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

Progress Report for Health-Related Coronial Recommendations

Biannual Report – February 2020

Acknowledgements

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

The patients and their families

The Office of the State Coroner, Western Australia

The Office of the Chief Psychiatrist, Western Australia

The Mental Health Commission, Western Australia

The WA Royal Australian College of General Practitioners

The WA Primary Health Alliance

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

ADF	Australian Defence Force
ATSI	Aboriginal and Torres Strait Islander
CAHS	Children and Adolescent Health Service
CLU	Coronial Liaison Unit
CRC	Coronial Review Committee
DOH	Department of Health
DOJ	Department of Justice
ED	Emergency Department
EMHS	East Metropolitan Health Service
FASD	Fetal Alcohol Spectrum Disorder
GP	General Practitioner
HSP	Health Service Provider
ICU	Intensive Care Unit
MHC	Mental Health Commission
NMHS	North Metropolitan Health Service
RACGP	Royal Australian College of General Practitioners
RPH	Royal Perth Hospital
RTPM	Real Time Prescription Monitoring
SMHS	South Metropolitan Health Service
SFMHS	State Forensic Mental Health Service
WA	Western Australia
WACHS	WA Country Health Service
WAPHA	WA Primary Health Alliance

Introduction

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

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

Executive Summary

This report includes details about the implementation of recommendations on two ongoing cases: Ms Dhu and Matthew Neil Hardy Tonkin. This report also includes information relating to the implementation or consideration of recommendations for three new cases, Annabel Nicol, Judy Sonia Bolton and James Ronald Chi.

There was a total of 5 recommendations for the cases in this report that were relevant to the WA health system. Of these 5 recommendations, 3 have been duly considered, actioned appropriately by health stakeholders and marked as complete or closed; and, 2 recommendations are ongoing at the time of this report. Progress will be updated on the ongoing recommendations in the next biannual report.

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

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

In addition to health-related coronial inquests with recommendations, the Coronial Review Committee (CRC) also considers health related coronial inquest findings where no recommendation is made. The CRC considers such inquests to identify opportunities for WA health system learnings and recognise where there is a need to implement improvements across the system. New cases with no health-related recommendations that were considered by the CRC during this reporting timeframe include: 5 Casuarina Prison deaths; Khamsani Victor Jackamarra; Fazel Chegeni Nejad; Aurelio Monterlegre Cruz; Colin George Graham; Robin David Macartney; Garth Cyril Heaven; Malcolm Patrick O'Driscoll; Child L; Ellie Marlene Hare; Frederick John Collard; Troy Michael Conley; Arthur James Bonney; Mark Quenton Fleury; Stephen Thomas Oxley; Timothy James Chandler; and Child KT.

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

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

Coronial inquests with recommendations

MS DHU

Ms Dhu, aged 22, died on 4 August 2014 as a result of staphylococcal septicaemia and pneumonia. A contributing factor to Ms Dhu's death was osteomyelitis complicating a previous rib fracture. Ms Dhu was in the custody of the WA Police Service at the time of her death. Ms Dhu had been escorted to hospital on two separate occasions for assessment; however, her illness was not detected.

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

The issue of sharing of medical information with WA Police was discussed by the Medical Directors' Forum which noted the difficulties in providing information to police. It was noted that Section 217 of the *Health Services Act 2016* (HS Act) 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.

However, it is stated in the *Health Services (Information) Regulations 2017* (the Regulations) regulation 4, that Section 217 of the HS Act is subject to a patient's consent to the disclosure of the information. Thus, there were concerns raised by the Health Service Providers (HSPs) if a patient does not consent.

Instead, Section 220(1)(i) of the HS Act and regulation 5(1) of the Regulations should be considered as they could allow the sharing of patient information with WA Police in circumstances where the disclosure is reasonably necessary to lessen or prevent a serious risk to the life, health or safety of any individual. Regulation 5 does not require a delegation or authorisation in the Authorisations and Delegations Schedules.

In any case, all HSPs have reported that their Authorisation and Delegations Schedules have been reviewed and updated to address the delegation of power to disclose information as stipulated in Section 217 of the HS Act.

February 2020 update

After discussion amongst relevant stakeholders about the challenges in the practicalities in empowering frontline staff to share patient information considering the legislation, all agreed there was a need for a consistent approach in setting policy. This need is met very well by the WA Country Health Service's Care and Discharge of Persons in Custody Policy (the Policy). It was identified as a good guide to frontline staff about their role and responsibilities for providing clinical information when transferring patients to other's care e.g. police custody. The Policy has been updated to refer to the HS Act and Regulations and was provided to the other HSPs to inform their approaches in providing guidance to their staff.

One HSP has developed a similar policy to WACHS and will be finalising the draft shortly and then implementing the new policy. Another HSP has completed updates to existing policies to address the recommendation. The other two HSPs are reviewing their current policies to include general guidelines for medical practitioners to consider the circumstances of the patient's

condition and make an assessment whether the circumstances meet the requirements for disclosure.

Of the 11 recommendations made by the coroner, ten have been deemed to be out of scope for the WA health system and one is now completed.

TONKIN

Matthew Neil Hardy Tonkin, aged 24, died on July 3 2014 of bronchopneumonia complicating oxycodone toxicity. Matthew was an Australian Army veteran. He became addicted to prescription drugs and doctor-shopped in order to obtain the drugs.

The main issues raised at the inquest were the means by which Matthew was able to obtain opioids by prescription despite known drug seeking behaviour and the status of a proposed real-time monitoring system of the dispensing of prescription opioid drugs. The recommendation made by the Coroner arose from the difficulty faced by medical practitioners in WA when attempting to obtain medical records from the Australian Defence Force (ADF) or the Department of Defence.

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

The Chief Pharmacist provided an update on the status of real time prescription monitoring (RTPM) in August 2019. WA was nearing completion of development work for a local regulatory system. WA is in negotiation with the Commonwealth regarding an agreement to interface with a national data exchange (NDE). WA has commissioned and completed several stakeholder consultation workshops on RTPM /NDE. WA has commenced preliminary discussions with the National Prescribing Service regarding promotion and education for clinicians. The WA health system continues to maintain and improve the existing prescription monitoring program in place in WA, until such time as RTPM is achieved.

February 2020 update

With respect to the doctor-shopping of prescription drugs, the CRC agreed to raise awareness of this inquest and the learnings by highlighting it to the WA Royal Australian College of General Practitioners (RACGP) and WA Primary Health Alliance (WAPHA).

Response from the RACGP was very supportive of the actions planned to be undertaken by the Department of Health's Coronial Liaison Unit and outlined their own related activity. These included the provision of the inquest findings to members, the availability of a range of resource materials and training program to be developed and delivered in 2020/21 financial year. They are committed to providing education about the most suitable ways of treating WA patients with chronic pain.

The WAPHA welcomed the information provided from the inquest and their response explained their focus on enhancing the capability of general practice, particularly the prevention and management of chronic pain in primary care. A range of workforce development activities for health professionals, promotion materials for consumers and support for people experiencing mental illness and issues with substance use was outlined.

The recommendation to liaise with the Department of Defence to consider a procedure to allow for the timely transfer of medical records of ADF members and veterans to treating medical professionals in WA was considered by the CRC. Correspondence has been progressed to the Commonwealth Department of Health to seek advice on any previous or planned activities in the transfer of ADF medical records. The outcome of this action will be provided in the next report.

NICOL

Annabel Nicol was on remand at Bandyup Women's Prison when she hung herself on 12 June 2015. Annabel had a history of depression and alcohol addiction. After admission into prison, she exhibited distress, behavioural issues and made several self-harm attempts that led to psychiatric review. Management options were limited. Annabel found time in the Crisis Care Unit isolating and was phased to the general unit and after the second adjournment of her sentencing, she hung herself, leaving notes to family members.

The Coroner made two recommendations relating to improving the mental health resources at Bandyup Women's Prison and the third recommendation was made to allow medical and nursing staff information to assist them to provide a better level of treatment.

The Department of Health's Coronial Review Committee has reviewed these findings and made enquiries with the relevant stakeholders across the relevant government departments.

Of the three recommendations, the first and third were deemed out of scope for the WA health system. The second recommendation was for the Government to commit funding to establish a 'female only' secure forensic mental health unit as a matter of priority.

Advice has been provided to the Minister for Mental Health on the feasibility of the recommendation. The establishment of appropriate infrastructure and forensic beds for vulnerable populations, including women and youth, is a priority for the Mental Health Commission (MHC). The MHC is working closely with the Department of Justice (DoJ) to progress any potential infrastructure that could be re-purposed for vulnerable populations, as a medium-term option.

The MHC is also working with the DoJ, DoH, North Metropolitan Health Service (NMHS) and the Chief Mental Health Advocate to estimate additional costs associated with the implementation of the proposed Criminal Law (Mental Impairment) Bill 2019. As part of the DoJ-led budget submission, funding will be sought for community mental health services and additional psychiatric in-reach as a result of the implementation of the legislation. Given the lack of forensic beds, the budget submission will include the need to develop an appropriate facility (and estimated capital and operational costs) to meet the increased demand on the forensic mental health system, directly associated with the implementation of the legislation.

The NMHS supports the principle of providing gender-sensitive, trauma-informed care for females and other vulnerable groups within existing and new forensic inpatient units. New developments need to consider this requirement for vulnerable forensic patients.

The recommendations have been considered and deemed closed.

BOLTON

Judy Sonia Bolton was a remand prisoner at Bandyup Women's Prison at the time of her death. She died on 10 December 2016 at Royal Perth Hospital (RPH) from acute myocardial infarction due to a coronary thrombosis.

Whilst the Coroner's inquest focused on the care provided at the prison medical centre, the care Ms Bolton received at RPH was also reviewed. As ongoing CPR was needed, the cath lab at RPH borrowed a LUCAS device from St John Ambulance as they did not have one of their own. In light of this, the Coroner urged the relevant Health Services to consider purchasing LUCAS machines for their respective cath labs.

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

All three health services with a cath lab have reported that their sites now have access to LUCAS machines.

The inquest recommendation has been duly considered and deemed completed.

CHI

James Ronald Chi, aged 69, died on 26 June 2017 in the Emergency Department of Broome Hospital from chronic obstructive pulmonary disease and coronary artery atherosclerosis, whilst an involuntary patient under the Mental Health Act 2014. James had significant physical and mental health issues. He was a long-term patient in the Broome mental health unit, Mabu Liyan, where he remained until his death.

The Deputy State Coroner noted that James smoked tobacco for several decades which led to the causes of his death. Death was found to have occurred by way of natural causes.

The Deputy State Coroner was satisfied with the supervision, treatment and care provided to James, however raised issues regarding the difficulty in accessing services and the lack of long-term supported accommodation for mental health patients in the remote region.

The Deputy State Coroner made one recommendation that relevant government agencies consider the desirability and feasibility of establishing a facility providing long-term supported accommodation for mental health patients in the Kimberley region.

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

The WA Country Health Service (WACHS) has advised that whilst long term residential psychiatric care for aged care clients is infrequently required in the Kimberley region, options are available. However, WACHS has highlighted the need for appropriate facilities for people who have significant behavioural issues related to acquired brain injury, Fetal Alcohol Spectrum Disorder FASD), mental health conditions and dementia.

The Coronial Review Committee will review and discuss the WACHS suggestion further in their subsequent meetings.

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

Coronial inquests with no health-related recommendation

Between 1 July 2019 and 31 December 2019, the CRC considered the following new coronial inquests where no health related recommendation was made: 5 Casuarina Prison deaths; Khamsani Victor Jackamarra; Fazel Chegeni Nejad; Aurelio Monterlegre Cruz; Colin George Graham; Robin David Macartney; Garth Cyril Heaven; Malcolm Patrick O'Driscoll; Child L; Ellie Marlene Hare; Frederick John Collard; Troy Michael Conley; Arthur James Bonney; Mark Quenton Fleury; Stephen Thomas Oxley; Timothy James Chandler; and Child KT.

Following is an overview of WA health system action taken in response to these deaths, 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).

5 Casuarina Prison Deaths

The inquest focused on the supervision, treatment and care provided to each of the deceased persons while they were prisoners, as well as the circumstances of their respective deaths. The Coroner found that each case was suicide. The Coroner heard evidence about the management of at-risk prisoners, some of the risk factors impacting on prisoner management and the strategies and tools employed to address those factors.

The Coroner made eight recommendations relating to improving prisoner welfare and enhancing the security of Casuarina Prison that were directed to the Department of Justice.

During the CRC discussion of the inquest, an action that arose was to liaise with the Mental Health Commission (MHC) to seek information of their plan/purchasing model for this at-risk prison population. The Coronial Liaison Unit (CLU) met with the MHC staff responsible for overseeing the forensic services area, providing mental health training for corrective services and coordinating the purchasing of psychiatric services for prisoners via the State Forensic Mental Health Service (SFMHS). Key information was provided by MHC about the in-reach psychiatric services provided to prisons and their work with the Department of Justice. The information from the MHC and the Department of Justice's response to the recommendations that was posted to the Office of State Coroner's website was provided to the CRC and members were satisfied with the information provided.

Dunkel

CRC discussion led to agreement to take action in light of this case to highlight the increasing trend of bariatric surgery for cosmetic reasons, the increased risk of issues/complications and to address consumer issues where there is a lack of full understanding of the serious nature of the surgery and potential risks.

The CLU has sought advice from St John of God Murdoch on any actions that have been implemented since this case and also requested information from the Health Networks within Department of Health for related activities in light of the work on the WA Healthy Weight Action Plan and Obesity Collaborative.

Comments relating to health services provided by WA Health stakeholders and correct at the time provided. This report was reviewed by the Department of Health's Coronial Review Committee.
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