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

Progress Report for Health-Related Coronial Recommendations

Biannual Report – February 2023 Executive Summary

Acknowledgements

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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

ACCHO	Aboriginal Community Controlled Health Organisation
ACEM	Australasian College for Emergency Medicine
EARA	Environmental Aggression Risk Assessment
ALO	Aboriginal Liaison Officer
ATSI	Aboriginal and Torres Strait Islander
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)
CCU	Community care unit
CHN	Child health nurse
CLASP	Changes in Lifestyle are Successful in Partnership
CLU	Coronial Liaison Unit
CPU	Child Protection Unit
CRC	Coronial Review Committee
CRS	Central Referral Service
DAMA	Discharge against medical advice
DNA/DNW	Did Not Attend/Did Not Wait
ECHS	Enhanced Child Health Schedule
ED	Emergency department
EDDS	Eating Disorder Specialist Service
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
GRAFT	Graylands Reconfiguration and Forensic Taskforce
HDU	High dependency unit
HHCT	Homeless Health Care Team
HSP	Health Service Provider
HWS	Healthy Weight Service
ICT	Information and communications technology
ISD	Impact statement and declaration
KEMH	King Edward Memorial Hospital
LDU	Low Dependency Unit
MDT	Multi-disciplinary team
MET	Medical Emergency Team
MHA	*Mental Health Act 2014*
MHC	Mental Health Commission
MHU	Mental health unit
NAIDOC	National Aboriginal and Islanders Day Observance Committee
NDIS	National Disability Insurance Scheme
NEDC	National Eating Disorders Collaboration

NMHS	North Metropolitan Health Service
OIS	Oncology Information System
OMS	Oncology Management System
ORP	Outpatient Reform Program
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
SATS	Oxygen saturation (Pulse oximeter)
SCGH	Sir Charles Gairdner Hospital
SECU	Secure extended care unit
SEHA	School Entry Health Assessment
SJGMPH	St John of God Midland Public Hospital
SMHS	South Metropolitan Health Service
SPOCC	Statewide Protection of Children Coordination Unit
SSU	Short Stay Unit
WA	Western Australia
WACHS	WA Country Health Service
WAEDOCS	WA Eating Disorders Outreach and Consultation Service
WAEDSS	WA Eating Disorder Specialist Service
WAPHA	WA Primary Health Alliance
WEAT	WA Emergency Access Target
WPI	Workplace inspections

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.

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 July 2022 to 31 December 2022 the CRC considered 13 coronial inquest findings (4 for discussion; 9 for noting).

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 Coroner's Court website at http://www.coronerscourt.wa.gov.au/default.aspx

Coronial inquests with recommendations

This report includes details about the implementation of recommendations of seven ongoing cases: Chad Riley, Child AM, Russell Brockliss, Robert Craig, Miss T, Jordan Williams and Morgan Edwards. This report also includes information relating to the implementation or consideration of recommendations for two new cases: Seth Yeeda and Quoc Tran.

There was a total of 16 recommendations for the cases in this report that were relevant to the WA health system. Of these 16 recommendations, nine have been duly considered, actioned appropriately by health stakeholders, and marked as complete or closed; and seven 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 years, 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 review for Aboriginal Health Impact Statement and Declaration (ISD). It is anticipated that the policy will be endorsed in February 2023. 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 television 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 suggested 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 WACHS Population Health will lead this work going forward, which will ensure alignment with the WACHS Health Country Kids program including Better Health initiatives. The next steps will include forming a WACHS working group and meeting with CAHS stakeholders.

In the meantime, there are standardised protocols within the WACHS Health Country Kids program for assessment of growth for children aged 0 to 5 years with key checks by Community Health Nurses (CHNs) through the Universal Child Health Schedule and as part of the School Entry Health Assessment (SEHA). Child Health Nurses routinely monitor weight and body mass

index (BMI) data and record it in the WACHS Community Health Information System as part of the child's clinical record. This is accessible throughout WACHS by any authorised clinician involved in the child's care. If concerns about weight are identified during a universal or targeted assessment, CHNs firstly work with parents and carers to promote and strengthen healthy lifestyle habits for all family members. Where additional support or resources are required, the CHN may refer to specialist services or programs.

Progress for the 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.

A functional brief that outlines the service parameters and key operational and functional requirements to inform the design and redevelopment of the Broome HDU, has been completed by WACHS. A funding proposal has been submitted for Government consideration for the redevelopment of the HDU, and timeframes will be confirmed upon funding approval. Detailed design planning will continue in early 2023. This work includes the establishment of key project stakeholders to inform the design planning process for the HDU and will ensure that it supports safe, high quality and culturally appropriate HDU level care for the Pilbara and Kimberley communities in line with the recommendations relating to the death of Mr Russell Brockliss.

On the understanding that work continues to secure funding for redevelopment works, and local patient safety risks are being monitored and addressed by WACHS, CRC members agreed to close this recommendation.

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 has advised that the Best Practice Multi-Disciplinary Team (MDT) Terms of Reference will ensure consistency in decision making and alignment with best practice for high risk patients. An essential component of this is to ensure the right information and people are present so treatment decisions are informed by available evidence and expertise. The best practice terms of reference include several requirements to streamline processes, set expectations and guide conduct of MDT meetings. To assist in the efficient implementation of standardised MDT TOR for high risk patients, SMHS is progressing ICT supported functions aligned with the Nest Practice MDT TOR for high risk patients.

The Head and Neck Cancer MDT has implemented the new TOR and technology. Head and Neck MDT outcomes are recorded in real time and distributed to meeting attendees immediately following the meeting. They are then uploaded to BossNet for immediate review by other teams. Outcome recommendations are discussed with patients immediately after the meeting, and they are provided with contact details of the cancer nurse coordinator giving them a direct link to a person within the hospital system and thereby facilitating ‘safety netting’. A letter to the patient’s general practitioner (GP) is auto generated and sent on the same day to streamline communication of the care plan.

A staff survey recently conducted to capture current status of MDT meetings at FSH, staff opinions on meeting effectiveness and opportunities for improvement found the large majority of respondents felt that meetings were effective and diagnostic results were reviewed, that treatment and management plans were decided as a group and that they had processes for sharing of information.

In addition to the recommendations, the coroner made suggestions that were considered by CRC. Regarding 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 Fiona Stanley Fremantle Hospital Group (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 both recommendations have been considered actioned and completed.

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 ALOs in the ED.

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

WACHS has advised that the Short Stay Beds which are co-located within the High Dependency Unit adjacent to the ED have now been operationalised, and admission to these beds directly from the ed is now considered business as usual.

The Kalgoorlie Health Campus had recently been successful in appointing an ALO to the ED; however, the employee has regretfully resigned, and the position is currently being advertised. The Goldfields has recently commenced trialling an ALO on-call service for the region. WACHS will evaluate the utilisation and value of this service in six months. More generally, WACHS continues to focus on implementing the WACHS Cultural Governance Framework. WACHS continues efforts to expand and support its Aboriginal workforce and increase access to face-to-face locally developed cultural awareness training for all employees.

On the understanding that the short stay unit is now operationalised, and continued efforts are being made to improve access to an ALO, CRC members agreed that both recommendations have been considered actioned and completed.

WILLIAMS

Jordan James Williams died, aged 20 years, 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.

CRC members agreed that the risks associated with suboptimal fencing and observation in mental health units warranted further exploration across the health system. Advice was sought from Health Service Providers (HSPs) about the systems and procedures that were in place to ensure mental health units are audited and inspected on a regular basis in order to address any risks associated with physical security in the unit, as well as the level of observation provided to mental health patients whilst occupying outdoor areas.

Each HSP has provided advice about systems and procedures in place to ensure risks associated with physical security are identified and addressed. In addition to inspections carried out by the Chief Psychiatrist as per *The Chief Psychiatrist's Standards for Authorisation of Hospitals under the Mental Health Act 2014 (MHA)*, strategies across the system included:

- Shift change environmental safety checks and regular environmental safety audits or workplace inspections to identify any risks to patient and staff safety
- Regular planned preventative maintenance and inspections, in addition to systems/processes supporting reactive maintenance
- Clear roles and responsibilities for staff in the identification, escalation and remediation of risks, as well as staff familiarity with emergency procedures and duress systems
- Involvement of committee and executive leadership
- Policies and procedure documentation which establish standards and expectations
- IT systems to support the management of maintenance issues and incidents
- Levels of observation for patients that are determined by individual patient risk assessment and balanced with therapeutic needs.

Regarding the coroner's recommendations, WACHS has advised that a tender has been awarded and remediation works to raise the height of boundary fencing are scheduled to be completed by April 2023. No response has been received from the Office of Rail Safety nor ARC Infrastructure following WACHS' formal correspondence advocating for the upgrade to fencing to restrict access to railway tracks.

Recommendation 2 has been deemed completed and, on the understanding that progress is dependent on securing funding, recommendation 3 has been closed. Further enquiries will be made with relevant stakeholders and progress of the first recommendation 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 reviewed these findings and made enquiries with the relevant stakeholders.

The SMHS has advised that the FSH Discharge from the Emergency Department Guideline has been reviewed by the ED Head of Department with draft amendments that address both recommendations. Once endorsed, the guideline will provide greater clarity and more detailed instructions in relation to symptoms to be monitored after a patient's discharge back to a residential care facility and the expected responses to a change in condition; and, will advise ED clinicians to make discharge decisions with caution adopting a lower threshold for admission for vulnerable patient groups such as those who are non-verbal and for whom no definitive diagnosis has been determined following initial assessment and examination.

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

YEEDA

Seth YEEDA died, aged 19 years, at West Kimberley Regional Prison as a result of rheumatic heart disease, which he had developed as a child. When he turned 18, a referral was made from the Aboriginal Medical Service to WA Cardiology, who provided visiting cardiology services for adults in the Kimberley on behalf of WACHS. He was unable to attend cardiology appointments made for him as he was in prison in Albany. Mr Yeeda was transferred to the West Kimberley Regional Prison in early December 2017. Unfortunately, the two referrals made by the PMO in December 2017 and January 2018 did not result in a cardiology review for reasons relating to a change in contracted cardiology service provider. After playing basketball in the prison grounds, he collapsed suddenly. Resuscitation attempts were not successful.

One of the three recommendations was directed to the Department of Justice and WA Country Health Service to work together to facilitate the provision of information regarding external referrals and appointments, addressing any issues of confidentiality.

The CRC has reviewed these findings and members recognised that oversight of how contractual stipulations were executed was critical, as well as ensuring a shared understanding between parties of the expectations for clinical governance.

Regarding the recommendation made by the coroner, further enquiries were made with the relevant stakeholders.

WACHS has advised that discussions have occurred between WACHS and Department of Justice officers, and local solutions have been identified within the Specialist Services and Waitlist Coordination teams. The WACHS Outpatient Reform Program (ORP) is continuing to progress work to bring WACHS regions into scope with the Central Referral Service (CRS), as the first phase to the implementation of Smart Referrals WA.

With an expected implementation date of 2024, Smart Referrals WA will be an integrated end-to-end digital solution that supports the delivery of efficient and transparent public outpatient referrals via a web portal accessible to all referral agencies, both internal and external to WA Health. This will include Department of Justice medical officers.

Historically, this service has been available for all Perth metropolitan Health Service Providers. WACHS is working with the CRS to draw regional public specialist services with the same benefits. Public services in the South West region went live on 6 December 2022 and work is on track for the Kimberley region to be the next region, aiming for March 2023. This service will notify referrers – such as a Department of Justice medical officer – that a referral has been received and accepted.

Regional ORP communications continues at a State and WACHS level. Engagement and communications with medical referrers continue to be facilitated by a regional ORP Project Officer.

On the understanding that Smart Referrals WA has a planned implementation date of 2024, the CRC members agreed to close this recommendation.

TRAN

Quoc Xuan TRAN died, aged 36 years, on or about 10 April 2019 by immersion (drowning) in the waters near Heirisson Island, East Perth. He was subject to a Community Treatment Order (CTO) under the *MHA* at the time for treatment of his schizoaffective disorder. Mr Tran presented to Royal Perth Hospital on 8 April 2019 seeking assistance with accommodation. He was seen by a Homeless Health Care Team (HHCT) worker who provided information about emergency accommodation options. Two days later, his body was located floating in the Swan River by a member of public. Clothing and personal effects belonging to him were found 400 metres away on Heirisson Island. Police concluded there was no evidence of suspicious activity.

The coroner recommended that the health service lobby the Mental Health Commission (MHC) to use its best endeavours to ensure that the planned Secure Extended Care Units (SECU) and the Community Care Units (CCU) are operational as soon as practicable.

The CRC has reviewed these findings and discussion included advice from EMHS that the CCU had opened and that at the time of the meeting, a SECU was in the process of opening. Members recognised that the issues arising in this case were also evident in other HSPs and agreed that advice about mental health service planning would be sought. Enquiries were made with the relevant stakeholders.

Given the need and benefit that further development of transitional housing services throughout WA to support consumer recovery, EMHS has written to the MHC, whilst also acknowledging that since this death has occurred the MHC has invested in the development of the transitional care unit Bidi Wungen Kaat Centre. Additionally, EMHS has worked cooperatively with the Graylands Reconfiguration and Forensic Taskforce (GRAFT) to establish the need for SECU beds across the EMHS catchment and the suitable size and locations for the establishment of these units.

NMHS has acknowledged that the Cabinet-appointed GRAFT has presented the Government of WA with a clear picture of what is needed to rebalance the public mental health system through to 2031/32, which includes the establishment of SECUs and CCUs throughout the state of WA. NMHS notes that these services are an important component of an integrated pathway of care for mental health consumers, to support them in successfully transitioning to community living. However, they are not an appropriate option for people requiring accommodation due to homelessness, and additional investment in a range of services is required to ensure people experiencing homelessness can access emergency and long-term accommodation.

SMHS' Mental Health Strategy Roadmap (2019) includes, as one of eight core components, the establishment and expansion of "Accommodation based services for rehabilitation, recovery and support". SMHS' goal is to establish these types of services to meet population demand, and with a focus on functional gains and transition towards greater independence. A key strategy for this is identifying and actioning opportunities to increase capacity in existing accommodation-based services, which includes CCUs. Of note is that the first CCU in WA was established in SMHS in November 2022. This service is run by Richmond Wellbeing with SMHS funding to provide the clinical component of the CCU. SMHS is participating in the MHC's development of the SECU model through representation on the GRAFT and through the Mental Health Leads Sub-Committee which is kept informed of progress.

SMHS continues to advocate with the MHC for models of care and co-commissioning partnerships with the WA Primary Health Alliance (WAPHA) and the National Disability Insurance Scheme (NDIS) for the expansion of accommodation-based services with a recovery focus for adults with severe and persistent mental health issues and complex needs.

There is no plan to establish SECUs or CCUs within CAHS as these types of facilities are not relevant to children under 18 years of age.

The '*WACHS Strategy, Planning and Service Development Policy*' and the '*WACHS Clinical Service Planning Policy*' outline the approach to ensure alignment of all planning and service delivery activities with WACHS' strategic documents, WA Health and broader government priorities, as well as WACHS clinical models and frameworks. The policies outline processes and governance mechanisms for escalation of requests for facility funding and planning to government and community partners where indicated, including lobbying for the establishment of services such as SECUs and CCUs. WACHS acknowledges that community-based residential and psychosocial support services, along with accommodation in general, have been identified as deficits in rural and remote communities across WA, though the specific options suggested, such as SECU and CCU services, will not be the only solutions for all communities and populations across WA.

On the understanding that the CLU intends to correspond with the MHC on behalf of the health system, CRC members agreed that a further update will be sought for this recommendation for the August 2023 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 July 2022 to 31 December 2022, the CRC considered the following new coronial inquests where no health-related recommendations were made: Livesey and Wynne. Further information is also provided for the following ongoing coronial inquests where no health-related recommendations were made: Baby H.

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 regarding 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 state-wide 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 five 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 supporting the identification of child abuse, including when injury is identified in non-ambulant children in community health services, was considered in recommendation four. Recommendation five 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 February 2023 Biannual Report.

The Perth Children’s Hospital (PCH) Child Protection Unit (CPU) has revised the Paediatric Injury Proforma (the Proforma), incorporating feedback from users and ensuring harm is comprehensively captured. The CPU will validate the use and efficacy of the updated Proforma, via a research project over the next twelve months, with ethics approval having been sought and granted. This will support and formalise current knowledge that the injury proforma is a highly specific screening tool at identifying injury concerns.

While there is overall consistency in the use of the Proforma state-wide, implementation of a single standardised Proforma across all hospitals is contingent on implementation of a Mandatory Policy (see below). It is anticipated that the ‘validated’ Proforma will be launched and disseminated in early 2024 (in line with the Mandatory Policy release).

Safety Net Meetings are ongoing across HSPs, with membership reflecting the diverse governance structure and resourcing at each individual hospital. The composition of the teams may include a Paediatric Consultant/Registrar and Paediatric/Emergency Department socials workers. Some hospitals also include a local child health nurse.

The CPU and the SPOCC will support the standardisation of Safety Net Meetings via the development of a procedure incorporating minimum requirements. Again, standardised implementation is contingent on a Mandatory Policy.

Development of education tools will support standardisation, with content to include: the importance of the injury proforma, injury identification in infants/young children, red flags suggestive for child abuse, the purpose of Safety Net meetings, and who to contact with concerns. Development of education tools can be completed after the approved final version of the validated Proforma and Mandatory Policy.

The Department of Health (Strategy, Policy and Planning) has begun the process of establishing a Child Safeguarding Program Team to lead and drive a system level coordinated response to child safeguarding issues and initiatives within the WA health system. This work is in its early stages, with a program plan expected in early 2023.

In the first quarter of 2023, CAHS will engage the Department's Child Safeguarding Program Team regarding development and sponsorship of a Mandatory Policy for the use of the standardised Paediatric Injury Proforma and Safety Net meeting procedure, to drive consistency in implementation. This work will run parallel to the validation period of the Proforma, so that at the end of the research project, the Mandatory Policy will be ready for release (along with the Proforma and Safety Net Procedure) in early 2024.

Work to identify processes, policies and tools to support identification of child abuse, including when injury is identified in non-ambulant children in the community health setting, is ongoing as part of business as usual functions. The SPOCC unit, in consultation with CPU, have reviewed and updated the CAHS Child Safety and Protection Policy and drafted the Mandatory Reporting of Child Sexual Abuse Procedure. Access to child safeguarding policies, links and education resources has been made more readily available with a link on the homepage of the CAHS HealthPoint/intranet.

CAHS is in the process of developing a 'Child Safeguarding Capability Framework' (Framework) which will outline four levels of capability for CAHS staff across the organisation to safeguard children and enable informed responses to child protection concerns. Once completed CAHS will make this available to WACHS and other HSPs for their adaptation/use.

Work to develop and promote education regarding injuries to non-ambulant children is ongoing as part of business as usual functions. Education materials produced by CAHS CPU and SPOCC specific to injuries in non-ambulant children were distributed and promoted to CAHS and WACHS Community Health staff in May 2022.

SPOCC and CPU will continue to produce education material to address Child Safeguarding in health contexts. The material will address issues relevant to National Child Safe Organisations, including injuries/bruising to non-ambulant children. When the Capability Framework is adopted within CAHS, it is intended that education requirements will be uploaded into the Learning Management System, which will provide data on completion and compliance rates.

The implementation of the recommendations from the SPOCC review will continue to be progressed and monitored by CAHS. No further updates will be provided in this report.

LIVESEY

Carole Livesey was last seen alive on 3 October 2017 after leaving the grounds of Rockingham General Hospital where she had been an involuntary patient under the *MHA*. Her admission was in relation to a diagnosis of anorexia nervosa and depression, with a recent suicide attempt. She was seen briefly at a nearby op shop, cold and in wet clothes, however she left before police attended. There have been no confirmed sightings since.

CRC members discussed the model of care for eating disorder services, with the Mental Health Commission funding a non-admitted multidisciplinary state-wide Eating Disorder Specialist Service (WAEDSS) with three Health Service Provider hubs within SMHS, NMHS and EMHS. At the time of the meeting, the expectation was that the SMHS service would be operational in 2022-23

Members agreed to seek advice from NMHS and EMHS, in addition to SMHS, about how their respective eating disorder hubs are working with their model of care so that a broader system update could be included in this report.

SMHS

The SMHS Eating Disorder Specialist Service (EDDS) will be a multidisciplinary service for consumers aged 16 years and over, providing step-down care from acute inpatient treatment, step-up care from community-based services, and primary care. The service will operate under the governance of community mental health services at Fremantle Hospital, under a shared care model that sees patients retaining contact with their GP and existing community mental health treatment teams (if applicable). The service will accept referrals for patients residing in the SMHS catchment and SMHS WACHS-link catchments (Great Southern, South West, Goldfields and Southern Wheatbelt).

In line with best practice, this service will be based in the community and away from acute hospital sites. The SMHS service hub will be based at Cockburn Integrated Health Hub with additional clinics in Mandurah based at the Peel Health Hub. These locations were chosen due to access, co-location with other services, and nearby food outlets including community cafes and supermarkets. The Cockburn accommodation allows for consulting rooms, group therapy rooms, meal preparation and dining. Major service components include triage and assessment, specialist multidisciplinary outpatient clinics (individualised treatment and group therapy) and a day program. There will be a phased approach to implementation of the service.

The purpose of the SMHS EDDS is to support care across the continuum of care for consumers with eating disorders. These non-admitted community outpatient services will have strong links to existing inpatient services (general medical and mental health) and community mental health services to ensure comprehensive integrated care. This will be based on clear referral pathways and robust, regular communication. The service model will build strong links and closely engage with primary care and community support services to ensure smooth transition of care and early access to treatment.

NMHS

Planning for the community-based eating disorder service elements within the Mental Health Commission’s Model of Service is well underway in NMHS.

An interim intensive outpatient program is currently operating in existing accommodation until purpose-fitted accommodation is ready to be occupied. Key medical and senior allied health positions in the specialist multidisciplinary team have been recruited. However, the available space is restricted, which is limits service provision to a small number of clients with complex presentations and needs. An adjunct dietetic service, to augment existing community-based treatment for eating disorders, is also being scoped for feasibility, with the intent to operate from the current location if possible. This NMHS intensive outpatient program will transition into the broader suite of Eating Disorder services that have been commissioned.

The NMHS EDSS elements include triage and assessment, an intensive day program, intensive clinical monitoring, specialist multidisciplinary outpatient program, and care navigation/transition coordination. These services will provide eating disorder treatment within a continuum of care framework in line with the National Eating Disorders Collaboration (NEDC) treatment framework “*Eating Disorders, the Way Forward. An Australian National Framework*”. The NMHS EDSS flexible day program will provide a step-up in treatment intensity for people with eating disorders who have not been able to make progress in existing community treatment settings, or step-down from hospital treatment in the transition back to outpatient treatment. Intensive clinical monitoring will also provide post-discharge support for consumers who do not attend the day program or are waitlisted for treatment.

NMHS EDSS will also support people with co-occurring mental health disorders and other complexities, which have the potential to negatively impact their eating disorder, through the Specialist Multidisciplinary Outpatient Clinic.

Models of care for the different service elements have been scoped, with initial drafts being evaluated at stakeholder workshops for further iteration and approval. Once the models of care are endorsed, positions will be established and aligned to the staffing profiles of these, and further recruitment will then be undertaken.

Suitable accommodation has been secured from which eating disorder services will operate. Lease terms have been finalised and a project manager is being appointed to manage the tender for fit out and works to be undertaken. Services will come online following fit out completion, which is expected to occur after 1 July 2023.

NMHS models of care are founded on a systemic framework that considers, and attempts to manage, the recognised difficulties in transitioning between services for our clients – and builds mechanisms for connection between services.

NMHS eating disorder specialist services will be aligned and integrated through three clear mechanisms:

- First a state-wide governance group has been established to align and connect all HSPs throughout the project development and rollout phase. Underlying this is a strong intent from the specialist eating disorder services themselves to collaborate and share information to ensure consistency.
- Second, the WA Eating Disorder Outreach and Consultation Service (WAEDOCS) provides state-wide consultation liaison, mentoring and support to clinicians managing clients with eating disorders in a range of settings including primary, secondary and tertiary care, to ensure access to optimal best-practice care. WAEDOCS provides evidence-based guidelines, training and resources and integrates clinicians across different services through facilitation and expert advice in case conferences. As the area-based specialist eating disorder services become operational, WAEDOCS also ensure collaboration and consistency in service delivery throughout the system.

  All specialist eating disorder services will be reviewed and evaluated using patient-related experience and outcome measures to improve consistency and provide best-practice care.
- Third, a Care Navigator (formerly referred to as transition coordinator) function will link NMHS EDSS services, and other HSPs to ensure supportive client transitions between services are maintained. The care navigator will ensure comprehensive handover and preparation between services for clients entering NMHS EDSS services and stepping back to primary care settings. Care navigation will be a function within all HSPs, to provide equitable state-wide access to treatment.

  The transition from child and adolescent health services to specialist adult eating disorder services, and the transition from regional services to metropolitan treatment are recognised as particularly significant and challenging. The care navigator will be crucial in linking clients between services with adequate preparation for these transitions. Cultural and developmental needs will be supported through these processes.

While in the planning phase for implementing the full model of service, NMHS EDSS staff are also currently providing information sessions to services such as community mental health teams, child and adolescent health services and acute medical units in tertiary hospitals.

EMHS

The inclusion of a third dedicated service in EMHS will enable a true area-based integrated specialist service in the EMHS corridor. Phased commencement of EMHS EDDS is planned from early 2023, subject to securing suitably qualified workforce and accommodation. The EMHS EDDS service model has been finalised and is directly aligned to the WAEDDS model of service. The purpose of the EMHS EDDS is to provide a continuum of care, including step-down care from acute inpatient treatment as well as step-up care from community-based services.

Across EMHS, Royal Perth Bentley Group, Armadale Health Service and St John of God Midland Public Hospital all currently deliver specialist care for inpatients with eating disorders through a coordinated multidisciplinary approach. This ensures a coordinated and timely treatment plan for all inpatients with eating disorders.

EMHS EDDS will provide an integrated pathway between acute inpatient services and post-acute care in the community. The service will have a strong interface with acute inpatient services to ensure an appropriate level of ongoing intervention and support outside of hospital is provided to EMHS inpatients with eating disorders.

WAEDOCS will continue to deliver support for system-wide expansion of eating disorder services including workforce training and development to build capacity and capability across the system. EMHS EDDS plans to work closely with both WAEDOCS and other HSPs to strengthen this interface and address the current service gaps for individuals with eating disorders within the public health system.

WYNNE

Cherdeena Shaye Wynne died, aged 26 years. She was being treated by paramedics when she suddenly ran from the ambulance. When police returned to remove her from the road, she was placed into prone restraint and handcuffed. Shortly afterwards she became unresponsive. Cardiopulmonary resuscitation was commenced with return of circulation; however, she never regained consciousness and was subsequently palliated at RPH.

Coronial Review Committee members discussed issues around the understanding of the *MHA* and Forms, communication breakdown between police and the hospital around the Forms, the downgrading of supervision from 1:1 care by a nurse, and the continued use of prone restraint. Members agreed to seek assurance from HSPs that policies relating to changes in patient supervision are clear in that nurses should not be decreasing the level of observation without discussion and authorisation from a medical practitioner. Information was also sought on ongoing training and upskilling of clinicians regarding the *MHA* Forms. Noting that HSPs had provided recent reassurance about seclusion and restraint policies, members agreed to seek assurance from Joondalup Health Campus and St John of God Midland Public Hospital.

EMHS sites are guided by the site’s Specialling and Supportive Observations policies which provide direction relating to the decision-making process regarding specialling management and supportive observations. Policy documentation outlines the roles of the multidisciplinary team, including nursing staff in relation to review and ability to implement a higher level of observation based on a change in clinical condition; provides clear direction on the requirement to decrease or lower a category of observation and the requirement to collaborate with the treating team, with the decision required to be documented in the consumer’s health care record by the treating medical officer; and, provides direction for general health areas and ED for the requirement to consult with mental health staff and specialty teams prior to the removal of the

special. This incorporates intentional rounding and environmental checks and escalation processes.

SMHS policies provide clear guidance on nursing responsibilities related to changing patients' observations. SMHS (site-level) policy documentation clearly outlines the requirement to consult a medical officer prior to lowering the level of observation, with decisions to be documented in the patient's medical record. Authority to discontinue specialling following patient reassessment lies with medical officers only. Policies allow for a nurse-led increase in the level of observation, with the medical team to be informed immediately.

Nursing responsibilities in relation to modifications of clinical observation of patients in a mental health context are clearly defined in policies and practices at NMHS Mental Health Services and the Women and Newborn Health Service, which include requirements that the psychiatrist, medical officer or registrar authorise any decrease in level of observation. Gaps have been identified for the Sir Charles Gairdner Osborne Park Health Care Group and Joondalup Health Campus, which will be appropriately addressed by NMHS.

Child and Adolescent Mental Health Service (CAMHS) policy requires that any changes to clinical observation level must be discussed with the psychiatrist or medical delegate and that any changes to clinical observation level must be documented in the progress notes.

Local WACHS policies address observation levels and the circumstances in which they can be modified by clinical staff. WACHS Mental Health is currently undertaking a quality improvement project with the aim of standardising the policy documentation suite for its mental health inpatient units. The WACHS 'Therapeutic Observations in Mental Health Units Policy' has been drafted and is in the final approvals process. This document clearly defines responsibilities for nursing and medical staff when modifying levels of patient observation. A decrease in the level of observation will only be permitted following consumer review by a medical officer.

Training for mental health staff across the health system includes eLearning packages provided by the Mental Health Commission, which are mandatory across most Health Service Providers (excluding some NMHS services). Additional training or educational sessions are offered to supplement staff awareness, and application of, the *MHA*.

EMHS has offered face-to-face sessions, including *MHA* question and answer sessions, as well as sessions about capacity and seclusion and restraint. EMHS sites complete regular reviews of all restraint and seclusion events with the staff involved. This review focuses on collaborative reduction and includes a review of the processes and forms completed.

All episodes of seclusion and restraint in the mental health unit at St John of God Midland Public Hospital (SJGMPH) are closely monitored and reported as per the requirements under the *MHA*. Quarterly reports are sent to the Office of the Chief Psychiatrist which includes the position and duration of restraint. Weekly restrictive practices reviews are held for all episodes of seclusion and restraint to monitor the adherence of the requirements under the *MHA* and ensure that the standard of care is in keeping the with Chief Psychiatrist's Standards for Clinical Care. Feedback is provided to relevant staff after the review, including what was done well, and what could be improved upon. Staff who work on the mental health wards attend Safety Intervention Training (Emergency and Advanced course), which includes training in restraint and seclusion.

SMHS supports clinicians engaging in upskilling sessions offered by the Office of the Chief Psychiatrist, in-house toolbox sessions led by senior clinicians and conducted onsite within mental health units, and face-to-face training is provided to registrars every six months at commencement of rotations. Some senior SMHS mental health staff are nominated as a resource to contact when clarity is required for *MHA* forms.

Ongoing training and upskilling of NMHS clinicians regarding the use of *MHA* forms varies across NMHS sites and services in aspects such as the format of training (eLearning, structured course, lectures etc.), whether the training is mandated or optional, and frequency of training. Requirements of this training are documented in relevant policy documents at Women and Newborn Health Service and Joondalup Health Campus. NMHS will ensure gaps identified by sites and services are appropriately addressed.

Seclusion and restraint policies used at Joondalup Health Campus adequately describe the safe application and risks associated with the use of prone restraint. All staff are trained in “PART”, which is offered as an initial three-day course. All mental health staff are then required to undertake a yearly refresher. Trainers work collaboratively with NMHS trainers to ensure consistency in technique and standards. Training focuses on how to avoid restraint as this is only used as a very last resort. Joondalup Health Campus patients who require restraint in prone position for three minutes and over, are then commenced immediately on physical observations and constantly monitored by SATS monitor.

Clinical staff across WACHS are encouraged to utilise local escalation pathways (including WACHS Mental Health Emergency Telehealth Services) or are advised to contact the Office of the Chief Psychiatrist’s Clinical Helpline when they have questions about the use of the *MHA*.

Authorised mental health practitioners across the health system comply with the Office of the Chief Psychiatrist’s requirements to support their roles and functions under the *MHA*, which includes regular clinical supervision, and discussion of key clinical issues which may include *MHA* processes and forms utilised. This training is regularly refreshed.

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