audits across service groups, with only 8% of SSG patients undergoing audits. Notably, 24% of audited patients may have completed their care but remained on waitlists, suggesting potential issues with data accuracy;

(d) Resourcing Requirements: conducting clinical audits requires substantial clinician time, particularly in specialties with high patient volumes waiting outside of time limits;

(e) Proposed Reporting Schedule: a reporting schedule was suggested for various service groups to analyse clinical dashboards and report metrics related to patients waiting outside of time limits, including the number of audits completed and clinical escalations. Each service group is encouraged to provide narrative context regarding their waitlist management strategies and challenges; and

(f) the Investigators noted that the THHS undertook audits of their outpatient and elective surgery patient waitlists including audits relating to categorisation of new patients.

8.7 Summary of conclusions

402. With respect to TOR 3.1 (a)(i), whether appropriate policies and procedures were in place the Investigators found:

(a) the Investigators found that the current THHS Outpatient Procedures were consistent with the SOSIS and other Statewide requirements. However, it is noted that several of the procedures that were in place had been revised or developed over the preceding 12 to 18 months (late 2024 to 2025), indicating to the Investigators that the THHS has been actively working to ensure compliance with the SOSIS. As recent as January 2025, there was evidence to suggest that TUH did not have SOSIS compliant policies and procedures in place in the outpatient setting. It is noted that the COO had a key role in oversighting procedure development within the THHS. The Investigators received inconsistent advice on whether a handover to COO 3 occurred in relation to the development and operationalisation of these procedures;

(b) the management of diagnostic imaging reports was identified as being problematic as there is suboptimal use of the EMR results reporting and validation function. Separately, there were patients referred for investigations privately who did not have their requests tracked, recorded in, or reported on through the EMR;

(c) there were rudimentary systems in place to ensure that private test results were reviewed and endorsed by clinical staff. The processes that THHS had in place to

[197] WIT.001.001.0237, THHS, *Outpatient Waitlist Clinical Audit – Reporting Schedule,* 1 August 2025.

track private results was not considered to be robust by the Investigators. This arrangement has led to patients experiencing Disrupted Care;

(d) the Investigators note that QH is progressing a statewide body of work related to closed-loop diagnostic reporting; and

(e) the Good Medical Practice Code[198] sets clear expectations that doctors must review, interpret, and act on pathology results in a timely and responsible manner. The Code emphasises that providing good clinical care includes ensuring that investigations are appropriately followed up, that abnormal or unexpected findings are recognised, and that necessary management or escalation occurs without delay. Doctors need to have reliable systems to track and review results, minimise the risk of missed or overlooked abnormalities, and communicate clinically significant findings and next steps to patients. These obligations reflect the Code's broader focus on patient safety, risk minimisation, and the use of safe, effective clinical systems.

Recommendation 4	That the THHS establish a robust internal policy governance process to ensure that internal policies, procedures, and standards are maintained and align with the SOSIS as they relate to the delivery of urology services.
Recommendation 5	(Priority) That the THHS CMO ensure that professional standards are complied with in the delivery of urology services as they relate to the follow up, endorsement and actioning of radiology and pathology investigations undertaken in the public and private sector for patients who are connected to or receive urology services.

403. With respect to TOR 3.1 (a)(ii), whether there was compliance with existing policies, procedures and standards, the Investigators have found that there was a level of non-compliance with existing policies, procedures and standards in the delivery of urology services:

(a) the failure to effectively implement organisational requirements with respect to the Bulk Check Out process and the associated patient booking systems has introduced risks, including non-adherence with the SOSIS;

(b) this is because the urology services team developed nuanced approaches to the direction to cease the Bulk Check Out process advised to all business units in December 2023;

(c) this variation in practice continued in urology services until November 2025;

(d) practically, the continued use of paper booking forms when the direction from COO 2 was for this to be gradually discontinued and all patient information including plans for further attendances and investigations were to be entered into the EMR, thus allowing administrative staff to update ESM accordingly. The continued use of the booking forms meant that clinical information entered onto the forms (e.g. management plans) was destroyed once an ESM entry was completed. The Investigators also noted that the previous process of having a team meeting to review cases at the end of an outpatient clinic had been discontinued, and that the re-booking process impacted on staff workloads;

(e) the use of the PDAR form within QH Refer in theatre and in the cystoscopy clinic also posed a risk. This is because of a range of factors, including, that there was limited

[198] Medical Board AHPRA, *Good medical practice: a code of conduct for doctors in Australia*, 1 October 2020. Electronic copy available at: https://www.medicalboard.gov.au/codes-guidelines-policies/code-of-conduct.aspx.

consideration of the change management process required within work units, the additional demands on clinician time when compared with the previous system. There was also no automatic function to generate PDAR forms once a patient was treated or discharged from hospital; and

(f) staff in urology services advised that PDAR forms were not completed for several patients of the service and that a new dashboard has been developed to assist in tracking this group of patients. This process presents similar risks to those experienced with the change in the Bulk Check Out process where patients were not booked or placed on the review patient booking list.

Recommendation 6	(Priority) That the THHS review the resource requirements within urology outpatients to ensure that the changes identified in the memorandum relating to the Bulk Check Out process circulated on 18 December 2023 and the implementation of QH Refer are resourced, operationalised effectively and are sustainable.

404. With respect to TOR 3.1 (a)(iii), the extent of any non-compliance with the policies, procedures, and/or standards, including whether this had any impact on the quality of care provided to patients, the Investigators have found:

(a) assessing compliance against the relevant THHS procedures was difficult as many of the key procedures had only been recently finalised and implemented and had not been reviewed since their implementation;

(b) as such the Investigators considered that the information that they obtained through witness evidence during the operational site visit to the urology outpatient area on 3 November 2025 to be a guide to compliance during the relevant period. During this visit, the Investigators were able to observe the process flows in the work area and received evidence that those process flows had remained largely unchanged from those that were in place during the relevant period. The Investigators noted that there had been a level of non-compliance from some medical staff with respect to categorisation of new GP Outpatient Referrals within five working days as required by SOSIS and non-compliance with the requirement to document care plans in the EMR as advised in a memorandum issued in December 2023 to cease Bulk Check Outs. Staff also advised that there had been a variable level of completion of the PDAR form in the clinic as was required after the QH Refer system was implemented. Staffing limitations were said to have contributed to these discrepancies; and

(c) it is noted that the workforce constraints and the non-compliance with the policies, procedures and standards in the delivery of urology services had an impact on the quality of care provided to patients. This resulted in patients experiencing Disrupted Care or experiencing a significant delay in accessing care as detailed in Section 9 of this Report.

405. With respect to TOR 3.1 (a)(iv), the efficiency of processes from initial referral to diagnosis and treatment, the Investigators have found that there was variability in the efficiency of services provided to TUH urology patients:

(a) the NQRH, the Elective Surgery Coordinator and their teams were professional and professionally managed. The NQRH are commended for their professionalism and diligence;

(b) the Elective Surgery Coordinator role was first established in 1996 to support the coordination of elective surgery in major Queensland hospitals. The Elective Surgery Coordinator and their team provide oversight of the elective surgery program at TUH as per the previously cited ESIS;

(c) there are areas of concern related to the initial referral categorisation of patients which was undertaken by a medical officer and the scheduling of review patients;

(d) with respect to the initial categorisation, delays in medical staff categorising referrals resulted in patients being delayed to their initial appointment. Although the constraints relating to the medical workforce existed, the THHS had visibility of this issue and could have considered some form of risk mitigation;

(e) the NQRH has access to data that demonstrates delays in internal processes within urology OPDs as it relates to new referrals that would assist in the management of the referral process. This relates to time to triage and categorise outpatient referrals;

(f) an area of inefficiency related to the need to "cut and paste" information from various systems which are logically connected to the patient's journey. This includes the NQRH having to "cut and paste" from QH Refer and the GP referral systems into ESM and administrative staff in outpatients having to "cut and paste" information from the EMR clinical module to the ESM. This presents a risk to the organisation if the transcribing of information is not completed with a high degree of accuracy;

(g) at an operational level there is a deficiency in the process controls (procedures and guidelines) within the urology outpatients area. Although staff in the area are aware of the need to have operational procedures and guidelines in place, they had not previously been resourced to develop them. Examples include the bladder cancer clinical pathway, procedures relating to the cystoscopy service and procedures relating to the management of high-risk patient cohorts such as those patients with abnormal histology; and

(h) the Good Medical Practice Code[199] requires doctors to provide safe, timely, and appropriate care, and this obligation directly supports compliance with QH's outpatient triage policies. The Code emphasises accurate clinical assessment, effective use of health-service systems, proactive risk management, and clear communication with patients and referrers. These principles require doctors to apply established triage criteria, ensure referrals contain sufficient clinical information, identify and escalate urgent cases, and manage patients within the timeframes and pathways set by QH. In doing so, the Code reinforces that doctors are professionally accountable for ensuring that triage decisions are defensible, consistent with policy, and aligned with patient safety and clinical urgency.

Recommendation 7(a)	(Statewide) That QH consider further developing the reporting of information collected as part of the Smart Referrals Workflow Solutions to ensure that outpatient services are aware of delays in the triage and categorisation of outpatients referred to the respective HHSs.
Recommendation 7(b)	That the THHS expand the resourcing of urology services to allow the development and maintenance of work instructions and clinical care pathways such as a service model, patient pathways for planned and unplanned care, a urology operational plan and production plan, the partly completed one relating to bladder cancer guidelines and guidelines for patients with a cancer diagnosis.
Recommendation 7(c)	(Priority) That the THHS CMO ensure that professional standards are complied with in the delivery of urology services

[199] Medical Board AHPRA, *Good medical practice: a code of conduct for doctors in Australia*, 1 October 2020. Electronic copy available at: https://www.medicalboard.gov.au/codes-guidelines-policies/code-of-conduct.aspx.

	as they relate to the triaging and categorisation of new GP outpatient referrals.

406. With respect to TOR 3.1 (a)(v), the extent the demand for urology services at TUH exceeded the capacity of TUH and the impact of this on times between reviews, the Investigators sought advice in relation to the demand capacity mismatch within urology services at TUH and conclude:

(a) it is the view of the Investigators that the level of staffing in the urology service was below the level that would be reasonable and necessary for the service to operate efficiently and safely. This may have been as consequence of challenges with medical recruitment;

(b) information was sourced from THHS, the QH HIU and the QH Health Workforce Division. The information provided included employment data as well as population-based workforce projections;

(c) in summary, the TUH had a shortfall of 1.7 FTE (approved FTE 3.5 and occupied FTE 1.8). The COO 1 indicated that they considered that "*a major underlying cause for the Disrupted Care resulted from only having 1.4 FTE SMO Urologists managing an ever growing service, despite ongoing attempts to recruit additional staff*";[200]

(d) when considering the population-based data, TUH would be expected to require an estimated 2.2 urologists to support the 267,192 ERP of THHS and North West HHS. This equates to of a total of 5.87 urologists. Given there are four urologists supporting this population, the estimated shortfall in urologists is estimated to be 2.0 FTEs (including the urology vacancies at TUH); and

(e) this will require a combination of targeted recruitment, strengthened training pathways, and redesigned models of care. Opportunities exist to expand trainee positions, develop extended scope nursing roles, and implement shared care pathways with GPs and general surgeons.

Recommendation 8(a)	(Priority) That the TUH establish dedicated Urology Case Coordinator and Nurse Navigator roles within urology services to work with the medical officers so that the medical staff can focus on the provision of specialist care.
Recommendation 8(b)	(Statewide) That the THHS HSCE works with QH and the HSCE from the Cairns and Hinterland HHS to progress workforce and service planning for the delivery of urology services with a focus on Northern Queensland. This may include consideration of: (i) Strengthening the training pipeline, increasing intake, and incentivising regional placements which will be critical to building sustainable capacity. (ii) Consideration of workforce demographics, including gender imbalance and ageing. (iii) Expanding specialist capacity to address regional gaps and reduce reliance on outsourcing.

[200] Consulted Parties' Natural Justice Response.

	(iv) Consideration of establishing Career Medical Officer roles within urology services.
Recommendation 8(c)	(Priority) That the THHS progress the sourcing of an additional 2.0 Full-Time Equivalent (FTE) urologists (noting that there are 3.5 FTE funded and 1.7 FTE vacant positions). . The recruitment activity is a priority and must include a Clinical Director for urology services. Recruitment should coordinate and actively engage with the specialist college and society with the active support of QH.

407. With respect to TOR 3.1(a)(vi), any processes that fell below expected standards and/or were not consistent with or in compliance with required policies, procedures, and standards, as identified by the Investigator/s, the Investigators have found that there were processes that fell below expected standards and/or were not consistent with or in compliance with required policies, procedures, and standards, as identified in (iii) above:

(a) one area not addressed in (iii) above relates to the interface with THHS cancer services;

(b) cancer services have a Genitourinary/Urology MDT in place to review the management of patients with urological disease.[201] From the information provided to the Investigators, the attendance by urologists at this Genitourinary/Urology MDT was consistent but has decreased over time reflecting the decrease in urology medical officers;[202] and

(c) the THHS should be commended for the work that they have undertaken in establishing an MDT framework.

Recommendation 9	(Statewide) That QH consider developing an overarching policy guideline for HHSs in relation to the operationalisation and management of MDTs within HHSs.

[201] WIT.002.001.0001 Transcript of Interview – Witness T, paragraph 11.
[202] WIT.002.001.0001 Transcript of Interview – Witness T, paragraph 11.

Section 9 - Clinical governance and incident management

9.1 Overview

408. In this section, the Investigators have addressed TOR 3.1(b), (c) and (d) which require evaluation of the following issues:

(a) the appropriateness of the THHS's follow-up, referral and escalation processes, based on reviews arising from clinical incidents involving urology services at TUH, during the relevant period;

(b) identification of the systemic issues during the relevant period and make specific recommendations and actions to comprehensively address these; and

(c) consideration of the implementation, monitoring and evaluation by THHS of actions and recommendations from previous reviews or analyses (including through incident analysis and any action plans) in relation to urology services at TUH during the relevant period.

409. To meet these TOR the Investigators, have:

(a) identified the Statewide requirements for clinical governance as set out in the National Model Clinical Governance Framework (2017) and QH Clinical Incident Management Guideline in Section 9.2 (responding to TOR 3.1(b));

(b) identified and assessed the relevant THHS policies and procedures against the statewide requirements and the national Framework in Section 9.3 (responding to TOR 3.1(b));

(c) analysed previous reviews that have been undertaken in respect of clinical governance, namely, the January 2024 External Review of Clinical Governance and the December 2024 ACHS assessment in Section 9.4 (responding to TOR 3.1(d));

(d) analysed THHS's implementation, monitoring and evaluation of actions and recommendations from previous clinical governance reviews in Section 9.4 (responding to TOR 3.1(d));

(e) analysed the clinical incidents involving urology services at TUH during the relevant period which allowed the Investigators to identify the systemic issues, recommendations and actions in Section 9.5 (responding to TOR 3.1(c));

(f) set out the THHS response to clinical incidents and analysed them in Section 9.6 (responding to TOR 3.1(d));

(g) identified systemic issues by reviewing SAC 1 case summaries during the relevant period in Section 9.7 (responding to TOR 3.1(c));

(h) reviewed advice by THHS to regulatory bodies during the relevant period in Section 9.8 (responding to TOR 3.1(b)); and

(i) reviewed the actions taken by the THHS in relation to the clusters that related to urology services at TUH in Sections 9.9 and 9.10 (responding to TOR 3.1(d)).

SUMMARY: Key observations, findings, and conclusions in relation to clinical governance and incident management

These observations, findings and conclusions are presented in a structured sequence so as to construct a picture of what occurred within the THHS. As a first step, the Investigators considered compliance with the relevant incident management guidelines. The Investigators then considered the findings of external reviews of governance. Following this, the

Investigators considered a thematic review of clinical incidents and a review of the THHS CIRs. The Investigators then summarised the relevant issues and the THHS' response to the relevant clusters.

THHS compliance with the Clinical Incident Management Guidelines

(a) In assessing the appropriateness of the THHS follow up, referral and escalation processes, it was important for the Investigators to first assess the governance structure in place within THHS that guided their response to clinical incidents. The Investigators considered that the THHS Clinical Incident Management Procedure (June 2024) provided this structure during the relevant period. Overall, the procedure provides a documented, system level framework that is aligned with the statewide guidelines.

(b) Based on the Investigators' review of the Riskman CIR reports provided as part of the Investigation process and as outlined in this Report, the THHS complied with the technical requirements of the THHS Clinical Incident Management Procedure (June 2024) with respect to the follow-up, referral and escalation processes arising from clinical incidents involving urology services.

Previous reviews of clinical governance

In considering the appropriateness of the THHS's follow up, referral and escalation processes, based on the reviews of clinical incidents involving the delivery of urology services, the Investigators also had the benefit of reviewing two reviews of key aspects of the clinical governance arrangements within THHS including arrangements relating to urology services at TUH.

<u>External Review of Clinical Governance - January 2024</u>

(a) In January 2024, TUH underwent an independent clinical governance review to assess compliance with NSQHS Standard 1 (Clinical Governance) following the identification of common governance themes arising from two prior Part 9 investigations. The review confirmed that the clinical governance requirements were largely met, with formal governance structures in place. The effective use of data for monitoring and improvement was evident. No accreditation gaps were identified, however, several medium-low-priority improvement opportunities were highlighted, which aimed at strengthening assurance and ensuring sustainability of performance.

(b) While governance structures were mature, the review noted several recommendations:

  (i) streamlining Committee reporting processes through dashboards with concise summaries and clear timelines for risks and actions;

  (ii) the risk register was identified as an area requiring refinement, with high-residual clinical risks grouped under single headings. Listing high-risk items individually and improving evaluation of risk controls in collaboration with risk owners was advised; and

  (iii) concerns were also raised about detecting poor performance and cultural risks, with advice to incorporate evaluation of clinician leaders' roles in fostering a safety culture with limited discussion of clinical variation at performance meetings, particularly in smaller units lacking external review.

(c) This review considered that the technical aspects of the procedures in place in THHS met the clinical governance requirements.

(d) The Investigators noted matters raised in this review including the style of reporting to the Board, the detection of poor performance and cultural concerns.

TUH – ACHS Assessment - December 2024

(a) This assessment reviewed compliance with the NSQHS Standards and resulted in the hospital being awarded a three-year accreditation. This outcome confirms overall compliance with national and state standards, while also highlighting several areas where continued improvement and sustained monitoring were recommended.

(b) The Investigators noted that:

(i) urology was not on the risk register during the ACHS accreditation site visit in December 2024 and was not listed as an emerging risk. It was also not specifically identified in any of the Board risk reports for the preceding six months;

(ii) outpatient Disrupted Care was identified on the risk register at the time of the accreditation however all but one of the risk treatments had been closed off. The closure forms were signed off by the previous HSCE; and

(iii) there was no risk meeting held in December 2024 when the ACHS accreditation site visit occurred. The January and February 2025 risk reports do not identify urology on the risk register.

(c) This review considered that the THHS met the clinical governance requirements.

Reviews of adverse clinical incidents

Thematic Analysis of SAC cases as at December 2025

(a) There were concerns held in relation to the cluster of clinical incidents associated with the care and treatment of patients prior to 31 July 2025. These cases are considered in detail in the following sections.

(b) In November 2025, 112 patients had been identified who received urology services from January 2022 to July 2023 and who had experienced Disrupted Care. When reviewed, these cases were associated with deficiencies in patient tracking, follow-up, and communication processes. These deficiencies created clinical risk, including delayed cancer diagnoses, breaches of Category 1 and 2 referral timeframes, and prolonged gaps in surveillance for high-risk patients.

(c) In December 2025, 254 patients had been identified who had received urology services during the relevant period and who experienced Disrupted Care. Of these patients, four suffered SAC 1 incidents (1.6%), 93 suffered SAC 2 incidents (36.6%), and 157 were recorded as being SAC 3 incidents (61.8%).

(d) The incident data is dominated by process-related risks. These included: booking of appointments, follow up, referral handling, and waiting list management, rather than as isolated incidents.

(e) Four SAC 1 incidents were identified and reflect the most serious patient safety exposure. Each patient was associated with missed follow up in the context of suspected or confirmed malignancy. Collectively, these cases evidence harm potentially arising from missed result disclosure, the absence of timely rebooking of appointments, and clinic cancellations without active recovery of care.

(f) The data points to a small number of recurring failure modes. There were missed rebooking opportunities including those related to patients who ‘Failed to Attend’ (FTA) or hospital initiated cancellations, limited clinical documentation, deficiencies in communication with patients' GPs, and waiting list management.

(g) The Investigators considered that there were also gaps identified in post procedure workflow where PDARs were not completed, causing follow-up to be absent despite documented plans.

(h) A smaller subset reflects communication issues. These weaknesses cluster within booking and results management pathways rather than within the frontline clinical decision-making pathways.

(i) Beyond the SAC 1 cohort, the case register contains multiple incidents referencing prostate cancer and urothelial malignancies including substantial delays in surveillance. While most incidents were categorised as SAC 2–3, the thematic alignment with cancer pathways makes the aggregate risk nontrivial.

(j) Failure signals within the SAC 2 subset are notable. Mentions of failed attendance and explicit FTA references appear in approximately 49.5% of cases. Hospital initiated cancellations or clinician unavailability occur in approximately 26.9% of cases and reschedules or list/template rearrangements feature in approximately 12.9% of cases. Together, these patterns demonstrate that once appointments are disrupted, recovery to a safe follow up pathway is not reliably executed.

(k) The case reviews are dominated by SAC 3 incidents, indicating widespread, systemic moderate-risk delays in follow-up and surveillance.

(l) SAC 4 cases are fewer and typically relate to discharge, private transfer, or administrative closure. However, documentation consistency remains a significant concern.

(m) Three system observations were noted by the Investigators:

  (i) Firstly, cancellation recovery is inconsistent. Where clinics are closed or clinicians are unavailable, many records lack evidence of a forced rebooking, safety netting letter, or waitlist placement.

  (ii) Secondly, result bearing incidents such as biopsy, TURBT/TURP histology, and post imaging reviews show repeated patterns of no appointment being booked or no documented patient disclosure, which elevates patient harm risks.

  (iii) Thirdly, the interface with outsourced diagnostics and procedures is fragile. There was more than one case that required ad hoc follow up of external imaging results, contributing to delays beyond expected care timeframes. These are resolvable with stronger coordination of the administrative pathway and clearer accountability.

<u>Analysis of SAC1 Clinical Incident Reviews as at December 2025</u>

(a) In assessing and identifying the systemic issues that lead to patients in delivery of urology services experiencing Disrupted Care, the Investigators have specifically reviewed six completed SAC1 CIR Reports provided to the Investigators by the THHS.

(b) The Investigators in relation to:

  (i) Case 1, 2 and 3 consider that there were further recommendations that the CIR could have considered had a more detailed analysis been undertaken to identify the underlying causes(s) of the patient experiencing Disrupted Care; and

  (ii) Cases 4, 5 and 6 consider workforce shortages, fragmented care coordination, and the absence of a defined bladder cancer pathway were key contributing factors to the prolonged care journeys and resulting adverse outcomes.

(c) More broadly, the Investigators believe that the provided dataset of four SAC 1 cases (out of 254 patients who were identified as experiencing Disrupted Care during the relevant period) underrepresents the true scale of harm experienced by patients and raises concerns about completeness of reporting, and the adequacy of governance oversight. The potential under-representation of cases suggests that the THHS may not have identified the breadth of serious incidents, thereby limiting the ability of the THHS to understand and respond to systemic risks.

Identification of Systemic Issues

(a) The Investigators consider that the identification of systemic issues during the period from January 2022 and July 2025 by THHS was limited.

(b) The THHS did consider the systemic issues when Cluster 1 was identified however a detailed assessment of the underlying cause was not undertaken for future clusters. As a consequence, the actions taken by THHS to address underlying causes lacked specificity and, on some occasions, created new problems which were not anticipated by the THHS.

(c) The Investigators identified documentation gaps in the cases reviews. Patients were not consistently placed on review waitlists, correspondence was not consistently sent to GPs, and outsourced imaging follow-ups were missed. These failures contributed to delayed treatment pathways, and breaches of referral timeframes.

(d) Additionally, there were delays identified in adverse clinical incident identification and reporting which meant that recurring adverse incidents and systemic risks related to the delivery of urology services in some cases were not identified or not addressed in a timely manner. Leadership gaps compounded these issues as did the perception of limited executive engagement with staff from urology services.

(e) There were rudimentary systems in place to track high-risk cohorts, such as patients requiring cancer surveillance or urgent post-operative reviews. For example, templates designed to monitor clinical variation were not completed at the unit level. This lack of visibility means critical cases were not prioritised, and delays went unnoticed until adverse outcomes occurred.

(f) The THHS had developed several RATPs in response to matters relating to the delivery of urology services, namely workforce challenges and patients experiencing Disrupted Care. However, the Investigators considered that these RATPs were complex and lengthy and would have been difficult for staff working in the service to operationalise.

(g) The Investigators believe that given the recurring nature of the issues affecting urology outpatients and other outpatient services that a “force function” is required to provide an additional layer of safety. Such a force function could be the development of a structured, closed loop clinical pathway to ensure that no patient inadvertently experiences Disrupted Care, that is a "Never Lost Pathway".

(h) Overall, the Investigators consider that some of the THHS actions represented a limited response to a complex issue and that the related change management was not as robust as it could have been.

Findings related to THHS implementation, monitoring and evaluation from previous reviews or analyses

(a) The Investigators draw upon external assessments of clinical governance systems, consider the structured THHS response to identified risks and consider how individual clusters were responded to.

(b) The Investigators considered that the formal RATPs developed were complex and would have been difficult for clinical staff to effectively operationalise.

Actions and findings relating to the THHS management of clusters

In relation to the THHS management of clusters discussed in Section 9.10, the Investigators find that:

Cluster 1

(a) There is no mention in the performance and accountability minutes for SSG with regards to any escalations in relation to patients experiencing Disrupted Care or specific actions being undertaken from July to December 2022 when the issue of patients experiencing Disrupted Care were first raised.

(b) With respect to a proposed look back recommended by the Director Medical Services Clinical Governance and Digital Health (**DMSCGDH**), it is noted that this was not progressed at this time.

Cluster 6

(a) This cluster of patients were found to be due to the manual rebooking process which were not followed where the paper booking forms were misplaced, delayed, or not acted upon.

(b) The governance over the change of process had a significant impact on the delivery of urology services and contributed directly to patients experiencing Disrupted Care.

(c) Despite good evidence that a more extensive look back should have been considered at this time to identify the patients who experienced Disrupted Care this was not undertaken. There seemed to be a focus on the bundle of booking forms identified and located in an [redacted] as the cause of patients experiencing Disrupted Care rather than undertaking a detailed analysis to identify the underlying causes. The Investigators consider that the THHS ought to have made inquiries to assure themselves that there were no other urology patients affected as there may have been other instances where the paper booking forms may have been misplaced or lost or not actioned but which were included in the bundle. If this was found to be the case then this would then have triggered a more detailed lookback.

(d) Actions seemed to be taken by the THHS without an appropriate level of analysis and without the consequences of the actions being adequately considered.

(e) It is noted that the BSQC considered recommending that a Part 9 investigation be undertaken by the THHS at the time.

Cluster 7

(a) This cluster of patients were at very high risk of having a malignancy and that the THHS should have been aware of this and acted accordingly.

(b) There was a lack of systems in place to track the MRI guided prostate biopsy outsourced patients within the THHS meaning that patient delays were not identified.

(c) This risk had previously been identified in June 2022 through an Internal Audit Report which was considered by BARC in July 2022.

(d) The system failure meant that patients lost their chances for timely treatment of their conditions.

(e) Standard reporting processes to inform the Executive and the Board with respect to the waiting times did not provide the fidelity required to monitor individual patients who were outsourced to the private sector for care where clinical reviews would have been required.

(f) THHS did not provide any information relating to any steps taken to address the emerging risk of the needle shortage after a complaint was received in March 2023. However, once the risk materialised in October 2023, THHS responded rapidly and urgent action was taken.

Cluster 8

(a) This cluster of patients were at high risk of malignancy and that procedural challenges in urology OPD lead to patients experiencing Disrupted Care.

(b) Staff had formally raised concerns about a range of matters affecting the administrative processing of patients' materials.

(c) There is evidence that the process that underpinned formal medical referrals were not managed appropriately.

(d) The THHS received a Patient Safety Net notification in relation to urology service. The Investigators note that this Patient Safety Net notification was managed in accordance with the THHS local procedures. However, the fact that further patients were experiencing Disrupted Care despite reassurance from senior officers at TUH that processes were adequate to prevent this demonstrates a potential lack of governance over the clinical areas of the business to ensure patient safety was being maintained.

(e) The Investigators note that the Patient Safety Net Notification was not advised to the BSQC or the Board.

Cluster 9

(a) Patients experienced Disrupted Care for a range of reasons including because clinic cancellations sometimes at short notice and where the rebooking process was not associated with the active recovery of care.

(b) The THHS should review the causes for late clinic cancellations including those due to leave management for medical staff in the urology service to ensure that adequate time is available to notify and reschedule patients or organise alternate arrangements and that the CMO establish a robust leave management procedure and monitor compliance with the procedure.

(c) When the previous HSCE became aware of short-term cancellations and continuation of paper booking forms in the delivery of urology services, they advised that they took steps to address this.

Cluster 10

(a) This cluster was due to a number of factors including: the rebooking process which was supposed to have moved to a fully electronic process but had remained as a paper based process in areas of THHS, missed rebooking opportunities after ‘Failed to Attend’ (FTA), hospital initiated cancellations and with no subsequent clinician notes, correspondence not being provided to GPs, and no waitlist placement.

(b) The Investigators consider that the rebooking process had been deficient since December 2023.

(c) The process that was used was driven by clinician preference and did not align with HHS procedural requirements.

(d) The impact of the memorandum requiring that Bulk Check Out be discontinued in outpatients had unintended consequences and was not initially supported by an approved procedure within the THHS.

(e) When the previous HSCE became aware in October 2025 of some clinicians continuing to use paper booking forms, they took steps to have it ceased.

9.2 Statewide requirements for clinical governance

410. The clinical governance requirements that are in place in Australia and in Queensland and that relate to health services are comprehensive and have been developed over the preceding three to four decades. With respect to the current Investigation, the following standards have been identified as being relevant. They include the:

(a) National Model Clinical Governance Framework (2017); and

(b) QH Clinical Incident Management Guideline (2024).

411. These two documents provide the overarching framework for incident management.

9.2.1 National Clinical Governance Framework (2017)

412. The National Model Clinical Governance Framework (2017),[203] developed by the ACSQHC, provides a consistent national approach to clinical governance in health service organisations. It is designed to ensure the delivery of safe, high-quality healthcare and continuous improvement in services. The framework is based on the NSQHS Standards[204], particularly the Clinical Governance Standard and the Partnering with Consumers Standard. It applies to both public and private health services and aims to address safety and quality risks across the Australian healthcare system.

413. The Clinical Governance Framework aims to ensure that patients and consumers receive safe and high-quality healthcare by establishing integrated corporate and clinical governance systems. It defines clinical governance, provides context for its integration into corporate governance, and outlines essential components for effective implementation. The framework emphasises the importance of culture in supporting clinical governance and highlights the roles and responsibilities of patients, consumers, clinicians, managers, and governing bodies in ensuring effective systems.

414. The Framework describes clinical governance as the set of relationships and responsibilities established by a health service organisation between its governing body, executive, clinicians, patients, consumers, and other stakeholders to ensure good clinical outcomes. It is an integrated component of corporate governance, ensuring accountability for delivering safe, effective, and high-quality healthcare services. Clinical governance systems provide confidence to the community and healthcare organisations that robust systems are in place to deliver and improve healthcare services.

415. Under the Framework, governing bodies, such as boards, are responsible for ensuring good governance and accountability. Their duties include appointing and evaluating the performance

[203] Australian Commission on Safety and Quality in Health Care, *National Model Clinical Governance Framework,* 2017. Electronic copy available at: https://www.safetyandquality.gov.au/sites/default/files/migrated/National-Model-Clinical-Governance-Framework.pdf. The Investigators note this has recently been replaced by the June 2026 version which is available at: https://www.safetyandquality.gov.au/resources/2026-national-model-clinical-governance-pdf

[204] Australian Commission on Safety and Quality in Health Care, *National Safety and Quality Health Service Standards,* Second Edition, May 2021. Electronic copy available at: https://www.safetyandquality.gov.au/publications-and-resources/resource-library/national-safety-and-quality-health-service-standards-second-edition.

of the chief executive officer, setting organisational strategies, approving budgets, monitoring performance, and ensuring compliance with safety and quality standards. Governance responsibilities are distributed throughout the organisation, but the governing body remains accountable for the outcomes and performance.

416. Under the Framework, clinical governance is described as an integral part of corporate governance, requiring leadership, policies, procedures, and monitoring mechanisms to ensure good clinical outcomes. It is of equal importance to financial, risk, and other business governance. Governing bodies must engage skilled clinicians at all levels to ensure effective clinical governance.

417. The Framework describes how culture plays a critical role in ensuring the delivery of safe and high-quality care. A positive safety culture is characterised by shared values, beliefs, and behaviours that prioritise patient safety and quality improvement. Key factors for sustaining such a culture include strong leadership, clear safety objectives, a supportive working environment, transparency, and effective teamwork. Health service organisations must foster a culture that emphasises safety, quality, and continuous improvement.

418. Clinicians are recognised as being responsible for delivering safe, high-quality care within well-designed clinical systems. They must maintain professional competence, adhere to codes of conduct, and actively participate in the development, implementation, and monitoring of governance processes. Clinicians also play a key role in mentoring colleagues and educating junior staff.

419. Managers, including clinical managers, are responsible for ensuring that systems supporting the delivery of care are well-designed and perform effectively. They must allocate resources, engage with clinicians, and oversee the implementation of safety and quality systems. Managers also play a critical role in strategic planning and policy development.

420. Governing bodies are accountable for the organisation's performance and the delivery of safe, high-quality care. They must establish a strong safety culture, ensure effective clinical governance systems, allocate resources, and monitor organisational performance. Governing bodies also have a responsibility to engage with consumers and ensure their input in decision-making processes.

421. The Framework was mandatory for all Australian hospitals and day procedure services undergoing accreditation under the NSQHS Standards. It provides a structure for health service organisations to develop and implement their own clinical governance systems, considering local needs and circumstances.

9.2.2 Clinical Incident Management Guideline (June 2024)

422. The QH Clinical Incident Management Guideline[205] provides a framework for managing clinical incidents across HHSs. Its primary purpose is to ensure best practice in incident reporting, analysis, and implementation of recommendations from reviews to minimise patient harm and improve safety. The Clinical Incident Management Guideline applies to all HHSs and aligns with the NSQHS Standards.

9.2.3 Best Practice Guide to Clinical Incident Management (January 2023)

423. The Clinical Incident Management Guideline is underpinned by a detailed Best Practice Guide to Clinical Incident Management.[206] This guide provides QH with a contemporary, system-wide framework for preventing, responding to, analysing, and learning from patient safety incidents. The guide reflects changes to relevant safety system concepts since it was originally released

[205] Queensland Health, *Clinical incident management guideline*, Guideline number: QH-HSDGDL-032-2, 1 July 2024. Electronic copy available at: https://www.health.qld.gov.au/system-governance/policies-standards/health-service-directives/patient-safety/clinical-incident-management.
[206] QHT.003.001.0001, Queensland Health, *Best practice guide to clinical incident management*, Second edition, January 2023.

in 2014,[207] and positions a Restorative Just Culture, patient partnership, and systems-based analysis as central pillars of safe, high-reliability healthcare.

424. A core message throughout the guide is that clinical incidents arise primarily from system vulnerabilities rather than individual failings. Contemporary human factors, science, systems theory, and Safety-II principles underpin the recommended analytical approaches. The guide emphasises that learning from incidents requires a culture where staff feel psychologically safe to report concerns, patients and families are treated as partners, and improvement is prioritised over blame.

425. The six-step Clinical Incident Management Process provides a structured, repeatable method for managing incidents from initial response through to organisational learning. It includes: (1) preparation and safety culture foundations; (2) immediate response and disclosure; (3) preparation for analysis; (4) analysis using concise, comprehensive, or multi-incident methods; (5) implementation and monitoring of recommendations; and (6) closing the loop through evaluation, dissemination, and continuous improvement.

426. A major enhancement in this edition of the guide is the integration of Restorative Just Culture. Restorative Just Culture shifts the focus from retrospective blame to forward-looking repair, accountability, and healing. It recognises the impact of incidents on patients, families, and clinicians ("second victims"), and seeks to rebuild trust through respectful engagement, transparency, and shared problem-solving. This approach aligns with global best practice and strengthens QH's capacity to learn from harm.

Incident Management Framework

427. The guide describes clinical incidents as events that can occur during healthcare delivery and may result in unintended patient harm. The guide emphasises the importance of consistent management and timely response to incidents at both local and state levels. Patient Safety Queensland (**PSQ**) provides support for HHSs by providing resources, training modules, and tools for incident analysis and Open Disclosure.

428. In line with the guide for SAC 1 incidents, incidents involving death or likely permanent harm, a clinical disclosure must occur within 24 hours, and reporting through Riskman must be completed within one business day. SAC 1 analysis reports must be submitted to PSQ within 90 calendar days to meet key performance indicators (**KPI**s) outlined in the Patient Safety Health Service Directive (effective October 2024).[208]

Reporting and Analysis Requirements

429. HHSs are required to maintain documented local processes for identifying, reporting, and analysing clinical incidents. These processes must include clear roles and responsibilities, preliminary risk assessments within 24 hours, and defined timeframes for comprehensive or concise analysis. Reports should include factual descriptions, contributing factors, and actionable recommendations. Consumer involvement in the analysis process is mandated to ensure transparency and patient-centerer care. PSQ reviews all SAC 1 reports to identify statewide trends and emerging risks, informing broader patient safety initiatives. Findings are shared across health services to promote learning and continuous improvement.

430. The guide places strong emphasis on translating analysis findings into actionable improvements. HHSs must establish processes for developing, prioritising, and implementing recommendations, including assigning responsible officers, setting timelines, and monitoring progress. Dissemination of key findings and recommendations to patients, families, and

[207] THS.002.001.0001 Queensland Health, *Best practice guide to clinical incident management*, First edition, June 2014.
[208] Queensland Health Service Directive, *Patient Safety,* Directive Number QH-HSD-032, effective 9 October 2024. Information available online: https://www.health.qld.gov.au/system-governance/policies-standards/health-service-directives/patient-safety.

stakeholders is required, along with consideration of statewide relevance. Continuous monitoring and evaluation are essential to ensure sustainability and impact.

Governance and Compliance

431. The guide underscores the need for robust governance structures to oversee compliance with reporting and implementation requirements. Continuous monitoring and executive oversight are critical to embedding these practices and ensuring accountability.

432. Failure to adhere to the processes outlined in this guideline introduces significant risks to patient safety and organisational integrity. These risks include delayed identification and management of clinical incidents, lack of transparency in reporting, and missed opportunities for systemic improvement. Non-compliance may result in regulatory breaches and the increased likelihood of adverse patient outcomes. Leadership must ensure timely implementation and rigorous monitoring to safeguard patient safety.

9.2.4 Approach to incident management

433. In investigating clinical incidents, it is appropriate to consider the use of a structured, systems based analysis that focuses on understanding how the system allowed the clinical incident to occur, rather than looking for individual error. This approach aligns with QH's Best Practice Guide[209] and National Model Clinical Governance Framework (2017).

434. The Investigators have considered the policy materials described in Section 9.2 above and feedback on the material contained in the Report in drafting Section 9 of the Report.

435. The Investigators are aware that modern safety science recognises that clinical incidents arise from multiple interacting factors. As a result, the contemporary role of undertaking detailed analysis to identify the underlying causes is less about finding the cause of a clinical incident and more about understanding how the system allowed the clinical incident to occur. This shift aligns with human factors principles and the move toward systems based safety investigations across Australian health services.

436. The Investigators consider that the investigation of clinical incident clusters also requires a structured, systems based approach that examines patterns across multiple events rather than analysing clinical incidents in isolation. This requires a multi incident analysis that identifies recurring themes and contributory factors across the events using safety science methods, including thematic analysis, human factors frameworks, and process mapping, to understand how organisational, human, and environmental conditions interact to create risk. Engagement with frontline staff is also essential to understanding how work is performed.

9.3 THHS compliance with Clinical Incident Management Guidelines

437. In assessing the appropriateness of the THHS follow up, referral and escalation processes, it was important for the Investigators to first assess the governance structure in place within THHS that guided THHS's response to clinical incidents. To this end, the Investigators considered that the THHS Clinical Incident Management Procedure (June 2024) provided this structure. This procedure is comprehensive and has been reviewed annually. It was in place during the relevant period.[210]

438. The procedure establishes a mandatory, organisation wide approach for reporting, reviewing, and learning from clinical incidents, including near misses. Its purpose is to ensure a consistent,

[209] THS.001.001.0276 THHS, *Clinical Incident Management Procedure,* Procedure Number: THHSCLI140740v12, effective from 27 June 2024, pages 1-4.
[210] THS.001.001.0276 THHS, *Clinical Incident Management Procedure,* Procedure Number THHSCLI140740v12, effective from 27 June 2024.

transparent, and patient centred response to any incident that results in, or could result in, unintended harm.

439. The procedure reinforces immediate safety actions as the priority, requiring staff to protect patients and colleagues, notify line managers, and document the incident promptly in both the clinical record and the Riskman system.

440. The procedure embeds a "Restorative Just Culture" that emphasises open communication, early disclosure to patients and families, and psychological support for all involved.

441. A structured SAC framework guides the level of investigation with SAC 1 incidents, for example, those involving death or likely permanent harm are subject to heightened oversight through THHS governance committees through to the Board level. The procedure also recognises potential high risk incidents that may not meet SAC 1 criteria but warrant a comprehensive analysis led by the Patient Safety Unit.

442. The procedure aligns THHS practice with national standards, legislative requirements, the QH Clinical Incident Management Guideline,[211] which is a revision of the earlier version of the guideline, and the Best Practice Guide to Clinical Incident Management.[212] The Investigators note that the Best Practice Guide to Clinical Incident Management does not mandate or prescribe the type of analysis to be conducted for a SAC 1 clinical incident (inclusive of reportable events as defined in the *Hospital and Health Boards Regulation 2023* (Qld) (**HHB Regulation**)). It highlights the importance of organisational learning, timely mitigation of risks, and closing the loop through implementation and monitoring of recommendations.

443. Education and support for frontline staff is recognised with the Patient Safety Unit providing training, informal engagement, and trend awareness across service groups.

444. Overall, the procedure provides a documented, system level framework that is aligned with the statewide guidelines.

445. Based on the Investigators' review of the Riskman CIR reports provided as part of the Investigation process and as outlined in this Report, the THHS complied with the technical requirements of the THHS Clinical Incident Management Procedure (June 2024) with respect to the follow-up, referral and escalation processes arising from clinical incidents involving urology services.

9.4 Previous reviews of clinical governance

446. In considering the appropriateness of the THHS' follow up, referral and escalation processes, based on the reviews of clinical incidents involving the delivery of urology services, the Investigators also had the benefit of reviewing two reviews of key aspects of the clinical governance arrangements within THHS. These reviews considered clinical governance arrangements within THHS including arrangements relating to urology services at TUH. They were as follows:

(a) a specific review of clinical governance conducted in January 2024 and which is summarised below; and

(b) the THHS ACHS Accreditation Report of December 2024, which is also summarised below.

[211] Queensland Health, *Clinical incident management guideline*, Guideline number: QH-HSDGDL-032-2, 1 July 2024. Electronic copy available at: https://www.health.qld.gov.au/system-governance/policies-standards/health-service-directives/patient-safety/clinical-incident-management.
[212] THS.002.001.0001 Queensland Health, Best practice guide to clinical incident management, first edition, June 2014.

447. These two reports provide further evidence of the level of compliance of THHS with the State and national guidelines and framework referred to above.

External Review of Clinical Governance - THHS - January 2024

448. In January 2024, the previous HSCE initiated a clinical governance review to assess compliance with the NSQHS Standard 1 (Clinical Governance) following the identification of common governance themes arising from two prior Part 9 investigations.[213] The review was conducted by an ACHS consultant who was shadowed by an officer from QH upon invitation from the EDCG. They confirmed that the clinical governance requirements were largely met, with formal governance structures in place. The effective use of data for monitoring and improvement was evident. No accreditation gaps were identified; however, several medium-low-priority improvement opportunities were highlighted, which aimed at strengthening assurance and ensuring sustainability of performance.

449. The review commended THHS for its comprehensive Clinical Governance Framework, which is closely aligned with the NSQHS Standards. There was evidence of strong engagement by both the Board and the Executive in safety and quality systems, including effective incident management, risk escalation, and Open Disclosure processes. THHS demonstrated extensive use of data to monitor performance and benchmark outcomes, and its partnerships with First Nation communities were recognised as well-established.

450. While governance structures were mature, the review noted that Committee reporting processes resulted in the Board receiving large volumes of unfiltered reports. Streamlining reporting through dashboards with concise summaries and clear timelines for risks and actions was recommended.

451. The risk register was identified as an area requiring refinement, with high-residual clinical risks grouped under single headings. Listing high-risk items individually and improving evaluation of risk controls in collaboration with risk owners was advised.

452. Concerns were also raised about detecting poor performance and cultural risks, with advice to incorporate evaluation of clinician leaders' roles in fostering a safety culture as there was limited discussion of clinical variation at performance meetings, particularly in smaller units.

453. This review considered that the technical aspects of the procedures in place in THHS met the clinical governance requirements.

454. The Investigators noted matters raised in this review including the style of reporting to the Board, detection of poor performance and cultural concerns.

TUH – ACHS Assessment - December 2024

455. THHS underwent a comprehensive Short Notice Assessment by the ACHS in December 2024.[214] The assessment reviewed compliance with the NSQHS Standards and resulted in the hospital being awarded a three-year accreditation. This outcome confirms overall compliance with national and state standards, while also highlighting several areas where continued improvement and sustained monitoring were recommended.

456. The assessment recognised several important achievements. Emergency preparedness had been significantly strengthened, with lockdown procedures tested and integrated into staff training. Medication safety systems had been enhanced through multidisciplinary review and increased audit frequency, while environmental cleaning processes had been standardised. The Investigators note that:

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[213] WIT.001.001.0076 The Australian Council on Healthcare Standards, *Governance Standard Consultancy: THHS,* January 2024.
[214] THS.001.001.0652 ACHS, *NS2.1 Short Notice Final Assessment Report,* Assessment Date 19 – 20 December 2024.

(a) while outpatients services were identified on the risk register, urology services were not specifically identified on the register during the ACHS accreditation site visit in December 2024 and were not listed as an emerging risk. Urology services were not specifically identified in any of the Board risk reports for the preceding six months;

(b) outpatient Disrupted Care was identified on the risk register at the time of the accreditation site visit with all but one of the risk treatments having been recorded as closed off. The closure forms were authorised by the previous HSCE; and

(c) there was no risk meeting held in December 2024 when the ACHS accreditation site visit occurred. The January and February 2025 risk reports do not identify urology on the risk register.

457. This review considered that the THHS met the clinical governance requirements. The Investigators note that this included a formal clinical audit program that operated across the THHS and was monitored through the ECGC.

9.5 The Investigators approach to reviewing clinical incidents

458. In July 2025, the THHS identified a patient that had been lost to service (**LTS**) who was connected to or received urology services. The patient was categorised as a SAC 1 because of their disease progression. After an initial review, the THHS identified that there were other patients who were subsequently identified as potentially being LTS.

459. At that time, the THHS was aware of several situations that had occurred over the preceding years where patients (including urology patients) had experienced Disrupted Care. These patients have been identified as clusters back to January 2022. In reviewing these patients, the Investigators have identified six clusters which are summarised in Section 7.7 of this Report. A summary of these clusters is outlined in Section 7.2.

The THHS Response

460. In responding to the various clusters, the THHS undertook clinical audits of urology outpatients dating back to January 2022. This audit included patients who are connected to or receive urology services and other patients who were identified as being associated with the six clusters. Following Cluster 10, THHS undertook a detailed audit of relevant patients.

461. Relevant patient data was drawn from the EMR and ESM systems. To assist with the audits, a dashboard that was created in 2023 was used to identify at-risk patients, including for example, patients who potentially experienced Disrupted Care.

462. Case by case reviews were required where the information contained in the EMR and ESM systems was incomplete or unclear. This work was undertaken by specialised nursing staff. Patients who experienced Disrupted Care required a medical review to determine if there had been any impact on their health. This review process was coordinated with urology services, with initial patient contact being made by senior nursing staff from urology services. When the staff identified concerns, they facilitated a medical review of the patients.

463. Patient data was logged into a case register which was maintained by the THHS. Extracts from this register were provided to the Investigators as the clinical audit progressed.

464. It should be noted that the clinical audit was ongoing and as such the data will continue to be updated.

465. The A/HSCE provided an initial set of data relating to the clinical audit to the Investigators in October 2025. Because of the urgency associated with the activity the initial set of data was

provided verbally. This was followed by more detailed data in November 2025 and December 2025.[215]

466. The Investigators were provided with access to the detailed data contained in a clinical audit case register (excel spreadsheet).

467. The THHS clinical audit was undertaken with an appropriate level of urgency by the THHS. However, the absence of a detailed methodology for patient selection and timeframes raises concerns about the audit and if it captured, to the full extent, the associated clinical risks. Without this assurance, there remains a possibility that additional patients were unaccounted for.

468. It is noted by the Investigators that the THHS has extended their audit timeframe back to 2021.

Recommendation 10	That the THHS formalises a detailed summary of clinical review methodology used for the clinical audit (triggered by Cluster 10) of patients who are connected to or receive urology services and had experienced Disrupted Care including their process for Open Disclosure and provides this to QH.

9.6 Reviews of adverse clinical incidents

469. In this Report, the Investigators have provided an analysis of the adverse incident case information to assess the follow-up, referral and escalation processes based on the clinical incident data and to identify systemic risks during the relevant period. This analysis is presented in three separate, but related sections of the Report as outlined below. This includes:

(a) a summary of the overall case numbers as presented in October, November and December 2025 at Section 9.6.1;

(b) a thematic analysis of SAC patients identified as of December 2025 at Section 9.6.2; and

(c) an analysis of SAC 1 patients as at December 2025 at Section 9.6.3.

9.6.1 Analysis of case numbers

470. The initial case numbers were provided verbally by the A/HSCE in October 2025. This was because the analysis was at an early stage and the THHS was seeking to assist the Investigators by providing an indication of the scope of the issues they were assessing.

471. The October 2025 case numbers are summarised below. This information provides an early picture of the scope of the Disrupted Care.[216]

Table 3: Clinical Incident data October 2025 (indicative)

Description	HHS Initial Data (October 2025)
Primary at-Risk Cases	576
Secondary At-Risk Cases	210
Total SAC Incidents	157
SAC 1 Incidents	4

[215] THS.001.001.1671 *Excel Bladder Cancer Data,* dated 16 December 2024; THS.001.001.1524 *Urology Audit Excel,* dated 17 November 2025; THS.001.001.1601 *Urology Audit Excel,* dated 17 November 2025.
[216] THS.001.001.1671 *Excel Bladder Cancer Data,* dated 16 December 2024; THS.001.001.1524 *Urology Audit Excel,* dated 17 November 2025; THS.001.001.1601 *Urology Audit Excel,* dated 17 November 2025.

SAC 2 Incidents	52
SAC 3 Incidents	83
SAC 4 Incidents	31
Lost to FU Cases	147
Delay to care Cases	10

472. As part of the Investigation process, the THHS subsequently provided more detailed information to the Investigators in November and December 2025.[217] These datasets contained personal details of patients and are therefore not included as attachments to this Report.

Table 4: Clinical Incident data November 2025 and December 2025

Description	HHS November Data (2025)	Change	HHS December Data (2025)
Total SAC Incidents	112		253
SAC 1 Incidents	4	-	4
SAC 2 Incidents	25	78	103
SAC 3 Incidents	58	98	156
SAC 4 Incidents	10	-	-

473. The Investigators note the following in relation to the above Table:

(a) the data relates to the patients that were identified during the clinical audit and who received care or treatment during the relevant period, including patients reported from Cluster 10;

(b) the THHS has progressively refined the case data through a desktop review and a clinical review when required. This process was ongoing and will result in further changes to this data;

(c) the "HHS November Data (November 2025)" is based on cases entered in Riskman between January 2022 and July 2025 and extracted in November 2025;

(d) the "HHS December Data (December 2025)" is based on cases entered in Riskman between January 2022 and November 2025 and extracted in December 2025;

(e) the increased case numbers noted in the column marked "Change" are the additional cases identified through the ongoing clinical audit;

(f) SAC 1 cases remained at 4 however there was one additional case added and one case was downgraded;

(g) SAC 2 cases increased by 78 cases;

(h) SAC 3 cases increased by 98 cases; and

(i) SAC 4 cases were not provided as part of the December 2025 curated data.

474. The Investigators appreciate that the THHS continues to review patients who are connected to or receive urology services at TUH and that this will take time to conclude and for the related SAC reviews to be finalised.

[217] THS.001.001.1671 *Excel Bladder Cancer Data,* dated 16 December 2024; THS.001.001.1524 *Urology Audit Excel,* dated 17 November 2025; THS.001.001.1601 *Urology Audit Excel,* dated 17 November 2025.

9.6.2 Thematic Analysis of SAC cases as at December 2025

475. The Investigators are mindful of the timeframe set in the TOR. The Investigators regard the relevant period to be related to when patients received their care and were potentially experiencing Disrupted Care as opposed to when they were formally registered in the clinical audit case register. This is because cases were identified as part of the clinical audit undertaken by the THHS during the second half of 2025 and recorded in the clinical audit patient case register at this time. This is relevant to the thematic analysis of SAC cases.

476. The November 2025 data identified 112 patients who are connected to or receive urology services from January 2022 to July 2023, who experienced Disrupted Care and where there were deficiencies in patient tracking, follow-up, and communication processes.[218] These deficiencies created clinical risk, including delayed cancer diagnoses, breaches of Category 1 and 2 referral timeframes, and prolonged gaps in surveillance for high-risk patients.

477. The December 2025 audit data identified 254 patients who are connected to or receive urology services during the relevant period who experienced Disrupted Care.[219]

478. The Investigators reviewed the SAC incidents for these patients who are connected to or receive urology services that experienced Disrupted Care during the relevant period. These datasets were recorded in the clinical audit register that was provided to the Investigators by THHS.

479. Over this period, 254 incidents were logged, with 4 being SAC 1 incidents (1.6%), 93 being SAC 2 incidents (36.6%), and 157 being SAC 3 incidents (61.8%).

480. The notification pattern shows a pronounced concentration of notifications in October 2025, with smaller volumes in August, September, and November 2025. This is consistent with an audit-driven surge in case identification.

481. The incident data is dominated by process-related risks with ‘Clinical Process’ as the primary incident type in 236 cases, while ‘Clinical Communication’ and ‘Patient Flow’ account for nine and eight cases, respectively.

482. Classification tags used to record information in the Riskman system reinforce this picture, with clinical process appearing frequently in the data, clinical communication present in 4.7% of incidents, and patient flow in a smaller proportion. This distribution indicates that most Disrupted Care cases arose from failures in routine operational pathways. These included booking of appointments, follow up, referral handling, and list management, rather than as isolated incidents.

483. Four SAC 1 incidents reflect the most serious patient safety exposure, each linked to missed follow up in the context of suspected or confirmed malignancy:

(a) one patient had a planned follow up that was not booked. He subsequently re-presented via GP referral and was found to have high-grade prostate cancer, with work up proceeding only after re-referral;

(b) a further patient underwent an MRI guided prostate biopsy with a Gleason score of 3+4=7 (ISUP 2) but was not recalled for results, leaving both the patient and GP unaware of a positive diagnosis until a new referral in 2025;

(c) a third patient had a follow up appointment cancelled and remained on a waitlist without rebooking, despite histology indicating a Gleason score of 4+5=9, a scenario with a clear risk of progression during delay; and

[218] THS.001.001.0871 *Urology Audit Results – Lost Unclear*, up to 31 July 2025 as at 22 October 2025.
[219] THS.001.001.0872 *Urology Audit Results – MRI Cohort,* up to 31 July 2025 as at 22 October 2025.

(d) the fourth patient was lost to follow up after an MRI guided biopsy confirming high-grade prostate cancer. Urgent efforts were later required to expedite imaging and clinic review.

484. Collectively, these cases evidence harm potentially arising from missed result disclosure, the absence of timely rebooking of appointments, and clinic cancellations without active recovery of care.

485. The data points to a small number of recurring failure modes. These are, missed rebooking opportunities after FTA or hospital initiated cancellations, with no subsequent clinician notes, no correspondence being provided to GPs, and no waitlist placement.

486. The Investigators considered that there were also gaps identified in post-procedure workflow, where PDARs were not completed, causing follow-up to be absent despite documented plans. List/template rearrangements, clinician unavailability, and outsourced procedure coordination also create multiple deferrals without an assured recovery step.

487. A smaller subset reflects communication issues, for example, incorrect recipient details on internal referrals, limited cross-team communication during prolonged inpatient fasting, or cancellations without direct patient contact and a lack of explicit plan updates. These weaknesses cluster within booking and results management pathways rather than within the frontline clinical decision-making pathways.

488. Beyond the SAC 1 cohort, the register contains multiple incidents referencing prostate cancer and urothelial malignancies. Several patients experienced substantial delays in surveillance, for example, bladder cancer flexible cystoscopy programs and active surveillance for prostate cancer, and at least one case recorded the patient as deceased in 2025 after experiencing Disrupted Care. While most incidents were categorised as SAC 2–3, the thematic alignment with cancer pathways makes the aggregate risk nontrivial. In oncology adjacent care, a process failure can quickly translate into clinical deterioration or missed treatment windows.

489. Three system observations were noted by the Investigators:

(a) firstly, cancellation recovery was inconsistent. Where clinics are closed or clinicians are unavailable, many records lack evidence of a forced rebooking, safety netting letter, or waitlist placement;

(b) secondly, result bearing incidents such as biopsy, TURBT/TURP histology, and post imaging reviews showed repeated patterns of no appointment being booked or no documented patient disclosure, which elevates patient harm risks; and

(c) thirdly, the interface with outsourced diagnostics and procedures was fragile. There was more than one case that required ad hoc follow up of external imaging results, contributing to delays beyond expected care timeframes. These are resolvable with stronger coordination of the administrative pathway and clearer accountability. This is important to resolve, noting the Investigators have been advised by the previous HSCE that it is accepted practice at THHS for patients with malignancies to be referred to external diagnostics.

490. Across the case register, there were 93 SAC 2 incidents, representing 36.6% of all logged incidents. Their primary incident type is related to clinical process (93 cases), with smaller contributions from clinical communication and patient flow. This combination positions SAC 2 incidents as operationally driven risks where gaps in booking, follow-up, referral handling, and results management have direct potential to escalate into patient harm.

491. Failure signals within the SAC 2 subset were notable. Mentions of failed attendance and explicit FTA references appear in approximately 49.5% of cases. Hospital initiated cancellations or clinician unavailability occur in approximately 26.9% of cases and reschedules or list/template rearrangements feature in approximately 12.9% of cases. Together, these patterns demonstrate

that once appointments are disrupted, recovery to a safe follow up pathway is not reliably executed.

492. Result bearing incidents were prominent. Biopsy or histology references were present in approximately 5.4% of SAC 2 incidents, and cancer related terms appear in approximately 7.5% of these records. This alignment with diagnostic result management increases the likelihood that delays will translate into missed treatment windows or prolonged uncertainty for patients.

493. Communication factors were documented in the classifications of 5.3% of SAC 2 incidents. While not the majority, the presence of communication issues alongside process failures indicates multi-factorial risk. Appointment disruption compounded by inadequate contact, incomplete correspondence, or unclear discharge decisions create multiple points where patients can experience Disrupted Care.

494. The notification patterns mirror the broader audit driven identification spike, with most SAC 2 notices concentrated in October 2025. This clustering suggests that the observed exposure is structural rather than episodic. Addressing this requires system safeguards that make it difficult for any result bearing encounter or cancer adjacent pathway to progress without a booked follow up, documented disclosure and an auditable recovery step after any disruption.

495. In summary, SAC 1 cases were related to patients with prostate cancer that have experienced Disrupted Care. These cases were either not booked for a follow up appointment or not followed up after diagnostic testing had been undertaken.

496. A material subset of SAC 2 cases reflect high-risk scenarios (suspected or confirmed malignancy, missed post-op reviews) requiring immediate prioritisation.

497. The case reviews are dominated by SAC 3 incidents, indicating widespread, systemic moderate-risk delays in follow-up and surveillance.

498. SAC 4 cases are fewer and typically relate to discharge, private transfer, or administrative closure. However, documentation consistency remains a significant concern.

Recommendation 11	That the THHS apply resource and scheduling interventions to target the SAC 2 cohort of patients identified during the clinical audit (triggered by Cluster 10) of TUH patients who are connected to or receive urology services, with a parallel, scalable process to reduce the SAC 3 backlog.

9.6.3 Analysis of SAC 1 Clinical Incident Reviews as at December 2025

499. In assessing and identifying the systemic issues that lead to patients in delivery of urology services experiencing Disrupted Care, the Investigators have specifically reviewed the SAC 1 CIR Reports provided to the Investigators by the THHS. These provide a greater depth of analysis than the standard SAC incident reports.

500. The THHS provided six completed CIR reports relating to actual or potential SAC 1 cases to the Investigators. These cases, after review, included three confirmed SAC 1 cases and a cluster of three SAC cases, which identified one SAC 1 case with two cases being re-categorised as SAC 2 cases. In total, there were four SAC 1 cases and two SAC 2 cases individually reviewed by the Investigators.

501. These cases are detailed below. The detail provided allowed the Investigators to consider further the referral and escalation processes relating to the incidents and the identification of systemic issues and the recommended actions considered by the THHS and the effectiveness of these actions.

Case 1:[220]

502. A [redacted] was lost to follow-up, experienced delays in oncology referral, and subsequently died from bladder cancer. This incident was classified as a SAC 1 incident, representing serious harm not reasonably expected, and was formally reported under the *Hospital and Health Boards Regulation 2012* (Qld).

503. The patient had a history of [redacted] and developed progressive urological symptoms from [redacted] 2021. A diagnosis of bladder small cell carcinoma was made in [redacted] 2023. Despite urgent need for oncology intervention, referral delays occurred, contributing to deterioration and death on [redacted] 2023.

504. The review team, including representatives from Urology, Medical Oncology, Radiation Oncology, and the SSG, conducted a comprehensive case review of documentation, timelines, and contributing factors. Family discussions were documented during end-of-life care planning.

505. It is noted by the Investigators that the CIR made no new recommendations as it was considered that the existing actions following previous clusters and the then RATP[221] were considered sufficient to mitigate future risks. Previous recommendations included developing a local bladder cancer pathway with defined time limits and early multidisciplinary referral.[222] Actions focused on continuing the RATP implementation, workforce recruitment, and care coordination improvements, with monitoring of pathway development.[223] The Investigators were advised in May 2026 that the TUH bladder cancer pathway had now been implemented but have not sighted a copy.

506. Enhancements to care coordination roles and systemic referral processes were identified as priorities. Progress is to be reported to the ECGC and the BARC, with evaluation submitted through PSC processes.

507. The Investigators consider that there were further recommendations that the CIR could have considered had a more detailed analysis been undertaken to identify the underlying causes of the patient experiencing Disrupted Care.

Case 2:[224]

508. A [redacted] was lost to follow-up and experienced an ultra-long delay in diagnosis and treatment of [redacted] cancer, resulting in metastatic disease requiring palliative care. This SAC 1 incident was reported under the *Hospital and Health Boards Regulation 2012* (Qld).

509. The patient was referred in [redacted] 2022 for lower urinary tract symptoms and elevated PSA, triaged as Category 2 (appointment within 90 days). The patient waited 549 days for their first specialist appointment and 782 days for their biopsy. A diagnosis of a high-grade [redacted] cancer with [redacted] metastases was made.

510. The review team examined referral triage, waitlist management, and service capacity and included staff interviews, audits of referral/waitlist data, and external specialist opinion. GP correspondence documented worsening symptoms, highlighting the patient's prolonged and distressing experience.

511. No new recommendations were made in the CIR which acknowledged ongoing work within urology services as it was considered that the risks were already addressed through the RATP,

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[220] Annexure E – SAC Review Summary; THS.001.001.1922 Cl[redacted] RiskMan.
[221] THS.001.001.0087 THHS Board, Cover Note: Urology Services Improvement Implementation Action Plan, 8 July 2025; THS.001.001.0031 THHS, *Risk Assessment and Treatment Plan,* 25 August 2023; THS.001.001.0189 THHS Board, *Board Audit and Risk Committee: Risk 362,* 19 March 2025; THS.001.001.0324 THHS, *Risk Assessment and Treatment Plan,* 28 August 2023.
[222] THS.001.001.0087 THHS Board, *Cover Note: Urology Services Improvement Implementation Action Plan*, 8 July 2025; WIT.003.001.0001 Transcript of Interview – Witness Q, paragraphs 43-55; WIT.002.001.0036 Transcript of interview – Witness L, paragraphs 25-29.
[223] THS.001.001.0087 THHS Board, Cover Note: Urology Services Improvement Implementation Action Plan, 8 July 2025.
[224] THS.001.001.1929 Cl[redacted] RiskMan.

which outlines 31 treatment actions including workforce recruitment, improved triage protocols, leave management, and real-time scheduling.

512. Further activities considered included escalation of systemic delays to the organisational level, consideration of an overarching custodian for cancer pathways, recruitment of additional SMOs and Fellows, exploration of fly-in/fly-out workforce models, and enhancement of Clinical Nurse Consultant (**CNC**) roles for care coordination. Evaluation was to be reported to governance committees, with a full review by December 2025. Organisational risk was formally escalated to Patient Safety and Clinical Governance Committees in March 2025.

513. The Investigators consider that there were further recommendations that the CIR could have considered had a more detailed analysis been undertaken to identify the underlying causes(s) of the patient experiencing Disrupted Care.

Case 3:[225]

514. A [redacted] transitioned [redacted] cancer management to [redacted] GP during a procedural appointment without formal handover, resulting in loss to follow-up and progression to metastatic disease. This SAC 1 incident was reported under the *Hospital and Health Boards Regulation 2012* (Qld).

515. The patient, initially managed with active surveillance for low-grade [redacted] cancer, requested transition of care to [redacted] GP in [redacted]. No discharge summary or formal communication occurred, leading to discontinuation of specialist surveillance. In early 2025, the patient presented with severe urinary symptoms and was diagnosed with metastatic disease to the [redacted]

516. The review team included representatives from the SSG, the GP Liaison Officer, the Interim Medical Director, and the previous CMO who reviewed the medical record, interviewed staff, and examined discharge and referral processes. Consumer input was not explicitly documented.

517. As no patient discharge summary was generated, the GP likely assumed TUH was continuing to provide surveillance. Referral management delays occurred in early 2025. Safety netting had improved with the introduction of a [redacted] Nurse in 2024, but systemic gaps in patient tracking remained.

518. No new recommendations were made by the CIR as they considered that actions were underway through the RATP.[226] These included developing a formal discharge process with clear handover and escalation parameters, strengthening shared care arrangements and GP education, exploring permanency for the Surveillance Nurse role, and addressing referral management delays through recruitment and process improvements.[227] Actions focused on continuing RATP implementation, workforce recruitment, and care coordination improvements, with monitoring of pathway development due by March 2026.[228]

519. Further improvements considered include enhancing communication systems between TUH and GPs and ensuring compliance with referral triage time limits. Implementation responsibilities

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[225] Annexure E – SAC Review Summary; THS.001.001.1933 Cl [redacted] THHS RiskMan Report, 10 March 2025.
[226] THS.001.001.0666 THHS, Risk Assessment and Treatment Plan, 19 December 2024 to 13 February 2025, updated 17 October 2025; THS.001.001.0088 Board Safety and Quality Committee, *Cover Note: Urology Services Action Plan and Update,* 11 August 2025; THS.001.001.1906 Board Executive Committee, *Cover Note: Risk Report,* 20 January 2025.
[227] THS.001.001.0087 THHS Board, *Cover Note: Urology Services Improvement Implementation Action Plan*, 8 July 2025; WIT.003.001.0001 Transcript of Interview – Witness Q, paragraphs 56-65.
[228] THS.001.001.0087 THHS Board, *Cover Note: Urology Services Improvement Implementation Action Plan*, 8 July 2025. WIT.001.001.0074 THHS, *Case Review Report,* signed 9 May 2025; WIT.001.001.0075 THHS, *Case Review Report*, signed 15 May 2025; WIT.001.001.0076 The Australian Council on Healthcare Standards, *Governance Standard Consultancy: THHS,* January 2024; WIT.001.001.0077 THHS Clinical Governance External Review, *Clinical Governance Improvement Action Plan*, final agreed plan 17 May 2024; THS.001.001.0652 The Australian Council on Healthcare Standards, *Final Assessment Report: THHS*, assessed on 19-20 December 2024; WIT.001.001.0079 The Australian Council on Healthcare Standards, *Initial Assessment Report: THHS*, assessed on 23-27 September 2024.

were assigned to specific roles including the Nursing Director, the GP Liaison Officer, and the Medical Director, with completion due by December 2025.

520. The Investigators consider that there were further recommendations that the CIR could have considered had a more detailed analysis been undertaken to identify the underlying cause(s) of the patient experiencing Disrupted Care.

Cases 4,5 and 6:[229]

521. Between January 2021 and December 2023, a cluster review was undertaken of 32 bladder cancer cases within the service. The review identified systemic delays in diagnosis and treatment, which contributed to disease progression and, in two cases, patient death. One of the patients was identified as a SAC 1 incident after review and formally reported under the *Hospital and Health Boards Regulation 2012* (Qld). Two associated cases were managed as SAC 2 Potential High-Risk Incidents.[230] The final report was endorsed and signed off by the previous HSCE in March 2025.[231]

522. The audit revealed significant delays across referral, diagnostic, and treatment pathways. Three patients experienced prolonged care journeys that resulted in adverse outcomes, highlighting the impact of systemic inefficiencies. Workforce shortages, fragmented care coordination, and the absence of a defined bladder cancer pathway were identified as key contributing factors.

523. An investigation was conducted utilising multi-incident analysis, clinical audits, mortality reviews, and expert opinion. The review team comprised representatives from the Medical Services Group, SSG, Clinical Governance, and external urology and oncology specialists. Consumer perspectives were incorporated through family meetings and patient feedback, ensuring that the investigation captured both clinical and patient experience dimensions.

524. The investigation confirmed that delays in referral and treatment were systemic across the cluster. Workforce shortages and limited care coordination capacity were significant contributors to risk. The absence of a local bladder cancer pathway with defined timeframes was identified as a critical gap. These findings were consistent with broader risks highlighted in the Queensland Cancer Strategy 2024,[232] particularly around workforce and service capacity.

525. The primary recommendation was the establishment of a local bladder cancer care pathway with clearly defined target timeframes and processes. Supporting actions included aligning care with international benchmarks, such as the NHS standard of referral-to-treatment within 62 days, enhancing care coordination roles (including expanded responsibilities for the CNC Urology), and improving workforce capacity through recruitment and alternative staffing models. Progress against these actions was being monitored through the RATP, which included 31 discrete initiatives. The Investigators were advised in May 2026 that the TUH bladder cancer pathway had been implemented but have not sighted a copy. With the implementation of the bladder cancer pathway, the Investigators acknowledge that the issues that arose in this cluster ought not to pose a future systemic risk.

526. Further quality improvement initiatives considered include alignment with the national optimal care pathway and the introduction of real-time scheduling improvements to reduce delays. Recommendations were scheduled for implementation and review within six months, with evaluation outcomes to be submitted to the ECGC and the BARC. Endorsement of the report

[229] THS.001.001.1476 THHS, *Multi Incident Analysis Review Report*, 25 March 2025; THS.001.001.1934 THHS, Triage Meeting Outcomes, 26 February 2025.
[230] THS.001.001.1476 THHS, *Multi Incident Analysis Review Report*, 25 March 2025, pages 2-3; THS.001.001.0301 THHS, *Multi Incident Analysis Review Report,* 1 January 2021 to 31 December 2023.
[231] THS.001.001.1476 THHS, *Multi Incident Analysis Review Report*, 25 March 2025; THS.001.001.0301 THHS, *Multi Incident Analysis Review Report,* 1 January 2021 to 31 December 2023.
[232] Queensland Health, *Queensland Cancer Strategy 2024*, July 2024. Electronic copy available at: https://www.health.qld.gov.au/__data/assets/pdf_file/0026/1354436/Queensland-Cancer-Strategy-2024_Digital.pdf.

was provided by the Director of the Medical Service Group, the Director of the SSG, the EDCG and the previous HSCE.

SAC 1 Case Summary

527. Overall, the SAC 1 incidents identify four patients who had cancer treatment delayed because they experienced Disrupted Care. One of the patients has subsequently died. It was noted that the recent SAC 1 reviews of patients who are connected to or receive urology services relied on the recommendations of the earlier SAC 1 reviews and that the more recent reviews did not provide additional recommendations as would be considered under clinical governance frameworks.

528. The identification of gaps and opportunities would have been facilitated by a more detailed analysis.

529. It is noted that four SAC 1 cases that were provided by TUH for review. The Investigators believe that this dataset underrepresents the true scale of harm experienced by patients and raises concerns about completeness of reporting and the adequacy of governance oversight. The potential under-representation of cases suggests that the THHS may not have identified the breadth of serious incidents, thereby limiting the ability of the THHS to understand and respond to systemic risks.

530. The Board advised the Investigators that the responsibility for ensuring completeness of CIR reporting rests with the HSCE and EDCG under the Clinical Incident Management Guideline.[233]

Recommendation 12	That the THHS ensure that current and future SAC 1 incidents identified through the current clinical audit (triggered by Cluster 10) are reviewed in such a way as to identify and mitigate underlying causes of patients experiencing Disrupted Care.
Recommendation 13	(Priority) That the THHS urgently obtain an independent review of the original SAC 2 cases identified through the current clinical audit (triggered by Cluster 10) of patients who are connected to or receive urology services to determine if any of these cases should be reclassified as SAC 1 cases pending clinical review. This is based on the Investigators' review of the SAC data where it appears that some SAC 2 cases should have initially been classified as SAC 1.

9.7 Identification of Systemic Issues

531. The Investigators consider that the identification of systemic issues during the period from January 2022 and July 2025 by THHS as clusters arose was limited. It was noteworthy that the THHS had not undertaken a detailed analysis to inform their response and SAC 1 CIRs.

532. The Investigators identified documentation gaps in the cases reviews. Patients were not consistently placed on review waitlists, correspondence was not provided to GPs, and outsourced imaging follow-ups were missed. These failures contributed to delayed treatment pathways, and breaches of referral timeframes.

533. There were rudimentary systems in place to track high-risk cohorts, such as patients requiring cancer surveillance or urgent post-operative reviews. For example, templates designed to

[233] The Board's Natural Justice Response.

monitor clinical variation were not completed at the unit level, resulting in no meaningful oversight at that level.

534. This lack of visibility means critical cases were not prioritised, and delays went unnoticed until adverse outcomes occurred.

535. Staff escalated requests for additional administrative and nursing resources through the Outpatient Planned Care Steering Group. There is no evidence before the Investigators that escalation to QH occurred.[234]

536. In response to the issues identified through the reviews of the various clusters identified in the AcciMap developed by the Investigators, the THHS had introduced changes to policies and processes within the service.

537. The Investigators consider that some of the THHS actions represented a limited response to a complex issue and that the implementation methodology was not as robust as it could have been. For example, there was no evidence that the memorandum dated 18 December 2023 related to the discontinuation of the Bulk Check Out process across the health service incorporated an effective implementation process including a post implementation review or audit.

538. Separately, a key procedure change relating to the development and implementation of a new THHS procedure, the Outpatient Appointment Management Procedure (Version 2 June 2025) was not fully operationalised until June 2025.

539. The THHS did consider the systemic issues, however, because a detailed exploration of the underlying cause was not undertaken, the actions to address underlying causes lacked specificity and, on some occasions, created new problems which were not anticipated by the THHS. An example of this was the circulation of the memorandum to suspend Bulk Check Out across the health service in 2023 which had unintended consequence by creating a new group of patients that experienced Disrupted Care.

540. The THHS had developed several RATPs to respond to matters in the delivery of urology services.[235] These related to workforce challenges and patients experiencing Disrupted Care. The Investigators considered that these RATPs were complex and lengthy and would have been difficult for staff working in urology services to operationalise. The previous HSCE advised that they were of the view that this is not true in practice.

541. The Investigators believe that given the recurring nature of the issues affecting urology outpatients that a "force function"[236] is required to provide an additional layer of safety. Such a force function could be the development of "Never Lost Pathways."

9.7.1 Consideration of the development of a Never Lost Pathway

542. The Investigators consider that the TUH urology outpatient service requires a structured, closed loop clinical pathway to ensure that no patient inadvertently experiences Disrupted Care at any stage of their care. The previous HSCE advised in May 2026 that a closed loop system is now in place for investigations.[237]

543. The Investigators note that the actions taken by the THHS to address patients who experienced Disrupted Care, who are connected to or receive urology services, have had limited impacts as

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[234] THS.001.001.2207 THHS, *Access to Planned Care Leadership Group,* 5 September 2024, page 8; THS.001.001.2235 THHS, *Outpatient Care Planned Care Steering Group,* 19 December 2024, page 10.
[235] For example, THS.001.001.0324 THHS, *Risk Assessment and Treatment Plan*, 28 August 2023, THS.001.001.0359 THHS, *Risk Assessment and Treatment Plan,* 19 December 2024 to 13 February 2025.
[236] A "force function" in patient safety refers to a design feature in a system or process that makes it impossible or extremely difficult for a person to perform an unsafe action. It's one of the strongest forms of error-prevention because it doesn't rely on memory, vigilance, or training. Instead, it physically or logically prevents the error from occurring.
[237] Consulted Parties' Natural Justice Response.

evidenced by the recurrent nature of patients experiencing Disrupted Care despite the development of RATPs.

544. The Investigators consider that a "Never Lost Pathway" would provide a systematic, risk based framework that would ensure that referral, investigation, and follow up actions were captured, monitored, and completed within defined clinical timeframes. This approach strengthens patient safety, reduces unwarranted variation, and supports compliance with clinical governance standards.

545. The pathway would begin with the identification of high risk clinical cohorts, including patients with elevated PSA, haematuria, renal masses, abnormal imaging, or postoperative surveillance requirements. These cohorts would then be prioritised because delays or missed follow up could result in significant clinical deterioration or delayed cancer diagnosis.

546. The pathway would be activated through defined trigger incidents. These may include the receipt of a specific (high risk) GP referral, abnormal pathology or imaging results, ED discharge requiring urology follow up, MDT recommendations, or specific (high risk) post-operative discharge summaries.

547. The Investigators consider that a digital health service such as THHS, with its advanced data analytics capacity including the development of local dashboards would be able to consolidate and report on information held in the EMR and ESM and other systems to provide a comprehensive data set and system to inform reporting on a "Never Lost Pathway".

548. Governance of any system and system ownership would need to be clearly defined by the THHS.

549. The Investigators further consider that there is an opportunity for QH to consider the development of "Never Lost Pathways" within its digital services.

550. The Investigators note that "Never Lost Pathways" would be most valuable in parts of the health system where fragmented processes, multiple handovers, or unclear accountability create a risk that patients may be overlooked.

551. They would be particularly important for categories of patients which could include:

(a) the follow-up of abnormal diagnostic results, where timely review and action are essential to prevent harm;

(b) outpatient referral and triage processes by ensuring that referrals are received, prioritised, and actioned within clinically recommended timeframes;

(c) transitions of care such as discharge from inpatient wards, or inter-hospital transfers;

(d) long-term surveillance for chronic or complex conditions that rely on structured recall systems to prevent silent deterioration; and

(e) supporting vulnerable or complex patient groups who are at greater risk of disengagement or missed follow-up.

552. THHS have expressed concern with their ability to implement a Never Lost Pathway for reasons including resourcing, technology capabilities, data reliability, training and compliance. THHS indicated they would however support the development and rollout of a Never Lost Pathway if it was a whole-of-QH initiative.[238]

[238] THHS Natural Justice Response.

553. The Investigators note the THHS advice, however, are of the view that a structured force function such as the Never Lost Pathway is required.

Recommendation 14(a)	That the THHS resource and support urology services to undertake the appropriate levels of clinical and administrative audits. These audits be monitored through the THHS governance structure so that the THHS BSQC can be assured that appropriate audits are in place and ongoing.
Recommendation 14(b)	(Priority) That the THHS work to establish a "Never Lost Pathway" within TUH urology services.
Recommendation 14(c)	(Statewide) That QH consider the opportunities to develop "Never Lost Pathways" for high risk clinical conditions within its digital framework, and particularly those related to cancer care as a system-wide patient safety initiative.

9.8 Advice provided to regulators

554. The *Advisory AS18/06: Accreditation assessment requirements of health service organisations post significant clinical or governance review,*[239] was first published in October 2018 and revised in April 2025. It requires that external and internal reports into safety and quality issues, clinical governance or safety breaches which are described in this advisory as major safety and quality reports are to be reported to the accrediting agency.

555. The *Health Ombudsman Act 2013* (Qld) (**HOA**) also establishes clear obligations for health service providers to notify the OHO when serious adverse clinical incidents occur. These provisions are designed to ensure transparency, accountability, and timely regulatory oversight in circumstances where patient safety has been compromised.

556. The HOA empowers the Ombudsman to investigate systemic risks in health services, including repeated adverse incidents or failures in care pathways.

557. The Investigators are not aware, from the documentation provided during the evidence gathering process, if such a notification has occurred to the regulatory bodies including the Coroner.

558. The Board advised the Investigators that it:

> observes the obligation to notify regulatory bodies (including the Coroner, Office of and Australian Commission on Safety and Quality in Health Care (ACSQHC)) under the Health Ombudsman Act 2013 (Qld), the CIM Guideline, and ACSQHC Advisory AS18/06 rests with the HSCE and clinical governance officers, not with the Board. If notifications were not made to regulatory bodies at the appropriate time, that is an operational failure by the officers responsible for such notifications. It is not a Board governance function.[240]

Recommendation 15	That the THHS confirm that appropriate notifications have been provided to the ACHS, the OHO and the Coroner following the clusters of patients experiencing Disrupted Care who are connected to or receive urology services and provide this confirmation to the THHS Board.

[239] Australian Commission on Safety and Quality in Health Care, *Advisory AS18/06: Accreditation assessment requirements of health service organisations post significant clinical or governance review*, 2 April 2025. Webpage can be accessed here: https://www.safetyandquality.gov.au/newsroom/national-standards-updates/advisory-as1806-accreditation-assessment-requirements-health-service-organisations-post-significant-clinical-or-governance-review.
[240] The Board's Natural Justice Response.

9.9 Findings related to THHS implementation, monitoring and evaluation from previous reviews or analyses

559. The Investigators note the TOR require them at item 3.1(d) to consider the implementation, monitoring and evaluation by THHS of actions and recommendations from previous reviews or analyses (including through incident analysis and any action plans) in relation to urology services at TUH during the relevant period.

560. In responding, the Investigators have been able to draw on external assessments of clinical governance systems, consider the structured THHS response to identified risks and consider how individual clusters were responded to.

561. The following sections of the Report relate to these areas:

(a) Section 9.9.1 responds to previous reviews at a system level of clinical governance within the health service and in particular the external review of Clinical Governance undertaken in January 2024; and

(b) Section 9.9.2 responds to governance, and the RATPs developed by the THHS in responding to emerging risks relating to urology services.

562. By structuring the material in this manner, system level responses through to individual case responses can be considered.

9.9.1 Clinical Governance Improvement Action Plan (2024)

563. Following the external review of Clinical Governance at TUH in January 2024, an improvement action plan was developed to address identified gaps and strengthen organisational resilience.[241] By July 2025, all actions were reported as completed, with strategic assessments confirming that recommendations across governance, risk management, workforce capability, and clinical practice oversight had been implemented.[242] The plan was formally tabled at key committees and received executive sign-off, ensuring alignment with organisational strategic priorities and embedding reforms into the hospital's governance framework.[243]

564. The action plan aimed to deliver structural, cultural, and operational improvements. Governance reporting was streamlined, reducing duplication and improving clarity for the Board. Committee structures and performance meetings were revised to enhance efficiency, and ensure discussions were focused on strategic priorities. Risk management processes were strengthened by listing high-risk clinical items individually, improving visibility, and integrating assurance models into reporting and internal audits.

9.9.2 Governance Response and RATPs

565. Clinical governance is designed to ensure accountability for safety and quality through structured systems such as incident management, risk assessment, and continuous improvement. While some of these systems existed and were supported by policies and procedures, operationally there were issues with their application and accordingly, not as evident as the Investigators considered that they should be in a tertiary service.

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[241] WIT.001.001.0077 THHS Clinical Governance External Review, *Clinical Governance Improvement Action Plan*, final agreed plan 17 May 2024.
[242] WIT.001.001.0077 THHS Clinical Governance External Review, *Clinical Governance Improvement Action Plan*, final agreed plan 17 May 2024.
[243] WIT.001.001.0077 THHS Clinical Governance External Review, *Clinical Governance Improvement Action Plan*, final agreed plan 17 May 2024.

566. There were delays identified in adverse clinical incident identification and reporting which meant that recurring adverse incidents and systemic risks in the delivery of urology services were not identified or addressed in a timely manner. Leadership gaps during the relevant period compounded these issues, executive engagement was perceived to be limited with staff from urology services reporting limited face to face engagement with the previous HSCE, the COO 1 and the EDCG. The previous HSCE advised they meet monthly with the leadership of each clinical service group, specifically the Service Group Director, Nursing Directors and Medical Directors. They attend the Medical Heads of Department meetings each month. They also indicated they meet specifically with the Medical Directors and the CMO each month.[244]

567. One of the management actions used by the THHS during the relevant period was the development of formal RATPs. These plans were considered critical actions to prevent recurrence of patients experiencing Disrupted Care, safeguard patient safety, and restore compliance with optimal care standards.

568. These RATPs were developed in response to the clusters of patients who received less than optimal urology care.[245]

569. The Investigators considered these plans and found them complex and on face value would have been difficult for clinical staff to effectively operationalise. The previous HSCE advised that this is not true in practice.[246]

570. The Investigators also note that the THHS has a published Clinician Engagement Strategy which identifies that:

> Clinicians need the support of, and their issues and opinions understood by, the Townsville HHS. Likewise, it is important that clinicians are enabled to understand the broader economic, legislative, technological and other service delivery pressures impacting the Townsville HHS.[247]

571. This statement implies that leaders must understand the lived experience of clinicians, and clinicians must understand the pressures shaping executive decisions and most importantly that leaders design systems with clinicians rather than design systems for clinicians.

572. In summary, the Investigators considered that a close working relationship between executive management and the front line clinicians is an important consideration. This is outlined in the THHS Clinician Engagement Strategy 2025 – 2028[248] which identifies that clinicians need the support from executive management and have their issues and opinions understood.

Recommendation 16	That the THHS consider how to further progress the THHS Clinical Engagement Strategy as part of the support for urology services.
Recommendation 17	The urology services RATPs be updated and streamlined to include responses to the issues identified in this Report.

[244] Consulted Parties' Natural Justice Response.
[245] THS.001.001.0189 THHS Board, *Board Audit and Risk Committee: Risk 362,* 19 March 2025; THS.001.001.0666 THHS, *Risk Assessment and Treatment Plan: Risk 362 RATP,* updated 17 October 2025; THS.001.001.1911 THHS, *Board Safety and Quality Committee: Risk 371,* 9 June 2025; THS.001.001.1537 THHS, *Risk Assessment and Treatment Plan,* 28 August 2023; THS.001.001.0663 THHS, *Briefing Note, RATP: Outpatient Lost to Service,* 5 October 2023; THS.001.001.0031 THHS, *Risk Assessment and Treatment Plan,* 25 August 2023; THS.001.001.1742 THHS, *Board Executive Committee, Risk Report,* 15 July 2024; THS.001.001.0172 THHS, *Cover Note: Board Audit and Risk Committee, Risk 259 Workforce Sustainability Deep Dive,* 17 July 2024.
[246] Consulted Parties' Natural Justice Response.
[247] THHS, *Clinician Engagement Strategy 2025 - 2028.* Electronic copy available at: https://cdn.townsville.health.qld.gov.au/tgh/documents/clinician_engagement_strategy_2025-2028.pdf.
[248] THHS, *Clinician Engagement Strategy 2025 - 2028.* Electronic copy available at: https://cdn.townsville.health.qld.gov.au/tgh/documents/clinician_engagement_strategy_2025-2028.pdf.

9.10 Actions and findings relating to the THHS management of clusters

573. The following is a summary of the background to, and actions taken because of, clusters occurring in the delivery of urology services within THHS. The Investigators findings are outlined below.

Cluster 1 (July 2022)

574. Eight patients experienced Disrupted Care in July 2022, including two urology patients.[249] The issues and themes of the incidents relating to urology were identified in a cover note to the Board on clinical incident trends in outpatient processes as being related to delay to follow up of critical results and outpatient scheduling.[250] The issues and themes identified for the remaining outpatients who experienced Disrupted Care were triage, scheduling and follow up of results.[251]

575. The Investigators were not provided with evidence indicating specific actions taken in relation to these patients that experienced Disrupted Care. The BSQC were however informed on at least two occasions of the case management (August 2022 and December 2022).[252]

576. There is evidence to suggest that a separate body of work was being progressed at the time in relation to the reporting of patients not being treated within recommended wait times, such as a urology audit of Category 2 and Category 3 patients waiting outside the recommended timeframe as requested by COO 1. This commenced in June 2022.[253] COO 1 advised that this was undertaken because of the increase in elective surgery and outpatient long wait lists post-COVID. The aim of the activity was to escalate any patients with clinically urgent requirements.[254] COO 1 further advised that the administrative audit aimed to support wait list management, ultimately reducing FTA's, removing patients who no longer required an appointment (e.g. they had moved to another catchment, been seen privately etc) and thus freeing up appointments for other patients. The wait list audit was to complement other actions relating to the management of Cluster 1 by the EDCG.[255]

577. The other resource consideration relating to urology services related to workforce availability.[256]

578. The Investigators noted that there was no specific mention in the performance and accountability Meeting minutes for SSG of any escalations in relation to patients experiencing Disrupted Care or specific actions being undertaken from this forum from July to December 2022 when the issue of patients experiencing Disrupted Care were first raised.[257] COO 1 advised that in 2022 the SSG performance and accountability meeting agendas did not specifically include standard line items for patient safety or risk areas. However, COO 1 advised that other meeting agendas and reports considered this information.[258]

579. In late 2022, COO 1 sought reassurance from the EDCG regarding the actual clinical risk that existed in the delay in treating urology Category 1 patients. This was delegated to the Nursing

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[249] THS.001.001.2042 THHS, *Executive Clinical Governance Committee Endorsed Meeting Minutes,* 28 July 2022, page 12; WIT.003.001.0004, *Lost to follow up risk submission,* 6 November 2025, page 1; WIT.003.001.0006 THHS, *Board Safety and Quality Committee: Clinical Incident Trends in Variation in Outpatient Processes,* 24 August 2022, page 230.
[250] WIT.003.001.0006 THHS, *Board Safety and Quality Committee: Clinical Incident Trends in Variation in Outpatient Processes,* 24 August 2022, page 229-230.
[251] WIT.003.001.0006 THHS, *Board Safety and Quality Committee: Clinical Incident Trends in Variation in Outpatient Processes,* 24 August 2022, page 230.
[252] WIT.002.001.0003 Transcript of Interview - Witness AE, pages paragraphs 19-29; WIT.003.001.0006 THHS, *Board Safety and Quality Committee: Clinical Incident Trends in Variation in Outpatient Processes,* 24 August 2022, page 230; WIT.002.001.0026 Transcript of Interview – Witness Y, paragraphs 22-23.
[253] THS.001.001.1305 Email, sent on 31 May 2022.
[254] THS.001.001.1305 Email, sent on 31 May 2022.
[255] Consulted Parties' Natural Justice Response.
[256] THS.001.001.0011 THHS, *Cover Note to the Board Executive Committee,* 17 October 2022, page 85; THS.001.001.2080 THHS, *Surgical Service Group: Monthly Performance Report,* June 2022, page 13.
[257] THS.001.001.2080 THHS, *Surgical Service Group: Monthly Performance Report,* June 2022; THS.001.001.2083 THHS, *Surgical Service Group Performance and Accountability Meeting,* 22 August 2022; THS.001.001.2090 THHS, *Surgical Service Group Performance and Accountability Meeting,* 20 October 2022; THS.001.001.2092 THHS, *Surgical Service Group Performance and Accountability Meeting*, 22 November 2022.
[258] Consulted Parties' Natural Justice Response.

Director Surgical Service Group (**NDSSG**) who responded to the EDCG and COO 1 and stated that all these patients needed to be seen by a medical officer with urology expertise to determine ongoing risk.[259]

580. In response to Cluster 1, an Outpatient Improvement Steering Group was established with the endorsement of the BSQC after the issue was escalated from the PSC.[260]

581. With respect to a proposed look back recommended by the DMSCGDH, it is noted that this was not progressed at this time.[261] The Investigators note that the DMSCGDH is trained as a specialist in medical administration.[262] In this context, some staff in the THHS expressed a view that there was limited priority given to the proposed look back not being progressed.

Cluster 6 (November 2023)

582. THHS initially identified 157 urology patients experienced Disrupted Care.[263] This cluster was reviewed by the Investigators and found to be due to the manual rebooking process which was not followed and the paper booking forms were misplaced, delayed, or not acted upon.[264]

583. The patients that had been found to have experienced Disrupted Care were transferred to the patient safety team for their review.[265] These were all deemed to be related to booking forms located on .[266] After an initial review the THHS Patient Safety team identified that there were no SAC 1 cases, several SAC 3 cases, and no significant concerns.[267] THHS identified the cause as human error and the EDCG advised Investigators that when human error was identified as the contributing factor, the matter was immediately escalated to the NDSSG for appropriate support and management.

584. COO 1 advised that the patient safety element was governed by the EDCG via the clinical governance unit (in terms of any potential patient harm).[268]

585. An action plan was subsequently developed by the EDCG to be oversighted by the Outpatient Planned Care Steering Group chaired by COO 1.[269] In total, 157 urology patients were eventually confirmed to be part of the cluster termed the “Urology Bundle".[270]

586. COO 1 advised that the Outpatient LTS Group, a specific committee with EDCG and Executive Director Digital Health and Knowledge (**EDDHK**) as Executive Leads, formed in 2023.[271] The Outpatient LTS Group’s purpose was to develop safeguards using digital tools and dashboard. The group also undertook reviews of patients, provided updates to the APCLG and were afforded a full remit to undertake whatever clinical audits were required. This Group reported into the APCLG, meetings which were also attended by the Medical Directors from each Service Group and the CMO.

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[259] THS.001.001.1378 Emails, sent on 12 August 2022, 14 August 2022, 15 August 2022, 19 August 2022.
[260] WIT.003.001.0006 THHS, *Board Safety and Quality Committee: Clinical Incident Trends in Variation in Outpatient Processes,* 24 August 2022, page 1-2.
[261] WIT.002.001.0022 Transcript of Interview – Witness AC, paragraphs 56-60.
[262] Royal Australasian College of Medical Administrators, *Scope of Practice*: *Medical Administration*. Electronic copy available at: https://racma.edu.au/app/uploads/2023/04/RACMA-Scope-of-Practice_Jan-2023_FINAL_web-version.pdf.
[263] THS.001.001.1735 THHS, *Board Safety and Quality Committee: Briefing Note,* 22 April 2024, page 1-2; WIT.003.001.0001 Transcript of Interview – Witness Q, paragraph 29; WIT.003.001.0004, *Lost to follow up risk submission,* 6 November 2025, page 2.
[264] THS.001.001.0047 THHS, *Board Executive Committee Urology and Outpatient Processes Update,* 15 January 2024, page 7.
[265] WIT.003.001.0001 Transcript of Interview – Witness Q, paragraph 29; WIT.002.001.0022 Transcript of Interview – Witness AC, paragraphs 41-44.
[266] WIT.003.001.0004, *Lost to follow up risk submission,* 6 November 2025, page 2; THS.001.001.1312 Email sent on 14 December 2023; WIT.002.001.0003 Transcript of Interview - Witness AE, paragraphs 19-29.
[267] WIT.003.001.0001 Transcript of Interview – Witness Q, paragraph 29.
[268] Consulted Parties' Natural Justice Response.
[269] WIT.002.001.0023 Transcript of Interview – Witness B and Q, paragraph 95-99.
THS.001.001.1771 THHS Board, *Cover Note: Urology Services Improvement Implementation Action Plan*, 8 July 2025;
THS.001.001.0047 Board Executive Committee, *Cover Note: Urology and Outpatient Processes Update*, 15 January 2024, page 2.
[270] THS.001.001.1312 Email, sent on 14 December 2023.
[271] Consulted Parties' Natural Justice Response.

587. The DMSCGDH, previous CMO, EDCG and COO 1 met on 4 September 2023 to discuss concerns about 10 new patients lost to care who were selected from a review of 30 randomly selected patients.[272] There were concerns there could be more patients who were LTS than had been identified. This data was provided to EDCG.[273]

588. In relation to concerns that had been raised, COO 1 provided reassurance to the DMSCGDH on 4 September 2023 that all patients were being booked into appointments before leaving clinics, however, this was later found not to be the case and more patients were subsequently discovered to have been LTS.[274]

589. In an email from COO 1 dated 28 September 2023 to the DMSCGDH, the COO sought clarification on the data source as some of the patients on the list of 10 did not appear to be lost to follow up. The COO 1 stated in his email that:

> There's no doubt we have some issues……Also note that the Access to Planned Care Group is in the process of ensuring all review waitlists are governed consistently and will provide further updates to ECGC in October.[275]

590. In October 2023, COO 1 sent an email to the NDSSG after reviewing the October performance data which indicated that no urology patients had been booked to be seen for at least a two-week period.[276] The NDSSG confirmed that only the [redacted] Urology was seeing patients as all other urologists were on leave.[277] In response, COO 1 gave permission for an International Medical Graduate to be recruited if that would help the situation.[278]

591. The consultants in urology services were becoming unsettled in relation to booking procedures and their workload in late 2023. [279] In November 2023, the [redacted] Urology sent an email to all urology administration staff indicating that [redacted] had bookings to see Category 3 patients in a clinic that [redacted] had set aside to see Category 1 patients only. The Category 3 patients had been booked in as the clinic was still largely unallocated the day prior and these patients had been waiting for 700+ days to be seen. [redacted][280] Towards the end of November 2023, there were also 100 category 2 patients who had been waiting for between 455 to 613 days for an outpatient appointment.[281]

592. Noting the large number of concerns in the delivery of urology services, the NDSSG requested the performance and business informatics team perform an end-to-end review of urology outpatients, of which LTS was a component.[282] The intent was to look at existing processes and identify any opportunities for improvement.

593. The APCLG developed an update on "Lost to Service" paper which was presented to the ECGC on 23 November 2023.[283] The key activities detailed in the paper and the minutes included:

(a) the need to achieve consistency around the governance of the review waitlist;

(b) a body of work related to the development of a dashboard;

[272] THS.001.001.1388 Email, sent on 8 September 2023.
[273] THS.001.001.1388 Email, sent on 8 September 2023.
[274] THS.001.001.1327 Email, sent on 4 September 2023.
[275] WIT.001.001.0137, Email sent on 16 October 2023.
[276] THS.001.001.1320 Email, sent 30 October 2023.
[277] THS.001.001.1320 Email, sent 30 October 2023, page 2.
[278] THS.001.001.1320 Email, sent 30 October 2023.
[279] THS.001.001.1311 Email, sent on 21 November 2021.
[280] THS.001.001.1311 Email, sent on 21 November 2021.
[281] THS.001.001.1405, Email, sent on 30 November 2023.
[282] THS.001.001.1313 Email, sent on 13 December 2023.
[283] THS.001.001.2035, THHS, *Executive Clinical Governance* Committee, dated 23 November 2023, page 4.

(c) discontinued liaison with eHealth Queensland regarding the improvement in the data collected (due date for reviews) in ESM module to support the dashboard development; and

(d) noted that the DMSCGDH raised concerns relating to patients that were lost to follow up and who were not on the outpatient review waiting list. COO 1 advised that the relevant leadership group had plans to address this and offered to meet with DMSCGDH offline to discuss the matter.

594. COO 1 also advised the Investigators that the review due date was made compulsory to populate in ESM on 5 December 2023 in THHS. This was not a mandatory field within the system itself which is managed as a corporate system by eHealth Queensland. COO 1 advised that by making the due date compulsory in THHS, Service Groups and Departments had visibility of how far patients were past their due date.[284]

595. An email was sent in December 2023 from the administration team leader for outpatient services to her line manager, as requested by the EDCG, confirming that the urology bookings officer was checking out patient appointments with outcomes once a clinic slip had been actioned for individual checkouts.[285] The urology bookings officer was instructed, at the time, by the administration team leader that patients were to be placed on the urology review waitlist rather than booking the appointment in advance. This would enable slots to be vacant for one to four week review patients to be booked, as well as not having patients booked too far in advance in case of specialist leave.

596. Assurance around these processes had been sought from the previous HSCE, through the EDCG, to ensure that workflows were not an ongoing issue in the urology outpatient area.[286] This followed a direction in late September 2023 for urology staff to leave appointments checked in/confirmed until follow up action had been completed.[287]

597. At the Planned Care Meeting on 15 December 2023, outpatient issues were discussed. After this meeting a memorandum was issued by the COO 2 on 18 December 2023 advising that Bulk Check Out procedures in clinics were to cease immediately.[288] The memorandum advised that from the time that it was issued that all service groups were to cease the Bulk Check Out of outpatients, that all clinical staff must ensure clinical documentation is present in EMR for all patient appointments by the end of a clinic and that this must include clear and specific follow-up instructions. Administrative staff were then to action each appointment individually from the instruction recorded in the EMR.

598. The Investigators are of the view that by implication, the paper booking forms were to be discontinued given the direction to medical staff to document follow up instructions in the EMR by the end of the clinic and the direction to administrative staff to act on the information in the EMR. COO 1 advised that the implementation across the THHS involved a hybrid process being maintained for a period whereby booking forms continued to be utilised while the new digital processes were being developed and implemented. This change was not implemented in the delivery of urology services until the end of October/November 2025 and as personally directed by the previous HSCE.

[284] Consulted Parties' Natural Justice Response.
[285] THS.001.001.1308 Email, sent on 5 December 2023 and 6 December 2023.
[286] THS.001.001.1308 Email, sent on 5 December 2023.
[287] THS.001.001.1319 Email, sent on 27 September 2023.
[288] THS.001.001.1718 Email, sent on 18 December 2023.

599. **Figure 8: A copy of the Bulk Check Out memorandum**

Townsville Hospital and Health Service

Internal Memorandum

To: All Staff

From: [redacted] **Phone No:** [redacted]

Subject: Outpatient Services

File Ref: AM: 20231218

Dear Colleagues,

On Friday, Service Group Directors, Medical Directors, Chief Medical Officer, Nursing Directors and Administration Managers, BPIO, Executive Director of Allied Health, Executive Director Digital Health and Knowledge and I met to discuss how we can improve the safe management of patients in our outpatient services.

Your participation in these improvements is critical and your cooperation is greatly appreciated. The information below will help you to understand the revised process.

In order to strengthen processes across outpatient services, **effective Monday 18 December:**

All Clinical Staff must:

- Ensure that clinical documentation is present in ieMR for all patient appointments by the end of the clinic. The note must include clear and specific follow up instructions, including required follow up when the patient did not attend. (e.g., review 3 months, RV 1/12, discharge, D/C to GP, rebook). Follow up instruction is documented in ieMR by the end of the clinic appointment.

All Service Groups will cease 'Bulk Check Out' from Monday 18 December.

All admin staff must:

- Action each appointment individually from instruction in ieMR clinical documentation.
- Ensure that the appointment is rebooked and Review Due Date field completed.
- Ensure patient is added to request list for future follow up.

Townsville Hospital and Health Service
Queensland Government
www.townsville.health.qld.gov.au
T +61 7 4433 1111
E THHS.COO@health.qld.gov.au
100 Angus Smith Drive
Douglas QLD 4814
Queensland Government

PART A

PART B

PART C

Administration Team Leaders or Managers within each Service Group are responsible for regular monitoring of outstanding appointments via the Past Outpatient Appointments dashboard.

- Appointments must remain at status 'Checked In' or 'Confirmed' until all follow up actions are completed in ESM.
- Where challenges arise, this must be escalated to Service Group Directors for support.

Appointment can be checked out only once all actions are completed in ESM with the corresponding appointment outcome:

- Follow up appointment required.
- Discharge from Medical Service.
- Referred for Elective Surgery.

I cannot emphasise the importance of this work enough. Together, we can continue to provide outstanding care to our patients. If you need support during this time, please talk to your line manager or consider accessing our employee assistance program Telus.

With Christmas just around the corner, I want to take the time to thank you all for your commitment to providing the best care possible for our patients. Your dedication is valued and appreciated.

Yours sincerely

[redacted]
Acting Chief Operating Officer
18 / 12 / 2023

600. COO 2 advised they acted in the COO role from for a four-week period between December 2023 and January 2024. The officer further advised that during this period the THHS was challenged with weather events, a COVID-19 outbreak affecting staff and reduced staffing levels over the Christmas period. The officer indicated that they consulted with senior managers across the health service prior to circulating the memorandum relating to the cessation of the Bulk Check Out process and that no concerns were raised with respect to this process by senior managers. A suggested plan was also provided to COO 2 for consideration that included a recommendation that a patient look back be undertaken and that post implementation audits be established. COO 2 indicated that they provided a detailed handover in relation to these matters to COO 1

on their return to duty.[289] COO 1 advised that they were updated of the change in process upon their return from leave in January 2024 and was supportive of it.[290]

601. There was discussion as to the implementation of the Bulk Check Out memorandum at the APCLG Meeting in January 2024, where it was recognised that *"paper based processes present risk and limited visibility of clinical plan."* A pilot was being undertaken in the paediatric service to inform the workflow and process which had commenced in early December 2023.[291]

602. COO 1 advised that, in terms of change management processes and post implementation checks, that this included the setting up of a dashboard for Service Groups to monitor and manage appointments that were unactioned (i.e. not yet checked out). COO 1 advised that the SSG facilitated regular meetings with the support of patient safety and oversaw the scheduling of patients and patient outcomes. This was supported by group education for Administration Officers by the BPIO team, as well as 'at the elbow' education undertaken to educate staff on the changes. COO 1 also advised that COO 2 approved four additional administration officers to support the additional workload and transition and that two of these were allocated to the SSG.[292]

603. COO 1 also indicated that a sample compliance audit was undertaken to assess how the rollout was being implemented in early January 2024 and that on 30 January 2024 they requested a clinical audit be undertaken within the SSG to check compliance and feedback any issues.[293] The Investigators do not have any documents before them detailing the sample compliance audit that was undertaken in January 2024. The Investigators note that the clinical audit referred to is described in the APCLG and was to look at patients LTS, following up on sampling and looking at specific waitlists and did not appear to be assessing compliance with the actions identified in the Bulk Check Out memorandum issued in December 2023.[294]

604. [redacted].[295]

605. The COO 1 and previous HSCE had been advised in an email on 7 December 2023 that this was the process being undertaken in urology and that appointments were not being booked in advance.[296] The lack of governance over the change of process had a significant impact on the delivery of urology services and contributed directly to patients experiencing Disrupted Care.

606. Outpatient administration staff were advised to not enter any information retrospectively into the review waitlist, but to focus on cases newly added to the review waitlist or booked.[297]

607. There is evidence to suggest that the Board were seeking assurance in relation to the delivery of urology services at TUH and that the EDCG was coordinating this. There are a series of emails to various staff in relation to an implementation action plan that would pull together the clinical governance and operational actions in a Board briefing paper to form the assurance for the Board. [298]

608. This approach provided the Board with assurances from staff who the Investigators noted were not directly managing the issues. This is evident in emails sent by the EDCG to staff in April 2025.[299]

[289] Consulted Parties' Natural Justice Response.
[290] Consulted Parties' Natural Justice Response.
[291] THS.001.001.2224 Access to Planned Care Leadership Group, *Meeting Book,* 8 February 2024, page 7.
[292] Consulted Parties' Natural Justice Response.
[293] Consulted Parties' Natural Justice Response.
[294]35, Access to Planned Care Leadership Group, *Meeting Book,* 29 February 2024, page 9.
[295] THS.001.001.1362 THHS, *Employee Outcome Letter,* dated 11 April 2024.
[296] THS.001.001.1534, Email, sent on 7 December 2023.
[297] THS.001.001.1310 Emails, sent on 30 November 2023, 5 December 2023, 6 December 2023.
[298] THS.001.001.1466 Email, sent on 15 April 2025.
[299] THS.001.001.1472 Email, sent on 15 April 2025; THS.001.001.1466 Email, sent on 15 April 2025.

609. The Briefing paper that was to be submitted to the Board was to respond to operational and clinical governance aspects which COO 1 was designated to lead.[300]

610. COO 1 advised that they recognised that the ability of a health service to undertake look backs, where matters impacting patient safety are identified. They also acknowledged the Investigators' conclusion that a detailed look back following Cluster 6 would have provided valuable information.[301]

611. Based on the above summary the Investigators formed the view that:

(a) despite good evidence that a more extensive look back should have been considered at this time to identify the patients who experienced Disrupted Care, this was not undertaken and that there seemed to be a focus on the bundle of booking forms identified and located in [redacted] as the cause of patients experiencing Disrupted Care rather than undertaking a detailed analysis to identify the underlying causes. The Investigators consider that the THHS ought to have made inquiries to assure themselves that there were no other urology patients affected as there may have been other instances where the paper booking forms may have been misplaced, lost or not actioned but which were not included in the bundle. If this was found to be the case then this would then have triggered a more detailed lookback; and

(b) actions seemed to be taken by the THHS without an appropriate level of analysis and without adequate consideration of the potential consequences of these actions.

Cluster 7 (November 2023)[302]

612. THHS identified 23 patients (including urology patients) who were outsourced to a private radiology service for a complex medical imaging procedure that experienced Disrupted Care.[303] This cluster was reviewed and found to be due to several factors including the lack of available specialist devices (prostate biopsy needles)[304], the patients having not been identified as requiring follow-up following the planned procedure,[305] patients being outsourced for the specialised procedure where there was no monitoring of the referred patients other than for the purposes of payment of procedures and that there was no feedback from the private imaging provider that patients were experiencing delays.[306] The Investigators are of the view that it would be expected that patients should have their biopsies completed within a six to 12 week diagnostic window after referral, and sooner (two to four weeks), if clinical suspicion is high.

613. On 14 March 2023, a complaint was received on behalf of a cancer patient from a local Member of Parliament (**MP**) through the office of the previous HSCE as the patient had been referred for an MRI guided prostate biopsy which was to be performed by an external provider but had been advised there were no needles available to complete the procedure.[307] The local MP was seeking assistance for the patient to ensure that their care was going to be progressed. The patient subsequently had a TRUS biopsy at TUH. The EDCG was forwarded a copy of the complaint. The email was also forwarded to the SSG who identified 11 other patients who were awaiting this procedure. The EDCG indicated that, at the time of dealing with the first complaint, it was understood that there was a temporary supply shortage of the biopsy needles.[308] The Investigators have no evidence before them regarding what steps were taken in relation to the

[300] THS.001.001.1532 Email, sent 22 December 2023.
[301] Consulted Parties' Natural Justice Response.
[302] THS.001.001.1735 THHS, *Board Safety and Quality Committee: Briefing Note,* 22 April 2024, page 1-2; THS.001.001.1699 THHS, *Board Safety and Quality Committee Meeting Minutes*, 13 December 2023, page 6.
[303] THS.001.001.1734 Board Safety and Quality Committee, *Briefing Note: Patient Safety Report,* meeting date 19 February 204, presented to Board on 4 March 2024, pages 1 and 11.
[304] THS.001.001.1699 THHS, *Board Safety and Quality Committee Meeting Minutes*, 13 December 2023, page 6; THS.001.001.1660 Email sent on 15 March 2023; THS.001.001.1655 Email sent on 26 October 2023.
[305] WIT.002.001.0019 Transcript of Interview – Witness Z, paragraphs 70-73.
[306] WIT.001.001.0258 Email, sent on 25 September 2025.
[307] THS.001.001.1660 Email sent on 15 March 2023.
[308] Consulted Parties' Natural Justice Response.

11 patients and the potential risk relating to the needle shortage, including whether inquiries were made in relation to the expected duration of the needle supply shortage. However, the Investigators can see that the 11 patients identified in March 2023 are included in the group of 23 patients subsequently identified in the Cluster 7 of November 2023.[309]

614. A further complaint was identified after an email was received from [redacted] 2023 about a patient who experienced a significant delay to being seen "*due to [their] waiting for needles for a procedure*".[310] This triggered an audit which identified further patients as part of the biopsy needle cluster and was escalated to EDCG and COO 1 who queried the level of clinical risk for these patients waiting for over a year.[311]

615. COO 1 notes that the clinical governance team were made aware of the issue in March 2023 but that COO 1 was not notified of the concern until October 2023. During this period, outsourcing of patients for MRI guided prostate biopsies to the private provider continued. COO 1 considers that the SSG should have ceased the outsourcing option and treated the patients at TUH from March 2023.[312]

616. The EDCG advised they first became aware of the needle shortage issue on 21 November 2023 and on the same date emailed Clinical Excellence Queensland (**CEQ**) asking whether they were aware of this issue.[313]

617. Despite earlier escalations from staff, this cluster was first raised by the EDCG with the previous HSCE on 21 November 2023 and the previous HSCE responded on 22 November 2023 requesting a meeting to discuss concerns.[314] The previous HSCE advised the Investigators that:

> it was [their] understanding that THHS clinicians were following up external diagnostic referrals.[315]

618. The previous HSCE advised the THHS Board on 4 December 2023 of the emerging issues regarding patient safety issues in the delivery of urology services.[316] These concerns related to the prostate biopsy needle shortage, patients being LTS as well as the "Urology Bundle".[317] The THHS Board requested an update at the December 2023 BSQC. [318] This was provided and actions undertaken by the executive were deemed to be appropriate by the committee.[319]

619. An email was sent by EDCG on 6 December 2023 seeking support for an external review of the 23 cases linked to the supply shortage of prostate biopsy needles.[320] The previous CMO advised that no staff had a capacity to undertake a review on an informal basis. EDCG subsequently advised they would seek support from CEQ to undertake this process.[321] This task was subsequently delegated to the NDSSG.[322] On 11 December 2023, urology staff were advised that THHS would not support the outsourcing of any MRI biopsy procedures and no further referrals would be approved or sent to external providers.[323]

620. When it was advised that a THHS urologist was not available to review the cluster of patients affected by the MRI prostate biopsy needle shortage, and that the previous CMO was not able to assist, the NDSSG was left to take responsibility for sourcing a urologist to review the cluster

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[309] THS.001.001.1426 Email sent on 4 January 2024; THS.001.001.1920 *Excel entitled 1 Jan 2022 - 31 July 2025 Riskman Patient Incidents*.
[310] THS.001.001.0474 THHS, Riskman Report, [redacted].
[311] THS.001.001.1655 Email, sent on 23 October, 25 October 2023 and 26 October 2023.
[312] Consulted Parties' Natural Justice Response.
[313] Consulted Parties' Natural Justice Response; WIT.008.001.0012 Email, sent on 21 November 2023.
[314] THS.001.001.1397 Email, sent on 21 November 2023.
[315] Consulted Parties' Natural Justice Response.
[316] THS.001.001.1701 THHS, *Board Safety and Quality Committee Meeting Minutes*, 4 December 2023, page 5.
[317] THS.001.001.1809 THHS Board, *HSCE Report*, 4 December 2023, page 1.
[318] THS.001.001.1409 Emails, sent on 5 December 2023.
[319] THS.001.001.1699 THHS, *Board Safety and Quality Committee Meeting Minutes*, 13 December 2023, pages 5-7.
[320] THS.001.001.1416 Emails, sent on 6 December 2023, 11 December 2023.
[321] THS.001.001.1417 Email, sent on 11 December 2023.
[322] THS.001.001.1413 Email, sent on 5 December 2023.
[323] WIT.008.001.0013 Email, sent on 13 December 2023.

of patients.[324] On 19 December 2023, the SSG confirmed that all patients, including patients in the "bundle" cohort, had follow up appointments scheduled, and that this was to be oversighted by the new Urology CNC with oversight by the Acting Surgical Service Group Director (**A/SSGD**).[325]

621. In February 2024, a brief was collated to inform the Board of the patient safety issues in the delivery of urology services.[326] The themes were broad and included patients LTS, delays to treatment due to the biopsy needle shortage and the "Urology Bundle" which was determined as being a performance issue relating to [redacted] The previous HSCE, COO 1, EDCG and previous CMO were all involved in determining the content of the brief collated to inform the Board of the patient safety issues in urology.[327]

622. No patients proceeded to MRI biopsy in the private sector.[328] All patients in this cluster were transferred to urology outpatients at TUH for urgent assessment. The patient who was the subject of the complaint in October 2023 was identified as being a SAC 1 and had a very poor prognosis.[329]

623. The THHS advised that, as of 8 March 2024, a revised figure of 22 patients had been impacted by the needle supply interruptions. This was because they had identified that one patient was found to have appeared twice on the procedure list.[330]

624. The THHS further advised that on 24 June 2024, a Patient Safety Report was presented to the BSQC which confirmed that 22 patients were affected, with one SAC 1 and 19 SAC 4 incidents. Two remaining cases required medical officer confirmation of their SAC rating, with preliminary review suggesting that minimal to no harm had come to those patients.[331]

625. The Investigators note that in June 2022, PwC undertook an Internal Audit of Medical Imaging and provided a Report.[332] The Report found:

(a) there were no defined process, roles, or responsibilities for outsourcing imaging activity; referrals sometimes made without the MIS' knowledge;

(b) outsourced imaging reports can often get misplaced and are not consistently uploaded to Picture Archiving and Communication System (**PACS**); and

(c) there was no formal monitoring, reporting, or confirmation process for outsourced specialised medical procedures (such as MRI guided prostate biopsies), making it difficult to track volume or match images to completed reports.

626. This Report was presented to BARC in July 2022 and with an implementation plan presented to BARC in March 2023. In relation to the out of hospital medical imaging, it was noted that *"the process / document has been developed; however no mutual agreements have been reached. Plan to have further meetings with all the stakeholders."*[333] The Investigators were not provided with information detailing what action THHS took after this point in time.

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[324] THS.001.001.1413 Email, sent on 5 December 2023.
[325] THS.001.001.1422 Emails, sent on 19 December 2023.
[326] THS.001.001.1734 Board Safety and Quality Committee, *Briefing Note: Patient Safety Report,* meeting date 19 February 2024, presented to Board on 4 March 2024, pages 1-11.
[327] THS.001.001.1400 Emails, sent on 24 November, 27 November 2023.
[328] THS.001.001.1396 THHS, *Patient Safety Urology Review*, 21 November 2023.
[329] THS.001.001.1655 Email, sent on 23 October, 25 October 2023 and 26 October 2023; THS.001.001.1659 Email, sent on 26 October 2025.
[330] THHS Natural Justice Response.
[331] THHS Natural Justice Response.
[332] WIT.007.001.0003, PwC Medical Imaging Department: Patient Workflows, June 2022, page 11.
[333] WIT.007.001.0004, Internal Audit Patient Flows recommendations and implementation plan, page 7.

627. COO 1 advised that outsourcing of these patients for the MRI prostate biopsy procedure was initiated in the delivery of urology services without COO 1 having visibility of this at the time.[334]

628. Outsourcing was an important activity to assist the THHS to manage workloads given the increasing radiology service demands. Outsourcing activities were monitored when there were detailed agreements in place. Where there were no detailed agreements with private radiology providers in place, as was the case with the outsourcing of MRI guided prostate biopsies, the monitoring was limited to tracking referrals for the purpose of paying accounts. COO 1 indicated that, on reflection, they considered that it would have been appropriate to have more comprehensive reporting in place e.g. the number that were "*outsourced but not yet undertaken*".[335] It is acknowledged that this parameter remains hard to capture on systems across the State. COO 1 also indicated that the SSG could have undertaken more detailed monitoring of these patients given that they were aware of the patients who were being outsourced and, where appropriate, escalated any identified concerns.[336]

629. The previous HSCE advised the Investigators in 2026 that:

> with the benefit of hindsight, the tracking and management of referrals to MRI diagnostics was lacking.[337]

630. The Investigators understand that there are two equally valid pathways for obtaining prostate biopsies, one involves an MRI and the second involves a procedure in an operating theatre. There was therefore an option for these cases that experienced Disrupted Care to progress down a surgical pathway had the delay in the private radiology service been identified. This would have resulted in their pathology having been identified at an earlier time with the option for earlier treatment.

631. Based on the above information the Investigators have formed the view that:

(a) standard reporting was in place to inform the Executive and the Board with respect to the waiting times for new Category 1 outpatients and Category 1 elective surgery. This type of reporting did not provide and was not expected to provide the fidelity required to monitor individual cases where clinical reviews are required such as for the outsourced MRI guided prostate biopsies;

(b) this cluster of patients were at high risk of having a malignancy and the THHS should have been aware of this and acted accordingly;

(c) there was a lack of systems in place to track the outsourced MRI guided prostate biopsy within the THHS meaning that patient delays were not identified;

(d) the system failure meant that patients lost their chance for timely treatment of their conditions;

(e) the THHS did not appreciate the gravity of this situation (i.e. patients with potential malignancy) despite having obtained information as to this risk in the PwC Internal Audit Report into Medical Imaging of June 2022 and as presented to BARC in July 2022;

(f) it is apparent from the material provided to the Investigators that the THHS was aware of the emerging risk of the needle shortage in March 2023. The THHS did not provide any information relating to steps taken after the complaint was received in March 2023 to address this risk; and

[334] Consulted Parties' Natural Justice Response.
[335] Consulted Parties' Natural Justice Response.
[336] Consulted Parties' Natural Justice Response.
[337] Consulted Parties' Natural Justice Response.

(g) once aware of the issue in October 2023, THHS responded rapidly and urgent action was taken.

Cluster 8 (December 2024)

632. 32 patients with bladder cancer were found to have experienced Disrupted Care following a clinical audit which commenced in mid-2024 and which was reported in December 2024.[338] This cluster was reviewed by THHS and the contributing factors were found to be clinical demand exceeding urology service capacity and Disrupted Care due to the referral pathway requiring a histological diagnosis prior to referral to oncology.[339]

633. The THHS advised that on 11 December 2024 the Clinical Director of Medical Oncology, emailed the previous CMO and others regarding bladder cancer diagnosis and treatment delays. They advised that two bladder cancer SAC 1 incidents the previous year had prompted Medical Oncology to review the bladder cancer treatment pathway at THHS. It was reported that the review indicated a systemic problem with significant delay, with time to treatment from presentation to specialist being five months at THHS compared to two months mandated by European guidelines, and that most delays related to time to diagnosis and surgery. It was also noted that the audit had been discussed at the relevant MDT and that the urology department was extremely busy.[340]

634. The Investigators also noted that an [redacted] in Urology Outpatients had forwarded an email 4 June 2024 stating they did not feel they were getting any support from urology services.[341] They stated that it wa [redacted] see gaps in the processes and had suggestions and concerns that were not being heard.[342]

635. A notification from Patient Safety Net was received on 15 May 2024 and discussed at the Patient Safety Net Executive Oversight Steering Group on 29 May 2024 which included attendance by EDCG, previous CMO and EDNMS.[343] The notification included concerns regarding lack of knowledge in bookings roles, the backlogs in emails and clinic slips and an abundance of patients getting missed, including cancer patients, as there was no support. Patients were said to not be seen within time due to the backlog of patients. This notification was in relation to all of outpatients, including urology.[344]

636. The Investigators note that THHS advised that they had not received any relevant notifications though Patient Safety Net. This was confirmed by the EDCG during an interview with the Investigators.[345] The EDCG advised that the notification wasn't identified because it was logged under the SSG relating to booking processes in the OPD and they confined their search to urology services only.

637. The Investigators note that this Patient Safety Net notification was managed in accordance with the relevant local THHS procedures. This notification from staff and the subsequent assurance sought by the COO from the Outpatient Planned Care Steering Group as to whether the above concerns had been resolved demonstrates a lack of awareness as to the clinical variation that had continued to occur in clinics and lack of governance present to have sufficient oversight into the processes being deployed in the outpatient setting, including urology clinics. The fact that further patients were experiencing Disrupted Care, despite reassurance from senior officers at

[338] WIT.003.001.0001 Transcript of Interview – Witness Q, paragraphs 35, 43-55; THS.001.001.1770 THHS, *Board Safety and Quality Committee Briefing Note,* 14 April 2025, page 2.
[339] THS.001.001.1770 THHS, *Board Safety and Quality Committee Briefing Note,* 14 April 2025, page 2, 17.
[340] Consulted Parties' Natural Justice Response.
[341] THS.001.001.1332 Email, sent on 4 June 2024, page 2.
[342] THS.001.001.1354 Email, sent on 3 June 2024, page 2.
[343] THS.001.001.1354 Email, sent on 3 June 2024, page 2.
[344] THS.001.001.1354 Email, sent on 3 June 2024.
[345] WIT.003.001.0001 Transcript of Interview – Witness Q, paragraph 90; WIT.002.001.0023 Transcript of Interview – Witness B and Q, paragraph 216.

TUH that processes were adequate to prevent this, demonstrates a potential lack of governance over the clinical areas of the business to ensure patient safety was being upheld.

638. Three of the 32 patients were identified as having significant delays to care, including one SAC 1 and two SAC 2's.[346] It is clear from the SAC 1 cluster review there were several contributing factors, including the urology consultant workload and referrals not being attended to.[347]

639. As a result, the bladder cancer working group was stood up with oversight from the EDCG and reported through to the Outpatient Planned Care Steering Group (previously known as APCLG).[348]

640. Accordingly, the Investigators found that the THHS received a Patient Safety Net notification in relation to urology service.

Recommendation 18	That the THHS review the information flows and reporting through Patient Safety Net to confirm that matters raised through this process are logged in line with the relevant policies and procedures in a way that facilitates local management.

641. Based on the above information, the Investigators formed the view that:

(a) this cluster of patients were at high risk of malignancy;

(b) staff had raised concerns about a range of matters affecting the administrative processing of patients' materials; and

(c) there is evidence that formal medical referrals were not managed appropriately.

Cluster 9 (March 2025)

642. An email was sent from the EDCG on 9 January 2025 to the A/HSCE which advised of three new SAC 1 cases.[349] One case was identified as part of a mortality review with two further cases escalated from Oncology.

643. This prompted a subsequent audit which revealed that 24,544 outpatients[350], including 655 urology patients, had potentially experienced Disrupted Care. This cluster was reviewed by THHS and found to be due to a range of causes.[351]

644. It was apparent following the new SAC 1 cases that, despite actions taken to date, patients were continuing to experience Disrupted Care. The previous HSCE and Board requested a formal review be undertaken by the Healthcare Improvement Unit of Outpatients, SSG and urology services.[352]

645. An email was sent on 4 April 2025 with concerns regarding urology patients still being LTS and incorrect forms being completed for patients.[353] There appeared to be significant confusion as to processes and allocation of tasks across the urology clinic roles with limited direction being

[346] THS.001.001.1770 Board Safety and Quality Committee, *Briefing Note*: *THHS Patient Safety Report*, 14 April 2025, page 2; THS.001.001.0301 THHS, *Multi Incident Analysis Review Report,* 25 March 2025, page 1.
[347] THS.001.001.0301 THHS, *Multi Incident Analysis Review Report,* 25 March 2025, page 1.
[348] THS.001.001.0087 THHS Board, *Cover Note: Urology Services Improvement Implementation Action Plan*, 8 July 2025, page 3.
[349] THS.001.001.1450 Email, sent on 9 January 2025.
[350] WIT.002.001.0036 Transcript of Interview – Witness L, paragraphs 25-29; THS.001.001.2260 THHS, *Outpatient Planned Care Steering Group,* 26 March 2025, page 93.
[351] WIT.002.001.0036 Transcript of Interview – Witness L, paragraphs 126-129.
[352] WIT.002.001.0030 Transcript of Interview – Witness E, paragraphs 48, 142-143.
[353] THS.001.001.1369 Email, sent on 4 April 2025.

provided. Actions relating to the RATP #362 associated with urology were delayed due to no allocated responsible officer or capacity within the team to address the issues.

646. In March 2025, the EDCG was made aware of a further SAC 1 incident in the delivery of urology services.[354] The EDCG emailed the previous HSCE to inform them that the patient did not appear to be LTS but rather had experienced poor management of care.[355]

647. Staff raised concerns in March 2025 that some of these patients were experiencing Disrupted Care due to this being a frequent occurrence. For example, a urology clinic that was cancelled on 29 December 2022, from 61 patients, 46 were cancelled, one was checked out and 14 were rescheduled. At this time, a review was undertaken in relation to cancellation of urology clinics at short notice.[356]

648. It is unclear as to whether the 46 cancelled urology patients were followed up for action or whether they experienced Disrupted Care.[357] Short notice cancellations appeared to be a trend that started at some point in 2022, however, was not realised as a significant issue until March 2025 when audits commenced to retrospectively assess whether the cohort of patients affected by clinic cancellations had experienced Disrupted Care.[358] This is possibly a significant number given the number of clinics that were cancelled due to a clinician not being available, as demonstrated by the first audit results received by the Investigators in October 2025.[359] COO 1 advised that throughout 2023, the APCLG maintained active oversight of short notice clinic cancellations, recognising their impact on service efficiency, administrative workload, and timely access to care.[360] The APCLG endorsed elevating approval authority to Medical Directors. Periodic audits, supported by the BPIO and administrative teams, reinforced compliance and provided targeted training where required.

649. The THHS advised that on 16 April 2025 the previous CMO issued a memorandum to all medical officers at THHS regarding the management of follow-up for outpatient appointments.[361] The memorandum noted that, following the Bulk Check Out memorandum of 18 December 2023 requiring all appointments to be actioned individually based on clinical instructions recorded in EMR, a recent review had identified ongoing instances of missing clinical documentation and continued use of paper-based booking forms and email communications to convey appointment follow-up instructions.[362]

650. An urgent request was also made by a consultant urologist to COO 3 regarding the state of equipment in urology at TUH. This was forwarded to the previous HSCE on 2 July 2025.[363] This exemplified the ongoing frustrations of the consultants undertaking work in urology at TUH.

651. A subsequent administrative audit of 21,019 clinic paper booking forms covering appointment dates from January to November 2025 was initiated by COO 3. [364] The THHS advised in July 2026 that this data has not been formally validated or presented to an oversight group or committee.[365] This aimed to review the plan of care documented on booking forms against the plan of care in the EMR.[366] As of December 2025, a total of 21,019 booking forms had been audited, including 529 booking forms from Urology patients.[367]

[354] THS.001.001.1457 Email, sent on 10 March 2025.
[355] THS.001.001.1460 Email, sent on 11 March 2025.
[356] THS.001.001.1461 Email, sent on 11 March 2025.
[357] THS.001.001.1461 Email, sent on 11 March 2025.
[358] WIT.001.001.0086 THHS, *Action Plan – Patient Safety Urology Working Group*, page 1.
[359] THS.001.001.0871 *Urology Audit Results – Lost Unclear*, up to 31 July 2025 as at` 22 October 2025.
[360] Consulted Parties' Natural Justice Response.
[361] THHS Natural Justice Response.
[362] THS.003.001.0054 Email, sent on 16 April 2025.
[363] THS.001.001.0352 Email, sent on 8 July 2025; THS.001.001.1576 Email, sent 2 July 2025.
[364] WIT.004.001.0017 Email, sent on 23 December 2025.
[365] THHS Natural Justice Response.
[366] WIT.004.001.0017 Email, sent on 23 December 2025.
[367] WIT.004.001.0019, *Results Summary, SSG Clinic Clip Audit,* 23 December 2025, pages 1-3; WIT.004.001.0017 Email, sent on 23 December 2025.

652. Reputational issues were also starting to arise within the service following this cluster of patients being identified, with an email from 11 July 2025 between senior officers at Mount Isa and the previous CMO indicating that 31 referrals were found to be needing support.[368] Other tertiary hospitals had been approached and indicated that they were unable to assist due to patient load. The advice received by Mount Isa staff was to consider sourcing a local urologist to assist.

653. Based on the above information the Investigators formed the view that:

(a) the three audits above have been considered together because the cause of Disrupted Care for urology patients was a failure to rebook patients who had been seen in outpatients and the three audits had temporal proximity;

(b) urology patients experienced Disrupted Care because of clinic cancellations, sometimes at short notice, and where the rebooking process was not completed;

(c) the THHS should review the causes for late clinic cancellations, including those due to leave management for medical staff in urology services, to ensure that adequate time is available to notify and reschedule patients or organise alternate arrangements and that the CMO should establish a robust leave management procedure and monitor compliance with the procedure; and

(d) when the previous HSCE became aware of the short-term cancellations and continuation of paper booking forms in the delivery of urology services, they advised they took steps to address this. The previous HSCE briefed the A/HSCE on these concerns before going on leave in September 2025 and advised that the A/HSCE took action in relation to the same.[369]

Cluster 10 (September 2025)

654. Out of the patients identified in Cluster 9 there was a subgroup of 576 patients who are connected to or receive urology services that experienced Disrupted Care after the Bulk Check Out memorandum was circulated in December 2023. [370] Although identified in September 2025, an analysis of this sub-group of patients showed they had contact or care prior to 31 July 2025. This analysis was based on detailed patient-level data provided to the Investigators by THHS.

655. This cluster was reviewed and found to be due to several factors including: the rebooking process which was supposed to have moved to a fully electronic process but had remained as a paper based process, missed rebooking opportunities after FTA, hospital initiated cancellations and no subsequent clinician notes, correspondence not being provided to GPs, and no waitlist placement.

656. In December 2024, the SSG identified an emerging risk in relation to a lack of available experienced urology medical staff, which was impacting the ability to provide clinical oversight of junior staff and an inability to meet service demand requirements.[371] The matter was raised with the ECGC, and a RATP was developed to formally register the risk.[372]

657. Following a review of three bladder cancer patients' journeys in March 2025, the PSC confirmed that there was a 'Delay in Care' in each case and they were confirmed as SAC 1 and SAC 2 cases.[373]

[368] THS.001.001.1564 Email, sent on 11 July 2025.
[369] Consulted Parties' Natural Justice Response.
[370] THS.001.001.1718 - Email, sent on 18 December 2023.
[371] THS.001.001.0189 THHS Board, *Board Audit and Risk Committee: Risk 362,* 19 March 2025.
[372] THS.001.001.2277 THHS, *Board Safety and Quality Committee Urology Services Action Plan Update,* 8 December 2025; THS.001.001.0189 THHS Board, *Board Audit and Risk Committee: Risk 362,* 19 March 2025.
[373] THS.001.001.0301 THHS, *Multi Incident Analysis Review Report,* 25 March 2025; THS.001.001.0189 THHS Board, *Board Audit and Risk Committee: Risk 362,* 19 March 2025.

658. A recommendation was made for the Medical Service Group and SSG to establish a local pathway for care for patients with suspected or confirmed bladder cancer.[374] A Bladder Cancer pathway has since been developed.[375]

659. At the Board meeting on 1 September 2025, the previous HSCE advised Board members of a SAC 1 incident involving a patient from the July 2023 urology clinic cohort who was LTS. The patient has subsequently presented with a significant diagnosis.[376]

660. A patient was seen in the urology clinic on 4 September 2025 following a re-referral in May 2025 from the GP. The patient was first referred in May 2024 and had an outpatient appointment in August 2024 requiring follow up appointment in six to eight weeks. This was confirmed as a SAC 1 incident.[377]

661. The previous CMO discussed the parameters of a potential retrospective LTS urology audit with the EDCG. Once this was performed, a further 10 cases of patients being LTS were identified and COO 3 directed that a service-wide audit be undertaken. The patient safety team identified concerns relating to urology services from 2023. For example, a senior staff specialist raised a case that they had entered in Riskman in August 2023 (a urology case they felt had significantly delayed cancer care at the time). [378] The case was not reviewed until October 2025 when the audit took place.[379]

662. The data included in the audit contained appointments from 18 December 2023 (in line with the Bulk Check Out memorandum), which demonstrated some reliance on ESM entry, increasing the importance of accurate and consistent data that reflected a clear outcome documented in EMR.[380]

663. A statewide taskforce was established on 19 September 2025 to review into urology care.[381]

664. Based on the above information the Investigators formed the view that:

(a) the rebooking process for patients attending urology outpatients had been deficient since December 2023;

(b) that the process that was used was driven by clinician preference and did not align with HHS procedural requirements;

(c) that the impact of the memorandum requiring that Bulk Check Out be discontinued in outpatients had unintended consequences and was not supported by an appropriately approved procedure within the THHS; and

(d) when the previous HSCE became aware in October 2025 of some clinicians continuing to use paper booking forms they took steps to have it ceased.

9.11 Summary of conclusions

665. Across the six clusters of clinical adverse incidents, there were a range of causes. With respect to the various clusters the Investigators formed the following views.

666. With respect to Cluster 1, in retrospect, while the response was consistent with what roles and responsibilities require, the information presented by Cluster 1 (namely, the variance and the

[374] THS.001.001.0189 THHS Board, *Board Audit and Risk Committee: Risk 362,* 19 March 2025.
[375] THS.001.001.0189 THHS Board, *Board Audit and Risk Committee: Risk 362,* 19 March 2025; WIT.001.001.0037 Email, sent on 27 October 2025.
[376] THS.001.001.1773 THHS Board, *Cover Note: Urology Services - SAC 1 Clinical Incident Update* 5 September 2025, page 1.
[377] THS.001.001.1300 THHS, *Initial Patient Safety Review Document*, 1 August 2024; THS.001.001.0189 THHS Board, *Board Audit and Risk Committee: Risk 362,* 19 March 2025.
[378] THS.001.001.1303 Email, sent on 3 October 2025.
[379] THS.001.001.1303 Email, sent on 3 October 2025.
[380] THS.001.001.1773 THHS Board, *Cover Note: Urology Services - SAC 1 Clinical Incident Update* 5 September 2025, page 4.
[381] THS.001.001.0189 THHS Board, *Board Audit and Risk Committee: Risk 362,* 19 March 2025.

scale of the different issues across several different clinics) raises some concerns which the Investigators are of the view should have been at least identified, if not considered in more detail.

667. With respect to Cluster 6:

(a) despite good evidence that a more extensive look back should have been considered at this time to identify the patients who experienced Disrupted Care, this was not undertaken. Further, there seemed to be a focus on the bundle of booking forms identified and located in [redacted] as the cause of patients experiencing Disrupted Care rather than undertaking a detailed analysis to identify the underlying causes. The Investigators consider that the THHS ought to have made inquiries to assure themselves that there were no other urology patients affected as there may have been other instances where paper booking forms may have been misplaced, lost or not actioned but which were included in the bundle. If this was found to be the case then this would then have triggered a more detailed lookback; and

(b) actions seemed to be taken by the THHS without an appropriate level of analysis and without adequate consideration of the consequences of the actions.

668. With respect to Cluster 7:

(a) this cluster of patients were at very high risk of having a malignancy, the HHS should have been aware of this and acted accordingly;

(b) there was a lack of systems in place to track the outsourced MRI guided prostate biopsy patients within the THHS meaning that patient delays were not identified;

(c) this potential risk had previously been identified in June 2022 and considered by BARC in July 2022;

(d) the system failure meant that patients lost their chances for timely treatment of their conditions and that the THHS did not appreciate the gravity of this situation (i.e. patients with potential malignancy) despite having obtained information as to this risk as outlined in the PwC Internal Audit Report into Medical Imaging of June 2022 and as presented to BARC in July 2022; and

(e) once aware of the issue, THHS responded rapidly and urgent action was taken.

669. With respect to Cluster 8:

(a) this cluster of patients were at high risk of malignancy and procedural changes in urology outpatients lead to patients experiencing Disrupted Care;

(b) staff had raised concerns about a range of matters affecting the administrative processing of patients' materials; and

(c) there is evidence that formal medical referrals were not managed appropriately.

670. With respect to Cluster 9:

(a) patients experienced Disrupted Care because of clinic cancellations, sometimes at short notice, and where the rebooking process was not completed;

(b) the THHS should review the causes for late clinic cancellations including those due to leave management for medical staff in urology services to ensure that adequate time is available to notify and reschedule patients or organise alternate arrangements and that the CMO should establish a robust leave management procedure and monitor compliance with the procedure; and

(c) when the previous HSCE became aware of the short-term cancellations and continuation of paper booking forms in the delivery of urology services, they advised they took steps to address this and cease the use of paper booking forms. The previous HSCE briefed the A/HSCE on these concerns before going on leave in September 2025 and advised that the A/HSCE took action in relation to the same.

671. With respect to Cluster 10:

(a) the rebooking process for patients attending urology outpatients had been deficient since December 2023;

(b) the process that was used was driven by clinician preference and did not align with HHS procedural requirements;

(c) the impact of the memorandum requiring that Bulk Check Out be discontinued in outpatients had unintended consequences and was not supported by an appropriately approved procedure within the THHS; and

(d) when the previous HSCE became aware in October 2025 of some clinicians continuing to use paper booking forms they took steps to have it ceased.

672. The Investigators note the THHS is continuing to progress activities relating to service improvement in urology services.

Recommendation 19	That the THHS reviews the findings for each of the clusters and consider if there are gaps that exist within the model of urology services that have not been addressed through the work that the THHS has undertaken since July 31, 2025.

Section 10 - Adequacy of Oversight of the TUH executive, HSCE and/or the Board

10.1 Overview

673. This section responds to TOR 3.1(e) which requires the Investigators to consider:

> ...the adequacy of the TUH Executive, the THHS Chief Executive and/or the THHS Board's oversight of issues of concern in relation to urology services at TUH during the relevant period.

674. In responding to this TOR, the Investigators note that:

(a) what constitutes the "issues of concern" in relation to urology services relevant to this TOR are those issues identified and expressly referenced as the same in Section 7.7 of this Report;

(b) the terms "adequately" and "oversight" are understood and applied by reference to the plain meaning of these terms; and

(c) this TOR also requires the examination of the adequacy of the oversight effected by the "THHS Executive" (distinct from the HSCE). The Investigators consider that COO 1 and the EDCG are the members of the "THHS Executive" who had oversight responsibilities in respect of THHS functions relevant to matters that arose in the delivery of urology services at TUH during the relevant period, namely operations and clinical governance. While the COO and the EDCG were supported by the CMO and the EDNMS, the COO and the EDCG were the officers responsible on a day to basis for these functions.

675. In responding to the matters under TOR 3.1(e), the Investigators have:

(a) identified relevant standards or requirements that applied to the TUH executive, THHS HSCE and Board in performing their functions, their role descriptions and the length of tenure and experience of each office holder to inform the Investigators' assessment of the adequacy of oversight including:

(i) the governance framework that establishes the THHS as a statutory body under the HHBA. This is set out in Section 10.2;

(ii) the safety and quality requirements as set out in the HHB Regulation. This is set out in Section 10.2.1;

(iii) the information provided to the Board and which provides a comprehensive summary of matters that a member of the Board should be aware of. This is set out in Section 10.3; and

(iv) the information available from the Australian Commission for Safety and Quality in Health Care which was specifically developed to assist governing bodies to manage matters relating to clinical governance. This is set out in Section 10.4;

(b) assessed the adequacy of the "Executive", HSCE and Board's oversight of the issues of concern in relation to urology services during the relevant period and have:

(i) provided a summary of the issues of concern that the Investigators identified with respect to the delivery of urology services. These were set out in detail in Sections 7.7 and 10.5;

(ii) provided a summary of the adequacy of the oversight that the THHS Executive, HSCE and Board exercised in relation to TUH urology services. This is set out in Section 10.6; and

(iii) provided a summary of the THHS governance oversight in relation to urology services. This is set out in Section 10.8; and

(c) provided specific recommendations relating to TOR 3.1(e). These are set out in Section 10.8.

SUMMARY: Key observations, findings, and conclusions in relation to adequacy of oversight by the TUH Executive, HSCE and Board

Cluster 1 (July 2022)

(a) The Investigators consider that the Board, previous HSCE, COO 1 and EDCG identified the patient safety risks presented by this cluster but at the time, did not identify the significance and systemic nature of the risks or the consequences of not remediating the systemic risks presented by Cluster 1.

(b) Clinical staff raised the need for a lookback with senior officers in the THHS staff. This lookback was declined. This request for a formal lookback was not raised with the BSQC or the Board.

(c) The Board did not provide adequate oversight in relation to the issues of concern that were escalated to it in relation to Cluster 1. There was a range of services and causes which pointed to a systemic issue. Therefore, the oversight provided fell short of what would reasonably be expected of a HHS Board presented with this information.

(d) The Investigators consider that as the entity which controlled THHS, the Board's oversight was not sufficient.

Cluster 6 (November 2023)

(a) Stronger and more comprehensive corrective actions should have been taken by the previous HSCE, COO 1 and the EDCG at the time that the cluster was identified to mitigate patient safety risks. A more detailed examination of the underlying cause of patients experiencing Disrupted Care should have been undertaken.

(b) The Investigators consider this represents a departure from what would reasonably be expected of these Executives, noting that by November 2023, the previous HSCE, COO 1 and the EDCG were aware of the issues of concern and the risks these issues presented; that there had not been a detailed analysis undertaken of these event and issues; that safety and quality staff were concerned and raised these concerns; and that patients continued to experience Disrupted Care. The Investigators consider that the oversight of the previous HSCE, COO 1 and the EDCG across the issues of concern was not adequate.

(c) The Board did not provide adequate oversight in relation to the issues of concern that were escalated to it in relation to Cluster 6. Between August 2022 and November 2023, the Board were provided with significant amount of information and updates as to the actions being undertaken to identify, benchmark and mitigate any risks in relation to outpatient processes and those specifically in relation to urology services.

(d) It is also noted that the BSQC in December 2023 contemplated a Part 9 investigation but discounted it based on the advice from the previous HSCE.

Cluster 7 (November 2023)

(a) The Investigators consider these responses to known issues were below what would have reasonably been expected by a Board and the Executive being the previous HSCE and the EDCG. The Investigators formed this view because there had been a prior internal audit that identified risks associated with the outsourcing of procedures to the private sector, that this known risk had not been addressed and the risk subsequently materialised. The Investigators further consider that these responses impacted adversely on patients safety and outcomes and as such, inadequate oversight was exercised by the previous HSCE and the EDCG.

(b) The Board did not provide sufficient oversight in relation to the issues of concern that were escalated to it in relation to Cluster 7. The Board advised they identified the risk associated with the lack of monitoring of outsourced procedures. The Board did not provide sufficient oversight of the issues of concern that were escalated to it.

Cluster 8 (December 2024)

(a) The Investigators consider that the continuance of clusters and the response to these circumstances, represents a departure from what would reasonably be expected of the previous HSCE and the EDCG. Further, noting that by this time, a series of clusters and adverse patient outcomes were known and yet it does not appear that appropriate consideration was given to whether the actions and steps taken by THHS were adequate to deal with the scale of the issue and whether there was a need to have the actions and steps taken to be assessed through external advice or escalated to QH. The fact that the clusters continued and there was a lack of consideration of these matters reflects that the previous HSCE and the EDCG did not exercise adequate oversight across the relevant areas of responsibility.

(b) The Board did not provide sufficient oversight in relation to the issues of concern that were escalated to it in relation to this cluster and the issues that were by this time well known to the Board. The Investigators are of the view that by continuing with the status quo and not seeking external advice the Board's response was insufficient with what would reasonably be expected and as such the Board's oversight was inadequate.

Cluster 9 (March 2025)

(a) The systemic problems were the result of actions taken in response to Cluster 6 and which were identified earlier.

(b) A detailed analysis to identify the underlying causes was not undertaken by the THHS.

(c) The THHS should have proactively identified that the short notice cancellations had an impact on the efficiency of the rebooking of patients which led to patients experiencing Disrupted Care and introduced controls to mitigate this risk.

(d) The Investigators note that the fact that the clusters continued represents the emergence of incidents that were the result of actions taken or not taken in relation to the earlier clusters being Cluster 1 and 6. As outlined in the Investigators' consideration of Cluster 6, the oversight of the THHS exercised by the Board was insufficient.

Cluster 10 (September 2025)

(e) Since August 2022 the Board were aware that there was variation in outpatient processes, including urology, that was resulting in adverse clinical incidents for patients. The Board had been aware of the specific deficiencies in outpatient services since the PwC FTA Internal Audit Report of June 2023. The rebooking process for patients attending urology outpatients had been deficient prior to August 2022 and remained

deficient after the Bulk Check Out memorandum issued in December 2023 which contributed to Cluster 9.

(f) The local processes within urology services were driven by clinician preference and did not align with HHS procedural requirements as outlined in the Bulk Check Out memorandum requiring medical staff to document follow up instructions in the EMR by the end of the clinic and the direction to administrative staff to act on the information in the EMR in December 2023.

(g) The systemic problems were in part the result of actions taken in response to Cluster 6 and which were identified above.

(h) The THHS did not operationalise a critical procedure intended to address the issues identified in Cluster 6 until June 2025. Version 1 of the Procedure was circulated in May 2024, endorsed by the APCLG in August 2024 and published in October 2024. However, there were resourcing issues identified and a revised procedure (Version 2) was approved in May 2025 and published in June 2025.

(i) The Investigators note that the fact that the clusters continued represents the emergence of incidents that were the result of actions taken or not taken in relation to the earlier clusters being Cluster 1 and 6. As outlined in the Investigators' consideration of Cluster 6, the oversight of the THHS exercised by the Board was insufficient.

The previous HSCE, COO 1 and the EDCG

(a) The Investigators are concerned that the assessment and management of the clusters represents a departure from good practice, specifically what would reasonably be expected of the previous HSCE, COO 1 (relating to Cluster 1, 6, 7 and 8) and EDCG. Sufficient information about the serious nature of the patient safety risk was before the previous HSCE and the EDCG as well as COO 1 but notwithstanding this, the previous HSCE, COO 1 and EDCG's assessment of the underlying causes was below the level reasonably expected of these executives and that the action plans that were developed did not comprehensively address the underlying causes of the clusters nor consider implementation actions and the monitoring of the effectiveness of the same.

(b) The Investigators have formed the view that if the assessment and management of Cluster 6 in October 2023 had been more comprehensive and included:

(i) a methodology that examined the underlying cause of adverse events;

(ii) the corrective actions flowing from this;

(iii) a stronger change management focus,

subsequent clusters (particularly Clusters 9 and 10) more than likely would have been avoided.

Governance oversight of urology services by the Board

(a) With respect to the Board, the Investigators consider that:

(i) based on review of various briefings and minutes of Board meetings, the Board considered in detail the various clusters and risk-related action plans. This demonstrates that the Board was monitoring the issues and concerns in the urology service;

(ii) the Board did not escalate their concerns in relation to the recurrent events relating to patients that experienced Disrupted Care who are connected to or receive

urology services or seek to brief QH or seek external advice prior to 31 July 2025. The Investigators acknowledge that THHS advised QH in October 2025; and

(iii) it is also noted that the Board could have directed the previous HSCE to undertake the activities as outlined above, that is, formalising a briefing to the Director-General and arranging for external advice in relation to the patients who had experienced Disrupted Care. In not suggesting, recommending or directing the previous HSCE to seek external advice at an earlier time, the Investigators consider that the Board has not complied with its responsibilities.

(b) With respect to the BSQC, the Investigators consider that:

(i) based on review of various briefings and minutes of BSQC meetings, the BSQC considered in detail the various clusters and risk-related action plans. The Investigators were also advised by the previous HSCE that he attended these meetings. This demonstrate that the BSQC was monitoring the issues and concerns in the urology service; and

(ii) the BSQC should have recommended to the Board that they seek external advice in relation to the various clusters at an earlier time and that they instead relied on briefings from the previous HSCE, COO 1 and EDCG.

(c) There was evidence to indicate that relevant risks were formally escalated to QH through formal Hot Issues Briefs in October 2025 and, at the time, that they were considered by the Board and its Committees to QH. The Investigators considered that this notification was not timely and should have been undertaken at an earlier period, either in December 2023 (in association with Clusters 6 and 7) or in April 2024 (in association with Cluster 8).

(d) Once they were briefed on the background to the issues in urology in October 2023 (Cluster 6) (and noting the high-level concern that the Board Directors held in relation to urology patients experiencing Disrupted Care and the risk that the problems may not be addressed) the Board should have sought external advice in relation to the matters to hand. This should certainly have been a consideration by April 2024 (Cluster 8).

(e) It is the view of the Investigators that, had the Board sought this external advice (through a direction to the previous HSCE), the issues with patients experiencing Disrupted Care or having their care significantly delayed could well have been mitigated.

10.2 Hospital and Health Boards Act 2011 (Qld)

676. The HHBA[382] establishes a legislative framework to govern the delivery of public sector and other health services in Queensland. The HHBA establishes the HHSs, outlines the roles, responsibilities, and functions of HHSs, the relevant HHS Board and board committees as well as associated entities. The HHBA also includes provisions for funding, performance management, confidentiality, safety, and quality assurance in the public health system.

677. HHSs are statutory bodies established to deliver public sector health services. A HHS Board is expressly declared to control the HHS.[383] How a HHS Board is to exercise control is not specifically prescribed under the HHBA other than to require that, in that exercise of control, a HHS Board must have regard to several matters, as prescribed under s 22(2) of the HHBA, which relevantly includes "*the best interest of patients and other users of public sector health services throughout the State*". As the body exercising control of the HHS, a HHS Board appoints a HSCE, which is subject to Ministerial approval.[384] HSCEs are expressly declared to be

[382] *Hospital and Health Boards Act 2011* (Qld).
[383] *Hospital and Health Boards Act 2011* (Qld) s 22.
[384] *Hospital and Health Boards Act 2011* (Qld) s 33(4).

responsible for managing the service including the delivering all performance, safety, quality, financial and activity obligations under the Service Agreement.[385]

678. Each HHS Board consists of at least five members appointed by the Governor in Council on the Minister's recommendation. Members must possess expertise in areas such as health management, business, finance, HR, clinical practice, legal matters, and community health.[386] The Investigators note that there have been changes in the composition of the Board over the relevant period.

679. Reflective of the status of HHS Boards as the entity that controls a HHS, HHS Boards are required to establish committees of the Board to oversight strategic issues, strengthen relationships with its HSCE, and oversee performance measures.[387] The Executive Committee of the board must include the chair or deputy chair of the board and at least two other members, one of whom must be a clinician.[388]

680. Under the HHBA, the primary role of the HHS Board is to ensure that the health service performs its functions effectively, safely, and in alignment with government expectations. The Board's role of controlling a HHS also means that a HHS Board, as the governing body, is responsible for the overall performance, strategic direction, and accountability of the HHS. HHS Boards are directly accountable to the Minister for Health for the delivery of HHSs, as defined in s.19 of the HHBA and detailed in the annual Service Agreement with QH.

681. In fulfilling this role and reflective of the fact that a HHS Board "controls" a HHS, a HHS Board is required to provide leadership and oversight of the HHS, ensuring that services are delivered efficiently, sustainably, and in accordance with relevant legislation, policies, and standards. This includes monitoring operational, financial, and clinical performance; ensuring the existence of robust systems for safety, quality, and clinical governance; and overseeing compliance with national and state requirements. A HHS Board must also ensure that the HHS maintains effective risk management, workforce governance, and consumer engagement mechanisms. These requirements are effected through a system of Board committees and arrangements that are established under the HHS regulatory framework.

682. These abovementioned functions, roles and responsibilities are reflective of a HHS Board being the entity which controls the HHS. In this capacity, issues such as safeguarding the quality and safety of care, maintaining public confidence, and ensuring that the HHS meets its obligations to the community and the Queensland Government, are matters which a HHS Board is ultimately responsible for under the HHS regulatory framework. That is not to say that there are no other critical actors and roles under the HHS regulatory framework which have clear responsibilities in these areas, but more so, that a HHS Board, as the entity which controls the HHS, and can, for example, direct the HSCE in the management of the HHS, is ultimately responsible for the performance of the HHS across all areas.

10.2.1 The Hospital and Health Boards Regulation 2023 (Qld)

683. The HHB Regulation details operational arrangements for HHSs including the following relevant provisions:

(a) Clinician Engagement Strategies: Clinician engagement strategies must outline objectives, consultation methods, key issues for discussion, and mechanisms for continuous improvement. The strategies should align with national and state standards, such as the NSQHS Standards, and integrate with other engagement strategies;[389]

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[385] *Hospital and Health Boards Act 2011* (Qld) s 19.
[386] *Hospital and Health Boards Act 2011* (Qld) s 23.
[387] *Hospital and Health Boards Act 2011* (Qld) ss 32A-32B.
[388] *Hospital and Health Boards Act 2011* (Qld) s 32C.
[389] *Hospital and Health Boards Regulation 2023* (Qld) r 18.

(b) Consumer and Community Engagement Strategies: These strategies must focus on consulting with consumers and communities, particularly those at risk of poor health outcomes or facing barriers to accessing healthcare. The strategies should include objectives, consultation methods, and mechanisms for measuring and reporting effectiveness. They must align with relevant policies and standards, such as the Australian Charter of Healthcare Rights;[390]

(c) Protocols with Local Primary Healthcare Organisations: The Regulation prescribes requirements for protocols between HHSs and local primary healthcare organisations. These protocols must address objectives, cooperation on key issues, information sharing, and alignment with other strategies to improve service delivery and health outcomes;[391] and

(d) Safety and Quality Committees: The Regulation outlines the procedures for quality assurance committees, including the appointment of chairpersons, meeting schedules, quorum requirements, and the conduct of meetings.[392]

684. With respect to this Investigation, in circumstances where the safety and quality of urology services at TUH is being considered, the Safety and Quality Committee (referred to as the BSQC within the THHS) has a critical role in these considerations. It is noted only Board members are formal members of a BSQC (or BARC) established under the HHBA. Neither the HHBA nor the Regulation authorises non-Board members to be appointed as members of these prescribed committees. Others may attend, advise, or participate, but they are not formal committee members.

685. The BSQC is established to assist the Board in fulfilling its statutory responsibilities for clinical governance. The BSQC is responsible for providing structured oversight and advice on the safety and quality of health services delivered by the HHS.[393]

686. In carrying out its functions, the BSQC assists the Board by monitoring clinical risks and incident trends and advising on strategies to minimise preventable patient harm. It also reviews performance data and clinical outcomes to identify unwarranted variation in care, ensuring that service delivery is consistent, evidence-based, and aligned with best practice. The BSQC also plays a key role in enhancing patient and carer experience that supports person-centred care.

687. Through regular reporting, the BSQC keeps the Board informed of emerging risks, performance against key safety and quality indicators, compliance status, and recommendations that aim to strengthen clinical governance.

688. Collectively, these functions of the BSQC ensure that the Board is equipped with the necessary oversight to meet its legislative obligations and to maintain a strong, effective clinical governance framework across the HHS, as the entity that controls the HHS under s.22 of the HHBA.

10.3 Good Practice Guide for Hospital and Health Boards

689. The "Good Practice Guide for Hospital and Health Boards"[394] published by QH, serves as a comprehensive resource for new and existing members of HHS Boards setting out relevant standards and expectations for these members. The guide is divided into two volumes: Volume 1 focuses on hard governance, detailing legislative and policy obligations, while Volume 2

[390] *Hospital and Health Boards Regulation 2023* (Qld), r 19.
[391] *Hospital and Health Boards Regulation 2023* (Qld), r 22.
[392] *Hospital and Health Boards Regulation 2023* (Qld), Part 5.
[393] *Hospital and Health Boards Regulation 2023* (Qld), r 45.
[394] Queensland Health, *Good Practice Guide for Hospital and Health Boards,* Volume 1, 2024; Queensland Health, *Good Practice Guide for Hospital and Health Boards,* Volume 2, 2024. The Investigators have considered the application of these documents in the context of the relevant period and acknowledge the documents have since been updated in 2026. The updated versions are available at https://www.health.qld.gov.au/system-governance/health-system/managing/statutory-agencies/foundations-resources.

addresses soft governance topics, such as leadership practices and fostering positive organisational cultures.

690. Volume 1 is also designed to support the induction of new HHS Board members and provides an overview of the Queensland public health system, the roles and responsibilities of various entities, and the formal relationships within the system.

691. It details the organisational structure within QH comprising QH, the Queensland Ambulance Service, and 16 independent HHSs and describes how the HHBA provides the framework for delivering publicly funded health services in Queensland.

692. The guide identifies seven strategic dimensions relating to HHS Boards:

(a) Safety: Prioritising patient, staff, and visitor safety in all decision-making processes;

(b) Sustainability: Ensuring optimal resource utilisation and long-term financial health;

(c) Performance: Exceeding expectations through meaningful data-driven decision-making;

(d) Governance: Establishing strong, clear, and inclusive accountability frameworks;

(e) Strategy: Developing visionary, holistic, and achievable plans for healthcare improvement;

(f) Connection: Maintaining open communication with community stakeholders; and

(g) Collaboration: Partnering across the healthcare system to enhance patient care and ecosystem value.

693. The Good Practice Guide for Hospital and Health Boards also describes how a positive organisational culture is essential for improving staff performance, productivity, and patient outcomes. Boards, as the entity that controls a HHS, are ultimately the stewards of culture and must actively create, embed, and maintain a constructive corporate culture. Boards must clearly define the desired culture, communicate it effectively, and ensure alignment between the intended and actual organisational culture. They influence culture through strategic decisions, modelling desired behaviours, and engaging with senior staff.

694. The Good Practice Guide for Hospital and Health Boards also outlines how clinical governance is used to ensure the safety and quality of clinical services. HHS Boards are accountable for the overall quality of care provided by a HHS. HHS Boards must leverage clinician members and safety and quality committees to stay informed about clinical risks and mitigation strategies.

10.4 NSQHS Standards and User Guide

695. It is the HHS Board's responsibility to ensure that patients receive the standard of care defined by the NSQHS Standards.[395] In order to advise members of governing bodies exercising their governance responsibilities about implementing the NSQHS Standards, the ACSQHC has also developed the NSQHS Standards User Guide for Governing Bodies.[396]

696. The Australian healthcare system is recognised as one of the best globally, with a high life expectancy and lower mortality rates compared to the Organisation for Economic Co-operation

[395] Australian Commission on Safety and Quality in Health Care, *National Safety and Quality Health Service Standards,* Second Edition, May 2021. Electronic copy available at: https://www.safetyandquality.gov.au/sites/default/files/2021-05/national_safety_and_quality_health_service_nsqhs_standards_second_edition_-_updated_may_2021.pdf.
[396] Australian Commission on Safety and Quality in Health Care, *National Safety and Quality Health Service Standards User Guide for Governing Bodies,* March 2019. Electronic copy available at: https://www.safetyandquality.gov.au/sites/default/files/resources/attachments//nsqhs_standards_user_guide_for_governing_bodies.pdf.

and Development (**OECD**) average.[397] Despite this, lapses in safety and quality, as well as unwarranted variations in care, persist, leading to significant human and financial costs. It is acknowledged that the delivery of modern healthcare is complex, comprising an intricate network of care services that patients must move between. In recognition of the heightened complexity of healthcare delivery, responsibility for acceptable standards of safety and quality have expanded with a particular focus on the role of governance and management processes in delivery.

697. Effective governance and management processes are essential to ensure safe and high-quality healthcare delivery. The NSQHS Standards, developed by the ACSQHC, aim to protect the public from harm and improve healthcare quality. Since 2013, all Australian hospitals and day procedure services are required to undergo accreditation to ensure compliance with these standards.[398] The NSQHS Standards do not specify how an organisation is to comply; rather, the Standards outline the safety and quality systems that organisations should have in place and requires health service organisations to implement systems and strategies that are applicable to their service context, patient population and service risks.

698. Section 6.2 of this Report provides an overview of the definitions of clinical and corporate governance. The Investigators highlight the following themes in relation to clinical and corporate governance set out in the NSQHS Standards User Guide:

(a) governing bodies (i.e. a HHS and HHS Board) have overall responsibility for the clinical governance system in a health service organisation. Governing bodies must recognise that they cannot govern clinical services well without the deep engagement of the clinicians in their organisation as individuals and teams at all levels contribute to the implementation and delivery of a clinical governance system;

(b) the NSQHS Standards adopt the National Model Clinical Governance Framework (2017),[399] which was in place at the times that the clusters occurred and consisted of five components:

(i) Governance, Leadership, and Culture;

(ii) Patient Safety and Quality Improvement Systems;

(iii) Clinical Performance and Effectiveness;

(iv) Safe Environment for Care Delivery;

(v) Partnering with Consumers;

(c) governing bodies are responsible for establishing governance systems, delegating operational responsibilities to management, and monitoring organisational performance. They must ensure that the organisation is effectively managed, meets desired standards, complies with legal obligations, and focuses on continuous quality improvement. Governance duties include appointing and supporting the HSCE, setting strategic plans, endorsing budgets, ensuring proper management systems, and evaluating organisational performance.

(d) To maximise clinical and patient safety, governing bodies must ensure they have appropriate systems and frameworks in place to obtain information that is timely,

[397] Australian Institute of Health and Welfare, *Measures of health and health care for Australia and similar countries,* 2 July 2024. Electronic copy available at: https://www.aihw.gov.au/reports/international-comparisons/international-health-data-comparisons.
[398] Australian Commission on Safety and Quality in Health Care, *Assessment to the NSQHS Standards*, Webpage can be accessed here: https://www.safetyandquality.gov.au/standards/nsqhs-standards/assessment-nsqhs-standards.
[399] Australian Commission on Safety and Quality in Health Care, *National Model Clinical Governance Framework,* 2017. Electronic copy available at: https://www.safetyandquality.gov.au/sites/default/files/migrated/National-Model-Clinical-Governance-Framework.pdf. The Investigators note this has recently been replaced by the June 2026 version which is available at: https://www.safetyandquality.gov.au/resources/2026-national-model-clinical-governance-pdf

reliable, comprehensive and suitable for their needs. It is recommended that a mix of information sources is utilised to identify emerging safety and quality issues at as early a stage as possible.[400] Governing bodies should routinely review the information to ensure that it addresses the current organisational priorities and any changes in performance.[401]

10.5 Identified issues of concern

699. The TOR requires the Investigators at various points to consider whether "issues of concern" were identified and escalated, and for the purposes of this Section, whether appropriate actions were taken and whether there was adequate oversight regarding these issues of concern.

700. The Investigators identified 25 issues of concern; 12 were operational issues within urology services, seven related to clinical governance and six related to corporate governance. Further, reflective of the requirements of the TOR, the issues of concern were identified as a result of the analysis undertaken by the Investigators of the incidents of Disrupted Care and the identification of "clusters" of Disrupted Care across the relevant period.

701. For convenience, the list of issues of concern below is repeated from Section 7.7 to identify the nature of the specific concerns identified by the Investigators, including the relevant clusters that each issue relates to:

(a) *Operational Management relating to urology services*:

(i) human factors in Clusters 1, 6, 7, 9 and 10;

(ii) variation and noncompliance local rebooking processes (when a specific procedure is not in place) in Clusters 1, 6, 8, 9 and 10;

(iii) variation and noncompliance administration procedures (not compliant with SOSIS) (Outpatient Appointment Management Procedure) in Clusters 6 and 9;

(iv) noncompliance with procedures in place in Clusters 8, 9 and 10;

(v) lack of Clinical Management Guidelines for high risk patients in Cluster 8;

(vi) use of Bulk Check Out process in Clusters 1 and 6;

(vii) clinical practice variation in Clusters 7 and 8;

(viii) medical leadership and accountability in Clusters 8, 9 and 10;

(ix) workforce constraints (Administration/Nursing/Medical) in Cluster 1 (medical), 6 (administration), 7 (medical), 8 (medical), 9 (medical and administration) and 10 (medical and administration);

(x) limited development of operational procedures in Cluster 8;

(xi) poor change management e.g. lack of effective consultation in Clusters 6, 7 and 8; and

[400] Australian Commission on Safety and Quality in Health Care, *National Safety and Quality Health Service Standards,* Second Edition, May 2021, p.53.
[401] Australian Commission on Safety and Quality in Health Care, *National Safety and Quality Health Service Standards,* Second Edition, May 2021, p.16.

(xii) governance structure not providing clear accountability for actions in Cluster 6 onwards.

(b) *Clinical Governance*:

(i) failure to undertake a detailed analysis to identify the underlying causes and process failures in Cluster 6 onwards;

(ii) limited understanding of the underlying causes of events in Cluster 6 onwards;

(iii) incomplete action in relation to clinical staff escalations in Cluster 6;

(iv) limited management of CIR by assuming that actions from initial reviews applied across new incidents. Namely, the completion of these was managed as a compliance exercise, and in that sense as a necessary transaction rather than a process for identifying system improvement opportunities in Cluster 8;

(v) limited awareness of Patient Safety Net escalations;

(vi) limited engagement with "look back" processes to identify all affected patients despite recommendations to do so in the context where affected patients could have potential malignancies in Cluster 1 onwards; and

(vii) limited actions to address closed loop reporting including results not being reviewed following a procedure (when performed) by the ordering clinician, patients not being rebooked for OPD appointment following outsourced procedures and to identify all patients affected by an incident or process failure in Cluster 7.

(c) *Corporate Governance*:

(i) limited tracking and management of outsourcing for procedures in Cluster 7;

(ii) limited recognition of the seriousness or significance of the clinical impacts of the adverse events where patients involved presented with actual or potential cancer or organ insufficiency in Cluster 7 and 8;

(iii) limited recognition of the importance of identification of the underlying cause for clinical incidents in Cluster 6 and 8;

(iv) limited recognition of the impact of executive movements and a series of officers in acting positions at a time when clusters of adverse events were being actively managed in Cluster 6, 7, and 8;

(v) limited recognition of the interconnectedness of the clinical incidents" in Cluster 6 onwards; and

(vi) limited recognition of the importance of seeking external advice in relation to the assessment and management of clusters that are of a serious nature.

702. This list of issues of concern demonstrates the scope and depth of the concerns identified by the Investigators and are drawn from the information contained in Section 7 which details the chronology of events, the analysis of the clusters identified in Section 8 that reviews the policies, procedures and standards in place within the THHS and the THHS's compliance with these, and Section 9 which overviews clinical governance and the THHS's management of the clusters.

703. As outlined in Section 7.7 of this Report the Investigators consider that the THHS identified 10 of these issues of concern in their assessment of the various clusters, that included urology patients. The issues of concern that were identified by the Investigators as being recognised by the THHS were principally related to the operational management of the work unit. The Investigators consider that this is not unexpected given the focus of the THHS on the operations within the HHS.

10.6 Adequacy of oversight by the TUH Executive, HSCE and Board

10.6.1 Background

704. It is noted that an initial interview with the A/HSCE and EDCG occurred on 7 October 2025.[402] At that stage, several of the issues of concern and three clusters of patients had been identified. They also detailed a recent clinical incident involving urology services that occurred in July 2025 following a GP re-referral of a patient. This incident formed part of Cluster 10 as identified by the Investigators. The officers also detailed the background to the radiology outsourcing cluster (Cluster 7) and the urology bundle cluster (Cluster 6).

705. The Investigators were advised in this interview, noting that this interview occurred at the commencement of the Investigation, that the underlying cause for the patients experiencing Disrupted Care in Cluster 6 was due to [redacted] failing to action appointments and that in response, the booking mechanics and procedures had been reviewed and revised accordingly.[403]

706. When the Investigators interviewed the DMSCGDH on 7 November 2025,[404] the extent of the issues during the relevant period became clearer. The officer described issues across 2021, 2022, 2023 and 2024. The officer identified successive events where patients experienced Disrupted Care across urology services and more broadly in the outpatient setting. The officer identified causes of the adverse clinical incidents that occurred during the relevant period as including, the unintended consequences of stopping the Bulk Check Out process after December 2023, human factors, failure to rebook patients after a clinic, and lost or misplaced clinic forms. Documents gathered and interviews with other officers including the Nursing Director, Health Care Standards,[405] supported the views as detailed by this officer.

707. The Investigators consider that the nature and extent of the initial description of the clusters provided to the Investigators by the A/HSCE and EDCG during their interview was limited to their then understanding of how patients connected to urology services had experienced Disrupted Care. This was not unexpected given that Cluster 10 remained under investigation by THHS at the time.

708. As outlined in Sections 7.2, six clusters were identified by the Investigators related to patients who are connected to or receive urology services.

709. The roles of HSCE, COO and EDCG, as senior leaders, had a critical role to play in the identification, management and learnings from the adverse clinical incidents within the THHS. The previous HSCE had escalated these matters to the Board and relevant Board committees including the BSQC.

710. The matters considered below comprise of the areas where the issues of concern relating to the clusters were identified by the Investigators. The assessment of the adequacy of the oversight of the relevant officers comprising the THHS Executive, HSCE and the Board during the relevant period are considered against each of the issues of concerns and the clusters as identified by the Investigators.

[402] WIT.002.001.0023 Transcript of Interview - Witness B and Witness Q, at paragraphs 68, 95-99, 110-111.
[403] WIT.002.001.0023 Transcript of Interview - Witness B and Witness Q, at paragraphs 95-99.
[404] WIT.003.001.0005 Lost to follow up risk timeline, November 2025. WIT.002.001.0003; Transcript of Interview - Witness AE, at paragraphs 19-29, 40-41, 76-77, 130,136, 168.
[405] WIT.002.001.0022 Transcript of Interview - Witness AC at paragraphs 18-20.

711. In setting these matters out below, the Investigators again restate their acknowledgment that:

(a) the assessment of these matters by the Investigators has been undertaken with the benefit of hindsight and reflection which was not necessarily available to the THHS when responding to these issues at the time;

(b) notwithstanding that acknowledgement, the Investigators have focused their assessment on the information available at the time issues and concerns arose and how these matters were managed; and

(c) the evidence before the Investigators relating to the response by the THHS to clusters.

10.6.2 Adequacy of oversight – Cluster 1 (July 2022)

712. With respect to Cluster 1, the Investigators consider that the Board, previous HSCE, COO 1 and EDCG identified the patient safety risks presented by this cluster, but at the time, did not identify the significance and systemic nature of the risks or the consequences of not remediating the risks presented by Cluster 1.

713. This was a missed opportunity to not only accurately identify the patient safety risks presented by the cluster but also to appropriately respond and implement a remediation strategy which may have prevented further instances or clusters of Disrupted Care.

714. At the time Cluster 1 was identified, the Investigators understand that the THHS considered this cluster was attributed to human error and a failure to follow procedures. The key information relevant to oversight of the issues of concern in relation to urology services are as follows:

(a) On 24 August 2022, thematic process issues were identified in Cluster 1 by the DMSCGDH who prepared a paper entitled "Clinical Incident Trends and Variation in Outpatient Processes" that was considered by the ECGC. This paper was approved by the previous HSCE and was presented to the BSQC in August 2022. The ECGC advised the BSQC through the previous HSCE that a working group would be established to review and identify best practice so as to standardise best practice processes in the outpatient settings across the organisation and inclusive of a thorough review of operational processes. That paper was noted by the BSQC, with the BSQC agreeing with the recommendation that a working group be established, noting that the findings of the working group would be the subject of a further briefing to the BSQC.[406]

(b) In September 2022, the EDCG convened the Outpatient Improvement Steering Group which met on five occasions. Evidence was presented to the Outpatient Improvement Steering Group based on mapping exercises, interviews, observations, shared learnings from the Clinical Redesign Team and findings from clinical audit reviews. The principal focus of this activity was the efficient management from initial referral through to the register of patients on the outpatient new referral waiting list. This included nurse triage and clinical categorisation. The Outpatient Improvement Steering Group prepared a document entitled the Specialist Outpatients Mapping of Referral Process[407] which identified, amongst other issues, that there was no visibility or KPIs relating to the completion of review appointments; that patients on the review waiting list could become lost to follow up if they were not manually added to the waiting list post completion of their initial appointments; and that there was no one

[406] WIT.003.001.0006 THHS, Board Safety and Quality Committee, *Clinical Incident Trends in Variation in Outpatient Processes,* 24 August 2022, page 1-2; THS.001.001.1689 THHS Board, Board Safety and Quality Committee, *Meeting Minutes #59,* 24 August 2022, page 7.
[407] WIT.009.001.0088, *Outpatient Improvement Steering Group,* "Specialist Outpatients Mapping of Referral Process - Current", 18 October 2022.

consistent method of reviewing results of diagnostic tests when requested internally or externally.

(c) On 24 November 2022, the Outpatient Improvement Steering Group finalised its draft recommendations. A briefing note was developed for consideration by the ECGC which included the Outpatient Improvement Paper (Figure 9 below). At this time the EDCG handed over the ongoing management of the recommendations contained in the Outpatient Improvement Paper to COO 1. Further, with respect to recommendation 7, it was agreed that it was:

> fairly multifaceted, not an easy fix and requires adequate time for discussion including a dedicated project person which is a resource consideration.[408]

(d) On 14 December 2022, a further paper entitled "Patient Safety Report", relevant to issues of concern relating to Cluster 1 was approved by the previous HSCE and presented to the BSQC by the EDCG which discussed the Outpatient Improvement Steering Group's review that had been conducted in relation to outpatient processes in specialist clinics. This paper identified the current state and improvement opportunities (the Outpatient Improvement Paper). The BSQC were advised that the APCLG (chaired by COO 1) would formalise an action plan against each recommendation with an update to be provided to the ECGC at the March 2023 meeting. The BSQC discussed and noted the Patient Safety Report which was required to be escalated to the Board for noting. A copy of the Outpatient Improvement Paper, which was presented in draft, is below.[409]

Figure 10: Copy of the Outpatient Improvement Paper

Outpatient Improvement Steering Group – Patient Safety Focus

Recommendations for Outpatients awaiting reviews 18/11/2022

Reviewed by EDCG and COO with minor changes 22/11/2022

	Identified Variations	Proposed Recommendations
1	Areas across the business have different positions involved in the triaging and review of referrals such as administrative officers and nursing staff.	Triaging/review of referrals needs to be standardised (written formal) across the business and managed by clinical staff only.
2	Inconsistent practices across the business for managing referrals awaiting categorisation	Utilise the current reporting mechanisms for flagging any referrals awaiting categorisation and develop an escalation process for referrals outside of KPI timeframes.
3	Inconsistent use of Smart Referrals system: - some referrals go directly to speciality areas and bypass Smart Referral system with administrative staff then scanning the referrals into ieMR - some areas are printing out referrals and handwriting on paper forms	Functionality of the Smart Referral system (SRWS) to be utilised for all referrals with referrals then uploaded by the Central Referral Hub for clinical oversight with the exception of those formally approved to opt out.
4	Different practices in departments to manage referrals to SMO for categorisation - the queue in Smart Referrals is inconsistent with referrals going to either a General medical Inbox or to Individual SMO Inbox - referrals for review that go to incorrect medical SMO are declined	All medical categorisation referrals to go to a General Medical Discipline Inbox in each department for review by a clinician. Triage/review nurse to redirect referrals to the most appropriate service rather than decline when referrals to are incorrectly assigned to their service.

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[408] THS.001.001.2046, THHS, *Executive Clinical Governance Committee Endorsed Meeting Minutes,* 24 November 2022.
[409] THS.001.001.1878 THHS, Board Safety and Quality Committee*, Patient Safety Report* , 14 December 2022, pages 2, 37-38.

5	The "Review" list is managed differently across the business. Some departments maintain their own excel spreadsheet while others use smart referral system functionalities. The "Review" dashboard is not an accurate reflection of all patients waiting for reviews across the business.	Functionality of the Smart Referral system ESM waitlists to be utilised across the business to manage all waitlists including those 'out of scope' and reviews, allowing reporting through operational performance lines. Standardise the dashboard data sets to reflect: - review wait times for every department - duplication of appts for the same patient - patients who have an appt and those that don't have appt - slots that are already booked for the same patient from a previous appt. - the '% in time' column is reflective of the clinicians requested review timeframe to allow for ease of identifying patients outside of clinically recommended timeframes.
6	Inconsistent practices when booking patients for follow up reviews	Find a solution so that the patient leaves their appt with a review appointment in hand
7	Inconsistent practices when booking appts to review diagnostic results (internal and external).	Develop a process for receipt of diagnostic results that is standardised across the business including when to escalate for clinical review
8	Inconsistent practices across the business to remove patients from waitlists.	Formalise the process for removal of patients from waitlist with clinical oversight in line with SOSIS guidelines.
9	Inconsistent practices across the business with managing Failure to Attend (FTA)	Consistently apply the process for managing FTAs so it is consistent across the business and ensures that the clinical loop of care is closed in line with SOSIS guidelines.

(e) On 6 February 2023, the Outpatient Improvement Paper was escalated to the Board where it was "noted". There is no discussion recorded in the minutes. The Investigators were not provided with a copy of the Outpatient Improvement Paper as presented to the Board and have presumed that it was identical to the above. Once noted by the Board, the BSQC marked the item as "Agreed Action: Close" on their action register on 22 February 2023.[410]

(f) On 23 March 2023, an update was provided by COO 1 to the ECGC advising that the Outpatient Improvement Steering Group had made number of recommendations and had now been closed with its work program being transitioned to the APCLG. At that time a broader piece of work was being undertaken by the APCLG. APCLG was to provide an update on their work to ECGC in May 2023.[411]

(g) On 19 April 2023, the BSQC were advised that lost to follow up clinical incidents were subject to review by COO 1, as there has been a recent increase in occurrences.

(h) On 25 May 2023, a paper entitled "Outpatient Processes Update" was presented to the ECGC by COO 1. This paper listed all the variations and recommendations identified in the Outpatient Improvement Paper and had actions against each item. The ongoing governance and responsibility sat with the APCLG. Two of the actions involved mapping exercises to be undertaken in relation to the Smart Referral system and follow up of diagnostic imaging. When discussed by the ECGC[412], the previous HSCE requested that accountable officers and timeframes for completion be added against each action and COO 1 agreed to add this information. COO 1 was to provide bi-monthly reports in relation to internal audits undertaken relating to inconsistent practices to remove patients from waitlists and FTAs.[413]

(i) In June 2023, an update on the review into outpatient processes being undertaken by the APCLG was provided to the BSQC through the previous HSCE. The APCLG had established two themes: Smart Referral use and the management of review

[410] THS.001.001.1683, THHS Board, *Meeting Minutes #129*, dated 6 February 2023, page 11; THS.001.001.1884 THHS, Board Safety and Quality Committee, *Meeting Minutes #62*, 22 February 2023, page 2.
[411] THS.001.001.2049, Executive Clinical Governance Committee, *Meeting Minutes*, 23 March 2023, page 4.
[412] THS.001.001.2050 Executive Clinical Governance Committee, *Meeting Minutes*, 25 May 2023, page 6.
[413] THS.001.001.0767, Executive Clinical Governance Committee, *Cover Note - Outpatient Processes Update,* dated 25 May 2023, page 2.

waitlists. The EDCG noted that a review of SAC 1 and 2 cases as they relate to LTS were subject to a risk assessment with findings to be provided to the APCLG.

(j) In June 2023, "Outpatient Lost to Service" was recognised as a risk and a “Lost to Service Risk Assessment and Treatment Plan” (ID #323) was developed and classified as High Risk.[414]

(k) On 23 July 2023, the ECGC minutes record that an extension was granted for an update on outpatient processes to be provided in September 2023.[415]

(l) In July 2023, the BARC were provided with the PwC FTA Internal Audit report for Outpatient Clinics which was discussed and endorsed for escalation to the Board for approval. The audit report also noted that local procedures were outdated, misaligned with the SOSIS, and inconsistently applied across clinics. The audit report identified widespread operational non-compliance, including failures to document follow up actions, inconsistent use of Not Ready for Care categories, and repeated rebooking of patients after consecutive FTAs without addressing underlying barriers to attendance. The audit highlighted that THHS did not have a bookings management procedure in place, which is a core SOSIS requirement.

(m) In August 2023, the Board discussed at length the PwC FTA Internal Audit Report for Outpatient Clinics. The briefing note set out three key activities: (1) review and establish risk-based objectives for FTA practices; (2) review and update key procedural documentation to align to SOSIS requirements; and (3) improve compliance and establish quality assurance processes for ongoing SOSIS compliance. These were assessed as medium priority.

(n) On 28 September 2023, the ECGC minutes record that an extension was granted for an update on outpatient processes to be provided in November 2023.[416]

(o) On 5 October 2023, a “Lost to Service Risk Assessment and Treatment Plan” (ID #323) was presented to, and endorsed by, the EARCC. The risk owners were the COO and the EDDHK by the COO 1 and the EDDHK. The sources of the risk were listed as great variability in workflows for scheduling outpatient appointments, current audit processes do not identify patients who were lost to service, that there was no automated functionality in ESM to flag that a patient has not been booked or waitlisted and an inability to accurately monitor the outpatient journey.[417]

(p) On 23 November 2023, a briefing note was presented to the ECGC to provide an update on outpatient processes. The Investigators do not hold a copy of the Briefing Note, however, understand from the minutes that five of the nine recommendations from the Outpatient Improvement Paper had been closed with ongoing work being progressed on the outstanding recommendations. There was discussion around recommendation 5 (management of review lists). It was also stated that THHS need to go "fully electronic" with the review waiting list, that it was time to remove paper booking forms from the service as these forms could be easily lost or misplaced. A target date of 24 March 2024 was set for this activity to be actioned. The DMSCGDH raised concerns relating to patients that were lost to follow up and not on the review list. COO 1 advised that the leadership group had a plan and are working through this activity and could meet offline to discuss the matter with the DMSCGDH [418]

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[414] THS.001.001.2143 THHS, Access to Planned Care Leadership Group, *Lost to Service Risk Assessment and Treatment Plan*, 3 August 2023, page 66.
[415] THS.001.001.2051, Executive Clinical Governance Committee, *Meeting Minutes*, 23 July 2023, page 5.
[416] THS.001.001.0662, Executive Clinical Governance Committee, *Meeting Minutes*, 28 September 2023, page 9.
[417] THS.001.001.0663 THHS, Executive Audit, Risk and Compliance Committee, *Briefing Note, RATP: Outpatient Lost to Service,* 5 October 2023.
[418] THS.001.001.2035, THHS, Executive Clinical Governance Committee, *Meeting Minutes,* dated 23 November 2023, page 4.

715. Based on the evidence, as detailed above in summary form, the Investigators consider that:

(a) The information about Cluster 1 that was available to THHS at that time these events transpired, including information concerning the variance of the issues and the scale of the different process issues across several different outpatient clinics, presented a clear indication that the events arising in Cluster 1 were related to a system (process) issue. This issue was identified by THHS and it was appropriately escalated from the PSC to the Board (via both the ECGC and the previous HSCE to the BSQC).

(b) The EDCG had led the Outpatient Improvement Steering Group which examined outpatient services over a three month period and which included the development of detailed workflows which principally related to new referrals for a select number of outpatient clinics (general referrals, respiratory, neurosurgery and high risk antenatal). The Outpatient Improvement Steering Group met with staff from these units and mapped out their patient flows in detail. The Group also reviewed outpatient waiting list data relevant to these clinics. The Investigators noted that urology was not one of the services that was reviewed and do not have information before them explaining why this was the case.

(c) The Investigators consider that the work of the Outpatient Improvement Steering Group was in part operationalised by the Central Referral Hub who the Investigators considered provide a high-quality service.

(d) The Board advised the Investigators that, in relation to Cluster 1, BSQC were informed that a review of clinical incidents had identified variation in outpatient processes relating to triage, scheduling and follow-up of results. The Board indicated that the matter was framed as a variation in outpatient processes requiring operational review, not as a systemic patient safety issue. The Board indicated that they believe that the BSQC responded proportionately.[419] Outpatient scheduling processes was listed as a key safety and quality risk and the BSQC supported the establishment of the Outpatient Improvement Steering Group.

(e) The Investigators are of the view that the Outpatient Improvement Paper produced by the Outpatient Improvement Steering Group (Figure 8 above) is not demonstrative of a *"thorough review of processes is required to analyse current state, variation, and benchmarking against best practice."* The Outpatient Improvement Paper does not identify all the process risks, is not sufficiently detailed and did not adequately address the risks which were identified. Some of the recommendations are superficial, lack detail and do not indicate that any evidence was collated or relied upon to produce them ("find solution" or "develop process"). The Paper was reviewed by the EDCG, COO 1 endorsed by the HSCE and escalated to the Board. There was no discussion recorded by the Board in relation to the Outpatient Improvement Paper. The Investigators are of the view that the Board should have questioned the adequacy of the Outpatient Improvement Paper given the serious patient risks that were intended to be addressed and as reasonably evident based on the information that had been provided to the Board. The Board advised that the Investigators' criticism that "*[t]here was no discussion recorded*" does not account for the fact that the substance had been scrutinised by BSQC before escalation to the Board; that the COO 1 had been assigned responsibility for formalising an action plan; and that the Board (through the BSQC) subsequently noted progress reporting on those actions.[420]

(f) While process mapping was undertaken for a number of services by the Outpatient Improvement Steering Group, it was not undertaken in relation to urology.

[419] The Board's Natural Justice Response.
[420] The Board's Natural Justice Response.

(g) The THHS advised that its:

> response to the issues identified in Cluster 1 was immediate, reasonable, and proportionate to the information then available. Within days of the Briefing Note being tabled at the ECGC on 28 July 2022, the matter was escalated to the BSQC. Within weeks, the EDCG and COO 1 had met and agreed to establish the Outpatient Improvement Steering Group. Within two months, the Outpatient Improvement Steering Group had commenced, Business Rules had been endorsed, a dedicated project officer had been assigned, and detailed process mapping had begun. Within four months of the Briefing Note, the Outpatient Improvement Steering Group had completed its work and presented nine recommendations to the ECGC. This is not the conduct of an organisation that failed to respond.[421]

(h) The Investigators note the advice provided by the THHS and that there was activity undertaken by the THHS in responding to the cluster. The Investigators maintain their concerns as outlined above.

(i) The Investigators consider that the Board did not provide adequate oversight in relation to the issues of concern that were escalated to it in relation to Cluster 1. This was because there were a range of service areas affected, a range of causes that had been identified and the impact that Disrupted Care had on affected patients, all of which, pointed to a systemic issue and was contrary to what would reasonably be expected of a HHS Board presented with this information. Within this context, there did not appear to be appropriate evaluation by the Board of the Outpatient Improvement Paper (presented in draft) produced by the Outpatient Improvement Steering Group which was intended to identify, benchmark and mitigate any risks in relation to outpatient processes. Further, the Board "noted" the matter and did not, for example, require to be updated on the progress in responding to the issues presented in the Paper, including patient safety and clinical risk.

(j) The Investigators consider that as the entity which controlled THHS, the Board's oversight was insufficient and, in that sense, not adequate.

10.6.3 Adequacy of oversight – Cluster 6 (November 2023)

716. Overall, it is the Investigator's view that, with respect to Cluster 6, despite good evidence that a more extensive lookback should have been considered to identify affected patients who had experienced Disrupted Care, no steps were taken to consider such an action and ultimately, this was not undertaken. The Investigators consider that the THHS ought to have made inquiries to assure themselves that there were no other urology patients affected as there may have been other instances where the paper booking forms may have been misplaced, lost or not actioned but which were included in the bundle. If this was found to be the case, then this would then have triggered a more detailed lookback. The Investigators' assessment of these circumstances is that, at the time, there seemed to be a focus on the bundle of paper booking forms located on [redacted] as the cause of patients experiencing Disrupted Care (despite being advised it was likely a process issue) rather than undertaking a detailed analysis to identify the underlying causes. This oversight ultimately resulted in these process issues not being properly interrogated and with an appropriate response not being forthcoming.

717. The key information relevant to oversight of the issues of concern in relation to urology services following on from the Cluster 1 narrative above relevant to both Clusters 6 and 7, given they both arose in November 2023, are as follows:

(a) The EDCG advised Investigators that on or about 21 November 2023 until April 2024[422], they held weekly Patient Safety Urology Review meetings with operational staff where progress updates were provided on patients who experienced Disrupted

[421] THHS Natural Justice Response.
[422] THS.001.001.1396, THHS, Patient Safety Urology Review, 21 November 2023.

Care and who were part of Clusters 6 and 7.[423] The Investigators were provided with the records for meetings held on 21 November 2023, 6 December 2023, 11 December 2023 and 15 February 2024.[424]

(b) On 4 December 2023, the previous HSCE first informed the Board of Cluster 6 via the HSCE Report. This report refers to a discussion with the previous CMO, COO 1 and EDCG relating to a cluster of patient safety issues in urology. These concerns related to three themes, they being potential performance issue relating to an administrative officer; delays in access to care for outsourced MRI guided prostate biopsies; and delays in sourcing particular probes for biopsies. The previous HSCE advised that these matters would be briefed in more detail at the next BSQC meeting or sooner if new information developed and further, that the matters relating to the administrative officer were being progressed.[425]

(c) The COO 1 also advised that there was active management established after Cluster 6 and that this included[426]:

(i) on 5 December 2023 a new field requiring the entry of "Review of Due Date" was established in ESM;

(ii) in December 2023, the Bulk Check Out instructions were circulated to staff by email;

(iii) in early 2024 the THHS piloted a new process within the outpatients department, including urology outpatients, to ensure patients were checked out with appropriate follow up arrangements;

(iv) management dashboards were deployed relating to the ESM waitlist and OPD Slot Capacity together with Quick Reference Guides via the intranet;

(v) reports and dashboard tools were developed to enable the Service Group Leads and Medical Directors to undertake look backs across targeted areas of their waiting lists. These were used to identify patients who potentially experienced Disrupted Care identified in Cluster 9;

(vi) in October 2024, the Outpatient Appointment Management Procedure and Outpatient Waitlist Clinical Audit Procedure were distributed; and

(vii) that outpatient administration staff were provided with training in December 2023 on new workflows.

(d) The COO 1 also advised that a review of all patients with no 'Review Due Date' recorded in ESM was undertaken. They further stated that "a*s at 29 November 2023 there were nearly 22,000 patients with no review due date entered (which is 56.8% percent of the patients). During 2024, over 21,000 patients were reviewed and updated with a due date. Data from December 2024 revealed that only 631 patients did not have a due date entered (which is 1.5% of patients). Of the 631 patients, Urology had 37 patients without a due date. This body of work is direct evidence that THHS was conducting lookbacks of patients with Disrupted Care, whilst the EDCG and her team were reviewing the specific Cluster patients, while the COO was*

[423] Consulted Parties' Natural Justice Response.
[424] WIT.009.001.0021 THHS, *Patient Safety Urology Review,* 21 November 2023; WIT.009.001.0024 THHS, *Patient Safety Urology Review,* 6 December 2023; WIT.009.001.0026 THHS, *Patient Safety Urology Review,* 11 December 2023; WIT.009.001.0030 THHS, *Patient Safety Urology Review,* 15 February 2024.
[425] THS.001.001.1809 THHS Board, *HSCE Report*, 4 December 2023, page 1.
[426] Consulted Parties' Natural Justice Response.

implementing large bodies of work relating to policies and procedures."[427] The Investigators consider that this represents a quality data audit, not a lookback.

(e) On 13 December 2023, the BSQC were informed that there was an emerging patient safety concern regarding urology which was identified following a patient complaint about a long wait for an appointment. When investigated, it was discovered this was not actioned by a bookings officer. A SAC 1 was identified but the remainder of the patients were yet to be reviewed.[428] The BSQC were informed there were three discrete areas of patient groups being reviewed:

(i) the patients whose booking forms were found on [redacted] (160 patients);

(ii) a group referred to external radiology, for MRI prostate biopsies where a shortage of biopsy needles for the procedure which was not flagged until 14 months after the shortage (14 patients) (Cluster 7); and

(iii) a third group of patients lost to follow up (34 patients).

(f) The Chair noted that this discussion was an interim update. The Chair requested a more wholesome (sic) brief for the Board. He questioned whether there was a dashboard or some other way at looking at what is happening with respect to the affected patients. He was of the view that the paper tabled did not provide sufficient information and that further information must be provided to the Board, including a framework to improve the process, information regarding the team and responsibilities and further information regarding the number and status of patients.

(g) The Investigators noted that the case numbers presented to the BSQC were indicative at this time.

(h) On 15 January 2024, an update was provided to the Board Executive Committee by way of a paper entitled "Urology and Outpatient Process Update".[429] The key points were listed as follows:

(i) outpatient scheduling processes is listed as a key safety and quality priority;

(ii) the Outpatient Improvement Steering Group was established by the COO 1 to conduct a thorough review of outpatient processes in specialist clinics to identify current state, variation and to advise and make recommendations to the ECGC and BSQC. The APCLG oversees all governance processes in relation to outpatient services;

(iii) additionally, a stand-alone Lost to Service RATP (ID #323) was endorsed by the EARCC on 5 October 2023 as an executive-level risk; and

(iv) following the identification of unactioned urology clinic follow up appointments in November 2023, further actions have been undertaken to manage both the immediate risk and the longer-term risks regarding review appointments.

(i) An updated version of the Outpatient Improvement Paper was included with accountable officer and a timeframe added. Of the now 12 variations listed, five were marked as closed, four had target dates and three had no timeframe allocated but

[427] Consulted Parties' Natural Justice Response.
[428] THS.001.001.1699 THHS, *Board Safety and Quality Committee Meeting Minutes*, 13 December 2023, page 5; THS.001.001.1893 Board Safety and Quality Committee, *Briefing Note*: *Patient Safety Report*, 13 December 2023, page 1-2.
[429] THS.001.001.0834 Board Executive Committee, *Urology and Outpatient Processes Update*, dated 15 January 2024 THS.001.001.1719 THHS, Board Executive Committee*, Meeting Minutes #100,* 15 January 2024, page 5.

PART A

PART B

PART C

appeared to be ongoing. The Investigators note that the most relevant variations and actions for the purposes of Clusters 6 and 7 are numbers #5 and #6 which relate to inconsistent review list and booking processes which had target dates of March 2024. Variation #7 also appears to be relevant for Cluster 7. The Board Executive Committee requested that the paper be presented to the Board.

(j) On 5 February 2024, the Board met and noted the papers tabled by the Board Executive Committee and BSQC (13 December 2023 and 24 January 2024).[430]

(k) On 19 February 2024, the BSQC met and were provided with a "Urology Update" report endorsed by the previous HSCE and presented by the EDCG. The SAC ratings of patients identified in Clusters 6 and 7 were assessed as being: two confirmed SAC 1s, two confirmed SAC 2s, three confirmed SAC 3s, 62 confirmed SAC 4s. A further 32 cases were likely to be categorised as SAC 3 or 4 after review. The previous CMO provided an update as to the actions being taken. The BSQC discussed that the THHS needs to assess all overdue outpatients not just patients of urology services. The Chair noted the paper tabled did not provide sufficient information and requested that further information is provided to the Board, including the status of each of the clinical cases, what is not known and a clear picture of numbers.[431]

(l) On 4 March 2024, the Board (via BSQC) were provided with a "Patient Safety Report" as endorsed by the HSCE which was discussed.[432] The Board noted that the urology issues continued to be managed with the SAC details outlined in the paper. The paper noted:

(i) there were 23 patients awaiting an MRI biopsy needle. All these patients have been scheduled, biopsied and/or scheduled for review appointments. There is one SAC 1 patient in his cohort, the remaining cases are being discussed with a medical officer to determine the level of harm;

(ii) there were a total of 159 unactioned booking forms in the “bundle stream” relating to follow up appointments/ reviews. Of these, 62 have been confirmed as SAC 4, a further 32 cases are being reviewed, seven patients have been seen and require further investigations and 58 patients who require a follow up appointment have been scheduled; and

(iii) there were 33 "other" incidents of patients being "lost to service" which were identified through consumer feedback, clinical incidents and other avenues. All these patients have been followed up or have appointments booked. There was one SAC 1 confirmed in this cohort.

(m) On 8 April 2024, the Board met and were provided with a "Urology Update" report which stated that as of 4 April 2025 SSG confirmed that all patients had been scheduled for an appointment or were surveillance patients. Actions taken were listed, including cession of the Bulk Check Out process and recruitment of an additional medical officer to urology, a new 0.8 FTE prostate surveillance nurse appointed and commencement of Saturday urology clinics. Updated data on SAC numbers were provided.[433]

(n) On 22 April 2024 the BSQC met and were provided with a "Urology Update" report which is the same report that was provided to the Board on 8 April 2024. The EDCG

[430] THS.001.001.1812 THHS Board, *Minutes*, 5 February 2024, page 13.
[431] THS.001.001.1717 Board Safety and Quality Committee, *Briefing Note*: *Patient Safety Report*, 13 December 2023, page 5. THS.001.001.1721 Board Safety and Quality Committee, *Meeting Minutes,* 19 February 2024, page 4.
[432] THS.001.001.1734 Board Safety and Quality Committee, *Briefing Note: Patient Safety Report,* meeting date 19 February 2024, presented to Board on 4 March 2024; THS.001.001.1725 THHS Board, *Meeting #145 Minutes*, 4 March 2024.
[433] THS.001.001.1735 THHS, *Board Safety and Quality Committee, Briefing Note,* 22 April 2024.

provided a summary to the BSQC and the update was noted. The BSQC resolved to escalate this paper to the Board.[434]

(o) The BSQC were also provided with a report on "Outpatient Processes Updates".[435] COO 1 provided a summary and the paper which was noted. The key points from the "Outpatient Processes Updates" were that outpatient scheduling processes were listed as a key safety and quality priority (the Investigators note this had been the top priority for ECGC since 22 February 2023), that the APCLG was overseeing all governance processes relating to outpatients, that there was a standalone RATP (Outpatients Lost to Service #323) and that following Clusters 6 and 7, further actions were being taken to manage both immediate and longer-term risks. Under implementation, an updated version of the Outpatient Improvement Paper was included with 12 identified variations, of which six were marked as closed, three had target dates and three had no timeframe allocated but appeared to be ongoing. The Investigators note that the most relevant variations and actions for the purposes of Cluster 6 are numbers #5 and #6 which relate to inconsistent review list and booking processes which were marked as closed with ongoing monitoring by APCLG. The actions taken to resolve this variation included the Outpatient Waitlist Dashboard and the addition of "review date" in ESM. It states that a mapping exercise was underway but there is no indication on the face of the document as to the status of that work.

(p) On 13 May 2024, the Board met and discussed the increased demand for urology services (both for THHS and across the State) noting that in April 2024 there were 500 "long wait" urology outpatients. The Action Plan was to be updated to include the number of long waits based on the initiatives documented and a review of resources required to address the capacity vs demand gap.[436] The Urology Report that was resolved to be escalated by BSQC in April 2024 is not specifically listed nor any discussion of it mentioned. The Board noted the papers as tabled.

(q) On 2 July 2024, the Board met and discussed several key matters related to urology services. Action Item BD20240513-776, concerning the Urology Forecast, was reviewed and determined to be effectively monitored by the BSQC. Consequently, the Board agreed to close this action item. Related to this action item, the Board noted that the requested data on urology services, including patient numbers, treatment timelines, and SAC ratings, was being reported through the EDCG Report at the BSQC. Additionally, the Board requested an update on any HR investigations related to a recent incident. An officer provided insights, indicating that the issue is "likely a systemic issue" rather than the result of individual staff actions. The officer also highlighted that clinical leadership has been considered and administrative changes were implemented in December 2023 to address identified concerns. The Board tasked the EDCG with confirming that the necessary information was included in BSQC reporting.[437]

(r) On 19 August 2024, the BSQC met and reviewed critical issues related to urology services in the "Patient Safety Report" that was provided by the Acting EDCG.[438] The final seven urology patients had been assessed for harm levels and confirmed as SAC 4 incidents. Additionally, the SSG conducted a review of urology follow-up paper booking forms that had not been actioned. It was confirmed that all 23 impacted patients have either been seen or are scheduled for follow-up appointments, ensuring no further delays in their care. Performance issues related to urology follow-ups were discussed, with the previous HSCE who provided assurance that the concerns were being actively addressed by HR. The Committee also noted interruptions in the MRI service due to delays in receiving equipment parts from the

[434] THS.001.001.1722 THHS, Board Safety and Quality Committee, *Meeting #70 Minutes*, 22 April 2024.
[435] THS.001.001.1736 THHS, *Board Safety and Quality Committee, Cover Note: Outpatient Process Update*, 22 April 2024.
[436] THS.001.001.1726 THHS Board, *Minutes*, 13 May 2024, page 5.
[437] THS.001.001.1727 THHS Board, *Minutes*, 2 July 2024.
[438] THS.001.001.1723 THHS Board Safety and Quality Committee, *Minutes*, 19 August 2024; THS.001.001.1900 Board Safety and Quality Committee, *Patient Safety Report*, 19 August 2024.

private service provider typically outsourced by THHS. The BSQC on 19 August 2024 noted the updates on urology patient reviews and follow-up actions as part of the Patient Safety Report.

(s) On 2 September 2024, the Board met and were provided with a "Patient Safety Report" which included a Case Review Report for a SAC 1 urology patient[439] and outlined that the patient was first referred on 27 October 2021 and became lost to follow up from 22 October 2022.[440] Due to the consequential delay in care, the patient lost the opportunity for curative treatment. It was noted that the family advised that they called TUH to follow up on the appointment progress multiple times but it was stated in the report that administrative officers had no capacity to document all received phone calls. It was also noted in the report that the urology department commenced a trial in February 2024 with an administrative officer situated within the urology clinics to action all patient rebooking/follow up plans. The recommendation was that the APCLG would ensure that the administrative process change made in December 2023 have appropriately safety netted patients from being lost to follow up.

(t) On 21 October 2024, the BSQC met and were provided with a paper on "Clinical Risks - Lost to Service"[441] which detailed that the RATP identified patients requiring review in outpatient clinics being lost to service due to variability in workflows and the lack of an appropriate audit process. The consequence was noted as being that there may be multiple patient deaths or permanent harm as an outcome. The identification of causes as well as analysis and evaluation of each risk lead to six treatment actions:

(i) explore the ability within the Oracle Health EMR ESM system to flag that a patient has not been booked or returned to the waitlist when a scheduled appointment does not occur. This was completed and implemented in late 2023;

(ii) standardise workflows to reduce variability across Service Groups. This remained ongoing but a number of actions had been taken;

(iii) establish a process to enable clinical oversight of patients prior to removal from outpatient waitlist (in line with SOSIS guidelines). The status was unclear from the report;

(iv) collaborative redesign of the THHS Data and Analytics Waitlist Dashboard. This remained ongoing but a dashboard was intended to be released in late 2024;

(v) operationalise ESM Scheduling View (existing EMR functionality) and ESM Dashboard (new). This was completed and tabled at ECGC in January 2024; and

(vi) create an automated audit report(s) to monitor patients who may be lost to service. This was completed and tabled at ECGC in January 2024.

(u) On 4 November 2024, the Board met and discussed the demand on urology services, noting that efforts to address long outpatient waits have now resulted in surgical long waits.[442] The minutes note that the Board discussed and noted various papers

[439] Cl [redacted] and Riskman No. [redacted].
[440] THS.001.001.1817 THHS Board, *Briefing Note: Patient Safety Report*, 2 September 2024, pages 10-17.
[441] THS.001.001.1811 THHS *Board Safety and Quality Committee*, *Meeting Minutes*, 21 October 2024; THS.001.001.1754 Board Safety and Quality Committee, *Cover Note: Waitlist Management*, 21 October 2024; THS.001.001.1854 Board Safety and Quality Committee, *Clinical Risks - Lost to Service*, 21 October 2024.
[442] THS.001.001.1729 THHS Board, *Meeting Minutes*, 4 November 2024, page 9.

escalated by the BSQC, however copies were not provided to the Investigators and there is no recorded discussion in the minutes.

(v) On 16 December 2024, the BSQC met and the EDCG presented a high-level summary of the annual SAC 1 Trend Analysis Report, which highlighted a decrease in the incidences of patients being "lost to service" compared to the previous reporting period.[443]

718. The Investigators consider that:

(a) The chronological overview as detailed above indicates that from August 2022, the Board were aware that there was variation in outpatient processes, including within urology services, and that this was resulting in adverse clinical incidents. Throughout the remainder of 2022 and 2023, a number of actions were taken by the Board, previous HSCE, COO 1 and the EDCG to regularise the outpatient variation and mitigate the risk. The Board were provided with regular updates on the actions being proposed and taken.

(b) By June 2023, with the provision of the PwC FTA Internal Audit Report, the Board was aware of the specific and serious deficiencies in the outpatient service including that local procedures were outdated, misaligned with the SOSIS, and inconsistently applied across clinics and that there was widespread operational non-compliance, including failures to document follow up actions, and repeated rebooking of patients after consecutive FTAs without addressing underlying barriers to attendance.

(c) The matters identified in Cluster 6 (which arose in November 2023) were of a serious nature and while the Board, previous HSCE, COO 1 and the EDCG took active steps to respond to these, these actions were insufficient , namely that a detailed analysis of the underlying causes was not undertaken and as a result a detailed action plan was not developed and which should have included an urgent update to procedures supported by a change management plan relating to the Bulk Check Out memorandum.

(d) The Investigators noted that the patient reviews and the actions by the THHS to support affected patients were professional and detailed and patient focused.

(e) The Investigators consider that the THHS should have considered this cluster in a broader context (e.g. check to see if all cases were identified) and not just the immediate response to support affected patient;

(f) The Board advised the Investigators that on 13 December 2023 the BSQC contemplated a Part 9 statutory investigation (the most escalatory governance lever available) only to be counselled against it by the previous HSCE.[444] It further advised that the Board was not told was that the EDCG had instructed the Clinical Audit Unit not to participate in retrospective audit work, that the outpatient dashboard was configured to show only forward-looking data and clinical staff advocating for a look-back had been refused at the operational level. The Board also observes:

> that had it been informed in September 2023 that a retrospective look-back had been proposed and refused at the operational level, the Board would have directed it proceed.[445]

(g) COO 1 advised that their recollection was that the THHS had identified factors including human error, the need for new outpatient processes, workforce limitations, compliance with outpatient processes and procedures by at least mid-2022. They stated that this is precisely why there was a significant body of work being undertaken

[443] THS.001.001.1724 Board Safety and Quality Committee, Minutes, 16 December 2024.
[444] THS.001.001.1699 THHS, *Board Safety and Quality Committee Meeting Minutes,* 13 December 2023, page 7.
[445] The Board's Natural Justice Response.

to streamline outpatient processes and why steps were being taken to address workforce pressures such as the approval of more administrative and clinical staff.[446]

(h) The Investigators note that once the impacted patients had been identified that there was a proactive management arrangement put in place to ensure that the affected patients received appropriate follow up care and treatment.

(i) The Investigators note that the response to Cluster 6 by stopping the Bulk Check Out process as per the memorandum of 18 December 2023 without appropriate change management being implemented, resulted in the HHS remediating, in part, one cause for patients experiencing Disrupted Care but creating a new pathway for urology patients to experience Disrupted Care (being the use of both paper booking forms and ESM). This remained in place for almost two years.

(j) With respect to change management, following the circulation of the memorandum in December 2023, the Investigators have not been provided with any evidence demonstrating there were specific unit based post-implementation audits undertaken to confirm that changes had been effectively implemented in the delivery of urology services. The Investigators were not provided with a documented change management plan.

(k) The COO 1 advised that the THHS had undertaken post implementation audits in the SSG from 2024 onwards and which were monitored weekly by the Administrative Team Leader and a Urology Clinical Nurse.[447]

(l) The THHS also introduced an outpatient dashboard to identify whether a patient who has been seen at THHS had been discharged from care or had a follow up appointment made. This initiative appears to have been successful in remediating some of the issues of concern.

(m) When the continued use of paper booking forms in the delivery of urology services was made known to the previous HSCE in October/November 2025, the previous HSCE took immediate steps to have this practice discontinued.

(n) The Investigators consider that a lookback should have been undertaken at the time that this cluster was identified and as recommended by staff working in the safety and quality team, to identify all patients who had experienced Disrupted Care rather than taking a forward-looking approach. This would have identified patients who experienced Disrupted Care at an earlier time. This was an oversight by the previous HSCE and EDCG.

(o) By not considering in detail the recommendation by staff for a lookback, the THHS not only lost the opportunity to improve patient safety but this also impacted negatively on the culture of speaking up for patient safety. The THHS advised that *"the Investigators' finding that the failure to consider the look-back recommendation negatively impacted the culture of speaking up for patient safety [was]not accepted. This finding is not supported by the evidence and does not fairly reflect THHS's demonstrated commitment to a strong speaking up culture."*[448] The Investigators do not agree with this position and notes the Board's advice that they would have directed the THHS to proceed with this activity had they been asked to consider the matter. The impact on organisational culture is discussed in a subsequent section of the Report which addresses complaint management.

PART A

PART B

PART C

[446] Consulted Parties' Natural Justice Response.
[447] Consulted Parties' Natural Justice Response.
[448] THHS Natural Justice Response.

(p) Resourcing requests for permanent administrative support from the clinical area (outpatients) were received but did not result in permanent administrative support. The previous HSCE advised in 2026 that:

> Resourcing requests were unfulfilled due to other competing priorities, or an inability to secure the services of specialists in a resource constrained environment.[449]

(q) The COO 1 advised that several additional positions were established across TUH to support outpatient services in general including two Administrative Officers to support the BPIO, four AO3 Administration Officers following Bulk Check Out process change, one AO3 Administration Officer in Gynae Oncology, one CNC Respiratory, and one BPIO Elective Surgery. With respect to urology the COO 1 advised that several positions were established including a 0.8 FTE Prostate Surveillance Nurse, a part-time GPSI in Urology and three additional Urology PHO's to offset workload resulting from the specialist vacancies. The COO 1 also confirmed for urology and other similar surgical services in THHS that the THHS supported the recruitment to minimum of four specialists where services were able to recruit staff.[450]

(r) The key procedure (Appointment Management Procedure) following the review of the clusters and, which was designed to mitigate risk was not fully operationalised until June 2025. This represents an unacceptable delay in the face of the known patient safety risks on foot at the time.

(s) A detailed analysis to determine the underlying cause was not undertaken, which the Investigators consider should have been undertaken by this time when the Board, previous HSCE, COO 1 and the EDCG were aware the scale of the issues and the systemic nature of the same.

(t) Stronger and more comprehensive corrective actions should have been taken by the previous HSCE, COO 1 and the EDCG at this time to mitigate the patient safety risks based on a more detailed examination of the underlying cause of patients experiencing Disrupted Care.

(u) The Investigators consider this represents a departure from what would reasonably be expected of the Board and these Executives, noting that by November 2023 the Board, previous HSCE, COO 1 and the EDCG were all aware of the issues of concern and the risks these issues presented; that the BSQC had raised the possibility of an independent investigation with the previous HSCE, that there had not been a detailed analysis undertaken of the event and issues; safety and quality staff were concerned about patients experiencing Disrupted Care and had raised these concerns including the need for a look-back; and that patients continued to experience Disrupted Care. The Investigators therefore consider that the oversight of the Board, previous HSCE, COO 1 and the EDCG across their relevant areas of oversight was insufficient, and in that sense not adequate.

(v) With respect to the Board and their oversight in relation to the issues of concern that were escalated to it in relation to Cluster 6. The Investigators note that between August 2022 and November 2023, the Board was provided with significant amounts of information as well as updates on the actions being undertaken to identify, benchmark and mitigate risks in relation to outpatient processes and relevant activities in relation to urology services. The Investigators also note that the BSQC in December 2023 contemplated a Part 9 investigation but discounted it based on the advice from the previous HSCE.

[449] Consulted Parties' Natural Justice Response.
[450] Consulted Parties' Natural Justice Response.

10.6.4 Adequacy of oversight – Cluster 7 (November 2023)

719. With respect to Cluster 7, this cluster of patients was at high risk of having a malignancy. The Investigators consider that the THHS should have been aware of this patient safety risk and acted accordingly. The Investigators recognised a lack of systems in place to track patients who are outsourced to private radiology services for specialised procedures within the THHS meaning that patient delays and patients experiencing Disrupted Care were not identified.

720. The key information relevant to Cluster 7 are the same as those relating to Cluster 6 above, with the addition of the below:

(a) on 23 June 2022, THHS received the PwC Internal Audit into Medical Imaging Report.[451] Relevantly the Report found:

(i) there were no defined process, roles, or responsibilities for outsourcing imaging activity; referrals sometimes made without the MID's knowledge;

(ii) outsourced imaging reports can often get misplaced and are not consistently uploaded to PACS; and

(iii) there was no formal monitoring, reporting, or confirmation process for outsourced specialised medical procedures (such as MRI guided prostate biopsies), making it difficult to track volumes or match images to completed reports.

(b) the PwC Internal Audit Report into Medical Imaging was distributed to the following stakeholders:

(i) On 7 July 2022, the Internal Audit Report was presented to EARCC for discussion and noting.

(ii) On 20 July 2022, the Internal Audit Report was presented to the BARC for discussion and endorsement. BARC stated that it had an:

> appetite for a more comprehensive assessment of the suggestive (sic) recommendations... with an implementation plan articulated and monitored.[452]

(iii) On 1 August 2022, the Internal Audit Report was presented to the Board for discussion and approval.

(c) on 14 March 2023, a complaint was received on behalf of a cancer patient from a local MP through the office of the previous HSCE as the patient had been referred for an MRI guided prostate biopsy which was to be performed by an external provider but had been advised there were no needles available to complete the procedure.[453] The EDCG was forwarded a copy of the complaint. The complaint was also forwarded to the SSG who subsequently identified 11 further patients who were awaiting this specialised procedure. The EDCG indicated that, at the time of dealing with the first complaint, it was understood that there was a temporary supply shortage of the biopsy needles.[454] The Investigators have no evidence before them regarding what steps were taken in relation to the 11 patients and the potential risk relating to the needle shortage including whether inquiries were made in relation to the expected duration of the needle supply shortage. However, the Investigators have confirmed

[451] WIT.007.001.0003, PwC Medical Imaging Department: Patient Workflows, June 2022, page 11.
[452] THS.001.001.1828 Board Audit and Risk Committee, Meeting Minutes, 20 July 2022, page 4.
[453] THS.001.001.1660 Email sent on 15 March 2023.
[454] Consulted Parties' Natural Justice Response.

that the 11 patients identified in March 2023 are all contained within the 23 patients later identified in the cluster of November 2023.[455]

(d) on 22 March 2023, BARC met and were presented with an update in relation to the MID Implementation Plan which was prepared in response to the PwC Internal Audit into Medical Imaging Report.[456] In relation to the out of hospital medical imaging, it was noted that *"the process / document has been developed; however no mutual agreements have been reached. Plan to have further meetings with all the stakeholders."*[457] The Investigators were not provided with information detailing what action THHS took after this point in time.

(e) COO 1 advised that the THHS responded to the PwC Internal Audit Report into Medical Imaging including increasing the tracking of some studies and establishing liaison meetings with private providers.[458] However, based on the information provided to the Investigators the tracking and management of specialised procedures such as the MRI Guided Prostate Biopsies had not been progressed.

721. The Investigators consider that:

(a) since the PwC Internal Audit Report into Medical Imaging of June 2022, the THHS was aware of the deficiencies in the systems used to support external referrals and that clinical staff referred patients directly to private services for investigation.

(b) the THHS was aware that this group of patients were at high risk of having malignancies and therefore should have had a greater focus and urgency as regards this cohort of patients.

(c) the THHS ought to have been aware that medical imaging procedures and surgical procedures were equally effective from a diagnostic perspective and as such could have recalled patients and progressed their care through surgical services at an earlier time.

(d) the system failure meant that patients lost their chances for timely treatment of their conditions and that the THHS did not appreciate the gravity of this situation (i.e. patients with potential malignancy) despite having obtained information as to this risk as outlined in the PwC Internal Audit Report into Medical Imaging of March 2022 and which was presented to BARC in July 2022 and the SSG being aware of the specific concerns relating to the outsourcing of urology patients for MRI guided prostate biopsies as early as 15 March 2023.[459]

(e) a detailed analysis as to the underlying cause was not undertaken, which the Investigators consider would have been an appropriate and reasonable response. A Case Review Report[460] undertaken in relation to a SAC 1 patient as part of this cluster concluded that in relation to the MRI prostate biopsy needle shortage that *"no recommendations have been made as the TUH ceased the outsourcing of MRI prostate biopsies in January 2024 and is in the process of establishing an in-house MRI prostate biopsy service".* This recommendation does not acknowledge the underlying systems issues.

(f) the Investigators consider these responses to known issues were below what would have reasonably been expected by a Board and the Executive being the previous HSCE, COO 1 and the EDCG. The Investigators further consider that these

[455] THS.001.001.1426 Email sent on 4 January 2024; THS.001.001.1920 *Excel entitled 1 Jan 2022 - 31 July 2025 Riskman Patient Incidents*.
[456] THS.001.001.1833 Board Audit and Risk Committee, Meeting Minutes, 22 March 2023, page 3.
[457] WIT.007.001.0004, Internal Audit Patient Flows recommendations and implementation plan, page 7.
[458] Consulted Parties' Natural Justice Response.
[459] THS.001.001.1660 Email sent on 15 March 2023.
[460] THS.001.001.1817 THHS Board, *Briefing Note: Patient Safety Report*, 2 September 2024, page 11.

responses impacted adversely on patients safety and outcomes and as such, it could not be said that the oversight exercised by the Board, previous HSCE, COO1 and the EDCG was adequate.

(g) the Board advised the Investigators that, with respect to Cluster 7, that it had pre-identified this risk category 16 months before the cluster emerged. It submitted that on 20 July 2022, BARC received the PwC Medical Imaging Internal Audit Report identifying the lack of monitoring for outsourced procedures, including MRI guided prostate biopsies, and required implementation plans. Further it stated that when the specific trigger occurred (biopsy needle shortage, October 2023), the Board was not informed and when the BSQC was briefed on 13 December 2023, the Committee was advised that all Cluster 7 patients were "booked in". The Board states that it had identified the risk, required mitigation, monitored implementation, and was not informed when the risk crystallised, exercised adequate oversight.[461]

(h) the Investigators consider that given the Board was aware of the risk posed by outsourcing specialised medical imaging procedure as identified in the PwC Medical Imaging Internal Audit Report from July/August 2022. Action plans were developed in response to the Audit report. No information was presented to the Investigators to indicate that the specific risk identified with respect to the outsourcing of specialised medical procedures such as MRI guided prostate biopsies was addressed. This risk materialised in November 2023 when Cluster 7 was recognised. Internal Audit is a function that is oversighted by the BARC and Board. The Investigators do not consider that the BARC and Boards oversight was sufficient as this specific risk was known by BARC and the Board and that the risk had not been addressed and closed out. As a consequence of the insufficient oversight at the level of BARC and the Board these risks were not fully mitigated and Cluster 7 occurred.

10.6.5 Adequacy of oversight – Cluster 8 (December 2024)

722. With respect to Cluster 8, this cluster of patients was also at high risk due to the high risk of malignancy and procedural changes in urology outpatients that led to patients experiencing Disrupted Care. In the relevant period prior to Cluster 8, staff had raised concerns about a range of matters affecting the administrative processing of patients.[462] There is evidence that formal medical referrals were not managed appropriately.

723. The key information relevant to oversight of the issues of concern in relation to urology following on from the narrative above relevant to Cluster 8 are as follows:

(a) on 11 December 2024, a Senior Staff Specialist and Clinical Director in Oncology notified internal staff including the previous CMO about an audit recently undertaken prompted by two SAC 1 incidents for bladder cancer patients the previous year. The audit identified 32 potentially affected patients. The previous CMO requested these concerns be logged in Riskman to be examined as patient safety concern.

(b) on 16 December 2024, the Nursing Director for Patient Services confirmed that one of the patients flagged by the oncologists already had a clinical incident logged against them from a mortality review earlier in the year that had not been progressed due to capacity issues. That clinical incident was deleted and replaced with the one flagged by the oncologists as they related to the same patient.[463] The Nursing Director Patient Services also foreshadowed a triage meeting to assess the 32 identified patients.

[461] The Board's Natural Justice Response.
[462] THS.001.001.1354 Email, sent on 3 June 2024.
[463] THS.001.001.1670 Email, sent on 17 December 2024.

(c) on 17 December 2024, the EDCG requested a Patient Safety meeting to discuss the audit findings.[464]

(d) on 8 January 2025, a triage meeting was held, attended by the EDCG, Acting DMSCGDH, previous CMO, Nursing Director Patient Services, SSGD and others. The meeting discussed the 32 patients identified in the audit and the minutes from the meeting state the outcomes included[465]:

(i) urology continued to experience capacity issues which was impacting access and was being managed through plans to bring locum coverage on board and had been discussed at ECGC;

(ii) the two SAC 2s would not yet be entered onto Riskman until the level of harm was understood;

(iii) feedback related to delays in urology or follow-on care would be reviewed;

(iv) the EDCG and previous CMO would seek feedback from their peers in relation to statewide KPIs for cancer care in this population;

(v) a review team was established; and

(vi) once this matter was better understood, discussions would be held around who would be best placed to conduct future audits.

(e) on 9 January 2025, the EDCG informed the A/HSCE (who was substantively the COO 1) that there had been a triage meeting the day prior to discuss one SAC 1 identified through a mortality review the year prior and two SAC 2s through an oncology audit.[466] The email stated that a cluster review was being coordinated with key clinicians and more information would be provided as it became available.

(f) on 24 February 2025, an update was provided to the EDCG and Nursing Director Patient Services advising that internal meetings had occurred on 17 February 2025 to obtain clinical opinions on the level of harm to three of the patients highlighted in the audit noting the audit was undergoing a multi-incident analysis. The recommended SAC ratings at the time were one SAC 1 and two SAC 2s. The email also flagged two other SAC 1 incidents within urology unrelated to Cluster 8. A meeting with key stakeholders was foreshadowed for 26 February 2025 with the author of the email asking for confirmation as to whether it should be extended to the COO.[467]

(g) a further triage meeting was held on 26 February 2025 with attendees relevantly including the EDCG, Acting CMO, SSGD, Nursing Director Patient Services and others. The decision arising from this meeting was endorsed by the EDCG. The minutes of the meeting state the outcomes included:[468]

(i) the intention of the audit was that it formed part of routine quality improvement processes completed by Registrars and to strengthen cancer pathways of care;

(ii) the attendees agreed to progress the SAC ratings as opined by Medical Oncology;

[464] THS.001.001.1451, Email, sent on 17 December 2024.
[465] THS.001.001.1652, THHS, *Triage Meeting Outcomes*, 8 January 2025.
[466] THS.001.001.1450 Email, sent on 9 January 2025.
[467] THS.001.001.1635, Email sent on 24 February 2025.
[468] THS.001.001.1934, THHS, Triage Meeting Outcomes, 26 February 2025.

(iii) it was acknowledged that system improvements may already be in place to address the issues highlighted and a recent feedback item was discussed, entered as a SAC 1 about a patient experiencing recent and significant delays to treatment;

(iv) the Urology RATP was planned to be tabled with EARCC on 27 February 2025 in relation to Urology service demand outweighing capacity; and

(v) Patient Safety would meet with Medical Oncology to review the remaining 29 patients to determine if harm arose due to the delay acknowledging that preliminary conversations were that significant harm was unlikely. There was discussion of not completing a review of all 32 patients on the basis that recommendations may remain the same and practices may have already improved. It was then stated that Patient Safety would identify any trending themes from the remaining 29 patients and once more was understood, usual process would be followed if additional cases were identified.

(h) on 27 February 2025, the EARCC read the 'Inability to Provide a Safe and Effective Urology Service to Junior Workforce' noting a comprehensive RATP had been completed with 31 recommended treatment actions.[469] The EARCC escalated the papers to the BARC as an agenda item.[470] The RATP was considered by BARC at its meeting on 19 March 2025 who requested it be tabled for discussion at the next meeting of BSQC and escalated as a separate agenda item to the Board.[471] It was considered and noted at the BSQC meeting on 14 April 2025.

(i) on 25 March 2025, the EDCG and previous HSCE signed off on a Multi Incident Analysis Report which detailed the analysis of Cluster 8 and was annexed in the Patient Safety Reports used to brief THHS committees and the Board. Considering the Inability to Provide a Safe and Effective Urology Service to Junior Workforce RATP, the Review team made one recommendation, namely establishing a local pathway of care for bladder cancer patients. The report noted, at the time of writing, that the remaining 29 cases identified in the audit were still under review.

(j) on 27 March 2025, the ECGC were presented with a Patient Safety Report.[472] The Investigators were not provided with the Patient Safety Report but note the minutes of the meeting state that this report included reference to Cluster 8 and the review team's recommendation. With respect to Cluster 8 and another escalated matter from PSC, it was stated that concerns had been raised across different specialities whereby there are delays "*not through anyone's mismanagement but with navigating the system and the multiple touch points which adds extra wait time to the journey which can have significant impact/outcome for each individual patient. It is a systemic problem...*" The ECGC accepted the report and an outcome was for COO 3 to reach out to the Reform Team in Brisbane and CEQ to request assistance with mapping cancer care pathways.

(k) on 14 April 2025, the BSQC was informed about Cluster 8 via a Patient Safety Report which annexed the Multi Incident Analysis Review Report.[473] They were informed via a THHS Patient Safety Report[474], that:

[469] THS.001.001.1642, THHS, *Inability to Provide Safe and Effective Urology Service and Supervision to Junior Workforce RATP*, 27 February 2025.
[470] THS.001.001.0314, THHS Executive Audit, Risk and Compliance Committee, *Meeting Minutes*, 27 February 2025, page 13.
[471] THS.001.001.1757 THHS Board Audit and Risk Committee, *Meeting Minutes,* 19 March 2025, page 6.
[472] THS.001.001.2058 THHS Executive Clinical Governance Committee, *Meeting Minutes*, 27 March 2025, page 7-8.
[473] THS.001.001.1760 THHS Board Safety and Quality Committee, *Meeting Minutes*, 14 April 2025, page 3 and 7.
[474] THS.001.001.1770, THHS, Board Safety and Quality Committee, *THHS Patient Safety Report*, 14 April 2025, page 2-3 and 17-28.

(i) the 32 cases subject to the audit had muscle-invasive or metastatic bladder cancer from January 2021 to December 2023;

(ii) three of the 32 cases were highlighted as having prolonged cancer journeys resulting in unexpected outcomes and patient harm. The causes contributing to these delays were:

- the demand for the THHS urology service exceeding current capacity of the service increasing time between reviews due to availability of specialists; and
- patients with suspected bladder cancer are only referred to the Genitourinary/Urology MDT once histopathology is known which can delay treatment by several weeks.

(iii) in respect of the issue relating to service demand exceeding capacity was determined to have been largely considered and addressed in the RATP 'Inability to provide safe and effective Urology Service and supervision to junior workforce';

(iv) in these circumstances, the review team only made one additional recommendation, which was to establish a local pathway of care for patients with suspected or confirmed bladder cancer with the goal of developing targeted timeframes.

(l) BSQC were informed by the EDCG that reviews into Cluster 8 were part of ongoing assurance and quality improvement efforts with efforts to improve cancer care pathways, including the urology cancer pathway, focusing on mapping patient journeys to identify bottlenecks and implementing solutions for timely care. Cluster 8 was also said to have been discussed in relation to the general urology update. The BSQC noted the information relating to clinical incidents and core patient safety business and discussed its contents. Later in the meeting, in response to a urology services update, among other matters, the BSQC also noted the RATP for 'Inability to provide a safe and effective urology service and supervision to junior workforce" as escalated by the BARC. The BSQC also created an action item for the previous HSCE, COO 3 and SSGD to identify the appropriate reporting frequency in relation to multiple components that related to Urology services to ensure governance oversight.

(m) on 6 May 2025, the Board were informed about Cluster 8 through a Patient Safety Report annexing the Multi Incident Analysis Review Report.[475] This Patient Safety Report detailed the same matters that were conveyed to BSQC.[476] The Board were informed by the EDCG that development of an early treatment pathway and a urology services implementation action plan were in place with oversight from the ECGC. Concerns were raised about bladder cancer patient monitoring emphasising the need for rigorous regulation to prevent adverse outcomes due to missed cases. The Board noted the information relating to clinical incidents and core patient safety business.

(n) on 22 May 2025, the ECGC met and considered a briefing note related to the Urology Services Action Plan.[477] The Investigators were provided with the Briefing Note but not the Action Plan as it was at this time. The ECGC decided the action plan would be a living document and regularly tabled at ECGC for monitoring and assurance and escalated to BSQC as appropriate. The ECGC accepted the Urology Services

[475] THS.001.001.1766, THHS Board, *Meeting Minutes*, 6 May 2025, page 3.
[476] THS.001.001.1823, THHS Board, *Cover Note: THHS Patient Safety Report*, 6 May 2025, page 2-3 and 19-30.
[477] THS.001.001.0845, THHS ECGC, *Briefing Note Urology Services Improvement Action Plan*, 22 May 2025.

Improvement Action Plan as presented. The SSGD was to provide the next status update and action plan at the July meeting. [478]

(o) on 9 June 2025, BSQC met and noted the Urology Services Improvement Action Plan which addressed delays in bladder cancer diagnosis and treatment. It was noted that while some actions were yet to commence and that most were underway. The BSQC was informed about the key gap being the absence of a state or national bladder cancer pathway, which HHS may lead in developing a local process. There was also discussion about expanding the process to other forms of cancer.[479] The two action items arising from the consideration were revisiting the risk rating for Risk ID #362 and providing an update in the next implementation action plan (due 11 August 2025) and establishing processes to mitigate delayed cancer diagnoses by defining pathways with timeframes for follow-ups (due 8 December 2025). The BSQC resolved to monitor the progress of the action plan and that regular updates would be provided in relation to the same. The Urology Services Improvement Implementation Action Plan was also to be escalated to the Board for noting.

(p) on 8 July 2025, the Board received a cover note for the Urology Services Improvement Implementation Action Plan which incorporated the recommendation for establishing a local pathway of care for patients with suspected or confirmed bladder cancer.[480] The Investigators were not provided with the minutes of the meeting but note that the cover note provided an update on the bladder cancer pathway, namely that a working group chaired by the EDCG had been established to progress this work. Further, in the Patient Safety Report for this meeting, they were also informed of a further SAC 1 report[481] with the contributing factor identified as a delayed referral to medical oncology following formal diagnosis of bladder small cell carcinoma. No additional recommendations were made in relation to the case because it contained similar themes to Cluster 8 and the actions recommended to address it. The Investigators note that this additional SAC 1 is not one of the three cases highlighted in the Cluster 8 audit but it remains unclear whether the case was one of the other 29 patients captured by the audit.

724. The Investigators consider that:

(a) the resourcing issues within THHS' urology services were well-known prior to the identification of Cluster 8 including but not limited to the Patient Safety Net notification in May 2024 and concerns raised by an administrative officer in June 2024.

(b) resourcing requests for permanent administrative support from the clinical area (outpatients) were provided but did not result in permanent administrative support.

(c) the THHS was aware that the patients involved were at high risk of having malignancies.

(d) medical referrals were not managed appropriately, and this issue was not effectively addressed.

(e) the response to Cluster 8 coincided with the RATP 'Inability to provide a safe and effective Urology Service and supervision to junior workforce' (Risk #362) which contained treatment actions addressing the contributing factor of demand for urology services exceeding capacity. This RATP featured heavily in the consideration of the response to Cluster 8.

(f) the THHS advised that *"the Investigators say the response to Cluster 8 was too heavily influenced by the RATP "Inability to provide a safe and effective Urology*

[478] THS.001.001.2059, THHS ECGC, *Meeting Minutes,* 22 May 2025, page 2-3.
[479] THS.001.001.1761, THHS BSQC, *Meeting Minutes,* 9 June 2025, page 6 to 7.
[480] THS.001.001.0087 THHS Board, *Cover Note: Urology Services Improvement Implementation Action Plan*, 8 July 2025.
[481] THS.001.001.1824 THHS Board, *Patient Safety Report*, 8 July 2025, page 11 to 17.

PART A
PART B
PART C

Service and supervision to junior workforce" (Risk #362). [THHS] does not accept this. Using the RATP process alongside the Cluster 8 response was not a governance failure, it was the right thing to do." The THHS further advised that *"the RATP is a structured, organisation-wide risk management tool. It is designed to identify and address risks that affect service delivery across the health service in a thorough and coordinated way. When a cluster review identifies a contributing factor that is already captured as a broader systemic risk in the RATP framework, it is appropriate to address that factor through the RATP process. Creating a separate, parallel process would be wasteful, would split accountability, and would undermine the risk management framework. The RATP, with its 31 endorsed treatment actions, is a more comprehensive and targeted tool for addressing systemic risk than any response developed in isolation. Using it was sound governance practice, not a failure. The Investigators' conclusion to the contrary is not accepted."*[482] The Investigators note the THHS response however retain their view that referring to a RATP that had been developed for other purposes may have been necessary but not a sufficient response to the cluster.

(g) it is unclear to the Investigators what action, if any, was taken to address the underlying system issues relating to referral management other than the proposed development of a bladder cancer pathway.

(h) while the Multi Incident Analysis Review Report was undertaken in relation to Cluster 8, it focused on three identified patients. The Investigators had not been provided with any documents relating to any action taken for the remaining 29 patients within the Cluster 8 audit cohort. The THHS advised in July 2026 that *"of those 29 patients, 27 had not experienced any disease progression before starting treatment, and it was determined that no harm had occurred. The other two patients were reviewed in detail... Neither patient was assessed as a clinical incident."*[483]

(i) the Investigators consider that the continuance of clusters and the response to these circumstances, represents a departure from what would reasonably be expected of the previous HSCE and the EDCG. Further, noting that by this time, a series of clusters and adverse patient outcomes were known and yet it does not appear that appropriate consideration was given to whether the actions and steps taken by THHS were adequate to deal with the scale of the issue and whether there was a need to have the actions and steps taken to be assessed through external advice or escalated to QH. The fact that the clusters continued and there was a lack of consideration of these matters reflects that the previous HSCE and the EDCG did not exercise sufficient oversight across their relevant areas of responsibility, and in that sense was not adequate.

(j) the Investigators consider that the Board did not provide sufficient oversight in relation to the issues of concern that were escalated to it in relation to this cluster and that the issues that were now well known to the Board. The Investigators are of the view that by continuing with the status quo and not seeking external advice that the Board's response was insufficient and not consistent with what would reasonably be expected of a HHS Board and as such it cannot be said that the Board's oversight was adequate.

(k) the Board advised the Investigators that:

> the 32 bladder cancer patients were known to THHS executives at the latest from December 2024 but not disclosed to the Board until 14 April 2025, at least a four-month (if not longer) delay. During that period, the Board was simultaneously receiving the SAC 1 Trend Analysis Report showing a decrease in lost-to-service incidents; receiving ACHS three-year accreditation with no criticism of the urology department; receiving the RACS Report 2024

[482] THHS Natural Justice Response.
[483] THHS Natural Justice Response.

> confirming accreditation; approving a $30M outsourcing contract; and supported formal escalation of notification to QH. A board receiving this combination of positive signals from multiple independent sources, without being informed of a material fact (32 bladder cancer patients), had no basis to conclude further action was needed.[484]

10.6.6 Adequacy of oversight – Cluster 9 (March 2025)

725. With respect to Cluster 9, urology patients experienced Disrupted Care. In some circumstances this was because of clinic cancellations at short notice including those initiated by clinical staff, and where the rebooking process was not completed. This complicated the underlying causes of patients experiencing Disrupted Care due to the ineffective rebooking processes.

726. The Investigators consider that:

(a) the THHS identified large numbers of urology patients who may have experienced Disrupted Care and established a response to this.

(b) the systemic problems were the result of actions taken in response to Cluster 6 and which were identified earlier.

(c) a detailed analysis to identify the underlying causes was not undertaken by the THHS, which the Investigators note is not mandatory but they consider is good practice.

(d) the THHS should have proactively identified that the short notice cancellations had an impact on the efficiency of the rebooking of patients which led to patients experiencing Disrupted Care and introduced controls to mitigate this risk.

(e) the COO 1 advised that they recognised that this was a statewide issue and that THHS had a process in place that proactively identified that the Short Notice Cancellations had an impact on the efficient rebooking of patients which led to patients experiencing Disrupted Care; and that the THHS had introduced controls to mitigate risk. These controls included ensuring that clinic slots were not booked to capacity too far in advance allowing any new Category 1's or those patients impacted by a clinical cancellation to take any open slots, creating a 'slot capacity' dashboard in January 2024 to enable oversight of future appointments and available clinic slots and scheduling additional weekend clinics.[485]

(f) the Investigators note that the fact that the clusters continued represents the emergence of incidents that were the result of actions taken, or not taken, in relation to the earlier clusters, in particular Clusters 1 and 6. As outlined in the Investigators' consideration of Cluster 6, the Board's oversight of the THHS was insufficient and in that sense not adequate.

(g) with respect to Cluster 9 the Board advised the Investigators that it:

> took five discrete governance actions within weeks including reconsidering meeting cadence, requiring unresolved outpatient matters be included in the Operational Plan, approving a clinical incidents management audit, requiring a comprehensive formal report with measurable indicators, and supported the RATP with 30 specific treatment actions." The Board further advised that "operational booking issues continued but were not brought to the Board's attention. The Patient Safety Net notification of May 2024, directly relevant to the conditions producing Cluster 9, was never disclosed to the Board.[486]

[484] The Board's Natural Justice Response.
[485] Consulted Parties' Natural Justice Response.
[486] The Board's Natural Justice Response.

10.6.7 Adequacy of oversight – Cluster 10 (September 2025)

727. With respect to Cluster 10, a substantial number of urology patients experienced Disrupted Care. While the THHS continues to deal with this cluster, on the information held, the Investigators consider that:

(a) Cluster 10 is a manifestation of previously identified issues of concern relating to urology services as follows:

(i) since August 2022 the Board were aware that there was variation in outpatient processes, including urology, that was resulting in adverse clinical incidents for patients. The Board had been aware of the specific deficiencies in outpatient services since the PwC FTA Internal Audit Report of June 2023;

(ii) the rebooking process for patients attending urology outpatients had been deficient prior to August 2022 and remained deficient after the Bulk Check Out memorandum issued in December 2023 which contributed to Cluster 9;

(iii) the local processes within urology services were driven by clinician preference and did not align with HHS procedural requirements as outlined in the Bulk Check Out memorandum requiring medical staff to document follow up instructions in the EMR by the end of the clinic and the direction to administrative staff to act on the information in the EMR in December 2023;

(iv) the systemic problems were in part the result of actions taken in response to Cluster 6 and which were identified above; and

(v) the THHS did not fully operationalise a critical procedure intended to address the issues identified in Cluster 6 until June 2025. Version 1 of the Procedure was circulated in May 2024, endorsed by the APCLG in August 2024 and published in October 2024. However, there were resourcing issues identified and a revised procedure (Version 2) was approved in May 2025 and published in June 2025.

(b) The Investigators were advised that a detailed analysis to identify the underlying causes was in the process of being undertaken by the THHS, which the Investigators note is not mandatory but they consider is good practice.

(c) The Board advised the Investigators that:

> the Board's response was the most immediate and escalatory of the entire chronology: a four-day audit deadline; supporting the [previous] HSCE in transitioning to a Part 9 investigation; supporting formal escalation to QH through Hot Issues Briefs; and BSQC itself raising "concerns about the adequacy of previous assurances". The Board's institutional memory was engaged immediately: "because we knew of the problems previously in Urology, that we did not hesitate to instruct straight away that we need to have a look at this and we need more information, and we need [it] now".[487]

(d) The Investigators note that the fact that the clusters continued represents the emergence of incidents that were the result of actions taken or not taken in relation to the earlier clusters, in particular Clusters 1 and 6. As outlined in the Investigators' consideration of Cluster 6, the Board's oversight of the THHS was insufficient and in that sense not adequate.

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[487] The Board's Natural Justice Response.

10.6.8 Summary

728. Overall, considering the above matters, the Investigators consider that the oversight (assessment and management) of the clusters, including urology patients, was inadequate and represented a departure from what would reasonably be expected of the Board, previous HSCE, COO 1 and the EDCG at various points across the relevant period.

729. The Investigators consider that a detailed analysis would have greatly assisted the THHS to better understand the clusters that they were managing. The Investigators undertook a process mapping exercise during their site visit to TUH during the week commencing 3 November 2025 of the clusters during the relevant period. This process mapping activity was informed by the interviews with officers from THHS. It was through these activities that the Investigators were able to understand how the various clusters were linked. This information was used to develop the AcciMap presented in Section 7.5 of this Report.

730. The Investigators consider that THHS should have undertaken a detailed analysis to inform them of the underlying causes of the patients experiencing Disrupted Care.

731. The Investigators also consider that across the relevant period and from as early as August 2022, the Board, previous HSCE, COO 1 and the EDCG accumulated sufficient information and awareness in relation to the patient safety risks presenting in urology services at TUH and THHS. Notwithstanding this level of awareness, it appears that it was not until 2025 that institutionally, sufficient steps were taken to appropriately recognise the scale and scope of the issues.

10.7 The roles of the HSCE, COO and the EDCG

732. With respect to the relevant executive positions that worked within the THHS these were identified in Section 5.4. The following represents a summary of these roles:

(a) the HSCE[488] is accountable for both the clinical and corporate performance of the HHS. Their Role Description includes an accountability for leading and fostering service delivery systems that ensure the provision of safe, high-quality and person-centred care and ensuring that risks to safe, high-quality and sustainable service delivery are effectively identified and managed;

(b) the COO[489] is responsible for operational decision making and ensuring that the health service runs smoothly and safely, balancing operational pressures with the need for innovation and service redesign. Their Role Description includes an accountability for leading the effective and efficient operational delivery of high quality and safe person-centred care through the alignment and focus of operational priorities and best practice; and

(c) the EDCG[490] provides advice to both the HSCE and the Board that clinical risks are being managed effectively and that patient safety remains of the highest priority. Their Role Description includes an accountability for leading the provision of safe, high quality patient care, encouraging learning from adverse events and promoting a culture of transparency, accountability and evidence-based service; ensuring that service standards, safety and quality are maintained through the adherence to defined clinical quality standards and relevant occupational health and safety policies, procedures and work practices; developing and maintaining systems of clinical governance which ensures that the THHS places patient safety at the heart of the organisation's functioning; and that systems and processes are integrated into service provision.

[488] QHT.002.001.0002 Role Description of HSCE, Undated.
[489] QHT.002.001.0003 Role Description of COO (4 May 2018); QHT.002.001.0001 Role Description of COO (Undated).
[490] QHT.002.001.0006 Role Description of EDCG.

733. The Role Descriptions for these roles particularise their responsibilities.

734. These three roles have interrelated responsibilities with respect to safety and quality and are considered by the Investigators to be more akin to the three sides of an equilateral triangle. This is distinct from the organisation's reporting structure.

735. The Investigators have made findings that relate to these roles. These findings particularise the accountabilities relevant to the executive roles as well as the Board. The accountabilities relating to the Board are considered in Section 10.8 of this Report.

736. The Investigators are concerned that the assessment and management of the clusters represents a departure from good practice, specifically what would reasonably be expected of the previous HSCE, COO 1 and EDCG. The Investigators consider that sufficient information about the serious nature of the patient safety risk was before the previous HSCE and the EDCG as well as COO 1 but notwithstanding this, the previous HSCE, COO 1 and EDCG's assessment of the underlying causes was below the level reasonably expected of these executives and that the action plans that were developed did not comprehensively address the underlying causes of the clusters nor consider implementation actions and the monitoring of the effectiveness of the same.

737. The Investigators have formed the view that if the assessment and management of Cluster 6 in October 2023 had been more comprehensive and included a methodology that examines the underlying cause of adverse events and had the corrective actions flowing from this had a stronger change management focus that subsequent clusters (particularly Clusters 9 and 10) are more than likely to have been avoided.

738. The Investigators are mindful of the types of patients presenting to an outpatient service. Where clinical services have patients presenting with potential or actual malignancies (e.g., prostate or bladder cancer) or have potential or actual organ compromise (e.g., strictures requiring urological stenting or patients that have had urological stents placed), the Investigators consider that this would infer that patients have a significant risk associated with their assessment and treatment. Services that include vulnerable patients, such urology services, should receive appropriate levels of support.

739. The Investigators consider that the assessment and management of the clusters by the previous HSCE and EDCG and COO 1 was a departure from good practice, specifically what would reasonably be expected of the previous HSCE, COO 1 and EDCG.

10.8 Oversight of issues of concern by the Board

740. The Investigators have considered the governance arrangements in place that oversight the THHS. This principally relates to the Board and its committees.

741. In this way the Investigators can specifically consider the adequacy of the oversight by the Board of the issues of concern that have been identified in the various clusters. Instances in which the Board and its Committees considered urology service issues of concern are summarised in this Report and in Annexure F.

10.8.1 The THHS Board

742. In considering the Board's oversight including its management and the provisions of the HHBA, discussed in Section 10.2, the Board is the central governance authority for the THHS and is accountable for controlling the service for which it is established.

743. As set out in this Report, the Board is assisted by various committees. Only Board members are formal members of a BSQC or BARC established under the HHBA. Neither the HHBA nor the Regulation authorises non Board members to be appointed as members of these prescribed committees. Others may attend, advise, or participate, but they are not formal committee members.

744. It is noted that the "Good Practice Guide for Hospital and Health Boards" referred to in Section 10.3 and published by QH serves as a comprehensive resource for new and existing Board Directors. It identifies seven strategic dimensions relating to Boards, the first of which relates to patient safety where it identifies prioritising patient, staff, and visitor safety in all decision-making processes. This is relevant in these circumstances to Board decision making as it relates to the clusters of patients who experienced Disrupted Care.

745. The Good Practice Guide for Hospital and Health Boards also details how Boards have an important role to play with respect to organisational culture.

746. Based on the interviews and meetings with Board Directors, the Investigators consider that the Board was aware of its responsibilities under the HHBA.[491] The Investigators consider that the Board had the depth and breadth of expertise as required under the HHBA. The make-up of the Board included Directors who had clinical backgrounds.

747. Details of the consideration given to the delivery of urology services by the Board, and Board committees including the BSQC, are identified in Annexure F in addition to what is set out throughout the Report. These materials demonstrate the large volume of information that was provided to and considered by the Board and BSQC. The Investigators note that in January 2024 it was recommended in the External Review of Clinical Governance that the Committee reporting processes resulted in the Board receiving large volumes of unfiltered reports. The Investigators agree with the recommendation that Board reports be streamlined. It is the Investigator's view that the continuance of this practice is likely to have been a contributing factor which inhibited the Board's capacity to identify the serious nature of the risk to patient safety presented by the circumstances in urology services at TUH across the relevant period.

748. Further, the Investigators consider that the practice of preparing "managerial board papers", or board papers which focus too heavily on granular operational and management information, which is not usually considered by a board, actively inhibits the capacity of the Board to see strategic and systems level risks. In the current circumstances, that level of oversight, being identifying and managing strategic issues and systems levels risk was effectively missing, the absence of which could be said to be a factor in the ability of THHS institutionally, led by the Board, to "join the dots" and understand the true scale and scope of the patient safety risks that unfolded and continued to unfold over the course of a three year period in urology services at TUH. The Board accepts this observation as a valid systemic lesson and has already actioned the January 2024 External Review of Clinical Governance recommendation to streamline Board reporting for strategic-level risk identification. The Board further advises that the practice of preparing "managerial board papers" is a finding that the information environment in which the Board was operating was itself a systemic failure.[492] The Investigators consider it is a matter for the Board to direct the content of the information being presented to it by the THHS.

749. The BSQC recognised the importance of the clinical support provided by THHS to patients who are connected to or receive urology services and were concerned when clinical incidents occurred. It is noted that at the December 2023 BSQC meeting[493] where the Committee was briefed on matters relating to Cluster 6 and Cluster 7, the Board Chair is recorded as advising that the discussion was "regarded an interim update and that he has requested a more wholesome (sic) brief for the Board". At this meeting the Chair also *"reiterated that the paper tabled [did] not provide sufficient information and further information must be provided to the Board, including a framework to improve the process, information regarding the team and responsibilities and further information regarding the numbers and status of patients."* It is also noteworthy that a member of the Committee during this meeting expressed "*concern that the issue was being blamed on* [redacted]

750. During the Investigation, a senior Board Director advised the Investigators that they were concerned when briefed on matters relating to patients who experienced Disrupted Care

[491] WIT.002.001.0012 Transcript of Interview – Witness AJ; WIT.002.001.0004 Transcript of Interview – Witness S; WIT.006.001.0197 File note of introductory meeting - Witness A.
[492] The Board's Natural Justice Response.
[493] THS.001.001.1699 THHS, *Board Safety and Quality Committee Meeting Minutes*, 13 December 2023.

however that this was not evidence of "worry" or "anxiety" nor was it of itself, evidence of a deficit in the previous HSCE, Executive Leadership Team or HHS staff updates. In their view, it was evidence of the Board diligently discharging its role in clinical incident management as outlined in CEQ Factsheet 11 and patient safety more generally.

751. The Board also indicated that in the circumstances of the clusters, which include urology patients, they should be able to rely on the advice of the Executive and did not consider that escalation to the Director-General as system manager was required until October 2025.

752. Overall, it is the Investigators' conclusion, for the reasons identified above, that the Board did not adequately exercise its oversight role in response to the patient safety risks that unfolded and continued to unfold across the relevant period in urology services at TUH and THHS. In the face of the evidence considered by the Investigators, the Board was aware of the serious nature of the patient safety risks in urology services as early as December 2022, but certainly by December 2023 when the Board were made aware of Clusters 6 and 7.

753. The Investigators also consider that an appropriate response and a reasonable response, certainly by December 2023, would have been for the Board to consider external advice, or advice or escalation to QH. The Investigators note that the BSQC did contemplate whether a Part 9 investigation was required in December 2023. It appears to the Investigators that notwithstanding the continued clusters, including those relating to bladder cancer, the Board did not consider it appropriate to seek external advice. External advice had been sought and accepted previously (in relation to unrelated matters) and so it is difficult to understand in the face of these issues why the Board maintained the status quo and continued with the processes that so far had not prevented the series of clusters from occurring.

754. The Investigators note that with respect to the escalation of significant issues within QH by HHSs that:

(a) QH uses a "Hot Issues Briefing" process to ensuring that significant clinical risks are identified early, escalated appropriately;

(b) the process for briefings sets out clear escalation pathways with primary route being from the HSCE to Director-General or relevant Deputy Director-General;

(c) the process is underpinned by whole-of-government legislation, primarily the *Financial Accountability Act 2009* (Qld)[494] (**FAA**) and the FPMS, which legally require statutory bodies to identify, manage, escalate, and report significant issues;

(d) the HHBA adds health-specific duties with respect to the escalation of issues affecting safety, quality and performance;

(e) the relevant provisions of the HHBA include:

(i) s 9 – System performance - Issues affecting performance must be escalated to the Chief Executive (**CE**) (within the health portfolio this is the Director-General);

(ii) s 11 – Safety and quality protections - Serious safety and quality issues must be escalated to the CE and Minister;

(iii) ss 35–39 – Service agreements - Issues affecting service agreement performance must be notified to the CE (and the Minister if unresolved); and

[494] *Financial Accountability Act 2009* (Qld).

(iv) s 19 – Functions of Services- HHSs must provide information and notify the CE and Minister of issues affecting service delivery.

(f) the QH Performance and Accountability Framework is also relevant. This Framework states that HHSs are "*accountable for their own performance through a Hospital and Health Board to the Minister*". This includes accountability for clinical safety and quality and patient experience. The Framework also creates a clear, mandatory escalation chain: Clinical incident → HHS internal governance → QH (system manager) → Director-General → Minister; and

(g) together, these instruments create a unified expectation that HHSs will maintain a high level of situational awareness and ensure that the QH and Minister are informed of emerging issues.

755. With respect to the Board, the Investigators consider that:

(a) based on review of various briefings and minutes of Board meetings, the Board considered in detail the various clusters and risk-related action plans. This represents compliance with the standard(s) that would be expected;

(b) the Board did not escalate their concerns in relation to the recurrent events relating to patients that experienced Disrupted Care who are connected to or receive urology services or seek to brief QH or seek external advice prior to 31 July 2025. The Investigators acknowledge that THHS provided advice to QH in October 2025;

(c) it is noted that the Board could have directed the previous HSCE to undertake the activities as outlined above, that is, formalising a briefing to the Director-General (in association with Cluster 6 and the subsequent clusters) and arranging for external advice in relation to the patients who had experienced Disrupted Care (in association with Cluster 6 and subsequent clusters). In not recommending or directing the previous HSCE[495] to seek external advice at an earlier time the Investigators consider that the Board has not complied with its obligations;

for completeness it is also noted that:

(d) the EDCG advised the Investigators that on 10 September 2025 the previous HSCE sought advice from the EDCG and THHS Director of Legal Services [redacted]

(e) THHS subsequently sought external advice from QH which is set out in more detail in Section 12.

10.8.2 The Board's Natural Justice Response

756. The Board advised that:[497]

> [it] considered that appropriate independent external advice was being sought by the HHS, with the Board's knowledge and support during the relevant period and did not at the time (nor in hindsight) consider that any additional external advice was necessary for the Board to perform its role and functions in the governance of the Service during the relevant period.

[495] Sections 20(1)(c), 33(4), 56(2), 125(2) and 190(2) of the HHBA.
[496] Consulted Parties' Natural Justice Response.
[497] The Board's Natural Justice Response.

> With the benefit of hindsight, we agree that it would have been optimal to have ensured that the [previous] HSCE had formally briefed the Director-General at an early opportunity (as we again note is the role of the HSCE under section 3.1.4 of the Clinical Incident Management Guideline).

757. The Board advised that it is not aware of any legislative mechanism which, at the relevant time, facilitated the Board (as distinct from the HHS/HSCE) to seek independent external advice or escalate directly. The Board further notes that:

> the Good Practice Guide confirms that the Board Chair's responsibility to liaise with and report to the Minister and Director-General is qualified by the words "where required", which indicates a conditional obligation, not a standing one.[498]

758. The Board advised that in the spirit of lessons learned and not admission of failure that it:

> accepts ultimate oversight responsibility but maintains it discharged role actively and per the expected standard. Persistence of clusters is attributable to structural workforce constraints and operational challenges.[499]

759. The Board further advised that the Disrupted Care occurred not because the Board failed to govern, but because evidence reveals that the operational systems below the governance layer failed to perform as directed, and the information architecture failed to surface that non-performance to the Board. These are systemic failures amenable to systemic recommendations (recommendations the Board supports and has already commenced implementing) but the evidence does not establish that they are the Board's failures. The Investigators note the Board's comments but remain of the view that they did not provide the appropriate level of stewardship.

760. The Board also advised that:

> the evidence further reveals that the Board's governance function was systematically deprived of the information it would have needed to detect those failures, by decisions made by its own executive team that were never disclosed to it.[500]

10.8.3 The BSQC

761. The BSQC was established under the Regulations and was compliant with those requirements. The Chair of the BSQC had an extensive health service background.

762. The Regulation requires the BSQC to oversee compliance with the NSQHS Standards, QH policies and directives, and relevant national and state agreements. It is evident from the content of minutes available to the Investigators that the BSQC undertook these responsibilities.

763. The BSQC is responsible for providing structured oversight, advice, and monitoring on the safety and quality of health services delivered by the HHS including monitoring clinical risks and incident trends and advising on strategies to minimise preventable patient harm. This function is directly related to the care that patients did not receive because they experienced Disrupted Care .

764. NSQHS Standards User Guide for Governing Bodies discussed in Section 10.4 provides additional information for governing bodies so that they are equipped to consider safety and quality matters at a Board committee level.

765. COO 1 advised that prior to 2023, the COO was not a member of the BSQC. This reflected a historical structure within THHS and in late 2022, COO 1 requested through the previous HSCE to join the BSQC as a member to enhance the coordination between performance and patient

[498] The Board's Natural Justice Response.
[499] The Board's Natural Justice Response.
[500] The Board's Natural Justice Response.

safety, plus increase the operational information flow to and from the Board to Service Groups. This was approved in late 2022 to early 2023, with their first meeting attendance in early 2023.[501]

766. With respect to the BSQC, the Investigators consider that:

(a) based on review of various briefings and minutes of BSQC meetings, the BSQC considered in detail the various clusters and risk-related action plans. The Investigators were also advised by the previous HSCE that he attended these meetings. This represents compliance with the standard(s) that would be expected; and

(b) the BSQC should have recommended to the Board that they seek external advice in relation to the various clusters at an earlier time and that they relied on briefings from the previous HSCE, COO 1 and EDCG.

10.8.4 Validation of advice

767. When presented with a complex problem the Board and its Committees sought briefing from senior leaders within the THHS, namely the previous HSCE, COO 1 and EDCG and confirmation that the arrangements that were in replace to respond to various clusters were comprehensive. This included receiving reports and seeking further information.

768. Situations where information is raised and after further consideration, accepted without external validation can reflect the decision-makers' trust in the information because it comes from an authoritative source, accepting information on its face value, or placing undue weight on aspects of the information.

769. In complex situations accepting information without external validation can lead to governance risks. The HHBA was designed to prevent such occurrences. Under the HHBA, Boards can escalate concerns or seek external advice before making decisions.

770. It is noted that the THHS Board, the BSQC and BARC formally considered concerns relating to patients who experienced Disrupted Care in the delivery of urology services.

771. These matters were identified on the Board and BSQC Committee agendas between 8 May 2023 and 8 July 2025 as included in Annexure F and as set out in this Report.

772. In considering the matters, the Investigators formed the view that the Board and its various committees noted the issues presented in the various Board and Committee Briefing Papers and made inquiries of the previous HSCE, COO 1 and EDCG including seeking assurances that the problems identified in the various Briefing Papers had been addressed or were being managed.[502]

773. The Investigators formed the view that the Board members did not hold expertise in relation to urology services or outpatient management (and nor should they, as a governing body).

774. The Board Directors recognised at the time the importance of service delivery for the community and were concerned about the adverse clinical incidents.[503] As a consequence, the Board Directors requested and received information to provide assurance that effective changes to the clinical service delivery models had been made. The Board Directors that the Investigators interviewed and met with and on reflection expressed concerns about the assurances provided and the level of information that they received from the THHS executive in the relevant period.[504] These concerns led these Directors to challenge the information that was provided and to seek

[501] Consulted Parties' Natural Justice Response.
[502] THS.001.001.2224 Access to Planned Care Leadership Group, *Meeting Book,* 8 February 2024, page 7.
[503] THS.001.001.2224 Access to Planned Care Leadership Group, *Meeting Book,* 8 February 2024, page 7.
[504] WIT.002.001.0012 Transcript of Interview – Witness AJ, paragraphs 50-58; WIT.002.001.0004 Transcript of Interview – Witness S, paragraphs 77-84.

validation of the material from the senior executives that attended the various Board and Board Committee meetings.[505]

775. It is also noted that these Board Directors at the time wanted assurance that the situation was in hand.[506] In the view of the Investigators this is an indicator of the level of concern held by the Board Directors.

776. It is the view of the Investigators that the Board, once they were briefed on the background to the issues in urology in October 2023 (Cluster 6) and noting the extremely high-level concern that the Board Directors held in relation to urology patients experiencing Disrupted Care and the risk that the problems may not be addressed, that they should have sought external advice in relation to the matters to hand. This should certainly have been a consideration by April 2024 (Cluster 8).

777. It is the view of the Investigators that had the Board sought this external advice the problems with patients experiencing Disrupted Care or having their care significantly delayed could well have been mitigated.

778. Given the concerns held by the Board that, in the view of the Investigators, the Board should have obtained external advice in relation to the material being presented to the Board, BSQC and BARC by THHS in relation concerns relating to the delivery of urology services at an earlier time.

779. In the view of the Investigators, this should have been undertaken after the 15 January 2024 Board meeting which followed the 23 December BSQC meeting where Cluster 6 was discussed and by the latest in April 2024.

780. The Investigators consider that QH may consider advising HHS Boards in relation to the circumstances where Boards should consider obtaining external advice in relation to the material being presented to them, by their HHS executive.

781. It is noted that the previous HSCE, COO 1 and the EDCG considered matters relating to the delivery of urology services and that these were discussed and agreed at the ECGC and the PSC.[507]

782. Through these discussions a senior clinician continued to raise concerns in relation to the approach being taken by the THHS.[508]

Recommendation 20	That the THHS Board consider the circumstances where the THHS should seek external advice when complex matters are presented to the Board. This should be a component of a formal decision-making framework. By detailing its approach, the Board will provide assurance that its governance processes are robust, transparent, and resilient. This will strengthen the organisation's capacity to anticipate and mitigate future risks, while strengthening public confidence in the integrity of THHS decision-making.
Recommendation 21	(Statewide) That QH provide formal advice to HHSs and their Boards in relation to the circumstances where HHSs should notify QH and/or the Minister's Office in relation to complex

[505] WIT.002.001.0012 Transcript of Interview – Witness AJ, paragraphs 50-58; WIT.002.001.0004 Transcript of Interview – Witness S, paragraphs 77-84; THS.001.001.1699 THHS, *Board Safety and Quality Committee Meeting Minutes*, 13 December 2023, page 6.
[506] WIT.002.001.0012 Transcript of Interview – Witness AJ, paragraphs 50-58; WIT.002.001.0004 Transcript of Interview – Witness S, paragraphs 74-84.
[507] THS.001.001.0087 THHS Board, *Cover Note: Urology Services Improvement Implementation Action Plan*, 8 July 2025.
[508] WIT.002.001.0003 Transcript of Interview - Witness AE, paragraphs 19-29.

	matters that they are considering and/or that may have Statewide significance.
Recommendation 22	That the THHS formally identify the circumstances that would require them to seek external advice or escalate complex matters to QH. The Investigators are of the opinion that this should be placed in a formal decision-making framework and provided to the Board for review.

10.8.5 Risk management

783. The FAA s.61 and the FPMS together establish a clear, mandatory framework for risk management and the escalation of significant concerns in relation to statutory bodies. The Act sets the statutory obligation, while the Standard prescribes the operational requirements that give effect to it.

784. Under the FAA, statutory bodies are legally responsible for establishing and maintaining appropriate systems of internal control and risk management. This obligation is broad and foundational, ensuring that risk oversight is embedded in the governance and financial administration of all public sector entities.

785. The FPMS operationalises this duty by requiring each statutory body to maintain a formal risk management system capable of identifying, assessing and mitigating both strategic and operational risks. The system must protect the organisation and the State from unacceptable costs or losses and ensure continuity of government service delivery. The Standard also allows for the establishment of risk management committees and requires alignment with whole-of-government frameworks.

786. Internal audit provides escalation mechanisms. Audit findings must be reported to accountable officers and audit committees, formally considered, and acted upon.

787. Together, the Act and the Standard create a multi-layered governance environment in which risks are actively managed by statutory bodies.

788. Risk management authority in Queensland HHSs is grounded in the HHBA, which establishes HHSs as statutory bodies. The HHS Boards therefore ensure effective governance, including systems for managing and overseeing clinical and corporate risk. The Board sets what risks should be escalated and reported to them through their local risk frameworks and with reference to functions of their local safety and quality committees as per the HHBA s.45 and BARCs as per s.47 of the HHB Regulation.

789. HHSs in Queensland therefore manage significant risks through a structured enterprise risk management framework that identifies risks early, documenting them in a risk register, applies mitigation strategies, monitors outcomes, and ensuring accountability through Board oversight.

790. HHSs are also required to adopt relevant QH and the national safety and quality frameworks.[509]

791. This requires HHSs to identify, assess and prioritise risks including clinical and operational, risks and escalate significant risks to the Board.

792. With respect to the THHS, the Board have a governance model in place to manage risks including safety and quality risks. The peak body in the THHS that oversees risk is the BARC.

[509] Queensland Health, *Clinical Incident Management Guidelines,* Guideline number: QH-HSDGDL-032-2. Electronic copy available at: https://www.health.qld.gov.au/system-governance/policies-standards/health-service-directives/patient-safety/clinical-incident-management.

793. The BARC received papers and presentations relating to risks including risks relating to unreported radiology which included urology investigations and risks relating to the delivery of urology services.[510]

794. The THHS Board, and the BARC formally considered RATPs relating to the delivery of urology services at TUH including the issues relating to the prolonged shortage of senior medical staff despite an active recruitment program.[511]

795. These matters were identified on the Board and BARC agendas between 6 May 2025 and 19 March 2025 and as summarised in Annexure F.

796. In considering these matters the Investigators formed the view that the Board noted the issues presented in the various Board and Committee briefing papers and accepted the risks and controls as presented by the THHS executive team.

797. It is noted that the Board and the Board Committee's role is one of governance as per the HHBA.

798. There was evidence to indicate that these risks were formally escalated to QH through formal Hot Issues Briefs in October 2025 and at the time that they were considered by the Board and its Committees. [512] The Investigators considered that this notification was not timely and should have been undertaken at an earlier period, either in December 2023 (in association with Cluster 6 and 7) and no later than in April 2024 (in association with Cluster 8).

799. The Board Directors that the Investigators interviewed or met with were, on reflection and in retrospect, concerned about the information that they received from the THHS executive.[513]

800. The Investigators note that the following risks were on the Risk Register in relation to urology services:

(a) Risk # 323: Described as Outpatient Lost to Service, entered in November 2023 as an Operational Risk and risk rated as High;

(b) Risk # 259: Described as Workforce Sustainability, entered in July 2024 as an Executive level risk and risk rated as High; and

(c) Risk # 362: Described as Inability to provide a safe and effective urology service and supervision to junior workforce, entered in March 2025 and a Service level risk and risk rated as High.

801. It is the view of the Investigators that the Board, once they were briefed on the background to the issues in urology in 2023 and had the RATP presented to them, and noting the concern that the Board Directors held in relation to the delivery of urology services as outlined in the RATP, that the Board should have tasked the previous HSCE with briefing the QH on the concerns held by the service.

802. It is the view of the Investigators that had the Board arranged for this risk to be raised with the QH, that the QH could have facilitated network support.

803. It is noted that the Board considered matters relating to the delivery of urology services at BARC meetings. After these discussions and presentations Directors had a level of unease with respect to the advice that they received.

[510] For example, THS.001.001.0189 THHS Board, *Board Audit and Risk Committee: Risk 362,* 19 March 2025.
[511] THS.001.001.0031 Board Audit and Risk Committee, *Meeting Book,* 22 November 2023, *Risk Assessment and Treatment Plan*, assessment undertaken 25 August 2023.
[512] THS.001.001.1917 THHS Board, *Cover Note: Urology Services Update*, 7 October 2025, page 20.
[513] WIT.002.001.0012 Transcript of Interview - Witness AJ, paragraphs 50-58; WIT.002.001.0004 Transcript of Interview - Witness S, paragraphs 28-33, 35-36, 39-40, 74-84.

Recommendation 23	That the THHS Board consider what circumstances would require it to escalate risks when complex matters are presented to the BARC and include details of this principle in the THHS Risk Management Framework.

Section 11 - Complaints and Culture

11.1 Overview

804. In this section, the Investigators have addressed TOR 3.1 (a)(vii) and (viii) and 3.1(f) and (g) which requires investigation of the following:

(a) whether issues of concern were identified and escalated effectively and whether appropriate actions were taken to address any issues of concern;

(b) whether any complaints or concerns have been received within THHS about the delivery of urology services (inpatient and outpatient), including but not limited to, any PIDs, staff, other health practitioners, and patient complaints;

(c) assessment of the adequacy of the THHS complaints management processes, including responses provided to these complaints and actions arising from them; and

(d) evaluation of the existing mechanisms and pathways for escalating and addressing systemic patient safety concerns.

805. The Investigators note that while items (b) to (d) fall under the heading "culture", there is no corresponding question relating to culture in the broader organisational sense and the Investigators, within the context of the TOR, understand this to be a reference to "safety culture" insofar as it is demonstrated through the initiation, management and closure of staff and patient concerns or complaints.

806. In responding to the above TOR, in the Report, the Investigators have:

(a) In Section 11.2 onwards considered patient complaints as follows:

(i) considered the Queensland Government and QH's requirements for patient complaints management in place during the relevant period;

(ii) set out the THHS policy and process for managing patient complaints and compared it to the Queensland Government and QH requirements to assess its adequacy;

(iii) identified all concerns and complaints received within THHS from patients relating to urology services via analysing the pathways available; and

(iv) analysed patient complaints based on Riskman summaries identifying key themes and then assessed the adequacy of the THHS complaints management process in terms of the activities undertaken to address and close complaints.

(b) In Section 11.4 onwards considered staff complaints as follows:

(i) considered QH's requirements relating to the management of staff complaints (grievances) in place during the relevant period;

(ii) set out the THHS staff complaints management process and assessed it against the QH requirements to assess its adequacy;

(iii) identified the concerns and complaints received within THHS from staff relating to urology services via analysing the pathways available and comparing the number of complaints received against comparable HHSs;

(iv) conducted a review of all complaints or concerns raised within THHS about urology services, including inpatient and outpatient care; and

(v) analysed all staff complaints and concerns received within THHS about the delivery of urology services. To analyse the adequacy of the THHS complaints management processes on deeper level presented three complaints as case studies to highlight recurring themes identified.

(c) In Section 11.6 the Investigators identify mechanisms and pathways for escalating and addressing systemic patient safety concerns and assessed these to determine their effectiveness in managing broader safety issues.

SUMMARY: Key observations, findings, and conclusions in relation to complaints and culture

Patient complaints management

(a) The Investigators consider that THHS's patient complaint management processes were consistent with the required policy standards during the relevant period, being the *Public Sector Act 2022* (Qld), and the QH Patient Complaints Management Policy, and aligned with the requirements as outlined in the HR Act, HHBA, *Information Privacy Act 2009* (Qld) (**IP Act**), and the HOA. However, the Investigators note that there s no publicly available complaints management policy published by the THHS; the determination of the need for a policy is a Board responsibility.

(b) The Investigators undertook an analysis of the complaints based on a sample of 126 Riskman Complaint Reports which were created between 13 January 2022 to 4 September 2025 but all related the Relevant Period.

(c) An analysis of complaint issues reveals recurring themes that impact patient care and operational efficiency. The most prominent themes include access and timing delays, communication breakdowns, clinical treatment concerns, and administrative inefficiencies.

(d) Notably, complaint volumes fluctuated across the review period, with noticeable peaks during periods of high surgical demand and resource constraints. Year-on-year analysis suggests persistent challenges in managing waitlists and ensuring timely communication.

(e) Having considered the rate of urology services related complaints, the Investigators considered that the year-on-year increase in complaints is significant and should have triggered a more detailed analysis of the complaint profile by the THHS.

(f) It is also noted that, had this been identified at an earlier time, it may have identified a need for the THHS to provided additional support for urology services.

Staff complaints

(a) There were [redacted] staff complaints (grievances) provided to the Investigators by the THHS as part of the Investigation evidence gathering process. The staff complaints fell into two categories, namely: complaints relating to workplace matters and complaints relating to clinical services.

(b) All the staff complaints were escalated to line managers for resolution as per the QH HR Policy E12 requirements and were resolved with line managers as per the provisions of the QH Employee Complaints and Grievance Management Policy.

(c) The THHS advised that there were no PIDs identified which were relevant to the TOR as part of the Investigation's evidence gathering process. However, the QH ESU were aware of one PID managed by the THHS which the QH ESU believed fell within the Investigation TOR. Two PIDs were also raised by officers interviewed by the Investigators as part of the Investigation. These were managed by the QH ESU.

(d) While no “Patient Safety Net” notifications were identified by the THHS during witness interviews, the Investigators identified one notification via “Patient Safety Net".

(e) Some of the staff complaints involved patient safety concerns relating to the delivery of urology services. These concerns were raised through a variety of mechanisms, including direct escalation to line managers, reporting through clinical governance channels, and use of the Patient Safety Net. The issues identified by staff primarily related to delays in access to care, challenges in service coordination, and risks associated with clinical workflow pressures.

(f) The Investigators acknowledge the processes were overall consistent with the relevant policy requirements.

(g) However, in considering the complaints raised in relation to the urology service, the Investigators became aware of three relevant cases, which led the Investigators to believe more consideration should have been given by the THHS to the staff concerns that were raised through management channels.

Pathways for escalating systemic patient safety concerns

(a) With respect to the delivery of urology services at THHS there is evidence that staff raised concerns through both formal and informal pathways.

(b) The formal complaints that the Investigators reviewed apart from a grievance that attracted PID status were of an operational nature.

(c) While an existing framework is in place, assessment indicates that THHS’ mechanisms for managing staff-raised patient safety concerns could be enhanced. Staff at interviews consistently indicated that when they raised concerns with their managers, they did not perceive that concerns were recognised or that corrective actions were taken.

(d) The Investigators consider that clinical professionals did not appear to be supported to undertake retrospective reviews, which created a culture in which staff felt unable to speak up and where concerns were not contributing to ongoing improvements in quality and safety within urology services. A culture that downplays clinical concerns undermines trust, damages morale, and potentially harms patients.

Identifying and escalating issues of concern

(a) Following a consideration of patient complaints, staff complaints and pathways for escalating systemic patient safety concerns, the Investigators identified some matters which did not appear to have been acted upon. The clinical and operational staff indicated that when matters were escalated, there was a limited response to the concerns and in some cases no action was taken. This had impacted managers who were reported as undertaking work outside their normal duties to address patient safety concerns.

(b) The Investigators note this perspective expressed by clinical and operational staff was different to that expressed by executive staff in relation to patient safety and reporting culture.

(c) It was also noted that the HHS was experiencing financial pressures and that management of budget and activity levels dominated discussions at SSG performance meetings. Because of this the focus on clinical safety was not evident on performance meeting agendas provided to the Investigators. This had the effect of reducing the opportunity for safety and quality being considered as part of the organisation's performance meetings.

It is the view of the Investigators that having regard to safety and quality issues being experienced within the THHS, that safety and quality issues should have been included in performance management meetings.

11.2 Queensland Government Patient Complaint Policies

807. As a starting point, the Investigators formed the view that it was necessary to identify and summarise the relevant policies within Queensland Government and QH relating to patients raising concerns or complaints. The relevant policies are listed below and discussed in more detail later in this section of the Report:

(a) Provisions of the repealed *Public Service Act 2008* (Qld) and *Public Sector Act 2022* (Qld); and

(b) Customer Complaint Management – QH Policy.[514]

808. The repealed *Public Service Act 2008* (Qld) and *Public Sector Act 2022* (Qld) provide mandated policy direction in relation to patient (consumer) complaint management.

11.2.1 Provisions of the Public Service Act (2008) and Public Sector Act (2022)

809. HHSs in Queensland are required to operate formal systems for managing consumer complaints. This obligation is grounded in statewide public sector legislation. The foundational requirement originated in section 219A of the *Public Service Act 2008* (Qld) (**PSA**),[515] which mandated that all Queensland Government departments establish and implement a customer complaints management system consistent with recognised Australian Standards. Although HHSs are statutory bodies established under the HHBA, they form part of the broader Queensland public sector and are therefore required to comply with the same principles of transparent, accountable complaint handling as outlined in the PSA.

810. With the transition to the *Public Sector Act 2022* (Qld)[516] and specifically section 264, this obligation has been modernised and broadened. The new Act requires all public sector entities, not only departments, to maintain effective systems for receiving, managing, and resolving customer complaints. This legislative shift reinforces that HHSs must operate robust, accessible, and procedurally fair complaints management frameworks as part of their core governance responsibilities.

811. In practice, each HHS gives effect to this requirement by developing and authorising their own local Complaints Management policies or procedures, aligned to the statewide Queensland Public Service Customer Complaint Management Framework.[517] These policies outline the principles, processes, delegations, and reporting obligations that ensure complaints are managed consistently, respectfully, and in accordance with legislative expectations.

812. Collectively, this legislative and policy architecture ensures that HHSs maintain transparent, consumer-centred mechanisms for addressing concerns, improving service quality, and upholding public confidence in Queensland's health system.

11.2.2 QH Customer Complaints Management Policy

813. QH maintains a comprehensive, consumer-centred complaints management framework designed to ensure that patient concerns are addressed in a timely, transparent, and

[514] Queensland Health, *Customer Complaint Management Policy*, Policy Number QH-POL-450. Electronic copy available at: https://www.health.qld.gov.au/__data/assets/pdf_file/0031/665095/qh-pol-450.pdf.
[515] *Public Service Act 2008* (Qld) s 219A.
[516] *Public Sector Act 2022* (Qld) s 264.
[517] Queensland Government, *Queensland Public Service Customer Complaint Management Framework*. Electronic copy available at: https://www.forgov.qld.gov.au/__data/assets/pdf_file/0032/405788/Queensland-Public-Service-Customer-Complaint-Management-Framework.pdf.

accountable manner.[518] The system is structured around a tiered set of pathways that support early resolution, provide clear escalation options, and ensure independent oversight where required. This approach aligns with the QH's broader commitments to patient-centred care, human rights, and continuous quality improvement.

814. The QH Customer Complaint Management Policy is engaged formally when patients, consumers or other parties raise their concerns directly with QH. Across all levels, QH's complaints management processes are underpinned by legislative obligations, including the *Public Sector Act 2022* (Qld), HR Act, HHBA, IP Act, and the HOA. These frameworks ensure that complaints are handled respectfully, confidentially, and with due regard for consumer rights and cultural safety.

815. The policy indicates that at the point of care, patients and families are encouraged to raise concerns directly with clinical staff, nurse unit managers, or local managers. This first-line approach enables rapid clarification of issues, immediate corrective action where appropriate, and reinforces a culture of openness and responsiveness. Most concerns are resolved at this level, supported by consumer liaison officers who facilitate communication, assist patients in navigating the system, and ensure concerns are documented and monitored.

816. The policy also indicates that where issues cannot be resolved informally, each HHS provides formal mechanisms for lodging complaints. These include online submission portals, dedicated email addresses, telephone contacts, and written options to ensure accessibility for all consumers. Formal complaints are managed by HHS consumer feedback or patient liaison units, which are responsible for coordinating investigations, and providing clear, evidence-based outcomes.

11.3 Patient complaints management in the TUH Urology Service

817. To assess the adequacy of the THHS patient complaints management process including responses provided to these complaints and actions arising from these, the Investigators have:

(a) set out the THHS patient complaint management framework in Section 11.3.1;

(b) detailed the THHS patient complaints management process in Section 11.3.2;

(c) provided a comparison of THHS patient complaints management to other HHS's in Section 11.3.3;

(d) assessed THHS's patient complaints management against the Queensland Government and QH requirements in Section 11.3.4;

(e) reviewed patient complaints and concerns received within THHS about the delivery of urology services within the relevant period in Section 11.3.5; and

(f) assessed the THHS's overall approach to and management of patient complaints relating to the delivery of urology services in Section 11.3.6.

11.3.1 THHS framework for managing patient complaints

818. THHS maintains a patient-centred framework for managing patient complaints that is designed to ensure concerns are addressed promptly, respectfully, and transparently.

819. The Investigators note that there is no publicly available patient complaints management policy published by the THHS.

[518] Queensland Health, *Customer Complaint Management Policy*, Policy Number QH-POL-450. Electronic copy available at: https://www.health.qld.gov.au/__data/assets/pdf_file/0031/665095/qh-pol-450.pdf.

820. The publicly available information indicates that the complaints management system is anchored by the Patient Feedback Service,[519] which functions as the central coordination point for all patient feedback, including complaints, compliments, and suggestions.

821. This service provides multiple accessible pathways for patients and families to raise concerns, including online submissions, dedicated email and telephone contacts, written feedback forms, and direct engagement with clinical staff. Interpreter services and options for anonymous reporting further support equitable access.

822. The THHS internet site[520] provides details of how they manage consumer feedback and how feedback can be provided. This includes the following statements:

> We love hearing from our community. Your feedback provides us with an opportunity to continually improve the delivery of the healthcare we provide.
>
> Whether you want to tell us what we are doing right, or where you believe there is room for improvement, the Townsville Hospital and Health Service values hearing from you.
>
> We take your privacy very seriously and all feedback is considered confidential. You can also provide feedback anonymously.
>
> We ensure that complainants or persons providing feedback will not be victimised, discriminated against, or adversely affected because of the making of a complaint.

823. The THHS internet site details how compliments, complaints and suggestions can be provided through a range of mechanisms including:

> Talk to your nurse directly or ask to speak to the manager of the area
>
> Complete the 'please tell us' form located throughout the health service
>
> Email THHS-Feedback@health.qld.gov.au
>
> Phone (07) 4433 1074 (Monday – Friday 8am – 4pm)
>
> Complete an online feedback form

824. The THHS internet site also details that complainants can expect:

> All patients, consumers, family members, and carers will have receipt of their complaint acknowledged within five calendar days of it being received by the health service
>
> All complainants will be informed about the complaint management process and have access to the necessary resources
>
> All complainants will be advised that they will be contacted in respect to the outcome of the review into their complaint; either in person, verbally or in writing
>
> Where possible, complainants will be contacted with the outcome of their complaint within 35 days of receipt of the complaint
>
> If patients are unhappy with the response, that there is an independent service provided by the Office of the Health Ombudsman.

[519] THHS, *Feedback form*. Electronic copy available at: https://cdn.townsville.health.qld.gov.au/tgh/documents/patient-opinion-please-tell-us.pdf.
[520] THHS, *Feedback site*, webpage can be accessed here: https://www.townsville.health.qld.gov.au/about-us/feedback/.

11.3.2 THHS patient complaints management process

825. Complaints within the THHS are received by the Patient Feedback Service and are formally logged in Riskman, triaged according to risk and urgency, and allocated to the relevant clinical or operational area for investigation. The process emphasises timely communication and clear, evidence-based responses. Local managers and clinical leaders play a key role in reviewing concerns, identifying contributing factors, and implementing corrective actions where required. The system also supports early, informal resolution at the point of care, enabling many issues to be addressed quickly through direct discussion with treating teams or nurse unit managers.

826. Where matters are complex, serious, or cannot be resolved locally, THHS provides escalation pathways, including referral to the OHO.

827. THHS routinely analyses complaint themes and trends and reports this information through THHS governance structures. As such, this information contributes to organisational learning and informs quality improvement initiatives across the health service.

828. The Investigators are aware that the Board Chair pays close attention to complaints related to the THHS and regularly meets with THHS staff to discuss the management of patient complaints.

11.3.3 Process comparison relating to patient complaints

829. THHS acknowledges complaints within five calendar days and, where possible, communicates outcomes to patients within 35 days.

830. The *Public Sector Act 2022* (Qld) does not provide specific timeframes for the management of complaints. It is noted that the Cairns and Hinterland HHS aim to acknowledge complaints within three calendar days and provide outcomes to patients within 30 days. Gold Coast Health acknowledges complaints within five days and notes longer timeframes communicating outcomes for complex matters.

831. A review of comparator timeframes (Cairns and Hinterland HHS; Gold Coast HHS) was performed to contextualise THHS's performance. This comparison was performed against like Health Roundtable facilities, with this information being publicly available.

832. The Investigators also undertook a normalised comparison of complaints with a large Queensland HHS. The normalised comparison of matched data by activity suggested that the complaint profile for THHS and the comparators were similar.

11.3.4 Assessment of patient complaint management against Queensland Government policy

833. THHS's patient complaint management process is aligned with the *Public Sector Act 2022* (Qld). Timeframes (five day acknowledgement; outcome within 35 days where possible) are consistent with policy and practice across HHSs with Cairns and Hinterland HHS and Gold Coast HHS used for benchmarking.

834. The Investigators consider that the patient complaint management processes were consistent with the required policy standards, that being the *Public Sector Act 2022* (Qld), and align with the requirements as outlined in the HR Act, HHBA, IP Act, and the HOA.

835. The THHS website also provides the detail of consumer feedback (for 2024-2025) as mandated by the *Public Service Act* (2022). This data is outlined below:

Total compliments received:	1,841
Total complaints received:	1,797
Complaints acknowledged within 5 days:	100%
Complaints resulting in further action:	60

Complaints resulting in no further action: 1,737

836. This further supports the Investigators view that THHS's complies with the Queensland Government standards.

11.3.5 Analysis of patient complaints relating to the delivery of urology services

837. The THHS provided the Riskman Reports for all complaints relating to the delivery of urology services from January 2022 to July 2025. These reports have been reviewed by the Investigators.

838. The Investigators considered that patient complaints reported through Riskman identified all patient complaints entering the THHS, and included information collected through the Patient Feedback Service and complaints received from external bodies who administer complaints systems such as the OHO.

839. The Investigators undertook an analysis of the complaints based on the Riskman Complaint Reports between 13 January 2022 to 4 September 2025.

840. Each of the complaint files were individually reviewed to allow themes to be identified and timelines to be considered.

841. Information recorded in patients' complaint files was reviewed to determine the nature of the complaint. The nature of the complaints was recorded against categories including Treatment/Clinical, Access & Timing, Communication, Administrative/Process, and Humaneness/Caring.

Table 5: Theme Mapping to QH-POL-450 Complaint Categories is summarised below

Theme	Policy Category
Treatment / Clinical	Complaints about products, projects or services delivered by the department (for example, clinical treatments or outcomes).
Access & Timing	Complaints regarding a decision or failure to make a decision, or an act or failure to act, often reflecting issues of scheduling, wait times, or access policies.
Communication	Complaints concerning staff conduct, or the customer service provided by the department's staff.
Administrative / Process	Complaints about policies, procedures, products, projects, or services, including administrative or procedural shortcomings.
Humaneness / Caring	Falls under staff conduct or customer service, particularly relating to empathy, dignity, or respectful care.

842. The above themes are aligned within the categories identified in the QH Customer Complaint Management Policy (QH-POL-450), which defines complaint categories such as: Decision-making (or failure), Actions (or failures), Policies, Procedures, Services, and Staff Conduct or Customer Service.

843. A total of 126 complaints relating to the delivery of urology services received between 2022 and 2025 were reviewed. This data is summarised in Annexure G.

844. The date received for each case was assigned to a calendar year and aggregated. Results from the complaints provided by THHS are as follows:

(a) 2022: 17 complaints;

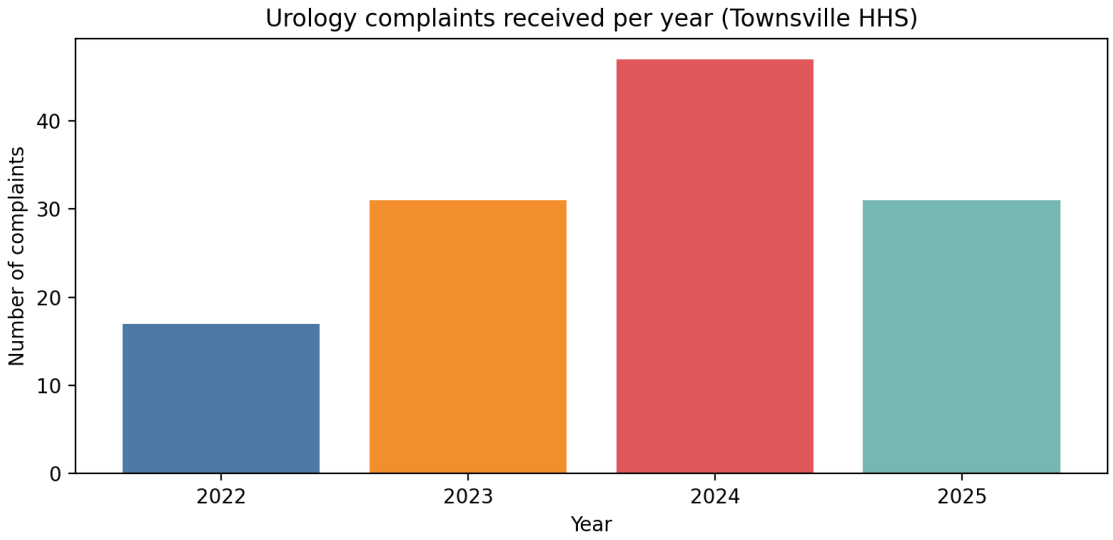
(b) 2023: 31 complaints (+82% YoY vs 2022);

(c) 2024: 47 complaints (+52% YoY vs 2023); and

(d) 2025: 31 complaints (partial year to 4 Sep 2025; not directly comparable to full years).

845. The data was summarised by complaints per year for visualisation. This is represented graphically in the Figure below.

Figure 11: Year-on-Year Comparison



846. Complaints were received through multiple channels, predominantly via telephone and email, with a smaller proportion through electronic forms and Ministerial correspondence. This pattern underscores the need for robust call management systems and timely response protocols.

847. An analysis of complaint issues reveals recurring themes that impact patient care and operational efficiency. The most prominent themes include access and timing delays, communication breakdowns, clinical treatment concerns, and administrative inefficiencies. These are summarised in the Table below.

Table 6: The distribution of complaints by recurring themes for the delivery of urology services[521]

Category	Number
Treatment/Clinical	86
Access & Timing	85
Communication	52
Administrative/Process	12

[521] The information in Figure 14 consolidates themes from TUH Urology complaints drawn from the RiskMan case summaries supplied by Townsville HHS, noting that each complaint may have contained one or more themes. The review window noted is 13 January 2022 to 4 September 2025.

Humaneness/Caring	6
Total	**241**

848. Based on the case dates provided by THHS, their median complaint closure timeframe for complaints relating to the delivery of urology services was approximately 12 calendar days.

849. Strategies to resolve complaints varied, with common approaches including apologies and explanations, clinical reviews, and formal closure after registering concerns.

850. Complaint volumes fluctuated across the review period, with noticeable peaks during periods of high surgical demand and resource constraints. Year-on-year analysis suggests persistent challenges in managing waitlists and ensuring timely communication.

851. Based on the analysis undertaken by the Investigators, the THHS may wish to consider strategies that could address operational concerns that gave rise to complaints such as:

(a) investigating opportunities to notify GPs when pathology and radiology results are transferred to a patient's My Health Record to ensure GPs are aware of the outcomes of investigations and can follow them up if necessary;

(b) conducting weekly waitlist huddles for Category 1 and 2 outpatients to proactively manage capacity; and

(c) expanding the role of the Nurse Navigator to provide a patient liaison service in areas such as catheter management and postoperative follow up.

852. Having considered the rate of urology service related complaints, the Investigators considered that the year-on-year increase in complaints is significant and should have triggered a more detailed analysis of the complaint profile by the THHS.

853. The data is at variance with the information that was presented to the Investigators during their Site Visit to the TUH, which was to the effect that the complaint rate in urology services was relatively unchanged over the review period.

854. The EDCG subsequently advised that although Urology recorded increases of 88% in 2023 and 53% in 2024, the absolute numbers (17 → 32 → 49) remained comparable to other specialties. As each specialty receives relatively few complaints per year, percentage changes can appear dramatic even when the underlying numerical shift is small and when compared with other low volume specialties was typical and not exceptional. The EDCG advised that the swings reflect the inherent instability of low-volume datasets rather than systemic service issues.[522]

855. The EDCG advised that the organisation-wide trend reinforces that increases in complaints related to urology services were part of a broader upward movement, not a specialty-specific signal, and that the data lacks the scale, persistence, and thematic coherence required to trigger escalation under standard organisational risk-detection frameworks.[523]

856. The Investigators remain of the view that the increase in the rate of complaints warrants further review. The Investigators are also of the view that complaints are an early warning system for issues within a service.

Recommendation 24	That the THHS review the processes in place to support thematic assessment of patient complaints in the delivery of

[522] Consulted Parties' Natural Justice Response.
[523] Consulted Parties' Natural Justice Response.

	urology services to identify changes to complaint profiles and implement appropriate actions to address underlying issues.

11.3.6 THHS Patient Complaint Management

857. Patient complaints relating to urology services were assessed as being managed in line with the relevant Queensland Government requirements.

858. The Board advised the Investigators that it observed that THHS does not have a publicly facing consumer complaints management policy. It stated that the development and publication of such a policy is an operational matter within the HSCE's management function under section 19 of the HHBA. The Board advised it has directed the previous HSCE to develop and publish a publicly facing consumer complaints management policy consistent with the Queensland Public Service Customer Complaint Management Framework.[524]

859. The Investigators however note that the determination of the need for a policy is a Board responsibility and THHS may wish to develop a publicly facing consumer complaints management policy.

860. It is also noted that the rate of complaints related to the delivery of urology services increased during the relevant period, and had this been identified at an earlier time, it may have identified a need for the THHS to provide additional support for urology services.

11.4 QH Staff Complaint Policies

861. As a starting point, the Investigators formed the view that it was necessary to identify and summarise the relevant policies and procedures within QH relating to staff raising concerns or complaints during the relevant period. The relevant policies are listed below and discussed in more detail later in this section of the Report:

(a) QH Employee Complaints and Grievance Management Policy; and

(b) QH Patient Safety Staff Escalation Process.

862. The QH Employee Complaints and Grievance Management Policy mandates the policy direction in relation to staff complaints management. This policy is supported by the QH Patient Safety Staff Escalation Process.

863. Regarding complaints raised by employees, it is important to recognise that employees within HHSs are employed by the Director-General, apart from the HSCE who is employed directly by the Board. As such, the QH terms and conditions of employment including those relating to complaints management are binding on the HHSs.

864. The THHS's internal procedures are required to comply with the identified legislation and policies including the Health Employment Directives.

11.4.1 QH Employee Complaints and Grievance Management Policy

865. QH manages employee grievances through a structured, principles-based framework designed to ensure concerns are addressed promptly, fairly, and transparently. The organisation's approach is governed primarily by HR Policy E12 – Individual Employee Grievances,[525] which establishes the mechanisms through which staff can raise concerns about workplace decisions,

[524] The Board's Natural Justice Response.
[525] Queensland Government, *Human Resources Policy: Individual employee grievances,* Policy Number E12 (QH-POL-140), August 2021. Electronic copy available at: https://www.health.qld.gov.au/__data/assets/pdf_file/0025/164095/qh-pol-140.pdf.

behaviours, or actions that they believe are unfair, unreasonable, or inconsistent with legislative or policy requirements.

866. The grievance management process emphasises early, local resolution wherever appropriate, encouraging employees and managers to address issues informally in the first instance. Where informal resolution is not possible or suitable, employees may lodge a formal grievance, which is then assessed and managed by an appropriately delegated decision-maker. The policy outlines clear expectations for procedural fairness, confidentiality, timely communication, and the provision of reasons for decisions.

867. QH's grievance framework operates within a broader legislative environment that includes the *Industrial Relations Act 2016* (Qld), HR Act, *Anti-Discrimination Act 1991* (Qld), IP Act, and the PID Act. This ensures that grievance handling is consistent with statutory obligations and supports a safe, respectful, and accountable workplace culture.

868. The system provides avenues for internal review where employees are dissatisfied with the outcome. External review mechanisms such as the Queensland Industrial Relations Commission remain available where appropriate. Collectively, the framework supports organisational integrity, reinforces employee confidence in decision-making processes, and contributes to a positive and legally compliant employment environment.

11.4.2 QH Patient Safety Staff Escalation Process

869. The QH Patient Safety Staff Escalation Process (**Patient Safety Net**), was implemented as a pilot on 9 October 2023 in four HHSs, including THHS. The formal statewide guideline (QH-GDL-985) took effect later, on 10 January 2025.[526]

870. The process to supports staff in raising patient safety concerns that are not resolved through local channels. [527] The new framework provides a clear, consistent, and confidential escalation pathway designed to ensure that concerns about actual or potential patient harm are identified early, escalated appropriately, and addressed with transparency and accountability.

871. The process emphasises local resolution as the first step, encouraging staff to raise concerns directly with their line manager or clinical leader. Where issues remain unresolved, or staff feel unable to raise concerns locally, the new escalation pathway provides structured options for progressing matters to senior leaders, patient safety specialists, or designated escalation points within the organisation.[528]

872. The approach strengthens QH's safety culture by ensuring that staff have reliable avenues to speak up and that concerns are met with timely assessment, clear communication, and appropriate action. It also enhances organisational oversight by enabling consistent monitoring of escalated concerns, supporting system-wide learning, and ensuring alignment with broader patient safety and clinical governance frameworks.

873. To operationalise the program, each HHS must establish a Patient Safety Net Oversight Committee responsible for managing reported concerns, monitoring recommendations, addressing conflicts of interest, and ensuring appropriate escalation to executive leadership and the BSQC. The committee must be multidisciplinary, include the Patient Safety Steward, and maintain strict confidentiality while balancing the need for sufficient information to address risks.

[526] Queensland Health, *Patient Safety Net guidelines*, Guideline Number QH-GDL-985, 10 January 2025. Electronic copy available at: https://www.health.qld.gov.au/system-governance/policies-standards/guidelines/patient-safety-net.
[527] Queensland Health, *Patient Safety Net guidelines*, Guideline Number QH-GDL-985, 10 January 2025. Electronic copy available at: https://www.health.qld.gov.au/system-governance/policies-standards/guidelines/patient-safety-net.
[528] Queensland Health, *Patient safety staff escalation sheet*. Electronic copy available at: https://www.health.qld.gov.au/__data/assets/pdf_file/0021/1202079/Attachment-1-Proposed-approach-v1.0.pdf.

874. Overall, the Patient Safety Net program provides a structured, transparent, and protective escalation mechanism that strengthens clinical governance and supports a safer reporting culture across QH.

875. It is noted that the Investigators have made Recommendations in Section 9.10 of this Report which relate to the Patient Safety Net program.

11.5 Staff complaints relating to the delivery of urology services

876. To assess the adequacy of the THHS staff complaints management process including responses provided to these complaints and actions arising from these, the Investigators have:

(a) set out the THHS staff complaint management framework as specified by QH and as per Section 11.5.1;

(b) detailed the THHS staff complaint management process in Section 11.5.2;

(c) assessed THHS staff complaints management process against the QH requirements in Section 11.5.3;

(d) reviewed staff complaints and concerns received by THHS about the delivery of urology services within the relevant period in Section 11.5.4;

(e) provided a series of Case Studies that detail the experiences of three specific staff who raised concerns relating to the delivery of urology services at TUH in Section 11.5.5; and

(f) assessed the THHS's overall approach to and management of patient complaints relating to the delivery of urology services in Section 11.5.6.

11.5.1 THHS staff complaint management framework

877. It is important to recognise that THHS is required to comply with HR policies set by the QH as all staff who work within the THHS are employed by the Director-General.

878. QH supports HHSs to operationalise employment-related policy matters through a structured suite of pathways including those that allow staff to raise concerns so that issues are managed transparently, fairly, and in accordance with QH policy and legislative requirements. The relevant HR policies are identified in Section 11.4.1 of this Report.

879. These pathways span local resolution mechanisms, formal grievance processes, patient safety escalation systems, workplace health and safety reporting, and access to external oversight bodies. Together, they form a comprehensive framework intended to support staff, strengthen organisational accountability, and promote a culture of safety and openness.

11.5.2 THHS staff complaint management process

880. The primary avenue for the resolution of most staff concerns is local escalation through line management. Within this context, staff are encouraged to raise issues directly with their immediate supervisor or manager. This early-resolution approach is designed to address matters promptly while maintaining effective working relationships.

881. Where concerns cannot be resolved locally, staff may lodge a formal grievance under QH's HR Policy E12 and Directive 11/20, triggering an internal review by an independent delegate and ensuring procedural fairness.

882. For matters involving unresolved patient safety concerns, THHS participates in the Patient Safety Net program, which provides a confidential, independent escalation pathway for staff who believe standard reporting processes have not adequately addressed a risk to patient safety.

This mechanism strengthens clinical governance and supports psychological safety by enabling staff to raise concerns without fear of reprisal.

883. Staff also have access to established workplace health and safety reporting systems for hazards, incidents, and psychological safety issues, as well as the Patient Feedback Service for concerns relating to patient experience or service quality.

884. Where internal processes are inappropriate or exhausted, staff may escalate matters to external bodies such as the OHO, the Queensland Ombudsman, the Queensland Human Rights Commission, or the Queensland Industrial Relations Commission.

885. Staff may also make a PID for matters involving corrupt conduct, maladministration, or present a substantial risk to public health or safety. Such disclosures provide a level of protection for the staff involved.

11.5.3 Assessment of staff complaints management against QH policy

886. Collectively, these QH pathways provide THHS staff with multiple, clearly defined options for raising concerns.

887. The primary pathway for most concerns relates to the QH Employee Complaints and Grievance Management Policy set out in Section 11.4.1.

888. From the formal staff complaints that the Investigators reviewed, the THHS was compliant with the relevant QH policy.

11.5.4 Analysis of staff complaints relating to the delivery of urology services

889. There were a small number of staff complaints provided to the Investigators by the THHS as part of the Investigation evidence gathering process. These are summarised below:

(a) the THHS provided [redacted] staff complaints (grievances) to the Investigators as part of the Investigation evidence gathering process;

(b) the staff complaints related to workplace matters and were managed in accordance with the QH Employee Complaints and Grievance Management Policy;

(c) although small in number, the complaints were escalated to line managers for resolution as per the QH HR Policy E12 requirements;

(d) the staff complaints fell into two categories, namely; complaints relating to workplace matters and complaints relating to clinical services;

(e) the complaints related to workload management, pay and entitlements, rostering, performance management, and staff workloads. Two of the complaints raised the failure to fill a key nursing position in urology services. One related to the [redacted] espect to urological procedures;

(f) all the staff complaints were resolved with line managers as per the provisions of the QH Employee Complaints and Grievance Management Policy; and

(g) the nature of the complaints appeared to be of a nature that would normally be expected in a work unit such as urology services at TUH.

890. The THHS advised that there were no PIDs identified which were relevant to the TOR as part of the Investigations evidence gathering process.[529]

891. There was, however, one PID managed by the THHS which the QH ESU were aware of and which they believed fell within the Investigation TOR. This is detailed below. Two PIDs were also raised by officers interviewed by the Investigators as part of the Investigation. These were managed by the QH ESU.

892. There were no "Patient Safety Net" notifications identified by the THHS during witness interviews. The Investigators however identified one notification via "Patient Safety Net".[530]

11.5.5 Case Studies relating to staff complaints about the delivery of urology services

[redacted]

[redacted]

[redacted]

[redacted]



11.5.6 Assessment of THHS staff complaints management

932. The Investigators considered various complaints systems and processes in place for THHS employees to make complaints and raise concerns about their experiences in the workplace. These systems involve both formal and informal pathways within THHS and include:

(a) staff complaints managed under the QH Employee Complaints and Grievance Management Policy;

(b) staff complaints directed to bodies external to the THHS;

(c) staff complaints managed through a PID; and

(d) staff complaints made through the Patient Safety Net program.

933. Staff utilised these pathways to raise their concerns and complaints and the THHS managed these in line with the relevant QH policies.

934. The Investigators note that in each of the case studies, staff chose to utilise either the PID framework or, in case study 1, made a complaint directly to a Minister. The Investigators are of the view this raises questions about how staff perceive the adequacy of the THHS complaints management processes. However, the Investigators note the limitations of drawing any conclusions in this regard given the small numbers of staff complaints.

11.6 Pathways for escalating systemic patient safety concerns

935. THHS has several established pathways for escalating systemic patient safety concerns, operating through both local clinical governance structures and statewide mechanisms.

936. At the local level, concerns can be raised through clinical line management, progressing from treating teams and Nurse Unit Managers to departmental directors and the EDCG.

937. Formal escalation also occurs through structured governance committees, including the PSC, the ECGC, and ultimately the BSQC, which provides oversight of significant or recurring risks.

[551] WIT.002.001.0022 Transcript of Interview - Witness AC; WIT.001.001.0115 Witness AC, *Grievance Outcome Letter,* 30 April 2024, page 4.

938. Where concerns are not resolved through these internal processes, QH provides additional escalation mechanisms. The Patient Safety Net offers a confidential, statewide pathway for staff to raise unresolved or sensitive patient safety issues, ensuring matters can be independently reviewed.

939. Staff may also escalate serious systemic concerns through the PID framework, which provides statutory protections for disclosures involving risks to public health, maladministration, or failures in governance.

940. Together, these pathways are intended to provide a clear, multi-layered escalation structure that enables staff to raise systemic patient safety concerns and ensures that significant risks are visible at the highest levels of governance.

941. With respect to the delivery of urology services at TUH, there is evidence that staff raised concerns through both formal and informal pathways.

942. The formal complaints that the Investigators reviewed apart from a grievance that attracted PID status were of an operational nature. While case studies 2 and 3 both raised patient safety concerns, these complaints were managed by way of the [redacted] Managing complaints in this way can result in the loss of an opportunity to identify and address legitimate patient safety concerns and, additionally, undermine staff confidence in using these frameworks to escalate patient safety concerns.

943. The THHS Executive believed that overall, the complaints and concerns that they were aware of were being effectively managed.

11.7 Findings and Recommendations

944. With respect to TOR 3.1(f) being to identify whether any complaints or concerns have been received within THHS about the delivery of urology services (inpatient and outpatient), including but not limited to, any PIDs, staff, other health practitioners and patient complaints, and assess the adequacy of the THHS complaints management processes, including responses provided to these complaints and actions arising from these, the Investigators' findings are outlined below.

945. With respect to patient complaints:

(a) that the THHS has received patient complaints and/or concerns relating to the delivery of urology services across both the inpatient and outpatient settings. The concerns raised predominantly related to communication, timeliness of care, coordination of follow-up, and, in isolated instances, the quality of clinical interactions;

(b) each patient complaint was managed through established health service wide processes, which formally logged, triaged, and allocated patient complaints to the relevant clinical leaders for investigation. Responses were provided within expected timeframes, and documentation demonstrates that complainants received clear explanations, apologies where appropriate, and information regarding corrective actions. In cases regarding clinical issues were identified, these were escalated through the safety and quality structures. For serious clinical incidents, Open Disclosures were undertaken with the patients; and

(c) overall, the THHS's consumer complaint management processes are consistent with QH's broader consumer feedback and patient safety frameworks.

946. With respect to staff complaints:

(a) the THHS has received several patient safety concerns relating to the delivery of urology services. These concerns were raised through a variety of mechanisms, including direct escalation to line managers, reporting through clinical governance channels, and use of the Patient Safety Net. The issues identified by staff primarily related to delays in access to care, challenges in service coordination, and risks

associated with clinical workflow pressures. No matters were identified by the THHS as having been raised through the formal PID pathway;

(b) some of the concerns raised by staff were managed through THHS's established patient safety and clinical governance processes. These reports were reviewed by the relevant leaders, with escalation to senior management where required. Documentation demonstrates that concerns were acknowledged investigated and considered;

(c) while the Investigators have not tested the veracity of the substantive allegations in the three case studies, or any other staff complaints considered in the Investigation, this snapshot has highlighted similarities in the contents of complaints in relation to the urology service and how they were managed; and

(d) the Investigators, while acknowledging the processes were overall consistent with the relevant policy requirements, believe more consideration should have been given by the THHS to the staff concerns raised through management channels, particularly in relation to the aspects of the complaints that related to patient safety.

947. With respect to TOR 3.1(g) being to evaluate existing mechanisms and pathways for escalating and addressing systemic patient safety concerns, the Investigators have found:

(a) the current processes provide a framework for identifying and addressing patient safety concerns raised by staff;

(b) the assessment indicates that THHS's mechanisms for managing staff-raised patient safety concerns could be enhanced. Staff at interviews consistently indicated that when they raised concerns with their managers, they did not perceive that concerns were recognised or that corrective actions were taken;

(c) clinical professionals did not appear to be supported to undertake retrospective reviews. A culture that downplays clinical concerns undermines trust, damages morale, and potentially harms patients; and

(d) this suggests a culture in which staff feel unable to speak up and where concerns do not contribute to ongoing improvements in quality and safety within urology services.

948. In summary, the Investigators have formed the view that:

(a) the THHS has contemporary committee structures in place to report on and monitor patient complaints; and

(b) there were concerns raised by clinical staff through management channels that were not given due consideration by the THHS. This included the critical importance of balancing forward-looking and retrospective safeguards as they related to the various clinical audits that were undertaken in relation to the delivery of urology services. Without both forward looking and retrospective safeguards, THHS risks failing their duty of care to patients.

Recommendation 25	That the THHS ensures that when patient safety concerns are raised, they are appropriately reviewed and clinical audit teams are empowered to conduct retrospective reviews, supported by digital systems that provide transparent and accessible data.

949. With respect to TOR 3.1 (a) (vii), whether issues of concern were identified and escalated effectively, the Investigators identified concerns in relation to the escalation of matters where the matters did not appear to have been acted upon.

950. The Investigators in their interviews with executive staff were advised that the THHS had a good patient safety culture and a good reporting culture.[552] The exception to this was reporting by medical staff.[553] The executive staff further advised that medical staff were likely to raise matters with a member of the leadership team directly.[554]

951. The Investigators in their interviews with clinical and operational staff that were directly or indirectly involved in providing urology services provided a different perspective. These staff indicated that they were aware of the escalation pathways.[555] They also indicated that, in the relevant period, when matters were escalated that there was a limited response to the concerns and in some cases no action was taken.[556] This impacted on managers who reported that they were undertaking work outside their normal duties to address patient safety concerns. This information was reaffirmed by COO 3.

952. It was also noted that in 2022-2023 the THHS was experiencing financial pressures and that management of budget and activity levels dominated discussions at the SSG performance and accountability meetings.[557] A focus on clinical safety was not evident on the performance meeting agendas provided to the Investigators. This had the effect of reducing the opportunity for safety and quality being considered as part of the organisation's performance meetings. COO 1 informed Investigators that he disagrees that performance and accountability meetings did not include equal discussions of finance, budget and activity levels, patient safety, service sustainability and access, risk and audit.[558]

953. It is the view of the Investigators that, having regard to safety and quality issues being experienced within the THHS, that the safety and quality issues should have been included in performance management meetings.

954. The Board advised the Investigators that this [was] a further instance of an operational-level decision that degraded the quality of the information reaching the Board. The Board did not know that safety and quality had been removed from the performance accountability meetings, and yet it is held responsible for not perceiving systemic risk that those very meetings were designed to identify.[559]

Recommendation 26	That the THHS reaffirms for executive staff, best practice arrangements for receiving and responding to issues and concerns relating to patient safety when these are raised by staff such as those raised in relation to the delivery of urology services. That the THHS ensure that patient safety and quality is an item on the agendas in key operational performance meetings across the health service and that safety discussions are facilitated through these forums. That the THHS consider implementing a professional development program for executives and managers that provides guidance on how to receive and respond to patient safety concerns while encouraging staff to speak up for patient safety.

[552] WIT.003.001.0001 Transcript of Interview – Witness Q, paragraphs 143-144.
[553] WIT.003.001.0001 Transcript of Interview – Witness Q, paragraphs 133-140; WIT.002.001.0028 – Transcript of Interview Witness I, paragraphs 14, 102-107; WIT.002.001.0004 Transcript of Interview – Witness S, paragraphs 92-94.
[554] WIT.001.001.0202 THHS, *Employee Engagement Survey,* November 2025, page 23.
[555] WIT.002.001.0032 Transcript – Witness K, paragraph 29.
[556] WIT.002.001.0034 Transcript of interview – Witness V, paragraph 38.
[557] WIT.002.001.0032 Transcript of Interview – Witness K, paragraph 42.
[558] Consulted Parties' Natural Justice Response.
[559] The Board's Natural Justice Response.

955. With respect to TOR 3.1 (a) (viii), whether appropriate actions were taken to address any issues of concern, the Investigators have responded to this matter in Section 9.10 against the clusters relating to the delivery of urology services:

(a) with respect to Cluster 1, the Investigators formed the view that in retrospect, while the response was consistent with what roles and responsibilities require, the information presented by Cluster 1 (the variance and the scale of the different issues across several different clinics) raises concerns which the Investigators are of the view should have been at least identified if not considered in more detail;

(b) with respect to Cluster 6, the Investigators formed the view that despite good evidence that a more extensive look back should have been considered at this time to identify the patients who potentially experienced Disrupted Care, this was not undertaken, and that there seemed to have been a focus on the bundle of booking forms identified located on [redacted]. The Investigators consider that the THHS ought to have made inquiries to assure themselves that there were no other urology patients affected as there may have been other instances where the paper booking forms may have been misplaced or lost or not actioned but which were included in the bundle. If this was found to be the case then this would then have triggered a more detailed lookback. The THHS also appeared to implement corrective action without consideration of the underlying cause of the incidents and without appropriate change management being implemented;

(c) with respect to Cluster 7, the Investigators formed the view that this cluster of patients were at high risk of having a malignancy and that the HHS should have been aware of this and acted accordingly. THHS did not appreciate the gravity of this situation and the various system deficiencies meant that patients lost their chances for timely treatment of their conditions;

(d) with respect to Cluster 8, the Investigators formed the view that this cluster of patients were at high risk of malignancy, that procedural changes in urology outpatients led to patients experiencing Disrupted Care, and that formal medical referrals were not managed appropriately;

(e) with respect to Cluster 9, the Investigators consider that a substantial number of patients experienced Disrupted Care. Some of the patients who experienced Disrupted Care did so because of clinic cancellations at short notice and in instances where the rebooking process was not completed in addition to the ongoing underlying issues relating to the outpatient rebooking process; and

(f) with respect to Cluster 10, the Investigators formed the view that the rebooking process for patients attending urology outpatients had been deficient since December 2023 and that a detailed assessment of the causes for patients who are connected to or receive urology services that experienced Disrupted Care had not been given appropriate consideration by the THHS.

Section 12 - Embedding a Robust Approach to Delivery of Urology Services

12.1 Overview

956. In this section, the Investigators have addressed TOR 3.2 which requires the Investigators to identify and assess the effectiveness and sustainability of any measure, including any policy, guideline, practice or process, identified and/or implemented by TUH staff or THHS during or after the relevant period to respond to issues related to the delivery of urology services at TUH as identified in TOR 3.1.

957. In considering this matter, the Investigators sourced material from the THHS and from staff that were interviewed as part of the Investigation process. This approach identified a range of initiatives including policies, guidelines, practices, and processes, that have been or are being implemented by the THHS in relation to the delivery of urology services at TUH.

SUMMARY: Key observations, findings, and conclusions in relation to embedding a robust approach to the delivery of urology services

Urology Service Progress

(a) The Investigators note that the THHS continues to stabilise the delivery of urology services, with progress in incident review, patient contact, and service capacity. System-level improvement work is also underway.

(b) The matters presented in this section represent measures under way or completed by the THHS through to December 2025 and are outlined below.

(i) THHS Investment Proposal: The THHS provided an investment proposal to QH seeking recurrent funding of $5.71 million to stabilise and sustain urology services and other services.

(ii) TUH Urology Services Operations Plan: The Urology Services Operations Plan (**the Operations Plan**) sets out a strategic approach to critical challenges in outpatient clinics, elective surgeries, and workforce sustainability.

(iii) TUH Urology Service Production Plan: The formalised Production Plan underpins the Operational Plan and aims to address critical issues, including staffing shortages, increasing service demand, and delays in patient care, while ensuring the highest standards of safety and quality.

(iv) TUH Urology Pathways: The THHS has documented patient flows outlining the planned and unplanned urology pathways from referral to treatment and discharge for patient care within the North Queensland region.

(v) TUH Surgical Services Implementation Plan: A comprehensive review commissioned by the THHS of its surgical services highlighted inefficiencies, governance gaps, and workforce challenges that were impacting quality, safety, and access.

(vi) THHS Board Urology Services Update: The Investigators note the Board has been provided with an update of the situation and has been kept abreast of the actions being taken by the THHS executive in responding to the identified issues within the delivery of urology services.

(vii) THHS Urology Services Reporting to QH: THHS has provided updates to QH where it advised that the THHS continues to progress its response to the urology

LTS cohort, with incident numbers stabilising and key remediation activities advancing.

(viii) Updated Audit Results: As noted, some of the audits being undertaken by THHS remain ongoing. The Investigators received further information from THHS in relation to some of these audits.

12.2 Urology Service Progress - August to December 2025

958. Between August and December 2025, THHS faced challenges in the delivery and governance of urology services at TUH.[560]

959. Capacity issues were escalated to the THHS in early August 2025 with urgent referrals and patient transfers from regional sites such as Mt Isa, being delayed or declined. This signalled capacity constraints in the delivery of urology services. In September 2025, operational issues were also identified by THHS with respect to the rebooking of outpatients in urology services.

960. In October 2025, a detailed clinical audit was commenced. In December 2025, the THHS pivoted to undertake detailed operational planning and production planning for the delivery of urology services.[561]

961. The matters presented in this section represent measures under way in THHS through to December 2025. These include:

(a) THHS Investment Proposal (21 October 2025);

(b) TUH Urology Services Operations Plan (Version - November 2025); [562]

(c) TUH Urology Services Production Plan (Version - November 2025);[563]

(d) TUH Urology Pathways (Version - December 2025);[564]

(e) TUH Surgical Services Implementation Plan (Version - December 2025);[565]

(f) THHS Board Urology Services Update (Version - December 2025);[566] and

(g) THHS Urology Services Reporting to QH (Version - December 2025).[567]

12.2.1 THHS Investment Proposal 21 October 2025

962. The THHS Board provided advice that on 21 October 2025 the THHS A/HSCE provided an investment proposal to QH. The proposal sought recurrent funding of $5.71 million to stabilise and sustain urology and other services service. The A/HSCE indicated that they considered that the proposal directly supported the Part 9 Investigation into the THHS Urology Services, following the identification risks relating to delayed access, loss to follow-up, and workforce fragility.

[560] WIT.002.001.0022 Transcript of Interview - Witness AC.
[561] WIT.003.001.0001 Transcript of Interview - Witness Q.
[562] WIT.001.001.0257 Urology Services Operations Plan November 2025.
[563] THS.001.001.2274 THHS, *Urology Service Production Plan*, latest version November 2025.
[564] THS.001.001.0026 THHS Board, *Board and Executive Meeting Feedback*, 21 June 2023, page 5.
[565] WIT.001.001.0192 THHS, *Surgical Services Implementation Plan*, December 2025; WIT.001.001.0257 THHS, *Urology Services Operations Plan November 2025*, 4 December 2025; WIT.001.001.0265 THHS, *Urology Services Operations Plan November 2025*, *Version 3,* 19 December 2025.
[566] WIT.001.001.0278 THHS Board, *Briefing Note, Urology Service Production Plan,* 1 December 2025.
[567] WIT.001.001.0276 THHS, *Planned Urology Pathway, Vol. 2,* 15 December 2025.

963. The A/HSCE also indicated in the correspondence that as the tertiary referral hub for the region, THHS continues to deliver strong performance and fiscal discipline; however, increasing demand and constrained specialist supply have placed sustained pressure on surgical and diagnostic capacity. The A/HSCE indicated that in his opinion these pressures now exceed the THHS current service model.

964. Further, the A/HSCE indicated that the THHS Board has maintained active oversight of urology performance and the broader system response through its Safety and Quality, Finance and Performance, and Audit and Risk Committees. The A/HSCE also advised that the THHS Board had been formally briefed on the proposal.

965. The A/HSCE indicated that the investment would focuses on strengthening urology and its critical clinical enablers. The proposed funding for 24.4 FTE would support urology staffing, anaesthetic/preoperative staffing, radiology staffing and embed structured clinical governance and data oversight.

966. The A/HSCE indicated that the proposal formed part of a broader program of reform led by THHS to strengthen clinical governance, continuity of care, and outpatient performance. Central to this is the outpatients optimisation to address Loss to Service, developed with Health Excellence Queensland across referral, treatment, and follow-up pathways.

12.2.2 Urology Services Operations Plan (Current version - December 2025):

967. A Urology Services Operations Plan (**the Operations Plan**),[568] covering November 2025 to June 2026, was developed. This sets out a strategic approach to tackle critical challenges in outpatient clinics, elective surgeries, and workforce sustainability. The primary goals of the Operations Plan is to optimise service delivery, reduce patient wait times, and align operations with national and international standards.

968. The Operations Plan notes that outpatient clinics were fully booked until April 2026, accommodating 72 new patients and 228 review patients each month. However, the Operations Plan also notes that these clinics are not operating at full efficiency due to vacancies in key positions.

969. The Operations Plan reports that, as of 30 November 2025, there are 667 long-wait patients across outpatient Categories 1, 2, and 3, with a total of 924 patients on the waiting list. Additionally, 167 referrals were pending categorisation for more than five days, delaying their addition to the waitlist. The Operations Plan notes that local teams lack the capacity to schedule review and post-discharge appointments until April 2026.

970. The Operations Plan references that elective surgery services face similar constraints, including limited capacity, and reduced access to anaesthetists. Despite these challenges, weekend theatre lists supported by external VMOs have proven successful, with minimal “did not attend” cases.

971. The HHS has identified several ongoing challenges, including workforce shortages, particularly in SMO and PHO roles; delays in referral categorisation; high rates of non-attendance (12.6%) and hospital cancellations (18.2%).

972. To address these issues, the Operations Plan proposes a mix of short and long-term strategies. These include outsourcing, engaging VMOs to meet the clinically recommended timelines for clinics and surgeries, conducting administrative audits to improve scheduling and discharge processes, implementing SMS reminders and standby lists to reduce non-attendance, and developing a comprehensive Urology Model of Service to enhance operational efficiency. Workforce reviews and targeted recruitment activities aim to fill critical vacancies, while

[568] WIT.001.001.0257 THHS, *Urology Services Operations Plan November 2025*, 4 December 2025; WIT.001.001.0192 THHS, *Surgical Services Implementation Plan,* December 2025.

alternative care models such as telehealth and chart review clinics were considered that would assist to increase THHS' capacity to manage new patients.

973. The Operations Plan potentially requires an additional monthly investment of $153,626.92 until the end of the 2025/26 financial year. This funding would enable the review of approximately 2,100 patients and the completion of 168 surgical cases by June 2026.

974. The expected outcomes of the Operations Plan include eliminating long-wait Category 1 patients, reducing Category 2 and 3 waits to zero, ensuring referral categorisation within five business days, lowering non-attendance rates to 7.6%, cutting hospital cancellations by 75%, and increasing capacity for new appointments.

975. Through a planning process, the THHS has documented many of the issues identified by and discussed with the Investigators with respect to the capacity and capability of urology services. The Operations Plan documents a recovery process for urology services.

976. The Operations Plan represents an initial step in responding to the issues related to the delivery of urology services at TUH.

977. The THHS should be commended for establishing a planning document that identifies the key actions required within the service to address capacity and capability issues in the delivery of urology services.

12.2.3 Urology Service Production Plan (Current version - November 2025)

978. The recently formalised Production Plan[569] underpins the Operational Plan and provides an overview of urology services production at TUH, highlighting the current challenges, progress, and future projections for outpatient and elective surgery services. The plan aims to address critical issues, including staffing shortages, increasing service demand, and delays in patient care, while ensuring the highest standards of safety and quality.

979. Urology services have made progress in addressing workforce challenges. Two temporary surgeons were contracted to support outpatient and elective surgery services. As of November 2025, they have conducted 65 outpatient consultations and completed five elective surgeries. Discussions are underway to extend their availability into 2026 to maintain service delivery. This has been facilitated by a Brisbane based senior surgeon appointed to assist THHS.

980. The Production Plan identifies the efforts that are being made to prioritise patients identified as LTS. These patients, who were previously lost in the system, are now being reviewed and managed to ensure their care is not delayed further.

981. Additionally, a telehealth-based option with Docto.com has been approved and will address the limited availability of urologists. Once logistical issues are resolved, 60 patients had been identified for telehealth appointments with qualified urologists.

982. The Production Plan notes that staffing constraints remain a critical issue, with a long-term deficiency in SMO positions. The Operations Plan notes that the previous recruitment efforts for the Clinical Director and staff specialist roles have been unsuccessful, despite repeated advertising over the past 12 to 18 months.

983. The Operations Plan also notes that the demand for urology services continues to rise. In October 2025, TUH received 384 referrals, representing a 13.9% increase from the previous month. Additionally, TUH agreed to accept Northwest HHS patients onto its waitlists, further affecting capacity.

[569] THS.001.001.2274 THHS, *Urology Service Production Plan*, latest version November 2025; WIT.001.001.0263 THHS Board, *Briefing Note, Out of Session Weekly Report*, 18 December 2025.

984. The Operations Plan notes that the outpatient waitlist had grown significantly, with 910 patients ready for care and 22 not ready for care as of November 2025. The Operations Plan further notes that ultra-long waits cannot be scheduled due to limited capacity and the prioritisation of high-need patients. Administrative audits of the waitlist are ongoing.

985. The Operations Plan notes that elective surgery services are similarly impacted. In October 2025, 64 patients were added to the elective surgery waitlist, while 89 were removed or treated. A total of 66 elective surgeries and 22 emergency surgeries were performed.

986. The Production Plan notes that procedural waitlists are often deferred due to staff leave and emergency surgical presentations.

987. The Operations Plan notes that elective surgery services were expected to perform 485 surgeries by December 2025, with a focus on long-wait Category 1 patients. Outpatient procedures are projected to reach 84 by December 2025.

988. Urology services are operating with a staffing deficit. Recruitment efforts were ongoing, with a closing date of 15 December 2025. Discussions were underway to secure locum support for February 2026 and extend contracts for temporary surgeons into 2026.

989. In summary, the Investigators have found that the Urology Service Production Plan outlines critical steps to address the challenges faced by TUH's urology services. While some progress has been made, staffing shortages and increasing demand continue to strain the service.

990. The implementation of the recommended Production Plan will be essential to improving service delivery and patient outcomes.

991. The performance data included in the Production Plan shows that despite the actions as outlined in the plan , the THHS continued to face a persistent structural constraint in the delivery of urology services, driven primarily by the availability of urologists across North Queensland. This shortage has created sustained pressure on outpatient access, elective surgery throughput, and the management of acute presentations, particularly for stone disease and urological cancers.

992. The THHS may wish to establish a dedicated innovation focused team in collaboration with QH's HIU to explore, plan and introduce appropriate service models pending the recruitment of additional specialist staff and noting the existing pressures on specialist urologists in terms of supervision.

993. The recently developed Urology Service Operational Plan represents an initial step in responding to the issues related to the delivery of urology services at TUH.

Recommendation 27(a)	(Priority) That the THHS approach QH and request further support from the QH Deputy Director-General, Workforce Division with respect to medical recruitment as this remains a key risk for the delivery of urology services. This supports an earlier recommendation relating to service and workforce planning.
Recommendation 27(b)	(Priority) That the THHS, in collaboration with the QH HIU, consider establishing a dedicated innovation focused team to explore, plan and introduce appropriate innovative service models pending the recruitment of additional specialist staff and noting the existing pressures on specialist urologists in terms of supervision. This may include consideration of the following: i. Enhance and formalise a networked hub-and-spoke model supported by visiting urologists from larger centres who

	provide scheduled fly-in fly-out clinics, block-time surgical lists, and virtual participation in MDT meetings. ii. Expansion of tele-urology consultations via telehealth, supported by local nurse practitioners and GPs who perform physical assessments, diagnostics, and follow-up. iii. Establishing high volume / lower-complexity clinics led by nurse practitioners, GPSI or Career Medical Officers. iv. Expand procedure-focused task delegation, where non-urologist clinicians are trained to perform selected procedures. v. For high-complexity surgical care, THHS expand access to the private sector's robotics and theatre platforms to enable urologists to undertake robotic prostatectomy and nephrectomy in block sessions. vi. Across cancer and stone disease, implement integrated Never-Lost Pathways to ensure patients move predictably through the system. This could be nurse led with specialist oversight. vii. Workforce attraction and retention initiatives including registrar rotations, joint public-private appointments, supervised international medical graduate pathways, and targeted incentives to attract and retain urologists in North Queensland. While these strategies will take time to mature, they provide the foundation for a sustainable future workforce.

12.2.4 Urology Pathways (Current version – December 2025)

994. The THHS has documented patient flows outlining the planned and unplanned urology pathways for patient care within the North Queensland region. This focuses on the processes from referral to treatment and discharge.[570.] These are outlined in the Figures below.

995. The planned pathways begin with a referral from a GP, private specialist, or inter-hospital transfer, which is sent to the NQRH. Referrals can be submitted via various channels, including General Practitioner Smart Referrals, facsimile, email, letter, or QH Refer. The referral undergoes administrative review to ensure compliance with CPC, SOSIS standards, and specialty alignment.

996. Once reviewed, referrals are categorised by a nurse and medical officer based on the type of care required, such as new, upgraded, continuing, or associated care. Patients are then assigned to specific clinics, including the Haematuria Clinic, Nurse-Led Complex Continence Clinic, and other specialised services. Surgical interventions, if required, are managed at the TUH through the Planned Procedure Unit (PPU) or as a day case. Post-surgery, patients follow a discharge pathway, which may include ongoing treatment, ambulatory care, or discharge to their GP, home, or community.

997. The unplanned pathway begins with a patient presenting to the TUH Emergency Department, either independently or via ambulance or inter-hospital transfer. Patients are assessed by the emergency team, and if admitted, they undergo further investigations and surgical procedures

[570] WIT.001.001.0276 THHS, *Urology Pathways*, current version December 2025; WIT.001.001.0273 THHS Board, *Cover Note, Service Agreement Performance Report – September 2025,* 3 November 2025.

as needed. Ongoing inpatient management is provided at TUH, with support from allied health professionals, doctors, and nurses.

998. For patients not admitted, follow-up care is coordinated through the GP, including PDAR, face-to-face consultations, telehealth, or chart reviews. Discharge options include returning to the GP, home, community, or ambulatory care services.

999. The processes outlined in these pathways align with QH policies and referral management coordinated through the NQRH which ensures compliance with CPCs and SOSIS.

1000. The unplanned and planned care pathways as outlined in the Figures below are consistent with accepted criteria.

1001. THHS has progressed the documentation relating to patient flows since the Investigators undertook a site visit in early November 2025.

Figure 12: Unplanned Care Pathway

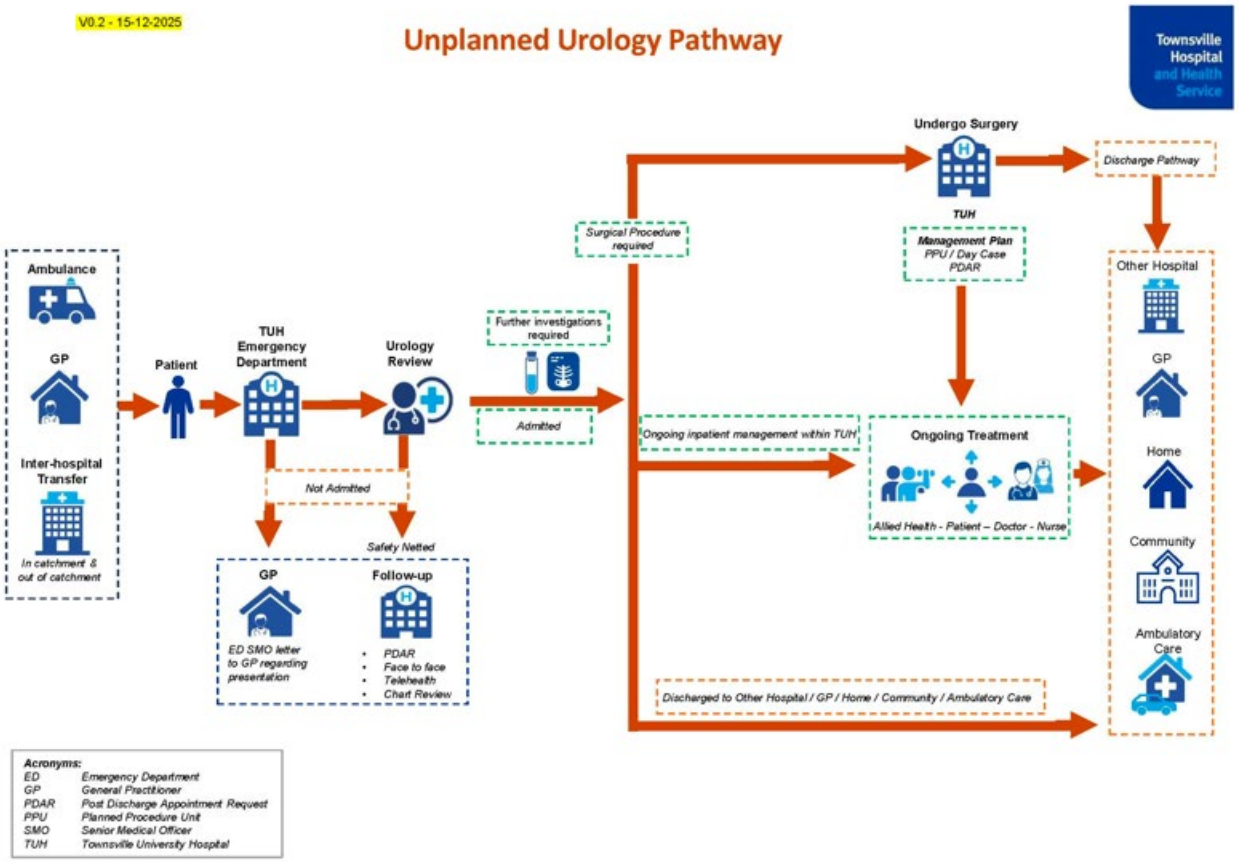
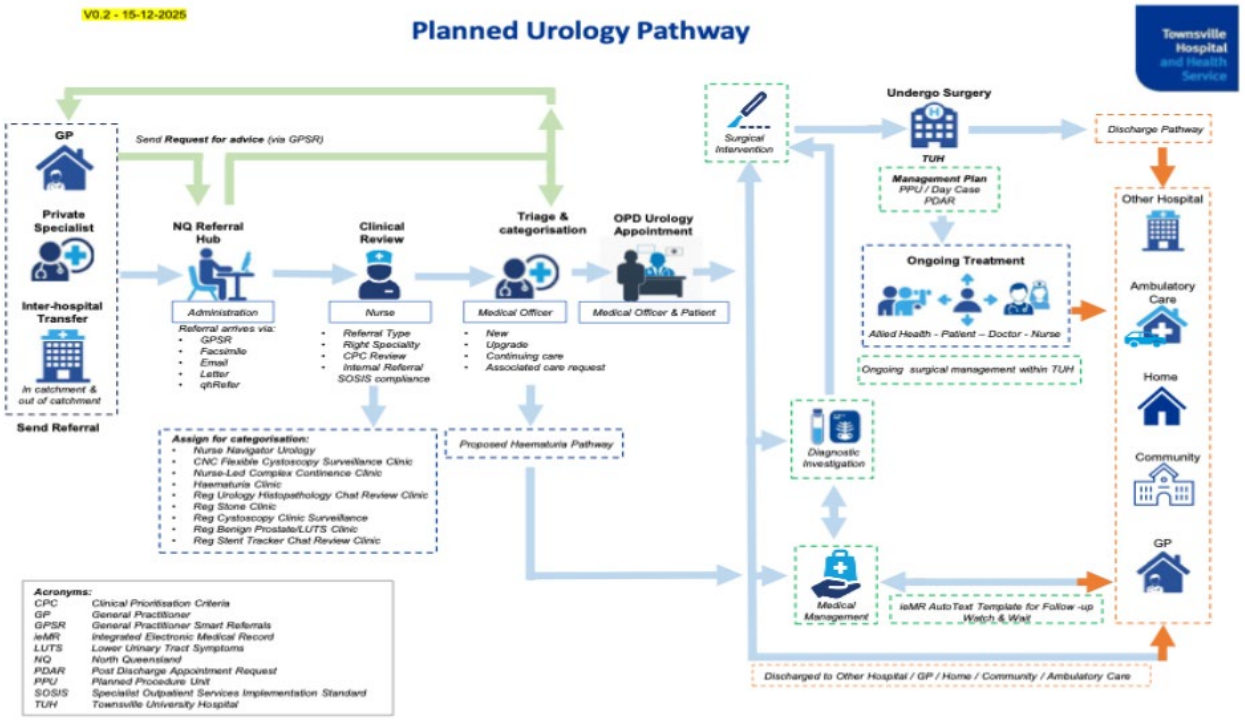


Figure 13: Planned Care pathway



12.2.5 Surgical Services Implementation Plan (Current version - December 2025)

1002. In June 2025, THHS commissioned a comprehensive review of its surgical services to address challenges in theatre utilisation, elective surgery waitlist management, and perioperative performance including issues relevant to the delivery of urology services.[571] The review, completed in October 2025, highlighted inefficiencies, governance gaps, and workforce instability that were impacting quality, safety, and access. This Implementation Plan[572] translates those findings into a structured program of work designed to stabilise operations, strengthen governance, and build sustainable capacity for future growth.

1003. The plan adopts a staged approach over three phases:

(a) the Stabilise phase (2026–2027) focuses on restoring governance structures, reducing variability in processes such as on-time starts and cancellations, and addressing workforce gaps in anaesthetics and perioperative nursing;

(b) the Strengthen phase (2027–2028) embeds integrated governance across perioperative streams, optimises list planning and pre-admission capacity, improves discharge processes through Post-Operative Discharge Support Service (PODSS) and Day of Discharge Unit (DDU), and standardises data and coding practices; and

(c) finally, the Sustain phase (2028–2029) scales extended hours prudently, formalises regional low-acuity pathways, invests in theatre expansion, and secures workforce pipelines and succession planning.

1004. The Investigators note the Implementation Plan which relates to surgical services including urology services and is consistent with the Urology Service Operations Plan and Production Plan.

[571] WIT.002.001.0030 Transcript of interview – Witness E.
[572] WIT.001.001.0192 Surgical Services Implementation Plan, December 2025.

12.2.6 THHS Board Urology Services Update (December 2025)

1005. The Investigators have been informed that the THHS Board was provided with updates on the existing situation, so that it could monitor progress in relation to the response to issues related to the delivery of urology services at TUH and the implementation of the Urology Services Action Plan.[573]

1006. The response to this update was outlined in a recent Board paper where it was formally tabled that the concerns regarding delays and gaps in urology services at TUH were first raised in September 2025 following a SAC 1 incident involving a patient LTS since July 2023.

1007. The Board paper outlines that as of 2 October 2025, 22 clinical incidents have been reported in Riskman, including three confirmed SAC 1 incidents and one pending confirmation. These incidents highlight significant delays in follow-up care, lost-to-follow-up cases, and treatment delays. An assurance review of patient records from January 2022 to July 2025 identified 576 patients requiring follow-up, with 210 patients needing further clinical review by specialists. To expedite this process, two external specialist nurses are scheduled to begin work on 8 October 2025. Additionally, a dedicated patient hotline (4433 0396) was established on 29 September 2025 to address patient concerns. As of 3 October 2025, the hotline has received 55 calls, with recurring themes including clinical care concerns, appointment cancellations, delays, lost-to-follow-up cases, and surgery wait times.

1008. It was also identified that urology services were facing significant waitlist challenges. As of 2 October 2025, the outpatient waitlist includes 869 patients, with 565 waiting longer than clinically recommended. The elective surgery waitlist has 348 patients, of whom 155 are beyond clinically recommended timeframes. Additionally, the outpatient review waitlist holds 1,395 patients, with 648 waiting beyond their requested review date. These delays pose a risk to patient safety and require urgent attention.

1009. To address these challenges, THHS has engaged additional resources, including senior urologists, a senior nurse with a Master's in Urology, and a senior surgeon from Metro South Health. These professionals would focus on stabilising services, addressing waitlists, and redesigning outpatient processes. Two external specialist nurses would assist with assurance reviews from 8 October 2025. COO 3 is drafting correspondence to the Director-General requesting further resources to stabilise services and support continuity of care.

1010. The Board paper notes that the Director-General has established a Statewide Urology Taskforce to address access challenges across Queensland. THHS is actively collaborating with the Taskforce to address statewide demand.

1011. The Board paper goes on to note that to address the significant challenges impacting urology services at TUH that a comprehensive set of priorities has been established. First and foremost, patient safety remains the highest priority. THHS will continue assurance reviews and clinical follow-ups for all identified patients, maintain strict oversight of Risk #362, and ensure Open Disclosure processes are in place for those affected.

1012. The Board paper also notes that the health service plans to implement sustainable staffing solutions to stabilise the workforce and explore alternative service delivery models, including telehealth and outsourcing, to expand capacity. Addressing equipment shortages will form part of this operational response to ensure continuity of care.

1013. The Investigators note the Board has been kept abreast of the actions being taken by the THHS executive in responding to the identified issues within the delivery of urology services.

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[573] WIT.001.001.0085 Urology Service Action Plan, updated November 2025; WIT.001.001.0084 Board Safety and Quality Committee, *Cover Note: Urology Services Action Plan Update,* 8 December 2025; WIT.001.001.0086 *Action Plan: Patient Safety Urology Working Group,* 10 December 2025.

1014. The Investigators consider the summary of the outcome of the clinical audit as outlined above is consistent with the Investigators' findings.

12.2.7 Urology Services Reporting to QH - 11 December 2025

1015. THHS updated QH and advised that the THHS continues to progress its response to the urology LTS cohort, with incident numbers stabilising and key remediation activities advancing to QH.[574] A total of 277 clinical incidents relating to LTS remain recorded for the period 1 January 2021 to 28 September 2025, with no changes to SAC ratings as of the date of the Report. Nine SAC 2 incidents have been downgraded to SAC 3 following review. An additional 19 delays-in-care incidents have been identified, including four SAC 1 matters, two of which are now complete and two progressing within expected timeframes.

1016. The THHS further advised that the combined 2021 look-back and 2022–2025 assurance reviews, that 258 patients required follow-up. All patients had been contacted, with 80 accepting appointments, 57 already seen, and a further 73 remaining uncontactable despite three attempts and formal correspondence to patients and GPs. A small number have declined care, sought treatment elsewhere, or were in other facilities. Nine patients have been redirected to the GPSI Urology clinic for review.

1017. It was also noted in the update that the additional 19 incidents outside the assurance review reflect gaps in outsourced MRI biopsy follow-up, missed planned appointments, and failures to rebook patients post-procedure due to absent e-Blue slips. These issues continue to inform targeted process redesign.

1018. The dedicated urology hotline had received 118 calls, with 96 escalated as formal complaints and three referred to OHO. Themes remain consistent: delays, cancellations, lost to follow-up, and concerns about clinical care. All feedback is logged in RiskMan and triaged by CNC Urology and CNC Prostate.

1019. The update also notes that a series of broader system improvements are underway. A Surgical Services taskforce is commencing a structured audit program across high-risk areas, expected to run for at least six months. The recent Closing the Diagnostic Loop review has identified opportunities to strengthen digital endorsement, escalation, and audit processes for outsourced radiology and pathology, with local solutions being progressed while awaiting statewide direction. The PDAR audit for post-surgical follow-up continues, with 843 of 1,018 cases completed and 151 requiring further clinical review. Referral management via the Smart Referral Hub is now being escalated to ECGC and the Board for oversight. Patient journey mapping has commenced to identify systemic risks.

1020. The update confirmed that service capacity continues to expand. A telehealth contract for 200 appointments was now active, with initial patients scheduled before Christmas and further appointments planned for January. Locum urologists are providing significant uplift, including 100 additional appointments this weekend and a further 210 outpatient appointments and 16 long-wait surgical procedures scheduled for January. This increased capacity is expected to ensure all LTS and ultra-long-wait patients receive an appointment by the end of January 2026. As a result, the previously proposed Vanguard contract is no longer required.

1021. Current outpatient waitlist data shows 959 patients waiting for care, with the largest volumes in Category 2 and Category 3 long-wait cohorts. 201 referrals remain awaiting medical officer categorisation. Year-to-date, 1,716 outpatient appointments have been completed. Elective surgery activity remains steady, with 445 procedures completed in the current financial year, including 273 Category 1 cases.

[574] THS.001.001.2290 Townsville University Hospital, *Weekly Urology Services Report to the Officer of the Director-General*, 11 December 2025.

12.3 Updated Audit Results

1022. As noted above, some of the audits being undertaken by THHS remain ongoing. The Investigators received further information from THHS in relation to some of these audits as follows.

12.3.1 Cluster 9

1023. The previous HSCE and EDCG indicated in May 2026 that the results of the booking forms audit demonstrated that:

(a) a proportion of appointments did not have clinical documentation associated with them (less than 3%);

(b) the plan of care on the clinic slips was different to the plan of care included in the EMR (approximately 2%); and

(c) where there was a documented plan of care, it was at times not actioned (less than 5%).

1024. The EDCG also advised that one case had no plan of care.[575]

12.3.2 Cluster 10

1025. In relation to Cluster 10, THHS confirmed that of the 576 patients THHS had confirmed that 276 patients were identified as "Lost to Care", a further 19 were "Delayed to Care" but there is no information before the Investigators as to the remainder of the patients. In total 295 patients were identified, all were reported in Riskman as clinical incidents with different levels of harm but included four SAC 1 and 92 SAC 2 patients.

1026. The previous HSCE and EDCG provided the following breakdown in relation to the 276 "Lost to Service" patients:[576]

[575] Consulted Parties' Natural Justice Response.
[576] WIT.008.001.0001 THHS, *Urology - Patient Safety and Complaints Update*, 2 March 2026, page 2.

Outcome Post Clinical Review / Other	# pts	Comments
Dx – declined further care	107	Contact with patients determined that they no longer required follow up, had sought treatment elsewhere and/or manage by their GPs.
Dx – No further care required	26	Chart review determined that no further care was required.
Dx – Treated	32	
Seen – for further review / investigations pending	56*	These pts all have active plans including appts booked, investigations pending post initial review or on referral. 10 pts have surgical procedures scheduled between Feb and April. The dates are clinically based with the exception of one patient who was not available, and one patient not scheduled until the stent is removed.
Ongoing surveillance	16*	These Patients continue to be seen and treated by Urology
Dx – no contact	35	Unable to contact following 3 x attempts by phone, written letters sent to patient and their GPS and recorded in ieMR.
Deceased	4	Clinical reviews determined that the deaths are unrelated to Urology conditions.
Total	276	

12.4 Summary

1027. The THHS continues to stabilise the delivery of urology services, with progress in incident review, patient contact, and service capacity. System-level improvement work is underway.

1028. In April 2026, the previous HSCE advised Investigators that he had "*approved in excess of $1m in expenditure on additional visiting urology services in this financial year from within THHS resources*". They further stated that as a result all patients identified as being LTS had been followed up and as of 23 April 2026 there was 74 people waiting longer than recommended for outpatient care, and just 60 people waiting longer than recommended for elective surgery. They stated that THHS is on a trajectory for no one to be waiting longer than recommended by the end of June and importantly no referrals waiting longer than five days for triage as of 23 April 2026.[577]

12.5 An approach to be considered by THHS

1029. The following is provided as a potential roadmap for THHS to consider which draws together actions already being undertaken by the THHS in relation to the delivery of urology services together with the Recommendations from this Investigation and draws on the Investigators' analysis of clusters as shown in the AcciMap.

Stage 1 – Initiation

1030. The THHS consider establishing a continuity of care structure within the delivery of urology services with a senior accountable executive who reports to the COO to progress operational matters including:

(a) the implementation of closed-loop protocols that document responsibility for follow up of ordered investigations;

(b) establishing ongoing clinical and administrative audit processes at the unit level;

[577] Consulted Parties' Natural Justice Response.

(c) establishing interim controls including a centralised patient tracking and escalation huddle that reviews all open referrals, pending diagnostics, and overdue appointments; and

(d) regular reporting on key indicators covering relevant activities.

1031. These activities relate to Recommendation 1, 5, 6, 7c, 8a, 8c, 11, 12, 13, and 14a in this Report.

Stage 2 – Formal redesign

1032. The THHS sponsor a formal process redesign activity using human factors methods to remove manual and inefficient processes and define clear role-based ownership for each transition point. In addition to the redesign activities, activities could include embedding methods for staff to safely raise safety concerns; workforce development opportunities including targeted training on the redesigned pathways, the development of integrated worklist and alerting solution within current systems and pathways to manage outpatient categorisation processes.

1033. These activities relate to Recommendation 7b, 8b, 14b and 27b.

Stage 3 – Consolidation of clinical and corporate governance

1034. Corporate governance should embed operational planning within the delivery of urology services including detailed production planning, quarterly Board reports of key metrics, digital modernisation of key pathways based on process mapping activities, embedding of a safety culture that emphasises learning from near-misses and psychologically safe reporting.

1035. These activities relate to Recommendation 4, 16, 18, 24, 25 and 26.

Section 13 - Statewide Learnings

13.1 Overview

1036. In this section, the Investigators have addressed TOR 3.3 which requires the Investigators to identify and report on practices and/or learnings derived from this Investigation which could be implemented state-wide, to the extent they apply to the public sector health system more generally and are relevant to improving and strengthening system safety, strengthening local or state-wide policies, procedures and/or standards, and reducing the likelihood of any adverse incidents occurring locally or system wide in the future.

1037. In considering this matter, the Investigators sourced material from the THHS and from staff that were interviewed as part of the Investigation process. This identified a range of opportunities which are outlined below.

1038. The Investigators also noted that there were several statewide activities on foot including those relating to the Statewide Urology Taskforce established by the Director-General and the procedural review relating to Closed Loop Radiology also established by the Director-General.

1039. In responding to these matters, the Investigators have summarised their findings under two categories. Firstly, those matters that the Investigators have identified as part of their Investigation and which relate to the Statewide Urology Taskforce or the Closed Loop Radiology program of work and secondly, matters that do not relate to the Statewide Urology Taskforce and the Closed Loop Radiology program of work.

SUMMARY: Key observations, findings, and conclusions in relation to Statewide learnings

Matters identified through this Investigation

(a) The specific practices and learnings identified during the Investigation which could be implemented Statewide are detailed in the related sections of the Report, being Recommendations 2, 3, 7(a), 8(b), 9, 14(c) and 21. These recommendations broadly relate to:

  (i) strengthening the SOSIS and confirming that compliance with the standard is mandatory;

  (ii) further developing the reporting of information collected as part of the Smart Referrals Workflow Solutions;

  (iii) progressing workforce planning for the urology workforce with a focus on Northern Queensland; and

  (iv) requesting that HHS Boards be asked to consider notifying the QH or the Minister for Health's office in relation to complex matters or matters of statewide significance.

(b) The Investigators have made three recommendations in this Report that are aligned with the work program for the Statewide Urology Taskforce. These are Recommendation 7(a), 8(b) and 8(c) and broadly relate to:

  (i) further developing the Smart Referrals Workflow Solutions;

  (ii) progressing workforce and service planning for the delivery of urology services; and

  (iii) increasing recruitment activity for urology.

(c) The Investigators have also proposed two recommendations that align with those of the Statewide Closed Loop Radiology process. These are Recommendation 5 and Recommendation 14(c) and broadly relate to:

(i) compliance with professional standards in the delivery of urology services; and

(ii) developing "Never Lost Pathways" for high risk clinical conditions.

13.2 Matters identified through this Investigation

1040. The specific practices and learnings identified during the Investigation which could be implemented Statewide are detailed in the related sections of the Report. As outlined below, they relate to:

(a) strengthening the SOSIS and confirming that compliance with the standard is mandatory;

(b) further developing the reporting of information collected as part of the Smart Referrals Workflow Solutions;

(c) progressing workforce planning for the urology workforce with a focus on Northern Queensland; and

(d) requesting that HHS Boards be asked to consider notifying the QH or the Minister for Health's office in relation to complex matters or matters of statewide significance.

13.2.1 Matters related to the Statewide Urology Taskforce

1041. The Statewide Urology Taskforce has developed a series of draft recommendations to address critical challenges in Queensland's public urology services.[578] These recommendations focus on five key areas: workforce, demand, process efficiency, safety and quality, and funding models.

1042. To tackle workforce shortages, the taskforce proposes increasing the number of urologists in the public sector by expanding training opportunities and revising supervision requirements for Specialist International Medical Graduates and other international graduates. Additionally, funding models be reassessed to make Queensland more attractive to interstate urologists, and that pathways be developed to support specialists returning from Fellowships overseas.

1043. In response to growing demand, the CPC[579] for nine urological conditions are proposed to be reviewed to improve categorisation sensitivity.

1044. The Statewide Urology Taskforce proposes to reduce delays in triage, categorisation, and waitlist placement by utilising nurses or GPSI. Clinical audits are proposed to be promoted to ensure that patients on waitlists still require specialist care.

1045. Safety and quality improvements are proposed to focus on standardising waitlist review processes to reduce variation and enhance transparency. Discharge pathways to primary care or alternative care models should be developed for semi-stable conditions, with GPSI workforce playing a key role. Community Health Centres or equivalent services are proposed to be scaled up to support post-surgical care for patients recovering from procedures such as prostatectomy or nephrectomy.

1046. It is also proposed that funding models be revised to attract urologists to the public sector, aligning with the workforce recommendations. These measures aim to create a sustainable,

[578] WIT.001.001.0186 *Statewide Urology Services Taskforce Draft Recommendations as at 21 November 2025*.
[579] Queensland Health, *Urology Clinical Prioritisation Criteria*, last updated 8 July 2021. Webpage can be accessed here: https://www.health.qld.gov.au/cpc/urology.

comprehensive, and networked model for urology services in Queensland, ensuring better access, efficiency, and quality of care for patients.

1047. The following comments are made to identify the concordance between the Statewide Urology Taskforce and this Investigation. The Investigators have made three recommendations in this Report that are aligned with the work program for the Statewide Urology Taskforce. These recommendations are extracted in the table below.

Recommendation 7(a)	(Statewide) That QH consider further developing the reporting of information collected as part of the Smart Referrals Workflow Solutions to ensure that outpatient services are aware of delays in the triage and categorisation of outpatients referred to the respective HHSs.
Recommendation 8(b)	(Statewide) That the THHS HSCE works with QH and the HSCE from the Cairns and Hinterland HHS to progress workforce and service planning for the delivery of urology services with a focus on Northern Queensland. This may include consideration of: (i) Strengthening the training pipeline, increasing intake, and incentivising regional placements which will be critical to building sustainable capacity. (ii) Consideration of workforce demographics, including gender imbalance and ageing. (iii) Expanding specialist capacity to address regional gaps and reduce reliance on outsourcing. (iv) Consideration of establishing Career Medical Officer roles within urology services.
Recommendation 8(c)	(Priority) That the THHS progress the sourcing of an additional 2.0 Full-Time Equivalent (FTE) urologists (noting that there are currently 3.5 FTE funded and 1.7 FTE vacant positions). The recruitment activity is a priority and must include a Clinical Director for urology services. Recruitment should coordinate and actively engage with the specialist college and society with the active support of QH.

13.3 Matters related to the Closed Loop Radiology program of work

1048. THHS is focused on improving patient safety by addressing gaps in diagnostic workflows, clinical governance, and system integration.[580] The Investigators have been advised that progress mapping of workflows is being undertaken. Challenges remain in operations within THHS, including the continued use of paper based orders, limited categorisation of radiology results, and gaps in tracking diagnostic investigations. Outsourced services also lack system-wide visibility and auditability, while discharge summary processes rely on manual methods that hinder efficiency.

1049. To address these issues, THHS is planning to streamline workflows by eliminating paper based orders, documenting medical imaging processes, and enhancing system integration. THHS

[580] WIT.001.001.0188 THHS, *Closing the Diagnostic Loop to Prevent Missed or Delayed Diagnosis - Gap analysis and Action Plan*, interim draft, 28 November 2025.

plans to strengthen clinical governance through expanded audits, policy reviews, and system enhancements to improve result categorisation and escalation processes. Digital endorsement in the EMR will be supported by training and clinical champions. Contracts with external service providers will be reviewed to ensure digital integration of results, and centralised solutions for external investigations will be explored.

1050. The two recommendations proposed by the Investigators that align with those of the Statewide Closed Loop Radiology process include Recommendation 5 and Recommendation 14(c):

Recommendation 5	(Priority) That the THHS CMO ensure that professional standards are complied with in the delivery of urology services as they relate to the follow up, endorsement and actioning of radiology and pathology investigations undertaken in the public and private sector for patients who are connected to or receive urology services.
Recommendation 14(c)	(Statewide) That QH consider the opportunities to develop a "Never Lost Pathways" for high risk clinical conditions within its digital framework, and particularly those related to cancer care as a system-wide patient safety initiative.

13.4 Findings and Recommendations

1051. As indicated, the recommendations relating to statewide activities were detailed throughout this Report so that they could be contextualised and linked with the issues and concerns identified by the Investigators in the sections where the findings and recommendations are considered.

1052. A list of seven recommendations which relate to statewide opportunities as per the requirements of TOR 3.3 are consolidated below. They include:

Recommendation 2	(Statewide) That QH consider developing a Cluster Adverse CIR Guideline and Toolkit to assist HHSs to respond to clusters. In so doing, QH may need to consider the structure, functioning and resourcing of HHS clinical governance teams.
Recommendation 3	(Statewide) That QH consider strengthening the SOSIS and confirming that compliance with the standard is mandatory for HHSs.
Recommendation 7(a)	(Statewide) That QH consider further developing the reporting of information collected as part of the Smart Referrals Workflow Solutions to ensure that outpatient services are aware of delays in the triage and categorisation of outpatients referred to the respective HHSs.
Recommendation 8(b)	(Statewide) That the THHS HSCE works with QH and the HSCE from the Cairns and Hinterland HHS to progress workforce and service planning for the delivery of urology services with a focus on Northern Queensland. This may include consideration of: (i) Strengthening the training pipeline, increasing intake, and incentivising regional placements which will be critical to building sustainable capacity.

	(ii) Consideration of workforce demographics, including gender imbalance and ageing. (iii) Expanding specialist capacity to address regional gaps and reduce reliance on outsourcing. (iv) Consideration of establishing Career Medical Officer roles within urology services.
Recommendation 9	(Statewide) That QH consider developing an overarching policy guideline for HHSs in relation to the operationalisation and management of MDTs within their services.
Recommendation 14(c)	(Statewide) That QH consider the opportunities to develop a "Never Lost Pathways" for high-risk clinical conditions within its digital framework, and particularly those related to cancer care as a system-wide patient safety initiative.
Recommendation 21	(Statewide) That QH provide formal advice to HHS's and their Boards in relation to the circumstances where HHSs should notify QH and/or the Minister's Office in relation to complex matters that they are considering and/or that may have Statewide significance.