ANNUAL REPORT 2024

Victorian Perioperative Consultative Council

Safer Care Victoria

Improving care before, during and after surgery



Acknowledgement of Country

We proudly acknowledge Victoria's Aboriginal communities and their rich culture and pay respect to their Elders past and present. We acknowledge Aboriginal people as Australia's First Peoples and as the Traditional Owners and custodians of the land and water on which we rely. We recognise and value the ongoing contribution of Aboriginal people and communities to Victorian life and how this enriches us. We embrace the spirit of reconciliation, working towards the equality of outcomes and ensuring an equal voice.





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Authorised and published by the Victorian Government, 1 Treasury Place, Melbourne.

© State of Victoria, Australia, Safer Care Victoria, May 2026.

ISSN 2652-9947 - **Online (pdf/word)**

Available at the Safer Care Victoria website <https://www.safercare.vic.gov.au> (2507254).

VICTORIA State Government

Abbreviations

ACSQHC	Australian Commission on Safety and Quality in Health Care
ANZCA	Australian and New Zealand College of Anaesthetists
ANZELA-QI	Australian and New Zealand Emergency Laparotomy Audit – Quality Improvement
ANZHFR	Australian and New Zealand Hip Fracture Registry
ASC	Anaesthetic Subcommittee
CCoV	Coroners Court of Victoria
CCS	Clinical care standard
CQRs	Clinical quality registries
CVC	central venous catheter
E-Deps	e-depositions
EL	emergency laparotomy
GIRFT	Getting It Right First Time
PMC	Patient Mortality Committee
SCV	Safer Care Victoria
SSC	Surgical Subcommittee
VASM	Victorian Audit of Surgical Mortality
VIFM	Victorian Institute of Forensic Medicine
VPCC	Victorian Perioperative Consultative Council



Contents

Abbreviations 3

Chair's report 6

Victorian Perioperative Consultative Council 9

About us 9

Governing legislation 9

Membership 9

Aim 9

Referrals 10

Reporting 10

Case confirmation 10

Engaging with consumers 12

Improving clinical documentation 12

Improving communication gaps between healthcare settings 12

Supporting consumers in setting appropriate expectations of the perioperative process 12

Improving the quality of informed consent discussions 12

Turning review findings into clinical practice improvements 14

Improving accountability in clinical governance 14

Anaesthetic Subcommittee 16

Surgical Subcommittee 20

1. Communication 21

2. Transfers within and between hospitals 21

3. Complex procedures 22

4. Implant tracking system or registry 22

5. Low registry participation 22

Learning from good practice – Safety II – Quality Improvement 24

Australia and New Zealand Emergency Laparotomy Audit – Quality Improvement (ANZELA-QI) 24

Australian Framework for National Clinical Quality Registries 24

Emergency laparotomy clinical care standard 24

ANZELA-QI in Victoria 26

Australian and New Zealand Hip Fracture Registry 28

Perioperative morbidity – sentinel events 32

Sentinel events: categories 1–10 32

Sentinel events: category 11 34

Perioperative mortality: Victorian Audit of Surgical Mortality report 35

Perioperative Mortality Committee 35

Victorian Institute of Forensic Medicine (VIFM) and the Coroners Court of Victoria (CCoV) **36**
Examination of perioperative deaths at VIFM 36
VIFM and Victorian Preoperative Consultative Council 36
Relevant themes from VIFM referrals 37

Projects with Safer Care Victoria and the Department of Health **39**
Perioperative Learning Health Network 39
Getting It Right First Time initiative 40
Enhancing surgical access and efficiency 41
Conclusion 44

The perioperative medicine perspective **46**
Shared decision-making 46
Communication skills to facilitate person-centred perioperative care 46

Perioperative nursing **47**
Communication about patient history 47
Clinical handover 48
Central venous catheter removal 48
Postoperative bowel assessment and monitoring to identify bowel obstruction 48
Dissemination of findings of internal reviews to frontline staff 48

Summary of clinical practice points and recommendations **50**
Clinical practice points 50
Recommendations 51

Appendix 1: VPCC and subcommittee members **53**

Appendix 2: Anaesthesia mortality glossary of terms – case classification **55**

Appendix 3: Sentinel event categories (Victoria) **56**

References **57**

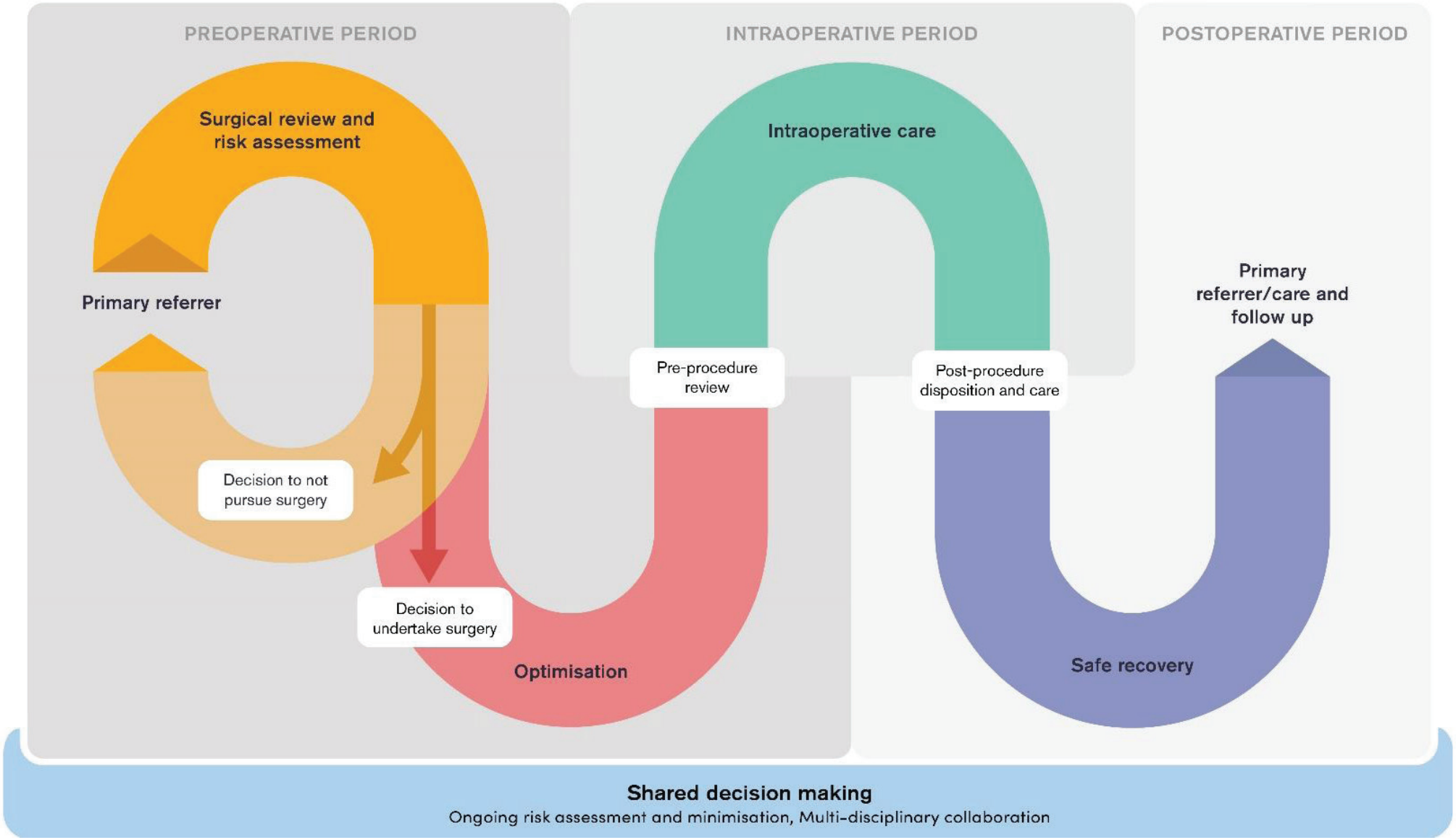
Chair's report

Health care in Victoria has an enviable safety record. This is to a significant extent due to the high quality of clinicians who deliver care and the high quality of facilities and their organisational support where health care is delivered. No system is perfect, but the Victorian Perioperative Consultative Council (VPCC) continues to play an important role in identifying areas where system-level improvements can be made, either through identifying areas of preventable harm (Safety 1) or encouraging best practices (Safety 2). There are several best practices, clinical considerations and recommendations in this report.

We highlighted communication issues in our previous two annual reports. This was again a recurring and critical theme throughout many case reviews in 2024. Effective communication is essential at all stages of the perioperative pathway. As outlined in Figure 1, courtesy of the Australian and New Zealand College of Anaesthetists' Chapter of Perioperative Medicine, the need for communication comes with initial referral, diagnosis and shared decision-making about the need for a procedure, if at all, and its expected outcomes.

Communication works in both directions of course, and for the best of personalised care and appropriate expectation setting, patients must be comfortable in sharing their goals and provide an accurate clinical history. Discussions can be challenging when outcomes are not as expected or if complications arise. Clinicians need the skills to compassionately, honestly and clearly discuss adverse outcomes. This includes applying shared decision-making principles.

Figure 1: Perioperative care framework



Reproduced with permission from the Australian and New Zealand College of Anaesthetists.[1]

From the VPCC's perspective, we have been pleased with Safer Care Victoria (SCV) support in redeveloping our website to aid communications of advice and recommendations. This makes our structure, purpose, activities, reports and recommendations more accessible.

Providing a safe environment for invasive procedures is also a responsibility of health services and clinicians. To this purpose, good clinical governance is essential. The VPCC and subcommittee members have identified gaps during case reviews and made recommendations to strengthen processes. These include appropriate credentialing of clinicians and their scope of practice, providing a safety culture where speaking up about concerns is encouraged and, importantly, sharing findings from reviews of cases where things did not go as expected.

Overall, it should be noted that the VPCC's relationship with the Victorian Audit of Surgical Mortality and Victorian Institute of Forensic Medicine for case referrals and review is strong, as it is with our 'sister' council, the Consultative Council on Paediatric Mortality and Morbidity. Our ability to consider and share our findings is improving, with a new website and with plans for a symposium on communication set for 2025. Our recognition of the need to expand our scope to include 'off the floor' interventional procedures is also leading to plans for legislative changes.

Once again, I extend my sincere gratitude to all members of the VPCC and its Anaesthetic and Surgical subcommittees for their dedication and invaluable contributions. I also wish to acknowledge the strong support provided by the team at Safer Care Victoria, whose efforts are instrumental in supporting and advancing the work of the VPCC.



David A Scott
VPCC Chair

Victorian Perioperative Consultative Council

About us

The VPCC was established as a multidisciplinary council in 2019 to build on the work of the former Victorian Consultative Council of Anaesthetic Mortality and Morbidity and the Victorian Surgical Consultative Council. The VPCC membership includes experts with a surgical, anaesthetic, nursing, consumer or other medical background. Members bring their diverse experiences, expertise, perspectives and lived experience to the council's agenda and deliberations.

Governing legislation

The VPCC operates in accordance with Part 4 (sections 33-48H) of the *Public Health and Wellbeing Act 2008* (the Act). Any discussions involving the identity of patients, clinicians or healthcare services are protected under Victorian legislation.

- Under section 39 of the Act, the chairperson of a consultative council may request general or specific information from a Victorian health service provider or pathology service that the chairperson considers is necessary to enable the council to perform its functions.
- Section 40 of the Act requires that the health service provider is authorised to provide such requested information.
- Section 41 of the Act outlines the circumstances in which information can be disclosed by the council.
- Sections 42 and 43 of the Act describe the confidentiality obligations that apply to the council.

Membership

Members of the council are appointed by the Minister for Health for a 3-year term. Members can serve multiple terms if renominated and then reappointed. The Minister for Health must approve any proposed council subcommittees, while the council determines membership.

Full details of the members of VPCC and its subcommittees are included in **Appendix 1.**

Aim

To improve perioperative care through engaging with clinicians and health services, SCV and Department of Health.



Roles and responsibilities

The VPCC:

- investigates and reviews cases of perioperative mortality and morbidity in Victoria to improve outcomes for patients before, during and after surgery
- identifies improvement opportunities in perioperative care and shares these with the health sector for the benefit of patients, their families and the wider healthcare community
- provides deidentified quarterly reports, including thematic analysis and key findings, to the Minister for Health
- holds workshops, forms working groups and commissions other activities, as necessary.

SCV supports the VPCC in its functions through providing secretariat support, data analysis, communication and publication support.

Referrals

The VPCC receives cases for review from numerous sources:

- Department of Health
- Sentinel Event Program (SEP)
- Victorian Audit of Surgical Mortality (VASM) through its Perioperative Mortality Committee (PMC)
- Coroner's Court of Victoria (CCoV) through e-depositions (E-Deps) and Coronial Admission and Enquiries (CAE)
- direct referrals from healthcare services and clinicians via the VPCC e-form <https://865164.my.site.com/VPCCFormNotification/s/>.

Reporting

Reporting to the VPCC is not mandatory. But healthcare services are encouraged to report on mortality and morbidity so the council can carry out its legislated functions effectively. We note that some adverse events do not reach the threshold for being identified via the above processes.

Case confirmation

Case reviews provide valuable insights and help identify emerging safety trends. The council's 2 subcommittees, the Anaesthetic (ASC) and Surgical subcommittees (SSC), conduct case analyses. These analyses include input from multidisciplinary professional and consumer representatives.

To recognise patterns in outcomes of interest, the VPCC also assesses various clinical quality registries such as the Australian and New Zealand Hip Fracture Registry (ANZHFR).

Consumers



Engaging with consumers
by Liat Watson, Denice Spence (VPCC and SSC members), Annie McPherson and Barbara Curzon-Siggers (ASC members)

Engaging with consumers

by Liat Watson, Denice Spence (VPCC and SSC members), Annie McPherson and Barbara Curzon-Siggers (ASC members)

In 2024 the consumer representatives from the VPCC, including the ASC and SSC, noted several recurring themes from cases involving preventable harm, many of which were linked to patient safety issues. Key themes included failure to identify high-risk patients before surgery, a lack of meaningful shared decision-making with patients, and communication breakdowns that led to missed or delayed follow-up of results. These cases reinforce that effective communication and consultation are essential to ensuring patient safety, supporting a positive consumer experience and enabling the process of informed consent. The consumer representatives have developed the following key points for clinicians to consider when engaging with consumers.

Improving clinical documentation

As noted in the VPCC Planning Day 2024 report, high-quality perioperative care extends beyond the operating theatre. It encompasses all interactions between clinicians and patients. Poor communication, often resulting from inadequate clinical documentation, continues to pose significant risks to patient safety.

To mitigate perioperative risks to patients and improving their health outcomes, an accurate and thorough record of how clinicians engage with patients – especially during decision-making about their care and the outcomes they value – plays a vital role in mitigating perioperative risk and improving health outcomes.

Improving communication gaps between healthcare settings

Reviews of recent cases have highlighted communication breakdowns between tertiary and primary healthcare providers. A key contributing factor is that hospital medical record systems are largely confined to individual health services, restricting the timely flow of information across care settings. The national My Health Record system offers a promising solution by enabling more comprehensive and coordinated patient information sharing. Its broader and more consistent use could significantly improve the exchange of clinical data exchange, leading to better patient safety and health outcomes.

To support high-quality care, future policy should mandate that all health professionals routinely update patient information in My Health Record to ensure accuracy and timeliness. Also, rather than requiring patients to actively provide consent for each data inclusion, the system could allow automatic linking of patient records to authorised healthcare providers strictly for professional clinical use. To foster public trust and encourage widespread adoption, it is essential to clearly communicate the privacy protections and benefits of such an information sharing system to consumers.

Supporting consumers in setting appropriate expectations of the perioperative process

There were recurring cases where patients' expectations about their surgical experience were not fully explored or addressed early in their surgical journey. This oversight may have contributed to the adverse event and, had the patient's expectations been addressed earlier, the outcome might have been different. By identifying what information matters most to consumers, understanding their expectations of the perioperative process and providing timely information, clinicians can help the consumers in setting appropriate expectations about the risks and possible outcomes of their surgical procedure.

Improving the quality of informed consent discussions

Informed consent processes could be improved to better support genuine, informed decision-making for patients. While procedural risks and general benefits are typically explained, there is often less focus on how specific risks and outcomes – especially clinically adverse ones – may affect individual patients.

For informed consent to be meaningful, the discussion must centre on what matters most to each patient, especially before surgery. Patients must be given a clear understanding of the potential risks, possible complications and realistic outcomes in terms of physical recovery or symptom relief. This ensures they are fully informed and able to make decisions that align with their needs and preferences.

Case study 1: Unexpected outcome – voice loss for a teacher

A high-school teacher had thyroid surgery during which a rare complication – damage to the vocal cords – was discussed as a low risk. However, the patient's occupation or how potential voice loss might affect her daily functioning were not properly considered. When the patient experienced prolonged hoarseness post-surgery, she became distressed and took extended leave from work.

Learning points: A more tailored consent discussion should have taken place, including questions about the patient's occupation and communication needs could have better prepared the patient for the potential impact of this complication. It might have also led to considering alternative timing or management options that aligned better with her personal and professional circumstances.

Case study 2: High-risk surgery in an older patient

A very unwell 91-year-old man who was diagnosed with metastatic adenocarcinoma with past history of hypertension and a previously inserted pacemaker was admitted to hospital with acute shortness of breath and a large pleural effusion. On day 3, he had video-assisted thoracoscopic surgery and a talc pleurodesis was attempted. After the procedure, extubation was unsuccessful, requiring reintubation and transfer to intensive care. His condition continued to deteriorate and, after clinical consideration, clinicians withdrew ventilatory support. He received palliative care and passed away 11 days later.

The patient's wife raised concerns that the anaesthesia had caused her husband's death. It was clear from the documentation that all treatments provided by his anaesthetist (and surgeon) were appropriate and timely. However, it wasn't clearly documented whether the risk of surgery was fully explained to the patient and his wife, particularly considering his significant comorbidities.

Learning points: This case highlights the importance of establishing clear goals of care, discussing and explaining the risks of surgery to both the patient and his wife. They could have understood the risks, enabling them to make fully informed decision whether to proceed with surgery or opt for palliative care. Such a discussion may also have better prepared his wife and his family for the potential risks and outcomes, including death, and allowed them the opportunity to say goodbye following his passing.

These case studies show that by individualising informed consent discussions:

- clinicians can help patients make decisions that best align with their personal and professional circumstances
- patients and families will better understand and can mentally prepare for potential complications
- support patients with clearer and more constructive communication if an adverse event arises.

Turning review findings into clinical practice improvements

The main goal of incident reviews after clinical adverse events is to produce strong, actionable recommendations that make care safer for all patients. But the effectiveness and strength of recommendations depends on how well the findings are shared with staff delivering care. From the consumer perspective, recurring themes in adverse events suggest that key lessons are not always shared effectively either within or across organisations.

Improving accountability in clinical governance

Individual practitioners and health service providers both share the responsibility of maintaining high standards of practice. This includes ensuring clinicians are appropriately credentialed and health services can deliver safe, quality care. A small number of VPCC-reported cases highlighted lapses in these processes. While these cases are exceptions, they highlight weaknesses in clinical governance systems. This is a concerning issue because the volume of procedures performed outside of acute public hospitals continues to grow.

Case study 3: Young woman's death in day surgery

A 30-year-old woman had a routine procedure at a day hospital. Her condition declined rapidly in recovery. The anaesthetist had left immediately after the surgery and was unavailable, and the recovery nursing staff failed to recognise her rapid decline. Although the surgeon and nursing staff-initiated resuscitation, along with concerted efforts from paramedics, she couldn't be revived.

Learning points: This case underscored critical lapses in both a health practitioner meeting professional responsibilities and broader facility governance. This ultimately affected the professional registration of the involved clinician as well as the status of the facility.

Conclusion

While the above focuses on the risk and shortcomings in parts of the health system, it is equally important to acknowledge the encouraging trend of clinicians increasingly involving consumers in care discussions and shared decision-making processes.

To ensure informed consent is safe and tailored to the needs of high-risk or vulnerable patients, clear, effective communication and thorough documentation must be consistently practised. This obligation doesn't just apply to surgeries but to all interventional procedures.



Subcommittees



Anaesthetic Subcommittee
by Ben Slater (VPCC member, ASC chairperson)

Surgical Subcommittee
by Wendy Brown (VPCC member, SSC chairperson)

Anaesthetic Subcommittee

by Ben Slater (VPCC member, ASC chairperson)

The Anaesthetic Subcommittee (ASC) is a multidisciplinary group comprising medical and nursing clinicians, along with consumer representatives. Its primary role is to conduct case reviews and identify key learning points that optimise anaesthesia practices and minimise harms. At its core, the ASC aims to identify emerging safety signals and communicate them to the anaesthesia community through the VPCC and SCV.

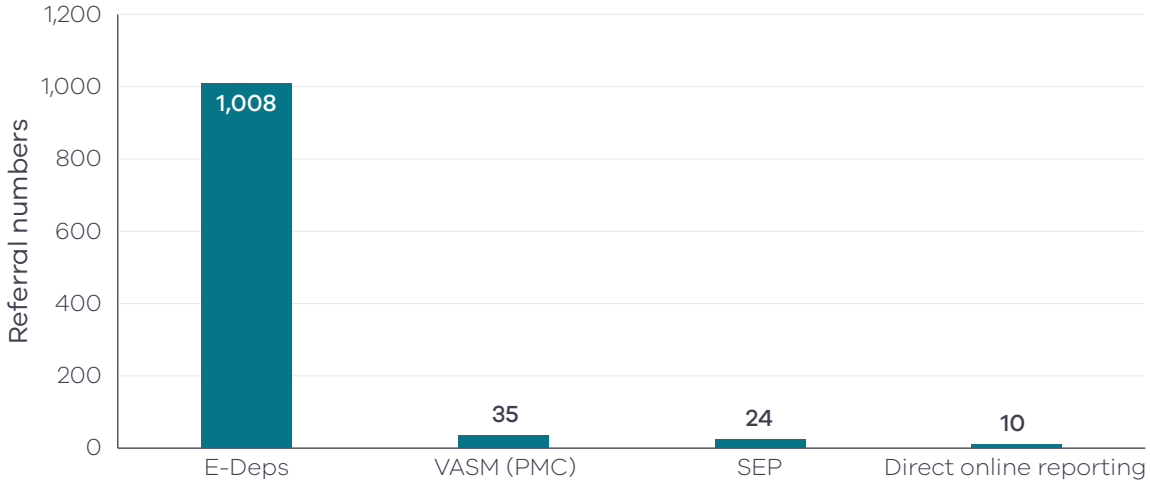
Composition

In 2024 the ASC included 8 anaesthetists, one of whom is the chair, 2 perioperative nurses, 2 consumer representatives, a pathologist and a surgeon. Regular attendees included the chair of the VPCC and the Director of Surgery at SCV. SCV was represented by the manager of the Governance Secretariat with administrative support provided by a senior project officer. A senior clinical advisor was also employed for the ASC, whose key role was to triage cases and identify emerging themes from those cases.

Information sources

In 2024 the ASC received perioperative adverse case reports from multiple sources, with most coming from E-Deps submitted via the CCoV (Figure 2A). This is followed by cases from VASM via the conjoint Perioperative Mortality Committee, Sentinel Event Program of SCV, and direct referral by Victorian clinicians through the VPCC online reporting portal.

Figure 2A: Number of cases received by ASC, grouped into referral sources, 2024

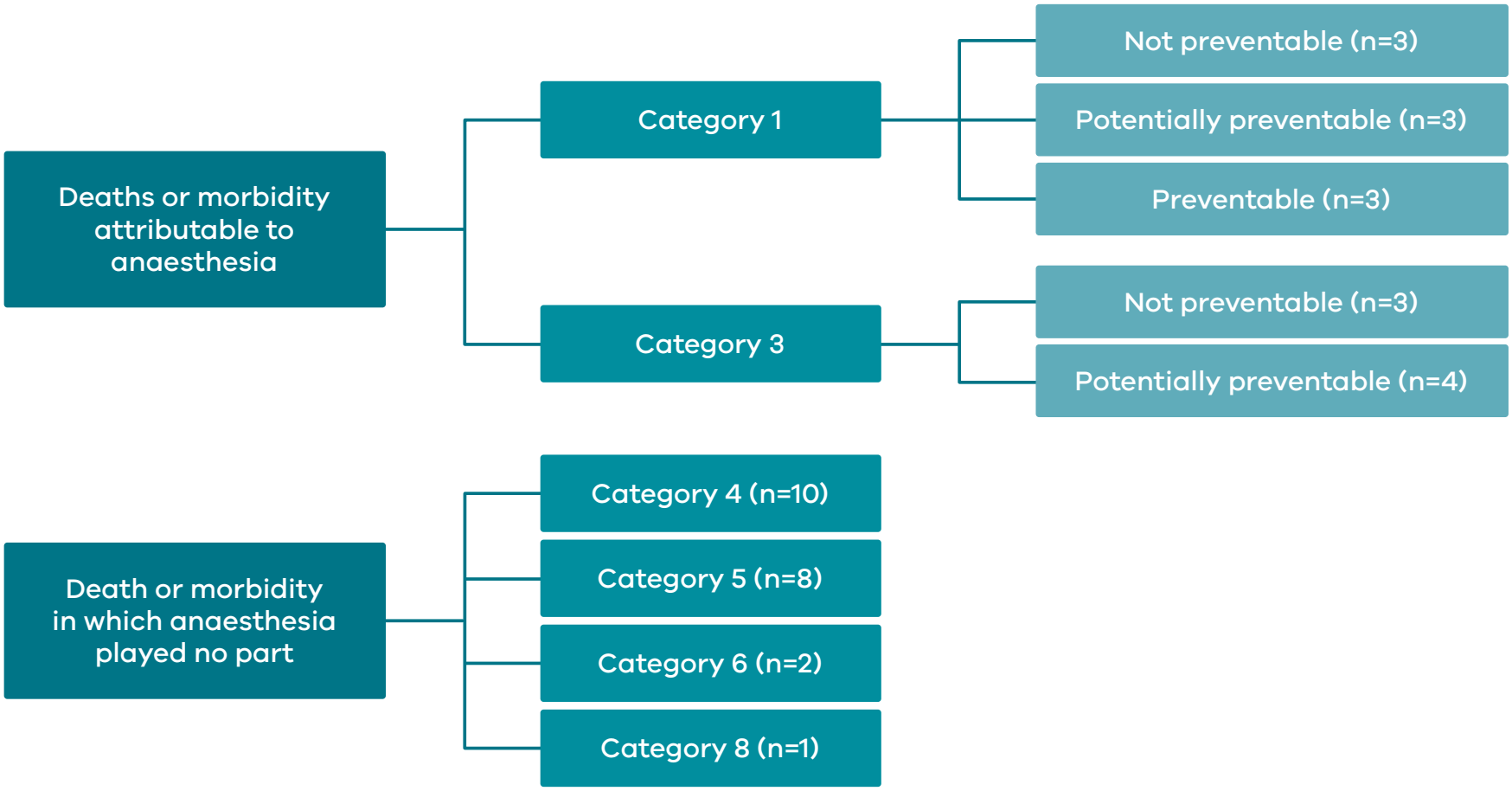


Processes and outcomes

The chair and senior clinical advisor assessed and triaged these cases, subsequently assigning 37 cases to ASC members for detailed clinical review (Figure 2B), where areas for improvement within anaesthetic practices were discussed and identified during the quarterly ASC meeting (refer to '2024 themes').

The subcommittee chair then presented the discussion and findings from these meetings to the VPCC, facilitating formal recommendations communicated to the Minister for Health, SCV, professional bodies such as the Australia and New Zealand College of Anaesthetists (ANZCA) and the wider practising community.

Figure 2B: Triaged cases grouped into classification categories (*n*=37), 2024



Refer to Appendix 2 for a detailed description of each category.

2024 themes

1. Preoperative care

In 2024 the ASC was pleased to see the 'Sip Til Send'[2] guidance adopted across many Victorian hospitals, a process actively facilitated by the VPCC. This guidance aimed at improving patients' preoperative experience by replacing the conventional 'nil by mouth' fasting approach with the allowance of moderate clear fluid intake before surgery. The policy also gained traction amid an intravenous fluid shortage in early 2024 and has since been widely integrated into practice.

RECOMMENDATION:

Preoperative hydration through 'Sip Til Send' programs are recommended for appropriate patients. This can improve patient experience and comfort and reduce the risks associated with prolonged fasting (such as minimising aspiration and regurgitation) and reduce distress, dehydration and associated haemodynamic and metabolic effects.[2]

During the ASC meetings, the adequacy of preoperative informed consent and advance care planning consistently emerged as important topics. As highlighted by the consumer representatives, informed consent is essential in ensuring patients and families understand the potential outcomes of surgical interventions, as well as the alternative treatment options available. Likewise, advance care planning is equally important in ensuring that if patients cannot advocate for themselves, their appointed representatives and healthcare team can act in line with the patient's values, goals and preferences. While many reviewed cases included excellent documentation of consent discussions about postoperative care limitations involving patients, treating surgical team, anaesthetists and intensive care physicians, some cases lacked clear documentation, making it uncertain whether these discussions took place. The ASC strongly advocates for clear and effective documentation of the shared decision-making processes, particularly for patients with significant medical comorbidities and those undergoing emergency surgery, where risks are often higher and time for reflection is limited.

CLINICAL PRACTICE POINT:

Preoperative informed consent and advance care planning are essential practices in health care. Every consumer should be actively engaged in shared decision-making to ensure care aligns with their values, preferences and goals.

2. Intraoperative care

There are 3 recurring key themes identified in the intraoperative period: aspiration, adverse drug reactions and central venous catheter (CVC) insertion and removal.

Aspiration

Aspiration events can occur throughout the intraoperative and postoperative periods, with intraoperative incidents most commonly happening during induction or emergence from anaesthesia. A notable aspiration-related death in 2024 involved a young man undergoing orthopaedic surgery after significant trauma. On reviewing the case, the ASC was divided on the adequacy of the anaesthetic care provided. Although a rapid sequence intubation was appropriately planned and performed, the decision was made not to apply cricoid pressure – a manual technique applied on the front of the neck to prevent stomach contents from regurgitating during anaesthesia administration. The ASC acknowledged that the frequency of aspiration events in such scenarios and the acceptance of using cricoid pressure as common practice are low. While some members felt that using cricoid pressure might have changed the patient's outcome, there is no strong evidence to support this. Also, some organisations, such as the European Resuscitation Council, no longer recommend cricoid pressure as part of rapid sequence induction.

We saw other aspiration events during endoscopy procedures, where anaesthetists provided sedation without airway protection devices.

Adverse drug reactions

Severe hypersensitivity to adverse drug reactions are rare but unavoidable complications of anaesthesia. They account for many of the anaesthesia-related mortalities the ASC reviewed. As noted in previous annual reports, the way these reactions are managed has improved through mandatory, standardised training in anaesthesia, continuing medical education and making anaphylaxis kits available in operating rooms.

Central venous catheter

In 2024 mechanical complications associated with CVC insertion and removal were linked to 2 reported mortalities. While there are protocols for CVC management, these cases highlighted the need for strict adherence to established protocols and ongoing training to ensure safe practice.

In 2023 the ASC contributed to an SCV practice advisory and established a recommendation on CVC management. To progress this work, the ASC has engaged with Australian and New Zealand College of Anaesthetists (ANZCA) to explore ways to promote techniques that reduce mechanical complications associated with CVC insertion and removal.

RECOMMENDATION:

Clinicians are recommended to adhere to current protocols on CVC management while awaiting robust guideline development aimed at minimising risks and CVC-associated mechanical complications.

3. Postoperative care

The postoperative period can be unpredictable. Even young, previously well patients having minor procedures may experience unexpected, life-threatening instability.

The ASC reviewed a reported mortality at a standalone day surgery facility, where we found multiple deviations from accepted medical practice. The ASC recommended to the VPCC that the matter be thoroughly pursued through all available avenues so similar incidents can be prevented. The learnings from this case highlighted that all hospitals and healthcare facilities providing surgical services must have robust protocols or guidelines for managing deteriorating patients after surgery. They must also ensure medical and nursing staff are appropriately qualified, credentialed and fully understand the institution's escalation pathways.

CLINICAL PRACTICE POINT:

Ensuring effective, appropriate postoperative care and early recognition of clinical deterioration are fundamental responsibilities of all surgical facilities. Establishing clear escalation pathways is essential in optimising patient safety and recovery outcomes.

Conclusion

The ASC has identified several recurring themes across all 3 phases of care. We will continue to refine our processes to better identify emerging safety signals in the perioperative sector, ensuring key perioperative themes are not overlooked. The committee is also becoming increasingly proactive in addressing areas of concern through intra-organisational channels and relevant professional bodies, efforts that will be further strengthened in the coming years. Work is also underway to improve the rate of direct online reporting, with the upcoming redesign of the VPCC website expected to simplify and improve accessibility to this process. Finally, I would like to thank the dedicated group of expert consumers and clinicians on the ASC for their time and efforts towards creating a safer health system.

Surgical Subcommittee

by Wendy Brown (VPCC member, Surgical Subcommittee chairperson)

Similar to the ASC, the SSC has a diverse group of members including anaesthetists, surgeons from various specialties, a general practitioner representative, nursing professionals and a consumer representative. Together, they provide expert insights and multidisciplinary perspectives to support perioperative safety and quality improvement.

The role of the SSC is to identify themes that underpin adverse surgical outcomes across our state as well as reporting on and supporting perioperative clinical practice registries. The committee considers information from surgical deaths that were potentially preventable referred by VASM, sentinel events reported to SCV, coronial E-Deps and clinical registry reports.

The total referrals from various sources are shown in Figure 3A. The subcommittee chair and senior clinical advisor assessed and triaged these cases, subsequently allocating 33 cases to SSC members for detailed clinical review in 2024 (Figure 3B). Among the cases, 32 resulted in mortality, while one involved serious morbidity. Also, annual registry reports for all relevant surgical specialties were reviewed to ensure there were no system-level issues that needed addressing.

Figure 3A: Number of cases received by SSC, grouped into referral resources, 2024

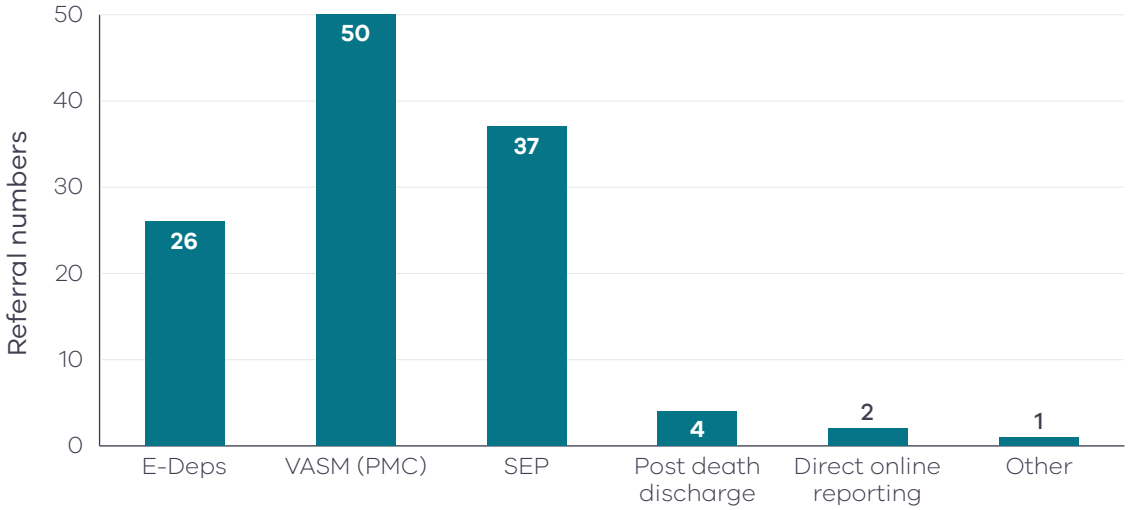
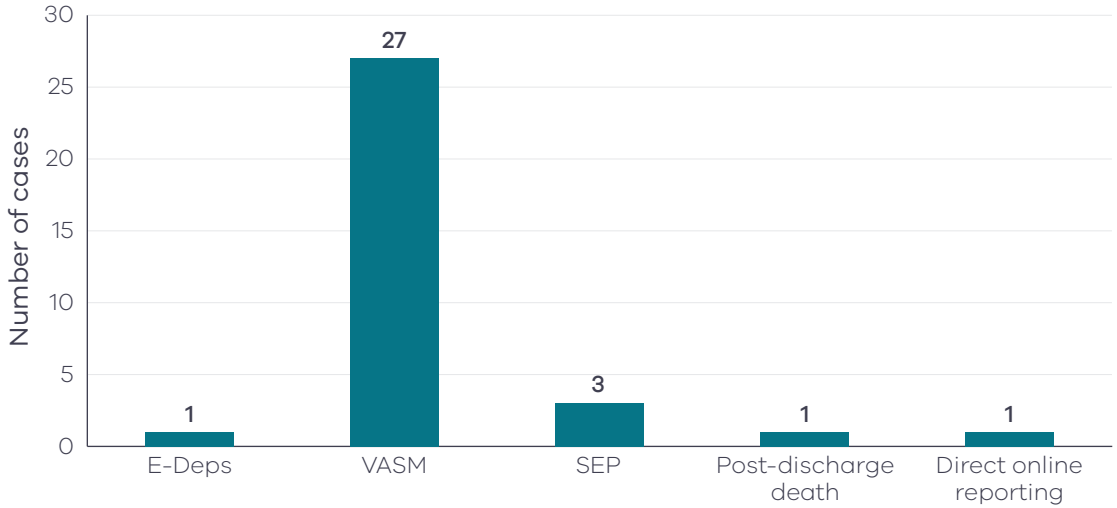


Figure 3B: Number of in-depth reviewed cases by SSC members, group into referral resources, 2024



Although each case offers important learnings, the review processes revealed consistent themes that present opportunities for consideration, education and system improvement. Key areas that presented opportunities to improve patient outcomes are discussed below.

1. Communication

Breakdowns in communication continue to be a recurring concern in cases involving suboptimal patient outcomes. These lapses occur both within clinical teams and between health services. Similar to findings from consumer representatives and the ASC, the risks associated with procedures were not always communicated effectively to patients, with some cases involving unnecessary surgeries. In 3 cases, the goals of care and advance care plan were not clearly documented, leading to inefficient medical management when an adverse event occurred. There were also 4 instances where staff failed to escalate care for deteriorating or complex patients, resulting in delayed interventions and adverse events.

2. Transfers within and between hospitals

As noted in previous reports, timely hospital transfers are a consistent concern. There were multiple cases where patients experienced delays in being admitted or transferred to the appropriate units, such as intensive care or stroke units, for proper management. The transfer process can be fragile: there are many steps, delays can creep in, and communication between hospitals can break down. The SSC is advocating for system reforms to make transfers consistent and timely, so people receive the care they need as close to home as possible. There were also multiple cases where treating clinicians did not initiate early transfer of complex patients for high-risk surgeries or procedures, leading to preventable deaths.

CLINICAL PRACTICE POINT:

Early involvement of the multidisciplinary team is critical for patients with complex medical histories because it supports thorough assessment, planning and coordination of both intrahospital and interhospital transfers before surgery.

3. Complex procedures

The Surgical Subcommittee of VPCC recognised adverse outcomes in rarely performed complex procedures in 2024. While adverse events are more frequently associated with complex procedures, some incidents occurred in hospitals that lacked the necessary resources, skills or knowledge to manage complications. This meant patients had to be transferred to facilities with higher-level support. To improve outcomes for Victorians, we need for a systems-based approach to delivering these procedures. SSC has raised this concern to the VPCC and is pleased to see SCV formally leading a working group reviewing the delivery of high-risk, low-frequency complex procedures.

RECOMMENDATION:

Treating surgical teams should evaluate their capacity to manage complex procedures. When necessary, facilitate timely transfer of patients to a hospital equipped to provide the required care.

4. Implant tracking system or registry

A registry or tracking system for non-permanent implants like ureteric and biliary stents and inferior vena cava filters require timely removal or replacement. Without a centralised system, patients may face unnecessary risks such as infections or obstructions. In 2024 the SSC noted a case where a patient had significant delays in her stents being reviewed. The stents had developed significant encrustation, requiring a complicated removal process that ultimately resulted in avoidable complications.

RECOMMENDATION:

Hospitals should maintain a register of non-permanent stent implants that includes a flagged time limits for review. This register must be checked and acted on regularly. Without this measure, it can lead to delays in removing non-permanent stents, which can lead to sepsis and other complications.

5. Low registry participation

The The Australian and New Zealand Hip Fracture Registry (ANZHFR) and and the Australian and New Zealand Emergency Laparotomy Audit Quality Improvement (ANZELA-QI) program are condition-specific registries that provide valuable opportunities for hospitals to benchmark care and implement interventions aligned with best practice standards, ultimately improving patient outcomes. However, only 12 Victorian hospitals take part in these registries. As in previous years, the SSC strongly recommends all hospitals actively engage with and contribute to these registries.



Case study 4: Cystectomy

An older patient had a cystoprostatectomy (removal of the entire bladder and the prostate gland) and a new urine passage made from part of his small intestine. He had previously had surgery to remove his rectum and anus, as well as radiation treatment to the pelvic area.

After surgery, the patient experienced pain with signs initially thought to be consistent with ileus. Unfortunately, over the next 48 hours the patient deteriorated and developed signs of abdominal sepsis.

The patient had emergency surgery to open the abdomen, which found a leak at the surgical join in the bowel. The abdominal cavity was cleaned, and the end of the small intestine was brought out as a stoma (an opening on the abdomen).

The patient was managed in intensive care unit after the second surgery but was palliated as per advance care planning when he deteriorated further.

Learning points: Cystoprostatectomy is a major operation with significant risk of bowel leakage with a previously irradiated pelvis, where bowel anastomosis healing may be poor, thereby increasing patient's mortality risk. Patients and their support people should be fully aware of these risks and the balance of benefit. Cases should be discussed by a multidisciplinary team with all options explored objectively.

Case study 5: Oesophageal perforation

A frail older patient with a history of pneumonectomy and severe chronic obstructive pulmonary disease had an endomucosal resection of an oesophageal lesion that was not causing obstruction.

The endomucosal resection resulted in an oesophageal perforation, but the comorbidities meant that open chest surgery was not possible. The perforation was therefore treated with trans-gastric drainage and jejunal feeding.

After surgery, the patient was managed in intensive care and discharged to a ward when stabilised. The patient died some days later in the ward.

Learning points: A multidisciplinary discussion should had been considered before the procedure to discuss the indication for endomucosal resection – considering the patient did not have any symptoms from the lesion – and to discuss other treatment options.

Learning from good practice – Safety II – Quality Improvement

Australia and New Zealand Emergency Laparotomy Audit – Quality Improvement (ANZELA-QI)

by James Aitken (ANZELA-QI Working Party chairperson)

In late 2024 there were 2 events that have already had a great impact on the ANZELA-QI program. They will have important consequences for all hospitals and state health departments.

Australian Framework for National Clinical Quality Registries

The first was the publication of the Australian Commission for Safety and Quality in Health Care's revised Australian Framework for National Clinical Quality Registries. This includes guidance to how clinical quality registries should use funnel plots and longitudinal statistical process control charts to present their data in timely manner. The framework is clear that aggregated or summary data as traditionally presented in annual reports is 'insufficient to meet the needs of safety and quality improvement across the health sector'.

The framework requires CQRs to report on their data quality. According to its outlier guidance, registries must report both 'complete' and 'partial' non-participation to the health service organisation as outliers at the alarm level.

Emergency laparotomy clinical care standard

The second was the Commission confirming to the VPCC and ANZELA-QI program its plans to develop an emergency laparotomy (EL) clinical care standard (CCS). A draft version for public comment is likely to be available in the second half of 2025, with a final version in mid-2026. Fortunately, the ANZELA-QI program has already addressed many of the commission's requirements, indicating that hospitals should strongly consider taking part in the ANZELA-QI program.

ANZELA-QI program monthly reports

Since September 2024 ANZELA-QI's monthly hospital reports have presented data using funnel pots and longitudinal statistical process control charts. These data show both care standard compliance and the underlying data quality for each hospital. Also, these reports have been developed with the Western Australian Department of Health, which has extensive expertise in quality improvement methodology. The report will soon form the basis of a near real time ANZELA-QI dashboard.

As part of its development, the ANZELA-QI's reports now include some 'secondary' analysis. This is because many ELs are time-sensitive, meaning delays can significantly impact patient outcomes. The initial focus of this extra analysis is on timely theatre access and managing sepsis in line with the commission's sepsis CCS.

A key challenge highlighted in these reports is the widespread issue of hospital non-participation. Even in hospitals that take part, cases are recorded inconsistently and data is often incomplete. For example, many hospitals fall into the categories of complete or non-participation by definition.

Unfortunately, the ANZELA-QI program lacks the authority to enforce hospital participation, whereas hospitals and state health departments do. There is likely to be increasing pressure to address poor participation when the EL CCS is published next year. Health services are expected to identify relevant CCS and implement those that will reduce risk to patients, improve quality and address areas of unwarranted variation from best practice.

Currently, there is no requirement for health services to report their CCS compliance through a clinical quality registry. But whatever method they select must be nationally consistent.

Conclusion

Taking part in the ANZELA-QI program will allow health services to provide evidence against several requirements of the National Safety and Quality Health Service Standards:

- measure and monitor data on safety and quality improvement (Action 1.08)[3]
- provide timely reports on safety and quality systems and performance (Action 1.09)[4]
- support clinicians to implement relevant CCS developed by the commission (Action 1.27)[5]
- identify and respond to healthcare variation (Action 1.28).[6]

Not only does the ANZELA-QI program offer health services an immediate and cost-effective means to compare and report their data in a nationally consistent way, it also supports continuous quality improvement in a critical area of care for both clinicians and consumers.



ANZELA-QI in Victoria

by David A Scott (VPCC chairperson)

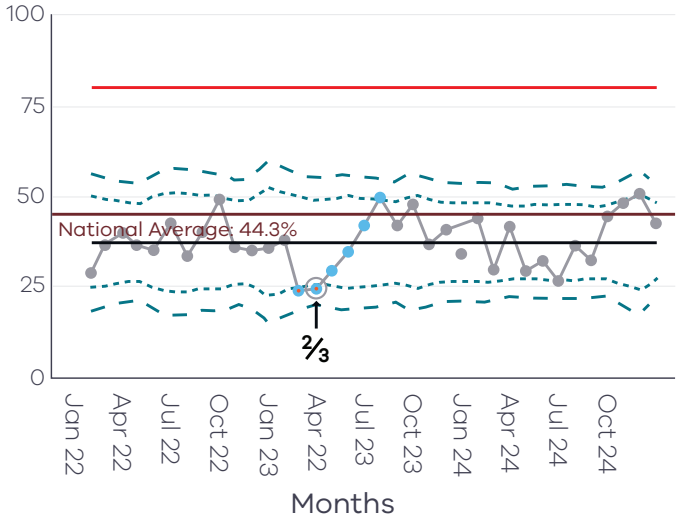
According to the latest unpublished report from the ANZELA-QI, there were 12 Victorian hospitals taking part in ANZELA-QI in 2024.[7] Within these hospitals, about 2,518 ELs were performed over the aggregated reporting period of January 2023 to December 2024. While data was available between 70% and 80% of cases, which is similar to the national average, some hospitals have yet to contribute or engage with the ANZELA-QI. Previous ANZELA-QI reports are on the Royal Australian College of Surgeons website[8] <https://www.surgeons.org/research-audit/morbidity-audits/morbidity-audits-managed-by-racs/anz-emergency-laparotomy-audit-quality-improvement>.

The overall in-hospital mortality (unadjusted) was 6.8% nationally and 7.4% for Victoria.[7] This indicates that EL is a high-risk surgery, justifying the need for interventions aimed at improving patient outcomes wherever possible. It is noted the 30-day mortality rate for the United Kingdom's National Emergency Laparotomy Audit is 9.2%.[7] However, this has improved over time. While the ANZELA-QI rate is lower in Australia, this may reflect a higher rate of decisions not to operate or other factors such as reporting hospital characteristics.

The VPCC strongly recommended involving geriatricians in perioperative planning and managing older EL patients in 2022 and 2023 – and continues to do so. Linking to this, early risk assessment can facilitate shared decision-making between clinicians and patients. Data for these has been highlighted below.

However, the completion rate for perioperative risk assessments in Victoria between 1 January 2022 and 31 December 2024 was 36.9%, which was lower than the national average of 44.3% (Figure 4A).[7] There is significant variability among hospitals, with rates ranging from 7.8% to 71.8%, which shows that high rates are achievable.[7] Despite some improvement over time, the rates are still below the desired target minimum of 75% (solid red line). Given its critical role in perioperative care and patient–clinician communication, increasing the risk assessment completion rate should be a priority. Risk assessment also guides perioperative management. For example, the proportion of patients with a calculated preoperative National Emergency Laparotomy Audit risk of death ≥ 5.0% for whom a consultant surgeon and consultant anaesthetist were present in theatre was 86.1%, which is higher than the recommended minimum and higher than the national average of 78.8%.[7] This shows that when risk assessments are performed they can effectively guide management.

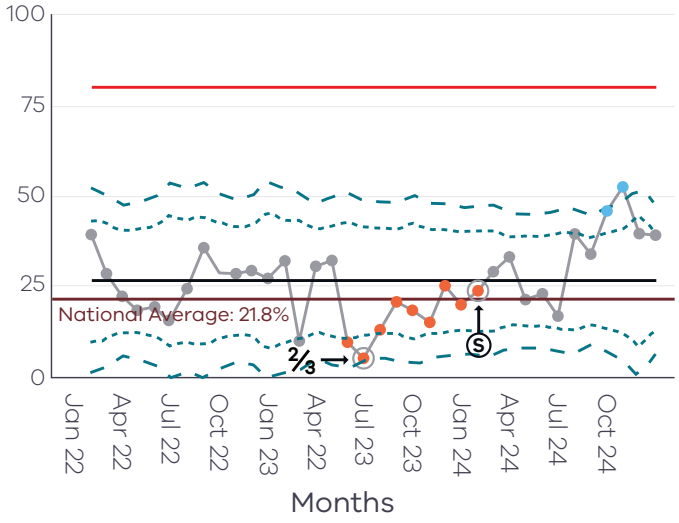
Figure 4A: Risk assessment completion rate over time, Victoria, 2022 to 2024



Adapted from an unpublished report created by ANZELA-QI and the Western Australia Department of Health. Blue dots indicate favourable.[7] The solid red line indicates the target rate, the brown solid line indicates the national average rate, whereas the black solid line indicates the Victorian average rate. The 2 dotted lines indicate the national upper and lower warning (95%) and control (99.8%) limits respectively.

For this period, only 26.7% of patients aged over 65 years in Victoria are assessed by a specialist in geriatric medicine (a geriatrician).[7] While this is an improvement from 2023 and is higher than the national average of 21.8%, it is concerningly low (Figure 4B) and also well below the target of 75%.[7] This shortfall may be due to organisational factors and resource constraints. It is important to note that the input of geriatricians, particularly in procedures such as total hip replacement for hip fracture patients, significantly improves perioperative outcomes. Therefore, Victorian healthcare services must prioritise increasing specialist involvement in surgical decision-making.

Figure 4B: Proportion of patients aged ≥ 65 years assessed by a specialist in geriatric medicine, Victoria, 2022 to 2024



Conclusion

Participation in the ANZELA-QI program continues to be incomplete, with key performance indicators still unmet at both the national and state levels. The VPCC strongly recommends that hospitals performing ELs, including private hospitals, take an active part in ANZELA-QI.

RECOMMENDATION:

The VPCC strongly recommends that all hospitals performing emergency laparotomies, including those in the private sector, actively engage in the ANZELA-QI program. This is especially important as the ACSQHC develops a clinical care standard for emergency laparotomy.

Adapted from an unpublished report created by ANZELA-QI and Western Australia Department of Health. Blue dots indicate favourable, whereas orange dots indicate unfavourable.[7] The red solid line indicates the target rate and the brown solid line the national average, whereas the black solid line the Victorian average. The 2 dotted lines indicate the national's upper and lower warning (95%) and control (99.8%) limit respectively.



Australian and New Zealand Hip Fracture Registry

by Marinis Pirpiris (VPCC deputy chairperson, SSC member)

The ANZHFR continues to play a transformative role in improving the care and outcomes of older adults presenting with hip fractures. Below is a summary of unpublished 2024 registry data highlighting significant clinical and system-level improvements across Victoria, while also identifying ongoing areas needing attention.

Expansion of hospital participation and data completeness

Victorian hospital participation in the ANZHFR increased in 2024. There were 17 major hospitals contributing patient-level and facility-level data, including regional sites such as Northeast Health Wangaratta and Bendigo Health, and metropolitan leaders like Alfred Health, Melbourne Health, Northern Hospital and St Vincent's Hospital Melbourne.

Data submission quality has shown marked improvement, and more sites are now capturing over 80% of patient cases. This progress was largely attributed to hospitals embedding hip fracture coordinators or orthogeriatric models of care, which support reliable, real-time data capture and care continuity.

Improvements in pain management and early care

Victorian hospitals have made substantial gains in early-phase care. About 85% of patients received nerve blocks before the operating theatre (Figure 5A), showing a notable rise from 77% in 2023.[9] The routine adoption of multimodal pain protocols such as fascia iliaca blocks and local anaesthetic infiltration has also significantly reduced reliance on opioids, thereby enhancing preoperative comfort and patient safety.

Cognitive assessment and delirium prevention

In 2024 preoperative cognitive screening rates in Victoria remain below the state average, at 70% compared with 80%.[9] However, delirium screening is more consistently conducted postoperatively, with 82% of patients assessed, matching statewide average (Figure 5B).[9] To address these challenges, hospitals are introducing delirium-prevention bundles and routine cognitive rounding, which will improve care quality, reducing the incidence of postoperative confusion and facilitating effective discharge planning.

Figure 5A: Percentage of patients with a hip fracture receiving nerve blocks before the operating theatre (OT), Victoria, 2020 to 2024

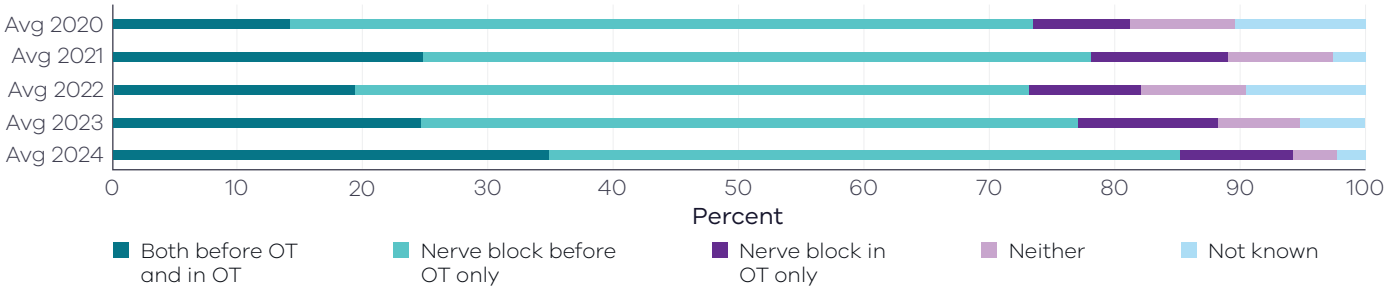
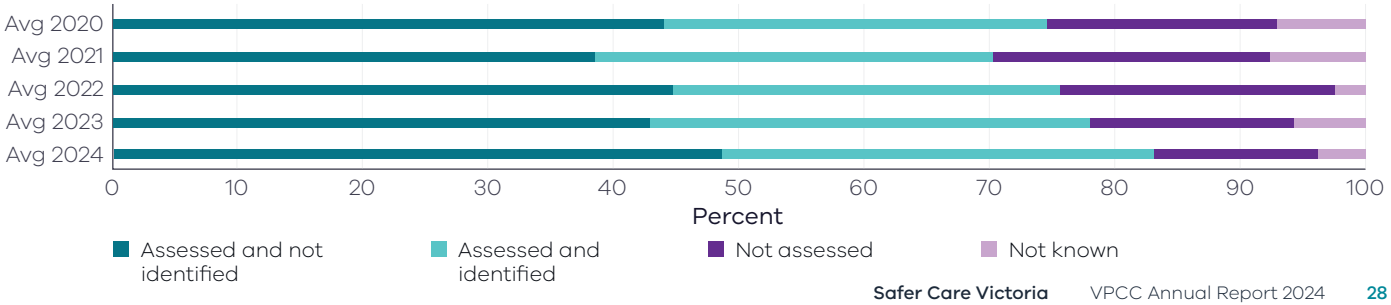


Figure 5B: Percentage of patients with a hip fracture receiving a delirium assessment after surgery, Victoria, 2020 to 2024



Time to surgery – mixed progress

Despite improved coordination, timely surgical access is still a major concern. In 2024 only 77% of Victorian patients received surgery within 48 hours, which is falling short of the ANZHFR national benchmark and showing no improvement over the past 3 years.

As of January 2024 the ANZHFR aligned its benchmark with the United Kingdom and European Union standards, reducing the target window to 36 hours.[9] But achieving this remains challenging, with only 57% of patients meeting the 36 hours (Figure 5C). This outcome is consistent with the Australian averages. Key barriers attributing to this include limited after-hours theatre access, competing emergency demand and constrained anaesthetic availability particularly in regional settings.[9]

Early mobilisation and functional recovery

Mobilising patients on the day after surgery is a critical target. Victoria reported a day 1 walking rate of about 46% (Figure 5D), falling below the Australian average of 53%.[9]

Mobilising patients in the early postoperative period presents multiple challenges, including patient-related factors and system-related barriers such as workforce shortages, especially in physiotherapy, and delays in weekend reviews.

RECOMMENDATION:

To support early mobilisation and functional recovery in postoperative hip fracture patients, innovative strategies including 7-day allied health rosters, geriatric-led mobilisation protocols and orthopaedic surgical permitted unrestricted weightbearing status are recommended.

Figure 5C: Percentage of patients with a hip fracture receiving surgery within and after 36 hours, by state, 2024

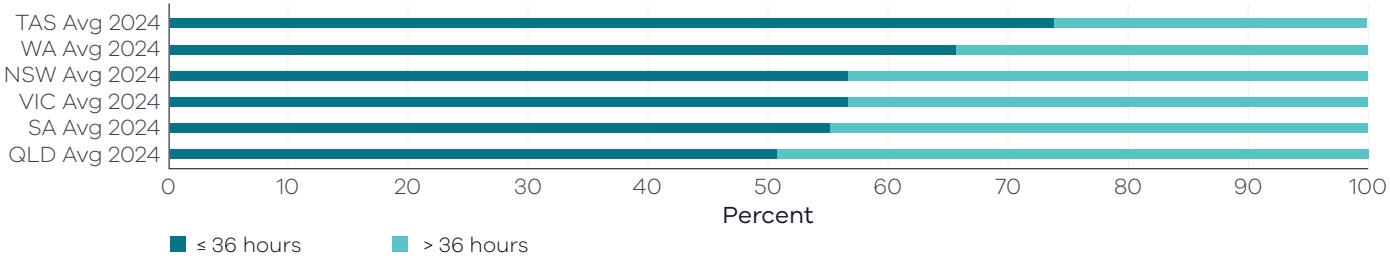
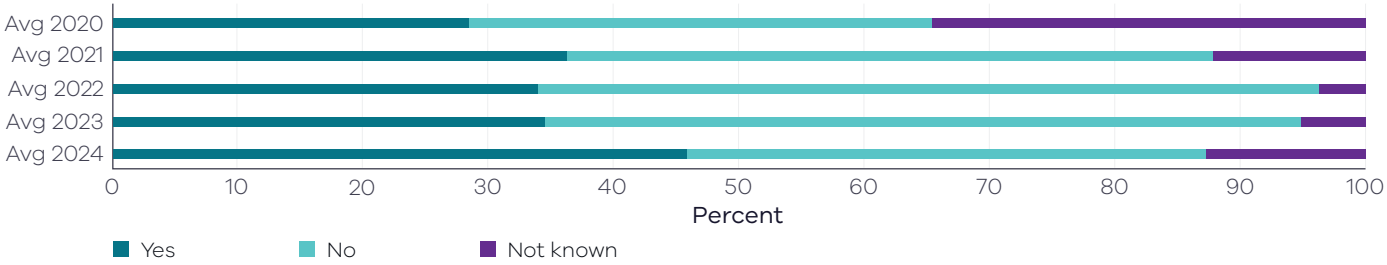


Figure 5D: Percentage of patients with a hip fracture who received first day walking after surgery, Victoria, 2020 to 2024



Osteoporosis management and secondary prevention

The ANZHFR data continues to show that osteoporosis management at discharge is consistent, though gradually improving over time. In 2023, 30–35% of patients were discharged with a prescription for bone protection therapy (bisphosphonates, denosumab). This improved modestly to 35–40% in 2024 (Figure 5E).[9] Despite well-established guidelines and the presence of statewide fracture liaison services in selected health networks, this gap represents a persistent missed opportunity for secondary fracture prevention. Encouragingly, some hospitals are now trialling embedding automatic osteoporosis alerts and referral pathways within discharge summaries.

System-level support and policy alignment

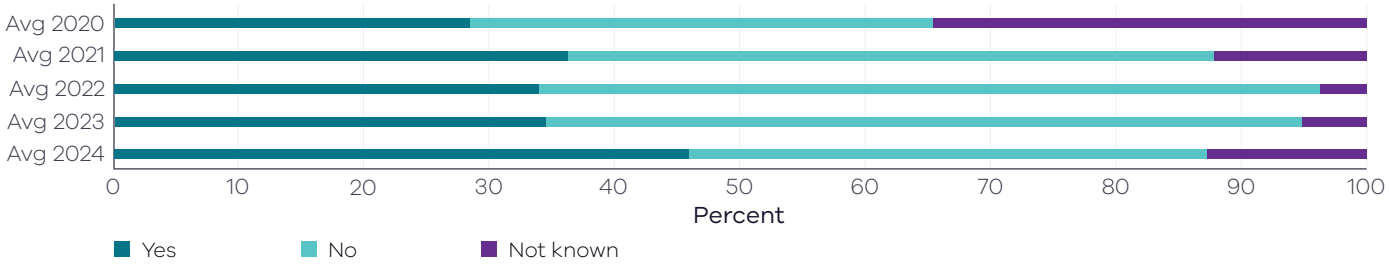
Victoria has shown strong alignment between clinical care and system-level support. This is exemplified by the VPCC and SCV actively promoting registry participation, with hip fracture outcomes being integrated into multiple quality dashboards. Also the Getting it Right First Time (GIRFT) initiative piloted in the Hume region is leveraging ANZHFR data to address unwarranted variation and improve consistency in care delivery across regional sites.

Conclusion

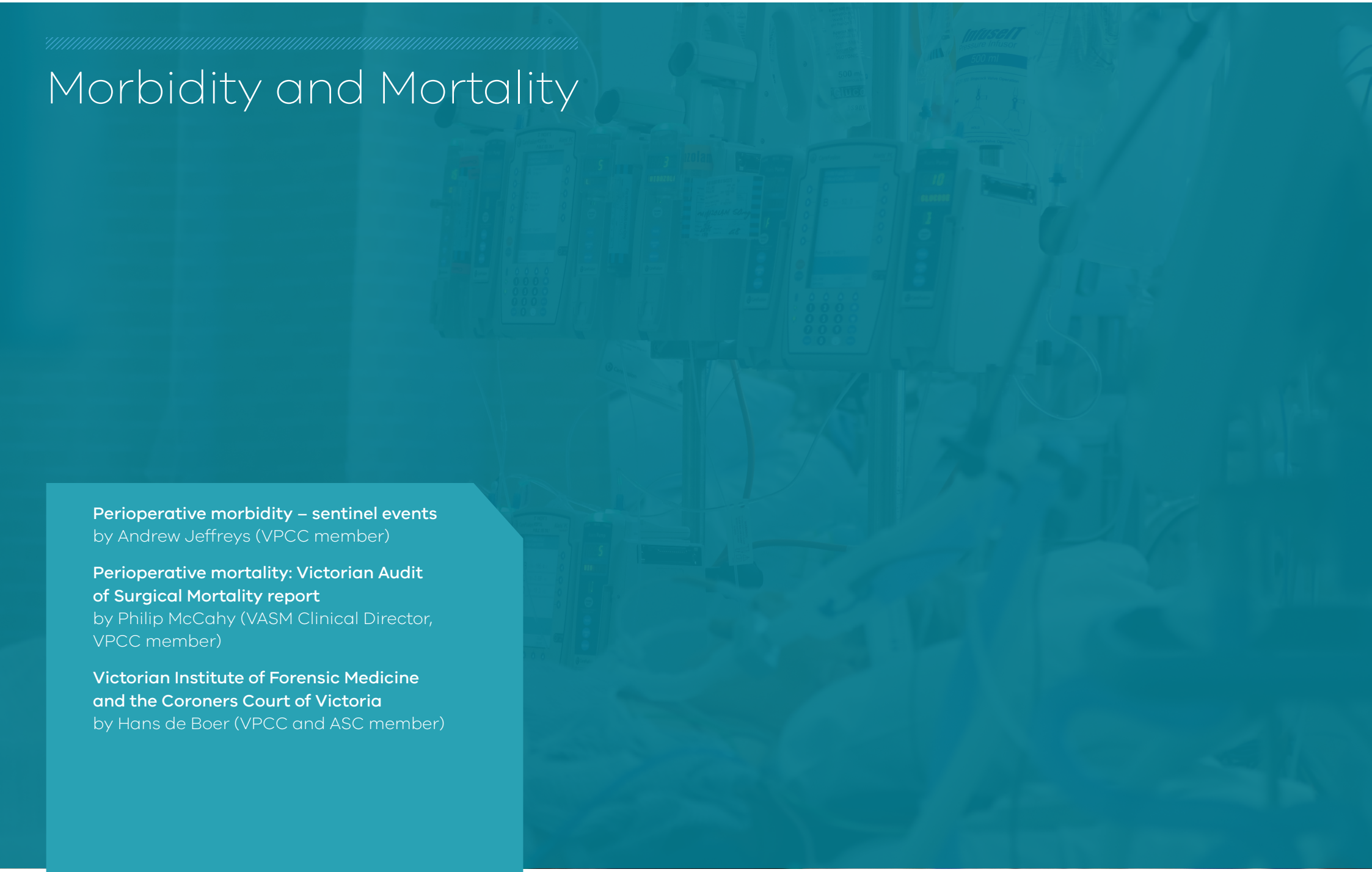
The 2024 ANZHFR data shows that Victoria is performing well in several domains of hip fracture care, particularly in pain management, delirium screening and interdisciplinary coordination. But timely access to surgery, early mobilisation and osteoporosis treatment are still key areas for targeted improvement.

Looking ahead, Victoria's challenge is to translate local excellence into system-wide consistency. Integrating registry data with hospital quality systems, enhancing staff resourcing and incentivising rapid surgery and secondary prevention will be critical to delivering on the promise of value-based, person-centred hip fracture care.

Figure 5E: Percentage of Victorian patients receiving individualised written information on preventing future falls and fractures, Victoria, 2020 to 2024



Morbidity and Mortality



Perioperative morbidity – sentinel events
by Andrew Jeffreys (VPCC member)

Perioperative mortality: Victorian Audit of Surgical Mortality report
by Philip McCahy (VASM Clinical Director, VPCC member)

Victorian Institute of Forensic Medicine and the Coroners Court of Victoria
by Hans de Boer (VPCC and ASC member)

Perioperative morbidity – sentinel events

by Andrew Jeffreys (VPCC member)

In Victoria, a sentinel event is 'an unexpected and adverse event that occurs infrequently in a health service entity and results in the death of, or serious physical or psychological injury/harm to a patient as a result of system and process deficiencies at the health service entity'.[10]

Serious harm is considered to have occurred when, because of a serious adverse patient safety event, a patient has either:

- required life-saving surgical or medical intervention
- a shortened life expectancy, or
- experienced permanent or long-term physical harm, or experienced permanent or long-term loss of function.

Sentinel events are categorised according to a national standard (refer to Appendix 3). Victoria has an extra category: *category 11 – All other serious adverse patient safety events resulting in serious harm or death*. This latter category offers a valuable opportunity for SCV and VPCC to gain insight into a range of events that could otherwise not be reported, denying the opportunity to learn and improve.

In period 1 January to 30 June 2024 the VPCC reviewed 44 sentinel event reports, mostly related to perioperative care. The chair of the SSC and/or ASC reviewed these referrals, identified and reported key themes as presented in their reports above.

Sentinel events: categories 1–10

Six reports were classified as one of the 10 primary ACSQHC categories of sentinel events.[11] (Table 1).

Table 1: Number of cases with its corresponding sentinel event category and outcome

Category	N	Outcome
Category 1: Wrong site		
Errors in preparation of imaging led to surgery at the wrong level for a spinal dural arteriovenous fistula, and disconnection of the wrong artery which caused right lower limb weakness	1	Permanent harm
Consented for right oophorectomy and bilateral fallopian tubectomy. Left ovary also removed in error	1	Permanent harm
Category 4: Unintended retention of a foreign object		
Broken metal jaw pad from needle holder remained in surgical site	1	Surgical remediation
Category 7: Medication error		
Incorrect intravenous dose of fentanyl administered on ward	1	High-level medical intervention
Muscle relaxant reversal error attributed to incorrect ampoule selection	1	High-level medical intervention
Haemorrhagic complication of anticoagulation incorrectly prescribed in response to an incorrect plan documented in the EMR	1	High-level medical intervention

Case study 6: Medication error

A man in his mid-40s had laparoscopic renal surgery under relaxant general anaesthesia. Muscle relaxation was reversed with an ampoule of what was thought to be pre-mixed neostigmine 2.5 mg and glycopyrrolate 0.5 mg after surgery. Shortly after reversal, he developed severe bradycardia that progressed to asystole. Advanced life support was provided including a brief period of cardiac compression. Stable circulation was restored, and he was transferred to intensive care for observation, spending another 5 days on the ward recovering from surgery. He experienced ongoing anxiety and rib pain but suffered no other effects from the episode.

Review of the anaesthetic ampoules and drug trolley revealed that similar appearing neostigmine 2.5 mg ampoules had been incorrectly mixed with the premixed ampoules in the one compartment. The likely cause of the cardiac arrest was the administration of unopposed neostigmine.

Comment: This report was a rare example where anaesthesia was the prime contributor to the event. The administration 'slip' type error was likely the last in several aligned 'holes' in the 'Swiss cheese' model of multiple steps leading to a significant error. These include ampoule appearance and design, theatre pharmacy stocking, drug trolley design and restocking practices, and potential human factors such as distraction and fatigue.

The institutional response was to remove pure neostigmine from the operating theatres to minimise the risk of a restocking and drug administration error.

The underlying factor contributing to this case study could be drugs with similar ampoules, inconsistent ampoule labelling by manufacturers (size and colour) and drug substitution that might be pharmacologically identical but different in appearances due to frequent drug shortages. To mitigate these sentinel events, the VPCC and ANZCA have encouraged stakeholders to communicate clearly with clinicians when drug suppliers are substituted and staff to stay vigilant in ensuring the correct drug is replenished within the drug compartments in theatre trolleys.

CLINICAL PRACTICE POINT:

To minimise drug administration errors, clinicians should remain vigilant when handling medications with similar ampoule appearances or inconsistent manufacturer labelling. Heightened awareness is especially important during periods of drug shortages, when alternative preparations may look unfamiliar or differ in packaging.

ACTION:

The VPCC and ANZCA have advocated for clear communication from pharmacies and within departments in situations of drug supplier substitution and an awareness by staff when restocking drug compartments in theatre trolleys.

Sentinel events: category 11

SCV uses category 11 for all other patient safety events leading to serious harm or death. Of the 44 perioperative care–related reports, 38 were category 11 events (Table 1).

The VPCC again captured several perennial themes when analysing these complex chains of events, often involving multiple teams in unwell patients and/or high-risk surgery or procedures. These themes have been highlighted in previous sections of this report:

- delay in diagnosis
- delay in care
- missed diagnosis
- suboptimal handover of care
- errors in communication
- failure to escalate care.



Perioperative mortality: Victorian Audit of Surgical Mortality report

By Philip McCahy (VASM Clinical Director, VPCC member)

Surgical mortality in Victoria remains within internationally safe rates (3–4/1,000 procedures), with the vast majority of deaths occurring after emergency surgery in patients with significant comorbidities. Over the past year VASM has been at the forefront in changing reporting and information sharing with surgeons, hospitals and health services without compromising protected information and patient privacy.[12]

At the time of writing, the 2023 VASM report is still under review and is expected to be released later this year. Initial analysis of surgical deaths reported in 2024 shows a slight reduction in notifications (1,846 to 1,737), along with an improvement in the proportion of cases (81.5%) that have completed assessment – an encouraging trend compared with earlier years in this decade. This improvement likely reflects greater surgeon engagement, potentially driven by the recent change in medical registration requirements that now recognises VASM participation as a high-level continuing professional development activity.

However, delays persist in both the notification process (median: 28 days) and the completion of surgical forms (median: 75 days), limiting the ability to provide near real-time analysis of surgical mortality.

Over the past year, state health departments have discussed enhancing surgical mortality reporting. These discussions aim to improve the dissemination of lessons learned from cases more rapidly and broadly. Several major developments are planned to strengthen the VASM system, with improvements expected to be reflected in next year's report.

Peer review findings showed that no clinical management issues were identified in 74.2% of cases, which is a slight decrease compared with the previous year. The nature and distribution of these issues remained consistent with trends from previous years. According to VASM assessors, just over 10% of preventable clinical management issues contributed directly to patient deaths. These cases form the basis of the Case Note Review Booklets and the online Case of the Month series, to which VASM contributes through the national ANZASM program.

Perioperative Mortality Committee

The multidisciplinary Patient Mortality Committee (PMC)[13] was established in 2021 after changes to Commonwealth legislation on qualified privilege allowing VASM data to be shared with the VPCC. It is now regarded as a leading example of effective information sharing between clinical quality registries and state health departments.

All VASM cases flagged by assessors or the clinical director are reviewed at monthly PMC meetings, with the option to refer cases to the VPCC's ASC or SSC for investigation. In 2024 the PMC reviewed 156 cases – just under 10% of all VASM cases – with 44 referred to the ASC and 34 to the SSC.

Themes identified from VASM and PMC case reports have informed ASC and SSC comments and recommendations, as outlined elsewhere in this report.

Victorian Institute of Forensic Medicine (VIFM) and the Coroners Court of Victoria (CCoV)

by Hans de Boer (VPCC and ASC member)

The Victorian Institute of Forensic Medicine (VIFM) is a statutory agency that serves the community and the courts by providing expert opinions. This helps reduce preventable deaths and promotes public health and safety. The institute also engages in research, education and training for medical and legal professionals.

VIFM's primary role is to provide expert services in forensic pathology, clinical forensic medicine and related disciplines. Coroners Court of Victoria (CCoV) is its main stakeholder, to which it offers medical expertise for investigating deaths under coronial jurisdiction ('reportable deaths'). Other key partners include:

- Victorian courts
- Victoria Police
- Monash University
- The University of Melbourne
- The Australian Federal Police
- legal and medical professionals
- public and private hospitals.

As set out in the *Victorian Coroners Act 2008*, a wide range of deaths must be promptly reported to the CCoV. These deaths are referred to the VIFM, where the forensic pathology department will conduct an examination. These deaths include homicides, accidents and suicides as well as natural, unnatural and unexplained deaths where the cause was initially not apparent. Each year, VIFM forensic pathologists examine around 7,500 cases.

Examination of perioperative deaths at VIFM

The coroner is the sole authority in determining the extent of a postmortem examination. But this decision is typically informed by a case discussion with a forensic pathologist from the VIFM. The pathologist conducts a preliminary review, which includes examining the medical record, external and radiological screening of the deceased, and information provided by the next of kin.

VIFM nurses engage directly with the next of kin to ensure cultural and religious considerations are respected, and to provide an opportunity for them to raise any concerns about the medical care provided. In cases of in-hospital deaths, medical practitioners must complete an E-Deps form. This form prompts clinicians to identify specific issues they want addressed during the postmortem investigation, helping to guide the scope and focus of the examination.

VIFM and VPCC

Most perioperative deaths occur in hospital during the same admission in which surgery was performed. The VIFM automatically refers the E-Deps of these cases to the VPCC. To ensure comprehensive oversight, this includes all deaths occurring after an anaesthetic procedure. In 2024, 1,088 cases were referred to the VPCC through this process, which were then triaged for in-depth review by the relevant VPCC subcommittees.

In addition to these referrals, the VIFM also refers perioperative deaths that occur after hospital discharge to the VPCC. Because these deaths are not always communicated back to the treating hospital, they represent a significant gap in routine health system reporting and learning. In 2024 the VIFM referred 28 post-discharge deaths to the VPCC. This centralised reporting of 'deaths after discharge' is unique within Australia and possibly unprecedented globally.

Relevant themes from VIFM referrals

Goals of care: The specific criteria of the coronial jurisdiction influence the types of cases that the VIFM refers to the VPCC. A significant subset involves older people with substantial comorbidities who experienced trauma that would typically require surgical intervention such as hip fractures, femoral fractures and subdural haemorrhages. In many of these cases, the elevated perioperative risk of morbidity and mortality was recognised before surgery. These scenarios often prompt critical discussions around goals of care, quality of life and whether non-surgical alternatives could have been considered. The importance of such discussions has also been highlighted in this report's 'Engaging with consumers' section.

E-deposition quality: To determine the scope and extent of a postmortem examination, the coroner and forensic pathologists rely on the information provided in the E-Deps. This document should offer a concise summary of the patient's medical history and most recent hospital admission, much like a discharge letter or summary. It should also include the clinician's opinion on the most likely cause of death. Importantly, the E-Dep prompts medical practitioners to outline any relevant issues such as differential diagnoses, suspected complications or specific concerns that may assist in guiding the investigation.

However, the quality of E-Deps submissions is variable, and key clinical details are often under-reported or insufficiently explained. This can impede a thorough investigation of the death, delay effective case triage and limit the ability to identify broader system-level improvements in perioperative care.

ACTION:

The VPCC has offered to collaborate with the CCoV to improve the completeness and reliability of data provided through E-Deps.

RECOMMENDATION:

Education and training must be provided to junior doctors completing E-Deps to improve the quality of documentation. This will support broader system-level improvements and highlight learnings in perioperative care.

Post-discharge thromboembolism: Most perioperative deaths occurring after hospital discharge were not directly attributable to the surgical procedure itself. Common themes identified in this cohort include an increased risk of pulmonary embolism and cardiovascular events during the perioperative period. It was deemed that some patients delay returning to hospital due to uncertainty about what symptoms are normal versus warning signs of complications. Also, cases were noted where patients were immobilised with devices like a moonboot despite not having lower limb surgery, subsequently developing thromboembolic events after discharge. These devices can impair calf muscle activity and increase deep venous thrombosis risk. However, its consequences may be underestimated, resulting in missed thromboprophylaxis.

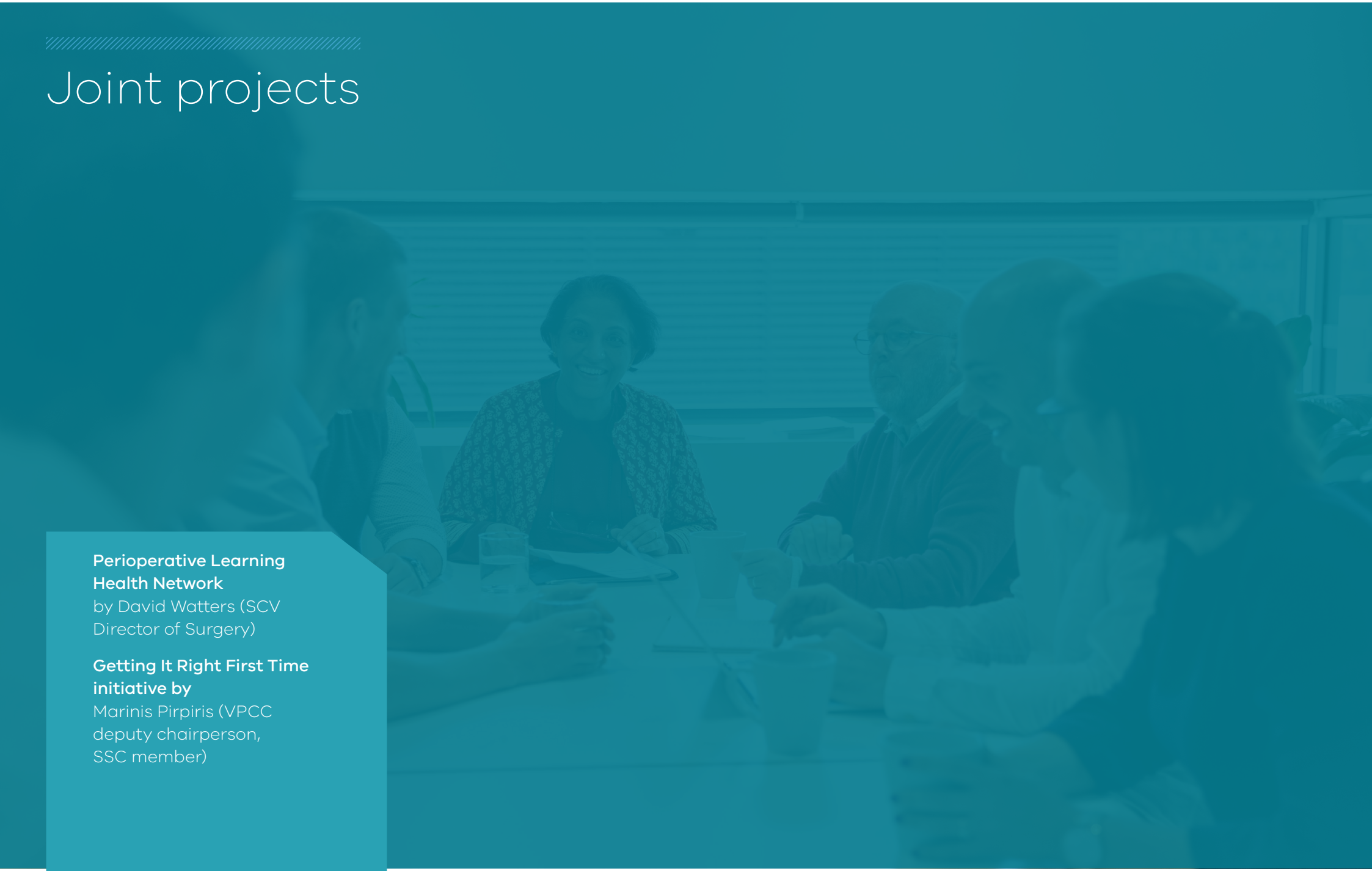
CLINICAL PRACTICE POINT:

Hospitals should review their venous thromboembolism guidelines to ensure they adequately address the deep venous thrombosis risk in patients who will be immobilised for a period after discharge.

RECOMMENDATION:

Patients must receive clear information about common postoperative symptoms, warning signs of potential complications and when to seek medical attention before getting discharge from the hospital.

Joint projects



Perioperative Learning Health Network
by David Watters (SCV Director of Surgery)

Getting It Right First Time initiative by
Marinis Pirpiris (VPCC deputy chairperson, SSC member)

Projects with Safer Care Victoria and the Department of Health

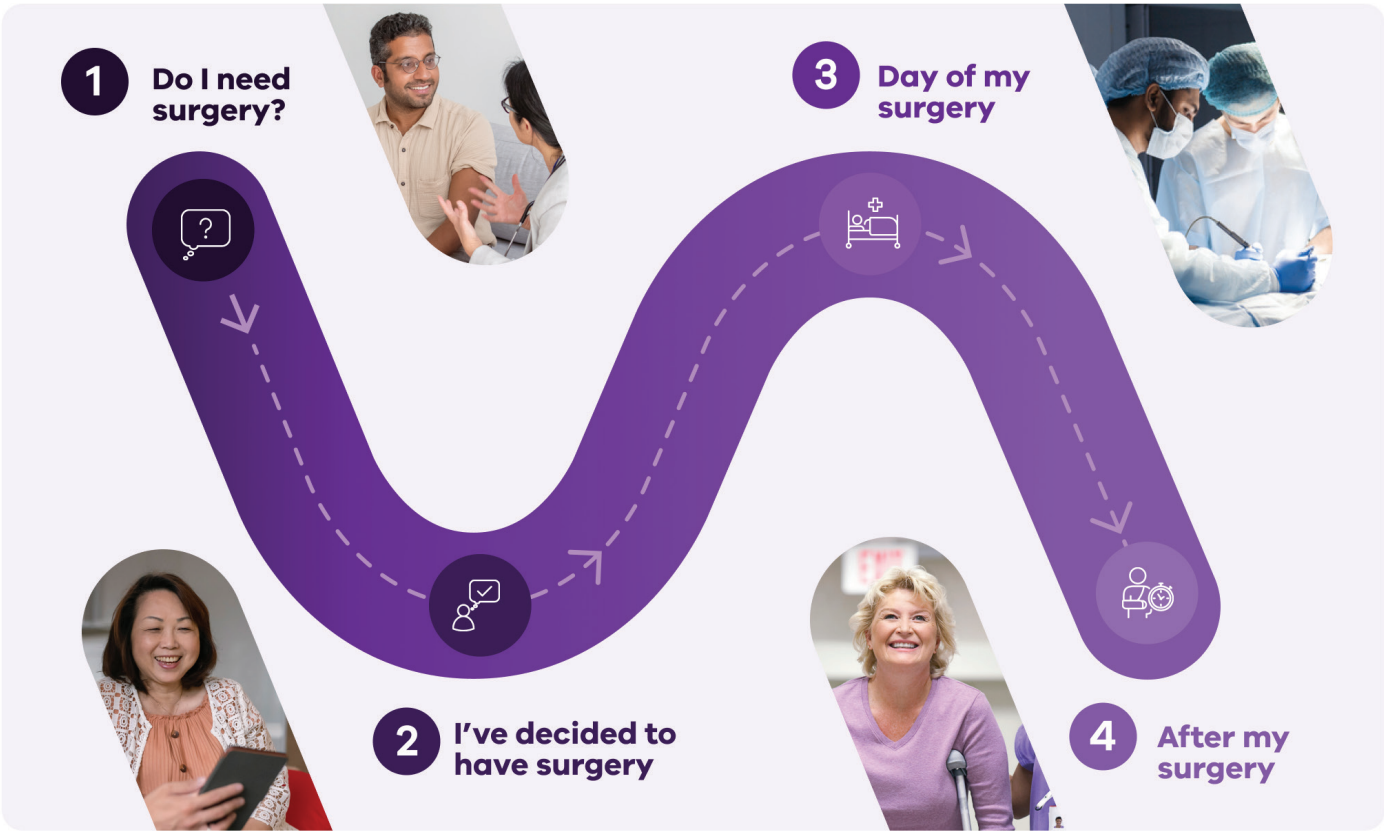
Perioperative Learning Health Network

by David Watters AM (SCV Director of Surgery)

SCV worked closely with the Department of Health on the Planned Care Recovery and Reform Program, led by Chief Surgical Advisor Professor Ben Thompson. While the Planned Surgery Reform Blueprint informed our work, it also introduced the term 'preparation list' for elective surgery waiting list, addressing the importance of engaging and supporting patients to prepare for their surgery once listed.[14]

In 2024 the Perioperative Learning Health Network introduced My Surgical Journey, a resource co-designed with consumers to help patients understand what to expect before, during and after surgery.[15] It outlines what optimal care should look like from the patient's rather than the clinician's perspective. It focuses on 4 key stages: Do I need surgery?, I've decided to have surgery, Day of my surgery, and After my surgery (Figure 7).

Figure 7: My surgical journey



Adapted from the SCV website.[15]

Discharge Optimisation for Planned Surgery

Led by the Value Based Health Team <https://www.safercare.vic.gov.au/improvement/projects/discharge-optimisation-for-planned-surgery>, the Discharge Optimisation for Planned Surgery project was piloted as part of the planned care reform initiative. This project aims to improve the safety of the discharge process and reduce the time patients spend in hospital after surgery. It introduces a simple, clear and evidence-based discharge checklist as part of the standard discharge process. Despite the relatively short timeframe, the 2024 pilot sites proved that length of stay could be safely and effectively reduced, with patients and staff reporting positive experiences. As a result, the program was expanded in the second half of 2024, achieving significant reductions in length of stay and cost, along with improved patient experiences without compromising outcomes.

Preventing Venous Thromboembolism and Supporting Anticoagulation Management project

This program, led by the Quality Use of Medicines Team, is part of a broader effort to establish a learning health system through targeted improvement projects, several of which are highly relevant to the perioperative sector. One upcoming project focuses on preventing venous thromboembolism <https://www.safercare.vic.gov.au/improvement/projects/preventing-venous-thromboembolism>, supported by an expert advisory group that includes several VPCC members. Reducing the risk of pulmonary embolism has been a longstanding priority for VPCC, and this project builds on foundational work initiated before the COVID-19 pandemic. As part of the initiative, the VPCC tool for investigating pulmonary embolism at the hospital level will be adapted for use at pilot sites during 2025 and 2026. Insights and learnings from this project will also inform a similar program aimed at supporting the appropriate use of anticoagulants for both medical and surgical patients.

Getting It Right First Time initiative

by Marinis Pirpiris (VPCC deputy chairperson, SSC member)

The GIRFT program represents a bold, system-wide approach to improving clinical care, reducing variation and delivering more consistent and sustainable health outcomes across Victoria. Focused initially on orthopaedics in the Hume region, the GIRFT program has catalysed significant advancements in patient care, workforce capability, system integration and governance.

Program overview

Developed with the Victorian Managed Insurance Authority and guided by insights from the successful UK model, GIRFT brings together clinicians, administrators and policymakers in a data-driven, patient-centred quality improvement initiative.

The orthopaedic stream in Hume served as a pilot for regional transformation, with an emphasis on measurable outcomes, evidence-based practice and clinical engagement.

GIRFT pilot program in Hume

Four hospitals – Albury Wodonga Health, Goulburn Valley Health, Kyabram District Health and Northeast Health Wangaratta – conduct most orthopaedic surgeries in the Hume region and have been identified as key sites for the GIRFT pilot program.

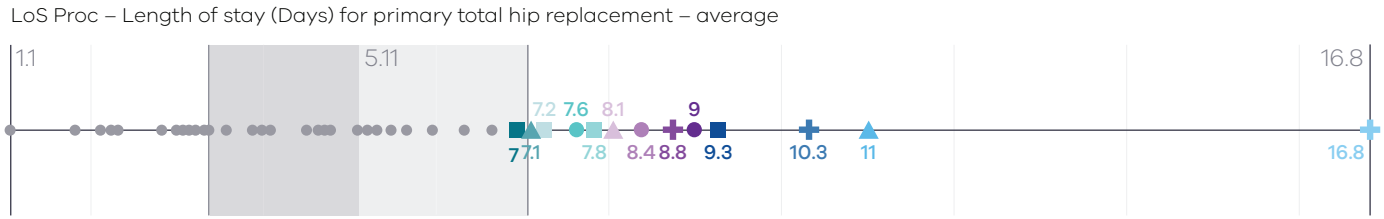
The GIRFT program is for patients who had one of the following procedures:

- hip replacement
- hip revision
- knee replacement
- knee revision
- hip fracture repair.

Data comparisons are made against state-level metrics, with participating hospitals represented in a box-and-whisker plot and benchmarked using the state's validated administrative datasets (Figure 8A).

Figure 8A: Average length of stay following primary total hip replacement

1st July 2024 – 31st December 2024



Health services are represented in this box-and-whisker plot using distinct colours and shapes to illustrate the indicator of median length of stay following primary total hip replacement. The box highlights the middle 50% of the data bounded by the lower quartile (25th percentile) and the upper quartile (75th percentile). The line within the box marks the median, dividing the distribution into 2 equal halves. The whiskers extend to minimum and maximum values within the dataset providing a clear picture of the variation. Hospitals can readily identify their own performance on the graph and compare it with that of other participating sites. The grey circles denote hospitals not actively participating to an analysis. This format enables clinicians and administrators to quickly and accurately assess how their institution is performing relative to their peers, supporting benchmarking and targeted improvement initiative.

Through a community of practice, health services adopted a shared learning approach to drive continuous improvement in clinical practice. A summary of key achievements through this pilot program is outlined below.

Enhancing surgical access and efficiency

The program successfully identified and addressed key bottlenecks in orthopaedic service delivery. By redesigning care pathways, recruiting targeted workforce roles and improving scheduling processes, participating sites improved surgical access significantly. This includes:

- increased surgical throughput without compromising care quality (Figure 8B)
- optimised patients' readiness for surgery by introducing prehabilitation and Enhanced Recovery After Surgery (ERAS) principles (Figure 8C).

Figure 8B: Numbers of hip arthroplasty performed in 2022, 2023 and 2024 in the 4 sites

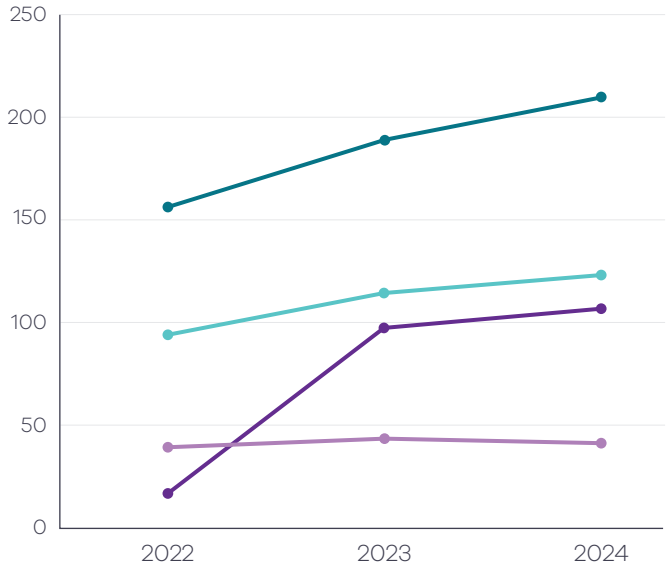
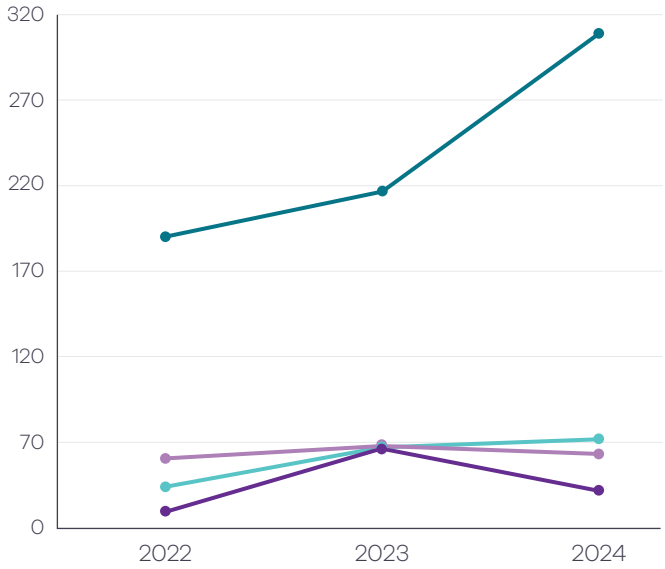


Figure 8C: Numbers of knee arthroplasty across 4 hospitals, with a significant increase in activity in one site following the introduction of a successful ERAS program (dark teal solid line)



Delivering evidence-based best practice

Through comprehensive service reviews and peer benchmarking visits, the GIRFT initiative identified key areas for improvement. Outcomes included:

- standardising implant selection and surgical techniques
- improving antibiotic stewardship and infection prevention protocols
- rationalising imaging and pathology use to minimise unwarranted investigations and associated costs.

Driving postoperative recovery and early discharge

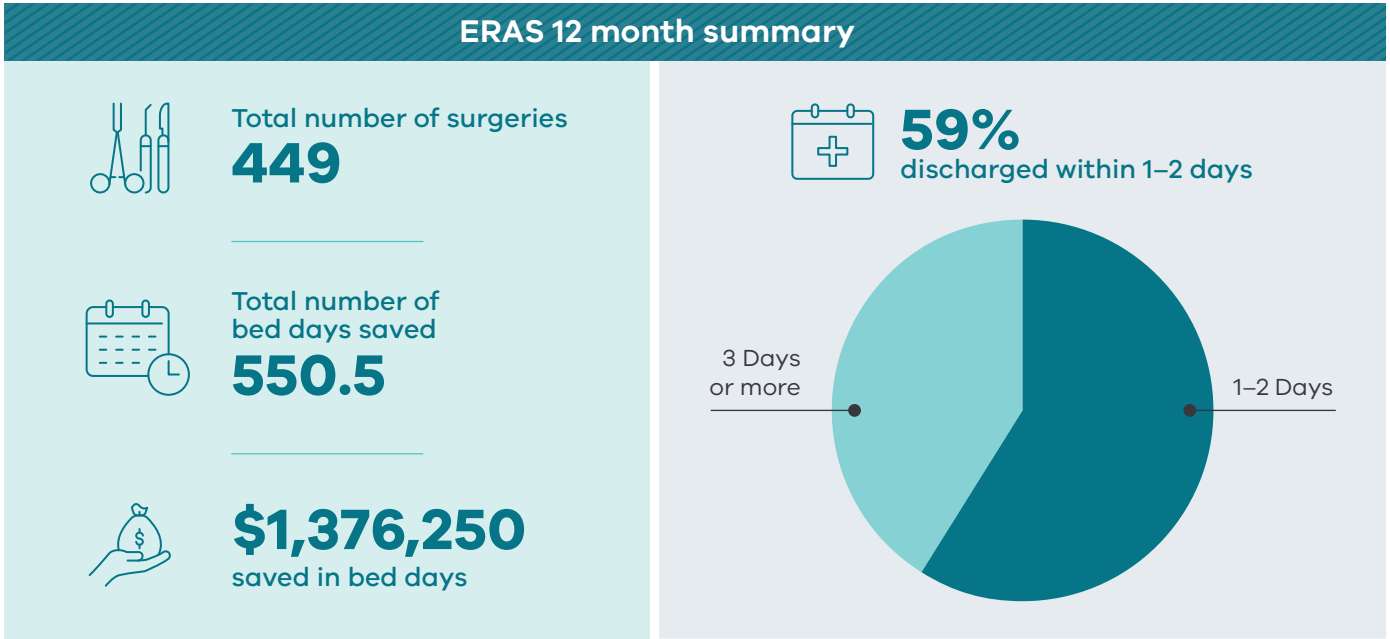
Embedding ERAS protocols across the region has led to substantial gains in postoperative efficiency and patient outcomes. This includes:

- 59% of patients undergoing primary hip and knee arthroplasty were discharged by Day 2. This is a significant advancement over historical averages (Figure 8D).
- Patients also reported high levels of satisfaction, reduced complications and a faster return to functional independence.

Workforce consolidation and clinical governance

For the first time in many years, all vacant Equivalent Full-Time (EFT) positions for orthopaedic surgeons across the region have been successfully filled.
A formal process is underway to appoint a regional department head of orthopaedics, paving the way for coordinated governance, strengthened quality assurance and strategic workforce development.
In parallel, clinical leadership forums and shared care models have strengthened accountability and continuity of care across geographically dispersed health services.

Figure 8D: A 12-month overview following ERAS implementation



Embedding a learning health system

The GIRFT program has prioritised learning through local data analysis, regular audit and structured feedback. As such:

- Participating sites now conduct routine audits of perioperative outcomes, including hospital readmissions (Figure 8E), infections and complications.
- All hospitals managing hip fracture patients have been incorporated into the ANZHFR, enabling robust external benchmarking and alignment with national care standards for older adults with fragility fractures.
- Incorporating hospital review data from the Australian Orthopaedic Association National Joint Replacement Registry enables national benchmarking and allows local care practices and prosthetic selections to be compared against national standards, thereby allowing early identification of prosthetic failures.
- Clinician-led continuous quality improvement projects are driving targeted improvements in preoperative optimisation, pain management, early mobilisation and discharge planning.

Figure 8E: Hospital readmission within 30 days of procedure for different health services

1st July 2024 – 31st December 2024



Health services are represented in this box-and-whisker plot using distinct colours and shapes to illustrate the indicator of median length of stay following primary total hip replacement. The box highlights the middle 50% of the data bounded by the lower quartile (25th percentile) and the upper quartile (75th percentile). The line within the box marks the median, dividing the distribution into 2 equal halves. The whiskers extend to minimum and maximum values within the dataset providing a clear picture of the variation. Hospitals can readily identify their own performance on the graph and compare it with that of other participating sites. The grey circles denote hospitals not actively participating to an analysis.

Strategic significance

The GIRFT program has shown that, with the right leadership, data and structure, even complex regional health systems can undergo rapid and sustainable reform. GIRFT's success in Hume:

- validates the value of investing in regional capability and local empowerment
- highlights the importance of peer engagement, with clinicians taking ownership of both data and solutions
- showcases a blueprint for scalable innovation, ready to be extended to other surgical disciplines and health networks across Victoria and Australia.

Looking ahead

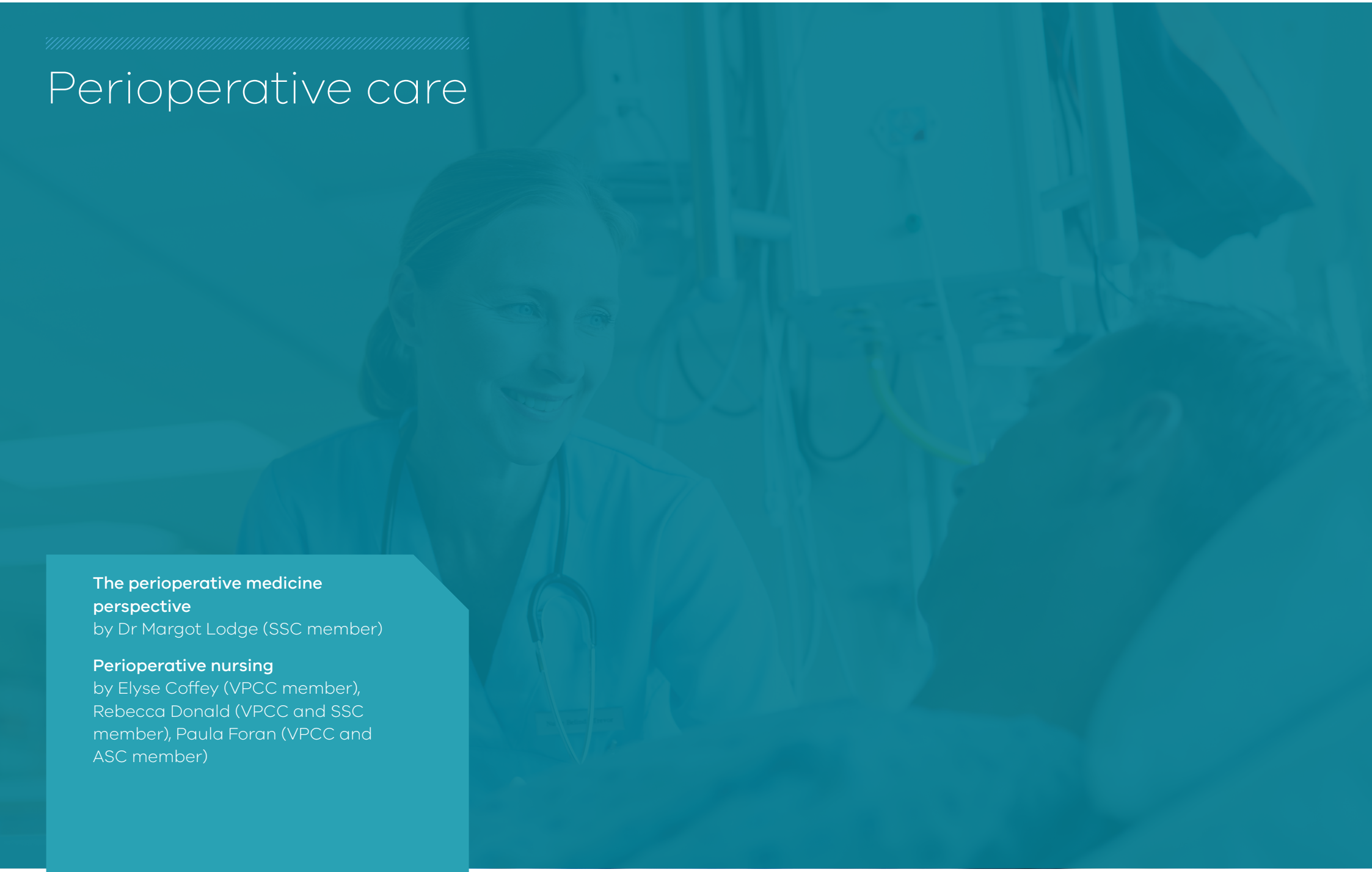
The GIRFT Hume pilot project in now undergoing a comprehensive program analysis, designed not only to measure outcomes but also to capture the depth of its influence across the region. The evaluation is structured to examine the program's efficiency, effectiveness and broader contribution to governance, clinical practice and patient care. The scope of this analysis extends beyond metrics. It aims to understand the cultural and systemic impact of the program and whether the pilot has fostered genuine collaboration across hospitals, strengthened regional partnerships and supported a culture of shared responsibility for outcomes. It will assess whether GIRFT has established a sustained learning environment, including facilitating a platform where challenges are openly acknowledged, successes are disseminated and continuous improvement is embedded into routine practice. Also, the evaluation will examine the program's influence on broader policy and funding models, exploring how the pilot may have influenced thinking around resourcing and access and whether GIRFT may act as a catalyst for enabling improved and more equitable access to patient care aligned with community needs. Finally, the analysis will provide an opportunity to understand the full reach of the program's impact, to distil lessons for future quality improvement and to inform potential future health system reform at regional and statewide levels.

Conclusion

The GIRFT orthopaedic stream in the Hume region has proven to be a high-impact initiative that delivers meaningful, measurable change. It has redefined what is possible when data is shared, clinicians are empowered and systems align with the singular goal of doing what is best for patients – getting it right the first time.



Perioperative care



The perioperative medicine perspective
by Dr Margot Lodge (SSC member)

Perioperative nursing
by Elyse Coffey (VPCC member), Rebecca Donald (VPCC and SSC member), Paula Foran (VPCC and ASC member)

The perioperative medicine perspective

by Dr Margot Lodge (SSC member)

The VPCC's multidisciplinary structure and subcommittees have helped raise awareness of the perioperative medicine team's role. In 2024 the importance of perioperative shared decision-making, and the need for a multidisciplinary team with communication skills to support this decision-making process, were frequently discussed themes.

Shared decision-making

Our population is ageing, with more people living with multiple medical conditions and frailty. Advances in surgery and anaesthesia now allow us to safely operate on patients once considered too high risk. However, just because we can does not mean we always should. Making decisions about the appropriateness of surgical intervention can be difficult, and the shared decision-making paradigm can support perioperative clinicians through this process.

Understanding the values and preferences of people being considered for surgery is at the core of perioperative shared decision-making. This has become apparent in multiple cases the VPCC and its subcommittees reviewed this year. We have seen that shared decision-making processes facilitate the most patient-centred management plan in perioperative care, especially where the appropriateness of surgery is uncertain, or where multiple surgical approaches exist. This is often a complex process that requires time, a multidisciplinary perioperative team and advanced communication skills.

RESOURCES:

SCV and La Trobe University jointly support a **community of practice** <https://www.latrobe.edu.au/chcp/projects/shared-decision-making> that offers valuable resources to enhance shared decision-making in health care.

Communication skills to facilitate person-centred perioperative care

The VPCC frequently considers 'non-technical' skills when reviewing mortality and morbidity. A recurring theme is that the ability to communicate risk and ascertain person-centred goals are extremely important in providing best perioperative care. We have reviewed numerous cases where excellent communication enabled the perioperative team to practise shared decision-making successfully. Future training for perioperative clinicians, no matter their discipline, will ideally include advanced communication and shared decision-making skills.



Perioperative nursing

by Elyse Coffey (VPCC member), Rebecca Donald (VPCC and SSC member), Paula Foran (VPCC and ASC member)

Communication about patient history

Admission and perioperative nurses play an important role in establishing a connection with patients, understanding their situation, and explaining the importance of providing an accurate medical history. Nursing and medical staff are reminded of the vital importance of encouraging patients to provide an accurate medical history. When patients may be impaired by age, illness or disability, seek input from family members. This enables accurate information capture and helps medical staff plan the most appropriate treatment pathways.

CLINICAL PRACTICE POINT:

Perioperative nursing staff should prioritise building trusting relationships with patients to encourage disclosure of previously unshared medical conditions or concerns. This enhances communication between patients and the treating team, contributing to safer, more informed care decisions.

Case study 7: The importance of an accurate preoperative status

A 75-year-old woman was scheduled for semi-elective surgery, attending both a preoperative anaesthetic consultation a week before surgery and a day-of-surgery preoperative consultation with the treating anaesthetist. Both times the patient reported having good respiratory and cardiac health, denying any chest pain or shortness of breath at rest or with exercise.

Immediately after anaesthesia, the patient's heart rate and blood pressure fell dramatically, which progressed to cardiac arrest. Prolonged advanced life support resuscitation efforts continued for over an hour, which resulted in return of circulation. The patient was then transferred to intensive care for management.

Later that day, family members revealed to the intensive care team in a progress meeting that the patient had been suffering 2 weeks of rapidly progressing cardiac symptoms including chest pain, exertional dyspnoea and decreasing exercise tolerance. Sadly, this vital medical information was not divulged before the procedure. Family members believed that the patient would not have grasped the concept of the importance of being transparent about their deteriorating condition. This knowledge would have likely changed the preoperative assessment, evoked increased preoperative testing, altered the patient advice, modified treatment and perhaps influenced her outcome.

Clinical handover

Gaps in clinical handover processes from one clinical area to another, such as to a post-anaesthesia care unit or a critical unit to ward, contribute significantly to adverse patient events. Perioperative nurses are reminded to use structured handover tools such as ISBAR (Identify, Situation, Background, Assessment, Recommendation)[16] to ensure comprehensive information transfer between clinicians.

Central venous catheter removal

Central venous catheter removal procedures continue to present avoidable risks to patients. Case reviews indicated that complications during CVC removal, including air embolism and bleeding, are often associated with inconsistent adherence to evidence-based removal protocols. As noted by the ASC, the ASC has approached the ANZCA via the VPCC to recommend improved protocols aimed at minimising mechanical complications of CVC insertion, management and removal.

Postoperative bowel assessment and monitoring to identify bowel obstruction

Early recognition of postoperative bowel dysfunction is critical for timely intervention. Cases of delayed diagnosis and intervention of bowel pseudo-obstruction or obstruction were seen both in emergency presentations and during postoperative care. Postoperative bowel dysfunction often follows abdominal or orthopaedic procedures and can be exacerbated by opioid analgesia. It is a preventable cause of morbidity and mortality, as bowel dysfunction can lead to significant discomfort, aspiration, obstruction and peritonitis.

Nursing staff are reminded of the importance of comprehensive postoperative bowel assessment, including:

- regular assessment and documentation of bowel sounds in all 4 abdominal quadrants
- careful monitoring and documentation of abdominal distension, including abdominal girth measurement when indicated
- precise recording of all bowel movements, including passage of flatus
- documentation of the character of any vomiting
- vigilant monitoring of subtle changes in vital signs, particularly increases in heart rate that may indicate evolving obstruction.

RECOMMENDATION:

Hospitals including inpatient rehabilitation facilities should emphasise the importance of postoperative bowel dysfunction recognition and management. This vigilance should continue until patients have resumed a normal diet after discharge. Prompt escalation of concerns about potential bowel obstruction is essential, even when symptoms appear mild or could be attributed to normal postoperative ileus.

Dissemination of findings of internal reviews to frontline staff

In cases of significant patient harm, a serious adverse patient safety event or root cause analysis is usually conducted and often comes up with clinical practice recommendations that would benefit patient care. But these finding are not consistently communicated to the staff best positioned to implement them, or to reassure them that appropriate actions will be taken based on the findings. To get the best out of such reviews and improve clinical outcomes, communication of serious adverse patient safety event findings to clinical staff should be more consistent.

Key points



Summary of clinical practice points and recommendations

CLINICAL PRACTICE POINTS:

1. **Effective communication and documentation** – Effective perioperative care relies on clear communication and accurate documentation of clinician–patient interactions. Inadequate records can compromise safety, while thorough engagement, especially in shared decision-making, can significantly improve outcomes.

2. **Informed consent and advance care planning** – Preoperative informed consent and advance care planning are essential practices in health care. Every consumer should be actively engaged in shared decision-making to ensure care aligns with their values, preferences and goals.

3. **Postoperative vigilance and escalation pathways** – Ensuring effective, appropriate postoperative care and early recognition of clinical deterioration are fundamental responsibilities of all surgical facilities. Establishing clear escalation pathways is essential in optimising patient safety and recovery outcomes.

4. **Timely assessment, timely transfer** – Early involvement of the multidisciplinary team is critical for patients with complex medical histories because it supports thorough assessment, planning and coordination of both intrahospital and interhospital transfers before surgery.

5. **Vigilance in medication handling** – To minimise drug administration errors, clinicians should remain vigilant when handling medications with similar ampoule appearances or inconsistent manufacturer labelling. Heightened awareness is especially important during periods of drug shortages, when alternative preparations may look unfamiliar or differ in packaging.

6. **Optimising venous thromboembolism prevention before discharge** – Hospitals should review their venous thromboembolism guidelines to ensure they adequately address the deep venous thrombosis risk in patients who will be immobilised for a period after discharge.

7. **Building rapport for better perioperative care** – Perioperative nursing staff should prioritise building trusting relationships with patients to encourage disclosure of previously unshared medical conditions or concerns. This enhances communication between patients and the treating team, contributing to safer, more informed care decisions.



RECOMMENDATIONS:

1. Preoperative hydration through 'Sip Til Send' programs are recommended for appropriate patients. This can improve patient experience and comfort and reduce the risks associated with prolonged fasting (such as minimising aspiration and regurgitation) and reduce distress, dehydration and associated haemodynamic and metabolic effects.

2. Clinicians are recommended to adhere to current protocols on CVC management while awaiting robust guideline development aimed at minimising risks and CVC-associated mechanical complications.

3. Treating surgical teams should evaluate their capacity to manage complex procedures. When necessary, facilitate timely transfer of patients to a hospital equipped to provide the required care.

4. Hospitals should maintain a register of non-permanent stent implants that includes a flagged time limits for review. This register must be checked and acted on regularly. Without this measure, it can lead to delays in removing non-permanent stents, which can lead to sepsis and other complications.

5. The VPCC strongly recommends that all hospitals performing emergency laparotomies, including those in the private sector, actively engage in the ANZELA-QI program. This is especially important as the Australian Commission on Safety and Quality in Health Care develops a clinical care standard for emergency laparotomy.

6. To support early mobilisation and functional recovery in postoperative hip fracture patients, innovative strategies including **implementing 7-day allied health rosters, geriatric-led mobilisation protocols and orthopaedic surgical permitted unrestricted weightbearing status** are recommended.

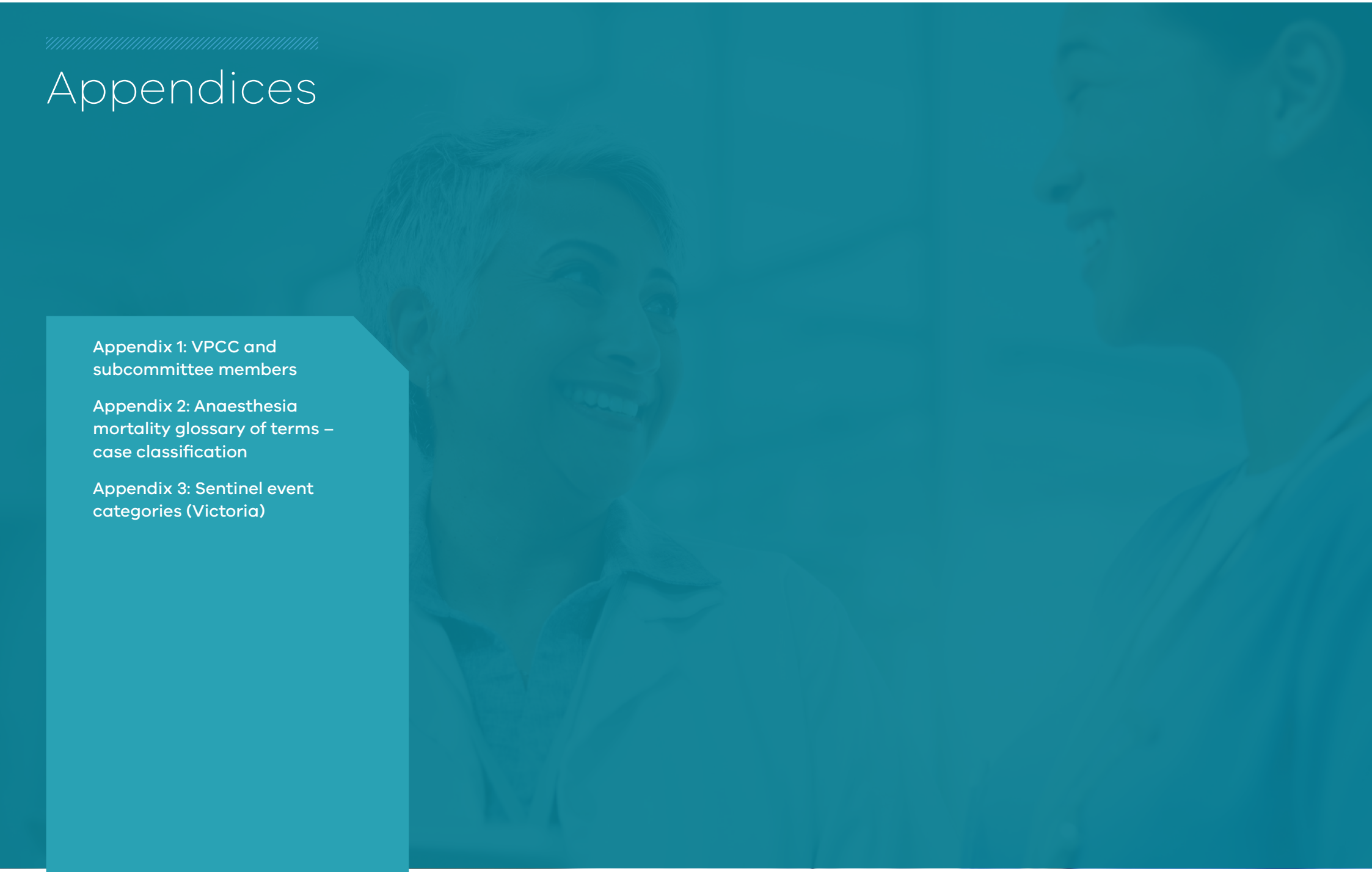
7. Education and training must be provided to junior doctors completing E-Deps to improve the quality of documentation. This will support broader system-level improvements and highlight learnings in perioperative care.

8. Patients must receive clear information about common postoperative symptoms, warning signs of potential complications and when to seek medical attention before getting discharge from the hospital.

9. Hospitals including inpatient rehabilitation facilities should emphasise the importance of postoperative bowel dysfunction recognition and management. This vigilance should continue until patients have resumed a normal diet after discharge. Prompt escalation of concerns about potential bowel obstruction is essential, even when symptoms appear mild or could be attributed to normal postoperative ileus.



Appendices



Appendix 1: VPCC and subcommittee members

Appendix 2: Anaesthesia mortality glossary of terms – case classification

Appendix 3: Sentinel event categories (Victoria)

Appendix 1: VPCC and subcommittee members

VPCC members

- David A Scott (Chairperson)
- Phillipa Hore (Deputy Chairperson)
- Marinis Pirpiris (Deputy Chairperson)
- Allison Evans
- Andrew Jeffreys
- Ben Slater
- Denice Spence (consumer representative)
- Fiona Brew
- Graeme Campbell
- Hans de Boer
- Liat Watson (consumer representative)
- Paula Foran
- Philip McCahy
- Rebecca Donald
- Wendy Brown

Anaesthetic Subcommittee members

- Ben Slater (Chairperson)
- David A Scott (VPCC Chairperson)
- Nam Le (ex officio – ANZCA VRC)
- Andrew Jeffreys
- Annie McPherson
- Craig Ironfield
- Graeme Campbell
- Hans de Boer
- Helen Roberts
- Hilary Madder
- Paula Foran
- Pierre Bradley
- Sharryn McKinley
- Tim Coulson

Surgical Subcommittee members

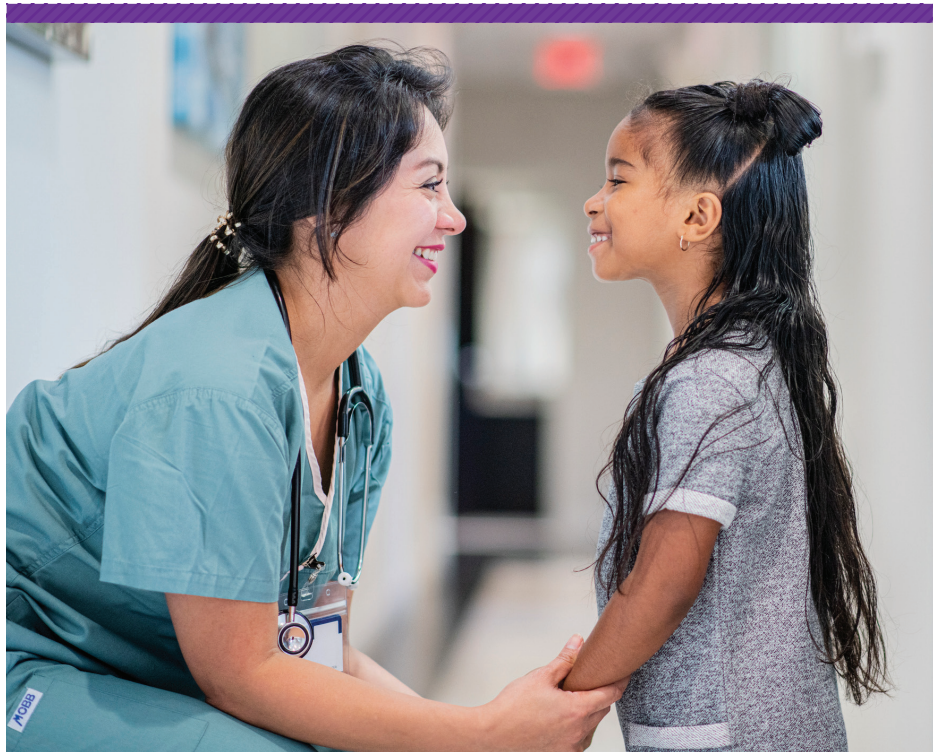
- Wendy Brown (Chairperson)
- David A Scott (VPCC Chairperson)
- Matthew Hadfield (ex officio – VSC RACS)
- Allison Evans
- Denice Spence (consumer representative)
- Julian Smith
- Jennifer Reilly
- Liat Watson (consumer representative)
- Marinis Pirpiris
- Margot Lodge
- Michael Homewood
- Patrick Lo
- Rebecca Donald
- Susan Shedda
- Tony Gray

The work of VPCC would not be possible without the generous assistance of many people and organisations, as listed below, who give us vital information on perioperative care. We thank them for their continued support and diligence in providing us with information to improve perioperative care for all Victorians:

- Coroners Court of Victoria
- Department of Health
- healthcare services
- individual practitioners
- Safer Care Victoria
- Victorian Audit of Surgical Mortality
- Victorian Institute of Forensic Medicine
- Victorian Regional Committee, Australian and New Zealand College of Anaesthetists
- Victorian State Committee, Royal Australasian College of Surgeons

The VPCC developed this report with support from the following SCV staff:

- David Watters
- Michelle Hawke
- Racheal Ninsiima
- Rebecca Van Wollingen
- Ryan Hon



Appendix 2: Anaesthesia mortality glossary of terms – case classification

Table 2: Case classification adapted from ANZCA[17]

A. Deaths attributable to anaesthesia	
Category 1	Where it is reasonably certain that death was caused by the anaesthesia or other factors under control of the anaesthetist
Category 2	Where there is some doubt whether death was entirely attributable to the anaesthesia or other factors under the control of the anaesthetist
Category 3	Where death was caused by both surgical and anaesthesia factors
B. Death in which anaesthesia played no part	
Category 4	Surgical death where the administration of the anaesthesia is not contributory and surgical or other factors are implicated
Category 5	Inevitable death, which would have occurred irrespective of anaesthesia or surgical procedures
Category 6	Incidental death which could not reasonably be expected to have been foreseen by those looking after the patient, was not related to the indication for surgery and was not due to factors under the control of anaesthetist or surgeon
C. Unassessable death	
Category 7	Those that cannot be assessed despite considerable data but where the information is conflicting or key data is missing
Category 8	Cases which cannot be assessed because of inadequate data
Category 9	A critical incident where a problem is identified but no morbidity occurs[18]

Appendix 3: Sentinel event categories (Victoria)

Figure 9: Sentinel event categories

SENTINEL EVENT CATEGORIES

1. Surgery or other invasive procedure performed on the wrong site resulting in serious harm or death
2. Surgery or other invasive procedure performed on the wrong patient resulting in serious harm or death
3. Wrong surgical or other procedure performed on a patient resulting in serious harm or death
4. Unintended retention of a foreign object in a patient after surgery or other invasive procedure resulting in serious harm or death
5. Haemolytic blood transfusion reaction resulting from ABO incompatability resulting in serious harm or death
6. Suspected suicide of a petient in an acute psychiatric unit or acute psychiaric ward
7. Medication error resulting in serious harm or death
8. Use of physical or chemical restraint resulting in serious harm or death
9. Discharge or release of an infant or child to an unauthorised person
10. Use of an incorrectly positioned oro- or naso-gastric tube resulting in serious harm or death
11. All other serious adverse patient safety events resulting in serious harm or death

For assistance, please contact the sentinel event program
by emailing sentinel.events@safercare.vic.gov.au
or calling 1300 543 916

Safer Care Victoria

Note: Sentinel event categories 1 to 10 apply nationally, whereas category 11 is specific only to Victoria.

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