

SESLHD PROCEDURE COVER SHEET



Health
South Eastern Sydney
Local Health District

NAME OF DOCUMENT	Serious Clinical Incident Management
TYPE OF DOCUMENT	Procedure
DOCUMENT NUMBER	SESLHDPR/240
DATE OF PUBLICATION	October 2025
RISK RATING	Medium
LEVEL OF EVIDENCE	National Safety and Quality Health Service (NSQHS) Standard 1 – Clinical Governance
REVIEW DATE	October 2028
FORMER REFERENCE(S)	SESLHDPR/320 - SAER Recommendations Compliance Monitoring SESLHDPR/549 - Reporting and Escalation of Serious Incidents
EXECUTIVE SPONSOR	Director, Clinical Governance and Medical Services
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FUNCTIONAL GROUP(S)	Clinical Governance
KEY TERMS	Australian Sentinel Event (ASE), Harm Score (HS), Clinical Incident Review (CIR), Privilege, Preliminary Risk Assessment (PRA), Reportable Incident Brief (RIB), Serious Adverse Event Review (SAER)
SUMMARY	This procedure outlines the processes for notifying, reporting and escalating, and investigating serious clinical incidents to learn from harm and implement actions to prevent reoccurrence.

COMPLIANCE WITH THIS DOCUMENT IS MANDATORY

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1. POLICY STATEMENT

This procedure operationalises the management of serious clinical incidents across SESLHD in accordance with the [NSW Health Policy Directive PD2020_047 - Incident Management](#) to ensure effective response to these events, including acting on lessons learned.

2. BACKGROUND

It is the responsibility of all staff to identify incidents and take immediate action to ensure the safety of patients, visitors, and other staff where required.

All incidents must be recorded in the incident management system (ims+) and should be escalated to the manager of the service or location where the incident occurred.

Serious incidents, those resulting in major harm (Harm Score 2) or unexpected death (Harm Score 1), require additional reporting and escalation. This procedure outlines the processes, roles and responsibilities for this within SESLHD.

Key definitions

Australian Sentinel Event (ASE): A wholly preventable patient safety incident resulting in death or serious patient harm. Refer to Appendix D in the [NSW Health Policy Directive PD2020_047 - Incident Management](#) for a list of ASEs.

Harm Score (HS): A score from 1 to 4 applied to incidents based on the outcome and additional treatment and/ or resources required.

- Clinical Harm Score 1 - Unexpected death or Australian Sentinel Event
- Harm Score 2 – Major harm
- Harm Score 3 – Minor harm
- Harm Score 4 – No harm or near miss

Clinical Incident Review (CIR): A structured process to identify what happened, why it happened, and what could be done to reduce risk and make care safer.

Privilege: The work of Preliminary Risk Assessment (PRA) assessors and Serious Adverse Event Review (SAER) teams attracts statutory privilege, which means it is not admissible in any proceedings. PRA assessors and SAER team members convened by the Chief Executive are bound by strict confidentiality requirements, making it an offence for them to disclose information obtained during the PRA or SAER, unless it is for the purpose of the PRA or SAER.

Preliminary Risk Assessment (PRA): A PRA is undertaken following all clinical Harm Score 1 incidents, or for any other incident where there are concerns warranting a risk assessment discussion, to assist to understand the events and identify immediate risks for action. The Chief Executive may direct a PRA be undertaken for clinical Harm Score 2, 3 or 4 incidents that may be due to a serious systemic problem.

Reportable Incident Brief (RIB): Serious incidents are notified and escalated internally and to the Ministry of Health via a RIB. *Refer to Appendix D in the [NSW Health Policy Directive PD2020_047 - Incident Management](#) for a list of reportable incidents.*

Serious Adverse Event Review (SAER): A review prescribed by the Regulations ([Part 2A of the Health Administration Act 1982](#)) undertaken by a SAER team for a clinical Harm Score 1 incident. A SAER can also be undertaken in relation to a clinical Harm Score 2, 3, or 4 incident if the Chief Executive determines it may be due to a serious systemic problem.

3. RESPONSIBILITIES

3.1 Employees will:

- Complete mandatory training: ims+ How to Notify an Incident (Course Code: 259009870).
- Immediately identify and notify all serious incidents to their Line Manager and in the ims+.

3.2 Line Managers will:

- Complete mandatory training: ims+ How to Manage and Review an Incident Record (Course Code: 266765062).
- Ensure immediate action is undertaken to address any ongoing risk following a serious incident.
- Advise the Facility/Service Clinical Practice Improvement Unit (CPIU) of the incident.
- Update the ims+ record of the incident with relevant information.

3.3 Facility/Service Clinical Practice Improvement Unit (or however named) staff will:

- Oversee Facility/Service incident management processes and ensure policy and procedure requirements are adhered to, and where there is flexibility for a local process to be determined ensure this is established and followed.
- Review incident notifications in ims+ daily (business days) and ensure appropriate Harm Score (HS) assigned.
- Notify General Manager/ Service Director and District Clinical Governance Unit of all HS 1 and HS 2 incidents.
- Facilitate Preliminary Risk Assessment (PRA) meetings on behalf of the Facility/Service General Manager as required (for all HS 1 incidents or clinical incidents where the HS needs to be determined).
- Complete Reportable Incident Brief (RIB) where required.
- Facilitate Serious Adverse Event Review (SAER) investigations.
- Monitor and report on respective Facility/Service serious incidents, including incident numbers, types, trends, and themes.

- Support capacity building within Facility/Service through encouraging completion of the [Competency Framework for SAER Team Leaders](#).

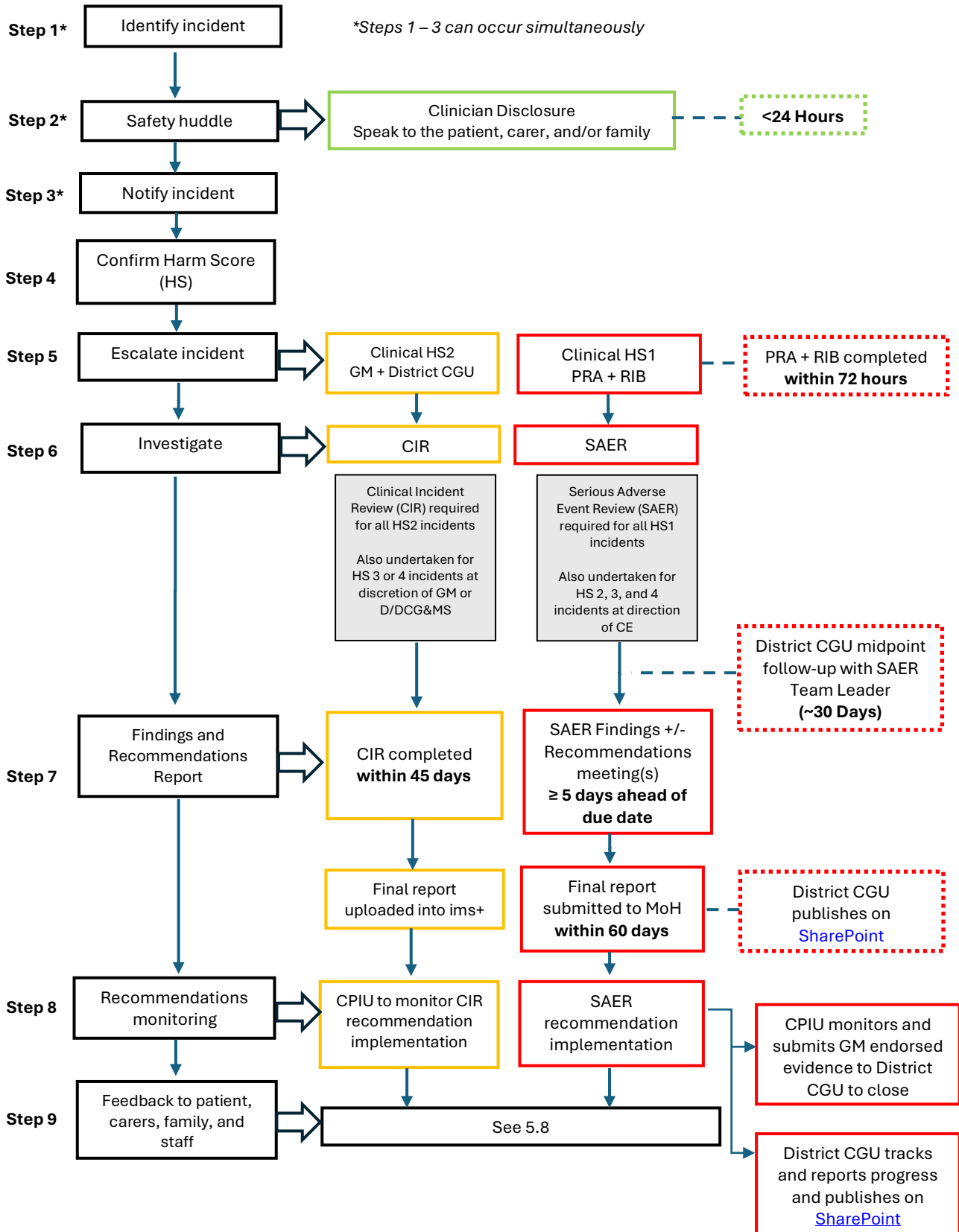
3.4 General Managers/Service Directors will:

- Ensure effective incident management processes within respective Facility/Service.
- Support a culture of recognition and reporting of incidents, especially serious clinical incidents.
- Ensure all HS 1 and HS 2 incidents are notified to the District Clinical Governance Unit within a reasonable timeframe and escalate clinical risks immediately to the Deputy Director Clinical Governance and Medical Services and Chief Executive as required.
- Lead PRA meetings, review and approve RIBs and SAER reports in relation to respective Facility/Service prior to submission to the Chief Executive.

3.5 District Clinical Governance Unit will:

- Oversee District incident management processes and ensure policy and procedure requirements are adhered to.
- Monitor serious incident notifications in ims+ daily on business days and follow up confirmation of HS as required.
- Notify the Chief Executive of all HS 1 incidents within 24 hours and HS 2 incidents via weekly report (or immediately where risk identified).
- Attend PRA meetings and send the final PRA report to the Chief Executive.
- Progress completed RIBs for Chief Executive approval and submit to Ministry of Health within stipulated timeframes (Part A 24 hours, Part B 72 hours).
- Support and/ or facilitate (as required) SAER investigations.
- Monitor and report on District-wide serious incidents, including incident numbers, types, trends, and themes.
- Support capacity building across the District through facilitating additional training opportunities and promoting completion of the [Competency Framework for SAER Team Leaders](#).

4. INCIDENT MANAGEMENT PROCESS



5. PROCEDURE**5.1 – 5.3 can occur simultaneously****5.1 Identification of incident**

- All staff are responsible for identifying incidents; most incidents are identified at the time, and a few are identified sometime after the event.

5.2 Safety huddle

- All staff must take any immediate action needed to ensure safety.
- A safety huddle is recommended, especially for serious clinical incidents, and should involve clinicians involved in care, a manager from the Division/ Program/ Service/ Ward where the incident occurred, and a clinical governance representative.
- Clinician disclosure should occur within 24 hours of incident identification in line with the [NSW Health Policy Directive PD2023_034 - Open Disclosure](#).

5.3 Notification of incident

- All staff must immediately notify any serious incident to their Line Manager and in the ims+.
- Line Managers must escalate any serious incidents to their Facility/Service CPIU and ensure immediate actions are undertaken to address any ongoing risks.
- Facility/Service CPIUs must review all serious incidents and notify their General Manager/ Service Director and District Clinical Governance Unit (CGU) of all HS 1 and HS 2 incidents as soon as reasonably practicable.

5.4 Confirmation of Harm Score

- Facility/Service CPIUs to ensure HS accurately confirmed in ims+ for all serious incidents.
- District CGU to review all serious incidents and ensure correct HS assigned.

5.4.1 Revision of Harm Score

- Where an incident is entered as an initial HS 2 and requires revision to a confirmed HS 3 or 4, Facility/Service CPIUs are to revise the HS and document the rationale for revision in the 'Progress Notes' section of the ims+ record; advice can be sought from District CGU as required.
- Where an incident is incorrectly entered as a HS 1, Facility/Service CPIUs are to seek approval for revision by emailing the incident details and rationale to SESLHD-CGU@health.nsw.gov.au.
 - District CGU will review the incident and seek Chief Executive approval for the revision where appropriate; the HS will be revised and confirmation of approval saved in the 'Documents' section of the ims+ record.

5.5 Escalation of incident

HS2 incidents

- Facility/Service CPIUs are to ensure all HS 2 incidents are reported to their General Manager/ Service Director and District CGU via SESLHD-CGU@health.nsw.gov.au as soon as possible.
- District CGU are to immediately escalate any HS 2 incidents where an ongoing risk has been identified, in addition to providing a weekly summary report to the Chief Executive, Executive Director of Operations, Director of Clinical Governance, Director of Nursing, and Director of Allied Health.

HS1 incidents

Preliminary Risk Assessment – Privileged

Purpose: Understand the events leading to the incident, identify/ mitigate/ escalate immediate risks, confirm HS and whether outcome expected/ unexpected, type of review methodology (not to commence the review), and potential team members.

- Facility/Service CPIUs are to facilitate a Preliminary Risk Assessment (PRA) meeting for all clinical HS 1 incidents and other incident as required (e.g. HS to be determined, high risk); invitees must include representatives from the local Executive and CPIU, District CGU, and other clinical experts (e.g. Heads of Department) as relevant to the incident (must not have been directly involved in incident) as approved by the Chief Executive.
- Facility/Service CPIUs are to confirm Aboriginality status in electronic Medical Record (eMR) and ensure Aboriginal Health Directorate notified and involved in process where Aboriginal person affected.
- Facility/Service CPIUs are to send the finalised PRA report to District CGU via SESLHD-CGU@health.nsw.gov.au immediately following the PRA meeting.
- District CGU are to review and submit the final PRA report to the CE for noting.
- The PRA report must be submitted to the Chief Executive within 72 hours.

Reportable Incident Brief

- Facility/Service CPIUs are to complete a Reportable Incident Brief (RIB) via ims+ for all HS1 incidents, and other incidents as required (refer to Appendix D in the [NSW Health Policy Directive PD2020_047 - Incident Management](#)), including where a lookback process is required – triggered when a clinical incident or concern leads to the notification and tracking of affected or potentially affected groups of patients (refer to [NSW Health Policy Directive PD2023_003 – Lookback](#)).
- General Managers/ Service Directors are responsible for approving RIBs related to incidents in their service prior to submission to District CGU.
- District CGU are to review RIBs approved by the General Manager/ Service Director and progress for further approval by the Deputy Director Clinical Governance and Medical Services and Chief Executive, followed by submitting to the Ministry of Health.

- RIB must be submitted within 72 hours.

5.6 Investigation

HS2 incidents

- All HS 2 incidents require a Clinical Incident Review (CIR) using the standardised SESLHD CIR template available on the [Templates and Forms](#) SharePoint page alongside supporting resources.
- A CIR can also be conducted for HS 3 and HS 4 incident where an in-depth review is warranted (e.g. systemic issues evident, further understanding of incident would be beneficial, patient/ family requesting).
- A CIR must be completed within 45 calendar days of the incident notification.
- The reviewer(s) should not have been directly involved in the incident, have some knowledge of processes where the incident occurred, have investigation expertise, and have relevant cultural expertise or seek this where required (e.g. Aboriginal representative*).

District CGU are able to provide advice, support, and training/ education on how to conduct a CIR (see [SharePoint](#) for further information).

HS1 incidents – Privileged

- All HS 1 incidents require a Serious Adverse Event Review (SAER) using an approved investigation methodology:
 - Root Cause Analysis
 - Concise Incident Analysis
 - Comprehensive Incident Analysis
 - London Protocol.
- A SAER may also be commissioned for HS 2, 3, or 4 incidents at the discretion of the Chief Executive with advice from the PRA assessors.
- A SAER must be completed within 60 calendar days of the incident notification.
- SAER Team Members should not have been directly involved in the incident, some should have knowledge of processes where the incident occurred, one member should be external to Facility/Service where possible, one member should have SAER expertise, representation from other relevant services may be required, and where required one member should have relevant cultural expertise (e.g. Aboriginal representative*).
- Facility/Service CPIUs are to complete the [Appointment of SAER Team Members](#) form with agreed Team Members (consideration given to completion of [Competency Framework for SAER Team Leaders](#)) and send to District CGU via SESLHD-CGU@health.nsw.gov.au following submission of the PRA report and RIB.
- District CGU are to review and progress for further approval by the Deputy Director Clinical Governance and Medical Services and Chief Executive; once approved the individual appointment letters will be sent to the nominated SAER Team Leader for further dissemination to other SAER Team Members.

- District CGU will also send SAER Team Leaders a 'Taxonomy Form' for completion and submission alongside the final report, and a 'Quality Self-Audit Checklist' for use as a guide when writing report (not required to be submitted to District CGU).
- SAER Team Leaders are to coordinate the investigation in alignment with the chosen approved methodology.
- SAER Team Leaders are to complete the [Interviewee Letter SAER](#) and provide to any person being interviewed as part of the investigation.
- District CGU will touch base with the SAER Team Leader at the midpoint (~30 days) of every investigation.

**Appropriate support and debriefing should be offered to Aboriginal staff involved in serious incident investigations in recognition of the associated cultural load.*

District CGU members are covered by statutory privilege and can be contacted for advice and support at any time throughout a SAER investigation.

5.6.1 Referring performance issues

- Where an individual performance issue has been identified at the time of an incident, PRA, or through the investigation process, this must be reported immediately to the Facility/Service General Manager/ Service Director and Deputy Director Clinical Governance and Medical Services in accordance with the [NSW Health Policy Directive PD2025_021 - Managing Misconduct, Serious Performance and Child Related Concerns](#).
- Facility/Service CPIUs are to complete the [SAER Letter Informing Chief Executive of Issues That May Involve Individual Performance](#) and an accompanying brief and submit to the Deputy Director Clinical Governance and Medical Services for review prior to submission to the Chief Executive to initiate a separate investigation into individual performance (out of scope of SAER investigation) by the respective professional lead.

5.7 Findings and Recommendations Report

Clinical Incident Review (CIR)

- Facility/Service CPIUs are to ensure a locally agreed process is in place for the completion and sign-off of CIR investigations.
- Finalised CIR reports are to be saved in the 'Documents' section of the ims+ record.
- District CGU are to monitor completion of CIRs in line with the due date and will follow up with Facilities/ Services and provide support as required.

Serious Adverse Event Review (SAER)

- SAER Team Leaders are responsible for writing the Findings Report in collaboration with other Team Members.

- SAER Teams Leaders are required to organise a Findings Report meeting with Facility/Service Executive and Deputy Director Clinical Governance and Medical Services at least five days ahead of the due date – the draft report should be shared with invitees prior to the meeting.

Purpose of Findings Report Meeting: To confirm the findings and determine whether recommendations are required based on the 'areas for review findings' (not to re-prosecute the case).

- Where 'areas for review findings' have been identified in the Findings Report, the SAER Team Leader is to proceed with a Recommendations Report meeting – this can be conducted in the same meeting or a separate meeting with additional invitees as relevant to support the identification of appropriate and robust recommendations; if additional team members are required for the recommendations meeting, Facility/Service CPIUs are to complete the [Appointment of Additional SAER Team Members](#) form and send to District CGU via SESLHD-CGU@health.nsw.gov.au ahead of the meeting.

Purpose of Recommendations Report Meeting (where required): To determine the recommended actions including timeframe, responsibility for implementing, and outcome measure.

- Following the Findings and Recommendations (where applicable) meetings and local sign-off, the final report(s) and completed 'Taxonomy Form' are to be submitted to District CGU via SESLHD-CGU@health.nsw.gov.au.
- District CGU are to review and progress for further approval by the Deputy Director Clinical Governance and Medical Services and Chief Executive, followed by submitting to the Ministry of Health.
- District CGU will return the final report to the SAER Team Leader and Facility/Service CPIU Manager and upload to the [SESLHD SAER Reports](#) SharePoint page.
- SAER Team Leaders are to share the final report with other SAER Team Members, staff interviewed as part of the SAER process, and staff assigned recommendations.
- Facility/Service CPIUs are to ensure final reports are tabled at the local peak Safety and Quality Committee, and shared with others as relevant (e.g. Division/ Program/ Service/ Ward where incident occurred).
- Facility/Service CPIUs are to update ims+ record status to 'Finalised' under the 'Details and Status' section.

5.7.1 Recommendations monitoring

Clinical Incident Review (CIR)

- Facility/Service CPIUs are to ensure a locally agreed process is in place to monitor the implementation of recommendations and evaluate

effectiveness, including oversight by the local peak Safety and Quality Committee.

Serious Adverse Event Review (SAER)

- Facility/Service CPIUs are to monitor the implementation of SAER recommendations (root cause/ contributing factor AND system improvement) and evaluate effectiveness.
- Facility/Service CPIUs are to seek General Manager/ Service Director endorsement to close a recommendation once complete and submit this alongside evidence of completion to District CGU via SESLHD-CGU@health.nsw.gov.au.
- District CGU are to record, monitor, and report on progress of recommendations (root cause/ contributing factor AND system improvement) to the District Patient Safety and Quality Committee, including updating the [SAER Recommendations](#) SharePoint page.

5.8 Open disclosure

Feedback to patient, carers, family, and staff should occur following review of a serious clinical incident.

Open disclosure is a process for ensuring that open, honest, empathic, and timely discussions occur between patients (and/or their support person) and health service staff following a patient safety incident.

Open disclosure is a key element of the early response and investigation of serious patient safety incidents. The [NSW Health Policy Directive PD2023_034 - Open Disclosure](#) sets out the minimum requirements for implementing open disclosure, which includes five essential elements:

1. An **apology** or expression of regret, which should include the words ‘I am sorry’ or ‘we are sorry’
2. A **factual explanation** of what happened
3. An opportunity for the **patient, their family, and carers** to relate their **experience**
4. A discussion of the **potential consequences** of the adverse event
5. An explanation of the **steps being taken to manage** the adverse event and **prevent recurrence**

It is important that the open disclosure process recognises and supports cultural needs e.g. Aboriginal people ([see Communicating Positively: A Guide to Appropriate Aboriginal Terminology GL2019_008](#)), culturally and linguistically diverse (CALD) communities.

Further information and links to resources on open disclosure can be found on the [Open Disclosure](#) SharePoint page.

A record of open disclosure conversations should be documented in the ims+ and patient healthcare record.

6. DOCUMENTATION

Templates for the documentation of CIRs, PRAs, RIBs, and SAERs, as well as supporting resources, are available on the District CGU SharePoint [Templates and Forms](#) page and [Management of Serious Incidents](#) page, as well as the Clinical Excellence Commission [Incident management policy resources](#) webpage.

Records pertaining to the PRA and SAER attract statutory privilege, which means they are not admissible in any proceedings, and are therefore bound by strict confidentiality requirements, making it an offence to disclose this information unless it is for the purpose of the PRA or SAER. Correspondence between PRA assessors and SAER team members should clearly make reference to the fact that the record is privileged and not for broader circulation.

Records pertaining to incident management must be managed in accordance with the [SESLHDHB/022 Corporate Records Management Framework](#), which includes storage in the Content Manager system.

7. AUDIT

- Facility/Service CPIUs are to ensure a locally agreed process is in place to monitor and report on serious incidents, including discussing at the local peak Safety and Quality Committee.
- District CGU are to monitor and report on serious incidents, including incident numbers, types, trends, and themes from findings and recommendations over time, through the bi-monthly District Clinical Governance Report, which is tabled at the following peak District committees:
 - Patient Safety and Quality Committee
 - Clinical and Quality Council
 - Quality, Safety and Culture Board Subcommittee
 - Executive Meeting.
- District Clinical Governance Reports are also published on the [Clinical Performance](#) SharePoint page once endorsed.
- District CGU may also conduct additional deep dive analyses and cluster reviews where further in-depth analysis is warranted.

8. REFERENCES

- [Health Administration Act 1982 \(NSW\)](#)
- [NSW Health Guideline GL2019_008 Communicating Positively: A Guide to Appropriate Aboriginal Terminology](#)
- [NSW Health Policy Directive PD2020_047 - Incident Management](#)
- [NSW Health Policy Directive PD2023_003 – Lookback](#)
- [NSW Health Policy Directive PD2023_034 - Open Disclosure](#)

SESLHD PROCEDURE

Serious Clinical Incident Management

SESLHDPR/240

- [NSW Health Policy Directive PD2025_021 - Managing Misconduct, Serious Performance and Child Related Concerns](#)
- [SESLHDHB/022 - Corporate Records Management Framework](#)

9. VERSION AND APPROVAL HISTORY

Date	Version	Version and approval notes
30 October 2025	1.0	New document to consolidate <i>SESLHDPR/549 Reporting and Escalation of Serious Incidents</i> and <i>SESLHDPR/320 Serious Adverse Event Review (SAER) Recommendations Compliance Monitoring</i> . Updates also made to processes outlined in procedure following refinements made as part of District-wide Incident Management Review Project. Approved at SESLHD Patient Safety and Quality Committee.