LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON ESTIMATES 2014-2015
Brendan Smyth MLA (Chair), Mary Porter MLA (Deputy-Chair), Giulia Jones MLA, Yvette Berry MLA

ANSWER TO QUESTION TAKEN ON NOTICE DURING PUBLIC HEARINGS

Asked by Mr Brendan Smyth on 20 June 2014: Dr Brown took on notice the following question(s):

Ref HD-No 8: Hansard Transcript 20 June 2014, page 70

In relation to Sentinel Events at the Canberra Hospital:

THE CHAIR: All right. Could you take on notice, then, say for instance the high risk and the extreme category, provide the details for those for the same year ranges?

Dr Brown: I can tell you now, Mr—

THE CHAIR: Well, give them to me now, but it would be nice to have them in writing.

Dr Brown: Okay.

THE CHAIR: Yes.

Dr Brown: There were 28 significant incidents in 13—from 1 July 2013 to 23 April 2014. They were broadly in the categories of death unrelated to the natural cause of an underlying illness, death of a client in custody, breach of patient confidentiality, and permanent loss or lessening of function.

And there were 20 high risk incidents, if you want that data for the same period. They related to incidents with potential to attract significant media attention, possible significant incidents, and a number of other miscellaneous—not miscellaneous in incidental, but a range of different incidences.

THE CHAIR: All right. You were able to rattle off the statistics for the seven years for sentinel. Could you just take on notice and give us the sentinel and the extreme and the high risk for the same period, for the last seven years?

Dr Brown: Sure.

Katy Gallagher MLA: The answer to the Member's question is as follows:–

Significant Incidents are incidents with an extreme or major outcome rating in line with the ACT Health Incident Management Policy and associated procedures.

A clinical significant incident with an ***extreme*** *outcome* means one of the following has occurred:

- Patient death unrelated to the natural course of the underlying illness and differing from the immediate expected outcome of patient management.
- Death of a client in custody (under MH order (e.g. EA, ED3, ED7 or PTO) or police custody)
- A national core sentinel events. These are:
    - Procedures involving the wrong patient or body part resulting in death or permanent loss of function
    - Suicide of a patient in an inpatient unit
    - Retained instruments or other material after surgery requiring re-operation or further surgical procedure
    - Intravascular gas embolism resulting in death or neurological damage
    - Haemolytic blood transfusion reaction resulting from ABO incompatibility
    - Medication error leading to the death of patient reasonably believed to be due to incorrect administration of drugs
    - Maternal death or serious morbidity associated with labour or delivery
    - Infant discharged to the wrong family.

A clinical significant incident with a ***major*** *outcome* means the following has occurred:

- Major and permanent loss of function (sensory, motor, physiological or intellectual) unrelated to the natural course of the underlying illness and differing from the expected outcome of patient management.

Categories of significant events exist other than clinical, for example, the information category. An incident with a major outcome under this category includes:

- Inappropriate storage or exposure of patient/client consumer or clinical records in a public area +/- breach in patient privacy and confidentiality.

High Risk incidents have an outcome rating of moderate, minor or insignificant and:

- would have resulted in a significant incident should it have eventuated (also referred to as a significant near miss),
- could attract significant media attention
- are possibly significant incidents although the status is unclear until further investigation is undertaken.

The following tables outline:

- Sentinel events by year
- Incidents with an extreme outcome rating by year (some of which are sentinel events and also appear in the sentinel event table)
- Major incidents by year
- High risk incidents by year

Reported Sentinel Events – Excluding Calvary Health Care ACT data

Year	Total Number of Sentinel Events
2007-08	2
2008-09	0
2009-10	5
2010-11	1
2011-12	2
2012-13	2
2013-14	0 (Note: 2013-14 data is for the period 1 July 2013 – 23 June 2014)

Reported Extreme Incidents – Excluding Calvary Health Care ACT

(Note: Sentinel events all have an Extreme outcome rating, and therefore may also appear in the sentinel event table)

Year	Total Number of Extreme Incidents
2007-08	Note: The use of Riskman for the notification of Significant Incidents (i.e. incidents with an extreme or major outcome rating commenced in January 2009). Prior to this time a different process was used and these incident types were not broken down into categories.
2008-09	9
2009-10	17
2010-11	24
2011-12	16
2012-13	22
2013-14	19 (Note: 2013-14 data is for the period 1 July 2013 – 23 June 2014)

Reported Major Incidents – Excluding Calvary Health Care ACT

Year	Total Number of Extreme Incidents
2007-08	Note: The use of Riskman for the notification of Significant Incidents (i.e. incidents with an extreme or major outcome rating commenced in January 2009). Prior to this time a different process was used and these incident types were not broken down into categories.
2008-09	1
2009-10	10
2010-11	14
2011-12	6
2012-13	17
2013-14	9 (Note: 2013-14 data is for the period 1 July 2013 – 23 June 2014)

Reported High Risk Incidents – Excluding Calvary Health Care ACT data

Year	Total Number of High Risk Incidents
2007-08	Note: The reporting of high risk incidents commenced in January 2009
2008-09	3
2009-10	21
2010-11	29
2011-12	22
2012-13	23
2013-14	20 (Note: 2013-14 data is for the period 1 July 2013 – 23 June 2014)

Approved for circulation to the Select Committee on Estimates 2014-2015

Signature: K. Gallagher Date: 30.6.14

By the Minister for Health, Katy Gallagher MLA