Policy Frameworks
Mandatory Policy
MP 0098/18
Effective from: 01 January 2019
Amended on: 17 February 2025

Review of Death Policy

1. Purpose

The purpose of the Review of Death Policy (this policy) is to ensure a consistent approach to the review of death process across the WA health system. It outlines the minimum requirements for the recording and review of patient deaths, 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 for Health Service Providers under the *Clinical Governance, Safety and Quality Policy Framework* pursuant to section 26(2)(l) of the *Health Services Act 2016*.

This policy is a mandatory requirement for the Department of Health pursuant to section 29 of the *Public Sector Management Act 1994*.

This policy is to be read in conjunction with MP 0122/19 *Clinical Incident Management Policy*.

2. Applicability

This policy is applicable to WA health entities, excluding Health Support Services.

Licensed private health care facilities may be required to comply with this policy pursuant to their licence requirements.

The requirements contained within this policy are applicable to the services purchased from contracted health entities where it is explicitly stated in the contract between the contracted health entity and the State of Western Australia or Health Service Provider. The State of Western Australia or Health Service Provider contract manager is responsible for ensuring that any obligation to comply with this policy by the contracted health entity is accurately reflected in the relevant contract and managed accordingly.

3. Policy Requirements

3.1 Deaths in scope of this policy

WA health entities must undertake a review of death process meeting the requirements of sections 3.3 and 3.4 of this policy for patient deaths:

- 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
- 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.

WA health entities are advised to review the deaths of patients who received care in ambulatory or community settings (such as community mental health patients, terminally ill patients in the community, and those using telehealth and virtual services) to identify any opportunities for improvement in the provision of health services and potentially preventable deaths.

3.2 Review of death via Clinical Incident Management and/or Western Australian Audit of Surgical Mortality (WAASM)

Where a patient's death is audited under the Western Australian Audit of Surgical Mortality (WAASM) and/or investigated as a Severity Assessment Code (SAC) 1 (SAC 1) clinical incident under MP 0122/19 *Clinical Incident Management Policy*, an additional review of the death under this policy is not required.

Where a patient's death is audited under the WAASM, WA health entities must provide the patient's medical record/notes (or a copy) to the WAASM in a timely manner when requested. If the original medical record/notes are provided, a copy is to be retained by the WA health entity.

3.3 Death in Hospital form

WA health entities must develop and implement a form that collects relevant information described in the *Death in Hospital Form* and is applicable to the local clinical context. The form may be expanded as needed to meet local requirements.

A clinician or clinical team responsible for the care of the patient at the time of death must complete the Death in Hospital Form immediately following or no later than 48 hours after, the death of the patient.

A copy of the Death in Hospital Form must be filed in the patient's medical record.

3.4 Review of death process

WA health entities must implement local processes and systems for reviewing deaths of patients, which include:

- Participation by the clinician or clinical team who had primary responsibility for care of the patient at the time of death.
- Capacity for an independent review of death to occur in circumstances where:
    - care was provided by multiple clinical disciplines
    - care was provided by several organisations prior to death
    - an individual clinician had sole clinical responsibility for the patient.

  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.
- Review of the patient journey in the period leading up to death. Where multiple clinical disciplines or health service organisations (including patient transport services and

non-admitted care providers) contributed to the care of the patient prior to death, participation in the review process by all disciplines/organisations must be sought where possible. All WA health entities and contracted health entities that contributed to the care of the patient in the period leading up to death are required to participate in the review process when requested by the WA health entity that is coordinating the review of the death.

- Examination of 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 for the implementation and evaluation of the 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, and that feedback is provided to the reviewers and relevant staff.
- 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 3.5 of this policy).
- Referral of deaths 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) as SAC 1 clinical incidents and undertake the notification and investigation in accordance with MP 0122/19 *Clinical Incident Management Policy*.
- Completion of the review of each patient death (including documenting the outcome of the review) within four (4) months of the date of death.

If the patient death being reviewed has been identified as in accordance with the *Voluntary Assisted Dying Act 2019* or relates to a baby born alive following a lawful abortion under the *Public Health Act 2016* who subsequently dies following the performance of the abortion, WA health entities are not required to categorise the preventability of the death. Information sharing restrictions in the *Voluntary Assisted Dying Act 2019*, *Public Health Act 2016* and *Health (Miscellaneous Provisions) Act 1911* may limit the information available when reviewing these deaths.

3.5 Scales for categorisation of the preventability of death

The categorisation of each patient's death in terms of preventability must be undertaken using the Health Roundtable criteria (Table 1).

Table 1: Health Roundtable criteria for preventability of death

Category	Description
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.
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.

For circumstances of stillbirth and neonatal death, the preventability scale adopted by the Perinatal and Infant Mortality Committee of WA is to be used (Table 2).

Table 2: Preventability scale adopted by the Perinatal and Infant Mortality Committee

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

3.6 Record keeping

WA health entities must 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)
- Clinical Incident Management System (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.

3.7 Reporting

On a half-yearly basis, WA health entities and licensed private health care facilities (pursuant to their licence requirements) must submit a report to the Department of Health's (Department) Patient Safety Surveillance Unit (PSSU) regarding deaths required to be reviewed pursuant to this policy.

The information required to be reported to the PSSU is set out in the *Review of Death reporting template (HSP and DoH)* and *Review of Death reporting template (Private health facilities and Contracted health entities)*. WA health entities and licensed private health care facilities (pursuant to their licence requirements) must submit their reports using this template, or in an alternate format agreed in advance with the PSSU that provides the same information.
WA health entities and licenced private health care facilities (pursuant to their licence requirements) 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 WA health entity or a licenced private health care facility (pursuant to their licence requirements) 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

3.8 Recommendations made by external agencies

The State Coroner and the WA Ombudsman may make recommendations that apply to WA health entities following their review of persons deaths. The Department is responsible for liaising with these agencies on behalf of WA health entities.

Upon request, WA health entities must provide:

- the Department's Coronial Liaison Unit (CLU) with information regarding the actions taken to implement coronial recommendations, and strategies to address risks identified through coronial inquest.
- the PSSU with the following:
  - any documents (e.g. local policies and procedures) requested by the WA Ombudsman in connection with their review of a person's death.
  - information regarding any recommendations applicable to the WA health entity made by the WA Ombudsman following their review of persons deaths.
  - actions taken to implement the WA Ombudsman's recommendations, and strategies to address risks identified through their reviews of persons deaths.

4. Compliance Monitoring

The PSSU, on behalf of the System Manager, will monitor compliance with this policy by requiring that WA health entities adhere to the reporting requirements set out in section 3.7 of this policy.

The PSSU may compare the reported information with other data sets such as SAC 1 incident records in the CIMS database, deaths 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.

The PSSU may require WA health entities to provide it with copies of their local policies, processes and forms/templates used to review patient deaths if considered necessary to confirm compliance with this policy.

5. Related Documents

The following documents are mandatory pursuant to this policy:

- Death in Hospital Form
- Review of Death reporting template – HSP and DOH
- Review of Death reporting template – Private health facilities and contracted health entities

6. Supporting Information

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

- Review of Death Guideline

7. Definitions

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

Term	Definition
Clinical governance	The set of relationships and responsibilities established by a health service organisation between its governing body executive, clinicians, patients, consumers and other stakeholders to ensure good clinical outcomes.
Clinical Incident Management (CIM)	The process of effectively managing clinical incidents with a view to minimising preventable harm.
Clinical Incident Management System (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.
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.
Severity Assessment Code (SAC)	The SAC rating is the way clinical incidents are rated in the WA health system. Clinical incidents are categorised using the SAC rating to determine the appropriate level of analysis, action and escalation. • **SAC 1:** A clinical incident that has or could have resulted in serious harm or death (including near miss incidents); and which is attributed to health care provision (or lack thereof) rather than the patient's underlying condition or illness. When the patient outcome of a clinical incident is death and during review it is determined that there is any possibility that it was preventable, it must be notified as a SAC 1 incident and investigated as such. • **SAC 2:** A clinical incident that has or could have resulted in moderate harm (including near miss incidents); and which is attributed to health care provision (or lack thereof) rather than the patient's underlying condition or illness. • **SAC 3:** A clinical incident that has or could have resulted in minor or no harm (including near miss incidents); 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 utilises 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.
WA health entities	WA health entities include: *(i)* Health Service Providers as established by an order made under section 32 (1)(b) of the *Health Services Act 2016.* (ii) Department of Health as an administrative division of the State of Western Australia pursuant to section 35 of the *Public Sector Management Act 1994.*
WA health system	The WA health system is comprised of: (iii) the Department of Health (iv) Health Service Providers (North Metropolitan Health Service, South Metropolitan Health Service, Child and Adolescent Health Service, WA Country Health Service, East Metropolitan Health Service, PathWest Laboratory Medicine WA, Quadriplegic Centre and Health Support Services); and (v) contracted health entities, to the extent they provide health services to the State.

8. Policy Contact

Enquiries relating to this policy may be directed to:
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9. Document Control

Version	Published date	Review date	Amendment(s)
MP 0098/18	22 November 2018	November 2021	Original version
MP 0098/18 v.1.0	29 April 2019	January 2022	Amendment as listed below.
• Related documents section updated to refer to two versions of Review of Death reporting template. • Related document: *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.1.1	15 November 2019	January 2022	Amendment as listed below.
• Policy requirements section: Reference to OD 0611/15 in section 3.2 removed and SAC definitions updated to align with revised MP 0122/19 *Clinical Incident Management Policy 2019.* • Supporting information document updated: Review of Death Guideline.			

MP 0098/18 v.2.0	12 October 2020	January 2022	Amendment as listed below.
• Related document: *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.2.1	20 October 2020	January 2022	Minor amendment as listed below.
• Related documents section: broken hyperlink amended.			
MP 0098/18 v.2.2	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.2.3	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.			
MP 0098/18 v.3.0	17 February 2025	February 2028	Policy review and amendments as detailed below.
• Purpose section: updated purpose statement, added reference to Department of Health and MP 0122/19 *Clinical Incident Management Policy.* • Applicability section: updated to WA health entities (excluding HSS) to include Department of Health and reference to Contracted Health Entities. Inclusion of licensed private health care facilities pursuant to their license requirements statement. • Policy requirements section and sub-sections has been re-ordered and renumbered to a more logical sequence. Policy requirement 3.4 reworded to reflect requirements of the *Voluntary Assisted Dying Act 2019* or when a death relates to a baby born alive following a lawful abortion under the *Public Health Act 2016.* • Policy requirement 3.7 amended to include the reporting for licensed private healthcare facilities (pursuant to their licence requirements) and contracted health entities. Other requirements have been reworded for clarity, with scope remaining the same. • Compliance monitoring section updated to reflect PSSU as the policy owner and responsibility for policy compliance on behalf of the System Manager. Inclusion of statement that PSSU may require WA health entities to provide copies of local policies, processes and other documents used to review patient deaths. • Related documents: *Death in Hospital Form*, Review of Death reporting template – HSP and DOH and Review of Death reporting template – Private health entities and contracted health entities updated. • Supporting information: Review of Death Guideline updated, and the Review of Death Flowchart removed and included as an appendix to the Review of Death Guideline. • Definitions section: Updated 'Clinical governance' and 'Severity Assessment Codes' definitions. Inclusion of 'WA health entities' and 'WA health system' definitions.			

Note: Mandatory policies that exceed the scheduled review date will continue to remain in effect.

10. Approval

Approval by	Dr David Russell-Weisz, Director General, Department
Approval date	13 November 2018

This document can be made available in alternative formats on request for a person with a disability.