Abridged SAPSE review reports

Background

When a Serious Adverse Patient Safety Event (SAPSE) occurs, a SAPSE review may be conducted by a SAPSE review panel appointed under Division 8 of Part 5A of the *Health Services Act 1988* (Vic) (**HS Act**).

Under section 128T(1) of the HS Act:

- A SAPSE review panel must prepare and produce a report for the appointing health service entity as soon as practicable after completing its investigation.

Under section 128V of the HS Act:

- A health service entity that receives a report under section 128T must:
    - Disclose the report as directed by the Secretary or to any prescribed person.
    - Offer the report (and provide a copy where accepted) to the relevant patient, a person nominated by the patient, or the immediate family, carer, or Next of Kin (NOK) if the patient is deceased or lacks capacity.

Important: It should be noted that section 128V of the HS Act requires the health service entity to offer the same report it receives from the SAPSE review panel to the patient, person nominated by the patient or family/carer/NOK.

Safer Care Victoria (**SCV**) is prescribed as a quality and safety body under section 134V of the HS Act. A health service entity may disclose 'confidential information' for a quality and safety purpose to a quality and safety body under section 134X(3)(b) of the HS Act. This includes information pertaining to SAPSE reviews. SCV have oversight of all sentinel events in health service entities in Victoria. SAPSEs are a subset of sentinel events.

The Minister for Health has authorised the sharing of confidential information between health service entities for the purpose of a review of an adverse patient safety event (including SAPSE reviews) where patient care was provided by multiple health service entities. The instrument was published in the Government Gazette on 29 August 2024.

Protections under the HS Act

If all requirements under the HS Act are met, the SAPSE review is protected. This includes:

- The SAPSE review report, or any evidence of or about it.
- Any document or any other evidence created solely for the purpose of providing information in the course of conducting the SAPSE review process, under the auspices of a SAPSE review panel.

These protections mean all evidence and documents relating to a SAPSE review may not be released under:

a. The *Freedom of Information Act 1982* (Vic) (**FOI Act**) under section 128U(4) of the HS Act, or;

b. Part 5 and HPP 6 of the *Health Records Act 2001* (Vic) (HR Act), under section 128U(5) of the HS Act.

Important: Only documents, evidence and reports created in the course of conducting the SAPSE review by the SAPSE review panel are protected. Ancillary reports developed outside of the SAPSE review panel may not qualify.

Issues identified by SCV

SCV has identified that reports held in the Sentinel Event Portal relating to SAPSEs, may differ from the version provided to patients, families, carers, or NOK. This creates:

- Challenges identifying which version of the report has been released to the family under SDC and SAPSE legislation, which also raises concerns about requests received under the FOI Act.
- Compliance with statutory protections, as the HS Act does not contemplate multiple versions of the SAPSE review report.
- Concern that any abridged version may not meet SCV quality assurance standards nor withstand scrutiny by other authorised bodies such as the Coroners Court of Victoria.

Implications for Statutory Duty of Candour (SDC)

The Victorian Duty of Candour Guidelines contains a requirement in the SDC process to complete a review for the SAPSE and produce a report outlining what happened and identified areas for improvement. If the SAPSE is also a sentinel event, the health service entity must also outline recommendations from the review findings in the report.

If a more detailed version of the SAPSE review report exists but is not shared with the patient or family, this raises concerns about:

- Transparency and completeness of information provided, and;
- Potential inconsistency with the intent of the SDC process.

Important: The existence of multiple versions of the report raises a concern that there has been information withheld, which may itself be considered inconsistent with the SDC.

SCV Recommendation

The intent of both the SAPSE review and the SDC process is to place the patient and their family at the centre of care. These processes exist to ensure openness, honesty, and transparency. Providing complete and accurate information fosters trust, enables learning, and drives improvement in healthcare delivery.

To ensure compliance and transparency, SCV recommends that the report provided within the Sentinel Event Portal is the SAPSE review report. This report should be provided to the patient, or their immediate family, carer, or NOK as part of the SDC and SAPSE review process.

If a consumer-friendly summary of the SAPSE review report is prepared, it must:

- Be created by the SAPSE review panel to maintain statutory protections, and
- Be provided in addition to the more fulsome report.

SCV also recommends that, when providing both the consumer-friendly and fulsome report, the rationale for creating an abridged version should be clearly explained. This approach removes ambiguity of withholding information, mitigates FOI concerns, and supports openness.

Important: If there are concerns relating to transparency and openness, the Secretary may otherwise direct that the health service provides a copy of the abridged version of the report to SCV, pursuant to section 128T of the HS Act.