CEC eChartbook Portal Extract

SCIDUA

Special Committee Investigating Deaths under Anaesthesia

Suggested citation: Clinical Excellence Commission [access date]. eChartbook Portal: Safety and Quality of Healthcare in New South Wales. Sydney: Clinical Excellence Commission. Available at: http://www.cec.health.nsw.gov.au/echartbook/cec-indicators-intro-echartbook/scidua Accessed (insert date of access).

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PDF file created: Friday, 10 February 2017

SCIDUA PROGRAM

Special Committee Investigating Deaths Under Anaesthesiaand

Why is this important? Anaesthesia is not a medical therapy in itself, but it is an essential precondition for effective clinical management and is administered so that a medical or surgical procedure can be performed [1]. Ideally, there would be no adverse outcomes from the anaesthetic and it should not contribute to the mortality that occurs from the underlying disease process or its treatment. In those terms, even one 'anaesthetic death' is one too many. Unfortunately, all current anaesthetic agents are either cardiovascular and/or respiratory depressants and their administration is subject to human error. It is therefore important to look for emerging trends, because anaesthetic, surgical and medical interventions change with time, and to monitor anaesthetic outcomes and look for ways to reduce any adverse events.

The Special Committee Investigating Deaths Under Anaesthesia (SCIDUA) has been reviewing anaesthesia-related deaths since 1960 in NSW and is the longest-serving committee of its type in the world. The SCIDUA is a statutory committee established under s20 of the *Health Administration Act 1982* (NSW), with members appointed by the Secretary, NSW Health under the delegation of the Minister for Health. Notification of deaths arising after anaesthesia or sedation for operations or procedures is a legal requirement in NSW. Section 84 of the *Public Health Act 2010* (NSW) [2] requires a health practitioner who is responsible for the administration of the anaesthetic or sedative drug, to report the death of a patient to the Secretary, NSW Health if:

> "A patient or former patient dies while under, or as a result of, or within 24 hours after, the administration of an anaesthetic or a sedative drug administered in the course of a medical, surgical or dental operation or procedure or other health operation or procedure (other than a local anaesthetic or sedative drug administered solely for the purpose of facilitating a procedure for resuscitation from apparent or impending death)."

Findings: Due to the small number of deaths notified at local health district (LHD) level, eight years of data (2008-2015) was combined for each LHD and specialty network. For NSW, yearly data was presented (Chart SC01). During the period 2008 to 2015, a total of 1,844 deaths were notified to SCIDUA.

Over the years, the total number of deaths after anaesthesia and sedation notified to SCIDUA has increased gradually. This increase in notifications is due to a decline in the number of notifications during the earlier years when amendments were made to the *Coroners Act 1980* (NSW). The legislative amendments removed the requirement to report a death associated with anaesthetic administration in the *Coroners Act 2009* (NSW), unless the "death was not a reasonably expected outcome of a health-related procedure…". To ensure that reporting to SCIDUA continued, the *Public Health Act 1991* (NSW) and *Public Health (General) Regulation 2002* (NSW) were amended to require notification of deaths arising after anaesthesia from 1 January 2010. The change in legislation appears to have affected the number of notified deaths to SCIDUA.

On 1 September 2012, the *Public Health Act 2010* (NSW) came into effect with s84 stipulating the requirement to notify deaths arising after anaesthesia and sedation for operations or procedures. Between 2013 and 2015, the average number of deaths notified to SCIDUA is about 270 per annum.

Implications: Mortality reporting to the SCIDUA has contributed to significant improvement in anaesthesia safety. Initially the committee looked for errors of management, when the mortality was one in 5,500 cases [3], and there were a large number of children and pregnant women died from anaesthesia. To date, anaesthesia administration is very safe, with an estimated mortality rate of one in 25,692 procedures and anaesthesia-related deaths largely occurred in very sick or elderly patients [4].

What we don't know: We currently do not have available a method to verify whether all anaesthesia and/or sedation deaths are reported to SCIDUA. The committee is confident that the data contains a representative sample of deaths in NSW. We now have available other reporting sources, within the Clinical Excellence Commission, to ensure major cases are not missed.

References:

[1] Beecher HK and Todd DP. A Study of the Deaths Associated with Anaesthesia and Surgery. Ann Surg. 1954 July; 140(1): 2-34.

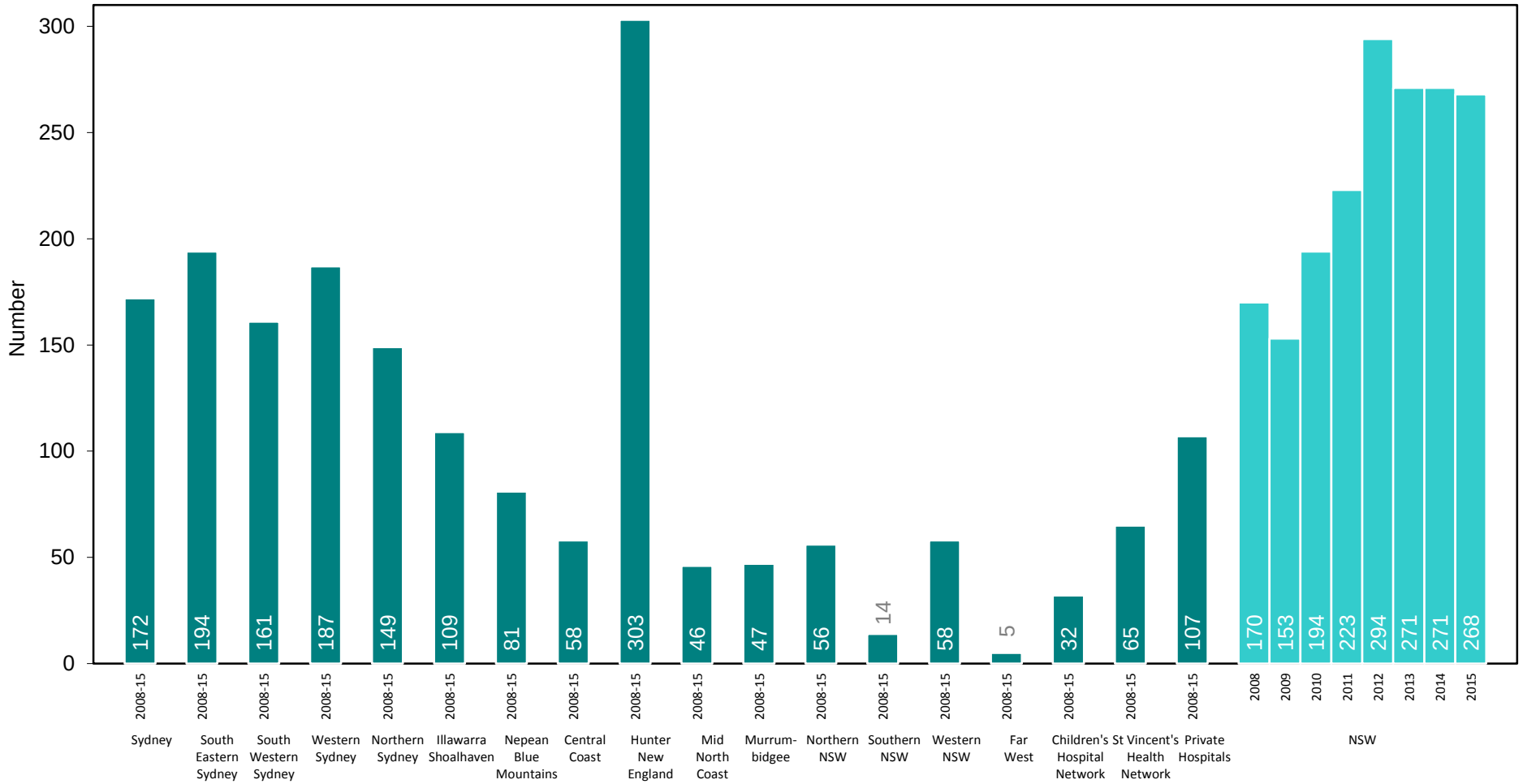
[2] *Public Health Act 2010* s. 84 (Austl.). Retrieved from http://www.legislation.nsw.gov.au/maintop/view/inforce/act+127+2010+cd+0+N

[3] Holland R. Anaesthetic mortality in New South Wales. British Journal of Anaesthesia. 1987; 59: 834–841

[4] Clinical Excellence Commission (CEC). Activities of the Special Committee Investigating Deaths Under Anaesthesia, 2014. Sydney: CEC; 2015. 39p.

Chart SC01 - Deaths notified to SCIDUA

All deaths notified to SCIDUA by LHD/SN and NSW, 2008-2015 (N=1,844)



Source: SCIDUA Team, Clinical Excellence Commission.

Data Definitions

Chart:	SC01
Admin Status:	Current, December 2015
Indicator Name:	Deaths notified to SCIDUA
Description:	All deaths notified to SCIDUA by LHD/SN and NSW, 2008-2015 (N=1,844)
Dimension:	Patient Safety
Clinical Area:	Initiatives in safety and quality health care
Data Inclusions:	Number of deaths notified to SCIDUA by LHD/SN
Data Exclusions:	None
Numerator:	Total number of deaths notified to SCIDUA by LHD/SN
Denominator:	None
Standardisation:	None
Data Source:	Clinical Excellence Commission: Special Committee Investigating Deaths Under Anaesthesia (SCIDUA)
Comments:	Not applicable.