This is a guide for clinicians presenting a case. The aim is to support and add structure to case presentation, and, in particular, to draw attention to potential system factors that may have contributed to the adverse event.

**Assessment (Discussion led by the Chair)**

*(Not all of the points below need to be discussed in every case)*

Why did it occur? Consider System error/s:
- Access to services / diagnostics / provider
- Assessment factors
- Care planning
- Communication / documentation
- Environment
- End of life management
- Equipment
- Investigations
- Observations and Monitoring
- Policy and guidelines
- Resourcing
- Supervision/training/delegation
- Teamwork
- Transfer
- Workforce

Consider Human and Patient factors such as:
- Cognitive based errors (bias)
- Loss of situational awareness
- Co-morbidities

**Recommendation**

*(Learning and improvement)*

- What did we learn from the case?
- What do we need to do to prevent this from occurring again?
- Who is responsible for actioning the recommendations?
- What system improvement can be implemented to minimise the risk and consequences of human error?

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Image: A Systems Thinking Model: The Iceberg

*Used with permission from Northwest Earth Institute, [www.nwei.org/iceberg/](http://www.nwei.org/iceberg/)*

**Introduction**

Introduce yourself and your role and clinical expertise.

**Situation and background**

- Describe the patient, their medical history
- Pathology results and imaging
- Any procedures performed / medical care provided
- What happened – analysis of how it was recognised and managed

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This document should be read in conjunction with the CEC’s [Recommended Guidelines for Conducting and Reporting Mortality and Morbidity / Clinical Review Meetings](http://www.clinex.com.au).

The CEC acknowledge the input from the NSW Paediatric Safety & Quality Network in the development of this resource.

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Morbidity and Mortality Meeting: Cue Card for Presenter.

Released February 2018, © Clinical Excellence Commission. SHPN (CEC) 180081