Review of Death Procedure

1. Guiding Principles

In accordance with the Western Australian Review of Death Policy, the care given to all patients who decease, present with a fetal death in utero or give birth to a stillborn foetus after 20 weeks of pregnancy, while in the care of the WA Country Health Service (WACHS) are to be examined to determine if that care was appropriate and to identify improvements where required.

This procedure outlines WACHS':

- minimum standards for review of deaths
- tools agreed for use
- reporting requirements.

2. Procedure

This procedure is to be read in conjunction with the Western Australian Review of Death Policy.

2.1 Initial Review

The MR37a WACHS Death in Hospital Form and Western Australian Review of Death Policy assist health practitioners to navigate the mandatory and statutory obligations that arise following an inpatient death.

- As soon as practicable following a patient death, stillbirth or death of a neonate a first line review of the care provided will be undertaken at health service level by the treating team.
- Health Round Table Criteria are to be used to categorise the death for preventability using the trigger questions adapted from the Royal Children's Hospital as guidance. (See Appendix 1)
- The review is to be entered into the Review of Death Web Application which can be accessed via Google Chrome.
- Death data is updated daily in the Review of Death Web Application
- Access to the Review of Death Web Application is arranged through the Regional Safety and Quality Team. Log on using your HE number and usual password.

2.2 Secondary Review

- The second line review is to be completed utilising the trigger questions/criteria identified above within four (4) months of the death and entered into the Review of Death Web Application.
- A multi-disciplinary regional committee is to monitor the review of death process ensuring improvement actions are followed up and learning is shared.
- Fetal deaths, Stillbirths and neonatal deaths will be monitored by the WACHS Perinatal Morbidity and Mortality Committee when established.

- Where the first and second line categorisation does not match, the monitoring committee is to determine the final categorisation or arrange further review if required and enter details into the Review of Death Web Application.

2.3 Reporting

Data sent on a six monthly basis from the Patient Safety Surveillance Unit (PSSU) is to be compared with regional death reviews to ensure all deaths have been reviewed.

Central Office Safety and Quality will extract data from the Review of Death Web Application for reporting purposes and will report to the Patient Safety Surveillance Unit on a six monthly basis the percentage of deaths that have been categorised, date of second line review, within four (4) months of the date of death.

3. Roles and Responsibilities

Health Service Managers are responsible for:

- ensuring first line review of death is undertaken by the treating team in a timely manner and entered into the Review of Death Web Application
- ensuring principles and requirements of the Western Australian Review of Death Policy are met.

Regional Clinical Leads of Safety and Quality are responsible for:

- ensuring that second line review is undertaken by independent qualified clinicians and entered into the Review of Death Web Application. *Examples of independent review include clinical governance, mortality review or mortality and morbidity committees, or clinical review by the Regional Director of Medical Services or their appropriately skilled clinical nominee who was not involved in treating the patient.*
- ensuring principles and requirements of the Western Australian Review of Death Policy are met
- scheduled multidisciplinary review meetings where reviews of death are discussed and recorded in the Review of Death Web Application including outcomes and evaluations of improvements resulting from review of death.

Regional Safety and Quality Teams are responsible for:

- record management of the review process including:
  - maintaining governance over reviewer access requests to the web application
  - training reviewers in the use of the web application
  - data integrity of reviews entered in the region
  - minutes of multi-disciplinary committee meetings including outcomes and evaluation of improvements resulting from review of death
    - (as mandated by state legislation and WACHS policy)
- reporting as required.

Central Office Safety and Quality Team is responsible for:

- maintaining governance over the provision of access to the web application
- internal and external reporting.

4. Compliance

Failure to comply with this policy document may constitute a breach of the WA Health Code of Conduct (Code). The Code is part of the Integrity Policy Framework issued pursuant to section 26 of the *Health Services Act 2016* (WA) and is binding on all WACHS staff which for this purpose includes trainees, students, volunteers, researchers, contractors for service (including all visiting health professionals and agency staff) and persons delivering training or education within WACHS.

WACHS staff are reminded that compliance with all policies is mandatory.

5. Evaluation

This procedure will be reviewed as required and in accordance with updates to the Western Australian Review of Death Policy.

6. Standards

National Safety and Quality Healthcare Standards 1.8; 1.28

7. Legislation

Coroners Act 1996

Health Act 1911

Health Services Act 2016

8. References

Review of Death Web Application

PSANZ Clinical Practice Guideline for Care around Stillbirth and Neonatal Death

Health Round Table Organisation

Royal Children's Hospital Melbourne Departmental Mortality Review form.

9. Related Forms

MR37a WACHS Death in Hospital Form

10. Related Policy Documents

Care of the Deceased Policy

11. Related WA Health Policy

MP0098/18 Western Australian Review of Death Policy

12. Policy Framework

Clinical Governance, Safety and Quality

13. Appendices

Appendix 1 - Health Round Table Criteria and Trigger Questions

Appendix 2 - Flowchart

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

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Directorate:	Safety & Quality	**TRIM Record #**	ED-CO-16-43744
Version:	4.00	**Date Published:**	2 June 2022

14. Appendix 1 – Health Round Table Criteria and Trigger Questions (adapted from Royal Children's Hospital)

Health Round Table Criteria	
Category 1	Anticipated death 1a: due to terminal or life limiting condition (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 health service taking preventive measures
Category 3	Unexpected death, which was not reasonably preventable with health care intervention
Category 4	Preventable death where steps may not have been taken to prevent it.
Category 5	Preventable death resulting from health care intervention or omission

Trigger Questions Consider all aspects of care including pre-admission care (e.g. ante-natal, anaesthetic clinic etc.),	**Yes**	**No**	**Comments**
Was there a delay in diagnosis, assessment or transfer?			
Was there a delay/barrier to initiating treatment?			
Was information provided incomplete, incorrect or misinterpreted?			
Did care provided deviate from policy or clinical practice guidelines?			
Were policy/guideline documents available/appropriate for use?			
Was there a complication due to treatment/procedure/operation?			
Was there a medication error which may have contributed to the outcome?			
Were there clinical risk factors that were not identified or not acted on?			
Was there a lack of availability, misuse of equipment or faulty equipment?			
Was there an adverse event* identified and if so, was it documented in the medical record?			
Was any deterioration recognised and responded to according to guidelines?			
Were abnormal results identified and followed up?			
Was assistance available and/or sought when required?			
Was the skill mix available appropriate/sufficient for activity?			

* Adverse Event - An incident where an injury/harm is caused by medical management or complication thereof, instead of the underlying disease.

Expected Death Questions	Yes	No	Comments
Was there adequate discussion with the family regarding the outcome?			
Was withdrawal or limiting treatment discussed with the family? If so, was there appropriate documentation?			
Was a timely referral made to palliative care?			
Was pain and suffering effectively controlled?			
Were the GP and referring doctor informed of the death?			

15. Appendix 2 – Flowchart