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

Progress Report for Health-Related Coronial Recommendations

Biannual Report – February 2022 Executive Summary

Acknowledgements

The past Chair of the Coronial Review Committee, Dr Michael Levitt, Chief Medical Officer and current Chair Professor Alison Jones, Acting Chief Medical Officer, Department of Health, Western Australia would like to acknowledge:

The patients and their families

The Office of the State Coroner, Western Australia

The Office of the Chief Psychiatrist, Western Australia

Department of Health staff, Western Australia

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

All WA health system staff involved.

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

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Abbreviations

ACEM	Australasian College for Emergency Medicine
ALO	Aboriginal Liaison Officer
ATSI	Aboriginal and Torres Strait Islander
BUG	Business User Group
CAHS	Child and Adolescent Health Service
CARE Call	Care and Respond Early Call
CaLD	Culturally and linguistically diverse
CLU	Coronial Liaison Unit
CPU	Child Protection Unit
CRC	Coronial Review Committee
EMHS	East Metropolitan Health Service
FSFHG	Fiona Stanley Fremantle Hospital Group
FSH	Fiona Stanley Hospital
GP	General Practitioner
HSP	Health Service Provider
HSS	Health Support Services
HWS	Healthy Weight Service
KAHPF	Kimberley Aboriginal Health Planning Forum
KEMH	King Edward Memorial Hospital
MGP	Midwifery Group Practice
MH	Mental Health
MHC	Mental Health Commission
MMHSN	Multicultural Mental Health Subnetwork
NaCS	Notifications and Clinical Summaries
NMHS	North Metropolitan Health Service
PARROT	Paediatric Acute Recognition and Response Observation Tool
PCH	Perth Children's Hospital
PMH	Princess Margaret Hospital
RANZCP	Royal Australian and New Zealand College of Psychiatrists
RCPA	Royal College of Pathologists of Australia
RPH	Royal Perth Hospital
SCGH	Sir Charles Gairdner Hospital
SJA	St John Ambulance
SMHS	South Metropolitan Health Service
SPOCC	Statewide Protection of Children Coordination Unit
VBAC	Vaginal birth after caesarean
WA	Western Australia
WACHS	WA Country Health Service

Introduction

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

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

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

Executive Summary

For the period of 1 July 2021 to 31 December 2021 the CRC considered 11 coronial inquest findings, including 3 new cases and 8 ongoing cases. This report details actions taken by the WA health system in response to these inquests along with case summaries. The summaries of these cases are included to provide the reader some context for the recommendations and changes described herein. They are not a full account of events surrounding the deaths. To access the full inquest findings, these are located on the State Coroner's website at http://www.coronerscourt.wa.gov.au/default.aspx

Coronial inquests with recommendations: This report includes details about the implementation of recommendations of 2 ongoing cases: Paul Strange and Cyril Churchill. This report also includes information relating to the implementation or consideration of recommendations for 2 new cases, Chad Riley and Child AM.

There was a total of 14 recommendations for the cases in this report that were relevant to the WA health system. Of these 14 recommendations, 10 have been duly considered, actioned appropriately by health stakeholders and marked as complete or closed; and, 4 recommendations are ongoing at the time of this report. Recommendations are not considered completed until they have been implemented in all applicable services (ongoing recommendations may be partially implemented). Closed recommendations are those that have been duly considered by the CLU and relevant stakeholders, and are either:

- not endorsed with reasonable justification
- have not been implemented as existing systems/processes have been deemed to adequately manage the risk
- the changes are extensive (i.e. part of a large-scale project spanning a number of years) and are a long-term commitment of the WA health system.

Progress will be updated on the ongoing recommendations in the next biannual report.

Where a recommendation is on-going (i.e. the case has been included in a previous edition(s) of the biannual report), information that was provided in a previous report(s) is included along with new information for completeness.

Coronial inquests with no health-related recommendations: In addition to health-related coronial inquests with recommendations, the CRC also considers health related coronial inquest findings where no recommendation is made for the WA health system. The CRC considers such inquests to identify opportunities for WA health system learnings and to recognise where there is a need to implement improvements across the system. One new case with no health-related recommendations was considered by the CRC during this reporting timeframe, Baby AM and 6 ongoing cases: Baby H, Levi Shane Congdon, FJ, Malakai Paraone JM and PT were considered. All new and ongoing cases with no health-related recommendations are included within the Executive Summary of this report. A summary of WA health system actions that have been taken in response to these cases as well as any system changes or actions which the CRC noted to have occurred (i.e. not in direct response to the death) and are relevant to a case are provided.

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

Coronial inquests with recommendations

STRANGE

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

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

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

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

The CRC reviewed these findings and made enquiries with the relevant stakeholders.

August 2020 Update

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

February 2021 Update

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

they have provided assurances of the existence of relevant policies and practices that are currently implemented and/or actioned system improvements including amendments to relevant care coordination and discharge policies within their services as required.

August 2021 Update

EMHS presented the proposal on aligning the NaCS Discharge Summary with the mental health Care Transfer Summary requirements to the NaCS BUG in February 2021 at which time the request was approved. Given the current competing priorities of Health Support Services (HSS), whom are responsible for completion of action items identified from the NaCS BUG, this work has yet to be commenced. EMHS remains committed to this recommendation and is working in collaboration with HSS and the NaCS BUG to ensure that the importance of the changes are understood and the work appropriately prioritised, in the interest of patient safety.

February 2022 Update

Advice was sought from HSS who advised the NaCS BUG have agreed on a prioritisation rating of High and 8 items have been added to the Enhancements and Defects Priority list to align the NaCS Discharge Summary with the mental health Care Transfer Summary. Two items have been scoped and deployed to production for March 2022. The remaining 6 items have not been assigned a release date. As the changes required to NaCS are extensive and part of a large scale information and communication technology project, CRC members agreed that recommendation 3 has been considered and deemed closed and acknowledged whilst the changes to NaCS have not been implemented to completion they are considered long term commitments of the WA health system.

CHURCHILL

Cyril Churchill, aged 68, died on 13 November 2017 from surgical complications following the removal of his inflamed gallbladder and delays in post-operative management. A laparoscopic cholecystectomy was performed and following the procedure, Mr Churchill's blood pressure became dangerously low despite repeated doses of medication, intravenous fluids and blood transfusions. Mr Churchill's treating team considered two possible explanations for his symptoms, but there was disagreement as to if there was internal bleeding or that his symptoms rather related to an infectious process, most probably a septic shower. A MET call was put out as Mr Churchill continued to be hypotensive despite treatment. As other staff arrived, there was a lack of clarity as to who was acting as team leader, and concerns over the risk of another general anaesthetic given Mr Churchill's blood pressure. After significant delay Mr Churchill eventually returned to surgery, where three litres of blood were drained, and a damaged aberrant branch of the cystic artery was repaired. Mr Churchill was transferred to Royal Darwin Hospital the next day with multiorgan failure as the result of prolonged hypotension. Despite treatment in the Intensive Care Unit, he did not recover and was palliated with his family present.

The Coroner found that death occurred by misadventure with the inadvertent cutting of an aberrant branch of the cystic artery leading to massive blood loss and subsequent multiorgan failure. It was noted that this is a recognised complication of cholecystectomy, with 20% of the population having aberrant cystic arteries.

The Coroner made five recommendations related to point of care ultrasound, health records management, clinical communication and clinical escalation roles including leadership of MET calls.

The CRC has reviewed these findings and made enquiries with the relevant stakeholders.

August 2021 Update

The WA Country Health Service (WACHS) provided a preliminary update regarding the implementation of the recommendations. Members agreed that recommendation four regarding improving communications between clinicians involved in patient care was applicable to all Health Service Providers.

February 2022 Update

The WACHS review of the findings and recommendations continued, with each Health Service Provider considering recommendation 4. In response to recommendation 1, WACHS have developed the *Use of Focused Ultrasound for Diagnostic Purposes in Emergency Departments Guideline.* The guideline includes minimum education, training and credentialing requirements for practitioners using ultrasound point of care as well as guidance as to the appropriate clinical circumstances in which it should be used. The guideline is currently seeking executive endorsement/approval.

In consideration of recommendation 2 and 3, the WACHS Health Records Management Policy and WACHS Documentation Clinical Practice Standard have been reviewed. The Policy and Standard are to be read together. The WACHS review of the Policy and Standard found that they provide adequate guidance on what constitutes a medico-legal report and why such documents may not appear on a patient's health record. In response to recommendation 3, the Standard was amended and includes the following requirement "entries made by clinicians in or for a patient's health record are not to be removed, left unfiled or deleted unless an appropriately authorised person determines it is to be removed in compliance with the requirements of relevant legislation".

No further amendments are planned to the Policy or Standard in response to the Coroners recommendations.

All Health Service Providers have governance mechanisms and programs in place that are available to staff to ensure effective communication and escalation occurs in resolving disagreement between clinicians as to the management of a patient during clinical deterioration. In response to recommendation 4 members observed mechanisms to include policies, escalation pathways, governance framework models, programs and staff training. In all Health Service Providers when the escalation process is not progressing in a timely manner then staff members can contact their ‘executive on call’ to assist. The WACHS *Recognising and Responding to Acute Deterioration (RRAD) Policy* requires sites to document and display internal and external contacts for escalation and medical emergency response. The escalation document includes advice that at any time the escalation process is not progressing in a timely manner, staff members can contact the relevant executive on call. CRC members observed the South Metropolitan Health Service, Fiona Stanley Fremantle Hospitals Group *Communicating for Safety Framework* as an exemplar, with the framework noted to highlight the relationship between each system, process, policy and documentation in one document. All Health Service Providers offer training to staff, and some Health Service Providers and individual hospitals have specific programs in place to support staff to speak up when clinicians disagree on the management of a patient. CRC members observed that whilst these programs have worked successfully in some Health Service Providers, others have found them to be less effective and that good cultural engagement can impact upon successful implementation.

In response to recommendation 5 the WACHS *Recognising and Responding to Acute Deterioration (RRAD) Policy* was reviewed and republished in November 2021 to include a clear statement that the role of Medical Emergency Response Team Leader is clearly identified at the start of the Medical Emergency Response call and thereafter when that leadership role changes.

The CRC members agreed that the recommendations 1 and 5 have been considered actioned and completed and recommendation 2, 3 and 4 have been considered and deemed closed.

RILEY

Chad RILEY, aged 39, died on 12 May 2017 after being restrained by police officers. Shortly after midnight on the day of his death Mr Riley was taken voluntarily to the Royal Perth Hospital (RPH) Emergency Department by Police. Mr Riley was triaged, and he requested to speak with the pysch team. Attempts to engage Mr Riley in conversation were made by several nurses and doctors with no success. Mr Riley did not wait to be assessed by a doctor in the Emergency Department. Over the next seven hours Mr Riley was seen on CCTV returning to the Emergency Department on a further four occasions each for a short period of time before leaving again and did not wait to be triaged. At the inquest it was noted that these four attendances may have gone unnoticed by Emergency Department staff. Shortly prior to midday Mr Riley was approached by Police in East Perth who were concerned that he required medical care and called for an ambulance. Mr Riley suddenly became engaged in a struggle and he was restrained by Police in a prone position. Whilst being examined by a paramedic Mr Riley stopped breathing, CPR was commenced, he was taken by Ambulance to the RPH Emergency Department however could not be revived.

The Coroner made six recommendations, two were directed to the East Metropolitan Health Service (EMHS) and 4 were directed to the Western Australian Police Force. The recommendations to the EMHS focussed on patients who do not wait to be seen after registration at ED and the availability of Aboriginal Liaison Officers.

The CRC has reviewed these findings and made enquiries with the relevant stakeholders.

CRC Members agreed that the recommendations directed to the EMHS were applicable to all Health Service Providers. The WA Country Health Service (WACHS) *Management and Review of 'Did Not Wait' Patients that Present to Emergency Services Policy* outlines the process of management and review for those patients who did not wait for treatment after triage
and the WACHS duty of care for the presenting patient. WACHS is currently the only Health Service Provider with a did not wait policy. However, in the absence of a policy all Health Service Providers advised that established processes are in place to identify and follow up patients who do not wait and confirmed further actions have been identified to strengthen these processes. The EMHS indicated that a did not wait policy is currently in development, informed by the WACHS policy. Advice included that The South Metropolitan Health Service (SMHS) intend to develop a do not wait policy, the North Metropolitan Health Service are undertaking further liaison to identify if a policy will benefit NMHS patients and the Child and Adolescent Health Service currently has a work instruction, and are formalising a procedure based on a recent audit and the WACHS policy. Health Service Providers have a number of mechanisms to monitor patients who do not wait including indicators in the Health Service Performance Report. The EMHS advised a combined discharge against medical advice and did not wait action plan has been developed, outlining a 12 month strategy to reduce both types of events.

WACHS advised a number of strategies that support the implementation of the did not wait policy. These include flow charts, referral to the local Aboriginal Medical Service if the patient cannot be reached, direct referral into homecare programs, increased waiting room nurse positions, Aboriginal Liaison Officer (ALO) presence in emergency department waiting rooms and increase in social work hours. Strategies also include identification of patients on webPAS with high risk of DNW to allow early assessment and follow-up of these patients on re- admission.

EMHS completed a review of the ALO resource allocation including specific ALO allocation to the Emergency Department during business hours. To support the provision of additional services where they may be most beneficial, an analysis of Emergency Department presentations from

patients that identify as Aboriginal is being conducted to address service gaps and support improved ALO rostering practices, during and outside of business hours on any day of the week. Furthermore, the health service has committed to recruiting an additional 5 FTE, which is above EMHS allocated budget, to support its commitment to enhancing ALO service provision and the subsequent standard of care to Aboriginal people. Other Health Service Providers advised that they currently provide a Monday to Friday ALO service, with only some hospitals providing an out of hours service with coverage to the Emergency Department. One Hospital is currently extending this service to the Emergency Department and is seeking to identify ways to increase access to seven days. Another hospital advised that a oncall service was trialled with coverage on weekdays from 9:00am to 5:00pm, however the service ceased due to minimal uptake and maintaining staffing for the on-call service. Another Health Service Provider advised they will monitor the demand for ALO services and consider providing services outside of working hours if required.

CRC members observed the link to the previous coronial inquest into the death of Levi Shane Congdon and use of the term excited delirium. Members also observed the link to the Victorian and New South Wales coronial inquests which recommended that the term excited delirium be removed from all police training material until such time that it is recognised by the relevant Australian Colleges. It was determined that advice should be sought from the colleges representing pathologists, emergency physicians and psychiatrists to determine their position on the use of the term. At time of publication of this report responses had been received from the The Royal Australian and New Zealand College of Psychiatrists (RANZCP) and Royal College of Pathologists of Australia (RCPA), and a response pending from the Australasian College for Emergency Medicine (ACEM). RANZCP advised that the college publishes a range of statements and guidelines to inform the work of its members, and that none of these publications make specific reference to excited delirium, nor is it included in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) or the International Classification of Diseases 11th edition (IDC-11). The RANZCP is supportive of ongoing training for police and other relevant professionals in the management of people with agitation and behaviour disturbance, and that given the term excited delirium is not used within guidelines for psychiatrists it should not be the primary focus of any police training. Training should include understanding of the terminology commonly used for people suffering from this condition, in a way that communicates the emergency nature of treatment required. Terminology commonly used includes acute behavioural disturbance or agitated delirium. Similarly, the RCPA advised that the college does not have a Position Statement on the use of the term Excited Delirium. The RCPA went onto provide further advice that police training should include the dangers of physical restraint especially in potentially intoxicated or agitated persons. The CLU will consider the advice of RANZCP and RCPA in relation to an existing action arising from the Congdon coronial inquest and WA Police.

Progress of these two recommendations will be updated in the next biannual report.

CHILD AM

Child AM, aged 3 years 11 months, died on 4 September 2015 from bronchopneumonia in an infant with obstructive sleep apnoea. Child AM was born in a remote community in the East Kimberley. She was evacuated from her community multiple times with obesity-related health issues, spending time in Broome Hospital, Royal Darwin Hospital, Halls Creek Hospital and Princess Margaret Hospital (PMH). Her final admission to PMH to monitor her respiratory conditions and introduce controlled weight loss programs was prolonged, after which time she was discharged into the care of a foster carer. She had also been referred to the Changes in Lifestyle are Successful in Partnership (CLASP) Service, which has since been replaced by the Healthy Weight Service (HWS) at Perth Children's Hospital (PCH). Two months after her last admission to PMH, Child AM died unexpectedly at home. She had fallen asleep on the floor in front of TV as was common for her and, when her foster carers tried to move her, they found that she was unresponsive. Resuscitation efforts were unsuccessful.

The Coroner made two recommendations related to the HWS at PCH including to introduce an outreach service and for the service to be culturally appropriate for Aboriginal families.

The CRC has reviewed these findings and made enquiries with the relevant stakeholders.

The CLU sought advice from the Child and Adolescent Health Service (CAHS). Following receipt of the CAHS response, advice was sought from the WA Country Health Service (WACHS). CAHS advice indicated that the HWS is a family-based lifestyle and weight management program at PCH. Children who meet the eligibility criteria are required to regularly attend PCH for a period of 6-12 months. Children not meeting the eligibility criteria or families unable to commit to the requirements for attendance are referred to alternative services. CAHS opined that extensive programs with significant face to face requirements cannot be delivered via outreach. Further CAHS acknowledged the limitations in service delivery models, as CAHS does not have a statewide remit for paediatric services and has no oversight of paediatric services provided by other Health Service Providers including WACHS. However, successful collaboration examples between CAHS and WACHS through established care pathways that enables tertiary care for country children were observed.

Early consultation has occurred between CAHS and WACHS to determine how best to approach children with severe obesity in the regions. Initial discussions suggest upskilling of local health care providers to deliver similar but not identical programs to the HWS would be the most cost effective and easiest to resource. Local demand and ability to maintain suitable staffing were acknowledged as limitations. Ongoing consultation is required to quantify what services currently exist in WACHS regions and how these can be supported and expanded or developed.

CAHS acknowledged the increasing need for the WA health system to deliver services that are culturally appropriate across Aboriginal and Culturally and Linguistically diverse (CALO) communities. However, it was opined that for a program to be applicable across the whole state and be successful, it must be tailored to and led by the local Aboriginal community and their Elders and capacity to do so is limited by resources and difficulty in creating and sustaining multiple different versions of a program. Following review CAHS consider that there are other avenues to assist Aboriginal families who access the HWS through involvement with the CAHS Aboriginal Health Team and WACHS to better engage Aboriginal families. CAHS and WACHS are continuing to explore these avenues.

Progress of these two recommendations will be updated in the next biannual report.

Coronial inquests with no health-related recommendation

Between 1 July 2021 and 31 December 2021, the CRC considered the following new coronial inquests where no health-related recommendation was made: Baby AM. The CRC also considered the following ongoing coronial inquests where no health-related recommendation was made: Baby H, Levi Shane Congdon, FJ, Malakai Paraone JM and PT and further information is provided since the last report.

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

New cases

BABY AM

Baby AM aged 5 days old, died on 14 September as the result of severe hypoxic ischaemic encephalopathy secondary to uterine rupture. Baby AM's mother experienced complications with her first pregnancy and induction of labour was attempted at 38 weeks to minimise risks to the baby. When labour failed to progress Baby AM's mother underwent a nonelective caesarean section. She felt traumatized by the experience, frustrated by what she saw as unnecessary interventions, and that she would have been able to deliver successfully if she'd been able to carry to term. Her second pregnancy was initially supported by a General Practitioner Obstetrician, and she was referred to a high risk clinic given her history and intention to attempt a vaginal birth after caesarean (VBAC). She declined attending the high risk clinic and met with a private midwife as she wanted to have continuity of midwife care throughout. After meeting with the private midwife, Baby AM's mother felt very confident about the plan to attempt VBAC at home. She knew of the potential risk of uterine rupture and poor outcome/death and felt confident of the private midwife's ability to respond to any complications during delivery. On the morning of 8 September Baby AM's mother was visited at home by the private midwife who advised that she was in the early stages of labour, but that labour was not established. The Midwife left and returned later that afternoon, by which time it was apparent something had gone wrong. Baby AM's mother was transferred to Busselton Hospital, and a nonelective caesarean section performed. Baby AM required resuscitation and transfer to Princess Margaret Hospital. An MRI at 4 days of age confirmed severe hypoxic ischaemic encephalopathy and active treatment was subsequently withdrawn.

The CRC observed the comments made by the Coroner in relation to care and public health matters. Members were advised that following the delivery of the Coroner's findings on 10 June 2021 a subsequent amendment has been made to MP 0141/20 *Public Home Birth Policy*. At the time of the inquest the Standard accompanying MP 0141/20 had previous caesarean birth listed as a condition requiring antenatal consultation with an obstetrician prior to being eligible for a public home birth program. However following a policy amendment in July 2021, previous caesarean birth is now listed under the exclusion criteria for the public home birth program. CRC Members discussed the encouragement made by the Coroner to WACHS to consider the provision of broader community midwifery services and or birthing centre options outside the Bunbury area and greater South West. WACHS advised that this has been considered and there are no current plans to amend the birthing models used in the South West acknowledging that births outside of Bunbury can be too far from a hospital that is equipped to manage the required level of care and current limitations in midwifery workforce. WACHS advised the Midwifery Group Practice (MGP) model has expanded in other WACHS regions with an MGP opening in Carnarvon. In support of improved continuity of care throughout pregnancy and delivery members

observed the WACHS policy for private midwives to be credentialed to attend deliveries in a public hospital and that currently this is not widely utilised by private midwives.

Ongoing cases

BABY H

Baby H died on 28 May 2017, aged 4 months. Two days before her death she was placed into the care of the Department of Child Protection and Family Support. The inquest identified multiple missed opportunities for concerns in regard to Baby H's health and wellbeing to be addressed. The cause of death was found to be head and neck injuries and manner of death was unlawful homicide.

CRC members observed the similarities to the inquest into the death of PT and noted of the three recommendations related to the *Children and Community Services Act 2004,* Recommendation one, repeated the recommendation from the PT inquest findings. Members observed that whilst the regulatory impact review proposed in both inquest recommendations was considered to be appropriate, the inquest findings could be reviewed to identify and suggest further areas of potential improvement as they relate to the WA health system.

During discussion of the Baby H inquest findings the CRC considered if the existing child at risk alert processes are sufficient and well managed by Health Service Providers, or if a more strengthened and coordinated approach is required. Members considered the rationale for why mandatory reporting of injuries in non-ambulant children had not previously been expanded, the role of child alerts and work underway to establish a statewide child safety alert system, and concerns that bruising in a non-ambulant child should have been recognised as a sentinel injury.

Discussion focussed on the role of paediatric injury proformas used across WA health system emergency departments. It was observed that, whilst the form originated from the Child and Adolescent Health Service, that the content and governance processes of injury proformas may vary significantly across and within Health Service Providers. It was agreed that the Statewide Protection of Children Coordination Unit (SPOCC) would undertake a review and analysis of existing Health Service Provider paediatric injury proformas and associated systems and suggest recommendations that could improve consistency and governance across the WA health system. Whilst equivalent paediatric injury proformas are utilised in emergency departments that provide services for children across the WA health system, differences have been observed in the supporting governance processes. Variation included the frequency and membership of 'Safety Net' meetings in which injury proformas are reviewed and the existence of and utilisation of policies, guidelines, and education and training offered.

Members also observed, in both the Baby H and PT inquests that the respective injuries were first identified in child health settings. In noting that there is no equivalent paediatric injury proforma in child health settings, an action was also agreed for WACHS to consider incorporating an injury proforma into the Community Health Information System for use by Child Health Nurses.

February 2022 Update

A report tabling the findings of the review and analysis undertaken by SPOCC was provided to the CRC by the Child and Adolescent Health Service. The report found that there are significant opportunities for improving consistency in the recognition and response of young children presenting with potentially non-accidental injuries in the WA health system. The review of paediatric injury proforma and safety net meetings across Health Service Providers identified a number of limitations and made 5 recommendations for improved governance and standardised

processes. Recommendations 1-3 included the establishment of a single standardised paediatric injury proforma for use in all WA hospitals, standardised governance for safety net meetings and the development of appropriate policies to support this consistent approach to implementation. The continuation of collaboration between CAHS and WACHS in non-ambulant children in community health services was considered in recommendation 4. Recommendation 5 highlighted the need to incorporate education regarding injuries to non-ambulant children into strategies addressing principle 7 of the National Principles for Child Safe Organisations. Each recommendation identified actions and a recommendation lead. The implementation of the recommendations will continue and progress of this inquest to be included in the next biannual report.

CONGDON

Shane Levi Congdon died on 13 November 2017, aged 27 years from methylamphetamine toxicity. The Coroner concluded that Mr Congdon had ingested a toxic dose of methamphetamine just prior to being apprehended by police officers, presumably to avoid being charged with its possession. The CRC observed as per the inquest findings, that a gap exists between the different agencies understanding of each other's emergency communication protocols, in particular in relation to the term 'excited delirium'. The CLU wrote to St John Ambulance (SJA) who confirmed that it is their preference that WA Police describe what they are seeing/hearing from the patient in front of them rather than to provide a clinical label, in case that clinical label is not correct. SJA confirmed that work is underway in both agencies in updating their training and guideline materials and discussions are underway in sharing training information between agencies. During discussion, CRC members questioned how the term 'excited delirium' came to be included in WA Police training and education materials.

February 2022 Update

At the October 2021 CRC meeting CRC members observed the similarities in the use of the term excited delirium between the Congdon and Riley inquests and the link to the Victoria and New South Wales coronial inquests. Following a review of the Riley inquest findings it was determined that advice should be sought from the colleges representing pathologists, emergency physicians and psychiatrists to determine their position on the use of the term. A response has been received from The Royal College of Pathologists of Australia and The Royal Australian and New Zealand College of Psychiatrists.

FJ

FJ died by suicide on 13 November 2016, by jumping from a sixth-floor balcony. FJ was an Iranian woman with a history of mental health issues who arrived in Australia in July 2012 as an 'unauthorised maritime arrival'. The CRC observed as per the inquest findings, FJs transition of medical care from her release from immigration detention on a protection basis and the comments made by the coroner on the ways this could be improved. The CRC observed that a period in which a suitable level of care was provided was whilst FJ was a patient of the Transcultural Mental Health Service, Royal Perth Hospital which is no longer in operation. The CLU has contacted the Mental Health Network (MHN) and Multicultural Mental Health Subnetwork (MMHSN) to seek further information on the proposed future delivery of transcultural mental health service models in WA.

February 2022 Update:

The CLU sought advice from the MHN and MMHSN regarding the 2018 project proposal to initiate a statewide Transcultural Mental Health Service. The CLU understands that in 2018 a project proposal to initiate a statewide Transcultural Mental Health Service was presented to, but not

endorsed by the Mental Health Commission (MHC). The MMHSN expressed to the CLU that in the absence of a targeted service, similar to the proposed statewide service model, that a gap exists in supporting the needs of consumers from culturally and linguistically diverse (CaLD) communities.

The CLU sought advice from the MHC in the absence of delivery of the proposed statewide transcultural Mental Health Service, the current and planned activities to deliver and improve access to transcultural mental health services in both inpatient and community mental health settings in WA. The Mental Health Commission provided advice on a number of strategies including the MHC Multicultural Plan which outlines the actions the MHC will undertake to equip the workforce with knowledge, skills and understanding to provide inclusive and culturally sensitive services that meet people's needs, regardless of their cultural background; and working with culturally diverse communities to develop policies, programs and services that meet the needs of people from CaLD backgrounds.

PARAONE

Malakai Paraone died at Princess Margaret Hospital on 26 August 2016 from sepsis at the age of 7 months. The CRC observed that Group A strep in children can have a vague presentation and that clues are tachycardia, fever and little in the way of other physical signs. CRC discussion included the Perth Children's Hospital (PCH) Sepsis Emergency Department guidelines which flag fever or hypothermia with tachycardia as possible sepsis. CRC members agreed that the tachycardia should have flagged further investigation. Following the update provided in the February 2021 biannual report, in which it was noted that the CRC discussed current Sepsis education and how awareness can be improved, this was considered further by the CRC. The Child and Adolescent Health Service advised following a pilot and extensive stakeholder consultation, on 28 April 2021 a new paediatric early warning system was implemented. The ESCALATION System includes the Paediatric Acute Recognition and Response Observation Tool (PARROT chart) which has replaced the previously used Children's Early Warning Tool (CEWT chart). The PARROT chart includes a new sepsis recognition escalation pathway and is supported by a dedicated training package.

February 2022 Update:

In August 2021 it was advised that The Department of Health had commenced investigating opportunities for implementation of a standardised systemwide approach to recognising to clinical deterioration and sepsis recognition escalation pathway, including implementation of the PARROT chart across the WA health system. PARROT Charts and training for nursing staff in the use of the charts are subsequently being rolled out across the WA health system. Within the PARROT charts, there is an Early Warning Score Escalation Pathway and a Sepsis Recognition Escalation Pathway where a patient's early warning score will trigger an urgent medical review within a specified timeframe. In addition implementation has occurred of a statewide family/carer support initiative called *Aishwarya's CARE Call* and a statewide escalation system for recognising and responding to clinical deterioration in paediatric patients. The initiative has included the introduction of waiting rooms phones and waiting room nurses in Emergency Departments and consumer information to support families/carers to escalate care when required.

JM

JM died on 9 July 2015 at Fitzroy Crossing Hospital from dehydration complicating diarrhoea, aged 10 weeks. The CRC observed that in the Kimberley, there are a number of protocols for babies under three months and for clinical staff to take any illness very seriously and to have a

low threshold for babies to be admitted for care. The Coroner made a suggestion that the visual aids proposed by the inquest witnesses on the signs of dehydration be developed and used.

August 2021 Update:
Following the update provided in the February 2021 biannual report, the CRC observed that there was insufficient information available to determine if the existing resources fulfilled the Coroner's suggestion for visual aids. WACHS has commenced a review of the existing consumer resources with respect to suitability of content, presentation and accessibility.

February 2022 Update:
Advice was provided on the outcome of the WACHS consumer evaluation of the existing consumer resources with respect to suitability of content presentation and accessibility. Consultation involved a survey of Kimberley health employees, focus groups and individual meetings with community members in 10 remote Aboriginal communities. The review found that the majority were satisfied with the resources, although it was evidenced by the comments that the resources could be greatly improved, particularly in relation to use of pictures and presentation. Updated resources have since been developed and tabled at the Kimberley Aboriginal Health Planning Forum (KAHPF) and the resources are undergoing robust review process to ensure they are culturally appropriate. Once the review is finalised the resources will be represented to the KAHPF for approval.

PT

PT died at age 5 years having been placed into care as a baby following a head injury that left her profoundly disabled. The inquest highlighted the risks of injury to non-ambulant children as serious injuries may be preceded by injuries of a lesser nature that should be regarded as sentinel injuries in these children.

CRC members observed in contrast to the State Coroners recommendation that a training program is available for mandatory reporters, however there are no legislative mechanisms that mandate completion of the program. In the absence of mandatory training, the Child and Adolescent Health Service (CAHS) provided an update to CRC members on the strategies that have already been implemented or are in development to improve the recognition and response to possible child abuse. Education, training and guidelines are currently available from the Statewide Protection of Children Coordination Unit (SPOCC), the Perth Children's Hospital Child Protection Unit (CPU) and the Mandatory Reporting Interagency Training Group. SPOCC plan to introduce a non-mandatory e-learning package on Child Abuse which will include the importance of recognising and reporting injuries in non-ambulant children. Risk mitigating strategies utilised by CAHS and other Health Service Providers include utilisation of non-mandatory Child Injury Assessment Forms/Injury Proforma which are reviewed at "Safety Net" meetings to ensure the correct determination about whether an injury was possibly due to child abuse with recall mechanisms in place if an injury that was thought to be accidental is deemed suspicious. WACHS have implemented a Clinical Alert for recording children at risk. SPOCC in conjunction with the CPU are in the process of developing a proposal for a consistent statewide child protection alert for the WA health system.

In the February 2021 biannual report it was noted that CRC members deemed that further information was required on the government actions in response to this recommendation with the CLU to make further enquiries with relevant Stakeholders. As per the above update provided on the Baby H inquest findings, in which the similarities between the two inquests were discussed,

the CRC determined that the inquest findings could be reviewed to identify and suggest further areas of potential improvement as they relate to the WA health system.

An action arising from the February 2021 biannual report was for the CRC to consider at a future meeting how clinician awareness of what to look for in abuse of non-ambulant children can be raised with the relevant colleges and stakeholders. In regards to improving clinician awareness of what to look for, the CRC observed that the SPOCC *Guidelines for Protecting Children 2020* are currently available only to those within the WA health system, and resources for General Practitioners in Western Australia are available from the Royal Australian College of General Practitioners and WA Primary Health Alliance.

February 2022 Update:

In response to the concerns raised in the inquest findings that the General Practitioner did not act upon PTs injuries sooner, the CLU wrote to the Royal Australian College of General Practitioners Western Australian faculty, Australian College of Rural and Remote Medicine and WA Primary Health Alliance. The correspondence provided a summary of the inquest findings. Noting the risks of injury to non-ambulant children, as serious injuries may be preceded by injuries of lesser seriousness that should be regarded as sentinel injuries in a non-ambulant child and that bruising in a non-ambulant child should be flagged as having a high index of suspicion. The correspondence requested that the information be shared amongst their members in the interest of future patient safety and that the Perth Children's Hospital Child Protection Unit be promoted amongst WA General Practitioners.

Updates in future biannual reports regarding the WA health system response to injuries in non-ambulant children will be provided via the Baby H inquest findings.

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