# Reportable incidents: unexpected death

## Serious Incident Response Scheme

A fact sheet for providers of residential care and flexible care in a residential aged care setting

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

Under the SIRS, all incidents and near misses should be recorded in a provider's incident management system (IMS) to ensure a timely and appropriate response that minimises impact, supports those affected and reduces the risk of recurrence.

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

This fact sheet covers reporting of incidents involving the unexpected death of a consumer.

## What is unexpected death?

Unexpected death of a consumer includes death in circumstances where:

- reasonable steps were not taken by the provider to prevent the death
- the death is the result of care or services provided by the provider or a failure by the provider to provide care and services.

This includes situations where you, as the provider, and any staff and health professionals working at your service:

- did not take appropriate steps to prevent or mitigate an incident which resulted in the death of a consumer
- did not take appropriate action to assess and treat a consumer following an incident and the consumer died because of injuries related to the incident
- was, or reasonably should have been, aware of a consumer's condition and did not take timely and adequate steps to assess and treat the consumer
- made clinical mistake(s) resulting in death
- did not deliver care and services in line with a consumer's assessed care needs or provided clinical care and services that were poorly managed or not in line with best practice, resulting in death.

A death may occur immediately or sometime after a 'mistake' was made or a 'failure' or incident occurred. Where the death could reasonably be considered to be related to a mistake, failure or incident, this should be notified to the Commission.

Your obligation to notify the Commission is in addition to notifying the coroner in accordance with state and territory requirements and applies even where a coroner has not yet determined the cause of death.

You are not required to notify the Commission of all deaths where the cause of death is yet to be confirmed, only those that could reasonably be considered to be related to a mistake, failure or incident. If the cause of death does not include circumstances mentioned under section 15NA(8) of the Quality Care Principles 2014, you are not required to notify the Commission of the unexpected death.

Some examples of what does and does not constitute an unexpected death can be found in the table on page 3. These examples are a guide only.

**All unexpected deaths must be reported to the Commission within 24 hours.**

## What are the additional reporting obligations relating to deaths?

Each state and territory has specific requirements in relation to the obligations of providers to notify a death to other bodies, such as the coroner and police.

If you are required to report a death to the coroner, it is the coroner's role to determine the date, place and circumstances and medical cause of that death. The Commission recognises that this process can take some time and that you may not be able to provide all required details at the time of reporting an unexpected death to the Commission.

The Commission will negotiate reporting timeframes with you as necessary, following submission of your initial notification. As part of this process you are expected to notify the Commission of significant new information if it becomes available.

## How can I find out more?

The Commission has published a suite of fact sheets about 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 an unexpected death? | What is not an unexpected death? |
|---|---|
| • Where a consumer falls while being moved or shifted, and the injuries sustained in the fall resulted in the consumer's death<br>• Where poor quality clinical care is provided to a consumer resulting in their death. For example, where a pressure injury or wound is untreated or not regularly tended to and becomes infected resulting in the consumer's death<br>• Where medical assessment or treatment is delayed, resulting in a consumer's death. For example, where a consumer falls and is not assessed immediately afterwards and later dies because of injuries sustained from the fall | • Where a consumer dies because of an ongoing illness, disease or condition that was appropriately assessed, monitored and managed (including where the consumer was receiving palliative care and appropriate end-of-life medications)<br>• Where a consumer is involved in an incident and later dies because of an unrelated condition or illness<br>• Deaths resulting from outbreaks of disease (for example, separate reporting processes have been established in relation to outbreaks of COVID-19) |

The above table is not an exhaustive list of examples – it is a guide only.
You should assess each incident on an individual basis.

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