Babies given to wrong mother

Transcript p3

The Hon. WALT SECORD: You are probably aware that there was a freedom of information request that revealed that between 2011 and 2015 there were seven known cases of babies being given to the wrong mother. What is the current state of play? How many babies have been reported?

Ms KOFF: I would have to take that on notice.

Ms JILLIAN SKINNER: Could you compare it to what it was previously? I would expect that it is a similar number, unfortunately, because that is the kind of thing that happens when there are these numbers of babies—98,000—delivered every year.

The Hon. WALT SECORD: When you get that information can you also provide a list of the hospitals where it occurred?

Ms JILLIAN SKINNER: That will disclose some privacy issues, will it not?

The Hon. WALT SECORD: Respecting privacy issues—

ANSWER:

For the six month period January – June 2016, there have been no reported incidents of babies being given to the incorrect mother recorded in the NSW Health Incident Information Management System.

Patient identity mix ups

Transcript p4

The Hon. WALT SECORD: Minister, how often are identity mistakes or patient mix-ups reported in the New South Wales health and hospital system?

Ms JILLIAN SKINNER: Say that again. Patient identity mix-ups?

The Hon. WALT SECORD: Patient identities—the names "Mark" and "Walt" having different identities. Mix-ups in that sense.

Ms JILLIAN SKINNER: I would have to take that on notice.

ANSWER:

Patient identification incidents refer to incidents associated with the matching of the correct patient, site, and procedure. NSW Health Policy PD2014_036 *Clinical Procedure Safety* describes the steps that must be taken to ensure that an intended invasive or diagnostic procedure (including surgical operations, endoscopy, dentistry, radiology, nuclear medicine, chemotherapy and radiation therapy procedures) is performed on the correct patient, at the correct site and, if applicable, with the correct implants/prostheses and equipment.

Details on numbers of incidents are published by the Clinical Excellence Commission and are available at www.cec.health.nsw.gov.au/

Incorrect amputations

Transcript p6

The Hon. WALT SECORD: Do we have incidents or cases in New South Wales where the wrong patient is operated on? I know that this is a bit grotesque, but sometimes is the wrong leg or arm removed due to errors?

Dr CHANT: I am aware, historically, from looking at reportable incident briefs [RIBs] over my career in health that there have been occasions where an operation may have commenced on an incorrect site. There was quite a lot of work done—I think it was five years ago—about wrong sites and time-out periods required in theatres, double-checking processes before commencing. These things are done in order to stand back and double-check the documentation: Is it written right on the consent form? Is it marked in the right place? That is as I recall it, from having looked at incidents over a long period of time. I do not have the contemporary data on that.

The Hon. WALT SECORD: Could you take that on notice, if you do not have it?

Ms CRAWSHAW: Just to note that in the severity assessment code matrix that the Minister has alluded to, incorrect patient or incorrect body part for the purposes of surgery is, if it results in significant loss or damage to the patient, a sentinel event and is treated very seriously.

The Hon. WALT SECORD: What is a significant loss to your patient?

Ms CRAWSHAW: If it was a significant injury to the patient as a consequence. You alluded to the idea of somebody having an amputation that should not have occurred—that sort of event.

The Hon. WALT SECORD: Wrong amputation. So could you take on notice in 2014-15 the number of mistaken amputations that have occurred in New South Wales?

Ms JILLIAN SKINNER: Can I advise you that the Clinical Excellence Commission reports this data—

Dr CHANT: Yes.

ANSWER:

During the 2014 and 2015 calendar years there were no Reportable Incident Brief notifications received relating to wrong amputation(s).

Kangaroo meat

Transcript p15

The Hon. MARK PEARSON: I understand that kangaroo meat might be a new horizon, so the Minister may wish to take this question on notice. I was contacted by kangaroo shooters who took me out in the field to highlight their concerns about kangaroo meat being used for human consumption. In 2009, 2010, 2011 and 2012 samples were taken from supermarkets by private investigators and they were sent off to laboratories to test for E.coli and salmonella, which was found on the carcasses in the chillers. Russia is the largest importer of kangaroo meat; it takes 77 per cent of our meat. It banned the importation of kangaroo meat because it also found E.coli, salmonella and other types of contamination.

A measure of the concern about this issue is the fact that the Russians were invited back to Australia by Macro Meats, the largest producer of kangaroo for human consumption both domestically and internationally. Before the Russians arrived, Macro Meats sent a memo to shooters advising that they would be receiving ascetic acid and they were to spray it on the carcasses to remove contaminants. I have a copy of the memo to the shooters. We then did further tests. The Russians opened the market for a short time and closed it again when they saw our results. In 2015, we did a comparison with lamb. Again, even though ascetic acid was still being used for the domestic market, and even though other levels of contamination had reduced, they were still there and were much higher than the levels in lamb.

I am raising this as a concern for the health of the people of New South Wales and Australia that there could well be a looming problem. It is very interesting that the way these kangaroos are prepared for human consumption is that they are shot during the night. The first animal might be shot, eviscerated and decapitated at
7.00 p.m. and stay on the back of the truck with ambient temperatures of up to 38 degrees at night during summer. It does not have to get to the chiller until one hour after dawn. If a farmer were to do that with asheep—shoot a sheep at 7.00 p.m., drive around with it on the back of a truck, eviscerated and decapitated, and turn up to a processing plant—it would be immediately rejected. My question is: Has the Minister ever had this information brought before her? In 2009 when these first tests came in I wrote to the Department of Health and the Food Authority. Has the Minister turned her mind to this or been advised about it? If not, would she consider it?

Ms JILLIAN SKINNER: I will. It has not been brought to my attention. That is before my time as Minister for Health. I think Dr Kerry Chant as the Chief Health Officer might be able to help.

Dr CHANT: I would be very happy to follow those issues up. As you know the New South Wales Food Authority and Primary Industries would be the regulators here but clearly health is the principal concern you are raising. We would be very happy to do that. I would like to note that particularly the issue with chickens—

ANSWER:

A search of records found no correspondence about kangaroo meat made to the NSW Ministry of Health during the last 16 years.

Any enquiry received about the safety and regulation of kangaroo meat preparation would be referred to the NSW Food Authority or NSW Department of Primary Industry who are the

regulating agencies. The NSW Food Authority has addressed the claim by The Hon Mark Pearson that kangaroo meat is contaminated with bacteria on a number of occasions.

The risk that meat for consumption will come into contact with pathogenic organisms, such as salmonella or E coli, is not a risk that is specific to kangaroo meat. This is a known risk factor for many types of meat and other food products.

As previously indicated, the NSW Food Authority or Department of Primary Industry are the agencies with legislative authority. However, the Chief Health Officer's staff have liaised with the NSW Food Authority concerning this issue:

a) All kangaroo game meat processed, manufactured or sold in NSW must comply with the *Australian Standard for Hygienic Production of Game Meat for Human Consumption*.

b) The NSW Food Authority enforces established handling and storage requirements for kangaroo meat to further reduce any risks due to microorganisms.

c) While the NSW Food Authority has strict systems and requirements in place to ensure kangaroo meat is safe, it is important that all raw meats are cooked and stored at the correct temperature. This helps to reduce the presence of any microorganisms that may be present in the meat and to prevent microorganisms forming after it is cooked.

Should NSW Health receive a complaint of illness in two or more people following consumption of kangaroo meat, or if kangaroo meat is identified as a common food history item among people identified within a food borne illness outbreak, NSW Health would investigate and work closely with the NSW Food Authority to determine whether the kangaroo meat was the source of the illness.

NSW Health has identified no outbreaks of foodborne illness linked to kangaroo meat.

Kangaroo meat

Transcript p16

The Hon. MARK PEARSON: I think the issue here is that, sure, raw meat will often have a certain amount of contaminant. But the tests showed that in kangaroo meat it was much higher for all those reasons I described. The industry recommends you cook the meat rare, so therefore you are not killing all the contaminants.

Dr CHANT: Generally the contaminants are not inside the meat unless the kangaroo was septic. It is really about the surface contamination, so searing it on both sides. But as I said, for the comminuted meat such as the mincemeat, because you have potentially put the outside surface contamination into the middle, that is why we are recommending that particularly for mince we do that. You are raising significant issues and I am happy to follow them up.

The Hon. MARK PEARSON: The levels of E. coli and salmonella are "high alert" according to Australian Quarantine and Inspection Service [AQIS] standards, so the levels of the other meats are "low alert" and are removed by cooking. But I think the measure—and this is what I think is a marker of the level of concern for the producer—is soaking the carcases in ascetic acid or spraying them. Clearly they are having to go to these steps.

Dr CHANT: Yes. I will follow up that issue.

ANSWER:

The risk that meat for consumption will come into contact with pathogenic organisms, such as salmonella or E coli, is not a risk that is specific to kangaroo meat. This is a known risk factor for many types of meat and other food products.

The NSW Food Authority or Department of Primary Industry are the agencies with legislative authority. However, the Chief Health Officer's staff have liaised with the NSW Food Authority concerning this issue:

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Legionnaires' disease

Transcript p35

The Hon. WALT SECORD: As of 29 August there were 83 notifications of legionnaires' disease in New South Wales, and that surpasses 2014 where there were 70 cases. How many deaths have occurred in New South Wales this year due to legionnaires' disease?

Ms JILLIAN SKINNER: From my recollection—I might be slightly out of date—it was two. I will ask Dr Chant to give more detail on that one.

The Hon. WALT SECORD: Were they able to determine the cause of the outbreaks and deaths?

Dr CHANT: As you aware, this starter is put on our—

The Hon. WALT SECORD: I check it every day.

Ms JILLIAN SKINNER: You can answer the question.

Dr CHANT: I will have to defer to that because you are probably more up to date than my briefing. I will provide that data to you.

ANSWER:

NSW Health established a *Legionella* expert panel to advise the Chief Health Officer on whether any new measures are required to strengthen prevention and control activities. The expert panel comprises public health physicians, environmental health officers, an infectious disease physician, a legal expert, industry experts, mechanical engineer and a local government representative.As of 6 September 2016 there had been 86 notifications of Legionnaires' disease in New South Wales in 2016, including three deaths. A total of 62 infections were due to the *Legionella pneumophila* strain and 24 infections were due to other *Legionella* strains. Two of the deaths were linked to infections with the *Legionella pneumophila* strain and one was linked to infection with the *Legionella longbeachae* strain (the strain most commonly linked to exposure to soil and potting mix).

It is often very difficult to pinpoint the source of an outbreak with accuracy. The main aim of a public health response is to stop the outbreak continuing as soon as possible by ensuring that cooling towers and other possible sources of infection in a location suspected to be the cause of the outbreak are controlled as quickly as possible. To achieve this, building owners are warned to maintain cooling towers to ensure they are free of contamination, and environmental health officers carry out door to door inspections of cooling towers.

A cooling tower that is the source of an outbreak may not be identified despite careful investigations. This is because a cooling tower may be only transiently contaminated by Legionella bacteria floating through the air, and water vapour from that cooling tower may infect people walking by, as well as contaminate other nearby cooling towers. However that cooling tower's continuous disinfection and regular cleaning processes may automatically decontaminate it, even before infected patients are diagnosed. Should the first cooling tower be tested, it may therefore test negative for *Legionella* (because it's been automatically disinfected), even though it's the real source of patients' infection, while the nearby cooling towers (contaminated by the first cooling tower, but not yet disinfected) may test positive, even if they have not caused any infections in patients.

NSW Health is developing special tests (such as whole genome sequencing) that can match the strains of bacteria found in patients and in cooling towers. However, even if a patient's strain matches a cooling tower strain it does not prove it was the source of infection as both the patient and that cooling tower may simply have been contaminated by another cooling tower that may never be identified (e.g. because it already had been disinfected).

Excessive alcohol consumption

Transcript p36

Reverend the Hon. FRED NILE: I have a related question which is more in your court. How much does the treatment of youth affected by excessive drinking cost New South Wales taxpayers through the health system?

Ms JILLIAN SKINNER: I would have to take that on notice, I am afraid.

ANSWER:

The NSW Government has invested $197 million in drug and alcohol services and programs as part of the 2016-17 Budget. This investment supports the delivery of a comprehensive prevention, early intervention and integrated care system through the public health, primary care and non-government sectors.

This includes a commitment by the NSW Government to invest an extra $75 million over four years to tackle drug and alcohol misuse in our communities.

The package of new investment focuses on supporting more young people, more families and more people into treatment.

Life expectancy – Aboriginal men in Wilcannia

Transcript p34 - 35

Mr JEREMY BUCKINGHAM: According to a paper they produced, life expectancy of Aboriginal men in that Wilcannia area was 27 years of age, which makes it one of the worst life expectancy of any cohorts of people on earth.

Ms JILLIAN SKINNER: Very worrying.

Mr JEREMY BUCKINGHAM: Would you like to comment on that and talk about what your Government is doing to deal with that?

Ms JILLIAN SKINNER: The variation in health outcomes for Aboriginal people is a major concern for everybody. We are working very hard to try to address that through a number of measures. We have done very well in some cases. I am due to visit Moree very soon to join one of the outreach obstetricians who works with Aboriginal communities and others to provide antenatal and postnatal care to families who come in from villages. That is considered to be one of the initiatives that has led to there being no difference between infant mortality for Aboriginal and non-Aboriginal children now. Aboriginal children's immunisation rates are higher than for non-Aboriginal children. So there is some fantastic work going on. I heard today of a marvellous program involving the Sax Institute and identification and involvement of young Aboriginal children with hearing problems. In relation to this, it is a challenge. Could you advise?

Dr CHANT: It is called the Study of Environment on Aboriginal Resilience and Child Health [SEARCH] project. Perhaps I can talk about the general approach.

Ms JILLIAN SKINNER: Yes.

Dr CHANT: As you are aware, some of the issues that are impacting on the differential in life expectancy, which is a true tragedy, between Aboriginal and non-Aboriginal people arise from the broader social determinants. There is very much a whole-of-government approach to some of these areas and that is led by Aboriginal Affairs. Murdi Paaki and all of the government agencies are working to support the initiatives of the regional consortiums, such as Murdi Paaki, in working through issues in a way that the community has identified for priorities. NSW Health is engaging in those processes and ensuring that there are appropriate linkages into the local service delivery structure.

In addition, we provide funding support for Aboriginal community-controlled services and we are working to support them to deliver high-quality services. We are moving to more outcome-based funding and less about the nature of the particular inputs in that funding and we are giving them more sustainable funding over three years, which will allow them to better meet the needs of their local community. We have also done a lot of work to support. We have one program called the Housing for Health program, which works into rural and remote communities and repairs and provides basic infrastructure necessary to sustain health, such as making sure that the water is running, that the electricity is safe, and that the things that are necessary and essential for preparing food are in place. That Housing for Health targets a range of communities. I can let you know the sites where we have done that work.

Mr JEREMY BUCKINGHAM: I would be very interested in that.

ANSWER:

The vision of NSW Health is health equity for all Aboriginal people. The goal is to work in partnership with Aboriginal people in line with the *NSW Aboriginal Health Plan 2013-2023*.

The NSW Government supports a strong and effective Aboriginal Community Controlled Health Service Sector. High quality, culturally safe, community controlled health services contribute to closing the significant gap in health disparities between Aboriginal and non-Aboriginal people.

NSW Health funds a range of programs in these services and in Local Health Districts to address early identification and management of chronic diseases. This includes a focus on modifiable risk factors including smoking, overweight and obesity, and drug and alcohol use.

Cardiovascular disease makes the largest contribution to the gap in morbidity and mortality between Aboriginal people and non-Aboriginal people. To address this gap, NSW Health is undertaking a range of activities as part of Better Cardiac Care for Aboriginal and Torres Strait Islander People (Better Cardiac Care), a national initiative supported by the Australian Health Ministers' Advisory Council (AHMAC) as part of the Australian Government's commitment to closing the gap in life expectancy for Aboriginal and Torres Strait Islander people.

Better Cardiac Care encompasses a range of initiatives to improve primary and secondary prevention to reduce the burden of cardiovascular disease among Aboriginal people.

NSW Health has delivered Housing for Health projects across NSW.

Projects have been implemented in the following Aboriginal communities:

- Armidale
- Balranald (Endeavour Drive)
- Baryugil
- Batemans Bay
- Bega
- Bellbrook
- Bodalla
- Boggabilla
- Bourke
- Bowraville
- Brewarrina
- Broken Hill
- Cabbage Tree Island
- Cobar
- Coffs Harbour
- Collarenebri
- Condobolin
- Coomaditchie
- Coonamble
- Coraki (Box Ridge)
- Cowra (Erambie)
- Cummeragunja
- Dareton (Namatjira Ave & New Merinee)
- Darlington Point
- Dorrigo
- Eden
- Enngonia
- Forster (Cabarita)
- Glen Innes
- Goodooga
- Goulburn
- Gulargambone
- Ivanhoe
- Karuah
- Kempsey
- Lake Cargelligo (Cudjallagong)
- La Perouse
- Leeton
- Lightning Ridge

- Lismore (Gunderimba)
- Macksville
- Maclean1
- Malabugilmah
- Menindee
- Moree (Mehi Cresent)
- Moree (Stanley Village)
- Moruya
- Muli Muli
- Mungindi
- Murrin Bridge
- Naranderra (Grong Grong)
- Naranderra (SandhillsAC Riverina AC)
- Narooma
- Narrabri
- Newcastle (Awabakal)
- Orient Point
- Peak Hill
- Pilliga
- Port Macquarie
- Queanbeyan
- Quirindi
- Tabulam (Jabulum)
- Tamworth
- Taree (Purfleet)
- Tenterfield
- Tibooburra
- Tingha/ Inverell
- Toomelah
- Tumut (Brungle)
- Tumut (Mudjarng AC)
- Walcha (Summervale)
- Walgett
- Walhallow
- Wallaga Lake
- Wanaaring
- Wee Waa
- Weilmoringle
- Wellington (Nanima)
- West Wyalong
- Western Sydney-Mount Druitt
- Wilcannia
- Willow Bend
- Yamba
- Yass

Projects have been implemented more than once in the following Aboriginal communities:

- Armidale 2
- Baryugil 2
- Bellbrook 2
- Boggabilla 2 and 3
- Bourke 2
- Broken Hill 2
- Cobar 2
- Coffs Harbour 2
- Coraki (Box Ridge) 2
- Cummeragunja 2
- Enngonia 2
- Ivanhoe SF3
- La Perouse 2
- Maclean2 / Nungera
- Maclean2 / Yaegl
- Malabugilmah 2
- Menindee 2
- Muli Muli 2
- Purfleet/Taree 2
- Toomelah 2 and 3
- Wallaga Lake 2
- Weilmoringle

- SF3
- Yamba2

Projects are currently being implemented in the following Aboriginal communities:

- Bodalla 2
- Casino / Kyogle
- Dareton 2
- Moree (Stanley Village & Mehi Cresent) 2
- Mogo
- Nambucca Heads (Bellwood)
- Williamtown (Worimi)