Health service investigation—snapshot report

Investigation focus: Hospital and Health Service compliance with mandatory notification obligations related to health practitioners (October 2024).

Wider learnings and recommendations for service improvements

The investigation highlights opportunities for health services to ensure compliance with mandatory notification requirements by:

a) ensuring they have clear procedures and guidelines in place outlining the decision-making framework, responsibilities and obligations for mandatory notifications related to health practitioners.

b) making procedures and guidelines related to mandatory notification obligations accessible and known to all staff.

c) developing standardised documentation and record-keeping practices for assessing and managing allegations related to health practitioners that may constitute notifiable conduct.

d) ensuring they have a robust accountability framework to manage allegations related to health practitioners effectively, ensuring allegations are handled appropriately and mandatory notifications are made when required, in accordance with the regulatory obligations.

Background

The *Health Practitioner Regulation National Law* (Qld) requires registered health practitioners, employers and health education providers to make mandatory notifications to the Office of the Health Ombudsman about registered health practitioners in certain circumstances. Circumstances that may trigger a mandatory notification include:

- impairment
- intoxication while practising
- significant departure from accepted professional standards
- sexual misconduct.

The Health Ombudsman opened an investigation into the failure of a health service entity to make a mandatory notification to the Office of the Health Ombudsman following a reported allegation of serious misconduct involving a registered health practitioner employed by the health service.

Issues investigated

The investigation was conducted to review the health service's failure to make a mandatory notification related to a health practitioner's conduct, and identify potential issues with systems and processes and oportunities for improvement.

The investigation examined the internal equiry process undertaken by the health service in response to the conduct allegations. This included documentation and record-keeping processes surrounding the reporting of the allegation and subsequent enquiry, the decision to conduct an informal enquiry and the accountability framework for mandatory notifications.

Key findings

The investigation findings revealed significant failures in the internal enquiry process conducted by the health service in response to the allegations. These included, failure to refer the matter to the designated panel for review, insufficient oversight by members of the executive and inadequate documentation and record keeping procedures. These issues were found to have compromised the transparency and accountability of the enquiry, and resulted in the failure to fulfill the organisation's obligation to make a mandatory notification.

At the time the allegations occurred, the health service did not have a procedure or guideline in place outlining the decision-making framework, responsibilities and obligations for mandatory notifications.

During the investigation process, it was noted the health service had made improvements to address the concerns identifed during the investigation process. This included, the implementation of a procedure relevant to mandatory notifications, the inclusion of decision-making processes and documentation requirements related to assessing and managing allegations in relevant business rules, and the strengthening of accountability and governance processes.