Australian Government
Aged Care Quality and Safety Commission

Aged care reforms

Reportable incidents: unexpected death

Serious Incident Response Scheme

A fact sheet for providers of home care and flexible care delivered in a home or community setting

The Serious Incident Response Scheme (SIRS) helps prevent and reduce the risk of incidents of abuse and neglect in aged care services that are subsidised by the Australian Government.

Providers have responsibilities to prevent, minimise the risk of, and respond effectively to any incidents of abuse and neglect in connection with the care they provide. All incidents and near misses must be recorded in a provider's incident management system (IMS) to ensure a timely and appropriate response that minimises harm, supports those affected, reduces the risk of recurrence and informs continuous improvement.

Under the SIRS, there are eight types of reportable incidents that must be recorded in a provider's IMS and also reported to the Aged Care Quality and Safety Commission (the Commission).

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What is unexpected death?

The unexpected death of a consumer is a reportable incident where the death is the result of care or services provided by the provider or a failure by the provider to provide care and services.

Home services providers must notify the Commission of any death where the provider, including staff and health professionals engaged by the provider:

- made a mistake resulting in death
- did not deliver care and services in line with a consumer's assessed care needs, resulting in death
- provided care and services that were poorly managed or not in line with best practice, resulting in death.

A reportable unexpected death may occur immediately or some time after the care and services were provided or failed to be provided.

The types of unexpected deaths in home services which are reportable are more limited than those in residential care. This recognises that home services providers have limited control and visibility over a consumer's day-to-day living circumstances. This may mean that a provider will not be aware of a consumer dying until sometime after the death occurs. Further, the provider may never be aware of the circumstances of their death.

Some examples of what does and does not constitute a reportable unexpected death can be found in the table on page 3. These examples are a guide only and should not replace your responsibility to consider the specific circumstances of each incident or near miss that occurs as part of managing your response.

Reporting unexpected death to the Commission

Incidents involving the unexpected death of a consumer only need to be notified to the Commission where the provider is aware of the death and has reasonable grounds to believe the unexpected death has occurred (or is alleged or suspected to have occurred) as a result of the provider's action or inaction.

Home service providers are not required to notify the Commission of a consumer's unexpected death if the cause was unrelated to either the care or services provided by the provider, or a failure by the provider to provide care and services.

Providers are also not required to report deaths where the cause of the death is yet to be confirmed. Providers should only report those where there are reasonable grounds to believe that the death may have occurred as a result of the provider's action or inaction.

All reportable unexpected deaths must be reported as a Priority 1 reportable incident to the Commission within 24 hours of the provider becoming aware

How can I find out more?

The Commission has published a suite of fact sheets relating to each type of reportable incident. To access these fact sheets and detailed guidance relating to the SIRS and incident management systems, visit agedcarequality.gov.au/sirs

Examples

What is a reportable unexpected death?	What is not a reportable unexpected death?
• Where a consumer falls while being moved or assisted by a staff member, with the injuries sustained resulting in the consumer's death. • Where a consumer was using equipment or supports provided by the service that malfunctioned and caused their death. For example, where grab rails have been installed and due to poor installation they break during use causing the consumer to fall and die. • Where poor quality clinical care is provided to a consumer resulting in their death. For example, where a provider is responsible for treating a consumer's wound and this is not appropriately treated and becomes infected resulting in the consumer's death. • Where a consumer is reliant on regular care and services and dies as a result of lack of services where a staff member repeatedly fails to attend (noting this would also be considered 'neglect').	• Where a consumer dies as part of an accident that was not connected to the care and services. • Where a consumer is involved in an incident and later dies as a result of an unrelated condition or illness. • Where a consumer dies due to an outbreak of disease, unconnected to the provision of care and services. • Where a provider is responsible for providing clinical or palliative care, a consumer dies as a result of an ongoing illness, disease or condition that was appropriately assessed, monitored and managed.

The examples in the above table are a guide only. You must consider the specific circumstances of all incidents resulting in the unexpected death of a consumer to determine whether to notify the Commission.

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