

Preventing Death After Medical Error: A Comparative Health Policy Analysis of Patient Safety, Accountability, and Institutional Learning in Indonesia and England

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ABSTRACT

Medical error became a health-policy problem when institutional systems failed to detect risk, establish a credible account of harm, or change unsafe conditions. This article compared how Indonesia and England organised reporting, investigation, disclosure, accountability, and learning when patient-safety incidents could result in death. A qualitative comparative health policy analysis was conducted using legislation, regulatory instruments, national patient-safety frameworks, investigation guidance, reporting arrangements, and peer-reviewed research. Indonesia had a substantial regulatory and hospital-governance basis for patient safety, but learning remained dependent on uneven local reporting capacity and hospital-level review. England had a more differentiated architecture through PSIRF, LFPSE, statutory candour, regulation, and independent national investigation, although investigation quality, family involvement, and implementation of recommendations remained variable. The comparison developed accountability-learning coupling as an institutional mechanism in which learning processes remained sufficiently separate to support candid evidence, while verified findings could still move into proportionate professional, managerial, or regulatory accountability. For Indonesia, the principal reform need was stronger linkage between local incidents, national learning, family-facing explanation, and verified implementation of corrective action.



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INTRODUCTION

Patient deaths associated with medical error often enter public discussion only after a clinician is accused, a family complains, or a legal process asks whether negligence occurred. By that stage, the event has already been translated into a dispute about responsibility. The translation is necessary in some cases, but it can hide the earlier policy failure. A wrong decision at the bedside may become fatal because deterioration was not escalated, a handover did not carry the relevant information, or an unsafe practice had been tolerated for months. Reviews of hospital adverse events continue to show that a substantial share of harm is preventable and that contributing conditions commonly cross professional and organisational boundaries (Sauro et al., 2021). Prevention therefore depends on information that is available before legal fault is settled. Near misses, awkward workarounds, repeated minor failures, and staff concerns can reveal a dangerous system while there is still time to change it.

Medical error, adverse event, preventable harm, and malpractice do not describe the same event. Error concerns a failed action or plan; harm is the consequence. Negligence adds a legal judgement about duty, breach, causation, and damage. Barsky et al. (2022) show why an unexpected outcome cannot simply be converted into professional wrongdoing. Patient-safety policy has to classify and investigate risk before a court or professional body decides liability. If learning begins only after negligence is proved, many hazards will remain untouched until the next patient is injured.

Indonesia has not ignored patient safety. Minister of Health Regulation No. 11 of 2017 established reporting, analysis, and corrective-action duties, while Law No. 17 of 2023, Government Regulation No. 28 of 2024, and Minister of Health Regulation No. 6 of 2026 place safety and quality within contemporary health-service governance. The difficulty is that these duties pass through

hospitals with very different staffing, leadership, technical capability, and tolerance for uncomfortable information. Comparative evidence found limited national visibility in Indonesia's incident-reporting system (Dhamanti et al., 2021). Later studies still identify fear, weak feedback, workload, knowledge gaps, and uneven support as reasons why reporting remains fragile (Dhamanti et al., 2022; Kartikasari et al., 2025). A rule can therefore be present nationally and thin in practice. Where reporting is experienced as extra work or a possible route to blame, the formal architecture records only part of the safety problem. The missing part is often the pattern that never becomes a report at all.

England has accumulated a denser set of institutions around the same problem. The Patient Safety Incident Response Framework (PSIRF) replaced the earlier Serious Incident Framework and asks NHS organisations to select proportionate responses for learning rather than investigate events solely because they cross a fixed severity threshold. The Learn from Patient Safety Events service (LFPSE) provides national event capture. Statutory candour sits alongside professional duties of openness, while the Health Services Safety Investigations Body (HSSIB) investigates selected system risks independently and does not determine civil or criminal liability. The architecture is more differentiated than Indonesia's, though it is not a finished model. Research on English incident investigation before full PSIRF implementation found inconsistent quality, limited learning, and uneven involvement of those affected (Louch et al., 2025). More recent analysis also shows that formal commitment to systems thinking does not prevent investigations from drifting back toward linear causes and weak recommendations (Bowditch et al., 2026).

The systems also make different things visible. Indonesia depends heavily on hospital governance and nationally prescribed duties. England separates local response, national reporting, regulation, candour, and selected independent investigation more explicitly. Neither arrangement can be judged from the number of reports or claims. High reporting may reflect unsafe care or greater trust in reporting; low reporting may signal safety or silence. What matters here is how an incident becomes usable knowledge, who controls that knowledge, and whether it can change practice without turning every safety inquiry into a liability proceeding.

This article develops that relationship as accountability-learning coupling. The idea is narrower than a call to “balance” blame and learning. Learning-oriented inquiry needs enough institutional distance from discipline and litigation to obtain candid accounts of work as it was actually done. Yet separation becomes dangerous when verified findings cannot reach managers, regulators, or professional bodies that have authority to act. Coupling describes a controlled connection between these functions: distinct purposes, different evidentiary thresholds, and a lawful route by which findings relevant to serious misconduct, governance failure, or unresolved system risk can travel into the appropriate accountability process. The study uses Indonesia and England to examine how far existing policy performs that work and what remains missing when serious harm may be fatal.

RESEARCH METHODS

The study used qualitative comparative health policy analysis based on secondary documents. Its unit of analysis was the policy pathway through which a serious patient-safety event becomes reportable information, an investigation, an explanation to those affected, and a possible source of change. Documentary analysis followed the READ approach, which treats policy texts as institutional material that allocates authority and legitimises particular responses to a problem (Dalglish et al., 2020). The study did not estimate malpractice prevalence or decide whether individual deaths were legally negligent.

The Indonesian corpus centred on Law No. 17 of 2023 on Health, Government Regulation No. 28 of 2024, Minister of Health Regulation No. 11 of 2017 on Patient Safety, Minister of Health Regulation No. 6 of 2026 on Hospitals, and public material on incident reporting and hospital quality governance. Earlier instruments were retained where they still explained an operative part of the reporting architecture. For England, the corpus included PSIRF and its supporting standards, LFPSE guidance, statutory candour, HSSIB's statutory and operational material, Care Quality Commission guidance, and related NHS patient-safety documents. Official sources were checked against the arrangements current in 2026 so that superseded policy was not described as present practice. The corpora are not equivalent in volume. They were assembled to trace comparable policy functions: who receives information, who can investigate, what is protected, how affected people are involved, and what happens to findings after an investigation closes.

Peer-reviewed studies from 2020 to 2026 were used to test institutional claims found in the policy documents, not as a systematic-review sample. Evidence was included when it addressed reporting behaviour, investigation practice, candour, family involvement, just culture, staffing, or learning. This prevents a formal rule from being treated as proof that the rule works. It also allowed implementation evidence from Indonesia and England to challenge the official policy narrative where appropriate.

Comparison was conducted by tracing the same policy problem through both systems rather than writing two country descriptions and placing them side by side. Coding began with incident visibility, investigation, accountability, candour, participation, and organisational learning. These categories were then collapsed where the evidence showed that the boundary was artificial. Candour, for example, could not be analysed separately from investigation because families often depend on the investigation for the explanation they are promised. Implementation capacity was recorded across categories when staffing, leadership, data infrastructure, or organisational resources affected the apparent operation of a rule. Contradictory evidence was retained. The presence of a database was not treated as proof of learning, and a statutory duty of openness was not treated as proof that affected families receive a satisfactory account.

The comparison is limited by unequal public visibility. England produces more national material on reporting and independent investigation, whereas Indonesian evidence is often hospital based. That difference can make England look more effective simply because its activity is easier to observe, while local Indonesian practice may be missed. The analysis therefore compares functions and failure modes, not institutional prestige. It also makes no causal claim that either architecture has reduced mortality. The question is whether policy makes potentially fatal harm more visible, investigable, explainable, and less likely to recur.

RESULTS AND DISCUSSION

1. Incident Reporting and the Production of System-Level Safety Intelligence

Indonesian patient-safety reporting is formally national but operationally dependent on hospitals. Internal structures receive reports, classify incidents, and decide what is escalated. Annisa et al. (2020) found that the performance of a patient-safety committee in Makassar depended on organisational context rather than formal existence alone, while Harsul et al. (2020) linked nurses' self-efficacy with reporting culture. Psychological safety matters for the same reason: staff speak about errors when previous disclosure has not produced humiliation or arbitrary sanction (O'Donovan et al., 2020). A hospital can therefore possess the required committee and reporting form while still producing a thin account of risk.

Low national reporting cannot be read as low harm. Dhamanti et al. (2021) found far fewer reports and less public national information in Indonesia than in the comparator systems they studied. Indonesian leaders later connected under-reporting with workload, knowledge, leadership, fear, and weak feedback (Dhamanti et al., 2022). Singh and Mahomed (2023) show the related tendency for reporting systems to become most visible after harm has already occurred. Reporting exposes a problem, and sometimes the reporter, to an organisation whose response is uncertain.

England's national infrastructure makes event capture more visible. LFPSE records and analyses patient-safety events nationally, while PSIRF asks organisations to choose responses according to learning need rather than apply one investigation model whenever a severity threshold is crossed. That distinction is useful because severity and learning value are not identical. A near miss can expose a defect that later kills a patient, while a death may occur despite appropriate care (Kadir, 2026c). Standardised national capture also allows patterns to emerge across organisations that would look isolated inside one trust. Yet the infrastructure can only analyse what enters it. A scoping review found recurrent weaknesses when digital reporting systems were cumbersome, poorly integrated with work, or detached from feedback (Gqaleni et al., 2024). More records do not by themselves create a learning culture; they can just produce a larger repository of unresolved events.

Cross-country numbers require particular restraint. England's national repositories make events easier to aggregate, while Indonesian reporting is more dependent on local submission and less publicly visible at national level. A crude comparison could therefore make England appear less safe simply because more events are captured, or make Indonesia appear safer because fewer enter the national record. Neither inference is defensible. The relevant policy question is whether data can reveal

recurrence early enough to trigger action. That requires stable definitions, enough clinical detail to distinguish superficially similar events, and feedback that reaches the organisations contributing the data. It also requires tolerance for an uncomfortable transitional effect: a better reporting system may initially make safety performance look worse. Visibility can increase before harm decreases. Treating that rise as failure would give hospitals a new reason not to report.

The two systems consequently have different visibility problems. Indonesia can lose information before it reaches a national learning function because local capability and feedback are uneven. England can capture much more, yet volume can hide whether the information is useful or whether staff see any reason to keep reporting. Just-culture research also warns that disclosure depends on predictable distinctions between human error and conduct that warrants sanction (Barkell & Snyder, 2021). Raw incident counts are therefore poor league tables. More defensible indicators sit later in the chain: reporting delay, completeness, quality of analysis, recurrence, and implementation of safety action. Patient reports can add another perspective because patients notice coordination and communication failures that professional systems miss (Hernan et al., 2021).

2. Post-Incident Investigation, Candour, and Institutional Accountability

Serious incidents in Indonesian hospitals are usually analysed within the organisation that delivered the care. Internal teams can reach records and staff quickly, which is useful, and local knowledge can prevent an inquiry from misunderstanding ordinary clinical work. Their position is less comfortable when the event implicates management, staffing, procurement, referral arrangements, or a tolerated workaround. Organisational proximity shapes what investigators can ask and which recommendations are realistic, even without deliberate concealment. Independence becomes a policy issue once the causes of harm sit partly inside the hierarchy that commissions the review.

England has made that boundary more explicit by separating several investigative and accountability functions. NHS organisations undertake local responses under PSIRF, regulators and professional bodies retain their own enforcement roles, and HSSIB can investigate selected national system risks independently. Systems-based investigation supports this division because its purpose is to understand how tasks, technology, supervision, staffing, information, and organisational decisions interacted rather than to search for a single root cause (Sampson et al., 2021). The distinction nevertheless survives only if investigation practice follows the theory. Bowditch et al. (2026) found that patient-safety investigations could still fall short of systems thinking, particularly in the way contributing factors and recommendations were constructed. Institutional separation does not protect a learning process from poor analysis.

Evidence gathered for learning can also point to conduct that cannot reasonably stay inside a protected safety process. A safety investigator should not become a disciplinary tribunal, but complete immunity is equally hard to defend. Clinicians involved in serious incidents may themselves experience guilt, isolation, and professional distress (White & Delacroix, 2020), which is one reason arbitrary punishment is destructive. Just-culture implementation therefore needs a consistent method for deciding how behaviour is classified and how staff are treated (Murray et al., 2023). The same discipline is needed when management conduct is involved. Repeated tolerance of a known unsafe condition does not become harmless “system complexity” simply because no manager intended a patient's death. A fair policy has to protect honest participation while leaving a credible route for serious misconduct or governance neglect to be examined elsewhere.

This is where accountability-learning coupling becomes more specific. The learning inquiry and the liability process should remain institutionally distinct because they ask different questions and work with different evidentiary thresholds. The learning inquiry can act on credible risk before negligence is proven. It can recommend redesign after recurrent near misses, even when causal attribution remains uncertain. A disciplinary or legal process must meet the standards required by its own rules. The processes still need a controlled interface. Verified evidence of deliberate concealment, reckless disregard, or governance failure cannot disappear simply because it was encountered in a safety review. Conversely, disciplinary authorities should not routinely seize the learning process as a shortcut to proof. Coupling therefore requires clear rules about what information can travel, who decides that transfer, for what purpose it may be used, and what procedural protection follows. England's protected HSSIB arrangements make the issue visible; Indonesia's hospital-centred model leaves more of it to institutional practice.

Families encounter the boundary from another direction. After a fatal incident, the provider still controls most of the records, specialist language, and professional accounts needed to explain what happened. England's statutory duty of candour creates an obligation to be open about qualifying incidents, but a legal duty cannot decide how an organisation speaks when facts remain uncertain. Bourke and Lichtenberg (2023) describe open disclosure as an ethical practice that depends on organisational support. Myren et al. (2022) likewise show that disclosure is shaped by timing, relationships, uncertainty, and the emotional position of clinicians. The statute creates a floor, not a complete conversation.

A standard disclosure can still leave the central questions unanswered, especially for people who already distrust institutions. Olazo et al. (2022) found that marginalised populations may interpret error disclosure through earlier experiences of exclusion. Families also contribute evidence. McHugh et al. (2024) found that English investigation policies often recognised involvement without fully recognising the epistemic value of patient and family knowledge, while Ramsey et al. (2022) show that meaningful involvement can improve investigation and poorly handled involvement can compound harm. Information about changes in condition, warnings, and failed communication may exist only in the family's account. Candour is therefore part of evidence production, not simply a courtesy after investigators have finished.

Indonesia protects patient rights to information and places communication duties within health-service regulation, yet incident-specific open disclosure is less institutionally developed than England's statutory model. Health workers interviewed in Indonesian hospitals reported concern about legal consequences, reputation, and inadequate support when disclosing incidents (Dhamanti et al., 2023). Patient engagement is also accepted more readily as a principle than embedded consistently in routine safety practice (Listiwati et al., 2023). The obvious response would be to legislate a stronger candour duty, but law alone may reproduce the English gap between formal obligation and lived practice. Staff need a credible distinction between honest disclosure and admission of legal negligence (Kadir, 2025b, 2026a). Families need access to verified facts, the reasoning behind causal findings, and evidence that promised changes were completed. Personal reflections supplied for learning may justify protection; the basic factual account of serious harm should not become secret merely because the system also wants candid staff participation.

3. From Local Incident Review to System-Level Organisational Learning

Patient-safety systems often weaken after the report is signed. Recommendations are recorded, an action plan is opened, and attention moves elsewhere. Learning requires more than a lesson written in a document; some part of work must change, and the change has to survive ordinary operating conditions. Mahmoud et al. (2023) identify feedback, leadership, resources, and visible corrective action as recurring conditions for effective learning systems. Staff notice when reports produce no visible response, and repeated requests for disclosure then begin to look like administrative extraction rather than a credible route to safer care.

England has more infrastructure for learning across organisational boundaries. LFPSE allows national aggregation, PSIRF promotes proportionate learning responses, and HSSIB can publish national investigations and recommendations. This gives recurrent hazards a visibility they would not have inside separate trusts. It still leaves a familiar gap between recommendation and practice. High-reliability research suggests that learning tools work best when they are timely, multidisciplinary, close to operations, and followed by action (Serou et al., 2021). Louch et al. (2025) found that the English system preceding PSIRF often struggled to translate investigation into consistent learning. The newer architecture addresses parts of that weakness, but a recipient can still accept a recommendation, write a response, and leave the relevant work largely unchanged. Publication increases accountability only when somebody remains responsible for what happens after publication.

Indonesia's gap is different. Local analysis and corrective action are already part of hospital patient-safety governance, but the public pathway from one hospital's incident to national learning remains comparatively thin. A hazard can therefore be recognised locally without becoming useful to another hospital facing the same problem. Dhamanti et al. (2021) identified this weakness in the comparative visibility of national reporting. The consequence is not simply a smaller dataset. It is the loss of opportunities for thematic analysis, rapid safety notices, and cross-hospital recognition of recurrent risk. A national platform would add little if it only counted events. Its value would come from

converting de-identified reports into patterns that hospitals can understand and then returning that analysis to the clinical level.

National visibility can also distort behaviour. Public rankings based on incident numbers may punish hospitals that report honestly and reward those that keep problems internal. A higher rate can reflect vigilance or service volume as easily as unsafe care. Policy should therefore follow the movement of an event through the learning cycle: how quickly it was reported, whether the causal account was credible, whether action was completed, and whether the same hazard returned. Gqaleni et al. (2024) similarly stress the connection between reporting, analysis, feedback, and improvement.

The return path matters as much as the reporting channel. A hospital that submits an incident needs more than an acknowledgement that the case entered a database. It needs to know whether similar events have occurred elsewhere, whether the national analysis changes the local understanding of risk, and whether a proposed action has worked in comparable settings. Without that return flow, national reporting remains extractive: information travels upward, but learning does not travel back. Feedback also gives reporters a practical reason to keep using the system.

The comparison therefore does not produce a simple ranking. England has stronger national differentiation and public visibility, but its institutions can fragment responsibility and generate recommendations that do not reliably change practice. Indonesia has a clearer dependence on hospitals, which can make the system responsive where local governance is strong and fragile where it is not. The common failure is a broken chain between information and action. Reporting without analysis produces accumulation; investigation without candour produces distrust; candour without change becomes apology without prevention; recommendations without verification allow the same risk to return under a new case number. Accountability-learning coupling is useful only if it reaches this final stage, where somebody with authority remains responsible until the corrective action can be shown to exist.

Table 1 Comparative Policy Architecture for Potentially Fatal Patient-Safety Incidents

Policy function	Indonesia	England	Comparative implication
Reporting and visibility	Hospital-centred reporting under national rules; national visibility remains uneven.	National event capture through LFPSE alongside local reporting and PSIRF response planning.	Raw report volume cannot be treated as a direct safety score.
Investigation	Predominantly internal hospital analysis; independence depends on local governance.	Local PSIRF responses plus independent HSSIB investigation of selected system risks.	Independent review is most valuable where risk exceeds one organisation or implicates governance.
Accountability interface	Safety review can sit close to professional, managerial, administrative, civil, or criminal responses.	Learning-oriented investigation is more explicitly separated from liability and regulatory processes.	Separation needs a lawful route for verified findings to move without turning inquiry into prosecution.
Candour and participation	General rights to information exist; incident-specific disclosure and family involvement are institutionalised.	Statutory and professional duties operate alongside investigation and family-involvement expectations.	Openness requires more than apology; families need explanation and a meaningful chance to contribute evidence.
Learning closure	Local corrective action exists, but cross-hospital learning and public feedback are comparatively thin.	National aggregation, thematic learning, and HSSIB recommendations are create greater visibility but do not guarantee implementation.	Safety action should remain open until implementation effectiveness can be checked.

Note. The table compares policy functions and failure modes, not the prevalence of medical error, malpractice, or mortality in the two countries.

4. Accountability Learning Coupling in Comparative Patient-Safety Governance

Fatal medical error is poorly served by a simple choice between punitive accountability and a learning culture. Real health systems contain both, and trouble begins when their connection becomes either too tight or too weak. Discipline that controls safety inquiry gives staff a reason to narrow disclosure and can pull investigators toward defensible individual acts instead of awkward organisational conditions (Kadir & Kadir, 2024). Learning that is insulated completely can absorb serious misconduct or repeated governance neglect into the language of complexity. Accountability-learning coupling addresses this institutional problem through separation without informational isolation. Investigation, professional discipline, management review, regulation, and litigation do not need one evidentiary standard or one decision maker. They do need a lawful interface through which verified findings can travel when another body has authority to act. That is more demanding than “balance.” It specifies why the processes are separate, when they should communicate, and what is lost when the boundary is badly designed.

That formulation adds something that the familiar language of just culture does not fully resolve. Just culture is primarily concerned with fair responses to behaviour and with avoiding indiscriminate blame. It remains essential, particularly because staff involved in serious incidents may suffer significant distress and because arbitrary sanction damages reporting culture (White & Delacroix, 2020; Barkell & Snyder, 2021). Yet fatal harm can also emerge from decisions that sit above the frontline. Budgets, staffing models, procurement choices, escalation rules, and tolerance of known workarounds may create the conditions in which one person's error becomes lethal. A policy model that classifies only the clinician's behaviour can be fair at the individual level and still leave institutional responsibility untouched. Coupling therefore has to include managerial and regulatory accountability, not simply a more humane disciplinary algorithm.

The evidentiary threshold is another reason to keep the processes distinct. A health system should not wait for proof of negligence before correcting a credible hazard. Recurrent near misses or a plausible pattern of contributing factors may justify redesign long before legal causation can be established. Safety investigation is allowed to work with uncertainty because its question is prospective: what conditions should change before the event happens again? Liability proceedings ask a narrower question about whether a legal standard was breached in a particular case. Confusing these tasks damages both. Staff may write every safety account as if it were future litigation evidence, while families may suspect that “learning” is a way to avoid a clear statement of responsibility. The policy challenge is to let the safety process remain exploratory without allowing uncertainty to become permanent ambiguity (Kadir, 2025a, 2026b).

England has developed more formal devices for managing that challenge. Independent national investigation, protected information, statutory candour, national event capture, and local PSIRF responses do not sit in one chain of command. This creates space for different questions to be asked. It also creates friction. Families may have to navigate several organisations, repeat their account, or receive answers at different times. Protected information can support candid investigation while also appearing inconsistent with the family's demand for explanatory truth. Quick (2022) argues that candour in healthcare involves more than acknowledging that harm occurred; it reaches the quality of the explanation. The English experience therefore warns against treating institutional differentiation as an end in itself. Separation is useful when it improves the quality of inquiry and the route to action, not when it multiplies procedures around the same bereavement.

Indonesia's present architecture creates almost the reverse problem. The rules already authorise patient-safety activity, but too much of the practical burden rests on the hospital. Where leadership is strong, local committees can investigate, communicate, and redesign care with speed. Where capability is weak, the same legal obligations may be satisfied mainly through documentation. Evidence on Indonesian reporting and disclosure repeatedly points to leadership, fear, knowledge, workload, and feedback as the conditions through which formal rules become practice (Dhamanti et al., 2022; Dhamanti et al., 2023). Adding another general obligation is unlikely to solve that problem. National policy needs to supply functions that individual hospitals cannot perform reliably for themselves, especially cross-hospital learning, technically independent review of selected system hazards, and monitoring of whether high-level safety actions are completed. The point is not centralisation for its own sake. It is to give local systems access to information and investigative capacity that cannot be generated inside one hospital.

A national Indonesian learning function need not reproduce HSSIB or import NHS labels. It should do what individual hospitals cannot do reliably: detect patterns across providers, examine selected incidents where governance or cross-organisational risk is prominent, and return usable findings to the system. Most incidents should still be handled locally. National investigation becomes defensible where a hazard recurs, spans institutions, concerns national policy, or cannot be examined credibly by the organisation implicated. Independence has value only if staff and families can see that the inquiry is not routine accreditation or a disguised disciplinary process. This would also reduce the pressure on single hospitals to solve national problems alone.

Reporting reform should begin with feedback rather than a demand for more forms. Hospitals need to know that submitted information has been analysed and returned as usable safety knowledge. Clinicians need local evidence that earlier reports led to changes. National summaries should avoid crude rankings and instead show recurring hazards, response time, implementation progress, and where learning remains incomplete. Patient-reported safety information can complement professional reporting because patients encounter failures in coordination and communication from a different position (Hernan et al., 2021). The infrastructure should also permit uncertainty. A report can be valuable even when it does not establish malpractice. In fact, the ability to learn before legal fault is proven is one of the main reasons for maintaining a patient-safety system separate from complaints and litigation.

Family involvement needs a similarly practical design. A broad promise of openness is less useful than a process that tells families who will contact them, when they can provide information, what the investigation can and cannot decide, and how they will receive the outcome. Ramsey et al. (2022) caution that poorly handled involvement can deepen harm, while meaningful participation can improve both legitimacy and the factual account. Indonesia can strengthen this function without immediately copying England's statutory formulation. The key policy move is to recognise that affected families are not external observers of a hospital's internal learning exercise. Their knowledge may alter the investigation, and their ability to see whether corrective action occurred is part of accountability after the clinical relationship has ended.

Implementation assurance is the point at which many otherwise credible reforms become symbolic. Safety recommendations should identify who has authority to act, what resource or process must change, and how completion will be verified. A recommendation that merely asks staff to exercise more care is especially weak where staffing pressure, burnout, unreliable technology, or poorly designed work predictably shape performance (Dall'Ora et al., 2022; Li et al., 2024). The English record shows that publication and formal response do not automatically close the gap between investigation and practice. Indonesia has an opportunity to build verification into the learning function before a large national repository develops the same weakness. Some recommendations will fail, others will need modification, and this should be visible rather than treated as non-compliance to be hidden.

The reform should remain selective. One new bureaucracy should not control reporting, investigation, disclosure, professional discipline, and compensation. Local hospitals need ownership of immediate safety improvement, while professional and legal institutions retain their adjudicative roles. National policy is most useful where information, independence, or implementation assurance cannot be produced credibly at hospital level. Pilot implementation across hospital networks with different capacities would reveal more than immediate uniform expansion, especially where digital infrastructure and investigator expertise remain uneven. Piloting would also show which safeguards work outside large referral hospitals before they are converted into national administrative requirements.

Public documents describe authorised structures rather than every concealed incident or local workaround, and the evidence base is more publicly developed in England than in Indonesia. The study therefore cannot show that either architecture has caused fewer preventable deaths. Its claim is institutional. Potentially fatal harm is harder to repeat unnoticed when reporting is credible, investigation can examine system conditions, families are not excluded from the factual account, and corrective action remains somebody's responsibility after the report is closed. Further empirical work will still be needed to test how these functions operate across different Indonesian hospital settings.

CONCLUSION

Preventing death after medical error requires action before an event has been converted into a malpractice dispute. Indonesia already possesses a significant regulatory basis for patient safety, but the

route from local reporting to national learning remains dependent on uneven hospital capability and limited public feedback. England has built stronger institutional differentiation through national event capture, PSIRF, candour requirements, regulation, and independent system investigation. That arrangement offers useful functions rather than a ready-made model. Its own problems - fragmented processes, uneven investigation quality, tension around protected information, and uncertain follow-through - show why additional institutions do not automatically produce safer care. The difference is institutional rather than simply legal.

Accountability-learning coupling captures what remains unresolved in both systems. Learning inquiry needs enough independence to examine uncertainty and system conditions without becoming a disciplinary shortcut, but verified findings cannot stop at the boundary of the learning process. For Indonesia, the priority is a stronger connection between hospital incidents and national learning, a credible route for selected independent review, family-facing explanation, and verification of corrective action. The meaningful test is not whether more reports are produced. It is whether another hospital can act on what the previous one learned before the same hazard becomes another death. That is the practical meaning of prevention in this comparison.

REFERENCES

- Annisa, F., Maidin, A., Mangilep, A. U. A., & Irwandy. (2020). Performance evaluation of patient safety committee in the regional general hospital of Makassar city. *Enfermería Clínica*, 30, 5–8. <https://doi.org/10.1016/j.enfcli.2020.06.003>
- Barkell, N. P., & Snyder, S. S. (2021). Just culture in healthcare: An integrative review. *Nursing Forum*, 56(1), 95–102. <https://doi.org/10.1111/nuf.12525>
- Barsky, M., Olson, A. P. J., & Astik, G. J. (2022). Classifying and disclosing medical errors. *Medical Clinics of North America*, 106(4), 675–687. <https://doi.org/10.1016/j.mena.2022.02.007>
- Bourke, E. C., & Lichtenberg, J. (2023). The duty of candour: Open disclosure of medical errors. *Clinical Ethics*, 18(2), 236–238. <https://doi.org/10.1177/14777509211070490>
- Bowditch, L., Molloy, C., King, B., Abedi, M., Jackson, S., Bierbaum, M., Yu, Y., Raggett, L., Salmon, P., Braithwaite, J., Westbrook, J. I., Clay-Williams, R., Lingam, R., Middleton, S., Magrabi, F., Mumford, V., & Hibbert, P. (2026). Do patient safety incident investigations align with systems thinking? An analysis of contributing factors and recommendations. *BMJ Quality & Safety*, 35(7), 443–455. <https://doi.org/10.1136/bmjqs-2025-019063>
- Dalglish, S. L., Khalid, H., & McMahon, S. A. (2020). Document analysis in health policy research: The READ approach. *Health Policy and Planning*, 35(10), 1424–1431. <https://doi.org/10.1093/heapol/czaa064>
- Dall'Ora, C., Saville, C., Rubbo, B., Turner, L., Jones, J., & Griffiths, P. (2022). Nurse staffing levels and patient outcomes: A systematic review of longitudinal studies. *International Journal of Nursing Studies*, 134, 104311. <https://doi.org/10.1016/j.ijnurstu.2022.104311>
- Dhamanti, I., Leggat, S., Barraclough, S., Liao, H.-H., & Abu Bakar, N. (2021). Comparison of patient safety incident reporting systems in Taiwan, Malaysia, and Indonesia. *Journal of Patient Safety*, 17(4), e299–e305. <https://doi.org/10.1097/PTS.0000000000000622>
- Dhamanti, I., Leggat, S., Barraclough, S., & Rachman, T. (2022). Factors contributing to under-reporting of patient safety incidents in Indonesia: Leaders' perspectives. *F1000Research*, 10, 367. <https://doi.org/10.12688/f1000research.51912.2>
- Dhamanti, I., Juliasih, N. N., Semita, I. N., Zakaria, N., Guo, H.-R., & Sholikhah, V. (2023). Health workers' perspective on patient safety incident disclosure in Indonesian hospitals: A mixed-methods study. *Journal of Multidisciplinary Healthcare*, 16, 1337–1348. <https://doi.org/10.2147/JMDH.S412327>
- Gqaleni, T. M., Mkhize, S. W., & Chironda, G. (2024). Patient safety incident reporting and learning guidelines implemented by health care professionals in specialized care units: Scoping review. *Journal of Medical Internet Research*, 26, e48580. <https://doi.org/10.2196/48580>
- Harsul, W., Irwan, A. M., & Sjattar, E. L. (2020). The relationship between nurse self-efficacy and the culture of patient safety incident reporting in a district general hospital, Indonesia. *Clinical Epidemiology and Global Health*, 8(2), 477–481. <https://doi.org/10.1016/j.cegh.2019.10.013>

- Hernan, A. L., Giles, S. J., Fuller, J., Johnson, J. K., Walker, C., & Dunbar, J. A. (2021). Nature and type of patient-reported safety incidents in primary care: Cross-sectional survey of patients from Australia and England. *BMJ Open*, 11(4), e042551. <https://doi.org/10.1136/bmjopen-2020-042551>
- Kadir, Z. K. (2025a). Fear and Control: Rethinking Criminal Policy through the Lens of Moral Panic. *International Journal of Law Analytics*, 3(2), 201–218. <https://doi.org/10.59890/ijla.v3i2.13>
- Kadir, Z. K. (2025b). Neurokriminologi Psikopat: Determinisme Genetik atau Deprivasi Lingkungan? *Aliansi: Jurnal Hukum, Pendidikan Dan Sosial Humaniora*, 2(6), 21–35.
- Kadir, Z. K. (2026a). Neurocriminology and the Next Generation of Criminological Theory: Integration, Limits, and Ethical Risks. *Punggawa Global Research: Jurnal Multidisiplin*, 1(1), 1–8.
- Kadir, Z. K. (2026b). Preventing Murder Without Expanding Punishment: Rethinking Homicide Policy Beyond Deterrence. *Punggawa Law Review*, 1(3), 49–58. <https://doi.org/10.67707/plr.v1i3.40>
- Kadir, Z. K. (2026c). Rural Criminology and the Cultural Authorization of Homicide: How Lethal Violence Becomes Socially Permissible. *Punggawa Social Inquiry: Journal of Crime, Culture, and Social Dynamics*, 1(1), 1–10.
- Kadir, Z. K., & Kadir, N. K. (2024). Examining of the Concept of Standard of Proof in the Indonesian Criminal Procedure Code. *International Journal of Global Community*, 1(1), 13–25.
- Kartikasari, B. K., Samirah, S., Nita, Y., Sulistyarini, A., & Zairina, E. (2025). Factors affecting patient safety culture and adverse drug reaction reporting among healthcare professionals in an Indonesian public hospital: A cross-sectional study. *International Journal of Risk & Safety in Medicine*, 36(3), 113–123. <https://doi.org/10.1177/09246479251323834>
- Li, L. Z., Yang, P., Singer, S. J., Pfeffer, J., Mathur, M. B., & Shanafelt, T. D. (2024). Nurse burnout and patient safety, satisfaction, and quality of care: A systematic review and meta-analysis. *JAMA Network Open*, 7(11), e2443059. <https://doi.org/10.1001/jamanetworkopen.2024.43059>
- Listiowati, E., Sjaaf, A. C., Achadi, A., Bachtiar, A., Arini, M., Rosa, E. M., & Pramayanti, Y. (2023). How to engage patients in achieving patient safety: A qualitative study from healthcare professionals' perspective. *Heliyon*, 9(2), e13447. <https://doi.org/10.1016/j.heliyon.2023.e13447>
- Louch, G., Macrae, C., Talbot, R., McHugh, S., & O'Hara, J. K. (2025). How were patient safety incidents responded to, investigated, and learned from within the English National Health Service before the implementation of the Patient Safety Incident Response Framework? A rapid review. *Journal of Patient Safety*, 21(5), e42–e55. <https://doi.org/10.1097/PTS.0000000000001349>
- Mahmoud, H. A., Thavorn, K., Mulpuru, S., McIsaac, D., Abdelrazek, M. A., Mahmoud, A. A., & Forster, A. J. (2023). Barriers and facilitators to improving patient safety learning systems: A systematic review of qualitative studies and meta-synthesis. *BMJ Open Quality*, 12(2), e002134. <https://doi.org/10.1136/bmjopen-2022-002134>
- McHugh, S., Louch, G., Ludwin, K., Sheard, L., & O'Hara, J. K. (2024). Involvement in serious incident investigations: A qualitative documentary analysis of NHS trust policies in England. *BMC Health Services Research*, 24, 1207. <https://doi.org/10.1186/s12913-024-11626-4>
- Murray, J. S., Clifford, J., Larson, S., Lee, J. K., & Sculli, G. L. (2023). Implementing just culture to improve patient safety. *Military Medicine*, 188(7–8), 1596–1599. <https://doi.org/10.1093/milmed/usac115>
- Myren, B. J., de Hullu, J. A., Bastiaans, S., Koksma, J. J., Hermens, R. P. M. G., & Zusterzeel, P. L. M. (2022). Disclosing adverse events in clinical practice: The delicate act of being open. *Health Communication*, 37(2), 191–201. <https://doi.org/10.1080/10410236.2020.1830550>
- O'Donovan, R., De Brún, A., & McAuliffe, E. (2020). A systematic review of factors that enable psychological safety in healthcare teams. *International Journal for Quality in Health Care*, 32(4), 240–250. <https://doi.org/10.1093/intqhc/mzaa025>
- Olazo, K., Wang, K., Sierra, M., Barr-Walker, J., & Sarkar, U. (2022). Preferences and perceptions of medical error disclosure among marginalized populations: A narrative review. *The Joint Commission Journal on Quality and Patient Safety*, 48(10), 539–548. <https://doi.org/10.1016/j.jcjq.2022.06.008>
- Quick, O. (2022). Duties of candour in healthcare: The truth, the whole truth, and nothing but the truth? *Medical Law Review*, 30(2), 324–347. <https://doi.org/10.1093/medlaw/fwac004>
- Ramsey, L., McHugh, S., Simms-Ellis, R., Perfetto, K., & O'Hara, J. K. (2022). Patient and family involvement in serious incident investigations from the perspectives of key stakeholders: A review

- of the qualitative evidence. *Journal of Patient Safety*, 18(8), e1203–e1210. <https://doi.org/10.1097/PTS.0000000000001054>
- Sampson, P., Back, J., & Drage, S. (2021). Systems-based models for investigating patient safety incidents. *BJA Education*, 21(8), 307–313. <https://doi.org/10.1016/j.bjae.2021.03.004>
- Sauro, K. M., Machan, M., Whalen-Browne, L., Owen, V., Wu, G., & Stelfox, H. T. (2021). Evolving factors in hospital safety: A systematic review and meta-analysis of hospital adverse events. *Journal of Patient Safety*, 17(8), e1285–e1295. <https://doi.org/10.1097/PTS.0000000000000889>
- Serou, N., Husband, A. K., Forrest, S. P., Slight, R. D., & Slight, S. P. (2021). Learning from safety incidents in high-reliability organizations: A systematic review of learning tools that could be adapted and used in healthcare. *International Journal for Quality in Health Care*, 33(1), mzab046. <https://doi.org/10.1093/intqhc/mzab046>
- Singh, S., & Mahomed, O. (2023). Nature and type of patient-reported safety incidents at a tertiary hospital in South Africa during the COVID-19 period (2018–2021): A retrospective review. *PLOS ONE*, 18(11), e0293933. <https://doi.org/10.1371/journal.pone.0293933>
- White, R. M., & Delacroix, R. (2020). Second victim phenomenon: Is ‘just culture’ a reality? An integrative review. *Applied Nursing Research*, 56, 151319. <https://doi.org/10.1016/j.apnr.2020.151319>
- Care Quality Commission. (2021). Regulation 20: Duty of candour. Care Quality Commission.
- Government of Indonesia. (2023). Law of the Republic of Indonesia Number 17 of 2023 on Health.
- Government of Indonesia. (2024). Government Regulation Number 28 of 2024 implementing Law Number 17 of 2023 on Health.
- Health Services Safety Investigations Body. (2026). Health services safety investigations and national patient safety investigation materials. HSSIB.
- Ministry of Health of the Republic of Indonesia. (2017). Minister of Health Regulation Number 11 of 2017 on Patient Safety.
- Ministry of Health of the Republic of Indonesia. (2026). Minister of Health Regulation Number 6 of 2026 on Hospitals.
- NHS England. (2022). Patient Safety Incident Response Framework. NHS England.
- NHS England. (2026). Learn from Patient Safety Events service and patient safety incident response standards. NHS England.