

Bacchus Marsh Lessons Forgotten: The False Economy of Cuts to Victorian Patient Safety – Public Release

Detailed report: validation of the SafetyVsBudget analysis, and why Safer Care Victoria and VAHI have not been enabled to improve safety and quality

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Objective and summary

Objective. To test whether recurrent short-term budget cuts in Victoria are undermining patient safety and quality in a way that costs more than they save, to check the earlier SafetyVsBudget analysis against public evidence, and to explain why Safer Care Victoria (SCV) and the Victorian Agency for Health Information (VAHI) have not been able to drive improvement.

In brief. The public record supports a pattern of repeated, short-notice savings demands on hospitals and the Department of Health, followed by partial top-ups ([VHA](#); [ABC](#)). Over the same period, the safety system has visibly fallen behind its own rules ([SCV](#)). Most sentinel events are notified late and reviews run well past their legal timeframes. Public quality accounts have been abandoned, citing resourcing pressure ([SCV](#)), and VAHI has been absorbed into the department ([VAHI](#)). SCV can review and recommend, but it relies on the Secretary, the Minister and health service boards to act ([AMA Victoria](#)).

The earlier analysis is directionally sound on the budget pressure and on the oversight gaps. Its headline dollar figures, however, are model outputs built from assumed inputs (\$261.0m cut, \$406.2m backend cost, \$145.2m net loss; see the validation table in Section 1). Some of its framing is also unsupported: "leaked files prove", "duty of candour penalties" and a template Treasury reference. These figures should not be presented as fact. A more cautious, transparent false-economy case is set out in Section 3.

Key findings

- **Notification is mostly late.** Only 26% of the 217 sentinel events notified in 2024–25 were notified within three business days, and 61% involved a patient death ([SCV Sentinel Events Annual Report 2024–25](#)).
- **Reviews breach their timeframes.** Single-agency reviews averaged 79 business days against a 50-day requirement, and multi-agency reviews averaged 106 against 75 ([SCV](#)).
- **The leaked quarterly data shows the same pattern.** Leaked SCV data showed 45% of investigations overdue statewide in October–December 2024, rising to 80–100% at some large services ([Border Mail](#)).
- **Savings demands are recurrent and short-notice.** They included 2024 model budgets with cuts, demands to break even and no further top-ups ([VHA](#)), and a Monash Health savings ask of about \$200m ([The Age](#)). These demands were followed by top-ups and more than \$1bn in combined hospital deficits ([ABC](#)).
- **Department capacity is shrinking.** Department of Health staffing, excluding SCV, falls from 2,279.4 to 2,029.1 FTE between June 2025 and June 2027, alongside savings targets of \$96.6m and \$108.1m ([DH questionnaire](#)).
- **Public accountability tools have been removed.** Mandatory quality accounts were permanently ceased, citing "ongoing increased resourcing and regulatory pressures" ([SCV](#)). VAHI became a division of the department in 2021 ([VAHI](#)) and is now described as the eHealth division ([SCV Annual Report 2023–24](#)).
- **SCV is structurally dependent.** It is an administrative office whose CEO is responsible to the Secretary ([Statement of Expectations](#)). It "can recommend changes, but only the government can implement" them ([AMA Victoria](#)).

- **Strong powers exist but are rarely visibly used.** The Secretary has powers of direction ([HSA s 42](#)), and the [2026–27 performance framework](#) allows escalation up to board dismissal. Visible use is rare: the clearest example remains the 2015 Djerriwarrh board dismissal ([ABC](#)).
- **Financial levers are used often; safety levers rarely.** In 2024 the Secretary and the Minister wrote to every board requiring services to live within budget, and the department required breakeven budget action plans and cut funded activity ([PAEC](#); [VHA](#)). Safety interventions have been case by case and mostly advisory (delegates and monitors). No public example was found of a s 42 direction or withheld funding because of a safety failure. Formal action on a cluster of deaths or serious morbidity is publicly documented only at Djerriwarrh (2015) and in the Albury Wodonga colonoscopy recall (2023). None was found for a service that was an outlier on a safety indicator (Section 4.3).
- **Resourcing affects safety.** Better nurse staffing is associated with lower mortality ([McHugh et al., Lancet 2021](#)), hospital crowding with higher mortality ([Sprivulis et al., MJA 2006](#)), and Victoria's medical indemnity premium for public hospitals rose 26.4% to \$380.9m in 2025–26 ([VMIA](#)) (Section 3.1).

Method and evidence labels

We extracted 441 claims from the SafetyVsBudget thread export and tested 37 headline claims against primary sources. These sources were SCV and Department of Health publications, parliamentary transcripts and questionnaires, VAGO reports, legislation and regulations, and reputable media reports, including media reports of leaked material already in the public domain. Only publicly available documents were used, including leaked material already reported in the media; no confidential or unpublished documents were used. Every claim in this report carries one of three labels:

- **Confirmed:** stated in a cited primary or reputable source.
- **Inferred:** a reasonable conclusion from cited facts, flagged as such.
- **Modelled / illustrative:** a calculation that relies on stated assumptions and is not a measured outcome.

1. Validation of the SafetyVsBudget analysis

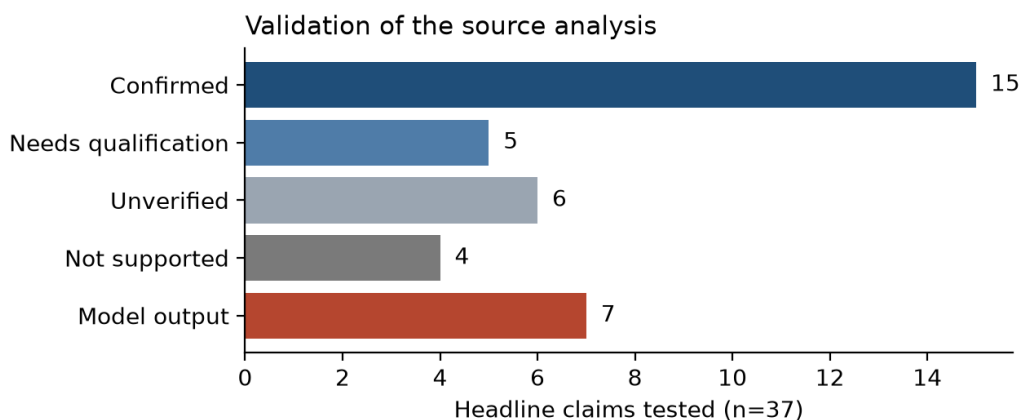


Figure 1. Classification of 37 headline claims in the source analysis and its template briefings. Source: this review.

Overall, the analysis correctly identifies the budget pressures, the sentinel event volumes, the duty of candour timeframes, the end of quality accounts and the 2025 reforms (validation table below). Its weakness is that simulation outputs are presented in the voice of established fact. The \$261.0m / \$406.2m / \$145.2m chain sums a scenario table built on assumed inputs: 5–18% staffing cuts, \$300k "breach penalty" blocks, friction multipliers and risk loadings. The analysis also quotes both \$1.95 and \$1.55 of downstream cost per \$1 saved; the table itself

implies \$1.56. The Treasury example carries a document reference and a "Cabinet in Confidence" label with no basis, and it should not circulate as though it were genuine.

Claim in source analysis	Status	Evidence
Health budget of \$32.3 billion in 2026–27	Confirmed	Minister Shing told PAEC 2026–27 funding exceeded \$32.3bn (PAEC hearing, 21 May 2026).
Labor \$1.5bn pledge: 12 EDs expanded 25%, 1,500 workers, waits cut up to 20%	Confirmed	ABC, 25 Oct 2026 .
Hospital deficits above \$1bn in 2023–24; Monash Health \$321.3m	Confirmed	ABC, 14 Nov 2024 .
Cash on hand: Goulburn Valley –7 days, Austin and Echuca –2, Peninsula 0	Confirmed	ABC, 14 Nov 2024 .
Monash Health asked to find about \$200m in savings	Confirmed	Draft 2024–25 budgets (The Age, 28 Jun 2024).
Budget Action Plans to reach breakeven; no further top-ups	Confirmed	Breakeven by 30 June 2025; small rural services asked for up to 70% of reserves (VHA).
12 Local Health Service Networks	Confirmed	Established 1 July 2025 (Department of Health).
Sentinel events about 190–245 a year	Confirmed	245 (2022–23), 193 (2023–24) (SMH); 217 (2024–25) (SCV).
915+ recommendations from 2024–25 sentinel event reviews	Confirmed	915 recommendations (SCV Sentinel Events Annual Report). The 682 findings figure was not checked.
SAPSE / duty of candour review timeframe of 50 business days	Confirmed	50 business days, 75 when several services involved (SCV).
Hospitals not consistently reporting preventable child deaths to SCV	Confirmed	AMA Victoria position, linked to Category 11 definitions (AMA Victoria).
45% of sentinel event investigations overdue (leaked SCV data)	Confirmed	Oct–Dec 2024 quarter (Border Mail).
Silver review: more than \$4bn in savings	Confirmed	Government response . The "1,000 jobs" figure was not found; 332 executive roles are confirmed.
HCC to be absorbed into SCV; VicHealth into the department	Confirmed	Government response .
Quality accounts no longer produced	Confirmed	Permanently ceased, citing "ongoing increased resourcing and regulatory pressures" (SCV).
"Ongoing 1% savings" by cutting back-of-house quality staff	Needs qualification	Non-clinical savings were sought (The Age) and the department has savings targets (DH questionnaire); a 1% compounding dividend on hospitals was not verified.
HAC framework attaches financial penalties	Needs qualification	A national IHACPA funding adjustment for HACs has applied since July 2018 (IHACPA); "automatic state clawbacks" of a stated value are modelled.
Down-classification of incidents (ISR 1 to ISR 2)	Needs qualification	VAGO found 39 sentinel events classed "minor" or "routine" and about 200,000 blank ISR entries, 2017–18 to 2019–20 (VAGO); the claimed financial motive is unverified.
Grattan: \$1.2bn avoidable spending	Needs qualification	Grattan (2018) estimates about \$1.5bn a year nationally if all hospitals matched the safest 10% (Grattan).
SCV has no enforcement powers	Needs qualification	SCV has no sanction powers, but the Chief Quality and Safety Officer can conduct reviews, require documents and enter premises (Landers).
Risk and quality teams cut by 10–15%	Unverified	No public source found. The Age reported a proposal to cut one in 10 allied health staff (The Age).

Claim in source analysis	Status	Evidence
Under-reporting of child deaths caused by back-office cuts	Unverified	The causal link is asserted, not evidenced; AMA cites definitions, not staffing (AMA Victoria).
About 1,500–2,000 SAPSEs and 250,000+ adverse events a year	Unverified	No public statewide count found; only sentinel events are published (SCV).
\$607.5m savings figure	Unverified	Not located in DH budget estimates or PAEC evidence .
\$7.8bn COVID debt repayment savings	Unverified	Not located in PAEC evidence or the Government response .
Hand hygiene ≥83% and staff flu vaccination ≥92% targets	Unverified	Not checked against the current Statements of Priorities (e.g. Melbourne Health SoP 2025–26).
Duty of candour attaches immediate financial penalties	Not supported	No penalty for public health services was identified (SCV ; Act). Private establishments face penalties for unreported sentinel events (40 penalty units, SR 77/2024).
"Leaked executive files and independent accounting audits prove" the net loss	Not supported	Leaks show budget pressure (The Age) but no audit supports the net figure.
Treasury memo "DTF-HEALTH-ABF-2026-N11", "Cabinet in Confidence"	Not supported	Template document; the reference does not appear in any public source searched, including the department's published framework . Do not circulate as genuine.
Secretary "signs off SCV standards" to make them binding under the Regulations	Not supported	The 2024 Regulations refer to Secretary-determined guidelines and do not mention SCV (SR 77/2024).
\$261.0m cuts → \$406.2m backend costs → \$145.2m net deficit	Model output	Sum of a simulation table built from assumed inputs; no matching figure in DH budget estimates or PAEC evidence .
\$1.55 returned cost per \$1 saved (elsewhere \$1.95)	Model output	Internally inconsistent; $406.2 \div 261.0 = 1.56$; no published source (Grattan and OECD give no such ratio).
VSP exit payouts \$118.4m	Model output	Assumed redundancy volumes; no published VSP cost for health found (Government response).
Automatic HAC deductions \$64.2m	Model output	Assumed incidence and price adjustment; actual adjustment rules in IHACPA .
Extended bed-day costs \$92.8m	Model output	Assumed length-of-stay effect; no Victorian estimate published (Grattan gives national costs only).
VMIA premium loadings \$112.5m	Model output	Assumed actuarial loading; not reported by VMIA or in DH estimates .
LHSN liquidity collapse / insolvency by FY28	Model output	Projection from assumed inputs; contrast actual cash positions in ABC .

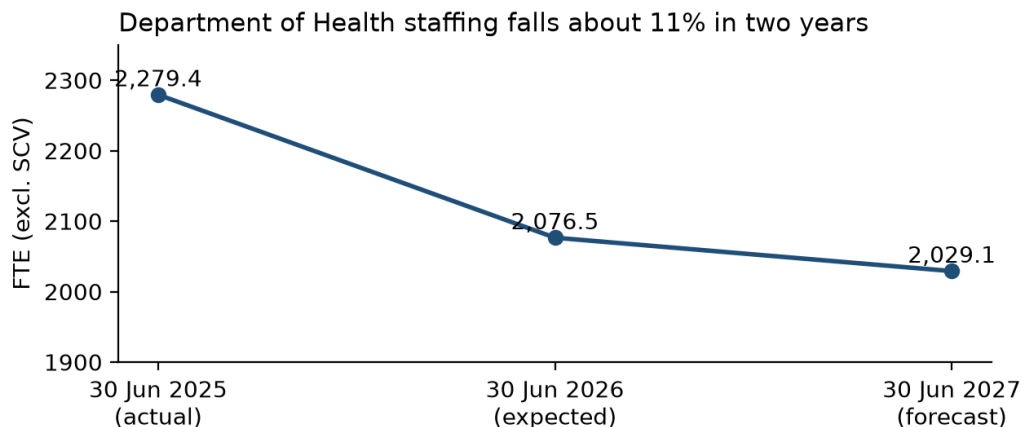
2. A pattern of recurrent short-term cuts

2024: a mid-cycle reset. In March 2024, leaked internal data showed 41 of 75 health services below the 14-day cash benchmark. A Treasury source warned that "running budgets like this doesn't give health services the security to do any forward planning" ([The Age, 19 Mar 2024](#)). In May, health services were told to contain costs, submit Budget Action Plans to break even by 30 June 2025, and expect no further top-ups. Some activity-funded services faced cuts of more than \$10m ([VHA](#)).

A secretly recorded executive meeting discussed bed and ward closures, ending BreastScreen, closing dialysis and special-care nursery capacity, and cutting one in 10 allied health staff. These were proposals, not decisions ([The Age, 28 Jun 2024](#)). Western Health froze recruitment and some theatre lists ([The Age, 26 Jun 2024](#)), and the opposition sought production of the model budgets in Parliament ([Hansard, 14 Aug 2024](#)).

Top-ups and deficits followed. After a backlash, the government put more money in and abandoned some planned mergers. Hospitals still recorded combined deficits above \$1bn, and the Minister said the deficits "did not affect patient care or safety" ([ABC, 14 Nov 2024](#)). The Secretary later described an "unusual two-stage appropriation process" for hospital budgets ([PAEC, Nov 2025](#)).

2025–26: the Silver review. The government response targets more than \$4bn in savings. These include 332 fewer executive roles, \$125m from reshaping VPS5–6 positions and a 10% cut to consultants. It also absorbs the Health Complaints Commissioner into SCV and VicHealth into the department ([Government response](#)). The department expects "no anticipated material impacts on frontline service delivery" from its own savings ([DH questionnaire](#)).



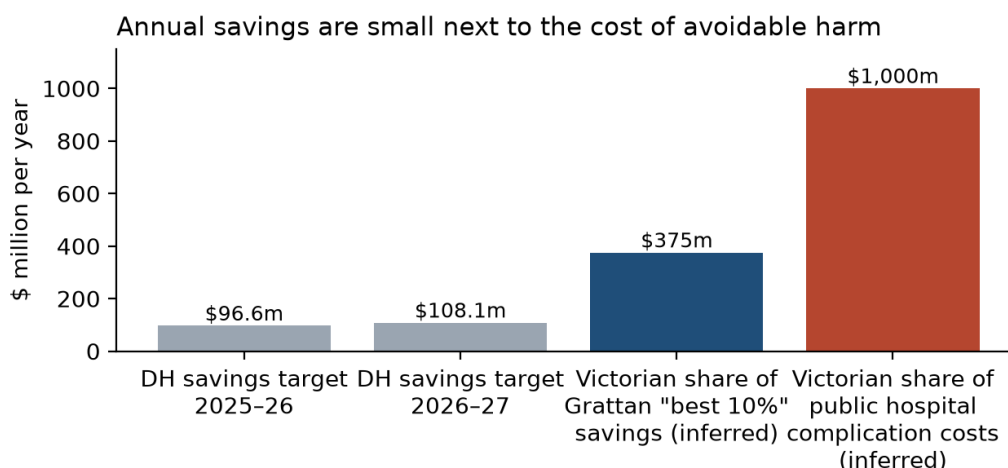
Source: Department of Health, 2026–27 Budget Estimates questionnaire (PAEC)

Figure 2. Department of Health FTE excluding SCV. Source: [DH 2026–27 Budget Estimates questionnaire](#). SCV itself reported 152.3 FTE (June 2024) and 167.43 FTE (June 2025) ([SCV Annual Report 2024–25](#)).

Inferred. The "frontline" definition used to protect services does not count clinical risk, incident review, data analysis or quality staff as frontline: savings are directed to "non-frontline shared services" ([PAEC 2026–27](#)) and are expected to have "no anticipated material impacts on frontline service delivery" ([DH questionnaire](#)). The pressure therefore falls on the functions that detect and learn from harm.

3. Is it a false economy? What the evidence supports

Harm is expensive. The OECD estimates that unsafe care accounts for 12.6% of health expenditure, and preventable harm for 8.7% ([OECD, 2022](#)). Grattan estimates that complications cost Australian public hospitals more than \$4bn a year, and that lifting all hospitals to the safety of the best 10% could save about \$1.5bn a year ([Grattan](#)). Since July 2018, the national funding model has reduced payment for episodes with hospital-acquired complications ([IHACPA](#)), so worse safety also costs hospitals revenue.



Sources: DH 2026-27 Budget Estimates questionnaire; Grattan Institute (2018). Victorian figures assume ~25% population share — illu

Figure 3. Illustrative comparison. Victorian figures assume Victoria carries about one quarter of national costs (an assumption, not a measured value).

Illustrative calculation (modelled)	Value	Basis
Victorian public hospital complication cost	> \$1.0bn a year	25% × Grattan national > \$4bn (Grattan) – assumption
Rise in complication cost that would erase the 2026-27 DH savings target (\$108.1m)	≈ 11%	$\$108.1\text{m} \div \$1.0\text{bn}$
Preventable-harm cost if the OECD 8.7% applied to the \$32.3bn budget	≈ \$2.8bn a year	Crude transfer of an OECD-wide ratio (OECD) – illustrative only
Rise that would erase the same savings on that base	≈ 4%	$\$108.1\text{m} \div \$2.8\text{bn}$
Victorian share of the Grattan "best 10%" opportunity	≈ \$375m a year	25% × \$1.5bn (Grattan) – about 3.5 × the annual DH savings target (DH questionnaire)

Interpretation (inferred). The savings sought from oversight and support functions are small compared with the cost of avoidable harm. Even a modest deterioration in safety would erase them (table above; [Grattan](#); [DH questionnaire](#)), and the forgone opportunity from not improving safety is several times larger. This does not prove that cuts have increased harm. Victoria does not currently publish the data needed to test that ([DH QON](#)), and that gap is itself part of the problem. The appropriate test is a prospective safety impact assessment for each savings measure, not an assertion in either direction.

Other costs are documented but not quantified:

- 20 new emergency beds at the Royal Children's Hospital are expected to stay unopened for lack of operational funding ([The Age, leaked email](#)).
- At Mildura, 150 critical referrals sat untriaged for up to 16 months ([The Age](#)), while a ministerial delegate sat on the board from February 2025 ([Government Gazette](#)).
- Northern Hospital has faced allegations of manipulated ambulance offload data ([HelloCare](#)).
- Ambulance Victoria faced WorkSafe action over psychological risk, with 87% of clinicians at high burnout risk ([The Age](#)).

3.1 Resourcing and safety: the clinical evidence

The false-economy case does not rest only on cost estimates. A consistent body of research links staffing, crowding and capacity to patient outcomes.

Link	Key finding	Source
Nurse staffing ratios	Queensland ratio legislation (27 hospitals): lower odds of death (OR 0.89). Each one fewer patient per nurse: OR 0.93 for death and readmission.	McHugh et al., Lancet 2021
Nurse workload	Each extra patient per nurse: about 7% higher 30-day mortality (US, 168 hospitals; Europe, 300 hospitals).	Aiken 2002 ; Aiken 2014
Nursing hours (Australia)	Mandated nursing hours per patient day in WA reduced mortality, sepsis, pneumonia and pressure injury.	Twigg et al. 2011
ED crowding and access block	WA: overcrowding raised the hazard of death at 7 days (HR 1.3). Occupancy of 100% or more: HR 1.3 against occupancy below 90%. ACT: 10-day mortality RR 1.34.	Sprivulis et al., MJA 2006 ; Richardson, MJA 2006
Delay to admission	England, 7.5 million admissions: 30-day mortality rises from 5 hours after arrival, in a dose-response pattern.	Jones et al., EMJ 2022
Bed occupancy and infection	Systematic review: high occupancy and understaffing are associated with spread of hospital-acquired infection.	Kaier et al. 2012
Doctor fatigue	AMA Victoria survey: 46% of Eastern Health junior doctors reported clinical errors due to workload or understaffing; 42% at the Royal Women's reported fatigue-related errors.	The West Australian
Cost of harm returns as premiums	Public hospital medical indemnity premium of \$380.9m in 2025-26, up 26.4%. Claims frequency rose 47% over four years. Premiums are partly rated on claims experience.	VMIA
Victoria's own policy logic	Parliament legislated minimum nurse and midwife ratios in 2025, on the premise that staffing affects safety.	Hansard, 6 Mar 2025

Interpretation. Most of these studies are observational. However, the consistent findings, dose-response patterns and natural experiments (Queensland, WA) make a causal link plausible. Savings that reduce staffing, open beds or patient flow are therefore likely to carry a safety cost. Part of that cost returns to the health budget through complications, longer stays and indemnity premiums.

4. Why SCV and VAHI have not been enabled

4.1 SCV's legal form compared with the Secretary's powers

Dimension	Safer Care Victoria	Secretary, Department of Health
Legal status	Administrative office under s 11 of the Public Administration Act 2004; the CEO is responsible to the Secretary (Statement of Expectations)	Statutory functions under the Health Services Act 1988, including funding, monitoring and improving quality (VAGO)
Review powers	The CQSO (the SCV CEO) can conduct reviews, require documents and enter premises; services must respond within 10 business days (Landers)	Receives CQSO reports and may publish standard review reports in the public interest (Landers)

Dimension	Safer Care Victoria	Secretary, Department of Health
Directions and sanctions	None. SCV "can recommend changes, but only the government can implement" them (AMA Victoria)	Written directions to hospitals on safety, staffing and information (s 42); 2026–27 escalation tiers up to a board delegate, Ministerial direction, board dismissal and administrator
Data	Receives sentinel event notifications and SDC reports; publishes de-identified annual reports (DH QON)	Owens VAHI/eHealth and the funding data, and decides what is published (VAHI ; DH QON)
Accountability	Annual report to the Minister (Statement of Expectations)	Responsible to the Minister and accountable to Parliament through PAEC (PAEC hearing)

A circulating summary of SCV's role is broadly right that SCV holds no sanctions. It understates the CQSO's statutory review powers, however, and its claim that the Secretary "signs off SCV's standards" under the 2024 Regulations is not supported: those Regulations refer to Secretary-determined guidelines and do not mention SCV ([SR 77/2024](#); [Landers](#)).

4.2 Dependency chain: who must act on SCV's findings

Step	Who acts	Observed weakness
Detect and notify	Health service	Only 26% of sentinel events were notified within 3 business days (SCV); child deaths were not consistently reported (AMA Victoria)
Investigate	Health service review panel	79 and 106 business days against 50 and 75 (SCV); 45% overdue in a leaked quarter (Border Mail)
Disclose to family	Health service (SDC)	Abridged reports may differ from the portal version (SCV statement)
Implement	Board and executive	In 2021, 40–70% of serious-incident recommendations were overdue at some audited services (VAGO via ABC)
Escalate and enforce	Secretary, Hospitals Victoria, Minister	Escalation decisions are not published (performance monitoring framework); no public record of s 42 safety directions was found (HSA s 42)
Learn statewide	SCV, VAHI and the department	Public data is de-identified by service (DH QON); quality accounts have ceased (SCV)

4.3 Willingness of the Secretary and Minister to act

The toolbox is extensive. It includes s 42 directions ([HSA](#)), ministerial delegates to boards ([Gazette, Mildura](#)), and a [2026–27 framework](#) allowing board dismissal, administrators and service suspension. Penalties also exist for private establishments: failure to report a sentinel event carries 40 penalty units under SR 77/2024, and failing to tell the Secretary of a serious patient-safety risk carries up to \$18,492 for a body corporate ([DH fines schedule](#)).

Inferred. Visible use against public health services for safety failures is rare. The defining case is the 2015 Djerriwarrh board dismissal ([ABC](#)); in the same period VAGO found the department "is not giving sufficient priority to patient safety" ([SBS](#)). Five years later, VAGO found only "some" improvement and a "limited" ability to assure safety ([Healthcare IT News](#)). Escalation actions taken against public services on safety grounds are not reported publicly, which makes willingness to act hard to evaluate. Meanwhile, the stated policy is that deficits "do not impact frontline care" ([PAEC 2026–27](#)).

Verified examples of powers being used. A review of public records shows two very different patterns. Financial directions were issued in writing to every service, with deadlines and approval steps. Safety interventions were reactive, usually followed media or review findings, and stopped short of removing boards except at Djerriwarrh.

Date	Financial or budget action	Who	Source
May 2024	Letter to boards: services "will be required to operate within their prescribed budgets for the remainder of 2023–24 and ongoing". A Minister's letter to boards on 8 May covered 2023–24 cash.	Secretary; Minister	PAEC hearing, Nov 2024
June 2024	Budget action plans requiring breakeven by 30 June 2025, needing department approval. Activity cuts left some services more than \$10m worse off. Small rural services were asked to contribute up to 70% of their cash reserves.	Department	VHA
June 2024	The department directed hospitals to find savings. The AMA reported recruitment freezes, fewer elective operations and frozen capital works.	Department	The Age ; ABC
19 Aug 2024	Hospitals Victoria began operating, with "strategic oversight of hospital finances" and a "more assertive role in the financial sustainability of the system". Quality is led by "other parts of the department".	Department	DH Annual Report 2024–25

Date	Service	Safety or governance action	Source
Apr–Oct 2015	Djerriwarrh Health Services	A delegate was appointed after a perinatal death cluster (7 of 11 deaths likely avoidable). The board was later dismissed and an administrator appointed. VAGO found that "appropriate and timely action could have averted some of the serious consequences".	VAGO 2016 ; ABC
Mar 2021	Yarram and District Health Service	Board delegate appointed for 12 months under s 40C(1). The Gazette states no reason.	Gazette
Dec 2022	Albury Wodonga Health	Delegate appointed for three months, after an SCV clinical governance review completed in September 2022. The Gazette states no reason.	Gazette ; AWH
Feb 2025	Mildura Base Public Hospital	Board delegate appointed under s 40C(1).	Gazette
June 2025	Northern Health	Alleged altering of ambulance offload times. The department investigated with the hospital, and calls for an external investigation were declined.	HelloCare
July 2026	cohealth	A review recommended dismissing the board (Herald Sun). Instead, the government appointed a board monitor for 12 months.	Premier

The Secretary has used s 42 directions, for example to require influenza vaccination of health care workers in 2022 ([Secretary directions](#)). However, no public example was found of a s 42 direction, or of funding withheld, because of a quality or safety failure. The 2024–25 framework treats "an actual or forecast deficit" and "overall safety and quality ... requiring systemic improvement" as equal triggers for performance support ([PMF 2024–25](#)). In practice, the visible response has been far stronger on the financial side. VAGO also found that the department did not monitor health services' compliance with the Victorian Clinical Governance Framework ([VAGO 2021](#)).

Actions on clusters of harm and on indicators. The public record shows formal action in response to a cluster of deaths or serious morbidity in two cases only:

- **Djerriwarrh (perinatal mortality cluster).** CCOPMM alerted the department to a cluster of perinatal deaths in March 2015. A board delegate was appointed in April 2015, an external investigation found 7 of 11 deaths likely avoidable, and the board was dismissed in October 2015 ([VAGO 2016](#)).
- **Albury Wodonga (serious morbidity linked to one surgeon).** In January 2023, Safer Care Victoria and the department commissioned a recall of about 2,000 colonoscopy patients ([SCV recall report](#)). Seven patients were later diagnosed with colorectal cancer ([ABC](#)). This was a clinician-level recall, not an intervention in the health service on performance grounds.

No public evidence was found of formal action taken because a service was an outlier on a mortality, morbidity, complication or other safety indicator. That means no published tier change, delegate appointment, s 42 direction, service suspension or funding consequence. The only systematic financial consequence linked to safety indicators is the national pricing adjustment for hospital-acquired complications ([IHACPA](#)). That adjustment is automatic and is not a Victorian intervention decision. At Mildura, harm from untriaged referrals surfaced while a delegate was already on the board, and no further public intervention was found ([The Age](#)). Statewide, SCV reported that errors contributed to 167 deaths in one year ([SMH](#)), with no reported service-level enforcement. Interventions may have occurred without being published, which is itself a transparency gap.

4.4 Health services meeting their obligations

- **Timeliness:** 26% of notifications were on time, and review times exceeded the requirement by 58% (single-agency) and 41% (multi-agency) ([SCV](#)).
- **Quality of reviews:** the 2021 VAGO audit found only 2 of 16 serious-incident action plans measured whether actions prevented recurrence, and services attributed delays to staff capacity ([VAGO, June 2021](#); [ABC](#)).
- **Inconsistent standards:** the [2026–27 performance framework](#) measures sentinel event reports within 30 business days, while SCV's guide and annual report use 50 business days ([SCV](#)). Leaked-data reporting also cited 30 days ([Border Mail](#)).
- **Resource burden:** health services describe duty of candour reviews as costing "thousands and thousands of dollars worth of staff hours", with rural services struggling to staff review panels ([Frontiers in Health Services, 2025](#)).

4.5 Quality accounts no longer produced

Quality accounts were introduced in 2016 and paused during COVID-19. A review then recommended that SCV permanently cease the mandatory requirement "due to ongoing increased resourcing and regulatory pressures", leaving publication to each service's discretion ([SCV](#)). **Inferred:** this removed the only routine, service-level public narrative on safety, at the same time as sentinel event reports are de-identified by service.

4.6 SCV governance reviews

SCV completed 12 in-depth reviews with health services between 2020 and 2023 ([SCV](#)). Albury Wodonga Health published its review (54 recommendations) and its progress, which showed 23% of actions complete at July 2023 ([AWH](#)). Other SCV clinical governance reviews of individual services have not been published. In 2024–25, SCV was monitoring implementation of 7 reviews across 10 services ([SCV Annual Report](#)). There is no consistent public rule on publication, and no public tracker of implementation.

4.7 VAHI

VAHI was created in 2017 alongside SCV and became a department division on 1 February 2021 ([VAGO](#); [VAHI](#)). By 2023–24, SCV described its partner as "the eHealth division, formerly VAHI" ([SCV](#)). VAHI still publishes performance data, which, for example, shows more than half of ED patients waiting over four hours ([The Age](#)). It no longer operates as an independent information agency. eHealth's former Deputy Secretary reports a "40%

reduction in FTE” ([L. Emerson, LinkedIn](#)), following a Deloitte affordability review of eHealth ([DH questionnaire to PAEC](#)). In May 2024 the Data Request Hub, which handled researcher and clinician data requests, accepted all requests subject to resources and cost recovery ([archived hub page, May 2024](#)). By January 2025 it could no longer process new requests from anyone outside the department ([archived hub page, January 2025](#)).

4.8 Legislation

- The Health Legislation Amendment (Quality and Safety) Act 2022 ([Act](#)) introduced the statutory duty of candour, protected SAPSE reviews, the CQSO and a duty of quality and safety, effective 30 November 2022 ([SCV](#); [Landers](#)).
- **Gap:** no penalty for non-compliance with the duty of candour by public services was identified. Compliance is reported quarterly through HealthCollect, but the results are not published by service ([SCV](#)).
- **Gap:** SCV has no statutory independence. Targeting Zero led to SCV and VAHI being created administratively ([Department of Health](#)), and absorbing the HCC into SCV will require legislation ([SCV Annual Plan 2026–27](#)).
- **Private sector:** the 2024 Regulations strengthen protocols and allow Secretary directions from 28 February 2026, with penalties for non-reporting ([SR 77/2024](#)).

4.9 Other factors

- **Absorption without resourcing:** SCV is taking on the HCC, a statewide formulary and statewide clinical governance ([SCV Annual Plan 2026–27](#)) while "reshaping its organisational structure" ([SCV Annual Plan 2025–26](#)).
- **De-identified reporting:** public sentinel event reports do not name services "due to patient privacy reasons" ([DH QON](#)).
- **Data integrity:** the 2021 audit found no comprehensive VHIMS data dictionary, which prevents statewide comparison ([Healthcare IT News](#)).
- **Election timing:** both major parties have made large health pledges ([ABC](#)), and caretaker conventions now apply to public bodies ([DPC](#)). Commitments on safety infrastructure should be sought from both sides.

5. Leaked and public-domain documents

Only material already reported in the media is used here; each item is linked to the report that published it. No confidential document was sought.

Document (as reported)	What it shows	Source
Internal hospital cash data, March 2024	41 of 75 services below the 14-day cash benchmark	The Age
2024–25 model budgets / whistleblowers	Short-notice cuts; three weeks to respond	ABC ; VHA
Recorded hospital executives meeting, June 2024	Proposed closures and cuts; Monash about \$200m	The Age
SCV quarterly sentinel event data, Oct–Dec 2024	49 events; 45% of investigations overdue	Border Mail
WorkSafe and Ambulance Victoria psychological risk reports	87% of clinicians at high burnout risk	The Age
RCH ED director email, September 2026	20 new beds unfunded to staff	The Age

6. Recommendations

1. **Legislate SCV as an independent statutory authority** with its own appropriation and with a duty to report to Parliament annually on whether its recommendations have been implemented.
2. **Require a published safety impact assessment** before any savings measure affects quality, risk, incident review, data or clinical governance roles, and treat those roles as protected safety-critical functions.
3. **Publish service-level timeliness each quarter**, covering sentinel event notification, review completion and duty of candour compliance, and align the 30- and 50-day standards.
4. **Reinstate a lean, standardised public quality account**, partly generated automatically from existing data to keep the burden low.
5. **Publish SCV and CQSO review reports by default**, with abridged privacy-safe versions where necessary, together with the department's response and an implementation tracker.
6. **Report escalation decisions**: publish the tier of each service under the performance framework and any s 42 directions issued on safety grounds.
7. **Publish the reasons for board delegate and monitor appointments** in the Gazette notice, with a public summary of outcomes when each appointment ends.
8. **Restore an independent health information function** with guaranteed researcher and public data access.
9. **Fund health services on multi-year envelopes** rather than mid-year resets followed by top-ups, so that safety capability is not the default adjustment line.
10. **Seek commitments from both parties** on these measures before the 2026 election.

7. Limitations

This review relies only on public documents and media reporting. It cannot measure whether specific cuts caused specific harms, because service-level safety and staffing data are not published. Some sources are paywalled media reports, summarised here as reported. Calculations labelled illustrative depend on stated assumptions. Secretary letters, performance improvement plans and tier decisions are not published, so the count of interventions in Section 4.3 may be incomplete.