October 2022

Protections for serious adverse patient safety event (SAPSE) reviews

### SAPSE reviews conducted in accordance with Division 8 of Part 5A of the *Health Services Act 1988* (Vic)(Act).

OFFICIAL

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| A note on terminology**Moderate harm**  Moderate harmmeans harm that requires a moderate increase in treatment to a patient, such as an unplanned or unexpected return to surgery, but does not include harm that causes permanent damage or injury to an individual.[[1]](#footnote-2) **Next of kin (NOK)** The term next of kin is broadly used to represent any partner, parent, legal guardian, child or sibling of 18 years or older, or executor when a harm event causes death. **Patient** This resource broadly uses the term patient to refer to any patient including inpatients, consumers, clients or residents that have suffered a SAPSE in the course of receiving health services. In circumstances where the patient lacks capacity or dies, the term patient also includes others who may be involved in the review process including immediate family, carers, next of kin, or any person nominated by the patient.[[2]](#footnote-3) Prolonged psychological harm Prolonged psychological harmmeans psychological harm which a patient has experienced, or is likely to experience, for a continuous period of at least 28 days.[[3]](#footnote-4) Protections Protections refer to the protections that apply to the serious adverse patient safety event (SAPSE) review process, that are set out in sections 128R, 128S, 128U and 128W of the *Health Services Act 1988*. When a SAPSE review is conducted in accordance with Division 8 of Part 5A of the *Health Services Act 1988*, relevant protections apply. **SAPSE** Serious adverse patient safety event (SAPSE) is an event of a prescribed class or category that:   1. occurred while the patient was receiving health services from a health service entity; and 2. in the reasonable opinion of a registered health practitioner, has resulted in, or is likely to result in, unintended or unexpected harm (which includes moderate harm, severe harm **or** prolonged psychological harm) being suffered by the patient.[[4]](#footnote-5)   This includes an event that is identified following discharge from the health service entity.  Note: Please also see definitions of moderate harm, severe harm, and prolonged psychological harm for context. SAPSE review A review of a serious adverse patient safety event conducted in accordance with Division 8 of Part 5A of the *Health Services Act 1988* (Vic)(Act). It refers to a protected review process. Secretary Secretary means the Department Head (within the meaning of the *Public Administration Act 2004*) of the Department of Health.[[5]](#footnote-6) Sentinel event Sentinel event means an unexpected and adverse event that occurs infrequently in a health service entity and results in the death of, or serious physical or psychological injury to, a patient as a result of system and process deficiencies at the health service entity.[[6]](#footnote-7) Severe harm Severe harm means harm that causes a permanent lessening in the functioning of an individual that is unrelated to the natural course of a person’s illness or underlying condition including harm that can lead to a person experiencing a permanent impairment or disability, or death.[[7]](#footnote-8) **Statutory Duty of Candour (SDC)** If a patient suffers a serious adverse patient safety event in the course of receiving health services, the health service entity responsible for providing those services owes a duty of candour to the patient, and must provide them with:   * a written account of the facts * an apology for the harm suffered * a description of the health service entity’s response to the event, and * the steps that the health service entity has taken to prevent re-occurrence of the event.   They must also comply with the steps set out in the *Victorian Duty of Candour Guidelines*.  **Note:** SDC may occur concurrently with a SAPSE review. |

# About this resource

This resource provides guidance concerning the requirements that are set out in Division 8 of Part 5A of the *Health Services Act 1988* (Vic)(Act), for the conduct of a SAPSE review and explains the legal protections associated with SAPSE reviews.

## Why use this resource?

This resource is to support clinicians and senior health service representatives establish and conduct SAPSE reviews in accordance with the Act*,* including:

* the requirements to undertake a SAPSE review
* purpose of legal protections applying to a SAPSE review, and
* when the legal protections will apply.

### Please read this resource in conjunction with:

* Policy: Adverse Patient Safety Events
* Victorian sentinel events guide, and
* *Victorian Duty of Candour Guidelines*.

## Why Safer Care Victoria developed this resource

Protections for adverse event reviews as part of a wider culture of change in health services across Victoria were a key recommendation of the *Expert Working Group: A statutory duty of candour* report. The expert working group was established to advise on legislative reforms arising from *Targeting Zero:* *Supporting the Victorian hospital system to eliminate avoidable harm and strengthen quality of care*.

The *Health Legislation Amendment (Quality and Safety) Act 2022* and associated resources are the result of five years of significant consultation, and were developed with input from expert healthcare workers, leaders and consumers. This resource should also be referred to alongside relevant legislation and the *Victorian Duty of Candour Guidelines*, which stipulates what Statutory Duty of Candour (SDC) is and key requirements and timelines.

* In 2017, an expert working group was appointed, led by Michael Gorton AM, to develop a consultation paper on the scope, processes, compliance measures and protections for adverse event reviews.
* This group received 61 submissions from stakeholders across the state.[[8]](#footnote-9)
* SCV consulted publicly on 27 recommendations in 2020–21, receiving 60 submissions from individuals, public/private health services, professional associations, colleges and insurers.
* SCV established an advisory group in 2021 to develop this resource and support the implementation of SDC in health service entities.

Scope of a SAPSE review and purpose

Health service entities should consider the relevant scope of a SAPSE review to determine if it is appropriate to conduct a SAPSE review in respect of each SAPSE. In making this decision, health service entities should also understand the purpose of protections for adverse event reviews.

After a SAPSE has occurred, the first priority is always the immediate safety and care of the patients and staff involved, then identifying if there is a risk to other patients, members of the public or staff members. After this, the health service should ensure that they have performed their Statutory Duty of Candour (SDC) as outlined in the Actand *Victorian Duty of Candour Guidelines,* or open disclosure as outlined in the Australian Open Disclosure Framework. The process for protections and the SAPSE review should occur as part of the ongoing dialogue associated with SDC.

## What is the scope of a SAPSE review?

A SAPSE review is a systematic process of analysis that must identify:

* what happened, including the sequence of events, their context and relevant facts of the SAPSE
* why it happened, including system factors that contributed to the event
  + factors external to the health service entity
  + organisational and management factors
  + working environment factors including assignment and performance of tasks, technology, team management and staffing allocation
  + patient factors
* what can be done to improve, including remedial measures that could be implemented to prevent a recurrence of a similar event and could improve the quality and safety of the health services provided by the health service entity.

The focus of the SAPSE review should be on identifying and improving the systems factors of the health service that contributed to the event. Throughout the review consultation and communication with the patient and/or NOK should be encouraged to ensure a collaborative and informed approach.

**Note:** a SAPSE review is not a type of review methodology. Types of review methodologies include:

* Root cause analysis (RCA)
* London Protocol
* AcciMap

## What are the purposes of legal protections that apply to SAPSE reviews?

Review processes are valuable quality and safety improvement processes, conducted in relation to serious adverse patient safety events, including where systemic issues are identified or suspected. Such processes are often interactive and sometimes involve speculative discussion about factors that may have contributed to an incident and/or related harm. The nature of those discussions could be inhibited and lead to unintended or perverse outcomes if details of the discussion were relied upon as evidence in legal proceedings.

The purposes of the protections are to assist with identification of systemic issues contributing to adverse events by:

* reducing concern about potential medico-legal risk to an individual or organisation, in order to encourage reporting of errors, and
* fostering information sharing within health service entities.

There is evidence that protections for adverse event review processes lead to:

* more robust discussion
* a better understanding of what occurred in a particular event, and
* more comprehensive and effective recommendations for improvements.

In turn the outcomes from a SAPSE review may help:

* improve the quality and safety within a health service entity, and
* prevent similar events from occurring in the future.

The protections will ensure that health service entities provide full and frank information during reviews, so that reviews can include robust consideration of quality and safety risks and recommend improvements.

# When protections for SAPSE reviews apply

Protections apply to all SAPSE reviews conducted in accordance with Division 8 of Part 5A of the *Health Services Act 1988* (Vic)(Act). Any review that does not follow this Division within the Act are not a SAPSE review and are therefore not protected.

## Which health service entities are included?

SAPSE reviews may be conducted by the following types of *health services entities*:

* a public health service
* a public hospital
* a multi-purpose service
* a denominational hospital
* a private hospital
* a day procedure centre
* an ambulance service within the meaning of the *Ambulance Services Act 1986*
* a non-emergency patient transport service within the meaning of the *Non-Emergency Patient Transport and First Aid Services Act 2003* that is licensed under that Act
* the Victorian Institute of Forensic Mental Health established by section 328 of the *Mental Health Act 2014*, or
* a prescribed entity that provides health services.[[9]](#footnote-10)

**Note:** The provisions concerning SAPSEs and SAPSE review processes apply from **30 November 2022**, and do not apply to events that occurred prior to this date.

## Requirements of a SAPSE review

The following requirements are outlined within Division 8 of Part 5A of the Act:

* the scope of a SAPSE review[[10]](#footnote-11)
* a SAPSE review panel must be appointed in accordance with sections 128P and 128Q of theAct, as well as relevant regulations
* a SAPSE review report must be produced by the SAPSE review panel containing required information[[11]](#footnote-12)
* the SAPSE review report must not contain relevant parties' name or address[[12]](#footnote-13)
* the SAPSE review report:
  + must be disclosed to the Secretary or any person nominated by the Secretary if requested[[13]](#footnote-14)
  + may be disclosed to a coroner or the Coroners Court for the purposes of an investigation or inquest[[14]](#footnote-15)
* the SAPSE review report must be offered to:
  + a patient
  + a person nominated by the patient
  + immediate family, carer or NOK if the patient is deceased or lacks capacity[[15]](#footnote-16)

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| **Important notes:**   * A formal review of all SAPSE is required, however a ‘SAPSE review’ is not mandatory for all SAPSE. It simply refers to a protected review process. * It will be at the discretion of the health service entity to decide whether a SAPSE review will be conducted for a SAPSE. * The protections apply separately to each SAPSE review, and do not have a cessation date under the Act. **If the requirements within Division 8 of Part 5A of the Act are not followed, then the review** **will not be protected, and it will not be a SAPSE review**. * When an event is not a SAPSE, health service entities cannot rely on the protections in Division 8 of Part 5A of the Act for any formal or informal reviews. * Section 139 does not apply to Division 8 of Part 5A of the Act. This means that a member of a Quality Assurance Committee gazetted in accordance with section 139 cannot rely on their membership of that committee to refuse to provide a copy of the SAPSE review report to the patient or their NOK. * The protections do not prevent a patient from seeking legal redress. |

* the SAPSE review panel members must not disclose any information acquired as part of the review process, except for the purposes related to their role as a panel member, or for the purpose of any recommendations made by the panel or disclosure that is required or permitted by the legislation[[16]](#footnote-17)
* the identity of the panel members must not be disclosed[[17]](#footnote-18)
* the SAPSE review must be suspended for prescribed reasons.[[18]](#footnote-19)

# Flowchart



\* Unless the patient has opted out.

\*\* Must comply with any elements in the *Health Services Act 1988* and relevant regulations.

# SAPSE review panel and report

There are requirements outlined within the *Health Services Act 1988* and relevant regulations concerning the SAPSE review panel size and composition. This section also includes requirements when a SAPSE occurs across two or more health service entities.

The CEO (however named) **may** choose to appoint a panel to conduct a review, however, **must** appoint a SAPSE review panel or a joint SAPSE review panel if directed to do so by the Secretary.[[19]](#footnote-20)

For the purposes of section 128Q(1)(e) of the Act, any person who is a member of a SAPSE review panel who has a potential or actual conflict of interest with respect to the SAPSE review they have been appointed to conduct, must disclose this to the other members of the panel.

## Membership of a SAPSE review panel

The membership of a SAPSE review panel:

* **must** include an external person who is not employed or engaged by the health service entity that appointed the panel
* **must** not include any person who was directly involved in the SAPSE under review
* **may** include independent experts
* **may** include consumer representatives
* **must** comply with any prescribed requirements. [[20]](#footnote-21)
  + the SAPSE review panel **must** consist of no less than 3 members
  + if a SAPSE review relates to an event that is considered a sentinel event, the review panel **must** also contain a consumer representative.

## Joint SAPSE review panel

If a SAPSE involves two or more health service entities, the CEOs (however named) of those health service entities may agree to appoint a joint SAPSE review panel in accordance with the Act and regulations.

In such a case, the Secretary may direct that a joint SAPSE review panel must be appointed and if the CEOs (however named) of the health service entities involved are unable to agree to appoint a joint SAPSE review panel, the Secretary may appoint the panel.[[21]](#footnote-22)

A joint SAPSE review panel:

* **must** include at least 1 member from each health service entity involved with the SAPSE
* **must** consist of no less than 4 members
* **may** include a representative appointed by the Secretary.

If the review relates to an event that is considered a sentinel event, it:

* **must** include a consumer representative.

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| Each member appointed to the SAPSE review panel or joint SAPSE review panel, must have appropriate skills and experience to conduct a SAPSE review. |

It is recommended that the SAPSE review panel may include:

* executive sponsor
* team leader
* facilitator
* external members, including consumer representatives, health service entity staff and independent experts.

See **Appendix 1** for more information on the recommended SAPSE review panel members’ roles.

## SAPSE review report

A SAPSE review panel must produce a report for the health service entity that appointed it, as soon as practicable after completing an investigation into the SAPSE. The health service entity must also comply with the sentinel event reporting timeline (if appropriate) and any other relevant reporting requirements.

A SAPSE review report **must** **contain one or more of the following elements** as considered appropriate by the panel:

* a description of the serious adverse patient safety event
* analysis identifying why the event happened and any factors that contributed to the event
* any recommendations about changes or improvements in a policy, procedure or practice relating to the provision of a health service that are intended to reduce the likelihood of, or prevent, the same type of event happening again.[[22]](#footnote-23)

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| See ‘Restrictions on SAPSE reviews’ for information on when to suspend a review. |

A report must not contain the name or address of the following:

* a person involved in providing the relevant health service
* a person who received the relevant health service
* a person who provided information to the SAPSE review panel
* a member of the SAPSE review panel.

## Disclosure of SAPSE review report

The SAPSE review report is generally kept confidential, with a few exceptions which allow the CEO of the relevant health service entity to provide a copy of the report to persons who have a genuine interest in the subject of the report. These limited exceptions are outlined below.

A health service entity that has received a SAPSE review report from a SAPSE review panel, must offer a copy to a person with a sufficient personal or professional interest in the subject of the report, including:

* a patient
* a person nominated by the patient
* the immediate family, carer or next of kin of a patient, if the patient is deceased or lacks capacity.[[23]](#footnote-24)

When the offer is accepted, the report must be provided. However, if an individual outlined above initially does not want a copy of the report, the health service entity should offer a clear path to obtaining a copy later.

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| If requested, a report must be disclosed to the Secretary, or anyone nominated by the Secretary.[[24]](#footnote-25) The Secretary may choose to nominate another person, for example the Chief Quality and Safety Officer, whose role includes the oversight and support of quality and safety reviews in health service entities. |

This permitted disclosure supports the rights of patients to request and access better information about what occurred in the course of their care. The purpose of the disclosure is to:

* ensure transparency and accountability
* improve the quality of the information provided to patients
* facilitate genuine engagement and open and honest exchange with patients
* enable just cultures in health service entities
* avoid possible non-disclosure by clinicians due to fears of medico-legal recourse.

There is a need to facilitate the flow of information from reviews to other reviews that are focused on the cause of the SAPSE. Therefore, a SAPSE review report produced by a SAPSE review panel may be provided to a coroner for the purposes of:

* an investigation under Division 1 of Part 4 of the *Coroners Act 2008*, or
* an inquest (within the meaning of the *Coroners Act 2008*) in respect of a death.[[25]](#footnote-26)

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| The SAPSE review report created as part of a SAPSE review cannot be requested under the *Freedom of Information Act 1982* (Vic) or *Health Records Act 2001*. In addition, a person involved in the SAPSE review cannot be required to produce the SAPSE review report before any court, tribunal, board, agency or other person. |

# Post a SAPSE review

## Follow up with the patient/NOK

As noted earlier, the SAPSE review report must be disclosed to the relevant parties. When the SAPSE review is complete, the health service entity should consider providing the patient or NOK with feedback through face-to-face interview or equivalent (e.g. videoconference) as agreed by the patient or NOK.

Further meetings may need to be organised as per patient preference to ensure closure on the process. If the health service entity considers all efforts have been undertaken to close the matter, then the matter may be referred to an external service.

## Recommendations from a SAPSE review

Reviews may result in multiple recommendations bounded by timeframes and specifying the areas affected, with particular reference to the people who are responsible for implementation of the recommendations. Following a review, health service entities must action these recommendations, and in doing so, aim to prevent the SAPSE from recurring, or to minimise its impact.

Safer Care Victoria suggests that the recommendations developed as part of the review process be shared with the staff in the affected area or disseminated to the health service entity as a whole dependent on the learnings. This will encourage continued learnings, and aim to improve awareness of potential risks, mitigating future occurrences.

**Note:** Recommendation monitoring timelines should be followed as outlined within the Victorian sentinel events guide if the SAPSE is classified as a sentinel event.

## What are the documentation requirements?

All documents in relation to a SAPSE review must be securely stored by the health service entity, and only accessible internally to those involved in the SAPSE review including panel members and those who appointed the panel. This however does not apply to the disclosure of the SAPSE review report to the patient as outlined within the relevant Acts.

The recommendations of the panel may inform quality improvement activities at the health service entity.

It may be beneficial that the documents relating to SDC be stored together in the appropriate location with the SAPSE review report and any documents created, or information obtained as part of the SAPSE review.

# Restrictions on SAPSE reviews

The focus of the SAPSE review should be on identifying and improving the systems factors relevant to the provision of the health service that contributed to the SAPSE. These may include factors external to the organisation, organisational and management factors, working environment factors, individual staff and patient factors.

The review is not an investigation into the professional or personal competence of a person providing health services. However, members of SAPSE review panels who are regulated health professionals have mandatory reporting obligations, including:

* the Health Practitioner Regulation National Law
* *s. 184, Children, Youth and Families Act 2005*[[26]](#footnote-27)*.*

There may also be other mandatory reporting obligations that apply depending on the particular circumstances.

If it is identified through the SAPSE review that a health professional has behaved in a way that constitutes notifiable conduct under the *Health Practitioner Regulation National Law Act 2009*, a member of the panel must submit a concern to Australian Health Practitioner Regulation Agency (Ahpra). It is recommended that this referral take place after a discussion has occurred with the relevant staff member.

A SAPSE review **must** be suspended where members of the review panel have reason to believe that the review has identified that the adverse event may involve a prohibited act(s). Prohibited acts include:

* evidence that an offence might have been committed by a member of the staff
* evidence of an impairment being medical unfitness because of the presence of a medical condition or disorder impaired capacity or ability that detrimentally affects the health practitioner’s ability to safely perform requirements of their roles
* the abuse of a patient
* acts that appear to be deliberately unsafe acts (other than an act that might be reasonably undertaken in the provision of a health service).

For the purposes of section 128Z(1) of the *Health Services Act 1988,* after the suspension of its activities, the SAPSE review panel must notify the CEO (however named) of the health service entity that is the subject of the SAPSE review in writing regarding the suspected prohibited act. The SAPSE review panel may recommence its review once it receives written notice from the CEO (however named) that either:

* the suspected prohibited act did not occur; or
* the suspected prohibited act is able to be investigated independently of the SAPSE review.

It may be necessary for the SAPSE review panel to seek legal advice in the event of a suspected prohibited act.

# Protections and confidentiality

When a review of a SAPSE is conducted in accordance with Division 8 of Part 5A of the *Health Services Act 1988*, protections apply to working documents, interview records, draft reports and SAPSE review reports. Relevant protections apply to panel members and persons who provide information to the panel.

## Protections from liability

To ensure that members of the SAPSE review panel can discuss the issues relevant to the SAPSE without being concerned about defamation, the legislation provides them with certain protections.

A person who is a member of a SAPSE review panel is not personally liable for anything done or omitted to be done in good faith:

* in the performance under the Act as a member of the SAPSE review panel, or
* in the reasonable belief that the act or omission was in the performance of a function under this Act as a member of a SAPSE review panel.[[27]](#footnote-28)

A member of the SAPSE review panel will also not be liable in defamation for anything they say in performing the SAPSE review functions, or for anything in the SAPSE review report.

In addition, a person who provides information to a SAPSE review panel in good faith, is also not personally liable for the giving of information in the reasonable belief that the information was necessary for the purposes of the SAPSE review.[[28]](#footnote-29) This means that relevant persons can provide information that is relevant to the SAPSE review without being concerned about possible legal action against them, such as defamation action.

Any liability resulting that would have applied to a member of the panel, or person giving information to the panel in these circumstances, instead attaches to the health service entity or entities that appointed the SAPSE review panel. In the setting of a joint SAPSE review panel where the CEOs could not agree, any liability resulting from an act or omission, attaches to the health service entities. [[29]](#footnote-30)

## Protections for persons who provided information relevant to the SAPSE review

Certain protections are included in the legislation for persons who provide information to the SAPSE review panel to allow people to speak freely to the panel if they have knowledge of the event, or any other information that is relevant to the SAPSE review, such as information about hospital systems.

A person cannot be required to give evidence in in a legal proceeding, or required to respond to any legal process, about:

* whether the person gave information to a SAPSE review panel
* what information the person gave to a SAPSE review panel
* a document the person gave to a SAPSE review panel that was created by the person for the purposes of the SAPSE review
* information the person was given, or questions the person was asked, by a SAPSE review panel.[[30]](#footnote-31)

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| These protections do not apply to legal proceedings about the actual SAPSE itself; they prevent a person being asked about their interaction with the SAPSE review panel. |

## Protections for SAPSE review panel members when requested to give evidence

To ensure that the SAPSE review panel can undertake their review without being concerned about the review report or working documents being requested by a court in medico-legal action, the legislation provides protections to ensure that those persons cannot be required to give evidence or produce relevant documents (including the SAPSE review report).

Evidence concerning the SAPSE review report and any working documents of the SAPSE review panel is not admissible in any court, tribunal, board or other agency proceedings. This means that a SAPSE review panel member cannot be required to give evidence about the proceedings of the SAPSE review panel.[[31]](#footnote-32)

## Protections of reports and working documents from legal proceedings

SAPSE review reports and working documents created specifically by (or for) a SAPSE review panel cannot be accessed under court orders or by request of any tribunal, board agency or other person. In addition, these documents are not admissible in legal proceedings (including civil, criminal and disciplinary proceedings). Disclosing the SAPSE review report to the Coroner or Coroner’s Court (as appropriate) must be for the purpose of an investigation or an inquest as outlined in the *Coroners Act 2008*.

The SAPSE review report and working documents of the SAPSE review panel are not required to be produced if requested under the *Freedom of Information Act 1982* (Vic) or *Health Records Act 2001.[[32]](#footnote-33)*

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| The protections do not apply to primary source documents such as medical records and other corporate records of the health service entity that are not developed to inform the SAPSE review. A patient's right to request their health records is not affected by the protections. |

## Confidentiality obligations applying to a member of the SAPSE review panel

This section applies to anyone that was or is a member of a SAPSE review panel. Any person involved on the panel must not disclose any information acquired by the panel performing the review, except for the following circumstances:

* in the course of exercising the person's functions as a panel member
* for the purpose of any recommendations made by the panel
* for the purpose of any required or discretionary disclosure of the SAPSE review panel (such as when the report is provided to the patient or the Secretary).

**Note**: Disclosure of information is an offence with a penalty of 10 penalty units.[[33]](#footnote-34)

## Confidentiality of SAPSE review panel members

A health service entity that has appointed a SAPSE review panel, or a member of staff of that health service entity, must not disclose the identity of any member of that panel.

**Note**: Disclosure of this information in the case of an individual is an offence with a penalty of 10 penalty units. In the case of a body corporate, the penalty is 50 penalty units.[[34]](#footnote-35)

# Appendix 1: Review team member roles

Having a balanced and effective team is a key element of a productive review. Review teams should be formed in conjunction with the executive sponsor and/or team leader. It is recommended that the following persons support or be part of the SAPSE review panel.

### Executive sponsor

The executive sponsor is a member of the health service entity’s executive who is not an active member of the review team, and therefore does not participate in review meetings.

Their role includes:

* allocating resources to the review
* being available as a contact point for escalation of issues
* reducing barriers during the review process
* supporting the review team to complete the review, including in formulating recommendations and sharing what has been learned from the review.

### Team leader (Chair)

The team leader is often a senior employee of the health service entity (such as a manager, nurse, midwife, engineer or doctor). It is recommended that they have previous experience in conducting adverse event reviews.

Their role in the review includes:

* identifying and managing conflicts of interest
* supporting the review team and acting as a first point of escalation for any concerns
* chairing the review team meetings
* informing the team of the ‘rules of engagement’ (for example, confirming every team member has a voice, and must actively listen to others)
* ensuring adherence to the review methodology
* ensuring any issues arising from the review are escalated accordingly.

### Facilitator

The facilitator is often a quality and safety professional, and should have training in the review methodology being utilised.

Their role in the review includes:

* coordinating team formation in conjunction with the executive sponsor and/or team leader
* coordinating logistics of the review such as team meetings and schedules
* gathering relevant information (e.g. patient histories, policies and procedures and interviews)
* sharing relevant information with review team members, maintaining the confidentiality and security of review information
* collating the review report.

### Team member

Team members are individuals who may or may not be employed by the health service entity. They can hold any role, including manager, nurse, midwife, engineer, doctor or consumer representative.

It is to note that this person must not have been involved in the event and should not be the manager of the unit/area where the event occurred.

Their role in the review includes:

* actively participating in the review process (including reading and analysing relevant information)
* adhering to the agreed rules of engagement of the team
* bringing their expertise to the review team (clinical, management, health service, consumer etc.).

### Additional responsibilities of specific team members

* **Consumer representatives:** provide a patient, family or carer perspective.
* **External members:** provide a clear and objective perspective on the information presented. They do not have current employment or association with the health service entity where the event occurred.

# Associated Act and other resources

[Expert Working Group report on statutory duty of candour](https://www.safercare.vic.gov.au/sites/default/files/2022-03/expert-working-group-report-on-statutory-duty-of-candour.docx)

[*Health Legislation Amendment (Quality and Safety) Act 2022*](https://www.legislation.vic.gov.au/as-made/acts/health-legislation-amendment-quality-and-safety-act-2022)

[*Health Services Act 1988*](https://www.legislation.vic.gov.au/in-force/acts/health-services-act-1988/175)

[*Health Services (Quality and Safety) Regulations 2020*](https://www.legislation.vic.gov.au/as-made/statutory-rules/health-services-quality-and-safety-regulations-2020)

[Learning and education | Safer Care Victoria](https://www.safercare.vic.gov.au/e-learning)

[Policy: Adverse patient safety events](https://www.safercare.vic.gov.au/publications/policy-adverse-patient-safety-events)

[Statutory Duty of Candour and protections for SAPSE reviews | Safer Care Victoria](https://www.safercare.vic.gov.au/support-training/adverse-event-review-and-response/duty-of-candour)

[Targeting zero report: Better, Safer Care, Delivering a world-leading healthcare system](https://www.dhhs.vic.gov.au/publications/targeting-zero-review-hospital-safety-and-quality-assurance-victoria)

[The Australian Open Disclosure Framework](https://www.safetyandquality.gov.au/our-work/open-disclosure/the-open-disclosure-framework)

[Victorian Duty of Candour Framework](https://www.safercare.vic.gov.au/sites/default/files/2022-10/Victorian%20Duty%20of%20Candour%20Framework%20-%20FINAL.docx)

*[Victorian Duty of Candour Guidelines](https://www.safercare.vic.gov.au/sites/default/files/2022-08/Victorian%20Duty%20of%20Candour%20Guidelines%20.docx)*

[[Victorian sentinel events guide](https://www.safercare.vic.gov.au/sites/default/files/2022-08/Victorian%20Duty%20of%20Candour%20Guidelines%20.docx)](https://www.safercare.vic.gov.au/publications/sentinel-events-guide)

1. Regulation 3A of the *Health Services (Quality and Safety) Regulations 2020.* [↑](#footnote-ref-2)
2. s128ZB of the *Health Services Act 1988*. [↑](#footnote-ref-3)
3. Regulation 3A of the *Health Services (Quality and Safety) Regulations 2020.* [↑](#footnote-ref-4)
4. For full definition, see Regulation 3B of the *Health Services (Quality and Safety) Regulations 2020.* [↑](#footnote-ref-5)
5. s3 of the *Health Services Act 1988*. [↑](#footnote-ref-6)
6. Regulation 3A of the *Health Services (Quality and Safety) Regulations 2020.* [↑](#footnote-ref-7)
7. Regulation 3A of the *Health Services (Quality and Safety) Regulations 2020.* [↑](#footnote-ref-8)
8. Expert Working Group. (2018). *A statutory duty of candour. Report to the Minister for Health.* 1 Treasury Place, Vic: Department of Health. [↑](#footnote-ref-9)
9. See definition of ‘health service entity’ in s4 of the *Health Services Act 1988.* [↑](#footnote-ref-10)
10. s128O of the *Health Services Act 1988*. [↑](#footnote-ref-11)
11. s128T of the *Health Services Act 1988.* [↑](#footnote-ref-12)
12. s128T of the *Health Services Act 1988.* [↑](#footnote-ref-13)
13. s128V of the *Health Services Act 1988*. [↑](#footnote-ref-14)
14. s128U of the *Health Services Act 1988.* [↑](#footnote-ref-15)
15. s128V of the *Health Services Act 1988.* [↑](#footnote-ref-16)
16. s128X of the *Health Services Act 1988.* [↑](#footnote-ref-17)
17. s128Y of the *Health Services Act 1988.* [↑](#footnote-ref-18)
18. s128Z of the *Health Services Act 1988*. [↑](#footnote-ref-19)
19. s128P of the *Health Services Act 1988.* [↑](#footnote-ref-20)
20. s128Q of the *Health Services Act 1988.* [↑](#footnote-ref-21)
21. s128P of the *Health Services Act 1988.* [↑](#footnote-ref-22)
22. s128T of the *Health Services Act 1988* [↑](#footnote-ref-23)
23. s128V of the *Health Services Act 1988* [↑](#footnote-ref-24)
24. s128V of the *Health Services Act 1988* [↑](#footnote-ref-25)
25. s128U of the *Health Services Act 1988* [↑](#footnote-ref-26)
26. s128Z of the *Health Services Act 1988.* [↑](#footnote-ref-27)
27. s128R of the *Health Services Act 1988.* [↑](#footnote-ref-28)
28. s128S of the *Health Services Act 1988.* [↑](#footnote-ref-29)
29. s128R and s128S of the *Health Services Act 1988.* [↑](#footnote-ref-30)
30. s128U and s128W of the *Health Services Act 1988.* [↑](#footnote-ref-31)
31. s128U and s128X of the *Health Services Act 1988.* [↑](#footnote-ref-32)
32. s128U of the *Health Services Act 1988.* [↑](#footnote-ref-33)
33. s128X of the *Health Services Act 1988.* [↑](#footnote-ref-34)
34. s128Y of the *Health Services Act 1988.* [↑](#footnote-ref-35)