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

Progress Report for Health Related Coronial Recommendations

Biannual Report – August 2019

Acknowledgements

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

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All medical and nursing 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
AKMH	Armadale Kelmscott District Memorial Hospital
ATSI	Aboriginal and Torres Strait Islander
BAU	Behavioural Assessment Unit
CAHS	Children and Adolescent Health Service
CLU	Coronial Liaison Unit
CMH	Community Mental Health
CRC	Coronial Review Committee
DOH	Department of Health
DPC	Department of Premier and Cabinet
ED	Emergency Department
EMHS	East Metropolitan Health Service
FH	Fremantle Hospital
FSFHG	Fiona Stanley Fremantle Hospitals Group
GP	General Practitioner
HDU	High Dependency Unit
HSP	Health Service Provider
ICU	Intensive Care Unit
MH	Mental Health
MHA	Mental Health Assessment
MHEC	Mental Health Emergency Centre
MHOA	Mental Health Observation Area
MHC	Mental Health Commission
NMHS	North Metropolitan Health Service
RACS	Royal Australasian College of Surgeons
RRAD	Recognition and response to acute deterioration
RTPM	Real Time Prescription Monitoring
SMHS	South Metropolitan Health Service
SPC	Suicide Prevention Coordinator
WA	Western Australia
WACHS	WA Country Health Service

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 of one ongoing case: Ms Dhu. This report also includes information relating to the implementation or consideration of recommendations for five new cases, Seanpol Martin Padraig O'Neill, Matthew Neil Hardy Tonkin, Melanie Reanna Tregonning, Pamela Edith Ashley and Christopher John Debnam.

The notable inquest into the 13 Kimberley Aboriginal Youth Suicides was released in February 2019. The WA health system is contributing to the whole-of-government project led by the Department of Premier and Cabinet (DPC). Recognising the significant work that is underway by all the participating government agencies, this report will not overlap or duplicate the details that will be part of the DPC-run project's outputs.

There were a total of 11 recommendations for the cases[1] in this report that were relevant to the WA health system. Of these 11 recommendations, nine have been duly considered, actioned appropriately by health stakeholders and marked as complete or closed; and, two 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: Ali Jaffari; William John Davis; Glenn William Strickland; Torran Jake Thomas; Lorna May Woods; Maris Kugis; Ronald Alan Giblett; Daniel Josef Adwent and SM.

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.

[1] This does not include the 42 recommendations in the Kimberley Youth Suicide inquest

Coronial inquests with recommendations

KIMBERLEY INQUEST

The deaths of 13 Aboriginal children and young persons in the Kimberley Region were investigated together because there were similar circumstances, life events, developmental experiences and behaviours that appear to have contributed to vulnerability to suicide. The State Coroner looked not just at the circumstances surrounding each death, but at the effects of intergenerational trauma, poverty, and colonisation on whole communities, as longitudinal factors that contributed to pre-existing vulnerabilities of the children and young persons, affecting their capacity to regulate emotion and manage ongoing trauma and stress.

The State Coroner noted that "Given the multifactorial problems that have been experienced in the Kimberley Region for generations, there is no justification for finding that the act or omission of a particular person, officer or agency caused or contributed to a suicide" and "No adverse comment is made against any family member. These are the people who have themselves endured significant trauma and disadvantage".

The State Coroner agreed with the Department of Premier and Cabinet (DPC) that providing existing Government departments with more funding is not the solution and that there are difficulties inherent in providing services to small dispersed remote communities.

The effects of intergenerational trauma upon Aboriginal persons are not generally understood in the wider community, and service providers need to adapt their programs to account for this. The diversity of Aboriginal peoples is to be recognised in connection with the offering of the programs. Intergenerational trauma is endured by entire communities. The State Coroner's 42 recommendations are aimed at preventing similar deaths, through healing and supporting this marginalised and disadvantaged community.

The WA health system is contributing to the whole-of-government project led by the DPC. The Statement of Intent on Aboriginal youth suicide[2] was released in May 2019 and is the WA Government's preliminary response to the recommendations from the State Coroner's Inquest into the deaths of 13 children and young persons in the Kimberley Region. The document outlines the WA Government's response to each of the recommendations.

The Department of Health's Coronial Review Committee (CRC) reviewed the findings and contributed to the WA health system's initial review of the recommendations. The CRC noted the long term benefits of the prevention and education actions that were recommended and concurred with the importance placed on the programs being community-led. The need for ongoing cultural awareness education for non-Aboriginal staff working in the WA health system was recognised as a key driver to enable further understanding of the Aboriginal culture.

The Department of Health's CRC discussed the importance of postvention; an intervention/program conducted after a suicide that aims to reduce the impact and support individuals, families and communities. Suicide postvention also aims to address the phenomenon known as suicide 'contagion', where a person's knowledge of (or exposure to) a suicide increases the likelihood of them viewing suicide as an option.

[2] https://www.dpc.wa.gov.au/ProjectsandSpecialEvents/Pages/Aboriginal-youth-wellbeing.aspx

The Department of Health's CRC noted that the Department of Education has an established postvention process, with designated postvention coordinators and sought information about a similar WA-wide process for adults, noting also that some people who suicide may not be current health system or other agency consumers.

The WA Mental Health Commission (MHC) is addressing postvention as part of WA's Suicide Prevention 2020 strategy. A number of suicide prevention coordinators (SPCs) have been appointed. One of the responsibilities of the SPCs is to undertake a needs assessment of postvention requirements in their region, create a coordination group and develop a postvention protocol. The postvention protocol will specify the process to be followed and agency roles and responsibilities in the event of suicide or suspected suicide.

The Department of Health's Coronial Liaison Unit has informed the WA health system's representatives for the DPC Aboriginal Youth Suicide Project so as to contribute to their input. Recognising the significant work that is underway by all the participating government agencies, this report will not overlap or duplicate the details that will be part of the DPC-run project's outputs. The inquest recommendations have been considered and deemed closed.

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.

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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.

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 will be reviewed by the other HSPs to inform their approaches in providing guidance to their staff.

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 ongoing. Progress will be updated in the next report.

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 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. Action will be undertaken to contact the relevant Commonwealth departments to seek advice on the best approach to address the transfer of ADF medical records.

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 and WA Primary Health Alliance.

The Chief Pharmacist provided an update on the status of real time prescription monitoring (RTPM). WA is nearing completion of development work for a local regulatory system which is anticipated to be finalised in October 2019. WA is in negotiation with the Commonwealth regarding an agreement to interface with a national data exchange (NDE). WA has commissioned and completed a number of 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.

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

O'NEILL

Seanpol Martin Padraig O'Neill, aged 30, died on 23 February 2015 at Armadale Kelmscott District Memorial Hospital (AKMH) from methadone toxicity and respiratory depression whilst an involuntary patient under the *Mental Health Act 1996*. Two broad areas for improvement were identified in the inquest findings; the monitoring of vital signs and managing risk of absconding. Three recommendations were made that detailed changes to specific AKMH's charts.

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

With respect to the three recommendations directed to AKMH, East Metropolitan Health Service has reviewed and extended the applicability to all mental health services within their remit.

The suggested changes to the documentation used to record observations of mental health patients when asleep and/or given sedating medications have been implemented. The revised charts have been accompanied by revised processes, policy and awareness raising with staff. Auditing is now underway to ensure the ongoing effectiveness of the changes.

The other Health Service Providers (HSPs) reviewed their own policies and processes with regards to the expectations of staff when recording patient observations whilst a patient is asleep, specifically signs of life and respiration rates. One HSP will consider amendment of policy to include more details in monitoring requirements and the other HSPs report their clinical standards and policies cover the expectations clearly.

All the HSPs have systems in place in mental health services that address the risk assessment of monitoring and observation requirements for patients given sedating medications. These include routine observations and recording on standardised documentation, escalation of care in accordance with standardised pathways and tools/checklists/charts and enhanced team nursing practices.

The initiation of medication reconciliation when any medications are being administered on an 'as needed' basis, especially in response to agitated patients is routine practice across the HSPs. One HSP is taking steps to document the daily reconciliation that the pharmacist conducts. All HSPs report that medication reconciliation is performed when prescribing an 'as needed' medication, taking into account the risks of interaction with other medications. Policies are in place and continue to be reviewed to specify the requirements for medication history, reconciliation and review at the appropriate times.

The recommendations have been considered, actioned and deemed completed.

TREGONNING

Melanie Reanna Tregonning, aged 31, died at home between 12 and 13 May 2014 as a result of incised wounds to the neck and arms after being discharged from Fremantle Hospital on 12 May without full psychiatric assessment. The manner of death was found to be suicide.

The Coroner highlighted the lack of resources put towards mental health treatment in WA, translating to a lack of mental health beds, a lack of properly trained and available psychiatrists and mental health professionals, and a lack of appropriate areas in which to assess an increasing number of patients. The recommendation made by the Coroner was to give priority to commissioning a Mental Health Observation Area at Fiona Stanley Hospital Emergency Department (ED). The Coroner also urged those reviewing the mental health service provided at public hospitals to focus on ways of ensuring mental health emergencies are treated as seriously as any other medical emergency, with appropriate resources directed to ensuring that they are treated by properly trained staff in appropriate therapeutic environments.

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

While South Metropolitan Health Service (SMHS) does not have a Mental Health Observation Area (MHOA), Fiona Stanley Hospital was commissioned with an 8 bed Mental Health Assessment unit (MHA) located in the Mental Health building and connected to the ED. The MHA allows for an extended assessment period in a therapeutic environment and, unlike a MHOA, accepts admissions for both voluntary and involuntary patients and those at high risk and/or on form 1.

SMHS view in relation to MHOAs is that while it is probably an ideal model if staffed and designed appropriately, it is not able to contain every patient in need of admission or assessment. It is likely to be very costly in terms of set up and ongoing staffing costs, particularly dual trained nursing and medical staff skilled confident in managing both acute mental and physical health. It is SMHS understanding that it is difficult to recruit and retain staff into MHOA positions.

The MHA beds at SMHS were designed for a maximum length of stay (LOS) of 72 hours. The unit currently has a LOS of 4.5 days. This is being driven by the lack of beds in the system and means the unit cannot function as effectively as intended. It is hoped this will be addressed when the 20 additional locked beds are commissioned at the Fremantle Hospital campus in 2022. There are no seasonal bed closures or use of the MHA beds for any other purposes.

The inquest recommendation has been duly considered and deemed closed.

ASHLEY

Pamela Edith Ashley, aged 64, died on 3 February 2016 at Armadale Kelmscott District Memorial Hospital (AKMH). The cause of death was determined to be a fatal cardiac arrhythmia in a lady with obstructed sleep apnoea and suffering an acute psychotic episode requiring sedation.

The Deputy State Coroner found the death occurred by way of natural causes. Expert opinion was given at the inquest that there are difficulties with the current mental health system which made it impossible for mental health facilities to properly care for acutely unwell mental health patients. Highly aroused patients have to be treated but the environment in a dedicated psychiatric facility is not protective of their clinical state, while an emergency department (ED) or acute setting is not therapeutic for their mental state. Mental health observation units were discussed as being an ideal model.

The recommendation made by the Deputy State Coroner was for the provision of mental health observation units attached to EDs, intensive care units, high dependency units for all hospitals that have mental health facilities to allow appropriate transition of mental health patients, with high clinical risk factors for sudden death, from acute areas to general mental health facilities.

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

One Health Service Provider (HSP) has a mental health observation area (MHOA) attached to its ED and two HSPs have plans for opening MHOAs to improve the service provided to mental health consumers. The other HSPs have co-management models in place to cater to the mental health patients depending on whether the medical or psychiatric presentation predominates.

All HSPs aim to provide care in the most appropriate clinical area based on the patient's needs. Recognising the need for a balance of clinical environments and staffing mix, HSPs have considered the need for mental health emergency centres (MHEC) and behavioural assessment units (BAU). MHOAs, staffed by mental health trained staff, are designed for the differentiated and medically cleared mental health patient that requires further observation before an appropriate pathway is determined. Behavioural Assessment Units (BAU), clinically governed by ED clinicians, provide care for the undifferentiated highly agitated and behaviourally disturbed patient. The co-location of MHOAs and BAUs with ED allows for the rapid transfer to high acuity medical care if needed and improve service integration with community mental health services.

The inquest recommendation has been duly considered and deemed closed.

DEBNAM

Christopher John Debnam, aged 40, died on 21 November 2014 at Graylands Hospital. The cause of death was determined to be consistent with cardiomyopathy with early pneumonia in a man with reported sleep apnoea and a high body mass index, due to natural causes.

The Deputy State Coroner was of the opinion that the supervision, treatment and care of the deceased in this case was reasonable, but expressed concerns regarding a lack of prior investigation of cardiac and respiratory conditions, and being in a facility that did not have extensive monitoring. The Deputy State Coroner made four recommendations that highlighted the need for good discharge planning to involve all stakeholders in care; the need for appropriate clinical investigation of community mental health patients with physical conditions; good documentation and communication; and the development of more acute care units for highly aroused mental health patients at high risk of cardiorespiratory arrest, such as mental health observation areas attached to acute facilities such as EDs, ICUs and HDUs.

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

Regarding recommendation 1, all Health Service Providers (HSPs) have policy/procedures in place which clearly outline the requirements for discharge planning and transfer of care for patients with mental health issues. Standardised documentation is used, engagement of stakeholders (including the patient, their carer and service to provide ongoing care) and post discharge follow up arrangements are outlined. Community mental health staff caring for community-based patients retain contact with inpatient mental health teams when their patients are admitted to hospital with the use of video conferencing.

The emphasis on clinical medical health issues in community mental health care as outlined in recommendation 2 is varied across the HSPs. Notably, one HSP has well developed processes for the monitoring of medical issues in community mental health patients and these would form part of the information handed over to inpatient teams if admission is indicated.

For recommendation 3, HSPs reported a range of policies, standards and guidelines to address the provision of safe monitored care for patients receiving sedation. Oximetric observations are considered depending on their clinical conditions and risk factors on balance with other risks based on the patient's individual needs.

Noting that essential sedation is an atypical requirement for contemporary mental health inpatient clinical care, HSPs stated that appropriate facilities exist for when highly aroused patients are sedated as suggested by recommendation 4. The importance that all relevant staff have sufficient training in sedation procedures was also noted.

The CRC considered the medication reconciliation procedures in place when mental health patients are being transferred within and/or out of hospital. HSPs described their medication reconciliation processes as a multidisciplinary team's responsibility on admission of a patient as well as on discharge and performed in conjunction with standardised handover processes.

The inquest recommendations have been duly considered and deemed closed.

Coronial inquests with no health related recommendation

Between 1 January 2019 and 30 June 2019, the CRC considered the following new coronial inquests where no health related recommendation was made: Ali Jaffari; William John Davis; Glenn William Strickland; Torran Jake Thomas; Lorna May Woods; Maris Kugis; Ronald Alan Giblett; Daniel Josef Adwent and SM.

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).

Thomas

The Coroner raised concern over information provided in first aid training about the treatment for heat stroke vs heat exhaustion. But the distinction between these relies on the clinical acumen of the first aid responders so the recommendations advised that the training be amended to remove the indecision or confusion by treating for heat stroke.

The CRC members deemed that raising awareness of heat stroke and the advice provided in the inquest was a public health issue. The Coronial Liaison Unit (CLU) coordinated with the relevant stakeholders to update the Department of Health's relevant internet sites about heat stroke as outlined in the inquest recommendation.

Woods

The CRC observed there were several missed opportunities for health professionals to raise the issue of appointing guardianship. This was in contrast to previous inquests that CRC have reviewed where guardians have been appointed at an earlier stage. Members also noted that Aboriginal services were not identified to engage with the deceased.

There may have been lack of awareness by clinicians that they have the ability to consider raising guardianship options. This will be raised with relevant stakeholders and the learnings will be highlighted in the Department of Health's annual From Death We Learn report that details this case.

Adwent

During their discussions of the issues raised in this inquest, CRC members observed that the case could provide lessons for surgeons and have contacted the Royal Australasian College of Surgeons (RACS) to disseminate the findings to their members.

This document can be made available in alternative formats on request for a person with a disability.