Government of **Western Australia**
Department of **Health**

Progress Report for Health-Related Coronial Recommendations

Biannual Report – February 2021

Acknowledgements

The Chair of the Coronial Review Committee, Dr Michael Levitt, Chief Medical Officer, Department of Health, Western Australia would like to acknowledge:

The patients and their families

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The Office of the Chief Psychiatrist, Western Australia

Department of Health staff, Western Australia

Health Service Provider's Executive Medical, Safety, Quality and Performance Units

All WA health system staff involved

The Coronial Liaison Unit (CLU) welcomes suggestions on how this publication series may be improved. Please forward your comments to Coronial@health.wa.gov.au

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Abbreviations

ATSI	Aboriginal and Torres Strait Islander
CAHS	Child and Adolescent Health Service
CAMHS	Child and Adolescent Mental Health Service
CLU	Coronial Liaison Unit
CRC	Coronial Review Committee
DOH	Department of Health
ED	Emergency Department
EMHS	East Metropolitan Health Service
GP	General Practitioner
HSP	Health Service Provider
MH	Mental Health
MSAC	Medical Services Advisory Committee
NaCS	Notifications and Clinical Summaries
NMHS	North Metropolitan Health Service
PBS	Pharmaceutical Benefits Scheme
PCH	Perth Children's Hospital
PMH	Princess Margaret Hospital
SMHS	South Metropolitan Health Service
WA	Western Australia
WACHS	WA Country Health Service

Introduction

The Department of Health's Coronial Liaison Unit (CLU) was established in 2005 to improve communication between the Department of Health and the Office of the State Coroner. Its main function is to facilitate quality improvement activity throughout the WA health system through the dissemination of coronial inquest findings and recommendations to appropriate stakeholders for implementation. The CLU provides biannual updates on the implementation of inquest recommendations to the State Coroner. This report provides updates on the implementation of coronial inquest recommendations that have implications for the WA health system.

The Coronial Review Committee (CRC) operates in connection with the CLU by providing executive strategic support. The CRC was formed in January 2014 with its main purpose being to improve the governance and decision making in relation to state-wide implementation and response to coronial recommendations. The CRC evaluates coronial recommendations and makes decisions about the level of response required. Members also review stakeholder responses provided for the biannual reports to the State Coroner to assess their completeness. Additionally, the CRC considers coronial cases with no recommendations but where there are learnings applicable to the WA health system.

The Department of Health supports the sharing of this information for the purposes of communicating lessons learned and quality improvement initiatives across the health system. The cases included in this report are those with outstanding actions at the time the report was prepared. The length of time taken to implement recommendations is dependent on a number of factors including the complexity and scale of required changes.

Executive Summary

This report includes details about the implementation of recommendations of 1 ongoing case: Paul Strange. This report also includes information relating to the implementation or consideration of recommendations for 2 new cases, Child SJC and Stephen Michael Kell.

There was a total of 7 recommendations for the cases in this report that were relevant to the WA health system. Of these 7 recommendations, 6 have been duly considered, actioned appropriately by health stakeholders and marked as complete or closed; and, 1 recommendation is ongoing at the time of this report. Progress will be updated on the ongoing recommendations in the next biannual report.

The summaries of these cases are included to provide the reader some context for the recommendations and changes described herein. They should not be relied upon as a full account of events surrounding the deaths. To access the full inquest findings, these are located on the State Coroner's website at http://www.coronerscourt.wa.gov.au/default.aspx

Actions taken by the WA health system in response to these inquests are provided along with these case summaries. Where a recommendation is on-going (i.e. the case has been included in a previous edition(s) of the bi-annual report), information that was provided in a previous report(s) is included along with new information for completeness. New information is differentiated by using the blue font colour in the tables of information at the end of the report.

In addition to health-related coronial inquests with recommendations, the (CRC) also considers health related coronial inquest findings where no recommendation is made for the WA health system. The CRC considers such inquests to identify opportunities for WA health system learnings and recognise where there is a need to implement improvements across the system. New cases with no health-related recommendations that were considered by the CRC during this reporting timeframe include: Nualla Christine Reilly, David Dungay, Brian Vincent Atwell, Michael Warren Dyball, Susan Jessica Elsie Windie, Malakai Matiu Ward Parone, PT, JM, Andrew John Key, Dragan Jacovic and Wayne Frederick Leese.

All new and ongoing cases with no health-related recommendation are included within the Executive Summary of this report. A summary of WA health system actions that have been taken in response to these cases as well as any system changes or actions which the CRC noted to have occurred (i.e. not in direct response to the death) and are relevant to a case are provided.

Suppression orders issued by the Office of the State Coroner for some cases, which prevent the disclosure of names and other identifiers, have been adhered to in this report. However, Aboriginal and Torres Strait Islander (ATSI) readers should note that this report may contain the names of deceased ATSI persons if no such order exists.

Coronial inquests with recommendations

STRANGE

Paul Strange, aged 30, died on 9 December 2016. The cause of death was determined to be suicide, after he hanged himself less than a fortnight after being discharged from a mental health unit. Paul had chronic major depression with anxiety and episodic interactions with mental health services.

The Coroner reviewed the care provided in hospital, in particular the lack of a documented safety plan, the absence of further risk assessment after an attempt at self-harm whilst on the ward, the absence of documentation around Paul's alleged requests not to involve his family in his care, the inadequacy of discharge planning and failure to arrange follow-up. The Coroner concluded that when viewed globally, the Paul's care at the hospital was suboptimal.

It was noted that the death had initially been notified under Clinical Incident Management Policy, but the incident was inactivated after case review and no formal investigation had been carried out by the Health Service Provider (HSP).

The Coroner made six recommendations, five were directed to the HSP (East Metropolitan Health Service) and one to the Office of the Chief Psychiatrist. The recommendations focused on the discharge planning procedures and suggested amendments to relevant mental health policies to include requirements to ensure the discharge planning process includes information about follow up appointments, contact details for support services and process for re-entry to health services if needed. The recommendations also included developing strategies to ensure staff were familiar with the relevant policies and examine the feasibility of establishing a post discharge follow-up team.

The Department of Health's Coronial Review Committee (CRC) has reviewed these findings and made enquiries with the relevant stakeholders.

The East Metropolitan Health Service (EMHS) has reviewed the findings and recommendations. They have established an EMHS Care Coordination Working Group to revise the current Care Coordination in Mental Health Policy to address a number of the recommendations. EMHS have also undertaken significant work with discharge summary compliance. With respect to ensuring staff are familiar with the key policies, the EMHS Mental Health Quality Improvement Program will establish and review policy awareness processes at orientation as well as an ongoing nature.

February 2021 Update

The EMHS review of the findings and recommendations has continued. The Care Coordination Policy has been revised and endorsed with implementation of the changes associated with the policy a priority. Work towards the use of a card showing the date and time of all the appointments for services they have been referred remains in progress. Similarly, the EMHS Discharge Communication Policy has undergone significant revision with policy implementation currently underway. In seeking to align the discharge template with the mental health Care Transfer Summary a proposal has been submitted to the statewide Notifications and Clinical Summaries (NaCS) Business User Group. In supporting post discharge follow up an Assertive Recovery Team model is being piloted as an enhancement to existing Assessment and Treatment Teams to provide more assertive community follow up and intensive wrap around support for patients, in partnership with non-government organisations and peer support workforce. During the CRCs

discussion the other HSP members agreed to consider the recommendations and subsequent actions outlined by the EMHS for applicability to their own services. Subsequently they have provided assurances of the existence of relevant policies and practices are currently implemented and/or actioned system improvements including amendments to relevant care coordination and discharge policies within their services as required.

Progress of recommendation three will be updated in the next report.

CHILD SJC

Child SJC died 20 November 2017 from complications relating to metastatic neuroblastoma aged 2 years and 5 months, whilst under the care of the Director General of the Department of Communities. Child SJC was diagnosed with Stage IV high risk neuroblastoma at 13 months of age and underwent intensive therapy at Princess Margaret Hospital (PMH) over the next 10 months. Child SJC relapsed in August 2017 and underwent immunotherapy with Dinutuximab Beta. Whilst the standard immunotherapy treatment regime for SJC's condition was treatment with Dinutuximab this was not available to patients outside of the United States of America following a surge in demand for the substance following positive clinical trials. PMH sourced approval to purchase an alternative known as Dinutuximab Beta until Dinutuximab became available again. Although Child SJC's treatment with chemotherapy and Dinutuximab Beta began on 10 August 2017, her tumours continued to grow and the treatment was ultimately unsuccessful.

The inquest focused on the involvement of the Department of Communities in Child SJC's life and on the management of her medical conditions. The Coroner was satisfied with the standard of care, supervision and treatment that was provided by the Department of Communities, PMH and hospice service of Silver Chain.

Given the positive effects on short-term survival with Dinutuximab and its current uncertainties about ongoing supply, the Coroner made one recommendation relating to the supply of Dinutuximab to be placed on the Pharmaceutical Benefits Scheme (PBS), so that at a national level, ongoing supply can be assured.

The Department of Health's Coronial Review Committee (CRC) has reviewed these findings and made enquiries with the relevant stakeholders.

The Child and Adolescent Health Service (CAHS) advised that a submission was made to the Pharmaceutical Benefits Advisory Committee for Dinutuximab Beta and they were advised in March 2020 that it was not considered. As the PBS covers medications used in outpatient settings Dinutuximab Beta would be more appropriately funded jointly by the Commonwealth and the States through the National Health Reform Agreement for medications used in inpatient settings and that assessment was to be made by the Medical Services Advisory Committee (MSAC). The MSAC submission was made in July 2020 and as of February 2021 the application remains open to consultation and there is no estimate of a close or review date as yet. CAHS advised of the clear escalation processes that are in place for the interruption of supply of a medication in seeking an alternative source. CAHS are satisfied that all appropriate actions have been undertaken.

The CRC members agreed that the recommendation has been considered and deemed it closed.

KELL

Stephen Michael KELL died 26 April 2015 at Graylands Hospital from the complications of large bowel obstruction, aged 35, whilst an involuntary patient under the *Mental Health Act 2014*.

The focus of the inquest was upon the supervision, treatment and care of Mr Kell prior to his death including whether he showed clinical signs of a bowel obstruction in the days prior to his death; and the possible causes of the bowel obstruction, specifically whether Mr Kell experienced a mechanical obstruction, and/or whether the antipsychotic medication clozapine impaired his gut motility, thereby contributing to the overall clinical picture. The State Coroner was satisfied that the supervision, treatment and care provided was appropriate to Mr Kell's needs. The coroner made two recommendations, one of which was directed to the Department of Health to amend the *Guidelines for the Safe and Quality Use of Clozapine Therapy in the Western Australian Health System*. The other recommendation was made to the distributors of clozapine, Pfizer and Mylan, and included updating their Product Information to highlight the risk of clozapine-induced gastrointestinal hypomotility, which was deemed out of scope for the WA health system.

The Department of Health's Coronial Review Committee (CRC) has reviewed these findings and made enquiries with the relevant stakeholders.

The CRC noted the recommendation directed to the Department of Health was reasonable and had already been completed. Mandatory Policy 0131/20 *High Risk Medication Policy* and Supporting Information document G*uidelines for Managing Specific High Risk Medications Relevant to the Organisation* were published in February 2020.

The CRC members agreed that the recommendation has been considered, actioned and deemed it completed.

Coronial inquests with no health-related recommendation

Between 1 July 2020 and 31 December 2020, the CRC considered the following new coronial inquests where no health-related recommendation was made: Nualla Christine Reilly, David Dungay, Brian Vincent Atwell, Michael Warren Dyball, Susan Jessica Elsie Windie, Malakai Matiu Ward Parone, PT, JM, Andrew John Key, Dragan Jacovic and Wayne Frederick Leese.

This section outlines any WA health system action taken, as well as system improvements that were noted by the CRC to have been implemented since a death occurred (i.e. not in direct response to the death).

Reilly

Ms Reilly died on 9 June 2017 as a result of multiple injuries sustained when she completed suicide by stepping out in front of a moving train. During the inquest the coroner raised concerns around the lack of supervision enabling Ms Reilly to leave unobserved, the scope of the specialling policy, the delay in reporting her absence to the police and that the investigation conducted by the Health Service Provider did not involve interviews with all staff involved. During the discussion of the issues raised in this inquest the South Metropolitan Health Service (SMHS) provided an update addressing the concerns raised by the Coroner and detailed the subsequent changes that have been implemented. The CRC observed that equivalent risk outlined in this case would exist in other Health Service Provider Emergency Departments and agreed that each of the other Health Service Providers should review their own relevant Emergency Department Services in light of the actions taken by the SMHS. The following summarises the improvements that have been implemented by both SMHS and the other Health Service Providers.

SMHS have updated the scope of the Specialling Policy which is now multidisciplinary. When a patient is placed “on forms” under the *Mental Health Act 2014*, this now triggers an automatic “special” by a mental health nurse (where available) or a discussion with the treating psychiatric team regarding a suitable alternative (RN or AIN) based on risk and the care and observations that are required. Other Health Service Providers have similar policies, procedures and processes in place, further actions have also been undertaken to update relevant policies to appropriately reference the requirements for the practice of nurse specialling.

The SMHS Emergency Department Mental Health Policy has been revised to clearly outline the roles and responsibilities of staff in contacting the Police in the event a patient goes missing, following the delay in reporting Ms Reilly’s absence to police. Likewise, each Health Service Provider has confirmed existence of similar policy requirements including staff members responsible and required documentation.

SMHS advised that once a patient is identified as being of concern or at risk, or is placed “on forms” the use of immediate hold/review flags in the Emergency Department Information System for psychiatric patients stating “Review before Discharge”. This then requires review by the psychiatric team before the patient can leave the department in response to the lack of supervision enabling Ms Reilly to leave unobserved. The remaining Health Service Providers indicated that either alternative risk mitigation processes and policies were in place or further action was being undertaken to implement similar flags. Alternative risk mitigation processes included adjusting staff-patient allocations or ratios, physically locating patients at risk of absconding in high visibility areas and/or moving patients to secure observation wards.

SMHS have implemented processes to address the concern that the investigation conducted by the Health Service Provider did not involve interviews with all staff involved. This includes informing investigation panel members of their responsibilities via email upon appointment to the panel and panel chair reiterating roles and responsibilities when convened for meetings. This is further supported by the implementation of a SAC1 tracker with key milestones to be met during an investigation process. Health Service Providers have indicated a variety of governance processes and strategies are currently implemented including site specific training and education, development of new resources including information for interviewers and interviewees and checklists.

Dungay

Mr Dungay, died on 29 December 2015 in the Mental Health Unit at Long Bay Hospital, Long Bay Correctional Centre, New South Wales from cardiac arrhythmia after being subjected to physical restraint in a prone position. NSW Deputy State Coroner Derek Lee made 20 recommendations. The Western Australia (WA) Director General Department of Health was contacted in May 2020 by the NSW non-government organisation, Justice Action. The purpose of the request from Justice Action was for all jurisdictions to review their restraint practices, especially in light of similar circumstances occurring in other states.

The Dungay inquest was considered by the CRC and it was observed that the WA coronial inquest into the death of Warwick Andrew Ashdown in 2011 identified similar issues. Mr Ashdown had been physically restrained, face down with his head, arms and legs being held at the time of his death. The CRC agreed that Health Service Providers would review actions arising from the Ashdown inquest for current arrangements regarding restraint including prone restraint monitoring, reporting and staff training (clinical and non-clinical) for all areas (including mental health) where restraint is applied. Health Service Providers have provided assurances that appropriate policies, procedures and arrangements are in place to monitor, report and train staff regarding the use of restraint in reinforcing that physical restraint is seen as a strategy of last resort and that care is provided in the least restrictive manner.

Health Service Providers indicated that when prone restraint is required that a variety of strategies are utilised to ensure close monitoring of patients. This included for some Health Service Providers during an episode of restraint monitoring the maximum time length of restraint, assigning a team member to monitor time, completion of a risk assessment when prolonged restraint is required and documented criteria and roles of clinicians in ensuring physical observations (airway, breathing and circulation) and wellbeing are monitored with requirements for patients to also be reviewed following restraint episodes.

Health Service Providers indicated compliance with the Chief Psychiatrist statutory standard regarding restraint reduction requirements for public and private mental health services. Practices included monitoring and recording the frequency and duration of restraint use, documentation in the patients medical record, utilisation of dashboards, clinical incident management review, and reporting to executive, committees and/or working groups. Practices however varied for the systematic and central recording and reporting of restraint in non-mental health settings. Subsequently CRC members discussed strategies for reporting non-mental health restraint at its February 2021 meeting.

All Health Service Providers have confirmed the requirements for Mandatory training amongst staff with programs incorporating best practice models, trauma-informed care principles, de-escalation techniques and restraint minimisation through both theoretical and scenario-based

training. Health Service Providers offer workplace aggression and violence training for all staff with additional mandatory training required for staff involved in restraint or seclusion and/or staff in areas of high risk including mental health and security with requirements for ongoing competency requirements and refresher training.

Windie

Ms Windie died in Carnarvon Hospital on 29 October 2016 from bowel obstruction aged 22. The inquest focused on the care provided to the deceased and the circumstances surrounding the possible failure of transfer to Sir Charles Gairdner Hospital. The Coroner noted since the deceased's death there have been improvements to the process of accepting transfers of patients into tertiary hospitals from rural hospitals, including the introduction of the WA Country Health Service (WACHS) Command Centre. The CRC were uncertain that the introduction of the Command Centre would have resolved the issues raised in this inquest and discussed other improvements that have been implemented. The North Metropolitan Health Service (NMHS) reported that an intra-hospital working group has been established to review issues regarding communication between clinical staff, escalation pathways and aims to address problems with clinical issues only being raised to a senior clinician after it is a critical situation for the patient. The NMHS agreed to expand the scope of the working group to include the escalation of clinical concerns of clinicians from referring hospitals to colleagues within the teaching hospital system including the discounting of the clinical judgement of clinicians outside the teaching hospital system. At the time of discussion by the CRC the working group had only met twice with updates to be provided at future CRC meetings to facilitate system-wide learning. During the discussion of the issues raised in this inquest, CRC members observed that the key clinical issues raised in this inquest were not given prominence. Further to this discussion the CRC considered that the clinicians involved in Ms Windie's last admission to hospital might not of had a full understanding of her medications/medical conditions. CAHS advised that a clinic has been established to ensure that complex patients have hand over to adult Health Service Providers. Progress of this inquest will be updated in the next report.

Paraone

Malakai Paraone died at Princess Margaret Hospital on 26 August 2016 from sepsis at the age of 7 months. The CRC observed that Group A strep in children can have a vague presentation and that clues are tachycardia, fever and little in the way of other physical signs. CRC discussion included discussion of the Perth Children's Hospital (PCH) Sepsis Emergency Department guidelines which flag fever or hypothermia with tachycardia as possible sepsis. CRC members agreed that the tachycardia should have flagged further investigation. CRC discussed current Sepsis education and how awareness can be improved. Progress of this inquest will be updated in the next report.

JM

JM died on 9 July 2015 at Fitzroy Crossing Hospital from dehydration complicating diarrhoea, aged 10 weeks. The CRC observed that in the Kimberley, there are a number of protocols for babies under three months and for clinical staff to take any illness very seriously and to have a low threshold for babies to be admitted for care. The Coroner made a suggestion that the visual aids proposed by the inquest witnesses on the signs of dehydration be developed and used. The Coronial Liaison Unit has made enquiries regarding available resources with WACHS.

PT

CRC members observed in contrast to the State Coroners recommendation that a training program is available for mandatory reporters, however there are no legislative mechanisms that

mandate completion of the program. In the absence of mandatory training, CAHS provided an update to CRC members on the strategies that have already been implemented or are in development to improve the recognition and response to possible child abuse. Education, training and guidelines are currently available from the Statewide Protection of Children Coordination Unit (SPOCC), the Perth Children's Hospital Child Protection Unit (CPU) and the Mandatory Reporting Interagency Training Group. SPOCC plan to introduce a non-mandatory e-learning package on Child Abuse which will include the importance of recognising and reporting injuries in non-ambulant children. Risk mitigating strategies utilised by CAHS and other Health Service Providers include utilisation of non-mandatory Child Injury Assessment Forms/Injury Proforma which are reviewed at "Safety Net" meetings to ensure the correct determination about whether an injury was possibly due to child abuse with recall mechanisms in place if an injury that was thought to be accidental is deemed suspicious. WACHS have implemented a Clinical Alert for recording children at risk. SPOCC in conjunction with the CPU are in the process of developing a proposal for a consistent statewide child protection alert for the WA health system.

CRC members deemed that further information was required on the government actions in response to this recommendation with the CLU to make further enquiries with relevant Stakeholders. On the provision of information, the CRC will consider at a future meeting how clinician awareness of what to look for in abuse of non-ambulant children can be raised with the relevant colleges and stakeholders.

Key

During the discussions of the recommendations raised in this inquest the CRC agreed for the CLU to liaise with the Mental Health Commission (MHC) about the Mental Health Co-Response (MHCR) Program. The MHC advised in 2019 increased hours of service in metropolitan areas and addition of two mobile teams was implemented. In addition, work has been undertaken to develop an appropriate model of service for regional areas in conjunction with the WA Police and WACHS. The MHC is considering all possible options for the future of the MHCR Program.

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