Clinical errors tend to be multifactorial and there are already established reporting mechanisms for effectively dealing with potential witnessed or personal errors.

In my experience the current system is sufficiently robust to investigate accurately whether an error had occurred and any follow-up action required. It can identify systemic and individual contributors to errors, as it is not always initially apparent the many variables contributing to a mistake until adequate investigation is completed.

Errors' magnitude and the resultant harm incurred also are on a spectrum. It has already been a feature of Professionalism education at undergraduate and postgraduate levels to explore the variety of mechanisms to tackle these errors. Of course, it is currently expected that serious potential errors are formally reported and already part of our professional responsibilities.

The proposed legislation appears to be a blanket system for reporting all potential errors which would be an extremely confusing system to navigate.