



Aboriginal and Torres Strait
Islander Health Practice
Chinese Medicine
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Dental
Medical
Medical Radiation Practice
Nursing and Midwifery
Occupational Therapy
Optometry
Osteopathy
Pharmacy
Physiotherapy
Podiatry
Psychology

Australian Health Practitioner Regulation Agency

Media statement

10 March 2017

Update on the status of investigations - health practitioners associated with Djerriwarrh Health Services (Bacchus Marsh)

In 2015 the Department of Health and Human Services (the Department) in Victoria was alerted to a cluster of potentially avoidable newborn and stillborn deaths at Bacchus Marsh Hospital (Djerriwarrh Health Services). This led the Department to commission Dr Stephen Duckett to [review of hospital safety and quality assurance in Victoria](#).

From August 2015, AHPRA began investigating a number of registered health practitioners who practised at Bacchus Marsh Hospital at the time of this tragedy and other matters that have been notified to us. As a risk-based regulator, our priority has been to make sure that any ongoing risk to the public with individual health practitioners has been addressed so patients are safer in the future.

We have now completed a number of investigations into health practitioners who worked at Bacchus Marsh Hospital at that time. For families who have suffered terrible loss, our focus has been on ensuring each investigation is thorough and fair and that they are properly informed about the outcome of an investigation.

In this statement we provide an update on the number of investigations that have been closed and provide information on the range of outcomes that have resulted. Privacy provisions in the National Law limit what we can say about actions taken about individual practitioners.

While our investigations are independent, we have communicated regularly with Djerriwarrh Health Service about the information we need to undertake thorough investigations. Djerriwarrh has informed us of the improvements that the health service has made in areas such as supervision, training and clinical governance. In some cases, practitioners have completed training mandated by the Djerriwarrh Health Service, and this has been sufficient to address the Boards' concerns about their standards of practice. As a risk-based regulator, our priority has been to make sure that any ongoing risk to the public posed by individual health practitioners has been addressed.

In addition to the investigations into individual health practitioners, we have also worked to improve how we assess and manage notifications as well as how we can contribute to system-wide improvements. This has included working with Victorian health services to increase awareness of mandatory reporting requirements as well as looking at ways we can work with Safer Care Victoria to help detect and respond to concerns about standards and safety. We have also established a regulatory compact with the Department of Health and Human Services which sets out the ways we will share and manage information in the public interest and within the National Law to improve patient safety.

What has been involved in these investigations?

The investigations we have undertaken have been complex. They have involved examining many thousands of pages of clinical records, gathering information to identify the individuals who provided care and establish what happened and what should have happened in each case. We have set up a special team to manage these investigations. We have also sought expert clinical advice to help analyse this information.

Usually, people come to us and tell us about their concerns about specific registered health practitioners. Most of the investigations about Bacchus Marsh Hospital practitioners are different because we have had to start with the medical records and work through them to:

- identify which registered health practitioners were involved in providing care to patients, and

- cross reference the information between each case to look for patterns or identify issues of concern about the standards of care provided by any individual registered practitioner.

How many matters have we considered?

We opened 96 matters involving 40 practitioners (some practitioners have been identified as being involved in multiple cases):

- 13 medical practitioners
- 23 midwives and nurses, and
- 4 others.

A number of these practitioners no longer work at Djerriwarrh Health Service. This includes five practitioners who have surrendered their registration during the period of AHPRA's and other investigations. This number includes some practitioners about whom immediate action has been taken. However, surrender of registration does not necessarily mean that investigations are discontinued, or that regulatory action will not be taken.

Where did these matters originate?

Of the 96 matters:

- 40 were as a result of 'own motion' decisions by the relevant health practitioner Board. Own motion is taken when a Board decides to initiate an investigation of its own accord, and
- 56 were as a result of a notification made to us, the majority of which were made by members of the public (80%). Some of these related to cases where the Board had already initiated an investigation.

How many investigations have closed?

- 23 practitioners have had all matters involving them concluded.
- 17 practitioners still have one or more outstanding matters.

Significant failings in clinical governance have previously been identified as contributing to the tragic events which occurred at Bacchus Marsh hospital. Clinical governance refers to the systems, processes and accountabilities which ensure the quality and safety of care in a health service.

Twelve of our investigations involve practitioners who have either significant non-clinical responsibilities or who had supervisor or clinical leadership roles which carried additional responsibilities for oversight of quality and safety. Some of these investigations have been completed.

What happened as a result of our investigations?

The table below outlines the outcomes for investigations which have now concluded. Note that some practitioners have been identified as being involved in multiple matters.

Outcome	Number	What does this decision mean?
No further action (NFA)	29 matters were concluded with NFA. Of those, 11 involved practitioners who are no longer registered.	No further action means that there is no current risk to the public that the board needs to manage. It is not a reflection of the validity or seriousness of the complaint or concern. An investigation might result in an outcome of no further action because the issue/s that led to the investigation has been addressed and rectified. The Board in making a decision of 'no further action' has been able to take into account additional training, supervision and professional development completed by the health practitioner to address the concerns raised. An outcome of 'no further action' may also be because the 'evidentiary threshold' has not been met.

Outcome	Number	What does this decision mean?
		An outcome of no further action may follow a complex investigation if it is determined that there is no current or potential future risk to the public.
Caution	7 matters involving 6 practitioners	A caution is intended to act as a deterrent so that the practitioner does not repeat the conduct or behaviour. Cautions are not normally published on the public register of practitioners, however, they are advised to any employers.
Condition or undertaking	6 matters involving 6 practitioners (7 matters also resulted in a caution)	Conditions restrict a practitioner's practice in some way. Imposing a condition means the practitioner needs to do something, or is prevented from doing something, in relation to their profession. Conditions that restrict a practitioner's practise of the profession are published on the public register of practitioners . There may also be conditions related to a practitioner's health. The details of health conditions are not usually published on the national register of practitioners.
Immediate action	5 practitioners	Interim restrictions have placed on their practice while investigations continue. All matters are risk assessed for the need for immediate action. This is reviewed as investigations progress and new material is obtained.

Will any matters proceed to tribunal?

If a Board reasonably believes a registered practitioner has behaved in a way that constitutes professional misconduct, the board must refer the matter to the responsible tribunal (in this case VCAT). Where a practitioner is no longer registered (because they have not renewed their registration or have surrendered their registration) the board must make a decision of whether to proceed with a referral to the tribunal. If there is public interest in doing so (because, for example, the board seeks an order that the individual should be prohibited from applying for registration in the future) then the board will continue with the referral.

If a matter is referred to the tribunal, both the existence of the proceedings and the outcome are generally published by the tribunal. A full list of potential outcomes from an investigation is available on the [AHPRA website](#).

For more information

Lodge an [online enquiry form](#)

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