



Speech by

Hon. Stephen Robertson

MEMBER FOR STRETTON

Hansard Thursday, 6 September 2007

MINISTERIAL STATEMENT

Surgical Deaths in Public Hospitals

Hon. S ROBERTSON (Stretton—ALP) (Minister for Health) (10.11 am): Later today I will launch a project that will see all surgical deaths in Queensland public hospitals be independently investigated. This is yet another state government measure to build a better, safer health system. We are providing \$1.15 million over two years to fully fund the Queensland audit of surgical mortality, which has already kicked off around the state. For the first time in Queensland all surgical deaths in public hospitals will be independently investigated and we expect all private hospitals to participate as the project is phased in.

The audit is being carried out by the Royal Australasian College of Surgeons and is a breakthrough project for patient safety and surgical excellence. A total of 15 public hospitals from the Gold Coast to Cairns, where the majority of public surgery takes place, will take part in the audit over the next two years. Over time, when this project is finetuned we expect all surgical deaths in every hospital, both public and private, to be independently investigated in Queensland.

The audits will improve both patient safety and surgical competence by encouraging greater transparency in healthcare outcomes. The findings will allow us to determine how deaths during or after surgery occur and how to develop ways to ensure that unnecessary fatalities are significantly reduced, if not fully eliminated.

But this initiative is not about blaming or finger-pointing. Any report that is published will not identify any surgeon. That is not the intent of the project. It is about sharing information, identifying risks and learning from past experiences. On that basis I encourage all surgeons in Queensland to fully cooperate with the audit so that they can make valuable contributions towards building a safer system.

This audit complements a range of other Beattie government strategies to address patient safety and to become more open and transparent about the care provided in our hospitals. These include the formation of the independent Health Quality and Complaints Commission, the new quarterly public hospitals performance reports, and the first annual report on critical incidents and sentinel events, which was released earlier this year.