Sentinel Events

Annual Report 2024–2025

Safer Care Victoria

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Acknowledgements

ACKNOWLEDGEMENT OF COUNTRY

Safer Care Victoria acknowledges the strength, resilience and enduring cultures of First Nations peoples as members of the world's oldest living cultures. We recognise First Nations peoples as Australia's First Peoples and honour the richness and diversity of Traditional Owners and Elders across Victoria.

We respect the lore, customs and languages practised by First Nations people in Victoria, and their deep spiritual and cultural connections to land and water. We are committed to a future based on equality, truth and justice, and recognise the ongoing systemic injustices facing First Nations people. Victoria's treaty offers a chance to address these wrongs, empowering First Nations people to make decisions for their communities, consistent with the principle of self-determination.

We pay our deepest respects to ancestors, Elders and leaders, past and present, whose strength and fortitude have paved the way for future generations.

ACKNOWLEDGEMENT OF LIVED EXPERIENCE

Safer Care Victoria acknowledges the consumers, families, carers, friends and loved ones who have experienced, or have been affected by, sentinel events. We are deeply sorry for their distress and grief. We bear witness to their stories in the sincere hope of improving safety and quality care for others.

Our appreciation extends to the clinical and non-clinical workforces that support people with lived experience.

CONTENT WARNING

The content in this report may be distressing because it references death and serious harm in patients of all ages, as well as death and harm from suicide, self-harm and mental illness.

ACKNOWLEDGMENT OF TERMINOLOGY

Due to the diversity of programs and specialties covered by the Sentinel Event Program we acknowledge different terms routinely used in these areas to refer to a 'patient' or 'consumer'.

The terms 'family', 'next of kin' and 'carer(s)' may also be used interchangeably. We acknowledge the diversity of the networks that patients/consumers affected by sentinel events have surrounding them.

THANK YOU

Safer Care Victoria's Sentinel Events and Safety Review team prepared this report in collaboration with experts across the health system. The team thanks St Vincent's Health and consumers for their invaluable contribution to this report and for continuing to share their experiences with the aim of improving our health system. Thank you also to Victorian health services for sharing lessons from sentinel events as we strive together to continuously improve the quality, safety and consumer experience of our health system.

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Foreword – Louise McKinlay, CEO

Safer Care Victoria (SCV) is committed to continuous improvement to support a safer health system for all Victorians. While most care delivered in Victoria leads to positive outcomes, there are times when things go wrong and patients, families, carers, consumers and staff are deeply affected. In those moments, it is essential that we respond with honesty, compassion and a shared commitment to learning.

SCV works in partnership with health services to lead improvement, provide insight and strengthen the quality and safety of care across the health system. We seek to understand the system factors that contribute to serious patient harm and to support health services to listen to, involve and support affected patients, carers, families and those close to them. Their experiences are critical to shaping safer care and informing action to prevent similar events in the future.

Insights from sentinel event reviews are vital to improving patient safety and reducing the risk of future harm. This report shares data, analysis and system insights from across Victoria to support health services to strengthen the care they provide.

This report includes analysis of reported harm events, emerging themes, a case study, guidance and recommendations for health services. It also highlights relevant resources and examples of improvement activity underway across SCV and the broader health sector.

This year's report shows continued improvement in several areas:

- Reporting of sentinel events has remained strong, particularly in the private health sector. This reflects a maturing reporting culture and stronger partnership with health services to support quality and safety improvement.
- Consumer representation on review panels has increased from 70% in 2021–22 to 99% in 2024–25. This indicates growing maturity in how health services partner with consumers and ensure review outcomes are informed by lived experience.
- External expert representation on review panels also increased to 99% in 2024–25, strengthening the rigour, independence and transparency of review processes.
- Completion rates for review recommendations at six and 12 months continue to improve, alongside a reduction in the time taken to complete reviews. This means more recommendations are being implemented sooner, supporting earlier learning and reducing the risk of recurrence.
- Open disclosure data for sentinel events continues to improve across Victorian health services. This reflects the growing integration of the statutory duty of candour into everyday practice. A case study from St Vincent's Health highlights leading practice in how the statutory duty of candour can be operationalised to support openness, transparency, partnership with consumers and continuous learning.
- Recommendations written using specific, measurable, achievable, realistic and time-bound (SMART) principles increased from 61% in 2021–22 to 81% in 2024–25, reflecting a stronger focus on recommendations that are clearer, more actionable and more likely to be implemented.

Several themes emerged strongly in 2024–25. This year's report focuses on four key areas where systems can be strengthened to improve the quality and safety of care:

- **Perioperative care (surgery-related):** examining events to strengthen recognition and response to deterioration, improve adherence to protocols and policies, and support safer communication and coordination across perioperative care.
- **Maternity and paediatric care:** analysing events to identify ways to improve outcomes for mothers, babies and children through stronger systems, earlier recognition of deterioration and better partnership with families and carers.
- **Mental health and self-harm:** strengthening support and interventions after discharge to reduce the risk of self-harm, including through adopting the *Zero Suicide Framework* to improve the pathway of care.
- **Medication errors:** identifying system-wide issues to promote safer medication management, particularly for anticoagulants, which continue to be the leading cause of medication-related sentinel events.

Safe care depends on every member of the health service team, including clinicians, administrative staff and support staff. Health services also work alongside government agencies that provide leadership, insight and guidance in adverse event management. Through this shared effort, we continue to learn from serious patient harm and strengthen the systems that support safe, high-quality care for all Victorians.

Louise McKinlay
Chief Executive Officer
Safer Care Victoria

Introduction

This report summarises the trends and insights Safer Care Victoria (SCV) has identified through the Victorian Sentinel Event Program during the 2024–25 financial year. It provides a clear and transparent account of reported sentinel events and highlights opportunities to improve the quality and safety of care across Victoria.

The report's purpose is to support health services to understand the system factors that contribute to serious harm and to use those insights, together with practical guidance and resources, to reduce the risk of recurrence. The themes are summarised throughout the report, but you will find more detailed data in Appendix 1: Data supplement. Refer to Appendix 2 for more information about the sentinel event identification, review and recommendation development process.

The report aims to be useful to consumers, carers and families by sharing evidence-informed information drawn from sentinel event data and highlighting SCV initiatives that support improvement across the health system.

As we reflect on the findings of the 2023–24 annual report, SCV remains committed to working in partnership with consumers, carers and families. Learning from sentinel events is central to improving people's experiences of safe, high-quality care and to strengthening the systems that support that care.

Several key themes emerged during 2024–25, and this report focuses on the four most common ones:

- perioperative care (surgery-related)
- maternity and paediatric care
- mental health and self-harm
- medication errors.

This year's report also includes a case study shared by a Victorian health service that highlights improvements in meeting statutory duty of candour obligations (SDC) under the *Health Services Act 1988*. The case study showcases a leading practice approach to implementing the SDC through partnering transparently, sensitively and proactively with consumers, carers and their families.

At SCV, we recognise that strong partnerships with health services are essential to improving quality and safety in health care. By sharing insight, promoting leading practice and supporting the adoption of effective models of care, we aim to strengthen care across Victorian health services.

Our goal is to strengthen sentinel event reporting and review processes in partnership with stakeholders while supporting consumers, carers and families – they are fundamental to this goal and central to strong clinical governance in Victoria.

This report discusses real events. It outlines improvements SCV is implementing at both the health service and system levels. By sharing these insights, we aim to support learning across the sector and to reduce avoidable harm across the health system.

We want this report to be accessible and relevant to Victorian consumers, families and carers and health services. To make this easier, you can find:

- actions that health services, consumers, carers and families may wish to take in response to information provided
- links to further reading and resources at the end of the report to help drive awareness of the Sentinel Events Program (including initiatives relevant to the key themes that extend beyond SCV) and continuous improvement
- a case study showcasing leading practice and an area of significant health service improvement in implementing the SDC obligation under the Health Services Act
- a glossary at the end of the report that explains technical terms.

Throughout this report, names and clinical details have been deidentified to protect patient and staff privacy. The data presented is based on sentinel event reporting only. Data has been rounded to the nearest percentage and, where infographics show multiple categories, only 80% of variables may be represented for easier interpretation.

We note that sentinel event data cited in this report is based solely on sentinel events reported by Victorian health services to SCV in the sentinel event portal and acknowledge potential limitations in this regard.

FEEDBACK AND FUTURE REPORTS

How did we do?

When you have finished reading this report, we would value your feedback. Please complete our **online survey** <https://forms.cloud.microsoft/pages/responsepage.aspx?id=H2DgwKwPnESciKEExOufKKKiKj4jFNJOpdpiDEyZVANUNlhBMkwyUTJERVNRQ0IzWElST1g0RVpUNC4u&route=shorturl> or use the **QR code** below to access it.

Do you have a consumer or health service story to share?

If you would like to be involved in developing future reports and share your story, please provide your contact details at the end of the survey or **email SCV** <sentinel.events@safercare.vic.gov.au>.

WHAT IS A SENTINEL EVENT?

The Australian Commission on Safety and Quality in Health Care (ACSQHC) defines sentinel events as 'a subset of adverse patient safety events that are preventable and result in serious harm to, or the death of, a patient'. In Victoria, sentinel events are defined as 'unexpected and adverse events that occur infrequently in a health service that result in the death of, or serious physical or psychological harm, to a patient because of system or process deficiencies'.[1]

Every Australian state and territory monitors and reports on 10 national sentinel event categories. Victoria has an extra reporting category – category 11. Category 11 covers 'all other adverse patient safety events resulting in serious harm or death' which fall outside standard national reporting.

The full list of these categories is in the SCV publication, *What to report* <https://www.safercare.vic.gov.au/report-manage-issues/sentinel-events/what-to-report>.

WHICH EVENTS ARE NOTIFIABLE IN VICTORIA?

Victorian health services must notify and review sentinel events that meet the criteria for the ACSQHC sentinel event categories (1–10) and those that fall under the Victoria-only category 11.

SENTINEL EVENT IDENTIFICATION

Clinicians usually identify sentinel events at the point of care, when the sentinel event occurred. Occasionally, sentinel events are not immediately identifiable, but may be identified:

- by other hospitals, primary care providers or the patient/consumer and/or their family/carers
- after a patient's discharge or death.

RESOURCE:

Victorian sentinel events guide

The *Victorian sentinel events guide* <https://www.safercare.vic.gov.au/best-practice-improvement/publications/sentinel-events-guide> has essential information for health services about identifying and managing sentinel events.

This resource includes:

- guidance for notifiable sentinel events, including information about psychological harm and life-saving care
- guidance on the Victoria-only category 11, including case studies and examples.

2024–25 SENTINEL EVENT DATA AT A GLANCE

In 2024–25 there were 217 sentinel event notifications, 24 more than in 2023–24. Since 2019–20, Victoria continues to see an overall trend of increasing sentinel event notifications (Table 1 and Figure 1). This trend is likely due to several factors including increased clinical governance and reporting culture maturity in health services.

For reporting purposes, we identified health services within tertiary, major and non-metropolitan hospital peer groups. We looked at notification rates across health service peer groups and noted the most significant reductions in the 'major' peer group. We also considered non-metropolitan services.

1. Safer Care Victoria (2024) *Victorian sentinel event guide: essential information for health services about managing sentinel events in Victoria* (Version 2), State Government of Victoria, Melbourne.

Table 1. Number of sentinel events notified across Victoria, 1 July 2019 to 30 June 2025

Year	Total sentinel events	Private	Public	Category 11	Categories 1 to 10
2019–20	**186**	20	166	163	23
2020–21	**168**	28	140	144	24
2021–22	**240**	43	197	212	28
2022–23	**245**	24	221	210	35
2023–24	**193**	33	160	169	24
2024–25	**217**	34	183	196	21

Figure 1. Total number of sentinel events notified across Victoria, 1 July 2019 to 30 June 2025

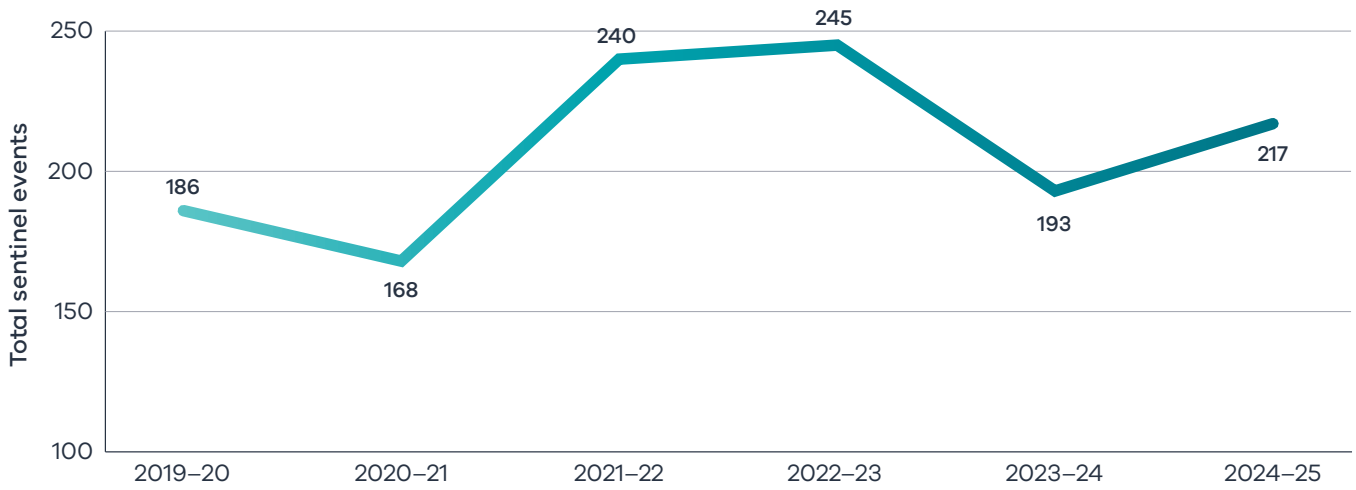


Figure 2 breaks down the year's sentinel events by the top seven categories. Figure 3 shows the top seven admitting specialties.

REVIEW PANEL COMPOSITION

SCV continues to see improvements in review panel composition, including stronger consumer and external expert representation (Figure 4). This is important in ensuring outcomes are informed by lived or living experience. Consumers include patients, carers, families and community impacted by health service treatment and care.

Their contribution is essential to safe, high quality care and to continuous improvement across the health system. Effective partnering provides accountability and transparency in service delivery and strengthens consumer participation in review processes.

2024–2025 at a glance

217 events reported an increase of 24 from 2023–24

Figure 2. Breakdown of sentinel events top seven categories or sub-categories at notification, 2024–25

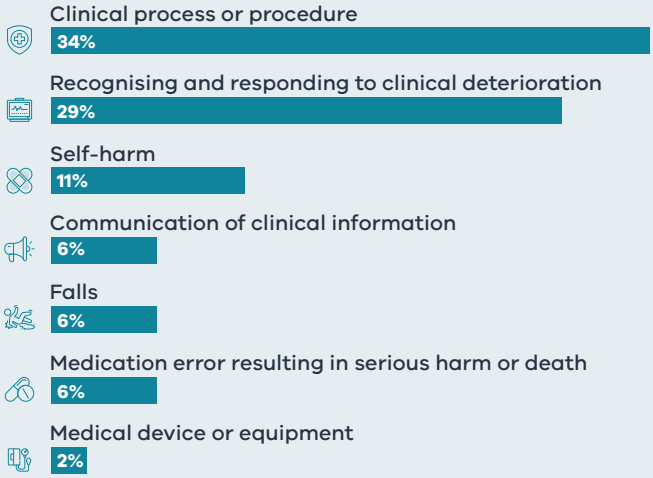


Figure 3. Sentinel events by top seven admitting specialties, 2024–25

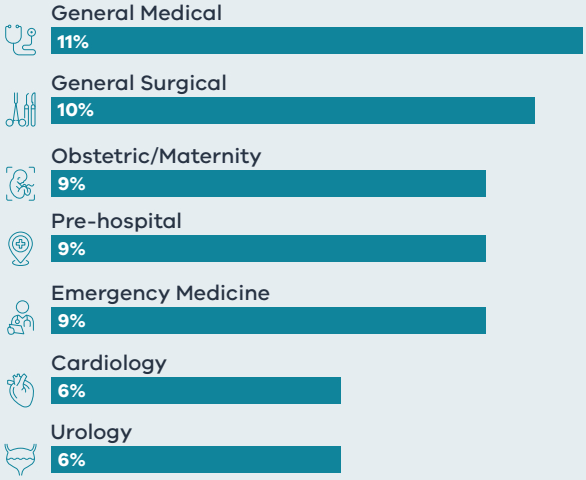
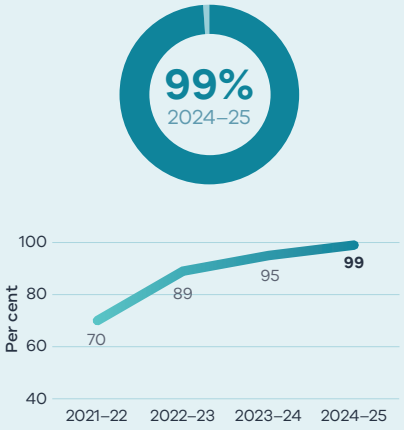
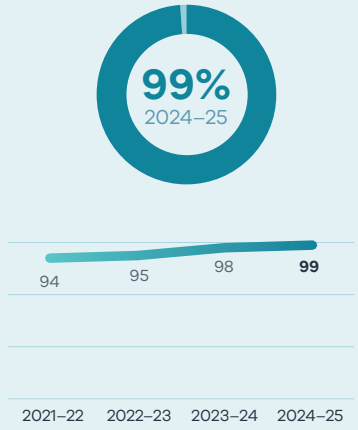


Figure 4. Review panel membership, 2021–22 to 2024–25

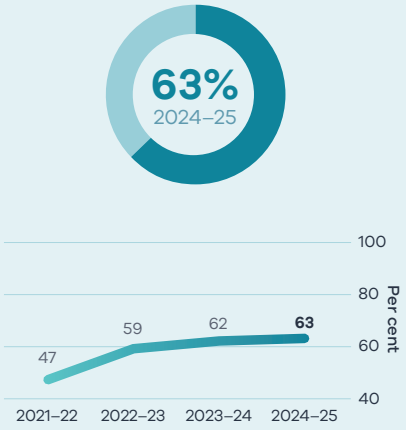
99% of review teams had a consumer representative



99% of review teams had an external expert



63% of reviews involved contributions from patients, their families or carers



682 findings

436 lessons learnt

915 recommendations were made

GUIDANCE FOR HEALTH SERVICES TO SUPPORT CONSUMER, CARER AND FAMILY ENGAGEMENT

Health services should ensure:

- a glossary is accessible to panel members to ensure technical terms are explained
- the review process is clearly explained to consumer panel members as part of their induction and access to a support person from health service consumer groups or consumer liaison is provided
- consumer needs are appropriately identified including, for example, culturally appropriate support or accessibility requirements
- time is made to introduce consumers to the panel chair about a week before their first meeting
- the panel minimises or avoids using technical jargon during meetings and consumers have the chance to review final reports
- networking opportunities with neighbouring or larger health services are used to help identify consumer representatives for panels and to share consumer resources
- the SCV Sentinel Events and Safety Review team is contacted if health services cannot find consumer representatives, especially if seeking a consumer with lived experience
- a learning package is developed using the SCV **online training modules** <https://www.safercare.vic.gov.au/best-practice-improvement/online-training-modules> and **guidance to support consumers in preparing for review panels** <https://www.safercare.vic.gov.au/report-manage-issues/managing-adverse-events#goto-toolsand-resources>.

GUIDANCE FOR CONSUMERS

If you are interested in working with a health service to improve the quality and safety of care, contact the health service and ask for information on how best to become involved. You could also visit the **Guides to consumer representatives on adverse event reviews webpage** <https://www.safercare.vic.gov.au/best-practice-improvement/publications/guides-to-consumer-representatives-on-adverse-event-reviews>.

IMPROVEMENT INITIATIVES AND RESOURCES

- **How to engage a consumer representative** <https://www.safercare.vic.gov.au/support-and-training/partnering-with-consumers/health-services/how-to-engage-a-consumer-representative>
- **Consumer representatives on review teams** <https://www.safercare.vic.gov.au/report-manage-issues/sentinel-events/involve-consumers-in-incident-reviews>
- **Guide to consumer remuneration** <https://www.safercare.vic.gov.au/sites/default/files/2019-01/Remunerating%20consumers%20a%20guide%20for%20government.pdf>

Key sentinel event themes in 2024–25

To maximise learning and improvement opportunities for Victorian health services, this report focuses on key sentinel event themes frequently reported to SCV during 2024–25.

This section analyses sentinel event data to:

- identify shared insights
- highlight key areas of improvement across the sector
- spotlight key SCV initiatives that support health services in these areas
- outline resources that support ongoing capability development and continuous learning.

This year's report covers four key themes:

- **perioperative care (surgery-related)**
- **maternity and paediatric care**
- **mental health and self-harm**
- **medication errors.**

1. SENTINEL EVENTS RELATING TO PERIOPERATIVE CARE (SURGERY-RELATED)

In Victoria, both SCV and the Victorian Perioperative Consultative Council review perioperative sentinel events. The council oversees, monitors and analyses cases of perioperative mortality and morbidity.

Perioperative sentinel events cover the entire perioperative period – before, during and after surgery. This category may also include events involving unfulfilled outpatient or referral processes, such as to oncology, or delayed recognition of a surgical problem when a patient presents to an emergency department.

In 2024–25 health services identified **65** perioperative or periprocedural sentinel events.

The perioperative care data presented in this report is drawn from the SCV sentinel event portal point of notification, where health services select relevant surgery, anaesthetic and procedure categories. Other cases may meet the criteria for this category but are not included in this analysis — for example, cases involving missed surgery or missed referrals.

Key themes

In 2024–25, **88%** of all perioperative events were Category 11 events. The top subcategories were:

- clinical process or procedure
- deteriorating patient
- communication of clinical information
- medical device or equipment.

The remaining perioperative-related sentinel events were from the following categories:

- category 1: procedure performed on the wrong site resulting in serious harm or death (3%)
- category 3: wrong surgical or invasive procedure resulting in serious harm or death (1.5%)
- category 4: unintended retention of a foreign object resulting in serious harm or death (4.6%)
- category 7: medication errors resulting in serious harm or death (2.9%).

Figure 5 lists the top five lessons learnt from errors involving procedure-related events.

Figure 5. Top five lessons learnt from surgical, anaesthetic or procedure-related events, 2024–25

Teamwork factors	24%	
Staff factors	23%	
Procedures and guidelines	18%	
Documentation, assessment and decision support	10%	
Systems and processes	4%	

GUIDANCE FOR HEALTH SERVICES TO INFORM CONTINUOUS IMPROVEMENT IN SURGICAL AND PROCEDURAL CARE

SCV's analysis of surgical and procedural sentinel events in 2024–25 identified several recurring system issues and opportunities to strengthen safety across the surgical care journey.

While the clinical circumstances varied, common themes highlighted the need for reliable systems to support early recognition and response to deterioration, effective multidisciplinary decision-making and clear communication across all stages of care.

The **top three themes** are:

- **Missed early recognition and management of complications:** This includes missed recognition or response to patient deterioration or a delayed escalation to senior staff.
- **Non-adherence to protocols, policies, procedures or pathways:** Safety processes were in place but were not reliably followed. This includes missed referrals, outpatient follow-up and reviews of pathology results.
- **Communication and handover:** Critical information was not consistently transferred, synthesised or acted on across teams and care settings.

Delays in recognising or escalating clinical deterioration

- Several sentinel events involved delayed recognition or escalation of clinical deterioration in the perioperative or post-procedural period. In these cases, early physiological warning signs or evolving symptoms were present but were not recognised as indicators of serious illness or were not escalated in a timely manner.

Health services should continue to reinforce the consistent use of deterioration recognition systems and escalation pathways for surgical patients – for example:

- reviewing track and trigger charts that help support clinical decision-making
- ensuring clear policies for transferring care
- initiating appropriate responses to patient and carer escalation.

Ensuring reliable perioperative safety processes are embedded in practice

Inconsistently adopting established perioperative safety processes was consistently identified across reviews, including:

- verifying and documenting patient or next-of-kin consent
- implementing airway management practices
- ensuring medication administration safeguards
- adding in surgical time-out procedures
- following postoperative monitoring requirements.

Simulation training helps embed these safety-critical processes into routine. Preparing as a multidisciplinary team is essential to improving reliability and reducing risk.

Strengthening preoperative assessment and multidisciplinary planning

This year's sentinel events highlighted opportunities to strengthen preoperative assessment and planning for complex patients, including:

- early multidisciplinary meetings to support coordinated care planning

GUIDANCE FOR HEALTH SERVICES TO INFORM CONTINUOUS IMPROVEMENT IN SURGICAL AND PROCEDURAL CARE (CONT)

- reviewing a patient's clinical history
- strengthening informed consent processes to support shared decision-making
- clearly discussing risks, benefits and treatment options, including non-surgical alternatives
- supporting appropriate patient and family expectations before surgery
- better coordinating perioperative care for high-risk patients
- having a physician with expertise in perioperative medicine assess and discuss all treatment options for:
  - elderly patients
  - patients with significant comorbidities.

Ensuring reliable communication and clinical handover

Communication and handover failures between teams and services were a recurring theme, including:

- critical information relating to medication plans, comorbidities, diagnostic uncertainty and follow-up responsibilities not being reliably transferred between clinicians or care settings
- delays in referrals, including oncology referrals
- missed or delayed outpatient follow-up
- delayed diagnostic interventions (for example, colonoscopy)
- failure to appropriately follow up one of multiple presenting conditions
- missed opportunities to strengthen systems for clear and timely communication at critical transition points, including surgical time-out and transfer-of-care procedures.

The ACSQHC has published its *Communicating for safety standard*. This standard aims to ensure timely, purpose-driven and effective communication and documentation that supports continuous and coordinated care for consumers.

Strengthening system reliability in surgical care

SCV's analysis reinforced the importance of system reliability in high-risk clinical environments by focusing on multidisciplinary collaboration, supported through:

- interdisciplinary training
- reliable safety processes
- embedding principals of safety culture
- early escalation.

More focus on system reliability will support health services to strengthen surgical safety and improve patient outcomes.

Reporting surgical, anaesthetic and procedure events

The surgical, anaesthetic or procedure event type should be used when the critical event occurred as a direct result of the surgical pre-planning, procedure or post-procedural care pathways. This classification is not required in cases where critical events resulted in restorative surgical care – for example, surgical repair of an injury following self-harm.

IMPROVEMENT INITIATIVES AND RESOURCES

SCV delivers targeted quality and safety improvement initiatives informed by sentinel event findings.

Key initiatives focus on:

- preventing venous thromboembolism and improving anticoagulant safety through strengthened risk assessment and evidence-based prophylaxis (end date 30 June 2026)
- improving perioperative discharge, recovery planning and patient preparation through discharge optimisation and enhanced recovery programs
- strengthening early sepsis recognition and timely antibiotic administration to improve outcomes in primary and postoperative sepsis.

The Department of Health's 2025 ***Planned surgery reform blueprint*** <https://www.health.vic.gov.au/planned-surgery-reform-blueprint> program outlines how to improve access to surgery.

'Think Aorta' awareness initiatives are being implemented across emergency departments, supported by targeted clinical prompts and educational materials.

Other clinical guidance resources that support continuous improvement in surgical and procedural care include:

- **Testicular torsion** <https://www.safercare.vic.gov.au/publications/testicular-torsion-clinical-practice-points>
- **Pulmonary embolism** <https://www.safercare.vic.gov.au/publications/pulmonary-embolism-pe-practice-points>
- **Concealed blood loss as a cause of postoperative deterioration – Clinical practice point** <https://www.safercare.vic.gov.au/publications/concealed-blood-loss-as-a-cause-of-postoperative-deterioration-clinical-practice-point>
- **Reducing peripheral intravenous cannula (PIVC) infections** <https://www.safercare.vic.gov.au/improvement/projects/reducing-picv-infections>
- **Preventing venous thromboembolism and supporting anticoagulation management** <https://www.safercare.vic.gov.au/improvement/projects/preventing-venous-thromboembolism>
- **Discharge optimisation for planned surgery** <https://www.safercare.vic.gov.au/improvement/projects/discharge-optimisation-for-planned-surgery> and **Celebrating improvement in planned surgery – results from 2024 to 2025** <https://www.safercare.vic.gov.au/news/celebrating-improvement-in-planned-surgery-results-from-2024-to-2025>
- **Sip Til Send fluid fasting guidance** <https://www.safercare.vic.gov.au/best-practice-improvement/clinical-guidance/non-urgent-elective-surgery/sip-til-send-fluid-fasting>
- **Morbidity and Mortality meetings – framework and toolkit** <https://www.safercare.vic.gov.au/publications/morbidity-and-mortality-meetings-framework-and-toolkit>
- **Considerations for a two-surgeon model of care – Clinical practice point** <https://www.safercare.vic.gov.au/publications/considerations-for-a-two-surgeon-model-of-care-clinical-practice-point>.

2. SENTINEL EVENTS RELATING TO MATERNITY AND PAEDIATRIC CARE

Maternity sentinel events

In 2024–25, **27** sentinel events impacted maternity and neonatal patients, compared with 25 events in 2023–24.

Key themes

In 2024–25, maternity notifications related to two themes:

- a deteriorating patient: 14 events
- a clinical process or procedure: 10 events.

Recurring sub-themes related to a delay in recognising patient deterioration and escalation to a senior obstetrician across three main areas:

- emerging high-risk maternal and fetal conditions during pregnancy without adjusted prebirth planning
- deteriorating cardiotocograph (CTG) monitoring during pregnancy or labour
- reported reduced fetal movements during pregnancy or labour.

Key contributing factors included:

- decision support being used but found not useful or difficulty locating policies: 25 cases (93%)
- environment factors, including overcrowding, lighting, temperature and alarm fatigue: 23 cases (85%)
- patient factors: 23 cases (85%)
- safety culture (four out of five event reviews).

Figure 6 lists the top five causes identified in maternity-related events.

Figure 6. Top five causes identified in maternity-related events, 2024–25

Procedures and guidelines	26%
Teamwork factors	22%
Staff factors	16%
Documentation, assessment and decision support	7%
Equipment, resources and medications	6%

GUIDANCE FOR HEALTH SERVICES TO INFORM CONTINUOUS IMPROVEMENT

SCV's analysis of maternity-related sentinel events identified recurring system-level issues across the care pathway. While individual clinical circumstances varied, consistent themes emerged as to the reliability of systems to support deterioration recognition, antenatal risk identification, intrapartum (during labour) monitoring and escalation of care. These included:

- delays in recognising and escalating maternal or fetal deterioration during pregnancy and labour
- early warning signs, including reduced fetal movements and CTG changes, not always recognised or escalated in a timely way
- in complex, time-critical settings, delayed escalation, which reduced opportunities for early intervention.

These findings highlight the importance of care models that consistently support early identification of deterioration and timely access to senior clinical decision-making.

Clinical process or procedure

How intrapartum fetal surveillance processes are applied in practice varied, including in:

- CTG interpretation
- escalation pathways
- use of clinical guidelines.

These variations reflected differences in local systems, workforce capability and how policies and procedures are interpreted and effectively implemented.

Recognition of high-risk and antenatal pathways

Sentinel event data highlighted gaps in how antenatal care pathways respond when clinical risks change over time. In some cases, care pathways did not reliably prompt reassessment or escalation when new risk factors emerged, which contributed to delays in intervention.

These findings highlighted the importance of antenatal care pathways that respond to changing risk and support timely multidisciplinary and senior clinical review.

Monitoring and escalation

SCV noted challenges with monitoring and escalation across multiple maternity sentinel events, including:

- difficulties in bringing together and interpreting clinical information
- delays in responding to abnormal findings
- escalating concerns across antenatal and intrapartum settings.

These findings highlight the need for monitoring and escalation systems that reliably support early recognition of deterioration and reduce reliance on individual judgement alone.

Summary

System insights show that improving safety requires strong, reliable systems that support clinicians, teams and consumers throughout the whole maternity care journey. The following system improvement examples from SCV focus on the common themes identified from maternity sentinel events.

Strengthening antenatal pathways and senior clinical involvement

Two approaches help optimise early management and reduce the likelihood of maternal or fetal deterioration later in pregnancy or during labour:

GUIDANCE FOR HEALTH SERVICES TO INFORM CONTINUOUS IMPROVEMENT (CONT)

- recognising the importance of antenatal care pathways that respond to changes in clinical complexity over the course of pregnancy
- proactively reviewing antenatal pathways, including early, face-to-face obstetric consultant involvement for women with increasing risk or reduced fetal movements, timely reassessment, shared decision-making and proactive care planning.

Improving monitoring and escalation systems

This year's sentinel event data highlights the importance of having monitoring and escalation systems that consistently support early recognition of deterioration and timely senior clinician input.

Strong systems help teams respond effectively in high-risk, time-critical situations and reduce reliance on individual vigilance.

IMPROVEMENT INITIATIVES AND RESOURCES

The following system improvement examples and resources focus on the common themes identified from maternity sentinel events:

- **The National Preterm Birth Prevention Collaborative Project** <https://www.safercare.vic.gov.au/improvement/projects/national-preterm-birth-prevention-collaborative> supports statewide prevention strategies
- **Maternal sepsis clinical guidance** <https://www.safercare.vic.gov.au/best-practice-improvement/clinical-guidance/maternity/maternal-sepsis> and development of a statewide maternal sepsis pathway support consistent recognition and timely response across maternity services.
- **The Victorian Maternity Services Taskforce** <https://www.safercare.vic.gov.au/councils/victorian-maternity-taskforce> was established to strengthen safe, reliable maternity care across Victoria, particularly in rural and regional areas.
- The ***Respectful maternity and newborn care framework*** <https://www.safercare.vic.gov.au/publications/respectful-maternity-and-newborn-care-framework> supports respectful, consumer-centred maternity care and guide clinicians.
- The **Safety Culture in Birth Suite** <https://www.safercare.vic.gov.au/improvement/projects/safety-culture-in-birth-suite> project and the **My Maternity Journey** <https://www.safercare.vic.gov.au/improvement/projects/my-maternity-journey> resource support safety culture and consumer engagement from conception to postpartum care.
- The **Maternal and Child Health Systems Focused Review Tool** <https://www.safercare.vic.gov.au/publications/mch-systems-focused-review-tool> and the **Maternal and Child Health – Systems Focused Review Training** <https://safercarevictoria.reach360.com/learn/course/ef75e894-7c08-4391-b624-29fad715a916> supports systematic adverse event reviews in maternal and child health services.
- The **Fetal Surveillance Education Program** <https://fsep.ranzcog.edu.au/> supports multidisciplinary capability in CTG interpretation, escalation and intrapartum care using the **RANZCOG IFS clinical guideline** <https://ranzcog.edu.au/wp-content/uploads/Intrapartum-Fetal-Surveillance.pdf>.

Paediatric sentinel events

Key themes

In 2024–25, **nine** (4%) sentinel events impacted paediatric patients. This is consistent with nine events (5%) reported in 2023–24.

In 2024–25, 67% of all paediatric notifications related to three themes:

- a deteriorating patient
- communication of clinical information
- a clinical process or procedure.

These sentinel events were most frequently reported from an emergency department and patient transport to hospital locations.

Recurring paediatric sub-themes in sentinel events related to the following key areas requiring vigilance:

- handover and communication of critical reports, results or imaging
- recognising deterioration, escalation and response
- delays in diagnosis and management.

Figure 7 lists the top five lessons learnt from this year's paediatric-related events.

Figure 7. Top five causes identified for paediatric events, 2024–25

Staff factors	25%
Teamwork factors	15%
Procedures and guidelines	11%
Systems and processes	8%
Workforce factors or work environmental factors	8%

GUIDANCE FOR HEALTH SERVICES TO INFORM CONTINUOUS IMPROVEMENT

An analysis of paediatric sentinel events identified recurring system issues across emergency, inpatient and community care settings. Consistent themes emerged in respect of how clinical deterioration was recognised and escalated, how critical information was communicated and handed over, and how delays occurred in diagnosis and management.

Deteriorating patients (recognition, escalation and response)

Several paediatric sentinel events involved delays in recognising, escalating or responding to clinical deterioration. In these events, early signs of deterioration, including abnormal observations, changes in behaviour or vital signs and parental or carer concerns, were present in complex and fast-moving care environments. However, systems did not consistently support timely recognition and escalation to ensure early intervention.

These findings highlight the importance of reliable systems to support early identification of deterioration in children, particularly in settings where children may not be able to clearly communicate symptoms or concerns.

Communication and handover of critical clinical information

Failure in communication and handover were a recurring theme in paediatric sentinel events. In several cases, critical information such as abnormal pathology results, imaging reports or specialist advice was not consistently handed over between clinicians, teams or services, or was not clearly actioned.

These findings highlight the importance of communication processes that ensure critical information is not only transferred but also clearly identified, understood and acted on, particularly at transition points such as shift changes, transfers of care and discharge.

Clinical process and procedure

SCV noted variation in following established clinical processes and procedures across paediatric sentinel events. This included delays or omissions in observing, monitoring, escalation processes and applying clinical pathways. In some events, procedures or policies existed but were not reliably embedded into practice, particularly during periods of high workload or after hours.

These findings reinforce the need for clinical processes that are practical, well embedded in governance processes and supported by clear guidance.

Delay to diagnosis and management

Delayed diagnosis and delayed initiation of appropriate management were significant contributors to harm in several paediatric sentinel events. For example, in some cases, abnormal findings were identified but not acted on in a timely way. In others, early clinical signs were attributed to less serious conditions, contributing to diagnostic delay and missed opportunities for early treatment.

These findings highlight the importance of systems that support:

- timely review of results
- escalation of diagnostic uncertainty
- early senior clinical input when a child's condition does not follow the expected course.

IMPROVEMENT INITIATIVES AND RESOURCES

The **ViCTOR pilot project** <https://www.safercare.vic.gov.au/improvement/projects/safer-care-for-kids-victor> improves early recognition and response to deterioration in children. The project focused on consistent use of the **Victorian Children's Tool for Observation and Response (ViCTOR)** <https://www.safercare.vic.gov.au/best-practice-improvement/clinical-guidance/paediatric/victor>.

The **Royal Children's Hospital Learning Platform** <https://learn.rch.org.au/> provides education programs for maternal and child health nurses focused on early identification and management of unwell children.

3. SENTINEL EVENTS RELATED TO MENTAL HEALTH AND SELF-HARM

The 2021 Royal Commission into Victoria's Mental Health System's final report included 74 recommendations (combining the interim and final reports), highlighting the need for system-wide reform.[2]

Key recommendations included improving collaboration to support mental health and wellbeing and enhancing safety and preventing harm.

Other recommendations included the importance of incorporating lived experience perspectives and better use of data to identify risk factors and transparent reporting mechanisms. These principles have been incorporated into the *Mental Health and Wellbeing Act 2022*, which emphasises the importance of:

- person-centred care
- upholding human rights as foundational
- treating people with dignity and respect
- fostering a culture that is open and transparent.

Key themes

In 2024–25 there were **two** sentinel events for category 6 (suspected suicide of a patient in an acute psychiatric unit or acute psychiatric ward) and **23** for category 11 subcategory 4 (self-harm).[3]

2. Royal Commission into Victoria's Mental Health System, Final report: summary and recommendations (2021).
3. Safer Care Victoria (2024) *Victorian sentinel event guide: essential information for health services about managing sentinel events in Victoria* (Version 2), State Government of Victoria, Melbourne, p 6.

25 In 2024–25, 25 sentinel events related to mental health showed a slight increase from 23 in 2023–24, 17 in 2022–23 and 16 in 2021–22.

This trend is primarily due to a steady **increase in reporting** under category 11, subcategory 4, which reflects strengthening engagement from the mental health sector

Events reported under category 6 have remained **low and relatively stable** over the past five years

The age group most represented in the reported data is **30 to 64 years old**

Of the events reported, **64%** occurred in community settings

The primary outcome recorded for these events was 'death', which reflects the notification criteria and is consistent with other sentinel event categories

Most patients in this category are **not** under a compulsory treatment order

Improved lived (and living experience) mental health consumer representation in sentinel event review panels

Consumers, family and carers with lived experience of mental illness or psychological distress are represented on sentinel event panels (Figure 8).

This is consistent with key recommendations from the Royal Commission as outlined above. As part of SCV's future improvement focus, we are considering changes to the sentinel event portal to improve the ability to partner with consumers, families and carers and to capture consumer representation more accurately.

Sentinel event data suggests the mental health sector supports consumers with lived experience of mental illness to take part in sentinel event reviews.

This reflects a collaborative culture of partnering with consumers, families and carers and a commitment to learn and improve across the sector informed by lived experience.

The data also indicates a high degree of compliance with a collaborative 'just culture' approach and ensuring external subject matter experts are included on sentinel event review panels.

Figure 8. Sentinel event panel composition, 2020–21 to 2024–25

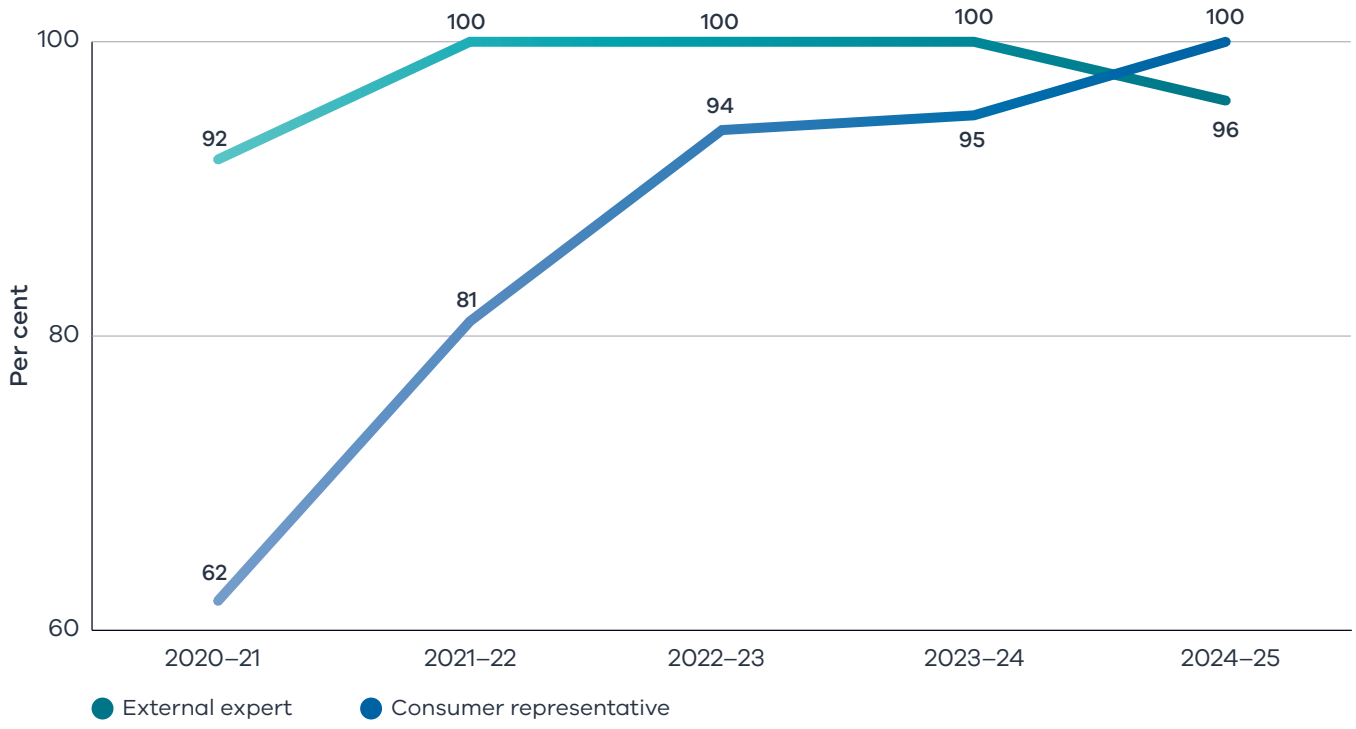
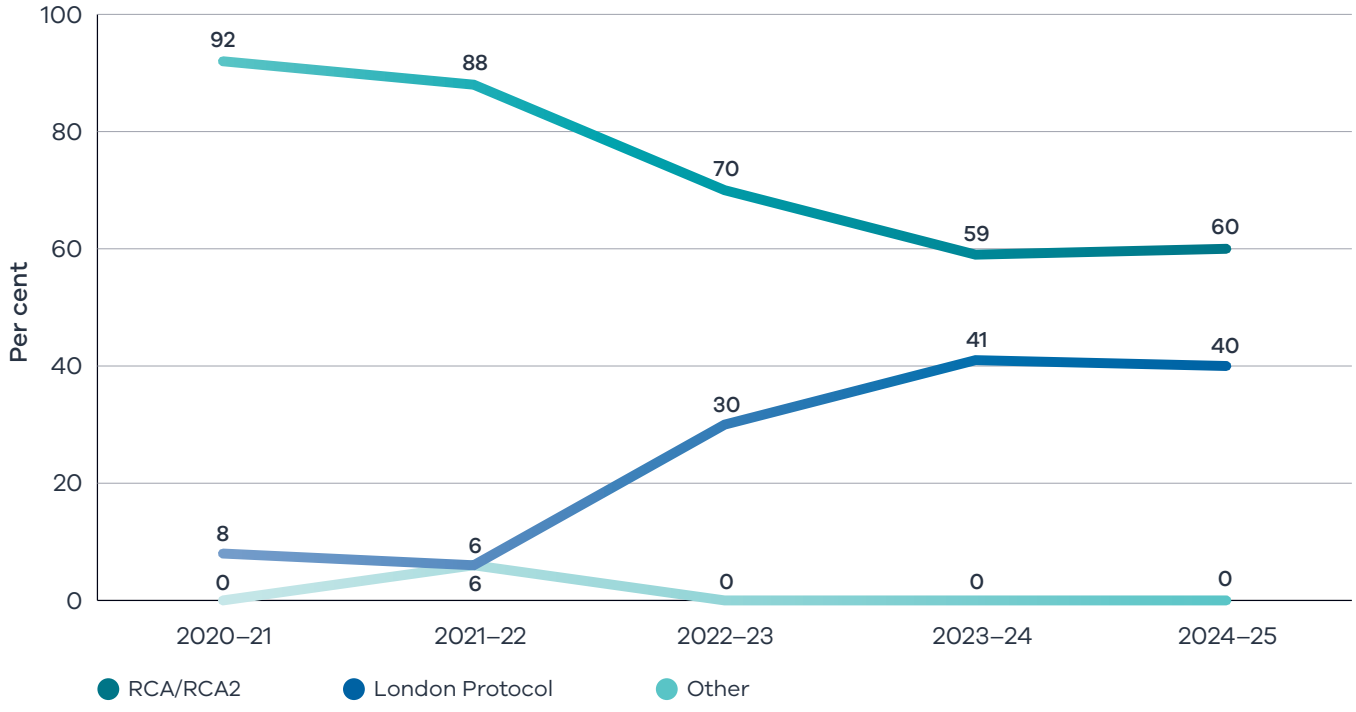


Figure 9 lists the methodologies used in mental health sentinel events over the past five years.

Figure 9. Methodologies used in mental health sentinel events, 2020–21 to 2024–25



These methodologies are discussed more in Appendix 2.

Summary

Over the past five years, consumer representation on sentinel review panels has increased from 62% to 100%. This reflects a strong and ongoing commitment to hearing and valuing the voices of consumers as a critical part of learning, reflection and service improvement.

Sentinel event analysis shows that the mental health sector is improving its engagement with a just reporting culture. This finding reinforces the need for system-wide improvements focused on preventing self-harm and suicide, *particularly during care transitions and at the point of discharge*.

The following resource from SCV responds directly to the themes identified through the sentinel event reviews. It highlights practical system improvements for consumers, families and their carers that aim to strengthen discharge planning, continuity of care and community support.

Improvement initiatives and resources

The Adopting Zero Suicide Framework Initiative

SCV has led an initiative involving 13 organisation-wide workshops conducted across 10 health services to self-assess their alignment with the *Zero Suicide Framework* <https://www.safercare.vic.gov.au/best-practice-improvement/mental-health-improvement-program/initiatives/zero-suicide-framework>. We have established ongoing partnerships with five of these services to help test, implement and evaluate recommended practice improvements to better align with the framework to improve the pathway of care.

4. SENTINEL EVENTS RELATED TO MEDICATION ERRORS

Medication errors are the most frequently reported of the category 1–10 sentinel events across all states and territories. In 2024–25 there were **12** medication error sentinel events (category 7) in Victoria. While this is a decrease from 2022–23, where 22 events were recorded, this decrease must be viewed with caution due to the varying factors that may influence reporting across the health system.

In 2024–25 a further **three** cases, under category 11, subcategory 3: 'deteriorating patient', had a clear link with medications and were attributed to opioid use, with or without other sedatives.

Patient safety events involving medication and intravenous fluids were the third most common type of event recorded in the Victorian Health Incident Management System, with most events reported as near misses or causing no harm.

These findings are consistent with previous years.

Type of medications involved in sentinel events

Heparin and other anticoagulants: **6 (40%)**

Sedatives including narcotics: **5 (33%)**

Non-APINCH[4] medication: **3 (20%)**

Anti-infective: **1 (7%)**

4. APINCH stands for antimicrobials, potassium and other electrolytes, insulin, narcotics and other sedatives, chemotherapeutic agents, and heparin and other anticoagulants. These are the group of medicines known to be associated with high potential for medication-related harm. For more information, visit APINCHS classification of high risk medicines <https://www.safetyandquality.gov.au/our-work/medicines-safety-and-quality/high-risk-medicines/apinchs-classification-high-risk-medicines>.

Type of medication chart used

Electronic medical record: **5**

Paper: **7**

Not described: **3**

Key themes

Anticoagulants, or the lack of anticoagulants causing a thrombotic event, continue to be the leading medication related to sentinel events, with six cases reported in 2024–25. Anticoagulants contribute to sentinel events in two main ways:

- where levels are too high and result in haemorrhage
- where an anticoagulant has been omitted, delayed or incorrectly prescribed, leading to a thrombotic event.

Acute venous thromboembolism (VTE) is the third most common cardiovascular disease after stroke and myocardial infarction. Pulmonary embolism (PE) is the most critical manifestation of VTE, requiring timely diagnosis and treatment to prevent morbidity and mortality.

In the 2024–25 sentinel event notifications, there were five cases related to PE. These fell into category 11 under the subcategories of:

- clinical process and procedure
- deteriorating patient.

Opioids and other sedatives were associated with five sentinel events, and review panels identified several key findings from these. One was the heightened risk associated with methadone use for any indication when combined with other sedatives, highlighting the need for improved clinician awareness around its use. Another was the lack of clear requirements for monitoring patients receiving combined opioids and sedatives, particularly those who are medication naïve, have sleep apnoea or have other respiratory comorbidities.

For non-APINCH medications, these sentinel events occurred where a wrong medication was given to a patient, be it through a wrong route, to the wrong patient or where a patient was allergic to the medication. These events show the importance of always following the '7 rights of medication administration', namely right patient, drug, dose, route, time, documentation and reason.

Review process and lessons learnt

Health service sentinel event panels review these events using either the London Protocol or root cause analysis methodology (RCA/RCA2). Of the 15 reviews, 11 (73%) used RCA/RCA2, while four (27%) used the London Protocol.

Figure 10 lists the top six lessons learnt from medication error events.

Figure 10. Top six causes identified from medication error events, 2024–25

Procedures and guidelines	19%
Documentation, assessment and decision support	19%
Teamwork factors	13%
Staff factors	12%
Organisation and management factors	11%
Systems and processes	11%

Comparison to analysis in previous years

The number of category 7 medication errors resulting in serious harm or death decreased this year to **12 events**, from 13 events in 2023–24 and 22 events in 2022–23

Anticoagulants were the most commonly involved medications in sentinel events across both 2022–23 and 2024–25

86% of recommendations applied SMART principles – a decrease from 87% in 2022–23.

Recommendations that are considered moderate or strong have increased from 13% in 2019–20 to 51% in 2023–24 and are relatively consistent at **49%** in 2024–25, indicating room for improvement in this area

GUIDANCE FOR HEALTH SERVICES TO INFORM CONTINUOUS IMPROVEMENT

Allergies

- Allergies should be confirmed and reconfirmed at each step of the consumer journey in a health service – at admission, during medication reconciliation and review, at medication administration and at discharge.
- All allergies must be clearly documented and the type and severity of reaction identified.
- Staff must ensure the consumer has the correct colour identification band if allergies are present.
- Allergies should be double-checked every time a medication is given.
- Extra care should be taken with documenting allergies on consumer information where paper charts are used.

Labelling of medication

- Incomplete or inaccurate labelling of injectable medicines, fluids and their devices is an ongoing risk to safely administering medicines.
- It is important to implement a standardised user-applied labelling system. View the ***National standard for user-applied labelling of injectable medicines, fluids and lines*** <https://www.safetyandquality.gov.au/sites/default/files/migrated/National-Standard-for-User-Applied-Labelling-Aug-2015.pdf>.
- The national standard outlines the various requirements for labels including the colour-coding system for labels.
- A key point in the standard is that all injectable medicines drawn up in a syringe that will leave the hand of the person filling it should be labelled **immediately**.

SYSTEM-WIDE IMPROVEMENT INITIATIVES AND RESOURCES

SCV's Safer Medicines at Transitions of Care (SMTC) Collaborative <https://www.safercare.vic.gov.au/improvement/projects/safer-medicines-at-transitions-of-care>, was a key Safer Together initiative that concluded as of 30 June 2026.

Safer Together is our statewide safety improvement program. It aims to establish a continuously improving learning health system that is safer, more person-centred, sustainable, and delivers better outcomes for Victorians.

Find out more about the **National medication management plan** <https://www.safetyandquality.gov.au/our-work/medicines-safety-and-quality/medication-reconciliation/national-medication-management-plan>.

The Department of Health's **SafeScript program** <https://www.safescript.vic.gov.au/> helps ensure clear and precise monitoring of many medications. SafeScript is computer software that allows prescribing and dispensing records for certain high-risk medicines to be transmitted in real time to a centralised database that can then be accessed by doctors and pharmacists during a consultation. Find more information for **prescribers and pharmacists** <https://www.health.vic.gov.au/safescript/safescript-for-prescribers-and-pharmacists>.

Other useful resources include:

- **Methadone use in the postoperative setting** <https://www.safercare.vic.gov.au/publications/methadone-use-in-the-postoperative-setting-clinical-practice-point>
- **Analgesic Stewardship Toolkit** <https://www.safercare.vic.gov.au/publications/analgesic-stewardship-toolkit>.
- **Victorian guideline for the prevention of venous thromboembolism in adult hospitalised patients** <https://www.safercare.vic.gov.au/best-practice-improvement/clinical-guidance/venous-thromboembolism/victorian-guideline>
- **Practice points for pulmonary embolism** <https://www.safercare.vic.gov.au/publications/pulmonary-embolism-pe-practice-points>
- **Preventing venous thromboembolism and supporting anticoagulation management** <https://www.safercare.vic.gov.au/improvement/projects/preventing-venous-thromboembolism>.

Recommendations from sentinel event reviews

DEVELOPING RECOMMENDATIONS

After each sentinel event review, health service panels develop recommendations and set out an action plan for implementing these recommendations. Recommendations are developed to address findings and lessons from the review. They aim to reduce the risk of similar events recurring, ultimately improving the quality and safety of patient care. In alignment with systems thinking and just culture, these recommendations should prioritise addressing systemic issues rather than focusing on individual fault.

WRITING RECOMMENDATIONS

Recommendations should be written and developed in line with SMART principles.

RECOMMENDATION STRENGTH

Recommendations are classified according to the level of tangible impact that the actions outlined in the recommendation will have in the health service. Moderate and strong recommendations focus on changing the design of systems to better support human performance (Table 2).

For more information, refer to Appendix 3: Guide to the recommendation strength.

Table 2. Strength of recommendations from the review of sentinel events, 2021–22 to 2024–25

Strength	2021–22	2022–23	2023–24	2024–25
Total recommendations	**1,149**	**1,159**	**758**	**915**
Weak	41%	48%	50%	46%
Moderate	44%	40%	38%	43%
Strong	15%	12%	12%	11%
Rated SMART	61%	83%	85%	81%

Note that the 'total recommendations' of 2024–25 data is incomplete due to reporting timeframes. This will be reported in the 2025–26 annual report.

COUNT OF RECOMMENDATIONS

915 recommendations

Weak **46%**

Moderate **43%**

Strong **11%**

81% were written using **SMART principles**

Up from 61% in 2021–22

S Specific

M Measurable

A Achievable

R Relevant

T Time-bound

There were **915** recommendations made for **682** findings and **436** lessons learnt during 2024–25 (Table 3).

The percentage of recommendations using SMART principles has increased from 61% in 2021–22 to 81% in 2024–25, showing a more concerted effort to make recommendations more relevant and capable of implementation (Table 3). The strength of recommendations has remained relatively stable over the previous four years, indicating room for improvement.

Table 3. Health service recommendations by area and strength of recommendations

Sentinel event area	No. of events	No. of recs	Percentage using SMART principles	Weak	Moderate	Strong
Perioperative	65	276	79%	48%	43%	9%
Maternity	27	154	90%	31%	51%	18%
Paediatric	9	41	78%	51%	39%	10%
Mental health	25	100	90%	47%	43%	10%
Medication errors	15	86	86%	51%	37%	12%

Note: Some sentinel events are included in more than one theme (for example, both maternity and medication). Therefore, recommendation counts are not unique, as the same event or recommendation may be included in multiple themes.

Progress of recommendations

Health services provide SCV with a recommendation monitoring report six months after notifying us of a sentinel event and again at 12 months, if required. This report describes the progress made against each recommendation and identifies any barriers to completion.

SCV notes the positive trend in recommendation completion rates at six and 12 months (Table 4), the corresponding decrease in the number of days to undertake a review and the use of SMART principles. This means more recommendations are being completed and implemented in a timelier manner, enabling learning and preventing events from happening again. We commend health services for this work.

Table 4. Progress of recommendation implementation at six and 12 months, 2021–22 to 2024–25

Completion rate	2021–22	2022–23	2023–24	2024–25
Complete at 6 months	38%	39%	49%	42%
Complete at 12 months (Complete at 6 +12 months)	74%	79%	80%	
In progress	20%	14%	12%	55%
On hold	2%	1%	1%	3%
Abandoned at 6 months	2%	3%	3%	1%
Abandoned at 12 months	2%	4%	3%	
Average time to completion (Complete at 6 +12 months)	186 days	178 days	162 days	
Average time to completion (Complete at 6 months)	126 days	136 days	126 days	
Average time to completion (Complete at 12 months)	249 days	218 days	218 days	

Note: Totals may not equal 100% due to rounding. Recommendations from events reported in financial years more than one year prior are largely finalised, with only a small number still in progress.

Top 5 recommendation categories in 2024–25

Standardise process	**18%**	Moderate 
New procedure/memorandum/policy	**13%**	Weak 
Further review and develop action plan	**12%**	Weak 
Share outcomes/education reference	**11%**	Weak 
Training	**8%**	Weak 

Engaging with impacted consumers, families and carers

Impacted consumers and their families and carers offer invaluable insights about the circumstances around a sentinel event. These perspectives often provide a review panel with unique perspectives that inform deliberations on the system issues that led to the event occurring, and the lessons arising from each event. Transparent consumer involvement can be healing and restorative, repairing trust between health services and impacted consumers.

More information on health services engaging with consumers is on the **Guides to consumer representatives on adverse event reviews webpage** <https://www.safercare.vic.gov.au/best-practice-improvement/publications/guides-to-consumer-representatives-on-adverse-event-reviews>.

There have been consistent improvements in health services reporting on family contributions to sentinel event reviews. In 63% of reviews this year, the patient, family or carer contributed or were offered the opportunity to share their version of events, raise questions and express any concerns.

Impacted consumers and their families or carers may choose not to engage with the review. The key step is that families or carers are offered the opportunity to contribute, understanding that their decision might change as the process unfolds and with time. The consultation process must be adaptable to the unique circumstances of each event and flexible in how it is conducted to respond to the needs of the impacted consumer.

HEALTHCARE COMPLAINTS ANALYSIS TOOL

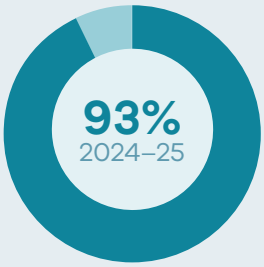
The sentinel events portal has embedded the **Healthcare Complaints Analysis Tool (HCAT)** <https://healthcarecomplaintsanalysis.com/> to capture the feedback consumers provide to sentinel event reviews. This evidence-based tool is used to code consumer feedback and helps to better understand the valuable contributions from consumers.

In 2024–25, there was a significant increase in the number of consumer feedback contributions. This can be attributed to improved health service engagement and better reporting, and this increase aligns with the rise in completing an open disclosure process (refer below).

In 2024–25, 126 (93%) of 135 sentinel events with family contribution had documented patient, family or carer feedback using the HCAT tool.

There were 523 feedback items documented in sentinel event reviews in 2024–25. This is an increase from 357 items in 2023–24, 295 items in 2022–23 and 210 items in 2021–22.

THE HEALTHCARE COMPLAINTS ANALYSIS TOOL (HCAT)



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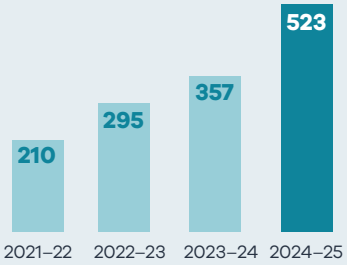


There were **523** feedback items documented in sentinel event reviews in 2024–25.

THE TOP 5 HCAT ISSUES RAISED BY CONSUMERS IN 2024–25

HCAT DOMAIN	CATEGORY	PERCENTAGE OF ISSUES RAISED
Clinical problems	**Safety** related to errors, incidents and staff competencies	33%
Clinical problems	**Quality** related to the clinical standards of healthcare staff behaviour	24%
Relationship problems	**Communication** related to absent or incorrect communication from healthcare staff to patients	21%
Management problems	**Institutional Processes** related to problems in bureaucracy, waiting times and accessing care	11%
Relationship problems	**Listening** related to family escalation of care	3%

GUIDANCE FOR HEALTH SERVICES TO INFORM CONTINUOUS IMPROVEMENT

Prioritise capturing family contributions in all aspects of engagement and review processes. Ensure family contributions are clearly identified and addressed in the review report.

For more information about how SCV uses the HCAT to interpret consumer feedback, visit the **Safer Care Victoria website** <https://www.safercare.vic.gov.au/best-practice-improvement/publications/thematic-interrogation-of-patient-complaints-in-the-state-of-victoria>.

OPEN DISCLOSURE

Open disclosure is the process of conducting open discussion about a sentinel event with the patient involved, their family and carers. It is built on ACSQHC's nationally consistent *Australian Open Disclosure Framework*. The framework has been recently updated to improve partnerships and communication between health services, consumers, patients and their families after a serious adverse patient safety event (SAPSE) that results in harm as defined in the *Health Services Act 1988*.

Open disclosure data for sentinel events in 2024–25 shows continued and sustained improvement among health services- however consumer satisfaction has decreased slightly. It reflects the embedding of the SDC into practice.

The data shows a slight increase in the number of open disclosure processes being completed in those Victorian health services that reported at six months[5] compared with previous years, with an increase in the percentage of full reports provided to consumers at the six-month mark (Table 5).

Table 5. Open disclosure indicators, 2021–22 to 2024–25

Indicator	2021–22	2022–23	2023–24	2024–25
Commenced at notification	83%	79%	85%	84%
Completed at 6 months	35%	58%	70%	72%
Full report provided to consumer at 6 months	9%	46%	68%	74%
Consumer reported they were satisfied with the outcome of the review	93%	91%	88%	85%

STATUTORY DUTY OF CANDOUR

The *Health Services Act 1988* requires health services to undertake an SDC process, unless a patient opts out, within 50 business days in the case of a SAPSE. (This can be extended to 75 working days where more than one health service is involved.) This process builds on the *Australian Open Disclosure Framework*.

The SDC is a legal obligation for Victorian health services to ensure consumers of health services (including mental health services), their families or carers receive:

- an apology
- honest and transparent communication
- a description of the health service's response to the event
- an outline of the steps that will be taken to prevent recurrence of the SAPSE.

5. More accurate data is collected at the full 12-month data collection point.

Case study: St Vincent's Health

Following a SAPSE review involving an oncology patient and a serious complication with a peripherally inserted central catheter line, the patient's son expressed deep gratitude that the process existed and that his concerns were taken seriously. A clinician involved in the case, who was initially sceptical of the process, reported a shift in perspective after witnessing its impact on the family, describing it as profoundly meaningful. The family reported feeling safe and heard after the service's chief medical officer made contact. They had been concerned there would be a 'sweeping under the rug' but articulated that this clearly wasn't the case. Review facilitators greatly appreciated the opportunity to hear first-hand accounts of the lived experience of the patient and their family and being able to weave the voice of the patient more easily through the report.

St Vincent's Health has worked hard to embed the requirements of SDC into its serious harm review processes. This has included improving the quality and clarity of open disclosure provided by the clinical teams, supported by a stronger organisational commitment to review SAPSEs.

In 2025 St Vincent's Health experienced a series of sentinel event reviews that had resulted in significant family and carer dissatisfaction. The reasons for the dissatisfaction with the review process included:

- delays in formalising the SDC processes
- providing conflicting information to carers and family about the review process
- delays in consumers receiving final reports
- frustration with the content and readability of the reports.

Reviews informed by consumers, carers and families

There were gaps in the way and the frequency in which St Vincent's communicated with patients and families while the review was underway. This included how the health service supported impacted patients and families through this stressful time.

In response to the consumer feedback, St Vincent's commissioned an analysis and review of its SDC process against best practice based on the intent of the SDC legislation. The review aimed to make process changes focused on encouraging a just culture and open and honest conversations about opportunities for improvement when things go wrong. It was anticipated that this would then translate into a more consumer, carer and family-focused experience of the SDC process.

The review, along with feedback from patients, families and staff, identified a series of potential improvement opportunities with a focus on earlier identification, clearer communication and *ensuring the consumer, carer and family voice is reflected throughout the process.*

Key improvements implemented by St Vincent's Health

Less time to validate incidents

- Reviewed the incident validation process to reduce the time taken to validate an incident to ease stress in patients and families.

Early identification of SAPSEs and proactive implementation

- Daily incident reviews, held as part of the Quality and Patient Safety team morning huddle, allowing SAPSEs to be identified earlier and the review process to begin sooner.

Review facilitator is accessible early in the process

- The SAPSE review facilitator now attends the initial SDC meeting to hear the patient or family story first hand to ensure it directly informs the review.
- Patients and families are asked for consent for the review facilitator to make contact and are encouraged to provide feedback at any stage.

Case study: St Vincent's Health (cont)

Supported, safe environment for consumers to participate

- When patients are reluctant to meet, St Vincent's makes extra effort to involve them in a way that feels safe and supportive, recognising this often improves their experience and strengthens the quality of the review.

Proactive monitoring to ensure timelines are met

- Implemented a weekly process to consider all open SAPSE reviews to monitor timelines and actions to identify and address any potential delays.

Leaders seen to endorse the process and are accessible

- For all sentinel events reviews, the chief medical officer is appointed as the contact for the patient/family. They contact the patient/family to introduce themselves and explain their role to reinforce transparency. They provide updates on the progress of the review before the final report is issued.

Provide counselling and support to consumers, families and carers who are impacted

- St Vincent's offers in-house psychological support for the patient/family and staff impacted by serious harm incidents and review processes.

Summary

St Vincent's Health has made meaningful improvements to the way SDC is operationalised, particularly in:

- strengthening communication
- embedding the consumer, family and carer voice
- improving the timeliness and oversight of reviews.

Early engagement and responsive feedback show that these changes are improving consumer, family, carer and staff experiences, reinforcing a just culture of openness and commitment to continuous learning.

Despite these advances, there are challenges with meeting the required timeframes in a way that supports consumers, carers and families at such a difficult time.

The framework needs to be refined to ensure it better supports compassionate, flexible and patient centred engagement during serious harm reviews and that appropriate psychological support is available for patients, family and staff.

IMPROVEMENT INITIATIVES AND RESOURCES

SCV has developed guidance to health services on how to strengthen these processes in **Consumer involvement following a serious adverse patient safety event: a 9-step guide for health services** <https://www.safercare.vic.gov.au/report-manage-issues/sentinel-events/adverse-event-review-and-response/resources-for-involving-impacted-consumers>.

SCV also published a position statement outlining the obligation on health services to comply with the Health Services Act and to provide consumers, families and carers with the detailed SAPSE report that health services submit in the sentinel event portal. View the **SCV Statement on abridged SAPSE review reports** <https://www.safercare.vic.gov.au/sites/default/files/2026-01/SCV%20Statement%20-%20Abridged%20SAPSE%20review%20reports_Dec%202025_FINAL.pdf>.

Further reading: improvement initiatives and resources

SCV has resources and information available to support health services and consumers to improve safety culture and prevent patient harm.

RESOURCES FOR HEALTH SERVICES AND LEADERS

- *Clinical Governance Framework* <https://www.safercare.vic.gov.au/best-practice-improvement/publications/clinical-governance-framework>
- *Victorian Safety Culture Guide* <https://www.safercare.vic.gov.au/publications/victorian-safety-culture-guide>
- *Adverse Patient Safety Events Policy* <https://www.safercare.vic.gov.au/best-practice-improvement/publications/policy-adverse-patient-safety-events>
- *Adverse Patient Safety Event Guideline* <https://www.safercare.vic.gov.au/best-practice-improvement/publications/policy-adverse-patient-safety-events>
- Falls Review Tool <https://www.safercare.vic.gov.au/best-practice-improvement/improvement-projects/older-people-and-palliative-care/falls-review-tool-pilot-project>
- *Partnering in healthcare framework* <https://www.safercare.vic.gov.au/publications/partnering-in-healthcare>
- ACSQHC sentinel events webpage <https://www.safetyandquality.gov.au/our-work/indicators-measurement-and-reporting/incident-management-and-sentinel-events>
- *Managing adverse events policy and guideline* <https://www.safercare.vic.gov.au/report-manage-issues/managing-adverse-events>
- Guides to consumer representatives on adverse event reviews <https://www.safercare.vic.gov.au/best-practice-improvement/publications/guides-to-consumer-representatives-on-adverse-event-reviews>
- Morbidity and mortality framework and toolkit <https://www.safercare.vic.gov.au/publications/morbidity-and-mortality-meetings-framework-and-toolkit>
- Quality improvement toolkit <https://www.safercare.vic.gov.au/best-practice-improvement/quality-improvement/toolkit>
- The Australian Open Disclosure Framework <https://www.safetyandquality.gov.au/our-work/open-disclosure/the-open-disclosure-framework#australian-open-disclosure-nbsp-framework>
- Online training modules: SDC <https://www.safercare.vic.gov.au/report-manage-issues/adverse-events/duty-of-candour>
- About the sentinel events portal <https://www.safercare.vic.gov.au/report-manage-issues/about-the-sentinel-events-portal>
- Just culture resources <https://www.safercare.vic.gov.au/report-manage-issues/sentinel-events/adverse-event-review-and-response/just-culture-training-and-resources>
- Thematic interrogation of patient complaints in Victoria <https://www.safercare.vic.gov.au/best-practice-improvement/publications/thematic-interrogation-of-patient-complaints-in-the-state-of-victoria>
- Maternal and Child Health (MCH) Systems Focused Review Tool and MCH Systems Focused Review Tool – Guidance <https://www.safercare.vic.gov.au/publications/mch-systems-focused-review-tool>

RESOURCES FOR PATIENTS, FAMILIES AND CARERS

- **What are adverse and sentinel events?** <https://www.safercare.vic.gov.au/consumer-resources/what-adverse-sentinel-events>
- **Resources for involving impacted consumers** <https://www.safercare.vic.gov.au/report-manage-issues/sentinel-events/adverse-event-review-and-response/resources-for-involving-impacted-consumers>
- **Guides to consumer representatives on adverse event reviews** <https://www.safercare.vic.gov.au/best-practice-improvement/publications/guides-to-consumer-representatives-on-adverse-event-reviews>
- **Duty of candour resources for patients, families and their carers** <https://www.safercare.vic.gov.au/consumer-resources/duty-of-candour-resources-for-patients-families-and-their-carers>
- **Health Voices Victoria** <https://healthtransformation.deakin.edu.au/our-research/health-voices-victoria/>

Appendix 1: Data supplement

Data in this report and data supplement has been compared with previous years, where possible. The number of years that can be included for comparison varies between indicators. This is due to changes to the reporting requirements for health services and the methods for collecting this data over time.

SENTINEL EVENTS REPORTING BY CATEGORY AND SUBCATEGORY

Table 6 lists the sentinel event notifications by category over the past three years.

Table 6. Sentinel event notification by category, 2022–23 to 2024–25

Australian sentinel event category	2022–23	2023–24	2024–25
1. Surgery or other invasive procedure performed on the wrong site resulting in serious harm or death	3	3	2
2. Surgery or other invasive procedure performed on the wrong patient resulting in serious harm or death	0	0	0
3. Wrong surgical or other invasive procedure performed on a patient resulting in serious harm or death	1	0	1
4. Unintended retention of a foreign object in a patient after surgery or other invasive procedure resulting in serious harm or death	4	2	3
5. Haemolytic blood transfusion reaction resulting from ABO incompatibility resulting in serious harm or death	0	0	0
6. Suspected suicide of a patient in an acute psychiatric unit or acute psychiatric ward	2	6	2
7. Medication error resulting in serious harm or death	22	13	12
8. Use of physical or mechanical restraint resulting in serious harm or death	0	0	1
9. Discharge or release of an infant or child to an unauthorised person.	0	0	0
10. Use of an incorrectly positioned oro- or naso-gastric tube resulting in serious harm or death	3	0	0
11. All other adverse patient safety events resulting in serious harm or death	210	169	196
Total	**245**	**193**	**217**

Subcategories are used based on the World Health Organization's International Classification for Patient Safety (ICPS) for events notified under the Victorian-only category 11 (Table 7).

Table 7. Sentinel event notifications as a percentage of all category 11 events, 2022–23 to 2024–25

Subcategory	2022–23	2023–24	2024–25
Nutrition	0%	1%	2%
Medical device or equipment	2%	2%	3%
Patient accident	2%	1%	0%
Resource or organisational management	5%	1%	1%
Communication of clinical information	6%	11%	7%
Self-harm	7%	10%	12%
Healthcare-associated infection	9%	1%	1%
Falls	9%	3%	6%
Clinical process or procedure	28%	38%	38%
Recognising and responding to clinical deterioration	33%	31%	32%
Total	100%	100%	100%

Observations from 2024–25 include:

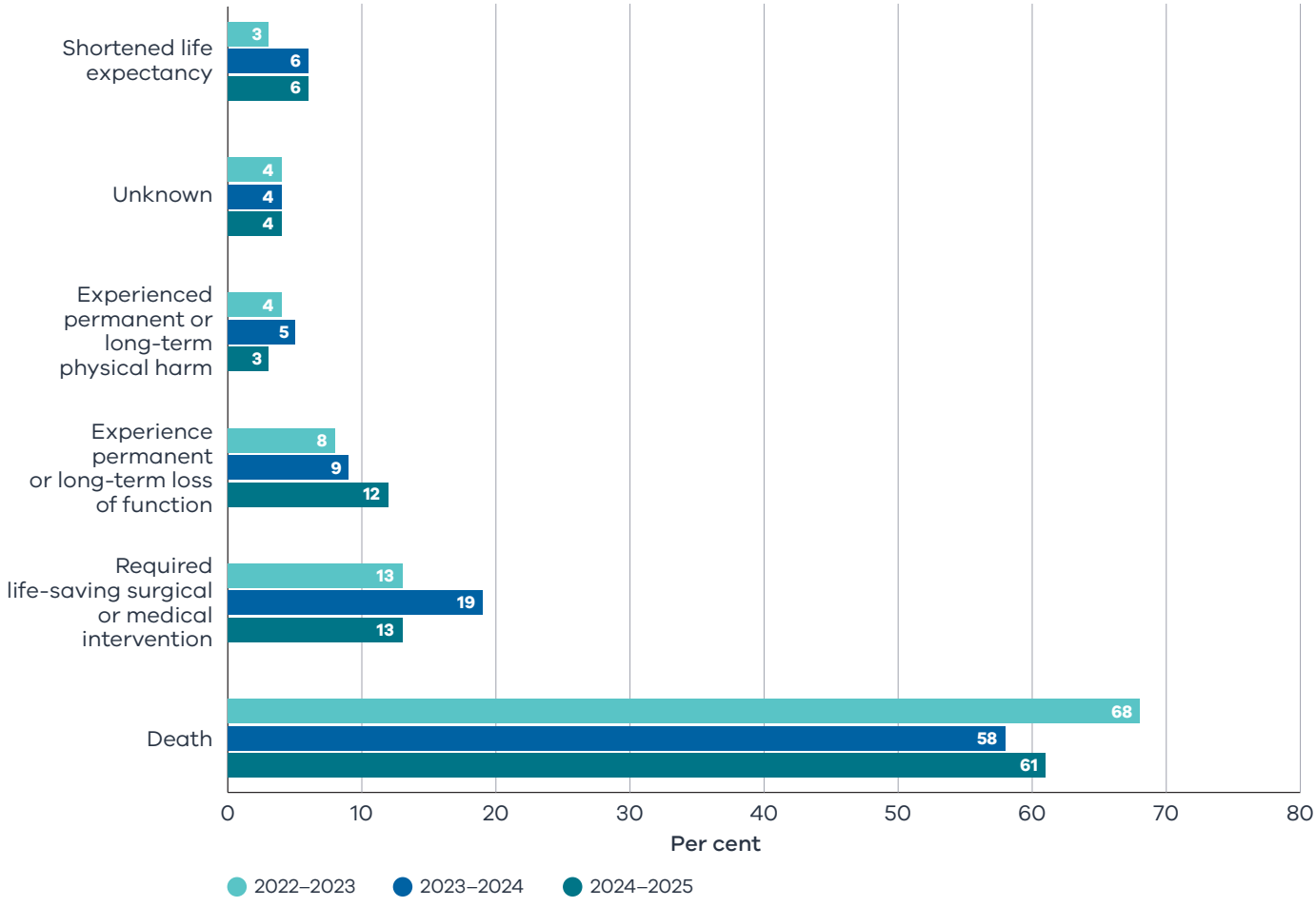
- 'Clinical process and procedure' were the most common event category in 2023–24 and 2024–25.
- The notification of 'falls-related' sentinel events did not occur for a short period in February 2024 due to the launch of the new SCV guide on reporting falls in 2023–24. This explains the significant reduction in notifications during that period.
- A reduction in healthcare-associated infections is noted in 2023–24 and 2024–25 compared with 2022–23.

Patient outcomes

Of the sentinel events reported in 2024–25, 61% resulted in the patient's death (Figure 11).

Health services must indicate the degree of harm to the patient when they notify SCV about a sentinel event. The full degree of the impact of the event may not be known at the time of the notification, and the patient outcome is not expected to be updated throughout the review.

Figure 11. Patient outcome by percentage of total sentinel events, 2022–23 to 2024–25



AGE OF AFFECTED PATIENT

The ages of patients affected by sentinel events are shown in Figures 12 and 13, and Table 8.

Figure 12. Age (years) of adults affected by sentinel events by percentage of total sentinel events, 2022–23 to 2024–25

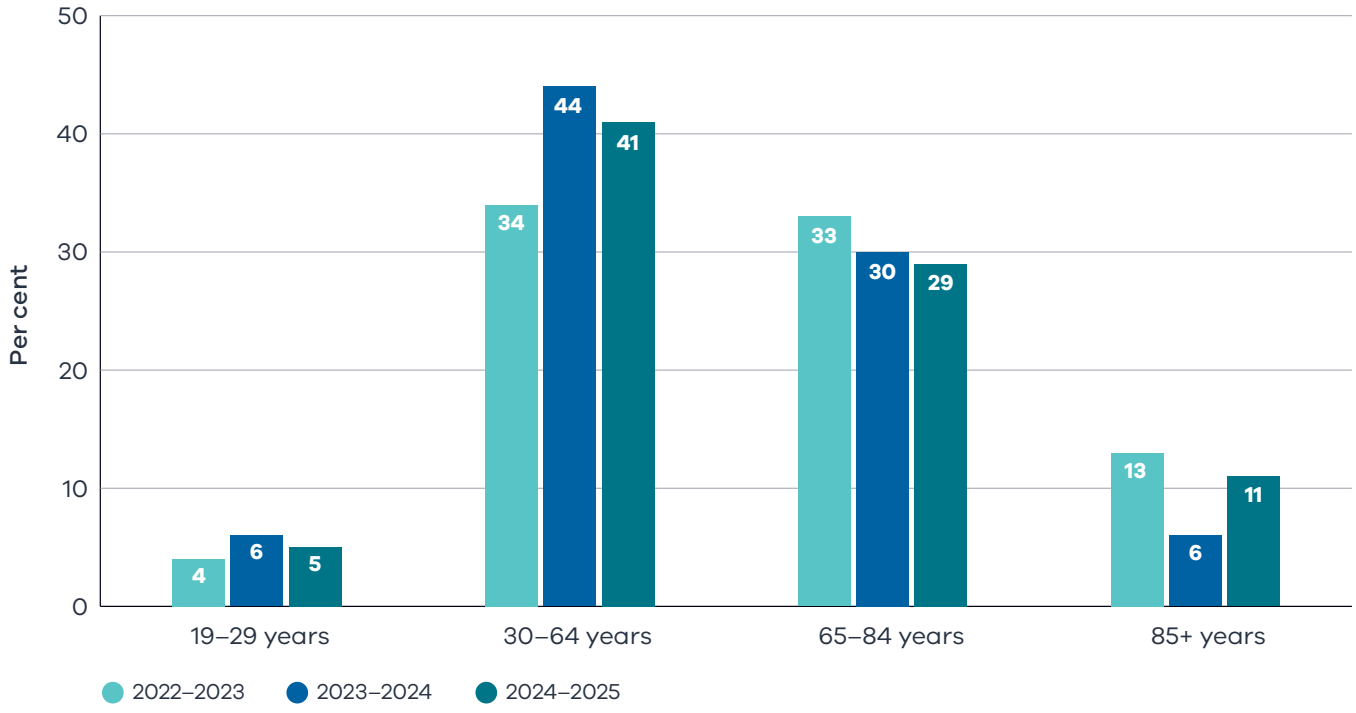


Figure 13. Age of babies, children and adolescents affected by sentinel events by percentage of total sentinel events, 2022–23 to 2024–25

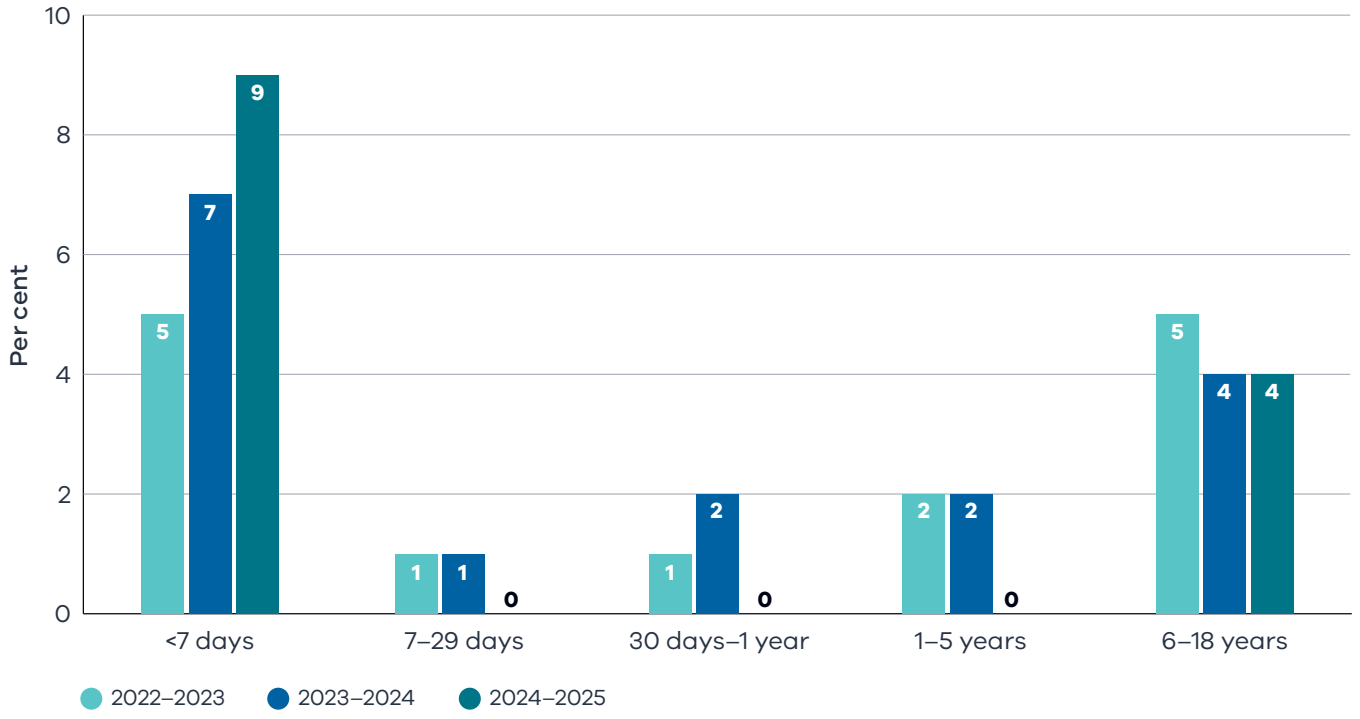


Table 8. Sentinel events affecting babies, children and adolescents by percentage of total sentinel events, 2022–23 to 2024–25

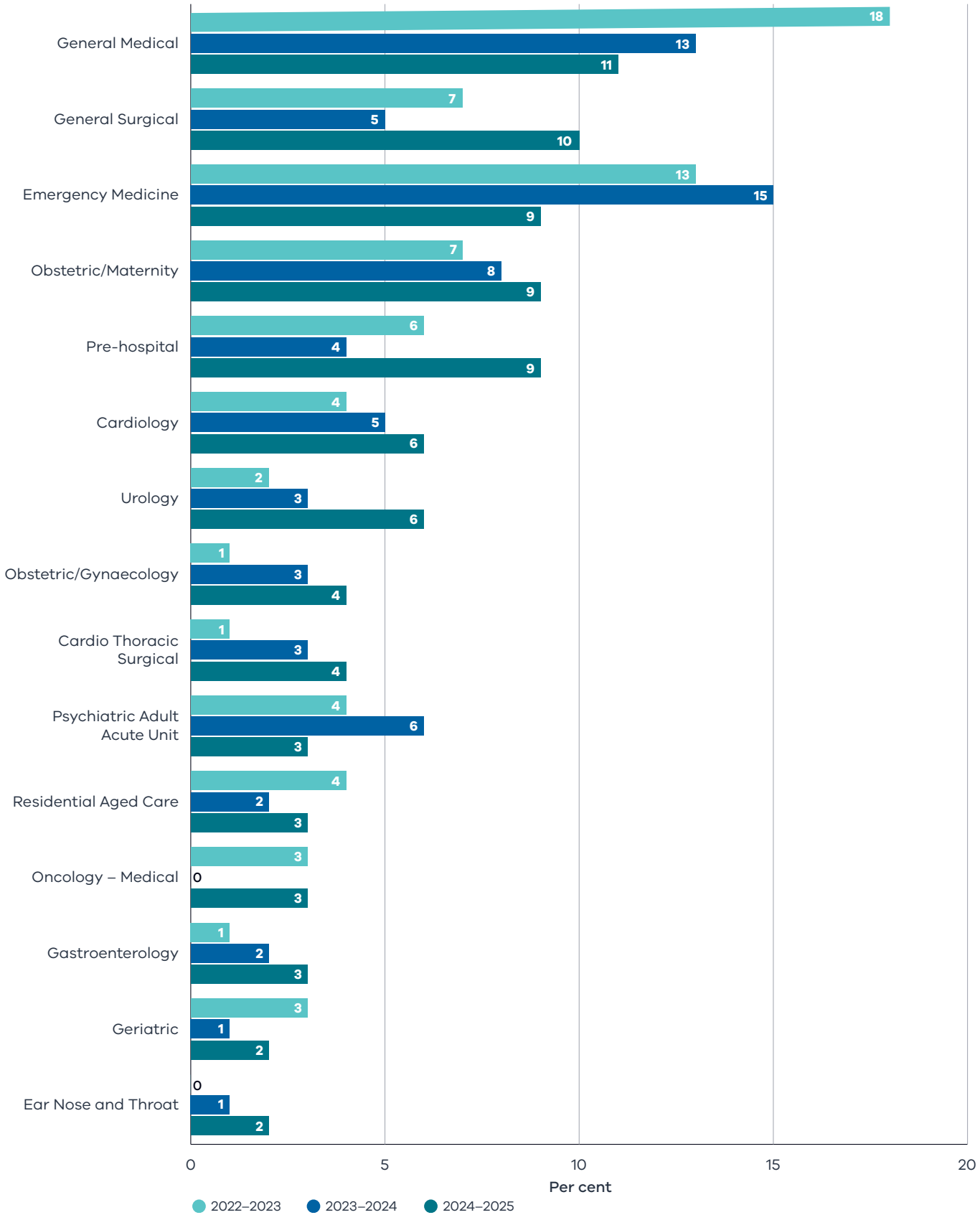
2022–23	2023–24	2024–25
14%	15%	14%

TOP ADMITTING SPECIALITIES

Reporting health services must identify the specialty providing care to the patient when the sentinel event occurred.

In 2024–25 General Surgical and General Medicine were the top two admitting specialties for patients when sentinel events occurred (Figure 14).

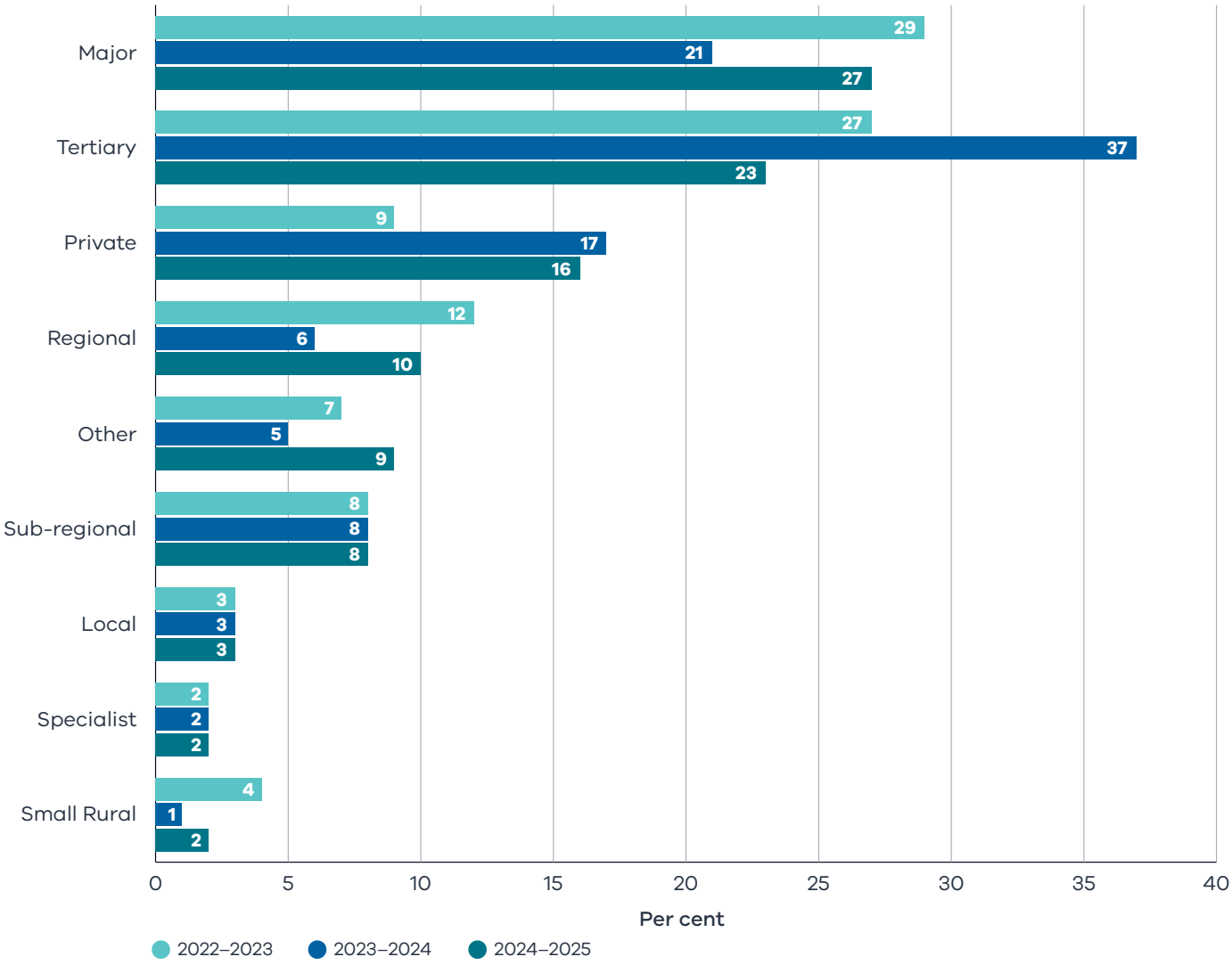
Figure 14. Sentinel events by top admitting specialty, 2022–23 to 2024–25



SENTINEL EVENT PEER GROUP AND LOCATION

Figure 15 shows that most sentinel events over the past three years occurred in major and tertiary hospitals, which may be explained by the complexity and numbers of patients they admit across Victoria. There has been an increase in the number of sentinel events reported by private health services since 2022–23. This could represent an increasing positive health service safety culture contributing to quality and safety improvements.

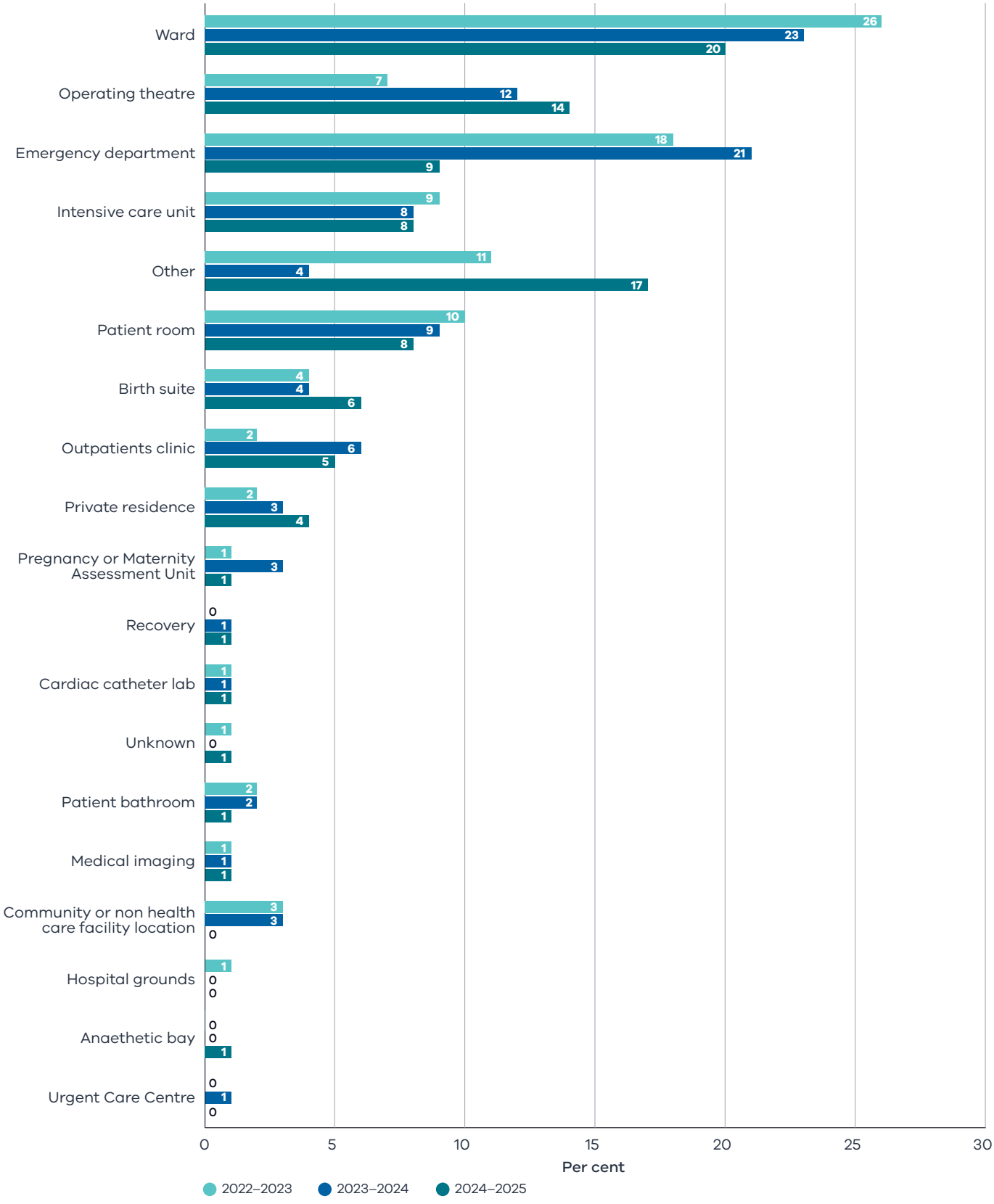
Figure 15. Percentage of sentinel events by health service peer group, 2022–23 to 2024–25



Note: Totals not 100% due to rounding

The location of sentinel events occurring in health services has remained steady across three years, reflecting areas where patients spend the most time receiving care (wards and patient rooms) or where complex, high-risk situations unfold (emergency departments, operating theatres and intensive care units) (Figure 16).

Figure 16. Percentage of sentinel events by location in the health service, 2022–23 to 2024–25



Note: Totals not 100% due to rounding

TIME TO NOTIFY SENTINEL EVENTS

Health services must notify SCV of a sentinel event within three business days of becoming aware of the event.

For 2024–25, Figure 17 and Table 9 show that:

- the average number of days to notify a sentinel event was 22.1 business days, reduced from 27.7 business days in 2022–23 and consistent with 2023–24
- 26% of sentinel events were notified within three business days, up from 17% in 2023–24.

This shows that health services have improved reporting notification times, indicating continuing improvement in reporting culture.

Figure 17. Number of business days to notify sentinel event, 2022–23 to 2024–25

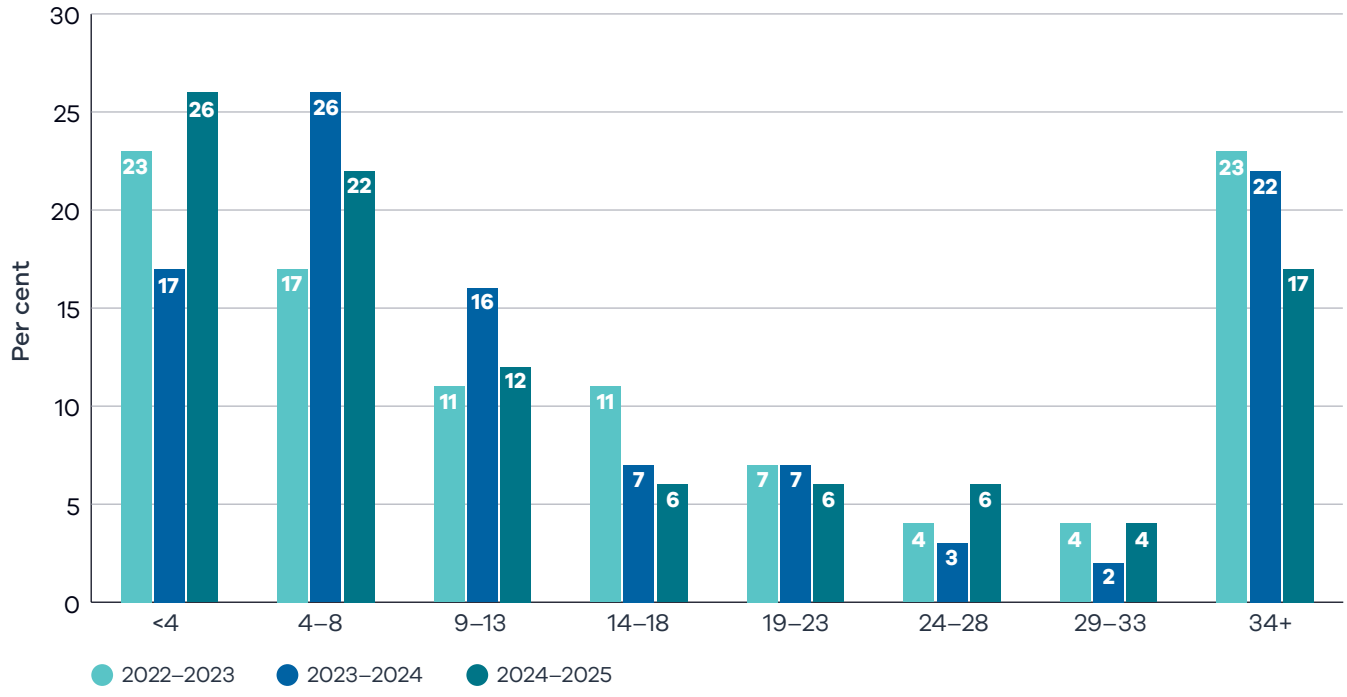


Table 9. Number of business days to notify sentinel event, 2022–23 to 2024–25

	2022–23	2023–24	2024–25
Average days to notify	27.7 days	22 days	22.1 days
Percentage of events notified within three business days	23%	17%	26%

TIME TO REVIEW SENTINEL EVENTS

This indicator measures the time taken from sentinel event notification to the submission of the recommendations formed by the health service's review of the event (part C of the sentinel event report).

The required timeframes for sentinel event report part C submission for a health service are:

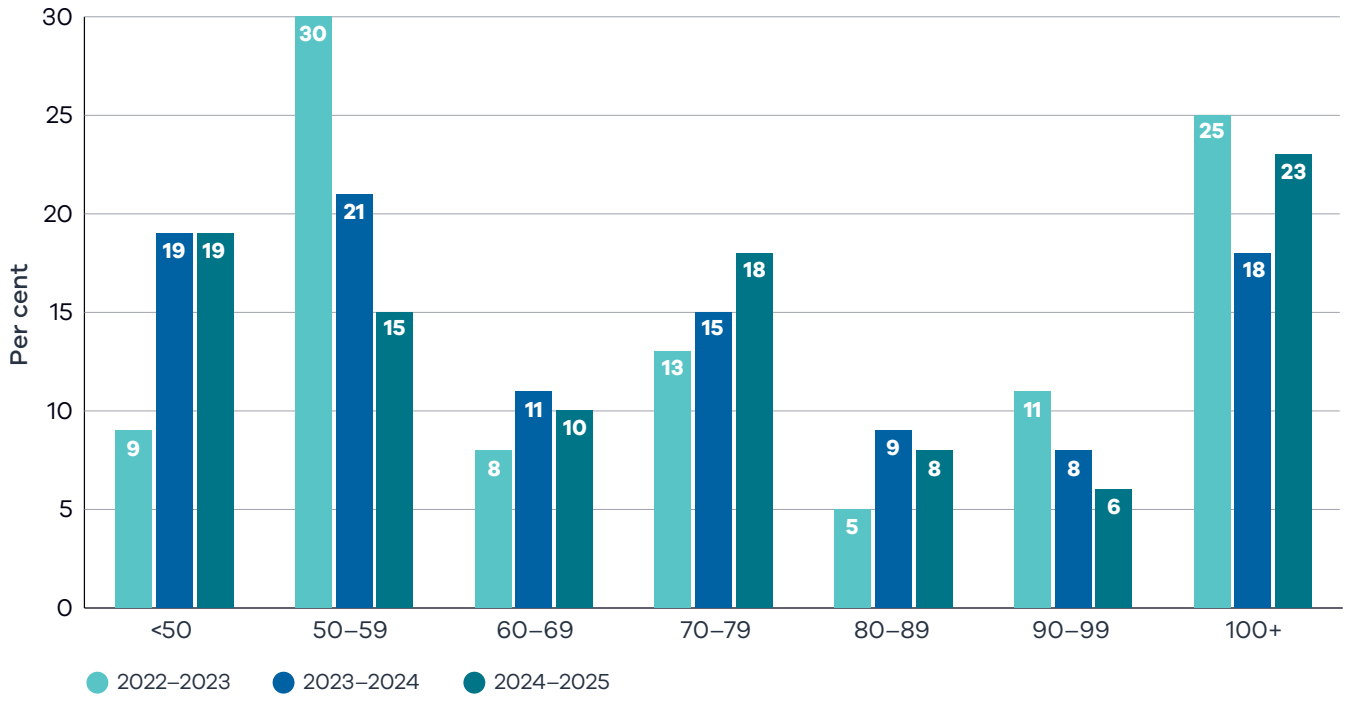
- 50 business days for a single agency review
- 75 business days for an approved multiagency review.

Figure 18 shows that the average number of days to complete a review in 2024–25 were:

- for a single agency review, 79 business days, compared with 76 business days in 2023–24
- for a multiagency review, 106 business days, compared with 93 business days in 2023–24.

The extended review time in 2024–25 indicates the need for improvement in both the effectiveness and efficiency of reviews.

Figure 18. Distribution of sentinel events (single agency and multi-agency reviews) by reporting timeframe, by percentage, 2022–23 to 2024–25



Appendix 2: Sentinel event identification and review process

SENTINEL EVENT IDENTIFICATION

Clinicians usually identify sentinel events at the point of care when the event occurred. Occasionally, sentinel events are not identified immediately but may be identified:

- by other hospitals, primary care providers, or the patient, consumer and/or their family or carer
- after a patient's discharge or death.

Below are several examples of how sentinel events may be identified.

Consumer feedback

It is vital that consumer experience and quality and safety teams work with consumers, families and carers to ensure SAPSEs and sentinel events identified by consumers are reported in a timely manner. SCV receives around six consumer complaints each year via the Minister for Health that are later recognised as sentinel events.

Morbidity and mortality reviews

Each health service has morbidity (illness) and mortality (death) review processes that look into incidences of patient harm or death. These reviews include a structured forum for peer review and education with the aim of learning lessons and preventing such events occurring again. SCV has developed the **Morbidity and Mortality meetings - Framework and toolkit** <https://www.safercare.vic.gov.au/publications/morbidity-and-mortality-meetings-framework-and-toolkit> to assist health services.

Other health services

Sometimes a patient is discharged or transferred to another health service and the second health service may become aware of a sentinel event occurring in the original health service. The second health service will then report the sentinel event to the original health service.

Coroner's notifications and reports

The Victorian Coroner may notify health services of a patient's death after discharge in cases where the death meets the criteria of a sentinel event.

Office of Chief Psychiatrist

The Office of the Chief Psychiatrist may become aware that the circumstances surrounding the death of a consumer of mental health services may meet the criteria of a sentinel event and will notify the relevant mental health service.

Primary care or other service providers

Primary care providers or other service providers are the key to successfully transitioning a patient back to the community. Primary care providers or other service providers sometimes identify that a sentinel event occurred when the patient was in hospital and will report the event to the treating health service.

GUIDANCE FOR HEALTH SERVICES TO INFORM CONTINUOUS IMPROVEMENT

Consider the clinical governance processes, policies and pathways that are in place at your health service that help to identify, escalate or refer possible adverse events.

Good questions to ask are:

- Are governance processes visible and accessible to staff?
- How are staff supported to identify, escalate and report a sentinel event?

THE SENTINEL EVENTS REVIEW PROCESS

Sentinel event reviews must follow a formal, structured systems-focused methodology that includes a written report detailing all aspects of the review.

SCV accepts various methodologies including RCA/RCA2, the London Protocol and AcciMap. SCV encourages organisations to adopt the robust and validated methodology they find most appropriate, efficient, tailored to the incident and to the needs of the health service.

For more on review methodologies, refer to the **Victorian sentinel events guide** <https://www.safercare.vic.gov.au/best-practice-improvement/publications/sentinel-events-guide> and the **Adverse Patient Safety Event guideline** <https://www.safercare.vic.gov.au/sites/default/files/2023-07/Adverse%20Patient%20Safety%20Event%20guideline_Safer%20Care%20Victoria_2.pdf>.

DEVELOPING RECOMMENDATIONS

After each sentinel event review, the review panel develops recommendations and sets out an action plan for implementing the recommendations. Recommendations are developed to address findings and lessons from the review. They aim to reduce the risk of similar events recurring, ultimately improving the quality and safety of patient care. In alignment with systems thinking and just culture, these recommendations should prioritise addressing systemic issues rather than focusing on individual fault.

Appendix 3: Guide to recommendation strength

Recommendation strength		Recommendation category	Example
	**Strong**	Architectural/physical changes in surroundings	Replace revolving doors at the main entrance into the building with powered sliding or swinging doors to reduce patient falls
	Strong	New devices with usability testing	Perform pre-purchase testing of blood glucose monitors and test strips to select the most appropriate for the patient population
	Strong	Engineering control (forcing functions that force the user to complete the action)	Eliminate the use of universal adapters and peripheral devices for medical equipment; use tubing/fittings that can only be connected the correct way
	Strong	Simplify process and remove unnecessary steps	Remove unnecessary steps in a process; standardise the make and model of medication pumps used throughout the organisation; use barcoding for medication administration
	Strong	Tangible involvement by leadership	Participate in unit patient safety evaluations and interact with staff; purchase needed equipment; ensure staffing and workload is balanced
	**Moderate**	Redundancy	Use two registered nurses to independently calculate high-risk medication dosages
	Moderate	Increase in staffing/decrease in workload	Make float staff available to assist when workloads peak during the day
	Moderate	Software enhancements or modifications	Use computer alerts for drug-to-drug interactions
	Moderate	Eliminate/reduce distractions	Provide quiet rooms for programming patient-controlled analgesia pumps; remove distractions for nurses when programming medication pumps
	Moderate	Education using simulation-based training with periodic refresher sessions or observations	Conduct patient handover in a simulation lab environment, with after-action critiques and debriefing
	Moderate	Checklist or cognitive aids	Use pre-induction and pre-incision checklists in operating rooms; use a checklist when reprocessing flexible fibre optic endoscopes
	Moderate	Eliminate look- and sound-alikes	Do not store lookalikes next to one another in the medication room
	Moderate	Standardised communication tools	Use read-back for all critical lab values; use read-back or repeat-back for all verbal medication orders; use a standardised patient handover format

Recommendation strength		Recommendation category	Example
	**Weak**	Double-checks	One person calculates dosage, another reviews their calculation
	Weak	Warnings	Add audible alarms or caution labels
	Weak	New procedure or memorandum or policy	Remember to check intravenous sites every two hours
	Weak	Training	Demonstrate the defibrillator during in-service training

Glossary

Term	Definition
Adverse patient safety event or 'adverse event'	An incident in which a person receiving health care is harmed. For more information on responding to an adverse event, visit the Managing adverse events webpage <https://www.safercare.vic.gov.au/report-manage-issues/managing-adverse-events>.
Australian Commission on Safety and Quality in Health Care (ACSQHC)	A Commonwealth Government entity for quality and safety in health care that sets the national sentinel event notification list. For more information, visit the ACSQHC's website <https://www.safetyandquality.gov.au>.
Carer	A person who provides unpaid care and support to either a family member or friend who has a disability, mental illness, chronic condition, terminal illness or general frailty.
Critical event	Identified when reviewing an adverse event, it is the point at which a different action would have altered the subsequent sequence of events and the outcome of patient harm.
Harm	Physical or psychological damage or injury to a person. Examples of harm are disease, suffering, impairment (disability) and death.
Healthcare Complaints Analysis Tool	An evidence-based, standardised tool for systematically coding consumer voice and organising and analysing complaints information to reliably assess healthcare problems, their severity and the level of patient-reported harm. The HCAT can be used for service monitoring, organisational learning and research into complaints and is an early indicator for patient safety risks.
Consumer	A patient, their family or carer(s).
Human factors	The environmental, organisational, human and job factors that influence human performance. The science of human factors applies theory, data and methodologies to understand interactions among humans and the systems in which they work.
International Classification for Patient Safety	A framework developed by the World Health Organization to categorise patient safety information using standardised sets of concepts with agreed definitions, preferred terms and the relationships between them. The Victorian category 11 sentinel event subcategories are based on the ICPS classification for incident type. For more information, visit the World Health Organization website <https://www.who.int/publications/i/item/WHO-IER-PSP-2010.2>.
Just culture	A culture that encourages balanced accountability between organisations and individuals and the application of systems-thinking principles to allow fair and just responses to adverse events.
Lessons learnt	The opportunities for improvement identified through the review process but that did not contribute to the adverse event.
Multiagency review	A panel review of an adverse event that involves two or more health services. All services involved in the harm of the patient are expected to take part in the review panel.
Open disclosure	The open and transparent discussion of adverse events that result in harm to a patient while receiving health care. This takes place with the patient, their family and carers.
Peer group	Grouping of health services of comparable size or clinical capability to allow for accurate comparison for the purpose of data reporting.

Term	Definition
Reporting culture	An environment where individuals have the confidence and feel safe to report safety issues without fear of blame, and where they can trust their concerns will be acted on.
Review finding	A summary statement that describes how a system issue or factor contributed to an adverse patient safety event.
Safety culture	The product of individual and group values, attitudes and behaviours that determine the commitment to and practice of organisational safety.
SAPSE	Serious adverse patient safety event that results in harm as defined in section 3 (1) of the *Health Services Act 1988*.
SCV	Safer Care Victoria.
SDC	Statutory duty of candour. In Victoria, SDC is a legal obligation that requires healthcare providers to openly and honestly inform patients and their families when a serious adverse patient safety event occurs, including providing an apology and explaining the details of what happened, as well as steps to prevent similar incidents from happening again.
Sentinel event	The most serious adverse event in which a patient dies or is seriously harmed.
SMART	Acronym used to define effective goals as; specific, measurable, achievable, relevant and time-bound.

Safer Care
Victoria