

## Reportable Incident Definition under section 20L of the Health Administration Act

**Document Number** PD2005\_634

**Publication date** 17-Nov-2005

**Functional Sub group** Clinical/ Patient Services - Governance and Service Delivery  
Clinical/ Patient Services - Incident management

**Summary** This Policy Directive is effective 1 January 2006 and defines when a matter is a "reportable incident" under the Health Administration Act. This definition determines when a Root Cause Analysis is required to be undertaken. To be read in conjunction with the NSW Health Incident Management Policy.

**Author Branch** Legal and Legislative Services

**Branch contact** Legal Branch 9391 9606

**Applies to** Area Health Services/Chief Executive Governed Statutory Health Corporation, Board Governed Statutory Health Corporations, Affiliated Health Organisations, Public Health System Support Division, Community Health Centres, Dental Schools and Clinics, Government Medical Officers, NSW Ambulance Service, NSW Dept of Health, Public Health Units, Public Hospitals

**Audience** All staff including managers, clinicians and contractors

**Distributed to** Public Health System, Community Health Centres, Dental Schools and Clinics, Divisions of General Practice, Government Medical Officers, Health Associations Unions, Health Professional Associations and Related Organisations, NSW Ambulance Service, NSW Department of Health, Public Health Units, Public Hospitals, Tertiary Education Institutes

**Review date** 17-Nov-2010

**File No.** 00/633

**Previous reference** N/A

**Status** Active

**Director-General**

**Compliance with this policy directive is mandatory.**

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## REPORTABLE INCIDENT DEFINITION UNDER SECTION 20L OF THE HEALTH ADMINISTRATION ACT

Under the provisions of Division 6C of Part 2 of the Health Administration Act 1982 when a “reportable incident” involving a relevant health services organisation is reported to the chief executive of the organisation, the organisation is to appoint a root cause analysis team in relation to the reportable incident.

Chief executives are required to comply with the root cause analysis provisions of the Act. The Department of Health and Health Administration Regulation 2005 has determined that “reportable incident” is defined as hereunder.

A “Reportable Incident” involves:

- (1) The incident must have had “serious clinical consequences” (as defined below) and the probability of recurrence must fall into one of categories (i) to (iv) listed below; OR
- (2) The incident must have had “major clinical consequences” (as defined below) and the probability of recurrence must fall into one of categories (i) to (ii) listed below;

Under section 20M of the Act, an RCA is required to be conducted once the incident has been reported to the Chief Executive.

The Chief Executive should be notified via a Reportable Incident Brief in accordance with the NSW Health Incident Management Policy.

### **“*Serious Clinical Consequences*”**

An incident with “serious clinical consequences” is one that involves:

- The death of a patient unrelated to the natural course of the illness and differing from the immediate expected outcome of the patient management;
- OR
- Sentinel Events reportable to Australian Council for Safety and Quality in Health Care, those being:
    - Procedures involving the wrong patient or body part
    - Suspected suicide of a person (including a patient or community patient) who has received care or treatment for a mental illness from the relevant health services organization where the death occurs within 7 days of the person’s last contact with the organization or where there are reasonable clinical grounds to suspect a connection between the death and the care or treatment provided by the organisation.

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*Title: Reportable Incident Definition Under Section 201 Of The Health Administration Act*

- Suspected homicide committed by a person who has received care or treatment for mental illness from the relevant health services organisation within six months of the person's last contact with the organisation or where there are reasonable clinical grounds to suspect a connection between the death and the care or treatment provided by the organisation;
- Retained instruments;
- Unintended material requiring surgical removal;
- Intravascular gas embolism resulting in death or neurological damage;
- Haemolytic blood transfusion;
- Medication error leading to death;
- Maternal death or serious morbidity associated with labour or delivery;
- Infant abduction or discharge to wrong family.

### ***“Major Clinical Consequences”***

An incident with “major clinical consequences” is one which involves a patient:

- Suffering a major permanent loss of function (sensory, motor, physiologic or psychologic) unrelated to the natural course of the illness and differing from the expected outcome of patient management;
- Suffering significant disfigurement as a result of the incident;
- At significant risk due to being absent against medical advice/absconding patient;

### ***Probability of Recurrence***

- (i) Frequent      expectation that the incident will recur immediately or within weeks or months;
- (ii) Likely        probability incident will recur more than once within 12 months;
- (iii) Possible     possibility incident may recur at some time every 1 to 2 years;
- (iv) Unlikely     possibility incident may recur at some time in 2 to 5 years.

Robyn Kruk  
**Director-General**