



Government of **Western Australia**  
Department of **Health**

# Review of Death Guideline

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## 1. Introduction

Reviews of death are one component of an overall approach to clinical governance that includes clinical risk management, clinical incident management and complaint management. The National Safety and Quality Health Service (NSQHS) Standards (second edition)<sup>1</sup> devote the entirety of Standard 1 to the importance of clinical governance within health service organisations.

Reviews of death provide valuable opportunities to examine the care provided to patients; to identify if the care was appropriate, whether it could be delivered differently or improved, and to evaluate the quality of end-of-life care and care during the terminal phase. Reviews of death may also identify cases where sub-optimal care may have contributed to the death of a patient, and that death may have been preventable.

“Evaluation should address the quality and safety of the end-of-life care provided, not just the potential preventability of death”<sup>2</sup>

The purpose of the Review of Death Guideline (this Guideline) is to provide Health Service Providers and clinicians with additional information to support their implementation of the Review of Death Policy (the Policy). This Guideline should be used in conjunction with the Policy and related / supporting documents including the *Death in Hospital Form* and *Review of Death flowchart*.

This Guideline also provides summary information that has a relationship to the Policy, including some of the other policy and statutory requirements that may exist when a patient dies. This Guideline does not over-ride, and is not intended to provide detailed information in respect of these requirements, and must be read in conjunction with the respective legislation, policies and supporting information.

Aspects relating to the requirements to certify and register deaths (including neonatal deaths and stillbirths) under the *Births, Deaths and Marriages Registration Act 1998* are not covered in this Guideline.

## 2. Statutory and mandatory reporting requirements following death

When a patient dies there are a number of statutory and mandatory reporting requirements that may apply given the nature and circumstances of the patient and/or their death.

The *Death in Hospital Form* (a related document attached to the Policy) provides a summary / checklist of the key statutory and mandatory reporting obligations that arise following the death of a patient.

The fact that reporting of a death to an external body is required or has occurred does not remove the need for local review of the death in accordance with the Policy.

### 2.1 Coroners Act 1996

The *Coroners Act 1996* defines the criteria for a reportable death and establishes the statutory responsibility for reporting a death to the coroner.

A reportable death is a Western Australian death:

- a) that appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from injury<sup>i</sup>; or
- b) that occurs during anaesthetic; or
- c) that occurs as a result of an anaesthetic and is not due to natural causes; or
- d) that occurs in prescribed circumstances<sup>ii</sup>; or
- e) of a person who immediately before death was a person held in care; or
- f) that appears to have been caused or contributed to while the person was held in care; or
- g) that appears to have been caused or contributed to by any action of a member of the Police Force; or
- h) of a person whose identity is unknown; or
- i) that occurs in WA where the cause of death has not been certified; or
- j) that occurred outside WA where the cause of death has not been certified by a qualified medical practitioner.

A 'person held in care'<sup>iii</sup> is a person in the care of a government agency under the authority of specific legislation. Of particular relevance to the health sector is the death of a person who was, at the time of death:

- a person under, or escaping from, control, care or custody under the *Children and Community Services Act 2004*; or
- admitted to any centre under the *Alcohol and Other Drugs Act 1974*; or
- held as an involuntary patient, or apprehended, detained or absent without leave within the meaning of the *Mental Health Act 2014*.

If any person (including family members, staff members or carers) has expressed any concerns about the care provided or other circumstances of the death, the death should be reported to the coroner.

Under the *Coroners Act 1996* (s.17) a doctor present at or soon after the death of a person must report the death immediately to a coroner (unless the death has already been reported) if:

- the death is or may be reportable; or
- the doctor is unable to determine the cause of death; or
- in the opinion of the doctor, the death has occurred under any suspicious circumstances.

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<sup>i</sup> In the health context it is important to note that 'injury' includes accidents and falls

<sup>ii</sup> Prescribed circumstances are circumstances described in the *Coroners Regulations 1997*

<sup>iii</sup> For the full definition of a 'person held in care', refer to Part 1 of the *Coroners Act 1996*

If there are any concerns or doubts as to whether a death should be reported to the coroner, the coroner's delegate should be contacted for assistance. Any person who reports a death must give to the coroner investigating the death any information which may help the investigation (s.18). Where a death is reportable under the *Coroners Act 1996* a death certificate should not be completed.<sup>3</sup>

The coronial process is summarised in Appendix 1. Further information about the coronial process in WA can be found at <http://www.coronerscourt.wa.gov.au/default.aspx>

### **2.1.1 Babies born alive after termination procedures**

The Coroner's Court of Western Australia has confirmed that where a baby is born alive following a termination procedure and subsequently dies, this is a reportable death under the *Coroners Act 1996*.

Health Service Providers and clinicians are reminded that once a fetus is born alive it becomes a legal person entitled to care in the same manner as all other patients, irrespective of the circumstances of the birth. Any act or omission after a live birth which causes the death of the baby, including a failure to provide appropriate medical care, may have legal consequences. However, as with all patients, there is no obligation on a clinician or Health Service Provider to provide futile medical care, and palliative care should be provided when needed.

## **2.2 Health (Miscellaneous Provisions) Act 1911**

The *Health (Miscellaneous Provisions) Act 1911* requires that three types of deaths must be notified to the Chief Health Officer (CHO) for Western Australia. The Office of the Chief Health Officer is one of the public health directorates of the Department of Health.

### **2.2.1 Death of woman as a result of pregnancy or childbirth**

The CHO must be notified whenever any woman dies as the result of pregnancy or childbirth, or as the result of any complications arising from this, as soon as possible after the death, preferably within 48 hours.

The medical practitioner and any nurse attending the woman at the time of death are responsible for making the notification.

Further information on how to make a notification and the information to be provided can be found at [http://ww2.health.wa.gov.au/Articles/N\\_R/Notification-of-death-of-a-woman-as-a-result-of-pregnancy-or-childbirth](http://ww2.health.wa.gov.au/Articles/N_R/Notification-of-death-of-a-woman-as-a-result-of-pregnancy-or-childbirth)

### **2.2.2 Perinatal and infant deaths**

The CHO must be notified whenever any child:

- of more than 20 weeks gestation is stillborn, or
- under the age of 1 year dies from any cause whatsoever.

The medical practitioner who certified the cause of the child's death is responsible for making the notification.

Further information on how to make a notification and the information to be provided can be found at [http://ww2.health.wa.gov.au/Articles/N\\_R/Notification-of-perinatal-and-infant-deaths](http://ww2.health.wa.gov.au/Articles/N_R/Notification-of-perinatal-and-infant-deaths)

### **2.2.3 Anaesthetic death**

The CHO must be notified as soon as possible, preferably within 48 hours, when:

- any person dies within a period of 48 hours following the administration of an anaesthetic agent
- any person dies as the result of any complications arising from the administration of an anaesthetic, or
- any medical practitioner is of the opinion that the anaesthesia or administration of an anaesthetic may reasonably be suspected as the cause of death or as contributing to the cause of death.

The person who administered the anaesthetic to the deceased, or the medical practitioner who forms the opinion that anaesthesia or the administration of an anaesthetic may reasonably be suspected as the cause of death or as contributing to the cause of death of that person, is responsible for making the notification.

Further information on how to make a notification and the information to be provided can be found at [http://ww2.health.wa.gov.au/Articles/N\\_R/Notification-of-anaesthetic-death](http://ww2.health.wa.gov.au/Articles/N_R/Notification-of-anaesthetic-death)

### 2.3 Mental Health Act 2014

The Chief Psychiatrist is responsible for overseeing the treatment and care of voluntary, involuntary, mentally impaired accused clients, and patients referred or detained under the *Mental Health Act 2014*. It is a statutory requirement that all notifiable incidents pertaining to psychiatric patients are reported to the Chief Psychiatrist as soon as practicable, ideally within 48 hours of the event.

The Chief Psychiatrist is to be informed as a matter of priority, of any death of a mental health patient while under the care of any mental health or other health service and any death that may implicate or involve mental health or other health services or stakeholders (*Mental Health Act 2014* section 525(a)). The Chief Psychiatrist is also to be advised of deaths, that mental health services become aware of, occurring within three months of a person being discharged or deactivated from mental health services.<sup>4</sup>

Notifiable incidents must be reported to the Chief Psychiatrist for persons receiving psychiatric care as:

- an inpatient of a mental health service
- an inpatient of a general health service receiving concurrent treatment from mental health services
- a client of community mental health services
- an inpatient of drug and alcohol services receiving concurrent treatment from mental health services.

Further information on how to make a notification to the Chief Psychiatrist can be found at <https://www.chiefpsychiatrist.wa.gov.au/monitoring-reporting/notifiable-incidents/>

### 2.4 Parliamentary Commissioner Act 1971

The *Parliamentary Commissioner Act 1971* provides for the Western Australian Ombudsman (Ombudsman) to investigate deaths of children and deaths that may be associated with family and domestic violence.

While the Department of Health and Health Service Providers are not required to notify the Ombudsman directly of child deaths or deaths that may be related to family or domestic

violence it should be noted that the Ombudsman has wide powers of investigation including the ability to obtain information relevant to the death from Health Service Providers, and to recommend improvements to public administration to prevent or reduce deaths across all agencies within the Ombudsman's jurisdiction. The Ombudsman also actively monitors the implementation of the recommendations it makes, and their effectiveness in preventing or reducing deaths.

### 2.4.1 Child death reviews

The Ombudsman's functions in respect of investigable deaths are to review the circumstances in which and why child deaths occur, to identify patterns and trends arising from child deaths, and seek improvements in public administration to prevent or reduce child deaths.<sup>5</sup>

An investigable death is defined as one in which:

- in the two years before the child's death, the CEO of the child protection agency had received information that raised concerns about the wellbeing of the child or a child relative of the child;
- in the two years before the child's death, the CEO of the child protection agency had determined that action should be taken to safeguard or promote the wellbeing of the child or a child relative of the child;
- in the two years before the child's death, any of the actions listed in section 32(1) of the *Children and Community Services Act 2004* was done in respect of the child or a child relative of the child;
- the child or a child relative of the child is in the care of the child protection agency, or protection proceedings are pending in respect of the child or a child relative of the child.

The Coroner notifies the child protection agency of all reportable deaths of children, and the child protection agency then notifies the Ombudsman of all child deaths notified to it by the Coroner. The Ombudsman assesses each notified death to determine if the death is an investigable death or a non-investigable death. All investigable deaths are reviewed and non-investigable deaths can also be reviewed.

### 2.4.2 Family and domestic violence fatalities

The family and domestic violence fatality review process is intended to identify key learnings that will positively contribute to ways to prevent or reduce family and domestic violence fatalities.<sup>5</sup> This may include making recommendations to prevent or reduce family and domestic violence fatalities.

A family and domestic violence fatality involves a relationship between two people (the person who died and the suspected perpetrator):

- who are, or were, married to each other; or
- who are, or were, in a de facto relationship with each other; or
- who are, or were, related to each other; or
- one of whom is a child who ordinarily or regularly resides or stays, or resided or stayed, with the other person; or
- one of whom is, or was, a child of whom the other person is a guardian; or
- who have, or had, an intimate personal relationship, or other personal relationship, with each other.

Suspected family and domestic violence fatalities are reported to the Ombudsman by the Western Australian Police Force.

### 3. Methodologies for the review of patient deaths

Multiple methodologies exist within the WA health system to review patient deaths. Where a patient's death is audited as part of the Western Australian Audit of Surgical Mortality (WAASM) and/or notified as a Severity Assessment Code (SAC) 1 clinical incident and investigated under the Clinical Incident Management (CIM) Policy, an additional local review of the death under the Policy is not required.

The *Review of Death flowchart* (a supporting document to the Policy) describes the interaction between the Policy and the CIM and WAASM processes. The CIM and WAASM processes are summarised below.

#### 3.1 Clinical incident management

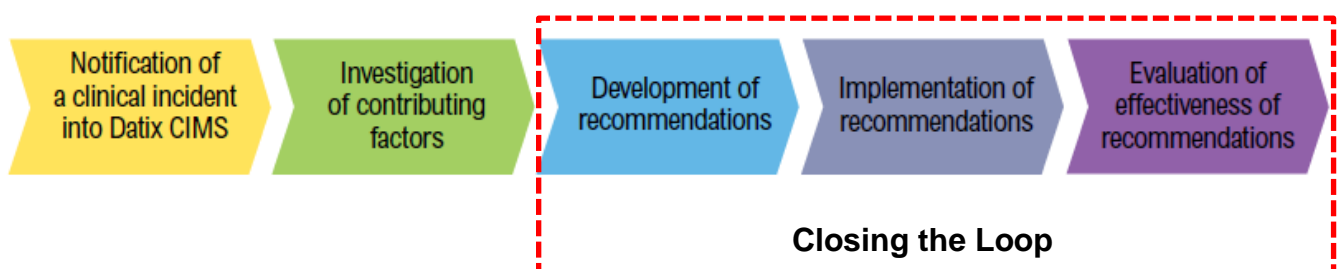
The CIM Policy<sup>6</sup> is a mandatory component of the Clinical Governance, Safety and Quality Policy Framework (CGSQPF) that applies to all Health Service Providers and details the requirements for the notification and investigation of clinical incidents in WA. Since its introduction the CIM Policy has led to an increase in the notification of potential clinical incidents with an outcome of serious harm or death (SAC 1 clinical incidents). It appears that increasing awareness of clinical incident notification requirements amongst clinicians has made it more likely that a death that may have been contributed to by health care (or a lack thereof) will be notified as a SAC 1 clinical incident at or around the time of death.

An example mortality screening form, which includes questions that may assist in the identification of SAC 1 clinical incidents, can be found at Appendix 2.

Key components of the CIM process (see Figure 1) include:

- notification of the incident into the approved clinical incident management system (Datix CIMS in the WA public health system)
- analysis and investigation to establish the course of events and identify contributing factors – for SAC 1 clinical incidents the CIM Policy requires investigation by a rigorous methodology such as Root Cause Analysis (RCA)
- the development of SMARTA recommendations to address the causative/contributory factors, minimise the likelihood of recurrence and lead to system improvement. SMARTA recommendations are:
  - **S**pecific
  - **M**easurable
  - **A**ccountable
  - **R**ealistic
  - **T**ime related
  - **A**ction strength
- implementation and evaluation of the actions taken in response to the incident to identify whether improvement has been achieved.

**Figure 1: The clinical incident management process**





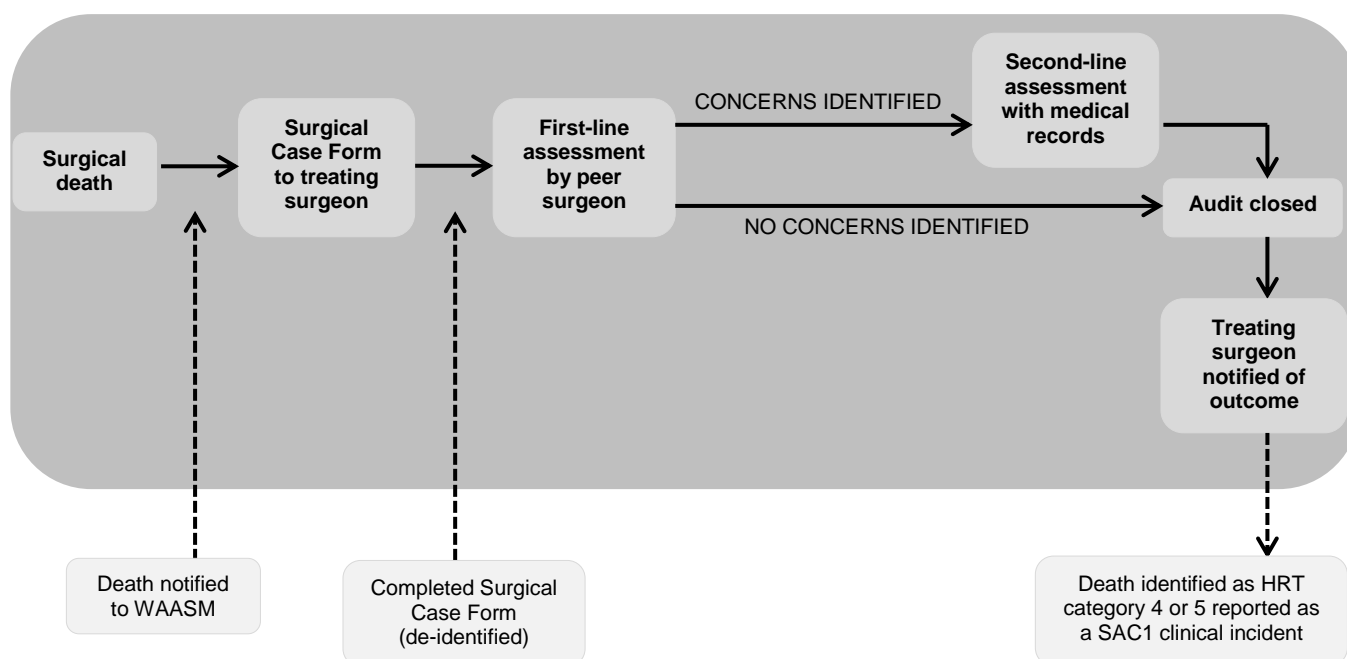
### 3.2 Western Australian Audit of Surgical Mortality

The WAASM is managed by the Royal Australasian College of Surgeons (RACS) and funded by the Department of Health. The WAASM follows a peer review methodology for surgically-related deaths. The audit includes deaths where no procedure was undertaken if the patient was under the care of a surgeon. Where a decision for terminal care had been made at the point of admission, only the deaths where a procedure was undertaken are included in the audit.

The RACS has mandated Fellows' participation in the WAASM process as part of their Continuing Professional Development (CPD) requirements. The Medical Board of Australia's CPD registration standard requires that medical practitioners who have specialist registration must meet the requirements for CPD set by the relevant specialist medical college.

Under the WAASM process (see Figure 2) peer assessors classify a death in terms of preventability using the Health Round Table (HRT) criteria.<sup>7</sup> The qualified privilege mechanisms that apply to the WAASM process currently limit the disclosure of information relating to audit investigations to participating surgeons. Consequently, treating surgeons are advised of their obligation to notify any death considered a preventable adverse event as a SAC 1 clinical incident in accordance with the CIM Policy. Notification as a SAC 1 clinical incident following review via the WAASM should be noted in the incident description in Datix CIMS.

**Figure 2: The WAASM process**



Further information regarding the WAASM, including qualified privilege, is available at the WAASM webpage:

<https://www.surgeons.org/research-audit/surgical-mortality-audits/regional-audits/waasm>

## 4. Reviews of death under the Review of Death Policy

The Policy requirements include that when reviewing the death of a patient, the review process includes both examination of the nature and quality of care provided to the patient considering their clinical and cultural context, and the capacity for independent review of the death to occur.

The review process should take into account whether culturally respectful and appropriate care was provided to Aboriginal and Torres Strait Islander persons, and other persons from culturally and linguistically diverse backgrounds, including their cultural considerations, beliefs and values at end-of-life. The incorporation of these components into processes for reviewing patient deaths may assist Health Service Providers to improve patient care in alignment with key state-wide initiatives, such as the *WA Aboriginal Health and Wellbeing Framework 2015–2030*<sup>8</sup>, and demonstrate compliance with Standard 1.4 of the NSQHS Standards (version 2). The ACSQHC has released the *National Safety and Quality Health Service Standards User Guide for Aboriginal and Torres Strait Islander Health*<sup>9</sup> to support health service organisations delivery of better and more appropriate care to Aboriginal and Torres Strait Islander persons.

The following information is provided to assist Health Service Providers in delivering comprehensive reviews of patient deaths, including terminally ill and palliative care patients, and effective governance of independent review processes.

### 4.1 Scope of the Review of Death Policy

The following information supports the scope of the Review of Death Policy (refer to section 3.3.1 of the Policy).

#### 4.1.1 Deaths of patients on leave, missing or absent without leave

Where patients, including mental health patients, are granted or take leave from inpatient settings and die while missing, absent or on leave, these deaths should be regarded by Health Service Providers as in scope of the Review of Death Policy, and reviewed in accordance with the Policy's requirements, if they are not being investigated as SAC 1 clinical incidents under the CIM Policy.

Where a patient dies while missing, absent or on leave from an inpatient setting and the death is being reviewed under the Policy, the examination of the patient journey in the period leading up to death should include the clinical decision-making around the suitability of the patient to be granted leave, or the factors that may have allowed the patient to go missing or absent without leave.

#### 4.1.2 Fetal death in utero and stillbirth

With active intervention, most infants born at 26 weeks gestational age and above have a high likelihood of survival, and virtually none below 22 weeks will survive. The chance of survival increases dramatically over these few weeks.<sup>10</sup>

Health Service Providers that provide maternity services should, as a minimum, review all cases of fetal death in utero (FDIU) and stillbirth occurring at 23 weeks gestational age<sup>iv</sup> and above in accordance with the Policy's requirements, where these have not been notified as SAC 1 clinical incidents. Health Service Providers may choose whether to review FDIU and stillbirth occurring before 23 weeks gestational age on a case-by-case basis.

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<sup>iv</sup> Please note that the requirements to report stillbirths to the Chief Health Officer under the *Health (Miscellaneous Provisions) Act 1911* and register stillbirths under the *Births, Deaths and Marriages Registration Act 1998* apply from 20 weeks gestational age

The review should include the antenatal care provided, as well as that given following the identification of FDIU and stillbirth. The [Perinatal Loss Clinical Practice Guideline](#) produced by the Women and Newborn Health Service may be useful when reviewing the quality of care provided in cases of FDIU and stillbirth.

## 4.2 Deaths of terminally ill and palliative care patients

National and local standards and statements relating to the provision of end-of-life and palliative care<sup>2,11-13</sup> recognise the importance of quality improvement and research to improve the delivery of health services to these patient groups.

When reviewing deaths of terminally ill (anticipated deaths) and palliative care patients, Health Service Providers should consider covering the following areas:

- Whether triggers or clinical indicators to identify patients approaching the end of life were correctly used and applied
- The effective prevention and treatment of the patient's symptoms
- Whether goals of care were established and achieved
- Documentation of the patient's preferences, and alignment of the care provided to their expressed preferences
- That terminal phase care was revised and a plan of care (e.g. Care Plan for the Dying Person) was documented to meet the unique needs of the patient, family and carers
- Feedback on patient experiences of care (if available)
- Feedback on the experiences of families and carers of patients who received end-of life care (if available)
- Whether any existing Advance Health Directive, Advance Care Plan or Goals of Patient Care Summary was enacted<sup>v</sup>
- The time lapse between deciding to palliate or referring to specialist palliative care, and death
- Transfers of care in the last weeks of life (e.g. transfers to or from intensive care, transfers from country to metropolitan hospitals)
- Whether unnecessary burdens were avoided (e.g. non-beneficial or unwanted observations, interventions, investigations and/or treatments).

## 4.3 Independent reviews of death

The purpose of independent mechanisms for the review of patient deaths, such as clinical review, mortality review and morbidity and mortality committees, is to allow learning from issues by modifying judgment and clinical decision making, to prevent the repetition of adverse events, and to improve patient care. These reviews can lead to improvements in patient safety via the identification of areas for system improvement and the implementation of actions to improve clinical practice.<sup>14,15</sup>

Health Service Providers should consider the following attributes of effective committees and meetings where independent mechanisms for the review of patient deaths are established:

- Terms of reference that describe functions and purpose should be developed and implemented, including the allocation of an executive sponsor to whom the committee/group is accountable

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<sup>v</sup> Further information and resources regarding Advance Care Planning and Advance Health Directives can be found at: <http://ww2.health.wa.gov.au/Health-for/Health-professionals/End-of-life>

- The composition of the committee/group should:
  - Be multi-disciplinary (i.e. include representatives from medical, nursing and allied health disciplines) and all levels of staff involved in the care of the patient should be involved
  - Include staff with the necessary expertise to review the quality of care provided to the patient and assess the potential preventability of the death
- The chairperson should be a senior member of the department or health service organisation, and is responsible for initiating and ensuring discussions are aligned to educational purposes and quality improvement, however the chairperson need not present individual cases
- Meetings should be conducted on a regular basis and scheduled well in advance to maximise clinician availability
- Capacity should exist for clinical staff to nominate cases they consider worthy of discussion at meetings
- Information regarding cases for discussion should be de-identified and presented in a consistent and structured manner
- Discussions should occur in a blame-free environment and focus on:
  - Identifying issues that relate to processes or systems of care that contributed sub-optimal care or adverse patient outcomes
  - Actions that can be recommended and implemented to improve standards of care or prevent adverse outcomes in the future
- Progress on the implementation and evaluation of the effectiveness of actions taken in response to mortality reviews should be brought back to subsequent meetings. Where an action recommended by the committee/group cannot be implemented this should be escalated appropriately within the health service organisation
- The committee/group should be supported by a secretariat that is responsible for the preparation of agendas and taking and filing of minutes. The minutes of each meeting should:
  - Identify the cases that were discussed (e.g. by UMRN)
  - Include the outcome of the review of each death, including the final categorisation with respect to preventability, and any actions recommended to be taken to improve standards of care or prevent adverse outcomes in the future (including the staff member accountable for progressing the actions)
  - Include details of progress on the implementation and evaluation of the effectiveness of actions recommended from previous meetings.

## 5. Responding to recommendations made by external agencies

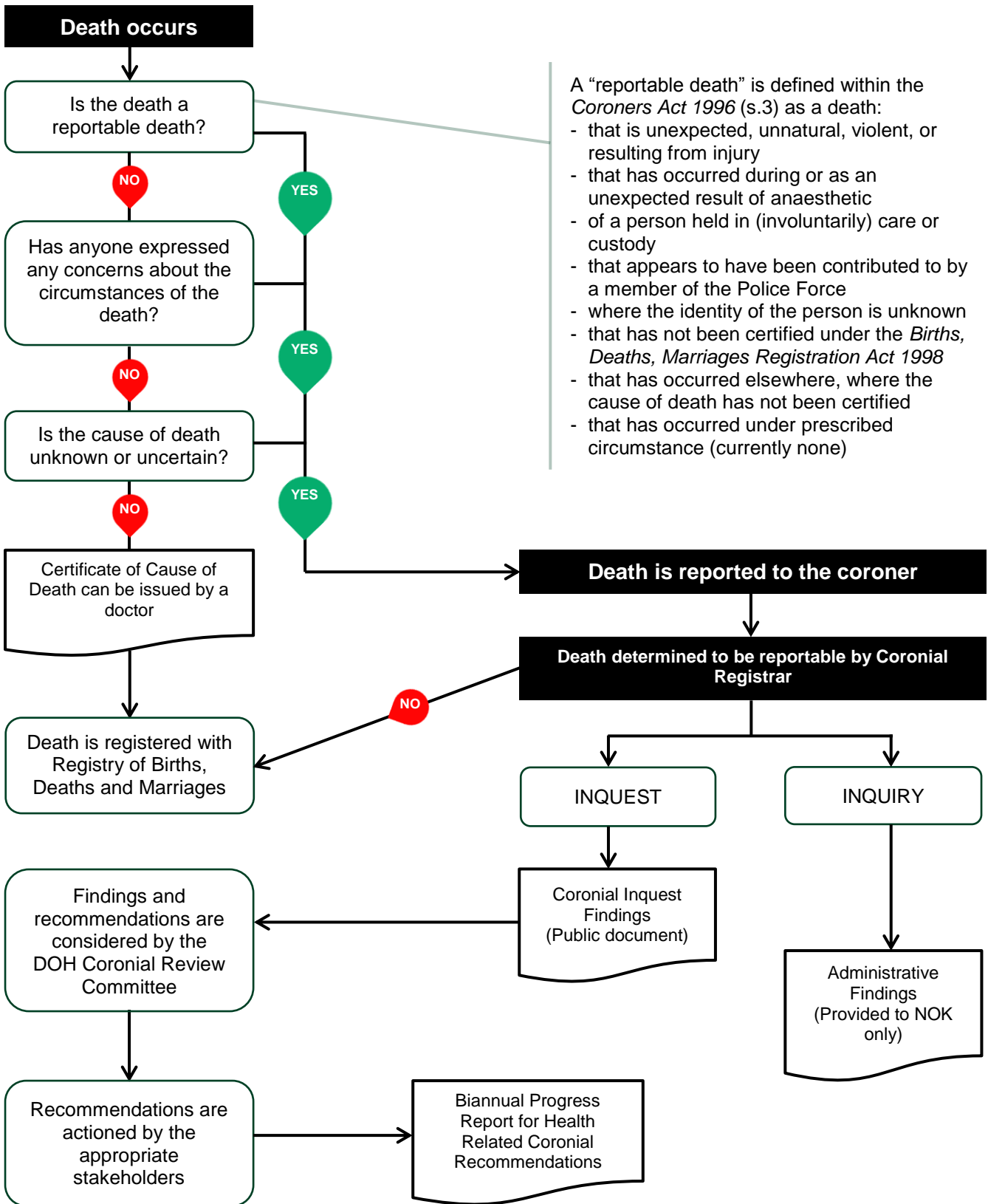
While the Review of Death and Clinical Incident Management processes expect that action will be taken when deficiencies or opportunities for improvement in health care delivery are identified, it is also possible that external review processes associated with death may result in recommendations applicable to the WA health system:

- At the conclusion of a coronial inquest the coroner may make recommendations relating to one or more Health Service Providers, or the health system more generally, with the aim of preventing further deaths in similar circumstances in the future.
- The WA Ombudsman may make recommendations to public authorities (including Health Service Providers) with respect to strategies for preventing or reducing child deaths and deaths associated with family and domestic violence.

It is in the interest of Health Service Providers to be responsive and transparent in their consideration of recommendations made by these agencies to improve public safety and to reduce or prevent such deaths. Where appropriate, recommendations should be seen as an opportunity to drive improvement across the WA health system, irrespective of where the recommendation is directed. The provision of timely and meaningful responses to external agencies will reflect the WA health system's commitment to ongoing improvement and ensuring patient safety.

# Appendices

## Appendix 1: Coronial process flow chart



## Appendix 2: Example mortality screening form

Adapted from the Royal Children's Hospital Melbourne Departmental Morbidity & Mortality Review form.<sup>16</sup>

Department:		Patient UMRN:	
Date of Admission:		Date of Death:	
Admission diagnosis:			
Completed by:		Date:	

### Section 1: Trigger questions

Question	Yes	No	Comments
Was there a delay in diagnosis/assessment?			
Was there a delay in initiating treatment?			
Was there a failure to recognize and/or respond to deterioration of the patient in a timely manner?			
Was there incorrect or misinterpretation of information?			
Did the care provided deviate from policies/procedures/guidelines?			
Was there a complication due to a treatment/procedure/operation?			
Was there a medication error?			
Was there a lack of availability, fault or misuse of equipment?			
Was there a delay in accessing appropriate resources/assistance to treat the patient?			
Were there difficulties accessing appropriately skilled staff when needed?			
Was an adverse event identified, and if so was it documented in the medical record?			

## Section 2: HRT categorisation of death (tick the most appropriate category)

Category		Description
<input type="checkbox"/>	Category 1	Anticipated death: 1a: due to terminal illness (anticipated by clinicians and family at the time). 1b: following cardiac or respiratory arrest before arriving at the hospital.
<input type="checkbox"/>	Category 2	Not unexpected death, which occurred despite the hospital/health service taking preventative measures.
<input type="checkbox"/>	Category 3	Unexpected death, which was not reasonably preventable with medical intervention.
<input type="checkbox"/>	Category 4	Preventable death where steps may not have been taken to prevent it.
<input type="checkbox"/>	Category 5	Unexpected death resulting from a medical intervention.

If the patient's death meets the criteria for HRT category 4 or 5 it must be notified as a SAC 1 clinical incident and investigated in accordance with the Clinical Incident Management Policy.

If the patient's death meets the criteria for HRT category 1 or 2 complete section 3 below.

### Section 3: Expected death questions

Question	Yes	No	Comments
Was there adequate discussion with the family regarding the outcome?			
Was withdrawal or limiting treatment discussed with the family?			
Was an Advance Care Plan or Advance Health Directive in place?			
Was a timely referral made to palliative care?			
Was organ or tissue donation considered?			
Was the patient's pain and suffering effectively controlled?			
Have the patient's GP and referring medical practitioner been informed of the death?			



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## Document control

Version	Date	Amendment(s)
1.0	November 2018	Original version published with Review of Death Policy MP0098/18.
1.1	April 2019	Updated to clarify aspects relating to Coroners Act, FDIU/stillbirth and deaths of patients on leave/missing/absent without leave.
1.2	November 2019	Updated section 3.1 to align with revised <i>Clinical Incident Management Policy 2019</i> MP 0122/19 and updated links in section 3.2 and references 6 and 14.

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