Anaesthetic Mortality Committee 2017 - 2018

Western Australia
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The WA Committee last met March 2\textsuperscript{nd} 2018.

ANZCA Mortality Subcommittee
• ANZCA mortality subcommittee did not meet in 2017
• Data for the ANZCA Safety of Anaesthesia triennial report, 2012- 2014 has now been completed and it was published in September 2017, it is available on the ANZCA website.
The Health (Miscellaneous Provisions) Act 1911 was updated and the implementation of the new Public Health Act 2016

- Changes included losing the ASA nominated representative on the committee after the current terms expire. A submission was made to reinstate this position, this has been accepted. The time frame for this occurring is not yet clarified and will depend on the timing of other changes to the act

- A full review of all the WA mortality committees’ legislative provisions will commence later this year.
We are developing a collaboration with the WAASM, (WA Audit of Surgical Mortality), which will aid in the identification of cases meeting the reporting requirements for anaesthetic mortality in WA. This will commence with cases reported to WAASM from the commencement of 2018.

This may result in requests for reports being sent to medical practitioners who administered an anaesthetic with a subsequent patient death if they have not submitted a report, for example, if they were not aware of the death or the reporting requirements regarding anaesthetic mortality. A email has been sent to all trainees and ANZCA Fellows informing of this possibility.

Outcomes of the individual case assessments identified in this manner by the AMC would remain confidential and would not be divulged to the WAASM.
There were 5 cases from events occurring in 2014, 2 from 2015 17 cases from 2016 and 36 from 2017.

A number of cases from 2015 and 2016 are still awaiting assessment by the WA AMC.

The assessed cases were considered to be in the following categories:

- Cat 1 (It is reasonably certain that death was caused by anaesthesia or other factors under control of the anaesthetist) - 0 cases
- Cat 2 (Some doubt if entirely attributable to anaesthesia) - 1 case
- Cat 3 (Anaesthetic and surgical factors involved) - 0 cases
- Cat 4 (Surgical death where the anaesthesia was not contributory) -4 cases
- Cat 5 (Inevitable death) - 51 cases
- Cat 6 (Incidental death)- 2 cases

- There was 2 cases which had been reported which were withdrawn from assessment as they did not meet the reporting criteria.
classification
Recent WA Anaesthetic Mortality Data

Of the classified in Categories 1, 2 or 3, causal or contributory factors were considered to be involved in contributing to the death as per the following classification:

• Aii – Pre operative management
• Dii - Inadequate Monitoring
• H - Medical condition of the patient
• 100% of the cases were ASA grades 3-5 and 54% were identified as urgent/emergent.
The majority of the deaths were in older patients with 75% of the patients ≥ 61 years old and 25% ≥ 81 years old.
Gender

- Male: 27
- Female: 32
• 10% in the operating theatre, 63% in the first 24 hours post operatively and 23% in the 24-48 hour period post operatively.
The majority of the deaths, 59%, occurred in ICU/HDU 10% of the deaths occurred in the operating theatre, and 18% in the ward environment.
• In 93% of cases there was a specialist or consultant anaesthetist involved in the patient’s care.
78% of the deaths occurred in metropolitan teaching hospitals – reflecting the complexity and urgency of the case mix.
• Most common surgical specialities associated with perioperative mortality are: Abdominal Surgery, Cardiac, Endoscopic procedures, Neurosurgery, Orthopaedic and Radiology
• Of note there is an increase in the number of neuro-radiology cases associated with acute stroke management.
Comments on data

Overall the data indicates that anaesthesia related deaths occur in older, sicker patients having non elective surgery.

The distribution of age, ASA, location of death, type of hospital and grade of anaesthetist was similar to previous years.

Of the deaths classified as anaesthesia related (category 1, 2 or 3), in all cases the medical condition of the patient was considered a factor in the death.

Some cases may have missed being reported. We do not currently have access to a system to reliably identify all deaths meeting the reporting requirements. Therefore, there may be situations in which an anaesthetist is unaware a patient died especially if the death was delayed or unexpected, in addition some medical practitioners may not be aware of the reporting requirements. Hopefully the collaboration with WAASM will help improve the ability to identify cases that meet the reporting criteria.
Reporting requirements and feedback process

Cases are required by law to be reported if death occurs within 48 hours of the commencement / induction of an anaesthetic  Or if the anaesthetic may have contributed to the death.

Reports must be sent as a hard copy to the Chief Health Officer, DOH marked confidential

After completion of the case assessment the reporting anaesthetist will receive a letter summarising the assessment by the investigator/committee

If the case doesn’t meet the requirements for reporting and assessment the reasons for this will be communicated to the anaesthetist involved.

A template to aid in the completion of mortality reports is available, please contact the Chair of the AMC, Dr Jay Bruce, at jennifer.bruce@health.wa.gov.au