24TH JUNE 2024

Final Report of the Independent Review

Reportable Deaths and Death Reporting Processes in Tasmanian Public Hospitals

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Foreword

Death certification is essential for familial, legal, medical, public health, and investigative purposes. It ensures that deaths are accurately documented and appropriately investigated when necessary.

The Panel has completed a detailed analysis of death certification processes at the Launceston General Hospital (LGH).

We have examined in-hospital mortality as reported in the core set of national hospital-level outcome indicators (the “CHBOIs”). The data indicates that the in-hospital mortality at the LGH is within expected nationally benchmarked parameters (Dept of Health (Tas) *Core Hospital-Based Outcome Indicators of Safety and Quality* reporting).

We found no evidence of systemic (hospital-wide) noncompliance with death certification processes. We were provided with sufficient oral and written evidence to be convinced that both junior and senior clinical staff were aware of relevant policies and adhere to them.

During the Review, we meticulously examined eighty six individual medical records. We would like to commend the clinical staff for their expert response to deteriorating patients and the empathetic care they provided to patients and their families during episode of care.

The Review identified significant issues in death reporting practices, particularly concerning a former staff member of the LGH.

The Panel has found that a former staff member engaged in a repeated pattern of acting outside the scope of Section 35 of the Registration of Births, Deaths and Marriages Act 1999 and has repeatedly inaccurately represented their standing to certify Medical Certificates of Cause of Death (MCCDs) in the relevant attestation on those MCCDs.

The Panel considers this a serious and sustained departure from the expected standards of knowledge, skill, and judgment. The Panel has therefore recommended that the former staff member be notified to the Medical Board of Australia on the basis that there is a consistent pattern of cases in which they have certified deaths which prima facie they were not qualified to certify and incorrectly attested as a medical practitioner who attended the patient in their last illness. This pattern of conduct raises the issue of unsatisfactory professional conduct.

The Department of Health (DoH) has commenced open disclosure with the families affected by our referrals to the coroner. The Panel wishes to place on record its concern for these families, who have already experienced significant grief and suffering at the loss of a loved one. We recognise they will experience that grief again because of actions of a staff member at the time their loved one’s death was reported to Births, Death, and Marriages.

The Panel has recommended the reporting of a number of deaths to the Coroners' office and referral of inaccurately attested MCCDs to Crown Law officers and/or the Registrar of Births, Deaths, and Marriages.

Finally, we want to express our sincere gratitude and admiration for the Secretariat for the Review, who have been responsible for ensuring the smooth functioning of the Review processes and has been responsive to the investigators' requests, whether during or outside business hours. In short, the investigators have felt fully and expertly supported throughout the Review.

Adjunct Professor Debora Picone AO

Panel Chair

Independent Review | Reportable Deaths and Death Reporting Processes in Tasmanian Public Hospitals

Executive Summary

Background

On 20th February 2024, the then Secretary of the Tasmanian Department of Health (DoH), Kathrine Morgan-Wicks, initiated a review into reportable deaths and death reporting practices within Tasmanian public hospitals following allegations of misconduct (the Review). Testimonies provided to the Select Committee on Transfer of Care Delays highlighted allegations about unreported deaths and falsified medical certificates at Launceston General Hospital (LGH). The full membership of the Panel is detailed at Appendix 1.

Purpose

The Review aimed to:

- Assess and improve death reporting practices and patient mortality review processes;
- Independently examine policies, protocols, and systems within the Tasmanian Health Service (THS) to ensure compliance and effectiveness; and
- Conduct a clinical review of specific cases where death reporting to the Coroner may have been mishandled or medical cause of death certificate altered by the Executive Director of Medical Services (EDMS).

The Panel provided the Acting Secretary with findings and recommendations on 17th May 2024, which is attached as Appendix 2.

Review Methodology

The Review was multi-faceted and involved:

- **Meetings with Staff Members**: Engaging with system administrators, quality patient safety advisors, executive directors of medical services, and medical consultants;
- **Meetings with Family Members and Staff**: Addressing concerns raised about the death certification process;
- **Policy and Document Review:** Undertaking a comprehensive review of departmental policies, protocols, and death reporting documents;
- **Interviews with Departmental Employees**: Collecting formal information and personal accounts from current and former employees; and
- **Review of Clinical Cases**: Detailed examination of numerous clinical cases to assess patient care and death circumstances.

Review limitations

- A former Hospitals North staff member declined an interview with the Panel, so the Panel has formed its views and recommendations in the absence of a response from this staff member.
- That said, the Panel has seen a response to a complaint by the former staff member which sets out in some detail their rationale (misconceived in the Panel's view) to certify death in this manner.
- The Coroner's Office was contacted on several occasions to discuss general issues of policy and practice, both historically and currently, in relation to the interface between the THS and the Coroner’s Office, Unfortunately, no-one from the Coroner's Office was available to meet with the Panel.

Conclusions

- The Review identified significant issues in death reporting practices, particularly concerning the actions of the former staff member.
- The Panel has recommended a total of 29 deaths be reported to the Coroners' office: in addition to this, 28 inaccurately attested MCCDs are recommended for referral to relevant authorities and/or the Registrar of BDM.
- The Panel has found that the former staff member has engaged in a repeated pattern of acting outside the scope of Section 35 of the Registration of Births, Deaths, and Marriages Act 1999 , and has repeatedly inaccurately represented their standing to certify MCCDs in the relevant attestation on those MCCDs. The Panel considers this a serious and sustained departure from the expected standards of knowledge, skill, and judgement for an experienced medical administrator.
- The Panel has therefore recommended the former staff member be reported to the Medical Board of Australia. This is on the basis that there is a consistent pattern of cases in which they have certified deaths which prima facie they were not qualified to certify, and incorrectly attested as a medical practitioner who attended the patient in their last illness. This pattern of conduct raises the issue of unsatisfactory professional conduct and whether they are a fit and proper person.
- The Review also identified several cases where, in the Panel's opinion, deaths should have been reported to the Coroner. In some instances, this non-reporting appears to have followed discussions with the Coroner's office at associate level. However, there is a lack of contemporaneous medical records in respect of these interactions between the former staff member and the Coroner's Office. As a result, the Panel is unable to ascertain what the reasons were for the cases appearing to be “returned” to the THS for death certification.
- Accordingly, the Panel has recommended that those cases, which, on review of the relevant documentation the Panel considered should have been reported to the Coroner, rather than certified by a doctor within the THS, now be referred to the Coroner.

> *The Panel wishes to emphasise that referral to the Coroner is being made in the interests of transparency and independent scrutiny.*
>
> *No inference should automatically be drawn that there is something suspicious or otherwise untoward about the deaths in question or the causes of death cited on the MCCDs.*

- The management of deaths administration and certification is a serious matter, carefully regulated through a comprehensive legislative regime. It is also an important duty from a medical professional perspective, and the deceased and their families are entitled to have processes and practices carried out with due skill, care, professionalism. Whilst THS does have comprehensive policies and electronic systems to support appropriate management of death reporting and certification, there are aspects that should be made clearer. Work is already underway to ensure these improvements are made.
- Recommendations have also been made to improve policies, protocols, and training to ensure accurate death certification and compliance with statutory requirements. The Panel commends ongoing efforts by the THS and the DoH to address these issues and enhance the safety and quality of patient care.

Summary of Recommendations

1. Certification of death by former staff member

1.1 The former staff member should be notified to the Medical Board of Australia on the basis that there is a consistent pattern of cases in which they have certified deaths which prima facie they were not qualified to certify and incorrectly attested as a medical practitioner who attended the patient in their last illness. This pattern of conduct raises the issue of unsatisfactory professional conduct and whether they are a fit and proper person. The supporting MCCD documentation should accompany the notification.

1.2 Cases of inaccurately attested MCCDs identified by the Panel, where the cited causes of death are consistent with the evidence available through the relevant patient records, should be referred to the Registrar of BDM for consideration of what action, if any, may be required.

1.3 Any guidance on the statutory requirements for certification of death by a medical practitioner must be made clear and consistent across all government websites.

1.4 The Registrar of BDM, as the person responsible for administering the BDM Act, should have primary responsibility for providing guidance on the application of the BDM Act to medical practitioners.

2. Referral of certain cases to the Coroner

2.1. That a cohort of deaths reviewed by the Panel be referred to the Coroner. The cohort comprises those deaths, the related medical records of which the Panel has reviewed, where the Panel has concluded those deaths appear to be “reportable deaths” which should have been formally reported to the Coroner rather than being certified by a THS medical practitioner.

3. THS Policy and Protocol Documentation

3.1. Issue directives to clarify the roles of medical administrators in reviewing but not certifying deaths.

3.2. Amend protocols to ensure clear guidance is given on: when to refer deaths to the Coroner; who can certify deaths in the THS; and the requirement to properly document any communication between the THS and the Coroner’s office in relation to specific cases.

3.3. The Mortality Module in the SRLS should be enabled to support contemporaneous recording of actions and advice around the death reporting process.

3.4. Policy and protocols are to reflect information in the THS Health Record Documentation Protocol, that an individual's health record is to be used as both a communication tool and as a medico-legal record of care and treatment. Clinicians are to document information relating to death reporting practices including, why or why it wasn't reported, conversations with other clinicians, EDMS, the Police contact for the Coroner and/or the Coroner's Office in the individual health record.

3.5. Ensure the relevant Protocol is amended to provide a specifically titled section on Certifying Death. This information should no longer be embedded within the section dealing with reporting deaths to the Coroner.

4. THS Training and Orientation

4.1. Ensure admitting consultants delegate MCCD responsibilities to competent junior staff only.

4.2. Include certification of deaths in locum staff contracts and remind them of their obligations under the BDM Act.

4.3. Ensure there is ongoing training for medical staff about their obligations under both the BDM Act and the Coroner's Act.

5. Quality Assurance

5.1. Implement clearer guidelines and documentation processes within the Mortality Module in the SRLS.

5.2. Improve the flowchart accompanying the Protocol to distinguish between certification and review processes.

5.3. Strengthen process relating to the internal review of all deaths to ensure:

- the accuracy of information on the MCCD;
- any queries of concerns relating to the MCCD are discussed with the individual medical practitioner making the certification, and all changes are initiated by the same individual;
- cases are identified for further review under service mortality review arrangement, and this includes a process to review the MCCD; and
- the cause of death is discussed with bereaved people, and it is readily established if they have questions or any concerns with care before death and have a contact for follow up (if required).

Review Terms of Reference and Methodology

Terms of Reference Dated 26th February 2024

Background

On Wednesday, January 24, 2024, a registered nurse (former employee) provided testimonial evidence 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 two more reports supporting the claims made at the hearing on 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, then 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 of this review it 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.
- Independently examine 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.

- A clinical review of 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 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 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 available 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.
- 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 as Next of Kin—noting that whilst the full circumstances surrounding the person's death may not be known until after further investigation, every effort should be made to inform them of the independent clinical review and its purpose; and
    - discussion and/or referral to the Coroner/Tasmania Police.
- For each clinical case review, the Panel Members must discuss their findings with the Chair and the full panel before making a final determination and giving 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 of the 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 have an understanding of:

  - *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).

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 Methodology

- The Panel has undertaken a detailed and multi-faceted review to gather comprehensive insights into death reporting practices and identify any areas of concern or deviations from expected standards.
- The following processes were included in the Review:
  - **Meetings with THS and Department staff:** The Panel engaged with various staff members involved in the death reporting process, including:
    - System administrators of the Safety Reporting and Learning System (SRLS)
    - Quality Patient Safety Advisors
    - Executive Directors of Medical Services
    - Medical Consultants
  - **Meetings with families and concerned individuals:**
    - The Panel met with several family members and others who had raised concerns regarding the death certification process.
  - **Meeting with the Registrar of Births Deaths and Marriages**
  - **Interviews with Departmental Employees:**
    - Interviews were conducted with current and former departmental employees. These interviews provided the Panel with formal opportunities to collect information and personal accounts of current and past practices regarding death reporting, including referral of reportable deaths to the Coroner.
  - **Policy and Document Review:**
    - Conducted a comprehensive review of current departmental policies, protocols, and available documents to guide, outline, and support death reporting practices across the THS.
  - **Review of Patient Records:**
    - Members individually undertook a comprehensive review of records of 86 clinical cases (Table 1) to examine the circumstances surrounding the patient's care at the time of death. This included:
      - Reviewing the available Medical Record
      - Examining the Mortality Module
      - Inspecting the Medical Certificate of Cause of Death (MCCD)
      - Assessing any SRLS events
      - After individual reviews, the Panel members met collectively to discuss their findings and reach a consensus conclusion.

Table - Source of patient (cases) referrals

Source	Number of Cases	Number of Cases previously Referred to the Coroner	Number of Cases Referred to the Coroner by the Panel	Number of Cases Referred to BDM	Nil further action Identified
Patient deaths were identified following multiple public callouts from the former Secretary, Kathrine Morgan-Wicks, in addition to those provided by current staff members.	23	7	7	0	7
A further lookback of DoH Records in the Mortality Module and cases flagged by members of the public	65	8	22	28	7
Total	88*	15	29	28	14

*Please note 2 cases were unable to be identified and therefore were unable to be reviewed by the panel.

Death Reporting and Certifying Processes in Tasmanian Public Hospitals

Introduction

- Certification of death in Tasmania serves several essential functions:
    - **Legal Documentation**: Provides an official record of death, which is necessary for legal purposes, such as settling estates, executing wills, and issuing a death certificate.

    - **Medical Accountability:** Ensuring accurate documentation of the cause of death is critical for medical records and maintaining the integrity of healthcare practices. It provides a basis for reviewing medical care leading up to death, which can help identify any medical errors or issues in patient care.

    - **Public Health Data**: It contributes to public health statistics and helps track mortality rates and causes of death. Assists in identifying public health issues and trends, which can inform health policies and preventive measures.

    - **Family and Community Needs:** Provides the deceased's family with an official record of the cause of death, which can be necessary for emotional closure and understanding of the circumstances surrounding the death. It facilitates funeral arrangements and other post-death processes.

    - **Coronial and Forensic Investigations:** When required, this documentation supports coronial investigations by providing initial details about the death. It ensures that any deaths involving unusual or suspicious circumstances are referred to the Coroner for further investigation.

- In summary, death certification is essential for familial, legal, medical, public health, and investigative purposes. It ensures that deaths are accurately documented and appropriately investigated when necessary.

Background – statutory requirements

- When a death occurs in Tasmania, and the cause of death can be comfortably ascertained by a relevant medical practitioner, and there are no grounds requiring reporting of the death to the Coroner under section 19 of the Coroners Act 1995, notification of death to the Registrar of Births Deaths and Marriages must occur under the *Births Deaths and Marriages Act 1999 (BDM Act)* by a relevant medical practitioner. That medical practitioner must satisfy the requirements to certify the death under the BDM Act.

- Notification of death is a prerequisite to the registration of that death by the Registrar. Correct management of death certification and notification to the Registrar of BDM is equally as important as ensuring reportable deaths are referred to the Coroner and represents the more common pathway for appropriate and transparent management of a person's death.

- Section 35 of the BDM Act governs the statutory obligations of relevant medical practitioners to certify and notify deaths to the Registrar where the death is not reportable to the Coroner.

- Section 35 provides instructions as follows:

> *Notification of death by medical practitioner*
>
> *(1) A medical practitioner who was responsible for a person's medical care immediately before death, or who examines the body of a deceased person after death, must, within 48 hours after the death, notify the Registrar of the death and of the cause of death in a form approved by the Registrar.*
>
> *Penalty: Fine not exceeding 10 penalty units.*
>
> *(2) A medical practitioner need not give notice under this section if –*
>
> *(a) another medical practitioner has given the required notice; or*
>
> *(b) a coroner or a police officer is required to be notified of the death under the Coroners Act 1995 .*
>
> *(3) When notice of a death is given, the medical practitioner must also give a certificate in a form approved by the Registrar, certifying the cause of death, to –*
>
> *(a) the Registrar; and*
>
> *(b) the funeral director or other person who will be arranging for the disposal of the human remains.*
>
> *Penalty: Fine not exceeding 10 penalty units.*
>
> *(4) Notice provided to the Registrar under this section is to be provided free of charge.*

- It is apparent from this section that a medical practitioner who satisfies one of two alternate eligibility requirements has a statutory obligation to certify and notify a death unless they are aware that another similarly eligible practitioners has done so, or, in the alternate, that the death has been reported to the Coroner.

- Failure to so certify and notify is an offence carrying a maximum fine of 10 penalty units. It is also arguably unsatisfactory professional conduct on the part of that practitioner in failing to diligently and competently carry out their duties to the deceased patient to manage the legalities and administrative requirements relating to their death.

- For these reasons every medical practitioner involved in clinical practice should be fully aware and properly understand their professional obligations in managing these after death responsibilities to their patients.

- The two alternative eligibility requirements giving rise to the obligation on the part of a medical practitioner to certify and notify deaths to the Registrar are:
    (i) the practitioner was responsible for a person's medical care immediately before death, OR
    (ii) the practitioner examines the body of a deceased person after death.

- The Registrar of Births Deaths and Marriages has issued a template Medical Certification of Cause of Death (MCCD) which forms an Attachment to this report. It is noted that the Mortality Module in the Tasmanian Health Service SRLS, which has enabled electronic reporting of deaths since 2020, contains an electronic MCCD which mirrors the template issued by the Registrar.

Tasmanian Health Service Policy

- The THS rightly has stringent policies and processes governing the management of deaths which occur or are to be certified within its facilities. The key policy document is titled *"Protocol - Death of a patient (including Coroners Notifications) – February 2020 – SDMS P20/79" (the Protocol)*.

- In respect of deaths which are to be certified and notified to the Registrar of BDM, rather than being reported to the Coroner, the Protocol has set out a strict and narrowly scoped set of requirements.

- If these are properly implemented and complied with, they will ensure that medical practitioners working within the THS act within the statutory parameters of their individual obligations under the BDM Act.

- This approach is entirely understandable for a complex organisation such as the THS where sound clinical governance of its various and diverse facilities is imperative.

- It is also consistent with cornerstone hospital policy and practice where the admitting practitioners (consultants or general practitioners depending on the role delineation of the facility) have the primary obligation for the care of the patients admitted under them, including the supervision of the treating team such as the junior medical staff involved in treating the patient.

- The Protocol states in section 2.4:

  If the death is not being reviewed by the Coroner, a Medical Certification of Cause of Death (MCCD) must be completed in the SRLS Mortality Module within 24 hours of death by:

  a. *the admitting Medical Officer responsible for the deceased at the time of their death, or*
  b. *b. by the General Practitioner, or*
  c. *their delegate (this must be a medical professional).*

  The MCCD should be completed in accordance with the instructions provided by the Registrar of Births, Deaths and Marriages (see Medical Certification of Death book for further instructions or/and through the Australian Bureau of Statistics - Information Paper: Cause of Death Certification Australia, 2008 – 1205.0.55.00)

  The certificate will undergo review by the Executive Director of Medical Services, or their delegate, before it is approved. Only when the certificate is approved can the body be collected by the funeral directors from the morturary.

  As post-mortem examination should be considered for all hospital deaths. This must be discussed with the admitting medical officer (Consultant/General Practitioner), prior to any discussions with family members or gain their consent. A hospital designated officer must authorise the request for the non-coronial post mortems according to the Human Tissues Act 1985.

- Attached to this Protocol is a flow chart diagram showing the two alternate pathways for managing the death of a patient within a THS facility, namely reporting the death to the Coroner, or certifying and notifying the death to the Registrar of BDM.

- Since 2020 generally certification of death and notification to BDM has occurred via the Mortality Module (MM) in the SRLS.

- The Panel has been briefed on the Mortality Module within the SRLS and this advice together with relevant extracts from the electronic MM. The MM within SRLS has two functions:

    - Mandatory Reporting to Coroner and/or
    - MCCD completion

- The process takes the reporter (Medical Professional) through the form sequentially (see relevant extracts below).

- In the case of certifying a death for the purposes of notification to the Registrar of BDM, both the electronic MCCD that is produced by the MM, and the down time paper form (to be used if the system is unavailable), include the following attestation to be completed by the medical practitioner who is actually certifying the death:

    "I hereby certify that I attended the above named deceased during the last illness and that the particular and cause of death written above are true to the best of my knowledge and belief."

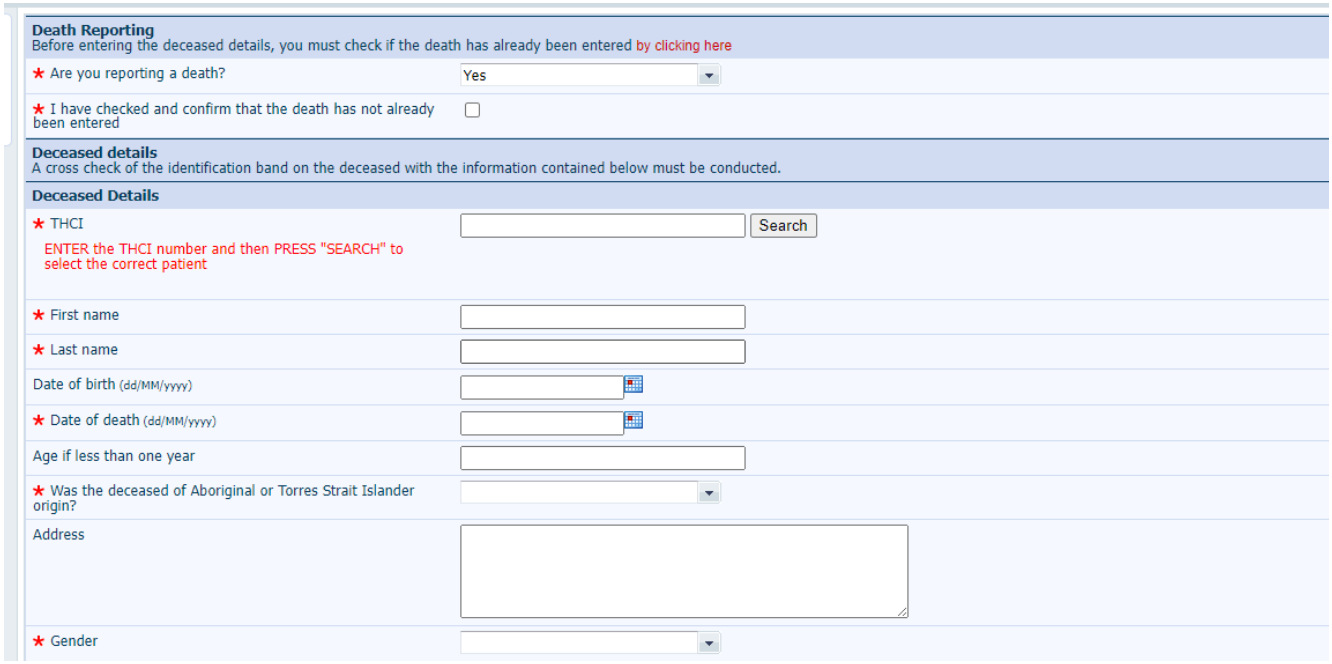
- Clearly within THS, consistent with the Protocol, only a medical member of the treating team can accurately and truly make this attestation. Furthermore, under THS policy (the Protocol and MM in the SRLS) medical staff are not given the option permitted under the BDM Act, to conduct a post mortem "examination" of the deceased in order to complete the necessary certification.

- This is understandable, given the vast majority of practising medical clinicians, particularly junior staff, would not necessarily have the skills or experience such as deep specialist knowledge or appropriate forensic medical training to undertake an "examination" of a quality and sufficiency to properly establish a cause of death.

- Discussions with a number of senior medical administrators within the THS has confirmed this stance is appropriate. The Panel is comfortable with this policy stance that relies on a medical member of the clinical team attending the patient assuming the responsibility for certifying the death and making the relevant attestation.

Extracts from Mortality Module in the SRLS

Deceased Details red* indicates a compulsory field.



Death Reporting
Before entering the deceased details, you must check if the death has already been entered by clicking here

* Are you reporting a death? Yes

* I have checked and confirm that the death has not already been entered

Deceased details
A cross check of the identification band on the deceased with the information contained below must be conducted.

Deceased Details

* THCI [Search]
ENTER the THCI number and then PRESS "SEARCH" to select the correct patient

* First name

* Last name

Date of birth (dd/MM/yyyy)

* Date of death (dd/MM/yyyy)

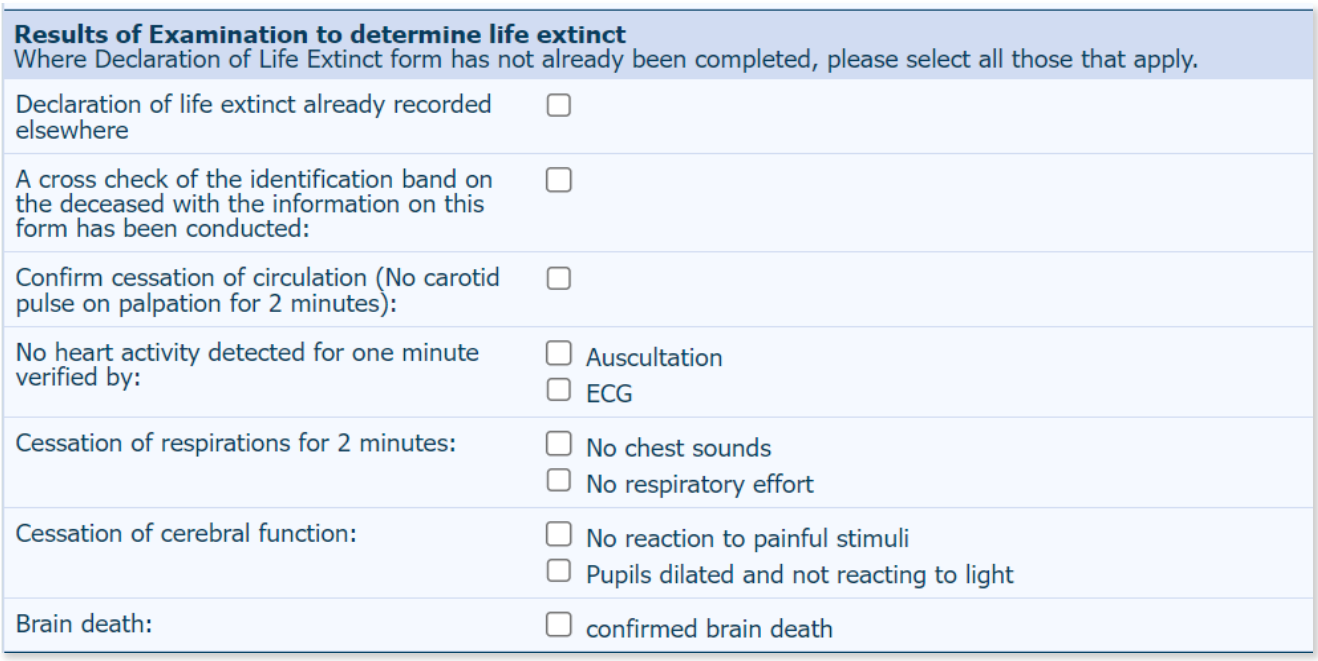
Age if less than one year

* Was the deceased of Aboriginal or Torres Strait Islander origin?

Address

* Gender

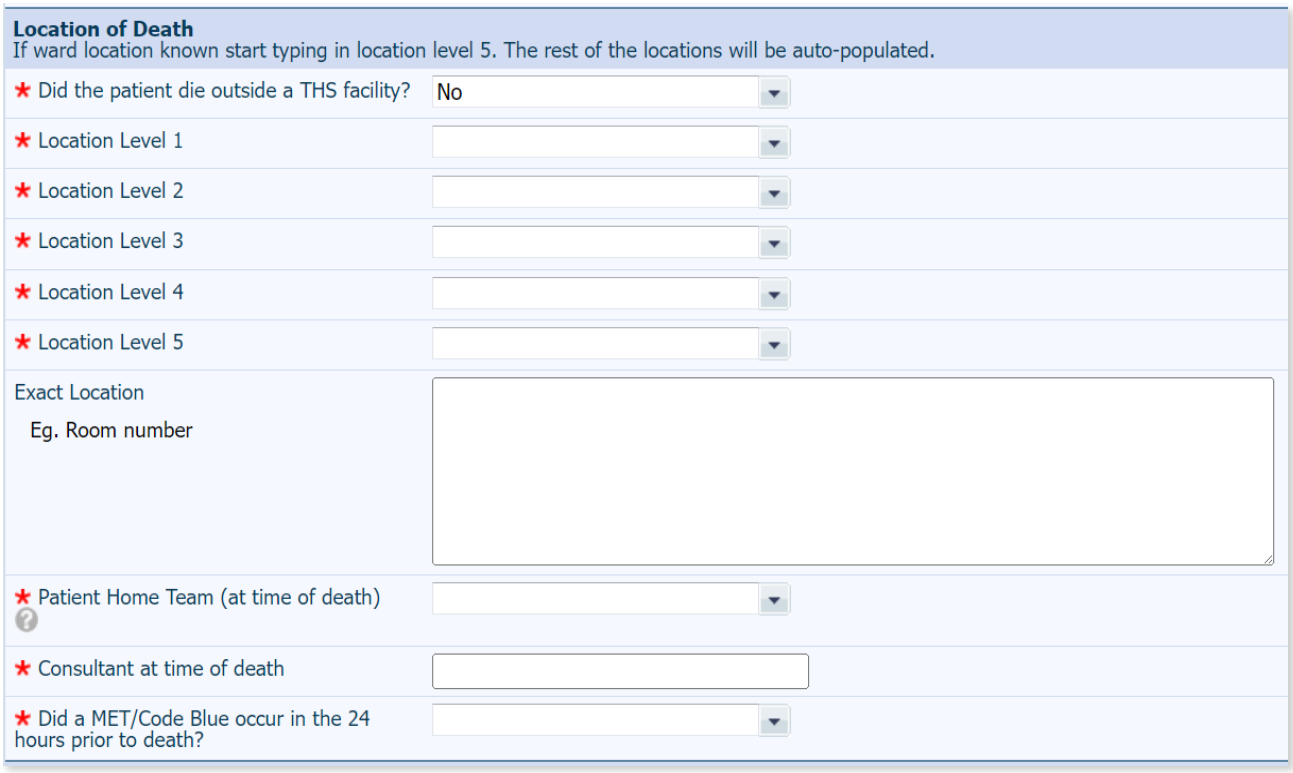
It then seeks **Results of Examination to Determine Life Extinct**



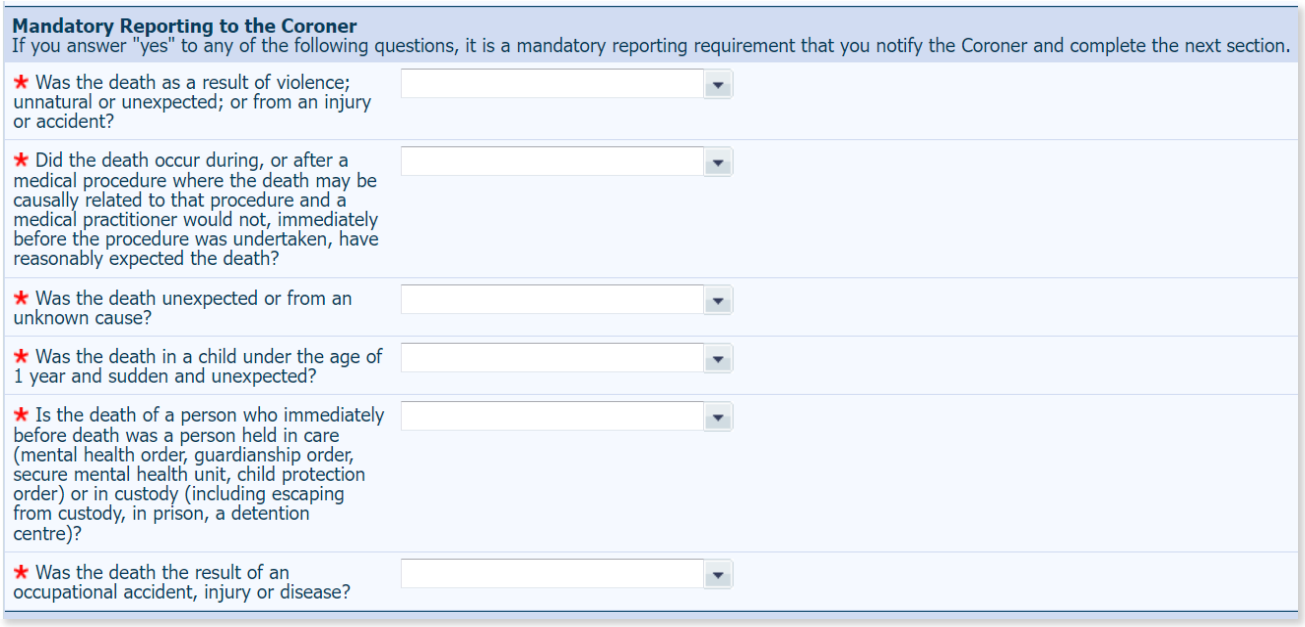
Results of Examination to determine life extinct
Where Declaration of Life Extinct form has not already been completed, please select all those that apply.

Declaration of life extinct already recorded elsewhere	☐
A cross check of the identification band on the deceased with the information on this form has been conducted:	☐
Confirm cessation of circulation (No carotid pulse on palpation for 2 minutes):	☐
No heart activity detected for one minute verified by:	☐ Auscultation ☐ ECG
Cessation of respirations for 2 minutes:	☐ No chest sounds ☐ No respiratory effort
Cessation of cerebral function:	☐ No reaction to painful stimuli ☐ Pupils dilated and not reacting to light
Brain death:	☐ confirmed brain death

Then the reporter is required to enter information on **Location of Death**



Mandatory Reporting to the Coroner



Coroners Notification Requirements - it is the answers to this section that either trigger more information for reporting to coroner, or the process for completed the MCCD & Certification.

Coroners Notification Requirements
If you answered yes to any of the questions above, you must now phone 131444 (Police Radio Control Room) and complete the Coroners report form.

If there is doubt as to the requirements to report this case, first discuss this with the Consultant looking after the patient. If there is still a question about reporting the case must be discussed with your local EDMS obtainable through the hospital switchboard. If required they (EDMS) will contact the Coroners office.

★ Did you contact the EDMS?	No
★ Select yes if this case was reported to the Coroner's office but they will not be investigating the death?	No
★ Reported to the Coroner (via Police Radio Control Room) and written coroners report required?	No

NOT Reported to Coroner – following screen and Death certification (MCCD)process.

Death Certificate Details
If this death has not been reported to the Coroner, complete this section so that a death certificate can be created.

★ Date last seen alive Include the date last seen alive by me, my colleague or as recorded in the patient notes.	
★ Post mortem status	

Cause of Death Details

If you document a mode of dying in 1a, eg. cardiac failure, you must document the cause of this in 1b eg. valvula heart disease. The sequence of causes of death must make medical sense i.e. 1a is due to 1b, which is due to 1C etc.

For "interval between onset and death" you must document a number and unit (eg. 7 days) or if not known write "unknown"

★ 1(a) Disease or condition directly leading to death	
★ (a) Approx interval between onset and death This MUST be a number and unit (eg. 7 days). Write "unknown" if not known.	
1(b) Antecedent cause - which caused 1(a)	
(b) Approx interval between onset and death	
1(c) Antecedent cause - which caused 1(b)	
(c) Approx interval between onset and death	
1(d) Antecedent Cause - which caused 1(c)	
(d) Approx interval between onset and death	
1(e) Antecedent cause - which caused 1(d)	
(e) Approx interval between onset and death	
Other significant conditions contributing to the death but not related to the disease or condition causing it.	

Other Details

★ Was an operation performed on the deceased within 4 weeks before death?	
★ Was the deceased pregnant within 6 week of death?	
★ Was the deceased pregnant between 6 weeks and 12 months of death?	
★ Was an injury/external cause involved in the death?	
★ Was this death expected as a consequence of this illness or injury?	

Submission and Certification
I hereby certify that I attended the abovenamed deceased during the last illness and that the particulars and cause of death written above are true to the best of my knowledge and belief.

Details of the Doctor reporting the death

★ Doctor's Name Start typing your surname, space space firstname	
★ Address / Phone	
★ Date reported (dd/MM/yyyy)	25/06/2024

Submit | Cancel

Yes - report to coroner.

Coroners Notification Requirements
If you answered yes to any of the questions above, you must now phone 131444 (Police Radio Control Room) and complete the Coroners report form.

If there is doubt as to the requirements to report this case, first discuss this with the Consultant looking after the patient. If there is still a question about reporting the case must be discussed with your local EDMS obtainable through the hospital switchboard. If required they (EDMS) will contact the Coroners office.

★ Did you contact the EDMS?	No
★ Select yes if this case was reported to the Coroner's office but they will not be investigating the death?	No
★ Reported to the Coroner (via Police Radio Control Room) and written coroners report required?	Yes

Death Report to Coroner Form
Complete all the questions below (* are mandatory). Upon submission of the report this will be reviewed by your local EDMS who will then distribute the report.

★ Dead on arrival to the hospital?	
★ Opinion of the treating team as to cause of death	
★ Any issues to be addressed at autopsy?	

Details of Admission

★ Date of presentation/admission	
★ Time of presentation/admission	
★ Admission diagnosis	
Secondary diagnosis	
★ Past medical history	
★ Type of admission	
★ Name of admitting Consultant	
★ Was cardiopulmonary resuscitation in progress on admission?	
Operative procedure or intervention	
★ What were the patient goals of care at the time of death?	

A. The goal of care is CURATIVE or RESTORATIVE

B. The goal of care is CURATIVE or RESTORATIVE with limitations

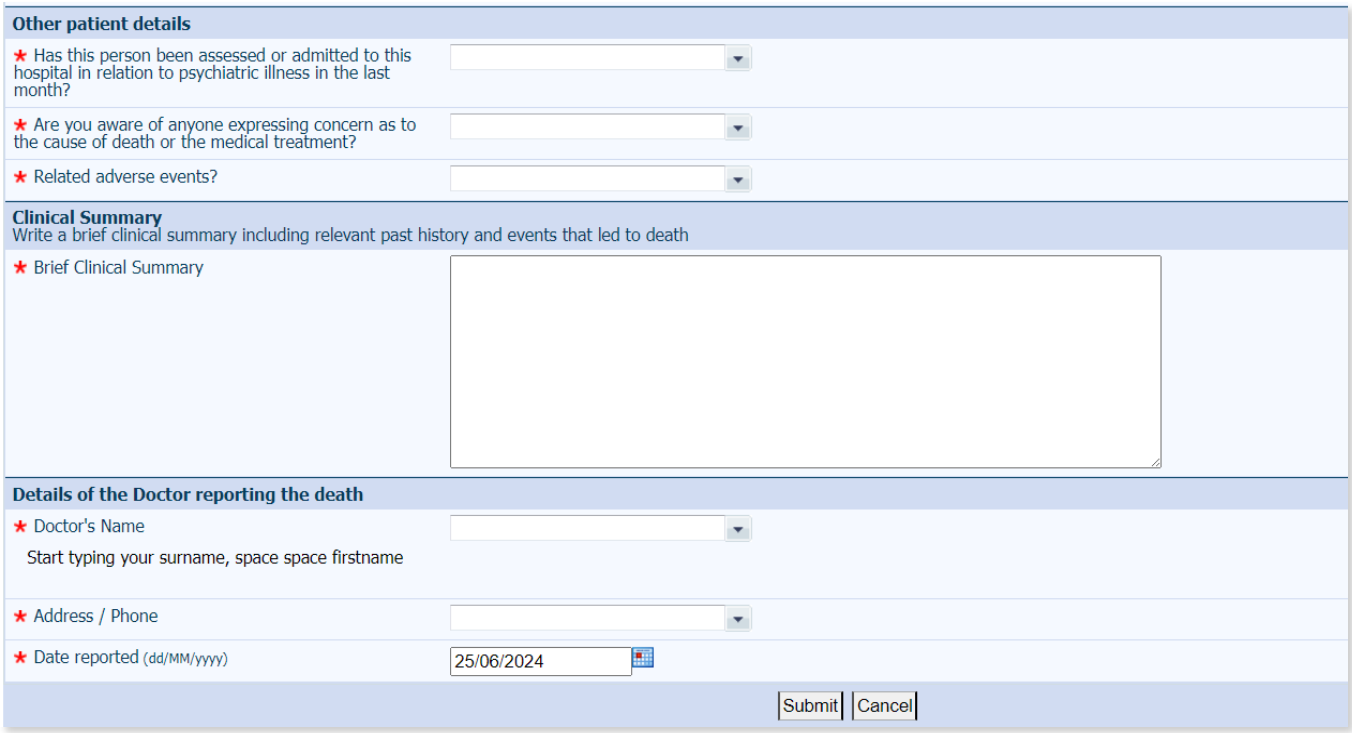
C. The goal of care is PALLIATIVE

D. The goal of care is COMFORT as the patient is dying

★ Was the patient documented as Not for CP resuscitation on admission?	
★ Did the patient have an Enduring Guardianship/Advance Care Plan?	
★ During the admission was the patient transferred to an area of higher dependency?	
★ Was this illness/injury related to current/previous employment?	

Date and time first seen by the responsible inpatient consultant:

Date (first seen)	
Time (first seen)	



- There are aspects of the Protocol and the related Flow Chart that could be improved by amendment and elaboration, as is the case with the actual design of the Mortality Module in the Safety Reporting and Learning System (SRLS). These are the subject of further observations and recommendations by the Panel.

Reporting to the Coroner vs death certification and notification to the Registrar of BDM

- The Protocol recognises that sometimes it is not always clearcut whether a death is a reportable death under the Coroners Act.

- The Protocol states:

  If there is any question about whether the case is reportable or not, the medical officer should discuss the case with the Consultant looking after the patient. If doubt persists, a senior member of the medical team looking after the patient should discuss the case with the on-call EDMS. If necessary, the on-call EDMS may then discuss the case with the Coroner's office and then provide advice to the medical team.

- In cases reported to the Coroner and accepted for investigation, a Coroner's Death Report form must be completed in the SRLS Mortality module.

- Completing the SRLS form will guide the user to complete either the Death Certificate, or the Report to the Coroner as applicable.

- The Panel has concerns with the current wording of the Protocol surrounding the seeking of advice from the Coroner in cases of uncertainty. We had hoped to gain the Coroner's Office perspective on these matters before formulating recommendations for amendment. Unfortunately, the Panel has been unsuccessful in achieving a meeting.

- The Panel also wanted to discuss the wording that appears on the Coroners' website relating to the obligations under the BDM Act to certify death.

- In particular, the Panel wished to discuss certain words that appear on the website information section titled "When to report a death to the coroner" [1] but do not appear in the BDM Act itself, nor on the BDM website, noting it is the Registrar of BDM who is the key officer responsible for administering the BDM Act.

- Whilst the opening paragraph of this information sheet correctly states the two alternate criteria that render a medical practitioner accountable for certifying a death, namely "responsible for a person's medical care immediately before death, or who examines the body of a deceased person after death" further along the information sheet states "You do not need to have treated the deceased within a certain period before death, (or ever) to complete a MCCD or report a death."

[1] When-to-Report-a-Death-to-the-Coroner-.pdf (magistratescourt.tas.gov.au)

- Given the absence of a meeting with the Coroners' office, the Panel's observations are necessarily informed only by its discussions with senior practising clinicians at THS and the patient records reviewed between 2020 and 2022.

- The Panel observed irregular practices of a former staff member, at the time in the death management process, whether as a certifier of death or as reviewer of the relevant death certificate prior to finalisation.

- The Panel has gleaned from the significant number of deceased patient records it has reviewed, and discussions with senior clinicians within THS, that uncertainty as to cause of death may sometimes arise because the relevant clinical team is not comfortably satisfied about the cause of death of the patient. This uncertainty is based on an absence of critical clinical information about the patient that potentially only a post mortem examination of some kind by a properly trained forensic medical examiner may solve.

- It is for this reason where no attending medical practitioner is comfortable to certify what the cause of death is, that a case should by default be reported to the Coroner on the ground that the cause of death is unknown (section 3 Interpretation "reportable death" (a) (vii) Coroners Act 1995).

- It is noted that the BDM Act enables a magistrate to order the registration of a death or registrable information about the death to be entered on the Register. The registrar can proceed to registration in cases where relevant information is provided by the Coroner, in relation to the cause of death and the Coroner authorising of the disposal of human remains.

- The Registrar can also proceed to registration if the Court orders it, or where "the Registrar is of the opinion that, having regard to all the circumstances of the case, it is proper that the death should be registered without relevant notice, certification or order…." (s. 34 (2) BDM Act).

- The Protocol refers to consulting with the Coroners' office in cases of uncertainty, and the evidence before the Panel indicates that this has occurred not infrequently.

- Furthermore, in those cases that appear to have been discussed with the Coroners' office and "returned" there are sometimes notations in the patient record that the medical staff have been advised that the Coroner has sent the case back as not reportable.

- However, there are no indication in the record as to who in the Coroners' office sent the case back and on what grounds the previous uncertainty of the attending team has been resolved sufficiently to now render a member of that team comfortable to certify the cause of death.

- In fact, there is a pattern where many of these cases initially referred to the coroner which subsequently "returned" to the relevant hospital, proceed to a death certification, not by the attending medical practitioner, but by the EDMS or their delegate.

- Putting aside the apparent lack of eligibility of a non-clinical staff member to certify deaths under the BDM Act and THS policy, which will be discussed later, precisely who the source of advice in the Coroner's Office was, and what qualifications they had to provide the relevant advice is not documented in the record.

- Whilst the Panel can envisage cases where a lay coroner's associate would be qualified to advise on whether the circumstances surrounding a death rendered the death reportable or not, it would be deeply concerning if the source of advice about the actual cause of death was a Non-Medical person.

- Cause of death certification is to be done by a medical practitioner because of the qualifications and clinical judgement required to properly discharge this function.

- If there is an absence, or potential interpretation, of clinical information that is giving rise to uncertainty about cause of death, clearly this needs to be discussed with someone with relevant medical qualifications and forensic skills. This is to provide advice which is sufficient to allay the hospital practitioner's concerns, remove their uncertainty and enable them to be comfortably satisfied as to cause of death.

- The Panel also wishes to record its concern about the wording in the Information Sheet referred to in section above which states, "You do not need to have treated the deceased within a certain period before death, (or ever) to complete a MCCD or report a death."

- Whilst the Panel can envisage circumstances where this statement may be true in respect of the completion of a MCCD, in the absence of further elaboration and context it may tend to confuse and appear inconsistent with the actual statutory eligibility test, namely, "was responsible for a person's medical care immediately before death".

- Furthermore, this statement on first blush could, to the unversed eye, appear inconsistent with the attestation required under the BDM template MCCD, which requires the relevant medical practitioner to attest that "I hereby certify that I attended the above named deceased during the last illness"……."

- An example of how the relevant statutory provision and the wording in the Coroner's note might consistently co-exist within the hospital setting is where a patient is admitted to hospital under the care of a designated consultant (specialist doctor) but is actually treated by junior medical staff and/or dies prior to the consultant actually physically seeing the patient.

- In those circumstances under routine hospital custom and practice the admitting consultant is still considered primarily responsible for the patient's care, including proper supervision of the treating team, and hence under both the BDM Act and THS Protocol responsible for certifying the death, or under THS Protocol delegating this task to a suitably skilled and qualified more junior medical member of the treating team, who can also qualify as "responsible for a person's medical care immediately before death".

Certification of death

- The Panel has reviewed 86 patient and associated death records with the vast majority being since the inception of digital records in 2020 until late 2022.

- The Panel has identified serious concerns with the death certification processes involving a former staff member of the LGH, as well as a number of areas for improvement of the death certification processes within the THS.

- Whilst it is perfectly acceptable, indeed good practice, to quality assure MCCDs through a review and approval process by hospital's medical administration, the review process is just that.

- The relevant reviewer cannot substitute their certification unless they are qualified to do so under both the BDM Act and the THS Protocol.

- The Panel has found numerous instances where former staff members have completed MCCDs either as the original certifier, or in substitution for a previous certifier who was a junior member of the treating team or a general practitioner in a district facility.

- Under the THS Protocol and electronic death certification form, a medical administrator is clearly not qualified to certify death.

- Whilst it is acknowledged that there are directors of medical services in hospitals across Australia that have part-time clinical appointments, there are no such roles within the THS.

- Furthermore, a review of the relevant role description and advice from the DoH indicates the those undertaking this duty do not carry a clinical patient load and therefore not credentialled to undertake clinical duties.

- This means that there are instances where staff members were not qualified to complete the death certificate under the Protocol as a consultant, general practitioner, or delegate, nor could they truthfully attest to the following underlined words in the MCCD form namely:

  > *"I hereby certify that I attended the above-named deceased during the last illness and that the particular and cause of death written above are true to the best of my knowledge and belief."*

- It is noted elsewhere that this attestation mirrors the required attestation under the template MCCD form issued by the Registrar of BDM.

- Notwithstanding this, and in breach of THS protocol, it is evident from the Panel's review of patient records and MCCDs, that former staff members did so certify and did so attest on numerous occasions.

- The Panel has viewed a detailed response provided by a former staff member in response to a complaint which in part raised concerns about the qualifications to certify the death.

- This response gives an insight into the misguided understanding the former staff member seems to have had about their ability to certify deaths.

- Their response is at Appendix 3 to this report and tellingly makes no reference to either Tasmanian Health Service Policy or more fundamentally the relevant legislation.

- The staff member misguidedly asserts reliance on hearsay about the patient and documentary review is sufficient to enable certification which is clearly at odds with both policy and legislation The latter requires direct involvement with the care of the patient immediately before death or examination of the deceased post mortem.

- The next question that arises is whether the former staff members, notwithstanding Tasmanian Health policy, were able to certify death under the BDM Act.

- As noted previously a medical practitioner has to satisfy one of two alternate criteria in order to certify death:

    (i) the practitioner was responsible for a person's medical care immediately before death, OR

    (ii) the practitioner examines the body of a deceased person after death.

    In respect of criterion (ii), the Panel has seen no evidence in the medical records reviewed or otherwise that the staff members examined the body of the deceased after death.

    Furthermore, as already indicated in certifying deaths the staff member's certification relies according to the attestation on criteria (i) in that they attest they attended the patient in their last illness.

- In any event in the Panel's opinion an administrator without specialist clinical or forensic medical training would not be qualified to identify cause of death through such an examination.

- The Panel tested this proposition with several EDMSs currently employed within the THS and there was general agreement that this was a sound position from a clinical and governance perspective. They added that that EDMSs are not credentialled by their hospitals to conduct such examinations.

- In respect of criterion (i), the Panel carefully considered whether a medical practitioner occupying a non-clinical position could satisfy this criterion in any circumstances.

- To assist in this regard, it also sought the expert views of several EDMSs within the THS, a few of which had also performed such roles interstate.

- It also reviewed the position description for administrator role. The Panel noted there was no mention of "patient care" responsibilities, and indeed a non-clinical administrator is not credentialled within a hospital to provide or supervise patient care.

- The Panel noted that while the role of a medical administrator, however called, in contributing to sound clinical governance of a hospital is a critical ingredient of fulfilling the hospital's non-delegable duty of care to its patient, the role would not be regarded as having a personal responsibility for the direct care that individual patients receive from their attending medical team.

- This is borne out by the fact that the positions are not generally joined as defendants in hospital negligence cases alleging breach of duty of care; rather it is the institution and/or the admitting consultant that are defendants in such claims.

- The preponderance of expert views from EDMSs within THS was similar. They did not regard themselves as satisfying criterion (i), and considered it was not sound practice for an administrator to complete (as distinct from review) MCCDs.

- THS policy has been formulated consistent with this position. The Panel has therefore concluded that it considers the better view to be that a non-clinical administrator does not satisfy criterion (i) under section 35 of the BDM Act, and that the former staff members should not have completed MCCDs within their roles in the THS.

- In any event a non-clinical administrator is not in a position to undertake the required attestation under the BDM pro-forma MCCD, which is reproduced in the Tasmanian Health Mortality Module of the SRLS.

Suggested reform and recommendations

- The Panel notes and commends the action underway by the current medical administration of the THS to provide clearer guidance on what is required, and what is not permitted when determining whether to certify a death or report a death to the Coroner.

    - Those changes are outline elsewhere in this report.

    - The Panel also notes and commends the move by the DoH to modify the Mortality Module in the SRLS to make the process to be followed clearer and better document who and why changes occur in the course of transparently managing the certification of death and contact with the Coroner's office that does not result in referral for investigation.

    - The Panel has found a subset of the cases it has reviewed where the cause of death appears in order and consistent with extensive medical information in the patient record, but the MCCD has been completed and apparently inaccurately attested by a former staff member, contrary to THS Policy, and potentially in breach of section 35 of the BDM Act.

    - The Panel sees no utility in referring this subset to the Coroner but remains concerned about the legal status and ramifications of these MCCDs. It therefore recommends that this tranche of MCCDs be referred to the Registrar of BDM to determine what further action, if any, should occur in relation to these cases and/or the death certificates related to these cases. The Panel has met with the Registrar to alert them to this referral and its reasons.

    - That that the former staff members be notified to the Medical Board of Australia on the basis that there is a consistent pattern of cases in which they have certified deaths which prima facie they were not qualified to certify and incorrectly attested as a medical practitioner who attended the patient in their last illness.

    - This pattern of conduct raises the issue of unsatisfactory professional conduct and whether they are a fit and proper person. The supporting MCCD documentation should accompany the notification, together with the response to a complainant referred to above which demonstrates the staff members lack of understanding or knowledge of who can actually certify death under THS Policy or the BDM Act.

The Panel further recommends:

(i) That the Department issue a directive to all medical administrators that their role is to review and approve MCCDs but that they should not certify deaths themselves either as an originator of a MCCD or as a substitute for a member of the medical team attending the patient prior to death.

(ii) That the Protocol be amended to remove the words “and accepted for investigation” and substitute the words “where an investigation is to proceed”.

(iii) That the Protocol make clear that any medical practitioner considering whether to complete the MCCD must be comfortably satisfied as to the cause of death before proceeding, otherwise the case should be referred to the supervising consultant or general practitioner for management of the death process. Furthermore, if there is no medical practitioner who attended the patient immediately before death, who is comfortably satisfied as to the cause of death, the death must be reported to the Coroner on the basis that the cause of death is unknown.

(iv) That where there is uncertainty as to whether a death that occurs at a THS facility is a “reportable death” under the Coroners Act, and there may be benefit in obtaining advice from the Coroner’s office prior to determining whether to report the death, the name of the person in the Coroner’s office giving advice and a summary of that advice should be contemporaneously documented in the medical record and the SRLS. In the event that there is uncertainty as to the actual cause of death, any consultation with the Coroner’s office should be with an appropriately qualified medical practitioner associated with that office. It is ultimately a matter for the clinical judgement of a medical practitioner within THS charged with certifying a death as to whether they are comfortably satisfied as to the cause of death.

(v) That admitting consultants only delegate responsibility for completing the MCCD to junior medical staff where they are satisfied that the junior staff have the skills and experience to competently discharge this important function.

(vi) That certification of deaths of patients who died whilst under their care should be expressly included in the contracts with locum medical staff; furthermore, as part of orientation of locums they should be reminded that it is an offence under the BDM Act to fail to certify and notify a death within 48 hours to the BDM Registrar for any patient they attended immediately before death, provided that death is not otherwise a “reportable death” under the Coroners Act, or the death has not already been reported by another medical practitioner.

(vii) That the flowchart accompanying the Protocol be amended to make clearer that the actual certification is distinct from the review and approval process and any corrections required as a consequence of the review by the EDMS should be referred back to the certifying medical practitioner for inclusion in the finalised MCCD that the certifying practitioner issues.

(viii) That guidance on the statutory requirements for certification of death by a medical practitioner be clear and consistent across all government websites, with the Registrar of BDM, as the person responsible for administering the BDM Act, being primarily responsible for providing any guidance of the application of the BDM Act to medical practitioners.

Acknowledgements

The Panel wishes to acknowledge everyone who has contributed their time, energy, and expertise to this important review, particularly clinical staff and patient safety and quality teams.

The review has involved a significant amount of work and has relied on the dedication and commitment of staff to positively engage with us and progress the review.

The Panel acknowledges the significant efforts that are ongoing across the Department of Health to make improvements to systems and reporting processes.

We would also like to acknowledge the families and friends of the deceased who shared their experiences with the Panel and are affected by this review, and hope that the outcomes from the review provide some level of clarity and comfort.

Appendix

1. Letter to Acting Secretary from Adjunct Professor Picone Dated 17 May 2024
2. Membership of the Independent Panel
3. Medical Certificate of Cause of Death issued from Registrar of Births Deaths and Marriages
4. Complaint Response Example

1. Letter to A/Secretary from A/Prof Picone Dated 17 May 2024

Contact: Adjunct Professor Debora Picone
Phone [redacted]
E-mail [redacted]

Dale Webster
A/Secretary Department of Health

Dear A/Secretary,

Subject: Findings Reportable Deaths and Death Reporting Processes in Tasmanian Public Hospitals Review.

As you are aware, the Independent Panel (the Panel) tasked with undertaking the Review into *Reportable Deaths and Death Reporting Processes in Tasmanian Public Hospitals* has been meeting regularly since late February 2024.

The Panel's initial focus was on meeting with staff members involved in the death reporting process, from system administrators of the Safety Reporting and Learning System (SLRS), Quality Patient Safety Advisors, Executive Directors of Medical Services alongside several Medical Consultants.

This investigation has included a comprehensive review of current Departmental policies, protocols and documents that are available to guide, outline and support death reporting practices across the Tasmanian Health Service.

The Panel also conducted interviews with current and former departmental employees. These interviews provided the panel with a formal opportunity to collect a range of information and personal accounts of both current and past practices regarding death reporting, including referral of reportable deaths to the Coroner.

The Panel has completed a comprehensive review of all *referred* clinical cases. These cases included patient deaths identified following the multiple public callouts from the former Secretary, Kathrine Morgan-Wicks, in addition to those provided by current staff members, and a documentation review.

This process identified 23 patient deaths for review. Two were ruled out as these were not deaths referred to in the anonymous reports received by the Department i.e., insufficient detail in two anonymous complaints resulted in the Secretariat team identifying four possible deaths, with the two correct deaths identified through a manual case review.

To ensure an independent process, the Panel members individually examined the circumstances surrounding the care of a patient at the time of death. This included reviewing the Medical Record, Mortality Module, Medical Certificate of Cause of Death (MCCD) and any SRLS events.

The Panel members then met collectively to discuss their findings and arrive at consensus.

Reportable Deaths

The Coroners Act 1995 (Tas) contains an exhaustive definition of 'reportable death'. The most relevant sections of the definition for medical practitioners are:

A death:

iv. that appears to have been unexpected, unnatural, or violent or to have resulted directly or indirectly from an accident or injury; or

v. that occurs during a medical procedure, or after a medical procedure where the death may be causally related to that procedure, and a medical practitioner would not, immediately before the procedure was undertaken, have reasonably expected the death; or

vii. the cause of which is unknown; or

ix. of a person who immediately before death was a person held in care or a person held in custody;

The THS process for reportable deaths is if you can answer "yes" to any of the following questions, it is a mandatory reporting requirement for the Medical Practitioner to notify the Coroner.

- Was the death as a result of violence; unnatural or unexpected; or from an injury or accident?
- Did the death occur during, or after a medical procedure where the death may be causally related to that procedure and a medical practitioner would not, immediately before the procedure was undertaken, have reasonably expected the death?
- Was the death unexpected or from an unknown cause?
- Was the death in a child under the age of 1 year and sudden and unexpected?
- Is the death of a person who immediately before death was a person held in care (mental health order, guardianship order, secure mental health unit, child protection order) or in custody (including escaping from custody, in prison, a detention centre)?
- Was the death the result of an occupational accident, injury, or disease?

Panel Findings

The Panels review of the 21 cases identified the following:

- Eight patient cases had already been referred to the Coroner and required nil further action by the panel.
- Six patient deaths were assessed by the Panel as meeting the current requirements of *The Coroners Act 1995* (Tas) and are recommended for referral to the Coroner (see details below)
- Seven cases do not require further assessment or referral as the Panel was able to attest that there was no indication that the case met the requirements of a Reportable Death.

A summary of the 6 cases is found below –

- **Case #1 Panel Assessment of Case:** Unexpected Death meets the requirement for referral to the Coroner.
- **Case #3 Panel Assessment of Case** Death post procedure/Unexpected Death meets the requirement for referral to the Coroner.
- **Case #6 Panel Assessment of Case:** Death Post Procedure/Unexpected Death meets the requirement for referral to the Coroner.

- **Case #8 Panel Assessment of Case:** Unexpected Death / Post Fall meets the requirement for referral to the Coroner.
- **Case #11 Panel Assessment of Case:** Unexpected Death meets the requirement for referral to the Coroner.
- **Case #20 Panel Assessment of Case:** Death Post Procedure meets the requirement for referral to the Coroner.

Please note: Details of the cases are found in a separate attachment to this letter, this information is not to be made public as it contains personal health information.

MCCD Certification and Amendments

The process of completing a MCCD requires a Medical Practitioner to certify that they attended the deceased during the last illness or in death, and that the cause of death was documented to be true to the best of their knowledge.

During the review of the initial 21 cases, it was observed that a former LGH staff member who was employed as a senior specialist medical practitioner completed or edited the MCCD on multiple occasions.

As the EDMS is a Medical Practitioner this does not preclude them from completing a MCCD, however the Panel determined that there are few instances when an EDMS would be required to complete the MCCD, acknowledging that it is the treating medical team that has the most in-depth knowledge about the deceased, their medical conditions and cause of death and that team is in the best position to write the most accurate MCCD and/or report to the coroner.

Regarding editing and updating the MCCD, it is acknowledged that the current process for death reporting on the Mortality Module requires the EDMS/Delegate to approve all MCCDs. The Panel heard from current EDMS staff that occasionally spelling errors are corrected, however any major changes would be referred to the individual who completed the initial entry to update/ amend.
The system allows for these edits/changes to be recorded and evidence of the rationale documented. In the instance where the former staff member made changes to the MCCD these changed were not always recorded but were noted upon review of the entry/audit function of SRLS.

Considering the above findings, the Panel determined to make the following interim recommendations for your consideration:

- Refer the 6 patients deaths as ‘Reportable Deaths’ to the Tasmanian Coroner
- A formal Open Disclosure process is undertaken by relevant Departmental and Health Service staff with families to advise them of the referrals and rational for referral to the Coroner. This process should be in line with local policies and the Australian open disclosure framework developed by the *Australian Commission on Safety and Quality in Health Care.*
- Given that this Panel has uncovered irregular practices by the former staff member, specifically the certification and/or alteration of MCCD without attending to the patient prior to or after death or accurately documenting alleged conversations with the Coroner’s office, the Panel will now undertake a comprehensive review of further MCCD certified by the former staff member.

In light of the additional case reviews, the Panel is expected to make further recommendations to you no later than June 14th, 2024.

Yours Sincerely

Adjunct Professor Debora Picone AO
Panel Chair
17 May 2024

2. Membership of the Independent Panel

Chair

Adjunct Professor Debora Picone AO

Adjunct Professor Picone is the CEO of the Australian Commission on Safety and Quality in Health Care, a position she has held since 2012. She is a highly respected leader in public administration, with extensive operating and leadership experience in the provision of healthcare services, governance, and hospital administration. Adjunct Professor Picone has led the development and implementation of a series of national system-wide safety and quality programs. Professor Picone was formerly the NSW Health Director-General from 2007-2011. Adjunct Professor Picone holds a Bachelor of Health Administration from the University of New South Wales; is a registered General Nurse (1978) and holds a certificate in Renal Nursing (1984). She was awarded a Member of the Order of Australia for service to public administration in New South Wales and is an Officer of the Order of Australia which was awarded for distinguished service to the community through the coordination of improvements to the safety and quality of health care.

Panel Members

Adjunct Professor Karen Crawshaw PSM

Adjunct Professor Crawshaw has held several senior executive positions within the NSW Public Service, including as NSW Health's Director Legal and General Counsel for 17 years. She was also Deputy Director-General and Deputy Secretary Governance, Workforce and Corporate for ten years until 2017, with responsibility for a broad range of policy areas including health system governance, regulation, legal services, workplace relations and human resources. Adjunct Professor Crawshaw has had key responsibilities for implementing NSW Health's implementation of major reforms in response to a number of royal commissions and other inquiries concerning the NSW public health system. She continues to provide strategic policy and legal advice to governments and health organisations, including state health departments and the Australian Commission on Safety and Quality in Health Care, and has served on a number of statutory boards and committees. She completed three terms as a member of the Australian Health Practitioner Regulatory Agency's governance body (Ahpra), and has recently been announced as the next Chair of the Board of Sydney Local Health District comprising a range of hospitals and services in metropolitan Sydney including Royal Prince Alfred Hospital, Concord Repatriation Hospital and Canterbury Hospital.

She is an adjunct professor in the Faculty of Medicine and Health at the University of Sydney, and was awarded a public service medal in the Queen's Birthday Honours for services to public health.

Ms Ann Maree Keenan

Ms Keenan is a highly respected health leader who has led significant healthcare reforms, workforce development changes, quality and safety reviews and statewide improvement initiatives. She has extensive experience in professional leadership, tertiary health service provision, corporate and clinical governance, and public administration. She held the position of Chief Nurse and Midwifery Officer and Deputy CEO at Safer Care Victoria for six years until July 2022. Prior to commencing with Safer Care Victoria, she spent 12 years as a health

service executive in a role that involved both professional and operational leadership. Ms Keenan holds post graduate nursing qualifications, is a Fellow of the Williamson Community Leadership Program, is a graduate of the Australian Institute of Company Directors and has a Master of Enterprise through University of Melbourne.

Associate Professor Amanda Walker

Associate Professor Amanda Walker has had a distinguished career holding several senior executive positions in NSW. She is currently the Clinical Advisor, CPES (Clinical Engagement/ Patient Safety), eHealth in NSW and previously held the role of Clinical Director, Australian Commission on Safety and Quality in Health Care from 2016-2023. Prior to this Associate Professor Amanda Walker was Clinical Director, NSW Clinical Excellence Commission from 2014-16. Associate Professor Amanda Walker brings to the Panel 25 years of experience in patient-centred Palliative Medicine and more than 12 years in safety and quality in health care to the digital health environment.

Associate Professor Amanda Walker is a Fellow of the Australasian Chapter of Palliative Medicine and holds a postgraduate diploma in Palliative Medicine from the University of Melbourne and clinical certification in Palliative Medicine. Associate Professor Amanda Walker has a Bachelors of Medicine and a Bachelor of Surgery from Sydney University.

3. Medical Certificate - Cause of Death Registrar - Births Deaths and Marriages

Office use Only

Medical Certificate of Cause of Death Date received ...../...../..... Death Reg. No.....

Details of Deceased

Surname

First names *(in full)*

Sex ☐ Male ☐ Female **Date of death** / /

Place of death

Age at death (show age in completed units—years (y) or months (m) or days (d) or hours (h) or minutes (min))

Was the deceased of Aboriginal or Torres Strait Islander origin? (If both, tick both "Yes" boxes)

☐ No ☐ Yes, Aboriginal origin ☐ Yes, Torres Strait Islander origin

Date last seen alive by me

Coroner Is this death being, or has it been reported to the Coroner? ☐ No ☐ Yes

Post mortem status ☐ Not to be conducted ☐ Has been conducted ☐ Yet to be conducted

Cause of Death Details **Part I**

		Cause	Approximate interval between onset and death
Disease or condition directly leading to death	*(a)*	due to	
Antecedent causes *(b) – (e)*	*(b)*	due to	
Morbid conditions, if any, giving rise to the above cause, **stating the underlying condition last**	*(c)*	due to	
	(d)	due to	
	(e)	due to	
Part II **Other significant conditions** contributing to the death but not related to the disease or condition causing it			

This means the disease, injury or complication which caused death—**not only** the mode of dying, such as heart failure, respiratory failure, etc.

Other Details

Operations Was an operation performed on the deceased within 4 weeks before death? ☐ No ☐ Yes (If "Yes" specify below)

Type of operation

Disease/condition

Pregnancy Was the deceased pregnant within 6 weeks of death? ☐ No ☐ Yes

Was the deceased pregnant between 6 weeks and 12 months of death? ☐ No ☐ Yes

Was an injury/external cause involved in the death? ☐ No ☐ Yes (If "Yes" specify below)

Manner of death (tick one box only) ☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be determined

Certification

I hereby certify that I attended the abovenamed deceased during the last illness and that the particulars and cause of death written above are true to the best of my knowledge and belief. (Please print name and address)

Name **Phone**

Address

Signature **Date** / /

F 7020400 u

Form CODMP (Medical Practitioner) Form CODFD (Funeral Director) Form CODR (Registry of Births, Deaths and Marriages)

4. Complaint Response Example

Tasmanian Health Service

GPO Box 1963, LAUNCESTON TAS 7250, Australia
Ph: (03) 6777 6777
Web: www.ths.tas.gov.au

Contact: Consumer Feedback Unit - Quality & Patient Safety Service, North
Phone: 1800 008 001
E-mail: north.feedback@ths.tas.gov.au
File: 13520

[redacted]

In your letter, you expressed concern over the issuing of a death certificate for your grandmother by myself. [redacted] I am permitted to issue death certificates based on the documentation in a patient's record, including the date and time of death based on the observations of our medical and nursing staff documented in the medical records.

[redacted]

26th May 2021

Department of Health and Human Services
EMERGENCY DEPARTMENT

Launce ton General Hospital
PO Box 1963 Launceston Tas 7250
Web: www.dhhs.tas.gov.au

Tasmania
Explore the possibilities

Contact: Department of Emergency Medicine, Launceston General Hospital
Phone: 1800 008 001

11th May 2021

[redacted]