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

OFFICIAL

Review of Death Guideline

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Contents

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 version 2)[1] devote an entire Standard 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"[2]

The purpose of the Review of Death Guideline (this Guideline) is to provide WA health entities and clinicians with additional information to support their implementation of MP 0098/18 *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*.

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 several 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* provides a summary / checklist of the key statutory and mandatory reporting obligations that arise following the death of a patient. Statutory and mandatory reporting of patient deaths should be completed as soon as practicable when it is identified that a death meets these requirements.

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[i]; or
b) that occurs during an 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[ii]; 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 under s44 of the *Births, Deaths, and Marriages Registration Act 1998*; or
j) that occurred outside WA where the cause of death has not been certified by a qualified medical practitioner.

Despite the definition of reportable death (as set out above), the *Coroners Act 1996* excludes a death under the *Voluntary Assisted Dying Act 2019*[iii] and certain deaths following the performance of an abortion[iv], from being a reportable death.

A 'person held in care'[v] 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 a 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*.

[i] In the health context it is important to note that 'injury' includes accidents and falls
[ii] Prescribed circumstances are circumstances described in the *Coroners Regulations 1997*
[iii] Refer to section 3A of the *Coroners Act 1996*
[iv] Refer to section 3B of the *Coroners Act 1996*
[v] For the full definition of a 'person held in care', refer to Part 1 of the *Coroners Act 1996*

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.

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. This is particularly relevant for deaths of persons with a disability, where research has suggested some deaths may be incorrectly attributed to natural causes or the persons' primary illness or disability.[3]

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.[4]

Where a death is reportable to the coroner the most recent medical records leading up to the person's death must be provided to the police immediately or, in any case, to the State Mortuary not more than 24 hours following death. This is to ensure that the post-mortem examination can be conducted in a timely manner. Where records are paper based, the originals are to be provided with copies retained by the WA health entity for any ongoing purposes. Should further medical information be requested by the police/coroner these records should then be provided as soon as practicable.

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

There are limited circumstances in which WA health entities can request copies of post-mortem reports prepared for the coroner to assist with mortality review processes, and consent is needed from the deceased's Senior Next of Kin. For further information about how to request access to post-mortem reports contact the Coroner's Court via coroner@justice.wa.gov.au

2.2 Health (Miscellaneous Provisions) Act 1911

The *Health (Miscellaneous Provisions) Act 1911* requires that the following 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. This includes the death of a woman following an abortion, which is to be treated as the result of pregnancy.

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 https://www.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
- under the age of 1 year dies from any cause whatsoever.

This excludes deaths that result from the performance of an abortion, which are not to be notified to the CHO.

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 https://www.health.wa.gov.au/Articles/N_R/Notification-of-perinatal-and-infant-deaths

Midwives responsibilities in relation to the notification of the outcomes of birth events, including stillbirths, are outlined at https://www.health.wa.gov.au/Articles/N_R/Notification-of-birth-events-and-cases-attended-by-midwives

2.2.3 Death of persons under anaesthetic

The CHO must be notified as soon as possible, 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
- 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 https://www.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 28 days of a person being discharged or deactivated from mental health services.[5]

Notifiable deaths 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.

Following receipt of a report of a notifiable death the Chief Psychiatrist:

- May investigate the incident, refer the incident to the Mental Health Commissioner, the CEO of the Department of Health, or a registration board, or take no action.
- Must notify the person in charge of the mental health service, in writing, of any decision to take action.
- May make any inquiries they consider appropriate and exercise any of their powers under sections 521 and 523 of the *Mental Health Act 2014*. These powers include visiting and inspecting mental health services, interviewing staff and patients, reviewing, and taking copies of medical records and directing the person in charge of a mental health service to provide relevant information.
- On completion of the investigation, provide a written report of the outcome of the investigation, which may include recommendations to the person in charge of the mental health service.

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.

WA health entities are not required to notify the Ombudsman directly of child deaths or deaths that may be related to family or domestic violence. However, of note, the Ombudsman has wide powers of investigation including the ability to obtain information relevant to the death from WA health entities, 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.[6]

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.

In addition to determining if a child death is an investigable death, since 1 July 2020, the Ombudsman also considers whether the child death will be reviewed by the coroner (reportable deaths) or an existing medical review mechanism (such as the *Perinatal and Infant Mortality Committee* or a WA health entity's Mortality Review Committee). The Ombudsman will review all investigable deaths as well as those child deaths that are not reviewed by one of these existing death review mechanisms.

The Ombudsman can also review other notified child deaths. A child death that is not defined as an investigable death may be reviewed by the Ombudsman under their own motion.

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.[6] 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 confirmed as a Severity Assessment Code (SAC) 1 clinical incident and investigated under MP 0122/19 *Clinical Incident Management Policy* (CIM Policy), an additional local review of the death under the policy is not required.

The *Review of Death relationship diagram* (see Appendix 2) describes the interaction between the Review of Death Policy and the CIM and WAASM processes. The CIM and WAASM processes are briefly summarised below; for more detailed information please refer to the dedicated resources available.

3.1 Clinical incident management

The CIM Policy[7] is a mandatory component of the Clinical Governance, Safety and Quality Policy Framework (CGSQPF) that applies to WA health entities 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 3.

Key components of the CIM process include:

- notification of the incident into the approved clinical incident management system (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 using a rigorous methodology
- the development of recommendations to address the contributory factors.

3.2 Western Australian Audit of Surgical Mortality (WAASM)

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.

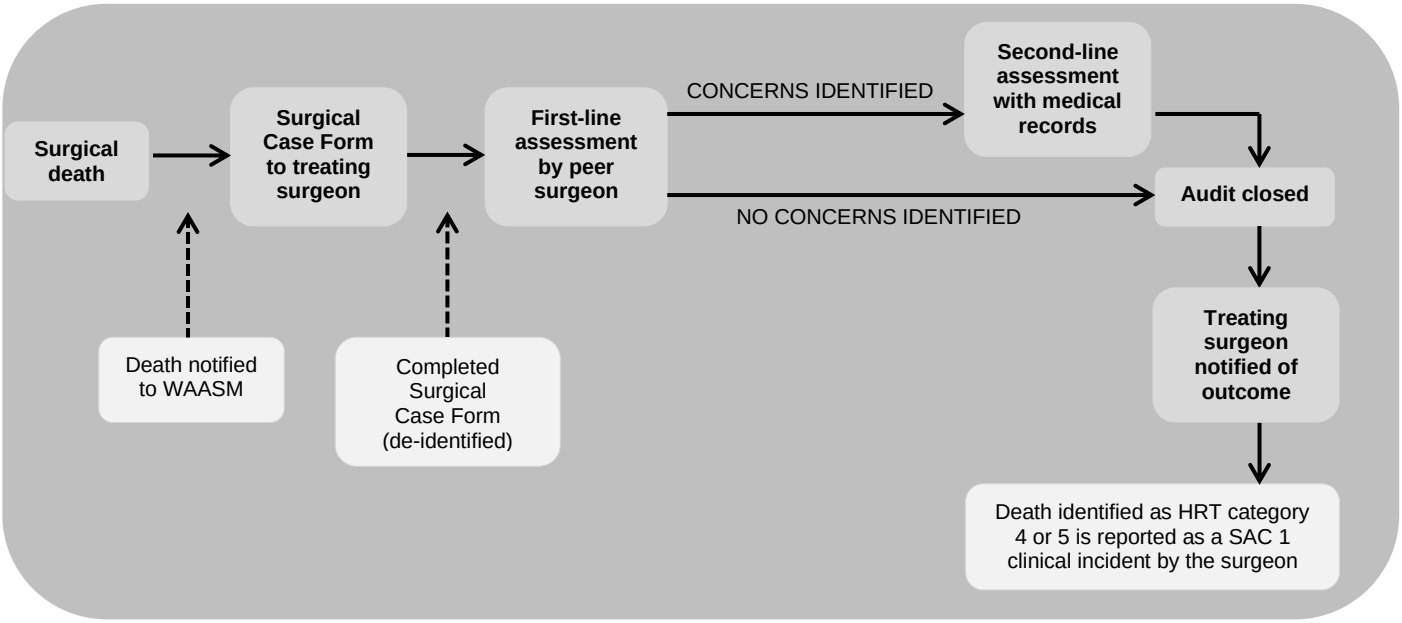
The audit includes deaths where no surgical procedure was undertaken if the patient was under the care of a surgeon. Where a decision for terminal care had been made at the point of admission, only the deaths where a surgical procedure was undertaken are included in the audit. Further information about the definition of deaths that are relevant for WAASM (the inclusion criteria) is available at https://www.surgeons.org/research-audit/surgical-mortality-audits/regional-audits/waasm/the-audit-process

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 1) peer assessors classify a death in terms of preventability using the Health Roundtable (HRT) criteria.[8] [vi]The qualified privilege mechanisms that apply to the WAASM process allow the disclosure of information relating to individual audit findings to participating surgeons only.

Consequently, where the WAASM finds that a death may be a potentially preventable adverse event, the treating surgeon is reminded of their obligation to notify the death 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 CIMS.

Figure 1: The WAASM process



In 2022, the qualified privilege covering the WAASM through the Commonwealth Qualified Privilege Scheme was amended. These changes permit the WAASM to advise the Department of Health of any patient deaths where the WAASM assessors have identified a potential HRT category 4 or 5 death. The information provided to the Department of Health by the WAASM is limited to the patient's UMRN, date of death and the hospital where they were treated.

Further information regarding the WAASM, including the audit process and qualified privilege, is available at the WAASM webpage:
https://www.surgeons.org/research-audit/surgical-mortality-audits/regional-audits/waasm

[vi] The reference to this report is a foundational piece of evidence, to which there are no links to the document. A copy of the report can be found by contacting PSSU@health.wa.gov.au.

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 consider 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 WA health entities to improve patient care in alignment with key state-wide initiatives, such as the *WA Aboriginal Health and Wellbeing Framework 2015–2030* [9] and demonstrate compliance with Action 1.04 of the NSQHS Standards (second edition version 2). The Australian Commission on Safety and Quality in Health Care (ACSQHC) has released the *National Safety and Quality Health Service Standards User Guide for Aboriginal and Torres Strait Islander Health*[10] 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 WA health entities 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 3.1 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 as in scope of MP 0098/18 *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 this 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 going 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.[11]

WA health entities 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[vii] and above in accordance with the policy's requirements, where these have not been notified as SAC 1 clinical incidents. WA health entities may choose whether to review FDIU and stillbirth occurring before 23 weeks gestational age on a case-by-case basis.

[vii] 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.

4.1.3 Babies born alive after abortion procedures

WA health entities and clinicians are reminded that once a foetus 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 to provide futile medical care, and palliative care should be provided when needed.

Cases where a baby is born alive following a lawful abortion and subsequently dies following the performance of the abortion are required to be reviewed under the policy if they are not being investigated as a SAC 1 clinical incident. WA health entities are not required to categorise the preventability of the death, and the review should focus on the quality of care provided.

WA health entities are reminded that this local review is not intended to inform other statutory reporting requirements. The *Health (Miscellaneous Provisions) Act 1911* states that no person is required to give any report or notification to the Chief Health Officer or any other person in relation to the performance of an abortion, or any birth, still-birth or neonatal death that results from the performance of the abortion.

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[2,12-15] 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, WA health entities 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[viii]
- 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)

[viii] Further information and resources regarding Advance Care Planning and Advance Health Directives can be found at: https://www.health.wa.gov.au/Health-for/Health-professionals/End-of-life

- Whether unnecessary burdens were avoided (e.g. non-beneficial or unwanted observations, interventions, investigations and/or treatments).

WA health entities that provide voluntary assisted dying services need to be aware of the application of section 106 of the *Voluntary Assisted Dying Act 2019* regarding the recording, use and disclosure of personal information. This will have implications for clinical documentation, noting that patient confidentiality under these laws continues after death. If written consent has not been given by the patient, disclosure of information related to voluntary assisted dying for the purposes of reviewing of the patient's death may not be appropriate.

Deaths of persons who have self-administered, or have been administered, a voluntary assisted dying substance in accordance with the *Voluntary Assisted Dying Act 2019* are within the scope of the policy. WA health entities are not required to categorise the preventability of these deaths, allowing the review process to focus on the quality of care provided to the patient.

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.[16,17]

WA health entities should consider the following attributes of effective committees and meetings where independent mechanisms for the review of patient deaths are established:

- Recognition of the role that mortality review committees play in clinical governance in health systems, and integration into existing quality and safety governance to support and enhance alignment across the system
- 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
- 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 that facilitates discussion and analysis of the systems and processes of care rather than the individuals who provided the care
- Discussions should occur in a safe and blame-free environment and focus on:

    - Identifying themes 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

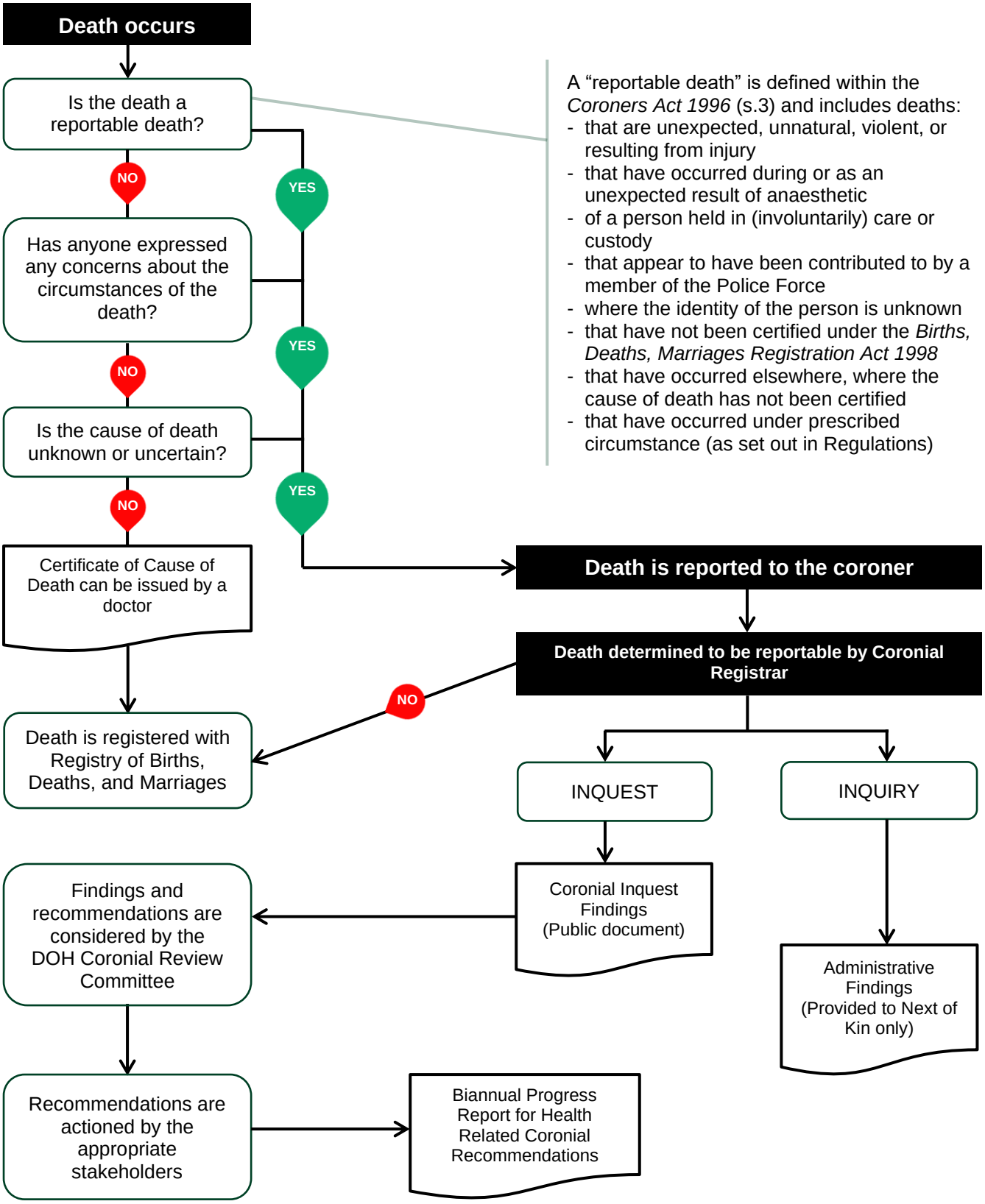
While the Review of Death and clinical incident management processes expect that action will be taken when deficiencies or opportunities for improvement in health care delivery are identified, it is also possible that external review processes associated with death may result in recommendations applicable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

- At the conclusion of a coronial inquest the coroner may make recommendations relating to one or more WA health entities, 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 WA health entities) with respect to strategies for preventing or reducing child deaths and deaths associated with family and domestic violence.

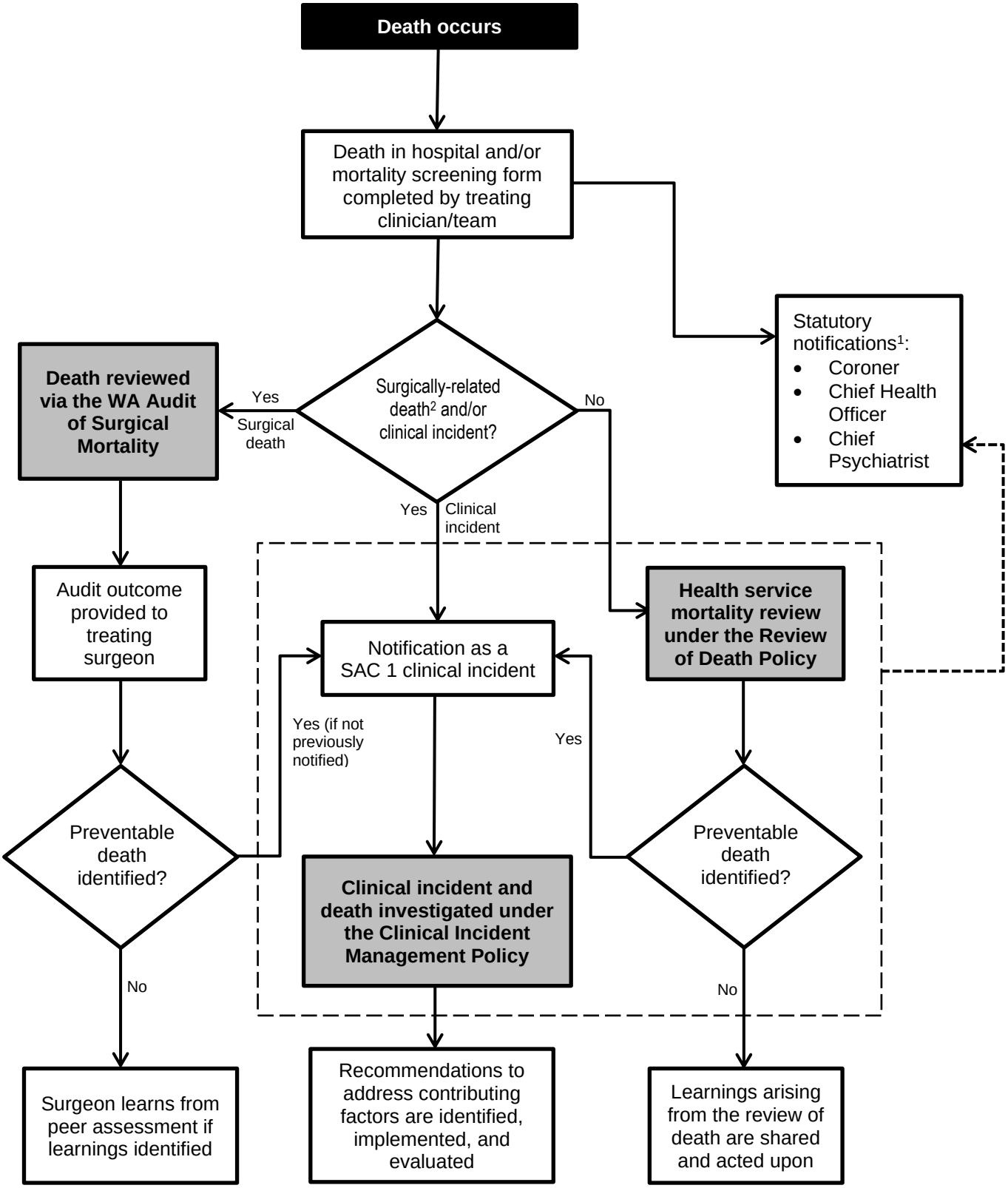
It is in the interest of WA health entities to be responsive and transparent in their consideration of recommendations made by these agencies to improve public safety and to reduce or prevent such deaths. Where appropriate, recommendations should be seen as an opportunity to drive improvement across 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: Review of Death relationship diagram



1. Requirements for statutory notification of a patient's death may be identified around the time of death or during a subsequent review or investigation. Statutory reporting should be completed as soon as practicable whenever it is identified that a death meets these requirements.

2. Surgically-related deaths include deaths under the care of a surgeon where a surgical procedure was performed, and where no procedure was undertaken unless a decision for terminal care had been made at the point of admission. A surgically-related death where a clinical incident is thought to have occurred must also be investigated as a SAC 1 clinical incident while being reviewed via the WAASM. Non-operative terminal care cases are reviewed under the Review of Death Policy unless a clinical incident is suspected to have occurred.

Appendix 3: Example mortality screening form

Adapted from the Royal Children's Hospital Melbourne Departmental Morbidity & Mortality Review form.[18]

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
☐	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.

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.
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 MP 0122/19 *Clinical Incident Management Policy 2019* and updated links in section 3.2 and references 6 and 14.

2.0	January 2025	Guideline review in alignment with policy review. Amendments include the following:
		• Terminology updated consistent with changes made to Policy
		  ○ Section 2.1: Information added:
		  ▪ To reflect those deaths under the *Voluntary Assisted Dying Act 2019* and certain deaths following the performance of an abortion, are no longer reportable to the coroner
		  ▪ regarding deaths of persons with a disability

		▪ regarding provision of medical records to the coroner/police ▪ regarding access to post-mortem reports. ○ Section 2.1.1 –Section has been deleted to align with abortion legislation reforms. Information about care of babies born alive after an abortion procedure has been moved to section 4.1.3 and expanded. • Section 2.2.1: Updated to reflect reporting requirements to the Chief Health Officer. • Section 2.2.2: Updated to reflect reporting requirements to the Chief Health Officer. • Section 2.2.3: Amended to align with the relevant legislation. • Section 2.3: Reference to 3 months changed to 28 days to align with Chief Psychiatrist policy and the *Death in Hospital Form*. Information added about the OCP processes. • Section 3: Reference to Review of Death flowchart changed to Review of Death relationship diagram (Appendix 2). • Section 3.1: Information has been simplified and updated to align with changes to MP 0122/19 *Clinical Incident Management Policy.* • Section 3.2: Updated to be provide more detailed and clearer information about WAASM. • Section 4.2: Updated to include information about the relationship between section 106 of the *Voluntary Assisted Dying Act 2019* and mortality review processes. • Appendices amended and inclusion of Review of Death Flow Chart. • References: New references added, references renumbered, web links checked and updated as required.

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