Victorian Statutory Duty of Candour Submission

Do you support the proposed content and format of the Victorian candour and open disclosure guidelines (noting they are a detailed legislative instrument underpinning high level primary legislation)?
Yes

Are there any matters which should be included or removed from the proposed content of the guidelines?
The Australasian College for Emergency Medicine (ACEM) is supportive of the proposed content and format of the Victorian candour and open disclosure guidelines. The fundamental purpose of both a statutory duty of candour and the standard practice of open disclosure is to foster an open and honest culture in health services and to improve the quality of care, particularly in terms of safety and person-centeredness.

The proposed statutory duty will sit alongside the existing Australian Open Disclosure Framework and the codes of conduct for health practitioners registered by the Australian Health Practitioner Regulation Agency (AHPRA). ACEM believes that this new legislative requirement must be but one part of a broader system of reform.

ACEM does not support a punitive approach in the reporting of breaches as this will limit transparency and lead to under reporting (see below).

Should the guidelines address how qualified privilege impacts on open disclosure process?
ACEM believes the guidelines should address the impacts of qualified privilege on the open disclosure process. Qualified privilege should cover in-hospital case reviews (including root cause analysis, in-depth case review, morbidity and mortality audit and unit-based reviews) as well as inter-agency reviews.

These meetings are invaluable as they explore factors that may have contributed to the incident and/or related harm. However, they are exploratory discussions by nature and follow an iterative process that refines and changes causation through review and consultation. Many clinicians are unaware of the potential effects of hindsight and outcome bias when determining the quality of care provided by others and this often leads to an inaccurate attribution of blame.

Protections for these reviews would have a significant positive impact on the success of the statutory duty of candour. Conversely, failing to do so would risk an environment that does not promote a just culture but rather perpetuates a “blame and shame” culture.

Protections are likely to reduce concern about medico-legal risk, and thereby facilitate more robust discussion and analysis during serious incident review.

As a speciality that interfaces with a broad range of health care providers, we support the inclusion of public and private hospitals and day procedure centres, ambulance services, the Victorian Institute of Forensic Mental Health, aged care services, registered community health centres and state-funded residential care services.

ACEM strongly supports the proposed changes to the Apology Law (Wrongs Act 1958). As noted in the Expert Review, currently the definition of the term ‘apology’ is limited. In a number of other Australian jurisdictions, admissions of fault or liability are defined as part of the apology and are

therefore protected. Protecting admissions of liability or fault in an apology encourages a fuller expression of regret, compassion, and sympathy for the harm a consumer has experienced.

ACEM supports the recommendation that:

1. an apology will not constitute an admission of fault and will not be relevant to any determination of fault or liability in the proceeding, even if the statement of sympathy, regret or compassion may admit or imply an admission of fault.
2. providing a description of improvements that has been, or will be, made to prevent similar harm in the future does not constitute an admission of fault.

Are there other issues or unintended consequences that should be addressed or considered as part of the development of the guidelines? Please note a draft of the guidelines will be released with the exposure draft of the legislation (anticipated in 2021).

- Ensuring organisations are adequately resourced to implement the training (at all levels and related disciplines).
- Ensuring that the administrative burden associated with implementation of the statutory duty of candour is minimised.

Do you support the proposed model for clinical incident reviews?
Yes

Are there any unintended consequences or issues with the model that should be addressed or considered?
ACEM would appreciate the inclusion of a multi-agency learning and review framework. Working and learning together as opposed to in silos has greater potential to reduce risk in other areas of the health system and enables other departments to prepare preventative measures using the insights learned collaboratively.

The Coroner's Court has a statutory obligation to find opportunities for prevention which is the same as incident investigations. Preventing access to the coroner's court risks duplication. A Memorandum of Understanding regarding what information is sought or freely given by health services to the court would be beneficial, reduces duplication, and allows findings to be disseminated more efficiently.

Should there be a mechanism to disseminate learnings and/or recommendations from incident review processes for quality and safety improvement purposes, including to those involved in the relevant case (although only relevant information may be provided to individual clinicians involved in the case)?
ACEM are champions for quality improvement and are highly active in engaging with our members to disseminate findings which enhance practice and patient safety. It is highly essential that mechanisms are developed to disseminate learnings and enable a system that is safer and encourages reporting to occur. We strongly believe that for the system to improve there must be transparency and shared learning. Failure to do so runs the risk that mistakes are repeated and more harm is incurred. A streamlined way of sharing findings and recommendations will speed closure for relatives and learning for clinicians and members involved.

To mitigate any unintended impact on decisions by health service entities about how incidents are classified, should there be a mechanism for a decision about an incident that does not meet the threshold for a protected incident review process and if so, what?
ACEM believes there should be standardisation of the triaging process to allocate a rating for a serious incident. The Expert Advisory Group recommended that protection be provided for Incident

Severity Rating (ISR) 1 or 2 as defined in the *Victorian health incident management policy*. If protection is afforded to these incidents, then Health Services may allocate a higher ISR to come under the protection mantle. If it is perceived that the protections are inadequate, health services may fail to report sentinel events in order to avoid a root cause analysis with an external report and the obligation of mandatory duty of candour. Either way, unless there is a combination of a transparent standardised process with clarity of levels of protection, gaming of the system may be an unwarranted outcome. The Targeting Zero report which recommended the introduction of mandatory duty of candour did so with the aim of increasing the safety of the system. ACEM strongly supports this and believes that the best way to achieve this outcome is to make reporting requirements simple and well supported. It is widely appreciated that under reporting of serious incidents is a significant problem and appropriate mitigations must be provided to increase this level.

What authorisations for information will ensure that protections for incident reviews do not restrict oversight and regulation of quality and safety, service delivery and professional conduct?
Sentinel event reviews are reported to Safer Care Victoria and there are statutory obligations to report the Coroners Court of Victoria and the Australian Health Practitioners Regulation Agency (AHPRA). In some instances, a WorkSafe review may be called in and authorise a health service to conduct a review or undertake an audit. In spite of any protections applied, if the learnings are shared in a de-identified way, the thematic issues raised and the recommendations developed to mitigate the risk of recurrence, should ensure that quality and safety risks are reduced. Note, only the Safer Care review specifically examines the system issues around the incident, whereas the other reviews may consider individual roles and professional accountability as well as system issues.

How and when should a statutory incident review team notify certain parties if they consider the incident to involve professional misconduct, unsatisfactory professional conduct, unsatisfactory professional performance or an impairment, to ensure there is clarity for services and practitioners?
This process should be in place currently and not be a new consideration. Serious incident reviews should be a systems analysis process with review members looking for system improvements. If professional accountability of an individual practitioner is identified as a contributing/root cause it should not be reviewed as part of the serious incident but be managed within the organisation's professional conduct process. If the issue falls under mandatory reporting responsibilities, the practitioner is referred to AHPRA. By addressing an individual or professional issue in this way, the statutory review process should not be impeded. Clarity regarding the interaction between these legal obligations is highly important. ACEM notes that unless the local rationality principle is applied, incompetence will be reported and overcalled over other reasons and a blame culture is adopted.

The Just Culture Guide developed by the NHS https://chfg.org/updated-just-culture-guide-nhs-improvement/ enables better conversation between managers and staff members involved. This guide highlights other essential principles to consider and takes a deeper look at incident root causes and potential wider actions.

Should incident review protections include personal protections for those conducting or participating in a statutory incident review process in good faith?
ACEM agrees that incident review protections should include personal protections for those conducting or participating in a statutory incident review process. The benefit of a statutory duty of candour is to ensure that health practitioners feel safe in acknowledging and reporting that something has gone wrong and participating in a panel that is conducting the review.