



Appendix 4. WA health system Severity Assessment Codes (SAC) – Summary

Excerpt from the [Clinical Incident Management Guideline 2024 \(effective January 2025\)](#)

	SAC 1	SAC 2	SAC 3
Actual/potential consequence to patient	Physical/psychological serious harm or death (including near miss); that has or could have been attributed to health care provision (or lack thereof) rather than the patient’s underlying condition or illness.	Physical/psychological Moderate harm (including near miss) that has or could have been attributed to health care provision (or lack thereof) rather than the patient’s underlying condition or illness.	Physical/psychological Minor or no harm (including near miss) that has or could have been attributed to health care provision (or lack thereof) rather than the patient’s underlying condition or illness.
Type of event/incident	<p>SAC 1 clinical incidents include (but not limited to):</p> <ul style="list-style-type: none"> National Sentinel Event Categories Any other clinical incident which results in serious harm (physical or psychological) or death of a patient Escalation of care to a higher level of care within the inpatient setting Increased length of stay greater than 7 days Near miss that could have resulted in serious harm or death. <p>National Sentinel Event Categories</p> <ol style="list-style-type: none"> Surgery or other invasive procedure performed on the wrong site resulting in serious harm or death. Surgery or other invasive procedure performed on the wrong patient resulting in serious harm or death. Wrong surgical or other invasive procedure performed on a patient resulting in serious harm or death Unintended retention of a foreign object in a patient after surgery or other invasive procedure resulting in serious harm or death. Haemolytic blood transfusion reaction resulting in serious harm or death. Suspected suicide of a patient in an acute psychiatric unit or acute psychiatric ward. Medication error resulting in serious harm or death Use of physical or mechanical restraint resulting in serious harm or death. Discharge or release of an infant or child to an unauthorised person. Use of an incorrectly positioned oro-or naso-gastric tube resulting in serious harm or death. 	<p>SAC 2 clinical incidents include, but are not limited to the following:</p> <ul style="list-style-type: none"> Increased length of stay (More than 72 hours to 7 days) Additional investigations performed Referral to another clinician Surgical intervention Medical intervention Increased frequency of mental health clinician review Near miss that could have resulted in moderate harm. 	<p>SAC 3 clinical incidents include, but are not limited to the following:</p> <ul style="list-style-type: none"> No harm Only first aid treatment required Minor harm resulting in increased length of stay of up to 72 hours Increased frequency of mental health clinician review Near miss that could have resulted in minor harm.
Actions – During Notification, Analysis, and Investigation	<ul style="list-style-type: none"> Implement any preliminary actions to mitigate further risk of harm to the patient, staff, or others Document summary, essential information, actions in patient’s healthcare records notes by end of notifier’s workday or as soon as practicable (within 48 hours). Submit information via CIMS or equivalent as soon as possible (within 48 hours). Inform relevant manager/appropriate executive within 24 hours, follow any local processes. Within 3 working days review and confirm SAC rating. After confirmation of the SAC rating into the CIMS, complete the SCIN Complete a SAC 1 notification to PSSU via CIMS within 7 working days. 	<ul style="list-style-type: none"> Implement any preliminary actions to mitigate further risk of harm to the patient, staff, or others Document summary, essential information, actions in patient’s medical notes by end of notifier’s workday. Submit information via CIMS or equivalent by end of notifier’s workday. 	<ul style="list-style-type: none"> Implement any preliminary actions to mitigate further risk of harm to the patient, staff, or others Document summary, essential information, actions in patient’s medical notes by end of notifier’s

	<ul style="list-style-type: none"> Implement a higher-level open disclosure response for incidents causing serious harm or death, or a lower-level response for near miss incidents**. Notify the local WHS team if a WHS hazard is suspected or identified as a causal or contributing factor to the incident. Undertake SAC 1 investigation by comprehensive analysis or other appropriate methodology. 	<ul style="list-style-type: none"> Notify the local WHS team if a WHS hazard is suspected or identified as a causal or contributing factor to the incident. Within 3 working days, confirm SAC rating. After confirmation of the SAC rating into the CIMS, commence initial investigation to identify human errors and system failures. Investigate at a local level using an appropriate methodology. Implement an appropriate level of open disclosure**. 	<p>workday or as soon as practicable (within 48 hours).</p> <ul style="list-style-type: none"> Submit information via CIMS or equivalent by end of notifier's workday or as soon as practicable (within 48 hours). Notify the local WHS team if a WHS hazard is suspected or identified as a causal or contributing factor to the incident. Within 3 working days, confirm SAC rating After confirmation of the SAC rating into the CIMS, commence initial investigation to identify human errors and system failures. Investigate at a local level using appropriate methodology. Implement an appropriate level of open disclosure**.
Reporting requirements	<ul style="list-style-type: none"> Final investigation reports with recommendations must be endorsed by the Chief Executive or by their steward(s) as per the approved delegation schedule. Submit completed investigation reports which are due within 45 working days of notification to PSSU. 	<ul style="list-style-type: none"> Complete investigation within 60 working days of incident notification*. 	<ul style="list-style-type: none"> Complete investigation within 60 working days of incident notification*.
Recommendations	<ul style="list-style-type: none"> All SAC 1 progress report must be submitted to the PSSU within six months (182 calendar days) of the investigation report submission. An evaluation report is also be forwarded to PSSU within twelve months (365 calendar days) of the investigation report submission. Lessons learned are to be shared at all levels of the service and the system where appropriate. 	<ul style="list-style-type: none"> Progress report of recommendations managed at a service level within 6 months (182 calendar days) of the investigation being completed. Evaluation report managed at a service level within 12 months (365 calendar days) of the investigation being completed. Lessons learned are shared at all levels of the service 	<ul style="list-style-type: none"> Progress report of recommendations managed at a service level within 6 months (182 calendar days) of the investigation being completed. Evaluation report managed at a service level within 12 months (365 calendar days) of the investigation being completed. Lessons learned are shared at all levels of the service.
<p>* The completion of the CIMS clinical incident form (notification and investigation sections) can constitute a final report. ** In accordance with the Australian Open Disclosure Framework.</p>			