THE WESTERN AUSTRALIAN REVIEW OF DEATH POLICY 2013
FOREWORD

The dedicated staff working in WA hospitals and health services strive to provide an excellent standard of healthcare. WA Health’s commitment to continual improvement includes learning from patient deaths, so as to provide the best possible care to future patients, and taking responsibility for errors and mistakes in healthcare delivery that lead to preventable patient harm and death.

When these tragic and preventable clinical incidents occur, WA Health employs a rigorous process to notify, investigate and rectify system errors to prevent another patient being harmed.

This process also includes the implementation and evaluation of recommendations so that we are continually learning from our mistakes in order to provide the best possible care to our patients.

Supporting this process, I am pleased to present the Review of Death Policy, which supersedes the 2008 Western Australian Review of Mortality Policy: Guidelines for Reviewing Inpatient Deaths.

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# TABLE OF CONTENTS

Contents

**FOREWORD**.................................................................................................................................1

**TABLE OF CONTENTS** .................................................................................................................2

**INTRODUCTION** ...........................................................................................................................3

  - Purpose........................................................................................................................................3
  - Scope...........................................................................................................................................3

  - The West Australian Audit of Surgical Mortality.................................................................4

  - Clinical Incident Management .................................................................................................5

  - The Interaction of the Review of Death Policy and Principles with the Western Australian Audit of Surgical Mortality and Clinical Incident Management Processes. .................................................................5

**STATUTORY AND MANDATORY REPORTING OBLIGATIONS THAT MAY ARISE FOLLOWING DEATH**............................................................................................................6

  - Statutory reporting obligations under the *Coroners Act 1996*...............................................6

  - The notification of certain deaths under the *Health Act 1911*...........................................7

  - Matters to be reported to the Chief Psychiatrist......................................................................7

**REVIEW OF DEATH PRINCIPLES** .............................................................................................8

**REPORTING RESPONSIBILITIES** ...............................................................................................9

Appendix 1. The interaction of review of death principles with clinical incident management processes, and the Western Australian Audit of Surgical Mortality. ..................10

Appendix 2. Examples of death categorisation tools ...................................................................11

Appendix 3. Reporting requirements to the Patient Safety Surveillance Unit ............................13

**References** ....................................................................................................................................14
INTRODUCTION

Reviews of death provide an important opportunity to examine the care afforded to a patient; to determine if it was appropriate or could have been delivered differently, and also to identify improvements in end of life care.¹

Research has identified that a percentage of hospital deaths, upon review, can be categorised as preventable.²,³ Patients who die in hospital are likely to have accessed a significant proportion of hospital services, and therefore their overall hospital experience can shed light on the everyday systems and processes of care¹. Reviews of death can provide assurance, ‘that patients have not died from unrecognised sub-optimal care’.⁴

The Patient Safety Surveillance Unit (PSSU) situated within the Performance Activity and Quality Division of the Department of Health is responsible for the monitoring, reporting and management of clinical incidents across the Western Australian health system.

Reviews of death form one component of safety and quality improvement processes, complementing information identified from the reporting and investigation of clinical incidents, and the investigation of patient complaints.⁴

This policy recognises the role that reviews of death play in improving the safety and quality of healthcare⁵, and the diverse systems established by Western Australian Hospitals and Health Services in reviewing and auditing deaths as specified by the Western Australian Review of Mortality (WARM) Policy, which this policy supersedes.

In response to the WARM Policy, hospitals / health services have established differing systems and processes to facilitate the review of deaths at their organisation. It is recognised that in many hospitals mortality and morbidity committees (MMC’s) facilitate review of death processes¹,⁶, with hospital-wide MMC’s reviewing the deaths of all patients in some settings, and specialty specific MMC’s reviewing a proportion of deaths in other organisations.

Purpose

The purpose of the Review of Death Policy (the Policy) is to ensure that all deaths are reviewed and categorised in terms of preventability, and that preventable deaths identified via a review are notified as SAC 1 clinical incidents and investigated as per the Clinical Incident Management Policy (CIM).

To support this requirement, public hospitals and licensed private healthcare facilities are to ensure processes incorporate the Review of Death Principles (p 8), recognising that many organisations already incorporate the Principles in existing local processes.
Scope
This policy applies to all deaths:

- that occur in public hospitals and licensed private health care facilities in Western Australia
- that occur under the care of Hospital in the Home (HITH) and Rehabilitation in the Home (RITH) services
- involving Nursing Home Type category and Care Awaiting Placement patients in Western Australian Government Hospitals

This policy does not apply to Commonwealth funded residential aged care facilities, however hospitals/health services are not limited from reviewing the deaths of this patient group, or those who received healthcare in other ambulatory or community care settings (for example community based mental health services), recognising that hospitals/health services have expanded the scope of mortality review processes defined within the 2006 and 2008 WA Review of Mortality Policy. Where this occurs, the Review of Death Policy Principles applies in these settings.

The West Australian Audit of Surgical Mortality
The Western Australian Audit of Surgical Mortality (WAASM) is an external, independent peer review of surgically related deaths. The WAASM is managed by the Royal Australasian College of Surgeons and funded by the WA Department of Health. The WAASM has been operating since 2002.

Upon notification of a surgical death, the consultant surgeon responsible for the care of the patient is forwarded a proforma for completion. Once returned, the de-identified proforma is then reviewed by an independent peer (first line assessment) who may also recommend the case for further review (second line assessment) by another independent peer if warranted. The second line assessment includes a review of the proforma and the patient’s medical record.

All deaths that occur in WA hospitals (including private hospitals), where the patient was under the care of a surgeon, are audited. The Royal Australasian College of Surgeons (RACS) has made participation in the WAASM process a mandatory requirement for Continuing Professional Development, with 100% participation in 2012.

Further information on the Western Australian Audit of Surgical Mortality is available from the Royal Australasian College of Surgeons website http://www.surgeons.org/for-health-professionals/audits-and-surgical-research/anzasm/waasm/
Clinical Incident Management

Following a death it may be apparent that healthcare factors may have contributed to the outcome, leading to the prompt notification of a clinical incident. The Clinical Incident Management (CIM) Policy (2012) guides clinical incident management processes in the WA health setting. The CIM Policy introduced Severity Assessment Codes (SAC), which are used to determine the appropriate level of incident analysis, action and escalation according to actual or potential harm caused to the patient by the delivery of health care, as opposed to the patients underlying condition or illness. SAC 1 clinical incidents include all clinical incidents/near misses where serious harm or death is or could be specifically caused by health care rather than the patient’s underlying condition or illness.

Key to clinical incident management is investigation, analysis and feedback. The CIM Policy requires SAC 1 clinical incidents to be appropriately investigated via a robust methodology (for example Root Cause Analysis) so as to identify contributory factors and enable the development of recommendations to prevent the reoccurrence of a similar incident. Organisations must forward to the Patient Safety Surveillance Unit a completed investigation report regarding the incident within 45 business days of notification, permitting awareness raising and actioning of recommendations that have a wider application.

The Interaction of the Review of Death Policy and Principles with the Western Australian Audit of Surgical Mortality and Clinical Incident Management Processes.

A flow chart of the interaction between the WAASM and CIM processes with Review of Death Policy Principles is found in Appendix 1. The CIM Policy provides greater clarity as to the process of notification and investigation of clinical incidents, including the type of incident requiring notification. This has led to an increase in notification of clinical incidents with an outcome of serious harm or death (SAC 1 clinical incidents) to the Patient Safety Surveillance Unit. It is believed that greater awareness of clinical incident notification requirements has made it more likely a death that is potentially as a result of healthcare will be notified as a SAC 1 clinical incident at or around the time of death.

Deaths audited as part of the WAASM process, and deaths notified as a SAC 1 clinical incident undergo rigorous investigation, and meet the Policy principles. An additional local review is not required for deaths reviewed via the above methodologies, noting that a death under the care of a surgeon has the potential to be investigated via both the WAASM process and, if identified at the time, as a SAC 1 clinical incident.

The qualified privilege mechanisms that apply to the WAASM process limits the disclosure of information relating to audit investigations to participating clinicians. Surgeons receive updates on the progress of applicable WAASM audit(s) quarterly, and are advised of their obligation to report any preventable adverse event deemed a SAC 1 clinical incident in accordance with the CIM Policy.

STATUTORY AND MANDATORY REPORTING OBLIGATIONS THAT MAY ARISE FOLLOWING DEATH

The Review of Death Policy does not supersede or replace any of the existing obligations and requirements that may arise following the death of a patient. Professional obligations include communication with the family and/or carer of the deceased and the open disclosure of clinical incidents that may have contributed to the death. Serious adverse events that result in a medico-legal claim or have the potential to result in a medico-legal claim must be reported to the hospital/health service Executive and the appropriate bodies.

Statutory reporting obligations under the Coroners Act 1996

A ‘reportable death’ under Section 3 of the Coroners Act 1996 must be reported to a Coroner or member of the Western Australian Police. Information Circular IC 0008/07 provides information on reportable deaths.

The Death in Hospital Form

Developed in consultation with the State Coroner, the Death in Hospital (DIH) Form and Guidelines provide a summary or checklist of the key statutory and mandatory reporting obligations that arise following an inpatient death.

The use of the DIH Form and accompanying Guidelines should assist hospital and health service staff to comply with their obligations under the Coroners Act 1996, the Health Act 1911 and other reporting directives in a timely manner.

The DIH Form may also be adapted to include other local reporting processes. To access the DIH Form and Guidelines in use at your organisation consult your local clinical governance or safety and quality unit.

A generic DIH Form and Guidelines can be accessed at the Office of Safety and Quality in Healthcare website:

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\(^c\) Open disclosure is the ‘open discussion of an incident that results in harm (or might result in future harm) to a patient while receiving health care’. The WA Open Disclosure Policy: Communication and Disclosure Requirements for Health Professionals Working in Western Australia is available from: http://www.health.wa.gov.au/circularsnew/attachments/395.pdf

The notification of certain deaths under the *Health Act 1911*

Under Section 336 of the *Health Act 1911*, there is a statutory requirement to notify certain deaths to the Executive Director, Public Health. Information Circular 0133/13\(^e\) identifies the following deaths that must be reported:

**The death of a woman as the result of pregnancy or childbirth**

‘Whenever any woman shall die as the result of pregnancy or of childbirth, or as the result of any complications arising from or following upon pregnancy or childbirth, the fact of such death shall be reported forthwith to the Executive Director, Public Health by the medical practitioner and any nurse who were at the time of the death attending such woman.’

**Certain deaths of children**

‘Whenever any child of more than 20 weeks gestation is stillborn or any child under the age of one year shall die from any cause whatsoever, the fact shall be reported forthwith to the Executive Director, Public Health.’

**Death of persons under anaesthetic**

‘Whenever any person shall die within the period of 48 hours following the administration of an anaesthetic agent or as the result of any complications arising from the administration of an anaesthetic, the fact of such death shall be reported forthwith to the Executive Director, Public Health by the person who administered the anaesthetic to the deceased.’

**Matters to be reported to the Chief Psychiatrist**

Operational Directive 0242/09 identifies matters that must be reported to the Chief Psychiatrist\(^f\), to acquit the responsibilities of the Chief Psychiatrist identified in the *Mental Health Act 1996*. ‘The Chief Psychiatrist is to be informed as a matter of priority, of any death of a patient while under the care of any mental health service and any death that may implicate or involve mental health services or stakeholders. This applies to voluntary and involuntary inpatients and patients cared for in the community. Reporting is to include people in the community whose death may be related to an untreated mental illness.’

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REVIEW OF DEATH PRINCIPLES

- Public hospitals and licensed private healthcare facilities are responsible for determining review processes, which must include participation by the clinician or clinical team who had primary responsibility for the patient at the time of death.

- Scope for the independent review of a death must exist in review processes. Examples where this may be required include, but are not limited to the review of a death:
  - involving multiple clinical disciplines, and
  - where care was provided by a number of organisations prior to a death.

  The review by a clinical governance or mortality and morbidity committee, or by a clinician independent to the clinical team who had primary responsibility for the patient are examples of independent input.

- Processes to support the local implementation and evaluation of any recommendations arising from a review of death must exist.

- Reviews of death must incorporate the categorisation of a death in terms of preventability. Examples of categorisation methodologies include the Health Roundtable Criteria for categorising death, and The Royal Children’s Hospital trigger questions (see Appendix 2).

- The categorisation of a death as to preventability must be completed within four months of the date of death.

- A death that is identified, upon review, as one caused by healthcare rather than the patients underlying condition must be notified as a SAC 1 clinical incident.\(^9\)

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\(^9\) Severity Assessment Code is the assessment of consequences associated with a clinical incident. The SAC rating (1, 2 or 3) is used to determine the appropriate level of analysis, action and escalation. SAC 1 includes all clinical incidents/near misses where serious harm or death is/could be specifically caused by health care rather than the patient’s underlying condition or illness. In WA, SAC 1 also includes the eight nationally endorsed sentinel event categories.
REPORTING RESPONSIBILITIES

Local Hospital / Health Service reporting

Hospitals / Health Services are required to maintain the following information on all deaths (where applicable) that fall within the scope of this policy:

- patient reference or de-identified code;
- date of death;
- date of review;
- categorisation level;
- date of completion;
- recommendations identified; and
- implementation status of recommendations.

Reporting to the Patient Safety Surveillance Unit, Department of Health

1. An outcome of a review of death may be the notification of a SAC 1 clinical incident. Western Australian public hospitals and licensed private health care facilities must identify when notifying a SAC 1 clinical incident if the notification was as a result of a review of death undertaken locally, or an outcome of a WAASM audit.

2. Western Australian public hospitals and licensed private health care facilities are to forward to the Patient Safety Surveillance Unit (on a six-monthly basis) the percentage of deaths categorised with respect to preventability within 4 months of the date of death.

Refer to Appendix 3 for further explanation of the reporting requirements to the Patient Safety Surveillance Unit.
Appendix 1. The interaction of review of death principles with clinical incident management processes, and the Western Australian Audit of Surgical Mortality.
## Appendix 2. Examples of death categorisation tools

### 1A. Death Categorisation based on the Health Round Table criteria

<table>
<thead>
<tr>
<th>Category 1</th>
<th>Anticipated death:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1a: due to terminal illness (anticipated by clinicians and family at the time).</td>
</tr>
<tr>
<td></td>
<td>1b: following cardiac or respiratory arrest before arriving at the hospital.</td>
</tr>
<tr>
<td>Category 2</td>
<td>Not unexpected death, which occurred despite the hospital/health service taking preventative measures.</td>
</tr>
<tr>
<td>Category 3</td>
<td>Unexpected death, which was not reasonably preventable with medical intervention.</td>
</tr>
<tr>
<td>Category 4</td>
<td>Preventable death where steps may not have been taken to prevent it.</td>
</tr>
<tr>
<td>Category 5</td>
<td>Unexpected death resulting from a medical intervention.</td>
</tr>
</tbody>
</table>
Appendix 2. (continued) Examples of death categorisation tools

1b. Trigger Questions and Death Classification utilised in the process of Mortality Review at the Royal Children’s Hospital, Melbourne

Trigger Questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was there a delay in diagnosis/assessment?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was there a delay in initiating treatment?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was there incorrect information provided or misinterpretation of information?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did the care management deviate from the policy or Clinical Practice Guideline?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was there a complication due to treatment/procedure/operation?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was there a medication error which may have contributed to the outcome?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was there a lack of availability or misuse of equipment?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was an adverse event* identified and, if so, was it documented in the notes?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was the deterioration in the patient recognized and responded to in a timely manner?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was assistance available when required?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was the skill-mix available appropriate?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Death Classification

<table>
<thead>
<tr>
<th>Classification</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Death was a likely outcome and all appropriate management was undertaken</td>
</tr>
<tr>
<td>2</td>
<td>Death was a likely outcome and all appropriate management was NOT undertaken</td>
</tr>
<tr>
<td>3</td>
<td>Death was unlikely and all appropriate management was undertaken</td>
</tr>
<tr>
<td>4</td>
<td>Death was unlikely and all appropriate management was NOT undertaken</td>
</tr>
</tbody>
</table>
Appendix 3. Reporting requirements to the Patient Safety Surveillance Unit.

**Reporting Requirement 1:**

Hospitals/ Health services must indicate when notifying a SAC 1 clinical incident (via the SAC 1 notification form) if the notification arose from a review of death or via the WAASM process.

This requirement provides a measure of the number of SAC 1 clinical incidents notified as an outcome of a review of death process.

**Reporting Requirement 2:**

Western Australian Public hospitals and licensed private health care facilities are to forward to the Patient Safety Surveillance Unit on a six-monthly basis the percentage of deaths that have been categorised (for preventability) within four months of the date of death.

Reports to the PSSU are due by the last business day in May for the previous July 1 to December 31 period, and the last business day in November for the previous January 1 to June 30 period.

<table>
<thead>
<tr>
<th>Purpose of the data:</th>
<th>To provide a measure of the percentage of in hospital deaths categorised (for preventability) within the required timeframe.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator:</td>
<td>The number of deaths where categorisation is completed within four months of the date of death.</td>
</tr>
<tr>
<td>Denominator:</td>
<td>The total number of in scope deaths that occurred within the reporting period.</td>
</tr>
<tr>
<td>Format:</td>
<td>Percentage</td>
</tr>
<tr>
<td>Reporting Frequency:</td>
<td>Six-monthly (July 1 – December 31 / January 1 – June 30)</td>
</tr>
<tr>
<td>Exclusions:</td>
<td>Deaths already notified as a SAC 1 clinical incident, and deaths audited as part of the WAASM process are excluded from the denominator.</td>
</tr>
</tbody>
</table>
References


