

Restoring Victoria's Patient Safety Capability (Public Edition)

Briefing for the RACGP and AMA Victoria Health Debate, Saturday 31 October 2026

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Background

The issue in brief

After the avoidable baby deaths at Bacchus Marsh, Victoria commissioned a review Targeting Zero in 2016. It responded by establishing new safety and quality agencies and systems for detecting, investigating and responding to patient harm. Over the last 3 years, successive budget cuts and department of health restructures, under multiple governments, are now dismantling that system and reintroducing the risks Targeting Zero set out to address. Safety and quality teams are part of clinical care, not back office. Cutting them is a false economy, because undetected harm costs more than the people and systems who can monitor and prevent it.

Timeline of changes

2015: national safety commission review of the avoidable baby deaths at Bacchus Marsh ([ACSOHC](#)²). **October 2016:** [Targeting Zero](#)¹ review of hospital safety and quality assurance. **January 2017:** Safer Care Victoria established ([SCV](#)²⁴). **June 2017:** VAHI established ([Riordan](#)³²). **June 2021:** Auditor-General finds key Targeting Zero reforms not enacted ([VAGO](#)³). **2024:** health service boards directed to live within budget ([PAEC](#)⁸). **By January 2025:** Data Request Hub, open to all requests in May 2024, closed to new requests from outside the department, including health services ([VAHI](#)²⁵; [VAHI](#)²⁶). **December 2025:** VPS review final report and government response ([Silver review](#)¹⁶; [Victorian Government](#)¹⁷). **February 2026:** 25 department executive roles removed ([PAEC](#)¹⁵). **By October 2026:** chief clinical officers listed as Department of Health roles ([DH](#)¹²). **To June 2027:** further savings scheduled.

What I have seen as a senior clinician

I am a specialist obstetrician, gynaecologist and urogynaecologist and an associate professor at the University of Melbourne, with more than two decades of practice in Victorian hospitals. I have held senior clinical governance and clinical informatics roles across Victorian public health services, and have been a senior clinical contributor to state and federal safety and quality initiatives. I am a founder of the Commonwealth-funded Australasian Pelvic Floor Procedure Registry and Chair of the International Urogynecological Association (IUGA) Special Interest Group on Obstetric Pelvic Floor & Anal Sphincter Injuries. In those roles I have seen serious adverse events unrecognised or unreported, mortality and morbidity reviews downgraded, not investigated or under-investigated. Often there were no minutes, no circulated recommendations and no tracked actions. Escalation, including to health service leadership, has not led to action, largely because of insufficient resourcing and inadequate clinical governance processes, or the way those processes are applied. The types of failure I have seen directly in the system include:

- **Severe maternal morbidity the system does not see.** Most severe acute maternal morbidity (SAMM) is managed without intensive care admission ([Duke et al.](#)⁵), so the current notifications largely miss it. A Safer Care Victoria SAMM capture, analysis and reporting initiative was paused in September 2024 “due to resourcing constraints”, and its data requests were put on hold in the Data Request Hub, which has since closed to requests from outside the department. This is how severe maternal morbidity goes uncounted, and its lessons go unlearned.
- **Unrecognised risk leading to harm:** Pregnant women with unrecognised serious medical conditions, who then become critically unwell in units without critical care capability requiring emergency transfer to tertiary intensive care. When the harm surfaces at the receiving hospital, the referring hospital's care is often never brought under review.
- **Detection and investigation of serious harm downgraded due to resourcing at central and hospital level.** Serious birth injuries and other complications reported at the highest severity rating, then downgraded for resourcing reasons and left unreviewed for months. This is the same misclassification the national safety commission found at Bacchus Marsh.
- **Reviews with no visible outcome.** Requests from treating clinicians for the findings of patient death and other serious incident reviews go unanswered. Sentinel events and serious adverse events having no transparent review processes, recommendations or tracked actions.

What the reviews after Bacchus Marsh found

- The [national safety commission \(ACSOHC\)](#)² found that at least seven Bacchus Marsh cases warranted the highest severity rating, but only one was reported at that level. The department's capacity “does not appear to be robust”. Its performance meetings “concerned themselves primarily with budget and activity data”, and the health service received a “perfect score”.
- In 2016, the [Targeting Zero](#)¹ report found that “budget cuts and staffing caps have gutted many departmental functions” and that “departmental oversight is weak across the system”. It described monitoring “not designed to detect catastrophic failings”, a system that was “obviously inadequate”, and a “dysfunctional incident reporting system” in which harm was “unreported, misclassified or lost”. It found the department was “failing to fulfil its key role as system manager” and that “patients suffer the consequences”.
- **The government of the day accepted the failure.** The Health Minister said “there has been a complete failure to drive cultural reform and leadership in this space. This is unacceptable” ([Targeting Zero](#)¹). The government's response, [Better. Safer Care](#)³¹, promised that “All Victorians should have confidence in our health system and expect that where avoidable harm does occur, lessons are learnt and every effort is made to ensure it never happens again”, and established Safer Care Victoria and VAHI to address the department's deficiencies.
- Five years later, the [Auditor-General \(VAGO\)](#)³ found that the department still “cannot regularly and easily detect trends and risks across the system”. It also found that Victoria “still does not have a fully functioning statewide incident management system”, with about 200,000 blank severity ratings and 39 sentinel events classed as “Minor” or “Routine”.
- **Coroners have called for the same capability.** In 2023 the State Coroner found that Annie O'Brien, 37, died in 2017 of septicaemia in pregnancy after attending a private hospital emergency department ([ABC News](#)²⁹). Neither hospital notified Safer Care Victoria of her death ([ABC News](#)³⁰). The coroner recommended that the department mandate root-cause analysis of sentinel events and serious adverse patient safety events in all public and private health facilities, and that Safer Care Victoria add sepsis in pregnancy to its sepsis guideline and develop handover and transfer tools. Acting on these recommendations depends on the review and improvement capability now being cut.

What is happening now

Victorian Safety and Quality

- **Safer Care Victoria and VAHI were the agencies created from Targeting Zero, and neither is independent.** Following Targeting Zero, in 2017 the government created Safer Care Victoria and the Victorian Agency for Health Information (VAHI) as administrative offices of the department. VAHI was set up to “collect, analyse and share information” on health service performance, “independently of the Department” ([Riordan](#)³²). From 1 February 2021 VAHI stopped being an administrative office and became a business unit within the department ([VAGO](#)³), and it now sits within

eHealth ([former Deputy Secretary](#)¹⁴). Safer Care Victoria remains an administrative office of the department ([SCV Annual Report](#)¹³). Targeting Zero had recommended an analytics and reporting body “independent from the department with its own statutory base” ([Targeting Zero](#)¹).

- **Undetected and un/under-investigated care costs money and is an opportunity cost**
 - **Harm goes unreported.** Severe maternal morbidity affects 3.42% of births ([Duke et al.](#)⁵), yet only 257 cases were notified in 2023 ([CCOPMM](#)⁶), so up to 90% may be missed. Mandatory quality accounts have been permanently ceased ([SCV](#)⁷).
 - **Harm is found late.** Of 217 sentinel events in 2024–25, only 26% were notified on time. Reviews averaged 79 and 106 business days, against standards of 50 and 75 ([SCV](#)⁴).
- **Unsafe care costs money.** Unsafe care consumes about 12.6% of health spending ([OECD](#)²¹). Hospital complications cost Australian public hospitals more than \$4 billion a year ([Grattan](#)²²). The public hospital medical indemnity premium rose 26.4% to \$380.9 million, as claims frequency rose 47% ([VMA](#)²³). Targeting Zero warned against relying on “external consultancies when the work would have been done better, and more cost-effectively” in-house.
- **Vital epidemiological and health data analytics expertise is being stripped out.** eHealth which now includes the state’s health information agency (formerly VAHI), reports a “40% reduction in FTE” ([former Deputy Secretary](#)¹⁴), following a Deloitte affordability review ([PAEC](#)¹⁵). Twenty-five executive roles were removed in February 2026 ([PAEC](#)¹⁵). Senior VPS5 and VPS6 roles, where specialist analysts and epidemiologists sit, are being reduced, and targeted separation packages are permitted ([VPS review](#)¹⁶; [government response](#)¹⁷). In May 2024 the Data Request Hub accepted all requests for hospital, mental health and alcohol and drug data, including from agencies outside the department, subject to resources and cost recovery ([archived hub page](#)²⁵). By January 2025 it could no longer process new requests from anyone outside the department, could not give health services their own underlying performance data or support service planning, and referred researchers to national bodies and data linkage; Safer Care Victoria staff were redirected to an eHealth business partner ([later archived page](#)²⁶). That notice remains in place ([VAHI](#)¹⁹). Department of Health IT services are transitioning to the shared government services provider Cenitex ([job advertisement](#)²⁰), with uncertain impact on existing eHealth capability.

Restructures, budget cuts and Department of Health implementation of Silver review-initiated recommendations

- **Budgets still come first.** In 2024 every health service board was directed to live within budget ([PAEC](#)⁸). There is no public record of the Secretary or the department enforcing safety and quality in the same way, for example through a [section 42](#)⁹ direction or a funding consequence. The VPS review was asked to “right-size program expenditure, consolidate public entities, and return the VPS towards its pre-pandemic share of employment”, including cutting the share of VPS5 and VPS6 roles to save \$125 million ([VPS review](#)¹⁶). The government promised that “frontline services will not be affected” and that it would “seek to retain expertise in the public service” ([government response](#)¹⁸). Yet it is safety and quality expertise that is being lost.
- **Cuts were not assessed for their effect on services.** The [Auditor-General](#)²⁸ found the department’s restructure proposal did not explicitly define its frontline roles. The department assumed frontline services would not be affected, did not consider impact assessments necessary, and did not test this through service-level monitoring.
- **None of Safer Care Victoria’s proposals were accepted.** Staff lodged 333 alternative proposals, and 58% were accepted or partially accepted, but none of the five for Safer Care Victoria was accepted (DH outcomes²⁷). They sought to consolidate intelligence and risk monitoring, add a risk-monitoring project officer, reinstate the Senior Consumer Engagement Officer, move a project officer into eHealth data engineering and reporting, and reinstate a role lost to severance packages. Four were rejected for financial reasons, as “contrary to the intentions of the management proposal, which is to deliver an operating model within the financial parameters set by government”; the fifth was rejected as fragmenting an integrated function. A stand-alone Victorian Population Health Survey team led by a senior epidemiologist was not accepted, and a Senior Epidemiologist role could not be reinstated “without impacting savings”.
- **Clinical leadership has been moved out of Safer Care Victoria into the Department of Health (see Table 1)**
 - Targeting Zero recommended that the Chief Medical Officer, Chief Nurse and Chief Allied Health Officer “should report to the CEO” of the new safety body ([Targeting Zero, p. 35](#)¹). As a result of the Silver review-initiated restructure, the chiefs have now “transitioned into the Department of Health” ([SCV](#)¹¹), and their published roles have shifted from system safety to their professions. Before: [SCV Annual Report 2024–25](#)¹³. After: [Department of Health senior officers](#)¹².

Table 1: Chief Clinical Officer roles

Role	Before restructure (SCV, 2024–25)	After restructure (Department of Health, Oct 2026)	Practical impact on awareness, advice, investigation and authority (author’s assessment)
Where the chiefs sit	Safer Care Victoria, led by the Chief Mental Health Nurse as Executive Director, Clinical and Professional Leadership Unit	“Transitioned into the Department of Health” (SCV ¹¹)	Separated from Safer Care Victoria’s sentinel event, incident intelligence and review teams. The chiefs no longer see emerging risks as they arrive, and must advise or act through departmental workforce lines
Chiefs as a group	“play a critical role in ensuring the safety of Victoria’s health system”; “response on a range of complex quality and safety... matters”	No collective safety role stated	No standing clinical forum to respond jointly to complex, cross-disciplinary safety issues
Chief Mental Health Nurse	“oversees and supports the work of Victoria’s chief clinical officers”	“represents the profession at all levels of government”; “promotes recognition of the mental health nursing profession”	The unit that coordinated the chiefs’ safety work is gone. Mental health safety concerns now depend on referral back to Safer Care Victoria
Chief Nurse and Midwifery Officer	“provides professional advice and direction to both government and the sector”	Split. Chief Nurse: no stated responsibilities. Chief Midwifery Officer (unnamed): “ensures the midwifery profession has a voice”	The largest clinical workforce and maternity care lose a single safety lead. Neither new role has a stated part in maternity incident review or SAMM
Chief Allied Health Officer	Appointed “at SCV”; “driven by a passion for system-wide improvement”	“leadership and strategic direction for Victoria’s allied health workforce”	A workforce strategy role, with no stated link to allied health incidents, reviews or improvement
Chief Paramedic Officer	“targeted healthcare reform to ensure we get the right care to the right person at the right time”	“strategic clinical, operational and policy advice to the Victorian Government”	Policy advice to government rather than clinical oversight of ambulance and emergency care incidents
Chief Medical Officer	Works with hospitals so they “have the right systems, governance and processes” for “high-quality, safe care”	Unchanged wording, still referring to Safer Care Victoria, though the role no longer sits there	Safety wording remains, but outside Safer Care Victoria the role has no direct line into its reviews, intelligence or the Chief Quality and Safety Officer’s statutory powers
Executive Clinical Director of Surgery	Listed as an SCV senior officer (archived page ¹⁰)	Not listed	Surgical clinical leadership is lost from safety review and improvement work

Questions for the debate

1. Acknowledging the problem

- 1.1 Do you accept that, since the initial improvements resulting from Targeting Zero, successive restructures and budget cuts have weakened Victoria's capacity to detect, investigate and respond to patient harm, and are reintroducing the patient risks identified in the Targeting Zero report?
- 1.2 Role of safety and quality teams in clinical care: Will you recognise that safety and quality, clinical governance, incident review and clinical analytics staff are part of clinical care teams, not "back office", in savings targets, VPS review implementation and "live within budget" directions to boards?
- 1.3 Do you accept that further cuts to these functions risk repeating the failures found at Bacchus Marsh?
- 1.4 An independent review of the implementation and long-term outcomes of Targeting Zero, incorporating the VAGO findings and taking account of the current health and fiscal environment and the VPS and health system structure, may be of benefit in identifying the challenges and opportunities to improve safety and quality for the community through improved detection, investigation and response capability across the health system.
Would you initiate and/or support the commissioning and unconditional release of such a review?

2. Key issues and priorities

- 2.1 Which of the identified issues would you prioritise, and what will be in your first budget?
- 2.2 Equal priority for safety: The national safety commission found departmental meetings "concerned themselves primarily with budget and activity data" (ACSQHC). Targeting Zero warned that a focus on financial targets can drive "critical understaffing and a neglect of safety and quality", and told the department to "cease to aggregate quality and safety with the financial and access dimensions of performance" (Targeting Zero, p. 84¹). The Auditor-General found that the separate safety and quality performance framework Targeting Zero called for had not been enacted (VAGO³). If health service boards' statements of priorities and the Department of Health's own actions do not prioritise safety and quality, health services are unlikely to do so either.
How will you ensure safety and quality outcomes are given similar prioritisation to meeting financial and activity-based targets in the next term of government?
- 2.3 Will you exempt statewide and health service safety and quality functions from further savings targets and separation packages?

3. Restoring, maintaining and increasing core capability

- 3.1 **Professional leadership:** Will you return the Chief Medical, Nursing and Midwifery, Allied Health, Mental Health Nursing and Paramedic officers to Safer Care Victoria, reporting to its CEO with direct safety oversight roles, as Targeting Zero recommended?
- 3.2 **Data analytics**
 - 3.2.1 Will you restore resources for the Data Request Hub to service government agencies external to the Department of Health, health services and researchers?
 - 3.2.2 Will you review the requirements of existing DH eHealth, shared government IT support providers and consultancies, to meet health system safety and quality monitoring and analytical requirements?
 - 3.2.3 Will you review the impact of the restructure on VPS epidemiological and health data analytical expertise within the Department of Health and the safety and quality agencies, and where recommended, restore resources to support in-house epidemiological and analytical expertise within safety and quality agencies?
- 3.3 **Maternal morbidity surveillance:** Will you fund linked, statewide surveillance of severe maternal morbidity, so that safety and quality teams and health services are resourced to learn from serious harm and improve care?
- 3.4 **Independence:** Will you legislate Safer Care Victoria and the health information agency as statutory bodies independent of the department, with protected budgets and the power to publish?
- 3.5 **Support for health services:** Will you ensure evidence-based funding for health service safety and quality teams, and reinstate public quality reporting, so that harm is found and acted on locally?

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