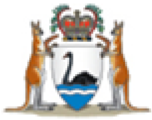


**Policy Frameworks**
MP 0098/18
Effective from: 1 January 2018

# Review of Death Policy

## 1. Purpose

The purpose of the Review of Death Policy (this Policy) is to ensure that Health Service Providers implement consistent policies, processes and systems for the recording and review of patient deaths in order to identify:

a. Potentially preventable deaths
b. Opportunities for improvement in the delivery of health services, including the quality of end-of-life care.

This Policy is a mandatory requirement under the *Clinical Governance, Safety and Quality Policy Framework* pursuant to section 26(2)(l) of the *Health Services Act 2016*.

This Policy supersedes Operational Directive 0448/13 *WA Review of Death Policy 2013*.

## 2. Applicability

This Policy is applicable to the following Health Service Providers:

- Child and Adolescent Health Service
- East Metropolitan Health Service
- North Metropolitan Health Service
- South Metropolitan Health Service
- WA Country Health Service
- Quadriplegic Centre
- PathWest.

Where a private health care facility has a licence requirement to comply with this Policy, any references to:

- Health Service Providers are to be taken as references to that private health care facility
- Hospitals are to be taken to include day hospitals.

## 3. Policy requirements

### 3.1 Death in Hospital form

Health Service Providers must ensure that:

- A 'Death in Hospital' form is developed and implemented and, at a minimum, collects the information described in the *Death in Hospital Form* (see section 5 Related Documents), and is applicable to the local clinical context. Health Service Providers may expand the *Death in Hospital Form* as needed to meet local requirements.
- A clinician or clinical team responsible for the care of the patient at the time of death completes the 'Death in Hospital' form immediately following, and no later than 48 hours after, the death of the patient.

- A copy of the 'Death in Hospital' form completed by the clinician or clinical team responsible for the care of the patient at the time of death is filed in the patient's individual medical record.

## 3.2 Reviews of death via CIM and/or WAASM

Health Service Providers must be aware that multiple methodologies exist 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 1 (SAC 1) clinical incident and investigated under the *Clinical Incident Management (CIM) Policy*, an additional review of the death under this Policy is not required.

The *Review of Death flowchart* describes the interaction between this Policy and the CIM and WAASM processes.

Where a patient's death is audited as part of the WAASM, Health Service Providers must ensure that:

- The patient's medical record/notes (or a copy) are provided to the WAASM in a timely manner, and
- If the original medical record/notes are provided to the WAASM, a copy is retained by the Health Service Provider.

## 3.3 Reviews of death under this Policy

### 3.3.1 Scope

Health Service Providers must implement local processes and systems meeting the requirements set out in Section 3.3.2 of this Policy for the review of all patient deaths that have not been referred to the WAASM or notified as SAC 1 clinical incidents including, but not limited, to those:

- That occur in hospitals in Western Australia
- That occur under the care of Hospital in the Home (HITH) and Rehabilitation in the Home (RITH) services, and
- Involving Nursing Home Type category and Care Awaiting Placement patients in Western Australian public hospitals.

This includes deaths of patients that are not for resuscitation (NFR), not unexpected (e.g. terminally ill and palliative care patients), or that occur in Emergency Departments.

Health Service Providers are encouraged to review deaths of patients who received healthcare in ambulatory or community care settings (e.g. community mental health patients, terminally ill patients in the community) to identify opportunities for improvement in the provision of health services and potentially preventable deaths.

### 3.3.2 Requirements for the review process

Local processes and systems for reviewing deaths of patients must:

- Include participation by the clinician or clinical team who had primary responsibility for care of the patient at the time of death.
- Include the capacity for independent review of a death to occur. Examples where an independent review is required include deaths where:
    - Care was provided by multiple clinical disciplines
    - Care was provided by a number of organisations prior to death
    - An individual clinician had sole clinical responsibility for the patient.



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Examples of independent review include clinical governance, mortality review or mortality and morbidity committees, or clinical review by an appropriately skilled clinician who was not involved in treating the patient.

- Include review of the patient journey in the period leading up to death. Where the patient received care from multiple clinical disciplines or health service organisations prior to death, participation in the review process by all disciplines/organisations should be sought where possible.
- Examine the nature and quality of care provided to the patient, considering their clinical and cultural context, to determine whether care was safe and culturally appropriate and if opportunities for improvement in the future may exist. Where opportunities for improvement in the delivery of health services are identified appropriate actions must be taken.
- Support the implementation and evaluation of the effectiveness of recommendations arising from reviews of death. This includes ensuring that overarching accountability for implementing recommendations, and the subsequent evaluation of their effectiveness, rests with senior members of staff.
- Incorporate the categorisation of the patient's death in terms of preventability using the Health Roundtable (HRT) criteria for preventability. For circumstances of stillbirth and neonatal death, the preventability scale adopted by the Perinatal and Infant Mortality Committee of WA (PIMC) may be used instead (see Section 3.3.5 of this Policy).
- Refer deaths that are identified on review as being caused or contributed to by health care rather than the patient's underlying condition (HRT category 4 or 5 and PIMC category 4, 5 or 6) for notification as SAC 1 clinical incidents and investigation in accordance with the *Clinical Incident Management (CIM) Policy*, where this has not already occurred.
- Ensure that the review of each patient death is completed (including documenting the outcome of the review) within four (4) months of the date of death.

### 3.3.3 Record keeping

To ensure good governance of local review processes, and that the reporting requirements under this Policy can be met, Health Service Providers are required to record and keep the following minimum information for all deaths that fall within the scope of this Policy:

- Patient identifier (UMRN)
- Date of death
- Date review of death completed
- HRT categorisation of the preventability of death (or for stillbirth/neonatal death the categorisation using the scale adopted by the PIMC)
- Datix CIMS reference number for deaths assessed as HRT category 4 or 5, or PIMC category 4, 5 or 6
- Details of any recommendations made
- The implementation and evaluation status of any recommendations.

### 3.3.4 Reporting to the Patient Safety Surveillance Unit

On a half-yearly basis Health Service Providers must submit a report to the Department of Health's (Department) Patient Safety Surveillance Unit (PSSU) regarding deaths required to be reviewed under this Policy. Deaths relating to patients receiving care in ambulatory or community care settings are not required to be included in this reporting.

The following information is to be provided for each hospital and health care facility to which this Policy applies:


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- The total number of deaths during the reporting period.
- The number and CIMS reference numbers for deaths during the reporting period regarded as out of scope of this Policy because they have been notified to the PSSU and are being, or have been, investigated as SAC 1 clinical incidents.
- The number of deaths during the reporting period regarded as out of scope of this Policy because they have been referred for review under the WAASM.
- The number of deaths during the reporting period that are in scope of this Policy where the review process has been completed (i.e. the quality of care has been reviewed and the death categorised with respect to preventability) within four (4) months of the date of death.
- The number and CIMS reference numbers for all deaths with a completed review that were assessed as HRT category 4 or 5 / PIMC category 4, 5 or 6 and notified as SAC 1 clinical incidents.

All information required to be reported to the PSSU can be recorded in the *Review of Death reporting template*. Health Service Providers must submit their reports using this template, or in an alternate format, agreed in advance with the PSSU, that provides the same information.

Health Service Providers must submit their half-yearly reports via email to PSSU@health.wa.gov.au by the following dates:
- 31 May, for deaths during the preceding period July to December
- 30 November, for deaths during the preceding period January to June.

If a Health Service Provider records no deaths during a reporting period a statement of this fact must be sent to the PSSU via email to PSSU@health.wa.gov.au

#### 3.3.5 Scales for categorisation of the preventability of death

This Policy requires the categorisation of each patient's death in terms of preventability using the Health Roundtable criteria (see below). For circumstances of stillbirth and neonatal death, the preventability scale adopted by the Perinatal and Infant Mortality Committee of WA may be used instead.

**Health Roundtable criteria for preventability of death**

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

**Preventability scale adopted by the Perinatal and Infant Mortality Committee**

| Preventability Score |
| --- |
| **No preventability**<br>1 = virtually no evidence for preventability |
| **Low preventability**<br>2 = slight to modest evidence for preventability<br>3 = preventability not likely; less than 50-50 but close call |
| **High preventability**<br>4 = preventability more likely than not; more than 50-50 but close call<br>5 = strong evidence for preventability<br>6 = virtual certain evidence for preventability |

### 3.4 Recommendations made by external agencies

From time to time the State Coroner and the WA Ombudsman may make recommendations that apply to one or more Health Service Providers, or the WA health system more broadly, following their review of persons deaths. The Department has retained an oversight role in the relationship between the WA health system and these agencies and the following requirements apply to all Health Service Providers:

- Upon request, Health Service Providers must provide the Department's Coronial Liaison Unit (CLU) with timely information regarding the actions taken to implement coronial recommendations, and strategies to address risks identified through coronial inquest. The CLU coordinates, on a periodic basis, the WA health system's response to the State Coroner in relation to health-related coronial recommendations.
- Upon request, Health Service Providers must provide the PSSU with timely information regarding:
    - Details of any documents (e.g. local policies and procedures) requested by the WA Ombudsman in connection with their review of persons deaths.
    - The nature of any recommendations applicable to the Health Service Provider that have been made by the WA Ombudsman following their review of persons deaths.
    - The actions taken to implement the WA Ombudsman's recommendations, and strategies to address risks identified through their reviews of persons deaths.

## 4 Compliance monitoring

Health Service Providers are responsible for monitoring and ensuring compliance with the requirements of this Policy. This includes monitoring and evaluating the effectiveness of local policies, processes and systems for the review of patient deaths.

Compliance with this Policy will be primarily monitored by the PSSU using information provided by Health Service Providers in accordance with the reporting requirements set out in Section 3.3.4 of this Policy.

The PSSU may compare this information with other data sets such as SAC 1 incident records in the clinical incident management system (Datix CIMS) database, deaths



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identified in the inpatient and emergency department data collections, surgical deaths submitted for peer review as part of the WAASM, and deaths being investigated by the State Coroner.

The PSSU may require that a copy of the completed 'Death in Hospital' form for a specific patient be provided to it should it become aware that a potentially preventable death may not have been notified as a SAC 1 clinical incident.

## 5 Related documents

The following documents are mandatory pursuant to this Policy:

- Death in Hospital Form
- Review of Death reporting template – HSP
- Review of Death reporting template – Private

## 6 Supporting information

The following information is not mandatory but informs and/or supports the implementation of this Policy:

- Review of Death flowchart
- Review of Death Guideline

## 7 Definitions

The following definition(s) are relevant to this Policy.

| Term | Definition |
|---|---|
| Clinical governance | Policies, processes and systems for maintaining and improving:<br>• Patient safety, quality and care; and<br>• The effectiveness and dependability of services provided by a Health Service Provider. |
| Clinical Incident Management (CIM) | The process of effectively managing clinical incidents with a view to minimising preventable harm. |
| Datix CIMS | The electronic online clinical incident management system used to capture and manage clinical incidents that occur within the WA public health system. |
| Health Roundtable (HRT) preventability scale | A scale for assessing the degree of preventability of a patient's death developed by the Health Roundtable Organisation and published in:<br>Health Roundtable insights: how to improve health care practices through Death Audits. 2001. |
| Perinatal and Infant Mortality Committee of WA (PIMC) preventability scale | A scale for assessing the medical preventability of death that has been adopted by the Perinatal and Infant Mortality Committee of WA and published in:<br>Wilson RMcL, Runciman WB, Gibberd RW, Harrison BT, Newby L, Hamilton JDI. The Quality in Australian Health Care Study. Med J Aust 1995; 163: 458-471. |
| Severity Assessment Code | The SAC rating is the way clinical incidents are rated in the WA health system. Clinical incidents are categorised using the SAC |



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| (SAC) | rating to determine the appropriate level of analysis, action and escalation.<br>• **SAC 1** - A clinical incident that has or could have (near miss) caused serious harm or death; and which is attributed to health care provision (or lack thereof) rather than the patient's underlying condition or illness.<br>• **SAC 2** - A clinical incident that has or could have (near miss) caused moderate harm; and which is attributed to health care provision (or lack thereof) rather than the patient's underlying condition or illness.<br>• **SAC 3** - A clinical incident that has or could have (near miss) caused minor or no harm; and which is attributed to health care provision (or lack thereof) rather than the patient's underlying condition or illness. |
|---|---|
| Western Australian Audit of Surgical Mortality (WAASM) | 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 audited. |

## 8 Policy contact

Enquiries relating to this Policy may be directed to:

Title: Manager, Patient Safety Surveillance Unit

Directorate: Patient Safety and Clinical Quality

Email: PSSU@health.wa.gov.au

## 9 Document control

| Version | Published date | Effective from | Review date | Amendment(s) |
|---|---|---|---|---|
| MP 0098/18 | 22 November 2018 | 1 January 2019 | November 2021 | Original version |
| MP 0098/18 v.2.0 | 29 April 2019 | 29 April 2019 | January 2022 | Major amendment: Section 5 updated to refer to two versions of Review of Death reporting template.<br>Death in Hospital Form updated to clarify aspects relating to the provision of medical records to the Coroner in the event of a reportable death. |
| MP 0098/18 v.2.1 | 15 November 2019 | 15 November 2019 | January 2022 | Minor amendment: Reference to OD 0611/15 in section 3.2 removed and SAC definitions updated to |

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|---|---|---|---|---|
| | | | | align with revised *Clinical Incident Management Policy 2019* MP 0122/19. Amendment also made to the supporting information *Review of Death Guideline*. |
| MP 0098/18 v.3.0 | 12 October 2020 | 12 October 2020 | January 2022 | Major amendment: *Death in Hospital Form* Section 3: *How to Report a Death to the Coroner* updated to reflect change of name from Coronial Investigation Unit to Coronial Investigation Squad, change to contact times, and change of transmission of form by fax to email to: Coronial.Investigation.Squad@police.wa.gov.au |
| MP 0098/18 v.3.1 | 20 October 2020 | 20 October 2020 | January 2022 | Minor amendment to fix a broken hyperlink in Section 5 Related documents. |
| MP 0098/18 v.3.2 | 22 June 2022 | 22 June 2022 | January 2022 | Minor amendment as detailed below. |
| Related Document: Death in Hospital Form Section 3: How to Report a Death to the Coroner updated to reflect availability of Coronial Investigation Squad 24 hours-a-day, 7 days-a-week. | | | | |
| MP 0098/18 v.3.3 | 28 June 2023 | 28 June 2023 | January 2022 | Minor amendment as detailed below. |
| Related Document: Death in a Hospital Form Section 5.2 Deaths Reportable to the Chief Psychiatrist amended to 28 days to reflect alignment with the Office of the Chief Psychiatrist's policy for mandatory reporting of notifiable incidents to the Chief Psychiatrist. | | | | |

## 10 Approval

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|---|---|
| **Approval by** | Dr David Russell-Weisz, Director General, Department of Health |
| **Approval date** | 13 November 2018 |

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