Department of Health

Tasmanian Government

Tasmanian Health Service Act 2018

Terms of Reference

Reportable Deaths and Death Reporting Processes in Tasmanian Public Hospitals

Background

On Wednesday 24 January 2024, testimonial evidence was provided by a Registered Nurse (former employee) to the Select Committee on Transfer of Care Delays (Ambulance Ramping). This evidence alleged that the Launceston General Hospital's (LGH) former Executive Director of Medical Services (EDMS) failed to report a patient's death pursuant to the *Coroners Act 1995* in at least one case, and possibly others.

Following this hearing, the Department of Health received a further two reports supporting the claims made at the hearing on the 24 January 2024, including one from a current Tasmanian Health Service employee.

On 6 February 2024, a Registered Nurse and Midwife, provided evidence to the Select Committee on Transfer of Care Delays (Ambulance Ramping). A statement to the committee outlined that the individual had "received 11 reports from doctors and nurses who have disclosed alleged misconduct relating to the death of a patient including falsified medical certificates of death in ward 5A, ward 5B, the intensive care unit, the operating room suite and the Emergency Department at the LGH."

The individual referenced that they had reviewed more than 55 Magistrate Court of Tasmania coronial investigation reports of deceased individuals who died at the LGH. Amongst these reports, through this process they identified two deaths which were not reported to the coroner by the LGH.

Following evidence at the hearing, the Department of Health received a further three anonymous complaints relating to death reporting practices at the LGH and Royal Hobart Hospital (RHH).

Given the complexity and seriousness of the alleged claims and complaints received since the hearings referenced above, the Secretary for the Department of Health committed to appointing an independent clinical expert/s to determine if the cases referred to (once identified) are reportable deaths and to review all processes and protocols relating to notification of death of a patient in Tasmanian public hospitals (Death Reporting Processes).

On Thursday 8 February 2024, Minister for Health, Guy Barnett, MP gave evidence to the Select Committee and confirmed his commitment to an independent Clinical Review of any identified case/s where it is alleged coronial reporting did not occur and of the Death Reporting Processes.

Purpose

The purpose is to undertake a review of:

- Death reporting practices (including mandatory reporting and data collection) and review of patient deaths (mortality review); to determine whether changes in practice are needed to improve the safety and quality of patient care.
- The policies, protocols, data, and systems across the Tasmanian Health Service to assess and determine the effectiveness of current practices and provide recommendations for improvement.
- Identified patient death/s, where the death appears to qualify as a reportable death but has not been reported to the coroner, or where the recommendation was to refer to the Coroner, but this was subsequently changed, or where there was an intervention by the EDMS office or where any alteration to documentation was made by the EDMS office in relation to the certification of death or in relation to any matter concerning whether to report a death to the Coroner.

Focus of the Review

Death Reporting Processes

- A review of all Death Reporting supporting documentation, including Medical Certificates of the Cause of Death (MCCD) Forms detailing a Declaration of Life Extinct (DOLE) and the *Death of a Patient (including Coroners Notification)* Protocol and *Tasmanian Health Service Audit Framework (incl. Annual Audit Program Schedule.*
- A review of all Mortality Review processes and supportive documentation including Mortality and Morbidity Review (*or however named*) meeting Terms of Reference, Agendas, Minutes, and Recommendation Tracking for evidence of learning and improvement.
- A review of current mortality data sources and reporting to establish the single source of truth for both local and national reporting.
- A review of the available Mortality Module (MM) Data since the role out of the MM in 2020.
- Consultation with health services staff and stakeholders, with communication and engagement activities undertaken via established clinical care networks (incl. Tasmanian Audit of Surgical Mortality (TASM) and the Council of Obstetric and Paediatric Mortality and Morbidity (COPMM) operational meetings, and forums, in addition to tailored approaches as needed.
- Determine whether appropriate escalation protocols, communication loops and feedback are in place to ensure clinicians at any level may request an internal review of a decision relating to a death within a hospital and that there is transparency in relation to death notification decision making.

Reportable Deaths

- Ensure appropriate reporting and review of patient deaths, in-line with established Death of a Patient (including Coroners Notification) Protocol.
- This will be achieved through the following –
    - A detailed review of the patient's health record and medical history, including any pre-existing conditions, chronic illnesses, recent treatments or surgeries and medications the person was taking at the time of death as well as Medical Goals of Care and/or Advance Care Directives to assist with determining if the cause of death and manner of death was documented.

- Identify whether the documentation of the final disease, injury, or complication that directly resulted in death was the same as reflected on the Medical Certificates of the Cause of Death (MCCD) Forms and Declaration of Life Extinct (DOLE).
- A review of any supplementary documentation available relating to the patient care and/or death i.e., Correspondence, Safety and Learning Reports, Morbidly & Mortality Meeting Agenda & Minutes etc.

- For any case where the recommendation was to refer to the Coroner, but this was subsequently changed, including where there was an intervention by the EDMS office or where any alteration to documentation was made by the EDMS office, in relation to the certification of death or in relation to any matter concerning whether to report a death to the Coroner, the panel is required to:
  - Establish the Facts surrounding the individual's death
  - Identify the rationale for change/s
  - Review any available evidence/information to support the decision not to report the death including any change/s or alteration in information
  - Identify if any change/s were communicated to the initial reporter.
- If an unreported reportable death is identified, the following should occur:
  - Discussion with the individual treating teams and/or care providers in attendance at the time of the patient's death, including the individual/s that completed the Medical Certificates of the Cause of Death (MCCD) Forms and Declaration of Life Extinct (DOLE).
  - Open Disclosure and discussion with the individuals nominated Next of Kin – noting that whilst full circumstances surrounding the persons death may not be known until after further investigation, every effort should be made to inform them of the independent clinical review and purpose of the review.
  - Discussion and/or referral to the Coroner/Tasmania Police.
- For each clinical case review, the Panel Member/s must discuss their findings with the Chair and full panel before making a final determination and advice to the DoH Secretary.
- The Panel will provide fortnightly status report updates to be tabled at the Health Executive, with any immediate safety risks or misconduct concerns escalated immediately to the Secretary, Department of Health.

Independent Panel Membership

The Panel will include experts in governance, safety and quality, medicine, and nursing:

- Chair: Debora Picone AO
- Panel Members: Associate Professor Amanda Walker, Ann Maree Keenan, Karen Crawshaw PSM

- All members will have read and understand:

  Health Act 1997

  Coroners Act 1995

Personal Information Protection Act 2004

Health Practitioner Regulation National Law Act 2010 (Tas)

Archives Act 1983

State Service Act 2000

- The Panel will be given access to all available data/information to support them to undertake a robust review and provide sound advice/recommendations to the DoH Secretary and other authorities (as required).

Department of Health Reference Group

The Panel will be supported by a Reference Group that will include:

- Chief Medical Officer
- Chief Risk Officer
- Deputy Secretary Clinical Quality, Regulation and Accreditation
- Deputy Secretary Hospitals & Primary Care
- Director- Health Information Management Services
- Nursing Director Statewide Quality & Patient Safety Service
- Director - Monitoring, Reporting and Analysis
- Director Office of the Secretary
- Manager Statewide Complaints & Oversight Unit
- Legal Service General Manager
- Other representatives as requested by Advisory Panel and approved by Secretary.

Secretariat

- The Office of the Secretary will provide the Secretariat function. This will include providing support to the Panel with meetings, research, the provision of documents and information for the Review as requested by the Panel.

Review Findings and Recommendations

- The Panel will report its findings and recommendations to the Secretary, Department of Health by 30 April 2024.
- Should the Panel require additional time to review and report, the panel is requested to prioritise its review death reporting practices by the agreed date.
- At the completion of the review, the panel will prepare a comprehensive report detailing the investigation's findings, methodology, and evidence.
- Any evidence of misconduct or criminal activity will be escalated immediate to the DoH Secretary and relevant authorities. Panel members with mandatory reporting obligations will also be expected to report accordingly in addition to this process
- The Panel will also offer recommendations based on the findings, including legal action, policy changes, disciplinary measures, or further investigations.