Royal Australasian
College of Surgeons

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists
*Excellence in Women's Health*

**2020 REPORT**

# The Western Australian Audit of Surgical Mortality (WAASM)

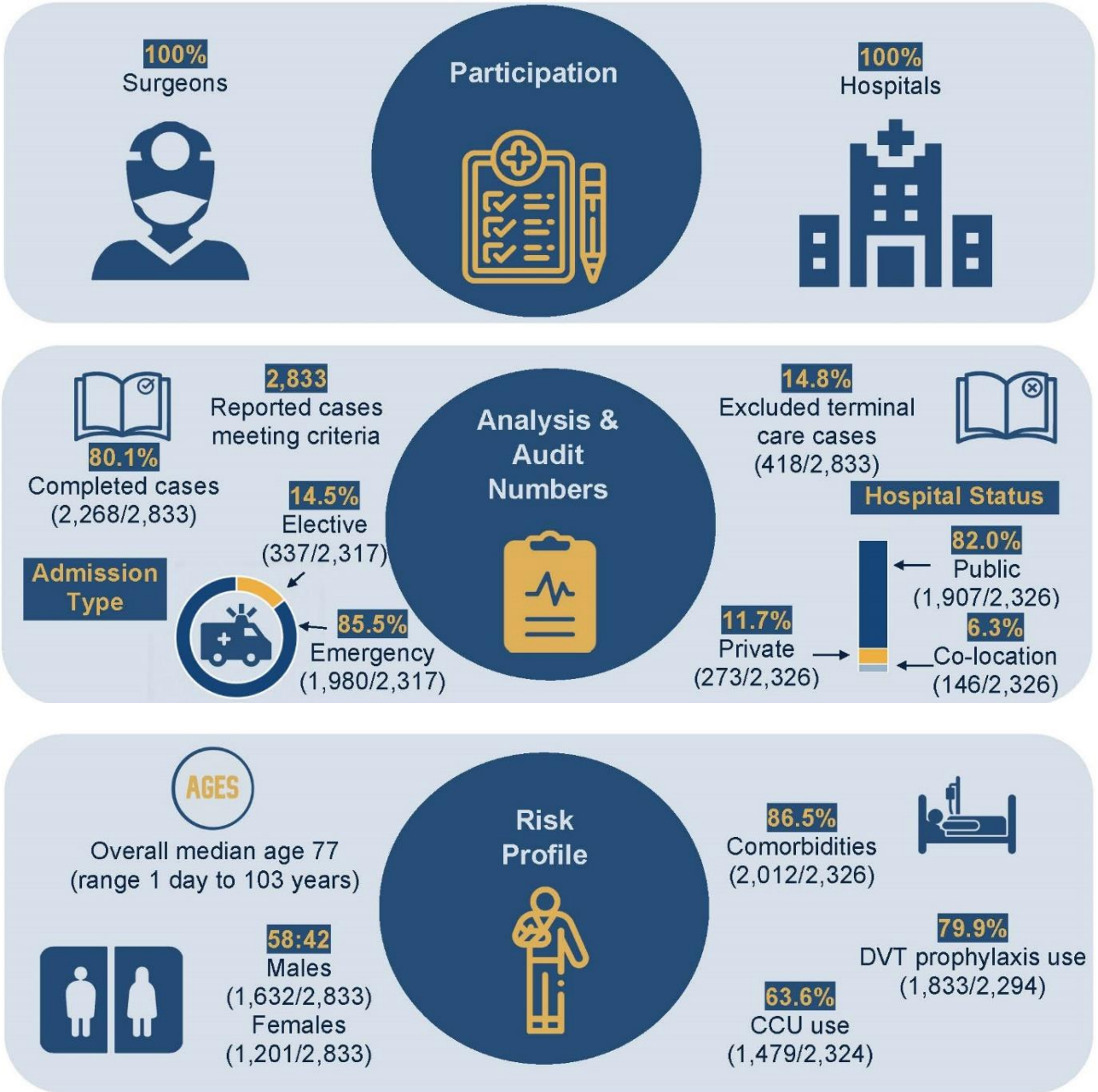
# Executive Summary

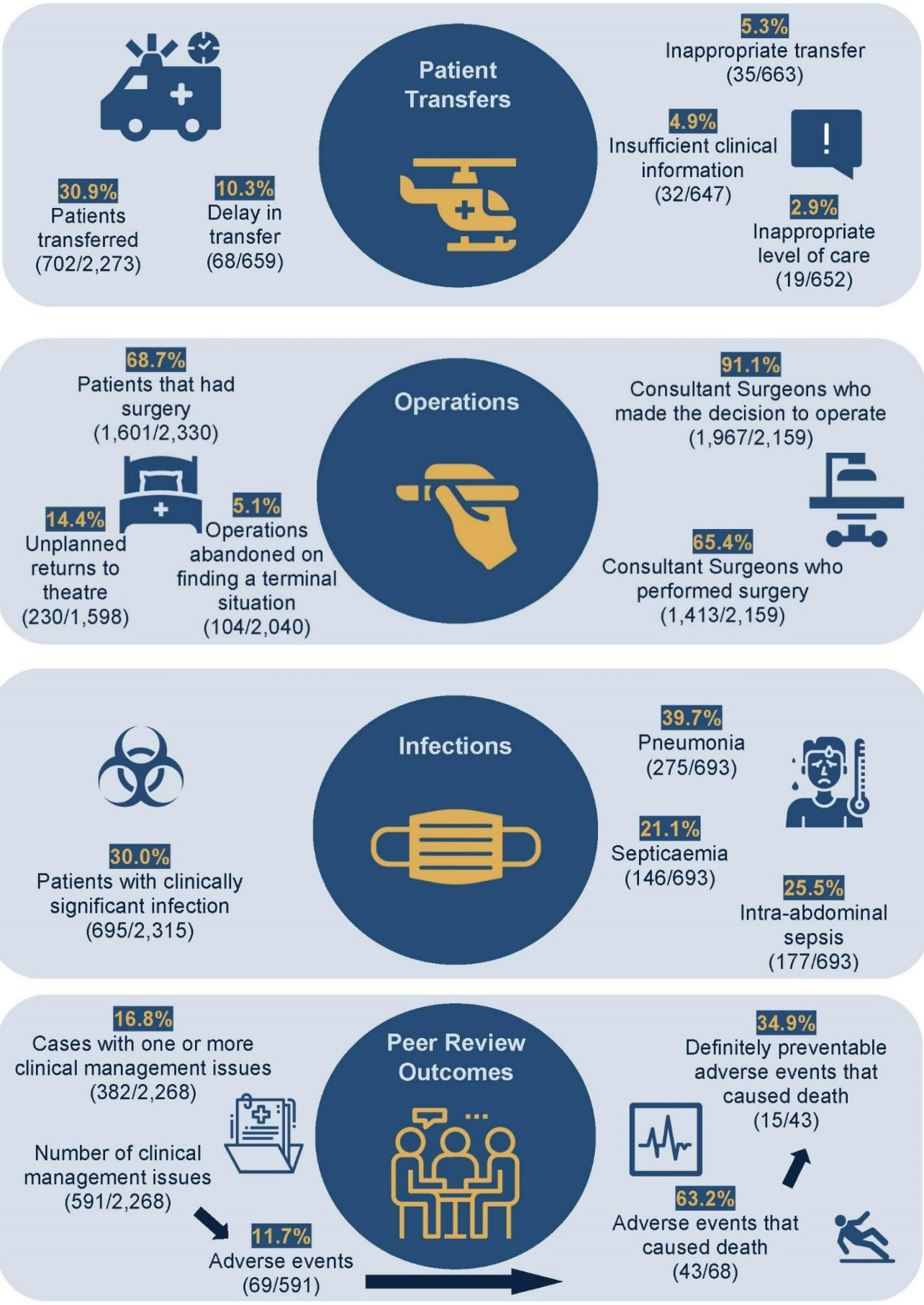
## Background

The Western Australian Audit of Surgical Mortality (WAASM) is an independent, peer reviewed audit of the process of care associated with surgically-related deaths in Western Australia (WA). The WAASM was established in 2001. It is funded by the WA Department of Health and has protection under federal legislation.

## Reporting Period

This report covers cases reported to the WAASM from **1 January 2015 to 31 December 2019**. Please note that for the data analysed the denominator may sometimes change in this report. This is mainly due to incomplete information provided in the surgical case and assessment forms, which results in missing data.




Patient Transfers
30.9% Patients transferred (702/2,273)
10.3% Delay in transfer (68/659)
5.3% Inappropriate transfer (35/663)
4.9% Insufficient clinical information (32/647)
2.9% Inappropriate level of care (19/652)
Operations
68.7% Patients that had surgery (1,601/2,330)
14.4% Unplanned returns to theatre (230/1,598)
5.1% Operations abandoned on finding a terminal situation (104/2,040)
91.1% Consultant Surgeons who made the decision to operate (1,967/2,159)
65.4% Consultant Surgeons who performed surgery (1,413/2,159)
Infections
30.0% Patients with clinically significant infection (695/2,315)
39.7% Pneumonia (275/693)
21.1% Septicaemia (146/693)
25.5% Intra-abdominal sepsis (177/693)
Peer Review Outcomes
16.8% Cases with one or more clinical management issues (382/2,268)
Number of clinical management issues (591/2,268)
11.7% Adverse events (69/591)
34.9% Definitely preventable adverse events that caused death (15/43)
63.2% Adverse events that caused death (43/68)