**Health and Disability Services (Safety) Act 2001:**

**Section 31(5) Reporting Guidelines**

**Scope:**

These Guidelines apply to all New Zealand health and disability service providers who have obligations under section 31 of the Health and Disability Services (Safety) Act 2001 (HDSS Act).

**Disclaimer**

It is important to note that these Guidelines are to give general guidance to those reporting under section 31(5) to know what type of events to report. These Guidelines do not cover every reportable event under section 31(5) and those reporting must use their discretion when assessing what must be reported. These Guidelines do not cover every type of reportable event. The Ministry does not take reliance on these Guidelines to be a defence for any lack of reporting.

Safety of Reporting:

* consumers and staff must be empowered to report events without fear of retribution;
* events that are reported must be investigated with a focus on determining the underlying system failures and not blaming or punishing individuals;
* providers must ensure a just culture prevails so individuals are not held accountable for system failures;
* incidents that involve a criminal act or substance abuse by the health practitioner, a deliberate unsafe act, or deliberate consumer harm will be managed in a separate process and may involve the relevant regulatory authorities.

**Background**

The HDSS Act section 31(5) requires that:

“*A person certified to provide health care services of any kind must promptly give the Director-General written notice of -*

*(a) any incident or situation (for example, a fire, flood, or failure of equipment or facilities) that has put at risk, may have put at risk, puts at risk, or may be putting at risk the health or safety of people for whom the person was or is providing the services; and*

*(b) any investigation commenced by a constable into any aspect of the services, their provision, or any premises in which they were provided; and*

*(c) any death of a person to whom the person was providing the services, or occurring in any premises in which they were provided, that is required to be reported to a coroner under the* *[Coroners Act 2006](http://www.legislation.govt.nz/act/public/2001/0093/latest/link.aspx?search=ta_act_H_ac%40ainf%40anif_an%40bn%40rn_25_a&p=2&id=DLM377056).”*

**Guidelines for Reporting**

Common themes for reporting under these categories are:

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|  **Section 31(5) :** | **Examples:****Note: These do not cover every reportable event under section 31(5), and those reporting must use their discretion when assessing what must be reported.** |
| Subsection (a) Health & Safety | * Evacuations
* Fire
* Natural Disaster
* Flood
* Equipment failure which puts at risk;
* health or safety of residents
* communication systems
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| Subsection (b) Police investigation commenced by a constable | * Intruders/trespassers/harassment
* Assault
* Missing medication
* Theft
* Missing residents
* Suspicious Deaths
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| Subsection (c) Coroner’s report | * Sudden Deaths
* Death certificate unsigned
* Death of a resident who is under a Compulsory Treatment Order (Mental Health)
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