

41 That the provisions regarding the constitution, 2.2
procedures and functions of all consultative councils
be consolidated in one part of the public health Act.

Comment:

Agree

42 That the public health Act retain separate 2.2
provisions for the establishment, functions and
procedure of the Consultative Council on Obstetric
and Paediatric Mortality and Morbidity.

Comment:

Agree and recognise the unique aspects of CCOPPM, particularly in
regard to the perinatal data collection unit and other aspects of its
terms of reference.

43 That, in relation to the Consultative Council on 2.2
Paediatric Mortality and Morbidity ("CCOPMM"):

- (a) The Act would define a "maternal death" as
the death a woman who was pregnant at the
time of death; or was pregnant within the 12
months prior to her death.
- (b) The provisions relating to the membership of
CCOPMM be simplified. A possible approach
may be to provide that CCOPMM is to consist
of not more than 12 members including a
chairperson and such other members, the
majority of whom shall be people with special
knowledge in the matters referred to the
council".
- (c) The requirements to report a birth to CCOPMM
in section 162G be retained, but extended to
also include mandatory reporting of birth
defects by hospitals, diagnostic laboratories
and prenatal screening facilities.
- (d) Section 22A of the Coroners Act 1985 (Vic) is
amended to provide that the Coroner must
notify CCOPMM of maternal and child deaths
(this does not include stillbirths). (Currently,
the Act provides that the Coroner may notify
CCOPMM of the death of a child that is
reported to the Coroner.)
- (e) Section 49B of the Births Deaths and
Marriages Registration Act 1996 (Vic) is
amended to provide that, in addition to being
required to report stillbirths and child deaths

to CCOPMM, the Registrar of Births, Deaths & Marriages must also notify CCOPMM of maternal deaths that are reported to the Registrar of Births, Deaths & Marriages.

Comment:

Mostly this recommendation pertains to CCOPMM. However, in regard to 43 (d) it may be appropriate to consider any amendment required (presumably to Section 22A) such that the Coroner must notify VCCAMM and VSCC of any deaths occurring in relation to anaesthesia and surgery. The central issue here relates to the definition of a reportable death to the Coroner. This is currently being addressed via the Discussion Paper on the Coroner's Act 1985 of the Victorian Parliament Law Reform Committee. In July 2005, VCCAMM made a recommendation to that discussion paper, on a preferred definition of a reportable death, in relation to medical treatment. This is defined as a death occurring during or within a specified time period after a health related procedure whereby a "health related procedure" is defined as being a dental, medical, surgical or other health related procedure, including the administration of an anaesthetic, analgesic, or other drug. This definition is the current one deployed in Queensland. Agreement about the preferred specified time period after such a procedure for reporting is difficult to achieve and is 24 hours in some jurisdictions and 72 hours in others. VCCAMM would support the additional provision of reporting beyond any specified time frame if in the particular case it was deemed by the reporting doctor to be important. It is to be hoped that the Review of the Coroner's Act 1985, will achieve consistency and clarity in this area. Notwithstanding any outcome from the Review of the Coroner's Act 1985, it would be VCCAMM's view that deaths in relation to anaesthesia, surgical and other procedures that are reported to the coroner should be notified to VCCAMM and VSCC. It is recognised that mandatory notification (as in recommendation 53) from the reporting doctor or health service provider to Councils of such deaths as defined above might negate the need for mandatory notification by the Coroner back to Council and could cause duplication. However, it would provide a robust mechanism for cross checking to ensure appropriate collection of caseload data for analysis.

44 That the public health Act retain the capacity for the Minister to establish a consultative council, or appoint a body as a consultative council. 2.2

Comment:

Agree

45 That the public health Act provide that a consultative council established or appointed by the Minister may be prescribed to: 2.2

(a) have confidentiality provisions based on the provisions currently applying to the Consultative Council on Obstetric and

Paediatric Mortality and Morbidity

- (b) disclose information in accordance with recommendation 52 below.

Comment:

- (a) Agree but it is noted that the confidentiality provisions as outlined in Section 162 H pertaining to CCOPMM could be simplified as in Section 24 A (1) and (2). In particular, clarification and uniformity surrounding confidentiality and disclosure is required.
- (b) Agree but see comments on recommendation 52 below

- 46 That the public health Act provide that consultative 2.2
councils established by the Minister, which are
prescribed as a consultative council for the purpose
of the confidentiality and disclosure provisions,
have the following core minimum functions
specified in the public health Act:
- (a) to monitor, analyse and report on key areas of concern as specified for each consultative council
 - (b) to liaise with other consultative councils on issues of common concern, including the development of appropriate systems for practitioners reporting relevant cases
 - (c) to improve practice by publication and dissemination of relevant information and practical strategies identified during deliberations of the council
 - (d) to consider, investigate and report on matters referred to the council by the Minister or Secretary
 - (e) to publish an annual report of the Council's research and activities.

Comment:

Agree but specifically with regard to (a), the key areas of concern should be specified by VCCAMM itself and not any external agency.

With regard to 46 (d), VCCAMM has a major concern with the inclusion of the Secretary (assuming it refers to the Secretary of the Department of Human Services). Such an inclusion could compromise the independence of Council and has the potential to position the Council as an "instrument" of the Department. It is important to reflect that VCCAMM has a 30 year track record of voluntary reporting for both mortality and morbidity and any perception of a lack of independence would carry a considerable risk of reduced reporting even if it there is mandatory notification. The fundamental aspect of VCCAMM's history has been the trust bestowed in it by the anaesthesia community and this is essential for high quality sustainable reporting. In addition, inclusion of the word "investigate" in 46 (d) may be interpreted in a punitive manner and we would prefer it to be replaced with "analyse". It is noted that the word "investigate" currently appears in VCCAMM's existing terms of reference but in the setting of mandatory notification, we would prefer to replace it with the word "analyse".

With regard to 46 (e), the word research should/could be omitted. It is debatable whether projects, reports and other activities undertaken by the councils constitute "research" in terms of its medical science context. In addition, the provision of a publishable annual report is constrained by both the availability of information to complete case report analysis in a timely manner as well as resources, including personnel and financial. VCCAMM is supportive but would recommend inclusion of the equivalent of Section 162 F (2) ie. "The Secretary shall make available to the Council the services of such employees (or resources) as are necessary for the purpose of enabling Council to carry out its functions."

46 should include an additional clause, eg. (f), referring to the need to keep a register of anaesthesia mortality and morbidity. This is currently part of the existing terms of reference for VCCAMM. Such a database is fundamental for the sustainable role of consultative councils. However, the development and maintenance of such a register is also dependent upon adequate resource allocation as outlined above.

47 That a consultative council established by the Minister has a chairperson and the majority of its members with special knowledge in the matters referred to the council in the order establishing the council. 2.2

Comment:

Agree

48 That the public health Act contain a provision allowing the Minister to empower the Consultative Council on Obstetric and Paediatric Mortality and Morbidity (or another consultative council established by the Minister) to co-opt any person with special knowledge or skill. This would include a consumer representative (or any other relevant person) to assist the council. Such a person should be regarded as a member of the consultative council to which they are appointed, until their period of co-option ends. 2.2

Comment:

It is preferable for the word "could" to replace "would" in the second sentence. VCCAMM considers the provision for co-option important but is not supportive of any provision mandating inclusion of a consumer representative.

49 That the public health Act include a provision enabling the Consultative Council on Obstetric and Paediatric Mortality and Morbidity and consultative councils established by the Minister to establish subcommittees. 2.2

Comment:

Agree. Presumably this relates to the subcommittees as defined in section 162 E (1) and (2) whereby subcommittees could include both council members and other persons as determined by Council.

50 That the public health Act include a provision enabling consultative councils to disclose information to another consultative council, if the council considers that the information is relevant to the functions of the other council. It is proposed that this power only be exercised following a formal determination by the council that such information should be disclosed to the other council. 2.2

Comment:

Agree but recognising the need for retention of absolute confidentiality across all of the consultative councils. Currently in VCCAMM, the application of the process of confidentiality is such that only the Chairman has identifiable knowledge of reported cases as full de-identification is undertaken before presentation to Council. This is regarded as an important mechanism for the preservation of confidentiality for both the individual who is the subject of the report and the reporting practitioner. It also provides protection to the members of council. Therefore, we consider the preferred mechanism for disclosure of information between councils to be by restricting the exchange of such identifiable information to the Chairs of the respective councils.

51 That consultative councils could, in appropriate cases, jointly examine matters. For instance, if there was a maternal death while the mother was anaesthetised, Consultative Council on Paediatric Mortality and Morbidity and the Consultative Council on Anaesthetic Mortality and Morbidity could jointly examine the death. 2.2

Comment:

Given the provisions in 49 and 50, this recommendation is not required. Joint examination by two full councils would not only be logistically impractical but also less likely to deliver an appropriate outcome than by deployment of subcommittee(s) and referral of matters between councils. Such a subcommittee could be jointly convened by two councils.

52 That the public health Act enable the Consultative Council on Obstetric and Paediatric Mortality and Morbidity and prescribed consultative councils to disclose information to the following specified entity or entities, if the councils determine it is in the public interest to do so: 2.2

- (a) the Secretary to the Department of Human Services
- (b) the Medical Practitioners Board of Victoria
- (c) the Nurses Board of Victoria
- (d) the State Coroner
- (e) a Ministerial Committee (ie the Victorian Child Death Review Committee)
- (f) a protective intervener under section 64(1) of the *Children and Young Persons Act 1989* (Vic), if the council believes on reasonable grounds that a child is in need of protection
- (g) (g) a day procedure centre, multipurpose service, private hospital, public hospital and denominational hospital within the meaning of section 3(1) of the *Health Services Act 1988* (Vic)
- (h) any person or body in another state or territory that the council determines has functions corresponding to a body referred to above
- (i) any other prescribed person or class of person.

Comment:

Agree. It is important to emphasise that such disclosure should be as determined by the relevant council itself to be in the public interest, and not as directed by any external agency. It is also important to re-iterate the point that in VCCAMM, the application of the process of confidentiality is such that only the Chairman has identifiable knowledge of reported cases as full de-identification is undertaken before presentation to Council. Therefore, a determination of "in the public interest" by VCCAMM would be undertaken by the full council with only the Chairman having identifiable knowledge in any particular case.

- | | | |
|----|--|-----|
| 53 | That the public health Act contain a regulation-making power regarding the mandatory notification of specified events by health service providers to prescribed consultative councils established by the Minister. | 2.2 |
|----|--|-----|

Comment:

Agree but the wording should be altered such that the specified events are as determined by the relevant council. In other words, the relevant council would provide a list of specified adverse events that would prompt mandatory notification by the health service providers. For instance, for VCCAMM, this would involve a list of specific anaesthesia related morbid adverse events as well as mortality. It is also important to address the issue of the source of the report, ie. the actual practitioner(s) involved and/or the health service provider. In addition, this recommendation should take account of the issues in recommendation 52, such that 52 and 53 must both be included. In other words, to have provisions for disclosure without mandatory notification would be inappropriate. It is again also relevant to emphasise the importance of preservation of confidentiality in relation to mandatory notification.

- | | | |
|----|---|-----|
| 54 | That the public health Act provide that a prescribed consultative council established by the Minister may request a health service provider to provide information to the council and the health service provider is authorised to provide that information to the council. This could be a general request or made in a particular case. | 2.2 |
|----|---|-----|

Comment:

Agree but councils should be empowered to obtain such information by an obligation by the health service provider as in recommendation 53. This should be mandatory. The definition of a health service provider should also include diagnostic laboratories, pathology (including blood banks) and medical imaging services as well as hospitals.