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

Progress Report for Health-Related Coronial Recommendations

Biannual Report – August 2022 Executive Summary

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The Coronial Liaison Unit 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
AWOL	Absent without leave
BMI	Body Mass Index
CAHS	Child and Adolescent Health Service
CaLD	Culturally and linguistically diverse
CAMHS	Child and Adolescent Mental Health Services
CCTV	Closed circuit television (video surveillance)
CLASP	Changes in Lifestyle are Successful in Partnership
CLU	Coronial Liaison Unit
COVID-19	Corona virus disease 2019
CPN	Child Protection Network
CPU	Child Protection Unit
CRC	Coronial Review Committee
CTO	Community Treatment Order
DAMA	Discharge against medical advice
DNA/DNW	Did Not Attend/Did Not Wait
ED	Emergency department
EDIS	Emergency Department Information System
EMHS	East Metropolitan Health Service
FSFHG	Fiona Stanley Fremantle Hospital Group
FSH	Fiona Stanley Hospital
FTE	Full time equivalent
GP	General Practitioner
HDU	High dependency unit
HSP	Health Service Provider
HWS	Healthy Weight Service
KEMH	King Edward Memorial Hospital
LDU	Low Dependency Unit
MDT	Multi-disciplinary team
MET	Medical Emergency Team
MH	Mental Health
MHC	Mental Health Commission
MHU	Mental health unit
NAIDOC	National Aboriginal and Islanders Day Observance Committee
NMHS	North Metropolitan Health Service
OMS	Oncology Management System
PATS	Patient Assisted Travel Scheme
PCH	Perth Children’s Hospital
PHC	Peel Health Campus
PMH	Princess Margaret Hospital
RANZCP	Royal Australian and New Zealand College of Psychiatrists
RCPA	Royal College of Pathologists of Australia
RkPG	Rockingham Kwinana Peel Group

RPH	Royal Perth Hospital
SAC	Severity Assessment Code
SCGH	Sir Charles Gairdner Hospital
SJA	St John Ambulance
SMHS	South Metropolitan Health Service
SPOCC	Statewide Protection of Children Coordination Unit
SSU	Short Stay Unit
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.

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.

Executive Summary

For the period of 1 January 2022 to 30 June 2022 the CRC considered 17 coronial inquest findings (9 for discussion; 8 for noting). Due to the increased COVID-19 impact on the WA health system during this period, CRC meetings were suspended for the months March, April and May 2022. No cases were considered in this three-month period.

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 two ongoing cases: Chad Riley and Child AM. This report also includes information relating to the implementation or consideration of recommendations for five new cases: Brockliss, Craig, Miss T, Williams, and Edwards.

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, two have been duly considered, actioned appropriately by health stakeholders and marked as complete or closed; and 12 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 ongoing (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. Detailed actions of Health Service Providers are contained within the tables of information at the end of this report, new information is differentiated by using the blue font colour.

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 (ED) 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 ED. Over the next seven hours Mr Riley was seen on CCTV returning to the ED 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 ED 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, resuscitation was commenced, he was taken by Ambulance to the RPH ED however could not be revived.

The coroner made six recommendations, two were directed to the East Metropolitan Health Service (EMHS) and four were directed to the Western Australian Police Force. The recommendations directed to the EMHS focussed on patients who do not wait to be seen after registration at ED (recommendation 1) and the availability of Aboriginal Liaison Officers (ALO) (recommendation 2).

The CRC has reviewed these findings and agreed that the recommendations directed to the EMHS were also applicable to all Health Service Providers. Enquiries were made with all relevant stakeholders.

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.

In the absence of relevant policy, all other 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 has developed a draft *EMHS Did Not Wait Policy* which is currently undergoing stakeholder consultation. It is anticipated that the policy will be endorsed by September 2022. The South Metropolitan Health Service (SMHS) intend to develop a do not wait policy; the North Metropolitan Health Service (NMHS) are undertaking further liaison to identify if a policy will benefit NMHS patients; and the Child and Adolescent Health Service (CAHS) currently has a work instruction, and are formalising a procedure based on audit findings and the WACHS policy.

Health Service Providers have advised of several further mechanisms to monitor patients who do not wait which included indicators in the Health Service Performance Report. In addition to this, 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 several strategies that support the implementation of the did not wait policy, including 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, ALO presence in ED waiting rooms and increase in social work hours. Strategies also include identification of patients on webPAS with high risk of ‘do not wait’ to allow early assessment and follow-up of these patients on re-admission.

In response the recommendation addressing the availability of ALOs, EMHS advised that an additional 5.1FTE ALOs have been recruited and EMHS is aiming to recruit an additional 0.8FTE for mental health services at Armadale Kalamunda Group. Following a review assessing where the additional ALOs would be most beneficial, the additional resources have been allocated accordingly. These include additional resourcing to a range of afternoon, evening and weekend services. In addition, EMHS have developed a suite of informative videos for Aboriginal people to be viewed in ED waiting rooms, free to air patient channel (TV) and outpatient areas. The Welcome to Country and Discharge Against Medical Advice (DAMA) videos were launched in NAIDOC week July 2022. These animation videos use subtitles and language translation.

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 ED. One Hospital is currently extending this service to the ED and is seeking to identify ways to increase access to seven days. Another hospital advised that an on-call 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.

- The Royal Australian and New Zealand College of Psychiatrists (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. The RANZCP suggested that police 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 Royal College of Pathologists of Australasia (RCPA) advised that the College does not have a Position Statement on the use of the term excited delirium. The RCPA provided further advice that police training should include the dangers of physical restraint especially in potentially intoxicated or agitated persons.
- The Australasian College for Emergency Medicine (ACEM) confirmed that, at present, the term excited delirium is not a term that its members would see being used within the ED setting. The term ‘acute severe behavioural disturbance’ is more commonly used by emergency physicians. This is a clinically defined syndrome which is broadly used by health professionals, and is the term used in clinical guidelines and protocols developed and referenced by ACEM’s members. The syndrome can be caused by a variety of underlying medical conditions and when a patient experiences acute severe behavioural disturbance, it is a prompt for clinicians to seek, and treat, any underlying conditions.

The advice of the three Colleges was included in correspondence to the Police Commissioner in relation to the Congdon and Riley inquest findings. This correspondence expressed concerns about the use of the term ‘excited delirium’ when communicating with officers and clinicians across the health sector. The response indicated that the relevant coronial findings had been reviewed within the WA Police Force and significant work had been undertaken to consider the use of the term excited delirium. This included liaison with the St John Ambulance to increase the collective understanding of each organisation’s terminology and processes; and advising WA Police Force personnel on the need to use plain language to describe symptoms wherever possible. The WA Police Force indicated an ongoing rationale for continued use of the term excited delirium, specifically existing training and education of officers which teaches the importance of managing the medical emergency as well as the behaviour in dynamic situations.

The CRC members agreed that recommendation 2 pertaining to recruitment of ALOs has been considered actioned and completed; and progress of recommendation 1 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 the 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.

Following receipt of advice from the CAHS, 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 state-wide 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 occurred between CAHS and WACHS to determine how best to approach children with severe obesity in the regions with initial discussions suggesting that 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.

CAHS acknowledged the increasing need for the WA health system to deliver services that are culturally appropriate across Aboriginal and Culturally and Linguistically diverse (CALD) 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 considered that other avenues existed to better engage Aboriginal families accessing the HWS through involvement with the CAHS Aboriginal Health Team and WACHS Aboriginal families.

WACHS has advised that they remain committed to collaborating with CAHS to develop effective pathways for country children to access specialist services at PCH and are due to meet in August 2022 to progress these recommendations. WACHS also advised that they had met with CAHS on the related issue of access to paediatric endocrinology and diabetes services and will be

represented on the Program Control Group that will oversee Stream 2, Phase 1: Paediatric Hospital Clinical Services Planning Review. One of the tasks of this group will be to consider secondary, tertiary and quaternary paediatric services and provide recommendations to inform whole of health system planning to meet the demand for paediatric health needs.

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

BROCKLISS

Russell David Brockliss was a 38-year-old man with a long history of treatment resistant mental illness, variably diagnosed as schizophrenia and schizoaffective disorder. Death was found to be consistent with acute cardiac arrhythmia in a man with focal coronary atherosclerosis and morbid obesity. His illness was complicated by poor adherence to prescribed medication regimes and illicit drug use. He was known to become aggressive when his mental health deteriorated, requiring admission to hospital where he would usually settle quickly with oral medication. At the time of his death Mr B was an involuntary patient being treated in a High Dependency Unit (HDU) of Broome Regional Hospital. He was found unresponsive at around 8:30am when nursing staff entered the room to complete observations and take blood samples. A MET call was initiated; resuscitation attempts commenced but were unsuccessful. It was thought that death was likely to have occurred before the last set of visual observations taken at 8:15am.

The coroner made one recommendation relating to funding for the redevelopment of the HDU which would facilitate regular visual observations and furnished in a way to enable easy access for resuscitation purposes.

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

In recognition that a major redesign and redevelopment of the HDU was required to ensure that all the requirements to function as an HDU were met, WACHS has completed a functional brief for a redevelopment and has had this costed. The WACHS is currently progressing a request for funds, with three separate proposed designs estimated to cost in excess of $9 million. The functional brief anticipates practical completion of works by December 2025. A Project Manager has been appointed to oversee the implementation of recommendations made to Kimberley Mental Health, including the findings of the Brockliss inquest. In the meantime, the risks associated with the closure of high-dependency care in the Mabu Liyan is regularly assessed to minimise the impact on the community, and patients' needs are assessed on an individual basis with alternative arrangements being made where required.

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

CRAIG

Robert Charles Craig died aged 73 years as a result of disseminated malignancy (known advanced lung carcinoma and mouth carcinoma) in a man with comorbidities including chronic obstructive pulmonary disease. At the time of his death Mr Craig was a sentenced prisoner. Due to a failure in communication between two specialty clinics within Fiona Stanley Hospital (FSH), Mr C did not receive the most appropriate form of chemotherapy to maximise radiotherapy for his lung cancer, nor did he receive treatment following surgical removal of his oral cancer. When the errors in treatment were realised, the optimal window for post-operative radiotherapy for the oral cancer had lapsed, and the lung cancer had metastasised to his liver.

The coroner made two recommendations relating to actions to ensure the accuracy of notes from discussions at multidisciplinary meetings; and the appropriate and timely triage of referrals via the e-Referral system.

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

The SMHS have advised that the best practice multidisciplinary team (MDT) terms of reference for head and neck cancers has been endorsed by Fiona Stanley Fremantle Hospital Group (FSFHG) Clinical Governance Committee. In addition, a best practice MDT terms of reference for high risk MDTs was developed and is currently being scoped in collaboration with clinical teams using technological solutions to support MDTs. SMHS aims to ensure this work will streamline processes including automating data linkage to pre-populate data where possible, establishing formal minimum agenda items and inbuilt approval and communications automation. Further, the e-referral system at FSH includes a mandatory text box requiring the referring clinician to state the reason for the referral and nature of the referral. Modifications have been made to the e-referral system for oncology to include mandatory fields including specifying the cancer involved, and whether the patient has been referred to Radiation Oncology. In addition, there is a field to indicate whether the patient has been discussed at an MDT meeting.

In addition to the recommendations, the coroner made suggestions that were considered by CRC. With regard to these suggestions, the SMHS have advised that:

- the SMHS MDT Terms of Reference will assist in ensuring that the most recent treatment plans are clearly and unambiguously labelled;
- MDT notes are already in their own folder on BossNet, via a filter function;
- one of the two cancer coordinators have commenced at FSFHG and the recruitment process has been initiated for the additional position;
- SMHS are implementing the CHARM Oncology Management System (OMS). The OMS will replace the existing paper toolset with a fully digitised system capable of managing the prescription, validation, ordering, dispensing and administration of chemotherapy.

The CRC members agreed that recommendation 2 has been considered actioned and completed and the progress of recommendation 1 will be updated in the next biannual report.

MISS T

Miss T died at home aged 16 from acute abdominal obstruction secondary to adhesions associated with severe pelvic inflammatory disease. Miss T sought medical care three times in the two weeks prior to her death. The first visit was to the hospital ED following an alleged assault. The second visit was to an Aboriginal medical service where she discussed several issues including the assault and new onset vaginal discharge. She was noted to have a BMI under 15 and leucocytes on urinalysis, with otherwise normal vital signs. She did not return the following day for further review as recommended. The third visit was via ambulance to the hospital ED after she had vomited through the night. With no other obvious signs of infection, a raised white cell count was attributed to dehydration. When her pain settled, and she was able to retain fluids, she was discharged following further review with advice to see her GP if she had concerns. Early the following morning, she started vomiting at home and an ambulance was called when she became unresponsive. Paramedics did not detect signs of life when they arrived, so resuscitation was not attempted.

The coroner made two recommendations relating to funding to enable the creation of a short-stay unit (SSU) at the regional ED; and the employment of Aboriginal Liaison Officers (ALO) in the ED.

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

WACHS have advised that Short Stay Beds established in 2012 have now been equipped with furniture and fittings and are in the process of being added to the bed administration system as formal beds for the health campus. Following this, briefings will be prepared to increase the sites staffing to support operationalising these beds; this will include nursing, and patient support services. Models of increasing the medical workforce within the HDU to support the SSU are also being explored. Once operational, the effectiveness of the SSU beds will be evaluated. The Kalgoorlie Health Campus has recently been successful in appointing an ALO to the ED. Further, a position has recently been filled to undertake work to change the model of service for ALOs to a service-wide, team-based approach with the goal to increase the sustainability and cultural appropriateness of the ALO service.

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

WILLIAMS

Jordan James Williams died, aged 20, when struck by a train after absconding from Kalgoorlie Health Campus Mental Health Unit (MHU) where he was an involuntary patient. Mr Williams had made multiple attempts to abscond; on one occasion he successfully scaled the fence of the courtyard and was found shortly afterwards. That same evening, he managed to escape again, and was struck by a train before he could be found.

Three recommendations were made relating to the height of the fencing around the MHU courtyard, the security of fencing surrounding the railway tracks, and resourcing to enable construction of a purpose-built mental health facility with appropriate staffing once established.

The CRC has reviewed these findings and discussion included advice from WACHS about the progress made against the three recommendations. Members noted that at the time of the June 2022 CRC meeting, the pre-tender estimates process had been completed and the tender for fencing works had closed with work anticipated to be completed by the end of August 2022. WACHS advised members that they had formally corresponded with the Office of Rail Safety and ARC Infrastructure to bring the matter of safety of railway fencing to their attention. Further, a business case had been submitted to Treasury for the proposed 2022-23 Budget; however, members noted that this had not been successful.

Further enquiries will be made with relevant stakeholders and progress of these three recommendations will be updated in the next biannual report.

EDWARDS

Morgan John Edwards died, aged 31 years, as a result of complications in association with intestinal volvulus. He was born with Smith-Magenis syndrome: a chromosomal abnormality that results in a range of developmental delays and skeletal abnormalities. He was non-verbal; and had Crohn’s disease and had previously experienced bowel obstruction from pseudo-volvulus. He lived in a group home, supported by two carers on morning and afternoon shifts, and one carer overnight. An ambulance was called one evening when a carer noted he had rapid breathing and groaning, and he was transferred to hospital. No clear diagnosis was found, and he appeared to improve without intervention so was discharged. Mr Edwards continued to be unwell the following day. During a routine annual review in the afternoon, his gastroenterologist had concerns about a potential chest infection and organised transfer to the ED. On arrival he was clearly very unwell. Whilst in the radiology department awaiting CT scan, Mr Edwards developed a ventricular tachyarrhythmia. Resuscitation attempts were unsuccessful.

Two of six recommendations were directed to SMHS and related to policy for discharge summaries to provide detailed instructions, and consideration of a lower threshold for admission for non-verbal patients.

The CRC has reviewed these findings and discussion included comments from SMHS about the two recommendations. Members noted that FSH has a dedicated discharge policy for ED, which includes a section for patients returning to a residential facility; however, the focus is on transport and contacting the facility. SMHS advised that the policy will be reviewed with consideration given to specify symptoms to monitor. Regarding the recommendation to advise ED clinicians to adopt a lower threshold for admission with respect to patients who are non-verbal, further consultation with ED clinicians is required.

Further enquiries will be made with relevant stakeholders and progress of these two recommendations will be updated in the next biannual report.

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. 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).

Between 1 January 2022 to 30 June 2022, the CRC considered the following new coronial inquests where no health-related recommendations were made: Walsh, Martin, Wani and Scott. Further information is also provided for the following ongoing coronial inquests where no health-related recommendations were made: Baby H and Congdon.

BABY H

Baby H died on 28 May 2017, aged four 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.

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.

An update on the implementation of these recommendations was sought from SPOCC for the August 2022 Biannual Report. Progression of these recommendations have been hampered due to COVID pressures on the WA health system, however, the following advice was provided.

The Child Protection Network (CPN) has supported the use of the current CAHS proforma however there was acknowledgement of the need to develop a standardised assessment tool. Moving forward the proforma scope, criteria for use and content will be reviewed in line with current best practices and new clinical decision-making tools. The review is expected to take three months and will involve clinical expertise from all HSPs.

Acknowledging the challenges in standardising Safety Net meetings for all services across the system, the CPN agreed on a minimum standard for a Safety Net team, which includes expectations for: the number and expertise of members; the frequency of meetings; record keeping; and, referrals to the Department of Communities and Police.

The CPN also recommended that HSPs nominate a clinical lead for the Safety Net team and ensure participants are adequately resourced to undertake the work. Further, it recommended that local Safety Net teams share information with the child's child health nurse and general practitioner particularly in scenarios of multiple presentations with accidental injuries.

To support standardisation of Safety Net procedures, the PCH Child Protection Unit (CPU) will work in collaboration with SPOCC to develop an e-learning module for all staff participating in Safety Net meetings. The module will cover the importance of injury identification in young children, red flags suggestive for child abuse, the injury proforma, the purpose of Safety Net meetings, and who to contact if there are concerns.

The CPN agreed that the injury proforma should be used for all children two years and under presenting with an injury, burn, immersion or ingestion. The CPN acknowledged that some centres could consider including older children noting that it has limited relevance in children over two years of age and it may be misleading to clinicians if used in this age group.

Safeguarding children through the ability to recognise, respond, record and report child abuse concerns is a core function of the WA health system. PCH CPU provides accredited medical education targeted to Paediatricians and Paediatric Registrars, and Emergency Department Registrar training. CPU also provides a range of clinical education on request to PCH, WACHS, CAMHS and Allied Health (and other agency) workforces and medical training requests. SPOCC provides education, guidelines and on-line resources to support WA health system staff in managing child abuse concerns.

The CPU and SPOCC have developed a video (85 minutes) titled 'non-accidental injury in non-ambulant children'. The content includes information on risk factors for abuse; sentinel injuries; bruising in infants; and abusive head trauma. The video has been promoted to CAHS - Community Health and WACHS and is accessed via the SPOCC health point page. In addition, Community Health teams can request additional targeted educational and team development activities with CPU and/or SPOCC to discuss issues and utilise case scenarios in the context of their work environment and to meet specific needs.

The CPU have developed additional educational films on child abuse including 'approach to non-accidental injury' that includes a specific reference to non-accidental injury in non-ambulant children and 'bruising' which are actively promoted to WA health system staff and accessed via the CPU health point page.

The implementation of the recommendations from the SPOCC review will continue and progress relating to this inquest will 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, particularly 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.

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 professional colleges representing pathologists (RCPA), emergency physicians (ACEM) and psychiatrists (RANZCP) to determine their position on the use of the term. As outlined in the update provided for the Riley findings:

- The 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).

- Similarly, the RCPA advised that it does not have a Position Statement on the use of the term Excited Delirium.
- The ACEM confirmed that, at present, the term 'excited delirium' is not a term that its members would see being used within the emergency department setting.

The advice of the three Colleges was included in correspondence to the Police Commissioner in relation to the Congdon and Riley inquest findings. This correspondence expressed concerns about the use of the term 'excited delirium' when communicating with officers and clinicians across the health sector. The response indicated that the relevant coronial findings had been reviewed within the WA Police Force and significant work had been undertaken to consider the use of the term excited delirium. This included liaison with the St John Ambulance to increase the collective understanding of each organisation's terminology and processes; and advising WA Police Force personnel on the need to use plain language to describe symptoms wherever possible. The WA Police Force indicated an ongoing rationale for continued use of the term excited delirium, specifically existing training and education of officers which teaches the importance of managing the medical emergency as well as the behaviour in dynamic situations.

WALSH

Samuel Mark Walsh was a 38-year-old man who, at the time of his disappearance, resided at a care facility under conditions related to a custody order under the *Criminal Law (Mentally Impaired Accused) Act 1996*. He had responded well to treatment and was granted Leave of Absence, however he failed to return on one occasion and was later discovered deceased in his vehicle in a remote WA area. It was concluded that there was a real possibility he had already died by the time his absence was first noted.

No recommendations were made; however, the case was discussed at CRC in January 2022. Members noted NMHS advice that the incident had highlighted opportunities for improvement for NMHS in terms of follow up processes and policies, and that these were reviewed at the time. Further assurance was sought in relation to the audit processes in place to ensure the process was functioning well.

NMHS subsequently advised that the relevant policy currently in place is the *NMHS MH Missing or Suspected Missing Patient Policy*. This is pending review awaiting the review of the Department of Health's *Missing Person Policy*. Compliance monitoring against the *NMHS MH Missing or Suspected Missing Patient Policy* includes clinical incident investigations or clinical reviews. The SAC1 Review Sub-committee is notified of SAC 1 clinical incidents relating to missing persons, including details regarding the missing person such as clinical risk assessment and current status.

Regarding ongoing evaluation, NMHS have an audit titled "Absent Without Leave (AWOL) / Missing Persons cases". This audit aims to identify trends, themes on incident types, locations and other parameters deemed relevant to the risk of AWOL which may indicate the need to implement measures to reduce their occurrence. The audit is scheduled annually, however competing priorities and COVID prevented this from occurring in 2020. A comprehensive report was prepared in 2019 which was tabled at MH Executive Committees. In May 2021, a report was run comparing Missing persons in Datix Clinical Incident Management System from 2018 to May 2021 and tabled at the Mental Health, Public Health and Dental Services Clinical Governance Committee.

NMHS highlighted that, in their current format, the analysis reports in 2019 and 2021, do not capture clinical risk assessment and management (Department of Health's *Clinical Care of People Who May Be Suicidal Policy*). The audit which captures this information and is more relevant at this point is the NMHS MH Clinical Risk Assessment and Management (CRAM) Audit. The 2022 NMHS MH CRAM audit has recently closed, and a report is due to be written.

MARTIN

Scott William Martin, aged 40 years, died following emergency surgery to remove two knives lodged in his back. He was a random victim of a man who had a background of criminal convictions, as well as heavy alcohol, THC and methamphetamine use. The offender was experiencing drug-induced psychosis at the time breaking into Mr M's apartment and attacking him. The offender had been released from police custody and dropped off at the address shortly before the attack. Following a review of statutory options to detain the offender, no criticism was made of the decisions relating to his release.

Recommendations were made regarding the continued funding and expansion of the Mental Health Co-response model.

This case was discussed at CRC in February 2022 and members noted the continuation of the Mental Health Co-response in Rockingham, Peel and Cockburn areas, with funding to be provided by the Mental Health Commission (MHC) to expand the service to operate from the Mandurah Police Station.

The CLU sought advice from the MHC regarding the status of the Mental Health Co-response model and the plans to broaden implementation to other areas. Advice received from the MHC indicated that, as part of the 2021 Election Commitment, funding had been allocated to expand the current program by increasing the metropolitan capacity to seven days per week in eight locations and the addition of two regional mobile teams, in Bunbury and Geraldton. The Geraldton regional model commenced in September 2021. This model involves a two phased approach, with a hub (town) model operating in the first instance and a spoke (remote) model to be implemented later in 2022. Further to this this, Aboriginal mental health workers are available to the regional teams, providing informed support from a local knowledge and cultural perspective.

It was advised that from July 2022, the mobile teams would expand to Bunbury and the Metropolitan Teams would increase from four to eight. The expansion was to include the provision of additional mental health and alcohol and other drug support at the Perth Watch House (inclusive of alcohol and other drug support workers and an Aboriginal Mental Health worker), an increase in Mental Health Practitioners at the Perth Operations Centre, and additional training for police officers and Mental Health Practitioners, particularly around trauma informed care. The WA Police Force, HSPs and MHC are working together on the expansion in the metropolitan area, and how this may be improved and enhanced to ensure the best possible outcomes for all.

WANI

Elia Wani died aged 29 years from acquired methaemoglobinaemia in association with sodium nitrite toxicity by manner of suicide. Mr Wani had been diagnosed with bipolar affective disorder. Following multiple inpatient admissions with deterioration related to nonadherence with medication regime, he was made subject to a Community Treatment Order. There was no record of him expressing any self-harm or suicide ideation or making any attempts at any stage, and no

evidence of recreational drug or alcohol use in the last few years of his life. He was reported by his family and health care team to be well with no risks identified. He was found unresponsive in his room and an ambulance was called. Mr Wani had left a note stating that he had ingested 25g of sodium nitrite to end his life. Resuscitation attempts by paramedics and hospital staff were unsuccessful.

The coroner made two recommendations relating to the regulation of sodium nitrate and raising awareness among suppliers of products containing sodium nitrite of its capacity to cause death in the context of suicide.

This case was discussed at CRC in February 2022 and members noted the response from the Therapeutic Goods Administration posted on the Coroner's Court website. Members discussed the algorithms for online search results with a search for sodium nitrite leading users to other consumables relevant to suicide. The Chair of CRC contacted the Director of New York Poisons Centre to raise this issue and highlight concerns about the search algorithms, with a view that this concern would be addressed to the American online retailer.

SCOTT

Jeremy Michael Scott was 63 years old when he died from metastatic renal carcinoma. His healthcare for the last third of his life had been provided through the prison system. Mr Scott had informed prison medical officers of a rectal mass on several occasions but declined rectal examination. By the time the mass was examined in hospital, investigations revealed a poorly differentiated adenosquamous carcinoma with widespread metastases. He rapidly developed liver failure and was deemed too unwell for treatment. He was palliated in hospital. Findings indicated there were several missed opportunities to diagnose the cancer in Mr Scott's last two years.

The coroner made two recommendations relating to the monitoring and tracking of referrals to health services for prisoners; and amendment of policy to prioritise annual reviews of vulnerable prisoners.

This case was discussed at CRC in February 2022 and members noted that there is currently no relationship to Health in terms of clinical governance or patient safety systems. The CLU extended an invitation to the Department of Justice to discuss the case with a view to share resources about clinical governance.

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