Office of the Victorian Information Commissioner

t 1300 006 842
e enquiries@ovic.vic.gov.au
w ovic.vic.gov.au

PO Box 24274
Melbourne Victoria 3001

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Statutory Duty of Candour Consultation
Safer Care Victoria

By email only: dutyofcandour@dhhs.vic.gov.au

Dear Safer Care Victoria,

Submission in response to Safer Care Victoria's Statutory Duty of Candour Consultation

The Office of the Victorian Information Commissioner (**OVIC**) is pleased to make a submission in response to Safer Care Victoria's Statutory Duty of Candour consultation.

OVIC is the primary regulator for information privacy, information security and freedom of information in Victoria, administering both the *Freedom of Information Act 1982* (Vic) (**FOI Act**) and the *Privacy and Data Protection Act 2014*.

A key function of OVIC is to promote understanding and acceptance by agencies and the public of the FOI Act. The object of the FOI Act in section 3 is to extend as far as possible the right of the community to access information in the possession of the Victorian Government and its agencies.

OVIC has a strong interest in promoting and enhancing transparency and access to information in Victorian agencies. As such, I am pleased to provide comments on the proposed statutory duty of candour, the Victorian candour and open disclosure guidelines (**guidelines**), and the proposed model for protections for clinical incident reviews.[1]

Background to the consultation

The Victorian government is proposing to introduce a high-level duty of candour law, which builds on existing requirements under the Australian Open Disclosure Framework (**Framework**). The proposed duty will require health service entities to apologise to any person seriously harmed while receiving care, explain what went wrong, and what action will be taken.[2] The statutory duty will complement obligations in the Framework to strengthen the duty to disclose.

The proposed reforms will increase transparency and access to information when communicating with affected parties while at the same time restrict access to, and the use of, certain information for the purpose of supporting quality improvement through clinical incident reviews.[3]

[1] Safer Care Victoria notes that input at this consultation stage will help Safer Care Victoria draft the Bill and develop the Guidelines: Safer Care Victoria, Reforms to foster an honest and open culture in health services, Engage Victoria consultation webpage, https://engage.vic.gov.au/reforms-foster-honest-and-open-culture-health-services.
[2] Safer Care Victoria, Reforms to foster an honest and open culture in health services, Engage Victoria consultation webpage, https://engage.vic.gov.au/reforms-foster-honest-and-open-culture-health-services.
[3] Ibid.

Safer Care Victoria is consulting on proposed guidelines, which will be developed as a subordinate legislative instrument to support the statutory duty, and a proposed model for protections for clinical incident reviews.

Serious adverse patient events or clinical events are categorised according to a scale from one to four. The proposed duty will apply to Category 1 (serious or catastrophic harm) and Category 2 (serious harm).[4]

Transparency is important for building trust

Victoria has an opportunity to lead the way in how health service entities facilitate access to information about clinical incidents to individuals and their families.

Recognising when things do not go to plan respects individuals' dignity and providing access to information about an incident enhances transparency and accountability. It enables the actions and decisions of health service entities to be scrutinised and better understood by individuals and their families.

Individuals know when something has gone wrong. They know because they experienced the incident and may continue to experience impacts flowing from it for some time whether that is physical, emotional or psychological. Acknowledging incidents and apologising for them helps to recognise trauma and suffering, and provides a level of assurance that steps are being taken to prevent something similar happening again to another person in the future.

Recognising that something has gone wrong, communicating this in an open and transparent manner, and taking steps to review and prevent it from happening again will enhance trust in the Victorian healthcare system.

Transparency by default – The statutory duty and guidelines

Victorian health service entities should be encouraged to take a *transparency by default* approach to communicating with individuals about patient care; promoting a culture that encourages candour, openness and honesty at all levels of the organisation.[5]

Organisational culture is crucial in how transparency is implemented in practice and a culture of candour and openness is needed to give genuine effect to a statutory duty of candour.[6] Transparency obligations must be business as usual rather than a compliance exercise.[7]

While building such a culture is perhaps outside the scope of the current consultation, OVIC encourages Safer Care Victoria to consider ways of building a culture of openness. For example, to help facilitate a

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[4] Safer Care Victoria, Consultation: Reforms to foster an open and honest culture in health services, Vimeo, https://vimeo.com/485334572.

[5] Care Quality Commission (United Kingdom), Regulation 20: Duty of Candour, Information for all providers: NHS bodies, adult social care, primary medical and dental care, and independent healthcare (March 2015), page 8: https://www.cqc.org.uk/sites/default/files/20150327_duty_of_candour_guidance_final.pdf.

[6] For example, the review of the implementation of the Australian Open Disclosure Framework found that organisational culture played a key role in how open disclosure was implemented in practice, with leadership, management and legal teams being key influencers of culture and the approach taken to implement open disclosure; Australian Commission on Safety and Quality in Health Care, Review: Implementation of the Australian Open Disclosure Framework Final Consultation Report (February 2020), page 2: https://www.safetyandquality.gov.au/sites/default/files/2020-12/implementation_of_the_australian_open_disclosure_framework.pdf; Similarly, the Royal College of Surgeons (United Kingdom) Duty of Candour Guidance for Surgeons and Employers, Domain 3: Communication, Partnership and Teamwork (2015) notes the effective application of the duty of candour is not a matter of compliance to legislation and regulatory guidance, it can only be part of a wider commitment to safety, learning and improvement, page 24.

[7] For example, the review of the Duty of Candour in the United Kingdom noted "candour cannot be an 'add on' or a matter of compliance; candour will only be effective as part of a wider commitment to safety, learning and improvement", Royal College of Surgeons, Building a culture of candour: A review of the threshold for the duty of candour and of the incentives for care organisations to be candid, page 2: https://www.rcseng.ac.uk/about-the-rcs/government-relations-and-consultation/duty-of-candour-review/#:~:text=The%20first%20addresses%20building%20a,applying%20lessons%20learned%20into%20practice.

transparency by default approach to healthcare delivery, OVIC suggests that the statutory duty of candour and related guidelines include a clear object and intent that promotes openness and transparency.[8] Any discretions conferred under the legislation and legislative instrument should be interpreted so as to promote the object of transparency and the provision of information wherever possible.[9]

Including a presumption of transparency will demonstrate the intention to provide access to as much information as possible to individuals who suffer an incident while receiving care. This will assist in any circumstances where there may be confusion regarding whether an event 'triggers' the duty. For example, the guidelines are intended to apply only to incidents with a high severity rating. If a staff member is unsure whether an incident falls within the threshold of the statutory definitions, there may be an unintended consequence of under-reporting and under-communication with patients about the incident. Clearly outlined objects and directions that are grounded in transparency will help to remove ambiguity regarding when to communicate information to patients under the duty.[10]

Take a proactive approach to transparency

OVIC recommends taking a proactive approach to providing apologies and access to information about the incident.

The Statutory Duty of Candour webpage notes that factual explanations of what happened (required to be provided under the duty) will not be protected under the duty and can be used as evidence in any legal proceedings.[11] It similarly notes that individuals will continue to have access to information about what happened in other ways, for example under the FOI Act, and changes to apology protections will not restrict the use of this information in any medico-legal claim.[12]

While individuals may request access to information through other methods such as the FOI Act, OVIC recommends the duty expressly requires health service entities to provide individuals with access to as much information as possible relating to the incident. For example, this could extend to commonly requested information such as file notes, patient files, and initial incident reports. This would pave way to a number of beneficial outcomes such as:

- Increasing the information available to an individual and allowing them to understand the events that led to the incident.
- Reducing the need for information to be requested from health service entities through formal information access mechanisms such as FOI.
- Decreasing both the time in which information is provided and the cost to the health service entity to process the FOI request.

[8] For example, the object of the FOI Act in section 3(1) is to extend as far as possible the right of the community to access information in the possession of the Victorian Government and its agencies.
[9] Section 3(2) of the FOI Act outlines Parliament's intention that the provisions of the Act must be interpreted to further the object in section 3(1) and that any discretions conferred under the Act shall be exercised as far as possible to facilitate, promote, promptly and at the lowest reasonable cost, the disclosure of information.
[10] OVIC also acknowledges that the Victorian Government's response to the Expert Working Group's report notes the guidelines will set out the minimum requirements for compliance as well as guidance and information to support best practice including a description of when the statutory duty will apply and when open disclosure should be undertaken for incidents that may not reach the threshold for the statutory duty of candour but which otherwise warrant an open disclosure process; Department of Health and Human Services, A statutory duty of candour: Victorian Government response to the Expert Working Group's report (November 2020), page 10: https://www2.health.vic.gov.au/hospitals-and-health-services/quality-safety-service/better-safer-care/statutory-duty-of-candour).
[11] Health.vic, Statutory Duty of Candour, https://www2.health.vic.gov.au/hospitals-and-health-services/quality-safety-service/better-safer-care/statutory-duty-of-candour.
[12] Ibid.

The proposed model for clinical incident reviews and providing access to information

The proposed model for clinical incident reviews notes that the report and working papers from the clinical incident review are exempt from the FOI Act and are not admissible in court.

Notwithstanding this, the proposed model notes the review report may be disclosed to third parties, such as a person whom the commissioning health service entity considers has a sufficient personal and professional interest.[13] However, permitted disclosure in this instance will not make the report available under the FOI Act, or admissible in court.

The basis for this exclusion seems to be that clinical incident review processes can involve "speculative discussion about factors that may have contributed to the incident and/or related harm" and that "inappropriate or perverse outcomes may result if this kind of information is relied on civil proceedings."[14]

OVIC makes the following comments regarding the proposed model and access to information:

- **Define who will have a sufficient personal and professional interest** – Currently, the proposed model outlines that the commissioning health service entity decides who has a sufficient personal and professional interest and therefore who may receive a copy of the report. While, practically, this appears sensible in ensuring the right people receive access to the report, it could have an unintended consequence of a perceived conflict of interest. This is because the entity in which the incident occurred is also the entity which decides who receives a copy of the report (which scrutinises what occurred in the entity). It may also cause inconsistent practices among health service entities and uncertainty for patients and their families. OVIC recommends prescribing a class or classes of person who may receive a copy of the report (such as the affected individual or their next of kin). This will remove some level of perceived conflict of interest, by removing the decision to provide access from the commissioning entity. In addition, this will provide certainty for health service entities, as well as patients and their families.
- **Develop a clear and transparent access process**– The FOI Act establishes an important process for requesting access to documents held by Victorian government agencies, including public hospitals. The FOI Act is an important transparency and accountability mechanism which balances the right to access government held information with protecting important public interests. OVIC notes the intention that the further use of reports from clinical incident reviews of serious incidents will be limited. For example, permitted disclosure will not make the report admissible in court nor available under the FOI Act.[15] If such reports cannot be requested through the FOI Act (and therefore outside the clear process for requesting access), then there must be a clear and transparent process for individuals with a sufficient personal and professional interest to obtain access to them.
- **Introduce oversight over access to information** – If a review report is not subject to the FOI Act, then OVIC no longer has review jurisdiction over any decision made to refuse access to a report and therefore removes OVIC's oversight over access to information under the FOI Act. Accountability is an important way to ensure the right people are receiving access to information that affects them personally and that decisions to refuse access to information are properly scrutinised. If the review report is not subject to the FOI Act, OVIC suggests introducing a level of oversight, outside of the commissioning health service entity, to ensure appropriate accountability and scrutiny of decisions to refuse access to a review report.

[13] The health.vic website refers to "consumers" which suggests members of the public rather than limiting access to clinicians; Further, the consultation webpage notes under the proposed model, reports will be offered to patients, family members and carers, consistent with candour and open disclosure: https://engage.vic.gov.au/reforms-foster-honest-and-open-culture-health-services.

[14] A Duty of Candour, Victorian Government response to the Expert Working Group, page 12.

[15] The FOI Act does not expressly place any limit on the further use or disclosure of a document released under that Act.

- **Ensure the proposed model does not restrict access to other medical information** – If a review report is not subject to the FOI Act, any mechanism which removes them from the scope of the FOI Act must not inadvertently make primary information relied on to draft the report also not subject to the FOI Act (for example, medical files).[16] This would have the unintended consequence of individuals not able to access parts of their medical files.

Thank you for the opportunity to provide comment on the consultation. OVIC will watch its progress with interest and would welcome the opportunity to comment on draft legislation, draft guidelines and the draft model for clinical incident reviews.

I have no objection to this submission being published by Safer Care Victoria without further reference to me. I also propose to publish a copy of this submission on the OVIC website but would be happy to adjust the timing of this to allow Safer Care Victoria to collate and publish submissions proactively.

If you have any questions about this submission, please do not hesitate to contact my colleague Sarah Crossman, Principal Policy Officer, at sarah.crossman@ovic.vic.gov.au.

Yours sincerely

Sven Bluemmel
Information Commissioner

[16] This appears to be the intention, as the Victorian Government response to the Expert Working Group's Report notes the protections in the proposed model for clinical incident reviews do not apply to primary source documents such as medical records and other corporate records of the health service entity as these are matters of fact and should be available to consumers and others to the extent that they currently are, page 12.