



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

From death we learn 2016

2017 Edition

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The patients and their families

The Patient Safety Surveillance Unit (PSSU) welcomes suggestions on how this publication series may be improved. Please forward your comments to PSSU@health.wa.gov.au.

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From Death We Learn and coronial inquest finding documents identified in this text can be downloaded from the following website: <http://ww2.health.wa.gov.au/Reports-and-publications/From-Death-We-Learn>.

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State Coroner's Foreword

It is said that the role of the Coroner's Court is to speak for the dead and to protect the living. This two fold role is a vital component of a civil society. The coroner's death prevention role is a matter of extraordinary social utility and a cornerstone of the coronial process. Throughout a coronial investigation, there are opportunities to address matters of public health and safety.

As an independent judicial officer, the coroner investigates a reportable death to find out how the deceased died and what the cause of death was. It is a fact finding exercise, aimed not at apportioning blame, but at establishing the circumstances attending the manner of the death. It is in the public interest for there to be a careful and thorough review of the information so that a sudden, unnatural or unexplained death is properly investigated and the cause and manner of that death is properly found and recorded.

Several cases included in this edition address the provision of care to vulnerable people in our community – prisoners, persons in police custody, asylum-seekers, children, the elderly, and people with chronic mental health problems. These people may face particular barriers to accessing healthcare, and this heightens the duty of care required.

For those held in care, the *Coroners Act 1996* makes provision for a mandatory inquest (s. 22(1)(a)). It reflects the community's concern with the quality of supervision, treatment and care of persons whose freedoms have been removed by operation of law.

You will note that in a number of the inquest findings referred to in this publication, the quality of the supervision, treatment and care of the deceased was deemed satisfactory and the coroner made no recommendations. Nonetheless, these cases still provide valuable opportunities for learning across the health system.

As expected, reports of deaths to the coroner are increasing every year, with 2,422 deaths notified in 2016/17.¹ As the number of relevant inquest findings has grown over the years, so too has this booklet. I hope you will once more benefit from reading this educational tool and discussing it with your colleagues.

I commend the ongoing efforts of the health services to improve health care delivery by their own inquiries and implementation of corrective actions, and through the detailed biannual reporting to me on actions taken in response to findings and recommendations. I hope that *From Death We Learn* will continue to supplement this as an educational tool.

I would like to acknowledge the families and friends of loved ones whose deaths have been investigated by the coroner. It is with utmost respect to those families that I support this publication in the hope that it helps to prevent harm to others in similar circumstances.

Ms Ros Fogliani

State Coroner

¹ Office of the State Coroner for Western Australia, Annual Report 2016 – 2017. Available at: http://www.coronerscourt.wa.gov.au/files/Annual_Report_2016_17.pdf

Editorial

This is the eleventh edition of *From Death We Learn*, released by the Coronial Liaison Unit. The Patient Safety Surveillance Unit supports the death prevention role of the coroners in publishing this booklet, in the hope that the lessons learned herein improve the care and outcomes for future patients.

Several cases in this edition highlight that the transition of care between different health services, or coordination of services between different government agencies, poses a risk to patients. The role of family and friends in this process is to be highly regarded.

This year's edition of *From Death We Learn* unfortunately opens with the death of a healthcare worker, and is a timely reminder that whilst health care workers focus on providing the best care to patients that they can, their own health and safety should not be forgotten.

Again, we see that the majority of cases in this edition have not resulted in coronial recommendations. Nonetheless, the Coronial Liaison Unit advocates that each of these cases presents an opportunity to learn and improve services across the WA health system. The key messages and discussion points included with each of the cases are reflective of some of the concerns expressed by members of the Coronial Review Committee.

The Coronial Liaison Unit would again like to highlight health practitioners' responsibilities in notifying the coroner of a reportable death in accordance with the *Coroners Act 1996*. The 'Death in Hospital Form' was developed in consultation with the State Coroner to assist health practitioners to navigate the key reporting obligations in a timely manner. While the information circular was withdrawn with the introduction of Policy Frameworks, the form is still available on the Coronial Liaison Unit website² and endorsed for use. The form may be modified by Health Service Providers to accommodate any additional mortality review requirements that sites have.

All hospitals and health services are encouraged to use this document to raise awareness among all health practitioners of the lessons learned from unexpected or preventable deaths.

² http://ww2.health.wa.gov.au/Articles/A_E/Coronial-Liaison-Unit

Abbreviations

| | |
|-------|--|
| ACAT | Aged Care Assessment Team |
| ADHD | Attention Deficit Hyperactivity Disorder |
| AWOL | absent without leave |
| BP | blood pressure |
| bpm | beats per minute |
| CAMHS | Child and Adolescent Mental Health Service |
| CLU | Coronial Liaison Unit |
| COPD | Chronic Obstructive Pulmonary Disease |
| CPFS | Department of Child Protection and Family Support |
| CPOP | Community Program for Opioid Pharmacotherapy |
| CPR | cardiopulmonary resuscitation |
| CRC | Coronial Review Committee |
| CT | computed tomography |
| DIBP | Department of Immigration and Border Protection |
| ED | emergency department |
| EEG | electroencephalography |
| ERCCD | electronic recording and reporting of controlled drugs |
| ETS | Emergency Telehealth Services |
| FHR | fetal heart rate |
| GCS | Glasgow Coma Score |
| GP | general practitioner |
| ICU | Intensive Care Unit |
| MBU | Mother Baby Unit |
| MHERL | Mental Health Emergency Response Line |
| MHU | mental health unit |
| NGO | non-government organisation |
| NICE | National Institute for Health and Care Excellence |
| OSC | Office of the State Coroner |
| RFDS | Royal Flying Doctor Service |
| SMP | Senior Medical Practitioner |
| VBAC | vaginal birth after caesarean |
| WA | Western Australia |

Introduction to the Coronial Liaison Unit

The CLU works within the Patient Safety Surveillance Unit at the WA Department of Health. Currently the CLU consists of two Senior Clinical Advisors and a Senior Policy Officer. It was established in 2005 as a health initiative to improve communication between the WA health system and the Office of the State Coroner. The CLU facilitates the allocation of health related findings from coronial inquests for implementation in hospitals and health services.

The Coronial Review Committee operates in connection with the Coronial Liaison Unit by providing executive strategic support. It 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 Committee 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.

The CLU, in conjunction with the Coronial Review Committee, reviews all public inquests that have a health care aspect to them and places the recommendations via the Chief Medical Officer with the appropriate area within the WA health system. Expert advice and comment on the recommendations and actions taken to improve patient safety in response to the inquest findings are fed back to the State Coroner in a biannual report.

For the purpose of quality improvement, the Coroner's Ethics Committee allows the CLU access to post mortem reports to assist clinicians to undertake mortality reviews. Where clinicians require post mortem findings to effectively review a death, an application for the post mortem reports can be made via the CLU.

The CLU continues to work with the Office of the State Coroner to share lessons learned from mortality review to improve future patient care.

Introduction to inquested cases

Under the *Coroners Act 1996 (WA)* every regional magistrate is contemporaneously a coroner. However, in practice the majority of Western Australian inquests in 2015 were conducted by the State Coroner Ms Rosalinda Fogliani, Deputy State Coroner Ms Evelyn Vicker, and Coroners Mr Barry King and Ms Sarah Linton.

There were 2,214 deaths reported to the Office of the State Coroner for full investigation in the 2015-16 financial year. A further 1,198 deaths were dealt with by review of the treating doctor's death certificate recording a cause of death, and were accepted by the coroner. In 2015-16 there were 58 public inquests held and finalised.³ Of the 58 inquests, 30 of them were mandated in accordance with the *Coroners Act 1996*.

Public inquests are judicial proceedings conducted in open court. The coroner is a judicial officer and receives evidence that is relevant to the inquiry. The objective of an inquest is to establish the facts surrounding the death of the person; the coroner must not appear to determine any question of civil liability or to suggest any person is guilty of an offence.

After taking the evidence at an inquest, a coroner must find, if possible:

- the identity of the deceased
- how the death occurred
- the cause of death
- the particulars needed to register the death under the *Births, Deaths and Marriages Registration Act 1998 (WA)*.

Where an inquest is mandated, for example, in the case of an involuntary mental health patient, the coroner must also comment on the quality of the deceased's supervision, treatment and care.

The coroner may also make comments and/or recommendations regarding any matter connected with the death, including public health or safety or the administration of justice. For example, comments may be made about the provision of healthcare or the actions of other public sector agencies. Where the death is of a person 'held in care' (which includes involuntary mental health patients, prisoners and persons in the custody of police officers, amongst others), a coroner is required to comment on the quality of the supervision, treatment and care of the person while in that care.

The CLU notes all coronial recommendations pertaining to healthcare and provides regular reports to the State Coroner outlining the responses to each recommendation from relevant stakeholders. These responses have been included in this report where the timeframe has allowed a response to be formulated prior to publication. In accordance with agreement from the members of the Coronial Review Committee, the executive summaries of the biannual 'Progress Report for Health Related Coronial Recommendations' have been made available online⁴ since February 2015.

³ Office of the State Coroner. Annual Report: 2015-2016 [internet]. 2015. Government of Western Australia. [cited 2 June 2017]. Available from: http://www.coronerscourt.wa.gov.au/files/Annual_Report_2015_2016.pdf.

⁴ <http://intranet.health.wa.gov.au/osqh/reports/> (WA health system access only)

A tragic accident

Key Messages

- All health employees and employers should be aware of the risks of fatigue and how to identify and manage fatigue.

A 64-year-old woman died as a result of multiple injuries sustained in a head-on collision whilst transporting a patient to meet the Royal Flying Doctor Service (RFDS) for transfer.

The deceased worked at a remote community health clinic, a single nurse post and the only health service within an approximate 200 km radius. The inquest was held to investigate the possibility that fatigue contributed to the death.

The nurse had previously described to a friend a heavy work load that required her to work more than an eight hour day and often included being called out at night. However, it was observed that she handled the work pressure well and coped well under normal circumstances.

It was reported that on the afternoon of the accident, the deceased appeared tired and explained that she had been on call-outs on the two previous nights and had very little sleep. She was advised to get some sleep and it appeared that she did this though it is not clear how long she slept for.

On the day of the incident, the nurse at another clinic (also a single nurse post) arranged a priority evacuation to hospital by RFDS for a patient with burns to her face and arms, and suspected inhalation burns. As the air strip near that clinic was not operational at the time it was agreed to transport her to the airstrip in the town where the deceased worked. When the nurse called the deceased to arrange pick-up of the keys to airstrip, the deceased offered to meet her half way to transport the patient to the airstrip. The deceased had stated that she had slept and eaten, and did not appear tired at the meeting point.

The road between the two towns is an unsealed, loose gravel road with a single carriage-way. It is unmarked and does not have lighting. The patient and her friend (who travelled with her to act as an interpreter) had the impression that they were travelling quite fast and recall travelling in the centre of the road. A utility vehicle was travelling in the opposite direction. The driver of the ute dipped his lights, slowed and steered to the left on approach to a crest in the road; however, collided head-on with the clinic vehicle.

The deceased was fatally injured and died at the scene. A truck driver came across the scene within the hour and notified emergency services. The other three occupants of both vehicles were seriously injured and airlifted to a metropolitan tertiary hospital.

Investigation revealed that the clinic vehicle was positioned “more over on the incorrect side of the road than on the correct side” and the ute still having significant room on the left. Nothing could be found to suggest that the crash occurred for any reason other than driver error.

Inquest findings and comments

The coroner found that death resulted from multiple injuries and that it was by manner of accident.

While the coroner could not entirely eliminate fatigue as a contributing factor to the collision, the evidence that was available generally suggested that it was unlikely that it was a factor.

WA health system actions

Halfway meets or transfers of patients at night between the two clinics have been ceased and all transfers now occur via the RFDS.

The new Nursing Post Orientation Manual at the site emphasizes the importance of not driving at night without the appropriate consultation; has established a maximum speed limit when driving the clinic vehicle; and, emphasizes the importance of driving according to road and weather conditions.

The nurses at both clinics are now required to submit a timesheet that includes actual overtime and recall time worked so that total working hours can be effectively monitored and managed. The requirement for a rest break of nine-and-a-half hours is communicated during orientation (unless emergency recall is required and absolutely necessary).

Coroner's recommendation

The coroner did not make any recommendations in this matter.

References

- [SMITH inquest findings](#)⁵

Discussion points

- Discuss different types of fatigue, their effects on performance, and how to mitigate such effects: e.g. lack of sleep, physical fatigue, decision fatigue, compassion fatigue.

⁵ http://www.coronerscourt.wa.gov.au/Inquest_into_the_death_of_gonda_alexandra_smith.aspx?uid=9824-3586-1122-2796

Prescription shopping

Key Messages

- Patients using multiple medications and demonstrating drug seeking behaviours should be identified early, but are often difficult to recognise. A thorough history and examination can be invaluable.
- This cohort of patients is often vulnerable and treatment can be challenging and complicated.
- Medications which are highly addictive should be prescribed with caution and patients should be monitored closely.
- There is a need for improved sharing of data with regard to prescriptions and high risk medications.
- The Schedule 8 medicines prescribing code was released in March 2017.

Case 1: Addiction and misuse of prescription medication - oxycodone

A 44-year-old man died as a result of combined drug effects after taking a combination of opioids and benzodiazepines obtained from multiple sources.

The deceased had been addicted to heroin in his twenties, and had been on methadone through the Community Program for Opioid Pharmacotherapy (CPOP) for many years. His past medical history included bipolar affective disorder, anxiety, chronic back pain, obesity and sleep apnoea. He had also been taking benzodiazepines regularly from an undisclosed source.

He attended two separate medical practices. He disclosed his prior intravenous drug use and current methadone and benzodiazepine use to one GP and requested help. He was re-registered in the CPOP and commenced on buprenorphine and naloxone, on which he continued on for several months.

The GPs that he saw at the two clinics both moved elsewhere, leaving the deceased with no authorised prescriber. He was prescribed oxycodone for his back pain by a new GP, unaware of his status as a registered drug addict.

A few months later, the deceased visited both practices on one day and was prescribed high doses of opioid medications by two different GPs; he filled the scripts at two different pharmacies. He and his partner crushed some of the tablets and took them intravenously. The following morning, his partner had difficulty waking him from sleep and later found him deceased.

Inquest findings and comments

The coroner found the cause of death was as a result of combined drug effect. The manner of death was by way of misadventure.

Post-mortem analysis revealed toxic levels of oxycodone, plus therapeutic levels of several different benzodiazepines. Expert opinion was that the effects of the multiple medications in conjunction with his obesity and sleep apnoea would have led to impaired ventilation and inability to maintain and protect his own airway.

Case 2: Addiction and misuse of prescription medication - oxycodone

A 26-year-old man died as a result of combined drug effects after taking a large amount of prescription drugs, in particular opioids and benzodiazepines.

The deceased had a history of using anabolic steroids and methamphetamines while training professionally as a competitive sportsperson. He sustained a sports injury to his shoulder which cut short his career in competitive sports. He then required medications to control the pain. He frequently changed jobs, and often partook in substance abuse. His other relevant past medical history was bipolar affective disorder for which he was on a variety of mood-stabilisers.

The deceased attended multiple GP surgeries requesting large amounts of prescription drugs and was caught forging prescriptions on two occasions. He also obtained prescriptions regularly from emergency departments where he attended frequently after accidents.

He became registered as a drug addict, and was enrolled in CPOP using buprenorphine. His authorised prescriber was never informed of his frequent attendances to other practices, and neither were those doctors due to legislative privacy requirements. His participation in CPOP was patchy and he also started to illegally obtain oxycodone. A letter was sent to the practice with regards to the above information and was filed in his notes, but there was no alert to the medical practitioners regarding this information.

Following a biopsy under anaesthetic, he was able to obtain a prescription of high dose opioids. He died at home post-ingestion of these tablets.

Inquest findings and comments

The coroner found the cause of death was as a result of combined drug effect and bronchopneumonia. The manner of death was by way of misadventure.

Post-mortem analysis revealed a left anterior descending artery occlusion, secondary to anabolic steroid abuse, early bronchopneumonia but no aspiration and oxycodone residue in the stomach. Toxicology revealed multiple drugs in the urine.

Case 3: Addiction and misuse of prescription medication – methadone

A 22-year-old man died as a result of combined drug effects after a dose of methadone.

He had an extensive juvenile criminal record and had used cannabis, heroin, and amphetamines in his teenage years. He was registered as a drug user and commenced on buprenorphine, but only lasted one week on the program. He was using benzodiazepines daily and was obtaining prescriptions from GPs and hospitals as well as from the black market. His other relevant past medical history involved suffering from seizures, which were thought to be due to drug use and withdrawal as a head CT scan and EEG were unremarkable.

He attended two main GP surgeries and obtained prescriptions for benzodiazepines from a range of GPs. One GP called the doctor shopping hotline, but he was not registered. Further attempts to decrease his benzodiazepine usage were unsuccessful.

After disclosing his daily heroin use, the deceased was registered with CPOP for methadone, and his GP refused the demands for more benzodiazepines. After his second dose of methadone, he was witnessed during the day to having slurred speech and clumsy movements. In the evening, his family saw him lying face down on his bed. A few hours later, he was found to be dead.

Inquest findings and comments

The coroner found the cause of death was as a result of combined drug effect. The manner of death was by way of misadventure.

The coroner was satisfied that the deceased had overstated his tolerance in order to obtain higher amounts of medicine than he needed. The family permitted an external post mortem examination only with limited tissue sampling. Toxicology revealed toxic levels of alprazolam and methadone, with therapeutic levels of other benzodiazepines and dextromethorphan, a cough suppressant.

Coroner's recommendations (all cases)

The coroner made the following recommendations for all three cases:

Secure Database

1. WA prioritise the real time collection of dispensing data from all pharmacies for all Schedule 8 and reportable Schedule 4 poisons.
2. All WA real time dispensed medicine data be held in a secure regulated database held by the WA government regulator.
3. WA regulate to ensure the supply or dispensation of all Schedule 8 and reportable Schedule 4 poisons are recorded in the secure regulated database held by the WA Government regulator.
4. WA regulate to provide both prescribers, registered pharmacists and authorised suppliers access to that secure data via secure software links to facilitate real time decision making around both prescribing, supplying and dispensing of Schedule 8 and reportable Schedule 4 poisons.
5. The current Schedule 8 (controlled drug) dependency register be part of that secure database and provide that information along with real time information about medicines dispensed on enquiry by a prescriber, registered pharmacist or authorised supplier.
6. The information from any register regulated (e.g. reportable Schedule 4 poisons) as part of the secure database, be similarly available on enquiry for dispensed medicines.
7. Once real time WA dispensing data is available for use there be a regulated time period to allow commercial practice case management software to be developed to facilitate real time access. Once that period is over it be regulated that prescribers access the available data prior to completing any prescription or supply for Schedule 8 or reportable Schedule 4 poisons. The intention is to ensure those with drug seeking behaviour understand prescribers must comply with regulation to enable a prescription to be written.

Benzodiazepines

8. All benzodiazepines be included as reportable Schedule 4 poisons.
9. There be a method implemented to assist prescribers and dispensers with decision making around benzodiazepine dependency, and restrictions imposed on recognised unsafe prescribing or supply. How that is achieved is up to the regulator. Again the concern is not with policing but providing prescribers with a mechanism with which to decline to prescribe in the face of undue pressure from drug seekers.

CPOP

10. CPOP prescribers be given information about a patient's prior CPOP programs and prescribers when seeking authorisation to commence a new program.

11. CPOP prescribers to provide advice when seeking authorisation as to other medications to be prescribed in conjunction with the authorised program medicine. This is to include reportable Schedule 4 poisons and amounts with intended reduction regime, if that is applicable.

Australia Wide Dispensing Information

12. The ultimate aim for the secure regulated database held by the WA Government regulator be for all prescription medicines to be captured. If medication warrants a prescription, it warrants monitoring.

13. The ultimate aim for real time ERCCD data should be for Australia wide access to dispensing data for medical practitioners, registered pharmacists and authorised suppliers.

WA health system actions

The WA Department of Health is awaiting the outcome of the planned national release of the uplifted Electronic Recording and Reporting of Controlled Drugs (ERRCD) program and has engaged with the Commonwealth about specifications for WA. It may be possible, within this system, to monitor the prescription of specific Schedule 4 drugs; however, this will need to be considered through consultation.

The *Medicines and Poisons Act 2014* replaced the *Poisons Act 1964* on 30 January 2017. The current "drug addict register" held under the *Health Act 1911* will transition to a new Schedule 8 record of dependent persons under the *Medicines and Poisons Act 2014*. The Act makes provisions for the sharing of this information to health practitioners for patients under their care.

Assessment of benzodiazepine usage is now routinely required as part of entry for patients entering the CPOP program. Patients will not be approved over a certain limit and are instead referred to Next Step for specialist support. Clauses for oversupplied persons came into effect with the *Medicines and Poisons Act 2014* on 30 January 2017.

References

- [BERRY inquest findings](#)⁶
- [HALL inquest findings](#)⁷
- [WESTLUND inquest findings](#)⁸
- [Opioids, benzodiazepines and other Schedule 8 medicines \(Department of Health\)](#)⁹

Discussion points

- What systems does your workplace have to help identify patients who might have substance abuse problems?
- What policies and processes are in place in your area for the management of patients with known drug and alcohol issues? How could care be improved?

⁶ http://www.coronerscourt.wa.gov.au/l/inquest_into_the_death_of_shayne_andrew_berry.aspx?uid=2243-4154-4520-6223

⁷ http://www.coronerscourt.wa.gov.au/l/inquest_into_the_death_of_daniel_james_hall.aspx?uid=3594-3494-6776-8200

⁸ http://www.coronerscourt.wa.gov.au/l/inquest_into_the_death_of_adrian_marcus_westlund.aspx?uid=7691-5538-6924-4373

⁹ http://ww2.health.wa.gov.au/Articles/N_R/Opioids-benzodiazepines-and-other-S8-medicines

Multi-agency care of at-risk child

Key Messages

- Memorandums of understanding exist between different entities or agencies to facilitate safe transition of care of vulnerable children.

A one-month-old baby died unexpectedly whilst living with his mother in prison.

His mother had a history of heroin use and criminal offending, with previous periods of incarceration. The Department of Child Protection and Family Support (CPFS)¹⁰ had been involved with her first baby after concerns about drug use during pregnancy, and co-sleeping after the baby was born.

Whilst pregnant with the deceased, his mother had been using heroin again. When she attended hospital for an infection, staff took the opportunity to contact CPFS and to arrange for her to start methadone as a substitute for heroin. She was then detained in prison on outstanding warrants, and began receiving ante-natal care including specialist drug and alcohol care.

The prison has a well-established Child Residence Program. Prisoners are expected to assume full responsibility for the care of their children, with the Department of Corrective Services noting their own duty of care to children residing at the prison. Staff from CPFS and from the Parenting and Early Childhood Service (Ngala) are based at the prison, as well as prison health services staff. A community child health nurse visits fortnightly. A four-week parenting program was held by the prison's early childhood educator, and the deceased's mother participated in this course. A communal house with shared facilities and an enclosed play area is available for prisoners with children. The State Department of Health guidelines on co-sleeping are followed, and prisoners may be evicted from this nursery unit house if found to be co-sleeping.

A pre-birth planning meeting between CPFS, obstetric staff, prison staff and the mother was held. The goal of this meeting was to share information between support agencies in order to ensure that the baby would be well cared for after his birth, preferably remaining in his mother's care. The CPFS would normally hold three such meetings prior to birth, but this was not possible due to the mother's late engagement with health services and CPFS. A second pre-birth planning meeting had been scheduled the day before the birth, but was postponed, to be rescheduled after discharge from hospital.

The pregnancy was complicated by placenta praevia and placenta accreta, so the mother was admitted to hospital around 34 weeks of gestation to mitigate the risk of sudden antepartum haemorrhage. This placed more restrictions on her freedom to move about, socialise or smoke, and she was given medication to help ameliorate her frustration. An elective caesarean section was planned, with hysterectomy expected to be necessary given the location of the placenta.

The deceased was delivered at 37 weeks by planned caesarean section, and a hysterectomy was required to control bleeding from placenta accreta. The deceased had some respiratory distress at birth and was managed in the special care nursery for hyaline membrane disease. He was monitored for neonatal abstinence syndrome, requiring only one dose of oral morphine

¹⁰ The Department of Child Protection and Family Support was incorporated into the Department of Communities in the machinery of government changes of 2017.

to treat withdrawal. He remained in the nursery when his mother was discharged back to prison when he was five days old.

The baby's mother suffered severe post-surgical pain, and was brought back to hospital the next day for pain management. An epidural was inserted and a small wound collection drained in theatre. The Anaesthetic Pain Service was involved to help optimise treatment as she was both quite drowsy and still complaining of severe pain. She required ketamine lozenges, tramadol, gabapentin, and oxycodone in addition to her usual methadone dosing. She was also receiving diazepam when necessary and quetiapine for agitation. There was concern about the mother's ability to provide safe care due to her excessive drowsiness, and plans were made to reduce medication doses to reduce her drowsiness before discharge.

The deceased's mother was reviewed by a psychiatry registrar who had considerable experience working with new mothers with drug and alcohol problems. He was satisfied that her drowsiness was improving; she was well bonded with the deceased and had no signs of any psychiatric condition. The deceased was discharged from the nursery to reside on the ward with his mother. Initially the mother was quite drowsy, falling asleep during feeds but her drowsiness improved over the next few days. Paediatric staff planned that the deceased was not to be discharged from hospital until his mother's pain medications and drowsiness were reduced.

A hospital social worker had been assigned to the deceased and his mother. Her role was to liaise with CPFS, the prison, and the hospital staff looking after both mother and baby. Part of her role was to update CPFS on the mother's parenting ability and attachment. She reported the concerns around the mother's drowsiness. Both the hospital and CPFS social workers were relatively new in their respective roles.

Midwives counselled the deceased's mother about the risks of co-sleeping, and provided her with a pamphlet on the subject. On more than one occasion she was found to be asleep in bed with the deceased at her breast, once with the bed rail down and a sheet covering the baby, and on one occasion became aggressive when staff woke her and offered to care for the baby in the nursery while she slept.

When the mother's pain and drowsiness had improved, she was discharged from hospital back to prison following review by medical staff of both mother and baby. The mother was on a low dose of gabapentin for another five days, tramadol with ibuprofen and paracetamol for pain, quetiapine for agitation, iron, a further three days of antibiotics, pantoprazole and frusemide. Diazepam, oxycodone, and ketamine had been ceased. She continued to take methadone daily. The baby had been gaining weight, and staff were satisfied with the deceased's care for the baby.

The usual practice would be for a post-birth meeting between CPFS and hospital staff to occur prior to discharge, however this did not occur. CPFS were only notified of the deceased's discharge back to prison with his mother after they had been discharged, probably as an oversight by the social worker. CPFS subsequently arranged for another meeting to be held with prison staff and the deceased's mother, scheduled for a fortnight after discharge.

The deceased was looked after by his mother in prison for the remainder of his life. Other inmates noted he had periodic breathing, which can be normal for a neonate. His mother sought treatment for some conjunctivitis in one of his eyes. The other residents of the nursery unit noted that his mother was tired and sleepy at times, and found her co-sleeping with him several times.

On the twelfth day after discharge from hospital, his mother fed him late in the evening as usual. A few hours later she woke to feed him, but found him cold and unresponsive. She called for help, and a fellow prisoner started CPR. Prison officers and a nurse attended, continuing CPR, but when ambulance officers arrived it was clear the baby had died.

Inquest findings and comments

The coroner made an open finding into the manner of death, with the cause of death unascertainable. Tiny doses of metabolites of diazepam and methadone were present in his blood, but thought to be so low as not to have been a risk. It was not clear if he had been found in his cot or in his mother's bed.

The coroner was satisfied that the care provided in hospital was of a high standard, despite some communication failures that were not contributory to the death. The health service has made changes subsequent to the death, and now ensures that a discharge planning meeting with prison staff is held prior to discharge.

The prison has made changes to its muster and cell checks to include accounting for children as well as for prisoners. This includes checking for co-sleeping. The coroner was supportive of the practice of children residing with their mothers in prison, often as a safer environment than might exist in the community for many women.

Coroner's recommendation

The coroner did not make any recommendations in this matter.

References

- [BABY Z inquest findings](#)¹¹
- [Memorandums of Understanding for at-risk children \(Department of Health\)](#)¹²

Discussion points

- What hospital policies and procedures are in place to guide the management or coordination of care for children deemed to be at risk?
- What memorandums of understanding exist at a State and local level with regard to the protection and care planning for children?

¹¹ http://www.coronerscourt.wa.gov.au/Inquest_into_the_death_of_baby_z.aspx?uid=6480-5496-5890-5504

¹² http://ww2.health.wa.gov.au/Articles/A_E/About-child-abuse-and-neglect/Child-abuse-and-neglect-operational-directives-MOUs-and-policies

Post-natal depression

Key Messages

- Managing post-natal depression requires the provision of care for both mother and baby. At times it may be difficult to ascertain what constitutes best care for both.

A 25-year-old woman died whilst an involuntary patient under the *Mental Health Act* at the time. Following the birth of her first child, the deceased had suffered depressive symptoms and made several attempts at self-harm. She received treatment in the Mother and Baby Unit (MBU) at a public hospital and she remained well until the birth of her second child. During the course of that admission she absconded several times from the ward.

The deceased became unwell within days of the uncomplicated birth of her second baby. She presented to the Emergency Department (ED) where she was assessed by the psychiatry team and referral made to the MBU again. She was reviewed the next day on a home visit.

The following day she was assessed in ED as being high risk and a plan was made to admit her to the MBU. However, after she absconded twice from ED whilst waiting, she was transferred to a mental health facility as an involuntary patient instead, as she was now regarded as too high a risk for the MBU.

The next day the deceased was transferred from the mental health facility to the MBU. She appeared to have improved, and the duty consultant at MBU had not only reviewed all available information from notes and staff, but had also travelled to the mental health facility to assess the deceased. Whilst there was a risk she might attempt to abscond, and a feeling that she might be hiding suicidal ideation from staff, it was decided that being treated in the MBU was the preferable option under the circumstances.

The MBU provides a home-like environment and is approved for involuntary mental health patients with moderate to severe symptoms in the first 12 months post-partum to facilitate at least some contact with and provision of care to the baby. The unit is not considered to be a secure unit, so referrals may be declined if it's felt a patient's risks cannot be managed safely. The smoking area is fenced, secured and only accessible by staff key card.

Unfortunately a history of absconding was not given any particular emphasis in risk assessments conducted. She was admitted to the MBU as an involuntary patient, with a plan for medication and 30 minute observation and more frequent observation when with her baby. She declined nicotine replacement therapy, and whilst the treating team did not feel that she needed to be specialised, it was decided that she would require a nurse escort to go the courtyard for a smoke.

The deceased appeared to be doing well over the next two days, continuing on 30 minute observations, with a plan to decrease this to hourly if she continued to improve.

On the day of her death the deceased went out for a smoke early in the morning with a nurse, appearing calm and settled. Within half an hour of returning to the ward, she scaled the wall in the laundry courtyard (available to all patients with no escort as thought to be secured) and walked to the nearby railway, where she was hit by a train. She died before she had been reported as missing.

Inquest findings and comments

The cause of death was found to be multiple injuries and the manner of death was suicide. The coroner was confident that if the deceased had been more securely contained, she would most likely have responded to treatment and been able to return home to her family.

Coroner's recommendation

The coroner did not make any recommendations in this matter.

WA health system actions

Several changes have been made at the MBU since the incident, including a standardised risk assessment that includes the history of absconding, modifications and restricted access to the laundry courtyard and adequate supervision of involuntary patients accessing the area. The coroner was satisfied that these changes should greatly reduce the risk of a similar event occurring again.

References

- [BELICA inquest findings](#)¹³

Discussion points

- What environmental risks to patients are present where you work? Can these be modified or mitigated?
- How can you promote bonding between mother and baby in similar situations?

¹³ http://www.coronerscourt.wa.gov.au/l/inquest_into_the_death_of_merita_belica.aspx?uid=2352-2765-6000-1068

Managing missing persons

Key Messages

- A standardised approach to missing persons is important, including having a rapid response to patients deemed to be at high risk who have gone missing.
- An assessment of an involuntary patient's risk to self should include their risk of absconding and wandering, as per the *Chief Psychiatrist's Guidelines*.

A 26-year-old man died while an involuntary patient under the *Mental Health Act*.

The deceased was diagnosed with ADHD in the year before his death and was prescribed dexamphetamine. Six months later he developed a psychotic illness, and admitted to taking up to six times the recommended dose of dexamphetamine. He was admitted to a locked ward as an involuntary patient with grandiose delusions and no insight; and commenced on olanzapine and quetiapine.

The deceased had family in Perth and New Zealand who were keen to have him transferred back to New Zealand to stay with his father following discharge.

As the deceased's symptoms improved while on treatment and he was no longer expressing delusions to staff, he was allowed escorted leave with family. His first unescorted ground leave was successful, but he did not return from the second and was brought back in by the police. Upon his return the deceased informed staff and that he had used a piece of rope to try to asphyxiate himself "to cause soul nurturing and grey matter neurogenesis", though he denied thoughts of self-harm. His dose of quetiapine was increased, and he stopped sharing delusional thoughts with the staff.

During the course of this admission, the deceased lacked insight into his condition, but was compliant with medication. A plan for discharge from the secure ward with the deceased's aunt, who would also accompany him to New Zealand, was made, and he was allowed leave with his aunt to get his passport renewal process underway.

Subsequently the deceased was moved to an open ward, after being assessed as being low risk to self or others, although this was not discussed with the treating consultant.

Four days before his death, during an approved leave with his aunt, she informed the deceased that his father may not be able to provide him with accommodation and support, and that the deceased would have to stay with an uncle in New Zealand instead. The deceased emailed his father, who responded supportively, but it is likely that he never saw his father's reply. Staff were not informed about this change of plan on discharge, and the deceased was reportedly engaged and appropriate that evening with staff.

The following day, the deceased went missing from the ward. Family were contacted, who asked for a search to commence immediately, but the police were not informed for about nine hours. Police searches of areas suggested by family were unsuccessful. He was sighted in the community two days later and in the early hours of the morning before being found hanging by the neck in a park by a jogger a few hours later.

Inquest findings and comments

The cause of death was found to be ligature compression of the neck (hanging) and death occurred by way of suicide. No quetiapine was found in his blood. The coroner was satisfied that while his mind was disturbed, he had formed an intention to end his life.

The coroner commented on the following issues

1. The decision to transfer the deceased to an open ward by the medical officer was found on review by the coroner to be reasonable when viewed with foresight.
2. The apparent delay in declaring the deceased absent without official leave (AWOL) and notifying the police was in keeping with the existing policy then, which has subsequently been altered to require immediate notification where there is documented evidence that the patient is at risk.

Coroner's recommendation

The coroner did not make any recommendations in this matter.

References

- [BENNETT-ROBERTSON inquest findings](#)¹⁴
- [Chief Psychiatrist's Guidelines](#)¹⁵
- [A practical guide for working with carers of people with a mental illness](#)¹⁶

Discussion points

- The new *Mental Health Act 2014* contains requirements for staff to share important information with patients, carers, and family members, but not vice-versa. How can you encourage patients, family, and carers to share information with staff?

¹⁴ http://www.coronerscourt.wa.gov.au/l/inquest_into_the_death_of_mark_warton_bennett_robertson.aspx?uid=2413-1215-4998-1874

¹⁵ http://www.chiefpsychiatrist.wa.gov.au/wp-content/uploads/2015/12/CP_Guidelines_December_20151.pdf

¹⁶ A practical guide for working with carers of people with a mental illness, March 2016, Mind Australia, Helping Minds, Private Mental Health Consumer Carer Network (Australia), Mental Health Carers, Arafmi Australia and Mental Health Australia, available at: https://www.mindaustralia.org.au/sites/default/files/publications/A_practical_guide_for_working_with_people_with_a_mental_illness.pdf

The role of the coroner

Key Messages

- For all reportable deaths, the coroner must find, if possible, the cause and manner of death.
- If the coroner's questions regarding a death remain unanswered, this can be a factor in the decision to hold a public inquest.

An 82-year-old man died at home from bronchopneumonia.

The deceased lived with his wife in regional WA and had multiple complex medical issues including insulin-dependent diabetes, a long history of depression and intermittent bouts of anxiety well managed with antidepressants and diazepam, osteoporosis and a past history stroke and of prostate cancer with radiotherapy and brachytherapy.

Following a fall at home, the deceased had ongoing pain in his right shoulder and ribs and other symptoms including depression, insomnia, urinary incontinence and constipation. A chest X-ray, undertaken for ongoing pain, was suggestive of moderate chronic obstructive pulmonary disease with normally aligned joints.

Two days later, the deceased presented to the local hospital complaining of cough leading to vomiting, difficulty in swallowing, pain in the right knee, neck, and right upper quadrant of the abdomen. He was noted in the triage notes to be anxious with a temperature of 38°C, blood pressure of 150/100 mmHg, a respiratory rate of 24/min, oxygen saturation of 95% and a pulse of 90-100 bpm, and was assigned a triage score of four (to be seen within one hour). There were no doctors at the hospital and care was provided by nursing staff with telephone support from the medical officer on call at another hospital about 35 kilometres away.

He was noted to have a "wet" chest on auscultation but in the absence of persistent high grade fever, a respiratory rate slightly high but not out of parameters for the age and given the clinical presentation and normal oxygen saturations, this was attributed to a chronic respiratory issue and infection was not considered a likely possibility. The abdominal pain increased in severity at the hospital and was considered to be the predominant concern.

The doctor on call at the other hospital was contacted at home by telephone for advice.

The deceased was prescribed Buscopan, Ketorolac and Maxolon with significant improvement in the pain, and subsequently discharged home around midnight with a plan to follow up with his GP the next morning or to present at another district hospital with medical staffing if symptoms recurred or worsened. Infection was not raised as a possible differential diagnosis.

Overnight the deceased continued to decline and developed difficulty in breathing. He collapsed while attempting to get into the car to return to the hospital. Emergency services were called and his wife commenced chest compressions.

Volunteer ambulance officers attended and resuscitative efforts were continued for 20 minutes but were unsuccessful.

As part of the investigation police officers from the local station, acting as coronial investigators, sought statements from the nursing staff and doctor involved in the deceased's care on the night before his death. As the coronial investigators experienced some difficulties obtaining all of the necessary information from relevant witnesses, the State Coroner directed that the matter should be listed for an inquest.

Inquest findings and comments

The coroner found that death was as a result of bronchopneumonia and acute bronchiolitis, and occurred by manner of natural causes.

A chest X-ray performed two days before the death revealed no sign of infection, suggestive of a rapidly progressive course.

Coroner's recommendation

The coroner did not make any recommendations in this matter.

WA health system actions

A clinical review into the death was undertaken and identified issues with record keeping of phone conversations; and, gaps in secondary assessments of patients prior to discharge in the physical absence of a doctor, which were addressed locally.

Emergency Telehealth Service (ETS) is now available at the site daily from 8.00 am to 11.00 pm, outside of which medical support is provided via telephone and videoconference. ETS was newly introduced and on trial at the time of the incident.

References

- [BROADRIBB inquest findings](#)¹⁷

Discussion points

- Why is it important to cultivate a 'no-blame' culture when clinical incidents are identified and investigated?
- What support is available to you if you have been involved in a case before the coroner or a serious clinical incident?

¹⁷ http://www.coronerscourt.wa.gov.au/l/inquest_into_the_death_of_donald_richard_broadribb.aspx?uid=1542-5988-2204-3500

Care of adolescent in adult service

Key Messages

- The risk of suicide can be dynamic, and risk assessments should be patient specific and reviewed whenever the clinical situation changes.
- Adolescent patients may be at increased risk when admitted to general adult wards. This risk should be taken into account when considering safe placement.

A 17-year-old boy died as result of ligature compression of the neck (hanging) while he was an involuntary patient under the *Mental Health Act* at the time.

The deceased was treated for Attention Deficit Hyperactivity Disorder (ADHD) from age three and suffered sexual abuse until age eight. He had behavioural issues, learning disability and ongoing social issues throughout his school life, and he took dexamphetamine until 16 years of age. About six months before his death, the deceased was referred by his GP to a community paediatrician in view of the practical difficulties in accessing adult psychiatry services for ADHD.

The deceased presented to the emergency department following an overdose of his regular ADHD medication after an argument with his girlfriend. He was admitted to the general ward as a voluntary patient in the care of a Senior Medical Practitioner (SMP) under the shared care model in place at the time.

The deceased was reviewed regularly during his admission by the SMP, adolescent mental health staff and once by a psychiatry registrar. He was assessed as having a moderately severe depressive episode with anxiety, high lifelong risk of suicide, but low to moderate immediate risk and was adequately contained in the hospital environment. He was commenced on fluoxetine and quetiapine, and was to remain in hospital with further inpatient review planned after the weekend.

The night before his death, the deceased informed his nurse that he had attempted to hang himself in the bathroom. Overnight he was moved to a single room with orderly guard. The SMP was informed in the morning about the suicide attempt and the fact that there was no physical evidence that he had actually done what he had said. The SMP had a brief encounter with the deceased that morning when he appeared relaxed when he greeted the doctor. The SMP returned to review the deceased later that afternoon but he appeared to be sleeping so was not disturbed.

Around mid-afternoon the deceased had a disagreement with his mother following which he ran out of the ward. Search attempts were made but were unsuccessful and the police were notified. About an hour later, he was found by a cyclist hanging by a rope around his neck from a tree in a local park.

Inquest findings and comments

The inquest found that death occurred as a result of ligature compression of the neck (hanging) and by manner of suicide.

The coroner considered that the hospital staff had done their best, with the resources available at the time, to provide the deceased with appropriate medical care whilst respecting his right to be treated in the least restrictive manner available.

The deceased's admission to the general ward rather than the mental health unit or transfer to Perth was discussed. The adult mental health unit was described as a less than ideal place for an adolescent, although more input from nurses with experience in mental health would have been available there.

Coroner's recommendation

The coroner did not make any recommendations in this matter.

WA health system actions

The shared care admission model has been replaced by direct admission under the care of a psychiatrist.

There has been increased staffing, including the recruitment of staff trained in child and adolescent mental health.

The hospital has been rebuilt and contains a new mental health unit; however there is currently no specific area or beds set aside for patients under 18. Adolescents can be admitted there with a chaperone instead of only to the general ward. Patients are now automatically moved from the general ward to the mental health unit (with chaperone) following suicide attempt until assessed by psychiatrist.

Standardised forms have been introduced, including suicide risk assessment forms.

References

- [DELLAR inquest findings](#)¹⁸

Discussion points

- How can we best manage vulnerable adolescent patients in adult facilities whilst awaiting specialist adolescent services?
- Under what circumstances can adolescent patients be admitted to adult wards? What requirements must be met under the *Mental Health Act 2014*? What specific risks need to be addressed?

¹⁸ http://www.coronerscourt.wa.gov.au/Inquest_into_the_death_of_jesse_richard_dellar.aspx?uid=4488-2736-1452-3980

Missed opportunities

Key Messages

- Factors other than primary mental illness can contribute to the risk of suicide and services have a responsibility to respond to a range of behavioural and social issues contributing to risk.
- Chronic longitudinal risk may relate to multiple factors and therefore many windows of opportunity for intervention may present during a person's life.

A 42-year-old Aboriginal man was found to have died of unascertained cause.

The deceased had an extensive forensic history, with history of alcohol and drug induced psychotic symptoms, and frequently presented to various hospitals with suicidal ideation when intoxicated. He did not engage with rehabilitation services. Other than regular depot antipsychotic medication, with which he was compliant, it was felt the scope for psychiatric intervention or treatment was limited.

In the month prior to his disappearance, the deceased tried to visit his children in Perth, but was prevented in doing so by his sister as he was intoxicated. He also found out that his brother had died around this time. He presented to two hospitals over the next few days, initially after cutting himself whilst intoxicated. He had psychiatric review, with input from Aboriginal Liaison Service and Social Work, whereby he stated his intention to attend his brother's funeral, then to go bush and shoot himself. He was deemed to be at chronic risk of self-harm but with little indication for psychiatric input. A few days later he was admitted to hospital overnight following an alleged assault with possible pancreatitis. The Aboriginal Liaison Team was again involved and he was discharged.

In early 2008, he was reported missing by his family and subsequent police investigations provided evidence suggesting that he was deceased.

Inquest findings and comments

An open finding was made regarding the manner of death, after consideration of possibilities of suicide, homicide, and deteriorating general health.

Coroner's recommendation

The coroner did not make any recommendations in this matter.

References

- [EURA inquest findings](http://www.coronerscourt.wa.gov.au/linquest_into_the_death_of_anthony_charles_eura.aspx?uid=2009-3198-8817-1920)¹⁹

¹⁹ http://www.coronerscourt.wa.gov.au/linquest_into_the_death_of_anthony_charles_eura.aspx?uid=2009-3198-8817-1920

Discussion points

- The provision of specialised services can have the unintended effect of creating 'silos' of care. How can your service ensure holistic care for patients with concomitant problems such as drug and alcohol use, chronic physical health problems, or social issues such as housing insecurity, familial conflict, or financial stress?

Persecutory delusions and cannabis

Key Messages

- The definition of risk is broader than just physical harm and risk assessment should consider psychological harm.
- Potentially paranoid preoccupation involving children or other vulnerable people should be of great concern and is a flag for proactive specialist mental health follow up.
- People often access multiple services, and it can be difficult to effectively coordinate care.

A 46-year-old woman took the lives of her daughters aged 10 and 12 years and then ended her own life.

The deceased had been involved in a prolonged custody battle for her three children with her ex-husband. While custody arrangements and access to the children varied over the course of the dispute, the children were living with their father and visiting the deceased at the time of their death.

The deceased suffered from chronic paranoid delusions and came to the attention of the Mental Health Emergency Response Line (MHERL) through the police when she contacted them with allegations that prominent figures were conspiring to sexually assault her children.

This was escalated to the regional Mental Health Service who contacted the deceased and invited her to attend the mental health service or discuss any problems. The offer was declined and the deceased also denied any intention of harming herself or others.

The Mental Health Service then wrote a letter to the local medical centre alerting them of the deceased and highlighting that that whilst they were not currently concerned about any risk factors, should she come to the attention of doctors at the medical centre, antipsychotic medication may be a useful treatment. While the deceased was subsequently seen thrice at the medical centre, the doctor there had found no indication of a mental health illness in the deceased and denied having seen the letter from the Mental Health Service.

The deceased had contacted the Crisis Care Unit and the police on multiple occasions with delusions and conspiracy theories including that her children were being sexually assaulted by multiple people. At no time were any specific safety concerns identified for the children.

Yet another occasion of contact with the health service was when the deceased saw a mental health nurse at a medical centre with a view of obtaining a letter to support her claim as a fit person to look after the children. Neither the mental health clinician nor the court-appointed clinical psychologist, nor the clinical psychologist whom she consulted for stress about two months before her death, identified any mental health issues in the deceased or thought that she would be a danger to herself or her children.

The deceased continued to suffer from increasing paranoia and delusions in the week leading up to the deaths and she continued to use cannabis.

On the day before the incident the deceased's daughters told their playmate that their mother had been 'acting crazy' and had been walking around with a Bible, saying something like 'Don't give your soul to the devil' and talking of demons and cleansing the soul.

The two girls were discovered dead by their grandmother. The police were called and the deceased was found dead in a locked bathroom in the house.

Inquest findings and comments

The cause of death was found to be multiple sharp force injuries for all three deceased; and, by manner of suicide for the mother, and by manner of homicide for the daughters.

The coroner inferred that the deceased's mental health illness, with chronic paranoid delusions exacerbated by cannabis abuse, and prolonged stress contributed to the events leading up to the deaths.

Coroner's recommendation

The coroner recommended that:

1. That the Department of Child Protection and Family Services and the Family Court of Western Australia, including independent children's lawyers, develop and implement a procedure to share proactively, where appropriate, information relevant to the health and safety of children the subject of custody disputes.
2. That the Family Court of Western Australia provides litigants in custody disputes with information indicating how mental illness may be considered by the Court
3. That steps be taken by Government to ensure so far as practicable that judges of the Family Court are able to obtain psychiatric reports when required to determine the best interests of children the subject of custody disputes.

While not a recommendation, the coroner highlighted the importance of reinforcing public education and awareness campaigns on the dire psychological consequences of cannabis use.

WA health system actions

Since this incident, there have been a number of initiatives within the regional mental health service to improve the provision of care to mental health clients including: a documented risk assessment of every client who consents to an assessment; and, a documented plan of action for each client developed by a team comprising a psychiatrist, the triage officer, the team leader and clinical nurse specialists, which includes collaboration with local services and police in an emergency.

While a one-stop-shop model with a single point of triage for all mental health services, from where a person could be referred to the appropriate agency, and more transparent sharing of information, was suggested by the coroner as the model for future consideration particularly in regional areas, the limitations on funding impacting the ability to achieve this at the present time was acknowledged.

References

- [GLEDINNING inquest findings](#)²⁰

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http://www.coronerscourt.wa.gov.au//inquest_into_the_deaths_of_heather_glendinning_and_jessica_rose_cuzens_and_jane_lesley_margaret_cuzens.aspx?uid=8480-1604-1418-4773

Discussion points

- The provision of specialised services can have the unintended effect of creating 'silos' of care. How can information sharing across agencies be maximised? How can fragmentation of care be minimised?
- Services have a professional and ethical responsibility to actively track risk going forward. How can individual health practitioners link together disparate episodes of care to identify underlying longitudinal escalating risk?

Opportunities for improving care

Key Messages

- There is a need for clarity around the agreed roles of health care workers and family members and carers.

A 75-year-old woman died from sepsis arising from contaminated pressure sores.

She had fractured her hip a few years before her death, and due to her fear of having another fall, spent much of each day seated on a chair. She had trouble with slowly healing leg ulcers, and pressure sores on her heels, thighs and buttocks. She had Type 2 diabetes, requiring insulin, and congestive cardiac failure, both of which contributed to the slow healing of wounds.

During a three week admission to hospital her pressure sores were reviewed, and gradually improved. The deceased was provided with a specialised pressure area care cushion and advised about pressure relief for the affected areas; however she did not use the cushion when she returned home.

An Aged Care Assessment Team (ACAT) recommended that she would best be looked after in residential care, but the deceased and her family declined this, preferring to look after her in the family home where she lived with her son. Her daughters lived nearby and helped with meals and housework. The highest level home care package was approved, allowing for personal carers and a nurse to visit three times a week to assist with showering and wound dressings. The deceased managed her own medication doses, with family assistance, and insisted on managing her own dentures. She was incontinent of urine and faeces, and told her family that she was able to change her own incontinence pads without their involvement. At times she refused care of her pressure areas and ulcers.

Over the next ten months she was visited at home by a regular team from a private home care service provider. The nurse visiting her home was often hindered by insufficient supplies of dressings from the home care service provider, as well as difficult documentation processes including a lack of integrated progress notes for each client, and no provision of wound assessment forms.

Initially she was relatively active; able to look after her own grooming and toileting, but gradually became less independent and mobile. Increased assistance with bathing was arranged, but the budget allocated in the home care package did not allow for daily dressings of her pressure sores.

Two months before her death the deceased's pressure sores deteriorated. She was seen at home by a locum GP when she developed a urinary tract infection, but she refused to get up from her chair to allow full examination. She was later seen at a local emergency department with back pain, though it is likely her sacral wounds were not seen by hospital staff.

In the weeks before her death there was breakdown of skin and some very deep sacral wounds. The visiting nurse raised her concerns over these with the deceased, her family, and her manager. The deceased did not change her habit of sitting on a chair for prolonged periods of time. The deceased became quite unwell and after initially refusing to go to hospital, was taken to the emergency department. Concern was raised about her care at home as hospital staff noted the contaminated deep sacral pressure sores, and that her dentures were blackened and

discoloured. She had developed sepsis and acute kidney failure. Despite antibiotics and medical management she died a few days later.

Inquest findings and comments

The coroner found that death was caused by organ failure due to sepsis from infected pressure sores, and by manner of natural causes.

The coroner commented that the infection resulted from deterioration in her condition in circumstances where, due to choices she consciously made, the likelihood of life-threatening infection was significant.

The coroner remarked that the family, the deceased, and the home care service provider staff members did not share a common view of roles and responsibilities for various aspects of the deceased's care. The coroner also commented on the failure to escalate the provision of care for the deceased as her condition declined – whilst the home care service provider was providing the maximum services available in the home care package, options such as purchasing increased services, or increased assistance from family members were not discussed.

Coroner's recommendation

The coroner made the following recommendations:

1. That, home-care providers assess their patients' needs on an on-going basis and, where a home-care provider considers that the care it is able to provide to a patient under a home-care provider meet with the patient and the patients' next of kin where appropriate to so inform the patient and to discuss the patient's further care.
2. That, if reasonably practicable, organisations providing home-care generate a document describing the roles and responsibilities of each person involved in a patient's care, including where applicable the patient's family or friends, and provide a copy of such a document to those persons at the outset of that care and from time to time when reasonably necessary.

WA health system actions

The Australian Government announced significant reforms to home care in the 2015-16 financial year under the 'Increasing Choice in Home Care' program. From February 2017 all home care packages have been provided to individual consumers rather than to approved home care providers. This change now gives consumers the ability to choose their provider, and change providers when their needs change.

The WA Department of Health forwarded the coronial inquest findings to the Commonwealth Department of Health for their attention.

References

- [NICEFORO inquest findings](#)²¹

²¹ http://www.coronerscourt.wa.gov.au//inquest_into_the_death_of_maria_carmel_niceforo.aspx?uid=6820-8095-3149-9805

Discussion points

- What screening measures and initiatives exist to ensure problems such as pressure sores, delirium, risk of falls, and elder abuse are not missed when patients enter an acute care setting?

Paediatric sepsis

Key Messages

- Sepsis has a high mortality rate and requires early recognition and resuscitation.
- All attendances to an emergency department should undergo standardised processes of triage, clinical review, and documentation.

A 6-year-old boy died of undertreated pneumonia in a regional hospital.

A few days prior to his death, his father, a registered nurse, had taken him to the hospital where he worked. Whilst the deceased had been unwell for a few days with flu-like symptoms and a rash, his father was paying a social visit to colleagues rather than seeking treatment for his son. His colleagues noticed the bright red rash, and suggested the boy be looked at by one of the doctors.

Without going through the normal triage process, a locum doctor was asked to review the deceased. The doctor felt it was most likely the boy was suffering a viral illness, as he did not have classic signs of scarlet fever or tonsillitis; however she wrote a prescription for antibiotics to be used if he became unwell. This consultation was not documented.

The following day the boy's mother, also a nurse at the hospital, took him back to the emergency department as he was still unwell with fever, rash, and a cough. The GP who saw him ordered a chest X-ray, and asked the locum doctor to review it as his shift was ending. There was some discussion at the inquest about the need to assess the boy's condition as well as the X-ray prior to discharge, and whether this was made clear in the handover.

The locum doctor reviewed the X-ray, considered it was normal, and discharged the boy home again. The radiologist's X-ray report was available the following day and indicated pneumonia.

The following day the deceased's mother took him to a medical centre, where the GP thought that he most likely had scarlet fever. The GP referred him back to the hospital for admission, where he was noted to have a fever, dehydration, and was in respiratory distress. He was admitted to the high dependency unit by the paediatrician on duty. Intravenous penicillin and maintenance fluids were commenced. During the afternoon and evening the deceased remained unwell, in a state of compensated septic shock with marked tachypnoea and tachycardia, until he deteriorated in the middle of the night and was unable to be resuscitated.

Inquest findings and comments

The coroner found that death was as a result of pneumonia complicating influenza A H1N1 infection and by manner of natural causes.

The issuing of a prescription for antibiotics to be used at the parents' discretion was discussed. The coroner noted conflicting opinions from expert witnesses and the NICE guidelines as to whether delayed prescriptions were an appropriate treatment strategy.

The coroner noted that there had been a delay in the availability of the X-ray report from the deceased's second presentation to the emergency department. It had been reviewed by the radiologist the following day and a typed copy of the report was not available until several hours later.

The coroner noted that the paediatrician's failure to diagnose and treat compensated septic shock meant the care provided was below the level expected. At the time of the inquest however, he was no longer working as a doctor in Australia.

Coroner's recommendation

The coroner made the following recommendations:

1. I recommend that the Department of Health determine whether doctors in the public health system should employ the strategy of delayed prescriptions of antibiotics, and provide guidance accordingly.
2. I recommend that the Western Australian Country Health Service consider and, if practicable, implement a procedure to ensure that, where appropriate, radiologists' reports of X-rays of children with potentially serious illnesses are provided to requesting clinicians with the least possible delay.

WA health system actions

A memorandum was issued requiring all employees and their family and friends presenting to the emergency department to do so via triage. Similar directives were issued at other sites across Western Australia. This has been followed by a policy requiring all patients presenting to country hospitals and nursing posts to be assessed and triaged appropriately.

Work was undertaken at the site to improve documentation, including the introduction of colour-coded graphical paediatric observation charts with escalation protocols.

The Coronial Review Committee members considered the strategy of delayed prescriptions and agreed that antimicrobial use was adequately governed by policies and guidelines and that delayed prescription might be an appropriate strategy in particular cases, and that clinical judgement would best determine which cases it could be employed.

There has been an improvement to real time reporting for radiology in regional areas, and there is now provision for after-hours review and reporting.

References

- [PARMAN inquest findings](#)²²

Discussion points

- What contributing factors can you identify from this case and what actions could be taken to minimise recurrence? Could this happen at your site?
- What systems and processes are in place to ensure adequate clinical handover of patients?

²² http://www.coronerscourt.wa.gov.au//inquest_into_the_death_of_sebastian_keith_parman.aspx?uid=1273-6573-1833-1330

Methadone toxicity

Key Messages

- Patients with mental health illnesses often have coexistent drug and alcohol problems – managing drug and alcohol issues is a core function of general mental health services.
- Sedating medication should be carefully monitored.

A 23-year-old man died as a result of combined drug toxicity due to being recommenced on methadone as an opioid substitute whilst an inpatient.

The deceased had a complex psychiatric and drug history and was diagnosed with schizophrenia in early adulthood. He had also been using illicit drugs since a young age, including marijuana, methamphetamine and then opioids. He had been attempting to seek assistance to wean off these drugs and had been on a methadone program for several years. He had multiple admissions for overdoses and psychotic episodes.

The deceased had been admitted as a voluntary patient to a hospital facility due to poor compliance with his anti-psychotic medications resulting in an exacerbation of his psychotic symptoms. On admission it was noted that 19 weeks had passed since his last methadone dose and it was decided that he was to be restarted on methadone. Hospital staff sought advice from an alcohol and drug treatment agency regarding an appropriate dosing regime, and were advised to commence the deceased on a higher starting dose than normal, with more rapid increased doses than usual. It was thought that due to his background of ongoing illicit opioid use, a higher dose would be required to settle his symptoms, and would be safe as he would be under closer observation in the hospital than in the community.

There was an assumption that hospital staff would have knowledge on the effects of methadone and monitor him accordingly. A few hours after his dose of methadone on the fourth day of treatment, he was noted to be more sedated than usual and went to his room. Visual observations were conducted over the next 90 minutes but when a nurse approached closer to check his vital signs, he was found to be unresponsive and cyanosed. Resuscitation attempts were unsuccessful.

Inquest findings and comments

The coroner found the cause of death was as a result of combined drug toxicity. The manner of death was by way of misadventure.

Expert opinion at inquest was that it was appropriate to restart methadone and the starting dose was reasonable. The inquest highlighted that it was important to conduct observations regularly and to be aware of the risks of methadone reintroduction.

Coroner's recommendations

The coroner made the following recommendations:

1. The Western Australian Department of Health give consideration to amending the current operational directive to cover all use of methadone in a hospital setting, whether as an

opioid substitute or otherwise. In particular, the directive should include information about the specific risks associated with commencing or re-commencing a patient onto methadone with guidelines on how such a patient is to be safely managed.

2. The Western Australian Department of Health and the Mental Health Commission give consideration to funding and placing specialist consultants within health care services to ensure the goal of integrating mental health and drug and alcohol services is progressed.
3. The Western Australian Department of Health give consideration to funding and facilitating training for staff at health care centres regarding this area.

WA health system actions

Since this incident, the introduction of a physiological chart as well as a guideline regarding the frequency of observations has been introduced in the health service to improve recognition and response to clinical deterioration. Policy guidance for prescribers in relation to prescribing medications for these patients have been developed and reinforced. The Mental Health Commission is better integrated within the health service, improving connections between those with mental health illnesses and drug and alcohol problems.

The Protocol for the 'Management of Community Program for Opioid Pharmacotherapy (CPOP) patients in a hospital setting' will be reviewed and is expected to include the use of methadone in opioid substitution and pain management, and information for health practitioners about specific risks associated with commencing or recommencing a patient onto methadone.

An arrangement has been made for an Addiction Medicine Consultant to work at the mental health service to provide consultation and treatment advice for managing patients with complex comorbidity mental health and drug and alcohol issues. This arrangement will be supported by a Memorandum of Understanding.

References

- [REID inquest findings](#)²³

Discussion points

- What policies, procedures, support mechanisms and other sources of information exist at your site for the management of patients with drug or alcohol problems?

²³ http://www.coronerscourt.wa.gov.au/linquest_into_the_death_of_geoffrey_mark_reid.aspx?uid=3141-1968-4001-5460

Chronic mental and physical illnesses

Key Messages

- Patients with chronic mental health problems often have a significantly decreased life expectancy compared to that of the general population due primarily to physical illness (not suicide).
- Facilitating physical health care for individuals with mental illness is a core function for mental health and general health services.

A 62-year-old man died as result of bronchopneumonia on a background of chronic obstructive pulmonary disease (COPD). He was an involuntary patient under the *Mental Health Act* at the time due to treatment-resistant schizophrenia.

The deceased had a long history of treatment resistant schizophrenia, complicated by his itinerant lifestyle and poor compliance with medications. He moved to Perth from NSW about 18 months before his death after absconding from a psychiatric unit there. His sister had recently been appointed as his guardian.

The deceased was admitted to a non-tertiary hospital about eight months before his death where he remained an involuntary patient until his death. His involuntary status was based on his chronic psychotic symptoms (grandiose delusions), his poor insight and judgement and the risk he posed to himself in a less restrictive setting.

The deceased had developed COPD as the result of heavy smoking, but believed the best treatment for his condition was to smoke more cigarettes. He often refused more conventional treatment such as inhaled steroids or antibiotics.

He developed type II respiratory failure four times during his admission, and was transferred each time to a tertiary centre for care. These episodes were often complicated by his aggressive refusal of medication, and need for security guards and physical restraint at times. His family expressed a wish that he remain at the non-tertiary hospital where he was relatively more settled, in full knowledge of the reduced level of medical care that could be provided there. It was clear that he was not physically well enough to be transferred back to NSW. His family made clear their wishes for no active resuscitation efforts in the event of his deterioration.

On the evening of his death, the deceased complained of feeling “not too good” and developed difficulty in breathing; eventually becoming non-responsive and dying that night.

Inquest findings and comments

The inquest found that death occurred as a result of bronchopneumonia on a background of COPD. The coroner found the manner of death was natural causes.

The coroner was satisfied that the deceased was given a high standard of care whilst at the hospital and that his death was anticipated due to the ongoing progression of his lung disease. The coroner found that efforts were made to keep the deceased as comfortable as possible during his final decline, while still managing his psychiatric symptoms.

Coroner's recommendation

The coroner did not make any recommendations in this matter.

References

- [RYAN inquest findings](#)²⁴

Discussion points

- This case explores the resolution of conflict between patient autonomy and medical paternalism. How does your health service navigate similar conflict?

²⁴ http://www.coronerscourt.wa.gov.au/l/inquest_into_the_death_of_giovani_wade_ryan.aspx?uid=4632-4451-4572-1795

Sepsis of unknown origin

Key Messages

- Sepsis may be difficult to identify in the early stages.

A 69-year-old woman died from multiple organ failure due to sepsis of unknown origin.

The deceased initially presented to a regional hospital after a fall where she sustained a spiral humeral fracture. After review and treatment, which included intravenous morphine for pain relief, she returned home.

She returned to hospital the following day reporting nausea and vomiting. There were concerns about a possible reaction to the morphine and susceptibility to renal impairment. She was admitted overnight and given intravenous fluids and her medications were adjusted.

The deceased presented again three days later with ongoing pain and her analgesia medication was changed.

Her last presentation five days later was with two days of vomiting and acute renal failure. Her husband had himself become unwell, and was unable to care for the deceased. She was assessed and commenced on oral rehydration as intravenous access was not able to be obtained. There was difficulty in obtaining a public or private hospital bed due to bed shortages; however, she was transferred to a metropolitan private hospital later that evening. After some initial signs of improvement, the deceased's condition deteriorated and she was admitted to the ICU in septic shock four days after admission. She died a week after admission.

No cause for sepsis was found on investigation with the exception of an infected left toe, which had been surgically removed during her time at the private hospital.

Inquest findings and comments

The coroner found that the deceased died as a result of multiple organ failure due to sepsis of unknown origin, and by manner of natural causes.

Expert opinion given at inquest was that the care provided to the deceased was reasonable in the circumstances existing at the regional hospital in 2012.

Expert opinion concluded that the deceased was a diabetic who did not have chronic renal impairment, but had kidneys vulnerable to insult such as dehydration which had previously recovered with appropriate rehydration. The coroner identified that the original death certificate was inaccurate in that the patient had never suffered chronic renal failure.

The coroner appreciated the family's concerns regarding her care but could find no evidence that a different course of action would have changed the outcome for the deceased.

Coroner's recommendation

The coroner did not make any recommendations in this matter.

WA health system actions

The coroner noted staffing changes at the regional hospital including the introduction of emergency medicine specialists in the ED and the introduction of observation charts and handover aids.

The coroner also noted that there is no indication that these measures would have altered the outcome for the deceased, although it may have provided reassurance to the family that appropriate care was provided.

References

- [SAULYS inquest findings](#)²⁵

Discussion points

- What standards, systems and processes exist to support patient centred care and to encourage engagement with carers?
- What observation charts are used at your site? How are actions triggered, and what are those actions?

²⁵ http://www.coronerscourt.wa.gov.au/linquest_into_the_death_of_janice_may_saulys.aspx?uid=1234-1450-3737-2347

Death of an asylum seeker

Key Messages

- Careful discharge planning should involve the patient, their family, carers, and support services. It is important to consider the availability of such supports after discharge especially over holiday periods.
- Transition between services is a high-risk period – timing for follow-up must reflect the urgency of an individual's needs.

A 39-year-old man died of hypoxic brain injury and organ failure following hanging. He was on a bridging visa having been released from an immigration detention centre four weeks before his death.

The deceased was an illiterate Tamil fisherman who had left his wife and child behind in Sri Lanka and travelled to Australia by boat, following his younger brother who had made the journey four months earlier. He was detained as an Irregular Maritime Arrival for five months in several detention centres. Whilst in detention he spoke of a desire to return to his wife and child in Sri Lanka, but later disclosed he was fearful of the possibility of torture if he returned home.

He received support from mental health staff during his time in detention. He had no prior history of mental illness, but was described as being stressed and anxious, isolated and lonely, and had difficulty understanding information and instructions. Antidepressants were trialled without success, and he took diazepam to help him sleep. Staff members were concerned over his mental health, and how he would manage his affairs in the community. The deceased underwent assessment by a psychiatrist a month prior to his release from detention, and it was felt that there was no evidence of depression or risk of self-harm, but that he needed social support. It was considered that releasing him on a bridging visa to live with his brother in Perth, with support from a non-government community service provider, would be the best approach. He was released from detention in early December.

Staff from the non-government organisation (NGO) arranged and paid for his flights to Perth, met him at the airport and took him to his brother's house. He met with his case manager a week after arriving in Perth, having attended two orientation sessions run by the NGO. The deceased brought the assessment prepared by the psychiatrist, and the case manager made a GP appointment for him for a fortnight later, but this was later cancelled as there would be nobody available to accompany the deceased to the appointment. A few days before Christmas the case manager contacted the deceased by phone, to discuss the GP appointment, and to inform him that the NGO would be closed over the holiday period, opening again in the New Year. She gave him information on emergency contact numbers for the NGO, and on calling '000' for emergencies.

Around Christmas the deceased became very quiet and withdrawn. He made three self-harm attempts, including placing a rope around his neck. His brother called the police for assistance, and the deceased was taken to hospital for review.

A psychiatric liaison officer interviewed him with the assistance of a telephone interpreter. Whilst admitting to being stressed and depressed, he stated his mood was good, and that the attempts to harm himself had been a mistake and would not happen again. A diagnosis of adjustment disorder was made, with risk of suicide deemed to be low. The nurse discussed this and plans for discharge with the emergency department registrar, but not with any other members of the psychiatric team. The plan for discharge was that the NGO would organise referral to a GP, or

to outpatient psychiatry or psychology services if necessary. He was asked to talk to his brother or to return to hospital if he had further thoughts of self-harm.

After discharge, the deceased deteriorated further, requiring prompting from his brother in every activity of daily living. His brother was very concerned, and made several attempts to contact the NGO, unfortunately calling the phone of the case manager who was on leave rather than the after-hours emergency number she had provided for use during the holiday period.

Less than a week after visiting hospital, the deceased hanged himself whilst his brother and other housemates were out. He was taken to hospital and resuscitated, but had sustained severe hypoxic brain injury and life support was withdrawn three days later and he died.

Inquest findings and comments

The coroner found that death arose by way of suicide.

The care provided by the Department of Immigration and Border Protection (DIBP) was reviewed, and the decision to release the deceased on a bridging visa rather than into community detention was discussed. Community detention was often preferred for individuals with significant physical or mental health issues because a higher level of support and supervision could be provided. However, as the deceased was able to live with his brother who had also arrived in Australia by boat some months previously, it was felt that further detention would not be necessary. He was eligible for six weeks of transitional support under the Commonwealth Community Assistance Support program via an NGO, including assistance in accessing medical and counselling services and orientation to the community. He was required to lodge a protection visa application during that time.

The DIBP acknowledged that many individuals managed under section 189(3) of the *Migration Act* are very vulnerable, and that the length of time required to process asylum claims exacerbates their distress. This is true for those in the community as well as those in detention centres. A psychiatrist has subsequently been appointed as Chief Medical Officer for the DIBP and has been tasked to improve the DIBP's processes around mental health. Greater access to torture and trauma counselling services has been provided.

The NGO has been able to access increased funding to provide suicide prevention training for its staff, and has developed a casework model for working with clients who experience suicidal ideation. The NGO has also seen an increase in client numbers and complexity.

Expert opinion of the care provided on the first visit to hospital was that there were missed opportunities for a more comprehensive assessment and for community follow-up to be organised. There were obstacles to conducting a full assessment, including language and cultural barriers, and it appeared the hospital staff were not aware of the NGO's lack of availability over the holiday period.

Coroner's recommendation

The coroner did not make any recommendations in this matter.

References

- [SELLAKATHIRKGAMAN inquest findings](#)²⁶
- [Chief Psychiatrist's Standards for Clinical Care](#)²⁷

Discussion points

- What additional vulnerabilities are conferred by the background and life experiences of asylum seekers and refugees, and what risks do they present to the provision of health care?
- What challenges are involved in the use of translation and interpretation services? Can it ever be appropriate to use a friend or relative as an interpreter?
- The Chief Psychiatrist's *Standards for Clinical Care* contains criteria for ensuring continuity, safety and quality of care for consumers and carers is maintained during transfer either between or within services. What does your service do to ensure it meets these standards of care?

²⁶ http://www.coronerscourt.wa.gov.au/linquest_into_the_death_of_anandakumar_sellakathirkgaman.aspx?uid=2280-6163-2676-2118

²⁷ http://www.chiefpsychiatrist.wa.gov.au/wp-content/uploads/2015/12/CP_Standards_2015.pdf

Death in custody

Key Messages

- Prisoners do not have the freedom to arrange their own medical care, and thus health care workers have a heightened duty of care towards them.
- Vital signs provide critical information regarding the general physical health of a person.

A 22-year-old Aboriginal woman died from undetected septicaemia whilst in police custody.

Four months prior to her death, the deceased had sustained two rib fractures. Whilst treated appropriately at the time, it is likely they never healed fully. She intermittently used amphetamines intravenously over the following months, and it is likely that this was a source of recurrent bacteraemia.

When she was taken into police custody over a matter of outstanding fines, the deceased complained to prison staff of pain from her old injury. She was taken to the local rural hospital for review at the emergency department. At triage, one of the police officers accompanying the deceased informed hospital staff that she had only started to complain of pain when informed she was to stay in the cells overnight. This was reiterated to the doctor who assessed the deceased, who reported having difficulty obtaining an adequate history from the deceased.

Her vital signs were normal and examination revealed no signs of acute illness. The treating doctor recorded that her impression of the deceased's condition was "behavioural gain" and after prescribing a strong analgesic and some diazepam, signed the 'Fitness to Hold' form and discharged the deceased back to police custody with instructions to return if her condition changed.

The following morning the deceased again complained of pain but wanted to sleep instead of return to hospital for review. During the afternoon, she was informed she'd be in custody for four days in lieu of payment as family could not assist with payment. She complained of pain again, and was taken back to hospital. At triage she disclosed recent use of marijuana and amphetamines prior to being taken into custody. The triage nurse noted that she was moaning with pain, had a fast heart rate and appeared dehydrated with warm skin. Her heart rate was 124 bpm but her temperature was not taken.

The emergency department was much busier that day, with staffing shortages and an unusually high number of patient attendances; the deceased waited for two hours in the air-conditioned police van before being seen by a doctor. The treating nurse did not check the triage notes; once again noted a fast heart rate and breathing rate; and did not take her temperature due to a lack of available thermometers.

The doctor who assessed her again noted a difficulty in assessing the deceased. He did not note her vital signs but included bedside ultrasound in his assessment, excluding pneumothorax and abdominal abnormality. His diagnosis was possible drug withdrawal and behavioural issues. He signed the 'Fitness to Hold' form and discharged her to police custody with another dose of Valium.

The following morning the deceased was very unwell. She was unsteady on her feet, vomited several times, and asked to be taken back to hospital. The police officers delayed transferring her to hospital for several hours, but when they noted she had collapsed and was unable to

stand, they dragged her from her cell and carried her to the police van in order to drive to hospital. On arrival at the emergency department the deceased went into cardiac arrest. Resuscitation attempts were not successful.

Inquest findings and comments

The coroner found that death was as a result of staphylococcal septicaemia and pneumonia in a woman with osteomyelitis complicating a previous rib fracture, and that death occurred by manner of natural causes.

Coroner's recommendation

The coroner made a number of recommendations in this matter. In connection with medical information provided by medical staff to police on the health of detainees, the coroner made the following recommendation relevant to WA health:

5. That Parliament consider whether legislative change is required in order to allow medical clinicians to provide the Western Australia Police Service with sufficient medical information to manage a detainee's care whilst in police custody. Allied to this is a consideration of the safeguards concerning that information.

WA health system actions

The issue of sharing medical information with WA Policy has been discussed by the Medical Directors' Forum. It was noted that section 217 of the *Health Services Act 2016* provides for disclosure of information by a Health Service Provider provided that it is, or is likely to be, relevant to:

- a) the treatment or care of a patient who has been, is being, or will or may be, provided with a health service by the health service provider
- b) the health, safety or wellbeing of a patient who has been, is being, or will or may be, provided with a health service by the health service provider.

The *Health Services Regulations 2017* were proclaimed in November 2017.

In relation to a recommendation, which was not directed at the WA health system, but which related to cultural training, the WA Department of Health reports that it has well established online and face-to-face cultural training programs which are being well utilised. It has been reported that 85% of regional staff have completed the online training and there is a 74% completion rate across the WA health system.

References

- [MS DHU inquest findings](#)²⁸

Discussion points

- Stigma associated with drug or alcohol use can contribute to misdiagnosis. What other patient factors might influence unconscious bias in health practitioners?
- What types of cognitive bias are there, and how do you guard against them?

²⁸ http://www.coronerscourt.wa.gov.au//inquest_into_the_death_of_ms_dhu.aspx?uid=1644-2151-2753-9965

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