Anaesthetic Mortality reporting in WA: General information

Information regarding reporting of Deaths within 48 hours of an anaesthetic to the Chief Health Officer for assessment by the Investigator and the West Australian Anaesthetic Mortality Committee

1. REPORTING REQUIREMENTS

Death of persons under anaesthetic must be reported to the Chief Health Officer:

a) Whenever any person shall die within the period of 48 hours following the administration of an anaesthetic agent or as the result of any complications arising from the administration of an anaesthetic, by the person who administered the anaesthetic to the deceased.
Note: The timing is considered to be from the commencement/induction of the anaesthetic, not its conclusion.

b) Where a medical practitioner who attended a person prior to the death of that person is of 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.

2. GUIDE FOR REPORTING

- Please use the on line E form for reporting cases via the WA DOH notification of anaesthetic death site: **https://ww2.health.wa.gov.au/Articles/N_R/Notification-of-anaesthetic-death**
- The report includes general data and an outline of the case details. The anaesthetic chart should also be uploaded with the report.
- For further information or assistance please contact the Office of the Chief Health Officer:
  Telephone: 9222 2295
  Fax: 9222 2322
  Email: edphwa@health.wa.gov.au

3. ASSESSEMENT OF CASE

A. The process

- The report written to the Chief Health Officer, Department of Health regarding the death is referred to the WA Mortality Committee Investigator who reviews the case.
- If it is clearly considered *not* to be in categories 1-3 (see below) the reporting anaesthetist is notified of this in writing and the finding will be reported to the Chief Health Officer.

- In all cases which the investigator considers may be in categories 1-3 or if he/she is unable to come to a definite conclusion, the de-identified documents related to the case are considered by the Anaesthetic Mortality Committee and a consensus reached regarding the classification of the case.
- The chair of the committee will then write to the anaesthetist involved regarding the assessment of the case.
- If the case does not meet the reporting requirements for notification, for example death occurred outside of the time frame required; the anaesthetist involved will be notified regarding the reason for this.

B. Classification system

- The WA Anaesthetic Mortality committee uses the ANZCA "***Glossary of Terms Case Classification"*** for assessing and classifying anaesthesia mortality.

- **Category A**: Includes deaths attributable to anaesthesia with 3 sub-categories:-
    - Category 1: Where it is reasonably certain that death was caused by the anaesthesia or other factors under control of the anaesthetist.
    - Category 2: Where there is some doubt whether death was entirely attributable to the anaesthesia or other factors under the control of the anaesthetist.
    - Category 3: Where death was caused by both surgical and anaesthesia factors.
    - ***These cases are further categorised based on causal or contributory factors****.*

- ***Category B****:* Are cases in which anaesthesia played no part in the death.

- **Category C:** Are cases which are unassessable by the committee

- ***For further details please see the linked full classification system Glossary of Terms Case Classification***

4. WA ANAESTHETIC MORTALITY COMMITTEE

a. Functions of the committee

- Assessments of all cases presented by the investigator were there was a death within 48 hours of the commencement of an anaesthetic or where an anaesthetic may have contributed to the patient's death. The committee may co-opt persons with specialised knowledge as necessary. The committee shall determine whether, in the opinion of the committee, the death might have been avoided and may add to such determination such constructive comments as the committee deems advisable for future assistance and guidance.
- The determination of the committee will be notified in writing to
    - the medical practitioner attending the patient or
    - the nurse or midwife (if any) who was attending the deceased at the time
- A yearly summary of the cases investigated is sent to the Chief Health Officer.
- Reports/summaries may be used for publications and for the purposes of teaching for assistance and guidance in avoiding and preventing anaesthetic morbidity and mortality, but

all reasonable steps shall be taken to preclude disclosure or identification of the person or persons concerning whom the investigation and resultant report was made.

- A summary of the data collected on WA mortality reporting is given each year at the WA ANZCA regional committee AGM.
- Data from WA mortality reporting contributes to the ANZCA triennial report on Safety in Anaesthesia

b. Membership of the committee

- The WA Mortality Committee is made up of 12 members appointed by the Minister and an investigator and his/her deputy.

- Each member is nominated by a specific committee or institution as follows:
    - A medical practitioner nominated by the state branch of the ANZCA, (this person will be the Chairman of the Mortality Committee),
    - A Professor of anaesthesia at the UWA.
    - A medical practitioner specialising in anaesthesia nominated by the state branch of ANZCA (this position is nominated by the WA branch of the ASA),
    - A medical practitioner specialising in anaesthesia nominated by the AMA (WA).
    - A medical practitioner specialising in obstetrics and gynaecology nominated by the RANZCOG
    - 2 general practitioners nominated by the state branch of the RACGP.
    - A medical officer nominated by the Chief Health Officer.
    - A midwife nominated by the Chief Health Officer.
    - A dental practitioner nominated by the state branch of the Australian Dental Association
    - A Professor of Clinical Pharmacology at UWA.

- The investigator, (and deputy investigator), are appointed by the Minister from medical practitioners who specialise in anaesthesia.

5. CONFIDENTIALITY

- The information reported to the Chief Health Officer and any documents, records, reports, or other particulars used in the investigation will remain confidential with only the Investigator, Chairman of the committee and the Chief Health Officer having access to any details of the patient, anaesthetist (s) or other personnel involved in the case.
- Cases which are viewed by the full anaesthetic mortality committee only use de-identified material for assessment.
- No information or records are admissible in any court or tribunal, board or person in any action or cause, except the Coroner's Court.
- After completion of the investigation all records, reports, statements and other documents will be returned to the care of the Chief Health Officer
- Data used for reports, publications and educational purposes will be treated in a way that the details of any case will not be able to be identified.

6. RELEVANT LEGISTLATION

- **The reporting requirements, process for assessment and the constitution and governance of the Anaesthetic Mortality committee is subject to the Health (Miscellaneous Provisions) Act 1911**
    - **Part XIII Subsection 336 B:** Death of persons under anaesthetic to be reported to the Chief Health Officer
    - **Part XIII C (Anaesthetic Mortality Committee)**

- For full details please see the relevant legislation: Link to the Health Act: https://www.legislation.wa.gov.au/legislation/prod/filestore.nsf/FileURL/mrdoc_44716.pdf/$FILE/Health%20(Miscellaneous%20Provisions)%20Act%201911%20-%20%5B17-f0-00%5D.pdf?OpenElement

- **Coroners Act 1996**
  https://www.legislation.wa.gov.au/legislation/prod/filestore.nsf/FileURL/mrdoc_45286.pdf/$FILE/Coroners%20Act%201996%20-%20%5B03-m0-00%5D.pdf?OpenElement
  Part 3 s. 17– Reporting of deaths

7. LINKS

a. ***Template for Reporting Anaesthetic Mortality Cases***

b. ***Glossary of Terms Case Classification***

c. **ASA Website: https://asa.org.au/**

d. **ANZCA SAFETY IN ANAESTHESIA REPORT 2015 -2017:** https://www.anzca.edu.au/safety-advocacy/standards-of-practice/anaesthetic-incident-reporting#

e. **LAST YEAR'S WA AMC yearly report to ANZCA WA Regional Committee: available via the ANZCA website**

8. CONTACT INFORMATION

For queries regarding reporting of death within 48 hours of an anaesthetic or a potential anaesthesia related death please contact the Chair of the WA Anaesthetic Mortality Committee, Dr Jay Bruce at jennifer.bruce@health.wa.gov.au