Safer Care Victoria

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Victorian Duty of Candour Guidelines

OFFICIAL

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1. Victorian Duty of Candour Guidelines

1.1 Introduction

These guidelines are the Victorian Duty of Candour Guidelines (**Guidelines**) made by the Minister for Health as permitted by section 128ZF of the *Health Services Act 1988* to set out the steps a health service entity must take to discharge the Statutory Duty of Candour (**SDC**) under:

(a) section 128ZC of the *Health Services Act 1988*;

(b) section 22I of the *Ambulance Services Act 1986*; and

(c) section 345B of the *Mental Health Act 2014*.

The Guidelines are a legislative instrument for the purposes of the *Subordinate Legislation Act 1994* and will take effect on **30 November 2022**.

1.2 Health service entities that must comply with these Guidelines

The following health service entities must comply with these Guidelines in discharging the SDC:

(a) a public health service;

(b) a public hospital;

(c) a multi-purpose service;

(d) a denominational hospital;

(e) a private hospital;

(f) a day procedure centre;

(g) an ambulance service within the meaning of the *Ambulance Services Act 1986*;

(h) a non-emergency patient transport service within the meaning of the *Non-Emergency Patient Transport and First Aid Services Act 2003* that is licensed under that Act;

(i) the Victorian Institute of Forensic Mental Health established by section 328 of the *Mental Health Act 2014*; and

(j) a prescribed entity that provides health services.[1]

1.3 Consequences for non-compliance with these Guidelines

The potential consequences for failing to comply with the SDC and these Guidelines include:

[1] See definition of 'health service entity' in section 4 of the *Health Services Act 1988.*

(a) the Minister or the Secretary may take into account the failure of a health service entity to comply with the SDC when assessing:
    i. whether the entity provides safe, patient-centred and appropriate services;
    ii. the quality and safety of health services provided by the entity;[2]
(b) the Minister may publish a statement on the Department's internet site setting out the name of a relevant health service entity if, in the Minister's opinion:
    i. the relevant health service entity has failed to comply with the SDC on two or more occasions; and
    ii. the failure to comply is of a serious nature.[3]

In the context of publication, this applies only to a relevant health service entity being:

(a) a public hospital;
(b) a public health service;
(c) a multi-purpose service;
(d) a denominational hospital;
(e) a private hospital; or
(f) a day procedure centre.[4]

Before publishing a statement, the Minister must give the relevant health service entity a reasonable opportunity to make oral or written submissions on the proposed publication of the statement.[5]

[2] s128ZE of the *Health Services Act 1988*; s22K of the *Ambulance Services Act 1986*; s345D of the *Mental Health Act 2014.*

[3] s128ZH of the *Health Services Act 1988.*

[4] s128ZG of the *Health Services Act 1988.*

[5] s128ZI of the *Health Services Act 1988.*

2. Definitions

In these Guidelines:

Apology means an expression of compassion, regret or sympathy in connection with any matter, whether or not the apology admits or implies an admission of fault in connection with the matter.[6]

Civil proceeding includes:

(a) a proceeding before a tribunal;

(b) a proceeding under an Act regulating the practice or conduct of a profession or occupation;

(c) a proceeding of a Royal Commission, whether established under the *Inquiries Act 2014* or under the prerogative of the Crown; and

(d) a proceeding of a Board of Inquiry or Formal Review established under the *Inquiries Act 2014*.[7]

Harm includes moderate harm, severe harm and prolonged psychological harm.[8]

Moderate harm means harm that requires a moderate increase in treatment to a patient, such as an unplanned or unexpected return to surgery, but does not include harm that causes permanent damage or injury to an individual.[9]

Next of kin (NOK) is the patient's next of kin which may be any partner, parent, legal guardian, child or sibling of 18 years or older, or executor when a harm event causes death.

Patient refers to any patient including inpatients, consumers, clients or residents that have suffered a SAPSE in the course of receiving health services.

In circumstances where the patient lacks capacity or dies, the term patient also includes others who may be involved in the SDC process including the patient's immediate family, carer, NOK, or any person nominated by the patient.[10]

Prolonged psychological harm means psychological harm which a patient has experienced, or is likely to experience, for a continuous period of at least 28 days.[11]

Protections refer to the protections that apply to the serious adverse patient safety event (SAPSE) review process, that are set out in sections 128R, 128S, 128U and 128W of the *Health Services Act 1988*. When a SAPSE review is conducted in accordance with Division 8 of Part 5A of the Health Services Act 1988, relevant protections apply.

[6] s128ZB(1) of the *Health Services Act 1988.*

[7] s128ZB of the *Health Services Act 1988*; s14 of the *Ambulance Services Act 1986*; s345A of the *Mental Health Act 2014.*

[8] Regulation 3A of the *Health Services (Quality and Safety) Regulations 2020.*

[9] Regulation 3A of the *Health Services (Quality and Safety) Regulations 2020.*

[10] s128ZB of the *Health Services Act 1988*.

[11] Regulation 3A of the *Health Services (Quality and Safety) Regulations 2020.*

Registered health practitioner means an individual who:

(a) is registered under the Health Practitioner Regulation National Law to practise a health profession, other than as a student; or

(b) holds non-practising registration under this Law in a health profession.[12]

SAPSE is defined as a serious adverse patient safety event in section 3(1) of the *Health Services Act 1988,* being an event of a prescribed class or category that results in harm to one or more individuals. A prescribed class or category is an event that:

(a) occurred while the patient was receiving health services from a health service entity; and

(b) in the reasonable opinion of a registered health practitioner, has resulted in, or is likely to result in, unintended or unexpected harm being suffered by the patient.

To avoid doubt, this includes an event that is identified following discharge from the health service entity.[13]

Note: Please also see definitions of moderate harm, severe harm, and prolonged psychological harm for context.

SAPSE review means a review of a SAPSE conducted in accordance with Division 8 of Part 5A of the *Health Services Act 1988*.

SDC means the statutory duty of candour set out in section 128ZC of the *Health Services Act 1988*, section 22I of the *Ambulance Services Act 1986* and section 345B of the *Mental Health Act 2014*.

Secretary means the Department Head (within the meaning of the *Public Administration Act 2004*) of the Department of Health.[14]

Sentinel event means an unexpected and adverse event that occurs infrequently in a health service entity and results in the death of, or serious physical or psychological injury to, a patient as a result of system and process deficiencies at the health service entity.[15]

Severe harm means harm that causes a permanent lessening in the functioning of an individual that is unrelated to the natural course of a person's illness or underlying condition including harm that can lead to a person experiencing a permanent impairment or disability, or death.[16]

[12] s5 of the *Health Practitioner Regulation National Law Act 2009* (Qld).

[13] Regulation 3B of the *Health Services (Quality and Safety) Regulations 2020.*

[14] s3 of the *Health Services Act 1988*.

[15] Regulation 3A of the *Health Services (Quality and Safety) Regulations 2020.*

[16] Regulation 3A of the *Health Services (Quality and Safety) Regulations 2020.*

3. SDC Requirements

SDC is a legal obligation for Victorian health service entities to ensure that patients and their families or carers are apologised to and communicated with openly and honestly when a SAPSE has occurred. It builds on the Australian Open Disclosure Framework currently utilised for all cases of harm and near miss.

3.1 SDC

If a patient suffers a SAPSE in the course of receiving health services, the health service entity responsible for providing those services owes a SDC to the patient and must do the following unless the patient has opted out:

(a) provide the patient with:

i. a written account of the facts regarding the SAPSE;

ii. an apology for the harm suffered by the patient;

iii. a description of the health service entity's response to the event;

iv. the steps that the health service entity has taken to prevent re-occurrence of the event;

v. any prescribed information; and

(b) comply with any steps set out in these Guidelines.[17]

3.2 Requirements

The steps set out in these Guidelines that must be followed are the Requirements below. The remainder of the Guidelines include recommendations that the health service entities may consider when discharging the SDC.

Stage 1: Apologise and provide initial information

- **Requirement 1:** The health service entity must provide a genuine apology for the harm suffered by the patient and initial information, as early as practicable (and **no longer than 24 hours**) after the SAPSE has been identified by the health service entity.
- **Requirement 2:** The health service entity must take steps to organise an SDC meeting within **3 business days** of the SAPSE being identified by the health service entity.

Stage 2: Hold the SDC meeting

- **Requirement 3:** The SDC meeting must be held within **10 business days** of the SAPSE being identified by the health service entity.
- **Requirement 4:** The health service entity must ensure that it provides the following in the SDC meeting:

[17] s128ZC of the *Health Services Act 1988*; s22I of the *Ambulance Services Act 1986*; and s345B of the *Mental Health Act 2014.*

- an honest, factual explanation of what occurred in a language that is understandable to the patient;
- an apology for the harm suffered by the patient;
- an opportunity for the patient to relate their experience and ask questions;
- an explanation of the steps that will be taken to review the SAPSE and outline any immediate improvements already made; and
- any implications as a result of the SAPSE (if known) and any follow up for the patient.

- **Requirement 5:** The health service entity must document the SDC meeting and provide a copy of the meeting report to the patient within **10 business days** of the SDC meeting.

Stage 3: Complete a review of the SAPSE and produce report

- **Requirement 6:** The health service entity must complete a review for the SAPSE and produce a report outlining what happened and any areas identified for improvement. If the SAPSE is classified as a sentinel event, the health service entity must also outline in the report clear recommendations from the review findings.
- **Requirement 7:** The report created from Requirement 6 must then be offered to the patient within **50 business days** of the SAPSE being identified by the health service entity. If the SAPSE involves more than one health service entity, this may be extended to **75 business days** of the SAPSE being identified by the initial health service entity.

Documentation and reporting

- **Requirement 8:** The health service entity must ensure that there is a record of the SDC being completed, including clear dates of when the SAPSE occurred and when each stage of the SDC was completed.
- **Requirement 9:** The health service entity must report its compliance with the SDC as legally required.

3.3 Where patients do not want to be involved in the SDC process

Patients may opt out from participating in the SDC process or from receiving information from a health service entity. If a patient confirms that they wish to opt out of the SDC process, the health service entity must:

- ask them to sign a statement to this effect and store this in an appropriate location;[18] and
- provide a point of contact, such as a consumer liaison officer, if the patient wishes to re-initiate the SDC process at any time.

When a patient has opted out, the relevant health service entity does not have to comply with the Requirements in these Guidelines, or the SDC process within the relevant Acts. However, it is recommended that the health service entity conduct an adverse event review to ensure relevant information is recorded when relevant staff are available. This is recommended as the patient may later re-initiate their participation in the SDC process and elect to receive

[18] s128ZC of the *Health Services Act 1988*

information required under the SDC.[19] If this occurs, the commencement date must be clearly documented in an appropriate location, and the requirements within these Guidelines must then be followed.

3.4 Circumstances requiring a delay

There may be circumstances where the SDC process needs to be delayed, including:

- if the patient lacks or has lost their capacity (either temporarily or permanently) through the harm; or
- the patient is medically unable to participate (either temporarily or permanently through the progression of their medical condition).

If the above applies and has been assessed and documented by an appropriate medical professional, the health service entity must undertake SDC with:

- the patient's immediate family, carer or NOK; or
- a person nominated by the patient.

This must occur, unless the relevant person is not available, or they have opted out.

When the patient recovers capacity, regardless of whether the SDC has occurred with a person outlined in the list above or not, the health service entity must commence the SDC process again with the patient (unless the patient has opted out). The agreed commencement date must be clearly documented in the appropriate location, and the requirements within these Guidelines must then be followed.

Important note:

If the patient requests a delay within the SDC process, or the patient is not yet ready to participate, the health service entity must:

- negotiate a preferred date for the health service entity to contact the patient; or
- provide the details of a point of contact, such as a consumer liaison officer at the health service entity, if the patient prefers to re-initiate the next interaction.

Once the patient and the health service entity have an agreed commencement date for the SDC, it must be clearly documented in the appropriate location, and the requirements within these Guidelines must then be followed.

If there is a delay in conducting the SDC meeting, the health service entity must continue with Requirements 6 to 9 regardless.

For further patient considerations, refer to the ‘Victorian Duty of Candour Framework’.

[19] s128ZC of the *Health Services Act 1988*

4. SDC process

When responding to a SAPSE, the immediate priority is the safety and care of the patients and staff involved, and then identifying if there is a risk to other patients, members of the public or other staff members.

The SDC process must commence as soon as a health service entity becomes aware of the SAPSE, either through the clinical incident management system or when identified by a clinician, patient, NOK, family or carer.

4.1 Stage 1: Apologise and provide initial information

4.1.1 Apologise

> **Requirement 1:** The health service entity must provide a genuine apology for the harm suffered by the patient and initial information, as early as practicable (and **no longer than 24 hours**) after the SAPSE has been identified by the health service entity.

The apology must be provided to the patient, or if the patient lacks capacity or has died, the patient's immediate family, carer, NOK or a person nominated by the patient, as early as practicable and clinically appropriate with regards to the needs of the patient. The health service entity may decide on the appropriate person to provide the apology, such as a suitably qualified health professional.

The health service entity should consider the following in providing the apology:

- express compassion, regret or sympathy;
- say the words 'I am/We are sorry'; and
- avoid jargon or legalistic wording.

Apology not an admission of liability

In a civil proceeding where the death or injury of a person is in issue or is relevant to an issue, an apology:

(a) does not constitute an express or implied admission of liability for the death or injury; and

(b) is not relevant to the determination of fault or liability in connection with that proceeding.

This is relevant whether the apology is made orally or in writing or is made before or after the civil proceeding was in contemplation or commenced.

Evidence of an apology made by or on behalf of a person or a health service entity in connection with any matter alleged to have been caused by the person or health service entity is not admissible in any civil or disciplinary

proceedings as evidence of the fault or liability of the person or health service entity in connection with that matter.[20]

Note: Nothing in this section affects the admissibility of a statement with respect to a fact in issue or tending to establish a fact in issue.

4.1.2 Provide initial information

The initial information may be provided with the initial apology, however, should ideally be performed by a suitably qualified health professional.

When providing initial information, the health service entity must:

- provide factual information that is known at the time about the event;
- offer written patient information on the adverse event review process (e.g. information flyer); and
- provide the details of key contacts the patient can liaise with, including where relevant, an Aboriginal Hospital Liaison Officer (AHLO).

When providing initial information, the health service entity should:

- be sensitive and empathetic;
- acknowledge that these events can be confronting matters for patients to deal with; and
- avoid inferring blame, admitting fault or offering opinion.

The health service entity may also consider providing further information including:

- confirming the patient knows how to access their health records if necessary;
- confirming any specific needs of the patient, including cultural or linguistic requirements;
- confirming how the patient would like to be communicated with;
- attempting to answer any questions the patient has since providing the initial information. If the questions cannot be answered immediately, the health service entity should record these questions and inform the patient they will be addressed as part of the SDC process;
- outlining how the patient can raise concerns outside of the SDC process, including the health service entity's internal complaints process, or the Health Complaints Commissioner (HCC) or Mental Health Complaints Commissioner (MHCC); and
- informing the patient they can still seek legal redress outside of this process.

Where the harm has resulted in the patient's death, the health service entity should consider:

- advising the NOK that there may be additional processes involving third parties, such as the Coroner, and that coronial investigations or inquests may incur lengthy timelines; and

[20] s128ZD of the *Health Services Act 1988;* s22J of the *Ambulance Services Act 1986*; s345C of the *Mental Health Act 2014.*

- providing psychological support for the NOK and any staff affected by the death.

4.1.3 Organise the SDC meeting

> **Requirement 2:** The health service entity must take steps to organise an SDC meeting within **3 business days** of the SAPSE being identified by the health service entity.

At a minimum, the health service entity must confirm with the patient:

- when and where the SDC meeting will be held;
- who will be at the meeting, including staff and representatives the patient would like to invite;
- details of the meeting, including informing them that they will have the opportunity to relate their experience and ask any questions they may have. The health service entity may recommend that the patient write these down in preparation for the SDC meeting; and
- details of key contacts, such as a family liaison person, if the patient has any questions before the meeting.

Note: See section 3.4 'Circumstances requiring a delay' for guidance.

In preparing for the meeting, the health service entity may consider the following:

- designing the meeting with the attendee's needs in mind, such as having the meeting over video conference;
- the opportunity for further planning and discussions before the SDC meeting;
- offering the patient practical and emotional support at each stage of the process, such as paying for travel or parking costs to attend the SDC meeting;
- having an internal planning discussion before the SDC meeting, including who will lead the meeting;
- ensuring all relevant facts have been collected and understood, including seeking advice from relevant staff;
- seeking advice from an AHLO for any events involving Aboriginal and Torres Strait island patients; and
- patient preference in regard to relevant staff at the meeting, if the patient requests certain staff do not attend.

4.2 Stage 2: Hold the SDC meeting

Prior to the SDC meeting, a health service entity must ensure the patient understands the agenda of the meeting and highlights any questions they may want answered.

A health service entity may anticipate emotional reactions from the affected parties or staff involved. Although research has shown that patients may feel anxiety, depression or trauma in response to an incident, these issues can be lessened when a clinician explains the incident compassionately and honestly to them.[21]

[21] O'Connor E, et al. (2010) Disclosure of patient safety incidents: a comprehensive review. *International Journal for Quality in Health Care,* 22(5), pp 371–379.

4.2.1 Hold the SDC meeting

Requirement 3: The SDC meeting must be held within **10 business days** of the SAPSE being identified by the health service entity.

At a minimum there must be:

- one member from the health service entity who is experienced and suitably qualified in open disclosure or the SDC process; and
- a senior member of the clinical team that was involved (e.g. doctor or nurse).

There may also be:

- a member of the quality team; and
- a trainee or junior staff member from a development and organisational culture point of view.

The SDC meeting is an opportunity for the health service entity to provide all required information, and for the patient to ask questions and relate their experience about the event.

Note: See section 3.4 'Circumstances requiring a delay' for guidance.

Requirement 4: The health service entity must ensure that it provides the following in the SDC meeting:

- an honest, factual explanation of what occurred in a language that is understandable to the patient;
- an apology for the harm suffered by the patient;
- an opportunity for the patient to relate their experience and ask questions;
- an explanation of the steps that will be taken to review the SAPSE and outline any immediate improvements already made; and
- any implications as a result of the SAPSE (if known) and any follow up for the patient.

In attending the SDC meeting, the health service entity must:

- take measures to make the attendees feel supported in the meeting. For example, provide materials for them to take notes, and offering a comfortable, quiet environment to conduct the meeting;
- present a full, frank and honest explanation of what is known to have occurred. Use terminology and phrases that are likely to be understood by the attendees. A professional interpreter should be considered in this meeting;
- apologise to the patient again for the harm suffered;
- allow the patient opportunity to relate their experience. Ask them to share their own thoughts on the event and the outcomes they are seeking from the SDC process;
- ensure there is sufficient time for the attendees to ask questions;

- explain the steps the health service entity is taking to review and manage the event, and any immediate improvements that have been made or will be made to prevent similar harm in the future (if applicable). This information may not be complete at the time of this meeting, however the patient should be informed that more details will be available in a subsequent review report; and
- inform those at the meeting about the implications of the SAPSE, especially any immediate or long-term health or other consequences (if known). Develop a plan to ensure the patient receives appropriate treatment, including notifying their local health service or general practitioner (if agreed).

Immediately after the meeting

The health service entity may consider compiling the initial details of the meeting and provide this to the patient immediately following, including:

- who was present;
- the time and date of the meeting;
- confirmation that all elements of the SDC were discussed;
- a point of contact for ongoing follow up;
- clear details of the future timelines and requirements of the SDC process; and
- any other comments or questions for noting.

A copy of this note should then be filed in the appropriate records.

4.2.2 Provide a copy of the SDC meeting report

Requirement 5: The health service entity must document the SDC meeting and provide a copy of the meeting report to the patient within **10 business days** of the SDC meeting.

The meeting report must include a detailed account of all the different elements of SDC that were discussed. Documentation of the SDC meeting should follow usual clinical documentation conventions and expand on the initial note given after the meeting.

The health service entity may consider offering the meeting report in a language understandable to the patient. If the report requires translation, inform the patient that this may require more time and document any delay in the appropriate location.

A copy of the SDC meeting report must be stored in an appropriate location.

4.3 Stage 3: Complete a review of the SAPSE and produce report

4.3.1 Complete a review of the SAPSE

Requirement 6: The health service entity must complete a review for the SAPSE and produce a report outlining what happened and any areas identified for improvement. If the SAPSE is classified as a sentinel event, the health service entity must also outline in the report clear recommendations from the review findings.

Requirement 7: The report created from Requirement 6 must then be offered to the patient within **50 business days of** the SAPSE being identified by the health service entity. If the SAPSE involves more than one health service entity, this may be extended to **75 business days** of the SAPSE being identified by the initial health service entity.

If the SAPSE involves more than one health service entity and the report is extended to 75 business days, this delay must be clearly communicated with the patient and documented in the appropriate location.

The report created as a result of the review must include the matters required by section 128ZC of the *Health Services Act 1988*, being:

- a written account of the facts regarding the SAPSE;
- an apology for the harm suffered by the patient;
- a description of the health service entity's response to the event; and
- the steps that the health service entity has taken to prevent re-occurrence of the event.[22]

As part of the SDC process, the review report must then be offered to:

- the patient; or
- if the patient is deceased or lacks capacity, a person nominated by the patient, the immediate family, carer or NOK of a patient.

The review is part of the ongoing information gathering process of the SDC. The resulting report forms part of the response to the patient. The health service entity must:

- avoid jargon or legalistic wording, and
- ensure the patient is aware of the timeline for review.

[22] Also see section 22I of the *Ambulance Services Act 1986*; and section 345B of the *Mental Health Act 2014*.

The health service entity may also consider offering the report in a language understandable to the patient. If the report requires translation, inform the patient that this may require more time and document any delay in the appropriate location.

Note: If the health service entity appoints a panel to conduct a review in accordance with Division 8 of Part 5A of the *Health Services Act 1988*, relevant protections apply to the review process, and it will be called a 'SAPSE review'. If a 'SAPSE review panel' is not formed to produce a 'SAPSE review report' in accordance with the *Health Services Act 1988* and relevant regulations, it will not be a 'SAPSE review' or have relevant protections apply. It is important to note that a 'SAPSE review' is not mandatory and does not need to be completed for all SAPSE.

Following the review

When the relevant review or investigation is complete, the health service entity should consider providing the patient with feedback through face-to-face interview or equivalent (e.g. videoconference).

5. Documentation and reporting

Requirement 8: The health service entity must ensure that there is a record of the SDC being completed, including clear dates of when the SAPSE occurred and when each stage of the SDC was completed.

Requirement 9: The health service entity must report its compliance with the SDC as legally required.

Mandatory documentation and reporting requirements will demonstrate compliance with the SDC process. While governed at an organisational level, relevant staff must be trained to adhere to and understand the steps required to ensure correct records are prepared and maintained.

The health service entity must ensure it:

- has an appropriate reporting system to monitor compliance with the SDC such as a clinical incident management system; and
- report compliance with the SDC undertakings to the relevant bodies as legally required. These reports allow the health service entity's board to monitor the SDC and must be made available for auditing by the relevant bodies.

The reporting requirements are detailed in:

- the *Health Services (Health Service Establishments) Regulations 2013* for health services that are health service establishments under the Act; and
- the Policy and Funding Guidelines for health services that are funded agencies.

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

6. Review

These Guidelines may be reviewed and updated periodically and following significant incidents if they occur. Feedback received from patients and NOK will be considered as part of the review process. Where possible, when the Guidelines are reviewed, collaboration will occur with local Aboriginal communities, culturally and/or linguistically diverse communities and people with a disability.

7. Further information

Further information and resources about the Statutory duty of candour <https://www.safercare.vic.gov.au/support-training/adverse-event-review-and-response/duty-of-candour> can be found on the Safer Care Victoria (SCV) website.

This includes a link to additional information and resources that have been designed for health service entities in Victoria outlined within this document. Relevant contact information can also be found on the SCV website.

8. Related Acts and other resources

Ambulance Services Act 1986

Expert Working Group report on statutory duty of candour

Health Legislation Amendment (Quality and Safety) Act 2022

Health Services Act 1988

Health Services (Quality and Safety) Regulations 2020

Learning and education | Safer Care Victoria

Mental Health Act 2014

Policy: Adverse patient safety events

Protections for serious adverse patient safety event (SAPSE) reviews

Statutory Duty of Candour and protections for SAPSE reviews | Safer Care Victoria

Targeting zero report: Better, Safer Care, Delivering a world-leading healthcare system

The Australian Open Disclosure Framework

Victorian Duty of Candour Framework

Victorian sentinel events guide

Safer Care Victoria