24 August 2017

Dear Victorian anaesthesia colleagues,

The Victorian Consultative Council on Anaesthetic Mortality and Morbidity (VCCAMM) has today released its 2012-14 Triennial Report. The report provides information derived from analysis of cases submitted to the Council for events that occurred during 2012 to 2014. While the recent report indicates a very high level of safety of anaesthesia, it must be acknowledged that the Council is unlikely to have captured all cases in which anaesthesia may have contributed to the death. We must therefore strive to improve the process for notification of potential anaesthesia related deaths.

The role of VCCAMM

The VCCAMM is required under Section 38 of the Public Health and Wellbeing Act 2008 (the Act), to undertake confidential inquiries into potential anaesthesia related mortality and morbidity occurring in any health services facilities or providers in Victoria. To improve notification and collection of surgical mortality cases, the VCCAMM has collaborated with the Royal Australasian College of Surgeons Victorian Audit of Surgical Mortality (VASM). The VASM assesses cases where a patient has died under surgical care in a Victorian Health Service via a peer review process. Where a case has been identified as either possibly or probably anaesthesia related, VASM notifies VCCAMM of the relevant case identity. The VCCAMM then seeks information directly from the health service provider as under section 39 and section 40 of the Act.

The VCCAMM are obliged under Section 42 of the Act to protect the confidentiality of this information, which involves not publishing identifying information, nor releasing it to any other party except in these limited circumstances as prescribed in the Act.

The council defines ‘anaesthesia-related mortality’ as one of the following:

- a death that occurs during an operation or procedure (or within 24 hours of its completion) performed with the assistance of sedative, analgesic, local or general anaesthetic drugs or any combination of these
- a death that may result (either partially or totally) from an incident during or after such an operation or procedure, even if more than 24 hours have elapsed since its completion.

The VCCAMM is the only jurisdictional anaesthesia mortality committee which also reviews morbidity data and this is very important to enhance the quality assurance process for our speciality. We also recognise the importance of collaboration with other specialist groups in the pursuit of improving perioperative outcomes for Victorian patients. It is anticipated that the VCCAMM will work with Safer Care Victoria to promote improved perioperative outcomes.

The council defines ‘anaesthesia-related morbidity’ as any event related to an anaesthetic procedure that causes a life-threatening incident, temporary or permanent disability, or significant distress. Morbidity is categorised as ‘major’ or ‘minor’ according to its severity and outcome.

What to report to VCCAMM

The VCCAMM requests that health services continue to provide notification of all cases of potential anaesthesia related mortality and morbidity, including the increasing anaesthesia caseload in a range of other procedures including endoscopy, interventional radiology and cardiology and for other cases in which anaesthesia services are required such as in emergency departments and intensive care units.
Relevant information to provide VCCAMM can include:

- the preoperative assessment, including medical co-morbidities, previous surgical history, current medications, investigations, airway or other anaesthesia issues
- operation or procedure report
- inpatient hospital notes
- emergency department notes
- relevant pre and post-operative investigations (including laboratory/radiology)
- summary of post-operative events, including ICU/HDU if relevant
- hospital discharge and medication summaries
- copy of the eMedical deposition to the coroner if applicable
- post mortem (if available)
- relevant data and/or documents, including age, gender, ASA-P classification, elective or emergency status, location of event leading to death, and location of death.


**Thank you for your contribution**

I would like to acknowledge the ongoing support of all Victorian anaesthetists and departments and seek your continued co-operation with the provision of case reports of all events in which there is potential for anaesthesia related mortality or significant morbidity. I would also like to acknowledge the great work done by the newly appointed VCCAMM and its case review subcommittee in their ongoing commitment to improving the safety and quality of anaesthesia and perioperative care for the Victorian community.

We welcome your feedback on the recent VCCAMM report, its suitability and effectiveness, and our reporting process. Please direct feedback, questions or concerns to the VCCAMM Confidential Project Officer Ms Sarah Kenny at vccamm@dhhs.vic.gov.au or 03 9096 8078.

Yours sincerely,

Associate Professor Larry McNicol
Chair
Victorian Consultative Council on Anaesthetic Mortality and Morbidity

Attachments: 1. Notice under section 39 of the *Public Health and Wellbeing Act 2008*
NOTICE UNDER SECTION 39 OF THE
PUBLIC HEALTH AND WELLBEING ACT 2008

1. SUBJECT:

2. PURPOSE:
This notice is issued pursuant to section 39 of the Act for the purpose of setting out clearly and defining the information requested to be reported to the Council. Further, this notice is issued to clearly specify the period of time by which such information must be provided, being within 28 days from the date of the event.

3. AUTHORITY:
Section 39 of the Act provides the Chairperson of the Council with the authority to issue this written notice. It also provides the authority for a Victorian health service to provide the information requested. Please refer to the Note in this section and Section 227 of the Act.

4. EFFECTIVENESS:
This notice takes effect from 1 January 2017 and is ongoing.