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

Pathways to Prevention

"From Death We Learn"

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Outline

- Investigating death: perspectives
  - Safety and Quality clinical governance systems within Health
  - Coronial System
- WA Health Coronial Review Committee
- From Death We Learn

Investigating death: Two Systems

- One in Health and one in Law
- Same material evidence
- Different investigation systems/models
- Similar quality improvement aims
- How do they work together?

Complementary Systems

WA Health

- 7,666 total hospital deaths
- Review within 4 months
- Clinical Incidents 434 p/a
- Local systemic analysis and recommendations
- DOH system-wide implications

Coroner's Act

- All 'Reportable' Deaths: 2,214
- 1-2% Inquest
- 1-3 years to findings
- Independent external review
- Recommendations

Coronial Review Committee

- Established 2014
- Membership – representatives across WA Health
- Coordinated response

Coronial Review Committee

- Biannual Progress Report to State Coroner
- Published on WA Health intranet
- Increased Transparency: encourage learnings and collaboration across Health

From Death We Learn

- Aim is Prevention via Education
- Annual Publication from the CLU at WA health
- FDWL DVD for education
- Aim is to raise awareness of the lessons learned from coronial investigations

From Death We Learn DVD

From Death We Learn

Inquest Into The Death of
Simon Herron

Government of **Western Australia**
Department of **Health**
Nursing and Midwifery Office

Government of **Western Australia**
Department of **Health**
Performance Activity and Quality

From Death We Learn

- Based on:
  - Inquests from the previous calendar year
  - Reported case investigations from both the coronial and clinical incident environment
- Factual cases resonate best with clinicians

From Death We Learn: Cases

- Key Messages
- Summary of the facts of the case
- Coroner’s recommendations or comments
- WA health actions
- References
- Discussion points

Inquest Example: Undiagnosed pulmonary embolism

- Key messages
  - Include the importance of asking for details of all medications including the oral contraceptive pill (OCP)
- Coroner’s recommendation
  - That general practitioners advise their patients to report the use of the OCP
- WA health
  - The hospital has implemented a ‘Diagnostic pathway for pulmonary embolism’
- Discussion points
  - What decision-making tools would be relevant when reviewing a young woman with chest pain?

Non-inquested cases

- 2 case studies to illustrate aspects of reporting deaths to the coroner
  - That a death related to injury is a reportable death
  - How to respond to a family who have requested not to have a post-mortem

Audience

- Broad audience within health
  - Doctors
  - Nurses
  - Allied Health
  - Safety and Quality staff
  - Post Graduate Education and Training

Challenges

Distribution with WA health 44,000 employees

Electronic/hard copy

Nature of the target audience

Time poor

Information overload

Feedback from our users

- 50 % Professional development/Tool for education
- 50 % To identify local quality improvement opportunities

Resources

- From Death We Learn: http://ww2.health.wa.gov.au/Reports-and-publications/From-Death-We-Learn
- Digital From Death We Learn Resources: http://www.nursing.health.wa.gov.au/home/digital_education.cfm
- Limited hardcopies available

- Questions?