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Investigation into the temporary closure of Alfred Health's adult lung transplant program

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Letter to the Legislative Council and the Legislative Assembly

To

The Honourable the President of the Legislative Council

and

The Honourable the Speaker of the Legislative Assembly

Pursuant to sections 25 and 25AA of the *Ombudsman Act 1973*, I present to Parliament my report of an investigation into the temporary closure of Alfred Health's adult lung transplant program.

G E Brouwer
OMBUDSMAN

9 October 2012

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Executive summary

1. This report resulted from a referral on 29 March 2012 by the Legal and Social Issues References Committee of the Legislative Council (the committee) under section 16 of the *Ombudsman Act 1973* (the Ombudsman Act) in relation to the temporary closure of Alfred Health's adult lung transplant program in September 2011.
2. In February 2011, the committee commenced an inquiry into 'options and mechanisms to increase organ donation in Victoria'.
3. In April 2011, in a written submission to the inquiry, Alfred Health requested 'an increase in the funding provided for transplantation to meet the increase in demand'. On 8 September 2011, at a public hearing of the committee, Alfred Health further highlighted the need for additional resources for the program.
4. On 22 September 2011, Alfred Health's adult lung transplant program was closed, re-opening on 28 September 2011. Alfred Health informed the media that the closure was due to a high workload in the program.
5. The committee called Mr Andrew Way, Chief Executive Officer (CEO) of Alfred Health to a hearing on 2 December 2011 to give evidence about the closure. He explained that the program was closed on a recommendation from his clinical staff that they 'could not actually continue to admit people'.
6. On 7 March 2012[1], Channel 7 News reported on a briefing provided by Mr Way to the Alfred Health board about the closure, dated 5 October 2011, which Channel 7 obtained under the *Freedom of Information Act 1982*.
7. The committee subsequently identified what it considered were inconsistencies in Mr Way's evidence to the committee and his briefing to the Alfred Health board about the reasons for the closure. In particular, the committee was concerned about the role that funding played in the closure.
8. My conclusions in relation to the matters referred to me by the committee are set out below:

Conclusions

The reasons for the closure and the role of funding

9. The committee requested that I investigate:

> The reasons for the cancellations/reductions, given varying explanations presented to the Standing Committee, the Alfred Health Board and the media and in particular the degree to which funding of the transplant unit was responsible.

1 Channel 7 News Victoria, 'Transplant Crisis', 7 March 2012, 6:00pm bulletin, reporter: Louise Milligan.

Reasons for the closure

10. Lung transplants at The Alfred doubled from 2006-07 to 2010-11 as a result of a federal initiative to increase organ and tissue donation; as well as medical advancements, which allowed more people to become organ donors after death.

11. In July 2011, in recognition of the increasing workload in the lung transplant program, Alfred Health gave in principle approval for a funding increase to recruit additional staff for elements of the program. At this time, Alfred Health expected that it would receive an additional $3 million funding from the Department of Health (the department) in its 2011-12 budget. Health service budgets are flexible and funds may be moved between different areas based on demand.

12. The budget provided by the department to Alfred Health in September 2011 did not include the additional $3 million that Alfred Health expected. Further complicating matters was that the budget did not specify that additional funds had been allocated for transplants.

13. As a result, Alfred Health withdrew its intended investment in the adult lung transplant program.

14. On 16 September 2011, after being advised by Mr Way of Alfred Health's decision to reduce its intended investment, Prof. Trevor Williams (Clinical Director responsible for the program) recommended that the adult lung transplant program be closed for two weeks.

15. The subsequent decision to close the program from 22 to 28 September 2011 was made by Mr Way on the advice of Prof. Williams.

16. On Prof. Williams' evidence, his recommendation to close the program and his reasoning for doing so did not change between his first recommending it to Mr Way on 16 September 2011 and the program closing on 22 September 2011.

17. Prof. Williams said the program's staffing numbers and funding were based on a historical figure of 40-45 lung transplants per year and The Alfred was tracking to perform twice as many in 2011-12. Consequently, he did not believe it was safe for his staff to continue to perform increasing numbers of transplants without additional staff.

18. Although funding was a central element to the closure, workload was also a factor. My investigation confirmed that the workload in the program was high at the time of the closure; medical staff felt pressured and expressed doubt whether continuing to perform increasing numbers of transplant operations without more staff was sustainable.

19. However, the evidence of these same physicians working in the program leads me to conclude that the closure was not an immediate necessity.

20. On this basis, Mr Way's statement to the parliamentary committee that the program 'could not actually continue to admit people' is not supported by the evidence of my investigation. Instead it would appear to be a misunderstanding of the reasons why Prof. Williams recommended the closure.

21. It is apparent that there was a lack of effective communication between Mr Way and Prof. Williams. Their evidence to my investigation differed about why the closure occurred and what could have prevented it.

22. The following are examples of these differences:

    - *Cap on activity:* Prof. Williams believed he was being asked by Mr Way to limit lung transplant numbers to 40-45 per year; Mr Way said that he set no specific limit.
    - *Patient safety:* Prof. Williams' primary concern was staff safety; Mr Way believed the concerns to be about patient safety.
    - *Immediacy:* Mr Way thought there was an immediate risk to patient safety; Prof. Williams' concerns were about medium to long-term sustainability of workload.
    - *Funding:* Mr Way believed that additional funding would not have made a difference on the day the program closed; Prof. Williams said extra funding would have prevented the closure.
    - *Recommendation to close:* Prof. Williams stated that his recommendation of 16 September 2011 to close the program (based on a funding shortfall) did not change; Mr Way took the recommendation on 22 September 2011 as relating to a separate issue (workload).
    - *Re-opening:* Prof. Williams said he recommended re-opening the program as he was told further funding to recruit staff would be provided; Mr Way believed that patient levels allowed the re-opening, not funding.

23. It is not clear why Mr Way and Prof. Williams held such differing views about key issues and events surrounding the closure of the transplant program considering their roles in the decision. Had communication between them been more effective, I believe the closure may not have occurred.

24. In response to my draft report, Prof. Williams said:

> Thank you for the opportunity to review your draft report … I have no substantive comments regarding the extracts of the draft report made available to me.

25. Mr Way said:

> I am greatly saddened by the conclusions that have been reached … At the time of the matters arising, and I would acknowledge that it was a stressful time, I and others in the management team took considerable time and effort to ensure that we were dealing with a matter separate from the underlying financial matters. Inevitably the discussions were that [oral], and they remain unrecorded and you have reached your conclusion on the evidence provided …
>
> [T]he health service will start to pull together a protocol or guideline that sets out how matters of concern, such as these should be escalated (it is an area where work is already ongoing, although not specifically relating to this type of escalation which is thankfully very rare) and recorded so that contrary recollections of events will be supported with a written record.

26. In response to my draft report, Ms Helen Shardey, Board Chairman, Alfred Health said:

> Alfred Health notes the commitment made by its Chief Executive to create a protocol or guideline that sets out how matters of concern should be dealt with, in particular how relevant advice is recorded to ensure a clear record of events. The Board of Alfred Health will monitor the development and implementation of such a protocol or guideline.

Alleged inconsistency of Mr Way's evidence

27. In its report, the committee said that the explanations for the closure that Mr Way gave to the committee and his board appeared inconsistent. The report stated:

> In that evidence [to the committee] Mr Way indicated that the decision to close was based entirely on advice from Clinical Staff that transplantations had to cease due to workload pressure. He did not advise the Committee that he had gone to the staff to advise them of the shortage of funding as is done in the briefing note to the Board [dated 5 October 2011].

28. The committee appeared concerned that Mr Way told the committee the closure was workload related, while apparently conceding to his board that funding played a role in the closure. In this regard, Mr Way told his board:

> Once it became clear that the minimal level of investments that we had hoped to provide to the rapidly growing adult lung transplant service were not likely to be possible, it became necessary to have a conversation with the clinical staff. This discussion caused the initial stories in the media on Saturday 17 September [2011].

29. Mr Way went on to tell his board:

> Subsequently and separately, the clinical director for the service advised me that the current clinical workload in the unit had reached something of a cross roads, in that in his view, there was such a high volume of clinical workload for the transplant physicians that he felt the possibility of unnecessary adverse clinical events was becoming too high. As part of that discussion I accepted the need to temporarily reduce the level of transplantation undertaken at The Alfred.

30. In his briefing to the board, Mr Way also acknowledged that funding and workload are arguably 'intrinsically linked'. He said:

> Had the initial investment not had to be reduced the current clinical team may have 'soldiered on' and covered the service. It is impossible to know with certainty.

31. The committee also stated that while Alfred Health had sought additional resources for the transplant program in its evidence in September 2011, Mr Way 'did not reiterate Alfred Health's previous evidence seeking additional resources for organ transplant activity. Rather, Mr Way provided a detailed analysis of how Alfred Health is funded'.

32. The committee said it was 'concerned that Mr Way was not as clear and open in his evidence to the Committee as he was in his explanation to the Alfred Health Board'.

33. Having reviewed Mr Way's evidence to the committee and his briefing to the board, it is arguable that Mr Way may have provided more detail or been more explicit in his briefing to the board than he was in his evidence to the committee. However, I do not consider that Mr Way's evidence was inconsistent:
    - Mr Way told both the committee and his board of the funding issues with the program and that, prior to the closure, Alfred Health made a decision to withdraw investment in the program as it did not receive the anticipated funding from the department.
    - Mr Way spoke to both the committee and his board about the connection between funding and workload. In this regard, he told the committee, 'You could argue that if we had made an investment a year ago and put more staff in, then of course that would not have happened, but the perfect view of hindsight is not easy sometimes to agree at the time'.
    - Mr Way told both the committee and his board that the clinical director's recommendation to temporarily close the program was made 'separately' to discussions about funding for the program and that the reason for the closure was workload. I note that board members interviewed during my investigation believed that the reason for the closure was workload.
34. It is surprising that Mr Way perceived funding discussions and the recommendation of Prof. Williams on 22 September 2011 to close the unit as separate, given that Prof. Williams repeatedly recommended a closure due to funding concerns in the preceding days.
35. However, Mr Way's evidence to both the committee and the board was consistent and appears to have reflected his view of the reasons for the closure at the time.

Impact of the closure on patients in critical need

36. The committee requested that I investigate the impact of the closure on patients in critical need.
37. In investigating this issue, I identified that, during the closure, one set of offered lungs was rejected by The Alfred. The lungs offered were from a 71-year-old individual whose Body Mass Index was in the obese range.
38. The evidence of the physician on duty at the time and clinical advice provided during my investigation indicated that, while the lungs were suitable for one patient on The Alfred's lung transplant waiting list, they would not have been used if the transplant program was operational, largely due to the age of the donor.
39. The organs were not used by any other state as no other transplant program in Australia, at the time, transplanted organs from donors over 65 years of age.

40. While my investigation concluded that the closure did not appear to have had an adverse impact on patients in critical need, it was fortuitous that The Alfred only received (and rejected) one organ offer during the closure, as in previous weeks it had received up to eight offers.

41. I also note that, according to the former CEO of Cystic Fibrosis Victoria, there was some impact on patients:

> This was really playing life and death potentially; was certainly playing with the heads and the emotions of not just the people on the transplant list but a wider range of people around them as well.

Appropriateness of Alfred Health's use of the Department of Health media unit

42. The committee requested that I investigate the appropriateness of Alfred Health's use of the department's media unit to manage media interest in the closure.

43. The committee referred to Mr Way's briefing for the Alfred Health board, dated 5 October 2011, in particular the following passage:

> The DH [Department of Health] necessarily has two important roles, one ensuring that patients are appropriately managed by the health service, and secondly the political direction set by the Minister for Health and Ageing is achieved. The briefings that were given to the Media were developed in collaboration with the DH media offices.

44. At interview, Mr Matt Viney MP, Chair of the committee stated that Mr Way's statement that the department's role was to achieve the political direction set by the Minister was 'worrying'. He said that, in his view, this had never been regarded as a departmental objective and that it was the role of the Minister's staff.

45. My investigation did not identify evidence of any inappropriate use of the department's media unit during the closure.

46. Although there was consultation between the departmental and Alfred Health media units in responding to the media, this was not conducted with the purpose of a particular political objective and was not unusual in the circumstances.

47. Mr Way's characterisation of the department's role as one of achieving 'political direction', as he set out in his oral evidence to my investigation, was in my view a mistake and misuse of the word, rather than being representative of the department's role or what took place.

Recommendation

48. In October 2011, shortly after the closure, the department and Alfred Health agreed to an independent costing review of the transplant program. However, the review is yet to be completed.

49. This is disappointing given ongoing concerns expressed by witnesses during my investigation about the adequacy of funding for the lung transplant program.

I recommend that:

Recommendation 1

The Department of Health and Alfred Health prioritise the completion of the costing review for the lung transplant program.

Response

The department and Alfred Health accept my recommendation.

Background

Referral from Parliament

50. The report of the Legal and Social Issues References Committee (the parliamentary committee), *Inquiry into Organ Donation in Victoria*, was tabled in Parliament on 29 March 2012.

51. The report made 21 recommendations. It also detailed the parliamentary committee's majority determination to take two further courses of action.

52. The first was to refer the following three matters to my office for investigation under section 16 of the Ombudsman Act:

    I) The reasons for the cancellations/reductions [of the lung transplant program], given varying explanations presented to the Standing Committee, the Alfred Health Board and the media and in particular the degree to which funding of the transplant unit was responsible.

    II) The impact of the cancellations/reductions on patients in critical need.

    III) The appropriateness of the use of the Department of Health (the department) media unit given Alfred Health's Chief Executive briefing note to the Board which states as follows:

    > *The DH [the department] necessarily has two important roles, one ensuring that patients are appropriately managed by the health service, and secondly the political direction set by the Minister for Health and Ageing is achieved. The briefings that were given to the Media were developed in collaboration with the DH media offices.*

53. Section 16 of the Ombudsman Act requires me to investigate any matter referred by a House of Parliament or one of its committees and to report to either the President of the Legislative Council or the Speaker of the Legislative Assembly depending on which house referred the matter.

54. The second action was for the parliamentary committee to recall Mr Way to clarify his evidence, to examine 'the perceived inconsistency of his evidence' and to provide a supplementary report to Parliament at the conclusion of that examination. Alfred Health sought to clarify the status of this action.

55. The action to recall Mr Way was challenged by some Members of Parliament, who argued that the parliamentary committee had no power to recall Mr Way beyond the set timelines for its inquiry. A motion to this effect was proposed by The Hon. David Davis, MLC, Victorian Minister for Health and was passed in the Legislative Council on 3 May 2012.

56. The Legislative Council resolution prevented the parliamentary committee from recalling Mr Way to clarify his evidence. However, during my investigation I considered the parliamentary committee's concerns about the perceived inconsistencies in Mr Way's evidence.

Investigation methodology

57. In investigating this matter, my office:
    - interviewed witnesses from Alfred Health, the department and other organisations
    - reviewed Alfred Health documentation including emails; board briefings and minutes; media communications; and transplant and patient data
    - reviewed documentation from the department, including emails; media policies and communications; ministerial briefings; and the Alfred Health Statement of Priorities (including drafts)
    - conducted a site visit of The Alfred hospital, which included visiting wards and the Intensive Care Unit (ICU) and meeting with key staff
    - conducted other research.
58. All witnesses interviewed were offered the opportunity to attend with a support person. They were also provided with written information regarding their obligations and legal rights under the Ombudsman Act.
59. In the course of the investigation, 28 witnesses were interviewed on oath or affirmation. All witnesses attended voluntarily. Six witnesses requested and were permitted to have a legal representative attend as their support person.
60. At the end of my report, I have attached a chronology of key events.

The lung transplantation program at Alfred Health

61. Alfred Health is a public health service established under the *Health Services Act 1988*. Alfred Health comprises three hospitals: The Alfred, Sandringham Hospital and Caulfield Hospital.
62. The lung transplant program has been operating at The Alfred since 1990. It is now one of the largest in the world and it services Victoria, South Australia, Tasmania and New Zealand. The Alfred is also the only paediatric[2] lung transplant centre in Australia.
63. The lung transplant program operates under the auspices of the Department of Allergy, Immunology and Respiratory Medicine (AIRMed). AIRMed is led by a Director and a Clinical Director (Prof. Trevor Williams) and covers a number of different areas, such as asthma and allergic diseases, adult cystic fibrosis, and general respiratory diseases, as well as lung transplantation. Within the AIRMed department, there is both an inpatient ward and an outpatient clinic, where care for all patients of the department, as well as lung transplant patients, takes place.
64. The head of the lung transplant program is Prof. Greg Snell. He is supported by respiratory physicians, surgeons, nurses and allied health staff.

2 Refers to the study and treatment of children's diseases.

65. The surgeons who perform lung transplants work more broadly within the hospital (in the cardiothoracic field) and are on call for transplant operations when organs become available. There are also a large number of other staff (coordinators, anaesthetists, physiotherapists and administrative staff) who provide assistance to the lung transplant program.

National reforms for organ and tissue donation

66. In 2008, the Council of Australian Governments (COAG) endorsed a national reform agenda to implement a world's best practice approach to organ and tissue donation in Australia.

67. The 2008 Federal Budget set aside $151 million over four years to establish the Australian Organ and Tissue Authority (the authority). The authority's role is to facilitate 'a nationally coordinated approach to organ and tissue donation for transplantation'[3] with a central aim of increasing what have been traditionally low levels of donation in Australia.

68. As part of the national reform, all state and territory health Ministers agreed to the establishment of a national network of organ and tissue donation agencies. This network is known as DonateLife.

69. Under the leadership of the authority, DonateLife has medical directors in each state and territory, who are responsible for delivery of the national reform agenda in their respective jurisdictions. They manage the hospital-based staff who are medical specialists in organ and tissue donation and employees who specialise in organ donor coordination, donor family support and data and audit.

70. DonateLife has also been involved in supporting hospitals to increase the number of Donation after Cardiac Death (DCD) donors. Previously, organ donation was generally only possible if a person died as a result of brain injury. Since 2005, medical advancements have led to an ability to use organs (for instance lungs, kidneys and livers) of people who have died as a result of cardiac failure.

71. Between 2000 and 2008 there was an average of 205 organ donors in Australia annually. Since the national reforms and the increasing use of Donation after Cardiac Death (DCD) donors, there has been a 60 per cent increase to 328 organ donors nationally in the 2010-11 financial year.[4]

72. Victoria, in particular, has experienced a significant increase in organ donations. The Victorian Medical Director for DonateLife said:

> Historically we used to have between 45 and 50 people who died and donated organs each year, and last year [2010-11] we had 107 deceased donors in Victoria.

73. Organ donation costs are funded by the Commonwealth, while the costs of organ transplantation fall largely to the various state governments.

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3 DonateLife website: http://www.donatelife.gov.au/the-authority/about-us.

4 DonateLife, *Annual Report 2011*, page 55.

74. The COAG endorsement of the national reform agenda in 2008 was reaffirmed through a commitment at the Australian Health Ministers meeting in February 2012. At this meeting, state Ministers, including The Hon. David Davis, MLC, Victorian Minister for Health:

> [R]eaffirmed their commitment to increasing Australia's organ and tissue rates by proactively promoting organ and tissue donations and committing to effectively manage retrieval, tissue typing and transplant issues pro-actively – so that all transplant opportunities presented by increased donation rates are realised.[5]

75. In 2006-07, The Alfred performed 36 lung transplants. Since this time, lung transplant activity at The Alfred has doubled and in 2010-11, The Alfred performed 70 transplants. In addition to the increasing number of transplants, the pool of transplant survivors is growing annually, and is now at around 400 people.

76. Many staff at The Alfred spoke of the growth in activity, explaining that transplant patients require lifelong treatment following the procedure. This has led to increasing outpatient numbers and activity in the outpatient clinics. Staff further stated that care of lung transplant patients is becoming more complex with an increasing ability to use marginal organs and to perform transplants on marginal patients.[6]

Health funding in Victoria

77. Following a program of public sector restructuring in the early 1990s, Victoria made changes to the way its hospitals are funded. Activity-based funding was introduced in 1993-94, with almost all Australian states and territories following suit to some degree.[7]

78. Activity-based funding essentially funds hospitals based on the activity that they undertake. A hospital budget is determined based on the number and type of patients that the hospital treats.

79. Funding for health services is agreed between the Minister for Health and the relevant health service board before 1 October each year. The Minister and the health service enter into an agreement, entitled a Statement of Priorities (SOP). The SOP outlines the key performance expectations, targets and funding for the coming year for the health service. Funding consists primarily of activity-based funding as well as some fixed grant or block funding.[8]

80. Adult lung transplants at The Alfred are funded by the department through this combination of activity-based funding and grants. Although grant funding can be specifically targeted to programs, such as lung transplants, the program is not funded separately to the overall activity of The Alfred.

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5 Australian Health Ministers' Conference *Communique*, 17 February 2012.

6 Marginal organs are those that once would have been considered unusable, for example, organs from older patients. Likewise, marginal patients are those who would previously have been considered unsuitable for transplantation.

7 S. J. Duckett, *Casemix funding for acute hospital inpatient services in Australia*, Medical Journal of Australia, 1998: 169 (8) pages 17 – 21.

8 Department of Health website: http://www.health.vic.gov.au/casemix/about.htm.

81. Instead, funding for the adult lung transplant program is allocated by the health service through distributing the total amount of activity-based funding provided by the department. At times, the department will specify that particular amounts of funding are to be directed to a specific area, such as emergency or maternity or transplant. However, this is generally only a small proportion of the overall funds allocated and may reflect an amount of funding provided to respond to recent growth in the area, rather than the total cost.

82. The health service allocates funds to the various areas from the pool of activity-based funding received, based on the level of expected activity in each of those areas. The budgets are flexible and funds may be moved between different areas based on demand.

83. In this regard, I note that the parliamentary committee raised concerns that funds had been diverted from the transplant program to other programs. Mr Way advised the committee that no funds were taken from the transplant program in the preceding three years. Nonetheless, health services are permitted under the SOP to transfer funds between different areas.

84. Health services may also make internal investments in different areas from their own resources and savings.

85. In contrast to the state-funded adult lung transplant program, the paediatric program is funded separately by the Commonwealth government.

86. The way that Victorian public hospitals are funded will change with the implementation of national health reforms. This is discussed later in my report.

Reasons for the closure and the role of funding

87. My investigation identified that the recommendation to close the Alfred Health lung transplantation program was made in response to a decision by Alfred Health to reduce its intended investment in the program.

88. Prof. Trevor Williams first recommended the closure on 16 September 2011 as he was concerned about the long-term sustainability of maintaining increasing workloads without additional resources and about restrictions that he believed had been placed on activity. He repeated his advice during the following days and on 22 September 2011 Mr Way closed the program in accordance with Prof. Williams' recommendation.

89. While there were concerns among staff about workload in the program, there was no immediate risk to patients. In fact, the physicians working at the time provided evidence that the workload, while high, was manageable.

90. Mr Way's evidence to the parliamentary committee and his board that the program 'could not actually continue to admit people' was consistent with his understanding of why the closure occurred. However, his understanding was incorrect, largely as a result of what appears to have been poor communication between Mr Way and Prof. Williams.

91. This section of my report details the events leading up to the closure, including key funding negotiations and decisions, to demonstrate how the recommendation to close the program came about.

92. My conclusions are set out in the *Executive summary* of my report.

Funding concerns prior to the closure

93. Concerns about the adequacy of funding for the lung transplantation program were discussed between senior management at Alfred Health and the department from early 2011.

94. Prof. Greg Snell, Medical Head of the lung transplant program at The Alfred said that he and other transplant staff first approached the Alfred Health administration about the increasing transplantation activity in January 2011. In March 2011, Prof. Snell prepared a paper pointing to the need to 'recognise [the] crisis' and identifying a 'significant risk of staff and service breakdown'.

95. The paper highlighted various issues, including the rapid and significant increase in transplant activity, the resulting pressures on existing staff and the need for additional staff. It was noted that while the Federal Government had invested towards increasing organ donation, no corresponding investment had been made to support the growing levels of transplantation.

96. The evidence of other medical staff involved in transplantation at The Alfred supported this view. At interview, Surgeon D said:

> It's predictable, we knew that donation was going to go up, we knew that DCD [Donation after Cardiac Death] was going to grow and it's predictably grown. So why hasn't there been provision made for both staffing and funding? Who throws $150m at donation and doesn't think there's going to be some knock on effect from that? I mean, that's just senseless.

97. At interview, Mr Andrew Stripp, Chief Operating Officer, Alfred Health, said that concerns about a lack of funding for the program were raised 'at all of the [quarterly] performance meetings' with the department in 2011 and that it was a significant issue.

98. On 19 April 2011, Alfred Health provided a written submission to the parliamentary committee, in which it outlined its belief that it needed additional resources to deal with the increase in donation numbers. It stated that until recently, transplantation was limited only by the lack of available donated organs. However, with the number of donated organs 'steadily and significantly increasing' hospitals were finding the major problem to be a lack of resources to enable use of the available organs.

99. Also in April 2011, Prof. Williams, in consultation with other physicians, prepared an internal budget bid to be considered by Alfred Health. It detailed that the program needed additional funding to recruit more staff to deal with the increasing activity.

100. At interview, Ms Mandy Sandford, Clinical Service Director, Alfred Health, said the program initially requested an additional $1.3 million.[9] Around July 2011, Alfred Health gave in principle approval for a funding increase of over $600,000 to recruit additional staff for elements of the transplant program.[10]

101. The Director of Management Accounting, Alfred Health said at interview that the above funding was an internal investment made by Alfred Health. He said:

> [T]he organisation will pick the things [to fund] that are the, sort of, the key issues, the 'must fund' issues irrespective of whether or not anything comes from the Department for it.

102. As requested in the internal budget bid, Alfred Health's internal investment was to fund the recruitment of extra staff for the program, including an additional transplant coordinator, transplant consultant and a transplant nurse. By August 2011, some of the positions had been advertised, but no appointments had been made.

The 2011-12 Statement of Priorities and funding shortfall

103. In August 2011, Alfred Health negotiated with the department to finalise its Statement of Priorities (SOP) for the 2011-12 financial year. At the same time, Alfred Health was preparing its 2011-12 budget for approval by the board.

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9 Approximate figure.

10 Mr Way stated that an additional $150,000 was also allocated to the operating theatres and anaesthesia to support the additional activity.

104. By 7 September 2011, the Alfred Health board had approved its 2011-12 budget on the understanding that some adjustments may be necessary once the SOP was agreed with the Minister for Health.

105. The approved budget included an additional $3 million of funding, which, according to the evidence of Mr Way and Mr Stripp, the department had indicated would be provided. Mr Stripp stated that these additional funds would help 'bridge the gap' between Alfred Health's budget and projected expenditure.

106. On 12 September 2011, the department issued the SOP to Alfred Health without this additional $3 million. According to Alfred Health, there was also no additional specific funding for the lung transplant program. Mr Stripp said:

> It was truly quite a surprise when it [the funding] didn't happen, like a significant surprise, unlike probably what I have experienced … it was a bit out of the box, we were pretty confident it was going to happen.

107. On 13 September 2011, in response to the SOP, Mr Way emailed Ms Frances Diver[11] at the department:

> [W]e have now received the SoP to be signed by the Minister, I thought I should drop you a note to let you know how we are tracking.
>
> As I am sure you will know it has not closed the gap at all. At my last Board meeting, the Directors made it very clear that they would not tolerate a loss in performance or an unbalanced budget. This means that I have very few directions to go.

108. In this email, Mr Way advised Ms Diver that Alfred Health was considering four options to close its funding gap. The first of these options concerned the lung transplant program:

> We are therefore withdrawing the investments we had made in the transplant programmes, and additionally will no longer hire private jets for interstate and international organ recovery.

109. Mr Way advised Ms Diver that this option is 'the most politically sensitive, but financially doable'.

110. One day later, on 14 September 2011, Mr Way provided a paper to the Alfred Health board for consideration at a board meeting scheduled for 19 September 2011. In the paper, Mr Way explained that as the anticipated additional funding of $3 million had not been received from the department, a number of savings initiatives would be implemented.

111. One of these savings related to the lung transplant program. Mr Way noted that Alfred Health had budgeted $1 million (including over $600,000 for new staff) to address the increasing activity and costs in lung transplantation. He proposed that this money be removed from the budget and recognised this would result in 'a decrease in lung transplant activity, particularly out-of-hours work where more than one transplant is required'. Additionally, he stated that no interstate or international organ retrievals would be undertaken.

11 Ms Frances Diver, Hospital and Health Services Performance Executive Director, Department of Health.

112. When asked by my officers at interview why he proposed to reduce the intended investment in the lung transplant program (rather than another program), Mr Way said:

> So we got to a position … where we were saying, 'well how do we balance our budget and manage the various constraints. What's the frame of reference we use to make decisions in that space?' So we went broadly speaking to the Statement of Priorities that said, 'here are the things that are important to the Government, that's where your priorities are' … the converse is if it's not in there it's not a priority.

113. As lung transplantation was not a priority in the SOP, Mr Way considered that this was one of the areas where investment could be reduced.

114. In an email response to Mr Way's paper, on 14 September 2011, a board member raised concerns about the proposed reduction in investment:

> I am concerned with the proposed saving on transplants. To save $1m through a "decrease in lung transplant activity" has the potential to be controversial … I would like to be informed of what alternatives there are for saving $1m. This proposed saving in my view has the potential to generate significantly more public antipathy towards AH [Alfred Health] than, say, an increase in waiting times for elective surgery.

115. Mr Way responded to the board member's email stating:

> [T]ransplantation is one of the few areas where we have the ability to control activity whilst managing to the [department's] required performance regime … cutting other services immediately cuts income. We will probably do between 15 and 20 less transplants in 11/12 than was the case in 10/11, although all the organs will be used, just not in Victoria.

116. At interview, the board member said he was satisfied with Mr Way's response and that the board consequently approved the savings initiatives.

Transplant staff become aware of the funding shortfall

117. On 14 September 2011, as funding decisions and negotiations were continuing, Mr Way sent an email to Prof. Trevor Williams, Clinical Director of the transplant program:

> It is with significant disappointment that I write to let you know about the Alfred Health funding situation and its impact on the Adult Lung Transplant Programme.
>
> After lengthy discussions with the DH [Department of Health] about this year's activity and funding, we have concluded with about $5m less than we had hoped.
>
> This means that the investment we were hoping to make from our own resources into the adult lung transplant programme to maintain activity at 10/11 levels is not possible as we do not have the resources.

118. Physicians at The Alfred gave evidence that they believed Alfred Health's withdrawal of this funding meant that the advertised positions would not be filled and that the program would need to revert to previous transplant activity levels of approximately 40-45 transplants per year. For example, Physician A said at interview:

> Trevor [Prof. Williams] spoke to myself and said that, in the days prior to the closure, that he had received an email suggesting two things if I remember rightly … one; there wasn't going to be funding available for those positions and two; there was a request that we curb activity to historical levels.

119. In response to Mr Way's email, Prof. Williams initiated an informal meeting with three of the program's physicians. They discussed how the program could continue without the additional funding, given what Physician B described as the 'pressure' on the program.

120. Physician B said:

> We discussed what the options were and everyone put their point of view forward … my thoughts were that we should just continue [transplanting] until someone put it in writing from higher up that there was no more money to do more transplants. Trevor [Williams] disagreed with that and he chose to suggest the two week cessation of transplantations.

121. The news of the withdrawal of funding was a concern for the physicians. At interview, witnesses gave evidence of high workloads in the program. Physician A said:

> The unit was operating very busy. We all have the ability to work long shifts and there was a sense that with the budget bid (and it was successful) and with the appointment of new staff there was a light at the end of the tunnel and that we will push on we will continue to do long hours, the overtime, because there is light at the end of the tunnel … The light gets snubbed out – there's going to be burn out occurring here, there's going to be safety issues to staff, this isn't sustainable.

122. Prof. Williams gave evidence of a 'finishing line' – the recruitment of additional staff – and said, 'you can imagine the morale in my team when what we had spent almost a year trying to get was taken away in one email'.

123. At interview, Mr Way also spoke of this sense of disappointment among the physicians:

> I think undoubtedly it [the reduction in intended investment] hit their morale, so where people have been working extended hours, not taking the leave they should have done, they thought frankly, 'Well why the hell should I bother continuing to stretch myself like this when there's no help coming? We'll just take it a bit easier'.

124. Following the informal meeting of the physicians, Prof. Williams emailed Mr Way on 16 September 2011 stating:

> If the board decide on capping the resources as outlined I think the immediate steps should be:
>
> 1. We notify [the Victorian Medical Director of Donate life] Tuesday PM that we will not be taking donor calls for a period of two weeks. At the time (after the initial 2 weeks) we would reassess if lung transplant numbers had dropped to a manageable level.

125. This email from Prof. Williams is the first time he recommends, in writing, closing the transplant program for two weeks.

126. Prof. Williams attached to his email a briefing for the Alfred Health Board to inform its decision about whether to reduce investment in the program. Prof. Williams' briefing highlighted the increase in lung transplant activity in recent years and the implications for the program if further funding is not found.

127. The implications presented were stark. Prof. Williams warned:

- for the first time transplant numbers will be limited by resources, not available donors
- death rates on the waiting list would likely rise to 13 per year[12]
- patients will wait longer for a transplant and the waiting list for transplants will grow.

The department clarifies 2011-12 transplant funding

128. Around 16 September 2011, the media became aware of concerns that transplant activity could be reduced due to funding issues and Alfred Health started to receive media enquiries. Alfred Health drafted a response to the media and consulted the department about its response. Alfred Health's draft response stated:

- The lung transplant program ran ahead of its funding for the last 18 months – with a 50 per cent increase in lung transplant activity since 2009-10.
- The 2011-12 budget provided only a 'small increase in activity funding'.

129. On 16 September 2011, as part of this consultation process, Mr Terry Symonds at the department[13] clarified with Mr Way that the 2011-12 SOP provided additional funding for transplants. At interview, Mr Symonds explained that due to an error made by staff at the department, the budget document failed to identify that additional funding of some $550,000[14] had been set aside for transplant growth.

130. Mr Symonds confirmed this advice to Mr Stripp in an email on the same day, stating that Alfred Health had been allocated $550,000 for transplant growth. Mr Symonds said:

> Needless to say, the department should have made explicit in our funding allocation [the] amounts that were tied to specific initiatives.

131. In this email, Mr Symonds also clarified that the 2011-12 SOP included a block grant of $300,000 for organ retrieval. The Director of Management Accounting, Alfred Health said:

> This was very clearly tagged, two words, 'Organ retrieval' $300,000 flat. And we didn't at all assume that that was to do with transplant. And to be honest, we weren't advised by the Department that that was transplant-related until this [transplant funding] was an issue.

12 From an average of two deaths per year, based on a waiting list of 40 patients.

13 Terry Symonds, Acting Director, Performance, Acute Programs and Rural Health.

14 Approximate figure.

132. After Mr Symonds' email, also on 16 September 2011, Mr Way advised the Alfred Health board that the department had clarified there was additional funding for transplant growth in the 2011-12 SOP and noted that the board paper provided on 14 September 2011 would need revision. The board subsequently approved the budget changes on 20 September 2011, acknowledging that the department had provided some growth funding to be directed towards transplantation, and therefore over $600,000 would be put towards the program.

The department offers additional $500,000

133. On 19 September 2011, one day prior to the above board meeting and two days after adverse media attention[15] for the program, Ms Frances Diver of the department offered Alfred Health an additional $500,000 funding for the transplant program.

134. According to the Director of Management Accounting, Alfred Health, the additional funding was 'the department's way of sort of trying to help the situation, I guess, but [the department] had asked for it not to be communicated too widely'.

135. Mr Stripp stated that a request from the department that additional funding not be publicised sounded 'familiar'. He said that he believed the department would be uncomfortable with the precedent set by a situation whereby adverse publicity about the program is followed by the allocation of additional funding by the department.

136. As noted earlier, Alfred Health was unaware that the $550,000[16] provided in the 2011-12 SOP was for the transplant program until this was clarified by the department. As such, Alfred Health had already allocated this funding to other areas of the health service. Mr Stripp said the $500,000 additional funding therefore effectively replaced the $550,000.[17]

137. At interview, Mr Symonds said the additional funding was offered 'without all the homework' being done to determine if the program was adequately funded, in order to resolve the dispute about funding and ensure the SOP was signed by the Minister for Health and the Alfred Health board.

138. In its response to my draft report, Dr Pradeep Philip, Secretary of the department, stated:

> The Department had formed a view by the end of 2010 that additional grant funds in the order of $550,000 could be justified by Alfred Health's increasing activity in the heart/lung transplant program … provision to this effect was made to Alfred Health's 2011-12 budget. It is unfortunate that a technical error in the presentation of that budget to Alfred Health failed to highlight that additional provision of $550,000 had been made for the lung transplant program. As a result, the amount was inadvertently allocated within Alfred Health's budget rather than being targeted to the lung transplant program. Following the identification of the Department's error, the Department took action to

15 K Hagan, 'Lung transplant cut back plan "beggars belief"', *The Age*, 17 September 2011, page 3.

16 Approximate figure.

17 Approximate figure.

> provide an additional once off grant of $500,000. Understandably, there was uncertainty about the sustainability of the increasing demands being experienced by the program during this time.

139. In response to my draft report, Ms Diver also said:

> The allocation of such funding is common practice given the nature of the health system and the funding is included in the SOP which is published annually on the Department of Health website.

140. The board was not made aware of the additional $500,000 grant at the 20 September 2011 meeting as it had yet to be agreed to between the department and Alfred Health's administration.

Meeting between transplant staff and Mr Way

141. As the funding negotiations continued between Alfred Health and the department, Mr Way agreed to meet with transplant program staff on 20 September 2011 to discuss the funding shortfall. Mr Way said:

> I went and explained, "we understand this is where you are, this is where we've got to, this is what we were thinking about in terms of an uplift [of funding]. It looks like we are not going to achieve that level of funding. We will undoubtedly get some but we are not sure how much it will be, but it won't be what everybody is looking for".

142. At the time of this meeting, it appeared that the program would have approximately $250,000 in funding for the recruitment of extra staff, less than half the amount originally anticipated.

143. My investigation identified that there was confusion about what was said at this meeting and what Mr Way's advice meant for the transplant program. Mr Way said that he did not set any restrictions on transplant activity for the year or advise the team that it would have to revert to historical activity levels. Instead, he considered the meeting was part of ongoing discussions about how the program could manage its budget.

144. However, clinical staff interviewed by my office gave evidence that they were asked to curb transplant activity at this meeting. Physician B said:

> He [Andrew Way] suggested that we curtail our transplant activity [to around 45 transplants]. He didn't give any specifics about how we should do that, in fact he was asked how we should do that and he said "that's up to you". They [the administration] wouldn't make any suggestions.

145. At interview, Mr Way said:

> That was the dilemma in all of this. No matter what we said we couldn't get them [the physicians] off that position [that activity was to be restricted to historical levels] …
>
> There was this eagerness to drop back to a very concrete position that I felt was unhelpful. We were trying to find a way of having a dialogue past that.

146. Following this meeting, in emails to Mr Way on 20 and 21 September 2011, Prof. Williams repeated his recommendation of a program closure. On 20 September 2011 he stated:

> It will take a little while to digest the best way ultimately to go forward. However at present there is no new resource for the short term (although some potentially on offer) and we have a substantial patient load that we struggle to provide an acceptable level of care for …
>
> My recommendation is:
>
> 1. We go off the donor roster for 2 week[s] and then review. It will allow us to clear the patient backlog in an orderly fashion. In 2 weeks we will reassess.

147. It is apparent that Prof. Williams had workload concerns at this time; however, the withdrawal of funding from the program remained his central concern. For example, his email to Mr Way on 21 September 2011 stated:

> My team have pulled out all stops to make the increased transplant a reality. I am concerned that without support, fatigue and it's [sic] consequences will set in. [I]t seems to me that as we are now well over our financial year target a brief period of reduced activity is appropriate[.]
>
> No crisis as such exists[.]
>
> The problem is the longer we delay things the more difficult it get[s.]

148. At interview, Prof. Williams clarified this last statement explaining that, by September 2011, the program had performed 20 lung transplants for the financial year. He said he understood Mr Way's advice to mean that the program could only perform another 20 lung transplants in the remaining nine months of 2011-12, as that was the activity level for which the program was funded. Prof. Williams said that represented 'a serious problem to us because people are on a waiting list expecting to be transplanted'.

149. Prof. Williams' email to Mr Way on 21 September 2011 further stated:

> Presently the team is fully on for transplant and will no[t] change this until other instruction[s] are forthcoming[.] [O]ur preferred option is to use all suitable donors that are made available to us but I accept this is not the present reality[.]

The program closure

Evidence of Prof. Williams and Mr Way

150. The lung transplant program was closed from 22 September 2011. This is confirmed in an email from Mr Way to Mr Williams, which stated:

> Thanks for your advice in regards to the current clinical workload in the department … patients' safety must remain our top priority.
>
> I would confirm our recent conversations and agree that we should:
>
> Seek to reduce adult lung transplant activity over the next two weeks, say from now until Monday 10th October 09:00.

151. There does not appear to have been a formal written advice released to notify staff at The Alfred of the closure. Prof. Williams orally advised the physicians on duty, Physicians A and B, of the closure. Mr Way notified the department and the Victorian Medical Director for DonateLife as DonateLife is the organisation responsible for coordinating and allocating donated organs.

152. At interview, Mr Way was asked why he agreed to close the adult lung transplant program. He said he was advised by Prof. Williams:

> [that] admitting further patients onto our transplant program at this time, will cause those patients that we have today to come to harm in all likelihood.

153. In response to my draft report, Mr Way clarified that Prof. Williams' advice to him 'related only to the transplant physicians' and not to other staff at The Alfred.

154. Prof. Williams' evidence to my investigation differed from Mr Way's with regard to the risk to patient safety. He said:

> The main safety issue I was concerned about was my staff safety … I had spoken to my staff many times and was concerned about the effects of the increased work being placed on them. Again if you had asked them directly they would have said, "I can deal with this", but in the circumstances, although an admirable response, it was not sustainable long term.
>
> It was not as if, if another patient came in, they would not be treated to the best of our abilities. But if it was another patient and another patient and another patient, then it may well have reached the situation where there was obvious and serious effects to patients and also completely overstretching the team that was still there.

155. Mr Way's evidence to the parliamentary committee was that the approach from his 'Clinical Director' (Prof. Williams) about the need to close the program due to workload issues was separate to discussions about a shortfall in funding for the program. He told the parliamentary committee:

> The complicating factor in this was that at about the same time – and I am sure not entirely independently, but it was separately – the clinical staff advised me that the workload in the department had reached a level where they could not actually continue to admit people.[18]

156. At interview, Mr Way said he did not consider that there was a link between the funding discussions and Prof. Williams' recommendation to close the program. As to what role funding played on the day the closure occurred, Mr Way said:

> If you had given me an unlimited amount of cash on that day, my understanding from the conversations we had about why we would close the unit [program] was that it wouldn't have made any difference …
>
> Short of ringing up Sydney and saying "would you close your transplant program and could we have your people?" I'm not sure what else we could have done, money undoubtedly was an underlying problem, or an underlying issue, but not one on that day that made the difference.

18 Victorian Parliament website: http://www.parliament.vic.gov.au/images/stories/committees/SCLSI/Alfred_Health_Corrected_021211.pdf.

157. However, in his briefing to the board, dated 5 October 2011, Mr Way stated:

> Arguably the two are intrinsically linked; an earlier investment may have reduced the necessity to reduce the program. Had the initial investment not had to be reduced the current clinical team may have 'soldiered on' and covered the service. It is impossible to know with certainty.

158. At interview, Prof. Williams gave evidence that he did not see the closure as separate from the funding discussions. He stated that his recommendation of a program closure (first made on 16 September 2011) was in response to the withdrawal of Alfred Health's intended investment and what he saw as instructions from Mr Way to reduce activity:

> As we were told that we have to cut it [activity] back then it was very clear that we needed to act at that point of time.
>
> My recommendation was based on the fact that to continue as we were going was not sustainable and would have led to adverse effects both for staff and for patients, which was the principal concern, but to suggest that this was independent of the other things [funding] that were going is not the conversation that I had [with Mr Way].

159. Prof. Williams said that his recommendation stood on 22 September 2011 – the day of the closure. He said:

> Having checked out what was happening, how many people we had in ICU, how many people we had in the ward, it still seemed that things had not changed substantially and my recommendation [of 16 September 2011] would stand.

160. Prof. Williams was asked at interview if he would have recommended the program closure if funding had not been withdrawn. He said:

> Probably not … basically because one of the things that would have sustained my team and their mental health was knowing that there was a clear path that was going to alleviate the burden that they found themselves placed under.

161. Mr Way's email confirming the closure states that it was not to have an effect on the paediatric lung transplant program or the heart transplant program. I note that the paediatric program was not closed, despite the same physicians and surgeons being involved in both the adult and paediatric lung programs.

162. The Alfred staff interviewed stated that The Alfred would not reject an opportunity to perform a paediatric transplant due to the limited number of suitable organs and the more critical condition of children waiting for lungs.

163. The fact that the paediatric program is federally funded also appears to have been a key factor in this program not being closed. Physician A said:

> My interpretation was that the paediatric lung transplant [program] has a separate funding avenue and there seemed to be a state issue with regards to funding of the adult program, there was sufficient federal funding for the paediatric program.

164. Prof. Williams said:

> We were absolutely, you know, being well resourced, well funded [for paediatric transplants], and we felt that it would be very unreasonable to not go ahead with that … it actually has a different tempo than adult lung transplantation in that they get desperately sick very quickly and none of them [are done for] quality of life reasons; they are all, you know, desperately sick, and we're trying to do it as a lifesaving procedure.

165. The closure of the program occurred while Prof. Williams was on leave. This leave was pre-approved for this period and was not as a result of the closure. At interview, Prof. Williams was asked about the decision to close the program at this time:

> What I needed to do was think, which was unfortunately going to occur on a beach in Queensland. Think about how they might deal with this [the request to reduce activity] and then sit down with the team to determine how they would prioritise people on the waiting list …
>
> To me it was essential that we slow things down. It made good sense that if I was on holiday, [the head of the program] was on holiday, the surgeons were going on holiday then we may as well slow it down then [rather] than to wait to some time later when everyone was back and then not be allowed to do transplants because of resourcing constraints.

Evidence of medical staff

166. The evidence provided by medical staff who work in the transplant program confirms that the workload was high leading up to the closure.

167. However, the evidence of the two physicians working in the transplant program leading up to and during the closure, Physicians A and B, was that the workload was sustainable. Physician B said:

> We needed more junior staff … otherwise I was very happy with the staffing levels. It was mostly the outpatients that we were struggling [with], rather than the inpatient load, and that was really where we needed the new position to start. But again, we were managing. Seeing many more patients than was ideal but managing with the expectation that the following year that that would improve [with additional staff].

168. At interview, when asked if the closure was a result of workload issues, Physician A said:

> [If that] means that we had to close the unit because we were way out here in extreme busyness with clinical activity on that given day, that's not true …
>
> Were [Physician B] and I alarmed that all of a sudden we had been left behind to an absolute storm of activity? Not at all. It just didn't cross our mind … we'd been there countless times; we've never felt that there was a threat to safety.

169. Many of the medical staff interviewed for my investigation also suggested there was particular pressure on the Intensive Care Unit (ICU), which had five transplant patients when the closure occurred. Data provided to my office confirms this number, but also shows that patient numbers did not drop below five until 6 October 2011, over a week after the transplant program had re-opened.

170. The Director of the ICU said at interview that he did not advise anyone at the hospital that the ICU could not cope with the number of transplant patients:

> I wasn't consulted and nor would I necessarily have been because my end just copes with ebbs and flows.

171. Likewise, the Nurse Manager for Ward 5 East, where transplant patients are cared for, advised that she was not consulted before the closure or asked if the nursing staff could handle the transplant workload. Data provided to my office shows that the number of transplant patients in the ward was not higher than in the months before or after the closure. When interviewed the Nurse Manager said:

> It's always busy, our beds are never empty, they're always full. As soon as one person is discharged there is another coming through the door.

172. One of the other main groups involved in lung transplantation are the surgeons, who perform the transplant operation. The Acting Director of Cardiothoracic Surgery said:

> I think the surgical unit was coping quite well with the workload. I don't recall there being any immense difficulty amongst the surgeons coping with it.

Minister's media release

173. The closure attracted media attention, particularly in *The Age* and *Herald Sun* newspapers. Many of the articles stated that the closure was the result of cutbacks to funding. In response, the Minister for Health issued a media release on 24 September 2011 stating:

> Alfred Health has advised that short-term changes to the Lung Transplant Program are not related to State Government funding but rather to workforce capacity issues at Alfred Health. Alfred Health has confirmed to the government that they are working on bringing more staff on board to meet rising demand.

174. Departmental media unit officers interviewed during my investigation gave evidence that this statement was prepared by the Minister's office, not the department. However, the statement appears to have been based on advice that the department provided to the Minister in the form of Proposed Parliamentary Question briefings.

175. In these briefings, the department advised the Minister that the reason for the closure was 'clinical workforce capacity issues'. The department's briefing appears to have been based on Mr Way's advice to Mr Symonds that the unit was at 'maximum capacity for the team to manage safely'. The briefings were signed-off by Mr Symonds and Ms Diver.

The re-opening

176. According to an email from Mr Way to Prof. Williams, the unit was to be closed from 22 September to 10 October 2011. However, the unit re-opened on 28 September 2011. Conversations between Mr Way and Prof. Williams continued throughout the closure.

177. In an email from Mr Stripp to Prof. Williams on 28 September 2011, Mr Stripp stated:

> Following our discussion this afternoon it is my understanding that you believe the clinical load within the hospital has lightened such that we can progressively reopen the adult lung transplantation program.

178. At interview, Prof. Williams was asked why the program was able to re-open on this earlier date. He stated that Mr Way advised him that additional funding ($500,000) was to be provided to allow for the recruitment of new staff:

> I had had a number of telephone conversations with both Andrew Way and Andrew Stripp during the week … and towards the end of the week there appeared to be some sort of breakthrough and Andrew Way said to me, 'Look, it does appear that the department are going to help us find more resources to this. We are going to be able to recruit more people. When do you think we can reopen?'

179. In this regard, Mr Way said:

> [T]hey [the physicians] advised me that they could take more patients again and that the workload had reduced …
>
> So we knew that the department were engaged with us, in trying to find more resources … I don't think I'd have said in the same breath, "here's money coming, when are you going to re-open?" I was asking for regular updates on how the unit was going and when it was going to re-open … Certainly if it's come across as, "I'm about to give you some money, will you re-open?" then I'd be very disappointed because that was certainly never the conversation I'd expected to have had.

180. Prof. Williams was on leave interstate at the time. At interview, he said he checked with his team to ascertain how many critically ill transplant patients there were. However, the decision to re-open was not made in consultation with, or on the advice of, the physicians working in the unit at the time, Physicians A and B. Physician B said:

> I received a call from Trevor [on 28 September 2011] to say that the positions had been re-instated and that we were free to do transplants again.

181. While the program was now able to recruit additional staff, there were no additional staff on the day of re-opening. One nurse started in the unit in September 2011; however, the remaining staff commenced from October 2011 to April 2012.

182. Similarly, while one of the surgeons returned from leave the day after the re-opening, this does not appear to have influenced the decision to re-open as the surgical team, as stated by its Acting Director, was able to cope with its workload. I also note that three physicians, including Prof. Williams, did not return from leave until a few days after the re-opening.

183. As outlined earlier, the number of transplant patients in the ICU had not significantly changed during this time. Likewise, the number of patients in the ward was not markedly different from 22 to 28 September 2011. Staff interviewed from both the ICU and the ward stated that they were not consulted before it was announced the transplant program would re-open.

184. At interview, when asked about the re-opening, Prof. Williams stated:

> It's a fair statement to say that with the availability of extra funding from the department and the clear statement from the hospital that they would rapidly expedite getting those extra bodies on board, that my concern about the patients safely exiting the ward were alleviated and that my team could see that progress was being made to deal with a very difficult situation that they had faced and the situation in terms of the patients had settled down because there had been no new transplants.

185. The view that the closure would not have occurred if funding had not been withdrawn is held by other witnesses interviewed for my investigation. For example, Mr Stripp said:

> If what we had expected had have happened and transpired [the department had provided an additional $3 million], that would have been sufficient to tide us over while we continued to have the debate with the department around our concerns around the grant for the program. I think it's entirely associated with what I've said which is the absence of the money and the withdrawal.

186. Other witnesses also stated that funding was the central cause of the closure. Physician B said:

> From my point of view, it was clearly funding related … If our funding hadn't been withdrawn, the closure would never have occurred.

Reaction to the closure

187. Many of the Alfred Health staff spoken to during my investigation were disappointed that the closure had occurred. An Intensive Care Specialist at Alfred Health, whose position is part funded by DonateLife, said at interview:

> Yeah I was pretty angry. I thought that it was inappropriate. From a personal level I thought that it was inappropriate.

188. Mr Way said:

> In my mind the fact that we ended up having to close the unit, for however many days, it was eight days or so, is an extremely sad time for the department.

189. The Victorian Medical Director for DonateLife was one of the first people notified of the closure. When interviewed she described what she felt the closure meant for DonateLife's role in trying to increase organ donation:

> [The closure] completely worked against all that we're trying to achieve. I mean here we are trying to promote donation, and encourage more Victorians and Australians to donate and benefit people who need transplants, and all of a sudden with the success we've been having, the service downstream was being suspended. I mean it's a disaster really.

190. One of the groups opposed to the closure was Cystic Fibrosis Victoria (CFV), an organisation representing the interests of people with cystic fibrosis, many of whom require lung transplantation. CFV's CEO at the time of the closure, said at interview:

> When I did start thinking about what reason could justify this action, I couldn't think of one to be honest. That it was to do with financing and funding was something that I felt was probably the case, which I felt very unhappy and very uncomfortable with … this is not a place where you actually say to somebody you know, 'hey don't worry for the next three weeks, you know, you can get the next round'.

Current issues

Ongoing funding concerns and costing review

191. Alfred Health staff interviewed during my investigation, including Mr Way and Mr Stripp, gave evidence that the transplant program at The Alfred continues to be under-funded.

192. However, departmental staff interviewed said that Alfred Health's funding for transplants and all its operations have been increased. This appears based, in part, on the increase in state funding for transplants of $2.7 million for 2011-12 across Victoria, of which Alfred Health received approximately $850,000. It should be noted that the funding increase covered all organ transplants, not only lungs.

193. One of the issues is that there is no agreed or set cost for a lung transplant.

194. Mr Way said at interview:

> Part of the underpinning resource issue is unwillingness on the system's part to have a review of what their costs look like because it will need a big investment and someone's going to have to find that.

195. Several concerns were raised by Alfred Health senior management and medical staff regarding specific aspects of lung transplant costs and how transplantation is funded:

    - Funding does not cover the cost of treating a transplant patient prior to the transplant operation. At interview, Prof. Williams provided an example of a patient who was hospitalised for 70 days prior to the transplant operation, on medication costing $1,500-2,000 per day.
    - Funding does not adequately cover the cost of treating patients after the transplant operation. A transplant patient requires lifelong treatment and at present there are approximately 400 transplant survivors who receive treatment at The Alfred.
    - Alfred Health must bear the costs of interstate organ retrieval, even where the retrieval is unsuccessful.
    - Funding for lung transplants is capped, with a combination of activity-based and grant funding set in each yearly budget. Transplant activity above the capped level is largely unfunded. This means that if costs for transplantation activity exceed that provided for in the budget (for example, when activity is greater than anticipated) the health service will need to meet these costs. This is different to the uncapped paediatric lung program, in which costs are met by the federal government based on the actual number of transplants that have occurred in any year.

196. Senior Alfred Health staff expressed a preference for an uncapped funding arrangement. This would replicate the federally funded paediatric lung transplant program and other state funded programs, such as burns treatment. Mr Stripp said:

> Our argument is that transplantation should be uncapped. We believe that we can't control, you know in a normal operating environment, we're not going to control what we do and what we don't do … Let's just uncap it. It's a tiny risk [in terms of costs].

197. In October 2011, shortly after the closure, the department and Alfred Health agreed to an independent costing review of the transplant program. Alfred Health had first approached the department about such a review in February 2011.

198. The aim of the review is to 'undertake a costing and revenue study of the delivery of the heart/lung transplant service at Alfred Health using the past 3 years costing/revenue data'. The review will take into account the following phases in the transplantation process: pre-transplant; organ retrieval; transplant episode; and post-transplant.

199. While agreed to in October 2011, the costing review was not completed at the time of my finalising this report. Witnesses stated that the review was delayed partly by ongoing negotiations between Alfred Health and the department regarding the scope of the review. Prof. Williams said the scoping document had been through 'about 10 iterations'.

200. Mr Symonds stated the delay was further caused by issues with the reliability of Alfred Health's costing data.

201. As a result of this delay, the review was not completed in time for the 2012-13 SOP and budgeting process. Mr Symonds said:

> It's frustrating, as you would expect. Clearly from everything we have talked about this afternoon [at interview], we would have hoped that a one off problem [the closure] from last year was resolved with a review in time for this year's budget and that hasn't happened.

202. In relation to the delay, Mr Way said:

> We're still waiting for the review that was agreed to over a year ago to start … it has taken far too long.

203. Given ongoing concerns about the adequacy of funding for the lung transplant program, it is disappointing that the costing review agreed by the department and Alfred Health in October 2011 is still not finalised. I consider the review should be prioritised.

National health reform

204. Future funding decisions may be affected by the National Health Reform Agreement signed by the Victorian Premier on 2 August 2011. The agreement introduces a new approach to financing, where the Commonwealth will provide funding on an activity basis, with block funding provided where appropriate. Funding for Victorian hospitals will, however, remain under state legislative and financial control.

205. At interview, the Director of Management Accounting, Alfred Health expressed concerns about the likely impact of the reforms on the lung transplant program. In particular, he noted the Commonwealth's preference for activity-based funding. He said this will provide a challenge for 'high-cost, low activity' services, like lung transplants, and questioned how the program will be able to maintain staff and education structures if activity (and therefore funding) is low in a year. In the current funding model, Alfred Health relies on lump sum and non-specified grants to maintain the program.

Discussions about curbing activity after the closure

206. Alfred Health's concerns that lung transplants continue to be insufficiently funded appear to have led to discussions about curbing transplant activity at The Alfred.

207. Physicians from The Alfred described a meeting with Mr Way and Mr Stripp in late 2011 where they were asked about options to reduce the number of transplantations performed.

208. Physician C said:

> [A]t the end of 2011 we were expressly told … "You know, you need to do less transplants.There's - you know, we need to find a way that, you know, you're doing less."

209. Physician B and C gave evidence that Mr Way and Mr Stripp asked whether they could consider not transplanting older people or people with smoking related diseases, for example.

210. Physician B stated that the physicians unanimously rejected the suggestion that they curtail transplant numbers.

211. At interview, Mr Stripp stated that he did not ask the unit staff to curb activity and that he would never give a direction or take a position on a clinical matter. However, he said he has raised questions around the type of patients they were transplanting on the basis of information he received from ICU and the surgeons about their transplanting of marginal organs.

212. In response to my draft report, Mr Stripp said, 'I have no comment to make on the sections of the draft report that reference me'.

213. At interview, Mr Way also stated that there had been no instruction from the administration to the unit to curtail transplant activity.

214. In his response to my draft report, Mr Way further said:

> I have no recollection of a meeting with [Physicians B and C] at the end of 2011. I have checked my diary and notes, and can find no record of any such meeting or having been invited to such a meeting … I am aware that in discussions about the rise in lung transplant numbers, questions had been posed about the possible increase in 'high risk' donations and recipients. I would have expected the unit to consider these issues as a matter of good clinical governance.

215. The number of transplants since the closure has dropped to levels similar to those of 2009-10. The physicians interviewed could not point to any specific examples of deliberate attempts to restrict activity. Their evidence was that donation numbers had in fact dropped. An Intensive Care Specialist at Alfred Health said:

> The numbers have gone down recently but they've gone down recently because our donor numbers have gone down … I don't think I'm aware of there being less organs actually accepted for lung transplantation.

Recommendation

I recommend that:

Recommendation 1

The Department of Health and Alfred Health prioritise the completion of the costing review for the lung transplant program.

Response

In response to my draft report, Dr Philip, Secretary of the department stated:

> I note your draft recommendation that the Department and Alfred Health prioritise the completion of the costing review for the lung transplant program. I can confirm that the Department recently reached agreement with Alfred Health as to the scope and costing data to be reviewed, and has in the past month released a Request for Quote for the review of lung and heart lung transplant costs at Alfred Health. A contract … has been awarded for this work which is expected to be completed in November 2012.

In response to my draft report, Ms Shardey, Board Chairman, Alfred Health said:

> Alfred Health acknowledges the considerable work undertaken by the Victorian Ombudsman in investigating the referral made under section 16 of the *Ombudsman Act 1973* …
>
> Alfred Health supports the recommendation …
>
> Alfred Health acknowledges the full and frank contributions made by its staff to the investigation. Whilst support was provided to staff who requested it through the Victorian Government Solicitor's Office, Alfred Health recognises the additional stress that such investigations cause staff and wishes to commend them for their participation and contribution.
>
> Alfred Health is aware of the concerns felt by patients and their families at the time of the temporary reductions in transplant service and is conscious of the attempts made to keep them directly informed of events as the situation progressed and changed through letters and e-mails.
>
> The funding model of transplant services in Victoria is complex. Health services are funded through a range of Commonwealth and State inpatient and outpatient activity based funds, State special purpose grants, teaching grants, research grants and donations. Inevitably this means that ascertaining whether a single service, such

as lung transplantation, is appropriately funded within a portfolio of other general and specialist services is very difficult. Whilst lung transplantation is not unique within the range of specialist services offered at Alfred Health, the lifelong nature of the care of patients post-transplant does need to be given special consideration in the funding model of this service. Whilst many of those staff interviewed presented concerns that the service is underfunded, Alfred Health welcomes the review initiated in 2011 and looks forward to the work on that review commencing.

Impact of the closure on patients in critical need

216. The parliamentary committee requested that I investigate the impact of the closure on patients in critical need.

217. In investigating this issue, I identified that, during the closure, one set of lungs was rejected by The Alfred. This occurred on 27 September 2011, the day before the program re-opened. The lungs offered were from a 71-year-old individual whose Body Mass Index (BMI) was in the obese range.

218. Documentation completed at the time of the organ offer stated:

> In view of restrictions put on us by admin he [Physician A, the physician on duty] refused the offer but indicated the lungs were good.

219. Physician A also notified Mr Stripp of the organ rejection by email on 28 September 2011, stating:

> One DCD [Donation after Cardiac Death] donor lung offer from Royal Melbourne declined last night, as per current instructions.

220. At the time of this rejection, there were approximately 40 patients on the adult lung transplant waiting list. At the time of finalising my report, two of those patients have since died.

221. While a detailed assessment of the donor lungs was not undertaken at the time by The Alfred's physicians, Physician A said that he considered the patients on the adult and paediatric waiting lists and found that he 'didn't have anyone critically unwell'. Physician A said, 'I'd made a mental note to myself that if there was someone in danger of dying I would have talked to Trevor [Williams] and Andrew Way … but that scenario didn't exist'.

222. He also noted that The Alfred's 'eligibility criteria for donors at that point was up to the age of 65'. Physician A was referring to the Transplantation Society of Australia and New Zealand's *Consensus statement on eligibility criteria and allocation protocols*, which (at the time) recommended that organs up to the age of 65 be considered for transplantation.

223. Despite these criteria, The Alfred had requested that DonateLife notify it of any donors up to the age of 75. Prof. Williams stated:

> under extraordinary circumstances we may have been prepared to accept [donors from 65-75 years of age], particularly if we were able to clearly ascertain that they were otherwise perfect donors and we had a recipient that we deemed had only days or weeks to survive.

224. I requested that Alfred Health review the available material to determine whether the lungs were suitable for any patients on the waiting list at the time, and whether The Alfred would have transplanted the lungs if the program was not closed.

225. Prof. Williams reviewed the matter and advised that although marginal donors are considered in some circumstances by The Alfred (including organs over 65 years of age), The Alfred had not accepted a DCD organ over the 65 years of age threshold at the time of the offer on 28 September 2011.

226. Prof. Williams said:

> The decision was made by [Physician A] based on the age been [*sic*] six years above the criteria at the time, the fact that the donor was obese which would have greatly increased the technical difficulties of doing the donor operation and finally that it was a donation after cardiac death donor which would likely limit our ability to fully evaluate the donor organ.

227. Prof. Williams stated that while the organs were suitable for one patient on the waiting list:

> Even in the circumstances that we were fully operational I do not believe that it was justifiable to use a 71 year old DCD donor which was 6 years above the stated maximum age for donors at the time.

228. This view was supported by the other physician working in the program at the time, Physician B, who said:

> It was a donor that would have been at the extreme of our acceptance criteria under any circumstances.

229. The organs offered to The Alfred were not used by any other state as no other transplant program in Australia at the time transplanted organs over 65 years of age.

230. My conclusions in relation to this issue are set out in the *Executive summary* of my report.

Appropriateness of Alfred Health's use of the Department of Health media unit

231. The parliamentary committee requested that I investigate the appropriateness of Alfred Health's use of the department's media unit to manage media interest in the closure.

232. The parliamentary committee referred to a briefing prepared by Mr Way for the Alfred Health board on 5 October 2011, in particular the following passage:

> The DH [Department of Health] necessarily has two important roles, one ensuring that patients are appropriately managed by the health service, and secondly the political direction set by the Minister for Health and Ageing is achieved. The briefings that were given to the Media were developed in collaboration with the DH media offices.

233. At interview, Mr Matt Viney MP, Chair of the parliamentary committee stated that Mr Way's statement that the department's role was to achieve the political direction set by the Minister was 'worrying'. He said that, in his view, this had never been regarded as a departmental objective and that it was the role of the Minister's staff. Mr Viney said that the wording of the briefing may indicate a misunderstanding by Mr Way.

The role of media units

234. The public service, including the media units at the department and Alfred Health, should be apolitical; their role is not to pursue the political direction of government, but to implement the policy objectives of the government.

235. Section 2.2 of the *Code of Conduct for Victorian Public Sector Employees* outlines this distinction:

> Public sector employees conduct themselves in an apolitical manner. They implement and administer the policies and programs of the elected government.

236. The government and its Ministers have their own media units whose role is to promote and pursue the political objectives of the government.

237. The Media Manager for the department said he was concerned upon seeing the briefing by Mr Way. At interview, the Media Manager said:

> I feel that that was an unfortunate way of putting that [the department's role] … this [the briefing] came as a surprise to us when it came out … I think we are here to carry out the policy of the government and I think the wording 'the political direction set', it implies something more.

238. The Media Manager also said:

> The government media unit is actually entirely political, they are appointed by the government itself. We are not government officials, we are departmental officials.

239. At interview, Mr Way said he had 'misused' the word political and it did not represent his view of the department's role or what took place. He outlined how he saw the department's role:

> So the Minister sets policy and the department is responsible for developing and implementing policy.

Interaction between the media units

240. As discussed earlier in this report, there was interest from media outlets prior to and during the closure of the lung transplant program. Alfred Health consulted with the department's media unit in order to prepare responses to media enquiries.

241. Referred to as media 'lines', these statements were sent back and forth between Alfred Health and the department. Primarily, this interaction was between the Manager of Public Affairs at Alfred Health and the Media Manager for the department.

242. The Manager of Public Affairs at Alfred Health said at interview:

> Normal process would be to make contact with them [the department's media unit]. Normally they would like to be involved or see the message that we're looking at sharing with the media before that statement is released.

243. He characterised the interaction between the two units around the closure as not unusual when there is media interest regarding a health service, such as Alfred Health. The Media Manager for the department was of the same view stating, 'there is nothing sinister in what we do'.

244. The email exchanges examined show there was disagreement between the two units about Alfred Health's media response. Particularly, the matter of funding was a point of contention with the department concerned that Alfred Health's intended reference to a lack of increased funding for the program was inaccurate.

245. While media statements were being prepared, the department clarified with Alfred Health that additional funding had been provided in its 2011-12 SOP. For this reason, the Media Manager for the department said:

> We made it known in no uncertain terms that we didn't believe that there was a funding issue because they had been provided with the funding.

246. As a result of this extra funding being identified, references in media statements to a lack of a funding increase were removed on the basis that they were inaccurate.

247. Mr Way said that he felt that the finalised media statements did not misrepresent what had occurred and that Alfred Health had not been unduly pressured by the department to follow a particular line. He said, 'no they challenged it [the statements] but I don't think that's an unreasonable thing for them to do'.

248. My conclusions in relation to this issue are set out in the *Executive summary* of my report.

Attachment A

Chronology

The following timeline illustrates key events and decisions relating to the closure of the lung transplant program at The Alfred:

- 19 April 2011 – Alfred Health provides a written submission to the Legal and Social Issues References Committee (the parliamentary committee) outlining its belief that it needed additional funding to deal with the increase in transplant activity.
- 8 September 2011 – Alfred Health provides evidence to the parliamentary committee inquiry (public hearing) and again raises the need for additional funding for the transplant program.
- 14 September 2011 – Mr Way, Alfred Health CEO contacts Prof. Williams, Clinical Director to advise of a shortfall in funding for the transplant program.
- 16 September 2011 - Prof. Williams suggests closing the lung transplant program (not accepting organs for transplant) for two weeks. This advice is repeated on 20 and 21 September 2011.
- 22 September 2011 - Mr Way decides that the lung transplant program will not undertake any new lung transplantation procedures prior to 6 October 2011.
- 28 September 2011 – The lung transplant program re-opens.
- 5 October 2011 - Mr Way provides a briefing to the Alfred Health board regarding the closure.
- 2 December 2011 – Mr Way provides evidence at a further public hearing of the parliamentary committee inquiry explaining that the closure was due to workload capacity.
- 7 March 2012 – Media reports (Channel 7 news) raise concerns about funding of the lung transplant program at The Alfred.
- 27 March 2012 – The parliamentary committee resolves to refer three matters to me for investigation under section 16 of the Ombudsman Act.

Ombudsman's Reports 2004-12

2012

Investigation into an alleged corrupt association
October 2012

Whistleblowers Protection Act 2001 Investigation into allegations of detrimental action involving Victoria Police
June 2012

Own motion investigation into Greyhound Racing Victoria
June 2012

The death of Mr Carl Williams at HM Barwon Prison – investigation into Corrections Victoria
April 2012

Whistleblowers Protection Act 2001 Conflict of interest, poor governance and bullying at the City of Glen Eira Council
March 2012

Investigation into the storage and management of ward records by the Department of Human Services
March 2012

2011

Investigation into the Foodbowl Modernisation Project and related matters
November 2011

Investigation into ICT-enabled projects
November 2011

Investigation into how universities deal with international students
October 2011

Investigation regarding the Department of Human Services Child Protection program (Loddon Mallee Region)
October 2011

Investigation into the Office of Police Integrity's handling of a complaint
October 2011

SafeStreets Documents - Investigations into Victoria Police's Handling of Freedom of Information request
September 2011

Investigation into prisoner access to health care
August 2011

Investigation into an allegation about Victoria Police crime statistics
June 2011

Corrupt conduct by public officers in procurement
June 2011

Investigation into record keeping failures by WorkSafe agents
May 2011

Whistleblowers Protection Act 2001 Investigation into the improper release of autopsy information by a Victorian Institute of Forensic Medicine employee
May 2011

Ombudsman investigation – Assault of a Disability Services client by Department of Human Services staff
March 2011

The Brotherhood – Risks associated with secretive organisations
March 2011

Ombudsman investigation into the probity of The Hotel Windsor redevelopment
February 2011

Whistleblowers Protection Act 2001 Investigation into the failure of agencies to manage registered sex offenders
February 2011

Whistleblowers Protection Act 2001 Investigation into allegations of improper conduct by a councillor at the Hume City Council
February 2011

2010

Investigation into the issuing of infringement notices to public transport users and related matters
December 2010

Ombudsman's recommendations second report on their implementation
October 2010

Whistleblowers Protection Act 2001 Investigation into conditions at the Melbourne Youth Justice Precinct
October 2010

Whistleblowers Protection Act 2001 Investigation into an allegation of improper conduct within RMIT's School of Engineering (TAFE) – Aerospace
July 2010

Ombudsman investigation into the probity of the Kew Residential Services and St Kilda Triangle developments
June 2010

Own motion investigation into Child Protection – out of home care
May 2010

Report of an investigation into Local Government Victoria's response to the Inspectors of Municipal Administration's report on the City of Ballarat
April 2010

Whistleblowers Protection Act 2001 Investigation into the disclosure of information by a councillor of the City of Casey
March 2010

Ombudsman's recommendations – Report on their implementation
February 2010

2009

Investigation into the handling of drug exhibits at the Victoria Police Forensic Services Centre
December 2009

Own motion investigation into the Department of Human Services – Child Protection Program
November 2009

Own motion investigation into the tendering and contracting of information and technology services within Victoria Police
November 2009

Brookland Greens Estate – Investigation into methane gas leaks
October 2009

A report of investigations into the City of Port Phillip
August 2009

An investigation into the Transport Accident Commission's and the Victorian WorkCover Authority's administrative processes for medical practitioner billing
July 2009

Whistleblowers Protection Act 2001 Conflict of interest and abuse of power by a building inspector at Brimbank City Council
June 2009

Whistleblowers Protection Act 2001 Investigation into the alleged improper conduct of councillors at Brimbank City Council
May 2009

Investigation into corporate governance at Moorabool Shire Council
April 2009

Crime statistics and police numbers
March 2009

2008

Whistleblowers Protection Act 2001 Report of an investigation into issues at Bayside Health
October 2008

Probity controls in public hospitals for the procurement of non-clinical goods and services
August 2008

Investigation into contraband entering a prison and related issues
June 2008

Conflict of interest in local government
March 2008

Conflict of interest in the public sector
March 2008

2007

Investigation into VicRoads' driver licensing arrangements
December 2007

Investigation into the disclosure of electronic communications addressed to the Member for Evelyn and related matters
November 2007

Investigation into the use of excessive force at the Melbourne Custody Centre
November 2007

Investigation into the Office of Housing's tender process for the cleaning and gardening maintenance contract – CNG 2007
October 2007

Investigation into a disclosure about WorkSafe's and Victoria Police's handling of a bullying and harassment complaint
April 2007

Own motion investigation into the policies and procedures of the planning department at the City of Greater Geelong
February 2007

2006

Conditions for persons in custody
July 2006

Review of the *Freedom of Information Act 1982*
June 2006

Investigation into parking infringement notices issued by Melbourne City Council
April 2006

Improving responses to allegations involving sexual assault
March 2006

2005

Investigation into the handling, storage and transfer of prisoner property in Victorian prisons
December 2005

Whistleblowers Protection Act 2001 Ombudsman's guidelines
October 2005

Own motion investigation into VicRoads registration practices
June 2005

Complaint handling guide for the Victorian Public Sector 2005
May 2005

Review of the *Freedom of Information Act 1982* Discussion paper
May 2005

Review of complaint handling in Victorian universities
May 2005

Investigation into the conduct of council officers in the administration of the Shire of Melton
March 2005

Discussion paper on improving responses to sexual abuse allegations
February 2005

2004

Essendon Rental Housing Co-operative (ERHC)
December 2004

Complaint about the Medical Practitioners Board of Victoria
December 2004

Ceja task force drug related corruption – second interim report of Ombudsman Victoria
June 2004

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