Progress Report for Health-Related Coronial Recommendations

Biannual Report – August 2021 Executive Summary

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

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Abbreviations

ATSI	Aboriginal and Torres Strait Islander
BUG	Business User Group
CAHS	Child and Adolescent Health Service
CARE Call	Care and Respond Early Call
CLU	Coronial Liaison Unit
CPU	Child Protection Unit
CRC	Coronial Review Committee
ED	Emergency Department
ED PSCQ	Executive Director Patient Safety and Clinical Quality
EMHS	East Metropolitan Health Service
GP	General Practitioner
HSP	Health Service Provider
HSS	Health Support Services
MH	Mental Health
MHC	Mental Health Commission
NaCS	Notifications and Clinical Summaries
NMHS	North Metropolitan Health Service
NSQHS	National Safety and Quality Health Service
PARROT	Paediatric Acute Recognition and Response Observation Tool
PCH	Perth Children's Hospital
SMHS	South Metropolitan Health Service
SPOCC	Statewide Protection of Children Coordination Unit
SJA	St John Ambulance
VTE	Venous thromboembolism
VTE Prevention CCS	Venous Thromboembolism Prevention Clinical Care Standard
WA	Western Australia
WACHS	WA Country Health Service

Introduction

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

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

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

Executive Summary

This report includes details about the implementation of recommendations of 1 ongoing case: Paul Strange. This report also includes information relating to the implementation or consideration of recommendations for 2 new cases, Renee Desiree Ruyzing and Cyril Churchill.

There was a total of 11 recommendations for the cases in this report that were relevant to the WA health system. Of these 11 recommendations, 5 have been duly considered, actioned appropriately by health stakeholders and marked as complete or closed; and, 6 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 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

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 biannual report), information that was provided in a previous report(s) is included along with new information for completeness. New information is differentiated by using the blue font colour in the tables of information at the end of the report.

In addition to health-related coronial inquests with recommendations, the CRC also considers health related coronial inquest findings where no recommendation is made for the WA health system. The CRC considers such inquests to identify opportunities for WA health system learnings and to 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: Macker Joseph Dinah, Jordan Robert Anderson, Tahlia Rose Bembridge, Simon John Sharpe, Paul Clifford York, Damien Purnell, Baby H, Levi Shane Clement Congdon, Baby JDU, Stephen Craig Solly and FJ. All new and ongoing cases with no health-related recommendation are included within the Executive Summary of this report. A summary of WA health system actions that have been taken in response to these cases as well as any system changes or actions which the CRC noted to have occurred (i.e. not in direct response to the death) and are relevant to a case are provided.

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

Coronial inquests with recommendations

STRANGE

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

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

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

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

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

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
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.

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

RUYZING

Renee Desiree Ruyzing, aged 21, died on 14 June 2015 from pulmonary thromboembolism in association with deep vein thrombosis following repair of a fractured ankle. The deceased sustained a trimalleolar ankle fracture whilst dancing. Due to the severity of swelling of her ankle, Ms Ruyzing received care at 3 public hospitals prior to surgery. She was treated with enoxaparin for venous thromboembolism (VTE) prophylaxis during this time. Her risk factors included recently commencing taking the oral contraceptive pill. Five days after the initial injury she underwent open reduction and external fixation at Fiona Stanley Hospital. The post-operative instructions provided did not include guidance on any further VTE prophylaxis as that decision would normally take place at the time of discharge. Two separate guidelines with differing protocols were in use at the time, however Ms Ruyzing was discharged home with no apparent VTE risk assessment or VTE prophylaxis. This was not identified when she was seen in the outpatient clinic for removal of sutures and replacement of cast. One month after the operation she developed chest pain, dyspnoea and palpitations, and was sent to the Rockingham General Hospital emergency department by her General Practitioner. Unfortunately, she collapsed in the waiting room and could not be revived.

During the inquest expert opinion was sought regarding the use of thromboprophylaxis following lower limb injury and surgery, and multiple guidelines were reviewed. No consensus opinion arose during the inquest regarding risk assessment or choice of anticoagulant, other than that VTE prophylaxis should have been provided to Ms Ruyzing for the period of immobilisation.

The Coroner made one recommendation for all Western Australian hospitals to implement a system of VTE risk assessment and prevention.

The Department of Health’s Coronial Review Committee (CRC) has reviewed these findings.

The CRC members discussed the Australian Commission on Safety and Quality in Health Care Venous Thromboembolism Prevention Clinical Care Standard (VTE Prevention CCS). The VTE Prevention CCS assists Health Service Providers in meeting the requirements of the National Safety and Quality Health Service (NSQHS) Standards for accreditation. The goal of the VTE Prevention CCS is to reduce avoidable death or disability caused by hospital-acquired VTE through improved identification of patients who are at risk, assessment of VTE and bleeding risk, and appropriate use of VTE prevention methods. The clinical care that patients should be offered in the prevention of hospital acquired VTE is reflected in seven quality statements. Quality Statements 1 (Assess and document VTE risk) and 7 (transition from hospital and ongoing care) of the VTE Prevention CCS were considered by the CRC as having particular relevance to the Ms Ruyzing’s care. In December 2020 the Executive Director Patient Safety and Clinical Quality (ED PSCQ) wrote to Health Service Providers asking them to share their progress and any potential challenges to implementing the VTE Prevention CCS, including Statement 1 and Statement 7. CRC members reviewed the Health Service Provider responses to the ED PSCQ correspondence and observed that challenges remain in risk assessment documentation and the lack of clinical consensus as to post-discharge thromboprophylaxis and VTE prevention. Members concluded that Health Service Providers have policies, compliance activities and supporting information for patients in place for the prevention of hospital-acquired VTE and following review have identified the implementation of the VTE Prevention CCS remains a work in progress, with ongoing monitoring to occur via NSQHS accreditation.

The CRC members agreed that implementation of the VTE Prevention CCS adequately addresses the Coroner's recommendation and the recommendation has been considered and deemed it closed.

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

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

Coronial inquests with no health-related recommendation

Between 1 January 2021 and 31 July 2021, the CRC considered the following new coronial inquests where no health-related recommendation was made: Macker Joseph Dinah, Jordan Robert Anderson, Tahlia Rose Bembridge, Simon John Sharpe, Paul Clifford York, Damien Purnell, Baby H, Levi Shane Clement Congdon, Baby JDU, Stephen Craig Solly and FJ.

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).

Bembridge

Thalia Bembridge, aged 4 years, died on 2 October 2015 from transverse colon volvulus following transfer from Bunbury hospital. The inquest examined the treatment and care provided to Tahlia at Bunbury Hospital; particularly the failure to identify the severity of her condition and the delay in transferring her to Princess Margaret Hospital once the decision to transfer her had been made. The CRC observed the changes made since the death as noted by the Coroner. As per the inquest findings WACHS advised of the processes in place surrounding the memorandum of understanding between the Bunbury Hospital Surgical and Paediatric teams, the utilisation of the Perth Children's Hospital (PCH) Clinical Practice Guidelines, and in principal agreement for transfer arrangements between Bunbury Hospital and PCH for children with ambiguous abdominal pain.

A number of policy mechanisms are in place to facilitate the early recognition and response to acute deterioration. *Recognising and Responding to Acute Deterioration Policy* requires all Health Service Providers and Contracted Health Entities to develop local policies for the early recognition and response to acute physiological and mental state deterioration. The WACHS *Clinical Escalation of Acute Physiological Deterioration including Medical Emergency Response Policy* was most recently reviewed and republished in November 2020. Bunbury Hospital paediatric ward participates in monthly audits of the current observation charts to monitor compliance with the Recognising and Responding to Acute Deterioration systems, with results reported to the local Hospital Patient Safety and Quality Committee. CRC members observed the requirements for all Health Service Providers to be accredited against the NSQHS *Recognising and Responding to Acute Deterioration Standard*.

In 2017/18 the Care and Respond Early Call (CARE Call) model for patient carer escalation was implemented in all WACHS regions. As of August 2021, patients and families at Bunbury Hospital have made 21 CARE Calls since the implementation in 2017.

There have been a number of changes to the transfer transport options from Bunbury Hospital to metropolitan tertiary centres. These include road ambulance, Royal Flying Doctor Service air and road transfer and rotary wing helicopter service. Transfers are further supported by the inter-hospital acute patient transfer coordination function in the WA Country Health Service Command Centre, a 24/7 virtual clinical hub which supports access to a range of clinical expertise via virtual technologies. This includes acute emergency and inpatient care; and facilitating and coordinating safe, timely and efficient patient transport to and from country and metropolitan hospitals for country patients. Bunbury Hospital has established a seven day per week Patient Flow Command Centre that is being operationalised to further streamline patient flow and inter hospital transfers.

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 however 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.

The SPOCC review and analysis task has been commenced with 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 Coronial Liaison Unit 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.

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 and Multicultural Mental Health Subnetwork to seek further information on the proposed future delivery of transcultural mental health service models in WA.

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

The Dungay inquest was considered by the CRC and it was observed that the WA coronial inquest into the death of Warwick Andrew Ashdown in 2011 identified similar issues. Mr Ashdown had been physically restrained, face down with his head, arms and legs being held at the time of his death. The CRC agreed that Health Service Providers would review actions arising from the Ashdown inquest for current arrangements regarding restraint including prone restraint monitoring, reporting and staff training (clinical and non-clinical) for all areas (including mental health) where restraint is applied. In the February 2021 biannual report information was detailed regarding the assurances provided by Health Service Providers regarding appropriate policies, procedures and arrangements are in place to monitor, report and train staff regarding the use of restraint in reinforcing that physical restraint is seen as a strategy of last resort and that care is provided in the least restrictive manner.

Health Service Providers indicated compliance with the Chief Psychiatrist statutory standard regarding restraint reduction requirements for public and private mental health services. Practices included monitoring and recording the frequency and duration of restraint use, documentation in the patients medical record, utilisation of dashboards, clinical incident management review, and reporting to executive, committees and/or working groups. In the February 2021 biannual report it was identified that practices however varied for the systematic and central recording and reporting of restraint in non-mental health settings. CRC further discussed strategies for reporting non-mental health restraint and identified governance occurs at local levels to monitor episodes of non-mental health restraint and further consideration is required for all Health Service Providers to improve reporting at area executive and broad level. CRC members observed that reporting all episodes of restraint is an NSQHS accreditation standard and that improvements in non-mental health restraint can be monitored via this mechanism.

Windie
Ms Windie died in Carnarvon Hospital on 29 October 2016 from bowel obstruction aged 22. The inquest focused on the care provided to the deceased and the circumstances surrounding the possible failure of transfer to Sir Charles Gairdner Hospital. The Coroner noted since the deceased's death there have been improvements to the process of accepting transfers of patients into tertiary hospitals from rural hospitals, including the introduction of the WA Country Health Service (WACHS) Command Centre. The CRC were uncertain that the introduction of the Command Centre would have resolved the issues raised in this inquest and discussed other improvements that have been implemented. The North Metropolitan Health Service (NMHS) reported that an intra-hospital working group has been established to review issues regarding communication between clinical staff, escalation pathways and aims to address problems with clinical issues only being raised to a senior clinician after it is a critical situation for the patient. The NMHS agreed to expand the scope of the working group to include the escalation of clinical concerns of clinicians from referring hospitals to colleagues within the teaching hospital system including the discounting of the clinical judgement of clinicians outside the teaching hospital system. Following the update provided in the February 2021 biannual report, the CRC observed that the NMHS intra-hospital working group deliverables on policy, strategies and data collection methodology continue and agreed that the inquest findings have been considered and deemed them closed.

Paraone
Malakai Paraone died at Princess Margaret Hospital on 26 August 2016 from sepsis at the age of 7 months. The CRC observed that Group A strep in children can have a vague presentation and that clues are tachycardia, fever and little in the way of other physical signs. CRC discussion included discussion of the Perth Children's Hospital (PCH) Sepsis Emergency Department guidelines which flag fever or hypothermia with tachycardia as possible sepsis. CRC members agreed that the tachycardia should have flagged further investigation. 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. The Department of Health is currently investigating opportunities for 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.

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. 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. As such WACHS has commenced a review of the existing consumer resources with respect to suitability of content, presentation and accessibility. Progress of this inquest to be included in the next biannual report.

PT
CRC members observed in contrast to the State Coroners recommendation that a training program is available for mandatory reporters, however there are no legislative mechanisms that mandate completion of the program. In the absence of mandatory training, 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 in abuse of non-ambulant children, 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.

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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