Information Circular

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Supersedes: IC 0006/07  
Number: IC 0061/09  
Date: 06-03256  
File No:

Subject: Death in Hospital Form & Guidelines

Issue
An inpatient hospital death requires health practitioners to be aware of a number of mandatory and statutory obligations particularly those reporting requirements under the Coroners Act 1996 and Health Act 1911.

The 2000 Douglas Inquiry identified the need to improve systems with respect to multiple reporting requirements.

The Death in Hospital (DIH) Form and Guidelines have been developed to assist health practitioners to navigate the key reporting obligations in a timely manner. The documents were developed in consultation with the State Coroner for statewide implementation.

Death In Hospital Form & Guidelines
The Death in Hospital (DIH) form provides a summary or checklist of the key statutory and mandatory reporting obligations that arise following an inpatient hospital death (Attachment A). Guidelines have also been developed to assist health practitioners complete the DIH form correctly and in a timely manner (Attachment B).

For the purposes of this Information Circular, an inpatient hospital death includes a death of a patient categorised as inpatient who might have died while on leave from hospital. All hospitals treating public patients are encouraged to use the DIH Form and Guidelines to comply with statutory and mandatory obligations following an inpatient hospital death.

The DIH Guidelines cover the key statutory and mandatory obligations following an inpatient hospital death under the following WA Health Directives and Circulars:

- Extinction of Life: see Operational Directive 0087/07
- Coroners Act 1996: see Information Circular 0008/07
- Sentinel Events reportable to the Director, Office of Safety and Quality in Healthcare see Operational Directive 0104/08
- Deaths reportable to the Chief Psychiatrist see Operational Circular 2061/06
This Information Circular does not override any information contained in the above documents but should be read in conjunction with them where further detail is required.

Implementation
Implementation of the DIH Form and Guidelines is strongly encouraged by all hospitals treating public patients from early 2007. All other hospitals may use this resource to improve their governance processes.

All hospital / health services will be responsible for printing and disseminating the forms throughout the ward and mortuary areas. It is recommended that copies of the DIH form and Guidelines be available on all hospital wards and mortuary areas.

The following Health Staff are to be informed of this Information Circular:
- Clinical staff including medical and nursing
- Mortuary and Post Mortem coordinators
- Relevant clerical staff
- Health Information staff
- Quality Improvement and Clinical Governance Coordinators

Officers in the Office of Safety and Quality in Health Care’s Coronial Liaison Unit are available to advise in the delivery and implementation of the DIH Form & Guidelines attached to this Information Circular.

Robyn Lawrence
EXECUTIVE DIRECTOR
INNOVATION AND HEALTH SYSTEM REFORM

This information is available in alternative formats upon a request from a person with a disability.
GUIDELINES FOR USING THE DEATH IN HOSPITAL FORM

The Death in Hospital (DIH) Form is designed as a tool to assist health practitioners comply with the key statutory and mandatory reporting obligations following a hospital inpatient death.

Use of the DIH Form and the 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 completed DIH Form should wherever practicable accompany the deceased person to the mortuary and eventually filed in deceased person’s Hospital Medical Record. The information documented will provide valuable information to Mortality Review Teams undertaking a review in accordance with the WA Review of Mortality Policy.

For each section of the DIH Form the following instructions are provided to assist staff use the tool correctly.

EXTINCTION OF LIFE

Assess the patient for Extinction of Life and document appropriately.

Where practicable proceed to consider whether the death is reportable to the coroner. Where this is not immediately practicable, a process should be established to ensure that the appropriate health practitioner considers at the earliest possible stage whether the death is reportable to the identified authorities.

IS THE DEATH REPORTABLE TO THE CORONER?

HOW TO REPORT A DEATH TO A CORONER.

The following reporting and notification process is strongly recommended as soon as practicable after the death of patient:

1. Complete the Section “Is the death reportable to the Coroner?”

2. If the answers to all of the questions in the above section are NO place the completed DIH Form in the deceased person’s Hospital Medical Record.

3. If the answer to any of the questions is YES:

   i) Report the death by telephone to the Police Coronial investigation Unit (PCIU) in the Perth Metropolitan area, or the local police in the first instance in the Country areas;

   ii) Forward the completed section by facsimile to the PCIU or local police; and
iii) Place a copy of the DIH Form on the deceased person’s Hospital Medical Record & the Hospital Coronal Investigation File.

NOTIFICATION OF A REPORTABLE DEATH UNDER THE CORONERS ACT 1996

On notification to the PCIU/police, the reporting health practitioner will be asked the following question: “Was the death an inevitable consequence of the deceased person’s illness or condition regardless of appropriate resuscitation, anaesthesia or surgery?”

1. If the answer to the question is NO then the death will become a “coroners case” and a post-mortem will be conducted.
2. If you are unable to provide an answer to this question then the PCIU or police will make a decision as to whether the death will become a coroner’s case.
3. If the answer is YES, then although the death is reportable pursuant to the Coroners Act 1996 (i.e. because one or more of the reportable criteria applies), further investigation such as a post-mortem may not be required unless the family of the deceased makes a request to the coroner.

Additional information on the provision of Hospital Medical Records

Where the death is confirmed to be a “coroners case” by PCIU / police and thus the subject of further investigation the deceased person’s Hospital Medical Record should be made available for submission to the Forensic Pathologist.

Hospitals staff should comply with their hospital policies with respect to the release of Hospital Medical Records, but note that when the original record is released a photocopy must be retained at the hospital or health service.

Hospitals and health services are responsible for ensuring that they have adequate procedures and policies in place to maintain the security and integrity of the deceased person’s original Hospital Medical Record prior to any release to the police for the purpose of a coronial investigation.

If a post-mortem is not required, the police (coroner’s investigator) will not collect the Hospital Medical Record. Where this is the case the original record should be retained at the hospital or health service in a manner where its integrity can be maintained at all times.

For further information on protocols for assisting coronial investigators refer to Operation Circular: 0008/07 Coroners Act 1996.
OTHER STATUTORY & MANDATORY REPORTING OBLIGATIONS

Health practitioners should note that in addition to notifying the Coroner they have an obligation to notify relevant authorities of deaths that are reportable under other statutes or WA Health mandatory policies. These are identified below:

Reportable Deaths to Executive Director Public Health under the Health Act 1911.

1. Death of a stillborn child that is greater than 20 weeks gestation, or any child up to one year of age (due to any cause). The medical practitioner who was attending at the time of stillbirth or certified that the death of the child had occurred must report the death.

2. Death of a woman as a result of pregnancy or childbirth or complications arising from these. The medical practitioner or nurse who attended the woman at the time of death must report the death.

3. Death of a person up to 48 hours following the period of administration of an anaesthetic agent or as any complications arising from the same. The person who administered the anaesthetic agent to the deceased person must report the death.

It is recommended that health practitioners reporting the death indicate on the DIH Form whether reporting / notification to the Executive Director Public Health has been completed. This will ensure that other appropriate staff that are responsible for the deceased person are aware of the notification status.

Sentinel Events

Sentinel Events are rare adverse events leading to serious harm or death that are caused by health care rather than patient illness. Sentinel Events may signal serious breakdowns in health care systems. These events require in-depth investigation to ascertain what happened and why, so preventive strategies can be implemented to reduce the occurrence of similar errors in the future.

The nationally agreed list of Sentinel Events includes the following:

- procedures involving the wrong patient or wrong body part;
- suicide of a patient in an inpatient unit;
- retained instruments or other material after surgery requiring re-operation or further surgical procedure;
- intravascular gas embolism resulting in death or neurological damage;
- haemolytic blood transfusion reaction resulting from ABO incompatibility;
- medication error leading to the death of a patient reasonably believed to be due to incorrect administration of drugs;
• maternal death or serious morbidity associated with labour or delivery;
• infant discharged to wrong family or infant abduction; and
• unexpected death or serious disability reasonably believed to be preventable.

All Sentinel Events must be reported via the Hospital Executive through to the Director of the Office of Safety and Quality in Healthcare within seven days of the event occurring. Notification should occur via the sentinel event reporting form is available on the Office of Safety and Quality website at: http://www.safetyandquality.health.wa.gov.au/clinical_incid_man/sentinel_events.cfm
The Sentinel event policy can be found by referring to the Operational Directive 0104/08.

Deaths reportable to the Chief Psychiatrist.

The death of a patient (voluntary or involuntary) under the care of a mental health service is to be reported to the Chief Psychiatrist. Notification should occur by email or by telephoning the Chief Psychiatrist on 9222 4462. The policy outlining this reporting requirement can be found by referring to Operational Circular 2061/06: Matters reportable to the Chief Psychiatrist. Further information can also found on the website: http://www.chiefpsychiatrist.health.wa.gov.au/reporting/index.cfm

HOSPITAL REQUIREMENTS

This section includes a limited list of other tasks or notifications that are generally carried out following an inpatient death. It is acknowledged that not all of these requirements will be applicable to all hospitals. The categories provided are the most common requirements, other suggestions for inclusion will be considered during the review phase.

REVIEW OF THE FORM AND GUIDELINES

It is envisaged that the DIH Form, and Information Circular and supporting Guidelines will be reviewed 12 to 18 months following release. All stakeholders will have the opportunity to provide input with respect to an updated version hence early implementation is encouraged.
Death in Hospital

Affix Hospital Identification here

Surname

UMRN

Given names

DOB

SEX

Address

Suburb

Postcode

Extinction of life

Death occurred in: ____________   ED ☐  Ward ☐  Theatre ☐  Other ☐  While on leave from hospital ☐

Doctor Certifying Life Extinct: Name __________________________________ Position ______________________

Signature ______________________ Date ____________

Date of Death: __/__/____  Time of Death: _____ : ______ Hrs.

Is the death reportable to the Coroner?

1. Is the cause of death unknown or uncertified by a medical practitioner? ☐ Yes ☐ No

2. Has the death or does the death appear to be have occurred in suspicious circumstances? ☐ Yes ☐ No
   ie Has the death possibly resulted from a criminal act?

3. Was the death or does the death appear to have been unexpected or unnatural?
   Eg. Complication following administration of a medication, diagnostic, medical or surgical procedure
   ☐ Yes ☐ No

4. Has the death or does the death appear to have occurred, in or following violent circumstances?
   Eg. Physical or sexual assault, domestic dispute
   ☐ Yes ☐ No

5. Has the death or does the death appear to have resulted, directly or indirectly from injury?
   Eg. Fall, motor vehicle, self harm
   ☐ Yes ☐ No

6. Has the death occurred during anaesthesia? Eg. General anaesthesia
   ☐ Yes ☐ No

7. Did the death occur as a result of, or does it appear to have resulted from anaesthesia?
   ☐ Yes ☐ No

8. Immediately prior to the death was the deceased person
   - Under the control, care or custody of the WA Police Force, Prison Service or Department for Community Development
     ☐ Yes ☐ No
   - Admitted to a centre under the Alcohol and Drug Authority Act 1974
     ☐ Yes ☐ No
   - An involuntary patient, apprehended or detained under the Mental Health Act 1996
     ☐ Yes ☐ No

9. Is the deceased person's identity unknown?
   ☐ Yes ☐ No

10. To your knowledge has any one expressed any concerns regarding the cause of the deceased person's death or medical treatment?
    ☐ Yes ☐ No

If you have answered YES to any of the above questions, the death is REPORTABLE to the Coroner.

Note: Where the original Hospital Medical Record is released for the purposes of coronial investigation, a photocopy must be retained at the hospital or health service.

How to report a death to the coroner

You must ring and fax this Form to report the death as per the following:

☐ PERTH: The Police Coronial Investigation Unit (PCIU) Telephone: 9420 5200 - (24 hrs) fax: 9324 1355

☐ COUNTRY: The local police.

Need to discuss any aspects of this death further? Telephone the Duty Delegated Coroner on 0419 904 478 9am-5pm (METRO) or the appropriate Country Registrar (COUNTRY).
### Notification of reportable deaths under the *Coroners Act 1996*

On notification you will be asked for information on the circumstances surrounding the death, which should be conveyed to the coronial delegate (e.g. the PClU/police officer to whom the death is reported). You should also consider the answer to the question "Was death an inevitable consequence of the deceased person’s primary illness or condition regardless of appropriate resuscitation, anaesthesia, or surgery?" In cases when the answer is 'yes' a post mortem may not be necessary.

<table>
<thead>
<tr>
<th>PClU/police officer notified by phone:</th>
<th>Date: <em><strong>/</strong></em>/______</th>
<th>Time: _<strong><strong>:</strong></strong> Hrs.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of PClU/police officer: (please print)</td>
<td>______________________________</td>
<td></td>
</tr>
<tr>
<td>Name of Doctor reporting (please print)</td>
<td>______________________________</td>
<td></td>
</tr>
<tr>
<td>Consultant notified</td>
<td>☐ Yes ☐ No</td>
<td>Contact Number ____________________</td>
</tr>
</tbody>
</table>

If the death is reportable a copy of this Form should be placed in the deceased person’s Hospital Medical Record as well as the Hospital’s Coronial Investigation File.

Where the death is NOT reportable:
- the original copy of this Form must be filed in the deceased person’s Hospital Medical Record
- you may complete the following Forms:
  1. Medical Certificate Cause of Death (BDM 202/201) and Completed? ☐ Yes ☐ No
  2. Certificate of Medical Attendant (Forms 7 WA Cremation Act) Completed? ☐ Yes ☐ No

### Other reporting obligations

#### Reportable deaths under the *Health Act 1911*

- A maternal death (arising from pregnancy or childbirth or associated complications) ☐ Yes ☐ No
- One involving a child who is still born (> than 20 weeks gestation), or under the age of 1 year ☐ Yes ☐ No
- One that occurred within 48 hours of administration of anaesthetic or as a result of complications arising from the same ☐ Yes ☐ No

If you have answered YES to any of the above questions, the death is reportable to the Executive Director Public Health. For further information refer to the Statutory Medical Notifications website (www.health.wa.gov.au/notifications).

#### Sentinel Events and deaths reportable to the Chief Psychiatrist

A ‘reportable’ death to the Coroner may also be a Sentinel Event. Sentinel Events are rare events that lead to catastrophic patient outcomes. For further information refer to the Office of Safety and Quality website (www.health.wa.gov.au/safetyandquality).

Sentinel Event deaths should be reported via the Hospital Executive to the Chief Medical Officer as per the Sentinel Event Policy.

The Chief Psychiatrist is to be informed of any death of a patient (voluntary or involuntary) while under the care of any mental health service. Reporting can be made via email or telephone to the Chief Psychiatrist.

For further information telephone the Office of the Chief Psychiatrist (08) 9222 4462.

### Additional hospital requirements

<table>
<thead>
<tr>
<th>Donor Coordinator notified</th>
<th>☐ Yes ☐ No</th>
<th>Discharge summary completed</th>
<th>☐ Yes ☐ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Permission for postmortem</td>
<td>☐ Yes ☐ No</td>
<td>Bereavement support</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>Nursing home notified</td>
<td>☐ Yes ☐ No</td>
<td>General Practitioner notified</td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td>Next of kin notified as designated in the Hospital Medical Record</td>
<td>☐ Yes ☐ No</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>